THE ROLE OF THE VOLUNTARY HOSPITAL TRUSTEE: A Case Analysis

by

KIRK ADDISON MITCHELL
B.A., University of Alberta 1974
D.P.A., Carleton University 1975
M.B.A., York University 1979

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE

in

THE FACULTY OF GRADUATE STUDIES
Program in Health Services Planning
Department of Health Care and Epidemiology

We accept this thesis as conforming to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA
April 1982

In presenting this thesis in partial fulfilment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

Department of Health Care and Epidemiology

The University of British Columbia
1956 Main Mall
Vancouver, Canada
V6T 1Y3

Date April 28, 1982

ABSTRACT

The purpose of this study is to provide a critical examination of the concept of hospital governance in a community hospital in British Columbia. The format of the thesis is to model the development of the Canadian health system in an extensive case analysis. The case analysis approach permits the expounding of theoretical concepts of hospital trustee roles and functions.

Through the application of qualitative research, the fundamental issue addressed was the involvement of the Lions Gate Hospital trustees with policy issues during a ten year period of analysis from January 1969 through December 1978. The hypothesis was that the hospital trustees were not substantially involved in policy making but were primarily concerned with operational management issues and this suggested that the role of the trustee did not evolve in concert with the change in the Canadian health system under national health insurance. The hypothesis was tested through application of the research methods of content analysis and grounded theory in a review of the minutes of the Board of Management and the annual reports.

In tracing the evolution of the Canadian health insurance program, it was shown that the enactment of the hospital insurance

components which preceded medical care insurance produced an emphasis on hospital care and diagnostic services rather than ambulant care. Cost sharing provisions initially for capital funding and later for operational costs encouraged and stimulated the demand for hospital facilities across Canada. With the advent of these third party Insurance schemes, the role of the hospital trustee should have changed from one of fundraiser to one of policy maker; however, the trustees at Lions Gate Hospital were found to be predominantly concerned with operational management issues rather than policy issues. National health insurance established the legitimacy of hospital trustees as policy makers and the professionalization of hospital administration established the feasibility of the Chief Executive Officers being held accountable for operational management. The missing link is support from the provincial government of British Columbia and the lack of definitive legislation and requirements embodied in the Hospital Act (RS Chapter 176; 1979). The current legislation inhibits policy making and long range planning and reinforces the conception of a hospital board as an administrative body.

The lack of policy development initiatives by the Lions Gate Hospital trustees resulted from the restrictive mandate of the Hospital Act, the inadequate funding system for hospitals, the process of trustee selection, the education process for hospital

trustees, the role of the Chief Executive Officer and the interaction with the organized medical staff. Weak and ineffective boundary spanning roles allowed the hospital trustees to function as an administrative board rather than a policy making board. The outcome of the analysis of the governance process at Lions Gate Hospital was an unfulfilled expectation that the hospital trustees would perform three basic functions - mandate, maintain and monitor.

TABLE OF CONTENTS

Chapter One: INTRODUCTION	Page 1
Chapter Two: OVERVIEW OF HOSPITAL GOVERNANCE	5
- Legal Parameters	6
-Trusteeship	7
-Citizen Board	10
-A Mandate for Policy Making	13
-Chapter Footnotes	15
Chapter Three: HISTORICAL DEVELOPMENT OF THE CANADIAN HEALTH CARE SYSTEM	17
-Constitutional Mandate	17
-Early Beginnings in Saskatchewan	20
-Hospital Insurance in British Columbia	21
-Contributions to National Policy	22
-Stages in Development of National Health Insurance	23
1) National Health Grants	24
2) Hospital Insurance	25
3) Medical Care	27
-Task Force Report on the Cost of Health Services	31
-Established Programming Financing	32
-Summary	33
-Chapter Footnotes	35
Chapter Four: HISTORICAL DEVELOPMENTS OF LIONS GATE HOSPITAL	38
-Historical Context	38
-Rate Board	41
-North and West Vancouver Hospital Society	42
-Regional Hospital Districts	44
-Lions Gate Hospital Description	46
-Summary	48
-Chapter Footnotes	50
Chapter Five: REVIEW OF LITERATURE ON HOSPITAL ORGANIZATION	51
-Evolutionary Stages	52
-Conceptual Model for Organizational Design	57
-Theoretical Framework for Hospital Organization	59
-Organizational Triad	64
1) Governing Board	65
2) Chief Executive Officer	68
3) Organized Medical Staff	74
-Summary	77
-Footnotes	81

Chapter Six: RESEARCH METHODOLOGY Page 87
- Qualitative Research 87
- Overview on Grounded Theory 88
- Substantive and Formal Theory 90
- Research Stages 91
1) Pre-Stage One 91
2) Stage One 92
3) Stage Two 92
4) Stages Three and Four 94
5) Stage Five 96
6) Stages Six and Seven 97
7) Stage Eight 98
8) Final Stage 99
- Reliability and Validity 100
- Summary 103
- Chapter Footnotes 104

Chapter Seven: ANALYSIS 106
- Initial Grounded Theory Approach 107
- Management Response Model Analysis 114
- Policy Issues 120
1) Hospital Funding 122
2) Quality of Care 125
3) Planning Activities 130
4) Abortion 134
5) Support of Provincial Interest Groups 146
6) Organizational Design 150
7) Operational Policy Development 153
- Summary 155
- Chapter Footnotes 156

Chapter Eight: CONCLUSION AND IMPLICATIONS FOR PLANNING 163
- Expectations for Hospital Governance 163
- Realities 167
- Generalizability 172
- Implications for Planning: Disappointed Expectations 173
- New Model for Trusteeship 175
- Planning Recommendations 176
- Chapter Footnotes 181

Bibliography 182

Appendices:
1) Grounded Theory Stages 213
2) Categories for the Grounded Theory Approach 214
3) Definition of Categories in the Grounded Theory Approach 215
4) McCool and Brown Management Response Model 219
5) Categories for the Management Response Model Analysis 220

6) Definitioin of Categories in the Management Response Model Analysis Page 221
7) Quality Appraisal Oversight Committee Structure 225
8) Criminal Code of Canada Legislation on Therapeutic Abortions 226
9) Terms of Reference for the Therapeutic Abortion Committee at Lions Gate Hospital 227
10) Directive to the Administrator 228
11) Performance Guidelines for the Chief Executive Oficer 231

LIST OF TABLES

Table	I	Historical Utilization Data for Lions Gare Hospital (Chaper Four)	Page 47
Table	II	Reliability Data of the Initial Grounded Theory Approach (Chapter Six)	101
Table	III	Reliability Data of the Management Response Model ANalysis (Chapter Six)	101
Table	IV	Average Score on the Grounded Theory Approach (Chapter Seven)	108
Table	V	Percentage Distribution of Major Categories from the Grounded Theory Approach (Chapter Seven)	109
Table	VI	Average Score from the Management Response Model Analysis (Chapter Seven)	115
Table	VII	Percentage Distribution of Major Categories from the Management Response Moded (Chapter Seven)	116
Table	VIII	Board Composition Comparisons (Chapter Eight)	173

ACKNOWLEGEMENTS

Acknowledgements are made to the following:

1) Dr. Anne Crichton (Chairman), Dr. Larry Moore and Dr. Nancy Waxler for their assistance as the Thesis Committee

2) Mr. John Borthwick and the staff of Lions Gate Hospital

3) Board of Management at Lions Gate Hospital

4) The British Columbia Health Association

5) Mr. Lloyd Detwiller and Mr. Robert McDermit and the staff of the UBC Health Sciences Centre Hospital for their support and encouragement

6) Mrs. Priscilla Harrington, Ms. Robin Laurence and Mrs. Marjorie Summerscales, Ms. Laurie Burnham, Ms. Catherine Falk, Ms. Viviene Roberts, Ms. Dorothy Stanfield, Ms. Pat Bernoe and Mrs. Ann Bishop for typing the Manuscript

7) Kathy for waiting patiently and enduring quietly

CHAPTER ONE

The purpose of the study is to provide a critical examination of the concept of the functioning of hospital boards in British Columbia. The format of the study is to model the development of the Canadian health system as an extensive case analysis. The case analysis approach permits the extrapolation of emerging hypotheses about the theoretical concepts of trustee roles and functions through application of content analysis and grounded theory as a strategy for qualitative research.

Lions Gate Hospital, a community hospital geographically situated on the North Shore was selected as the hospital for analysis during a ten year period from January 1, 1969 through December 31, 1978. Through the application of grounded theory, the fundamental issue addressed in this thesis is the involvement of the trustees at Lions Gate Hospital with policy issues. The hypothesis is that hospital trustees are not substantially involved in policy making, but are primarily concerned with management issues since the role of the trustee has not evolved in concert with the change in the Canadian health system under national health insurance.

The question was developed and researched in order to delineate the present roles and functions fulfilled by hospital trustees over

a defined time period. The process of hospital governance has been criticized as a legal anachronism and praised as a finely tuned set of checks and balances that has resulted in needed developments and needed controls. Background data on Lions Gate Hospital was reviewed and synthesized to produce the initial set of categories for analysis for the ten year period of analysis from January 1969 through December 1978. The initial content analysis categorizations did not directly address the hypothesis and the initial methodology was augmented with the grounded theory approach to facilitate the sorting of information into comprehensible data trends. The significant change in methodology provided for a more satisfactory substantive analysis of hospital governance. The application of the grounded theory approach was not intended to generate formal theory related to the concept of hospital governance.

Data collection was initiated in June 1979 and completed in September 1979, including the initial content analysis that was subsequently modified by the grounded theory approach and the management response model analysis.

The study is presented in three major sections. The first section provides a basic introduction to the responsibilities of trustees in order to provide an overview of the focus for the thesis, a cursory examination of the legal parameters of hospital

governance and the principles of hospital trusteeship are provided. The inception of voluntary accreditation is presented to indicate the evolution of standards for hospital governing boards. The concept of a citizen board is examined in order to illustrate the trustees' mandate for policy making. There follows a description of the evolution of the Canadian health care system in terms of national health insurance.

Hospital governance in Canada has been linked to policy making and planning by means of the evolution of the Canadian national health insurance system. The National Health Grants Program (1948), the Hospital Insurance and Diagnostic Services Act (1958) and the Medical Care Act (1968) dramatically altered the role of the hospital trustee from fundraiser to policy maker.

Hospitals in Canada have traditionally been operated by corporate bodies utilizing a voluntary governance structure comprised of unpaid voluntary lay trustees, elected by members of a hospital society or appointed by the provinical government. Voluntary governance of Canadian hospitals was modelled on the American and British practice of community involvement with a mandate to raise money to support construction and operating. With the introduction of third party payment schemes including the Hospital Insurance and Diagnostic Services Act (1958) and the Medical Care Act (1968), the

provincial governments became the primary funding sources for hospitals and the role of the hospital trustee was fundamentally altered.

There follows an account of the historical development of Lions Gate Hospital. The literature review then presents a contextual overview of hospital governance in terms of conceptual models for organizational design, the theoretical framework for hospital organization and the organizational triad comprised of the governing board, the Chief Executive Officer and the organized medical staff. The second section provides an overview of the research methods, including both content analysis and the subsequent change to the grounded theory approach. The third section provides an analysis of the data trends and outlines the major findings and conclusions derived from the study and the implications for planning.

CHAPTER TWO

Chapter Two begins by outlining the legal parameters of the governance structure, introducing the concept of trusteeship and discussing the work of citizen boards. The evolution of the role and function of hospital trustee is traced and their mandate for policy making is presented.

Policy making and planning have been closely linked in the domain of hospital governance through the evolution of the Canadian national health insurance system. The National Health Grants Program (1948), the Hospital Insurance and Diagnostic Services Act (1958) and the Medical Care Act (1968) dramatically altered the role of the hospital trustee from fundraiser to policy maker. Throughout the following chapters the Canadian health system is modelled in a case analysis and it will be illustrated that policy making in Canadian hospitals has become an interaction of countervailing forces of the hospital trustees, Chief Executive Officers and the community with the government. The hospital board reflects the public conscience and acts as a buffer between the hospital and the larger community that supports it. The chief executive officer clarifies and enunciates policy, reconciles conflicting points of view, mediates disputes, protects patients and hospital employees from external threats and endeavors to keep the institution solvent.[1]

Legal Parameters

The governance structure of a British Columbia hospital is subject to two sets of general law - the law which relates to corporations in the operational jurisdiction of the Health Act (1960) and the Hospital Act (RS Chapter 176; 1979) as the law governing institutions which provide health services in British Columbia. The Hospital Act (1979) states

> " Every hospital ... shall ... have full control of the revenue and expenditure of the hospital vested in its board of management (and) ... have a properly constituted board of management and such by-laws, rules, or regulations as may be deemed necessary by the Minister for the proper carrying-out of the administration and management of the hospital's affairs and the provision of a high standard of care and treatment for patients, and the constitution and by-laws, rules, or regulations of a hospital shall not become effective until approved by the Minister ..."[2]

The development of quasi-public corporations such as hospitals and universities with no clearly delineated shareholders differs substantially from the private sector corporation because members of the public corporation do not have a proprietary interest.[3] The general corporate jurisdictions in Canada vest operational control in a board of directors with the directors appointed either by order-in-council or elected in accord with the provisions of the incorporating documents. Thus, the board is the mechanism by which the artificial corporate "person" makes decisions and formulates policy with the authority to bind the corporation whilst at the same time the board is accountable to the corporate entity.[4]

As the corporate power and authority is vested in the hospital trustees, there is a corresponding responsibility on the trustees to act in favour of the hospital. The duty of the trustee to the hospital supercedes the legal duty to any other organization or entity. The responsibilities of a hospital trustee are two-fold including fiduciary duties (ie: good faith, honesty, unfettered discretion and conflict of interest) and the duties of care and skill.[5]

Trusteeship

The functions of a hospital board of trustees are virtually interchangeable with the functions assigned to a private sector board of directors for a corporation. Both are intended to be policy making bodies and the implementation of policy decisions is intended to be an administrative function. In 1924, the American Hospital Association defined the functions of the hospital trustee as including: the determination of policy, maintenance of professional standards, coordination of professional interests with the administrative, financial and community requirements, directing administrative personnel in the implementation of policy and the provision of adequate financing by securing a sufficient income and by enforcing expenditure control.[6]

The original delineation of the trustee role in Canadian hospitals was significantly altered by the development of the Canadian health care

system with the evolution of national health insurance. The advent of insurance schemes and the initiation of the National Health Grants Program in 1948 by the federal government altered the role of the hospital trustee from a primary responsibility for fundraising and support of hospital operating costs. However, as hospital insurance and medical care insurance developed, the hospital trustee role did not evolve with the advent of the third-party payment schemes. Whilst the Hospital Insurance and Diagnostic Services Act (1958) and the Medical Care Act (1968) made it legitimate and feasible for hospital trustees to dramatically alter their role, the initiative for change has not found a large body of support.

Trustee education initiatives were undertaken by the British Columbia Health Association during the 1970's in order to assist the development of trusteeship skills; however the educational programs were unable to shift the emphasis away from administrative concerns toward policy making and long range planning issues. High turnover pattern with hospital trustees precluded any longitudinal benefit as the well informed trustees became those whose term of office was soon to expire. Thus the hospitals in British Columbia continously faced the reality of largely inexperienced hospital trustees with a very narrow perspective on the role of hospital governance.

Previous attempts to clarify the role of the hospital trustee in Canada have included efforts by the Ontario Hospital Association to

delineate a code of ethics.[7] In 1970, the Catholic Hospital Association developed a summary statement of responsibilities and functions for trustees and the summary was endorsed by the British Columbia Health Association. The summary statement delineated the major responsibilities and functions of a hospital trustee as follows:

"... 1. To determine the hospital's objectives and major policies.

2. To assure that major plans and programs are designed to meet objectives.

3. To establish a suitable mechanism for conducting the business of the board.

4. To approve hospital organization and major authority delegation patterns.

5. To select and appoint the chief executive officer (administrator).

6. To maintain a qualified medical staff.

7. To provide for long-range financial stability.

8. To make major hospital decisions.

9. To safeguard hospital assets.

10. To approve broad policies concerning relationships with external groups or organizations.

11. To analyze and evaluate the total hospital operation including all activities and services ..."[8]

The "state of the art" definitions provide for a base-line of responsibilities including legal responsibility, community responsibility, financial responsibility, medical staff appointment

responsibility and a planning responsibility.[9]

Since the inception of the voluntary hospital accreditation program in 1918, standards have been developed for the governing body and management of Canadian hospitals. Through the numerous transitions culminating in the creation of the Canadian Council on Hospital Accreditation in 1959, it was not within the province of the voluntary accreditation program to decree effective organization and internal relationships in Canadian hospitals.[10] Thus, in establishing standards for hospital boards, the Canadian Council on Hospital Accreditation established the underlying principle of hospital governance in Canada, as being that hospital governing boards had the overall responsibility for the conduct of the hospital in a manner consonant with the hospital's objective of delivering a high quality of patient care.[11] The standards established by the Canadian Council in Hospital Accreditation have reinforced the principles of a citizen board for Canadian hospitals.

Citizen Board

Juran and Louden have described a citizen board as one of society's most important institutions because the board is intended to determine social policy and is responsible for the provision of community services.[12] Assuming that the basic responsibility of a

hospital board in a community hospital such as Lions Gate Hospital is to act as the community conscience, the role and function of the trustee has moved from a mandate for fundraising toward a representation of community goals and aspirations. The evolution of national health insurance established the legitimacy and feasibility of the change in hospital trustee role; however, the transition has not found a broad base of support and has produced an outpouring of criticism regarding the selection and election methods for voluntary trustees for Canadian hospitals. Critics have claimed that because hospital trustees are unclear as to their appropriate role, they interfere in complex administrative matters, delay policy decisions and create operational nightmares.[13]

> "... Hospital boards are still trying to operate as they did in the past. Trusteeship is no longer relevant to the hospitals for which it purports to set direction and policy. At best, the contribution of hospital boards is only marginally positive. At worst, they are obstacles to efficient decision-making and a source of frustration ..."[14]

A 1977 white paper on hospital trusteeship published by the British Columbia Health Association concluded that the existing system for obtaining hospital trustees produced a finely tuned set of checks and balances that had resulted in needed developments and needed controls.[15] Throughout the debate the provincial government in British Columbia stressed that boards were to become more reflective of the consumer and the community,[16], however, the Ministry of Health did not develop explicit guidelines or directions

indicating the process for achievement of increased consumer or community representation.

The tradition of voluntary governance has been conceptualized as a traditional and integral part of the social welfare system with a mandate to identify problems, initiate policy, contribute knowledge, solicit support, interpret programs, report community feedback and collaborate in planning.[17] Voluntary governance has also been conceptualized as the trustee of community values and the conscience of community life.

In the final analysis trustees hold the operation of hospitals in trust as a public service. Every hospital has now become in fact a public agency; and it is required to gain and hold public confidence. To do this means a two-way relationship of trust. The wider public has come to realize that for the hospital to perform its unique mission the hospital has to have its own special degree of freedom, of elbow room, of leisure time, and of absence of influence from outside pressures.[18]

Hospital trustees in providing voluntary governance for Canadian hospitals continue to occupy a place of major importance in the community welfare enterprise.

> "... Administration is not and cannot be a one-man show. No enterprise can be performed by one person, unless it is the most simple of endeavors. Administration usually involves the

cooperative efforts of many persons. Indeed, administration is a system of people working together, it is a pattern of cooperative activity in which the specialized talents of various individuals are brought together to achieve a common purpose. By definition, administration is a team operation ..."[18]

A Mandate for Policy Making

Whilst there is widespread agreement that it is the mandate of a hospital board in Canada to develop policy[20] and the mandate of the administration to implement the policy decision, there is abundant evidence in the Canadian health care system to support that operationalizing the basic concept is not a simplistic process. In fact, the process of policy making is so involved and complicated that it has served as an area of significant conflict and confusion.[21]

While hospital trustees, hospital administrators and the senior bureaucrats in the provincial government understand the conceptual distinction between the policy making and the administrative domains, implementation has been problematic due to the lack of clarity as to what constitutes "policy". Because policies are fluid and dynamic in nature, they are subject to changing needs and conditions and do not represent a final and absolute product.[22]

Policies are developed to facilitate the development of plans, problem solving and the attainment of objectives through the

provision of a framework for carrying out assignments and delegated responsibilities in order to maintain authority and control.[22] A policy is analogous to a road map and permits the selection of a preferred route from a full range of alternatives. Policies represent general guidelines for prospective decision-making and are intended to shape those decisions in order to maximize their contribution to the goals of the enterprise. Thus, policies are the instruments by which goals are achieved.[24]

With the delineation of policy guidelines by the hospital trustees, the chief executive officer formulates the procedural mechanisms by means of rules and regulations to provide a blueprint as to the how, the who, the when and the where of patient services and programs. In practice, policy making is largely a matter of improvisation and of making the best of the finite resources and inputs available to you; therefore as in other aspects of life, this is seldom ideal.[25]

The application of policy necessitates the exercise of initiative, judgment, imagination and administrative skill on the part of all members of a hospital organization.

> "... policies are intended not to restrict initiative but to provide automatic safeguards to functioning so that the interests of both the organization and the public are served to best advantage ..."[26]

CHAPTER TWO FOOTNOTES

1) P. Wooding "Who Makes University Policy?" Saturday Review (April 17, 1965) pages 65-66.

2) Hospital Act (RS Chapter 176) 1979.

3) L.E. Rozovsky "Health and Corporation Law" Canadian Hospital Law (Ottawa: Canadian Hospital Association) 1979; page 7.

4) Ibid; page 9.

5) Ibid; pages 10-13.

6) M.T. MacEachern "Foreword" in J. A. McNamara; What the Hospital Trustee Should Know (Chicago: Physician's Record Company; 1931) pages 27-28.

7) Code of Ethics for Hospitals (Ottawa: Ontario Hospital Association) 1966; page 5.

8) Guidelines on the Responsibilities, Functions and Selection Criteria for Hospital Board of Trustees (Chicago: Catholic Hospital Association) 1970; page 9.

9) R.A. Hay "Responsibility and Authority in 1977" Hospital Trustee (May 1977) pages 17-18.

10) "Introduction" Guide to Hospital Accreditation (Ottawa: Canadian Council on Hospital Accreditation) 1977; page ix.

11) "Governing Body and Management" Guide to Hospital Accreditation(Ottawa: Canadian Council on Hospital Accreditation) 1977; page 1.

12) J.M. Juran and J. K. Louden The Corporate Director (New York: American Management Association, Inc) 1966; page 7.

13) "Drop Hospital Boards Says Union Brief" Vancouver Sun (March 6, 1973).

14) Ibid

15) L.E. Ranta (Editor) White Paper on Hospital Trusteeship (Vancouver:
B. C. Health Association) 1978.

16) "Drop Hospital Boards Says Union Brief" op.cit.

17) V.M. Seider "Volunteers" Encyclopedia of Social Work (New York: National Association of Social Workers) 1965; pages 830-836.

18) O. Tead Trustees, Teachers and Students - Their Role in Higher Education (Salt Lake City: University of Utah Press) 1957; page 23.

19) J.D. Millett "National Conference of Professors of Educational Administration" The Community School and Its Administration (September 1965) page 2.

20) Policy is defined by the author as a standing plan or general guides to future decision making that were intended to shape thoe decisions so as to maximize their contribution to the goals to the enterprise. Thus, as a guideline for action, policy is conceptualized as the instrument by which goals were achieved.

21) H.B. Trecker Citizen Boards At Work: New Challenges to Effective Action (New York: Association Press) 1970; page 69.

22) Boardmanship - A Guide for the School Board Member (Sacramento: California School Board Association) 1969; page 8-9.

23) The Council Manual (New York: Girl Scouts of America) 1969; page 33.

24) A.J. Kahn Theory and Practice of Social Planning (New York: Russell Sage Foundation) 1969; page 130.

25) L.H. Jenrich "Social Policy Comes From Knowing Families" Making Yours a Better Board (New York: Family Service Association of America) 1954; page 34.

26) V.H. Hodgson Supervision in Public Health Nursing (New York: The Commonwealth Fund) 1939; page 63.

CHAPTER THREE

Chapter Three traces the historical development of the Canadian health care system from the times of confederation in 1867 through the early beginnings of third party insurance schemes. The contributions of Saskatchewan and British Columbia to national policy are outlined and the stages for the development of national health insurance are presented in a review of the National Health Grants Program in 1948, the Hospital Insurance and Diagnostic Services Act (1958), the Medical Care Act (1968), The Task Force Report on Health Costs (1970) and the Established Programs Financing Act (1977).

Constitutional Mandate

At the time of Confederation and the drafting of the British North America Act (1867), governmental involvement in health care services was minimal. Individual Canadians and their families were compelled to rely on their own resources, with hospitals administered and financed by private charities and religious organizations.[1]

The British North America Act (1867) made specific reference to health in the distribution of legislative powers with the federal

government granted jurisdiction over quarantine and the establishment and maintenance of marine hospitals. The provincial governments were granted jurisdiction over the establishment, maintenance and management of hospitals, asylums, charities and charitable institutions for the hospital, other than marine hospitals. Since the provinces were assigned jurisdiction generally over all matters of local and private nature in the province, it is presumed that such power was deemed to cover health care, whilst the provincial power over municipal institutions provided a convenient system to deal with such matters.[2] Thus the provision of health care services has traditionally been acknowledged as primarily a provincial responsibility.[3] Nevertheless, a measure of responsibility in health matters has been expressed over the years since 1867 in numerous federal government policies.[4]

In the post-Confederation period, hospitals were sponsored by various religious groups as towns and cities developed across Canada. The Order of the Grey Nuns provided almost every major Canadian city with a general hospital and the Salvation Army provided a maternity hospital. The Sisters of the Misericorde and the Sisters of Saint Joseph operated institutions in Western Canada, and at the same time most of the provincial universities developed their own medical schools with an affiliated teaching hospital.

During this post-Confederation period, physicians established themselves as a society of professionals. As individual entrepreneurs, dependent upon fees paid by individual patients, physicians enjoyed a standard of living considerably above the average and a unique role in the community that derived from crisis intervention. Since medical specialization had barely begun, the physician was most often a general practitioner and fees were tailored according to the ability of the patient to pay. Although as medicine it was uncomplicated, inefficient and largely unsuccessful by present standards, the result was a social gratitude and respect for physicians that bordered on awe. Throughout the period leading up to World War II, medical practice changed radically with increased specialization and hospitals became medical production complexes - vast, awesomely effective and emotionally cold. The religious orders began to withdraw because of the financial inputs required to establish and run hospitals. Throughout this metamorphosis, Canada became part of the growing voice for government action and state medicine.

The federal government passed the Employment and Social Insurance Act (1935) in an attempt to establish a federal program providing certain social security benefits including health benefits. It was envisaged the program would be financed by premiums levied on the population by the federal government. The

question of jurisdiction was raised and the Supreme Court of Canada ruled the Employment and Social Insurance Act (1935) "ultra vires" since the power to levy a direct premium on provincial residents was a matter pertaining to health and welfare and thus came within the provincial jurisdication.[5] The precedent was delineated that national programs for health and welfare could only be accomplished through programs administered by the provinces or by constitutional amendment.

Early Beginnings in Saskatchewan

Immediately after World War II, many Canadian provinces began to establish universal insurance schemes and Saskatchewan emerged as the leader with the introduction of the Saskatchewan Hospitalization Act (1946) which provided a universal compulsory hospital program covering virtually all residents of the province. The Health Services Act (1946) established broad health region programs, financed by personal and property taxes and supported by the provincial government.[6] With the introducton of the Saskatchewan Hospitalization Act (1946), the government served notice that the legislation was the initial phase of a long range plan to provide completely socialized health services.

Hospital Insurance in British Columbia

The British Columbia Hospital Insurance Service (BCHIS) was introduced in 1948 and was modelled on the Saskatchewan plan. The British Columbia plan was established with a dual collection system (ie: payroll deduction and "pay direct"[7]) in order to deal with the concentration of the provincial population in the lower Mainland area and in Victoria and the vast expanse of unorganized territory which precluded the efficient municipal collection system initiated in Saskatchewan. However, the transient and seasonally-employed labour force in British Columbia made the premium collection system difficult to administer efficiently and accurately.

To deal with the magnitude of the administrative burden, coinsurance payments ranging from $2.00 to $3.50 per patient day were introduced in 1951;[8] however, imposition of coinsurance payments did not remove the problem of high premiums in general and the arrears question in particular. Thus, hospital insurance became an emotional and controversial election issue in 1952 and resulted in the defeat of the Liberal-Conservative coalition and the election of the Social Credit Party, under the leadership of Premier W.A.C. Bennett. The Social Credit government made significant policy changes including the elimination of the six (6) month prepayment and waiting period, revision of coinsurance payments, abolition of

liability for accounts in arrears and a change in participation to make hospital insurance a voluntary plan. On April 1, 1958 a revised policy was announced that abolished premiums for hospital insurance and increased the social services retail sales tax from three percent to five percent[9] With the changed revenue system, the turmoil, bad publicity and political repercussions of the insurance phase of the British Columbia Hospital Insurance Service were over and all efforts were now directed to the development of the hospital system, improvement of standards and refinement of the system of paying hospitals for insured services.[10]

> "... British Columbia had also paid part of the tuition costs in educating Canadian governments in the formulation of effective policies and administrative procedures in this most complex of the social insurances. It had demonstrated the danger of trying to import an administrative system from another jurisdiction differing in both its economic and political organizations. It had alerted other provinces to the necessity of a much longer lead time for planning and design of the program and for creating the policies of the administrative organization. But the polularity of the policy of universal prepayment, as distinct from criticism of its maladministration, could not be doubted. Like Regina, Victoria became a Mecca for health authorities in all other provinces in the mid 1950s as they prepared to introduce their own programs ..."[11]

Contributions to National Policy

Both Saskatchewan and British Columbia made important contributions to national policy with the experience gained from their initiatives with hospital insurance. Their combined experience indentified the difficulties of universal coverage and

established the feasibility for the federal government to consider universal coverage as a condition for the distribution of grants. The benefits of hospital insurance were developed as service programs rather than indemnity coverage. Saskatchewan and British Columbia introduced uniform accounting systems which allowed an all-inclusive daily rate in order to meet the costs of providing services to all insured patients and achieve a balanced budget. Both Saskatchewan and British Columbia provided for standards by establishing consultative expertise to inspect hospitals, participate in the analysis of hospital budgets in order to ensure the maintenance and/or raising of standards and to provide assistance for hospital construction grants.[12] These precedents were later incorporated into the requirements laid down by the federal government as the basic conditions for receiving federal grants.

Stages in Development of National Health Insurance

The constitutional mandate established by the British North America Act (1867) has provided a different approach to national health insurance than is evidenced in other countries in the world. Thus, instead of having a national plan, Canada has national programs that are achieved through interlocking provincial plans, all of which share certain common features.[13] National health

insurance programs were implemented in Canada in three (3) main stages - National Health Grants Program in 1948, the Hospital Insurance and Diagnostic Services Act (1958) and the Medical Care Act (1968).

1) National Health Grants

The first phase of national health insurance for Canada was initiated in 1948 with the introduction of National Health Grants Program by the federal government as the foundation for a national system of health insurance. The grants inaugurated in 1948 were in the fields of hospital construction, health surveys, professional training, public health research, general public health, mental health, tuberculosis control, cancer control, venereal disease control and aid to crippled children. Subsequently other grants including one for rehabilitation after a disability were added. This paved the way for the second step by leading to a standard accounting and reporting system for Canadian hospitals, an upgrading of the diagnostic services and through the hospital construction grant, an upgrading of the physical facilities.[14]

Throughout the 1950's interest in health insurance had grown and provincial governments were pressing the federal government for some action in this field.

"... The provincial governments were finding it very difficult to raise the necessary revenues to meet the escalating cost of providing hospital services. Many Canadian hospitals were in financial trouble, especially the smaller and rural ones. Technology was beginning to burst forth and also unionization of hospital workers had become a fact. While hospital workers had previously been the poor cousins of the labor force, with increasing militancy the unions were insisting that the wage gap be closed and eventually eliminated between the hospital workers and the rest of the working force. The hospitals were finding it extremely difficult to finance their operations and keep up their standards because less than 40 percent of the population at that time had some hospital insurance coverage and much of it was not adequate ..."[15]

2) Hospital Insurance

The Hospital Insurance and Diagnostic Services Act (1958) was designed to provide a diverse range of necessary hospital and diagnostic services[16] at little or no cost to the patient, thereby removing financial barriers to adequate care which existed for many Canadians prior to the introduction of the program. The program incorporated five (5) general principles including: comprehensiveness of services, universal availability of coverage to all eligible residents; no barriers to reasonable accessibility of care, portability of benefits and public administration of the provincial programs.[17]

Throughout the development of hospital insurance legislation, existing traditions were maintained as far as possible. The pattern of hospital ownership and operation (ie: voluntary boards and

municipalities[18] that existed prior to the introduction of the Hospital Insurance and Diagnostic Services Act (1958) were retained and provincial autonomy was maintained. The policy allowed each provincial government to decide on methods of administration and of financing its share of program costs while still ensuring a basic uniformity of coverage throughout Canada.

Inpatient services were delineated by the legislation as including: accommodation, meals, necessary nursing service, diagnostic procedures, most pharmaceuticals, the use of operating rooms, case rooms, anaesthesia facilities and radiotherapy and physiotherapy if available. In addition, outpatient services were included in provincial plans and authorized for contribution under the Hospital Insurance and Diagnostic Services Act (1958). Individual Canadians were permitted to select the hospital of their choice for treatment provided their physician had admitting privleges with the only limit to the duration of insured services being the extent of medical necessity. Provincial governments were permitted to include additional benefits in their provincial plans without affecting the federal-provincial agreements. Whilst some provincial plans provide additional services (ie: nursing home care), such additional services were not cost shared under hospital insurance. The principles of universal availability of benefits to all eligible residents and portability of benefits were reflected in provisions for each provincial plan.[19]

3) Medical Care

In the early 1960's the federal government established a Royal Commission on Health Services, chaired by Chief Justice E. M. Hall. The commission was appointed in part due to the pressure on the federal government by the Canadian Medical Association. The medical profession favoured a "supplement not supplant approach"[20] to health insurance. The Canadian Medical Association endorsed the concept of subsidies geared to income tax exemption thresholds for any Canadian who purchased policies from insurance companies or profession-sponsored plans.

During the 1961 doctors strike in Saskatchewan, the medical profession denounced state medicine as a double threat - challenging their higher income status and threatening to make them civil servants. They envisioned national health insurance as effectively destroying their initiative, their coveted independence and the social respect which Canadians had so long accorded them.

