Research Article

Hospital Documentation Planning: The Concept and the Context

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Abstract: Documentation planning is defined in this article as a process within an institution to select an appropriate documentary record for the institution. The author describes the functions and component institutions of the U.S. health care system, identifies the functions of hospitals within the system, offers an analysis of hospital activities and administrative organization, and presents a typology of hospitals. This information provides the informational context within which a documentation plan can be developed for a particular hospital. A similar planning approach may also be applied to other types of institutions, organizations, and corporations.

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The author is also the principal investigator of a project, "Documenting the U.S. Health Care System: Analysis, Assessment, and Planning," funded by the National Historical Publications and Records Commission, the end result of which is a book, tentatively titled Documentation Planning for the U.S. Health Care System, *to be published in 1993.*

"ANALYSIS," ACCORDING TO T. R. Schellenberg, "is the essence of archival appraisal."[1] Deciding what material to collect, the archivist's most intellectually stimulating task, has become progressively more challenging since the middle of this century because the nature of institutions and organizations has changed. In modern society, institutions are often components of multinational conglomerates or divisions of holding companies; even freestanding institutions are not self-contained but are linked to other institutions and organizations, both public and private, through cooperative agreements, funding arrangements, and government regulations. These interconnections complicate the archivist's task by increasing the duplication of information and physically dispersing records. At the same time, reprographics and communications technologies have become more sophisticated, increasing the quantity of records produced and the amount of information stored. To address these changes, the archival profession must adopt a proactive approach to documenting institutions and pay increasing attention to the several levels of analysis underlying the archival selection process.

Archivists have written and spoken extensively in recent years about the need for such an activist approach to the purposeful, systematic selection of records with enduring value. Proponents of the documentation strategies concept have emphasized several points: (1) the need for conscious, intentional planning; (2) the need to make specific appraisal decisions based on an awareness of the universe of available documentation and an understanding of the activities from which the records resulted; and (3) the importance of cooperation—between archivists, records creators, and researchers and between archivists in different repositories. Larry Hackman, one of the foremost proponents of the documentation strategies concept, has argued that "by definition . . . a documentation strategy cannot be formulated by archivists within a single institution, or carried out by a single repository, or even developed or executed only by archivists."[2]

Whether or not one agrees with the need for, or efficacy of, large-scale cooperative documentation-strategies initiatives, it should be clear that decisions on selecting the records of a single institution for preservation, whether by an archivist employed by that institution or one working at a historical society or other collecting repository that has acquired a body of institutional records, should also be informed by an understanding of the place of that institution in the larger universe and by consultation with creators and users of the records. Indeed, it could be argued that large-scale, interinstitutional documentation strategies are possible only if the participating institutional archives have first come to terms with their internal issues. In order to accentuate the distinction from the documentation strategists' call for interinstitutional planning and cooperation, the internal process advocated in this article will be referred to as *documentation planning*.

Archivists can meet the challenge of documenting contemporary institutions by carefully deciding what they are going to

[1]Theodore R. Schellenberg, "The Appraisal of Modern Public Records" in Maygene F. Daniels and Timothy Walch, eds., *A Modern Archives Reader: Basic Readings on Archival Theory and Practice* (Washington, D.C.: National Archives and Records Service, 1984), 68.

[2]Larry Hackman, "To the editor," *American Archivist* 52 (Winter 1989): 8. Similar expressions can be found in Helen Willa Samuels, "Who Controls the Past," *American Archivist* 49 (Spring 1986): 115; and Larry Hackman and Joan Warnow-Blewett, "The Documentation Strategy Process: A Model and a Case Study," *American Archivist* 50 (Winter 1987): 14. For an overview of the way the documentation strategy concept has evolved in archival literature, see Terry Abraham, "Collection Policy or Documentation Strategy: Theory and Practice," *American Archivist* 54 (Winter 1991): 44-52.

document and then formulating systematic plans that lead to the deliberate selection of an appropriate documentary record. A documentation plan is formulated in two stages:

- **analysis** of the institution, its relation to other institutions of the same general type, and its larger societal context, and
- **selection** of the functions to be documented, and deciding which departmental, laboratory, office, or other unit activities or projects will be chosen to support the selected functions.[3]

This strategic plan is formulated by an archives advisory committee, comprising the archivist, records manager, legal counsel, medical records specialist, and appropriate administrators, physicians, and historical researchers; the committee considers both internal administrative needs and external research uses. In this planning process, a general knowledge of historical trends, historiographic techniques, and traditional appraisal criteria remains critically important, as does a specific understanding of the institution's mission, culture, and resources.[4] Although the documentation planning model is focused on hospitals in this article, it is applicable to a variety of types of institutions. In fact, Schellenberg suggested a somewhat similar strategy for appraising government records.[5]

Hospitals, like many other modern institutions, have become part of an intricate and complex web of regulations and relationships, which raises difficult issues for archivists concerned with maintaining a representative record. The purpose of this article is to provide the analysis necessary to devise a hospital documentation plan. The information presented here should benefit not only archivists employed by hospitals but also those at historical societies, university libraries, or other collecting repositories that may have acquired hospital records. It includes a brief overview of the U.S. health care system, an analysis and typology of hospitals, and a description of their place within the system.[6] The following pages outline the functions of our health care system, identify the institutions and organizations that carry out these functions, and analyze the administrative organization and selected activities of hospitals in relation to their specific functions within the overall system. Thus, the article provides the basis for hospital documentation planning.

Overview of the U.S. Health Care System

Since World War II, the American health care system has grown into a "vast industry," accounting for 11.6 percent of the gross national product.[7] In 1989 the nation spent $604.1 billion on health care, more per person than any other country.[8] The health care system in this country, complex and constantly changing, may best be described as decentralized and competitive.[9] Indeed, if a health care system is defined as "a group of curative and preventative

[3]It is important to understand that there is not a one-to-one correlation between functions and departments. A department may support several functions.

[4]An actual documentation plan devised for Children's Hospital, Boston will be included in the author's forthcoming book on documenting the U.S. health care system.

[5]Theodore R. Schellenberg, *Modern Archives: Principles and Techniques* (Chicago: University of Chicago Press, 1956), 52.

[6]For the purposes of this article, the U.S. health care system is defined to exclude alternative forms of health care, such as acupuncture and homeopathy.

[7]Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982).

[8]Julie Rovner, "Congress Feels the Pressure of Health Care Squeeze," *Congressional Quarterly Weekly Report*, 16 February 1991, 415; "Pay Now, Pay Later," *Economist*, 24 June 1989, 67.

