HEART OF THE MATTER

Who Should Run Our Hospitals?

Over the past century, the management of American hospitals has changed dramatically. These changes have occurred as a result of major shifts in the social and financial environment and have had a major effect on how medicine was practiced in the past and how it will be practiced in the future.

SIDNEY GOLDSTEIN, M.D.

The American hospital as we know it today was established in the late 19th and early 20th centuries largely by the Catholic, Protestant, and Jewish communities to provide care for the elderly and chronically ill patients who otherwise would not be cared for at home.

With the development of surgical techniques from tonsillectomies to cholecystectomies in the mid-20th century, they became the workshop of general surgeons, who largely controlled the hospitals. With the subsequent development of antibiotics and medical treatment for cardiovascular disease, the internal medicine specialties demanded a larger role in institutional management.

The increased complexity and expense of medical care led to concerns about how to provide a financial base for medical care and led to the establishment of private medical insurance programs, and ultimately, to Medicare and Medicaid. Hospitals were no longer concerned about being a health resource but suddenly became a profit center. Community hospitals expanded in order to meet the needs of new technologies with the support of grants and loans from the federal government.

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With this growth, the management of the hospital of the 20th century required the creation of a new breed of hospital staff: the hospital administrator. They were hired to manage the financial and administrative aspects of these new and growing organizations. Although the hospital administration was structured to provide equipoise between the medical and financial priorities of the hospital, that balance was not easily maintained, and as the financial aspects became central, the hospital administrator became supreme and physicians lost control.

Today, the American hospital has become central to the support of nonprofit and for-profit regional and national health care conglomerates, and control has become the province of boards of directors with little medical input and larger community control. As a consequence, the physician has now become a real or quasi-employee of the hospital.

In a recent perspective paper, Dr. Richard Gunderson (Acad. Med. 2009;84:1348-51) emphasizes the need to train physicians to provide leadership for the future management of the hospital. He points out that in 1935, physicians were in charge of 35% of the nation's hospitals, but that number has shrunk to 4% of our current 6,500 U.S. hospitals. The academic medical community has largely ignored its role in preparing medical students for administrative leadership as it focused on the clinical knowledge required for the medical competence.

Dr. Gunderson, of Indiana University in Indianapolis, advocates the identification of student leaders in the selection of medical students and proposes the inclusion of courses in medical finance and social issues in the medical school curriculum in order to prepare them for a leadership role in redefining the future of medical care and hospital management.

Amanda Goodall, Ph.D., a senior research fellow at the Institute for the Study of Labor in Bonn, Germany, provides an even more challenging analysis of the importance of medical leadership at the hospital (Social Science Med. 2011;73:535-9). She notes that these changes in leadership are not unique to the United States but also have taken place in European hospitals. Using a quality scoring system, she analyzed the quality performance of 100 of the U.S. News and World Report's Best Hospitals 2009 in the fields of cancer, digestive disorders, and heart and heart surgery. She found a positive correlation between hospital quality ranking and physician CEO leadership.

Those of us who have grown up through this management evolution have seen its real impact on the care of hospital patients. Some of the changes have been positive, while others have proved frustrating for both patients and physicians who practice in the new environment.

The need for leadership by those of us who have direct patient care responsibilities is essential for an inclusive decision-making process. When patient care comes to discussion at the board meeting, physicians and nurses bring to the process a perspective that only they can provide. It is essential that their voices be heard. ■

DR. GOLDSTEIN, *medical editor of* CARDIOLOGY NEWS, *is professor of medicine at Wayne State University and division head emeritus of cardiovascular medicine at Henry Ford Hospital, both in Detroit. He is on data safety monitoring committees for the National Institutes of Health and several pharmaceutical companies.*

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Editorial Offices 5635 Fishers Lane, Suite 6000, Rockville, MD 20852, 877-524-9335, cardiologynews@elsevier.com

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