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Professional Education for Tomorrow's Hospital Administrators—as Viewed by a Hospital Planner*

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ONE of the major problems of the areawide hospital planner today is the misunderstanding of his function by almost everyone, including professionally educated hospital administrators. Most think that we are concerned with evolving an over-all *scheme of arrangement* for hospitals in a metropolitan area or region, with each unit carefully interrelated with all the other units in an aesthetic whole, which precludes duplication, overlapping and gaps in service. The secure administrator favors this type of planning, because he likes to know where the other hospitals fit in the scheme. He is confident that he can convince the planner to adapt the scheme of arrangement to meet his own hospital's aspirations, if the planner lacked the wit to reflect these aspirations in the first place. Less secure administrators oppose this type of planning, because they fear loss of self-determination.[1]

Both reactions are wrong because they are based on a faulty con-

* This paper is adapted from a talk which the author presented at the Tenth Anniversary Institute of the Program and Bureau of Hospital Administration, University of Michigan, Ann Arbor, on June 3, 1965. His talk was one of a series in which professional education for tomorrow's hospital administrators was analyzed from a number of different viewpoints: a hospital administrator, an educator, a physician, and a hospital planner. As in the other papers, Mr. Sigmond's analysis of professional education is preceded by a statement of the viewpoint of the planner.

[1] For a more detailed discussion of the hospital planning process see Sigmond, R. M., "The Hospital Planning Process and the Community," in *Areawide Planning,* Report of the First National Conference on Areawide Health Facilities Planning, Chicago: American Medical Association, 1965, pp. 100–12.

ception of areawide planning. The hospital planner today is not concerned with a scheme of arrangement, but with a *scheme of action.* Planning involves visualizing the future, establishing goals and programs for achieving goals, and continuous re-evaluation of goals and of implementation programs. Planning avoids fitting individual units into the strait jacket of an over-all scheme of arrangement. Planning involves interrelating independently established goals and implementation programs, so that they don't conflict and cancel out.

Planning is an integral part of any activity that will be changing over time. It is a process, not a technique. Since hospitals are rapidly changing institutions, every hospital administrator must be a planner. The areawide planner helps the hospital administrator to plan; he does not plan *for* him.

In a "scheme of arrangement" approach to planning, all the key variables are converted to constants. A "scheme of action" approach to planning avoids the tendency to freeze the pattern and hold back progress. A "scheme of action" approach helps the hospital administrator to identify the key variables and to deal with them in a realistic way.

For the hospital planner, the only constant is change. Tomorrow's hospitals will be different from today's hospitals—with or without a systematic planning process. With a successful planning process the changes will be less surprising, less painful and more closely related to valid professional objectives.

The planner is especially interested in any decisions which must be made today but which will have lasting impact in the years ahead, such as investment in buildings and in education of personnel. If these decisions for the future are made in relation to today's needs without consideration of the shape of the future, the new buildings and personnel will probably constitute a serious handicap to progress as the future unfolds.

Tomorrow's hospital administrator should be educated for leadership in administration of tomorrow's hospital. But he must also be prepared to help in administering today's hospital, and in easing the transition from today's hospital to tomorrow's hospital.

Education for tomorrow's hospital administrator must be based on visualization of tomorrow's hospital and of the nature of the transition period ahead.

TOMORROW'S HOSPITALS: A PREDICTION BASED ON ANALYSIS OF HISTORY

The hospital planner has a fairly effective tool to predict the characteristics of tomorrow's hospitals—within limits. This tool is historical analysis, which demonstrates that the hospital is a dynamic institution that reflects changes in the community and changes in medical technology—but with a significant time lag. Because of this lag, the forces that will shape tomorrow's hospitals are already at work today. To visualize the future, all that is necessary is to identify these forces and assess their impact.

This approach is much more accurate in predicting *what* will happen than *when* specific changes will occur. Also, prediction must be limited to general directions; the exact path cannot be plotted, especially at individual institutions. But the somewhat clouded crystal ball of historical analysis reveals enough for purposes of a discussion of education for tomorrow's hospital administrator.

