The changing role of the institution in health care

The 1970 Harvey Cushing oration

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The dramatic changes in institutional health care since Harvey Cushing's era are reviewed by the director of the American Hospital Association, and predictions made concerning the even greater changes in the years ahead. The author sees the hospital's role in health care as growing rather than diminishing and urges the medical profession to actively shape its future. He calls outmoded the concept of the hospital as a set of walls but believes its influence must spread into all segments of health care. Its role as the guarantor of the quality of care must likewise be spread, and he believes that the traditional fee-for-service solo practice will not be acceptable to the large purchasers of health care except in those instances where there is a close physical and organizational tie to the central institution, the hospital. He asks in view of the importance of the hospital, that those who work in it and for it should look to see if the traditional organizational pattern of our voluntary hospital can meet the demands to be placed upon it by such sophisticated purchasers as Blue Cross, insurance, and government. He foresees increasing adoption of the straight-line organization in the hospital rather than the orthodox triad of governing board, medical staff, and administration.

Key Words · Harvey Cushing · health care · hospitals · American Hospital Association

The invitation to give the Annual Cushing Oration especially delighted me because the man for whom this lectureship is named got his real beginnings at the institution I had the privilege of serving for many years, and where Earl Walker, president of the American Association of Neurological Surgeons, is now the distinguished head of neurosurgery. I am not able to add to the body of the Cushing memorabilia because, although I was active at The Johns Hopkins Hospital during the later years of Dr. Cushing's life, I never had the opportunity to meet him. I always regretted his decision, because of ill health, to decline the repeated invitations to grace the 50th anniversary ceremonies at the Hopkins in 1939. I was assistant director at the time and undoubtedly would have had an opportunity to meet one of the few surviving men of medicine who had made the beginnings of that institution such a glorious episode in the history of medicine.

One similarity, in addition to the M.D. degree, between Dr. Cushing and myself led me to decide the subject of my paper today. Dr. Cushing's professional life was bound up in institutional medicine. So was mine. In quite different fashions, of course. He was a practitioner, a teacher, and a researcher. I
am an administrator, and my career has been focused on the organization and delivery of health care services to large groups of people, rather than to the individual patient.

My use of the word "institution" rather than the more familiar "hospital" is no accident. Hospitals changed mightily during and after Dr. Cushing's life, but the word still connotes a building, a set of walls to house a lot of people who come to that building because they are sick, and a lot of other people and a lot of equipment to care for them. We must think of the hospital as an institution in the broader sense, a complex of inpatient services, outpatient services, a base for home health care services, a modern-day "family physician" to large segments of our population, as well as a place for teaching and research.

Dramatic as the changes were during Dr. Cushing's life, the changes in the role of the health care institution have been greater since his death. And it is my estimation that there will be even greater changes in the future, especially before the 1970's are concluded. It might be wise to provide a backdrop from the past for our discussions of likely changes in the future.

I am sure that you are as fed up as I with the oft-repeated description of the hospital of the past as "a dying place for the sick poor." But a century ago, and perhaps somewhat later, this was an unfortunate fact. The great hospitals were too often just that. In England, because the great institutions remained largely a place for the poor, a system of cottage hospitals was developed where the rich or the near rich could go when they needed care beyond the reach of a Harley Street consulting room.

To digress for a moment, a friend of mine sent me an amusing reference to this cottage hospital system from a lecture by D. S. Lees, a British economist. Mr. Lees is no friend of the National Health Service. He remarked that "forecasting population is among the simpler exercises of social prophecy. Yet the Registrar General has been constantly put out by the persistence of women in having babies in larger numbers than thought likely and, perhaps, even desirable. Despite all our technical progress, the method of making babies is still somewhat old fashioned—a cottage industry evidently subject to large and unpredictable changes in productive activity." Then, my friend noted, the comment could have been added: "It is not only a cottage industry but it employs a great deal of unskilled labor."

