

# AHSCs: The Complex Simplicity of Service



COMMENTARY

*Robert Woollard*, MD, CCFP

Royal Canadian Legion Professor and Head, Department of Family Practice,  
University of British Columbia



“Patient – One who suffers...”

- Oxford English Dictionary

## ABSTRACT

*The literate and effective dissection of the problems of the modern Academic Health Sciences Centre (AHSC) represents a significant contribution by Lozon and Fox. However, the fundamental issues may be both simpler and more intractable than they describe. The hospitals, medical schools and research institutes that compose the AHSC have individually and collectively drifted away from an ethos of service with the patient at its centre. Systems theory teaches us that "emergent behaviour" wherein the AHSC becomes more than the sum of its parts will only be achieved when there is commitment to a common purpose aided by mutual respect and the generalist perspective necessary for its full expression.*

*As social and health trends underscore and support the need for aggregative and problem focused education and research, it is not clear that AHSCs are reacting in an effective way – increased isolation from community and generalist care leaves highly specialized institutions vulnerable to criticism of both irrelevance and sub-optimal care. A re-affirmation of unambiguous commitment to both study (research and educate) as well as serve those who suffer provides the most likely avenue to make the 21st century "the best of times" for the AHSC.*

THE LEAD PAPER in this issue closes with the opening lines of Dickens' *A Tale of Two Cities* describing the era of the French Revolution and terror in those great cities London and Paris. Embedded in this apt quote is the heart of Dickens' genius – his ability to vivify the large trends and societal shifts in the lives of the common people who made, suffered and occasionally triumphed in the many revolutions (French, industrial, urbanization, trade, etc.) of the past few centuries. Those revolutions have bequeathed to us, in the 21st century, both great benefits and great hazards. I will argue that the choice of this particular quote is doubly apt in the current context because our Academic Health Sciences Centres (AHSCs) have singularly failed to account for the lived lives of the patients who suffer under their care. This lack of a Dickensian lens is a major factor in why these are more often seen as the “worst of times” when our theoretical capacity to serve those who suffer should make this the “best of times.”

My immediate proposition is that after two centuries of revolutions (including a scientific one thrown in) it is time we affirmed some fundamental purposes for the human condition and explored the utility of aggregation and convergence rather than specialization and divergence – especially as it applies to healthcare, and most especially as it applies to the AHSC. The authors (Lozon and Fox) are correct in describing the absence of systematic thinking and actions as they apply to the modern AHSC. They provide a rich array of examples of what they describe as “the lessons from this lack of systems thinking.” This is an important contribution to a complex debate.

To better understand that debate, it is important to understand the “large trends” and important traditions that underpin the current varied, but unsustainable, state of AHSCs across the country. The authors correctly allude to the historic convergence of universities, medical schools and (somewhat later) hospitals as having provided some major benefits to societies that have supported (in various ways) these three core features of civil and humane societies. This convergence, which staggered across Europe and its diaspora from Montpellier and Padua in the 14th century, can be argued as having been motivated and accomplished by a social consensus to alleviate human suffering by developing the knowledge necessary to care and the institutions necessary for the provision of that care. The complex and frequently counterproductive (remember Ignaz Semellweiss) manner in which these trends played out should humble both the authors and Mr. Drucker whom they also quote. In short, many elsewhere and elsewhere have done much better with less than we have in discharging the social obligations inherent in the privilege of being healers, teachers and organizers of care.

There is a significant irony in the fact that it is an institution containing the social repository for the best healers, thinkers and teachers that is having a persistent problem in reflecting on its purpose and determining its most effective organization. The authors are correct in their diagnosis of a breathtaking lack of systems thinking in the complex interrelationships that constitute the 21st-century AHSC. Even formal organizations such as ACMC have reflected on

this fact (Vagel et al. 1994). So where is it that we, in the authors' phrase, "got it wrong"?

