Changing Hospital Goals*

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The greatest need of hospitals today is the formulation of *new concepts for a changing world.* This can be achieved only through a new approach to planning. Formerly, we planned for *buildings;* now the challenge is to plan for *change.* Fantastic change in health care lies before us. The hospital must tool up to understand, anticipate, and adapt to change, and to give leadership in these changing times.

Later on, we must review together the nature of these impending changes in detail. The root causes of the changes are already with us: technological advances, increasing specialization, rising effectiveness of medical services, rising public expectations, soaring costs, and shifts in sources of financing. The key issue in the health field for the next twenty years—for which we must begin to plan now—is simply this: How to deliver high quality comprehensive medical care to people at the prices they can afford to pay.

It will take years to shape a workable solution. We can and must solve the problem of delivering effective, economical health care. If we do not, the hospital will lose its autonomy.

A new style of planning is required to meet this type of challenge. The key feature is a new way of looking at goals and at relationships between ends and means; a systematic and open approach to the interrelationships between goals of various elements of a system and the goals of the system itself, and to evaluation of progress in achieving these objectives.

I. Introduction

What are the goals of a hospital? Has anyone or any committee at your hospital ever tried to formulate a precise statement of the hospital's goals since the time that the hospital's charter was filed with the Courts? As a matter of fact, do you really know what the hospital's legal documents set forth as the purposes of your hospital? Do your hospital's goals or purposes relate in any way to the health problems of your community?

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In recent years, health planning agencies have been raising more and more questions about hospital goals. The modern style of problem solving advocated by planners—involving such techniques as systems analysis and cost effectiveness—is based on "arranging ends and means so that decision makers have clearer ideas of the choices open to them and better ways of measuring results against both expectations and objectives."[1] More open and deliberate attention to selection of the goals toward which action is directed is the essential first step in an effective planning process.

A few hospitals have undertaken a systematic effort to define their corporate goals. They found this task to be frustrating, difficult and time consuming. Those which have been successful have found that the result was well worth the bother; the pay-off is unbelievable. After goals are formulated precisely, many knotty problems—especially those involving medical staff relationships, capital investment and community service—can be seen in a new light that reveals acceptable solutions previously not seriously considered.

II. Current Hospitals Goals

Many hospitals believe that they have well defined goals, but analysis has indicated that these goals are hardly ever expressed in terms of community service. Few have expressed their goals in written form. One must learn about them by questioning key officials.

The most common response is optimum patient care or high *quality patient care*. Obviously, quality patient care is a necessary hospital goal, but is it a sufficient goal? No hospital should plan for second rate patient care or for high quality dog care. Of course, high quality patient care, but for which patients and what services? The necessary goal of high quality patient care is meaningless in terms of planning the future role of the hospital in relation to community requirements and resources. It contributes nothing, because it reduplicates a goal of every hospital. Furthermore, some hospitals—especially in urban centers—appear to be striving for best patient care by serving only the best patients. There is some evidence that a narrow focus on quality of service has interfered with hospitals' potential to improve the health of the people.

The fundamental mistake is to set goals in relation to patients, instead of people. Hospitals *serve* patients, but they should *plan* in relation to people, both sick and well. This has been well understood in statewide planning of beds for in-patient care for many years. We provide a ratio of one bed per in-patient served at any given time, but we plan a bed complement per 1,000 people, sick and well. Planning in relation to patients ducks the issue.

Some hospital officials tend to define their goals in terms of providing *safe and comfortable accommodations* and services. Their building programs are designed to overcome fire hazards, crowded conditions, outmoded facilities, leaky roofs, etc. Again, necessary but not sufficient! Every hospital should strive to provide safe and comfortable accommodations, but this limited goal by itself does not provide a basis for community support. Every other hospital is doing the same. None can do less. Again, the statement of goals ducks the issue.

When questioned about long-range goals, some hospital officials reply in terms of *effective utilization of facilities* and services. Who can argue against this goal? But, clearly, this is another necessary but insufficient goal. Presumably, the hospital exists to serve the community; the community does not exist to serve the hospital. To imply that the basic goal is to serve the facilities is to mix up means and ends. At best, it assumes that the existing facilities—the status quo—should be protected against the forces of change. At worst, this approach ducks all consideration of community health requirements altogether. A pathetic example of this kind of planning is found in the many ineffective steps taken by some hospitals recently to improve use of their obstetrical facilities. The fact is that investment in modernized facilities and addition of more obstetricians to the medical staff usually has very little influence on a declining birth rate. Planning primarily in terms of maximizing use of facilities involves the community in the kind of circular process that can only lead to fundamental restructuring of the system.

