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# The Physician, the Hospital and the Community

LAWRENCE HOBAN

American health services and practitioners have in recent years been put under the scientific microscope of public opinion and have undergone an exhaustive analysis by numerous committees, commissions and agencies, both of private groups and of the state and federal governments. Prompted by increasing public demand for better health care and public outrage at increasing costs, hundreds of reports have been made and unprecedented legislation has been enacted in efforts to improve and expand health services.

Perhaps the two most outstanding reports which will probably govern the future development of health services in this country are "Health is a Community Affair"<sup>1</sup> and "The Graduate Education of Physicians."<sup>2</sup> The theme of all these reports is that all health services and educational programs must undergo a "thorough-going organization" and that the relatively planless system which now exists must be changed. The reports call for "breadth, depth, and intensity of administration and organization to a degree heretofore unknown in the health field, at least in this country."<sup>3</sup> The objective is to weld together all segments of the health field, public and private; to provide comprehensive health care for the entire nation; and to establish standards for licensure for all health agencies and pro-

fessional personnel and for evaluation of quality of care at all levels.

Good health has now been declared a civil right, not a privilege. "The health of our people is, inescapably, the foundation for the fulfillment of all our aspirations," said President Lyndon B. Johnson in a 1965 special message to Congress, and the objective of government is "good health for every citizen to the limits of the country's capacity to provide it."<sup>4</sup> To achieve this, one of the Task Forces of the National Commission on Community Health Services stated that "all of the health professions, all of the health organizations, all of the medical specialties must merge their capacities to help achieve the goal of comprehensive personal health services for all Americans by 1975."<sup>5</sup> Comprehensive personal health care is defined as including health maintenance, prevention of disease where possible, diagnosis and treatment where disease exists, and rehabilitation at all stages of disease to prevent aftereffects. It is stated that such services to be comprehensive must be available to all people, in all walks and all areas, throughout life."

New patterns of administration and delivery of health care services are being developed and the entire thrust and organization of such patterns is predicated on the concept

that health is a community affair and that the consumer shall be the focus of all organization. In the last few years, under changes in State law and by evolvement of medical thought and community action, state hospital advisory boards, licensing councils, Blue Cross and Blue Shield boards, regional planning groups and community action forums have changed their composition to eliminate a dominance by hospital administrators and physicians and to reflect more the interests of the consumer of health services. Almost all federal health legislation in the last two years provides for a majority of consumer (community) representation on advisory boards and councils established. Separate systems which now exist for the indigent, for veterans, for psychiatric patients and for other groupings are to be integrated into community-wide programs with the hospital as the center for community health services and the regional medical center as the locus for the more sophisticated modules of care and for medical education and research. The general hospital will have to provide for acute, chronic and psychiatric care with emphasis on prevention, care and rehabilitation and with accessibility to all segments of the community, availability of professional talent and readiness to serve emergencies on a 24-hour, 7-day a week basis. Either in the hospital or affiliated with it will be extended care facilities, self-care units, rehabilitation units, home care programs, geriatric day centers, foster family programs and outpatient services. Associated with it

will be homemaker services, nutritional advice, meals on wheels and other out of hospital services.

#### THE CHANGING ROLE OF THE HOSPITAL

The impact of this "thoroughgoing organization" on the individual hospital will be, I believe, to change its role, at least in urban areas, in the following ways:

1. The hospital will no longer be an intra-mural service isolated from the full spectrum of environmental and personal health services. Total medical care will be provided on the hospital health campus, not in "an atmosphere of sporadic bursts of concentrated attention" but "as a continuing lifelong program of health maintenance."
2. The hospital will affiliate into the total community and regional health network. This will involve affiliation with regional health centers for the referral of patients for modules of care which it cannot itself provide and for medical education and research purposes. It will involve affiliation with Junior Colleges for paramedical education. It will involve affiliation with city, county and state public health departments and with voluntary associations for public health education purposes.
3. Community medical practice will be integrated with the

hospital and will be based in, on the site of, or immediately adjacent to the hospital where ambulatory care services such as multiphasic testing will be available as a resource for the physician.

4. The hospital may have to give up some elements to new non-profit service organizations, such as, purchasing, laundry, some business functions, dietary service, computer services and perhaps laboratories. Such services will be centralized and shared by all providers of health services in the community.
5. Patient information will be pooled from all sources—hospital, doctor's office, public health department—in a central depository of data which will be available to any element of the total health structure on a confidential inquiry basis, so that the patient, a mobile person who changes jobs  $5\frac{1}{2}$  times and his residence 9 times in his lifetime, can always have his medical history available to his physician.
6. Demands will be made for boards of directors of all hospitals to be reorganized to reflect consumer representation.
7. The hospital will lose some of its autonomy since the planning and utilization of

facilities on an overall community basis will require the subordination of individual institutional interests to community needs.