They correctly describe a debilitating degree of complexity in the relationships that constitute the current AHSC. Indeed, this complexity seems capable of tripping many participants into a culture that can only be described as "learned helplessness." We are frequently faced with circles of finger-pointing policy-makers, professionals and administrators that place the blame for our collective failures on the shoulders of others; or more persistently (and perniciously) on the faceless and hence implacable "system." Those involved in international work may find this helplessness in the face of a relative wealth of resources somewhat difficult to fathom. Let us think why this might be the case.

One reason posited by the authors is a lack of common vision for "the AHSC as a whole." While the various component parts may be graced with an assortment of posters and plaques referring to *their* commitment to service, research and teaching, the authors provide a distressing picture of limited real coherence and internal trust at the level of the AHSC enterprise *itself*. This lack of a common vision statement is likely a consequence of the lack of a defining consensus about the *purpose* of the AHSC as an entity that is greater than the sum of its parts.

In adaptive systems theory the transition point whereby a higher order system gains coherence and provides more than the collective of its component subsystems is termed "emergent behaviour." It is expressed in as variable a range as multicellular organisms and the Edmonton Oilers of a certain era. The nature of

emergent behaviour is somewhat system-specific but depends fundamentally on the defining purpose of the system – be it survival, winning, producing or, in the case of systems arising from human volition, an organizing *idea*. In its best expression it contains a commitment to the improvement of the human condition.

In the case of the universities, the healing professions and the public service, a reasonable common purpose might be characterized as an *ethos of service* – a joint commitment to the welfare of those who suffer, i.e., patients. If this affinity seems natural and is routinely attested to by each of the three groups, why do the authors (and the rest of us) have such difficulty in finding the emergent behaviour that would be an expression of this joint commitment – arguably in its highest expression in the AHSC?

Is it because the operative purpose of the AHSC is not the ethos of service but rather one of attracting and organizing funding and fixed resources – to no obvious higher purpose? Should this be the case, they have been remarkably successful with health expenditures routinely exceeding population growth and, as the authors point out, the 6% of hospitals designated "teaching hospitals" receiving "36% of the total operating expense pool." Some of the recommendations embedded in the authors' paper would see this success enhanced – whether through explicit commercialization of research results or cost conversion through clinical trials. I would prefer to think that neither the causes nor the solutions are to be found in the explicit monetization of the mission.

In fact, it may be that the problem is both more simple and more complex.

Simpler in the sense that the focus is more defensible and enduring. More complex because the difficulty arises in the very nature of how medical science and industrial society have conducted themselves for the past two centuries. In short, the focus must be unambiguously on the welfare of patients, and the methods must embrace generalism and the human *at least* as avidly as they have embraced specialization and technology in the past. In their discussion about teamwork, the authors quite correctly describe “a healthcare environment that has been built on the premise of highly specialized and qualified professionals.” That may be a large part of the problem! If we look at the three-legged stool of education, research and service that characterizes much of the discourse and the major components (university, hospital and medical school) of the AHSC, we might reflect on how the patient has drifted from the centre of focus.

In education, we began the 20th century with the apogee of William Osler’s ideas of the patient as the door to learning. After long sojourning in an increasingly dense thicket of expanding specialized disciplines, we are latterly seeing an evolving consensus on the value of problem-based learning and the patient-centred method (Woollard et al. 2001), both of which arise from generalist traditions. Together with early clinical exposure in the undergraduate curriculum and the extension of the science of evidence-based medicine into the clinical curriculum, we are seeing an educational system on the threshold of emerging to address both the science and art of medicine. However, this will only be achieved if the patient is the focus or thread that

brings these traditions together.

Second, in the realm of research, we have observed the patient increasingly parsed into ever tinier elements until we have the current Arthurian grail quest wherein the human genome is seen as the ultimate repository of the truth of health, illness and the human. A wonderful expression of this quaint hope may be found in Dickens’ fellow Victorian, Tennyson, when he reflected in a “Flower in a Crannied Wall” that “...but *if* I could understand what you are, root and all, and all in all I should know what God and man is” (1869; Bush 1951).

