Agenda for a critical exploration of Current Problems in Medical Care

By E. M. BLUESTONE, M.D.

Here is a catechism—but with questions only. The author draws here upon his extensive experience in hospital administration and his pioneering work at Montefiore Hospital in New York to ask, cogently and incisively, the perplexing questions current today in the fields of hospital and medical services administration. When originally presented last December his audience was United Community Services of Metropolitan Detroit, but his "agenda" is for all who plan and direct the course of health and medical affairs in private and governmental hospitals, in public health, in social service, and in the civic and official organizations of the community. From them the answers must come.

THE MODERN STUDENT of medical care seems almost to be laboring under an embarrassment of riches these days, so much successful experimental material is at his disposal. Social and medical possibilities are clamoring for conversion into actualities at such a rapid pace that the planner is left breathless in the process. We shall have to excuse his enthusiasm on the one hand and his disappointment on the other when he finds the going slow. Opposition must be met, satisfied, or overcome. New problems are sometimes created as old ones are solved. The best example of this seeming paradox is found in the lengthening of the life span, which, however desirable, brings with it the necessity for making the later years comfortable. The problem in procedure is therefore how to apply new remedies for old difficulties and how to find additional remedies—an unending chain.

The most extensive, and perhaps the most difficult, of the basic problems is the one the patient exhibits when he is suffering from prolonged illness, whether he is ambulatory, bedridden, or alternating between the two. Here is an exceptional case in which the solution of one major problem automatically liquidates a great many others. Relieve the chronic difficulty and the acute difficulty will be relieved in the process. Since one of the penalties of greater longevity is that it takes a longer average time to die than ever before, we are all the more constrained to deal with this manifestation intensively. That the approach is social, economic, and political, as well as medical, goes without saying. The family and the environment play a major role in any consideration of such a subject. Preventive medicine and environmental medicine hold many keys that are ready for use.

Listed here are some of the items on the agenda of unfinished business, with explanatory

notes, for the consideration of the participants as they deliberate such questions at the council table. Each of these items calls for decisive action and each requires a combination of social and medical techniques in research, which are at our disposal, ready for study and application.

1. We need a definition of such terms as "acute," "chronic," "convalescent," "custodial," "aged," "hospital," "home," "curable," "incurable," "social medicine," and "socialized medicine." At the moment, the sick man suffers patiently while those who plan for him too frequently permit themselves to be confused by these terms.

At what point, for example, shall we separate acuteness from chronicity? Can we establish a common denominator for the two and use it for all practical purposes? What is the impact of duration of illness on the provision of medical care, and does the service correspond to the requirements of the case? How is a convalescent patient distinguished from a so-called chronic patient? Is there any advantage in providing for the elderly separately and apart from all other social and medical services? Or is it better to identify them with all other age groups in accordance with their social and medical needs? When are we justified in labeling a patient "custodial" with regard to medical care? At what point, if any, during the course of illness is a hospital justified in dismissing a patient and transferring him to less capable hands?

It is easy to see how hospital policy can be revised and formulated on a more equitable basis when such questions are answered correctly and in absolute terms in relation to each other.

2. The trends in medical care for each of these definitions need stating, particularly with reference to prolonged illness (formerly known hopelessly as chronic disease) and the aging process. Most of these are well known, even though we resist their full acceptance, while others still wait to be brought to public view in a practical way. There is, for example, the continuing trend toward finding new ways of closing the gaps in hospitals between (*a*) acute and chronic; (*b*) income and expenditure; (*c*) space demand and space supply; (*d*) social service and medical service; (*e*) intramural and extramural care; (*f*) current medical economics and the science of medicine; and (*g*) principle and practice generally.

This involves the consideration of such things as voluntary prepaid insurance plans, including group medical practice; home care for those who do not require a hospital bed; and substitutes for the patient's home under the medical jurisdiction of the hospital for those who do not require a hospital bed and cannot be taken care of in their own homes, either immediately or by subsidy of one kind or another. The outpatient department's services will have to be considered; provision of doctors' office space on hospital premises; the integration of tuberculosis and mental disease in the work of the general hospital; the principle of full-time medical service in hospitals; the shifting emphasis in medical education; and the reunion (including the integration) of health and medical care. The obvious purpose in appraising these trends is to apply them productively to plans for medical care.