To return to a serious vein, we all know that in the pre-Semmelweis days, the large teaching hospitals often violated the Nightingale dictum that the first obligation of the hospital was to do no harm. Henry K. Beecher, then chief of the anesthesia service, Massachusetts General Hospital, once quoted John Bell, the great surgeon of the early 1800's, on his concern with hospital gangrene. Dr. Bell asked: "What then is a surgeon to do? Is he to try experiments with ointments and plasters while the men are dying around him? Is he to seek for washes and dressings to cure such a disease as this? . . . No! Let him bear in mind that this is a hospital disease, that without the circle of the infected walls the men are safe. Let him, therefore, hurry them out of this house of death. . . ."

Dr. Beecher also cited data published by Sir James Y. Simpson to show that post-amputation mortality varied directly with the size of the hospital:

"In hospitals with 600 to 301 beds, 4 in 100 die. In hospitals with 300 to 201 beds, 29 in 100 die. In hospitals with 200 to 101 beds, 23 in 100 die. In hospitals with 100 to 26 beds, 18 in 100 die. In hospitals with 25 beds or less, 14 in 100 die."

Now we know the reverse is generally true. Another traditional and passing function of the hospital was to protect the well on the outside from the contagiously, mentally, and dangerously ill on the inside. Those of us who have given our careers to the healing arts must shudder at the recollection that it was a hospital, the hospital of St. Mary of Bethlehem, that gave us our word "bedlam."

By the time Cushing came to Baltimore, a great change had taken place. The fact that the hospital was a proper place for the well-to-do as well as the only hope for the sick poor had been recognized. The Johns Hopkins Hospital was designed with this in mind. Two private pavilions were constructed and at the opening ceremonies the planner of the hospital had this to say:

"People are beginning to find out that when they are afflicted with certain forms of dis-

Edwin L. Crosby
Role of the institution in health care

ease or injury they can be better treated in a properly appointed hospital than they can be in their own homes, no matter how costly or luxurious these may be. In the hospital they can have not only all the comforts of home, but more; not only skilled medical attendants and skilled nursing, but the use of many appliances and arrangements specially devised for the comfort and welfare of the sick which can hardly be found in any private house, and also freedom from noise and many petty annoyances including in some cases too much sympathy and in others too little. This hospital, then, is to provide for the rich as well as for the poor and for those who can and ought to pay for the help given as well as for those who cannot."

I am sure that many critics of the modern hospital, would disagree with some of the remarks of Dr. John Shaw Billings, especially as they relate to the amenities. But the thrust of his remark was prophetic. I am sure he never dreamed that, in less than a century, our goal is to make the sick poor a thing of the past, in the sense of being able to pay for their care either directly or indirectly. But more later of this and the factors that brought it about.

Our greatest institutions, before and just after the turn of the century, saw teaching and learning as their most significant contributions. This is not to say, in any way, that the Oslers, the Halsteds, and the Cushingst to again concentrate on Baltimore—did not render magnificent care, within the bounds of knowledge at the time, nor were they insensitive to their professional obligation to the individual patient. But it was education and research that made institutions like The Johns Hopkins and Massachusetts General and the Peter Bent Brigham the places they were.

While I wouldn't presume to say that it was a typical episode, for it may have been an isolated incident, it was an apparent sub-ordination of patient care responsibilities that led Henry M. Hurd, the first director of The Johns Hopkins Hospital, to write a sharp note to Dr. Cushing. As recounted by Fulton, he wrote "to suggest that some more orderly and definite arrangement be made for the efficient administration of the surgical department. I have tried to see you this morning but have not succeeded in finding you. There seems to be present a lack of responsibility somewhere for the routine care of patients..." Dr. Hurd complained that a surgical patient needed attention at 3:00 p.m. and no surgeon could be found until 6:00 p.m. He commented that "it is hardly sufficient excuse for a resident officer to claim that he was engaged in a laboratory, and hence could not be found."

The advantages of the hospital for patient care were most evident at the beginning of this century in surgery. But even in those medical matters for which little but nursing could be done, the hospital was still the place of choice because it had become the training center for skilled nursing. Its efforts, and Florence Nightingale's, had established standards of nursing care that would have delighted her. As Brian Abel-Smith has noted: "The purpose of the hospital was now to cure the sick rather than to act as a store house for sick persons." And he further said: "In the process of cure, the doctor needed a skilled auxiliary who was constantly attending the patient and who would handle, supervise and treat each patient as he directed. The nurse also needed to be able to observe accurately the condition of the patient and report the relevant details to the doctor. For these tasks, the nurse required a suitable disposition, some medical knowledge, and much supervised practice."

