The Construction of Lines of Care and the Hospital Medicine

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What is the role of Hospital Medicine in the construction of Lines of Care for patients with chronicle diseases?

Abstract

In a context of Brazilian public primary care that does not provide effective preventative care to general population, this report aims at describing the implementation of a project of hospital medicine based on models of Hospitalist movement in a tertiary Hospital, with a profile of complex and mostly older patients, and at providing care that focus on patient security, with humanized and global assistance, objecting better outcomes on assistance and care.

The intervention resulted in substantial reduction in length of stay and in improving quality of care and satisfaction of most patients included in the project.

Introduction

The principal Brazilian health system is the Sistema Único de Saúde (Unique Health System) which has as a manager the Brazilian Government. However, the health legislation allows a complementary health system: the private health system.

The complementary health system has its own legislation and a regulatory organ different from the Sistema Único de Saúde (Unique Health System). Its principal operational characteristics are (a) independent functioning among the Health Units,(b) relationships among the punctual based on commercial or operational agreements to meet their own interests,(c) the patient has access to any of the Units,(d) the criterion applied to the choice of the access suffers the influence of lay opinions and marketing campaigns,(e) there is a strong appeal to the choice of medical specialties and to high

complexity exams,(f) the Health Services have infrastructure directed to the acute clinical conditions and to the invasive therapies.

This way, the Complementary Health System is fragmented, with the predominance of the Health Units interest, has access to the Health Services defined by non-medical criteria, has a predominant choice of the medical specialties and high complexity exams, and has medical services with focus on the invasive therapies of the acute illnesses.

The operational and economic result of this system is being costly and not having focus on the patient.

The case of Hospital da Cruz Vermelha do Paraná (Red Cross Hospital of Paraná State) develops in this inhospitable environment of the Complementary Health, and it will be analysed by the light of the Complexity, Decision Making and Learning Theories.

Hospital as a complex and professional organisation

The complex systems are organised in networks formed by several agents, who are active and autonomous elements whose behaviour is determined by a set of rules and by the pieces of information in relation to their performance and to the environment conditions. The system global behaviour emerges as an effect of the combination of the interactions among the diverse components (STACEY, 1996; LISSACK; GUNZ, 1999).

The organisations like hospitals have a structure which fits better in a format called professional, managed by a high complex operational work, despite being stable when done. The professional organisations are linked to a flexible way in their operational nucleus, some of them feebly united and other ones strongly united (WEICK, 1976).

Therefore, a hospital is a complex organisation, in which professionals of the Health area, of the administrative and support area act in sectors and services which relate to each other in a network system. These sectors and services have their own structural and functional characteristics, with simple or complex nature. The relationships among the diverse sectors and assisting, managing and supporting services have elements which qualify them as strongly united or feebly united (PERROW, 1986).

Only after a deep analysis of the organisational network of the hospitals, understanding its dynamics, its degree of dependence, the circumstances in which its links are weak and, consequently , identifying which systems are strongly united or feebly united it is possible to know the reality of the organisational structure of the organisation (PERROW,1986).

In order to survive in such a competitive environment, and to defend themselves against threats, the hospitals develop creative systems and with a self-organisation characteristic (STACEY, 1993; AGOSTINHO, 2003). The ability to create must be embedded in its structure, by means of three systematic practices: improving, exploring and innovating. These are the necessary conditions for the arising of the emerging strategies with base on the institutional learning.

The Learning in a Complex Organisation - Hospital

For Stacey (1996), the complex adaptive systems consist of a number of components or agents which interact among them, according to a set of rules which demand them to examine the behaviour of each one, and to answer to it , in order to improve the behaviour of the group , and consequently of the system which they belong to. That is, the system acts in order to build the learning.

Still in this theory, the human agents and the system which go round the behavioural loop of the discovery, choice and action are clearly engaged in a learning process that directs the process of evolutionary feedback in which what one does affects the other ones, and then, comes back to affect the first one.

In this learning process, Stacey (1996) describes as a legitimate network the formal and intentional interaction officialised by the members with more power of the organisation or by the culture or ideology of it. Another category of interactions is established by the agents during the interactions in the legitimate network. The result of this is another network, that is, a kind of shadow in the legitimate network, which consists of informal links, not only social ones but also political ones. In this shadow network, the agents develop rules for the interactions. Such rules are shared by small groups or by all the system. The groups and the organisational culture formed by the shadow network do not make part of the ideology or of the culture sanctioned in the legitimate network.

For Stacey (1993), all the human interactions take the form of a feedback system because the consequences of one action always feed back to affect the subsequent action. And as the human relations happen with different intensities, not only for more but also for less, these interactions form a non-linear feedback system.

The feedback is positive for the learning when the agents or the system insert some information into the loop discovery-choice-action in order to amplify it or to unbalance it. This is the way how the broadcasting of new ideas which change the activities – innovation happen. The rule shadow of an organisation is frequently managed by this

feedback. It is a non-linear feedback network, in which this feedback is very probable, and even usual, and sometimes small events provoke big consequences (STACEY, 1996).

Daft and Weick (1984) highlight that the organisational interpretation is the process of translation of the present events in the external environment, the development of models to understand them, the unveiling of meaning and the assembly of conceptual schemes among the key-managers. One notices that this process is not simple and it is difficult of implementation.

Yet according to these authors, the concepts and images of the interpretation can be organised in three steps which constitute the global learning process.

