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The Social Beauty of Children's Hospitals

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ABSTRACT. In the nineteenth century, the great French writer and philosopher Victor Hugo in his immortal novel *Les Misérables* introduced a profound idea of Social Beauty. This concept, rooted in principles of justice, compassion, and collective solidarity, posited that humanity could construct a world governed by moral and ethical harmony. A century and a half later that very *Beauty* was revived within children's hospitals. This study explores a distinctive phenomenon: the formation of a milieu where professional excellence and interpersonal harmony coalesce among healthcare providers, patients, administrative staff, and governing bodies. Based on five decades of author's international experience, a philosophical and economic model of healthcare organization is presented. The Children's Hospital Public Economy Model places humanity, care, and trust at its core. The model undergoes rigorous analysis, outlining its key principles, structural components, strengths, and vulnerabilities. A comparative assessment of institutions operating under different methodologies demonstrates how the underlying values of a system directly influence its outcomes. Moreover, the study advances the proposition that the principles embodied in pediatric hospitals may serve as a foundational paradigm for societal organization at large. Illustrative examples are provided, showing the expansion of this model from a single medical institution to a nationalwide network of children's hospitals in Canada. Thus, the article provides contributes to interdisciplinary discourse at the intersection of medical ethics, organizational theory, and social philosophy, proposing a replicable model that could be a roadmap for sustainable health and social development, bringing modern society closer to the point where the ideals envisioned by Victor Hugo are not merely imagined, but institutionalized.

KEYWORDS: Public economy, Social Beauty, Children's Hospital Public Economy Model (CHPEM), children's hospitals, pediatric healthcare, altruistic leadership, human nature, moral incentive

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Красота общественного строя детских больниц

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РЕЗЮМЕ. Опираясь на многолетнюю практику работы в детских медицинских учреждениях разных стран, автор описывает понятие «красоты общественного строя» — особой атмосферы заботы, взаимопомощи и человечности, присущей детским больницам, рассматривая ее как противоположность коммерциализации и отчужденности, усиливающихся в современной медицине. На основе анализа накопленного опыта в статье формулируется базовая концепция организации работы детской больницы, направленной на максимально эффективное и успешное функционирование. Предлагаемая концепция формулируется как целостная философско-экономическая модель медицинской деятельности, в центре которой находятся человек, забота и доверие. Концепция, которая была разработана на основе наблюдения, анализа и обобщения успешных практик, рассматриваемая как интегральная система, получила название общественно-ориентированной экономической модели детского здравоохранения (ОЭМДЗ). Представленная модель охватывает не только финансовые и управленческие методы, но и включает нравственные принципы построения рабочих взаимодействий. Модель подвергается всестороннему анализу, в котором раскрываются ее основные принципы, структурные компоненты, выявляются сильные и уязвимые стороны, а также проводится сравнительный разбор эффективности одних и тех же учреждений, работающих по различным методикам, что наглядно показывает, как ценности, лежащие в основе системы, непосредственно влияют на ее результаты. В статье раскрывается уникальный феномен формирования среды, в которой достигается гармония профессиональных и межличностных отношений между медицинским персоналом, пациентами, административными работниками и руководством учреждения. Показан существенный трансформационный потенциал модели, выходящий за рамки единичных медицинских учреждений, способный служить фундаментом для формирования эффективных кооперации между больницами, а также для развития региональных и национальных систем здравоохранения. Теоретическое обоснование предполагает, что системное внедрение принципов ОЭМДЗ способно привести к структурным изменениям в организации социума, создавая более эффективную и гуманную модель общественного устройства.