8. The crisis in hospital costs will precipitate a system of incentives and penalties or rigid rate setting, which will force hospitals into consolidations and mergers on the premise that better utilization and efficiency can be achieved in larger units.
9. Hospital associations will function in some respects as a board of directors for member hospitals in the negotiation of reimbursement formulae, data processing programming and legislative matters.

#### IMPACT ON PHYSICIANS

The efficient and effective functioning of the comprehensive health care delivery system will depend on its organization in relation to quality, quantity, cost, time and place. To maintain quality, there must be effective control to provide minimum standards for the qualifications and continuing education of the health care professionals and for the availability of the full spectrum of medical specialists. To achieve quantity and control cost, there must be effective utilization of manpower and facilities, of which there will be a continuing shortage—at least for the next two decades. To provide accessibility as to time and place, there has to be planning of

location and size of services and facilities, including doctors' offices.

All of these factors affect the physician who is the prime provider and key professional in any health care delivery system. The physician is the one who decides who enters the hospital, to which hospital the patient shall go,<sup>8</sup> at what time he shall enter, his length of stay, what diagnostic tests shall be done, the treatment and medications to be administered. The physician's decisions relate to every facet of the hospital's operation. Organization then will likely be felt by the physician in the following ways:

- a) He may have to function either as a primary personal physician who is the integrating and continuity factor in comprehensive care or as a specialist team member. In either event, his privileges at the hospital will be delineated more clearly than in the past and will be related directly to his formal residency training.
- b) He may have to change from a solo practitioner to a member of a team of medical and paramedical professionals. Only a team can bring to bear on any patient the full spectrum of resources available in the community.
- c) He may have to change from an individual in a private office

setting to a member of an organization in the institutional practice of medicine, whether this be in a hospital, a clinic or in group practice, and whether it be in a loose affiliation or in a tight-knit association. Group practice has received limited endorsement from the AMA and ACS and is encouraged by various consumer interests and by government. Financial encouragement for construction of group practice facilities is available under the Model Cities Act PL 89-754 and under Title XI of the National Housing Act. Institutionalized practice is necessary for the pooling of medical record information, for maximum utilization of facilities, for the better evaluation of patient care, and for continuing education. Particularly, it will be required in order to bring to bear on the patient the variety of skills and specialized knowledge of the medical and paramedical personnel and for the sharing of necessary expensive equipment that cannot be afforded by the solo practitioner.

- d) He may change from having several staff appointments to having active staff appointment at only one primary hospital, the center for comprehensive community health care in his community.

e) He may change from a private practitioner to a partner with government and from independence in practice to interdependence with his colleagues or total dependence on the hospital or clinic organization. Instead of determining his own fees, he may have to negotiate with fiscal intermediaries of government for flexible "reasonable rates" or for set fee schedules.

f) He may change from optionally providing for his own continuing education to being required, in order to maintain staff privileges, to attend formal programs which may be established under the Regional Medical Programs.

g) He may lose still more medical functions to new types of doctors' assistants and paramedical aides, and to nurses who are already performing many functions which five years ago were considered the exclusive province of the physician. At the same time he may have to take on new responsibilities to the community such as staffing ambulatory and emergency departments, directing home care programs and immunization programs in schools and health centers, and participating in paramedical education, both in the clinical aspects on the community health campus and as a faculty member of a Junior College. Public health education may also come under his direction with training in medical self-help, cardiac resuscitation, etc., being given to the entire

population on an organized basis through the school system and at the community health campus.

#### STATUS OF PHYSICIAN IN THE HEALTH ORGANIZATION

All of these changes—though they may bring advantages—will curtail the complete independence of the physician, and with the transition of the practice of medicine from the independent "corner store" private practice to the "super-market" institutional practice located in the hospital or group practice, the doctor must seek security in other forms. The author believes that the position of the doctor in the hospital and the organizational structure in which he practices should be re-examined and re-defined, for the following reasons:

1. The hospital medical staff is becoming increasingly the organizational center of the professional activities of the whole medical care system in the community.
2. Under several Court decisions in recent years, notably the *Darling* decision in Illinois,<sup>9</sup> the hospital is now responsible for the medical acts and judgments of the physician.
3. The physician is becoming increasingly involved in the organizational workings of the hospital.
4. Increasingly, the physician is affiliating with only one hospital and thereby becoming increasingly dependent upon a single hospital for privileges.