The first step is the tracking which is defined as the process of monitoring the environment and to provide environmental data for the managers. The second step is the interpretation when meaning to the data is given, perceptions are shared and cognitive maps are built. In the third phase the learning happens, which involves a new action based on interpretation. The organisational interpretation is analogue to the learning of a new ability by the person. The act of learning provides new collective insights for the members of the organisation (DAFT; WEICk 1984).

Child (1972) concludes that the environmental conditions do not directly interfere in the organisational structure, but indirectly, with base on the interpretations of these conditions by the decision –makers and their respective actions. The author uses the term “decision-makers” to refer to the group of professionals who work in the front line and who detain power in the professional organisations. Cyert and March (1963) use the term ”dominant coalition “to highlight this group. The dominant coalition has the following characteristics: (a) its members can have the formal or informal power; (b) it refers to the group which collectively detain the power for a specific period of time; and (c) it has the power to decide about the structure of the organisation.

The beginning of Hospital Medicine – Hospitalist Model

The Hospital da CRUZ Vermelha do Paraná (The Red Cross Hospital of Paraná State) is a general hospital, having as an anchor service the Cardiology Service and the Cardiac Surgery. It has 172 beds, being 30 beds of Intensive Therapy; the average of admissions is 1113 per month. The Emergency Room service makes in average 7000 procedures and is composed of 5 consulting rooms, 12 beds with monitors and one emergency room. The hospital has an Operating Centre with 07 operating theatres and carries out about 800 surgeries.

Until November 2013, the Hospital da Cruz Vermelha (HCV) had a model of hospital medicine characterised by visiting doctors with little interaction among them and among the other health professionals. The Services and Sectors of the Hospital, like the Emergency Room, Intensive Therapy and Admission Unit had fleeting relationship and with high index of conflicts among them and with the support managerial Sectors, that is, they were few united people (Weick, 1976, Perrow, 1986).

From this date on, the board of directors of the Hospital made the strategic decision to implement the hospitalist model of hospital medicine, and contracted the first two doctors to take care of a determined group of patients who were admitted in the Admission Unit.

As these patients had in their majority chronicle comorbidity in advanced phase and a clinical outpatient care handling by more than one specialist and with several complementary exams done, the medical practice had as objectives: (a) to increase the power of observation about the patients,(b) to have the Investigation Plan and Therapy as the centre of approach to the patient,(c) to use the Medical History of the patient as the instrument of communication between the interdisciplinary team and (d) to have as focus of assistance the patient's need of health.

The premises of the Hospitalist doctors' team created at that time and which last until nowadays are: (a) doctors with generalist graduation, (b) to have time disposability to work every day of the week and take part of the rota at weekends, (c) capability to work in team, (d) to be responsible to take care of patients per hour, to take part in on e of the Committee of the Hospital.

The interaction with other health professionals

The hospitalist doctors started their jobs having as central activity the Therapeutic Diagnosis Plan, registered in the Patient's Electronic Medical History. In this document there was the entire patient's therapeutic guidance for the period of the predictable admission, in other words, it was the formal communication among the professionals- Legitimate Network (Stacey, 1996). This action was the stepping stone for a strengthening of the interaction among the hospitalist doctors- shadow Network (Stacey, 1996).

As an unfolding part of this action the other health professionals responded to the hospitalist doctors' informal approach in order to discuss the patient's clinical case and to align the assisting actions of the Therapeutic Diagnosis Plan, creating an interaction set of rules to improve the performance o f all the involved professional. This situation

is the effect of the combination and interaction among the components of the professional team organising themselves (STACEY, 1996; LISSACK; GUNZ, 1999).

The same way that through the mediation of the Therapeutic Diagnosis Plan the hospitalist doctors have influenced the assisting practice of the other health professionals, they have also contributed for the alignment of the therapeutic diagnosis plan and the medical actions of the hospitalist doctors –feedback- when they started to communicate the patient's clinical changes , being through the register in the patient's electronic medical history or through discussions which used to happen during the visit to the patient, characterising a modified subsequent action , based on learning (Stacey,1993).

The evolution of this action was the creation of small assisting meetings, during the professionals' visits, in order to discuss the clinical cases of the patients who did not have a good response to the Therapeutic Diagnosis Plan –an innovation, based on self-organization in the assisting practice (Stacey, 1993; Agostinho, 2003).

Interaction with specialist doctors

With the complexity of patients' chronicle pathologies, the hospitalist doctors needed specialist doctors' support. However, every time this support was requested, the specialist doctors had the behaviour to be responsible for the patient and to set aside the hospitalist doctor of the conduction of the case, characterising a weak interaction and a fragmented assisting practice.

The hospitalist doctors have exposed this difficulty for the Hospital board of directors. This group-dominant coalition (Cyert&March, 1963) have made the decision to make institutional the specialist doctors'support, creating a system of reference and counter-reference among the hospitalist and specialist doctors, respectively, in such a way that the conduct of the therapeutic diagnosis plan would be under the responsibility of the hospitalist doctor. In this case, the interpretation of the decision –makers (Child, 1972) was to create a system which could strengthen the interaction between the doctors and could maintain the conduction of the Therapeutic Diagnosis Plan by the hospitalist doctors' team (Daft&Weick, 1984).

In order to give support for this system of reference and counter-reference with the hospitalist doctor's conduction, the board of directors have made formal a routine of work-legitimate network- for the most demanded medical specialties, in which these doctors had the obligation to stay in the Hospital during a certain pre-determined

period of time to answer the requested opinions and to discuss the alignment of the therapeutic diagnosis plan.