The Royal Commission on Health Services was released in 1964 and completely rejected the Canadian Medical Association and the insurance industry approach to national health insurance. The Commission came out strongly in favour of a parallel shared cost program to the hospital insurance program as mandated by the

Hospital Insurance and Diagnostic Services Act (1958). Thus, the Commission advocated a universal and government operated program for medical services consisting of ten (10) provincial plans, subsidized by matching federal fund to parallel hospital insurance programs. The Canadian Medical Association and the insurance industry had based their estimates on those needing subsidies on only the premiums for medical services. The Commission, on the other hand, looked at the total package of health services, which in 1962, averaged approximately $350 for a family. Assuming that five percent was the maximum that a consumer could reasonably allocate to health services, then all below an income of $7,000 a year would be entitled to subsidy. This would have required "means-testing" half or more of the population in 1962, an administrative task not worth the effort. It was clearly more cost-effective to subsidize the insurance funds than millions of individuals.[21]

The Commission did advocate the retention of the fee-for-service principle for physicians in order to gain a measure of support from the medical profession. Chief Justice Hall reported:

> "We determined that the fee-for-service method was a practical one to recommend for Canada. The capitation method which was reasonably successful in England was virtually unknown to medical practice in North America. If the program was to be successful it had to have much cooperation from and acceptance by the medical profession as was possible to obtain. In the aftermath of the Saskatchewan strike we discerned a growing support for a medicare program from many doctors, particularly among the younger practitioners and in the teaching hospitals."[22]

National health insurance represented the last major legislative accomplishment of the Liberal government, under Prime Minister Lester B. Pearson. Under the British North America Act (1867) health care was delineated as a provincial responsibility; therefore, the federal government could only introduce it into a province if the provincial government concurred. But how could any provincial government refuse? The federal share was being paid out of general revenues, which came from all Canadians. Thus, if a province opted out, its citizens would bear their share of the total national load and not recieve any compensating benefit in return.

In 1965, Prime Minister Lester B. Pearson announced his intention to implement Medicare and stated:

> "... This proposal does not require detailed agreements. It calls only for general federal-provincial understanding as to the nature of the health program which will make a federal fiscal contribution appropriate. The Federal Government believes that there are four criteria on which such an understanding should be based ..."[23]

The four criteria raised by Pearson included: comprehensive coverage, universal availability, portability and a non-profit basis for public accountability.

The Medical Care Act (1968) stipulated that comprehensive coverage must be provided for all medically required services rendered by a physician or surgeon. With no dollar limit or exclusion except that the service was not medically required, the

federal program encompassed all services traditionally covered as benefits by the private insurance plans and incorporated preventive and curative service (ie: mental health and tuberculosis) traditionally covered through the public sector in each province and provided to individuals by physicians in public health agencies.[24]

The Medical Care Act (1968) stipulated that the provincial plans must be universally available to at least ninety-five percent of the eligible provincial population. A uniform set of terms and conditions was intended to ensure that all Canadians had access to coverage and to prevent discrimination in premiums because of previous health, age, non-membership in a group or other considerations. Each province was entitled to select either a voluntary or compulsory approach. Utilization charges were not precluded provided the charges did not block reasonable access to necessary medical care. The provincial plans were required to provide portability of benefit coverage between provinces and while Canadians were temporarily absent from their province of residence. Each provincial plan was mandated to be administered on a non-profit basis by a public authority accountable to the provincial government for financial transactions. The four basic criteria were intended to provide flexibility for each province in the determination of its own administrative arrangements for the operation of their medical care insurance plan and to choose the manner in which to finance the plan (ie: through premiums, sales tax, provincial revenues or a combination of these methods).[25]

Task Force Report on the Cost of Health Services

The National Health Grants Program in 1948, the Hospital Insurance and Diagnostic Services Act (1958) and the Medical Care Act (1968), established national health insurance in Canada; however, the cost of health services had risen so rapidly between 1948 and 1968 that the need for rationalization of the economic inputs had become apparent. The Task Force on the Cost of Health Services in Canada was established jointly by the federal and provincial governments in 1969 with a mandate to investigate how to maintain health service costs at a reasonable level without adversely affecting the quality of care, to examine the cost of hospital services, medical care and public health and to study the rising cost of health service in Canada by developing recommendations, standards and guides for practical action.[26]

Four main points emerged from the Task Force Report on the Cost of Health Services in Canada (1970). Firstly, health care was described as a labor intensive industry and the cost of health services was closely related to wage and salary levels.

> "... increased productivity and better operation of the health care system can reduce the impact of these increases upon total cost.
>
> It is necessary that the efforts of this vast force of

essential, dedicated people be deployed with the utmost skill to ensure maximum productivity ..."[27]

Secondly, the remorseless escalation of cost was criticized for failing to encourage enconomy and efficiency.

> "... Only after major reforms in the health care system have been achieved should Canadians be asked to pay additional monies for maintaining and improving existing standards..."[28]

Thirdly, regionalization of health services was described as essential to cost efficiency in order to rationalize administrative complexity, confusion, competition and inefficiency.[29] Fourthly, the need for public understanding and cooperation was outlined in order to support the needed reorganization and strengthening of cost efficiency required by the health care system.

> "... The annual increase in costs must be sharply curtailed or else something will have to give - the pocket of the taxpayer, the quality of the present service, or the most obviously desirable alternative albeit a most difficult achievement in terms of detail, debate and compromise, the present structure must be reformed in all its aspects to continue delivering the goods while curtailing the rise of cost ..."[30]

Established Programs Financing

The Established Programs Financing Act (1977) contained significant amendments for the Hospital Insurance and Diagnostic Services Act (1958) and the Medical Care Act (1968) and focused on new financial arrangements for medical care and hospital insurance. The change from cost-sharing to bloc grants was developed to permit federal contributions to the established programs of hospital

insurance, medical care and post-secondary education to take the form of the transfer of a predetermined number of tax points rather than a sharing of provincial costs.[31] The tax room vacated by the federal government permitted the provincial governments to increase their tax rates so as to collect additional revenue without necessarily increasing the tax burden on Canadians. The yield from the provincial taxes was intended to increase faster than the growth of the Gross National Product.

The transfer payments were conditional upon the provincial health insurance plans meeting the four criteria of the federal health insurance legislation that included comprehensive coverage, universal availability, portability and non-profit basis for public accountability. In 1977, the cash payments approximated the value of the tax room transferred and were in the form of per capita payments calculated in accordance with the bloc grant formula. The per capita payments were subsequently escalated yearly in accordance with changes in the Gross National Product and adjusted so that all provinces would receive equal per capita cash contributions by April 1982.[32]

Summary

In reviewing the Canadian health system analysts have remarked

that it might have been advisable to bring in the medical program first and thus encourage ambulant care and then later to phase in the hospital insurance program.[33] The National Health Grants established in 1948 emphasized hospital care and diagnostic services. Thus, in the mid 1950's, many hospitals were in financial trouble and only a minority of the population had adequate hospital insurance coverage at a time when unionization and technology were beginning to cause additional financial complexities. With increasing demands for insurance coverage outside of heavily industrialized and unionized metropolitan areas, the provincial governments felt obliged to help in the financing of hospital operations since Canadian hospitals had been built primarily as community projects and operated essentially on a non-profit basis.

CHAPTER THREE FOOTNOTES

1) M. Leclair "The Canadian Health Care System" in S. Andreopoulos National Health Insurance: Can We Learn From Canada? (Toronto: John Wiley and Sons) 1975; pages 11-12.

2) B. E. Pearson "Constitutional Responsibilities in the Health Field" Canada Year Book: An Annual Review of Economic, Social and Political Developments in Canada (Ottawa: Supply and Services Canada) 1978; page 199.

3) M. Leclair; op.cit.; page 12.

4) B. E. Pearson; op.cit.; page 199.

5) M. Leclair; op.cit.; page 13.

6) Ibid

7) M. G. Taylor; Health Insurance and Canadian Public Policy (Montreal: McGill - Queen's University Press) 1978; page 167.

8) Ibid; page 168

9) Interview with L. F. Detwiller, formerly Commissioner of the British Columbia Health Insurance Service from 1950-1954, Assistant Commissioner from 1954-1955 and Assistant Deputy Minister from 1957-1962.

10) M. Taylor; op.cit.; page 169.

11) Ibid.

12) Ibid; pages 197-198.

13) M. Leclair; op.cit.; page 25.

14) By 1966 the grants available totalled more than $60,000,000 annually. In December 1967, the government announced its intention of reducing the national health grants as the provinces began to participate in the federal government's plan for financial assistance for a nation-wide medical care program. With the exception of the Professional Training Grant and the Public Health Research Grant, all others were phased out by March 31, 1972. From 1948 to March 31, 1970 when the Hospital Construction Grant was terminated, federal assistance

had been approved toward the cost of space for more than 130,000 hospital beds (Canada then had approximately 150,000 general and allied special beds) and 15,000 bassinets in newborn nurseries. In addition, federal construction grants made possible more than 24,000 beds in nurses' residences, 900 beds in interns' residences and more than 7,000,000 sq. feet for public health hospital laboratories, community health centers, teaching areas in hospitals and diagnostic and treatment areas available to inpatients and outpatients. The Professional Training Grants provided more than 30,000 bursaries to health personnel and an equal number have benefited from assistance for short courses.

15) M. Leclair; op.cit.; page 14.

16) Facilities covered under the program included general, rehabilitation (convalescent), and extended care (chronic) hospitals together with specialized hospitals such as those providing maternity or pediatric care. The program also covered diagnostic services in non-hospital facilities. Specifically excluded under the program were tuberculosis hospitals and sanatoria, hospitals or institutions for the mentally ill, and nursing homes, homes for the aged, infirmaries or other institutions whose purpose was to provide custodial care.

17) Ibid; page 23.

18) Ibid; page 35.

19) B. E. Pearson; op.cit.; page 202

20) M. Leclair; op.cit.; page 19.

21) Ibid; page 20.

22) Ibid

23) Ibid; page 35.

24) B. E. Pearson, op.cit.; pages 200-201.

25) Ibid

26) J. W. Willard, et.al.; Task Force Report on the Cost of Health Services Canada : Summary (Ottawa: Queens Printer, Volume 1) 1970; page 2.

27) Ibid; page 6.

28) Ibid; page 7.

29) Ibid

30) Ibid; page 7-8.

31) B. E . Pearson, op.cit.; page 202.

32) Ibid

33) M. Leclair, op.cit.; page 22.

CHAPTER FOUR

Chapter Four outlines the historical developments of the North Vancouver General Hospital, the Hamilton plan of 1949 and the creation of the North and West Vancouver Hospital Society. The impact of the Rate Board and the Regional Hospital District are described in order to provide a basic description of Lions Gate Hospital evolution.

Historical Context

In 1908, three nurses established hospital services in a private home located in North Vancouver as the early beginning of a hospital on the North Shore. In 1910, the nurses amalgamated with a private hospital owned and operated by five physicians residing on the North Shore. By 1920, the accomodation was inadequate and the District of North Vancouver acquired premises and opened a thirty bed hospital for the North Shore; however, by 1927 these premises were overcrowded and the City of North Vancouver collaborated with the District of North Vancouver to finance, build and operate the sixty-six bed North Vancouver General Hospital which opened in 1929. Subsequently, the additions brought the official bed capacity of the North Vancouver General Hospital to one hundred and ten (110) beds and then to one hundred and forty beds.[1]

A change in operation of the North Vancouver General Hospital was initiated at the request of the Board of Directors in 1946 with the intention of placing the hospital under a "society" to be incorporated under the provincial Societies Act (1936). The directors indicated the change would relieve municipal taxpayers of any financial liability for any deficit. Hospital deficits would become the responsibility of the provincial government.[2] The other advantage of the plan was that it cleared the way for the City of West Vancouver to join in making North Vancouver General Hospital a facility for the entire North Shore.[3]

In 1949, the "Hamilton Report" prepared by James A. Hamilton, the pre-eminent proponent of hospital administration education from the University of Minnesota, was submitted to the provincial government. Hamilton made a profound impression on the senior health officials in British Columbia with his approach to problem definition and problem solving. As an outside consultant, Hamilton recommended a plan to deal with the capital funding of hospital costs throughout British Columbia. The plan was needed because of the hospital construction initiatives that developed in many communities with the local communities required to provide only twenty-five percent of the capital cost with the remaining seventy-five percent of the cost provided by government. Hospital construction was then used as an incentive to attract physicians.

However the plan did not become operational because British Columbia had no health planners to hold the boundaries of such a design in place.

With the advent of the National Health Grants in 1948, the North Shore became a political battleground as various factions argued for and against separate hospitals for West Vancouver and North Vancouver. Not unlike other hospitals throughout Canada, the North Vancouver General Hospital confronted budgetary deficits and decreased operating budgets. The British Columbia Hospital Insurance Service, created in 1948, demanded economical and efficient operations since the provincial government was paying hospital costs and controlling hospital expenditures. Hospitals throughout British Columbia were forced to make the best possible deal with the British Columbia Insurance Service - and then live up to it. The efforts to streamline operations at the North Vancouver General Hospital brought heated criticism for the British Columbia Hospital Insurance Service from the new media on the North Shore.

> "... The hospital situation is a mess. It would appear that every possible attempt is being made to operate this government bureau just as the liquor control board is being operated - give the people nothing, insult them regularly and take everything away from them. Those who are behind the thinking of the hospital scheme must sit up nights planning ways and means of agitating the electorate ..."[4]

Rate Board

The creation of the British Columbia Hospital Insurance service in 1948 changed the financial modus operandi from a simple cash box operation with a community and philanthropic mandate to a complex financial and political system. When the Social Credit Party came to power in 1952, a decision was made on the issue of the exclusive or inclusive per diem rate. Thus the Saskatchewan model of a premium system was selected and the inclusive per diem rate was established in British Columbia. The Rate Board introduced a rudimentary bargaining process into the health care system, with each hospital being allocated an individual per diem rate, with the board having the delegated vote of the legislature.

By the time the North and West Vancouver Hospital Society was established in 1953, the Rate Board had become an integral part of the hospital insurance system in British Columbia. As a compilation of financial control mechanisms and evaluation mechanisms for all hospital services in British Columbia, the Rate Board represented the most significant policy decision in providing the financial resources to the hospitals in British Columbia. The significance of the policy was that with budget allocations related to the level of hospital services; therefore, the potential catchment area for funding changed from the local area to the entire provincial

revenues as the community hospital became a vital and necessary enconomic input for each community.

North and West Vancouver Hospital Society

The concept of a new North Shore facility to provide a centrally located hospital was affirmed in December 1953 with a decision to form a North Shore hospital society.[5] The success of the National Health Grants Program established in 1948 can be seen in the newsletter material circulated by the hospital society.

> "... In the final analysis, it is the inescapable responsibility of all progressive and growing communities to equip themselves with adequate hospital facilities. Delays in doing so can seriously affect the health and the economy of the community ..."[6]

In 1956, the British Columbia Hospital Insurance Service recommended construction of a two hundred and eighty-five bed hospital to meet an estimated population of 90,000 by 1960.[7] In December 1957, the municipal North Shore Electorate voted overwhelming approval for a new hospital to serve both West Vancouver and North Vancouver,[8] and served notice they wanted an end to political bickering over the whys and wherefores and wanted the work done expediently.[9] In September 1958 the hospital by-law was placed before the municipal North Shore electorate and was passed by a resounding ninety percent majority.[10]

The Hospital Insurance and Diagnostic Services Act (1958) provided the final impetus and Lions Gate Hospital was officially opened in April 1961. Ownership of Lions Gate Hospital was the responsibility of the North and West Vancouver Hospital Society and the responsibility was delegated to a Board of Management representing the three North Shore municipalities. The Board of Management was accountable to the North and West Vancouver Hospital Society for the administration of the hospital operations.[11] The duties of the board were delineated as follows:

"... 1. We are responsible to the community for the quality of medical service provided for the hospital.

2. We are empowered to appoint the Medical Staff.

3. We appoint the Administrator who acts as our agent in all dealings both with the Medical staff and the administrative staff.

4. We elect the extent and type of services offered to the public.

5. We protect the community's investment and advise on the prudent use of its income and assets.

6. The Board sets a broad policy for the Administrative staff and for the Medical staff. They in turn define and regulate their own activities.

7. We meet regularly to review reports from both these boards and to recommend and set policy and action.

8. It is our duty through the Society to foster community interest and understanding and to seek its support in any major improvement. The Board also works with various community agencies to promote preventative medicine and other related health services.[12]

Regional Hospital Districts

Between the time of the Hamilton plan in 1949 and 1966, capital funding of hospitals became a high profile political issue in British Columbia. By 1966, the capital funding problems indentified by Hamilton in 1949 continued unabated and regional hospital districts were established by the provincial government to serve as a buffer between the Ministry of Health and the hospitals in British Columbia. Whilst the provincial government had approved capital hospital construction far in excess of the resources available, the concept of regional hospital districts provided the provincial government with a political buffer to claim they had approved the capital funding and that the decision was the jurisdiction of the regional hospital district. In the Greater Vancouver Regional District the provincial government approved capital projects of more than $160 million but provided the regional district with funding of $52 million. Thus, the political advantage provided to the provincial government by such a buffer was significant.

The Social Credit government introduced the concept of regionalization and followed the concept with legislation under the Regional Hospital District Act (1967) that recognized the need for the planning of hospital services on a district basis. The fact that there was to be organized prospective planning of hospital

facilities was a giant step forward for the provincial health care system in British Columbia. Powerful opposition emerged to the concept of regionalization from the municipal level politicians. The Mayor of the City of North Vancouver (C. Coates) indicated that regional hospital districts were the beginnings of a metropolitan government above the municipal level which would relegate the municipal government to a role of collecting taxes.[13] Despite the opposition, the legislation was enacted for the purpose of establishing hospital districts with a broad tax base for raising the local share of hospital construction funds.[14] The Regional Hospital District Act (1967) did not destroy the function of existing hospital boards or put more control in the hands of government as the municipal politicians feared.

The regional hospital district of Fraser-Burrard was created by Letters Patent and included most of the lower Mainland area and seventeen (17) hospitals, including Lions Gate Hospital. The emphasis of the regional outlook was one of "planning". The North and West Vancouver Hospital Society emphatically endorsed the concept.

> "... Hospital services must be provided on a regional basis, and that needless duplication has to be avoided. We have no petty prides at Lions Gate. We will provide the services that the community needs, and the services that the region needs and on the basis of past performance, we will provide them at a top level standard..."[15]

Lions Gate Hospital Description

Located in North Vancouver, Lions Gate Hospital services the three affluent communities of the North Shore - the City of West Vancouver, the City of North Vancouver and the District of North Vancouver - with a catchment area population of approximately 150,000 citizens. Table I illustrates the basic utilization data on Lions Gate Hospital during the ten year period of analysis.

An estimated eighty percent of all the patient days that the citizens of the North Shore utilize are at Lions Gate Hospital. A number of patients equal to those utilizing other hopsital facilities in the lower Mainland, come to Lions Gate Hospital from communities along the Sunshine Coast as far north as Powell River.

Lions Gate Hospital has approximately 225 physicians and surgeons on the medical staff consisting of a balance between general practitioners and medical specialists. While not serving a teaching hospital for medical students, Lions Gate Hospital is a primary clinical practice site for all of the clinical and technical health science professions. The hospital, with 456 acute care beds and 169 extended care beds, employs approximately fourteen hundred employees and is served by the largest organized hospital volunteer program in British Columbia.

Table I: Historical Utilization Data for Lions Gate Hospital

Fiscal Year	Total Budget	Budget Variance	Bed Capacity	Patient Days	Inpatients	Outpatients	Occupancy Rate	Average Stay
1969	6,497,637	6,514	326/72	153,300	15,873	29,568	N/A*	10.5
1970	7,361,959	-291	326/72[a]	154,501	16,970	30,094	N/A*	9.9
1971	8,991,876	-127,295	654/72	194,101[b]	17,660[b]	31,402	N/A*	9.4[c]
1972	10,508,662	104,489	654/72	222,944[b]	16,951[b]	32,574	N/A*	9.7[c]
1973	12,021,678	105,208	654/72	219,227[b]	16,479[b]	35,897	84%	10.1[c]
1974	15,507,517	34,149	654/72	219,611[b]	16,713[b]	39,450	84%	9.8[c]
1975	19,145,833	-163,273	654/72	217,548[b]	17,119[b]	38,623	83%	9.4[c]
1976	20,336,964	26,115	654/72	208,640[b]	16,369[b]	37,057	78%	9.3[c]
1977/78[d]	28,635,056	-615,397	625/72	269,510[b]	21,296[b]	49,458	87%	9.3[c]
Annualized	22,908,771	-492,318	N/A*	215,608[b]	17,037[b]	39,567	N/A*	N/A*
1978/79	25,222,549	-812,778	625/72	217,342	16,532	44,365	89%	9.8[3]

Notes:

a) The rated bed capacity indicates acute beds on the right and bassinets on the left.

b) Figures include extended care patient.

c) Figures exclude extended care patients and refer only to acute care patients.

d) This period represents a 15 month fiscal year due to the B. C. Hospital Programs Standardizing hospital fiscal years in accordance with the provincial government of April 1 through March 31.

e) Figures have been annualized to provide an indication of trends for a twelve month period for statistical comparison.

N/A* Indicates data not available.

Since the inception of the North and West Vancouver Hospital Society in 1953, the selection of trustees has not changed dramatically. The majority of the trustees have been prominent municipal politicians or entrepreneurs or managers of small or medium sized businesses on the North Shore. The experience at Lions Gate Hospital has been to emphasize business connections, reputations and general visibility on the North Shore as desirable attributes for prospective trustees.

Summary

The North and West Vancouver Hospital Society has continued to the present day to be composed of concerned citizens of the North Shore dedicated to ensuring that a good standard of hospital and health care is available to their community. The basic objectives of the hospital society remain unchanged and are as follows:

a) To establish, maintain and operate a hospital for the care of persons suffering from illness or disabilities requiring hospital care.
b) To carry on educational activities related to the care of the sick or the promotion of health.
c) To promote and carry on scientific research related to the care of the sick and injured.
d) To participate in any activity designed and carried on to promote the general health of the community and to co-operate with any organization in the community having similar objectives.
e) To co-ordinate the provision and operation of hospitals and hospital services in the area of the North Shore.[16]

The essential characteristic of Lions Gate Hospital is embodied in the following passage from the 1978 annual report:

> "... A desire to participate and ensure the delivery of health care to those in need is demonstrated by all who associate themselves with this Society, the hospital, the auxilliary and other voluntary organizations. Without such a community spirit, very little would be accomplished. This has been the way at Lions Gate for many years - may it always be so..."[17]

CHAPTER FOUR FOOTNOTES

1) "History of Lions Gate Hospital" Employee Handbook (North Vancouver: Lions Gate Hospital) 1977; page 5.

2) "Hospital Board Favors Society" Vancouver Daily Province (September 20, 1946).

3) Ibid

4) "Hospital Mess" District News (July 12,1951).

5) "North Shore Hospital Society Formed" Vancouver Sun (December 16, 1953).

6) North and West Vancouver Hospital Society Newsletter (October 31, 1956).

7) "Councils Must Act Now to Get Needed New Hospital or North Shore People May Have to Go Without" North Vancouver News (February 25, 1957).

8) "Election Results on North Shore" Vancouver Sun (December 13, 1957).

9) D. Baird "Shore Lines" Town Crier (January 13, 1958).

10) "North Shore Votes 90% For Hospital" Vancouver Province (September 8, 1958).

11) "Key Role Played by 21 Directors" The Citizen (April 20, 1961).

12) R. G. Bailey "Hospital Board Duties Outlined" The Citizen (April 20, 1961).

13) A. Arnason "Hospital Regions Stick City Two Ways - Mayor" Vancouver Province (April 14, 1967).

14) I. Street "Greater Vancouver District Has $2 Billion Assessment" Vancouver Province (April 21, 1967).

15) Lions Gate Hospital Annual Report (North Vancouver: North and West Vancouver Hospital Society) 1967; page 3.

16) "North and West Vancouver Hospital Society and Lions Gate Hospital" Employee Handbook (North Vancouver: Lions Gate Hospital) 1977; page 1.

17) Lions Gate Hospital Annual Report (North Vancouver; North and West Vancouver Hospital Society) 1978; page 3.

CHAPTER FIVE

Chapter Five outlines a review of the literature based on hospital organizational theory including a discussion of the voluntary organization, a conceptual model for organizational design, and a theoretical model for hospital organization. The organization triad is reviewed in terms of the governing board, the Chief Executive Officer and the organized medical staff.

The community hospital is an organization that mobilizes the skills and efforts of a number of widely divergent groups of professional and nonprofessional personnel to provide a highly personalized service to individual patients. The chief objective of a community hospital is to provide adequate treatment and care to patients within the limits of technical knowledge, effective organization and finite resources; moreover, the principal product or output is patient care and the central concern is the life and health of the patient.[1] The key objective of service to the patient is the underlying principle of a community hospital in Canada.

The ultimate legal and moral responsibility for the operation of a hospital and the standards of patient care rest with the governing board. Thus, hospital trustees are considered legally accountable

for any failure to exercise this authority in formulation and enforcement of such rules as may be deemed necessary for the safety of the patient.[2]

Evolutionary Stages

With the introduction of national health insurance starting in 1948 with the National Health Grants Program and followed by the Hospital Insurance and Diagnostic Service Act (1958) and the Medical Care Act (1968), the role of the hospital trustee began to evolve. The legitimacy and feasibility of the evolution in trustee role was a process in which the hospital boards in Canada were required to move beyond providing basic financial support for the hospital to more actively auditing the results of hospital performance and facilitate the questioning of the viability of the hospital's long term direction and success.[3] The evolutionary process did not find a broad base of support within the Canadian health care system that clung tenaciously to the nebulous but avowed principles of voluntary governance.

Throughout the period from the inception of the National Health Grants in 1948 through to the present, there have been endless critiques of the concept of the voluntary hospital board in Canada and recommendations that the whole system be revamped with the

government responsible for hospital operations since the advent of third party payment mechanisms granted virtual control to the government.[4] The democratic process of checks and balances inherent in the initial conceptions of voluntary governance did not solidify support from the movement away from structural and financial issues toward process considerations. In large part, the difficulty confronting an orderly evolution in trustee role was the lack of a strong conceptual model for the voluntary organization. Perrow criticized the conceptualization of the voluntary organization from the perspective of organizational analysis.[5]

> "... The major categories of functions (of a voluntary association) are as pressure groups to alter the behavior of governmental or economic organizations, either because members are reluctant to have services provided by these other types, or because the other types have failed to provide services..."[6]

The limitations of the voluntary governance concept created a need for other factors of trust such as reputation for high quality service and confidence in the fiduciary responsibilities of the hospital trustees. The problem was clearly a source of tension.

> "... One consequence is that limitations on voluntariness constitute a convenient target for displacement of disaffection factors which may originate in other contexts..."[7]

Whilst the traditional concept of a voluntary organization derived for a charity purpose with a mandate for service to a deprived group, the Royal Commission of Health Services (1965) modified the concept to include a governmental role. Govan encouraged and praised voluntarism.

> "... (the) vital role of voluntary effort in our democratic life... the organization of people into associations whose aims and objectives are focused around specific areas of interest is an essential part of Canadian life. The development of the voluntary health agency as part of the Canadian way of life should be maintained and encouraged..."[8]

Goven's study in the mid 1960's occurred at a time when the activities of the Community Chest[9] and United Way organizations in British Columbia were at their peak.[10] By 1972, a national review by Carter for the Canadian Council on Social Development indicated that fundraising for voluntary organizations had become increasingly difficult[11] as the government funded services were taking over from the philanthropic organizations. In addition, Carter examined the prospects for the use of volunteers[12] at a time when philanthropy was being challenged by mutual aid groups.

The concept of consumer participation in social programs became a major topic of debate during the early part of the decade. In Quebec the CLSC's, managed by local boards, were to be established as the intake centres for health and social services.[13] Pilot clinics had been established in Saskatchewan and Ontario to pioneer the development of Community Health Centres; in the sixties,

however, the concept generated considerable hostility from the traditionally oriented medical profession. The role of consumers and whose interests consumers represented was very unclear in Community Health Centre context[14]. What was clear - particularly in the anglo-saxon areas of Canada - was that consumers were not wanted on the management committees for they posed many threats to the autonomy of physicians by questioning the development of service provisions.

The debate over consumer representation had major implications for hospital boards in Canada. Whilst they had their traditional territory of fundraising and financial management, innovations into the realms of program development or other external relations activities were guarded and cautious in anticipation of a negative reception with the community. Thus, trustees were required to tread carefully in moving forward into the decade of the seventies.

In 1971, the Minister of National Health and Welfare (J. Munro) moved beyond the changes to the financial aspect of health care services and outlined his disenchantment with hospital boards stating that many boards were not reflective of the community because boards of trustees were composed of individuals who did not understand or reflect the interests of the total community.[15]

"... Consumers must play a greater part in offering health services ... Health care is the only industry oriented more to the needs of the provider than the consumer ... Consumers must be represented in sufficient numbers on the hospital boards..."[16]

The emphasis on consumerism and community participation were the first indications of the legitimacy, feasibility and support of trustee responsibility for community planning, participation and action.[17] Kahn characterized board level participation in policy and planning as a "community presence"[18] in relation to the social welfare service. Such a presence dramatized the public interest with concern and symbolized full participation in a network of service and institutional provision.

"... The disagreement over the importance of boards of directors relates not only to sociological questions but to policy ones as well ... it is worth noting that questions of proper and improper activities of boards of directors preoccupy several arms of government..."[19]

The Canadian Hospital Association and the British Columbia Health Association have resolutely defended the voluntary governance system. The associations claimed the greatest virtue of the trustee system has always been that it is one that can be sensitive and responsive to local needs, both in the hospital and in the community.

"... The community hospital board is the chain that joins together the patient and his needs, the community in which he lives and the government that, as paying agency, is certainly entitled to a hand in what must be a partnership endeavour ... Just as the community requires the voluntary board of trustees to interpret and meet those needs, so does the hospital organization itself require the existence of its voluntary

board. Not only does the board have a vital role to play within the complex ... but it stands on guard to ensure that limitations and arbitrary decisions from above are not mere extensions of bureaucratic expansion undertaken without local interest being of paramount concern..."[20]

Beneath a reserved consensus, hospital boards in Canada have not been enthusiastic in their support for the concept of consumer representation. While the hospital industry worried that consumerism would interject the grit of public controversy into the administrative machinery of the hospital world, the consumer lobby worried that the most likely forms of consumer representation would be too deferential toward the hospitals and would adopt a passive style of public participation.[21] Marmor indicated that consumer representation was no panacea and that its role could not be separated from policy issues facing the hospital and health care field.[22]

Conceptual Model for Organizational Design

Organizational design is characterized as a decision process to bring about a coherence between the goals or purposes for which an organization exists, the patterns of division of labor and interunit coordination and the personnel who do the work to produce the final output.[23] The theory of organizational design mainly developed in the American literature is concerned with maintaining a coherent fit between choices of strategy (ie: domain, objectives

and goals), organizing mode (ie: composition of subtasks, coordination) and integrating individuals (ie: training, reward system). Galbraith delineated a model consisting of two methods for achieving organizational design coherence. The two approaches were reducing the need for information processing (ie: environmental management, creation of slack resources, creation of self-contained tasks) and increasing the capacity to process information (ie: investment in vertical information systems, creation of lateral relations).[24]

An organization must adopt at least one of the five strategies when faced with greater uncertainty and must deal with boundary spanning roles since boundary roles are the link between the environment and the organization.[25] Boundaries represent the definition of the role of formal authority in an organization and are performed by information processing and external representation.

The contingency theory of organizational design states that there is no one best way to organize; however, not all the ways to organize are truly effective.[26] Galbraith indicated that organizational effectiveness is limited by three types of bottlenecks - theoretical, resource or organizational.[27] Theoretical bottlenecks occur when there is not sufficient information to effect the desired change, resource bottlenecks occur

when there is sufficient knowledge but implementation funds are lacking and organizational bottlenecks occur when there is sufficient knowledge and adequate implementation funds but no system exists to carry out the problem-solving effort.

Theoretical Framework for Hospital Organization

The sociology of hospital organizations has been dominated by the Weberian model of bureaucracy with attention focused on the form of the bureaucratic mode of administration rather than purpose. The central characteristic of the Weberian model is an organizational world of rules and regulations, with patterns of behavior and interaction understood and accepted for the attainment of organizational goals.[28] The bureaucratic model is characterized by a well-defined authority structure and well-defined objectives for the organization which tend to result in computational, optimizing or rational types of decision strategy.[29]

The hospital organization in Canada is clearly part of a political system because of the advent of third party insurance schemes. A model based on power and conflict emanates from Weberian concerns with the distinctions between power and authority, forms of imperative coordination and the presumed rationality of bureaucracy.[30] A focus on power leads to an examination of how

power is transformed into authority and Blau indicated such a focus less likely to emerge if the focus was upon legitimacy and organizational functioning.[31] The bureaucratic and political models complement one another[32] since the existence of power and conflict serve not merely as an aberration from "proper bureaucratic functioning" but as natural and endemic with the bureaucratic organization representing one approach to the structuring of power and dealing with conflict.

The internal organization of hospitals has long interested social scientists and theorists; however, despite the vast amounts of literature on the subject, there has been little progress since there is no consensus on appropriate analytical models of hospital behavior including the reason that hospitals adopt specific organizational structures.[33]

A community hospital is a highly formal task-oriented and quasi-bureaucratic organization which relies upon formal policies, written rules and regulations and formal authority for controlling much of the behavior and work relationships of its members. The emphasis on formal organizational mechanisms, procedures and directives provides an authoritarian system characterized by clear linear patterns of accountability and status differences among organizational members.[34] Despite an emphasis on rational

organization, the community hospital has retained the authoritarian characteristics due to the counterforces at work including a lack of tolerance for error or negligence, a concern for maximizing efficiency with predictability of performance and a strong adherence to the traditional and familiar methods[35] of operation.

A distinctive feature of a community hospital is the absence of a single line of authority in the organization. Smith outlined a "duality" concept of hospitals with two (2) lines of authority - administrative and clinical[36] - existing within the organization. Whilst the administrative authority extends from the hospital trustees through the Chief Executive Officer to Department Heads and hospital employees, the clinical authority extends primarily through the physicians as members of the organized medical staff.

> "... Basically, a hospital may be viewed as an organization at cross purposes with itself. It is the kind of human institution about which people constantly complain that they are caught "in the middle". What they are caught in the middle of is a direct function of the basic duality of hospitals..."[37]

The authority in a community hospital is shared by an organizational triad consisting of the hospital board, the Chief Executive Officer and the organized medical staff. Authority within a community hospital does not emanate from a single source and does not flow along a single line of command. Whilst the hospital trustees have ultimate authority and overall responsibility for the institution, the operational administrative responsibilities are

delegated to the Chief Executive Officer. The organized medical staff have no line of authority in the community hospital and are outside of the lay and/or administrative line of authority.[38] Although the hospital board is in theory the ultimate source of authority, the trustees have only limited defacto authority over physicians.[39] The medical staff are subject to only minimal organizational authority due to their status of not being employees but rather of being "guests" who are granted privileges to practice in the hospital.