HISTORICAL BREAKTHROUGHS

Historical analysis suggests that there have been two major upheavals or breakthroughs in the characteristics of the hospital as a community institution, and that a third upheaval is about to take place. Professional hospital administrators were not involved at all in the first two breakthroughs. In fact, the birth of the professional hospital administrator was one of the predictable results of the second. The professional hospital administrator has a key role to play in the impending third breakthrough.

The first breakthrough occurred at the end of the nineteenth century as the result of technological advances which made it possible to control cross-infection, and which made the hospital a safe place for care of the sick. Prior to this time, the hospital was used only by the poor and the homeless, and then only as a place of last resort. Sick people were cared for at home, unless they had no home or had to be

removed from the community as public nuisances. Care in hospitals was primarily custodial, and results were poor. Those who supported the hospitals did not use them. Those who used them did not pay for the service. Physicians contributed their services out of humanity, and for educational and research values.

With the development of aseptic technique, doctors began to admit their private patients to the hospital. Treatment of large numbers of sick people in single locations led to improved powers of observation, new discoveries and new techniques, specialization of labor and rapid advances in medical science and technology. These advances, in turn, led to improved health care and to a rapid rise in public expectation. By the end of World War I, the hospital was recognized as *the doctors' workshop,* in general use for rich and poor alike. Patients paid the hospital for certain services and their physician for other services, but each physician was responsible for "his" patients. The physician "ordered" services *a la carte,* and his orders were carried out. The hospitals were small, the services relatively uncomplicated and problems of coordination were relatively minimal. The need for a professional administrator was not felt; the physicians administered their own cases.

MEDICAL KNOWLEDGE EXPLOSION

The second major breakthrough resulted from the growth of specialized medical knowledge, which led to uncertainty about the quality of care provided by the individual physician. This uncertainty, in turn, led to the development of better training of physicians, recognized medical specialists, and recognition of the need to establish standards and controls of medical practice within the hospital framework. Under the auspices of the American College of Surgeons and the American Medical Association, approval programs were established for general hospitals, with highest standards for those training interns and residents. The initiative for these developments came from medical organizations, and the major emphasis was properly placed on the hospital's medical staff as the primary instrument to assure quality. But the approval programs applied to the hospital as an institution, not to the medical staff. The medical staff began to evolve from a loose pro-

fessional association to become an integral part of the administrative structure of the hospital. The hospital began to emerge as a *professional health center*, with institutional responsibility for an identifiable, coordinated program of patient care services, including control of quality, education and research.

The hospital continued to serve as the doctors' workshop as in the past, but the basic focus was shifting to institutional responsibility for the quality and scope of services. Coordination became much more difficult, and professional administration was needed and eventually was born. The beginning of the transformation of the hospital from a doctors' workshop to a professional service center can be dated from approximately 1918, the first year of the approval program of the American College of Surgeons. Professional administration did not begin to emerge as a dominant force until two or three decades later.

CRITICAL TRANSITION

The primary task of the professional administrator to date can be viewed as helping to bring about this transition from primary focus as a doctors' workshop to a professional service center. In most hospitals today, this transition is by no means completed or thoroughly understood and accepted by all physicians or the general public. This breakthrough has involved primary emphasis on quality of care, on coordination to produce and control quality, and on involvement with education and research programs. At the most developed hospitals, this transition established the dominance of hospital-practice-oriented physicians, primarily specialists, over community-office-practice-oriented physicians, primarily general practitioners. This development was accompanied by increasing complexity and effectiveness of hospital services, ever greater emphasis on diagnosis and treatment as contrasted with custody and personal care, increased specialization, ever more complicated mechanisms of internal coordination and control—and rapid withdrawal from community involvement. The focus of the professional hospital administrator—especially in the metropolitan area, where he was likely to be found—was internal, not external. His hospital world was extremely complex, a world of its own. Costs rose

rapidly, and became a major concern of the hospital administrator. High utilization of income-producing resources became the key focus of financial planning.