The specialist doctors who were willing to take part of this relationship, the nephrologists, the nutrologists and the infectologists declare their satisfaction while acting this way. This fact was fundamental for other specialties to manifest the interest to take part of this relationship system as well, characterising a self-organisation with strengthening of the interaction between the doctors and the new process of relationship of the specialist doctors with the Hospital (Stacey, 1996, 1993).

The unfolding part of this action was the increase of this relationship for surgery specialties, in such a way that nowadays when a patient with a chronicle disease needs that an orthopaedic surgical, urologic and general surgery procedure to be carried out, he or she is admitted under the hospitalist doctors' care.

Relationship of the Admission Unit with the Emergency Room

A chronicle problem of the Hospital was the admission o f a patient coming from the Emergency Room to an admission Unit. The fragility of this process, characterised by the little interaction between the Sectors (Weick, 1976; Perrow, 1986), was so big that it used to threaten the patient's safety, because the doctors' admission conduct was exclusively focused on the acute process which used to motivate the admission, not taking in consideration the patient's other clinical conditions, and the time between the consult of the doctor of the Emergency Room and the visit of the hospitalist doctor did not meet the necessary observation for the control of the patient's unfavourable clinical condition evolution .

In order to solve the hospitalist doctors' demand, once again the medical board of director of the Hospital together with the hospitalist doctors, dominant coalition, has modified the structure with 12 observation beds of the Emergency Room for a structure of an Intermediate Care Unit (Cyert&March, 1963). Like this, all the patients who had an unstable clinic condition and who needed an intermediate assisting care between the care at their disposal in the admission Unit and the intensive care at their disposal in the Intensive Therapy Unit used to be admitted in these beds, under the care of the hospitalist doctors 'team, based on the therapeutic diagnosis plan, but also under the attentive look of the Emergency Room's doctors'team concerning the unstable clinic conditions control.

The new formal structure- legitimate network, created by the dominant coalition, helped the interaction of the doctors of the two teams in the informal situations- shadow network (Stacey, 1996).

The hospitalist doctors' preoccupation about the patient's safety was the starting point for the creation of a safe environment during the patient's interaction process (Daft&Weick, 1984). It was also up from the hospitalist doctors' demands that there was the solution of another problem which used to threaten the patient's safety: the high frequency of cardiac respiratory failure in the Admission Unit.

The specialist doctors have noticed that some patients did not satisfactorily answer to the care indicated in the therapeutic diagnosis plan, that they had as an evolution the clinic worsening and the implantation of a case of instability which non rarely used to lead to a case of cardiac respiratory failure.

The solution of this problem was the creation of a patient's flux in the initial phase of the non-answer to the therapeutic and diagnosis plan for the observation beds of the Emergency Room. This flux was created by the dominant coalition, hospitalist doctors and the medical board of directors of the Hospital (Cyert&March, 1963). However, the care and alignments of the therapeutic and diagnostic plan of these patients used to continue under the responsibility of the hospitalist doctors. Only the management of the clinical conditions which used to originate the instability was under the Emergency Room doctors' care.

The interaction of these two medical teams was profitable under two aspects. The first one was the influence of the medical practice based on the therapeutic diagnosis plan which the hospitalist doctors practised in the Emergency Room doctors. And the second aspect was the reinforcement of this patients' flux of the Admission Unit for the Emergency Room. This flux started to be an Emergency Room doctors' practice every time that these ones helped intercurrence in the in the Admission Unit and diagnosed that the patients were in instable clinical conditions (Stacey, 1993).

Relation of the Admission Unit and the Intensive Care Unit

The flux of patients' admission directly to the Intensive Care Unit was frequent and such fact at the moment of the discharge of the patient for the Admission Unit used to provoke the situation of an initial contact of the patient who was already an inpatient for a certain time in the Hospital with the hospitalist doctor.

This situation was a reason of hospitalist doctors' complaint as they did not have any participation in the patient's therapeutic diagnosis conduct until the moment of the

transfer for an Admission Unit. In order to solve this weak bond and fragility in the continuity of care for the inpatients (Weick, 1976; Perrow, 1986), the Hospital technical board of directors with the hospitalist doctors – dominant coalition – (Cyert&March, 1963) have promoted the interaction of the two teams making formal the routine- legitimate network-that the patients admitted to the Intensive Care Units would also be under the clinical responsibility of the hospitalist doctors. This way, the interaction between the hospitalist doctors and intensive care doctors became more intense in the shadow network, as well as the fragility of discontinuity of care given to the patient was solved (Stacey, 1996).

Relation of the Admission Unit and the Outpatient Unit

The hospitalist doctors aware of the hospital environmental threats for the patients have informed the Hospital technical board of directors that the high discharge of inpatients could precociously happen if there were some guaranty of continuity of care decided in the therapeutic diagnosis plan after the discharge, in the ambit of the outpatient care follow-up, in the period of time determined by the hospitalist doctor (Stacey, 1993; Agostinho, 2003).

Facing the exposed problem, the Hospital board of directors has created an after discharge outpatient unit with the aim to guaranty the continuity of the care for the patients and to promote the discharge as soon as the patient's clinical conditions allow(Daft&Weick, 1984). The criterion applied to the choice of doctors who work in this outpatient unit has had the same premises of the choice of hospitalist doctors.