КЛЮЧЕВЫЕ СЛОВА: общественная экономика, красота общественного строя, общественно-ориентированная экономическая модель детского здравоохранения, ОЭМДЗ, детские больницы, детское здравоохранение, нравственные принципы, нравственная мотивация, гармония профессиональных и межличностных отношений

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ABOUT THE AUTHOR

Dr. Robert Rennebohm is a pediatrician and pediatric rheumatologist whose name has become synonymous with hope for patients affected by Susac's syndrome — a rare and poorly understood autoimmune disorder characterized by a triad of encephalopathy, retinal vasculopathy, and cochlear dysfunction Today, Dr. Rennebohm is recognized as one of the world's most respected and distinguished experts on this condition. His recommendations are widely applied, and patients and clinicians worldwide seek his professional advice.

Despite his demanding international schedule, Dr. Rennebohm actively contributes to advancing evidence-based pediatric rheumatology in Russia, serving as a visiting professor at the St. Petersburg State Pediatric Medical University and providing care to children in St. Petersburg.

Robert Rennebohm received his MD from the University of California, San Diego School of Medicine in 1972. He subsequently completed his pediatric residency training at IWK Children's Hospital at Dalhousie University in Halifax, Nova Scotia , followed by fellowship in pediatric rheumatology at Cincinnati Children's Hospital Medical Center.

Early in his career, Dr. Rennebohm played a key role in the development of pediatric rheumatology while working at Beijing Children's Hospital in China. He then spent two decades at Nationwide Children's Hospital and Ohio State University in Columbus, Ohio, where he served as Associate Professor of Pediatrics and Chief of Pediatric Rheumatology.

Since 2008, he was Clinical Professor of Pediatrics and Pediatric Rheumatology at Alberta Children's Hospital in Calgary, Canada. A few years later, he joined the pediatric rheumatology department at Cleveland Clinic, where he founded the unique International Susac Syndrome Consultation Service. Here, under the leadership of Dr. Rennebohm, an innovative interdisciplinary approach to patient care was developed.

A defining aspect of Professor Rennebohm's approach is his principled scientific openness, reflected in his willingness to engage in productive dialogue and his respect for all reasoned perspectives. Dr. Rennebohm shares not only his achievements but also the difficult lessons that clinical practice has taught him. He keeps consistently emphasizing the importance of considering all informed alternative opinions as valuable resources for the further development of the healthcare economic model he is advancing.

We invite everyone willing to share their knowledge, pose challenging questions, and collaborate in the pursuit of balanced answers to join this open scientific dialogue. Whether critical or supportive, all professional observations and comments are sincerely welcomed.

INTRODUCTION

I have had the great privilege of spending my 50 year Pediatrics career working in Children's Hospitals — seven children's hospitals, in four countries, on three continents: IWK Hospital for Children (Halifax, Nova Scotia, Canada), Cincinnati Children's Hospital (Cincinnati, Ohio), Columbus Children's Hospital (Columbus, Ohio), Alberta Children's Hospital (Calgary, Alberta, Canada), Cleveland Clinic Children's Hospital (Cleveland, Ohio), Beijing Children's Hospital, and Saint Petersburg State Pediatric Medical University and Children's Hospital (St. Petersburg, Russia).

I mention this because it is the *Social Beauty* that I have experienced in Children's Hospitals that gives me confidence that it is possible for increased Social Beauty to be created in the larger society and in the world as a whole [1, p. 88–98]. I believe the social philosophy, spirit, leadership approach, social behavior, and economic model of Children's Hospitals [1, p. 109–122], individually and collectively, can serve as *an inspirational and practical social and economic model* for society at large [1].

The Children's Hospital economic model is not just an idealistic pie-in-the-sky idea. It has already been developed, implemented, and successfully practiced by pediatricians for many decades, to the great benefit of society. It has already proven to be practical, affordable, and realistic. In fact, as I will explain in a moment, it is impractical and unrealistic to expect Children's Hospitals to optimally serve children if those hospitals embrace and

practice a corporate social and economic model. I say that because my pediatrician colleagues and I have personally experienced how Social Beauty has been sacrificed and children have ceased to be optimally served, when altruistic Children's Hospitals have been transformed into corporate institutions, governed by corporate beliefs, directives, and behaviors. Our experience in Children's Hospitals has, by extension, strongly suggested that it is impractical and unrealistic to expect Humanity and general economies to be optimally served by a corporate social and economic model.