The goals of the professional hospital administrator are usually expressed in terms of high quality patient care, broad scope of service, a well-functioning team of chiefs of service and department heads identified with the institution and financial stability.

The third major breakthrough in the role of the hospital in relation to the community is just ahead. It will result from the *increasing concentration* of an ever higher proportion of the community's ever more complex health resources in the hospital. The hospital as the professional service center has become the key factor in community health and cannot much longer escape the consequences. Since its activities largely determine the level of community health, it must broaden its goals to embrance not only better care for patients, but *optimum health services for people*. The hospital is about to be transformed from a professional health service center to a *community health service center*. As this added goal gradually moves into top priority position in the years ahead, hospital organization, service and administration will undergo dramatic changes.

THE PRIMARY HOSPITAL GOAL

Although hospital planning is primarily an individual hospital process, the initial identification of optimum health services as the primary hospital goal originated with groups outside the hospital inrerested in planning for a multi-hospital area. Areawide planning was applied in only a very few places, notably New York City, before it was adopted as national policy in 1946 with the passage of the federal Hill-Burton legislation. In order to obtain Hill-Burton funds for hospital construction, each state was required to prepare a state-wide plan on an area basis, setting forth a coordinated network of base, intermediate, and district hospitals and public health centers. The goal was optimum health care for the people, and the underlying assumption was that the hospital should serve as the focus of all community health services.

Almost from the beginning, however, Hill-Burton state plans were used primarily as a set of formulae for distributing limited federal funds to individual hospitals on an objective basis. The underlying goal of optimum health services was side-tracked.

A resurgence of interest in areawide planning within the past ten years has centered around its potential as a cost control mechanism. Within the past few years, however, there is evidence that the rapidly growing areawide planning agencies, now being systematically subsidized by federal funds, are beginning to re-define their goals in terms of optimum health services for people.

FRAGMENTED PATIENT CARE

The individual hospital has tended to view optimum health services for people as an inevitable consequence of fulfillment of other hospital goals, rather than as a primary goal in itself. There is little evidence, however, that pursuit of individual hospital goals automatically results in optimum health services for the people. Increasing evidence suggests the opposite. As patient care has become better and better because of its increased specialization and mechanization, it also has become more and more fragmented and, in effect, less and less available to the individual. The people in need of care have greater and greater difficulty in making contact with this complex system so as to find their way to the right place at the right time.

This may be the reason why basic health indices in this country, such as the infant mortality rate, which were improving rapidly for many years, are now leveling off—and at worse levels than in some other countries with more orderly (though possibly less innovative) distributive systems of medical care.[2]

In most hospitals today, there is no knowledge of community-based health indices. No one is assigned responsibility for knowing; no one seems to care. It almost appears that hospital officials expect the people to serve the hospitals (by generating a flow of patients) rather than the hospitals to serve the people.

[2] National Center for Health Statistics. *The Change in Mortality Trend in the United States.* Public Health Service Publication No. 1000–Series 3–No. 1, March, 1964. USGPO.

Hospitals have tended to concentrate more and more on the *productive* processes and have increasingly neglected or overlooked the *distributive* processes of health care. Needs are thought of in terms of patients, rather than of people. The common view seems to be, "If our hospital provides the best patient care, the people will come here when they are in need . . . other hospitals will be striving for this same objective, but our hospital will be best . . . this competitive quest for excellence will provide the community with optimum health care."

As a consequence of this approach, most hospitals couldn't care less about community needs, as distinct from needs of *their* patients, and *their* service programs. The very best hospitals are most divorced from community needs, despite (or because of) their concentration on the newest features of high quality patient care. To these hospitals, community service is a euphemism for service to the poor, although the poor, hopefully, are becoming smaller and smaller segments of most communities. Increasingly, in hospital circles "community hospital" is a belittling term, a term of derision, describing a hospital that is not in tune with the times.