The patient's permanence in this outpatient unit is temporary and meets the need of the end of care decided by the therapeutic diagnosis plan of the clinical condition which has motivated the admission. At this moment, the patient is discharged of this outpatient unit to the outpatient unit of the Family Doctors and Community for the follow-up of the outpatient care management of the chronicle clinical conditions.

Hospitalist Doctors and their hospital medicine practice

The inpatients' profile in the Hospital da Cruz Vermelha do Paraná (Red Cross Hospital of Paraná State) follows the Brazilian reality: a great majority of aged patients and with multiple comorbidity, generally badly treated. It was in this scenario that the

hospitalist doctor's practice has demonstrated to be of greater value in the increase of the assisting quality.

The practice defined by the hospitalist team (Stacey, 1996; Lissack&Gunz, 1999) is fundamentally centred in the patient and as a consequence all its activities are based on two assisting pillars: the patient's safety and the global vision of the person.

The patient's safety aims at the minimization of the quarter damage. The quarter prevention is a new term for an old concept: in the first place not to cause damage (Jamoulle, 2015). In this context, the hospitalist doctor aims at the safe discharge, however always the most precocious possible within the patient's clinical stability, taking into consideration the potential risks inherent in the admission, with sever repercussion and sometimes on a long term, with the decrease of the functional capacity and changes in life quality, many times irreversible ones (Siqueira AB et al. 2004).

In the medical practice, the hospitalist doctors have applied such contents in daily small actions which globally have resulted in a better care for the patient, such as:

(a)safe prescription , with attention to diverse particularities , like : the potential drug interactions or adverse effects to which the most fragile population is at bigger risk , saving the evening period whenever possible and avoiding this way the Delirium in vulnerable population; understanding the characteristics of the hospital flora of its service and acting in the choice of antibiotic therapy with aim at the lower spectrum with better action; maintaining medication of daily use which can be potentially increase the outcomes and ceasing the deleterious (drug reconciliation); impeccable symptoms management.

(b) rational request of complementary exams, understanding the context about the over diagnoses and over treatment, getting to know the potential false-positive and false –negative of their more prevalent exams. For such, there was the integration with the Radiology team, establishing daily time of disposability for the discussion of cases and together the understanding about which diagnosis possibilities best fit each case (Stacey, 1996).

(C) Scientific meetings: weekly meetings among hospitalist doctors for the discussion of new literature which gives the basis for such practices, with discussion about difficult cases for the sharing of points of view, always aiming at the medicine based in evidences applied to a unique person, in order to generate the best medical practice possible. Monthly meeting discussion about preventative deaths happened in the service, fed by the Hospital Death Committee, with focus on the understanding of errors of flux or assisting errors in order to generate prevention action of new occurrence and learning for the clinical staff (Stacey, 1993).

(d) Guarantee of safe care transition: even in the patient's transfer among sectors of the hospital as well as for the outpatient care ambit, the hospitalist doctor integrates to the other assisting team permeating the work in all spheres, in the role of the organizer of general care lines for that patient in special, maintaining the Therapeutic Diagnosis Plan homogeneous, not depending o the institutional sector in which the patient is located.

The global vision of the person, another assisting pillar of the hospitalist doctor's activity, becomes a fundamental approach in the reality of complex patients, in special the aged ones, in a Brazilian context of little emphasis on primary attention and, therefore, minimum preventative approach. As the aged person's assistance presents multidisciplinary character, where professionals of several areas associate themselves to offer a global assistance for the patient, the concept of iatrogenic in geriatrics has a broader meaning, relating itself to the conducts taken by various members of the team (Carvalho-Filho and col.6, 1996).

In the daily actions of the hospitalist doctors of HCV, we understand the applicability of such concepts by some daily actions taken, like:

(a) Coordination of the multidisciplinary assisting team of the patient, signalizing its needs based on the Therapeutic Diagnosis Plan and discussing ways to meet such needs.
(b) Comanagement of the inpatient with other specialties.
(c) Communication abilities and patient's inclusion and their family members in an active way in the process of getting sick and treatment.

Hospitalist doctors and the palliative care

After some months of implantation of the hospitalist medicine in HCV, it was created a Group of Palliative Care by the dominant coalition, result of a growing as a result of the patients' profile assisted in the service, but also as the fruit of a dissatisfaction in the way death and the moments which preceded it used to be conducted so far (Cyert&March, 1963).

The implantation started with the restructuring of the multidisciplinary team, composed of hospitalist doctors and teams of nurses, physiotherapy, psychology, speech therapy, and social assistance. It was determined that the nursery would be responsible for the coordination of services, doing active search of patients with profile and criteria for inclusion even in the environment of Emergency Room or the Intensive Therapy Units and signalizing to the hospitalist team, recording daily the list

of patients, filing data and signalizing in the medical record in a clear way after the inclusion so that in all the hospital environment the patient could be clearly identified as included in the group.

The works started with the theoretical structuring of the group and the determination of the principal precepts which would guide the activities, as highlighted:

(1) Indication by hospitalist doctors of patients in Admission Units with criteria of inclusion in the group, already starting the jobs of the patient's and their family members' sensibility ;(2) multidisciplinary meetings between team and patient (when lucid) and their family members to make the inclusion formal;(3) Establishment of the phase of the palliative care in which the patient is- with clear data in medical record.