The existing parallel structures of administration and medical staff were not designed for such mutual-ity of interests and working relationships. The committee structure of the hospital medical staff is narrow in scope and is slow and unresponsive in the action-oriented dynamics of modern day-to-day health care administration. Recognizing this, the Joint Commission on Accreditation of Hospitals has relaxed its requirements for specific committees and has opened the way for innovation of structure provided that the functions related to the administration and review of patient care are retained.<sup>10</sup> Perhaps clinical departments should be placed under full time medical administrators and their scope of activities expanded to include some of the present committee functions and additional advisory functions to the hospital administration in respect to hospital policies, staffing and equipment. Apart from the coming need for continuous medical liaison with community agencies—public health departments, voluntary agencies, school programs, etc.—the multiplicity of medical administrative detail now required in relation to hospital utilization under the Medicare and Medicaid programs, infection control, planning of departmental and educational meetings, disaster preparedness, evaluation of care, etc. are such that it is impossible for a voluntary chief to perform the function satisfactorily in any hospital of 200-beds or over.

Another area needing review is in relation to a physician's privileges

and appointments. Privileges should be more clearly delineated and hospital appointments could be placed on a 2 or 3 year rather than a 1-year basis—especially for physicians who will affiliate primarily with one hospital—subject to proper safeguards for the procedural removal of a physician in the event of proven incompetency.

With the exception of the oral surgeon and dentist, whose roles in comprehensive health care should be undisputed, medical staff bylaws generally do not make any provision for inter-professional relationships or multi-disciplinary approach to patient care such as in multiple injury cases, maxillofacial trauma and burns management. Also, microbiologists, Ph.D's in bacteriology, chemistry, etc., clinical psychologists, physicists, biologists and others could function as consultants to physicians in direct patient care. And, ultimately, the place and role of others in comprehensive health care—optometrists, podiatrists and chiropractors—will have to be delineated.

Outside the staff structure and subject to the bylaws of the governing authority of the hospital, the physician should also be eligible to serve on the hospital board of directors, not as an elected staff member nor even as an appointed representative of the staff, but as a member of the community qualified to bring the expertise of his profession to bear on the decisions in the governing board process.

## IMPLICATIONS FOR CATHOLIC HOSPITALS

Congressional health legislation in the past three years, recent Court decisions that the non-profit hospital is "in substance and effect, public in character and scope,"<sup>11</sup> and the concept that health is a community affair have profound implications for all private hospitals. The physician could well speculate on the implications which may arise in the future from this and other Court decisions in relation to his personal status as a *private* physician dependent upon the services of a *public* institution. Might not the nature of his activities and functions be labelled as *public* at a later date and attendant controls follow?

For Catholic hospitals and for Catholic doctors there are some points of special significance in relation to comprehensive health care and community medicine. Last year the Maryland Court of Appeals declared that the "purposes and activities" of Church-related hospitals were "secular in nature"<sup>12</sup> and now insistent demands that hospital boards of directors reflect broad representation of the community could, without adequate safeguards, lead to a governing body which would not have the same convictions on ethical directives as a board composed of religious membership and thus lead ultimately to a dilution of Catholic principles governing the conduct of the hospital.

Problems will arise also in relation to the role of the Catholic hospital and the Catholic physician in participation in the full spectrum

of family planning, including the "technique" of sterilization which is included under the heading of comprehensive health care. Other areas of conflict may arise between the hospital's operation and the therapeutic abortion laws in states where they have been passed. Training in therapeutic abortion technique may be made mandatory in residency training programs in the future and the Catholic Obstetrician-Gynecologist may be unable to maintain, at the same time, his economic security and his conscience clear.

At the same time opportunities also present themselves. Catholic physicians, both in individual action and through their Guilds, could work in consort with the Catholic Hospital Association and State Conferences in fostering clergyman-physician relationships in the care of "the whole man," in sponsoring Medico-Legal-Moral Seminars, in giving leadership in community forums for the establishment of needed narcotic and alcoholic treatment centers, in developing position statements on medico-ethical aspects of patient care and in upholding the dignity of the human person in a health system which will have a dominant emphasis on the scientific qualities of good patient care.

Although Catholic sources have no monopoly on compassion, the Catholic hospital and the Catholic physician have an opportunity to inject a strong Christian influence into the secular governmental-sponsored health network now emerging.



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4. President Johnson's Health Message to Congress, March 1, 1966.
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