A community hospital in Canada is a complex social organization that differs significantly from private sector and other large scale organizations on a range of important charteristics. The main distinguishing features are:

... 1. The main objective of the organization is to render personalized service-care and treatment to individual patients, rather than the manufacture of some uniform material object. And the economic value of the organization's products and objectives is secondary to their social and humanitarian value.

2. By comparison to industrial organizations, the hospital is much more directly dependent upon, and responsive to, its surrounding community, and its work is much more closely integrated with the needs and demands of its consumer and potential customers. To the hospital and its members, the patients' needs are always of supreme and paramount importance.

3. The demands of much of the work at the hospital are of an emergency nature and nondeferrable. They place a heavy burden of both secular-functional and moral responsibility upon the organization and its members.

Correspondingly, the organization shows great concern for clarity of responsibility and accountability among its different members, and very little tolerance for either ambiguity or error.

4. The nature and volume of work are variable and diverse, and subject to relatively little standardization. The hospital cannot lend itself to mass production techniques, to assembly-line operations, or to automated functioning. It is a human rather than a machine system, with all the attributes this entails. Both the raw materials and end products of the organization are human. And, being human, they participate actively in the production process, thus having a good deal of control over it.

5. The principal workers in the hospital - doctors and nurses - are professionals, and this entails various administrative and operational problems for the organization.

6. By comparison to industrial organizations, the hospital has relatively little control over its workload and over many of its key members. In particular, it has little direct control over the doctors and over the patients - two of its most essential components. In the short-stay hospital, the patients are not only a very heterogeneous and very transient group, but are also, mainly and ultimately, in the hands of their doctors, who are not employees of the organization.

7. The administrator has much less authority, power, and discretion than his managerial counterparts in industry because the hospital is not and cannot very well be organized on the basis of a single line of authority. The simultaneous presence of lay, professional and mixed lay-professional lines of authority in the hospital creates a number of administrative and other problems, which business organizations are largely spared.

8. The hospital is a formal, quasi-bureaucratic, and quasi-authoritarian organization which, like most organizations of this kind, relies greatly on conventional hierarchical work arrangements and on rather rigid impersonal rules, regulations, and procedures. But more importantly, it is highly departmentalized, highly professionalized, and highly specialized organization that could not possibly function effectively without relying heavily for its

internal coordination on the motivations, actions, self-discipline, and voluntary, informal adjustments of its many members. Coordination of efforts and activities in the hospital is indispensable to organizational functioning, because the work is of a highly interactional character - the activities of organizational members are highly interlocking and interdependent, and the various members can perform their role only by working in close association with each other.

9. The hospital shows a very great concern for efficiency an predictability of performance among its members and for overall organizational effectiveness..

10. Finally, the community general hospital is an organization which is important to us all, and which is becoming increasingly important. Several basic social trends tend to ensure this: the accelerating accumulation of new medical knowledge, new medical, surgical, and nursing procedures, and new drugs and medicines; rising levels of family income in the nation; increased use of the general hospital for numerous different diseases and health needs; and a growing demand by the general public for the best possible quality of medical-surgical and nursing care..."[40]

Organizational Triad

The traditional organization design of a community hospital in Canada displays three domains - the administrative domain dealing with the Chief Executive Officer, nursing, professional programs, support services and the staff functions (ie: personnel, finance and staff development), the organized medical staff domain and the voluntary governance domain including the hospital board. While authors Rakich, Longest and O'Donovan have described the three domains as an organizational triad[41] others have defined the same

domains as a "wobbly three-legged stool".[42] Gordon outlined the relationship within the organizational triad as stemming from power relationships, control relationships and the alternatives available to the negotiated order.[43]

> "... The governing authority has a corporate responsibility for all activities related to the achievement of its purpose, including all aspects of patient care ... in discharging its corporate responsibilities, the governing authority organizes, or causes to be organized, all elements of the institution in such a way that accountability is maintained throughout the structure. This requires that specific functions be assigned to all organizational components of the hospital and that appropriate delegations of authority be made commensurate with the responsibilities assigned. In addition, all delegations of responsibility and authority should be clear-cut, without overlap, gaps or duplication..."[46]

1) Governing Board

Governance is collective in action since it requires a majority of participants to be in agreement before a policy is adopted in the operational management of the hospital. The individual hospital trustees have only collective authority for the purpose of determining and modifying the overall role of the institution and have no individual authority for its operation.[47] Perrow traced the evolution of the shifting locus of power and control in a voluntary hospital from the trustees as the original repositories of control to the physicians and finally to the Chief Executive Officer.[48] While the overall responsibility for the operation and services of a community hospital are vested in the governing board,[49] the Catholic Hospital Association delineated the responsibility

of the hospital board as a fiduciary obligation that cannot be divested through delegation.[50]

The vulnerability of non-profit organizations to criticism of their governing structure derives from the lack of political theory to legitimate it. Drucker stressed the need for priority attention on the specific responsibilities of the directors and the work needed in order to discharge them.[51]

> "... We know far too little about managing the service institution - it is simply too recent a phenomenon. But we do know that it needs to be managed..."[52]

The key opportunity to enhance accountability to the public lies in the performance of the hospital boards.[53]

Trustees, in their capacity as nonpaid community participants, are the hospital constituency best suited to provide the linkage between the delivery of services and the community population the hospital exists to serve. The linkage role has been characterized as support for the hospital trustee as a public advocate.[54]

> "... The public at large is looking more and more to hospital boards as public advocates in the hospital system. Trustees are accepting the challenge, believing that they are in the best position to cement the relationship between the institution and the service population. This heightened activity by boards might well be viewed as a symbolic representation of the layman's ability to participate equally in the determination of his own medical destiny..."[55]

Umbdenstock indicated that the health care system has witnessed the evolution of hospital boards from the role of honorary figureheads of years ago to the current role of knowledgeable counselors.[56]

The governing board in a community hospital has a corporate responsibility for all activities related to the achievement of its purpose, including all aspects of patient care. Thus, the board organizes all elements of the institution in a manner that facilitates accountability throughout the organization by means of appropriate delegation of authority.[57] In order to provide outcomes in the form of quality care, comprehensive programs, accessible services and efficient utilization of scarce resources,[58] the hospital board has a professional and community responsibility. Professionally, the board is legally responsible for the care of patients and must retain the authority necessary to exercise this responsibility.[59] Transgression of this authority disturbs the balance between the responsibility for patient care and the authority to ensure patient care. At the community level, the board is responsible for the provision of hospital facilities and the promotion of community interest in the hospital in order to mobilize the support of individuals, corporations, community organizations and local governments.[60]

> "... The governing board must define goals and objectives to meet community health care needs and establish policy to meet those goals and objectives. In addition, the board must accept the moral and legal responsibility for the quality of services provided by the health care institution and for ensuring quality of service provided by others within the institution. The assumption of these responsibilities by the governing board constitutes "acts of governance..."[61]

Hospital governance is inherently intertwined with the domain of patient care responsibilities to the extent that trustees who are unwilling to make patient care policy decisions are saying that they do not understand the business of the hospital. Johnson indicated that if trustees do not understand the business of the hospital they should not serve as trustees.[62]

From the perspective of the burden of health care, Abbis emphasized the need for the obligatory symbiosis of the voluntary system with the government[63]. The governing boards require better organization in order to be able to assert themselves in the formation of governmental policies and negotiate from a position of strength.

2) Chief Executive Officer

In order to facilitate the basic administrative principles including planning, organizing, implementing and evaluating, McGibony developed the basic principles of hospital administration as the objective analysis with evaluation of

problem and resources, the formation of objectives, policies, functions and relationships; the effective organization of resource; management methods developed for the attainment of objectives and continous evaluation and accountability.[64] The hospital administrator serving as a Chief Executive Officer in a community hospital is mandated to manage the manpower, material, technological, informational and capital inputs in order to achieve the desired outputs and/or outcomes for the hospital. Whilst the Chief Executive Officer may delegate authority within the organizational structure, accountability for designing, changing and operating an efficacious operation rests solely with the Chief Executive Officer.

The function of the hospital administrator as the Chief Executive Officer is to manage an interactive set of social and technical processes occurring within a formal organizational setting with the purpose of accomplishing predetermined objectives through the utilization of human and physical resources.[65] McKerrow described the role of Chief Executive Officer as a series of generalist roles and responsibilities (ie: leadership, labor relations, public relations and figurehead) and as a series of specialist roles and responsibilities (ie: organizer, interpreter of legislation, advisor on treatment issues, protector of confidentiality and the traditional administrative role).[66]

The Chief Executive Officer has only those duties specifically or by implication, delegated by the hospital trustees. Whilst it is the governing board which is mandated by the provisions of the Hospital Act (RS Chapter 176, 1979) to have the legal responsibility for the conduct of the hospital, the trustees appoint an administrator to manage the hospital operations.

"... the board may fix specific duties upon the administrator and grant authority to discharge these duties. Delegation of authority may be broad or narrow, depending on the policy of the board, but the administrator receives only that authority delegated by the board..."[67]

As a representative of the hospital board, the Chief Executive Officer carries out the policy directives of the trustees and is responsible for periodic reports on the nature of the hospital's operation. The Chief Executive Officer is expected to attend meetings of the governing board and the sub-committees in order to advise and keep the hospital trustees informed on significant trends which enable them to fulfill their mandate of policy formulation.

> "... (including) information (on) and explanation of significant economic, legislative, and social factors which influence the hospital field in general and this hsopital in particular; activites of (municipal, provincial, regional) and national organizations which are related to the hospital's program of service; conditions within the hospital which may require action by the governing board; (and) technical and scientific advances in the health field..."[68]

In practice, the primary source of authority accorded the Chief Executive Officer is the governing board, which delegates the responsibility and authority for managing the hospital operations.[69]

The essential responsibilities of the Chief Executive Officer have been delineated by the American Hospital Association as including:

a) Submitting for approval a plan or organization for the conduct of hospital operation and recommending changes when necessary.

b) Preparing a plan for the achievement of the hospital's specific objectives and periodically reviewing and evaluating it.

c) Selecting, employing, controlling and discharging all employees.

d) Submitting for approval an annual budget showing expected receipts and expenditures.

e) Recommending the rates to be charged for hospital services.

f) Having charge and custody of and being responsible for all operating funds of the corporation.

g) Representing the hospital in its relationships with other health agencies.

h) Serving as liaison and channel of communications between the governing board or its committees and the medical staff.

i) Assisting the medical staff with its organizational and medical-administrative problems and responsibilities.

j) Submitting to the governing board reports showing the professional service and financial experience of the

hospital, and submitting such special reports as may be requested by the governing board

k) Advising the governing board on matters of policy formulation..."[70]

The generic role model for a Chief Executive Officer has been developed in components, with knowledge and/or skill areas linked to each role component. The internal management role component encompasses organizational design, personnel management, financial management, logistical management, service delivery and legal work as the requisite knowledge and/or skills. The organizational development role component encompasses planning knowledge and/or skill; the external relations role component encompasses community relations, organizational relations and government relations knowledge and/or skill; the environmental surveillance role component encompasses market research as the requisite knowledge and/or skill.[71]

The internal management role component for the Chief Executive Officer incorporates five (5) areas of expertise as presented in detail below:

... ORGANIZATIONAL DESIGN
- Determining how authority and responsibility are divided among individuals and departments.
- Determining formal communication patterns within the organization.

- Developing/improving management information systems an procedures to get feed back on operations.
- Determining matters for the governing board or owner(s) to consider.
- Defining the general course and goal priorities for the organization.

PERSONNEL MANAGEMENT
- Determining departmental staffing levels.
- Determining salary scales and fringe benefits for management personnel.
- Training and development of management personnel.
- Recruiting management personnel.
- Recruiting other personnel.
- Placement and/or promotion of management personnel.
- Disciplining and/or dismissing management peronnel.
- Advising, counseling, and/or otherwise motivating management personnel.
- Advising, counseling, and/or otherwise motivating other personnel.
- Evaluating the work of management personnel.

FINANCIAL MANAGEMENT
- Containing the cost of professional services provided to patient.
- Improving efficiency/productivity in non-professional departments.
- Encouraging more conservative or prudent utilization of facilities and services.
- Developing/improving accounting practices.
- Developing/improving budgeting practices.
- Developing/improving cost finding practices.
- Determining the cost of existing or proposed services (cost studies).

SERVICE DELIVERY
- Improving the accessibility of the organization's patient care services to the community.
- Determining what patients think about the care they receive.
- Dealing with inquiries and complaints from patients, patient relatives or enrollees.

LEGAL WORK
- Obtaining corporate liability, malpractice, and other types of insurance.
- Dealing with suits against the organization and other legal matters...[72]

Even though administrative authority may be delegated to subordinates, it must be remembered that the accountability rests solely with Chief Executive Officer. It is the Chief Executive Officer who must answer to the governing board for the operation of the hospital. The state of the art is that it is the hospital trustees - and no other body - that hold the ultimate legal responsibility for the hospital.

3) Organized Medical Staff

The third component of the organizational triad is the organized medical staff. The medical staff of a community hospital are defined as the organized group of physicians and dentists authorized by the governing board to attend patients and participate in related duties, functions and institutional matters. The terminology "organized" is of major significance. The Canadian Council on Hospital Accreditation requires that:

"... There shall be an organized staff that has the delegated responsibility for the medical (and dental) care provided to patients and for the ethical conduct and professional practices of its members as well as accounting therefore to the governing body..."[73]

The organized medical staff is directly responsible for the quality and scope of medical/dental services delivered in a

hospital.[74] Since the advent of national health insurance in Canada, the medical staff have been prevented from unilaterally establishing the scope of medical/dental services offered in a hospital; however, with national health insurance, the organized medical staff became responsible for informing the hospital trustees of the community's medical needs in order that the board may approach the provincial Ministry of Health with a proposal to establish new programs or modify existing programs.

The governing board delegates to the organized medical staff the accountability for patient care management but retains ultimate responsibility for the quality of patient care. Thus, while the hospital trustees must approve the medical staff by-laws, recommendations for appointment, privileges an discipline and implementation of structured clinical appraisal, neither the governing board nor the Chief Executive Officer holds any direct, day-to-day supervisory authority over the medical staff.[75]

> "... The establishment, maintenance, and improvement of professional standards, the diagnosing and treating of patients, the review, analysis, and evaluation of medical care are responsibilities of the Board. But not being qualified to carry out these functions it assigns them, along with commensurate authority, to the organized medical staff and its officers. This does not mean the Board can divorce itself from the manner in which the medical staff fulfills its functins. On the contrary, although it delegates authority, and can just as easily recall it, the Board is still responsible for what the medical staff does,

and hence, must hold the medical staff accountable for its actions..."[76]

The organized medical staff has a unique relationship to the governing board and Chief Executive Officer since the medical/dental staff are not employees of the hospital and are not theoretically or conceptually considered as an integral part of the hospital organization. The relationship is indicated on a hospital organizational chart by a dotted line to indicate communication rather than direct authority. The responsibilities of the organized medical staff in a community hospital are outlined below:

"...1) To implement policies and procedures designed to provide patients with the best possible medical care - within the hospital's available resources.

2) To recommend medical staff appointments and clinical privileges in order to provide a balanced and competent medical staff...

3) To develop and implement a quality (appraisal) mechanism, including peer review of the process and outcomes of care...

4) To provide continuing medical education for its members...

5) To develop an organizational structure that will enable the medical staff to relate to the board and to govern itself.

6) To provide... medical education.

7) To conduct medical research..."[77]

The community hospital that thrives in the short run and survives in the long run is the one that best exploits the

forces that tend to unite the board and the medical staff, while minimizing the elements that tend to divide them.[78] Blanton indicated that a strong, effective medical staff was the most important determinant of constructive board-medical staff relations.[79]

The growing body of opinion advocating medical/dental staff membership on hospital governing boards in Canada since the Medical Care Act (1968) has been harshly criticized by legal experts on the basis of possible disruption of efficient management, a loss of the hospital's independence and damage to the hospital's public image.[80] Since the object of a community hospital is the paramount interest and responsibility of the governing board to provide patient care services and facilities, the fact that physicians have an interest in the hospital cannot be allowed to overrule the interests of the patients. Rozovsky indicated the key to the problem is to avoid conflict of interest and that the hospital trustee has only one interest - the hospital and its patients.[81]

Summary

Throughout this chapter, definitional parameters have been established for governance and management.

> "... Management is work planning and work performance... Governance is decision making about purposes, policies, programs and resources..."[82]

The distinction between policy and administrative functions is of major significance. Boards in the public sector were originally conceived as a clearinghouse of ideas and experiences.[83] As the original conception evolved with the developments of national health insurance through the Hospital Insurance and Diagnostic Services Act (1958) and the Medical Care Act (1968) the hospital boards in Canada gradually moved toward their modified function as a policy board. The policy board is distinguished by the final authority resting with the trustees even though the authority to manage the operation of the hospital may be delegated to the Chief Executive Officer. Policy-making legitimacy meant that agency policy was determined by the trustees and served as the policy governing the operation of the hospital.

The diverse range of externalities faced by a community hospital necessitated that a board consider the changing needs and characteristics of the community within the catchment area and the operational experience of the organization in terms of critical review and evaluation. Within the policy process, the hospital trustees confronted the responsibility of goal setting. Long range

goals represented the essence of policy-making leadership in a manner that Tuttle delineated as requiring integrity, perseverance, faith, ability to plan, vision, initiative and courage.[84]

The mandate of the Hospital Act (1979) has provided only a narrow mandate for management issues rather than broad policy issues. Because the role of the hospital trustee has not evolved in concert with the changes in the Canadian health system under national health insurance, administrative boards have emerged in British Columbia, as the norm.

> "... The board plays a central role in relating the likely needs of the future to predictable resources; it has the responsibility for husbanding the endowment; it is responsible for obtaining needed capital and operating funds; and in the broadest sense of the term it should pay attention to personnel policy. In order to fulfill these duties, the board should be aided by, and may insist upon, the development of long-range planning by the administration... When ignorance of ill-will threatens the institution or any part of it, the governing board must be available for support. In grave crises it will be expected to serve as a champion..."[85]

Spencer outlined the major functions of an administrative board as the development of objectives, determination of program activities, determination of qualitative and quantitative service levels, establishment of long range plans, provision of adequate resources and to provide evaluation. [86] Newland indicated a need to restrict the administrative functions of boards and rely upon them for broad policy control, public relations, organization of community resources and advice.

> "... In an organization that is structured on an executive leadership model, board members who fail to understand this distribution of functions may seriously disrupt administration..."[87]

Koontz applied the basic responsibilities of a corporate board to an administrative board and explained trusteeship as a safeguard mechanism on behalf of the community, the providers and the consumers.[88]

> "... (boards) should insist upon review of performance and plans... force consideration of limiting factors... and ask discerning questions..."[89]

Hospital trustees play an important social and economic function in ensuring that the institution is properly managed and that the interests of those it represents are faithfully followed. Hospital boards need not be regarded as a legal anachronism.

> "... there are important social and practical reasons for an effective board of directors. There is always the danger of abuse of power by (those) who may forget their fiduciary relationship... In addition, executives, necessarily embroiled in the immediate problems of operations, can benefit... by an impartial superior authority approving their proposals and actions, goading them into looking at problems from a broader point of view, and taking responsibility for major decisions affecting the successful growth and continuity of the company..."[90]

Although the frequent cry is to abolish the voluntary governance system for Canadian hospitals, the essential problems and deficiencies appear to be rooted not in the concept but in practice, with attitudes largely determined by societal conditions.

CHAPTER FIVE FOOTNOTES

1) B. S. Georgopoulos and F. C. Mann "The Hospital as an Organization" in J. S. Rakich and K. Darr Hospital Organization and Management (Toronto: SP Medical and Scientific Books) 1978; page 19.

2) J. R. McGibony Principles of Hospital Administration (New York: G. P. Putnam's Sons) 1969; page 147-148.

3) W. R. Boulton "The Evolving Board: A Look at the Board's Changing Roles and Information Needs" Academy of Management Review (October 1978) page 828.

4) "Voluntary Boards: Should They Continue to Run Our Hospitals?" Hospital Administration in Canada (March 1971) page 6.

5) C. Perrow "Members as Resources in Voluntary Organizations" in W. R. Rosengren and M. Lefton Organizations and Clients (Columbus, Ohio: Merrill Publishing) 1970; page 94.

6) Ibid; page 98.

7) T. Parson "How Are Clients Integrated in Service Organizations?" in W. R. Rosegren and M. Lefton Organizations and Clients (Columbus, Ohio: Merrill Publishing) 1970; page 13.

8) E. S. L. Govan Voluntary Health Organizations in Canada (Ottawa: Royal Commission on Health Services) 1965; page 166.

9) Priorities for Health, Welfare and Recreation Services in the Greater Vancouver Area (Vancouver: Community Chests and Councils of Greater Vancouver) 1965.

10) N. Carter Case Studies in Social Planning: Planning Under Voluntary Council and Public Auspices (Ottawa: Canadian Council on Social Development) 1972.

11) N. Carter; Trends in Voluntary Support for Non-Governmental Social Service Agencies (Ottawa: Canadian Council on Social Development) 1974.

12) N. Carter; Volunteers: The Untapped Potential (Ottawa: Canadian Council on Social Development) 1974.

13) C. Castonguay; Health Insurance: Report of the Commission of Inquiry on Health and Social Welfare (Quebec City: R. Lefebvre Co.) Volume I; 1967.

14) J. Hastings (Editor) The Community Health Centre in Canada (Ottawa: Department of National Health and Welfare) 1972.

15) J. C. Martin "A Brief to the Minister of National Health and Welfare on the Voluntary Trustee System" Canadian Hospital (May 1972) pages 2-3.

16) Ibid

17) A Blueprint for Board Members (Omaha, Nebraska: United Community Services) 1958; pages 21-22.

18) A. J. Kahn "The Citizen's Role in Social Welfare Policy" Children (September/October 1963) page 188.

19) M. N. Zald "The Power and Functins of Boards of Directors: A Theoretical Synthesis" American Journal of Sociology (July 1969) page 98.

20) J. C. Martin; op.cit.; page 2.

21) T. R. Marmor "Consumer Representation: Beneath the Consensus, Many Difficulties" Trustee (April 1977) page 3-7.

22) Ibid; page 40.

23) J. R. Galbraith Organization Design (Don Mills, Ontario: Addison-Wesley Publishing Company) 1977, page 5.

24) Ibid; page 49.

25) H. Aldrich and D. Herket "Boundary Spanning Roles and Organization Structure" Academy of Management Review (April 1977) pages 217-230.

26) J. R. Galbraith; op.cit.; page 28.

27) Ibid; pages 1-2.

28) K. Walsh, et.al. "Power and Advantage in Organization" Organization Studies (February 1981) page 131.

29) J. Pfeffer and G. R. Salanick "Organizational Decision-Making as Political Process" Administrative Science Quarterly (Spring 1974) page 135.

30) K. Walsh; op.cit.; page 132.

31) P. Blau "Critical Remarks on Weber's Theory of Authority" American Political Science Review (October 1963) pages 305-316.

32) J. Pfeffer and G. R. Salanick: op.cit.; page 151.

33) F. A. Sloan "The Internal Organization of Hospitals: A Descriptive Study" Health Services Research (Summer 1981) page 203.

34) B. S. Georgopoulos and F. C. Mann; op.cit.; page 21.

35) Ibid; page 32.

36) H. L. Smith "Two Lines of Authority: The Hospital's Dilemma" in E. G. Jaco (Editor) Patients, Physicians and Illness (New York: Free Press) 1958; page 468.

37) Ibid.

38) A. D. Bauerschmidt "The Anomalies of Hospital Organization" The Implications for Management (Miami, Florida: University of Florida) 1968; pages 142-143.

39) B. S. Georgopoulos and F. C. Mann; op.cit.; pages 25-26.

40) Ibid; pages 27-28.

41) J. S. Rakich, B. B. Longest and T. R. O'Donovan Managing Health Care Organizations (Toronto: W. B. Saunders) 1977; page 176.

42) R. L. Johnson "The End of the Wobbly Three-Legged Stool" Trustee (May 1976) pages 20-22.

43 P. J. Gordon "The Top Management Triangle in Voluntary Hospitals" Journal of the Academy of Management (April 1962) page 72.

44) Ibid.

45) R. L. Johnson; op.cit.; page 20.

46) Ibid: page 2.

47) E. A. Johnson and R. L. Johnson Contemporary Hospital Trusteeship (Chicago, Illinois: Teach 'Em Inc.) 1965; page 30.

48) C. B. Perrow "Goals and Power Structures" in E. Friedson (Editor) The Hospital in Modern Society (New York: Free Press) 1963; page 114.

49) L. D. Prybil and D. B. Starkweather "Current Perspectives on Hospital Governance" Hospital and Health Services Administration (Fall 1976) pages 67-75.

50) Guidelines on the Responsibilities, Functions and Selection Criteria for Hospital Boards of Trustees (St. Louis: Catholic Hospital Association) 1974; page 7.

51) P. F. Drucker "The Real Duties of a Director" Wall Street Journal (June 1, 1978)

52) P. F. Drucker "Managing the Third Sector" Wall Street Journal (October 3, 1978).

53) L. Williams "Company Boards Need Diversity" Chicago Tribune (February 26, 1978).

54) R. J. Umbdenstock "We Only Have to Ask" Hospitals (October 16, 1978) page 11.

55) R. J. Umbdenstock "Trustee Emergence As Public Advocate Documented in 1978 Literature" Trustee (April 1979) page 28.

56) R. J. Umbdenstock "Governance: A Decade of Steady Growth" Trustee (April 1980) page 19.

57) R. L. Johnson; op.cit.; page 20.

58) B. McCool and M. Brown "The Management Response: Conceptual, Technical and Human Skills of Health Administration (Toronto: W. B. Saunders) 1977; page 11.

59) "Code of Ethics for Hospitals" Statement on Hospital - Government Relations (Ottawa: Ontario Hospital Association) 1973; page 3.

60) Ibid.

61) Governance of Health Institutions (Chicago, Illinios: American Hospital Association) 1974.

62) R. L. Johnson; op.cit.; pages 21-22.

63) C. Abbis "Sharing the Burden of Health Care" Hospital Trustee (March/April 1978) page 2.

64) J. R. McGibony; op.cit.; page 195.

65) J. S. Rakich, B. B. Longest and T. R. O'Donovan; op.cit.; page 189.

66) W. McKerrow "The Roles and Responsibilities of a Hospital Administrator" Health Law in Canada (Spring 1980) pages 10-12.

67) D. G. Warren Problems in Hospital Law (Germantown, Maryland: Aspen Systems Corporation) 1978; page 16.

68) "Hospital Governing Board" Management Review Program (Chicago, Illinois: American Hospital Association) 1971; pages 5-6.

69) D. G. Warren, op.cit.; page 21.

70) "Hospital Governing Board"; op.cit.; page 33.

71) I. K. Kuhl, "Activities Grouped by Role Component and Knowledge/Skill Area" The Executive Role in Health Service Delivery Organizations (Washington, D.C.: Association of University Programs in Health Administration) 19 ; page 14.

72) Ibid; page 20.

73) A. L. Swanson (Editor) "Medical and Dental Services" Guide to Hospital Accreditation 1977 (Ottawa: Canadian Council on Hospital Accreditation) 1977; page 11.

74) "How the Board Relates to the Medical Staff and the Chief Executive Officer" Hospital Trustee (March/April 1978) page 14.

75) Ibid; page 16.

76) K. J. Williams "Challenges Facing Hospital Medical Staff" Hospital Progress (October 1970) page 58.

77) "How the Board Relates to the Medical Staff and the Chief Executive Officer"; op.cit.; page 14.

78) W. B. Blanton Jr., "A Physician Looks at Board-Medical Staff Relationships" Trustee (June 1979) page 28.

79) Ibid

80) L. E. Rozovsky "Abolish Medical Staff on Hospital Boards" Hospital Trustee (November/December 1977) page 5.

81) Ibid.

82) J. D. Millett Management, Governance and Leadership: A Guide for College and University Administrators (New York: American Management Association) 1980; page 67.

83) Citizen Boards in State Welfare Departments (New York: Advistory Committee on Citizen Participation, Community Chests and Councils of America, Inc. and the National Social Welfare Assembly) December 1950, page 3.

84) E. M. Tuttle School Board Leadership in America (New York: McGraw-Hill) 1963; pages 27-30.

85) Statement on Government of Colleges and Universities (Washington D.C.: Association of Governing Boards of Universities and Colleges) Winter 1966; pages 9-10.

86) S. Spencer "Developing Effective Board and Committee Organization and Functioning" Building Board Leadership for the Years Ahead (New York: National Jewish Welfare Board) 1963; page 42.

87) C. A. Newland "Current Concepts and Characteristics of Administration" Child Welfare (June 1963) page 276.

88) H. Koontz The Board of Directors and Effective Management (New York: McGraw-Hill) 1967; pages 24-27.

89) Ibid; page 28.

90) Ibid; page 24.

CHAPTER SIX

Chapter Six describes the research methodology used in this study and provides an overview of the grounded theory approach and the McCool and Brown management response model as illustrated in Appendix Four. The research methodology employed was significantly altered during the data collection process because the original methodology - content analysis - was not successful in directly addressing the hypothesis. The content analysis did provide the framework for categorization of data; however, the "grounded theory" approach was introduced to augment the initial categories and to permit a sorting process for the extensive data. The change in methodology served primarily as an information sorting mechanism and led directly to substantive analysis in the area of hospital governance.

Qualitative Research

The orientation of the longitudinal research into the governance process at Lions Gate Hospital during the ten (10) year period from January 1969 through December 1978 was the application of "grounded theory"[1] as a qualitative research methodology. The differences between qualitative and quantitative research methodologies are in the overall form, focus and emphasis of study.

> "... Qualitative investigators tend... to describe the unfolding of social processes rather than social structures that are often the focus of quantitative researcher... qualitative researchers in contrast to their quantitative colleagues claim forcefully to know relatively little about what a given piece of observed behavior until they have developed a description of the context in which the behavior takes place..."[2]

Contextual understandings and emphatic objectives are achieved through direct and intimate knowledge of a research setting in order that the data collected and analyzed are symbolic, contextually embedded, cryptic and reflexive.[3] Downey and Ireland contended that the supposed analytical match that is ideally sought between problem and method invariably leaves considerable latitude for use of both quantitative and qualitative techniques.[4]

Overview on Grounded Theory

In the course of their research into aspects of health institutions in 1964, Glaser and Strauss developed an approach to the handling of qualitative data and to the formulation of theoretical propositions which the authors described as grounded theory. The terminology grounded theory was meant to describe the process involved in the discovery of theory from data systematically obtained and analyzed in social research.[6] Glaser and Strauss advocated the development of their approach in order to counter what they regarded as undesirable aspects of the orthodoxy which then prevailed in sociology with research concerned with the quantitative

testing of hypotheses.[7] By contrast, the use of grounded theory enabled researchers to develop their own theories relating to the substantive area which they were studying and encouraged creativity in doing so.

The advantages to the researcher in using grounded theory are many. It promotes the development of theoretical accounts and explanations which conform closely to the situations being documented in order that the theory is intelligible to and usable by those in the situation studied and is open to comment and correction by them. The theories developed are complex rather than oversimplified ways of accounting for a complex world and such a quality enhances their appeal and utility.[8] A further advantage of the approach is that it directs the researcher immediately to the creative core of the research process and facilitates the direct application of both the intellect and the imagination to the demanding process of interpreting research data.[9]

There are pitfalls inherent in the grounded theory methodology. Brown indicated that the grounded theory approach is likely to be of a maximum use when it is dealing with qualitative data of the kind gathered from participant observation, from the observation of face-to-face interaction, from unstructured interviews, from case study material or from documentary

sources.[10] The quality of the final research product arising from grounded theory is directly dependent upon the quality of understanding which the researcher develops during the course of the investigation rather than is the case with many other approaches to social inquiry.

Substantive and Formal Theory

Glaser and Strauss emphasized comparative analysis in order to generate two types of theory - substantive and formal. Substantive theory deals with empirical areas of sociological inquiry such as the governance process in contrast to formal theory which deals with conceptual areas of sociological inquiry such as formal organization, authority and power.[12] Merton delineated both types of theory as "middle range" on the continuum between the "minor working hypotheses" of everyday life and the "all-inclusive" grand theories.[13] This thesis is focused on the substantive area of hospital governance, not on the formal areas of formal organization, authority and power.

> "... Substantive theory faithful to the empirical situation cannot... be formulated merely by applying a few ideas from an established formal theory to the substantive area. To be sure one goes out and studies an area with a particular sociological perspective, and with a focus, a general question, or a problem in mind..."[14]

Substantive theory helps generate new grounded formal theories and to reformulate previously established ones; therefore, it becomes

the strategic link in the development of and formulation of formal theory based on data,[15] as a design for the cumulative nature of knowledge and theory.[16]

Research Stages

The qualitative research on Lions Gate Hospital was developed as a case study utilizing documentary sources. The grounded theory methodology followed nine separate stages including: category development, category saturation, development of definitions, refinement of definitions, category exploitation, development of linkages between categories, development of linkage considerations, theory integration and testing of emerging relationships. Appendix One illustrates the nine stages as extracted from Glaser and Strauss.[17]

1) Pre-Stage One

In the pre-stage one phase, the basic preparation was carried out by collecting literature on hospital governance and reviewing the documentary sources available at Lions Gate Hospital. The transcribed minutes of the hospital board meetings were the basis of the initial review and analysis as a sampling procedure. In research studies employing a sampling technique, observations are made on a limited number of dimensions in order

that generalizable inferences may be made of the larger grouping of dimensions from which such samples have been drawn. Sampling was the reliability measure for the empirical area of study.

A sampling of the Lions Gate Hospital board minutes required a decision on appropriate sample size. Berelson indicated a small, carefully chosen sample of the relevant content produced just as valid results as the analysis of a great deal more - and with the expenditure of much less time and effort.[18] Thus, the decision was to systematically sample one month from each of the ten years during the period of analysis from January 1969 through December 1978. The sample included recorded minutes of the board from January 1969, Februrary 1970, March 1971, April 1972, May 1973, June 1974, September 1975, October 1976, November 1977 and December 1978. A conscious decision was taken to exclude meetings in the months of July and August from the sample on the premise that major governance issues would be deferred during the summer months. Subsequent review indicated that regular board meetings occurred in July, regular meetings did not occur in August; however, extraordinary meetings were infrequently utilized to deal with single issues related to capital construction projects.

2) Stage One

The sampling procedure led to the tentative sorting of phenomena into categories which the author had perceived and which were considered to be of potential relevance to the inquiry at hand. The labels applied to categories in the sampling procedure tended to be somewhat long-winded and ungainly. Through on-going review and modification during the sampling, the category labels were changed to fit the phenomenan described in the data accurately. When the fit was not precise, the labels were revised and modified until the fit was improved since the value of the grounded theory approach depended upon a precise fit as the basis for subsequent analysis.