While this specialized, reductive paradigm has accomplished great things, its role is *in principle* incomplete in addressing the kind of complex, interrelated, interdependent and chronic problems that characterize a typical patient that the AHSC seeks to serve. The sources of disease and wellness are increasingly seen as well beyond the traditional scope of the healthcare “system.” That is one reason why the political (not the academic or professional) class has pushed the research enterprise increasingly towards aggregative, interdisciplinary, problem-focused and community-engaged research. AHSCs are only belatedly and reactively beginning to embrace this research paradigm – one that is generalist in its nature – and this is at a time when generalists are almost vanquished from most AHSCs.

Finally, in the service realm the evolution of very large institutions with specialized wards and even sites has had to confront the reality of the changing face of illness care. Inpatients are older, have multi-system disease, have an increased burden of chronic disease and

arrive at an increasing state of acuity as the limits of home and community care are exceeded. Notwithstanding the promise of electronic tracking and record-keeping, the evolving role of “hospitalists” must be seen in part as a failure of effective integration and continuity of care across the AHSC, whose mandate arguably should embrace the full spectrum of care. This is somewhat at variance with the idea of “bi-directional partnerships for primary and secondary care between the AHSC and community hospitals,” which sees the latter as simply a peripheral filter to decant the right/best patients to the AHSC, defined by their “tertiary.” Instead, it envisions a patient-centred embrace of primary and secondary care *within* an AHSC that fosters the kind of education, research and service that explicates, follows, addresses and reaches the needs of patients. In short, a blending of the specialist and generalist traditions – a marriage of the high Victorian and the Taoist “whole.”

How does this relate to adaptive systems behaviour or misbehaviour? Again, it is both simple and complex. We have the emerging capacity to organize ourselves around a less ambiguous focus – that of serving the patient. As the authors note, information systems are decidedly a double-edged sword depending on how they are deployed. They point out that “health information systems are only just in their infancy and currently show little capacity to demonstrate cross-functional integration or standardization of measurement.” On the other hand, even at their current stage of development they are capable of mischief since “control of the healthcare system is often driven by

those who gather and report data. This may have unintended consequences on the AHSC.” They then close with a delightful, if worrisome, turn of phrase in expressing concern that providers may be driven to “manage by the data, or manage to optimize the data.” Together with their concern that selective use of data by various components of the AHSC can drive priorities and/or resources in directions unhelpful to the needs of patients, this is the precise *antithesis* of emergent behaviour organized around an ethos of service. The centrifugal movement of resources and activities into various sites, programs, institutes, centres, etc., may represent an understandable search by academics and professionals for an appropriate scale and congruence of colleagues (Woollard and Ostry 2000) or even something as banal as a sequestration of funding supports and is certainly in keeping with traditions of science that go back as far as the gentleman scientists of Robert Boyle’s 17th century (Shapin 1994). However, it is *not* a step in the direction of emergent behaviour of an AHSC capable of accomplishing great deeds in service to the society whose resources support it in the reasonable expectation that it will return the favour.

Woven throughout the lead paper in this issue are numerous examples of the intimidatingly complex nature of the AHSC. The authors have highlighted a number of ways in which this complexity can contribute to a culture that one could term “learned helplessness” among the entities that could constitute an effective AHSC. It would be a disservice to the authors to leave it at that. The reader of this issue may rather wish to heed their enjoiner to “develop a process whereby

clear, explicit and thoughtful missions and visions are developed.” However, if this is done with a narrow focus that is not centred on patient need and embracing of the generalist perspective, it will be a limited vision trapped in the 20th century.

Dickens in a very real sense saw into the soul of the 18th century, dissected the living body of the 19th century and envisioned what should be in a just and healthy 20th century. Only parts of his vision came to be, and we are again witness to “the best of times, and the worst of times.” It ill behoves us to embark on the 21st century with an exhausted, helpless and self-pitying sense of poverty in the midst of plenty. What the next century holds for us is beyond our ability to foretell, but one is certain that if we work to ensure that they are the “best of times” for our patients, then we can expect that the same will follow for the AHSC.

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