In a second moment, the activities of continued education of the assisting teams of the other areas of the Hospital started, including all the nursery staff, the team of Emergency Room and the Intensive Care Units and the specialist doctors staff (Weick.1976; Perrow, 1986). Such work of change of institutional concepts had its start not only informally (shadow network), with discussions at the bed edge by the team of hospitalist doctors with the other members of the multidisciplinary team, as well as with institutional character (legitimate network), by means of Direction actions, through the Scientific Extraordinary Meetings of the entire assisting staff (Stacey,1996).

The results were very remarkable and the acceptance by the patients and family members was very satisfactory. Nowadays we have 181 patients included in the Group of Palliative Care, 380 patients who came to death under the humanized optic of care, without invasive measures taking them far from their family members in ICUs and with impeccable management of their symptoms and pains.

About the experienced gained with the Group, the hospitalist doctors, nowadays, have incorporated for all the patients accompanied in the Admission Units diverse concepts of the Palliative to its daily routine of management (Stacey, 1993), among which we can mention(a)Integrating the psychological and spiritual aspects in the patient's care;(b)Offering a supporting system which allows the patient to live as actively as possible until the time of his/her death –giving conditions of life quality, functional rehabilitation and autonomy whenever possible;(c) Offering support system to help the family members during the patient's illness, understanding the essential role that these ones play in the process of treatment of any disease- for such, the meetings between the team with their family members are held every time there are demands of explanation, worsening of the prognostic , unpredictable evolution or any other demand of the team or of the patient and their family members, and (e)impeccable

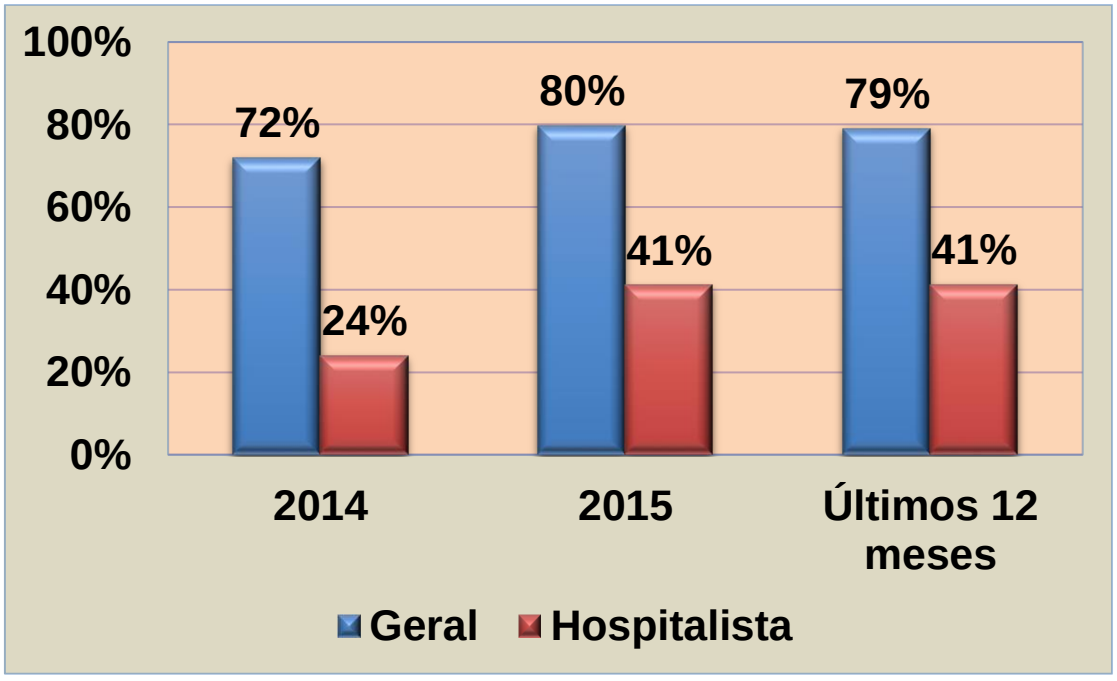
management of pain and other symptoms which affect not only the patients with acute diseases but also the chronicle ones.(ANCP 2009)

Results and Measures

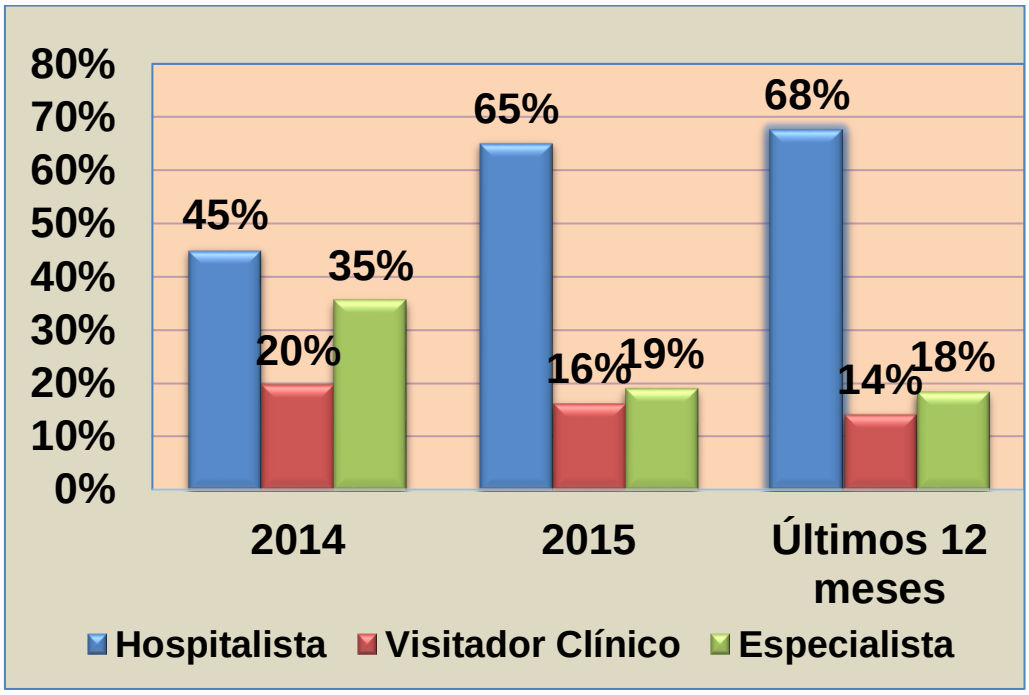
The control mechanisms of the hospital Medicine, in the hospitalist model, developed by the Hospital board of directors were: (a) weekly meetings to accompany the works and to solve operational problems which arose with the interaction of teams,(b) to stimulate the hospitalist doctors to make notes about risky situations which used to threaten the patient's safety and (c) the creation of result indexes which are monthly analyzed with the coordination of hospitalist doctors.