3. We need an evaluation of social and medical pressures, tensions, and resistances in connection with illness in all its forms. What is the quality and quantity of these individual and communal phenomena emanating inside or outside of the hospital? Are they well based, honestly applied, and helpful? How much anxiety, as well as eagerness, is associated with them, and, if these pressures are well-founded, how shall we deal with the resistances which they may create? The answer to this question will take us beyond the realm of statistics. Workers in the field are constantly exposed to these manifestations and are sometimes caught between the proverbial millstones. This subject must be treated at the council table with statesmanlike understanding.

4. A practical formulation of the scientific requirements in the management of prolonged illness is needed. This refers both to medical necessity and to social necessity, evaluated with scientific accuracy wherever possible, but with the realization that a sick person must never be subjected to the rigid standards of the exact

sciences. Scientific requirements go beyond the goal of certain well-meaning philanthropists who feel that food, shelter, and clothing (custodial care) are all that may be required by a person who has the misfortune of living under a prognosis of incurability.

5. We need a forceful statement on the menace of rigidity in hospital planning, and this refers to function as well as to structure. In particular, we must be alert to this menace when we plan for prolonged illness, because rigidity commits the hospital "in bricks and mortar" over a long period of years during which adaptations will undoubtedly be required. One of the architectural problems is how to get flexibility of design so that adjustments to changing conditions may subsequently be made easier.

6. We need a reaffirmation of the principle of individualization of care for patients under all circumstances. There is now the possibility of home care programs, which, in turn, stimulate greater interest in individualizing the care of patients who have no choice but to enter a hospital.

7. Among the supporting statements for the various items on this agenda should be a well-reasoned critique of the older and still prevailing methods of dealing with prolonged illness in homes, hospitals, and elsewhere. Only on the basis of such studies will revised plans for patient care find acceptance. We must be sure that we are dissatisfied with what we have and profit from experience before we adopt substitutes. A conservative point of view requires the strongest hypothesis to justify any kind of experimentation.

8. The criteria for admission to any hospital will have to be redefined and restated in the light of the deep-seated changes which the laboratories of modern medicine have been offering. Having emerged from the prescientific era, we are now in a position to get a better turnover of hospital beds or offer them to patients for longer periods, as necessary—so long, in fact, as they may have to remain close to the highly concentrated diagnostic and therapeutic facilities of the hospital. The new resource of home care can relieve the hospital of the necessity for retaining any other kind of patient within its walls.

9. As the policies which govern the admission of patients to general hospitals are rewritten, we should, at the same time, outline the criteria for the retention of the patient in his own home. Under what circumstances is he best cared for in this way?

10. Another item on the agenda is a recommendation on the criteria for the transfer of a patient, either from the hospital or from his home, to a substitute for his home. If a home for the aged, like a so-called home for incurables or a nursing home, should be a substitute for the patient's own home, then we should restate the conditions under which guests may be admitted and retained in these establishments. We must, however, keep in mind that these institutions are substitutes for the patient's home and never for the hospital.

11. The time has come to restate the special criteria for admission to homes for the aged. If we are to discontinue the practice of establishing so-called hospitals within homes for the aged, there is all the more reason for revising the conditions for admission. In the rare instances in which a home for the aged has been able successfully to establish a hospital within its walls, it has in fact added another hospital to the community. In order to establish a hospital within a home, the institution must be prepared to meet the challenging clinical problems which characterize prolonged illness and age in general. It should be able to absorb acute medical and surgical cases without further effort. Such an institution is indeed compelled to do this in emergencies. In connection with this item we must consider the relationship of a home for the aged, which as I have already pointed out is a substitute for the patient's own home, to the general hospital from which it should be able to draw medical sustenance.

12. What criteria shall we recommend for admission to custodial establishments generally? These decisions should follow the lines

recommended for an institutional home for the aged.

13. If, after careful study, we find that it is virtually impossible to maintain a convalescent establishment solely for this specific purpose, what shall we do about it? This establishment, too, is a substitute for the patient's home and not a substitute for the hospital. If a convalescent patient is safely on the road to partial or complete recovery from acute or chronic disease, his requirements will doubtless be about the same as those for anyone who is recuperating from overwork and seeks a change and rest on a farm, in mountainous areas, or at the seashore. We must not confuse the convalescent patient with any other type of patient, for if we do, we shall perpetuate a confused and distorted plan of medical care which makes of the convalescent institution a catchall establishment for the admission of patients (with the possible exception of mental and tuberculous patients) who may not be acceptable to the "acute" general hospital.