It is, therefore, proposed that Humanity could create and enjoy much more Social Beauty if the world were to implement and emulate the social philosophy, social behaviors, and economic model of Children's Hospitals. As explained in accompanying articles, the Children's Hospital model could be called the *Children's Hospital Public Economy Model (CHPEM)* [1].

CHILDREN'S HOSPITALS DURING TWO DIFFERENT ERAS

During the first 25 years of my pediatrics career, Children's Hospitals were bastions of altruism. During the last 25 years, or so, many children's hospitals have increasingly become bastions of corporate activity. I have personally experienced both phenomena, including transitions from one to the other. In the process I have learned much about human nature, economic models, moral incentive vs. monetary incentive, corporate behavior, and what I came to value as "the most precious freedom" (at least for me and for many pediatricians, pediatric nurses, and health care workers) [1].

First I will share what I noticed, felt, and learned during the 25-year "Social Beauty Era" (or "Altruistic Era." Then I will share what I learned and felt during the "Corporate Era."

THE SOCIAL BEAUTY ERA (ALTRUISTIC ERA)

I call it an honor and privilege to work in children's hospitals because, during the Social Beauty Era, the social philosophy of children's hospitals [1] (in all of the countries and continents in which I have worked) was based on a *positive understanding of human nature* — an understanding that *upregulated the expression of and gave practice to the best capacities of our human nature* [2]. The motivating force in children's hospitals was a *moral incentive* to meet the health needs of children in an exemplary fashion [1]. Physicians, nurses, technicians, administrators, clerical personnel, janitorial staff all worked and contributed out of *a willing sense of social duty*, a desire to be part of a *deeply meaningful* social effort. They did not need or want monetary incentive. They simply expected an appropriate salary. Great *creativity* and *innovation* naturally occurred out of a commitment to increasingly serve children better. *Altruism* was the naturally assumed behavioral practice — so natural, so assumed, and so beautifully practiced that the word "altruism" did not need to be uttered or written — it just naturally flowed through the hospital, inspiring best behaviors and lifting spirits of everyone, including, most importantly, the children and their parents. I was able to enjoy what for me is *the most precious freedom* [1]. Our work was an intellectual and social pleasure.

While *Beijing Children's Hospital (BCH)* was under the leadership of Dr. Zhu Fu Tang, it exemplified the Social Beauty Era and exemplary practice of the Children's Hospital Public Economy Model (CHPEM). One of the greatest experiences I have ever had as a pediatrician were the 2 months I worked at BCH in 1981. Dr. Zhu Fu Tang had invited me to help BCH and other children's hospitals in China develop the subspecialty of pediatric rheumatology. I have never met more knowledgeable, more altruistic, more dedicated, or kinder pediatricians than those I met in 1981. I have never worked in a more admirable hospital than the BCH of 1981.

Dr. Zhu Fu Tang (1899–1994) founded BCH in 1955. He was the first Chairman of Pediatrics at BCH and is the most highly respected and revered pediatrician in China's history. In 1943 he published China's most important Textbook on Practical Pediatrics.

Dr. Zhu exemplified a pediatrician who was not only a brilliant clinician, teacher, and researcher, but also demonstrated extraordinary character, social insight, wisdom, and leadership ability. He was a "natural leader", meaning that he had an innate and practiced ability to kindly, compassionately, fairly, effectively, humbly, competently, and inspiringly lead others, and was incorruptible [1]. Among Dr. Zhu Fu Tang's many gifts was his ability to accurately recognize which pediatricians at BCH had an abundance of empathy, were particularly kind and altruistic, and were natural leaders — in addition to being excellent clinicians [3]. He possessed the wisdom to make sure that positions of leadership (at BCH and at other children's hospitals in China) were populated by excellent clinicians who were natural leaders and demonstrated exemplary humility, unselfishness, honesty, and incorruptibility.