[9]J. Rogers Hollingsworth, *A Political Economy of Medicine: Great Britain and the United States* (Baltimore: Johns Hopkins University Press, 1986), 3, 163.

service components—organized, coordinated, and controlled to achieve certain goals," then our "system" is, in fact, more accurately described as a nonsystem, largely because of the predominance of free enterprise and the absence of nationalized health care.[10]

Far more than other nations, the U.S. is characterized by a mix of public and private health care institutions and organizations. The resulting "system" is stable and resilient because it is decentralized and diverse and because the medical profession itself exercises tremendous power through organizations such as the American Medical Association. The government's role is also powerful and is primarily exercised through government regulations, especially regarding third-party payment mechanisms and health care standards.

Broadly viewed, the health care system has six major functions:

- **Patient care,** comprising diagnosis and treatment
- **Health promotion,** including activities such as fitness programs and information campaigns
- **Biomedical research**
- **Education and training** of health care professionals
- **Policy formulation and regulation:** policy formulation involves coordinating health care services within a specified region or jurisdiction on a suprainstitutional level; regulation establishes standards for institutions and practitioners.
- **Provision of goods and services,** such as pharmaceutical, wheel chairs, diagnostic and therapeutic equipment, and malpractice and health insurance.

These functions are carried out by diverse institutions and organizations that interact and overlap with one another, each encompassing one or more functions in its mission, sometimes along with other functions that are not related to health care. The institutions may be classified as:

- **Health care delivery facilities,** e.g., hospitals, nursing homes, and hospices
- **Health agencies and foundations,** e.g., the U.S. Department of Health and Human Services, National Health Council, and the Robert Wood Johnson Foundation
- **Biomedical research facilities,** e.g., Boston Biomedical Research Institute, and Acupuncture Research Institute of Monterey Park, California
- **Facilities for educating health professionals,** e.g., Massachusetts College of Pharmacy and Allied Health Sciences, Forsyth Dental Center School for Dental Hygienists, Bowman Gray School of Medicine
- **Associations of health professionals and volunteers,** e.g., the American Medical Association, the American Association of Health Care Administrators, the American Cancer Society
- **Health industries,** e.g., Merck, Codman and Shurtleff, Johnson and Johnson, Blue Cross and Blue Shield.[11]

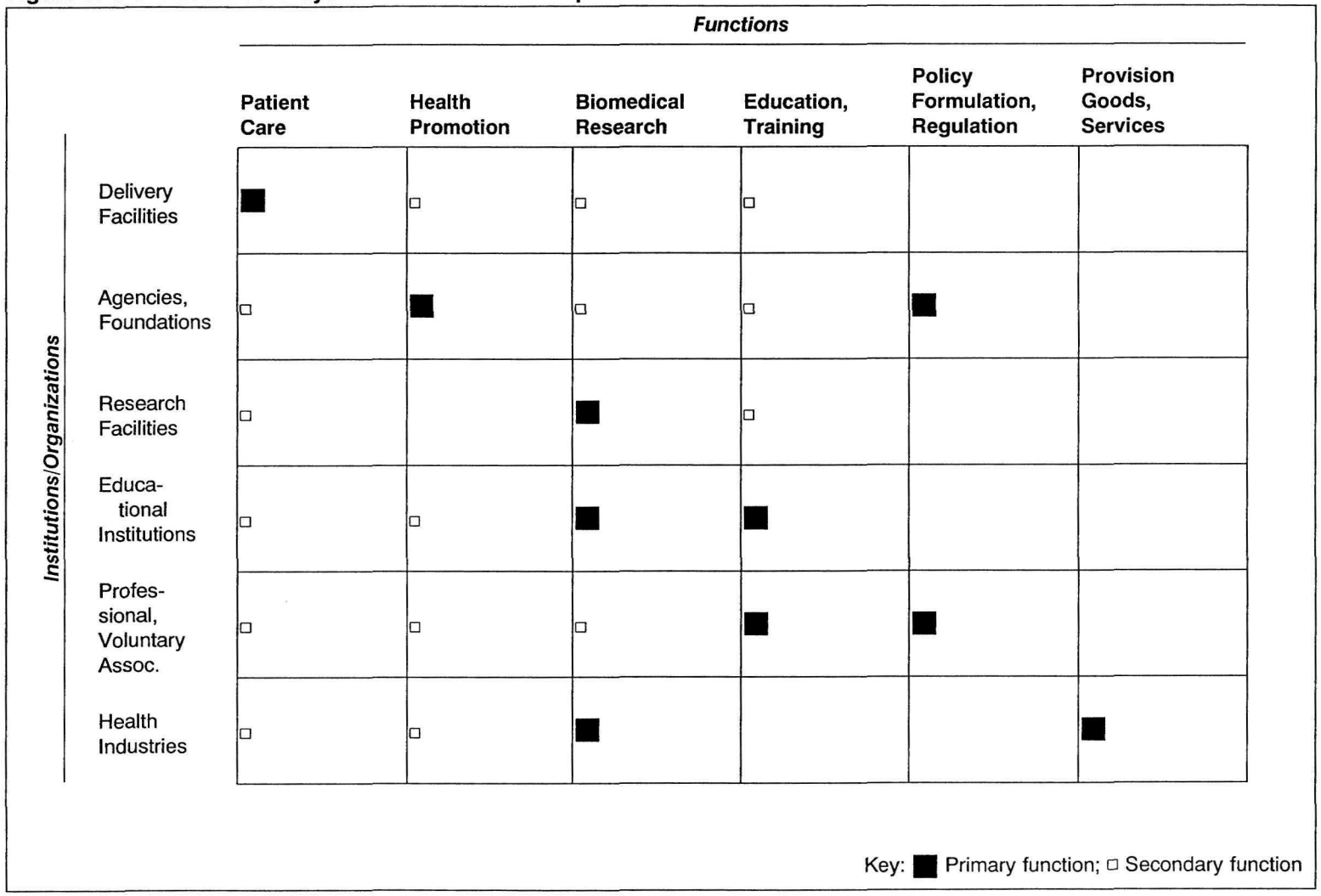
They are funded by government, voluntary contributions, investors, philanthropic foundations (notably the W.K. Kellogg, Robert Wood Johnson, and Rockefeller Foundations), or a combination of these methods.

The matrix in figure 1 provides a graphic representation of the conjunction of the health care system's functions and institutional components. Although necessarily artificial and schematic, the matrix provides a context for understanding how hospitals fit into the overall health care system.

[10]James M. Rosser and Howard E. Mossberg, *An Analysis of Health Care Delivery* (New York: John Wiley and Sons, 1977), 1. See also Milton I. Roemer, *An Introduction to the U.S. Health Care System* (New York: Springer, 1986), 2.

[11]Adapted from Rosser and Mossberg, *Analysis of Health Care Delivery*, 24-63, and Roemer, *U.S. Health Care System*, 5-12.