14. Though much is being said about the place of the tuberculous patient in the general hospital, we are still far from translating this principle into practice. How can the care of the tuberculous patient be integrated with the care of all other patients in the general hospital and what conditions should govern his admission? The active treatment of this disease, based on modern scientific knowledge, and the passive treatment, which characterized the care given previously and still being given, should be evaluated from this point of view.

15. Almost the same questions apply to the mental patient in the general hospital. What are the relative advantages of integration in a general hospital as compared with isolation and segregation in a distant special hospital? If integration is desirable, what is the best kind of experimental beginning and how can the hospital trustee be made receptive to such new ideas?

16. If integration is not accepted as a wholesome trend in the management of the tuberculous or the mental patient, what alternative structural and functional plan can we safely fashion? Specifically, we have yet to express ourselves firmly on the place of the mental patient in (*a*) the mental institution, (*b*) the home for the aged, (*c*) the home for incurables, (*d*) the nursing homes, and (*e*) all other custodial types of institution. Much of this applies to the tuberculous patient. To what extent is it desirable to alienate either of these patients from the environment generally, to which they will be expected to return, and their families.

17. An essential part of the study of this pressing and vital problem is an item about the significance of a waiting list of patients for admission to a hospital and rejected applicants for admission. What is the effect of a waiting list on hospital morale as well as on the patient himself? At this point there must be an offer of alternative methods of care. This study would be incomplete without a thorough analysis of rejectees in any medical establishment. A hospital must not only know and understand what it does, it must know and understand what it does not do, and then help to make good the difference.

18. No study of medical care can be complete without an analysis of the relationship of housing in the community to the program of hospital care. Throughout the ages at least one reason for the existence of the hospital has been the inadequacy of home facilities during certain phases of illness. Such an analysis would lead into a field of study which would produce, in the end, far better use of hospital beds than we have thus far seen, while individualizing the care of the patient outside as well as inside of the hospital.

19. The requirements of good chronic care as seen from the angle of social (environmental) medicine should be considered carefully. A clear statement should be issued after careful study of these requirements, and facilities should thereafter be adjusted to meet these requirements. Specifically, is the home for incurables, home for the aged, convalescent home, nursing home, or hospital for chronic diseases, the best place for this kind of patient? If so, why? If not, why not?

20. How shall the vicious circle between poverty and prolonged illness be broken? At what point does a person require the kind of assistance, social or medical, which will prevent poverty from precipitating prolonged illness and prolonged illness from precipitating poverty? In the long run, they do their deadly work together.

21. What standards should be recommended for the establishment of substitute homes for the homeless patient and for the home-poor patient when intramural hospital service is not indicated? Should medical facilities be added to these substitute resources and, if so, to what extent? If not, how can these substitute homes be related to the work of the general hospital? In some instances only a custodial type of care is required, but in more instances continuous medical care is required. If general hospitals transfer their undesired patients to less capable hands at a time when scientific medical care is most needed, how shall this practice be controlled?

22. In the analysis and the evaluation of the reasons for the current practice of transferring patients from the so-called acute general hospitals to second-class institutions, we should deal specifically with (*a*) the financial reason for transfer, including a statement of remedies; (*b*) the medical reason, including a statement of remedies; and (*c*) lack of space, including a statement of remedies.

23. How shall we define and evaluate for practical purposes such new terms as "geriatrics" and "gerontology" in relation to medical care? What are their possibilities and what are their limitations? Is geriatrics a separate specialty like pediatrics, or a problem in acute illness or prolonged illness as the case might be? In other words, at what point in the calendar of a man's life are we justified in making any kind of arrangements for his medical care that may deprive him of the best that is available to those who were born into the world after him?

24. What is the relative emphasis that is being placed on various phases and stages of illness and, in particular, the duration of illness? To what extent does the pressure of urgency dominate planning and how much consideration can be given to nonurgent conditions, which may, in fact, be far more frequent and far more devastating in their prolonged effects?

25. An important item on the agenda is the need for placing responsibility for correct and up-to-date planning. Who is responsible when a person is deprived of the kind of social and medical care that he may need at various critical periods in his life? There must be a level at which responsibility can be fixed. What is this level and how shall it be controlled?

