Roundtable Seminar In Syracuse

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How could the results of a study of Syracuse's hospital situation be interpreted to health leaders, citizen leaders, and the community-at-large? The staff of the Community Health Information and Planning Service, Inc. (CHIPS) chose a roundtable seminar technique, with outside expert consultants and local leaders participating, to accomplish this educational task. The seminar was carefully planned to generate a meaningful dialogue about a rational hospital system for the area, a dialogue that would lead to implementing the study.

Background

In the two decades after World War II, hospital development in the Syracuse metropolitan area was marked by controversy and intermittent infighting. Between 1950 and the early 1960's, there were four major studies of hospitals and health affairs conducted under varying auspices with both local citizen leaders and expert consultants from outside the community participating. Each study resulted in a report with specific recommendations. Many of these recommendations were progressive and forward looking and, if implemented, would have put the Syracuse area in the forefront of hospital development. In conducting the studies, however, the study process was generally blunted, the politics of Syracuse's hospital situation were more or less ignored, and the planning process, which involved the active participation of all interested parties, was not used. The result was that while some of the less sweeping recommendations were put into effect, the more important ones lay buried in reports which sat gathering dust on community shelves.

The one recurrent theme in the recommendations of all four studies was that the community should

establish a permanent unit which could assume responsibility for health planning in the future and could promote continual efforts to implement sound recommendations. Several attempts to initiate such a planning group aborted for one reason or another and, by the mid-1960's, community leaders were aware that another point of crisis in the hospital situation had been reached.

In the early fall of 1965, the United Community Chest and Council of Syracuse and Onondaga County, Inc., established a select 12-man committee to determine what kind of health planning body the community should have. This project was undertaken with the help of two local foundations. Less than a year later, CHIPS (Community Health Information and Planning Service, Inc.) was to become an incorporated, tax-exempt, nonprofit organization, established to conduct comprehensive health planning in the metropolitan area. Within weeks of its incorporation, CHIPS had assembled a staff of three full-time professional workers and had expanded its original committee membership of 12 to a board of 27. In contrast with the earlier committee, this new board had a better balance of health professionals and citizen leaders, who were in the majority.

As a fledgling organization in the community, CHIPS found itself in an awkard position. Each of the major voluntary hospitals in the area had well-developed plans for major expansion and construction, making it immediately apparent that if CHIPS did not move quickly to evaluate these plans, the opportunity to influence the coordination of hospital services would be lost for at least a generation. Moving in on the hospital situation so soon after formation forced the CHIPS staff to break with accepted practice in planning organizations—namely, that a planning organization should undertake a relatively simple, foolproof, guaranteed successful, and short-term project for its first activity.

Instead, CHIPS had to tackle an extraordinarily complicated and emotionally tinged problem in its community—and in doing so, was forced into a role exactly opposite from that which it would have preferred. Instead of being able to work with the hospitals and their long-range planning committees in developing plans which were sound from a community point of view, the staff and board of CHIPS were forced to review and evaluate the independently prepared plans of individual hospitals and comment on not only their strengths but also their weaknesses and discrepancies.

To be certain that evaluation of the hospitals' plans was based on a solid foundation, the CHIPS staff devoted virtually all its initial program time to a major study of the hospitals in the metropolitan area. This profile study had six basic parts: demographic data, including population projections and information about general community development; an inventory of existing hospital services and facilities; a physician and hospital personnel inventory; a survey of patient origin; a bed utilization study; and a review of the hospitals' modernization needs.

With the full cooperative participation of all 12 hospitals, the study was completed in the record time of 6 months; the data from this comprehensive benchmark review were published, without recommendations, in April 1967. What the CHIPS organization faced at that point was the compelling need to interpret the study's facts and figures and the current hospital situation to health leaders, citizen leaders, and the community-at-large, to set the stage for the development of recommendations and their planned dissemination to the community some 8 weeks later.

Planning the Seminar

In designing its hospital study, CHIPS had been fortunate in securing counsel and guidance from Jack C. Haldeman, M.D., president of the Hospital Review and Planning Council of Southern New York, as it was then known. Having completed the study, we turned again to Dr. Haldeman with our problem of how to make the study and its results of greatest use to the community. It was from Dr. Haldeman that the idea of the roundtable seminar grew. The general concept of the seminar was to use a group of nationally known expert consultants, in conjunction with local health and citizen leaders, to review and analyze the study results, particularly in light of national trends in acute hospital care. The seminar was to bring together three groups: expert consultants from various aspects of the health field, drawn from outside the community; consultants with positions of health leadership within the community; and a group of participant-observers from the community. We selected eight national consultants.