He was very careful to not put physicians in positions of leadership or power if they tended to be opportunistic, arrogant, egotistical, short on empathy, dishonest, unprincipled, or corruptible, even if they were otherwise very intelligent and academically accomplished. He fully appreciated the importance of altruism. He purposefully created a culture that fostered unselfishness and transformed behavior in the direction of altruism. He fully appreciated how a culture of opportunism, one that emphasized monetary incentives and revenue generation, could transform physicians to become less empathetic, less altruistic, and less effective. At the same time, however, he strongly and wisely warned against the overzealous and intolerant insistence on altruism that, later, often occurred, often abusively, during the Cultural Revolution (1966–1976).

During the Social Beauty era, *IWK Children's hospital, Cincinnati Children's Hospital, Columbus Children's hospital,* and *Alberta Children's Hospital* also exemplified the Children's Hospital Public Economy Model (CHPEM). During the Social Beauty era Cincinnati Children's Hospital was one of the most highly respected children's hospitals in the world and proved that great innovation and creativity could occur under the CHPEM. For example, it was at Cincinnati Children's Hospital that Albert Sabin, a salaried academic physician, developed the oral polio vaccine.

To this day, pediatricians at the *Children's Hospital at Saint Petersburg State Pediatric Medical University* still exemplify the spirit and behaviors of the Children's Hospital Public Economy Model (CHPEM).

THE CORPORATE ERA

Unfortunately, over the past 25 years, the Social Beauty model (the CHPEM) has increasingly been sabotaged and replaced by a corporate model (sometimes gradually and insidiously, sometimes precipitously, sometimes partially, sometimes wholly) in many Children's Hospitals, particularly in the USA. The characteristics of the corporate model, and the transition towards that model is exemplified by what transpired at Columbus Children's Hospital (since renamed Nationwide Children's Hospital), where I worked from 1986–2008 [1, p. 116–122].

This transition started in the late 1990s. The hospital's Board of Directors (which consisted predominantly of current or former corporate leaders, wealthy entrepreneurs, and wealthy philanthropists) decided that the hospital could become better, wealthier, and more efficient if it adopted a corporate philosophy and corporate behaviors and business practices. The idea was to run the hospital like financially successful corporations have been run. Advice was sought from a powerful international corporate consulting firm. One revenue-generating policy that was encouraged was to invest most heavily in subspecialty programs that had the greatest potential for increasing revenues (i.e., procedure-oriented programs whose procedures were generously reimbursed by insurance companies) and to invest less in subspeciality programs whose activities were not so generously reimbursed by insurance companies. This policy failed to honor the principle that all ill children need optimal help regardless of how much revenue their care might generate.

Monetary incentives were greatly emphasized. Physicians were expected to increase their generation of revenues, by seeing more patients, maximizing fee-for-service billing, and reducing activity for which they could not bill. Educational sessions were devoted to learning how to "maximize billing opportunities".

Notably, a new policy was developed regarding the scheduling of outpatient visits. This scheduling policy was based on the fact that payment (by health insurance companies) for a 60 minute evaluation of a "new patient" was greater than the payment for three 20 minute "follow-up" visits. This meant that a physician could generate more revenue for the hospital by loading his/her daily clinic schedule with many "new patient" visits, rather than many "follow-up" visits. Physicians were encouraged to schedule as many new patients as possible and reduce follow-up appointments, so that their daily clinic schedules could increasingly become populated by new patient evaluations. This policy does not honor the great need for and importance of follow-up visits. The Chief of one of our pediatric subspecialty divisions was highly praised as an institutional "hero" for optimally implementing this scheduling policy in his division. All other subspecialty divisions were strongly encouraged to emulate the "hero's" subspecialty division.

Another measure to increase revenue generation was to discourage physicians from spending time doing research, if that research was not funded by a grant. Unfunded research could be done, but only on a physician's own free time, not on "company time". This policy failed to honor the principle that research is an essential part of academic pediatrics, whether it is funded or not. Furthermore, there is no funding available for many worthy research projects. This policy resulted in a significant reduction in unfunded research activity.

Columbus Children's Hospital is a teaching hospital associated with the Department of Pediatrics at Ohio State University School of Medicine. The physicians employed by the Department of Pediatrics and the Children's Hospital are academic pediatricians. One of their responsibilities is to teach pediatric medicine to medical students and residents. Although there was no specific policy to reduce the amount of time physicians spent teaching medical students and residents, the academic pediatricians quickly realized that it was very difficult to meet onerous revenue generation expectations if they spent a generous amount of time teaching. (Teaching is a "non-billable" activity.) As a result, teaching suffered. Teaching the next generation of physicians is an extremely important responsibility of a medical school and department of pediatrics.

Another policy change was that naturally altruistic leaders, who were not inclined to emphasize monetary incentive and revenue generation, were replaced by leaders who were very enthusiastic about implementing corporate practices and policies. Altruistic leaders were "not a good fit" for the new corporatized institution. Leaders with business savvy who were particularly excited about revenue generation were desired, and they elevated like-minded individuals to positions of power. Soon, the majority of leadership positions throughout the institution were populated by those who were most committed to revenue generation and a corporate culture. Those who were most altruistic were increasingly marginalized, even punished.

One particularly altruistic pediatrician was sent to a clinic in Kansas that is devoted to evaluation of impaired physicians. That pediatrician's "impairment" was "difficulty adjusting to change" and resistance to change — the change being the transition from an altruistic institution to a corporate institution. After an intensive week-long evaluation, the Kansas clinic's final diagnosis for this pediatrician was "pathological altruism".

Because of policies like those explained above, there was a change in how physicians were viewed and evaluated. Prior to the late 1990s (i.e., during the Altruistic Era) academic pediatricians were *physicians who served patients*. We then became "*medical providers*" who *served* "*clients*". Then, even worse, we became "*revenue generators*" who *served the corporation* (during the Corporate Era).

Incidentally, another corporate decision was a clever change in the name of the hospital. Since the Nationwide Insurance Company, which is based in Columbus, was providing a large amount of funds for the corporate transformation of the hospital, it was decided to change the name to Nationwide Children's Hospital.

To be fair, it is true that during the corporate era, the new Nationwide Children's Hospital grew tremendously, regarding the size of faculty, size of physical plant, quantity and breadth of clinical services, amount of funded research activity, and national and international prestige. This was due to the enormous infusion of money from corporate entities and philanthropists. *However, it is important to realize that equal or better improvements could have been accomplished, without sacrificing fundamentally important principles, if the same amount of money had been made available to improve and expand the original, non-corporatized Columbus Children's Hospital under the leadership of altruistic pediatricians*. It was not the corporatization of the hospital that improved its size, scope, and prestige — it was the enormous infusion of corporate money that made that possible.

CONCLUSION

Altruistic pediatricians, pediatric nurses, and children's hospital workers know how well the Children's Hospital Model worked during the Social Beauty Era. We have thoroughly experienced it; we have lived it; we have practiced it, with great success, internationally, at an affordable price for society. We have confidence in it.

We also know what happens when the Social Beauty Era Children's Hospital Model is replaced by a Corporate Era Model. We have experienced that transition. We can predict with confidence and accuracy what will happen.

We also know the root cause of the corporate model's side effects and its hold on power [1]. For these reasons we should feel confident in proposing that the Social Beauty Era Children's Hospital social and economic model — what we will refer to as the Children's Hospital Public Economy Model (the CHPEM) in accompanying articles — is a practical and realistic model for creation of Social Beauty in society as a whole and that the corporate social and economic model is not [1]. Indeed, the corporate model has failed in health care and is increasingly failing to create widespread Social Beauty in the world as a whole (look at all the horrible wars, as just one example) [1].

ADDITIONAL INFORMATION

The author read and approved the final version before publication.

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