Thus, while it took the advent of the chemotherapeutics in the '30's and '40's to bring about the amazing advances on the medical wards that anesthesia, asepsis, and the contributions of men like Cushing had brought much earlier to surgical care, the care of the medical patient was to a large degree directly related to the skill of the doctor-directed nurse. The hospital was the place that these skilled nurses could be found. So even before the chemotherapeutics, the hospital was as much the appropriate site of care for the medical patient as for the one with a ticket for the operating theater.

There can be no gainsaying the fact that the increasing centrality of the hospital aroused the opposition of many physicians, generally those in the fee-for-service, solo practice sector. I think the resistance was both misguided and as useless as King Canute trying to beat back the waves. Medical scientists were accomplishing wonders that needed the hospitals for their effective delivery to the patient, and there were social forces working toward the same result.
It wasn't medicine but money, or rather the lack of it, that first stimulated a true social consciousness about the necessity of the hospital. The Baylor school teachers who banded together at the beginning of the hard times in 1929, and the hospitals and community agencies that put together the prepayment movement in the decade between 1935 and 1945 were the pioneers of the movement that would prove to be of lasting significance to every segment of our health care system. The hospitals of this nation, and the organizations that represented them, saw the pooling of dollars as a method of solving the depression and post-depression plight of the nation's hospitals, large or small. Viewed from a less self-serving standpoint, this action dramatically lowered the financial barrier to institutional health care for millions of our people. The active development of the third party principle introduced the consumer as an active participant in health care delivery. Once this was done, the system would never be the same.

Before the advent of third party prepayment the consumer was a largely unheard, unsophisticated, or ignored voice. The providers of medical care thought they knew best, and in most cases they did. I think it most unfortunate that during the key decade, the 1930's, organized medicine turned aside the notion of prepayment. One may argue endlessly over whether or not Morris Fishbein ever described prepayment as a socialistic interloper between physician and patient, but such arguments are quite fruitless. What is not arguable is that organized medicine, namely the American Medical Association, did not support prepayment for physician services as vigorously as the organization of hospitals promoted prepayment for hospital services. If this had been done, I think a more harmonious development of a system of health care would have resulted and much bitterness would have been avoided. I think it was inevitable that the dominant role of the institution would grow, but I also think that, had medicine pushed for prepayment as hard as hospitals did, we might have avoided much of the criticism we have quite properly sustained for promoting unneeded hospitalization because of our pattern of insuring the horizontal rather than the vertical patient.

Two events of the 1940's should be mentioned in this review of the development of institutional care. The first was the fortuitous set of circumstances that permitted the inclusion of health care as an employment fringe benefit. Management, working under wartime cost-plus contracts and forbidden to raise wages generally, was often not averse to the inclusion of a health benefit in most labor management contracts. This put some powerful third parties, for example the automobile industry and the United Automobile Workers, squarely into the middle of medical care. Still the emphasis was on hospitals, whether on either side of the “Blues,” Blue Cross and Blue Shield. Still another factor of the 1940's was the Hill-Burton Act and the proliferation of hospitals throughout the nation made possible by a combination of federal grants and local monies. As the transformation of the hospital from a place for dying to a place for recovering was the major achievement of the Cushing era, the insertion of a third party, private and governmental, into the health care system was the most significant development of the 1935-45 decade. This involvement of the third party grew and grew until it reached a point where it has been estimated that the Great Society infused from 60 to 70 billion dollars into health care programs in this country. The introduction of the third party and of these vast sums of money accelerated the broadening of the institutional role.