Moderator of the seminar was George Bugbee, director of the University of Chicago's Center for Health Administration Studies; hospital planning was represented by Dr. Haldeman; private medicine was represented by Waring Willis, M.D., a member of the American Medical Association's Committee on Medical Facilities; public health was represented by Roscoe P. Kandle, M.D., New Jersey State Commissioner of Health; health insurance was represented by Bennett J. McCarthy, vice-president and general manager of Michigan Blue Cross; hospital administration was represented by D. Eugene Sibery, executive director of the Greater Detroit Area Hospital Council; medical education was represented by Richardson Noback, M.D., executive director of the Kansas City General Hos-

pital and Medical Center; and the New York State Health Department was represented by Deputy Commissioner Robert C. Whalen, M.D.

Among the local consultants were the county commissioners of health and mental health, the president of the Upstate Medical Center—State University of New York, the community chest's vice-president for planning, the president of CHIPS, and others whose roles in the community made them leaders in the development of health services. The participant-observers group included representatives from hospitals, local government, mass media, county medical society, potential capital funding sources, and other citizen leaders.

Physical Arrangements

The physical arrangements for the seminar were carefully arranged in advance. The meeting was held at a local motel which offered convenient access and parking. The conference room had a large table seating approximately 25 people which provided space for all the national consultants, the local consultants, and CHIPS staff to sit so they could talk easily. Around three sides of the table and directly behind it, two rows of chairs were arranged, providing seating for an additional 60 participant-observers. Representatives of the mass media were seated behind the fourth side.

The timetable for the seminar was also planned carefully and was followed strictly. Members of the national consultant group arrived in Syracuse in time for a dinner meeting the evening before the seminar was officially scheduled to begin. This meeting gave representatives of the CHIPS executive committee and the CHIPS staff an opportunity to orient the national consultants with regard to the physical arrangements, time schedule, and, most important, the specifics of the Syracuse hospital situation. Since copies of the CHIPS study had been sent to these consultants in advance, much of the meeting time was used in answering questions which they had about the study and its observations. In addition, CHIPS representatives used the opportunity to discuss those historical and political aspects of the hospital situation which were necessary for these consultants to know but which did not need to be mentioned in the open meeting.

Seminar Sessions

The roundtable seminar began officially the following morning. The orientation session was opened by the CHIPS president, Robert J. Collins, M.D., who set the stage by reviewing the history of the Syracuse hospitals and highlighting the major observations from the CHIPS study. Then, each local consultant offered his view of the hospital situation, with special emphasis on the problems he perceived. This general orientation was completed just before the luncheon break.

The luncheon was completely unstructured and relaxed and gave all of the participants an opportunity to mingle informally and discuss the morning's orientation. Immediately after lunch, moderator Bugbee reassembled the group, and the afternoon session began with some general comments about trends in health care from the national consultants and additional questioning of the local experts with regard to the Syracuse hospital situation. It was at this point that the local observers were welcomed and invited to make comments and ask questions of the consultants and staff. The remainder of the afternoon was spent in give-and-take questioning and discussion until the meeting was recessed in the late afternoon.

At the request of the national consultants, no formal program had been planned for that evening. They used the dinner hour and the early evening to confer in private, sharing their observations and perceptions and determining how the concluding session of the seminar would be handled.

The seminar reconvened the following morning with Mr. Bugbee in the chair. Each national expert made a presentation from his special viewpoint, reacting to particular aspects of the Syracuse situation which he felt to be of importance and outlining the various alternatives which he felt faced the Syracuse community in developing a more rational hospital care system. The consultants were careful not to favor any particular alternative, thus avoiding any impression that they were telling the community what to do; rather, they took pains to point out various alternatives, and the advantages and disadvantages of each. The presentation provoked a great deal of reaction and discussion, in which all the local participants were active. At the end of the morning, Dr. Collins once again assumed the chair, and after thanking the national experts and the local participants officially closed the seminar.