26. Since prolonged illness characteristically exhibits diminishing financial returns from patient sources, how shall we make up the social and medical deficit to enable us to restore the sick man to partial or complete usefulness in his community? What are the relative positions of government and philanthropy in an effort like this and what is the position of the practicing medical profession toward this financial problem which involves them automatically? Can we buy medical time and medical interest with money and with opportunity? If so, under what conditions?

27. As we deliberate on the question of financial currency in relation to the care of the patient, we should give some thought to clinical currency. Specifically, to what extent should such a subject as prolonged illness influence medical education and medical research in the hospital, in the home, and in the substitute for the patient's home?

28. An important item on the agenda is an open-minded study of the principle of full-time medical service in the top clinical and laboratory divisions. What are the relative merits of full-time hospital service and the kind of prevailing voluntary service in hospitals which compels intramural and extramural competition for the service of physicians?

29. Since the poor may always be with us and since the intermediate type of institution—too often a substitute for the general hospital—

will doubtless prevail for some time to come, what structural and functional obligations shall we impose on it? I refer here specifically to the possibilities of preventive medicine at one end and rehabilitation at the other.

30. What responsibility shall be assigned and what agency shall publicize any new patterns which may evolve? What methods shall we recommend to obtain the acceptance of the public generally as well as interested persons specifically?

Omitted from this presentation are those problems in political economy which, to be sure, have a strong bearing on the agenda. While I am concerned primarily with good medical care for everyone, regardless of age, social condition, duration of illness or the illness itself, environmental medicine teaches that employment and a good economic background are prime factors in preventing disease or its consequences. Business and industry have a strong contribution to make in prevention, first by the application of the principles of industrial hygiene and occupational medicine, and second by encouraging a program of rehabilitation that will enable the recently sick to return to work. Fortunately, much successful experimental evidence is available to enable us to reach decisions on most, if not all, of the items enumerated in this agenda. We are left, therefore, with the need for adjusting the social and medical resources evolving patterns of care. Needless to add, there are many opportunities for additional experimental work on a continuing basis until problems like these can be resolved.

Public Health Service Staff Announcements

Dr. Sidney Farber has been appointed to serve on the National Advisory Cancer Council of the Public Health Service for 4 years beginning October 1, 1953. Dr. Farber is the scientific director of the Children's Cancer Research Foundation, Boston, professor of pathology at the Harvard University Medical School, and chief pathologist of the Children's Hospital, Boston. Since November 1947, Dr. Farber has served the National Cancer Institute of the Public Health Service as a special consultant on clinical research problems. He is well known for research on the chemotherapy of cancer in children, particularly leukemia.

Dr. Floyd S. Daft has been named director of the National Institute of Arthritis and Metabolic Diseases, National Institutes of Health, by the Surgeon General of the Public Health Service. Dr. Daft, acting director of the Institute since the retirement of Dr. Russell M. Wilder on July 1, 1953, had been assistant director of the Institute and chief of laboratory research since 1951. A member of the scientific staff of the National Institutes of Health since 1937, he has directed nutrition studies, particularly on the B vitamins, and conducted a study of the substance later identified as folic acid. His investigations have contributed to the understanding of dietary deficiencies causing anemia, cirrhosis of the liver, and other metabolic diseases.

Dr. Maurice C. Pincoffs has been recently appointed to serve on the National Advisory Arthritis and Metabolic Diseases Council by Surgeon General Leonard A. Scheele of the Public Health Service. Dr. Pincoffs has been professor of medicine at the University of Maryland since 1922, and is president of the Medical and Chirurgical Faculty of Maryland, regent and a recent president of the American College of Physicians, and councilor and ex-president of the American Clinical and Climatological Association. For many years, he has been editor of the *Annals of Internal Medicine.*

Dr. Russell S. Boles, internist and gastroenterologist, Philadelphia, and **Dr. Thomas P. Almy,** associate professor of neoplastic diseases, Cornell University Medical College, have been appointed to the Cancer Control Committee of the National Cancer Institute, Public Health Service. Their 4-year terms are effective October 1, 1953. Dr. Boles succeeds **Dr. Charles F. Branch,** Lewiston, Maine, and Dr. Almy succeeds **Dr. Edmund G. Zimmerer,** Des Moines, Iowa.