Appendix Two illustrates the revised categories utilized to aggregate the data for application of grounded theory. The instrument as shown in Appendix Two was intended to present the contents of board meetings into six major area including government issues, hospital issues, geographical issues germain to the North Shore, consumer/citizen participation issues, interest group issues and therapeutic abortion issues.

3) Stage Two

The categories developed during the sampling process were saturated by accumulating additional categories until the author

was fully aware of what was meant when any new phenomenon encountered was classified into the category in question. Berelson indicated that a well-planned system of categories was crucial to effective analysis[19] and thus grounded theory research stands or falls by its categories since the labels contain the substance of the investigation.

The primary requirements for any set of categories was that they be tailored accurately to fit the needs of the study in order to provide the answers to the question posed, be mutually exclusive and be exhaustive.[20] Because categories in this research endeavour were considered exhaustive only when there was a category in which to place every item of relevant content, considerable attention was paid to the need for saturation of each category. Categories were considered mutually exclusive only when there was one appropriate category in which to place each item.

4) Stages Three and Four

When the stage of theoretical saturation was reached, the task of developing complete and thorough categorization was initiated in order to state examples of dimensions encompassed in each category. The Explicit definitions clarified those aspects recognized implicily when a new dimension was classified into the category concerned.

The task of producing definitions for the categories that arose from the data was crucial to the grounded theory methodology and analysis as it provided the basic foundation for a deeper and more precise understanding of the nature of the phenomena of hospital governance. Occasionally it was discovered that the theoretical saturation previously perceived was spurious in that more than one type of instance was classified under the given heading because of a less than rigorous examination. Appendix Three illustrates the final definitions that evolved for the twenty categories on the initial grounded theory approach.

The categories developed for this research endeavour derived specifically from the content of the documented board minutes. The categories were developed in terms of both direction and subject matter.[21]

"... A category consists of a range of possible indicators, all of which are given the same label and are therefore handled equivalently to all subsequent treatment of the data. If it were possible to list all the variations of content which indicate a given category, such a list would provide a complete operational definition of the category..."[22]

In order to refine definitions, the original definitions were used to sensitize the author to recognize additional aspects of hospital governance and to stimulate further

analysis. The original definitions evolved through review and refinement to the point where they suggested possibilities for extension of the inquiry in a number of directions. This was the operational process that close examination of the data was intended to stimulate.

Glaser described the analytical review process as a "drugless trip"[23] when the process of writing in a fairly restricted way about definition spills over into a more extensive and more discursive discussion of the data and the patterns of ideas needed to sort through the material collected.

5) Stage Five

Utilizing the McCool and Brown management response model[24] conceptualized in Appendix Four, the categories were exploited to provide further insight into hospital governance. Appendix Four was the initial point of reference in building speculatively upon the theoretical concept outlined as the basic hypothesis of the research on hospital governance. From such a base, an analysis with related categories evolved including a number of directions for thought and a number of directions for provisional hypotheses. The management response model led to the development of six (6) categories that sorted the dimension into levels (ie: policy and management) and analytical

frameworks (ie: manpower interdependence, consumerism, accountability and organizational complexity) as illustrated in Appendix Five. The categories in the management response model analysis were theoretically saturated, defined and evolved through revision until finalized as outlined in Appendix Six. The categories developed from the context of the McCool and Brown management response model and were significantly linked to the overall hypothesis of the thesis.

Glaser advised analysts to avoid "logical elaboration" as there was a danger of elaboration exceeding the bounds of the data and building up speculative theoretical edifices upon a fragmentary empirical base. However, there is a sense in which all theory contains the potential for exceeding the bounds of the data from which it was generated as it does not appear possible to avoid all forms of "logical elaboration".[25] The issue was clearly one of balance and an attempt to avoid the pitfall of excessive logical elaboration which in the absence of data might have produced a thin, poorly grounded and unconvincing analysis.

6) Stage Six and Seven

The linkages between the categories in the analytical frameworks in the Brown and McCool management response model

allowed the author to consider tentatively attributing causal properties and causal direction to some of these links, while others were regarded as more tentative and hypothetical while seeking additional data to confirm or deny the existence of the kind of relationship postulated in the hypothesis. In considering the conditions under which the linkages held, the research spilled over into postulating linkages between categories in the analysis provided by the McCool and Brown management response model.

7) Stage Eight

By this point in the research, it was readily apparent that there were considerable differences between the grounded theory approach in which an existing body of theory was approached with questions and propositions arising from the author's own detailed examination of a body of data and the alternative approach of beginning with a body of theory and courting the danger of trying to squeeze the data into a form which fit with the theory. In the grounded theory approach, criteria existed for deciding whether existing theory has a useful contribution to the hypothesis and the suitability of theory was assessed by the criteria. By contrast, the alternate approach would have weighed the suitability and admissability of data by reference to criteria developed from theory. This second path was not one

which was likely to lead to sociological and/or insightful discoveries on the process of hospital governance.

When the emerging relationships were specified, they formed the nucleus of a theoretical statement which in its initial form was not elegant but which had two (2) major attributes - closeness of fit and degree of complexity. The emerging hypothesis on hospital governance possessed a cumbersome degree of complexity to the extent that it did not fall readily into a set of simple logical propositions which expressed its essence. However, the emerging theory did reflect the complexities of the hospital governance process which has been studied. This study was concluded at the stage of an emerging hypothesis and did not proceed to the ultimate completion of a statistically-based survey analysis.

8) Final Stage

Glaser and Strauss advocated the use of a "constant comparative method"[26] in order to determine the limits of the propositions developed in the emerging theory through confirming and disconfirming instances. Their contention was that this could be done by identifying the central proposition or propositions of the emerging theory, specifying the key variables and dimensions which were likely to affect the

propositions and then trying to seek out situations in which the various variables were pushed to their limits, in order to check whether or not the original effects still held. The "constant comparative method" analysis was employed to test emerging relationships in hospital governance within the limited scope of the thesis as a case analysis.

Reliability and Validity

In the simplest terms of research methodology, reliability of grounded theory approach meant that the repeatability with consistency of results and validity was the extent to which the measurement mechanism was accomplishing the measurement intent. Problems of reliability and validity were taken into account at every stage of the research methodology including the design, sampling, counting, analysis and interpretation phases.

Reliability is a problem that each researcher must solve to his own satisfaction within the limits of the study design and resources.[27] In measurement, reliability means that all investigators utilizing the same techniques on the same documentary source would concur in their findings. The comparative results prepared by the same investigator on a random selection of documentation recorded during the month of July in each year from 1969 through 1978 some months later, indicated 94.6% agreement of

the initial grounded theory approach [28] as shown on Table II below.

Table II: Reliability Data of the Initial Grounded Theory Approach

	Government Issues	Hospital Issues	Area Issues	Community Issues	Interest Group Issues	Abortion Issues
Mean	92.3%	93.4%	94.5%	96.1%	93.2%	98.1%

Average = 94.6%

With a range from a low of 92.3% agreement on government issues to a high of 98.1% agreement on abortion issues, the average level of agreement of 94.6% was considered a satisfactory indicator of reliability.

The comparative data prepared on a random selection of documentation recorded during the month of July in each year from 1969 to 1978, indicated 96.9% agreement on the management response model [29] analysis as shown on Table III below.

Table III: Reliability Data on the Management Response Model Analysis

	Policy Issues.	Management Issues.	Manpower Interdependence Issues	Consumerism Issues	Accountability Issues	Organizational Complexity Issues
Mean	98.7%	97.0%	96.0%	97.1%	96.4%	95.9%

Average = 96.9%

With a range from a low of 95.9% on organizational complexity issues to a high of 98.7% on policy issues, the average level of agreement of 96.9% was also considered a satisfactory indicator of reliability.

Lasswell and Dietz found that coders could achieve ninety percent agreement even when the categories were somewhat vague; however, they indicated that a correlation of less than seventy-five percent was considered too low for satifactory reliability.[30] Thus, the level of agreement at 94.6% on the initial analysis and 96.9% on the management response model analysis were considered a satisfactory indicator of reliability. The testing for reliability was conducted prior to the tabulation of results in an effort to minimize the error factor in coding and measurement.

Validation - proof that the instruments measure what they purport to do - was a more difficult obstacle for the grounded theory approach since the primary purpose of validation was to indicate the usefulness of the measurement. Direct validation of grounded theory methodologies are not well documented in the literature and Lasswell and Dietz indicate the lack of documentation is due to the mere counting of concepts presenting no problems in validation.[31] Thus, it was sufficient validity for the author to take into account the total context from which the documentation appeared in the board minutes and annual reports of Lions Gate Hospital.[32]

SUMMARY

The crucial consideration in the grounded theory approach was what the researcher expected to derive from the data. The longitudinal research undertaken for the case analysis approach in this thesis was developed in order to show which aspects of the governance process - policy or management - were dominant in order to draw inferences and insight.

> "... Inference, then, should be contingent upon both reliability and validity; and validity depends upon reliability. It is important to remember, however, that establishing reliability does not insure validity of the ... analysis except in those cases where only direct measurement is involved. The more complicated procedure - eg: evaluative assertion analysis - offer greater problems. But attention to the solutions of validity problems is not without its reward. Where validation is properly handled the study is generally of considerably more value ..."[33]

CHAPTER SIX FOOTNOTES

1) B. C. Glaser and A. L. Strauss; The Discovery of Grounded Theory: Strategies for Qualitative Research (Chicago, Illinios: Aldine Publishing Company) 1968.

2) J. Van Maanen; "Reclaiming Qualitative Methods for Organizational Research: a Preface" Administrative Science Quarterly (December 1979); pages 520-526.

3) Ibid; page 521.

4) H. K. Downey and R. D. Ireland; "Quantitative Versus Qualitative: Environmental Assessment in Organizational Studies" Administrative Science Quarterly (December 1979) pages 630-637.

5) B. C. Glaser and A. L. Strauss; op.cit.

6) Ibid; page 2.

7) Ibid; pages 15-18.

8) B. A. Turner "Some Practical Aspects of Qualitative Data Analysis: One Way of Organizing the Cognitive Processes Associated with the Generation of Grounded Theory" Quality and Quantity (April 1981) page 227.

9) Ibid

10) G. W. Brown "Some Thoughts on Grounded Theory" Sociology (January 1973) pages 1-16, volume 7.

11) B. C. Glaser; Theoretical Sensitivity: Advances in the Methodology of Grounded Theory (Mill Valley, California: Sociology Press) 1978.

12) B. C. Glaser and A. L. Strauss; op. cit.; page 32.

13) R. K. Merton Social Theory an Social Structure (New York: Free Press of Glencoe) 1957; page 5-10.

14) B. C. Glaser and A. L. Strauss; op. cit.; page 33.

15) Ibid; page 34.

16) Ibid; page 35.

17) Ibid.

18) B. Berelson; Content Analysis in Communication Research (Glencoe: The Free Press) 1952; page 174.

19) Ibid

20) C. R. Bush "A System of Categories for General New Content" Journalism Quarterly (Spring 1961.

21) B. Berelson; op.cit.

22) B. Cartwright "Analysis of Qualitative Material" in L. Festinger and D. Katz (Editors) Research Methods in the Behavioral Sciences (New York: Dryden Press) 1963; page 437.

23) B. C. Glaser; op.cit.

24) B. McCool and M. Brown The Management Response: Conceptual, Technical and Human Skills of Health Administration (Toronto: W. B. Saunders Company) 1977.

25) B. C. Glaser; op.cit.; pages 101-115.

26) B. C. Glaser and A. L. Strauss; op.cit.; pages 101-115.

27) G. Stempel "Increasing Reliability in Content Analysis" Journalism Quarterly (Autumn 1955) pages 449-455.

28) The comparative coding utilizing the grounded theory approach was compiled by the author in both coding procedures.

29) The comparative coding utilizing the management response model was compiled by the author in both coding procedures.

30) H. D. Lasswell and N. Leites; Language of Politics (New York: G. W. Steward Publishers, Inc.) 1949.

31) Ibid

32) I. de Sola Pool; Trends in Content Analysis (Urbana; University of Illinois Press) 1959; page 213.

33) R. Budd, W. Thorp and K. K. Thorp; An Introduction to Content Analysis (Iowa City: University of Iowa) 1968; page 28.

CHAPTER SEVEN

Chapter Seven provides an analysis of the findings derived from the study of hospital governance at Lions Gate Hospital. The hypothesis tested was that the hospital trustees were not substantially involved in policy making, but were primarily concerned with operational management issues since the role of the hospital trustee did not evolve in concert with the change in the Canadian health care system under national health insurance. The fundamental issue of this thesis was the exploration of trustee involvement at Lions Gate Hospital with policy issues during a ten year period of analysis from January 1969 through December 1978. The analysis of the data compiled in this research was intended to provide a critical examination of the concept of the thesis and to model the development of the Canadian health system as an extensive case analysis.

The data were aggregated on the governance process at Lions Gate Hospital from January 1, 1969 through December 31, 1978 by means of an application of the grounded theory approach[1] and established the context for further analysis by means of the McCool and Brown management response model.[2] The grounded theory approach was employed as a sorting mechanism after attempts at utilizing content analysis proved unsatisfactory. The management

response model was employed in order to address the stated hypothesis that hospital trustees were not substantially involved in policy making but rather were involved in operational management.

The grounded theory approach and the management response analysis provided an insight into the major governance trends and patterns during the ten year period of analysis from January 1969 through 1978. The trends outlined throughout Chapter Six were developed on the basis of a general analysis (See Appendix Two) by means of the initial twenty categories originally developed for content analysis and a set of specific decision rules (See Appendix Three) to govern coding procedures. The general analysis was followed by a highly specific anaysis (See Appendix Five) by means of six clearly defined categories developed as an adaptation of the McCool and Brown management response model. A set of specific decision rules to govern coding procedures was developed for the initial grounded theory approach and the management response analysis.

Initial Grounded Theory Approach

The initial grounded theory approach utilized the categories as illustrated on Appendix Two. The instrument was intended to sort the contents of board meetings and annual reports into six major

areas including government issues, hospital issues, geographical issues germain to the North Shore, consumer/citizen participation issues, interest group issues and therapeutic abortion issues. Because the twenty sub-categories on Appendix Two were not discrete units of analysis, each single issue was coded into all of the appropriate sub-categories. Thus, a single issue might be coded several times into a multiple units of analysis since categories were not considered as discrete. Thus the initial data generated by the grounded research approach was tabulated as illustrated on Table IV below.

Table IV: Average Score on the Initial Grounded Theory Approach

Year	Total Items Discussed	Total Coded Issues	Numerical Difference from Mean = 515.9	% Difference
1969	320	435	- 80.90	-15.68%
1970	327	416	- 99.90	-19.36%
1971	354	423	- 92.90	-18.01%
1972	369	434	- 81.90	-15.86%
1973	384	473	- 42.90	- 8.32%
1974	411	509	- 6.90	- 1.34%
1975	484	630	+ 14.10	+22.12%
1976	472	603	+ 87.10	+16.88%
1977	441	563	+ 47.10	+ 9.13%
1978	525	673	+157.10	+30.45%
Sub-Total	4,087	5,159	--	--
Mean	408.7	515.9	--	--

The initial data showed a gradually increasing trend in the total number of issues for most years except in 1970, 1976 and 1977. The decline in 1970 could not be attributed to any specific cause;

however, the declines in 1976 and 1977 were largely attributable to the change-over period in the Chief Executive Officers and the presence of an acting Administrator. By 1978, the new Chief Executive Officer had become well established and the total number of issues considered by the board dramatically increased by 21.32%. The data also indicated a 23.46% increase in the total issues considered between 1974 and 1975 as a result of the increasing complexity of the health care system and the growth of Lions Gate Hospital began to impact on the process of hospital governance.

Trending patterns, shown in percentage comparisons of the six major areas generated by the initial grounded theory approach, are presented on Table V below.

Table V: Percentage Distribution of Major Categories From the Grounded Theory Approach

Year	Government Issue	Hospital Issues	Area Issues	Community Issues	Interest Group Issues	Abortion Issues	Yearly Total
1969	11.7%	68.5%	3.2%	4.4%	12.2%	0	100%
1970	5.5%	75.0%	2.4%	1.7%	15.4%	0	100%
1971	5.9%	71.4%	1.7%	5.4%	15.6%	0	100%
1972	7.4%	70.3%	1.8%	6.5%	13.6%	.5%	100%
1973	9.7%	65.1%	2.1%	6.1%	16.3%	.6%	100%
1974	10.4%	63.1%	2.6%	7.1%	16.5%	.4%	100%
1975	11.4%	60.9%	3.0%	4.3%	15.6%	0	100%
1976	10.9%	60.7%	3.3%	5.3%	19.6%	.2%	100%
1977	9.2%	62.8%	2.0%	2.3%	22.7%	0	100%
1978	12.6%	55.1%	2.8%	4.8%	16.9%	.6%	100%
Mean	9.5%	65.4%	2.5%	4.8%	16.4%	.2%	--

The government issues including the North Shore community plan, British Columbia Hospital Program and the Greater Vancouver Regional District (consisting of municipal, regional, provincial and federal levels of government) were defined in terms of decision rules as outlined by Appendix Three. The trend in government issues was one of significant yearly variances from the mean of 9.5%. The variances were attributable to the establishment of the regional hospital districts at the regional level, the increasing complexity of British Columbia Hospital Insurance Service and the British Columbia Hospital Programs division of the Ministry of Health at the provincial level and the response to Badgley's Report of the Committee on the Operation of the Abortion Law[3] at the federal level.

The hospital issues including the annual meetings, the election of officers, finance schedules and property acquisitions (consisting of the hospital society, hospital board, hospital operations and hospital construction) were defined in terms of decision rules as outlined by Appendix Three. The trend in hospital issues was one of a general yearly decrease. With a mean of 65.4%, hospital issues were clearly the area of greatest attention from the trustees at Lions Gate Hospital; however, the range was considerable with a high point of 75% in 1970 and a low point of 55.1% in 1978. The hospital issues fell below the mean of 65.4% in each year during the analysis commencing in 1973.

Whilst issues related to the hospital society significantly increased during the ten year period of analysis, issues related to the hospital board were significantly increased by the public controversy over trustee election in the context of divergent community perspectives on therapeutic abortions. The issue of hospital operations showed variances that generally correspond to and paralleled variances in hospital construction; however, the shared service arrangements with St. Mary's Hospital in Sechelt, British Columbia, contributed to significant variances in hospital operation issues between 1972 and 1976.

The area issues consisting of the City of North Vancouver, District of North Vancouver and the City of West Vancouver were defined in terms of the decision rules as outlined in Appendix Three. The trend in area issues was one of only minor variances from the mean of 2.5%. The variances corresponded to and paralleled the major construction projects undertaken by Lions Gate Hospital. The community issues such as patient claims and volunteers (consisting of consumerism and citizen participation) were also defined in terms of the decision rules outlined in Appendix Three. The trend in community issues was one of significant yearly variances from the mean of 4.8%. Consumer issues increased each year from 1971 through 1975, with a slight decline in 1976. The trend in consumer issues followed the highly visible expansion of

the Hospital and the intense publicity surrounding the annual meetings because of the abortion controversy. Likewise, citizen participation by means of the hospital auxiliary and volunteers increased in concert with the major construction initiatives and in parallel with the specialized equipment requirements because of the new facilities.

The interest group issues including the Medical Staff Advisory Committee, the Victorian Order of Nurses, and collective agreements (consisting of medical issues, nursing issues, professional/support issues including the Hospital Employees Union, Health Sciences Association and the International Union of Operating Engineers and labour relations issues including British Columbia Health Association and the Health Labour Relations Association) were defined in terms of the decision rules outlined in Appendix Three. The trend in interest group issues was one of significant yearly variances from the mean of 16.4%. The trend in medical issues was a steady increase from 1973 through 1978 as a result of increased activity in evaluating the quality of medical care provided by specific physicians. In addition, the abortion controversy contributed to the pattern of increase from 1975 through 1978.

The trend in nursing issues, professional/support services and labour relations issues was a consistent pattern of significant

increase from 1975 through 1978 as a result of dramatically increased unionization of the hospital work force and the management level decision to create the Health Labour Relations Association as a provincial entity to deal with collective bargaining. The signficant variances in 1976 and 1977 were directly attributable to the introduction of wage controls by the federal government in 1976.

The abortion issues, consisting of pro-choice issues, pro-life issues, and planned parenthood were defined in terms of the decision rules outlined in Appendix Three. The trend in abortion issues was one of significant variances from the mean of .2%; however, the total number of board discussions documented in the board minutes made further analysis highly questionable because of the limited sample.

The initial grounded theory analysis was useful in establishing an embedded context for further analysis and in establishing basic relationships between the categories of data. However, the data did not address the hypothesis in determining whether hospital trustees were involved in policy making operational management issues. The next stage in the analysis was to distinguish between policy and management issues.

Management Response Model Analysis

The McCool and Brown management response model[4] illustrated in Appendix Four was employed to separate the issues into two levels - policy and management. Policy was defined by the author as a standing plan or general guides to future decision-making that were intended to shape those decisions so as to maximize their contribution to the goals of the enterprise.[5] Policy was conceptualized as the instrument by which goals were achieved. In contrast, management was defined by application of the McCool and Brown model as the process of planning, organizing, directing, controlling and evaluating the efforts of organizational members and the use of organizational resources in order to achieve stated organizational goals.[6]

The management response model analysis utilized the six sub-categories as illustrated in Appendix Five to sort the management issues into four analytical frameworks including manpower interdependence, consumerism, accountability and organizational complexity. Because the six sub-categories were discrete units of analysis, each single issue coded as a management issue was then further coded into one analytical framework. Thus, a management issue was coded into a single unit of analysis since the categories for the analytical frameworks were considered as discrete. Thus,

the management response data was tabulated as illustrated on Table VI below.

Table VI: Average Score on the Management Response Model Analysis

Year	Total Items Discussed	Total Coded Issues	Numerical Difference from Mean = 408.7	% Difference
1969	320	320	- 88.70	-21.70%
1970	327	327	- 81.70	-19.99%
1971	354	354	- 54.70	-13.39%
1972	369	369	- 39.70	- 9.71%
1973	884	384	- 24.70	- 6.04%
1974	411	411	+ 2.30	+ .56%
1975	484	484	+ 75.30	+18.42%
1976	472	472	+ 63.30	+15.49%
1977	441	441	+ 32.30	+ 7.83%
1978	525	525	+116.30	+28.46%
Sub-Total	4,087	4,087	--	--
Mean	408.7	408.7		

The management response data showed a gradually increasing trend in the total number of issues except in 1976 and 1977. The declines in 1976 and 1977 were attributable to the changeover period in the Chief Exectutive Officer and the presence of an acting Administrator. Like the initial data, the management response data showed that by 1978 the Chief Executive Officer had become well esablished and the total number of issues considered by the board dramatically increased by 20.63%. The data also indicated a 26.30% increase in the total issues considered between 1973 and 1974 as a result of the growing complexity of the governance process at Lions Gate Hospital.

Trending patterns, shown in percentage comparisons of the six categories generated by the management response analysis, are presented on Table VII below.

Table VII: Percentage Distribution of Major Categories From the Management Response Model.

Year	Policy Issues	Management Issues	Inter dependence Issues	Consumerism Issues	Accountability Issues	Organizational Complexity Issues
1969	6.6%	93.4%	6.6%	2.8%	50.6%	33.4%
1970	4.6%	95.4%	4.4%	3.8%	54.4%	33.0%
1971	5.9%	94.1%	4.6%	3.1%	43.8%	42.7%
1972	15.2%	84.8%	3.8%	2.4%	36.0%	42.5%
1973	15.4%	84.6%	5.5%	2.3%	29.9%	46.9%
1974	8.1%	91.9%	3.1%	3.1%	37.0%	48.7%
1975	9.7%	90.3%	4.9%	2.1%	33.7%	49.6%
1976	7.2%	92.8%	5.3%	1.5%	36.0%	50.0%
1977	6.8%	93.2%	9.1%	.9%	33.1%	50.1%
1978	17.3%	82.7%	8.6%	.6%	29.5%	44.0%
Mean	9.7%	90.3%	5.6%	2.3%	38.3%	44.1%

The management response data definitely affirmed the hypothesis in that the trustees of Lions Gate Hospital from 1969 through 1978 were not substantially involved in policy making. The trustees were overwhelmingly concerned with operational management issues rather than policy issues. The data clearly shows that the role of the trustee at Lions Gate Hospital had not évolved in concert with the change in the Canadian health system under national health insurance. In order to garner insight into the governance process at Lions Gate Hospital, the management issues were scrutinized in

terms of the four analytical frameworks - manpower interdependence, consumerism, accountabiliaty and organizational complexity.

The manpower interdependence issues (conceptualized as the mutual dependence of health care providers on advances in health technology and knowledge[7]) were defined as the mutual dependence of health care providers based on advances in health technology and knowledge and in terms of the decision rules as outlined in Appendix Six. The trend in manpower interdependence issues was one of relatively small yearly variances from the mean of 5.6%. The variations were attributable to the technological advances and the significant advances in unionization and provincial collective bargaining by all health professionals and supportive personnel.

The consumerism issues (conceptualized as an organized effort by those who received health care to exert some influence on the availability, cost and quality[8]) were defined as the organized efforts of those who receive health care to exert some influence on availability, cost and quality and in terms of the decision rules as outlined by Appendix Six. The trend in consumerism issues was one of significant yearly variances from the mean of 2.3%. Consumer issues ranged from a high of 3.8% in 1970 to a low of only .6% in 1978. The general pattern was one of a gradual decline, with significant decreases occurring in 1975 and continuing through

1978. The analysis did not indicate a satisfactory explanation for this trend; however, the total number of board discussions documented in the board minutes made further analysis highly questionable because of the limited sample.

The accountability issues (conceptualized as the requirement embodied in law, institutional regulations and custom for health care providers to make known and be answerable for data concerning availability, cost and quality[9]) were defined as the requirement embodied in law, institutional regulations and custom for health care providers to make known and be answerable for data concerning availability, cost and quality and in terms of the decision rules as outlined by Appendix Six. The trend in accountability issues was one of significant yearly variances from the mean of 38.3%. Accountability issues ranged from a high of 54.4% in 1970 to a low of 29.5% in 1978. The general pattern was one of a gradual decline. The decline in accountability issues directly paralleled the generally increased emphasis being placed on organizational complexity issues primarily and manpower interdependence issues secondarily. From the evidence it appears the trustees at Lions Gate Hospital began to choose to emphasize organizational complexity over accountability issues, as evidenced by the management response data. Whether the trustees were conscious of the choice is unclear.

The organizational complexity issues (conceptualized as the structural form of the enterprise consisting of an intricate combination of elements due to advances in health technology and knowledge[10]) were defined as the structural form of the enterprise consisting of an intricate combination of elements due to advances in health technology and knowledge and in terms of the decision rules as outlined by Appendix Six. The trend in organizational complexity was one of significant yearly variances from the mean of 44.1%. Organizational complexity issues ranged from a low of 33% in 1970 to a high of 50.1% in 1977. The general pattern was been one of a gradual increase, with a significant 9.7% increase between 1970 and 1971. The increased emphasis being placed on organizational complexity issues paralleled a decreased emphasis on accountability issues; moreover, there did not appear to be an explicit attempt to balance the emphasis on each of the management responses.

The management response model was utilized to sort governance issues into two basic categories - policy and management. Employing explicit definitions and decision rules developed by the author for policy issues, the definitions developed by McCool and Brown for management issues and the four analytical frameworks and the decision rules developed by the author for management issues and the analytical frameworks, the hypothesis of the thesis was addressed. The management response data confirmed the hypothesis unequivocally

by proving that the trustees at Lions Gate Hospital from 1969 through 1978 were not substantially involved in policy making. The performance of the trustees, by concerning themselves overwhelmingly with operational management issues rather than with policy issues, suggested that the hospital governance process at Lions Gate Hospital did not evolve in unison with the change in the Canadian health care system under national health insurance.

Policy Issues

The application of the McCool and Brown management response model lead to the delineation of issues into two (2) levels - policy and management. The management issues were defined by the management response model as outlined in Appendix Six. Policy was defined by the author in Chapter Two and applied to the management response model; however, it was necessary to emphasize that policy issues require a continuous examination of boundaries. During the ten year period of analysis from January 1969 through to December 1978, the Lions Gate Hospital trustees spent 90.3% of their efforts on operational management issues and only 9.7% of their efforts on policy issues. The range, in terms of policy issues was a low of only 4.6% in 1970 and a high of 17.3% in 1978. The policy issues encountered during the ten year period of analysis were sorted by content analysis into seven major categories and included the following issues: hospital funding, quality of care, planning,

abortion, provincial interest groups, organizational design and policy development.

As outlined previously in Chapter Five, the Galbraith theory of organizational effectiveness,[11] when applied to Lions Gate Hospital board indicated that a "theoretical bottleneck" occurred since the trustees did not appear to possess sufficient knowledge to effect the change in orientation away from concern for operational management issues to an emphasis on policy issues. Thus, the seven issues that emerged from the research were synthesized in the context of policy analysis.

> "... Health policy analysis involves the drawing together and evaluation of existing research, information and informed judgment regarding the implications of alternative strategies for dealing with a specific problem or set of problems associated with the delivery of health services. It attempts to articulate and provide evidence for the pros and cons of alternative options or strategies facing a decision-maker in the health arena..."[12]

Each of the seven policy issues was reviewed individually based on the information generated by the content analysis of the issues coded as policy making in the management response model analysis. The basis of each discussion was the recorded documentation of the board minutes and annual reports. The documentation was supplemented by relevant literature and synthesized into an analytical perspective.

1) Hospital Funding

In terms of hospital funding, the Lions Gate Hospital trustees struggled with the changes which came out of national health insurance. The changes introduced by the National Health Grants in 1948, the Hospital Insurance and Diagnostic Services Act (1958) and the Medical Care Act (1968) moved community hospitals away from their original function as a charitable insititution relying on philanthropic gifts and donations to their present state in which daily operating and construction costs are funded from the public purse.

Throughout the period of analysis, Lions Gate Hospital grappled with financial dilemmas that stemmed from public sector funding based on beds rather than programs and a primitive budgetary system introduced by the provincial government that did not have the flexibility required to deal with impact of national health insurance. The ongoing dilemma was whether to reduce the quality of quantity or services rendered by the hospital or whether to reduce costs, without affecting services by becoming more efficient. With an inadequate budgeting system for hospitals at the provincial level, the only method available to the Ministry of Health in controlling the hospital expenditures was an arbitrary and annual financial cutback. The end result was a crude and incremental "muddling through"[13]

process that generated much ill will and confusion and did not produce cost-effectiveness or an improved quality of care.

> "... Apply the financial tourniquet if we must, but let's not kill the patient with shock in the process..."[14]

The trustees clearly delineated their frustrations with the hopsital funding system in British Columbia and presented the problem in the 1978 annual report.

> "... Lions Gate Hospital continues to experience serious under-funding problems. Our Provincial Government, in an attempt to curtail spiralling health-care costs, appears to choose under-funding as a means of control over individual hospitals. Since eighty percent of our expenditure is taken up in wages and the balance in supplies which are subject to inflation, your board has been forced into a choice of curtailing services or experiencing a deficit. With a prime responsibility of ensuring the provision of the best possible health care to the North Shore Community, the Board maintains that if services are to be curtailed in order to conform to inequitable funding, then the decision and choice of curtailment must be taken by government. As taxpayers, each of us expects government to effect all possible economies in expending public funds..."[15]

By 1978, the Lions Gate Hospital trustees had enlisted the assistance of the British Columbia Health Association to study the question of hospital funding in collaboration with the Ministry of Health. The Joint Funding Project was established with the stated purpose of:

"... indentifying an equitable funding system for those health care institutions in which designated programs are being conducted or planned. Its purpose is not to justify greater expenditures in the health care field but to aim for optimum use of the available financial resources in a manner which was clearly understood by all parties..."[16]

The review indentified four (4) primary requirements for a successful planning, budgeting and evaluation system. The review delineated a need for planning the provision of health services in terms of both capital and operating funding.

"... planning by the Health Ministry and planning by hospitals has often been independent and furthermore not been related to budgeting. Planning by both parties and budgeting should be interrelated..."[17]

Secondly, the need for communication between the hospitals and the Ministry of Health was addressed.

"... The future funding system must provide for two way communication between the hospitals and the Ministry of Health. Good communication would be enhanced by common information..."[18]

Thirdly, hospital output measurement was addressed

"... any future funding must be based on measure of service and workload..."[19]

Fourthly, the significant aspect of standards of performance by hospitals was presented.

"... a funding system should recognize difference performance standards for different hospitals. These standards are expected to vary for different groups of hospitals. These standards must recognize not only costs but also service levels and quality of health care..."[20]

The initial assessment of the Joint Funding Project was:

"... it has become apparent ... that the fundamental problems with the financing of hospitals lay outside the funding system. The lack of an overall health care plan for the province with agreed to role or goals statements for hospitals have impeded the development of any rational and equitable funding system..."[21]

"... Hospitals will be required to accept and adjust to changing roles within the health care delivery system ... it is likely that hospital representatives will want to become more active and articulate in representing the needs of the community they serve..."[22]

"... The Ministry will be required to accept the employment intensive nature of hospital costs, and prepared to justify openly their positions on funding curtailments arising from the planning process or economic constraints..."[23]

For such a system to operate effectively, both parties - Lions Gate Hospital and the Ministry of Health - must receive common statistical activity data and financial cost information by means of a management information system. Thus, the data would provide the impetus for linking together planning, budgeting and evaluation systems within Lions Gate Hospital and permit the trustees to monitor financial progress and deal with long range considerations and contingencies.

2) Quality of Care

In terms of quality appraisal, the Lions Gate Hospital trustees adopted an incremental, problem-solving approach within the governance process. Quality of care issues dealt with by

the trustees were exclusively confined to medical practice issues. There was no evidence of a structured clinical appraisal system as mandated by the Canadian Council on Hospital Accreditation nor an organized monitoring or evaluation of other direct patient care activities or indirect support services.

Quality of care is the primary objective for which hospital trustees are both legally and morally responsible; moreover, all policy decision, including medical care, are the responsibility of the hospital board.[24] However, throughout the period of analysis, quality of care was not an issue of major emphasis, despite the diverse range of medical practice topics addressed including the appointment of the Medical Co-ordinator, transfer of function protocols, regional bed matrix proposals, patient care guidelines and the cost-effectiveness of clinical programs. As important as the financial statements and their accompanying deficits may be, the trustee's first obligation is to the patients and the care they receive.