We present some indexes which demonstrate the increase of the number of patients who are under the responsibility of the hospitalists team and the average of permanence of these patients.

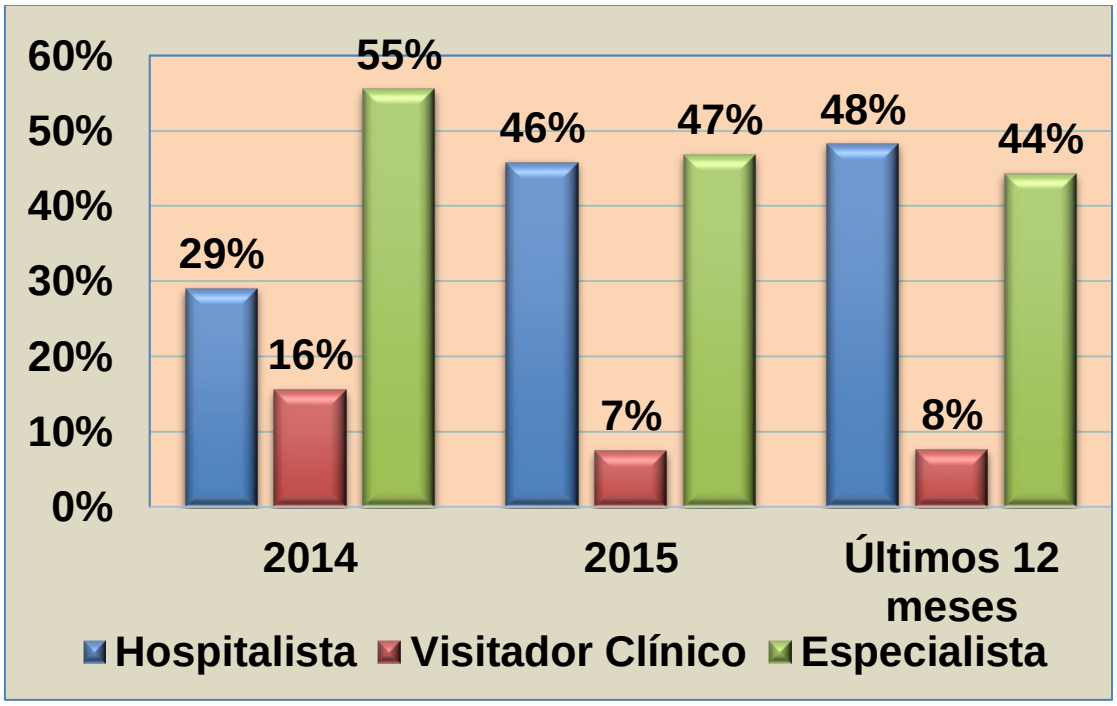
RATE OF OCCUPATION (graph 1) last 12 months/ general (blue)/ hospitalist (red)