A fourth answer that is frequently provided with respect to the goals of an individual hospital is in terms of *meeting the needs of the medical staff*. Here, we are getting much closer to the mark, for the physicians are the key to community health service, the indispensable link between the hospital and the community. In a real sense, a hospital's community consists almost entirely of the people who look to that hospital's medical staff for health protection. Clearly, one of the goals of a hospital is to meet the needs of the medical staff.

But even this statement of hospital goals, although it points in the right direction, in itself represents an insufficient formulation of goals, for two reasons. First, in the absence of a community-oriented formulation of policy of the hospital with respect to future medical staff appointments, the future relationship of the hospital to the community is as vague as when the hospital is planning solely in relation to optimum patient care. Like other people, physicians retire, become incapacitated and die. A hospital which is planning only in relation to its existing medical staff is not engaging in long-range planning.

Some may wonder why the single element of a policy on medical staff appointments isn't obvious and self-evident: appointment of the best qualified physicians available. Unfortunately, the issue can't be resolved that simply. Even assuming that the task of ranking the quality of physicians can be carried out, the fact remains that every hospital can't limit itself to the best, if the needs of all people served by all physicians are to be met. All licensed physicians should have appointments at good hospitals, especially those physicians at the lower end of any scale of quality. Affiliation with a good hospital is the only effective protection the public has against incompetent physicians. Each hospital has a responsibility to face this issue in formulating its policy on medical staff appointments.[2]

There is a second reason why a hospital runs into difficulties by defining its goals solely in terms of meeting the needs of the medical staff. Since World War II, the number of medical staff appointments per physician in multi-hospital communities has been rising at a rapid rate. Today, most physicians have staff appointments at two or more hospitals. If hospitals plan in terms of the total needs of their medical staffs, the degree of duplication of facilities and services will greatly inflate capital and operating costs and will result in such low rates of utilization of facilities and services as to threaten quality standards.

In a situation in which the typical hospital finds that it represents less than a majority of the medical staff appointments of its own medical staff, it must develop a medical staff appointment policy that involves consideration of the other hospitals with which it shares its most important resource, its physicians.

Other goals are reported by hospital officials who have been questioned: fiscal solvency, institutional survival, prestige for those associated with the institution, improved education and research programs. As with the other examples given, detailed analysis indicates that these may be necessary or desirable but are insufficient goals for community service institutions.

The individual hospital has tended to view improved health of the people in the community as an inevitable consequence of fulfillment of other hospital goals rather than as a primary goal in itself. There is little evidence that pursuit of the specific goals mentioned above will automatically result in improved health for the people. Increasing evidence suggests not. As patient care has become better and better because of its increased specialization and mechanization, its component parts have also become more and more fragmented and, in effect, less and less accessible to the individual. The people in need of care have increasing difficulty finding their way to the right service at the right place at the right time. While patient care potential keeps improving, the gap between potential and result appears to be widening.

In most hospitals today, there is no knowledge of community-based health indices, no particular concern for how well the community is doing. No one is assigned responsibility for knowing: no one seems to care. From an analytic point of view, the hospital is the key to community health, but the hospital does not explicitly set its goals or programs accordingly—and therefore falls far short of its potential.

The current situation offers a striking analogy with the situation that existed 50 years ago with respect to quality of care. From an analytic point of view, 50 years ago the hospital as an institution was the key to the quality of care provided its patients. But the typical hospital did not accept this obvious fact and did not develop its programs accordingly. The individual physician was supposed to be responsible for quality, the institution wasn't supposed to have anything to do with it, except to serve the physician. This was fine, except that it didn't fit the emerging realities—for two reasons. For one thing, some physicians weren't as good as some others, and needed supervision and control. But more impor-

tant, the physician couldn't function effectively in an organizational vacuum. He needed the services of the hospital organized in a coordinated, quality-focussed manner. So about 50 years ago with physician leadership, mainly through the American College of Surgeons, each hospital was encouraged *as an institution* to face up systematically to its responsibility for quality. When hospitals began to assume systematic, explicit, corporate responsibility for quality, as a result of public support of the efforts of the American College of Surgeons, there was a major struggle in many hospitals. Many physicians didn't really understand or accept the whole concept. That struggle isn't over yet in all the hospitals in this country or among all the physicians. But today, it is generally accepted that the hospital as an institution, working through the medical staff—not as a collection of individual physicians, but as an organized entity of the hospital—is responsible for quality.