> "... In the eyes of the law, a member of a hospital board is not just another committee member. He is a trustee charged with the fiduciary's responsibility for the administration of his trust. Whether he be given the title of director or trustee, his duties are the same, as these designations are inter-changeable..."
>
> ... Officers and directors shall stand in a fiduciary relation to the corporation and shall discharge the duties

> of their respective positions in good faith, and with the diligence, care judgment and skill which ordinary prudent men would exercise in similar circumstances and in like positions..."[25]

Quality appraisal policy development was not well understood by the Lions Gate Hospital trustees. A comprehensive program would substantially improve the qualitative decision making and complement the quantitative decision making within the hospital. Thus, quality appraisal would be defined as a plan of action to achieve organizational excellence in the delivery of direct patient care and indirect support services and conceptualized as a process where standards are set, the level of achievement of those standards are measured and action is taken to correct indentified deficiences.[26] The standards would describe the quality of direct patient care and indirect support services desired and feasible in Lions Gate Hospital.[27] A quality appraisal program includes three basic activities:

> "... 1) Standards/Criteria/Auditing
> 2) Surveillance/Monitoring/Evaluation
> 3) Corrective Action/Problem Solving..."[28]

The present "state of the art" in quality appraisal at Lions Gate Hospital is a focus on the problem-solving perspective rather than for the achievement of patient care

goals. Concentrating on technical excellence (i.e., structure and process), the problem-solving quality appraisal system does not deal with the parameters of quality that patients emphasize (i.e., ease of access, minimal delay, acceptability of care.)[29]

Instead, Lions Gate Hospital trustees should be focusing their attention on the need to plan for the achievement of quality of care goals both efficiently and effectively. The use of a planning model for quality appraisal rather than a problem-solving model changes the scope of the quality appraisal system to include both long range and intermediate range changes. Quality of care concerns would not be limited to the goodness (i.e., process) of a specific event but would be broadened to emphasize the effectiveness (i.e., outcomes) of the care provided or services rendered.[30]

> "... In a planning model methods, designs or programs are formulated beforehand with an outcome in mind, action is prospective and is activated by a goal or objective for achieving outcomes in quality ... Planning for quality assurance needs and making appropriate hospital changes will ensure the success of these increasingly proactive methods..."[31]

Because quality appraisal approaches are based on the elements of structure, process and outcome, quality of care issues must be interdigitated across the hospital organization.

Structure is concerned with the organization and resources available to support the provision of services and/or programs. Thus, the presently constituted Executive Committee at Lions Gate Hospital should deal with structural issues including administrative policy, budgets, staffing, equipment, capital expenditures and organizational design. Process is concerned with the events and activities that do or do not occur when the patient and the health care providers interact and there is a need to create a Quality Appraisal Committee, representative of the direct patient care and the indirect support service departments, to deal with process issues including clinical practice standards, service output standards, identification of educational needs, behaviorally-based job expectations and co-ordination of clinical reference manuals. The Medical Staff Advisory Committee deals with process issues but from a medical practice perspective.

Outcomes are the end results of health care which are measured epidemiologically in terms of health status. Thus, the Lions Gate Hospital board is accountable and responsible for outcome elements with a mandate to ensure that the appropriate monitoring assessment and corrective action are taking place. In order to meet such a responsibility, the trustees could develop a Quality of Care Oversight Committee[32] as a permanent sub-committee of the board. The Quality of Care Oversight Committee, shown in relation to the other committees, on

Appendix Seven would monitor the quality of care. Although not directly involved with the monitoring, the Quality of Care Oversight Committee would ensure that quality appraisal systems were established to monitor direct patient care, indirect support services and medical care, to assess the information that was required during monitoring and to take appropriate corrective measure when it was deemed necessary.

> "... In the years ahead ... boards are going to have to measure up to patient care responsibilities ... Trustees who are unwilling to make patient care policy decisions are really saying they don't understand the business of the hospital. If they don't understand the business, they should not be trustees..."[33]

3) Planning Activities

In terms of planning, the Lions Gate Hospital trustees were concerned almost exclusively, with the construction of physical facilities on a short-range or intermediate range basis. Whilst the general value of planning to a community hospital depends on its objectives, needs and circumstances, the activity of planning in itself is always beneficial[34] because it enables the decision makers to make rational decisions.

> "... Rational planning models in the public sector are synonymous with comprehensive and corporate attempts to handle broad social problems. Expressed in the purest terms, the aims of rational planning are:

- the specification of objectives,
- the evaluation of outcomes against objectives,
- the measurement of present and future costs,
- the evaluation of alternative courses of action, and
- the interpretation and implementation, through appropriate decision-making structures, of plans and policy making..."[35]

Throughout the period of analysis, there was no explicit recognition of any differences in planning levels. The long range planning issues at Lions Gate Hospital were a mixture of both policy planning and program planning. Policy planning involved the determination of the Hospital's overall purpose and direction, the scope of Hospital activities and the general principles governing resource allocation.[36] Policy planning may be described as strategic or long range planning and is the domain of the trustees and the Chief Executive Officer.

"... Governing board. The board establishes policy on planning as well as on other major hospital concerns. It makes decisions for the institution that should reflect the intent of the long-range plan. The board is responsible for representing the community in the long-range planning process. This responsibility involves making sure not only that community representatives are members of the board, but also that an assessment of the community's health care needs is made and is used as a basis for the long-range plan. The board must also give final approval to the long-range plan..."[37]

Program planning deals with the purpose and scope of a program, desirable program outcomes and service standards, the

activities and resources required to achieve these outcomes and the information needed both to monitor program progress and to assess program impact.[38] Program planning is in the domain of the senior administrative personnel. By contrast, operational planning deals with the implementation and operations in the hospital departments, specification of activities, resource allocation, work scheduling and the monitoring of activities in relation to established standards.[39]

In 1969, the Long-Range Planning Committee was established as sub-committee of the Lions Gate Hospital board and was mandated to develop a continuing plan for the orderly development of hospital facilities on the North Shore and to consider methods for providing health care to the community.[40] In 1972, trustees considered whether the committee should be disbanded or granted stronger terms of reference.[41] The Long-Range Planning Committee was officially disbanded in September 1972 by the North and West Vancouver Hospital Society;[42] however, by 1975 the trustees were clearly lacking a long range perspective as to how Lions Gate Hospital would serve the community in the future.[43] The prevailing sense was one of a "non-system" in the sense that the existing ad-hoc arrangments did not result in a coherent or rational whole.[44]

"... There is a lack of overall planning due primarily to diversified interests, some of which are based on political interests ... The present provincial government has a tremendous task in planning and rectifying 20 years of neglect ... It is going to be a difficult job because the needs of hospital planning change so rapidly. Unless there is a change in the funding and thinking on the part of the provincial government - and in Ottawa - the problem will be much worse in 1980. We are not dealing with a sausage machine, but proper facilities for health care..."[45]

Planning at Lions Gate Hospital tended to be partial rather than comprehensive, concerned with increments rather than rigorous review. It emphasized the organization of expanded services rather than objectives and strategies for improving health status. Incrementalism was advanced primarily as an approach in response to the inability to fulfil the requirements of the rational model.

"... The essence of the incrementalism is partisan mutual adjustment; the conscious antithesis of rational planning. Planning becomes an institutionalised bargaining system seeking to involve the multifarious interests of the relevant parties ... In consequence, the concept of incrementalism is rooted in a belief that choice, in practice, is very limited. There is little point in generating and formulating strategies when the political and economic resources to sustain and implement them do not exist. Thus the choice is confined to alternatives that differ only slightly, or incrementally, from the existing policy. Reform takes place on a piecemeal basis and the consequences of such reform will then be handled in a similar fashion..[46]

Lions Gate Hospital required a Long Range Planning Committee to coordinate institutional planning efforts developedby the governance process, however, the trustees were not consistent in ensuring that all programs were based on a solid epidemiological base and did not require that health problems be examined in terms of their seriousness (ie., incidence, prevalence, impact on mortality and/or morbidity), the quality of scientific evidence for the valildity of potential interventions (ie., anecdotal clinical reports, randomized clinical trials) and the feasibility of intervention (ie., political and fiscal contraints). The framework for planning would involve the clarification of the overall mission with measurable objectives and priorities established in relation to those goals and the strategies for achieving the stated goals. Attention paid to long range planning as part of the governance process at Lions Gate Hospital would result in the delineation of the overall mission and objectives, reduction in role ambiguity, enhancement of the capability to deal with the external environment, enhancement of the ability to minimize uncertainty.[47]

4.) Abortion

In terms of abortion, the Lions Gate Hospital trustees adopted a "muddling through"[48] approach in their governance

process. As a policy issue, abortion had profound implications for Lions Gate Hospital because the concern with abortion cut deeply into moral principles of the anti-abortion forces on the North Shore and professional ethics and thus was an emotionally charged issue. Like other profound issues involving the principles of life and death, abortion represented an issue with no apparent resolution.[49]

> "... It's an uncomfortable issue where compromise doesn't exist. It has infinite political and social implications. But it may be a long time before society comes to a consensus abouat abortion. The abortion struggle is now so bitter that even language has become a weapon in battle. The label each side has given itself - pro-life or pro-choice - is attacked by the other side as propaganda..."[50]

The Criminal Code of Canada (Part VI, Chapter C-34) was amended in 1969 by the federal government in order to provide a statutory mandate for the procurement of therapeutic abortions and is presented in Appendix Eight. The criteria outlined in the legislation for a therapeutic abortion program are that the abortion must occur in an accredited hospital with diagnostic and medical support services, that each abortion must be approved by a Therapeutic Abortion Committee consisting of three physicians who cannot perform abortions at the hospital in which they serve as a committee member, that the physician performing the abortion cannot be a member of the Therapeutic Abortion

Committee and that the Therapeutic Abortion Committee must review the case at a committee meeting and the decision must be made by a majority of the committee members.[51] The terms of reference for the Therapeutic Abortion Committee at Lions Gate Hospital are shown on Appendix Nine.

The requirements for granting therapeutic abortions differs widely across Canada as a function of differing perspectives on the concept of health.[52] The flexibility permitted by the Criminal Code and the divergent connotations of health produced confusion, unclear standards and/or social inequity.[53] Interpretation of the abortion law indicated that health had the following five components.

> "... a) Physical health. Usually there is little disagreement here. If the mother's physical health is seriously in danger - a rare event nowadays - most doctors would allow therapeutic abortion and always do.
> b) Mental health. Again, it is rare to have an extremely serious mental problem arise as a result of pregnancy, but, if so, it would be an acceptable indication to most.
> c) Eugenic health. This phrase covers those cases where there is a danger of an abnormal fetus - German measles in the first trimester, etc. This has happened increasingly since the advent of amniocentesis.
> d) Ethical health. Not a clearcut group, but it includes cases or rape and incest with resulting pregnancy.
> e) Social and Family health. This group causes the most controversy. The vast majority of applications fall here..."[54]

Lions Gate Hospital trustees implemented a therapeutic abortion program in January 1970; however, by June of 1970, the trustees were forced to issue a policy statement restricting therapeutic abortions to residents of the North Shore or to those whose families are regular patients of a physician practising on the North Shore[55] because of the service demands. In parallel with these developments the anti-abortion forces became incorporated with the provincial Registrar of Companies as the "Pro-Life Society of British Columbia". The anti-abortionists claimed that acceptance of destruction of life in the womb opened the door for the destruction of life at any stage of human existence.

> "... In defiance of the long held Western ethic of intrinsic and equal value for every human life regardless of its stage, condition or status, abortion is becoming accepted by society as moral, right and even necessary. It is worth noting that this shift in public attitude has affected the churches, the laws and public policy rather than the reverse. Since the old ethic has not yet been fully displaced it has been necessary to separate the idea of abortion from the idea of killing, which continues to be socially abhorrent. The result has been a curious avoidance of the scientific fact, which everyone really knows, that human life begins at conception..."[56]

During 1970, the first full calendar year subsequent to the Criminal Code amendments, the national statistics indicated that British Columbia performed 8.2 abortions per 100 live births, in

contrast to the national rate of 3.0 abortions per 100 live births. In the first year, British Columbia had exceeded the national average by 250% and the Ministry of Health commissioned a study of therapeutic abortion facilities in the Greater Vancouver Regional Hospital District. The report on abortions at Lions Gate Hospital stated:

> "... About 40 therapeutic abortions per month are performed in this institution of which only 15% are carried out on a Daycare basis. The average in-patient duration of stay was 2.2 to 2.5 days which was considered excessive by the committee. It would appear from our interviews with the representatives of the Lions Gate Hospital that more Daycare cases could be performed if sufficient space and increased nursing services could be obtained. It was quite apparent that their present case load could be handled more efficiently and that a resonable increase in demand could be met without much expansion of existing facilities in West Vancouver..."[57]

The lack of appropriate preventative birth control counselling in British Columbia was confirmed by a research study undertaken by the United Community Services in Vancouver during 1973 which delineated the five major reasons for therapeutic abortions in the period of 1969 through to 1972. The reasons included: unreadiness for child bearing, marital status, economic reasons, family planning and age or ill health. The Canadian Medical Association issued a policy statement[58] in 1974 that rejected abortion on demand and sought to protect the rights of both the physician and the patient

> "... The key issues regarding abortion are not medical but rather social, ethical, moral-religious with medical overtoned or involvement. While, as a segment of society and involved funcioning professionals, physicians must have and offer their

opinions on the subjects, they cannot and should not be expected to provide all the answers to the myrial of related issues. For the patient, her family, the attending physician and hospital staff concerned, the issue is, and will remain, a very personal one..."[59]

In a published study of therapeutic abortions performed at Lions Gate Hospital, Dr. M. Hunter confirmed that social and economic factors were considered by the Therapeutic Abortion Committee.

> "... We neither passed judgment on, nor rejected the reasons given; we accepted the surgeon's statement. Nevertheless, one cannot help but have personal views and it was often difficult to refrain from presuming that 'she is in no position to raise a child' indicated inconvenience rather than incipient emotional disaster..."[60]

In February 1976, the Pro-Life Society presented an emotionally based brief to the federal cabinet. The presentation repeatedly raised the rhetorical question: "Did you every think it would come to this?" and reported that under the present law, any hospital that established a Therapeutic Abortion Committee granted practically all applications, except where the pregnancy had gone beyond the fifth month of gestation.[61] The anti-abortionists submitted a revised version of the brief to the provincial government of British Columbia and cited the "disproportionate number of allegedly legal abortions"[62] in British Columbia.

The Berger Commission reported to the provincial government in 1976 on needed changes in family and children's law in British Columbia. The report stated:

> "... that the time of greatest vulnerability in a child's life is the prenatal period ... and that this might be seized upon by anti-abortion groups as confirmation of their views. However it's a question of constitutional jurisprudence - the province cannot do anything to prevent women from applying to therapeutic abortion committees if they wish. That option must be open to them as abortion comes under federal law..."[63]

The report was criticized for alleged "muddled thinking" by the anti-abortion forces who contended the report was not accurate.

> "... (The author's) statement that the province can do nothing to prevent women from applying to "therapeutic" abortion committees is just not true. The federal legislation governing the establishment of these committees is enabling legislation only, and each province is free to decide whether or not to establish them. So if the provincial government agrees with the Berger Commission, it can merely close these committees down. If the provincial government accepts the Berger report and retains the committees its thinking is as muddled as the (authors')..."[64]

The anti-abortionists criticized all Therapeutic Abortion Committees for their failure to adhere to the most limited interpretation of the Criminal Code and for their failure to determine whether a danger to the life or health of the mother existed on medical grounds.[65] Lions Gate Hospital was cited as an example since a study of therapeutic abortion indicated that during a forty-four week period, six hundred and five applications for abortion were received and approved. The basis

of the approval were 8.1% for social reasons, 4.5% for medical reasons, 4.1% for psychiatric reasons and 83.3% for reasons that the physician indicated the mother was not in a position to raise a child.[66] Thus, the Pro-Life Society alleged that Lions Gate Hospital actively encouraged applications for abortion for non-medical reasons.[67]

In February 1977, the federal government released the Report of the Committee on the Operation of the Abortion Law prepared by sociologist Robin Badgley et.al. The report recommended regional centres as the best place for safe abortion rather than in the present hospital system.[68] The report strongly reinforced the widely held view that the abortion law was poor legislation since it was not being applied equitably across Canada.[69] The Pro-Life Society of British Columbia labelled the Badgley report as an "equal opportunity to kill."[70]

> "... Laws are to be enforced. Policies are implemented. The abortion law is supposed to protect the lives of unborn children, but government policy appears to be to be to promote their destruction ... The Badgley report is a red herring - designed to draw the public's attention away from the plight of the defencless unborn child by promoting the false belief that women have a 'right to abort' and are being denied equal access to abortion..."[71]

The anti-abortion forces were well organized by 1977 with three divisions established - educational, counselling and political. The Pro-Life Society represented the educational division and Birthright represented the counselling division by providing information and counselling to pregnant, distressed women and their families. The political division - the Coalition for Life - devoted their attention to the following strategies:

> "... - Efforts to elect federal candidates who promise to work toward amending the Criminal Code to have therapeutic abortions outlawed in Canada.
> - Attempts to change hospital abortion policy by voting anti-abortionists onto hospital boards.
> - Lobbying politicians to cut off funds to Planned Parenthood and women's groups that, in their view, encourage women to seek abortions.
> - Attempts to infiltrate these groups to learn what they are doing on the abortion issue.
> - Advertising campaigns using bill-boards, public transit and media ads to gain support for their cause..."[72]

The result of the explicit political strategies was to create a focal point for public attention on the abortion controversy by using the forum of trustee elections at Vancouver General Hospital, Lions Gate Hospital, Surrey Memorial Hospital and Victoria General Hospital. Whilst the battleground was trustee elections, it was clear that the elections were the

means to an end since abortion was a federal-provincial issue and not an issue that could be legislatively changed at the level of the hospital. The inherent danger in the political strategy of using trustee elections as a forum was that the emphasis on a single issue downplayed the complex policy decisions that are involved in running a major health care centre.

By 1978, the Ministry of Health was deeply disturbed by the continuing controversy generated by the election of hospital trustees on the basis of their personal position on abortions. The question was that if a single interest group gained control of a hospital would that group have a broad enough view to direct the hospital affairs? The provincial government indicated clearly that if a total health spectrum was not served a hospital board that decisive action would be taken[73] in the form of a public administrator being appointed to assume all responsibility vested in the hospital society and trustees. The implicit message was that if a hospital received public funding, it should be required to provide therapeutic abortions and that the decision should not be made by individual hospital societies.[74]

With the appointment of a public administrator in 1978 to deal with the complex management problems at Vancouver General

Hospital, the focus of the anti-abortionists switched to the North Shore and Lions Gate Hospital. Following the familiar pattern, memberships in the North and West Vancouver Hospital Society increased by 600% between 1977 and 1978[75] and set off a chain of events including legal wrangling over application procedures,[76] residency requirements[77] and considerable public debate. Amidst concern that a confrontation on the abortion issue would disrupt the operations of Lions Gate Hospital, the trustees maintained the hospital had a prime responsibility to provide health care to the North Shore and that a single interest group purporting interest in only one aspect of health care was a matter which concerned the board.[78]

> "... There is no value in adding a disruptive troublemaker to your board just because he demands a piece of your action. Regardless of whom you select ... the dissidents will not be satisfied. They will claim that your nominees do not represent them, and that's probably true. However, they will represent the community and that's what counts..."[79]

Subsequent to the study, the Chief Executive Officer and the Chairman of the Board of Management utilized their boundary spanning roles and expertise to manage the external environment on the North Shore. During the election of trustees in September 1980, North Shore residents were explicitly asked to consider the question of whether or not Lions Gate Hospital

should perform therapeutic abortions and whether trustee selection should be based solely on the candidate's position on abortion. The result was a clear mandate to continue providing therapeutic abortions at Lions Gate Hospital and to select trustees as community representatives, rather than as representatives of single interest groups. The current climate is one of tenuous calm and guarded collaboration as the fragile requirements of compromise have replaced political optimization in the governance process at Lions Gate Hospital.

5) Support of Provincial Interest Groups

In terms of provincial interest groups, Lions Gate Hospital trustees were active supporters of the British Columbia Health Association and the Health Labour Relations Association in their approach to governance. Since the Health Labour Relations Association was an outgrowth of the British Columbia Health Association, the mandate of the two bodies are distinctly similar. Because public regulation by government tends to encourage organizations to band together to press their interests on the decision-making governmental body,[80] both British Columbia Health Association and the Health Labour Relations Associations seek to impact on the provincial government through group solidarity.

> "... (governments) often require the positive co-operation of interest groups if (policies) are to be effectively carried out, and what is more natural than to give the groups a direct voice of some sort both in the formulation and administration of policies which cannot be administered without their support?..."[81]

The primary function of the British Columbia Health Association is representation of the interests and concerns of the membership through liaison with the provincial government. The role of the association is to act as an intermediary between the health care organizations in British Columbia and the provincial government.[82] Similarly, the role of Health Labour Relations Association is to develop a common direction for the management side, unifying the labour relations policies through becoming accredited as their bargaining agent.[83]

The interplay of roles and functions on governmental structure, activities and attitudes indicated that the essential characteristic of both associations was that of a pressure group. Structure was important in determining the form of pressure group politics and policy was important in determination of the scope and intensity.[84] A pressure group is conceptualized as

> "... An organized aggregate which seeks to influence the content of governmental decisions without attempting to place its members in formal governmental capacities ... individuals who consciously band together, amalgamate their strength, consult on questions of organization strategy, and undertake action in pursuit of their goals..."[85]

Because pressure groups generally require a measure of legitimacy before they become a political force,[86] the involvement of hospital trustees is crucial to the successful use of strategies by the associations.

> "... A policy may demand, in its formulation or administration, some skill or knowledge over which members of a special group have, or are believed to have, a monopoly ... it may be impossible to carry out a policy without some sort of active support by the group..."[87]

The British Columbia Health Association and the Health Labour Relations Association meet regularly with the Minister of Health and other government representatives to discuss health care issues and concerns on behalf of members; however, the focal point for pressure group activity is toward the administrative mechanisms rather[88] than the political arenas. Since the aim of interest articulation is to affect governmental outputs, the emphasis is on "access-oriented communications"[89] by generating a receptive attitude at the political and administrative levels by means of regular and private meetings rather than confrontation.

> "... there is a relationship between the effectiveness of pressure groups and the character of the administrative structure upon which they act. A close 'clientele relationship' between group and administrative department always tends to give the group important advantages..."[90]

The most significant contributions of the provincial interest groups were the development of the Joint Funding Project in 1979 and the Hospital Role Study.[91] The initiatives of the Lions Gate Hospital trustees in terms of hospital funding were acknowledged earlier in this chapter as leading directly to the establishment of the Joint Funding Project. The Hospital Role Study evolved out of the funding review as an explicit plan to classify and categorize the present and future roles of the hospitals in British Columbia in order to deal with optimal allocation of resources in terms of costs and quality. The Hospital Role Study was initiated because hospital classification, in conjunction with the funding review, was essential for rational planning and policy making. Warham indicated that the essence of policy is a conscious and long term process in which objectives and resources are identified and related to each other.[92]

> "... equality of rights should apply within categories and relationships, and that these categories and relationships having ... been determined, rights should apply impartially to all who fall within them ... equality demands not the same treatment for all, but differential treatment based on significant differences..."[93]

The pattern of involvement of the British Columbia Health Association as a representative of the membership interacting with the

Minstry of Health was conceptualized by Birrell and Murie as a bargaining process with the parties dependent on each other and a cooperative process utilizing consultation with adjustment of preferences and interests to meet the demands of others by peaceful persuasion.[94] The Hospital Role Study did not constitute a plan but rather defined the parameters for future negotiations.

6) Organizational Design

In terms of organizational design, the Lions Gate Hospital trustees adopted a "muddling through"[95] approach in their governance process. Whilst organizational design was clearly a responsibility of the Chief Executive Officer, the period of analysis showed numerous instances of ambiguity and confusion about the roles and functions of the trustees and the Chief Executive Officer. The trustees dealt with multiple design issues but failed to lead the governance process toward an end of maintaining a coherent fit between the strategy (i.e., domain, objectives and goals), the organizing mode (i.e., subtasks and co-ordination) and the integration mechanisms (i.e., selection and reward systems).[96] Thus, Lions Gate Hospital followed a "naturalistic" approach and each design problem was dealt with incrementally without conscious planning or deliberate organization in order to forestall problems before they arose.

In 1972, the trustees approved a three month trial period for shared services between Lions Gate Hospital and St. Mary's Hospital in Sechelt, British Columbia. The inital arrangement was intended to provide Sechelt with larger facilities, improved patient care and economies of scale.[97] The Ministry of Health agreed to the arrangement provided that the costs did not exceed those that would have been experienced had the activities been carried out at St. Mary's Hospital.[98] Subsequently, the relationship was modified and Lions Gate Hospital was contracted to provide a consultative role only on a fee for service basis, pending the recruitment and selection of an Administrator for St. Mary's Hospital.[99]

The shared services arrangements raised vociferous opposition within a faction of the Lions Gate Hospital board; moreover, the discontent was exacerbated by a particularly bizarre set of administrative decisions by the Chief Executive Officer. The Administrator moved his residence to Sechelt,[100] appointed his wife as Adminstrator at St. Mary's Hospital,[101] actively pursued the possibility of a shared service arrangement with the Queen Charlotte Islands General Hospital,[102] allowed a local Initiatives Program project to be developed at Lions Gate Hospital outside of administrative control[103] and was seemingly unable to attract and retain a qualified nursing

administrator.[104] Thus, when the Administrator re-organized the Department of Nursing and informed the trustees of the re-organization in December 1973, the trustees seized the opportunity and immediately focused on the responsibilities of the Administrator.

The annual meeting in 1974 saw the election of a new Chairman of the Board, who provided a strong impetus for clearly delineating the duties of the Chief Executive Officer. In April 1975, the trustees convened a special meeting and outlined a detailed directive to the Administrator outlining the duties and responsibilities (See Appendix Ten). Thus, in May 1975, the Administrator submitted his resignation and cited a growing conflict between a status quo board and a professional administrator.[105] He indicated to the media that he would be focusing his future attention on trusteeship and

> "... in educating those trustees who are handicapped by their fears of the future and helping them rise above their lower order ego needs for prestige..."[106]

Since the appointment of the present incumbent, the reciprocal relationship between the board and the Chief Executive Officer has been defined and the proliferation of organizational design issues have been minimized. As a result,

the governance process was separated from the organizational design process after 1976 - a clear indication of the benefits accruing from a sorting of roles and function between the trustees and the Chief Executive Officer.

7) Operational Policy Development

In terms of operational policies, the Lions Gate Hospital trustees were involved in a series of policy discussions on an incremental basis. Because the basic planning levels were unclear and did not distinguish between the strategic or policy level, the program level and the operational level, a clear system of operational policy development did not emerge from the administration or from the governance process. Policies dealing with fiscal constraints, smoking regulations, visiting hours, interdenominational chaplaincy services, etc., were each addressed separately and without a sense of integration.

By establishing uniformity and consistency within the hospital, policies are intended to bring about quick and effctive decisions.

> "... Without a governing policy it would be necessary to refer each case to the board for decision. When there is a policy, the decision can be made at the point of occurrence without delay..."[107]

Policy development and planning are linked together since planning is a necessary prerequisite to policy making. Planning and policy decisions are intended to be interdigitated in a process to establish priorities for finite resources, to measure the distance and difficulty between the current situtation and the desired objectives, formulation of programs in terms of planning, budgeting and evaluation and to provide a periodic review of both objectives and programs in light of experience with incremental changes over time.

Policy development is not well understood by the Lions Gate Hospital trustees. A basic protocol to facilitate ongoing policy development would include a Board Manual at the strategic level an Administrative Manual at the program level for interdepartmental administrative matters and Program Manuals and Departmental Manuals at a clinical practice or technical level. Effective policies flow out of a process of participation and are evolutionary as they flow out of operational requirements.

Policy making, planning and operational management are inherently related and cannot be dissociated. New policies should emerge out of an evaluation of the effectiveness of old policies. Implementation of policies in the spirit of their

intent is an integral responsibility of all hospital personnel, including the trustees.

Summary

The data analysis generated during a ten year period of the governance process at Lions Gate Hospital affirmed the hypothesis of the study in that the trustees were not substantively involved in policy making. The trustees were overwhelmingly involved with operational management issues amounting to 90.3% of the total issues considered and only 9.7% spent on policy issues.

In looking at the seven major areas of trustee involvement with policy making at Lions Gate Hospital, the basic characteristic was the "science of muddling through".[108] The change in Chief Executive Officer during 1976 fundamentally changed the policy making process and began to redirectc trustee actions toward "rational policy through mutual adjustment".[109]

CHAPTER SEVEN FOOTNOTES

1) B. C. Glaser and A. L. Strauss; The Discovery of Grounded Theory: Strategies for Qualitative Research (Chicago, Illinois: Aldine Publishing Company) 1968.

2) B. McCool and M. Brown; The Management Response: Conceptual, Technical and Human Skills of Health Administration (Toronto: W. B. Saunders Company) 1977.

3) R. Badgley; Report of the Committee on the Operation of the Abortion Law (Ottawa: Department of Supply and Services) 1977.

4) B. McCool and M. Brown; op.cit.; page

5) K. A. Mitchell; Policy Development (Vancouver: U.B.C. Heath Sciences Centre Hospital) June 1980; page 1.

6) J. R. McGibony; Principles of Hospital Administration (New York: G. P. Putnam's Sons) 1969; pages 147-148.

7) B. McCool and M. Brown; op.cit.; page 5.

8) Ibid; page 4.

9) Ibid;

10) Ibid; page 5.

11) J. R. Galbraith; Organizational Design (Don Mills, Ontario: Addison-Wesley Publishing Company) 1977; page 1-2.

12) S. M. Shortell and W. R. Richardson; Health Program Evaluation (St. Louis: C. V. Mosby Company) 1978; page 9.

13) C. E. Lindblom "The Science of Muddling Through" Public Administration Review (Spring 1959) pages 79-88.

14) "Don't Scare the Patients" Vancouver Sun (February 10, 1976)

15) Lions Gate Hospital Annual Report (North Vancouver: North and West Vancouver Hospital Society) 1977; page 2.

16) G. Gilley Background and Introduction to the Joint Funding Project (Vancouver: B. C. Health Association) May 25, 1979; page 2.

17) Ibid; page 3.

18) Ibid; page 3-4

19) Ibid; page 4.

20) Ibid; page 4.

21) Ibid; page 4.

22) J. B . Buchanan, Chairman of the Joint Steering Committee for the Joint Funding Project in a Memorandum to the Minister of Health and the President of the B. C. Health Association (December 20, 1979) page 3.

23) Ibid; page 3.

24) A. Naqui "The Basics of Trusteeship" Hospital Trustee (March/April 1979) page 21.

25) C. Abbis Liable or Not? The Trustee (Speech delivered to the Canadian Hospital Association) 1976; page

26) K. A. Kinloch Nursing Quality Assurance Program (New Westminster, B. C.: Royal Columbian Hospital) 1979; page 1.

27) K. A. Kinloch Surrey Memorial Hospital Quality Assurance Plan for Nursing (Surrey, B. C.: Surrey Memorial Hospital) 1981; page 1.

28) N. S. Martin Developing Departmental Quality Assurance Programs in the Hospital (Tucson, Arizona: Health Information Development Association) 1981; page

29) H. Blum; "Evaluating Health Care" Medical Care (December 1979) page 919.

30) J. Marshak - Gustafson, S. Kopher and M. Terze "Planning is the Key to Successful Quality Assurance Programs" Hospital (June 1981); pages 71-72.

31) Ibid; page 68.

32) G. Troyer and S. Solman "Committee Can Help Oversee Hospital's Quality Assurance Activities" Hospital (June 1981) page 89.

33) R. L. Johnson; "The End of the Wobbly Three-Legged Stool" Trustee (May 1976) page 20.

34) L. Reinharth, H. J. Shapiro and E. A. Kallman; The Practice of PLanning: Strategic, Administrative and Operational (Toronto: Van Nostrand Reinhold Company) 1981; page 4-5.

35) K. Lee; "Health Care: Planning, Policies and Incentives" Future (December 1979) page 483.

36) K. A. Mitchell, Health Planning Overview (Vancouver, B. C.; U.B.C. Health Sciences Centre Hospital) 1982; page HP-1.

37) "Trustee Development Program Topic 3: The Planning Process" Hospital Trustee (May/June 1974) page 15.

38) K. A. Mitchell, op.cit.

39) Ibid

40) Board of Management Minutes (North Vancouver, B. C.: Lions Gate Hospital) October 15, 1969.

41) Ibid; (June 21, 1972) page 279.

42) Ibid; (September 20, 1972) page 287.

43) Ibid; (December 20, 1978) page 211.

44) J. J. May "The Planning and Licensing Agencies" in C. Havighurst (Editor) Regulating Health Facilities Construction (Washington, D.C.: American Enterprise Institute for Public Policy Research) 1979; page 47.

45) B. Jackson "B. C. Hospitals Stricken by Political Malady" The Financial Post (May 3, 1975) page C-8.

46) K. Lee; op.cit.; page 484.

47) J. S. Rakich, B. C. Longest and T. R. O'Donovan; Managing Health Care Organizations (Toronto: W. B. Saunders Company) 1977; page 92.

48) C. E. Lindblom; op.cit.; pages 79-88.

49) R. Badgley; op.cit.; page 17.

50) C. Gainor; "Abortion: Debate of Our Lives" Vancouver Sun (September 6, 1980).

51) L. E. Rozovsky; Canadian Hospital Law (Ottawa: Canadian Hospital Association) 1980; page 109-111.

52) R. L. Badgley; op.cit.; page 278.

53) Ibid; page 17.

54) D. Lintern; "Interpretation of Abortion Law Takes Ability" British Columbia Medical Associatin News (February 1980); page 3.

55) Board Minutes (North Vancouver: Lions Gate Hospital; June 17, 1970) page 193.

56) "A New Ethic for Medicine and Society" California Medicine (September 1970) pages 67-68.

57) J. F. McCreary; Report of the Committee to Study Abortion Facilities in the Greater Vancouver Regional Hospital District (November 1971).

58) Babies by Choice Not By Chance (Vancouver: United Community Services; Monograph 1: Therapeutic Abortion and Contraception) 1973; pages 18-19.

59) D. A. Geekie; "Abortion: A Review of Canadian Medical Association Policy and Positions" Canadian Medical Association Journal (September 7, 1974) page 2.

60) M. E. Hunter; "Applicatons for Abortion at a Community Hospital" Canadian Medical Association Journal (November 16, 1974) page 102.

61) Brief to the Federal Cabinet Meeting in Vancouver (Vancouver: Pro-Life Soceity of British Columbia; February 10, 1976).

62) Brief to the Provincial Government of British Columbia (Vancouver: Pro-Life Society of British Columbia; May 1976) page 3.

63) K. Aslop "Warding Off Abuse" The Vancouver Province (January 24, 1976) page 40.

64) Ibid;

65) "Abortion" The Vancouver Province (October 20, 1973).

66) Brief to the Provincial Government of British Columbia; op.cit.; page 6.

67) Ibid; page 7.

68) M. Trueman "Specially Equipped Regional Centres Best Place for Safe Abortions, Badgley Report Says" Globe and Mail (February 10, 1977).

69) D. Sellar "Ottawa Awaits New Abortion Debate: Vancouver Province (February 11, 1977).