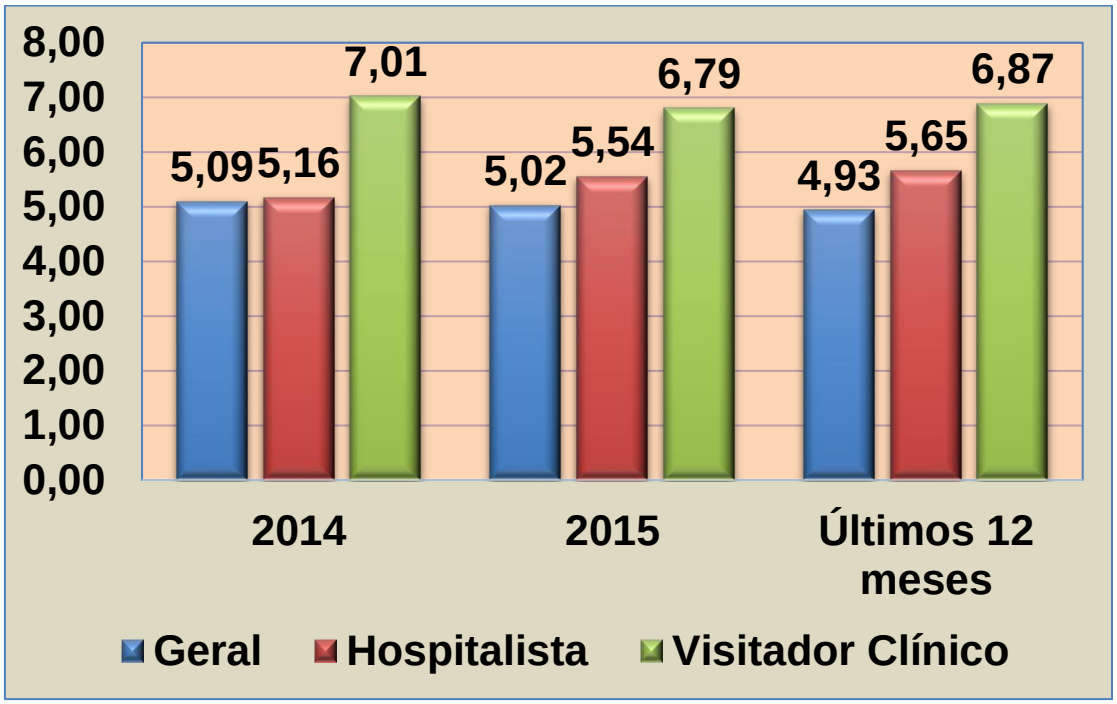
DAY CLINIC PATIENT (graph 2) last 12 months/Hospitalist (blue)/clinic visitor(red)/Specialist(green)



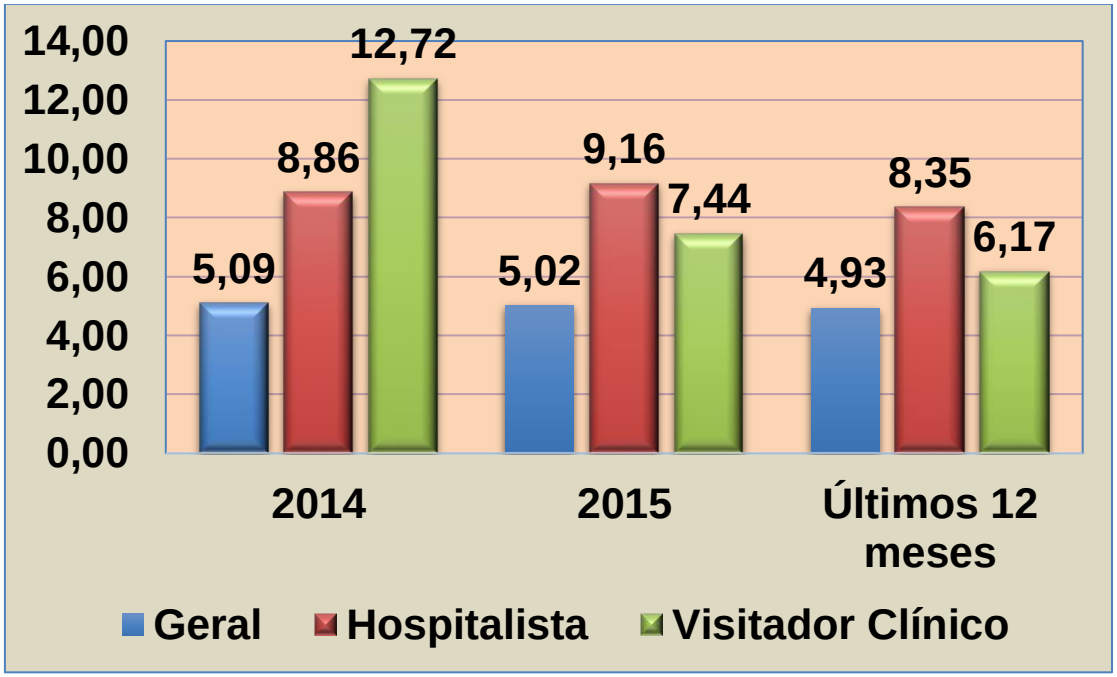
PATIENT SURGICAL DAY (graph 3) last 12 months/Hospitalist (blue)/Clinic visitor(red)/Specialist(green)