The same situation applies with respect to community health today as with quality 50 years ago. The hospital is obviously a major key to community health, even though it does not pursue this goal as such. The hospital should accept this goal and develop explicit programs in terms of making the most effective contribution to community health. Hospitals and their medical staffs should begin to set their goals and restructure their programs accordingly—before outside pressure becomes too great.

Here's the way the American Hospital Association put it in a recent policy statement:

"The hospital, with its medical staff, is now the major health resource in most communities. To meet the expanded responsibilities of this position, it is essential that it widen its concerns to include the totality of health services, and with others, to provide leadership in their attainment. The hospital should be prepared to assume a primary position in the implementation of community health plans. Each hospital, then, through its governing body, medical staff, and administrator, has a clear mandate continuously to examine its organization and facilities in the light of this central role in coordinating the principles of optimum health services."[3]

Any hospital which accepts the goal of optimum health services can expect to become a unit in a multi-hospital network that assumes responsibility for delivering a full range of coordinated health services to a defined population. The term "hospital care" will tend to disappear from the language as lacking in meaning. Health care services will be provided under the hospital's roof and elsewhere; all health care services will be related—in one way or another—to the hospital and its medical staff. The double standard with respect to quality of patient care in and out of the hospital, will begin to disappear. The hospital will be equally concerned with the quality of the care received by patients before entering the hospital, during their stay in the institution, and after leaving it. The hospital will be at least as concerned with distributive processes as with productive processes.

The hospital "room and board" services will be identified as the true ancillary services—ancillary to the diagnostic, treatment, and rehabilitative in-patient and out-patient services that will make up the basic services of the hospital.

The hospital will be concerned not only with getting the patients out of hospital beds, but with keeping them out. Relationships with health departments and with other health and welfare agencies will be much more intimate and time consuming. Many hospitals will assume landlord relationships with these other agencies.

In the coordinated network of facilities that will evolve, three distinct types of hospitals will emerge and establish identity (although there will be many healthy mongrel specimens):

(a) A large number of hospitals will be identified with a specific community, and will concentrate on distributive processes. These community hospitals will place major emphasis on prevention, early diagnosis and treatment, and on affiliation arrangements with other institutions for more complicated procedures and educational programs.

(b) A smaller number of larger regional hospitals will have more comprehensive service programs and a secondary affiliation with a medical school complex. These regional hospitals will provide service to

a group of nearby community hospitals with which they will maintain close working relationships.

(c) A still smaller number of hospitals will have primary medical school affiliations, a major commitment to education and research, and will provide the most complex services. These medical school hospitals will develop working relationships with the regional hospitals to assure optimal health services in their areas of influence. At the medical school hospitals, major emphasis will be on productive processes.

Some of these multiple hospital systems or complexes may evolve—through merger—under single management. In most cases, however, autonomy of the individual institution will be preserved. The system will function by a series of more or less formal affiliation agreements, involving joint medical staff appointments, cost sharing, joint trustee committees, etc.

Although the overall goals at all three levels will be identical—comprehensive health services—each will tend to place greater or lesser emphasis on productive and distributive processes. Each will be dependent on the others, however, and autonomy for each institution will necessitate invention of formal mechanisms for resolving constructive conflict among the different units.

III. Implications of New Hospital Goals for the Medical Staff

The emerging hospital goal of comprehensive health care for the people in the community will eventually affect almost every aspect of a hospital's medical staff, just as did the emergence of the goal of quality. Only the highlights can be suggested at this time. I will briefly touch on nine points. You will think of others.

1) Basis for Evaluation of Performance. One of the primary functions of a hospital medical staff is evaluation of the staff's performance. Traditionally, this has involved analysis of the records of the services provided in the hospital. What is the hospital's death rate? The hospital's infant mortality rate? The caesarian section rate? The infection rate? With the shift in goals to comprehensive health of people, evaluation will be based not only on *hospital* records, but also on *community* records. What is the community's death rate? Its infant mortality rate? What are the leading causes of death and disability and what effect is the hospital having on these rates? Isn't something wrong with the hospital's programs if the community's infant mortality rate is rising while the hospital's is falling? Does a rise in heart attacks only call for expanded coronary care units or does it also demand hospital-based programs to preserve and protect functioning coronary arteries in the community?

Can a hospital medical staff be satisfied only to foster tender loving care within the hospital? Shouldn't it also educate and motivate those who are potentially best qualified to provide this essential ingredient of good health: the consumers? Who could be more willing and able to provide tender and loving care than the individual himself?[4] As programs reach out beyond the hospital, so must techniques for evaluation of their success.

Community-based evaluation requires agreement on the community of responsibility. Today, the only practical approach is geographic. Delineation of a service area can be based on analysis of residence of patients and on location of offices of the attending staff. The hospital's defined community can be large or small in area and population. It can contain few or many other health institutions. But some community must be identified if a hospital's medical staff is to be in a position to evaluate the impact of its activities in the light of the goal of community health. This does not mean that a hospital medical staff would not serve patients from outside its community. Of course, it would serve anyone who seeks needed care that the hospital is in a position to provide. But it will direct its major energies to the problems of its own community and will measure its success in terms of the health indices of its own community.

In this context, other institutions serving the same community are collaborators rather than competitors. In general, it is preferable for a hospital to designate a service area with relatively few other institutions, since collaboration is time consuming

and assessment of a single institution's effectiveness is difficult in a multi-hospital community. Merger may be the only solution in the long run in some areas. But careful delineation of interlocking responsibilities of affiliated institutions may be a more practical immediate answer. In any event, few medical staffs will be able to evaluate their performance except in joint programs with other institutions.

Hospital medical staffs will of course continue to evaluate the specific activities of their members in the hospital. But the staff will also be concerned with assessment of activities outside of the hospital and with evaluation of interrelationships with agencies not directly under the control of the hospital.

2) Basis for Determining the Scope of the Hospital's Services. With a new goal of comprehensive health for the people in the hospital's defined community, every hospital will recognize that it cannot provide all services required by all of its patients and potential patients. To achieve its goal, each hospital medical staff will have to devote major energy to working out convenient and effective continuing affiliations and relationships with other institutions for those services which it does not provide itself. The key to all such inter-hospital arrangements will be the medical staff member with multiple staff appointments.

Patterns will emerge that will gradually identify formal classifications of general hospitals: medical school hospitals, regional hospitals and community hospitals. The Joint Commission on Accreditation of Hospitals will develop interrelated but separate standards for medical staff organization of each type of hospital.

3) Classification of Medical Staff Appointments. Current terminology of staff appointments—honorary, consulting, active and courtesy—does not have relevance to emerging hospital goals. They will change to reflect the growing interdependence among hospitals in meeting community health problems. Medical staff appointments will be worked out jointly among two or more institutions. The fundamental medical staff classification will be into two groupings: basic staff appointments and secondary staff appointments. Every individual physician will have one and only one primary appointment, which will be with that hospital to which he looks for identification with community health programs. In cooperation with the hospital, most physicians will also work out one or more secondary staff appointments at other hospitals. These may be *"overflow"* secondary appointments to meet situations when the basic hospital's facilities are overtaxed. Or they may be *"specialty"* secondary appointments to meet the physician's needs for specialty services not available in the basic hospital, such as delivery rooms, cobalt, teaching programs, etc. Or they may be *"consultant"* secondary appointments to provide specialized service or supervision in an affiliated hospital lacking certain skills in its basic staff.

Allocation of duties, privileges and time will be worked out by each physician in coordination with the hospitals granting basic and secondary appointments—in order to assure a smoothly functioning coordinated hospital system and an orderly professional career for the physicians involved.

Physicians with primary staff appointments will be subclassified into those who are geographically full-time and those with offices elsewhere in the community. Medical staff responsibilities will be restructured so that geographic full-time men will assume primary responsibility for control of quality and other production processes while the community-based physicians will assume greater responsibility for control of the distributive and delivery processes. A major challenge facing medical staffs is this restructuring to achieve appropriate channels for identifying, balancing, and resolving constructive conflicts among medical spokesmen for productive and distributive processes. In doing so, old-fashioned general practitioner-specialist and town-gown conflicts will be transformed into entirely different and more productive interchanges.

4) Criteria for Staff Appointment. New goals will result in new criteria for staff appointment. The search for the best men will be subordinated to the necessity to attract all the licensed practitioners who are providing a significant volume of service to the people in the hospital's service area. To achieve its goals, the hospital has special responsibility to bring in and influence physicians at the lower end of the quality scale. Anne Somers' recommendation that all

licensed physicians be legally required to have a staff appointment would be most helpful in this connection.[5]

As all licensed physicians join the medical staff, the public will have to be helped to understand that quality of care is dependent as much on the quality of medical staff organization as on the skills of the individual physician. But there is much evidence that the public may be ahead of hospital officials in recognizing that the era of the Great Man in medicine is ending.