70) "Abortion Study Attacked" Vancouver Sun (February 14, 1974).

71) Ibid

72) R. Oberlyn "Organized Anti-Abortionists Take the Lead in Desperate Fight For Life" Vancouver Sun (June 24, 1978).

73) "Minister to Stay Out of Abortion Battle" Vancouver Sun (May 30, 1978).

74) "Three Ring Meeting" Vancouver Province (July 24, 1978).

75) Board Minutes; op.cit.; page 216.

76) R. Hall "The Mountain Ear" The Citizen (September 13, 1978).

77) C. Gainor "Anti-Abortionists Lose Fight at Lions Gate" Vancouver Sun (September 28, 1978).

78) "Right to Vote Challenged" Sunday News (September 17, 1978).

79) R. R. Cadmus; "Community Responsibility Ain't Easy" Trustee (February 1980) page 25.

80) H. Eckstein "The Determinants of Pressure Group Politics" Pressure Group Politics: The Case of the British Medical Association (London: Allen and Unwin) 1960.

81) Ibid; page 173.

82) General Information (Vancouver: British Columbia Health Association) May 1979.

83) "New Hospital Negotiator Wouldn't Ban Strike Right" Vancouver Sun (January 11, 1976.

84) H. Eckstein; op.cit.; page 189.

85) P. Rivers; Politics by Pressure (London: Harrop and Company Limited) 1974; page 50.

86) H. Eckstein; op.cit.; page 177.

87) Ibid; page 187.

88) Ibid; page 167-168.

89) A. P. Pross; Pressure Group Behavior in Canadian Politics (Toronto: McGraw-Hill Ryerson Limited) 1975; page 13.

90) H. Eckstein; op.cit.; page 188.

91) D. Layton (Editor) Hospital Role Study - A Discussion Paper on Hospital Services in British Columbia (Victoria: Ministry of Health) 1979.

92) J. Warham The Concept of Equality in Social Policy (Vancouver: University of British Columbia) 1974; page 11.

93) Ibid

94) D. Birrell and A Murie "Ideology, Conflict and Social Policy" Journal of Social Policy (Spring 1975) pages 254-256.

95) C. E. Lindblom; op.cit.;

96) J. R. Galbraith; Organization Design (Don Mills, Ontario: Addison-Wesley Publishing Company) 1977; page 5.

97) Board Minutes; op.cit.; page 27.

98) E. H. O'Dell; Shared Services: An Experience Analysis and an Opportunity (North Vancouver, B. C.: Lions Gate Hospital) September 1972; page 3.

99) Board Minutes; op.cit.; (October 12, 1972) page 289.

100) Ibid (May 16, 1973) pages 2QXFA.

101) J. M. Hannay; Shared Services for Lions Gate Hospital and St. Mary's Hospital (Vancouver, B. C.: University of British Columbia Department of Health Care and Epidemiology) December 1972.

102) Board Minutes; op.cit.; (July 18, 1973) page 323.

103) Ibid (December 15, 1972) page 251.

104) Ibid (December 19, 1973) pages 341-342.

105) "Lions Gate Hospital Head Quits, Cites Crisis" The Citizen (May 7, 1975).

106) "Bragg Quits, Alleges Conflict" The Times (May 4, 1975).

107) Council Manual (New York: Girl Scouts of America) 1969; page 33.

108) C. E. Lindblom; op.cit.;

109) C. E. Lindblom; "Rational Policy Through Mutual Adjustment" in A. Etzioni, et.al (Editors) Social Change - Sources, Patterns and Consequences (New Yord: Basic Books 1973; pages 493-499).

CHAPTER EIGHT

Chapter Eight provides a presentation of the conclusions and implications for planning that emerged from the study of hospital governance. The previous chapters have confirmed the hypothesis of the study that the Lions Gate Hospital trustees were not substantively involved in policy making but were primarily involved in operational management matters since the role of the hospital trustee did not evolve in concert with the change in the Canadian health system under national health insurance. This chapter does not repeat a summary of the findings but rather explores the impediments to changes through presentation and discussion of the author's expectation of hospital governance, the realities of the governance process, the generalizability of the data and analysis, the implications for planning in terms of disappointed expectations, a new model for trusteeship and a set of planning recommendations.

Expectations for Hospital Governance

The previous chapters have outlined the failure of hospital trustees to evolve into a policy body and that the problems in hospital governance have led critics to describe the hospital governance process as a legalistic anachronism rather than a vital force for influencing corporate affairs in a positive manner [1]. Governance, under the Canadian national health insurance system, was

intended to deal with strategic and corporate long range planning and policy matters and was not intended to involve the program and operational administrative concerns including planning, organizing, directing, controlling and evaluating.

An administrative board by definition is meant to indicate that final administrative authority rests with the board, even though the authority to manage the operation of the hospital may be delegated to the Chief Executive Officer [3]. By contrast, a policy making board is one in which that actual agency policy is determined by the board and this is the policy governing hospital operation [3]. The functions of an administrative board are:

1) To establish the legal or corporate existence of the hospital;

2) To take responsibility for formulating general objectives, (lower level operational) policies and programs;

3) To inspire community confidence in the hospital because of the competence and dedication of the board members as active trustees;

4) To assume responsibility for the provision of adequate finances and to be accountable for the expenditure of funds;

5) To provide conditions of work, personnel policies, and staff, with a particular responsibility for the selection and evaluation of the Chief Executive Officer;

6) To understand and interpret the mission of the hospital to the community;

7) To study, know and interpret general community needs to hospital staff;

8) To relate the services of the hospital to the work of other health agencies and to concentrate upon the improvement of community conditions;

9) To conduct periodic evaluations of hospital operations with a view toward improving and strengthening the productivity and quality of care;

10) To provide the continuity of experienced leadership so that major staff changes will not weaken the hospital[4].

Following the introduction of national health insurance in Canada, the expectation was that hospital trustees would become policy makers and perform three basic functions -- mandate, maintain and monitor [5]. The mandate role of the hospital trustee was to delineate a mission statement in order to permit the formulation of policy, the identification of purpose, the definition of objectives, and the delegation of authority and responsibility to the Chief Executive Officer.

The maintenance role of the hospital trustee embodies the successful implementation of the governance mandate by means of approving the program developed by the Chief Executive Officer to achieve policy objectives and to support the program with appropriate resource allocations. Having been delegated the necessary authority by the governance mandate, the Chief Executive Officer was to be responsible for the effective execution of the mandate. Thus, the responsibilities of the Chief Executive Officer were to include planning a program to achieve the mandate objectives, submitting the program to the trustees for approval and information, obtaining authority to acquire and organize the necessary resources, implementing and maintaining the program and

reporting the results achieved to the board.

After having prepared a mandate and having taken action to initiate and maintain the necessary program, the hospital trustee was to monitor the outcomes or outputs achieved by comparison of the results achieved with the policy objectives and established governance criteria. The monitoring role was intended as a means to support and facilitate achievement rather than as a judgmental control and to review the governance functions of mandating, maintenance and monitoring to ensure that hospital operations remained current and effective.

The Chief Executive Officer, having been delegated accountability and responsibility for effective execution of the mandate, was to be accountable to the board for the results achieved. Thus, the Chief Executive Officer was to submit summary reports to the trustees that highlighted progress and problems in a meaningful fashion and sought the support and counsel of the hospital trustees as required because of the trustee obligation to serve in a fiduciary capacity.

In the sections that follow, the inability of hospital trustees to reach the author's expectations of moving towards governance in terms of mandating, maintaining and monitoring are discussed. The major findings offer a diverse range of insights into the inability of the Lions Gate Hospital trustees to clearly establish the hospital governance process as one of mandating, maintaining and monitoring.

Realities

The introduction of national health insurance by means of the National Health Grants in 1948, the Hospital Insurance and Diagnostic Services Act (1958) and the Medical Care Act (1968) established the legitimacy for hospital trustees to move away from their role of overseeing the fundraising and operational management of the hospital and concentrate their efforts on long range planning and policy making.

The professionalization of hospital administration occurred in concert with and as a result of the introduction of national health insurance. Chief Executive Officers became increasingly well-educated and articulate in the management processes of planning, organizing, directing, controlling and evaluating. Thus, the legitimacy was reinforced and the feasibility was established for hospital trustees to become involved in policy making and long range planning.

The major impediment to hospital governance was the restrictive mandate of the provincial Hospital Act (RS Chapter 176; 1979)) which precludes an effective policy making role for hospital trustees in British Columbia. The restrictive mandate of the Hospital Act was compounded by a hospital funding system in British Columbia that was characterized as slow, uncertain and counterproductive. The funding system operated by the British Columbia Hospital Programs in the Ministry of Health was a retrospective budget adjustment methodology

that results in hospital trustees and Chief Executive Officers facing uncertain funding throughout much of the fiscal year. With neither the funds nor the professional staffing required for a community hospital operation, it was hardly surprising that the Board of Management at Lions Gate Hospital spent considerable time on an annual basis grappling with a woefully inadequate hospital funding system.

The advent of the third party payment schemes did not produce a financial system beyond the capability of a rudimentary accounting system. Federal-provincial cost sharing and bloc grant initiatives failed to improve the situation. Coupled with the lack of a provincial health plan, the funding system simply exacerbated the restrictive mandate of the Hospital Act with the result that the potential for policy making and long range planning initiatives were compromised.

The second major impediment to hospital governance and the functioning of the Lions Gate Hospital trustees as an administrative board was the selection process for trustees. The traditional reliance on small and intermediate sized business executives and politicians from the North Shore municipalities allowed the governance process to become overwhelmed by operational management issues because management was what the trustees knew. The trustees were not knowledgeable about strategic long range planning and policy making processes and hence avoided such issues by delving

into administrative matters. In addition, the rapid turnover of trustees exacerbated the situation.

While the right business connections, reputations and general visibility on the North Shore were adequate qualifications for the less exacting trustee responsibilities in previous years, the present day boards need to be concerned with critical examination of hospital decisions, policy making and long range planning. Hospital trustees need to understand their role as one of boundary spanning between the hospital and the external environment including the provincial government, the interests of the physicians, health care providers and administrators and the local community.

The educational initiatives of the British Columbia Health Association need to be augmented and reinforced by the Chief Executive Officer at Lions Gate Hospital on an on-going basis. The educational programs for hospital trustees in British Columbia require a much greater emphasis on policy making and long range planning issues including the development of mission statements, guiding principles and outcome oriented objectives. Hospital performance and trusteeship as assessed by governments, unions, consumer organizations, professional associations, the media and the public, indicates that the process for trustee selection at Lions Gate Hospital needs to become more rigorous.

At Lions Gate Hospital, it would seem there is no recruitment policy for potential trustees which makes clear the need of the

hospital for expertise and competence at the governance level. In an organization such as a community hospital that is structured on an executive leadership model, board members who fail to understand the fundamental distribution of policy and administrative functions may seriously disrupt administration [6].

The third major impediment to hospital governance was the education process for trustees. Whilst the British Columbia Health Association was the primary force for trustee education, during the period of the study its Trustee Orientation Program disproportionately emphasized the administrative functions rather the policy making and long range planning processes, which all hospital trustees must be able to perform in order to mandate, maintain and monitor.

The fourth consideration was the role of the Chief Executive Officer and the Chairman of the Board in the governance process. The administrator could influence the emphasis of the trustees on administrative or policy issues only to the limited extent of specialized knowledge. Clearly, the emphasis of the Lions Gate Hospital trustees began to shift away from operational management to long range planning issues in 1976 with the appointment of the present Chief Executive Officer. The new Chairman of the Board played a similar role in effecting a subtle shift in orientation to policy and long range planning matters.

While the analysis included the ten year period from January 1, 1969 through to December 31, 1978, it appeared that the Lions Gate Hospital trustees were gradually beginning to encompass a range of strategic planning and strategic management activities. In the case of therapeutic abortions, the indications were that a definitive attempt was initiated subsequent to the analysis to use the capability of the boundary spanning roles to effect environmental management. At the end of the ten year analysis, the trend was beginning to become evident in qualitative terms although it was not reflected in the quantitative data trends.

A final consideration was the interaction of the trustees with the organized medical staff. The interaction was generally reactive rather than proactive and tended to emphasize problem solving. The trustee involvement in areas such as clinical practice, quality appraisal and program development were guarded and cautious, with little evidence of assertiveness or risk taking. The elected President of the Medical Staff Advisory Committee, and the Medical Coordinator functioned as mediators between the physicians and the trustees during the rare instances when conflict emerged between the two parties.

In summary, the governance process at Lions Gate Hospital illustrated that much of the initiative for major policy comes from the clinical and administrative professionals outside the board itself because many choices are grounded on specialized knowledge

which the trustees do not have. However, because the trustees are, in a sense, outsiders to the hospital system, the trustees were able and were called upon to mediate between the professional goals of the competing groups.

Generalizability

The issue of whether the Lions Gate Hospital board is typical of all community hospitals in British Columbia is of major significance in terms of the generalizability of the research findings. In order to establish similarity between from Lions Gate Hospital and the other community hospitals in the province, a comparative review of board composition was undertaken using the data generated by the British Columbia Health Association in a 1981 survey of provincial health care institutions [7].

The average size of a hospital board in British Columbia is twelve trustees [8] and this compares favourably with the Lions Gate Hospital board with fourteen trustees. Whilst 85% of the provincial hospitals have some elected trustees [9], only 63% of the hospitals located in the Lower Mainland area of British Columbia have some elected trustees [10]. The provincial average is 79% of the boards with a majority of elected trustees and 21% with a majority of appointed trustees [11]. Lions Gate Hospital with 64% of the board members being elected trustees and 36% of the board members being appointed trustees compares favourably with the trends shown on Table VIII on the following page:

Table VIII: Board Composition Comparisons.

	Provincial Average	Lower Mainland Average	Lions Gate Hospital
% of elected trustees	59	48	64
% of appointed trustees	41	52	36

The type of ownership is a significant factor in determination of the balance between elected and appointed trustees. In the lay hospitals throughout British Columbia, which are operated by voluntary societies incorporated under the Societies Act (Chapter 362, R.S.B.C. 1960), 84% of the hospitals have more than 50% of their board members elected [12]. By contrast, only 67% of the lay hospitals in the Lower Mainland area have more than 50% of their board members elected [13].

The comparison of the Lions Gate Hospital board with the boards throughout British Columbia and the Lower Mainland area of the province indicates that Lions Gate Hospital is a typical operation. The research data chould be generalized to other hospitals in British Columbia, thus broadening the applicability of the findings on hospital governance beyond the confines of Lions Gate Hospital.

Implications for Planning: Disappointed Expectations

The study of hospital governance at Lions Gate Hospital has raised many indications for change in hospital governance processes

and the implications for planning are outlined. Governance in hospitals throughout British Columbia has been increasingly challenged and questioned by consumers, taxpayers, politicians, health care providers and administrators who voice dissatisfaction with the policy making process -- or lack thereof -- in hospitals. The critics have argued that the traditional organizational triad of the governing board, the Chief Executive Officer and the organized medical staff was not relevant to the organizational needs of a community hospital. The more recent trends in hospital governance indicated that hospital boards made overall policy, the organized medical staff recomended and implemented policy concerning medical services and the Chief Executive Officer recommended and implemented policy concerning financial and support services, the relation of medical services to support services and the relation of the hospital to other organizations and interest groups.

The expectations of hospital governance as a policy making process did not materialize because while the decision making control shifted to the provincial governments as the funding agencies with national health insurance, the hospital trustees did not achieve the fundamental change in both attitude and perspective. Therefore, the hospital governance process became a reactive rather than proactive force at Lions Gate Hospital.

New Model for Trusteeship.

The changes in the Canadian health care system with the advent of national health and the professionalization of hospital administrators, does not in any way lessen the contribution of trustees. Rather the growing complexities and challanges facing the health care system and the Chief Executive Officers makes the trustees' contribution potentially more useful and more necessary than ever before. A hospital trustee deals primarily with the Chief Executive Officer and the organizational medical staff and poses the fundamental problem of administrative versus clinical authority.

"...The board members' prestige and formal power in the cummunity are usually at least as great as that of the physician and therefore they are better able than anyone else to maintain a balance between technical scientific claims and other interests. Relations between board, medical staff, and administrator are complex and rest finally on mutual understanding and accomodation rather than formal lines of organization. This triad of human relations affects more than the three top agents. It profoundly influences the internal relations of the hospital as a whole, as well as its ties with the outsid world..."[14].

Involvement of Lions Gate Hospital trustees with policy matters was and should continue to be of three sorts -- initiation, transmission and/or mediation of policy [15]. Ambulatory care planning exemplified the initiation of a significant change in policy and orientation. The closing of the medical staff divisions exemplified the transmittal of a policy forced on Lions Gate

Hospital by the Canadian Council on Hospital accreditation as an external agency. The shared services arrangement with St. Mary's Hospital in Sechelt, British Columbia exemplified the mediation process of governance as the trustees monitored the project and attempted to resolve divergent aims.

Planning Recommendations

In order to function as a policy board, the Lions Gate Hospital trustees should begin developing a clear mission statement, with a set of annual goals and objectives. The mission statement represents the most important document Lions Gate Hospital will ever produce because it will establish the direction, tone, capacity, patient catchment area and the medical and clinical strengths of the hospital.

A large organization such as a community hospital also requires the setting of annual goals and objectives in order to permit strategic planning as the mechanism for developing policies, plans or performance in a meaningful way. The North and West Vancouver Hospital Society should be actively recruiting potential trustees with specialized and expert competence in policy making in order to avoid stagnation of board membership. The society needs an ongoing program to recruit new members to fulfill a planned mix of governance skills and explicit mechanisms to remove ineffective or uninvolved members in order to provide for new and different talents.

The Board of Management needs studiously to consider an appropriate and performing committee substructure. Whilst no board can discharge its responsibilities by doing all of its business in board meetings, a streamlined structure consisting of an Executive Committee to deal with financial, personnel and public relations matters, a Long Range Planning Committee and a Quality Appraisal Oversight Committee could be a reasonable distribution of workload and responsibilities. The subcommittees could digest detailed inputs and evaluate present policies, plans and programs in an organized way for trustee consideration and action.

The skillful assignment of individual trustees to the board subcommittees provides a method for broadening the contribution of individual trustees, particularly if such assignments were made to achieve an appropriate blend of skills. Constant attention to defining what it means to be a hospital trustee and the employment of ongoing educational efforts offers the potential of ameliorating the relative heterogeneity of the Lions Gate Hospital board.

The complexity of the national health insurance program in Canada and the health care delivery system in British Columbia, impinges on the effectiveness of all hospital trustees. Thus, voluntary trustees must have opportunities to learn enough about the hospital industry in order to gain at least a basic understanding of the major forces felt by the health care institutions. While it is recognized that the volunteer trustee has limited time for

education, the trustee has a responsibility to make a reasonable effort to learn about hospital governance.

The Lions Gate Hospital Board of Management should be actively supporting the Trustee Orientation Program sponsored by the British Columbia Health Association and pushing the trustee education programs provided by the association toward a policy making emphasis rather than the study of operational management issues. The explicit shift by the Trustee Orientation Program to a policy making emphasis is required to counter the lingering and simplistic view that the goal of a community hospital is basically charitable and social. The educational programs are needed to dilute the traditional view of charitable trusteeship in order that the policy making and monitoring role of the board be clearly delineated. The educational program requires a clear understanding of the responsibilities of a hospital trustee in British Columbia and the British Columbia Health Association should be encouraged to develop a comprehensive role description, in behavioral terms, for hospital trustees.

A clear role description for hospital trustees is necessary in order to ensure a balanced and extensive scope of responsibilities that are directed toward measurement, present and future oriented, focussed on results and subject to continuous monitoring. As an initial step toward the development of a comprehensive role description for hospital trustees, the Lions Gate Hospital Board of

Management should be dealing with three functions with significant impact on the well-being of the hospital. Firstly, the trustees have a duty to evaluate and monitor the performance of the Chief Executive Officer in accordance with the guidelines made available by the Health Administrators' Association of British Columbia (See Appendix Eleven). Through performance evaluation, the trustees can begin to understand the work of the Chief Executive Officer and to assess compensation suitability. Secondly, the trustees are responsible for emphasizing planning rather than problem solving as the framework for decision making in the governance process. Thirdly, all of the trustees must be prepared to act as external advocates for Lions Gate Hospital in particular and for the health care system in general. Unrealized opportunities for service can be found through trustee participation in community-based and consumer-involved agencies that impact on the future of health care institutions.

> "...It is apparent that the potential power of (those)...who serve as trustees of our health care institutions needs to be better recognized, developed and used. A hospital governing board that is properly organized, led, and put to work is vital to attracting and retaining the interest of those qualified to act as effective trustees. Thus, an understanding of hospital governance -- its problems and its influence -- becomes a most important foundation for the future development of our health care system."[16]

In reviewing the evidence, it became apparent that only when trustees fulfill the complete spectrum of responsibilities are they

able to meet their primary obligation to provide the best possible services to their community. Hospital trustees must understand and have conviction about the overall purposes and mission of the institution. For only with conviction, can a trustee be thoroughly informed in order to interpret the mission of the institution to the community. Trustees are required to work hard to provide the hospital with the total resources required to render cost-effective programs and a feasible and realistic quality of care. Board members must have a vision of the institution in the years ahead and translate that vision into a comprehensive long range plan.

The need for hospital trustees to function at a policy making level is clear. The Lions Gate Hospital board must now concentrate on making the explicit transition from an administrative board to a policy making body as envisioned with the advent of the national health insurance system in Canada. As a policy making board, the Lions Gate Hospital trustees would perform three basic functions -- mandate, maintain and monitor.

CHAPTER EIGHT FOOTNOTES

1) M.F. Heller, Jr.; "The Board of Directors: Legalistic Anachronism or Vital Force" California Management Review (Spring 1972) page 24.

2) Citizen Boards in State Welfare Departments (New York: Advisory Committee on Citizen Participation, Community Chests and Councils of America, Inc. and the National Social Welfare Assembly; Bulletin 154 (December 1950) page 3.

3) Ibid.

4) H.B. Trecker; Group Processes in Administration - Revised and Enlarged (New York: Woman's Press) 1950; pages 97-98.

5) R.J. Makouski; "Mandate, Maintain and Monitor: A Model for Hospital Governance" Trustee (January 1976) page 34.

6) C.A. Newland; "Current Concepts and Characteristics of Administration" Child Welfare (June 1963) page 276.

7) Results of a Survey of Health Facility Board Composition (Vancouver: British Columbia Health Association) December 1981.

8) Ibid; page 7.

9) Ibid; page 8.

10) Ibid; page 8

11) Ibid; page 16

12) Ibid; page 21

13) Ibid; page 23

14) T. Burling, E.M. Lentz, R.N. Wilson; "The Board of Trustees" in J.S. Rakich and K. Darr (Editors) Hospital Organization and Management (Toronto: Spectrum Publication Medical and Scientific Books) 1978; page 75.

15) T. Burling, E.M. Lentz and R.N. Wilson; op. cit.; page 77.

16) R.M. Paget "Ten Barriers to Board Performance" Trustee (March 1979) page 27.

BIBLIOGRAPHY

- A -

1) Abbis, C. "Hospitals and Government: We Need One Another" Trustee (July 1978) page 28-29.

2) Abbis, C. "Liable or Not?" The Trustee (Speech to the second national convention of the Canadian Hospital Association in Ottawa, Ontario) 1976.

3) Abbis, C. "Sharing the Burden of Health Care: Part One" Hospital Trustee (March/April 1978) page 31.

4) Abbis, C. "Sharing the Burden of Health Care: Part Two" Hospital Trustee (November/December 1978) page 30-31.

5) A Blueprint for Board Members (Omaha, Nebraska: United Community Services) 1958;

6) "Abortion" The Vancouver Province (October 20, 1973).

7) "Abortion Study Attacked" Vancouver Sun (February 14, 1974).

8) "Accountability for Quality of Care" Patient Care Health Care Memorandum XXVII (Vancouver: British Columbia Health Association) May 1978.

9) Agnew, G. H. "Canadian Hospitals 1920 to 1970: A Dramatic Half Century (Toronto: University of Toronto Press) 1974.

10) Aldrich, H. and Herker, D. "Boundary Spanning Roles and Organization Structure" Academy of Management Review (April 1977) pages 217-230.

11) A Manual For Hospital Trustees (Don Mills: Ontario Hospital Association) 1976.

12) "A New Ethic for Medicine and Society" California Medicine (September 1970) pages 67-68.

13) Anton, T. "Power, Pluralism and Local Politics" Administrative Science Quarterly (March 1963) page 425-457.

14) A Primer for Hospital Trustees (Washington, D.C.: Chamber of Commerce of the United States) 1974; page 2-43.

15) "A Privilege is Not a Right" Dimensions in Health Service (May 1977) page 4.
16) Arnason, A. "Hospital Regions Stick City Two Ways - Mayor" Vancouver Province (April 14, 1967).

17) Aslop, K. "Warding Off Abuse" The Vancouver Province (January 24, 1976)

- B -

18) Babies By Choice Not By Chance (Vancouver: United Community Services; Monograph 1: Therapeutic Abortion and Contraception) 1973;

19) Badgley, R. Report of the Committee on the Operation of the Abortion Law (Ottawa: Department of Supply and Services) 1977.

20) Bailey, D.R. "A Future Course for Boards of Trustees" in H.R. Cathcart Trusteeship - Essential to Health Service (Des Moines: Iowa Hospital Association) 1973.

21) Bailey, R.G. "Hospital Board Duties Outlined" The Citizen (April 20, 1961).

22) Baird, A. "Shore Lines" Town Crier (January 3, 1958).

23) Baker, J.C. Directors and Their Functions (Boston: Harvard University) 1945.

24) Bales, R.F. Interaction Process Analysis: A Method for the Study of Small Groups (Cambridge: Addison-Wesley Press) 1950.

25) Barr, J.W. "The Role of the Professional Director" Harvard Business Review (May/June 1976) page 18-20, 24, 26, 30, 186 and 188.

26) Bates, D. "Are Ethics of Industry Appropriate to Medical Care?" Hospital Trustee (September/October 1979) page 12-14.

27) Bauerschmidt, A.D. "The Anomolies of Hospital Organization" The Implications for Management (Miami, Florida: University of Florida) 1968;

28) BCHA Membership Summary (Vancouver, B. C.: BCHA) January 20, 1980.

29) Berger, S. "Put New Trustees on the Right Track - Right at the Start" Trustee (July 1977) page 46-47.

30) Berkowitz, N. and Bennis, W. "Interaction Patterns in Formal Service - Oriented Organizations Administrative Science Quarterly (June 1961) page 25-50.

31) Berleson, B. Content Analysis in Communication Research (New York: Free Press) 1952. Chapter 1, page 13-25 and Chapter 3, page 114-134.

32) Berleson, B. "Content Analysis" in G. Lidzey (Editor) Handbook of Social Psychology (Don Mills: Addison-Wesley Publishing Company) 1954.

33) Birrell, D. and Murie, A. "Ideology, Conflict and Social Policy "Journal of Social Policy (Spring 1975) pages 254-256.

34) Black, J.A. "Who Really Calls the Financial Shots" Hospital Trustee (November/December 1977) page 20-22.

35) Black, R.G. "The Monitoring Role of the Trustee: The View From the Boardroom" Hospital Trustee (September 1978) page 5-8.

36) Blain, G. "Participatory Democracy in Health Care Facilities" Hospital Trustee (May/June 1978) page 28-30.

37) Blanton Jr., W.B. "A Physician Looks at Board-Medical Staff Relationships" Trustee (June 1979) page 28.

38) Blau, P. "Critical Remarks on Weber's Theory of Authority" American Political Science Review (October 1963) pages 305-316.

39) Blum, H. "Evaluating Health Care" Medical Care (December 1979) page 919-925.

40) Boardmanship - A Guide for the School Board Member (Sacramento: California School Board Association) 1969;

41) Boulton, W.R. "The Evolving Board: A Look at the Board's Changing Roles and Information Needs" Academy of Management Review (October 1978) page 827-836.

42) "Bragg Quits, Alleges Conflict" The Times (May 4, 1975).

43) Brief to the Federal Cabinet Meeting in Vancouver (Vancouver: Pro-Life Soceity of British Columbia) February 10, 1976.

44) Brief to the Provincial Government of British Columbia (Vancouver: Pro-Life Society of British Columbia) May 1976.

45) Brosseau, B.L.P. "The Voluntary Hospital System is Not to Blame" Dimensions in Health Service (November 1976) page 7.

46) Brosseau, B.L.P. "Watchdogs for the Voluntary System" Dimensions in Health Service (March 1977) page 6.

47) Brown, G.W. "Some Thoughts on Grounded Theory" Sociology (January 1973) pages 1-16.

48) Brown, R.E. "The Hospital and the Community" The Citizens and the Hospital (Durham, North Carolina: Duke University) 1973, Chapter 1; page 3-7.

49) Browne, W.G. and Montamedi, K.K. "Transition at the Top" California Management Review (Winter 1977) page 67-73.

50) Budd, R., Thorp, W. and Thorp, K.K. An Introduction to Content Analysis (Iowa City: University of Iowa) 1968.

51) Budd, R., Thorp, W. and Thorp, K.K. An Introduction to Content Analysis (Iowa City: University of Iowa School of Journalism) 1968.

52) Bush, C.R. "A System of Categories for General News Content" Journalism Quarterly (Spring 1961) page 13-15.

- C -

53) Cadmus, R.R. "Community Responsibility Ain't Easy" Trustee (February 1980) page 25.

54) Caraca, J.P. "Trusteeship Means Time and Committment" Hospital Administration (August 1975) page 11, 24.

55) Carney, T.F. Content Analysis: A Technique for Systematic Inference from Communications. (Winnipeg: University of Manitoba Press) 1972.

56) Carter, N. Case Studies in Social Planning: Planning Under Voluntary Council and Public Auspices (Ottawa: Canadian Council on Social Development) 1972.

57) Carter, N. Trends in Voluntary Support for Non-Governmental Social Service Agencies (Ottawa: Canadian Council on Social Development) 1974.

58) Carter, N. Volunteers: The Untapped Potential (Ottawa: Canadian Council on Social Development) 1974.

59) Cartmill, G.E. "The CEO should have the Same Powers as a Corporation President" Trustee (August 1970) page 6-10.

60) Cartwright, B. "Analysis of Qualitative Material" in L. Festinger and D. Katz (Editors) Research Methods in the Behavioral Sciences (New York: Dryden Press) 1963.

61) Carzo Jr., R. "Some Effects of Organization Structure on Group Effectiveness" Administrative Science Quarterly (March 1963) page 393-424.

62) Cathcart, H. "Governance and Administration: A Joint Venture" Trustee (October 1975) page 19-21.

63) Cathcart, H.R. "The Trustee as Community Advocate of Growing Importance" The Hospital Trustee Reader (Chicago: American Hospital Association) 1975; page 24-30.

64) Cathcart, H.R. Trusteeship - Essential to Health Services (Speech in Des Moines, Iowa to the Iowa Hospital Association) April 26, 1973.

65) Caywood, S.A. "Is the Hospital Serving Its Community? Five Measures Will Tell." The Hospital Trustee Reader (Chicago: American Hospital Association) 1975, page 149-151.

66) Chabot, L.W. "On an Effective Board" Harvard Business Review (September/October 1976) page 40-42 and 46.

67) Chandler, M. "His Time to Clean Up the Boardroom" Harvard Business Review (September/October 1975) page 73-82.

68) Checker, A. and Knapp, R.M. "A Profile of Teaching Hospital Governing Boards" Trustee (August 1975) page 20-22.

69) Citizen Boards in State Welfare Departments (New York: Advisory Committee on Citizen Participation, Community Chests and Councils of America, Inc. and the National Social Welfare Assembly) December 1950.

70) Clark, B.C. "The Trustee's View" in J. E. C. Walker, et.al. Evaluation of Care in the University and Community Hospital (New Haven: Conneticut Health Service Research) 1970 . Chapter 4; page 20-21.

71) Code of Ethics for Hospitals (Ottawa: Ontario Hospital Association) 1966.

72) Code of Ethics for Hospitals "Statement on Hospital - Government Relations (Ottawa: Ontario Hospital Association) 1973, page 3.

73) Cohn, V. "The Public's View Part Two: The Changing Scope of Health Care" in Hospitals in the 1980's: Nine Views (Chicago: American Hospital Association) 1977, page 145-161.

74) Conrad, W.R. and Glenn, W.R. "Introduction" "The Way of Democracy - Voluntarism" The Effective Voluntary Board of Directors - What it is and How it Works (Chicago: Swallow Press) 1976, page 1-5.

75) Constitution and By-Laws (Vancouver: British Columbia Health Association) May 31, 1979.

76) "Consumers on the Board?" Modern Health Care (February 1975) page 72-76.

77) Copeland, M.T. The Board of Directors and Business Management (Boston: Harvard University) 1947.

78) Council Manual (New York: Girl Scouts of America) 1969.

79) "Councils Must Act Now to Get Needed New Hospital or North Shore People May Have to Go Without" North Vancouver News (February 25, 1957).

80) Crichton, A. Policies for Health Care Facilities (Speech to the Trustee Orientation Program sponsored by the British Columbia Health Association) October 1981.

81) Cunningham, R.M. Governing Hospitals: Trustee and The New Accountabilities. (Chicago: American Hospital Association) 1976.

82) Cunningham Jr., R.M. "Who's Minding the Store?" Trustee (March 1978) page 31-34.

83) Cunningham Jr., R.M. "Who's On Boards?" Governing Hospitals (Chicago: American Hospital Association) 1976; pages 34-48.

- D -

84) de Sola, Pool I. (Editor) Content Analysis (Urbana: University of Illinois Press) 1959.

85) de Sola, Pool I. The Prestige Press (Cambridge: Massasschuttes Institute of Techology Press) 1970.

86) de Sola, Pool I. Trends in Content Analysis (Urbana: University of Illinois Press) 1959.

87) Directorate Analysis: The Board of Directors, Its Significance, Its Evaluation (New York: American Institute of Management) 1959.

88) Donabedian, A. "The Quality of Medical Care" Science (May 26, 1978) page 856-863.

89) Donnelly, P.R. "Duties, Responsibilities, Structure and Membership of a Board of Trustees" Hospital Progress (August 1970) page 6-11.

90) "Don't Scare the Patients" Vancouver Sun (February 10, 1976).

91) Downey, H.K. and Ireland, R.D. "Quantitative Versus Qualitative: Environmental Assessment in Organizational Studies" Administrative Science Quarterly (December 1979).

92) "Drop Hospital Boards Says Union Brief" Vancouver Sun (March 8, 1973).

93) Drucker, P.F. "Managing the Third Sector" Wall Street Journal (October 3, 1978).

94) Drucker, P.F. "The Real Duties of a Director" Wall Street Journal (June 1, 1978).

95) Dubin, R. The World of Work (Englewood Cliffs: Prentice Hall) 1958.