Figure 1. U.S. Health Care System: An Archival Perspective



Hospitals' Place in the System

Of all the institutions that engage in health care delivery, hospitals are the most central to the United States health care system. Hospitals were not always the focus of medical practice, as they are today. In the eighteenth and nineteenth centuries, only the sick poor went to hospitals. The upper and middle classes received medical care at home. Since the early part of this century, however, the hospital has become "central to the delivery of patient care, to the training of health personnel, and to the conduct and dissemination of health-related research."[12] Because of the proliferation of the use of expensive medical technology in both diagnosis and treatment, however, the hospital has become the one pervasive and indispensable institution in our health care system. In 1990 there were 6,821 hospitals in the United States, as compared to 3,457 institutions of higher education.[13] In the same year $194.2 billion was spent on hospital services, representing 39 percent of the $494.1 billion spent on all health care.[14]

Hospitals perform four of the six functions of the U.S. health care system. In addition to the patient care, education, and research functions, many hospitals have health promotion programs (although it should be noted that, historically, the U.S. health care system has emphasized treatment over prevention). Regulation is not a function of hospitals, which are themselves regulated by federal, state, and local government agencies. Neither are they involved in health care policy formulation at the national level. Hospitals do, however, influence health care policy and regulation at the local level and nationally through the lobbying activities of state hospital associations and the American Hospital Association.

Types of Hospitals

A hospital may be broadly defined as a health care treatment facility with six or more inpatient beds.[15] Hospitals in this country comprise a heterogeneous, decentralized, and fragmented grouping of institutions about which it is extremely difficult to generalize.[16] Nevertheless, it is important to attempt to categorize them and describe their similarities and differences, thus providing a broad context within which archivists can construct documentation plans. As with most efforts at classification, some hospitals cannot be neatly placed into one category (e.g., mobile hospitals) or fit equally well into several categories (women's and children's hospitals).

For the purpose of this study, hospitals will be categorized in terms of five characteristics: (1) ownership or control; (2) whether the hospital is freestanding or part of a larger organization; (3) type of patient treated or services provided; (4) whether or not the hospital is involved in education and training; and (5) whether or not the hospital engages in biomedical research. (See figure 2.)

The first three characteristics—ownership or control, whether the hospital is part of a larger organization or freestanding, and

[12]Stephen J. Williams and Paul R. Torrens, *Introduction to Health Services* (New York: Wiley, 1984), 172.

[13]American Hospital Association, *Hospital Statistics*, 1988 Edition (Chicago: American Hospital Association, 1988). Unless otherwise noted, all subsequent statistics are from the 1989-90 edition of the same publication. "Fact File: Number of Colleges by Enrollment, Fall 1987," *Chronicle of Higher Education*, 16 August 1989, A2.

[14]Katharine R. Levit, et al., "National Health Expenditures, 1990," *Health Care Financing Review* 13 (Fall 1991): 29-54.

[15]American Hospital Association, *Guide to the Health Care Field*, 1987 Edition (Chicago: American Hospital Association, 1987), A13. For the purpose of this article, homeopathic and osteopathic hospitals, which fall outside the scope of conventional medical practice, are excluded from this definition.

[16]John Z. Bowers, *An Introduction to American Medicine—1975* (Washington, D.C.: U.S. Department of Health, Education, and Welfare, 1977), 121.

Figure 2. Typology of Hospitals

- ▶ **Ownership/Control** (see figure 3)
- ▶ **Freestanding or Part of Larger Organization**
  - Freestanding
  - Larger organization
    - Holding company
    - Health maintenance organization
    - Health care company
    - Multi-hospital system or chain
    - Part of a university, industry, business
- ▶ **Patients Treated or Services Provided**
  - Type of Patient Treated
    - African-American hospitals
    - Geriatric hospitals and nursing homes
    - Hospitals for employees of specific businesses/industries
    - Hospitals serving American Indians/Alaskan natives
    - Military hospitals
    - Pediatric hospitals
    - Prison hospitals
    - School/university infirmaries
    - Veterans hospitals
    - Women's hospitals (sometimes includes children's hospitals)
  - Type of Service Provided
    - Alcohol/drug abuse hospitals
    - Burn hospitals
    - Cancer hospitals
    - Chronic disease hospitals/ hospices
    - Communicable diseases hospitals
    - Diabetes hospitals
    - Epilepsy hospitals
    - Eye and/or ear, nose and throat hospitals
    - General medical and surgical hospitals
    - Hospitals for the mentally retarded
    - Immunology and respiratory (inc. tuberculosis) hospitals
    - Leprosaria
    - Maternity hospitals
    - Orthopedic hospitals
    - Physical rehabilitation hospitals
    - Psychiatric hospitals
- ▶ **Hospital Engages in Education and/or Training**
- ▶ **Hospital Engages in Biomedical Research**

Figure 2. Continued

the type of patient treated or services provided—are the most important characteristics from an archival standpoint, because they have the greatest impact on the types of records created and where they are located. If a hospital engages in educational activities or biomedical research, their records will obviously reflect these activities. Conversely, if a hospital does not engage in education or biomedical research, no records reflecting these activities will exist. Because the patterns of hospital ownership and control are relatively complex and varied (see figure 3), as are the configurations in which a hospital is part of a larger organization, they are described in detail below.

Government owned or controlled. The federal government, most states, and many local governments own and operate hospitals. In 1988 the federal government ran 5 percent of the nation's hospitals; state and local governments operated 23 percent.

In the federal government the organization most directly concerned with health care is, of course, the Department of Health and Human Services (DHHS). In turn, the division of the DHHS most directly concerned with health care delivery is the Public Health Service (PHS) which comprises eight agencies: the Agency for Health Care Policy and Research; the Agency for Toxic Substances and Disease Registry; the Alcohol, Drug Abuse, and Mental Health Administration; the Centers for Disease

Figure 3. Hospital Ownership or Control

- ▶ **Government Ownership**
  - Federal
    - Dept. of Health and Human Services, Public Health Service
      - Health Resources and Services Admin.
      - Indian Health Service
      - National Institutes of Health's Clinical Center
    - Department of Defense
      - Army
      - Navy
      - Air Force
    - Department of Veterans Affairs
    - Department of Justice, Bureau of Prisons
    - Department of Transportation, U.S. Coast Guard
  - State
    - State health agencies (long-term facilities for the chronically ill, mentally retarded, and mentally unstable)
    - State prison/reformatory hospitals
    - State university medical school hospitals
  - Local
    - District hospitals
    - County hospitals
    - City/county joint hospitals
    - City hospitals
- ▶ **Private Ownership**
  - Voluntary (nonprofit)
    - Church or religious order
    - Private university
    - Fraternal organization
    - Business/industry
    - Community group
    - Health maintenance organization
    - Health care cooperative/ collective
  - Proprietary (for-profit)
    - Individual owner
    - Partnership
    - Corporation