At any rate, more attention will necessarily be given to delineation of privileges and to supervision, as less attention is given to quality as a criterion for staff appointment.

5) Criteria for Education Programs. In the past, justification to hospital trustees for expensive educational programs for interns and residents often was the "rub off" effect on the education and standards of the medical staff itself. Increasingly, with new goals, the hospital's educational program will focus more directly on the medical staff, with house staff, if any, participating actively in the hospital's continuing education program. More and more, house staff will be viewed as colleagues, as part of the geographically full-time staff, as integral members of the medical staff. Narrowing of income differentials between house staff and other medical staff will contribute to this trend.

House staff members will benefit from and approve of the shift in emphasis by full-time and volunteer service chiefs to concern for overall educational upgrading and organization of the medical service as a whole.

6) Criteria for Research Programs. Hospital-sponsored research will inevitably shift its emphasis to study of delivery patterns, patient care evaluation and results, as contrasted to non-community, non-patient-related laboratory and animal studies of problems only remotely related to the activities of the busy hospital. The idea that research—any research—enhances the quality of care and prestige of a hospital will die a slow death, but it will die. Research goals will be related to hospital goals. Hospitals will become major centers of research in community health and medical care.

7) Increased Medical Staff Concern for Non-Institutional Care. The broadened goal of comprehensive health for people will inevitably involve the hospital's medical staff much more deeply in systematic approaches to care of ambulatory patients and homebound patients.

There are almost limitless opportunities for the hospital's personnel and facilities to be as helpful to physicians in serving these patients as in serving in-patients. Conservation of physician time—his and the community's most precious health resource—will be the key to most effective community health programs.

Much of the activity of nurses in intensive care units, for example, requires more professional skill than does much of the activity of a physician seeing upper respiratory infection cases in his office. A great burden of unchallenging work can be lifted from physicians' shoulders if they insist on as much help from hospitals with their ambulatory and homebound patients as with their in-patients. This can be facilitated as physicians work more closely together in hospital-based office facilities. Pediatricians, psychiatrists and obstetricians are likely to lead the way in this development, but others will not be far behind.

8) Promotion of Free Choice of Private and Service Arrangements. In the past, hospitals offered two classes of care—private and clinic service—dependent in most hospitals on the ability of the patient to pay. But many affluent patients—like those attending the Mayo Clinic—preferred clinic service to selecting their own private physicians. And as most practitioners know, many poor people preferred private service to clinics, even if it meant large unpaid bills. With Medicare and Medicaid and other programs, the ability-to-pay distinction between clinic and private service seems to be obsolescent. But many hospitals may be expected to continue to offer both types of service—on a free choice basis—with many

physicians, as in the past, serving in both capacities. As many of the poor move from a clinic to a private physician relationship they could never before enjoy, many of the affluent will shift from a private to a clinic relationship that they could never before enjoy. Many new organizational patterns will emerge; much will depend on the ingenuity of medical staffs in adapting to new forces.

9) Administration of Fee-Splitting. Traditionally, one of the most important medical staff functions has been to stand in the way of fee-splitting, because of the threat to quality of care that this practice represented. With broadened goals, the medical staff will re-evaluate this situation and will itself jump into fee-splitting with both feet. In the new health care world, controlled fee-splitting is the only alternative to abandonment of fee-for-service payment altogether. Unsavory fee-splitting wil be controlled by medical staff involvement in administration of a variety of "ethical" fee-splitting arrangements rather than by outlawing the whole practice. Fee-splitting administration is already a major responsibility of many medical staffs in connection with Title XIX patients.

IV. Conclusion

A goal is the result or achievement toward which effort is directed. Our goals represent our view of the future toward which we are heading. In the past, a hospital has been judged by its great physicians, by its number of beds, teaching program, ancillary services, or massive buildings. When it comes to judging a hospital for massive community support from here on out, the key criteria will be its goals.

The hospital that is able to formulate sound community-oriented goals is in contact with the health care realities of today, is sensitive to changing forces and is probably effectively organized to help the community achieve better health. Such a hospital will attract far stronger community support than one which has not been able to achieve a consensus on realistic community health goals. The hospital which has not formulated written goals at all will be as backward as a hospital without a functioning medical records committee. Community-oriented goal formulation is extremely difficult and time consuming. The time to start on it is now.

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