At this point, a private luncheon had been arranged for members of the CHIPS executive committee and staff and the national consultants. This luncheon lasted about 3 hours and provided an opportunity for the experts to share their specific recommendations about ways in which hospital development in the Syracuse area might move. Because these specifics were shared with the CHIPS representatives in executive session, the CHIPS staff and board were free to modify the recommendations made by the experts in ways dictated by their knowledge of community and hospital politics.

Dual Educational Process

From every point of view, the roundtable seminar was successful. Through the mechanism of

a single conference, a dual educational experience was fostered. First, consumers—represented by hospital trustees, representatives from the mass media, and other civic leaders—and, second, providers—represented by hospital administrators, medical staff, and other health professionals—were helped simultaneously to see differing viewpoints about medical care, the role of the hospital as a community resource, and the place of the hospital in the developing community system of health care.

At the same time, the perspectives of the community's health planning leaders, including the CHIPS representatives, were being broadened, and their awareness of the variety of factors which needed to be incorporated in the planning process was being heightened remarkably. While this dual educational process was going on within the seminar itself to the benefit of key persons and participating representatives, a broader community impact was being stimulated by reports of the seminar and its deliberations which appeared in all the newspapers and on radio and television.

Although there had been some misgivings when the seminar was first planned about extending invitations to representatives of the mass media, our experience demonstrated the wisdom of inviting participation from the press, radio, and television. Reporting of the seminar was complete and accurate because the representatives of the press, radio, and television were able to attend the sessions and were allowed to question participants during meal and coffee breaks. The positive effect of this publicity was reflected in increased general understanding about the perplexities of the hospital dilemmas we were confronting and increased knowledge about possible alternative solutions.

As had been hoped, the seminar provided an educational assist to the basically political process of planning which was required to move developments forward in the hospital care system. Because CHIPS was a voluntary organization without any legal sanction or authority, it had to rely on persuasion, development of consensus, and cooperation to make its planning effective—in other words, be sure that its planning would lead to action. The national consultants were of such caliber that it was obvious to everyone that, because they were beholden to no one, they could indeed maintain a high degree of objectivity and impartiality in evaluating the hospital situation in Syracuse.

Their perceptions and perspectives were apparently seen as valid ones by the community, and the alternatives they outlined, with advantages and disadvantages, were accepted as reliable input—a view which easily might not have prevailed had the same input come from the relatively untried CHIPS staff and executive committee. In addition, the national experts were able to emphasize some of the negative observations of the CHIPS study in a way which the CHIPS personnel themselves could not have done as effectively. In this sense, the experts validated results of the CHIPS study. This validation appeared to be particularly true of the observations which highlighted unwarranted duplication and lack of coordination among hospitals; for example, the two separate open heart surgery units, each doing scandalously few operations per year. When the national consultants decried these aspects of hospital care in Syracuse and had facts and figures from the CHIPS study to back them up, their viewpoints were seen as unassailable.

Finally, the seminar also provided a real clarification of the points at issue—some of the matters where compromises were needed. One example was the highlighting of hospital services, such as pediatrics and obstetrics, with low bed occupancy. It was clear that the hospitals needed to agree among themselves concerning these under-used services if the community was to avoid continuing waste of scarce resources. The ability of the seminar to focus on these problem issues helped assure that the study findings in some touchy areas would not be ignored.

Recommendations Implemented

One measure of the success of the roundtable seminar is that 3 years after the June 1967 publication of the CHIPS recommendations (which were derived to a large extent from the seminar discussions), the lion's share of those recommendations are now being implemented in the Syracuse community, in principle if not in finite detail. For example, the merger of two hospitals put Syracuse well on the road toward realizing the recommended goal of three major hospital centers. The Hospital Executive Council, an interhospital planning group, has been formed to facilitate and to coordinate any further hospital planning. Opportunities to share services, equipment, and personnel are being explored. A joint campaign to raise money for two voluntary hospitals and a large nursing home has just been successfully completed.

Another measure of success of that initial seminar is that when the CHIPS second major study on long-term care was completed, another 2-day roundtable seminar was held to discuss the results of that study and the future of long-term care in our metropolitan area with similar salutary results.

In summary, the roundtable seminar, as we have experienced it in the Syracuse area, offers an extremely useful technique, a multifaceted educational endeavor, that can be conducted on a number of broad fronts simultaneously, thus enhancing and facilitating the planning process.