Having heard over and over again that the hospital was the community health center, a group of distinguished hospital skeptics took a look at the validity of this statement. They agreed that “the hospital has established itself as the citadel of medical service in modern society.” But they insisted at the outset that:

“The changing needs of the public are demanding a changing hospital. . . . Although they were loosely linked by common purposes, by membership in hospital associations, and sometimes by overlapping medical staffs, most hospitals developed as autonomous units and carried out their missions in relatively isolated completeness. . . . The general hospital developed in a fashion separate from the health service provided outside its walls. Its attention has been directed primarily, and sometimes exclusively, inward.”

Then the group enunciated a doctrine that, although far from fulfilled and far from
Role of the institution in health care

universally accepted, sets forth, at least as far as I am concerned, what must be the role of the hospital in the 1970's:

"The concept of the hospital as a collection of the necessary facilities and personnel to provide medical care within its building or set of buildings is no longer viable in today's medical care system. The hospital now must be an organizational as much as a physical creature, an organized arrangement of all medical resources necessary to bring the individual, wherever located, into contact with the skills of his physician and other members of the health care team. It must serve as an arrangement by which our communities provide the organization, the people, the buildings, and the necessary materials and make available medical, nursing, and other professional care for the prevention, diagnosis, and treatment of disease and eventually for the rehabilitation of the sick and injured, when these resources are beyond the capabilities of the individual patient or physician. At the center of this circle of medical resources must be the general hospital."

A similar view has been expressed in somewhat different words but with essentially the same message at a later date. Mrs. Anne R. Somers, a noted observer of the health care scene contended that the hospital "which has already emerged as the principal workshop for most of the health professions and is becoming a de facto community health center should now be officially assigned the role of organizational catalyst, referral center, and professional monitor of the quality and quantity of care rendered not only on its own premises but throughout its community or service area."

There are those who dissent with this statement of the centrality of the hospital, considering that an admission to the general hospital is an admission of failure and that some other system, not based on the hospital, will emerge. I disagree. Whether the core be hospital or community health center, health care in the coming decades will be institutionally based. The home and private office as the primary sources are being phased out except as they bear a direct relationship to an institution, either through corporate links as between a group and a hospital, or with office practice on some logical basis in a building that is part of or adjacent to a hospital.

Let us admit that the organized consumer, of whom I spoke earlier, is demanding organizational improvements to increase accessibility of health care and to guarantee that it is of a high and single quality. I think it is quite significant that two regional hospital association meetings of this spring featured attacks on the fee-for-service solo practice system with pleas for a prepaid group practice method based on a hospital. To spurn these as the expected party line of the late Walter Reuther and his colleagues is to avoid the real world. They are sophisticated critics and to dismiss them as nonprofessionals will not work.

Consumer groups also want to know whether the product they are buying is produced as efficiently as possible but also they want to know about its quality. They know that historically the institution, the hospital, is the only organized guarantor of the quality of care. The medical schools, the various specialty boards, the professional colleges and societies are concerned with the education of the physician. The county medical society is concerned with the proper guild functions of the medical profession. Only one organizational unit concerns itself on a continuing basis with the quality of patient care. That entity is the organized medical staff of the hospital. This institutional influence must be expanded into all of the decentralized parts of the system, the health center, the home, the physician's office.

Some say that we don't have a system, that we have more of a nonsystem. I don't think this is true, but I would certainly admit that the system is a very loose confederation. I think there is going to be a tightening up in the very near future. There will be more mergers. There will be more systems and subsystems.

I wish I knew what the total system would look like, but one thing is certain, it is going to be different. If it is true, as I think it is, that the role of the institution will be changed but will grow in the years ahead, is it not time that we looked at the organization of the central institution, the hospital, to determine whether or not it is viable? Everyone agrees that the role of the institution must change, some saying that it must be greater, and some saying that it must be more diffuse. But no one gainsays the necessity for sound organizational structure. Tradition-
ally, the hospital has been distinguished by what a colleague calls "the hospital trinity," governing board, medical staff, and administration. He believes that this concept is an act of faith that is quite acceptable in theology but won't be up to the greater demands put on this institutional complex and by the penetrating analyses to which it will be subjected. We all know that in this trinity there have been, from time to time, the first among equals. Sometimes it was the governing board. Sometimes it was the medical staff. Most recently, it has been seen as a dichotomous relationship with governing board and administration linked and with the medical staff as a separate but equal arm. Only the management skills that have brought such success to our country in other enterprises will suffice now.