Control; the Food and Drug Administration; the Health Resources and Services Administration; the Indian Health Service; and the National Institutes of Health. Within the PHS, for example, the Alcohol, Drug Abuse, and Mental Health Administration jointly administers, with the District of Columbia, St. Elizabeth's Hospital in Washington, D. C., which is a psychiatric hospital for residents of the District of Columbia and the Virgin Islands; the Health Resources and Services Administration provides health care services to Hansen's disease (leprosy) patients and others at the Gillis W. Long Hansen's Disease Center in Carville, Louisiana; the Indian Health Service runs hospitals for American Indians and Alaskan natives; and the National Institutes of Health's Warren Grant Magnuson Clinical Center consists of a 540-bed hospital and laboratory complex.[17]

Other departments of the federal government are also involved with health care delivery. The Department of Defense, for example, controls U.S. Army, Navy, and Air Force hospitals, both in this country and abroad, providing health care services to military personnel and their dependents. Through the Department of Veterans Affairs, the federal government also operates approximately 165 veterans hospitals, the majority of which are general hospitals, but some of which are psychiatric hospitals. The Health Services Division of the Department of Justice's Bureau of Prisons provides health care services for prisoners in federal institutions and runs the Medical Center for Federal Prisoners, a large referral hospital. The Department of Transportation runs U.S. Coast Guard hospitals in Kodiak, Alaska, and New London, Connecticut.

State governments operate long-term facilities providing care for the mentally ill

[17]The Clinical Center provides patient care only to individuals with illnesses that are being studied at one of the institutes; general diagnostic, treatment and emergency services are not offered.

and retarded and have done so in the past for tuberculosis patients (e.g., Glenridge Hospital, Glenville, New York (1909-1978). State prison, state reformatory, and state university medical school hospitals (e.g., The University Hospital at the University of Michigan Medical School) are also controlled by state governments.

Local governments embodied in districts, counties, and cities may also run hospitals. District hospitals, found in a few states including California, are governed by boards of directors who are elected by district residents; county hospitals are generally run by county boards of supervisors (e.g., Cook County Hospital, Chicago); city hospitals are owned by municipal governments and managed by appointed boards of citizens (e.g., Boston City Hospital). Sometimes city and county governments jointly control a hospital.

Most public hospitals were founded to provide health care to the indigent who were not served by voluntary hospitals. Today, public hospitals include some teaching hospitals, a small number of large general hospitals treating primarily the indigent, some hospitals in urban areas in which the patient profile is similar to that in voluntary hospitals, and many small rural hospitals.[18]

Privately owned or controlled. The country's "ethnic and religious diversity . . . gave rise to a sizeable voluntary [hospital] sector in America."[19] Historically, voluntary or nonprofit hospitals were established by community leaders or religious or ethnic groups to serve the "deserving poor" and individuals who became ill while away from home. Voluntary hospitals provided free care and were paternalistic toward their patients; however, they did not treat indigent, contagious, morally lacking, mentally ill, or chronically ill patients. This task was left to public hospitals.[20]

Voluntary hospitals, which comprise 48 percent of U. S. hospitals (1988), are owned and operated by seven types of organizations: (1) churches or religious groups, including Baptist, Lutheran, and Roman Catholic churches, the Salvation Army, the Sisters of Mercy and The Alexian Brothers; (2) private universities (Boston University Hospital); (3) fraternal organizations (Shriners); (4) industry (railroad and lumber companies); (5) community groups composed of citizens who organize to provide health care for their community and make modest annual contributions (Beth Israel Hospital, Boston)[21]; (6) health maintenance organizations (Kaiser Permanente); and (7) cooperatives that are owned by those who use their services (Group Health Cooperative of Puget Sound).[22]

Proprietary or for-profit hospitals are usually set up as a partnership or corporation. They emerged where community groups could not raise the funds necessary to establish voluntary hospitals. Proprietary hospitals owned by individual physicians were also common in the late nineteenth century and well into the twentieth century because it was convenient for them to set up hospitals in close proximity to their offices. Furthermore, by starting their own hospitals, physicians who did not have admitting privileges in existing hospitals could treat the patients who needed hospitalization instead of turning them over to a col-

[18]Hollingsworth, *Political Economy of Medicine*, 80-81.

[19]Hollingsworth, *Political Economy of Medicine,* 5.

[20]Hollingsworth, *Political Economy of Medicine*, 75.

[21]It is interesting to note that Jewish hospitals fall into this last category rather than the first, for they are supported by members of the Jewish community but not controlled by the synagogue. Similarly the black hospitals that existed during the segregation era were community hospitals supported by the African-American community.

[22]Revised and updated from Florence A. Wilson and Duncan Newhauser, *Health Services in the United States* (Cambridge, Mass.: Ballinger, 1985), 9.

league. Such hospitals, once common, are now rare.

During the Depression, many proprietary hospitals were closed or merged with voluntary or public hospitals. After the passage of Medicare and Medicaid legislation in 1965, however, the number of proprietary hospitals began to increase because they were now reimbursed for interest on their debt, plant depreciation and capital equipment.[23] When for-profit hospitals came to be reimbursed by the government for Medicare and Medicaid patients, they became more like voluntary hospitals. Furthermore, voluntary hospitals became more like for-profit hospitals because the government reimbursed them for some of their charity work.

Prior to 1965, the American public held a strong prejudice against the for-profit hospital sector because the practice of medicine had been viewed as charity or a service to humanity. This prejudice was reduced to some extent once voluntary and proprietary hospitals became more like each other.[24] Proprietary hospitals, however, continue to lag behind the hospital industry as a whole in providing outpatient services, emergency services, health promotion services, and education for medical professionals.[25]

For the past several years the number of proprietary hospitals has remained stable.[26] In 1988 approximately 12 percent of hospitals were proprietary, representing a decrease of 6 percent since 1950; however, the number of beds in proprietary hospitals increased by roughly 148 percent, and the number of admissions by 86 percent.

Degree of independence. Whether a hospital is freestanding or part of a larger organization is important in understanding where documentation is located. Obviously, if the hospital is freestanding there are fewer possibilities than if it is part of a larger organization. There are several configurations for a hospital within a larger organization. A hospital may be one of the institutions comprising a holding company. The Massachusetts Eye and Ear Infirmary, for example, is a nonprofit subsidiary of the Foundation of the Massachusetts Eye and Ear Infirmary, which also owns a for-profit real estate company. A few health maintenance organizations (HMOs), such as Kaiser Permanente, own one or more hospitals.[27] Hospitals are also owned by health-care corporations, such as National Medical Enterprises, Inc., which in 1988 owned 500 hospitals, 25 ambulatory-care centers, and 140 pharmacies. Multi-hospital systems are three or more voluntary hospitals (e.g., Adventist Health System) or government hospitals (e.g., Veterans Administration hospitals) that collaborate through ownership, management, or lease arrangements to enhance patient care. Their for-profit counterparts are hospital chains such as Hospital Corporation of America, which was founded in 1968 by Thomas F. Frist, a Nashville physician, and Jack C. Massey, who made Kentucky Fried Chicken a national chain.[28] Finally, hospitals may be part of a university, industry, or busi-

[23]Hollingsworth, *Political Economy of Medicine*, 74.

[24]J. Rogers Hollingsworth and Ellen Jane Hollingsworth, *Controversy About American Hospitals: Funding, Ownership, and Performance* (Washington, D.C.: American Enterprise Institute for Public Policy Research, 1987), 63.

[25]Ekaterini Siafaca, *Investor-Owned Hospitals and Their Role in the Changing U. S. Health Care System* (New York: F & S Press, 1981), 117.

[26]Russell C. Coile, Jr., *The New Medicine: Reshaping Medical Practice and Health Care Management* (Rockville, Md.: Aspen, 1990), 29.

[27]In some cases, HMOs do not own hospitals but have agreements with specified hospitals where their members are treated.

[28]This collaboration marked a turning point in the U.S. health care system. In 1968 few hospitals were part of for-profit chains, but by 1983 13 percent of nonfederal acute-care hospitals were controlled by chains. Donald W. Light, "Corporate Medicine for Profit," *Scientific American* 255 (December 1986): 38.

ness. (Government could also be considered in this category of larger organizations, although government ownership is dealt with in the previous section.) The University Hospital in Boston, for example, is owned by Boston University, and at the turn of the century many of the larger railroad, mining, and lumbering companies built, owned, and operated hospitals for their employees.[29] With the dramatic rise in the cost of operating health care facilities and the increased availability of group health insurance, company-owned hospitals are no longer common.

Regional patterns. Certain patterns of hospital ownership and control are more prevalent in some areas of the country than in others. Proprietary hospitals were begun in areas where the population was too poor or too scattered to support a voluntary hospital. The majority of proprietary hospitals (73.3 percent in 1981), therefore, are located in the South, West, and Southwest.[30] California, Texas, Florida, and Tennessee claim the most proprietary hospitals.[31] Voluntary hospitals are still most prevalent in the northeastern, mid-Atlantic, and midwestern states where the wide variety of religions and ethnic groups were able to amass the necessary capital to fund hospitals in the late nineteenth and early twentieth centuries.[32]

Functions of Hospitals

Hospitals differ from each other and from other institutions, not only by their ownership and control but also according to the functions that they serve. Four of the functions—patient care, health promotion, biomedical research, and education and training—replicate the broad functions of the U.S. health care system, as portrayed in figure 1. The fifth, administration, is not unique to hospitals, but is a requisite part of all institutions. It is important to understand all of these functions and their record-keeping implications in terms of the distinctions between hospitals and businesses.

American hospitals are similar to businesses and have become more so since the passage of Medicare and Medicaid legislation in 1965, which created a large base of paying population for which hospitals competed. Since the mid-1960s nonprofit hospitals have been forced to adopt some of the management activities employed by for-profit hospitals, such as marketing.[33] It is not uncommon for nonprofit hospitals today to have marketing departments, or marketing managers in other departments. Nonprofit hospitals were again forced to adopt some of their for-profit counterparts' strategies in 1983 when the federal government changed its method of Medicare reimbursement from "reasonable cost" to a fixed rate based on patient diagnosis (diagnosis-related groups, or DRGs).[34] Thus, all hospitals were forced to become more efficient or they would lose money treating Medicare patients.

Hospitals also have several important differences that set them apart from businesses. The major difference, and the one that probably has the most effect on records creation, is the nature of the hospital's or-

[29]Starr, *Transformation of American Medicine*, 202.

[30]Siafaca, *Investor-Owned Hospitals*, 62.

[31]Hollingsworth and Hollingsworth, *Controversy About American Hospitals*, 27, 62.

[32]Hollingsworth and Hollingsworth, *Controversy About American Hospitals*, 26-27. For more current hospital statistics broken out by region, consult the latest annual edition of the American Hospital Association's *Hospital Statistics*.

[33]Light, "Corporate Medicine," 42.

[34]DRGs are a form of prospective payment under Medicare for inpatient hospital services. Under this system hospitals are paid a specified amount for services provided based on a patient's classification into one of approximately 500 DRGs, regardless of what the care actually costs. Some adjustments are made for teaching hospitals and regional variations in cost of living. Also, psychiatric, rehabilitation, children's, and long-term hospitals are excluded from DRG regulations.

ganizational structure. Hospital organization is not strictly hierarchical, but is composed of two main components: the administrative component and the clinical or medical component. Each component is organized differently, and there is no theoretical model that integrates them.[35]

The administrative component, which is responsible for hospital management, is usually organized in a strict hierarchical fashion. The organization of the medical component, which is responsible for patient care, education and training, and biomedical research, is flatter and its members typically work in teams across department lines. To complicate matters, the two components overlap, and many hospital employees report to two supervisors: an administrator and a physician. The chief technician of a pathology laboratory, for example, reports to the physician in charge of the medical operations of the laboratory and to the administrator responsible for the laboratory's financial operations. This administrative/medical dichotomy has also affected the credentials of hospital chief executive officers, which have alternated historically between management and medical degrees. The current trend in nonprofit hospitals is toward physician chief executive officers.

Another significant difference between hospitals and businesses is that while businesses employ all the individuals on their staffs, many physicians who work in hospitals may not be employed by the hospital. In the past, very few physicians were paid by hospitals; instead, hospitals extended privileges to physicians to admit their patients. The patient paid two fees, one to the physician and the other to the hospital for use of the facilities, nursing care, diagnostic tests, and medication. In contrast, certain types of physicians, such as radiologists and anesthesiologists, have traditionally been salaried hospital employees. Other arrangements between physicians and hospitals are now common practice (in part because of an increase in the number of physicians, cost-containment pressures, and increased competition), and now hospitals routinely employ physicians individually or as groups. To further complicate the issue, physicians in teaching hospitals may also be employed by an affiliated medical school. Whatever the arrangement between physicians and hospitals, the two-pronged organizational scheme is the prevailing pattern.

There are several significant differences between hospital patients and consumers of business products and services. Patients are not always able to comparison shop; they generally are not concerned with the cost of health care, especially if they have health insurance; and they have little control over what they are buying, because the physician decides which drug or procedure is best for them, although sometimes patients will be offered a choice among a small number of treatment options.

Other differences between hospitals and businesses include the fact that hospitals do not manufacture a uniform product or provide a uniform service; hospitals provide health care services that are tailored to each patient. In addition, physicians significantly influence both the supply and the demand for a service or product, while in business supply and demand are determined independently. Finally, technological advances in business are usually cost-efficient; in hospitals they usually are not cost-efficient, because technological advances increase cost, particularly as specially trained personnel are needed to operate new and often expensive diagnostic and therapeutic equipment.[36] However, some

[35]Luther P. Christman and Michael A. Counte, *Hospital Organization and Health Care Delivery* (Boulder: Westview Press, 1981), 28.

[36]Jonathon S. Rakich and Kurt Darr, eds., *Hospital Organization and Management: Text and Readings*

departments or services within a hospital, such as pharmacies, gift shops (often run by the auxiliary), and optical shops may be run like businesses.

Administration. All institutions engage in administrative activities that are necessary for them to do business. Hospitals are no exception; they engage in budgeting, staffing, and often marketing activities like other businesses. Archivists must understand the administrative activities and mechanisms peculiar to hospitals, particularly accreditation and regulation, in order to make sense of the records that result from the activities. Because of the nature of hospital organization noted above, the administrative and patient-care functions overlap. For this reason, many of the activities and mechanisms discussed in this section may also be discussed under the patient care function.

Since 1952 hospital accreditation has been carried out by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO). Representatives of five organizations comprise the Commission: the American College of Physicians, the American College of Surgeons, the American Dental Association, the American Hospital Association, and the American Medical Association. In accrediting hospitals, the JCAHO is concerned with three areas: (1) quality of patient care; (2) hospital organization and administration; and (3) hospital facilities. The accreditation process consists of an extensive survey that is filled out by hospital administrators and a site visit by a JCAHO accreditation team, consisting of a physician, one or two nurses, and sometimes a hospital administrator. Hospitals may be accredited for three years, with or without contingencies, and hospitals that are regarded as "marginal" are publicly identified as such. Although the JCAHO is a private organization and JCAHO accreditation is not mandated by law, Medicare and Medicaid legislation require hospitals to meet standards equal to JCAHO standards in order to receive payment; thus, virtually all hospitals seek JCAHO accreditation.

Hospitals are the most extensively regulated institutions in the United States.[37] Most of this regulation has been instituted since the passage of Medicare and Medicaid legislation in the mid-1960s, and hospital regulation has increased dramatically. Prior to that time, regulations were aimed mostly at the condition of the facility. Today, they have been expanded to cover quality and cost of care. Regulation of hospitals has been described as lacking in "consistency, parsimony and clarity."[38] This is because they are regulated by a wide range of private organizations (e.g., Blue Cross and JCAHO), and public agencies representing all three levels of government, with little attempt at coordination. Often, regulations of different bodies conflict with one another.

Hospital regulation falls into four categories: (1) facilities regulation; (2) planning regulation; (3) quality and appropriateness of care; and (4) payment.[39] All states require hospital facilities to be licensed, although the scope of mandatory regulations varies from state to state, and in some states JCAHO accreditation guarantees state licensure. State licensing regulations usually concern hospital organization (requiring an organized governing body, organized medical staff, and

(New York: SP Medical and Scientific Books, 1983), 597-600.

[37]Siafaca, *Investor-Owned Hospitals*, 29.

[38]American Hospital Association, *Hospital Regulation: Report of the Special Committee on the Regulatory Process* (Chicago: American Hospital Association, 1977), 2.

[39]Siafaca, *Investor-Owned Hospitals*, 33; and American Hospital Association, *Hospital Regulation 1977*, 113.

administrator), provision of certain specified services, and standards for facilities, equipment and personnel. State governments also have certain building code requirements that apply to all facilities. These include regulations regarding elevator and boiler performance, waste disposal, fire safety, and electrical and plumbing facilities. In addition, hospitals are subject to state and federal legislation that affects, for example, the dispensing of narcotics and alcohol, the disposal of hazardous waste, radiation safety, water and air quality, labor practices including job safety, and educational requirements for teaching programs.

Planning is defined by the American Hospital Association as "an orderly process for determining the health care needs of a specific population and developing an appropriate health care capability to meet those needs."[40] The federal government has been involved in hospital planning regulation since 1946, when the Hill-Burton Hospital Survey and Construction Act was passed. This legislation provided for hospital construction or renovation mostly in rural areas where there was a shortage of beds.

Currently, certificate-of-need legislation at the state level controls capital expenditures for construction, expansion, and modernization of health care facilities as well as the purchase of costly technology such as computerized tomography (CT) scanners and magnetic resonance imagers (MRIs). The purpose of this legislation is to avoid unnecessary duplication of services and to control costs. If the cost of a proposed renovation or piece of equipment is more than a specified amount, hospitals must acquire a certificate-of-need in order to be reimbursed under Medicare and Medicaid legislation. The certificate-of-need review process involves considerable documentation and lengthy reviews at the local, regional, and state levels, and it may take up to four years to complete.[41]

Quality and appropriateness of care, the third type of hospital regulation, has been in effect since passage of the 1965 Medicare legislation, which requires that the appropriateness and necessity of care provided to Medicare patients be evaluated by examination of patient records. Because of this regulation, hospitals established quality assurance and utilization review committees to monitor and analyze patient admissions, length of stay, and allocation of resources. In 1972 the federal government legislated the creation of Professional Standards Review Organizations (PSROs), composed of local physicians who are paid by the U.S. Department of Health and Human Services to monitor physician behavior and establish standards of care that reflect local patterns of practice. Since 1984 the review contracts have been awarded to peer review organizations (PROs), which are nonprofit, community based, physician directed agencies, and have more authority than the PSROs. PROs review admissions and readmissions, validate diagnoses, and review exceptional cases and quality of care. If medical audits reveal unacceptable practice, the government does not reimburse the offending hospital for Medicare and Medicaid patients. In many cases hospitals participate in the review process through in-house Professional Services Review Departments, which are monitored by the PRO.

Quality of care in hospitals is also regulated by several mandatory committees that

[40]American Hospital Association, *Hospital Regulation 1977*, 11.

[41]David Barton Smith and Arnold D. Kaluzny, *The White Labyrinth: A Guide to the Health Care System* (Ann Arbor, Mich.: Health Administration Press, 1986), 56; and Jesus J. Pena and Valeria A. Glesnes-Anderson, eds., *Hospital Management: Winning Strategies for the 1980s* (Rockville, Md.: Aspen, 1985), 120.

seek to ensure a high standard of patient care. These committees may be overseen by a hospital's Professional Services Review Committee or another group with quality assurance responsibilities. They include the Credentials Committee, which assures that physicians have the necessary and appropriate credentials; the Infection Control Committee; the Medical Records Committee, which reviews the "content, appropriateness and timeliness"[42] of official patient records; the Pharmacy Committee, which reviews drug utilization and patient responses; the Radiation Committee; the Safety Committee; and the Tissue Committee, which examines tissue removed from patients to determine whether surgery was indeed necessary.

While the other types of regulation indirectly aim at controlling costs, the final type of hospital regulation, regulation of payment, directly influences the cost of hospital services. At both the state and local levels, retrospective reimbursement has been replaced by prospective payment. At the state level, payment regulation is sometimes controlled by a rate-setting commission that prospectively approves rates for hospital services. The federal government controls rates for inpatient hospital care to Medicare and Medicaid patients through diagnosis-related groups. Historically, only fees for hospital services were regulated; physicians are reimbursed according to a system of "customary, prevailing, and reasonable" charges. This is changing with the adoption by federal regulators, some private insurers, and other third-party payers of the recently formulated Resource-Based Relative Value Scale (RBRVS) for physician fees. Due to go into effect in 1992, the RBRVS standardizes physician fees according to three factors: (1) education and intensity of work; (2) cost of providing the service; and (3) cost of physician training.[43]

Just as hospitals are accredited by the JCAHO and licensed by the states, health care practitioners must also meet professional accreditation standards, often set by professional associations, and state licensure requirements.[44] Licensure usually involves fulfilling certain educational requirements and passing an examination. Which of the numerous health care professions require licensure, however, varies among the states. In most states the hospital is responsible for ensuring that medical and technical personnel meet government standards. Therefore, hospitals often employ registrars, whose function is to document the credentials of physicians and other health care practitioners.

Patient Care. Patient care, which encompasses diagnosis and treatment, is the primary function of hospitals and what distinguishes them from other institutions within and outside of the health care system. Patient care is often divided into three levels—primary care, secondary care, and tertiary care— based on the severity of the condition to be treated. Primary care denotes care that is simple to give, or evaluation of a condition and referral to a specialist. Although primary care does not require hospitalization, individuals may receive primary care in a hospital setting. The treatment of individuals with infections, or victims of minor accidents, and the provision of annual physical examinations are

[42]Donald I. Snook, Jr. and Edita M. Kaye, *A Guide to Health Care Joint Ventures* (Rockville, Md.: Aspen, 1987), 195.

[43]William C. Hsiao, et al., "Resource-Based Relative Values: An Overview," *Journal of the American Medical Association*, 28 October 1988, 2347-53.

[44]The American Hospital Association defines licensure as "the process by which an agency of government grants permission to an individual to engage in a given occupation, upon finding that the applicant has attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare be reasonably well protected." (AHA, *Guidelines: Licensure of Health Care Personnel* [Chicago: AHA, 1977], 1.)

examples of primary care. Secondary care is more specialized care for conditions that require hospitalization. The treatment of burn and serious accident victims and the extraction of tonsils are examples of secondary care. Tertiary care is the most specialized and generally involves the most advanced medical knowledge and technology available. Academic medical health centers specialize in tertiary care, which includes treatment for cancer and for congenital and metabolic disorders.[45] Some hospitals engage in all three levels of care, although many smaller hospitals refer patients needing tertiary care to larger hospitals.

Diagnoses may be made by health care professionals without the aid of technology (as when they prescribe treatment on the basis of their observations or the answers patients give to questions they ask) or with the aid of technology. There are three main categories of diagnostic technology: sample analysis, intrinsic energy analysis, and external energy probes. Sample analysis consists of analyzing the chemical and cellular components of body fluids and tissues. Examples of sample analysis include blood tests, tumor biopsies, and spectroscopy. Intrinsic energy analysis measures internal energy conditions, such as temperature, sound, and pulse. Electroencephalographs, for example, are devices that record the electrical activity of the brain. The third category of diagnostic technology, external energy probes, is used to determine the size, shape, and location of internal organs. External energy probes work by shooting beams of energy into the patient and analyzing the energy that comes out. Examples of external energy probes are ultrasound and x-rays.[46]

Hospital laboratories are an important element in patient diagnosis. Two types of laboratories—clinical pathology and research—may exist in a hospital, but only clinical pathology laboratories are involved with diagnosis. Through sample analysis, they provide information that assists health care personnel in diagnosing disease.

Patient treatment may be classified as internal therapy (medication), external therapy (casts, bandages, advice on life-style changes), mental therapy, or surgery. Patient treatment may further be distinguished according to whether the patient remains in the hospital overnight (inpatient) or is treated and released (outpatient). Hospital outpatient departments first appeared in the 1920s, and since then they have increased in number, scope, and complexity.[47] The services provided on an outpatient basis are general diagnosis and treatment for nonemergency conditions to individuals referred by themselves or a physician and emergency care. It is noteworthy that in the last several years the length of hospital stays has decreased, and some procedures, such as cataract surgery, that were previously performed on an inpatient basis are now performed as "ambulatory surgery," eliminating the need for an overnight hospital stay. This change is due to improved techniques and to revised Medicare and Medicaid reimbursement regulations aimed at cost containment.

Health promotion. Health promotion, or consumer health education, is the process of communication and education that "helps each individual to learn how to achieve and maintain a reasonable level of health appropriate to his particular needs and interests, and to be motivated to follow . . . health practices which contribute to his state of health and well-being."[48] Historically, hospitals in the United States

[45]Rosser and Mossberg, *Analysis of Health Care Delivery*, 16.

[46]Williams and Torrens, *Health Services*, 287.

[47]Milton I. Roemer, *Ambulatory Health Services in America*, 48

[48]Myra E. Madnick, *Consumer Health Education: A Guide to Hospital-Based Programs* (Wakefield, Mass.: Nursing Resources, 1980), 1.

have not participated very actively in health promotion. In 1984 less than 1 percent of the federal government's health care budget was used for health promotion.[49] This trend seems to be reversing, because by 1987 health promotion programs were offered in more than one-third of U.S. hospitals.[50] Community hospitals are especially conscientious about health promotion, and it is not unusual for them to offer, free or at a moderate cost, literature concerning health issues, and health education classes in, for example, how to stop smoking, reduce stress, and maintain a healthier diet. Health promotion programs may also include health support groups, health screening, physical fitness classes, family life education, and rehabilitation.

Biomedical research. Biomedical research in a hospital setting is similar to scientific/technological research with a clinical dimension; thus, the records of research done in hospitals are similar to those produced by research in a university.[51] Furthermore, hospitals may embark on research projects jointly with universities or corporations, thus affecting the location of project records. Recently, the trend in hospitals has been to increase research and development activities with the goal of developing new products and business ventures. This type of diversification enables hospitals to remain viable in a competitive environment.[52] Biomedical research in whatever setting is regulated just as scientific/technological research is regulated. Hospitals, as other institutions in which research is carried out using animals or humans, must have Animal Care Committees and Human Subject Committees. These are federally mandated committees that closely monitor federally funded research involving animals or humans. If abuses occur, committee members are obliged to report them to the National Institutes of Health.