- E -

96) Eckstein, H. "The Determinants of Pressure Group Politics" Pressure Group Politics: The Case of the British Medical Association (London: Allen and Unwin) 1960.

97) Elder, M.W. "Perceive, Relate to the Public" Hospitals (April 1976) page 109-116.

98) "Election Results on the North Shore" Vancouver Sun (December 13, 1957).

99) Elling, R. and Helsbsky, S. "Organizational Differentiation and Support: A Conceptual Framework" Administrative Science Quarterly (September 1961) page 185-209.

100) Eppert, R. "A Trustee Views the Voluntary Hospital System" Trustee (January 1968) page 1-30.

101) Estes, R.M. "Consumerism and Business" California Management Review (Winter 1977) page 5-11.

102) Estes, R.M. "The Emerging Solution to Corporate Governance" Harvard Business Review (November/December 1977) page 20-23, 26 and 164.

103) Etzioni, A. "Two Approaches to Organizational Analysis: A Critique and A Suggestion" Administrative Science Quarterly (September 1960) page 257-278.

104) Evans, R.G. "The Supply and Demand of Health Care" Hospital Trustee (May/June 1978) page 6-7.

105) Evolving Responsibilities of the Corporate Director (London, Ontario: University of Western Ontario) 1966.

106) Ewell Jr., C.M. "Evaluation of Administrative and Organizational Effectiveness in Hospitals" Hospital and Health Services Administration (Winter 1976) page 2-26.

107) Ewing, R.S. "Getting Back in Touch with the Community: A Task of Trustees" Trustee (November 1977) page 36-38.

- F -

108) Flanagan, J.C. "The Critical Incident Technique" Psychological Bulletin (July 1954) page 327-358.

109) Feingold, E. "Citizen Participation: A Review of the Issues" The Citizenry and the Hospital (Durham, North Carolina: Duke University) 1973, Chapter 2; page 8-16.

110) Ferrari, L.A. Canadian Directorship Practices: A Profile (Ottawa: Conference Board in Canada) 1977.

111) Festinger, L. and Katz, D. "Analysis of Qualitative Material" Research Methods in the Behavioral Sciences (Toronto: Holt, Rinehart and Winston) 1953. Chapter 10; page 421-470.

112) Festinger, L. and Katz, D. "Method in Data Collection" Research Methods in Behavioral Sciences (Toronto: Holt, Rinehart and Winston) 1966; page 382-385 and page 387-417.

113) Feuer, M. Handbook for Corporate Directors (Englewood Cliffs: Prentice-Hall) 1965.

114) Freidson, E. The Hospital in Modern Society (New York: The Free Press of Glencoe) 1963.

115) Freitag, W. and Hirsch, N.G. "Deficit Thinking and Hospital Governing Boards" Trustee (August 1974) page 12-17.

116) French, J. and Raven, B. "The Basis of Social Power" in D. Cartwright (Editor) Studies in Social Power (Ann Arbor: University of Michigan Press) 1959.

- G -

117) Gainor, C. "Abortion: Debate of Our Lives" Vancouver Sun (September 6, 1980).

118) Gainor, C. "Anti-Abortionists Lose Fight at Lions Gate" Vancouver Sun (September 28, 1978).

119) Galbraith, J.R. Organization Design (Don Mills, Ontario: Addison-Wesley Publishing Company) 1977, pages 1-2.

120) Garber, A.B., Sparks, L.R. and Korngold, A.J. Hospital Crisis Management - A Casebook (Germantown, Maryland: Aspen) 1978. Chapter 8: "The Board of Directors" page 147-168.

121) Geekie, D.A. "Abortion: A Review of Canadian Medical Association Policy and Pisitions" Canadian Medical Association Journal (September 7, 1974) page 2.

122) General Information (Vancouver: British Columbia Health Association) (May 1979).

123) Georgopoulos, B.S. and Mann, F.C. "The Hospital as an Organization" in J. S. Rakich and K. Dorr (editors) Hospital Organization and Management (Toronto: SP Medical and Scientific Books) 1978; page 19.

124) Gerbner, G., Holsti, O.R., Krippendorff, K., Paisley, W.J., and Stone, P.J. The Analysis of Communication Content (Toronto: John Wiley and Sons) 1969, Chapter 1 and 2; page 3-56.

125) Gilley, G. Background and Introduction to the Joint Funding Project (Vancouver: British Columbia Health Association) May 25, 1979; page 2.

126) Glaser, B.C. Theoretical Sensitivity: Advances in the Methodology of Grounded Theory (Mill Valley, California: Sociology Press) 1978.

127) Glaser, B.C. and Strauss, A.L. The Discovery of Grounded Theory: Strategies for Qualitative Research (Chicago: Alpine Publishing Company) 1967.

128) Glasser, M.A. "Current Health Care Problems as seen by Consumers" The Hospital Trustee Reader (Chicago: American Hospital Association) 1975, page 159-164.

129) Gordon, C.W. and Babchuk, N. "A Typology of Voluntary Organization" American Sociological Review (February 1959).

130) Gordon, P.J. "The Top Management Triangle in Voluntary Hospitals" Journal of the Academy of Management (April 1962) page 72-73.

131) Gouldner, H. "Dimensions of Organizational Committment" Administrative Science Quarterly (March 1960) page 468-490.

132) Govan, E.S.L. "Voluntary Health Organization in Canada Royal Commission on Health Services, 1964-65 (Ottawa: Queen's Printer) 1965, Chapters 1-3; page 1-25 an Chapter 8; page 163-202.

133) Governance of Health Institutions (Chicago, Illinois: American Hospital Assocation) 1974.

134) "Governing Body and Management" Trustee Topics (Vancouver, B. C.: British Columbia Health Association) January 1977.

135) Greenberg, D.S. "The Public's View" Part Three: Public Accountability and Consumerism, in Hospitals in the 1980's : Nine Views (Chicago: American Hospital Association) 1977. Page 203-213.

136) Greenleaf, R.K. Servant Leadership - A Journey Into the Nature of Legitimate Power and Greatness (New York: Paulist Press) 1977.

137) Greenleaf, R.K. "The Trustee and the Risks of Persuasive Leadership" Hospital Progress (May 1978) page 50-52, 99.

138) Griffith, J.R. (Editor) "The Role of Trustees" Cost Control in Hospitals (Ann Arbor, Michigan: Health Administration Press) 1976, page 20-21.

139) Gross, B.M. "What Are Your Organization's Objectives? - A General Systems Approach to Planning" Human Relations (August 1965) page 195-215.

140) Guba, E. "Morale and Satisfaction: A Study in Past-Future Time Perspective" Administrative Science Quarterly (September 1958) page 195-209.

141) Guide to Hospital Accreditation (Ottawa: Canadian Council on Hospital Accreditation) 1977; page ix.

142) Guidelines on the Responsibilities, Functions and Selection Criteria for Hospital Boards of Trustees (Chicago: Catholic Hospital Association) 1970.

143) Guidelines on the Responsibilities, Functions and Selection Criteria for Hospital Boards of Trustees (St. Louis: Catholic Hospital Association) 1974; page 7.

- H -

144) Hagen, E. and Wolff, L. Nursing Leadership Behaviour in General Hospitals (Columbia: Institute of Research) 1962, Chapter 3; page 38-58 and Chapter 8; page 146-150.

145) Hall, P., Land, H., Parker, R., and Webb, A. "Emerging Propositions" Change, Choice and Conflict in Social Policy (London: Heinemann) 1975; pages 474-509.

146) Ham, C.J. "Power, Patients and Pluralism" in K. Barnard and K. Lee Conflicts in the National Health Service (London: Croom Helm) 1977, Chapter 5; page 99-120.

147) Hannay, J.M. Shared Services for Lions Gate Hospital and St. Mary's Hospital (Vancouver, British Columbia: University of British Columbia Department of Health Care and Epidemiology) December 1972.

148) Hastings, J. (Editor) The Community Health Centre in Canada (Ottawa: Department of National Health and Welfare) 1970.

149) Hay, R.A. "Responsibility and Authority in 1977" Hospital Trustee (May 1977) page 17-18.

150) Hay, R.A. "The Trustee-Government Relationship in Hospital Management. Canadian Hospital (August 1967) page 51-54.

151) Health Care Governance (Nashville: Tennessee Hospital Association) 1973.

152) Health Care Trusteeships: Committment and Challenge (Vancouver: British Columbia Health Association)1977.

153) Hedgepeth, J.H. "The Darling Case in Perspective - And a New Court Speaks" Hospital Medical Staff (November 1972) page 34-39.

154) Hedgepeth, J.H. "The Physician Errs, The Hospital Pays: Sound Law in this Case?" Hospital Medical Staff (November 1972) page 34-39.

155) Heller Jr., M.F. "The Board of Directors: Legalistic Anachronism or Vital Force" California Management Review (Spring 1972) page 24-30.

156) Herzlinger, R. "Why Data Systems in Non-profit Organizations Fail" Harvard Business Review (January/February 1977) page 81-86.

157) "History of Lions Gate Hospital" Employee Handbook (North Vancouver: Lions Gate Hospital) 1977; page 5.

158) Hodgson, V.H. Supervision in Public Health Nursing (New York: The Commonwealth Fund) 1939.

159) Holsti, O.R. Content Analysis for the Social Sciences an Humanities (Toronto: Addison-Wesley Publishing Company) 1969, Chapter 1; page 1-14 and Chapter 3; page 43-67.

160) Hospital Act (RS Chapter 176) 1979.

161) "Hospital Board Favors Society" Vancouver Daily Province (September 20, 1946).

162) "Hospital/Co-Professional Communications" Patient Care Health Care Memorandum XXVII (Vancouver: British Columbia Health Association) December 1979.

163) "Hospital Governing Board" Management Review Program (Chicago, Illinois: American Hospital Association) 1971; page 5-6.

164) "Hospital Mess" District News (July 12, 1951).

165) "Hospital Trusteeship: Public, Social and Political Responsibility" Canadian Hospital (August 1970) page 28.

166) Howard, G.G. "Anatomy of a Hospital Trustee" Harvard Business Review (May/June 1973) page 65-71.

167) Howard, G.G. "Anatomy of a Hospital Trustee" Harvard Business Review (May/June 1978) page 65-71.

168) "How the Board Relates to the Medical Staff and the Chief Executive Officer" Hospital Trustee (March/April 1978) page 14.

169) Hunter, M.E. "Applications for Abortion at a Community Hospital" Canadian Medical Association Journal (November 16, 1974) page 1092

170) Hyde, L.S. "The Public's View" Part One: Organization of Hospital Resources, in Hospitals in the 1980's: Nine Views (Chicago: American Hospital Association) 1977; page 91-104.

- I -

171) "Information to be Expected from a CEO" Hospital Trustee (March/April 1978) page 18.

- J -

172) Jackson, B. "B. C. Hospitals Stricken by Political Malady" The Financial Post (May 3, 1975) page C-8.

173) Janowitz, M. and Delany, W. "The Bureaucrat and the Public: A Study of Informational Perspectives" Administrative Science Quarterly (September 1957) page 141-162.

174) Jenrich, L.H. "Social Policy Comes From Knowing Families" Making Yours a Better Board (New York: Family Service Association of America) 1954; page 34.

175) Johnson, E.A. "Giving the Consumer a Voice in the Hospital Business" Hospital Administration (Spring 1970) page 15-26.

176) Johnson, E.A. and Johnson, R.C. "The Governing Structure: Consumerism in Hospital Governance" Contemporary Hospital Trusteeship (Chicago: Teach 'Em Inc.) 1975; page 42-47.

177) Johnson, E.A. and Johnson, R.L. Contemporary Hospital Trusteeship (Chicago: Teach 'Em Inc.) 1965.

178) Johnson, E.A. and Johnson, R.L. "Introduction" Contemporary Hospital Trusteeship (Chicago: Teach 'Em Inc.) 1975; page 12-13.

179) Johnson, E.A.and Johnson, R.L. "The Governing Structure: Governance in the Health Field" Contemporary Hospital Trusteeship (Chicago: Teach 'Em Inc.) 1975; page 14-17.

180) Johnson, E.A. and Johnson, R.L. "The Hospital Setting: Separating the Challenges" Contemporary Hospital Trusteeship (Chicago: Teach 'Em Inc.) 1975; page 18-24.

181) Johnson, R.L. "Changing Role of the Hospital's Chief Executive: Should He Be a Member of the Governing Board?" Hospital Administration (Summer 1970) page 21-34.

182) Johnson, R.L. "The End of the Wobbly Three-Legged Stool" Trustee (May 1976) page 20-22.

183) Juran, J.M. The Corporate Director (New York: American Management Association) 1966.

184) Juran, J.M. and Louden, J.K. The Corporate Director (New York: American Management Association, Inc.) 1966, page 7.

- K -

185) Kahn, A.J. "The Citizen's Role in Social Welfare Policy" Children (September/October 1963) page 188.

186) Kaiser, L. "Fighting Trustees Needed" Health Care in Canada (November 1978) page 35.

187) Katz, E. "Health Care Politics in Alberta" Dimensions in Health Service (January 1980) page 30-32.

188) Kaufman, K., Shortell, S., Becker, S. and Neuhauser, D. "The Effects of Board Composition and Structure on Hospital Performance" Hospital and Health Service Administration (Winter 1979) page 37-62.

189) Kennedy, T.P. "Control, Not Interference, is Board's Responsibility" The Hospital Trustee Reader (Chicago: American Hospital Association) 1975; page 10-16.

190) Kerley, R.D. "Cost Effectiveness... It Begins With the Governing Board" Ontario Hospital (October 1978) page 8-11.

191) Kernaghan, S.G. "A Slow Move to the Front of the Class" Trustee (February 1975) page 22-25.

192) "Key Role Played By 21 Directors" The Citizen (April 20, 1961).

193) Kinloch, K.A. Nursing Quality Assurance Program (New Westminster, B. C.: Royal Columbian Hospital) 1979; page 1.

194) Kinloch, K.A. Surrey Memorial Hospital Quality Assurance Plan for Nursing (Surrey, B. C.: Surrey Memorial Hospital) 1981; page 1.

195) Klein, R. and Lewis, J. The Politics of Consumer Respresentation (London: Centre for Social Policy Studies) 1976.

196) Koontz, H. The Board of Directors and Effective Management (New York: McGraw-Hill) 1967; pages 24-27.

197) Kralewski, J.E. "Leadership in the Evolving Health System" Social Policy (Annual Meeting of the California Hospital Association) November 1969.

198) Kuhl, I.K. "Activities Grouped by Role Component and Knowledge/Skill Area" The Executive Role in Health Service Delivery Organization (Washington, D. C.: Association of University Programs in Health Administration) page 14.

- L -

199) Lanser, R.E. Visible Traits of Boards of Directors (Ph.D. dissertation; Standford University) 1969.

200) Lasswell, H.D. and Leites, N. Language of Politics (New York: G. W. Stewart Publishers, Inc.) 1949.

201) Layton, D. (Editor) Hospital Role Study: A Discussion Paper on Hospital Services in British Columbia (Victoria: Ministry of Health) 1979.

202) Lebow, J.L. "Consumer Assessments of the Quality of Medical Care" in G. P. Turner, J. Mapa (Editors) Humanizing Hospital Care (Toronto: McGraw-Hill) 1979; page 177-189.

203) Leclair, M. "The Canadian Health Care System" in S. Andreopoulos (Editor) National Health Insurance: Can We Learn From Canada? (Toronto: John Wiley and Sons) 1975; pages 11-12.

204) Lee, K. "Health Care: Planning, Policies and Incentives" Future (December 1979) page 483.

205) Lentz, E. "Hospital Administration - One of a Species" Administrative Science Quarterly (March 1957) page 444-463.

206) Letourneau, C.U. "The Seven Deadly Sins of Trusteeship" Hospital Management (January/February 1956) page 53-54, 128.

207) Levin, H. "Power and Conflict - Key Concepts in Community Dynamics" The Citizenry and the Hospital (Durham, North Carolina: Duke University) 1973, Chapter 3; page 17-30.

208) Levin, P.J. "The Public Hospital: Public Enemy or Public Trust?" Hospitals (April 16, 1976) page 60-63.

209) Lewis, R.F. "Choosing and Using Outside Directors" Harvard Business Review (July/August 1974) page 70-78.

210) Lindblom, C.E. "Rational Policy Through Mutual Adjustment" in A. Etzioni, et.al (Editors) Social Change - Sources, Patterns and Consequences (New York: Basic Books 1973; pages 493-499.

211) Lindblom, C.E. "The Science of Muddling Through" Public Administration Review (Spring 1959) pages 79-88.

212) Lintern, D. "Interpretation of Abortion Law Takes Ability" British Columbia Medical Association News (February 1980) page 3.

213) Lions Gate Hospital Annual Report (North Vancouver: North and West Vancouver Hospital Society) 1978.

214) "Lions Gate Hospital Head Quits, Cites Crisis" The Citizen (May 7, 1975).

215) Liswood, S. "Hospital and the Public Trust" Dimensions in Health Service (January 1975) page 47.

216) Litwak, E. and Meyer, H. "A Balance Theory of Coordinating Between Bureaucratic Organizations and Community Primary Groups" Administrative Science Quarterly (June 1966) page 33-58.

217) Longstaffe, J.R. "Are Your Trustees Doing Their Job?" Dimensions in Health Service (June 1975) page 24-26.

218) Longstaffe, J.R. "Improving the Trustee's Performance" Hospital Trustee (November/December 1978) page 9-12.

219) Longstaffe, J.R. Speech by Chairman of St. Paul's Hospital, Vancouver, to the Sixty-First Annual Conference of the British Columbia Health Association (May 9, 1978) page 1-35.

220) Lovdal, M.L., Bauer, R.A. and Treveston, N.H. "Public Responsibility Committees of the Board" Harvard Business Review (May/June 1977) page 40-42, 46, 50, 57, 60, 64, 178 and 180-181.

221) Luthens, F. and Stewart, T. "General Contingency Theory of Management" Academy of Management Review (April 1977) page 181-195.

- M -

222) Mace, M.L. "Attracting New Directors" Harvard Business Review (September/October 1976) page 46, 48, 54, 58, 180, 182, 183.

223) Mace, M.L. "Becoming More Aware and Knowledgeable" Harvard Business Review (September/October 1975) page 170-173.

224) Mace, M.L. "Designing a Plan for the Ideal Board" Harvard Business Review (November/December 1976) page 20-22, 26, 30, 32, 36 and 198.

225) Mace, M. Directors: Myth and Reality (Harvard Business School) 1971.

226) Mace, M.L. "Legal Guidelines for Directors" Harvard Business Review (September/October 1975) page 18-20, 23 and 168.

227) Mace, M.L. "The Board and the CEO" Harvard Business Review (March/April 1977) page 16, 17, 20, 22, 26, 30, 32, 160, 162 and 164.

228) MacEachern, M.T. "Forword" in J.A. McNamara What the Hospital Trustee Should Know (Chicago: Physicians Record Co.) 1931 page 4.

229) MacKinnon, F. "Bad Management of Good Government" Hospital Trustee (November/December 1977) page 14-15.

230) Makavski, R.J. "The Dual Role of the Medical Staff". The Hospital Trustee Reader (Chicago: American Hospital Assoc. 1975) page 136-141.

231) Makowski, R.J. "Mandate, Maintain, Monitor: A Model for Hospital Governance: Trustee (January 1876) page 34-36.

232) Maniha, J. and Perrow, C. "The Reluctant Organization and the Aggressive Environment" Administrative Science Quarterly (September 1965) page 238-257.

233) Marbut, R.G. "Management Information Systems for Directors" Harvard Business Review (November/December 1975) page 14-16, 18, 22, 24, 166 and 188.

234) Marmor, T.R. "Consumer Representation: Beneath the Consensus, Many Difficulties: Trustee (April 1977) page 37-40.

235) Marshak - Gustafson, J. Kopher, S. and Tereze, M. "Planning is the Key to Successful Quality Assurance Programs: Hospital (June 1981) page 71-72.

236) Martin, J.C. "A Brief to the Minister of National Health and Welfare on the Voluntary Trustee System" Canadian Hospital (May 1972) page 2-3.

237) Martin, J.C. "A Stong Board is an Informed Board" Hospital Trustee (January/February 1978) page 5.

238) Martin, J.C. "Too Little ... Too Late" Dimensions in Health Service (September 1978) page 8.

239) Martin, N.S. Developing Departmental Quality Assurance Programs in the Hospital (Tucson, Arizona: Health Information Development Association) 1981.

240) May, J.J. "The Planning and Licensing Agencies" in C. Havighurst (Editor) Regulating Health Facilities Construction (Washington, D.C.: American Enterprise Institute for Public Policy Research) 1979.

241) McCool, B. and Brown, M. The Management Response: Conceptual, Rechnical and Human Skills of Health Administration (Toronto: W. B. Saunders) 1977 page 11.

242) McCormack, T. "Citizen Participation" in E. A. Pickering (Editor) Report of the Special Study Regarding the Medical Profession in Ontario (Toronto, Ontario: Ontario Medical Association) 1973 page 1-36.

243) McCreary, J.F. Report of the Committee to Study Abortion Facilities in the Greater Vancouver Regional Hospital District (November 1971).

244) McDougall, W.J. Corporate Boards in Canada: How Sixty-Four Boards Function (London, Ontario: University of Western Ontario) 1968

245) McDougall, W.J. The Effective Director (London, Ontario: University of Western Ontario) 1969.

246) McDougall, W.J. (Editor) The Role of the Voluntary Trustee (London, Ontario: School of Business Administration) 1976.

247) McGeorge, R.K. "The Intimate Relationship Between the Board and the Chief Executive Officer". Hospital Trustee (January/February 1978) page 6-8.

248) McGeorge, R.K. "Relationship of the CEO to the Hospital Board" Hospital Administration in Canada (June 1976) page 48-49.

249) McGibony, J.R. Handbook for Hospital Trustees: A Guide to Service (College Park, Maryland: Hospital Publication) 1965.

250) McGibony, J.R. Principles of Hospital Admistration (New York: G. P. Putnam's Sons) 1969.

251) McKerrow, W. "The Roles and Responsibilities of a Hospital Administrator" Health Law in Canada (Spring 1980) page 10-12.

252) McLeod, J.T. "Consumer Participation, Regulation of the Professions and Decentralization" in R.G. Foulkes (editor) Health Security for British Columbians (Victoria: Queen's Printer) 1974 page 1-12, 25-45, and 59-64.

253) McLeod, J.T. Consumer Participation, Regulation of the Professions, Decentralization of Health Services (Regina: Research and Planning Branch of the Saskatchewan Department of Public Health) 1971.

254) McNamara, J.A. What the Hospital Trustee Should Know (Chicago: Physician's Record Company; 1931).

255) Medical Leadership in Hospitals (Vancouver, B. C. March 1979). British Columbia Health Association.

256) Merton, R.K. Social Theory and Social Structure (New York: Free Press of Glencoe) 1957.

257) Millett, J.D. Management, Governance and Leadership: A Guide for College and University Administrators (New York: American Management Associataion) 1980.

258) Millett, J.D. "National Conference of Professor of Educaional Administration" The Community School and Its Administration (September 1965) page 2-11.

259) "Minister to Stay Out of Abortion Battle" Vancouver Sun (May 30, 1978).

260) Mitchell, K.A. British Columbia Health Association as a Pressure Group (Vancouver: University of British Columbia) March 1980.

261) Mitchell, K.A. Health Planning Overview (Vancouver: U.B.C. Health Sciences Centre Hospital) 1982; page HP-1.

262) Mitchell, K.A. Policy Development (Vancouver: UBC Health Sciences Centre Hospital) June 1980; page 1.

263) Mitchell, K.A. Policy Development (Vancouver: UBC Health Sciences Centre Hospital) February 1982; page PD-5.

264) Mittenthal, R.A. and Mahoney, B.W. "Getting Management Help to the Nonprofit Sector" Harvard Business Review (September/October 1977) page 95 and 97-103.

265) Mueller, R.K. "The Hidden Agenda" Harvard Business Review (Vol. 55, September/October 1977) page 40-41, 44, 46, 48, 52 and 192.

- N -

266) Naqui, A. "The Basics of Trusteeship" Hospital Trustee (March/April 1979) page 21.

267) National Industrial Conference Board. Corporate Directorship Practices (Ottawa: Department of Consumer and Corporate Affairs) 1967.

268) Nelson, C.A. "Trusteeship Today - Weeding Out the Weaknesses" The Hospital Trustee Reader (Chicago: American Hospital Assoc.) 1975 page 31-37.

269) Nelson, R.A. The Governance of Voluntary Teaching Hospitals in New York City (New York: Josiah Macy Jr. Foundation) 1974.

270) "New Hospital Negotiator Wouldn't Ban Strike Right" Vancouver Sun (January 14, 1976).

271) Newland, C.A. "Current Concepts and Characteristics of Administration" Child Welfare (June 1963) page 276.

272) "North and West Vancouver Hospital Society and Lions Gate Hospital" Employee Handbook (North Vancouver: Lions Gate Hospital) 1977, page 1.

273) North and West Vancouver Hospital Society Newsletter (October 31, 1956).

274) "North Shore Hospital Society Formed" Vancouver Sun (December 16, 1953).

275) "North Shore Votes 90% For Hospital" Vancouver Province (September 8, 1958).

- O -

276) Oaklander, H. and Fleishman, E. "Patterns of Leadership Related to Organizational Stress in Hospital Settings" Administrative Science Quarterly (March 1969) page 520-532.

277) Oberlyn R. "Organized Anti-Abortionists Take the Lead in Desperate Fight For Life" Vancouver Sun (June 24, 1978).

278) O'Connor, R.D. "Straight Talk About Strengthening Trustee - CEO Communication" Trustee (October 1977) page 28-30.

279) O'Dell, E.H. Shared Services: An Experience Analysis and an Opportunity (North Vancouver: Lions Gate Hospital) September 1972; page 3.

280) Orr, D. "On Employee Representation and Cooperation" Harvard Business Review (January/February 1977) page 36-38, 42, 46, 50, 54 and 170.

- P -

281) Papp, W.R. "Consumer-Based Boards of Health Centres: Structural Problems in Achieving Effective Control" American Journal of Public Health (June 1978) page 578-582.

282) Parson, T. "How are Clients Integrated in Serivce Organizations?" in W.R. Rosengren and M. Lefton (Editors) Organizations and Clients (Columbux, Ohio: Merrill Publishing) 1970 page 13.

283) "Patient Care Evaluation Procedure" BCHA Trustee Orientation Program (Vancouver, B.C.: BCHA) 1979.

284) Pearson, B.E. "Constitutional Responsibilities in the Health Field" Canada Year Book: An Annual Review of Economic, Social and Political Developments in Canada (Ottawa: Supply and Services Canada) 1978, page 199.

285) Perrow, C.B. "Goals and Power Structures" in E. Friedson (editor) The Hospital Modern Society (New York: Free Press) 1963 page 114.

286) Perrow, C. "Members as Resources in Voluntary Organizations" in W.R. Rosengren/M. Lefton Organisation and Clients (Columbus, Ohio: Merrill Publishing Co.) 1970 Chapter 1, page 1-17 and Chapter 5, page 93-116.

287) Peterson, S. Canadian Directorship Practices: A Critical Self-Examination (Ottawa: Conference Board in Canada) 1977.

288) Pfeffer, J. "Size, Composition and Function of Hospital Boards of Directors: A Study of Organization-Environment Linkage" Administrative Science Quarterly (September 1973) page 349-364.

289) Pfeffer, J. and Salanick, G.R. "Organizational Decision-Making as Political Process" Administrative Science Quarterly (Spring 1974) page 135.

290) Phillips, D.F. "The Public Policy Issues Facing Hospitals in the 1980's" Part Four: Public Policy Issues; in Hospitals in the 1980's: Nine Views (Chicago: American Hospital Association) 1977 page 215-234.

291) Pickering, E. "Radical Approach to Hospital Board Structure" Hospital Administration in Canada (October 1974) page 24.

292) Porter, K.W. "Think System, Not Institution Hospital Trustees Told" Trustee (February 1978) page 41-43.

293) Price, J.L. Organizational Effectiveness: An Inventory of Propositions (Homewood; Illinois: Dow Jones-Irwin) 1968.

294) Price, J.L. "The Impact of Governing Boards on Organizational Effectiveness and Morale" Administrative Science Quarterly (December 1963) page 361-378.

295) Priorities for Health, Welfare and Recreational Services in the Greater Vancouver Area (Vancouver: Community Chests and Councils of Greater Vancouver) 1965.

296) Pross, A.P. Pressure Group Behavior in Canadian Politics (Toronto: McGraw-Hill Ryerson Ltd.) 1975: page 13.

297) Prybil, L.D. "Hospital Boards Face Increasing Demands" Hospitals (April 1, 1977) page 103-106.

298) Prybil, L.D. "Hospital Boards Face Increasing Demands, 1976 Literature Shows" Trustee (April 1977) page 43-45.

299) Prybil, L.D. and Starkweather, D.B. "Current Perspectives on Hospital Governance" Hospital and Health Service Administration (Fall 1976) page 67-75.

- Q -

300) "Quality of Care and Other Things" Patient Care - Health Care Memorandum XXVII (Vancouver: British Columbia Health Association) June 1978.

301) Rakich, J.S. Longest, B.B. and Donovan, T.R.O., Managing Health Care Organizations (Toronto: W.B. Saunders Company) 1977.

302) Ranta, L.E. (Editor) White Paper on Hospital Trusteeship (Vancouver: B.C.: Vancouver General Hospital) 1972.

303) Ranta, L.E. and Tryggvosar, G. Hospital/Community Relations - An Examination of the Nature of Agency Interaction Patterns (Vancouver, B.C.: Vancouver General Hospital) 1972.

304) Read, A. The Company Director, His Functions, Power and Duties. (London: Council of the Institute of Directors) 1953.

305) Reeder, L.G. "The Patient-Client as a Consumer: Some Observations on the Changing Professional-Client Relationship" in G.P. Turner and J. Mapa (Editors) Humanizing Hospital Care (Toronto, Ontario: McGraw-Hill Ryerson Ltd.) 1979 page 135-144.

306) Reinharth, L. Sapiro, H.J. and Kallman, E.A.; The Practice of Planning: Strategic, Administrative and Operational (Toronto: Van Nostrand Reinhold Company) 1981 page 4-5.

307) Results of a Survey of Health Facility Board Composition (Vancouver: British Columbia Health Association) December 1981.

308) Reuber, G.L. "Redesigning the Health Care System" Hospital Trustee (March/April 1978) page 5-7.

309) "Right to Vote Challenged" Sunday News (September 17, 1978).

310) Riska, E. and Taylor J.A. "Consumer Attitudes Toward Health Policy and Kownledge About Health Legislation" Journal of Health Politics Policy and Law. (Spring 1978) page 112-123.

311) Rivers, P. Politics by Pressure (London: Harrop and Company Ltd.,) 1974.

312) Rogatz, P. "The Trustee as Advocate for Society: A New Perspective on Quality of Patient Care." Trustee (June 1976) page 14-16.

313) Roles and Processes of Trusteeship (Minneapolis, Minnesota: University of Minnesota: Independent Study Program for Health Care Trustees) 1974.

314) Rosengren, W. "Communication, Organization and Conduct in the Therapeutic Milieu" Administrative Science Quarterly (June 1964) page 70-90

315) Rosengren, W. "Structure, Policy and Style: Strategies of Organizational Control" Administrative Science Quarterly (June 1967) page 140-164.

316) Rourke, A.J.J. "New Trustee: Out of the Board Room, Into the Action Modern Hospital (October 1969) page 120.

317) Rozovsky, L.E. "Abolish Medical Staff on Hospital Boards". Canadian Hospital (May 1973) page 34.

318) Rozovsky, L.E. "Abolish Medical Staff on Hospital Boards" Hospital Trustee (November/December 1977) page 5-6.

319) Rozovsky, L.E. Canadian Hospital Law (Ottawa: Canadian Hospital Association) 1979.

320) Rozovsky, L.E. "Conflict of Interest on Hospital Boards." Dimensions in Health Service (February 1979) page 8-9.

321) Rozovsky, L.E. "The A,B,C's of Trusteeship" Hospital Trustee (March/April 1978) page 28-30.

- S -

322) Saunders, J.V.D. "Characteristics of Hospitals and Hospital Administrators Associated with Hospital - Community Relations in Mississippi" Rural Sociology (October 1960) page 229-232.

323) Seider, V.M. "Volunteers" Encyclopedia of Social Work (New York: National Association of Social Workers) 1965 page 830-836.

324) Sellar, D. "Ottawa Awaits New Abortion Debate: Vancouver Province (February 11, 1977).

325) Selltiz, C., Wrightsman, L.S. and Cook, S.W. "Communications" Research Methods in Social Relations (Toronto: Holt, Reinhart and Winston) 1976 page 386-397.

326) Shaping an Improved Concept of Trustee Responsibilities (Toronto, Ontario Hospital Association) 1968.

327) Shortell, S.M. and Richardson, W.R. Health Program Evaluation (St. Louis: C.V. Nesby Company) 1978 page 9.

328) Silvers, G. "The Ineffective Trustee" The Hospital Trustee Reader (Chicago: American Hospital Assoc.) 1975 page 51-55.

329) "Six Rules for Maintaining the Effectiveness of the Board - Administrator Relationship" in E.A. Johnson and R.L. Johnson. Contemporary Hospital Trusteeship (Chicago: Teach'em Inc.) 1975 page 38-44.

330) Sloan, F.A. "The Internal Organization of Hospitals: A DEscriptive Study" Health Services Research (Summer 1981) page 203-230.

331) Smith, H.L. "Two Lines of Authority. The Hospital's Dilemma" in Jaco E.G. (editor) Patients, Physicians and Illness (New York: Free Press) 1958 page 468-477.

332) Snell, B. "The Monitoring Role of the Trustee: The View From the Administrator's Office" Hospital Trustee (September 1978) page 6-12.

333) Sorenson, R.R. The Art of Board Membership (New York: Association Press) 1954.

334) Spencer, S. "Developing Effective Board and Committee Organization and Functioning" Building Board Leadership for the Years Ahead (New York: National Jewish Welfare Board) 1963 page 42-57.

335) Stark, N.J. and Huber, G.A. "Five Ways to Curb Conflict in Your Hospital" Trustee (March 1977) page 16-18.

336) Statement on Government of Colleges and Universities (Washington, D.C.: Association of Governing Boards of Universities and Colleges) Winter 1966.

337) Statement on Hospital-Government Relations (Don Mills: Ontario Hospital Association) 1976.

338) Steers, R.M. Organizational Effectiveness - a Behavioral View (Santa Monica, California: Goodyear Publishing) 1977.

339) Stempel, G. "Increasing Reliability in Content Analysis" Journalism Quarterly (Autumn 1955) page 449-455.

340) Steps to Self-Evaluation of Hospital Board Performance (Lutherville: Maryland Hospital Education Institute) 1977.

341) Stewart, C.T. "Standards of Care for Trustees" Harvard Business Review (January/February 1978) page 14-16, 21, 28, and 148.