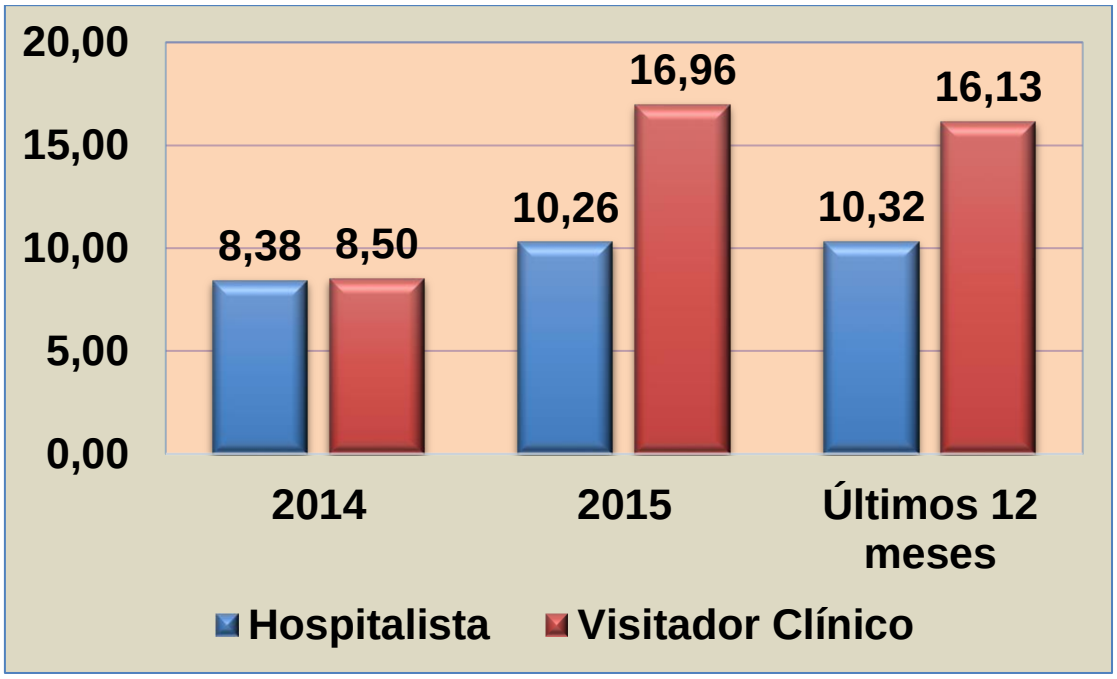
AVERAGE OF CLINIC PERMANENCE (graph 4) last 12 months/General (blue)/Hospitalist (red)/clinic visitor (green)



AVERAGE OF SURGICAL PERMANENCE (graph 5) last 12 months/General (blue)/Hospitalist (red)clinic visitor (green)



AVERAGE OF PATIENTS ' PERMANENCE IN PALLIATIVE CARE(graph 6)last 12 months/Hospitalist (blue) /Clinic visitor (red)



Conclusion

The expertise of hospitals is to make productive the knowledge of their professional in advantage of the need of people's health. Therefore, no knowledge classifies above any other knowledge. The place of each professional is determined by their contribution for the common task and not by their superiority or inferiority.

The acting towards the systematic learning based on the monitoring of the environment, in the interpretation of the pieces of information, in the choice of a new action , based on this interpretation, go to a macro system which creates, learns and develops its way in the future of Hospitals, ass complex organisations .

The formation of the hospitalist team with focus on the need of the patient's health and on the resources which the Hospital provide for their disposal, was an initial action which motivated the alterations in the Hospital structure.

The initiative of the hospitalist doctors to promote the strengthening in the interactions between the health professionals , being specialist doctors or other professional categories(shadow network) were accompanied by modifications in the working processes of the assisting area (legitimate network).

The creation of a group of decision-makers formed by the hospitalist doctors and by the hospital medical board of directors has allowed this change in the hospital environment. And the systematisation with which these changes happened characterise the institutional learning.

The result of the decision-making of the hospitalist group and the hospital medical board of directors have created lines of care which guide the actions of the health professionals of the Hospital, guarantee a safe environment for the patient and a new logic of assisting practice towards the need of the patient's health.

Therefore, the improvement of assisting practice to meet the needs of the patients' health motivates all the professionals to be creative and to use the resources at their disposal in the learning of the hospital structure development.

The hospitalist doctors' behavior was fundamental for the development of lines of care which have improved the interaction among the professionals and among the sectors, creating a favorable environment for the learning an the improvement of the assisting practice.

All this process characterizes a change in the culture of the Hospital, for the adoption of actions in the sense of having the patient's need of health in the first place.

In agreement with this new culture, the next challenges of the Hospital are: (a) developing a Team of "Hospitalist Nurses ", (b) developing a Team of " Hospitalist General Surgeons" and (c) developing an outpatient care assistance for the patients in palliative care.

Bibliography :

AGOSTINHO, M. C. E. Administração complexa: revendo as bases científicas da administração. RAE-eletrônica, v. 2, n. 1, 2003.

Carvalho-Filho, E.T. et al. Iatrogenia no idoso. *Rev. Bras. Med.,* 53:117-37, 1996.

CHILD, J. Organizational structure environment and performance: the role of strategic choice. SAGE Social Science Collections, 1972.

CYERT, R. M.; MARCH, J. G. A behavioral theory of the firm. Englewood Cliffs, New Jersey: Prentice-Hall, 1963.

DAFT, R. L.; WEICK, K. Toward a model of organizations as interpretation systems. Academy of Management Review, v. 9, n. 2, p. 284-285, 1984.

Jamoulle M. Quaternary prevention: first, do not harm. *Rev Bras Med Fam Comunidade*. 2015;10(35):1-3.

LISSACK, M. R. GUNZ, H. P. Managing complexity in organizations: a view in many directions. London: Quorum Books, 1999.

Manual de cuidados paliativos / Academia Nacional de Cuidados Paliativos (ANCP). - Rio de Janeiro; Diagraphic, 2009.

PERROW, C. Complex organizations. A critical essay. McGraw-Hill, Inc. p. 200-208, 1986.

Siqueira AB, Cordeiro RC, Perracini MR, Ramos LR. Functional impact of hospitalization among elderly patients. Rev Saude Publica 2004;38(5):687-94.

STACEY, R. Strategy as order emerging from chaos. Long Range Planning, v. 26, n. 1, p. 10-17, 1993.

STACEY, R. Complexity and creativity in organizations. San Francisco: Berrett- Koehler, 1996.

WEICK, K. E. Educational organizations as loosely coupled systems. Administrative Science Quarterly, v. 21, n.1, p. 1-19, 1976.