I insist that we in health care must copy, in our structure, this straightline organization. This is in no way meant to dilute the individual physician's authority over his individual patient. It is intended to bring some corporate order to the total institutional management. The concept of a board of trustees with a hired chief executive officer serving as its president is becoming an increasingly common pattern in this country. I don't think this is going to happen everywhere overnight, and I don't think it will happen without much resistance and, unfortunately, much resentment, especially among physicians. Nor do I think this need be so.

The real management decisions are not made at the board level. Mark Berke, in his inaugural address as president of the American Hospital Association, pointed out that the decisions that count are developed at a lower level. He wanted the doctor in the act. As he put it, a doctor or two on the board of trustees may be the name, but it isn't the game. He wanted, as I do, the doctor involved where the action is, at the medical department level where the operating philosophies and policies are developed, are debated, and are sent upstairs to the governing board, a board that ratifies or vetoes but rarely originates.

Another institutional change is in the offering, it seems to me. The proliferation of rigid licensures is hampering the effective delivery of health care. When you finished medical school and internship, you were a competent physician and you didn't need a license to tell you so. But as you wanted to do more, you went to your peers to prove your ability to do so, to prove that you had sufficient additional training and experience in your chosen specialty. And then when it came to actually doing it, you were subjected to the critical judgment of the organized medical staff of the institution in which you wanted to do it.

A story was told at a recent hospital meeting of an attempt in one state to pass a licensing law for inhalation therapists. The examination was written, of course, by the inhalation therapists and when it was analyzed, it turned out that only three or four of the inhalation therapists in the state could pass the examination if they were required to have a license. Hospitals and physicians objected but apparently to no avail. This state happens to be wildly enthusiastic about its university's football team and when it was discovered that this would disqualify the man who gives oxygen to winded football players, such a hue and cry went up that the licensing law was promptly dropped.

This matter is germane to my topic of the role of the institution because licensure of all allied health professions often leads to raising standards and increasing exclusivity. It creates fiefdoms within the institution. It produces a philosophy of credentialism that tends to hold the person in the slot for which he is licensed or accredited, not by the user of his services, but by a group with an understandable but vested interest. This rigidity is injurious to good management and it is offensive to those labor organizers who see these rigid rules as denying upward mobility to their union membership. And so we now hear increasing cries to have the institution, the hospital if you will, be the warrantor of all the personnel functioning within the organization.

As you can see, the institution has changed since the day of Dr. Cushing. I think it will change in nature and in influence in the future. These changes cannot help but affect the physician in his daily practice. I think that these changes will be better for all concerned, especially the public, if they are fashioned by those of us who are most intimately concerned on a day-to-day basis with them.
Role of the institution in health care

I've already said and repeated my conviction that health care in the 1970's will be increasingly oriented to the institution. This institution must be broadly defined, and must be a complex, or to use the popular word, a "system." It will be many things in many ways, some of them quite different. And this is as it should be. Alan Gregg once wrote that variety is not just the spice of life, it is essential to it. Neither you nor I want a monolithic system. But if we are to avoid that fate, we must demonstrate that we have the desire and the ability to deliver care efficiently and evenly and to demonstrate its high quality and the competence of those who make it work.

I don't say that the hospital as a hospital will be all things to all men, but I think it will be at the center of our health care, as physicians’ workshop, as the institutional base for visiting nurses services, for health care agencies, for health education programs, and sometimes as family physicians.

We have a lot at stake, you and I. It is idle to wish for the good old days. I don’t think they were all that good, and I know they’re not coming back. George Santayana noted in essence that he who ignores history must be prepared to repeat it. We can shape the changing role of the institution or it will be shaped for us.

I would like to close with a quotation of a dear and learned friend of mine, the late Dr. James Mackintosh of the London School of Tropical Hygiene and Public Health: “It is exciting to live in a revolution, it is tragic not to recognize it.”

References

7. Lees, D. S. Inaugural address, University College of Swansea, 1966, p. 11.
8. Mackintosh, J. M. Personal communication, 1941.

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