342) Stone, P.J. Dunphy, D.C. Smith, M.S. and Ogilvie, D.M. The General Inquirer: A Computer Approach to Content Analysis (Cambridge, Mass: Massachusetts Institute of Technology Press) 1966.

343) Street, I. "Greater Vancouver District Has $2 Billion Assessment" Vancouver Province (April 21, 1967).

344) "Supporting the Present System of Hospital Trusteeship" Trustee Topics (Vancouver: British Columbia Health Association) September 1978.

- T -

345) Taylor, F. "Do Trustees Meet Today's Community Needs?" Trustee (January 1974) page 26-32.

346) Taylor, M.G. Health Insurance and Canadian Public Policy (Montreal: McGill - Queen's University Press) 1978.

347) Tead, O. Trustees, Teachers and Students - Their Role in Higher Education (Salt Lake City: University of Utah Press) 1957.

348) "The Board and Patient Care" BCHA Trustee Orientation Program (Vancouver: British Columbia Health Association) 1979.

349) The Board of Directors: New Challenges, New Directions. (New York: Conference Board) 1972.

350) The Council Manual (New York: Girl Scouts of America) 1969 page 33.

351) The Realities of Hospital Care in B.C. (Vancouver: British Columbia Health Association) March 1979.

352) "The Role of the Chief Executive Officer" BCHA Trustee Orientation Program (Vancouver, British Columbia Health Association). 1978.

353) Thompson, J.D. Organizations in Action (New York: McGraw Hill Ryerson Ltd.) 1958.

354) "Three Ring Meeting" Vancouver Province (July 24, 1978).

355) Trecker, H.B. Citizen Boards at Work: The Challenges to Effective Action (New York: Associated Press) 1970.

356) Trecker, H.B. Group Processes in Administration - Revised and Enlarged (New York: Woman's Press) 1950.

357) Troyer, G. and Solman S. "Committee Can Help Oversee Hospital's Quality Assurance Activities" Hospital (June 1, 1981) page 57-91.

358) Trueman, M. "Specially Equipped Regional Centres Best Pace for Safe Abortions, Badgley Report Says" Globe and Mail (February 10, 1977).

359) "Trustee Development Program Topic 3: The Planning Process" Hospital Trustee (May/June 1974) page 12-24.

360) Trustee Handbook (Regina: Saskatchewan Health Care Association) 1973.

361) Trustee Orientation Program: Summaries of Presentations. (Vancouver: British Columbia Health Association) 1978.

362) Trustee Orientation Program: Summaries of Presentations. (Vancouver: British Columbia Health Association) 1979.

363) Turner, B.A. "Some Practical Aspects of Qualitative Data Analysis: One Way of Organising the Cognitive Processes Associated With The Generation of Grounded Theory" Quality and Quantity (April 1981) page 225-241.

364) Tuttle, E.M. School Board Leadership in America (New York: R.R. Bowker) 1968.

- U -

365) Umbdenstock, R.J. "Governance: A Decade of Steady Growth" Trustee (April 1980) page 19-23.

366) Umbdenstock, R.J. "Trustee Emergence As Public Advocate Documented in 1978 Literature" Trustee (April 1979) page 26-31.

367) Umbdenstock, R.J. "We Only Have to Ask" Hospitals (October 16, 1978) page 11-17.

368) Underwood, J.M. "Filling Board Vacancies: A Trustee Examines the Selection Process" Trustee (September 1969) page 20-23.

369) Van Maanen, J. "Reclaiming Qualitative Methods For Organizational Research: A Preface" Administrative Science Quarterly (December 1979) page 520-526.

370) Vance S.C. Boards of Directors: Structure and Performance (Eugene, Oregon: University of Oregon) 1964.

371) Vance, S.C. The Corporate Director: A Critical Evaluation (Homewood, Illinois: Dow Jones-Irwin) 1968.

372) "Voluntary Boards: Should They Continue to Run Our Hospitals?" Hospital Administration in Canada (March 1971) page 6-8.

373) "Voluntary Trustee System: Brief to Minister of National Health and Welfare" Canadian Hospital (May 1972) page 30-31.

374) Wachong, J. The Concept of Equality in Social Policy (Vancouver: The University of British Columbia) 1974.

375) Wainberg, J.M. Duties and Responsibilities of Director's in Canada (Don Mills: CCH Canadian) 1975.

376) Walsh, K. et al. "Power and Advantage in Organization" Organization Studies (February 1981) page 131-144.

377) Warner, M.M. Community Participation in Primary Health Care in the U.K. and Canada (Ph.D. dissertation; University of Wales) 1978.

378) Warren, D.G. Problems in Hospital Law (Germantown, Maryland: Aspen Systems Corporation) 1978.

379) Wasyluka, R.G. "New Blood for Tired Hospitals" Harvard Business Review (September/October 1970) page 65-74.

380) Watson, I.C. Directors of Corporations - Salaries, Pensions, etc. (Ottawa: Conference Board in Canada) 1976.

381) Westernan, J.H. "Teaching Hospitals and Governance" Journal of Medical Education (July 1975) page 694-695.

382) "What Happens When Hospital Trustees are Elected Instead of Appointed?" Hospital World (April 1974) page 1.

383) What You Should Know And Do As A Trustee On The Governing Board (Winnepeg: Manitoba Hospital Association) 1972.

384) "What's Your Opinion?" Re: Influence of administrators exerted on trustee decisions. Trustee (March 1975) page 36-37.

385) "What's Your Opinion?" Re: Whether CEO's should be a voting board member? Trustee (February 1976) page 31-32.

386) Whillits, R.D. "What Boards of Trustees Do" The Hospital Trustee Reader (Chicago: American Hospital Association) 1975 page 3-9

387) White Paper on Hospital Trusteeship (Legislation Committee; Vancouver: British Columbia Health Association) 1978.

388) Whiting, A.L. "Stamp of Obsolesence: Are Hospital Boards Representatiove of the Communities They Serve?" Hospital Administration in Canada (August 1976) page 40.

389) Whittome, P. "Health Care Trusteeship" Hospital Trustee (September/October 1979) page 19-25.

390) Whittome, P. Keynote Speech: National Conference for Health Care Trustees (Ottawa: Canadian Hospital Association) September 20-21, 1979.

391) Willard, J.W. et al. Task Force Report on the Cost of Health Services in Canada: Summary (Ottawa: Queen's Printer) Volume 1; 1970 page 2.

392) Williams, K.J. "Challenges Facing Hospital Medical Staff" Hospital Progress (October 1970) page 58.

393) Williams, L. "Company Boards Need Diversity" Chicago Tribune (February 26, 1978).

394) Wilson, B.A. "A Board Searches for a CEO" Hospital Progress (December 1978) page 48-52 and 62.

395) Wooding, P. "Who Makes University Policy?" Saturday Review (April 17, 1965) page 65-66.

396) Woodward, C.E. "Organizing the Search for Governing Board Talent" Trustee (February 1975) page 30-31.

- Y -

397) Young, T.K. "Lay-Professional Conflict in a Canadian Community Health Centre: A Case Report" Medical Care (November 1975) page 897-904.

398) Young, V.G. The Library Trustee - A Practical Guidebook (New York: R.R. Bowker) 1969.

399) Yuchtsman, E. and Seashore, S.E. "A System Resource Approach to Organizational Effectiveness." American Sociological Review (December 1967) page 891-903.

- Z -

400) Zald, M.N. "The Power and Function of Boards of Directors: A Theoretical Synthesis" American Journal of Sociology (July 1969) page 97-111.

401) Zald, M.N. "Urban Differentiation, Characteristics of Boards of Directors and Organizational Effectiveness. American Journal of Sociology. (September 1967) page 261-272.

PREVIOUSLY COPYRIGHTED MATERIAL

IN APPENDIX ONE, LEAF 213, NOT MICROFILMED.

APPENDIX ONE

GROUNDED THEORY RESEARCH STAGES

STAGE	APPLICATION
1. Category Development	Use of documentary sources and data available to develop initial categories which fit the data closely.
2. Category Saturation	Accumulate examples of each category until it is clear that future instances would be included.
3. Develop Definitions	Define each category by stating the general criteria for placing and including further instances.
4. Refine Definitions	Use the definitions as a guide to emerging features of importance in further fieldwork and as a stimulus to theoretical reflection.
5. Category Exploitation	Search for categories requiring integration and categories requiring separation.
6. Development of Linkages Between Categories	Document relationships and develop hypothesis about the linkages between categories.
7. Linkage Considerations	Examine apparent or hypothesized relationships and attempt to sepcify the conditions.
8. Theory Integration	Attempt to build bridges to existing theory at this stage, rather than at the outset of the research.
9. Testing of Emerging Relationships	Identify the key variables and dimensions and see whether the relationship holds at the extremes of these variables.

CATEGORIES FOR GROUNDED THEORY RESEARCH

GOVERNMENT				HOSPITAL				AREA				INTEREST GROUP				ABORTION			
Municipal	Regional	Provincial	Federal	Society	Board	Operations	Construction	N. Vanc.	W. Vanc.	Consumerism	Citizen Partic.	Medical	Nursing	HEU	BCHA	Pro-Choice	Pro-Life	Planned P.	General
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20

APPENDIX THREE

DEFINITION OF CATEGORIES IN THE GROUNDED THEORY APPROACH

MUNICIPAL GOVERNMENT:	the level of authority through which the political units of West Vancouver and North Vancouver exercise authority.
Examples Include:	- City of North Vancouver - City of West Vancouver - District of North Vancouver - Municipal representatives / appointments - Community plan
REGIONAL GOVERNMENT:	the level of authority through which the political unit of the Greater Vancouver Regional District and the Greater Vancouver Regional Hospital District.
Examples Include:	- GVRD - GVRHD - Hospital construction - Planning - Disaster exercises - Patterns of care - Management science / engineering
PROVINCIAL GOVERNMENT:	the level of authority through which the political unit of the province of British Columbia exercises authority.
Examples Include:	- Provincial Government - Ministry of Health - British Columbia Hospital Insurance Service - British Columbia Hospital Programs
FEDERAL GOVERNMENT:	the level of authority through which te political unit of the dominion of Canada exercises authority.

Examples Include:
- Government of Canada
- National Health and Welfare
- Lalonde Report (1974)
- Report of the Committee on the Operation of the Abortion Law.

HOSPITAL SOCIETY: an organized group of members registered under the provisions of the Societies Act sharing a commonality of interest in the North and West Vancouver Hospital Society.

Examples Include:
- Societies Act
- Society Directors
- Annual Meeting for organizational issues.

HOSPITAL BOARD: the body of persons organized by the North and West Vancouver Hospital Society and having control and management of Lions Gate Hospital as stipulated by the provisions of the Hospital Act.

Examples Include:
- Regular/special meetings
- Board of management
- Board of directors
- Attendance
- Minutes
- Correspondence
- Next Meeting
- Adjournment
- Elections
- Elections of officers
- Appointment of committee
- Legal aspects/issues
- Information presentation of departmental operations

HOSPITAL OPERATIONS: a series of procedures as a method of organizational functioning.

Examples Include:
- Consulting reports
- Honorariams
- Correspondence

CONSUMERISM: the organized effort by those who receive health care to exert some influence on availability, cost and quality.

Examples Include:
- Patient claims
- Letters of appreciation and complaint
- Life memberships in hospital society
- Annual meeting

CITIZEN PARTICIPATION: the involvement of a non-consumer constituency in hospital related acctivities.

Examples Include:
- Auxiliary
- Volunteers

MEDICAL: issues related to the physician practice at Lions Gate Hospital.

Examples Include:
-Applications
- Medical Staff Advisory Committee
- Chief of Staff
- Medical Coordinator
- Teaching Status
- Ambulance service
- Annual Report of medical staff
- Delinquent Charts
- B. C. Medical Association
- College of Physicians and Surgeons
- Canadian Medical Association

NURSING: the activity of assisting the individual, sick or well in the performance of those activities related to health.

Examples Include:
-Victorian Order of Nurses
- Home Care
-Registered Nurses Association of BCIT
- Canadian Nursing Association
- Nursing Education

HOSITAL EMPLOYEES UNION/
HEALTH SCIENCES ASSOCIATION/
INTERNATIONAL UNION OF
OPERATING ENGINEERS: the collective bargaining units for the support program personnel, the health professional disciplines except (medicine and nursing and the heating workers) in the hospital industry in British Columbia.

Examples Include:
- Collective Agreements
- Certifications
- Management exclusions
- Grievances

BRITISH COLUMBIA HEALTH
ASSOCIATION/HOSPITAL
LABOUR RELATIONS ASSOCIATION: interest groups established by the collective agencies in the health industry to provide a political lobby for the service providers and to deal with labour relations matters.

Examples Include:
- Negotiation
- Collective bargaining
- Mediation
- Conciliation
- Arbitration
- Area Council
- Delegation of Bargaining Authority
- Rose Report

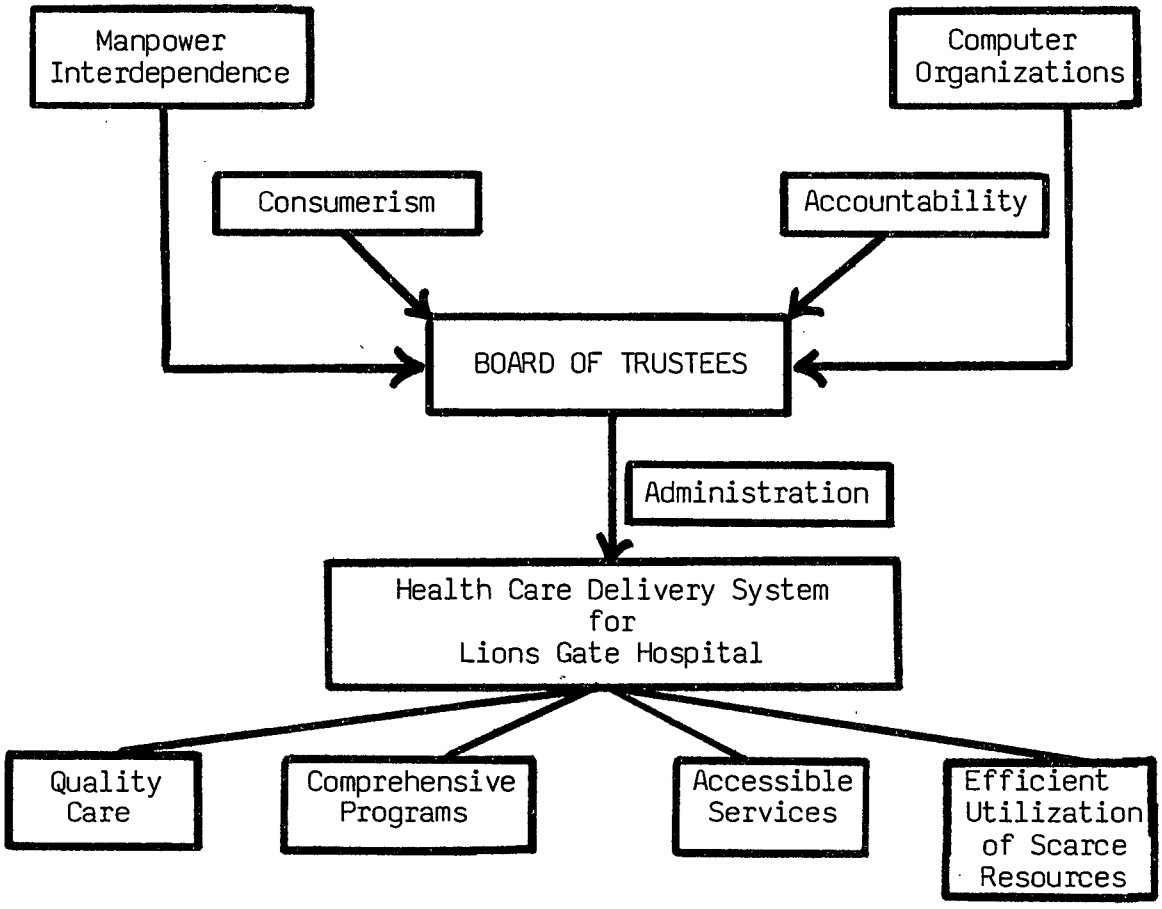
PRO-CHOICE: interest group established by a collective of diverse groups with a philosphical commonality advocating a choice for women on the question of abortion.

Examples Include:
-Vancouver Status of Women
- Concerned Coalition for Choice on Abortion

PRO-LIFE: interest group established with a philosphical commonality advocating the abolition of

APPENDIX FOUR

McCOOL AND BROWN MANAGEMENT RESPONSE MODEL



1977 © Adapted from B. McCool and M. Brown; The Management Response: Conceptual, Technical and Human Skills of Health Administration (Toronto: W. B. Saunders Company) 1977, page 3.

CATEGORIES FOR THE MANAGEMENT RESPONSE MODEL ANALYSIS

LEVEL		ANALYTICAL FRAMEWORK			
Policy	Management	Manpower Interdependence	Consumerism	Accountability	Organizational Complexity
1	2	3	4	5	6

APPENDIX SIX

DEFINITION OF CATEGORIES IN THE MANAGEMENT RESPONSE MODEL ANALYSIS

POLICY: is a standing plan or general guides to future decision-making that are intended to shape those decisions so as to maximize their contribution of the goals of the enterprise. Policy is the instrument by which goals are achieved.

Examples Include:
- long term care program
- paediatric planning
- smoking
- tobacco sale ban
- medical staff membership
- cancellation of privileges
- Rose Report (BCHA)
- Hospital Systems Planning Study
- hospital heliport
- Societies Act
- Trustee Orientation Program
- Joint Funding Project (hospital funding)
- By-law amendments
- planning
- abortion
- budgets
- North and West Vancouver Hospital Society
- patient access to records
- problems in other agencies

MANAGEMENT: is the process of planning, organizing, leading and controlling the efforts of organizational members and the use of other organizational resources in order to achieve stated organizational goals.

Examples Include:
- regular/special meetings
- attendance
- minutes

- accreditation
- administrator's report
- medical staff report
- medical staff Advisory Council
- finance committee
- building committee
- personnel committee
- auxiliary report
- adjournments
- Chairman's report
- Joint Conference Committee
- HLRA
- BCHA
- CT scanner
- raffle
- operating advance
- Northern Expansion
- medical staff appointments
- medical coordinator's report
- parking garage
- auxiliary report
- correspondence
- dental emergencies

MANPOWER INTERDEPENDENCE: is the mutual dependence of health care providers based on advances in health technology and knowlege.

Examples Include:
- medicine
- nursing
- pharmacy
- dietetics
- social work
- rehabilitation
- psychology
- speech pathology
- clinical laboratory
- nuclear medicine
- radiology

CONSUMERISM: is the organized efforts by those who receive health care to exert some influence on availability, cost and quality.

Examples Include:
- patient claims
- letters of appreciation and complaint

ACCOUNTABILITY: is the requirement embodied in law, institutional regulations and custom for health care providers to make known and be answerable for data concerning availability, cost and quality.

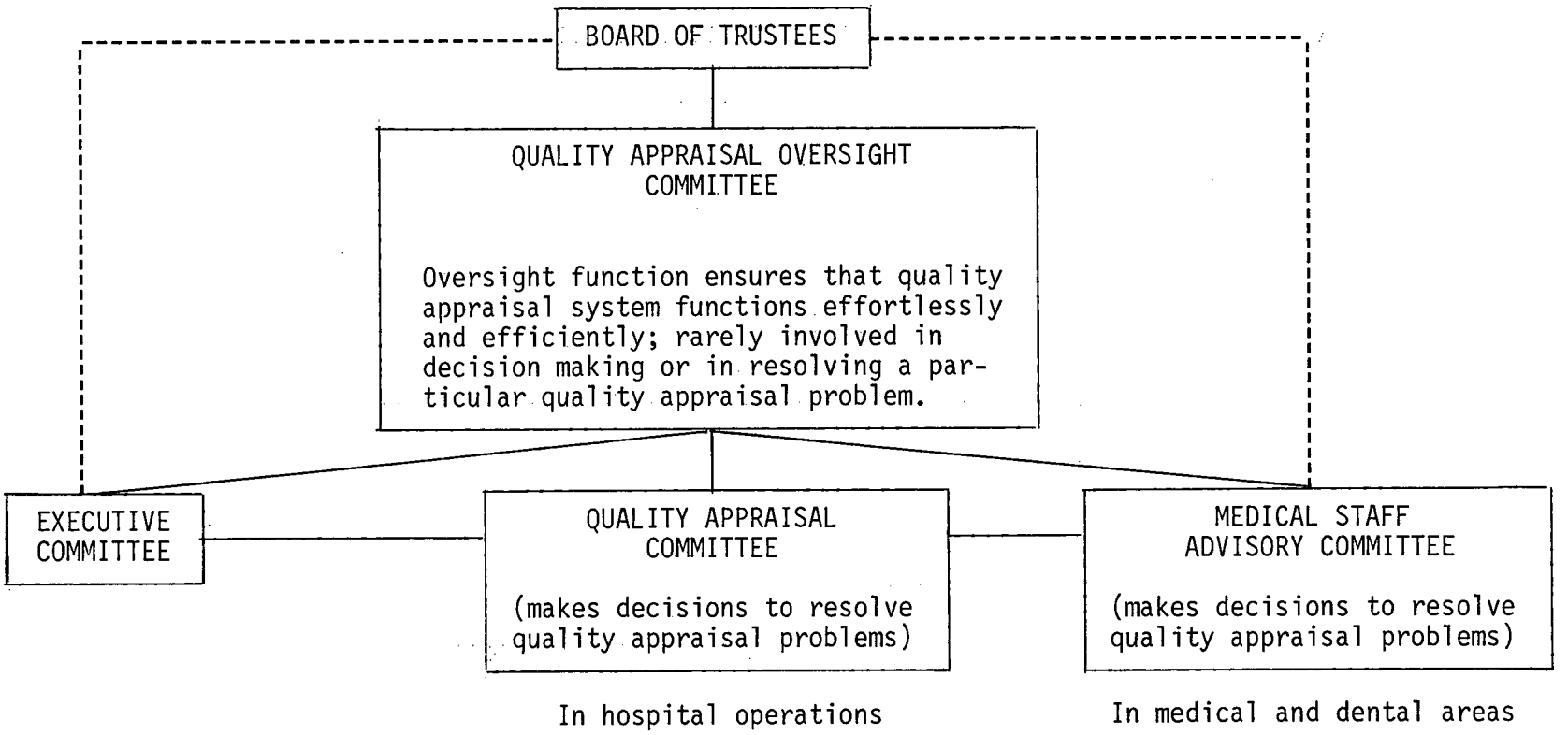
Examples Include:
- finance committee
- building committee
- capital equipment
- construction
- statistics

ORGANIZATIONAL COMPLEXITY: is the structural form of the enterprise consisting of an intricate combination of elements due to advances in health technology and knowledge.

Examples Include:
- personnel
- board appointment
- Trustee Orientation Program
- chairman's report
- administrator's report
- organizational design
- medical staff appointment
- paediatrics planning
- auxiliary report
- collective bargaining
- minutes
- attendance
- adjournment
- by-law amendments
- rehabilitation day care
- municipal representation
- regular/special meetings
- ambulance training
- staffing workload
- total parenteral nutrition costs
- new technologies
- nuclear medicine instrumentation
- teaching responsibilities

- organizational design
- medical staff appointment
- paediatrics planning
- auxiliary report
- collective bargaining
- minutes
- attendance
- adjournment
- by-law amendments
- rehabilitation day care
- municipal representation
- regular/special meetings
- ambulance training
- staffing workload
- total parenteral nutrition costs
- new technologies
- nuclear medicine instrumentation
- teaching responsibilities.

QUALITY APPRAISAL OVERSIGHT COMMITTEE STRUCTURE



------- Normal reporting relationship other than quality appraisal

_____ Reporting relationship for Chairman and designated committee members for quality appraisal.

CRIMINAL CODE OF CANADA LEGISLATION ON THERAPEUTIC ABORTIONS

Procuring miscarriage

251. (1) Every one who, with intent to procure the miscarriage of a female person, whether or not she is pregnant, uses any means for the purpose of carrying out his intention is guilty of an indictable offence and is liable to imprisonment for life.

Woman procuring her own miscarriage

(2) Every female person who, being pregnant, with intent to procure her own miscarriage, uses any means or permits any meas to be used for the purpose of carrying out her intention is guilty of an indictable offence and is liable to imprisonment for two years.

"Means"

(3) In thi section, "means" includes

a) the administration of a drug or other noxious thing,

b) the use of an instrument, and

c) the manipulation of any kind.

Exceptions

(4) Subsectons (1) and (2) do not apply to

a) a qualified medical practioner, other than a member of a therapeutic aboartion committee for any hospital, who in good faith uses in an accredited or approved hospital any means for the purpose of carrying out his intention to procure the miscarriage of a female person, or

b) a female person who, being pregnant, permits a qualified medical practitioner to use in an accredited or approved hospital any means described in paragraph a) for the purpose of carrying out her intention to procure her own miscarriage, if before the use of those means, the therapeutic abortion committee for that accredited or approved hospital, by a majority of the members of the committee and at a meeting of the committee at which the case of such female person has been reviewed,

c) has by certificate in writing stated that in its opinion the continuation of the pregnacy of such female person would or would be likely to endanger her life or health, and

d) has caused a copy of such certificate to be given to the qualified medical practitioner.

APPENDIX NINE

TERMS OF REFERENCE FOR THE THERAPEUTIC ABORTION COMMITTEE AT LIONS GATE HOSPITAL

COMPOSITION

i. The Committee shall consist of not less than three members of the Medical Staff.

ii. The Chairman and members of the Committee shall be appointed annually by the Medical Staff Advisory Council upon the recommendation of the Cheif of Staff.

FUNCTION

i. The Therapeutic Abortion Committee shall consider and determine questions relating to terminations of pregnancy of less than 20 weeks duration within the Lions Gate Hospital, and carry out their duties in compliance with Section 251 of the Criminal Code of Canada.

REGULATIONS

i. No member of the Committee may perform a therapeutic abortion in this or any other hospital while a member of the Committee.

ii. No application for permission to carry out a therapeutic abortion shall be accepted by the Committee after 1600 hours on the day prior to the meeting of the Committee unless the doctor concerned appears before the Committee unless the doctor concerned appears before the Committee personally to verify the urgency of the application.

iii. The Committee shall report to the Medical Staff Advisory Council through the Chief of the Division of Obstetrics and Gynaecology.

iv. The report shall contain all the data required under Section 251 of the Criminal Code of Canada and shall further include:

a) The number of cases presented to the Committee.

b) The number of cases approved by the committee both in total and divided into the following groups:

1) Pregnancies of less than 9 weeks gestation .

2) Pregnancies of between 9 and 12 weeks gestation.

3) Pregnancies of more than 12 weeks gestation.

APPENDIX TEN

DIRECTIVE TO ADMINISTRATOR

Pursuant to the By-Laws of the North and West Vancouver Hospital Society and to the Hospital Act Regulations and particularly Regulation 8 thereof, the Board of Management of Lions Gate Hospital resolves and directs as follows:

1. The Administrator of the Hospital shall have the authority and duties hereinafter defined and subject to such amendments hereto as may, from time to time, be adopted by resolutin of the Board of Management.

2. The Administrator shall be the representative of the Board and shall execute all orders of the Board concerning the administration of the Hospital.

3. The Administrator shall have vested in him the power to exercise the functions of the Board at times when, in the opinion of the Chairman of the Board, it is inconvenient to call a meeting of the Board.

4. The Administrator shall attend all meetings of the Medical Staff of the Hospital and of the Board of Management and shall act as connecting link between them.

5. The Administrator shall organize the administrative functions of the Hospital, delegate duties and establish formal means of accountability on the part of subordinates, and shall submit in writing such organization of such functions and duties to the Board of Management for its approval so soon as he has established the same. From time to time the Administrator shall recommend to the Board of Management, for their approval, any necessary amendments to such organization.

6. The Administrator shall reommend to the Board of Management the establishment of such Hospital departments as, in his judgement, are desirable and shall carry any such approved establishment into effect and shall provide for departmental and inter-departmental meetings, and attend or be represented at such meetings.

7. The Administrator shall recommend to the Board of Management for its approval the responsibilities of the Medical Co-ordinator. The Administrator shall name Hospital departmental representatives to Medical Staff Committees where appropriate and when requested by the Medical Staff, and shall report such nominations to the next meeting of the Board of Management for its approval.

8. The Administrator shall report to the Board of Management and to the Medical Staff on the overall activities of the Hospital, including working relationships with other community bodies, at the regular monthly meetings of the Board of Management and of the Medical Staff.

9. The Administrator shall report to the Board of Management from time to time and in any event, on a quarterly basis on the working relationships which he has established with other community bodies and with appropriate Federal or Provincial authorities and shall also report to the Board upon any local developments that affect health care in the hospital.

10. THe decisions of the Administrator shall prevail on all questions of Hospital administration unless they are countermanded by the Board of Management.

11. The Administrator shall be responsible, subject to such policy decisions as may, from time to time, be laid down by the Board of Management, for the overall results achieved by the Hospital in term of:

a) Effective management of patient care and its quality to the extent that such care is administered by employees of the Hospital;

b) Effective management of physical plant and personnel;

c) Effective management of financial resources;

d) Community acceptance of programs and services;

e) Employment and discharge of employees of the Hospital, except that the engagement or termination of employment of the Senior Assistant Administrator, the Assistant Administrators, the Comptroller and the Medical Co-ordinator shall be subject to the prior approval of the Board of Management.

12. The Administrator shall report to the Board of Management at its regular meetings on all matters of importance in the management of the Hospital, and shall, from time to time, as may be necessary, make recommendations for policy changes in the management and administration of the Hospital and the Board shall consider such recommendations and determine the policy to be followed in respect to the matters raised.

13. The Administrator shall prepare long range planning schedules and capital financing proposals arising out of his recommendations and shall, from time to time, present them to the Board for approval, or for such other action as the Board may determine.

14. The Administrator shall conduct periodic reviews of the performance of the staff employed by the Hospital and shall report thereon to the Board of Management at the conclusion of each review.

15. The Administrator shall in his capacity as the connecting link between the Medical Staff of the Hospital and the Board of Management consult, as necessary, with the President of the Medical Staff, the Chief of Staff, and the Medical Co-ordinator to the end that the Medical Staff and the Administrative Staff work in harmony together. In case of any disagreement on a matter of policy between the Administrator and any of the President of the Medical Staff, the Chief of Staff and the Medical Co-ordinator the matter shall be referred to the Joint Conference Committee.

16. The Administrator shall be responsible for the system of accounting of the Hospital and for the maintenance of the records of the Hospital.

17. The Administrator shall perform any other duty assigned to him by the Board of Management in connection with the management and operation of the Hospital.

APPENDIX ELEVEN

PERFORMANCE GUIDELINES FOR THE

CHIEF EXECUTIVE OFFICER

1. WORKLOAD: Is the workload planned and delegated where appropriate?

   HAS EXCEEDED REQUIREMENT
   HAS MET REQUIREMENT
   HAS NOT MET REQUIREMENT

COMMENT:

_____

_____

_____

_____

_____

2. ORGANIZATION: Are activities/time well organized and effectively co-ordinated with others?

   HAS EXCEEDED REQUIREMENT
   HAS MET REQUIREMENT
   HAS NOT MET REQUIREMENT

COMMENT:

_____

_____

_____

_____

_____

3. PROBLEM SOLVING: Are problems anticipated, identified, thought through, solved in realistic and practical way, and where appropriate are effective recommendations made?

3. PROBLEM SOLVING: Continued

HAS EXCEEDED REQUIREMENT
HAS MET REQUIREMENT
HAS NOT MET REQUIREMENT

COMMENT:

4. POLICY: Is an active role taken in policy formulation? Are policies maintained in an organized manner and reviewed periodically?

HAS EXCEEDED REQUIREMENT
HAS MET REQUIREMENT
HAS NOT MET REQUIREMENT

COMMENT:

5. SENSE OF RESPONSIBILITY: Are decisions made and is responsibility accepted for those decisions? Is a conscientious and loyal attitude to the position and facility demonstration?

HAS EXCEEDED REQUIREMENT
HAS MET REQUIREMENT
HAS NOT MET REQUIREMENT

COMMENT:

5. SENSE OF RESPONSIBILITY: Continued

---

6. ASSERTIVENESS: How well are ideas presented? How effective is group participation? Is assertiveness used effectively without undue agressiveness?

HAS EXCEEDED REQUIREMENT
HAS MET REQUIREMENT
HAS NOT MET REQUIREMENT

COMMENT:

---

7. INTERPERSONAL RELATIONSHIPS: Are interpersonal relationships good? Is co-operation shown? Is good discretion shown?

a) INTERNAL

VERY GOOD AT GETTING ALONG WITH:
Public/Patients Board Medical Staff Auxiliary Staff

GOOD AT GETTING ALONG WITH:
Public/Patients Board Medical Staff Auxiliary Staff

WEAK IN SOME WAYS AT GETTING ALONG WITH:
Public/Patients Board Medical Staff Auxiliary Staff

b) EXTERNAL

VERY GOOD AT GETTING ALONG WITH:
Government Staffs Press Allied Organizations Community

GOOD AT GETTING ALONG WITH:
Government Staffs Press Allied Organizations Community

7. INTERPERSONAL RELATIONSHIPS: Continued
WEAK IN SOME WAYS AT GETTING ALONG WITH:
Government Staffs Press Allied Organizations Community

COMMENT:

_____

_____

_____

_____

_____

8. LEADERSHIP SKILLS: Is effective direction given to staff? Are adequate feedback and follow up systems in place? Are regular staff meetings held? Are staff concern dealt with promptly and fairly?

HAS EXCEEDED REQUIREMENT
HAS MET REQUIREMENT
HAS NOT MET REQUIREMENT

COMMENT:

_____

_____

_____

_____

_____

9. APPEARANCE, MANNER AND GENERAL IMPRESSION: Consider overall bearing, way of talking, manner and deportment.

HAS EXCEEDED REQUIREMENT
HAS MET REQUIREMENT
HAS NOT MET REQUIREMENT

COMMENT:

_____

_____

_____

9. APPEARANCE, MANNER AND GENERAL IMPRESSION: Continued

10. HANDLING DUTIES WITHOUT STRESS: Is confidence and maturity display on the job or does it appear that undue stress is prevalent?

HAS EXCEEDED REQUIREMENT
HAS MET REQUIREMENT
HAS NOT MET REQUIREMENT

COMMENT:

11. OPEN-MINDEDNESS AND ADAPTABILITY: Interested in and receptive to new ideas and situations?

HAS EXCEEDED REQUIREMENT
HAS MET REQUIREMENT
HAS NOT MET REQUIREMENT

COMMENT:

12. INITIATIVE: Are ideas to improve the facility's services contributed?

13. GENERAL COMMENTS:

FOR EXECUTIVE COMMITTEE

SIGNATURE OF C.E.O.:

DATE: