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Research Article

The Organization of a Catholic Hospital: What are the Specific Characteristics?

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Abstract

Although clinical guidance is an important part of WHO's mandate, the Organization also receives ongoing requests from countries to provide advice on how best to organize and manage health systems. At the operational base of these systems is the Hospital, a structure in direct contact with those requesting health services. A complex organization, with multiple and heterogeneous components, from which arises the diversity of profiles of the different healthcare actors who work together daily: surgeons, doctors, pharmacists, nurses, medical analysis technicians, maintenance workers, administrators, etc. The organization of the Hospital must therefore consider this hetero complexity, ensuring not only an overall organization of the structure, but also and above all an organization adapted to its nature/specificity. And one of the specificities of health structures is the private Catholic confessional character of many of them, founded either by bishops in charge of dioceses or by religious congregations, which associate the preaching of the Good News with assistance to sick/suffering people. As a result, it is essential for anyone involved in the chain of organization of a Catholic hospital institution to consider its confessional character, for optimal and comprehensive care of patients, by "ministers" in the service of life, and in respect of the ethics and dignity of every human being.

Keywords: Catholic, Dignity, Ethics, Hospital, Organization, Human being

Introduction

While clinical guidance is an important part of WHO's mandate [1], the Organization also receives ongoing requests from countries to provide advice on how best to organize and manage health systems. And, according to WHO, in many developing countries, poor health systems are one of the main barriers to accessing essential health care. However, poor countries are not alone in facing problems of inadequate health systems, as large parts of the population in some rich countries do not have access to quality health care because social protection systems are not always equitable. In others, there is an escalation of expenditure due to inefficient use of resources. This requires a paradigm shift in management and governance, financing and resource allocation, as well as accountability frameworks and public health actions [2].

At the operational base of the health system is the Hospital, a structure in direct contact with those seeking health services, and which, according to the WHO (1957), is: " ... *the element of an organization of a medical and social nature whose function is to provide the population with complete medical care, curative and preventive, and whose external services radiate to the family unit considered in its environment; it is also a centre for teaching medicine and biosocial research.* » [3]. A complex organization, with multiple and heterogeneous components, from which results the diversity of

profiles of the different healthcare professionals who work together daily: surgeons, doctors, pharmacists, nurses, medical analysis technicians, maintenance workers, administrators, etc.

The organization of the Hospital must therefore take into account this hetero complexity, ensuring not only a global organization of the structure, but also and above all an organization adapted to its nature/specificity. And one of the specificities of health structures is the private Catholic confessional character of many of them, founded either by dioceses or by religious congregations, which have always perceived the service of the sick as *"an integral part of their mission ",* by associating *"the preaching of the Good News with assistance to the suffering"*. It is therefore essential for anyone involved in the chain of organizing a Catholic hospital to consider its denominational character, for optimal and comprehensive care of patients, while respecting the dignity of every person.

History of the Hospital

It is difficult to define the period in history when men created institutions, shelters for those who needed care, protection or simply support at the end of their lives [4]. The origins of medicine itself go back a long way, most likely to the Neolithic period when, once the simple goals of protection of the group (shelter); access to food; and reproduction of the species had been surpassed, humanity was able to conceive of other fields of abstraction such as, for example, religion or a sketch of science (astronomy, mathematics, botany). This medicine was undoubtedly part of shamanic practices, and could have had a certain amount of sophistication, as evidenced by the discovery of prehistoric skulls with healing trepanation holes. This suggests a relative survival of their owners [5].

It is difficult to imagine today what the first hospices in France looked like. In the Middle Ages, these dilapidated establishments with architecture inspired by religious buildings were managed by the Church, which carried out its duty of charity by taking in and feeding the poorest and the sick [6]. Under the Ancien Régime, the General Hospital established in each large city, far from offering care, was more of an institution where beggars and vagabonds, prostitutes and the insane were locked up. In their collective work *"L'hôpital en France, du Moyen Âge à nos jours: histoire et architecture",* published by Lieux Dits, researchers Pierre-Louis Laget, Claude Laroche and Isabelle Duhau trace the major periods of architectural evolution of hospitals, a history closely linked to the history of medicine and our knowledge in the field of health sciences.

With the Renaissance and the emergence of the State, a municipal hospital policy was gradually established; hospitals came under the supervision of the bourgeoisie, and the shift from religious hospitals to secular hospitals took place. We are thus witnessing an evolution in the conception of patient care, and a shift from a religious function to a social function, where the hospital succeeds the Church [7]. At the end of the 19^{th} century, the combination of the rise of socialist ideas and the new medical weapons born from Pasteur's discoveries favoured the emergence of a new health strategy whose ultimate stage was the collective assumption of the cost of health care. Until then, apart from certain aspects of public order, the individual, solely responsible for his health, had to assume this cost himself and could only count on family solidarity in the event of illness or accident [8].

It was in 1945, at the end of the Second World War, that the current French social security system was established, which includes compulsory health insurance [9]. In many respects, the Second World War led European societies to reform and even rebuild themselves. The 19^{th} century had separated health policy and social policy, transformed the hospital for the poor into a hospital for care. The second half of the 20^{th} century would bring these two concerns together in a shared desire to reduce social inequalities and the most unjust of all: inequality in the face of illness and death. In the more general framework of a welfare state that must ensure that all citizens have the means to access decent living conditions - from childhood to old age, in all areas (education, housing, work, retirement, etc.) - health became a right and the state must ensure that it was open to all [8].

Health systems have undergone a series of overlapping reforms over the last century, from the advent of national health care systems to the development of social insurance schemes. Subsequently, primary health care was seen as the means to achieve universal coverage at affordable cost: the goal of health for all. Despite its many advantages, this approach was criticized for not paying enough attention to the demand for health care and for focusing almost exclusively on a certain perception of needs. When these two notions did not coincide, the resulting systems failed, because they were unable to establish an adequacy between their supply of health services and the needs for health care [10].

To briefly illustrate the role of contemporary health systems, WHO, in its World Health Report 2000, paid special attention to a birth of symbolic importance. United Nations experts had calculated that the world population would reach six billion on 13 October 1999. On that day, in a maternity ward in Sarajevo, a boy was born who was designated the six-billionth person on the planet. His life expectancy was then 73 years, which corresponds to the current Bosnian average. The child was born in a large urban hospital staffed by highly qualified midwives, nurses, doctors and technicians. These staff had at their disposal state-of-the-art equipment, medicines and treatments. The hospital is part of a modern health service connected to a vast network of people and interventions that, in one way or another, will work to assess, maintain and improve the health of this child for the rest of his or her life, as for other members of the population. "*All of these partners who provide services, finance them or define policies to administer them form a health system"* [10], of which the hospital is the basic cell, responsible for providing health services to populations.

The hospital is no longer considered a cold and impersonal *"healing machine",* but rather an open place of care and research that must be pleasant. The hospital seeks to adapt to the needs of patients and their families and the trend is now towards the human-

ization of care and the autonomy of patients [6]. Therapeutic garden at the Cancéropôle in Toulouse, video projections in patients' rooms in Montreal, connected rooms at the Lille University Hospital, an atmosphere that takes up the codes of hotel architecture and application of the principle of complete forward movement in the outpatient surgery platform of the Pitié Salpêtrière... today, from design to operation, developers, builders, architects and doctors continue to transform this healthcare universe and imagine together what the hospital of tomorrow will look like...

New trends in the humanization of care lead to the construction of human-sized and easier-to-manage establishments. Establishments whose architecture is increasingly better adapted to the requirements of patient comfort and safety, and which require rethinking the structural and internal organization of the Hospital, for optimal and comprehensive care of the patient.

Special Features of the "Hospital" Organization

The architecture of our hospitals has its roots in the hospices or hôtel-Dieu of the Middle Ages. The first places of care were run by religious people who welcomed the dying, the needy and pilgrims; the driving force that governed these places was charity [11].

The architecture of hospitals is ecclesiastical, identical to churches: large naves with lengths between 30 and 100meters, heights of ±20meters and widths of the order of 15 to 20meters. It allows for large air volumes and creates ventilation in the upper part, in the crossings of the vaults. The quality of the ventilation is then the only guarantee of the hygiene of the places. To maintain a certain temperature in the beds, in which two or three patients lie, they are canopied, closed on the sides by large hangings. This period will last five centuries. The Hôtel-Dieu de Tonnerre and the Hôtel-Dieu de Beaune are two examples of this.

The first change took place with the capture of Constantinople (1453). Temporal power replaced spiritual power, and benevolence took the place of charity. Architecture became monumental, like the palaces of the Renaissance. Buildings were carried out on two, three or even four levels, each 6 to 8metres high [12]. The staircases were very wide so that the sick would not fall off the stretcher during transport. The floors, made of oak barrels, had spans of around ten metres, and the rooms were longer and narrower than in the Middle Ages.

It was in Italy that the first hospital characteristic of this period was born: *the Ospedale Maggiore* di Milano, also known as *Ca'Granda*, is the oldest hospital in Milan. (Archit. Filarete, 1456), described as *a "cross-shaped hospital"*. Another characteristic model is the *"courtyard hospital",* the representative example of which is the Saint-Louis Hospital in Paris (1609), still in operation.

Hygiene has made little progress: ventilation continues to be a concern. Several people are present in the same bed and epidemics continue. But we still see the development, at the end of this period, of prevention systems:

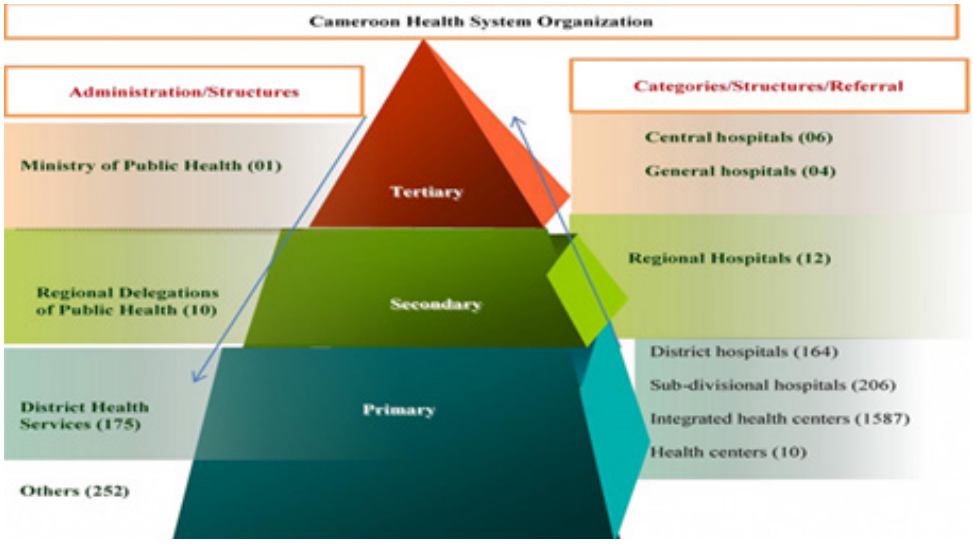
1. Isolation of the sick; walls and self-sufficient living.
2. Location near a watercourse to drain and evacuate contaminated materials.
3. Separation of patients into specialized rooms.

Doctors take their place in the hospital; they are the only ones who can prescribe remedies. But problems undermine the hospitals, announcing the changes to come. The Hôtel-Dieu in Paris (four to six patients per bed, 615 patients in 760 m^2) becomes a feared place; epidemics spread there. The improbable rate of morbidity (25%) is the basis of a new reflection and an investigation by Jacques Tenon, a French surgeon [11]. The latter, seduced by the Royal Naval Hospital in Plymouth, England, launches the wave of pavilion hospitals: each pavilion is isolated from the others; there is no longer a large concentration of patients. One of the first models of the genre is the Lariboisière hospital in Paris (1846-1854).

The pavilion architecture (the Granges Blanches hospital, Brugmann hospital in Brussels) will be present from 1850 to 1930. The end of the 19th and the beginning of the 20thcentury is the time of: industrialization; land speculation; the birth of unions; ventilation techniques and artificial lighting. It is the death warrant of the pavilion.

The first hospitals of a new type, the monobloc hospital (1930-1970), were created in America: New York Hospital (1929) and Los Angeles Hospital (1932). In France, the first model of this type was Beaujon (1934), then La Cité hospitalière de Lille (1934). Techniques were developing. It was imperative to reduce travel. 1970 was the birth of the compact hospital, the most representative model of which was the Bichat hospital in Paris. This is the model of the "Tree" hospital, with: its different levels (earth/ground); its logistics; its roots (technical platform); its trunk of vertical circulation; its branches (hospitalization).

Thus, the institutional architecture of a public health establishment can vary depending on several parameters, such as for example the level at which one is located on the pyramid, as illustrated in the diagram below (Figure 1).



Source: Ministry of Health in *Tandi, et al.*, 2015.
Figure 1: The structure of the health system in Cameroon [13].

The diagram represents the structure of the health system. The primary, secondary and tertiary levels are also designated by the levels: central; intermediate; and peripheral. The central (tertiary) level is under the supervision of the Ministry of Public Health and defines the strategies, coordination and regulation of public health policies. The intermediate (secondary) level coordinates activities at the regional level and supervises technical support to the 10 regional delegations of Public Health. The peripheral (primary) level brings together the operational health formations, which are in charge of the implementation of national health policies [13].

This will result in more elaborate and complex structures from an administrative and organizational point of view, at the level of General/Central Hospitals, University Hospitals, etc. And more simplified structures at the level of District Hospitals, District Medical Centres (CMA), Integrated Health Centres/Dispensaries, etc.

The Hospital, a Separate Organization

The hospital is an organization, as a set of actors focused on common general objectives which, to achieve them, resort to a division of labour and to methods of coordination and control.

The RIH (Internal Regulations of Hospitals), in its Article 2 (2011) stipulates that: " *The hospital constitutes an integrated element in the national health system. To this end, it is the focal point of support for basic health care. It receives patients referred by the less specialized primary level in order to benefit from specialized skills and technical facilities and it refers to the primary level patients whose state of health allows it in order to ensure continuity of care*".

According to Henry Mintzberg, a management specialist, the hospital is one of the so-called multi-purpose and multi-agent organizations. It is a complex structure that must respond to various functions: care, teaching, research, prevention, health education, etc. Thus, beyond its true vocation, the hospital manages a series of other missions that are necessarily linked to the first and that all contribute to the smooth running of the latter, towards achieving its primary objective: optimal and comprehensive care of the patient.

The Organizational Structure of the Hospital

The hospital is a complex structure, identified by Mintzberg as part of professional bureaucracies. In his book *Management, a Journey to the Centre of Organizations,* published in 1989, he defines the organization as a collective action in pursuit of the achievement of a common mission, and the structure as the sum total of the means used to divide the work between distinct tasks and then to ensure the necessary coordination between these tasks. Subsequently, he represents the 6 (six) components of the organization in a buffer-shaped diagram as illustrated below [14,15] (Figure 2).

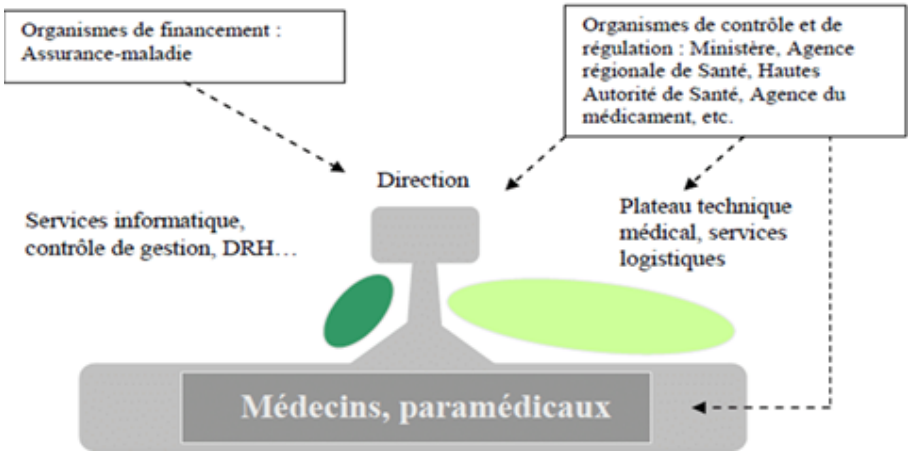


Figure 2: Professional bureaucracy applied to the hospital [15].

The Strategic Summit

As its name suggests, the strategic summit is located… …at the top of the company! It is the management body of the organization, where decisions are made. Its goal is to ensure that the organization fulfils its mission effectively.

In hospitals, this may include the supervisory authorities (health department, etc.), the head of the establishment and his team, including the director of care, general care coordinator. The latter " *...is appointed by the head of the establishment. Under the latter's authority, he exercises general coordination functions for nursing, rehabilitation and medical-technical activities. He is a member of the management team and has hierarchical authority over all health managers delegated by the head of the establishment* " [16].

The Hierarchical Line

The hierarchical line is made up of the management of the organization. Indeed, these are the company's executives who serve as a transmission belt between the strategic summit and the operational centre. These are the managers who supervise the operators, but also managers who supervise other managers. The hierarchical line embodies the voice of the strategic summit and aims to spread its message to the teams located at the bottom of the hierarchical pyramid.

The notion of hierarchy underlies that of subordination and therefore of authority. For example, in the coordination of care, doctors and nurses report on their actions to senior managers who are their heads of department and who participate in their evaluations. In the same way, all heads of department exercise their functions under the authority of the general director.

The Operational Centre

The operational canter is the basis of any organization. It consists of the members of the organization with operational tasks (in other words, workers, professionals or operators), that is, tasks directly related to the production of goods or services.

In a hospital structure, it is made up of care units and medical-technical services. Composed of a large number of services, as well as the greatest number of medical, paramedical and medical-technical professionals, it constitutes the real hub of the hospital, due to its direct relationship with the client and their environment. By client, understand the patient to whom the hospital services are offered for a fee.

The Technostructure

Within the organization, the technostructure's mission is to serve the organization by providing the framework, planning and controlling the work of others. It therefore has an impact on the work of others (especially the operational canter). Overall, it corresponds to the Human Resources department. It thus brings together functions ranging from recruitment to planning, including training and the establishment of regulations within the organization.

These are analysts and specialists who carry out administrative tasks and who coordinate/control the work of others, such as the medical information department or the management control unit.

Logistics Support Functions

Support functions correspond to other functions. They have neither the purpose of providing the working environment nor an operational purpose. For example, the legal department, the maintenance department, the catering department, the IT department, the logistics department, the communications department, etc.

In short, these are units of personnel performing ancillary functions, necessary for carrying out the mission of the entire hospital organization.

6th part: The Ideology of the Organization

Ideology (often forgotten, even neglected), according to Mintzberg corresponds to what is also *called " culture "*. It is made up of the traditions, values and beliefs of an organization. It is what distinguishes one organization from another organization, its " *soul*

" so to speak, because it is what gives the organization a certain form of life.

NB: Actors located inside the company can make decisions or implement actions. They are influential people who form an internal coalition.

Hospital Governance: How is a Hospital Run?

The Hospital, Patients, Health and Territories (HPST) law of July 21, 2009 redefines the governance bodies of public health institutions [17]. Hospitals now have a Supervisory Board (SC) and are managed by a director, assisted by a Board of Directors. The hospital management activities, which are the responsibility of the Board of Directors, are separated from the control activities, entrusted to the Supervisory Board. The composition and missions of these bodies are defined by the Public Health Code, in its articles L6143-1 to L6143-8 [18]

The Organization of the Hospital: Who are the Actors?

The hospital is both a guarantor of social cohesion (via the treatment of illness and the prevention of epidemics), in search of greater performance (via the quality of care) and a strong symbolic place (via equal access to care and technical performance offered to all).

Hospital stakeholders are increasingly differentiated between "decision-makers" and "social stakeholders". Once dominant, doctors and employee unions have seen their role diminish, with decision-makers increasingly external to the establishments - regional hospital agencies, victims' associations, economic lobbies.

For hospital staff, it is necessary to move quickly, to meet the challenges of modernization, evaluation, automation, profitability, in a relationship with patients that is sometimes rewarding, sometimes trying. In addition to professional logic, there are departmental affiliations, participatory systems and new patient rights [19].

Many bodies are involved in the organization of the hospital. This is the case, for example, in France, for the law on hospital reform and relating to patients, health and territories, better known as "*Hospital, patients, health and territory* ", abbreviated to HPST [20]. This law results from the General Review of Public Policies (RGPP) which can be summarized in four main points, including: the modernization of health establishments; the improvement of access to quality care; prevention and public health; the territorial organization of the health system.

The Director

The director, chairman of the board of directors, leads the general policy of the establishment. He represents the establishment in all acts of civil life and acts in court on behalf of the establishment. He has the authority to:

a) To regulate the affairs of the establishment other than those listed in numbers 1° to 15° and other than those which fall within the competence of the supervisory board listed in article L. 6143-1. He participates in the meetings of the supervisory board, whose deliberations he carries out.

b) Exercise authority over all staff in compliance with the ethical or professional rules that apply to health professions, their responsibilities in the administration of care and the professional independence of the practitioner in the exercise of his art;

c) Order the establishment's expenditure and revenue. He has the power to compromise. He may delegate his signature, under conditions determined by decree.

d) By way of exception, the director of the group's support establishment exercises these powers on behalf of the healthcare establishments that are part of the territorial hospital group, for all of the activities mentioned in Article L. 6132-3;

e) The director of the establishment or the group's support establishment may delegate his powers to a member of the management team in application of 5° of II of Article 25 bis of Law No. 83-634 of July 13, 1983 on the rights and obligations of civil servants if he considers himself to be in a situation of conflict of interest within the meaning of the same Article 25 bis. He shall inform the supervisory board and, where applicable, the supervisory boards of the other healthcare establishments that are part of the group.

After consultation with the board of directors, the director:

1. Concludes the multi-year contract mentioned in Article L. 6114-1;
2. Decides, jointly with the chairman of the medical committee of the establishment and in liaison with the chairman of the nursing, rehabilitation and medical-technical care committee, on the policy of continuous improvement of the quality and safety and relevance of care, as well as the conditions of reception and care of users;
3. Establishes the single social report and defines the terms of an incentive policy;
4. Determines the investment program after consulting the medical committee of the establishment and the nursing, rehabilitation and medical-technical care committee with regard to medical equipment and submits it for approval to the supervisory board;
5. Sets the statement of revenue and expenditure forecasts provided for in Article L. 6145-1 and the overall multi-year financing plan, after consulting the supervisory board;
6. Closes the financial account and submits it to the supervisory board for approval;
7. Determines the internal organization of the establishment. With regard to clinical and medical-technical activities, the di-

rector and the president of the establishment's medical committee jointly determine the internal organization and jointly sign the activity canter contracts in application of Article L. 6146-1;

8. May propose to the director general of the regional health agency, as well as to other health establishments and professionals, the establishment and participation in one of the forms of cooperation provided for in Title III of Book I of this Part or in the coordination support mechanisms and specific regional mechanisms mentioned in Articles L. 6327-2 and L. 6327-6;
9. Concludes acquisitions, disposals, exchanges of real estate and their allocation as well as leases of more than eighteen years;
10. Concludes long-term leases pursuant to Article L. 6148-2, partnership contracts pursuant to Article 19 of Ordinance No. 2004-559 of June 17, 2004 on partnership contracts and rental agreements pursuant to Article L. 6148-3;
11. Submits the establishment project to the supervisory board;
12. Concludes the public service delegations mentioned in Article 38 of Law No. 93-122 of 29 January 1993 relating to the prevention of corruption and transparency in economic life and public procedures;
13. Establishes the internal regulations of the establishment;
14. In the absence of an agreement on the organization of work with the trade union organizations representing the staff of the establishment, decides on the organization of work and rest times;
15. Submits to the regional health agency the recovery plan mentioned in the first paragraph of Article L. 6143-3;
16. Establishes the plan detailing the measures to be implemented in the event of an event leading to a disruption in the organization of care, particularly during exceptional health situations, mentioned in Article L. 3131-7;
17. Submits to the supervisory board the acquisitions of interests and the creation of subsidiaries mentioned in Article L. 6145-7.
18. Defines, after consulting the chairman of the establishment's medical committee, the conditions for carrying out and supervising activities involving the presentation, information or promotion of health products or training, in particular in their use, particularly with a view to compliance with the charters mentioned in Articles L. 162-17-8 and L. 162-17-9 of the Social Security Code.

Health establishments also have consultative bodies, such as:

a. the Medical Establishment Committee (CME);
b. the Technical Establishment Committee (CTE);
c. nursing, Rehabilitation and Medical-Technical Care Commission (CSIRMT),
d. the Health, Safety and Working Conditions Committee (CHSCT)
e. the Committee for The Fight Against Nosocomial Infections (CLIN)

The Directory

The Board of Directors, also called the Board of Directors (CD) or Executive Council (CE), is the hospital body that advises the Director in the management and daily running of the establishment. A collegiate body, the Board of Directors is a place for exchanging managerial, medical and nursing points of view [21]. It is responsible for developing the medical strategy and management policy, and is responsible for steering the establishment, both in relation to the supervisory authorities (multi-year contract of objectives and means, statement of revenue and expenditure forecasts, etc.) and internally (contractualization policy with the divisions). This steering involves:

1) Monitor the application of establishment policies (quality - security, reception, management, etc.);
2) Set objectives for the poles/different services;
3) Evaluate the results of their implementation.

In accordance with the Public Health Code, article L6143-7-5, the board of directors is composed of ex officio members on the one hand, and of members of the establishment's staff, including a majority of members of the medical/paramedical/pharmaceutical staff/, on the other hand, according to the guidelines of the Public Health Code, in its Article L6143-7-5 [18]

Members by Right

1. The Director: Chairman of the Board of Directors
2. The President of the Medical Establishment Commission (CME), Vice-President
3. The President of the Nursing, Rehabilitation and Medical-Technical Care Commission (Care Coordinator, General Supervisor, etc.)

Elected Members

The number of elected members may vary depending on the importance and specific characteristics of each hospital establishment (category; obedience (public, private, religious or secular, etc.); etc.).

The director may also, on the advice of the chairman of the medical committee of the establishment and after consultation with the board of directors, appoint up to three qualified persons, who may be representatives of users or students. These persons participate in advisory capacity in the meetings of the board of directors.

The Board of Directors' mission is to:

1) Prepare the measures necessary for the development and implementation of the establishment project and the multi-year contract and, as such, the deliberations provided for in Article

L. 6143-1. He coordinates and monitors their execution.

2) Prepare the medical project as well as the training and evaluation plans mentioned in numbers 2° and 3° of article L. 6144-1;

3) Contribute to the development and implementation of the safeguard or recovery plan provided for in Article L. 6143-3;

4) Provide an opinion on the appointment of clinical and medical-technical activity centre managers and department heads;

5) Designate the health professionals with whom the nursing, rehabilitation and medical-technical care committee provided for in Article L. 6146-9 may conduct joint work in matters falling within its competence.

The Board of Directors is required to meet formally, at least once a month, and at any time upon convocation by its Chairman, in the event of an urgent situation requiring reflection and deliberation. And each meeting is the subject of a Minutes of the clauses of its main articulations.

The term of office of the members of the board of directors is determined by Decree/Decision/Service Note/..., according to the practices in force in each organizational context. This term of office ends with the cessation of the exercise of the functions of its chairman, in the capacity of which he was a member of the board of directors.

NB: In the event of a tie, for any decision to be taken following a deliberation, the director has the casting vote.

The Supervisory Board

The CS, also called the Board of Directors (BoD), decides on the strategy and exercises permanent control over the management of the establishment. It deliberates on:

1) The establishment project mentioned in Article L. 6143-2 and, annually, the methods of its implementation within the establishment and its structures, presented by the director and the president of the establishment medical committee;

2) The constitutive agreement of university hospital centres and the agreements entered into pursuant to Article L. 6142-5;

3) The financial account and the allocation of results.

4) Any project tending towards a merger with one or more public health establishments.

5) The annual report on the establishment's activities presented by the director.

6) Any agreement between the public health establishment and one of the members of its management board or supervisory board.

7) The statutes of the hospital foundations created by the establishment.

8) The equity investments and creation of subsidiaries mentioned in Article L. 6145-7;

9) The multi-year investment plan.

He gives his Opinion on:

a) the statement of revenue and expenditure forecasts, the overall multi-annual financing plan and the investment programme;

b) the governance charter mentioned in III of article L. 6143-7-3;

c) the policy of continuous improvement of quality, safety of care and risk management as well as the conditions of reception and care of users;

d) acquisitions, disposals, exchanges of real estate and their allocation, leases of more than eighteen years, long-term leases and partnership contracts mentioned in Article L. 6148-2;

e) the establishment's participation in a territorial hospital group;

f) the internal regulations of the establishment.

The Supervisory Board is Presented Annually with:

1) The observations of the Director General of the Regional Health Agency on the state of health of the population of the territory and on the healthcare provision available there;

2) University, teaching and research activities carried out by the university hospital centre with which the establishment has concluded an agreement under Article L. 6142-5;

3) The assessment, jointly prepared by the director and the chairman of the establishment's medical committee, of the actions implemented by the establishment to improve access to care and the gradation of care, in line with the policy of the territorial hospital group.

The CS is Entitled to:

a) At most five representatives of local authorities, their groups or the metropolis, designated from among themselves by the deliberative bodies of local authorities, their groups or the metropolis, including the mayor of the municipality where the main establishment is located or his representative, the president of the departmental council or his representative, etc.;

b) Up to five representatives of the medical and non-medical staff of the public establishment, including one representative elected from among the members of the nursing, rehabilitation and medical-technical care committee, the other members being appointed on an equal basis respectively by the establishment medical committee and by the most representative trade union organizations taking into account the results obtained during the elections to the establishment social committee;

c) Up to five qualified persons, including two designated by the director general of the regional health agency and three, including two user representatives within the meaning of Article L. 1114-1, designated by the State representative in the department.

The Internal Organization of a Hospital

The traditional organization of the hospital seems less and less relevant, given the growing demands imposed on it by society, the deep aspirations of the staff who work there, and the new context of globalization that characterizes our era.

Also, in the dynamics of promoting comprehensive and optimal patient care, the governing bodies of hospital institutions are required to constantly review the internal organization of this structure, in the service of life. An organization that must ensure the establishment of balanced governance, on the one hand, between the administrative/financial and medical professions of the Hospital and, on the other hand, between the hospital and its environment (local authorities, administrative authorities and users).

Hospitals are organized into activity centres, which gradually replace services and departments. The clinical or medical-technical activity centres are under the responsibility of a tenured practitioner, who has authority over all medical, care and management teams and a management delegation from the director.

In addition to the functions and responsibilities of the governing bodies elucidated above (Director, Board of Directors, CA), within the hospital various bodies contribute effectively to its internal organization, towards the achievement of pre-established objectives. Thus, we can find there: An Establishment Medical Commission (CME); A Nursing, Rehabilitation and Medical-Technical Care Commission; An Establishment Technical Committee; A Hygiene, Safety and Working Conditions Committee (CHSCT); etc.

Noticed

It should be noted that this list is not exhaustive, each hospital establishment being able to create as many bodies as possible, depending on its size/nature/philosophy: its targeted objectives, etc. However, all these components of the internal organization of the hospital must have a common organizational vision which tends all towards achieving the primary objective of this institution: comprehensive care of the patient.

Also, for anyone involved in this internal organization of the hospital, a new project means a new organization and new operation, because reproducing the existing system is excluded from the outset. It will therefore be a question of reviewing, for example:

- the technical platform, the size of which is not the accumulation of the existing, but must take into account the evolution of the activity (number of beds, number of new and old cases received in consultation, new specialties, etc.);
- the patient's circuit, which will have to consider new arrangements, etc.

Special Case of Catholic Hospital Structures

There is no doubt that the first legislator for Catholic health institutions is the Holy Father, through his *"Pontifical council for the pastoral care of health care"*. And the Catholic Church has always perceived the service of the sick as "an integral part of its mission", associating "the preaching of the Good News with the assistance and care of the sick".

Health Workers Charter

The Holy See has updated its "Charter for Health Care Workers," published under the auspices of the Pontifical Council for the Pastoral Care of Health Care in 1995. The new document, updated to consider the ethical issues that have arisen in recent years, was presented on 6 February 2017 at the Vatican. It encourages those in the health care world to promote the "right to health" for all [22]. The text of the new "Charter for Health Care Workers" constitutes a revision and update of this document, while maintaining its original structure, which focuses on the vocation of health care workers as ministers of life. In addition to the advances in medical science and their possible repercussions on human life, issues of a medico-legal and socio-sanitary nature are addressed.

In a message, Cardinal Peter Turkson, Prefect of the Dicastery for Integral Human Development, which now includes the Dicastery for Pastoral Health Care, paid a posthumous tribute to Archbishop Zygmunt Zimowski, signatory of the new Charter. The work, Cardinal Turkson wrote, is "his legacy to the pastoral care of health care and to the world of suffering, to which he devoted so much energy and for which he worked with sacrifice and determination, until the last hours of his earthly existence."

Monseigneur Jean-Marie Mupendawatu, delegate secretary of the Dicastery, explained that this new Charter "reaffirms the sacredness of life". Thus "healthcare workers are (...) servants of life and are called to love and accompany it".

"Freely you have received, freely give" (Pope Francis, Vatican City, December 2018)

In his message for the 26th World Day of the Sick 2018 (February 11), made public on December 11, 2017, Pope Francis presents his vision of a pastoral care of health. Catholic health structures, says the Holy Father, are called to express the sense of giving, gratuity and solidarity [23]

The Church is an eternal *" field hospital"*, irradiated by *"the healing power of Christ"*, Pope Francis repeats. If Mary's maternal vocation is born from the painful mystery of the Cross, this has been realized many times in Favor of the sick during the two-thousand-year history of the Church [24]. *" In countries where public health systems are sufficient, for example, the work of Catholic congregations, dioceses and their hospitals, not only provides quality medical care, but seeks to place the human person at the center of the therapeutic process and carries out scientific research in respect of life and Christian moral values"*, Francis pointed out. From such an observation then arises the need for care, even if *"one can no longer heal "*, and the need for the joy that such a mission should provoke.

Service to the sick includes several aspects, the Pope explains in this message, carefully praising *the " quasi-sacrificial "* generosity of many founders of Catholic health institutes.

After generosity comes creativity, suggested by charity, and commitment to scientific research. *"Above all,"* warns the Pope, " *it is a question of preserving Catholic hospitals from the risk of entrepreneurship, which throughout the world seeks to bring health protection into the context of the market."* **Organizational intelligence and charity must therefore prevail,** so that the sick person may be worthily respected. Indeed, if there is something that Jesus left as a gift to the Church, it is his " *healing power».*

Ethical Loyalty

The new document follows the same pattern as the old one – in three parts: procreation, life, death – explained Antonio Gioacchino Spagnolo, director of the Institute of *Bioethics and Medical Humanities* of the Catholic University of the Sacred Heart of Rome [25]. He presented the new features of the Charter, which reports on the advances in biomedical research and new socio-health realities. The text broadens its spectrum: in addition to the classic figures of health professionals, it is also addressed to biologists, pharmacists, health legislators, etc.

"The Charter," explained Antonio Gioacchino Spagnolo, "aims to support the ethical fidelity of the health professional in the choices and behaviors in which the service of life takes shape." It is about "offering the clearest possible guidelines for the ethical problems to be faced in the world of health in general, in harmony with the teachings of Christ and with the magisterium of the Church."

The "Procreation" section specifies "criteria for infertility care and references to natural methods, not only for fertility regulation but also as methods for achieving pregnancy." Topics covered include: freezing of ovarian tissue as an "ethically acceptable response to oncological therapies that may impair female fertility"; new attempts at human generation in the laboratory, procedures "morally unacceptable"; preimplantation diagnosis, "expression of a eugenicist mentality which legitimizes selective abortion to prevent the birth of children affected by various diseases."

The second section, "Life," confirms "the long-standing position on abortion by inserting new articles on embryonic reduction, interception, contra gestion, anencephalic foetuses, ectopic pregnancies, protection of the right to life."

The Charter, continued Antonio Gioacchino Spagnolo, also addresses "the issue of access to medicines and technologies" for populations in developing countries. It encourages health professionals to "promote awareness among institutions, social welfare organizations, and the health industry, so that the right to health protection is extended to the entire population and we achieve health justice." The text emphasizes the role of the "clinical ethics consultation" (art. 140) which promotes the resolution of problems "through shared diagnostic and therapeutic choices at the patient's bedside, within the framework of the values of medicine and ethics."

Finally, the last section, which concerns the terminally ill, deals with nutrition and hydration; the anticipated expression of the patient's wishes regarding their treatments; the ethical nature of deep palliative sedation in the phases close to the moment of death. In the background of this section, Antonio Gioacchino Spagnolo specified, there is "the sense of respect for the patient in the final phase of his life, excluding and anticipating death (euthanasia) and/or prolonging it through therapeutic obstinacy".

NB: From all the above, it is important to remember that the organization of the hospital must always consider the organizational context, which includes elements that can have a direct or indirect, positive or negative impact on an organization:

Conclusion

The Hospital is a professional bureaucracy type organization [26] with multiple and heterogeneous components, with a diversity of profiles of the different actors who rub shoulders on a daily basis: doctors, surgeons, pharmacists, nurses, laboratory technicians, maintenance workers, administrators and others. A good hospital manager, who wants to succeed in a competitive environment, must take into account this hetero-complexity, in this particular institution *"where neither error nor delay are tolerated, due to a vital prognosis that can be engaged at any time"* [27]. And if, in the pyramid scheme of an organization, it is a brain (manager) that functions and speaks on behalf of all, - the others tend to go into standby mode and are generally considered intelligent only if they obey the boss -, a hospital manager should absolutely avoid this kind of operation. It will be in his interest to make the three main professional components (medical, nursing and administrative) work and converge towards their reason for being within this institution: optimal and comprehensive care of patients. In this scheme, managers (directors, medical advisors, general supervisors, etc.) play a leading role in adapting the organization of Catholic hospital institutions to their primary identity as institutions serving life, not death.

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Conflict of Interest

None.

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