Education and training. Education and training may occur in a hospital setting at many levels. Hospital personnel are educated regarding infection control and safety procedures; laboratory and radiology technicians are trained; nursing students are provided with undergraduate education or specialty training; graduate students earn M.S. degrees in nursing, dietetics or physical therapy; other graduate students work on research projects in hospital departments or laboratories, and medical students have rotations, which lead to Ph.D. and M.D. degrees, respectively; physicians are given postgraduate education as residents or fellows; and the entire range of allied health care professionals attends hospital sponsored in-service programs or continuing education courses in order to retain their certification or licensure, or to update their knowledge and skills. To this end it is not uncommon for hospitals to have an education department or for medical departments to hire managers to deal primarily with education. Hospitals may also provide the clinical facilities necessary for programs that they do not sponsor. In addition hospitals often provide trustee education, management development, and patient and community health education programs.

Certain hospitals are identified as teaching hospitals. According to the American Hospital Association, a teaching hospital is "a hospital that allocates a substantial part of its resources to conduct, in its own name or in formal association with a college, courses of instruction in the health disciplines that lead up to the granting of recognized certificates, diplomas, or degrees, or that are required for professional certi-

[49]Joseph A. Califano, *America's Health Care Revolution: Who Lives? Who Dies? Who Pays?* (New York: Random House, 1986), 60.

[50]Coile, *The New Medicine*, 152.

[51]For a discussion of scientific/technological research from the standpoint of its component activities, see, Joan K[rizack] Haas, Helen Willa Samuels, and Barbara Trippel Simmons, *Appraising the Records of Modern Science and Technology: A Guide* (Cambridge: MIT Press, 1985).

[52]Coile, *The New Medicine*, 35.

fication or licensure."[53] Although this definition does not mention research, the reality is that more often than not, teaching hospitals also engage in biomedical research.

Although the term *teaching hospitals* traditionally referred to affiliation with medical schools, today it also denotes affiliation with other educational institutions. The Veterans Administration Hospital in Ann Arbor, Michigan, for example, is affiliated with the University of Michigan Medical School and thirty-four other educational institutions. Historically, most teaching hospitals in the United States were public hospitals; however, more recently the majority of teaching hospitals are voluntary.[54] For-profit hospitals avoided engaging in teaching and research because they were not profitable activities; however, a few investor-owned companies began purchasing or leasing teaching hospitals in the early 1980s for a variety of complex reasons.[55] In 1979, 17 percent of voluntary hospitals, 8 percent of public hospitals, and 1 percent of proprietary hospitals were affiliated with medical schools.[56]

Hospital Classification as a Basis for Documentation Planning

Analyzing hospital functions and classifying hospitals enables archivists to identify what is routine and what is unusual about a particular hospital. They are then able to use this information as part of the context for devising institutional documentation plans. Hospitals are classified by choosing one element from each of the five hospital characteristics: ownership or control; whether it is freestanding or part of a larger organization; type of patient treated or services provided; whether it engages in education and training; whether it engages in research. However, all possible combinations of hospital characteristics do not exist. For example, there are no for-profit Department of Veterans Affairs hospitals; neither are there for-profit leprosaria, or voluntary religious hospitals serving Amer-

Figure 4. Documentation Planning Checklist

- Who owns or controls the hospital? See figure 2.
- Is the hospital freestanding or part of a larger organization?
- Are the hospital's services limited to a certain population group? See figure 1.
- Does the hospital provide services only for a specific condition or range of conditions? See figure 1.
- Does the hospital engage in education and/or training? If so, who is taught (hospital employees/staff, technicians, nurses, physicians, etc.) and at what level (undergraduate, graduate, post-graduate, continuing education)? Are the programs operated through affiliation with other institutions?
- Does the hospital engage in biomedical research? Is the research administered through the hospital or through an affiliated institution? Are other institutions involved in administering, funding, regulating, conducting the research?
- Does the hospital have a health promotion program?
- What level(s) of patient care does the hospital provide: primary, secondary, and/or tertiary?
- Is this type of hospital usual or relatively unusual for its geographic area? In what ways, if any, is it unusual? Does it have significant regional/national importance?

[53]"Definition of a Teaching Hospital," American Hospital Association Memorandum, 11-15 November 1967, as quoted in William E. Hassam, *Hospital Pharmacy* (Philadelphia: Lea and Febiger, 1986), 45.

[54]Hollingsworth and Hollingsworth, *Controversy About American Hospitals*, 47.

[55]Bradford H. Gray, ed., *For-Profit Enterprise in Health Care* (Washington, D. C.: National Academy Press, 1986), 145.

[56]Gray, *For-Profit Enterprise*, 109.

ican Indians or Alaskan Natives. The Massachusetts Eye and Ear Infirmary (MEEI), for example, would be classified as a voluntary (secular) hospital that is a subsidiary of a holding company. The Infirmary treats patients with diseases of the eye, ear, nose, or throat, and engages in education, training, and research. In addition, it is affiliated with Harvard University and is one of only fourteen eye, ear, nose, and throat hospitals in the United States and the only one in New England. Another example of hospital classification: the Ann Arbor Veterans Administration Hospital is a federally owned hospital that is part of a multi-hospital system of approximately 165 veterans hospitals. It serves veterans and engages in education, training, and research activities (having affiliations with 34 educational institutions).

Archivists could then use this classification information to make documentation planning decisions. Because the Massachusetts Eye and Ear Infirmary is the only eye, and ear, nose and throat hospital in New England, a documentation plan would ensure, at a minimum, documentation of its unique functions. After careful analysis the MEEI archives advisory committee (as defined in the introductory section of the article) might decide to document the Infirmary's education and training function only as it relates to educating Harvard Medical School students, but to document certain administrative activities, biomedical research, patient care, and health promotion more fully. On the other hand, it might not be so important to document all five functions of Cambridge Hospital to the fullest extent possible because it is one of a few hundred medium sized, local government owned, freestanding, general hospitals; however, it is a Harvard University teaching hospital, which sets it somewhat apart from city hospitals in other parts of the country. The City of Cambridge might decide to focus on patient care and health promotion (to document the hospital's relationship to the city), and education, particularly in relation to Harvard Medical School. See figure 4 for a checklist of questions useful in classifying a specific hospital and determining its place within the context of hospitals in general.

Conclusion

This article has presented an overview of the U. S. health care system from an archival perspective, a typology of hospitals, and a functional analysis of aspects of hospitals that have an impact on records creation, location, and retention. When combined with an understanding of institutional goals, culture, and resources and a knowledge of historical trends, historiographic techniques, and traditional archival appraisal criteria, this analysis will enable archivists, with the assistance of planning committees, to assess how adequately a specific hospital has been or should be documented, to devise documentation plans for specific institutions, and to devise cooperative collecting agreements. This strategic planning framework is not limited in usefulness to hospitals, but could be employed equally as effectively with other types of institutions, such as museums, engineering firms, and insurance companies.