PEOPLE AND THEIR TOTAL NEEDS

As the hospitals have simultaneously become the chief community health resource, while avoiding direct identification with community needs, conditions have been created that require another major shift in the goals of individual hospitals. The new emphasis will be on optimum health services for people. The new focus on *people* and their total *needs* will be much broader than the current focus on *patients* and their *care*. Patients will be recognized as special cases (albeit *very* special cases) of people. The focus will be on people, and on delivering comprehensive health care services of high quality, convenient availability, and lowest possible cost. The pressure for a shift in goals will come from hospital planning associations, government, prepayment agencies, knowledgeable spokesmen for consumer groups, hospital associations, individual hospital leaders, and individual physicians.

Already, the Board of Directors of the American Hospital Associa-

tion has issued a Statement on Optimum Health Services,[3] which concludes that:

> The hospital, with its medical staff, is now the major health resource in most communities. To meet the expanded responsibilities of this position, it is essential that it widen its concerns to include the totality of health services and, with others, to provide leadership in their attainment. The hospital should be prepared to assume a primary position in the implementation of community health plans. Each hospital, then, through its governing body, medical staff, and administrator, has a clear mandate continuously to examine its organization and facilities in the light of this central role in coordinating the principles of optimum health services.

DEFINITION OF OPTIMUM HEALTH SERVICES

The American Hospital Association has provided the most authoritative definition of optimum health services to date, identifying six characteristics: (1) a team approach to care of the individual under the leadership of the physician; (2) a spectrum of services, including diagnosis, treatment, rehabilitation, education and prevention; (3) a coordinated community and regional system; (4) continuity between hospital and non-hospital aspects of patient care; (5) continuity between hospital in-patient and out-patient services; and (6) continuing programs of evaluation and research in quality and adequacy in meeting the needs of the patient and the community.

Of these six characteristics of optimum health services, the third merits quotation in full in a paper by an areawide planner:

> (3) A coordinated community and/or regional system that incorporates the full spectrum of health services, and provides for coordination of care from the time of the patient's primary contact with the system through the community hospital to the university hospital and/or medical center and other health agencies. Each should provide the portion of the total spectrum of health services that is feasible in terms of the type of community it serves and the over-all pattern of health facilities of the region in which it exists.

Evaluation of almost any hospital's program in terms of the AHA Statement on Optimum Health Services is a most shattering experience. Only a handful of hospitals can measure up. The situation is

[3] Statement on Optimum Health Services, Publication S17, Chicago: American Hospital Association, 1965.

comparable to that which faced hospitals when the Standardization Program of the American College of Surgeons was first tested in 1918. In both situations, a new set of standards—logical beyond dispute, and required by a new set of conditions—defines a crisis situation for hospitals.

Since most hospital officials and public representatives are not aware of the wide gap between optimum health services and the existing programs of the hospitals, no crisis exists as yet. But the crisis is fast approaching.

Most hospital officials and physicians can be expected to have great difficulty in applying the AHA Statement on Optimum Health Services to a specific institution. The broad concepts of optimum health services are not easily understood, and are therefore not yet taken seriously. The American Hospital Association and other groups now face the task of translating the broad concepts of optimum health services into a series of specifics which will be understandable and useful to hospital officials, including leaders of the medical staffs, in redefinition of hospital goals.

MULTI-HOSPITAL GROUP

One point is clear. Except in very unusual circumstances, a single hospital—by itself—cannot be expected to provide optimum health services. Coordination with other institutions is required. Each hospital if it wishes to provide optimum health services must become a part of a multi-hospital group or system. This conclusion is equally applicable to the medical school teaching hospital, to the large non-affiliated teaching hospital with approved intern and residency training programs, and to the small community hospital. If the goals of each of these different kinds of hospitals is to be related to optimum health services, each of these—but especially the teaching hospitals—must join forces with other institutions. Common management may be desirable in this situation, but is not as important as a common point of view.

Tomorrow's hospital will be a unit in a multi-hospital network that assumes responsibility for delivering a full range of coordinated health services to a defined population. The term "hospital care" will be in

the process of disappearing from the language as lacking in meaning. *Health* care services will be provided under the hospital's roof and elsewhere; all health care services will be related—in one way or another—to the hospital and its medical staff. The double standard, with respect to quality of patient care in and out of the hospital, will be disappearing. The hospital will be equally concerned with the quality of the care received by patients *before* entering the hospital, *during* their stay in the institution, and *after* leaving it. The hospital will be at least as concerned with distributive processes as with productive processes.

The hospital "room and board" services will be identified as the true ancillary services—ancillary to the diagnostic, treatment, and rehabilitative in-patient and out-patient services that will make up the basic services of the hospital.

The hospital will be concerned not only with getting the patients out of hospital beds, but with keeping them out. Relationships with health departments and with other health and welfare agencies will be much more intimate and time-consuming. Many hospitals will assume landlord relationships with these other agencies.

THREE TYPES OF HOSPITALS

In the coordinated network of facilities that will be evolving, three distinct types of hospitals will emerge and establish identity (although there will be many healthy mongrel specimens):

(a) A large number of hospitals will be identified with a specific community, and will concentrate on distributive processes. These *community hospitals* will place major emphasis on prevention, early diagnosis and treatment, and on affiliation arrangements with other institutions for more complicated procedures and educational programs.

(b) A smaller number of large regional hospitals will have more comprehensive service programs and a secondary affiliation with a medical school complex. These *regional hospitals* will provide service to a group of community hospitals in the region with which they will maintain close working relationships.

(c) A still smaller number of hospitals will have primary medical

school affiliations, a major commitment to education and research, and will provide the most complex services. These *medical school hospitals* will develop working relationships with the regional hospitals to assure optimum health services in their areas of influence. At the medical school hospitals, major emphasis will be on productive processes.

Some of these multiple hospital systems or complexes may evolve—through merger—under single management. In most cases, however, autonomy of the individual institution will be preserved. The system will function by a series of more or less formal affiliation agreements, involving joint medical staff appointments, cost sharing, joint trustee committees, etc.

Although the over-all goals at all three levels will be identical—optimum health services—each will tend to place greater or lesser emphasis on productive and distributive processes. Each will be dependent on the others, however, and autonomy for each institution will necessitate invention of formal mechanisms for resolving constructive conflict among the different units.

Greatest challenge will face the large regional hospital. Lacking both a specific community identification and a dependent medical school, its very identity will be vitally related to the coordinated system itself.

TOMORROW'S HOSPITAL ADMINISTRATOR

Tomorrow's hospital administrator will find himself increasingly projected outward into the community and community affairs. Those who are not prepared for this shift in emphasis will probably just be ejected out.

The administrator's primary interest will be in (a) ascertaining community needs, identifying and becoming acquainted with spokesmen of community and consumer interests as well as other health interests, and (b) adapting the hospital's program to community needs and resources in order to achieve optimum health services for the people.

Consumer representatives who still visualize solutions to health problems in terms of improved *financing* programs will be increasingly aware that the basic solutions involve improvement in *organizational* arrangements. Consumer representatives will be more knowledgeable.

There will be more of them, including new types. Direct spokesmen for low income groups, other than labor union, welfare agency and government spokesmen, are beginning to emerge. Failure to recognize this development may project hospital administrators into the headlines, receiving the same treatment as Kerr, Gross, and Willis have received in the field of educational administration.

In the transition to tomorrow's hospitals, the professional hospital administrator will strive to pursue professional objectives without getting caught in the crossfire of conflicting interests of consumers and producers of health care services. This role will be easier to handle if the composition and attitudes of hospital boards of trustees shift to reflect valid consumer interests more adequately; also, if key medical staff members are encouraged to view their valid specialized interests in a broad framework of optimum health services.

CHANGING THE FOCUS

Tomorrow's hospital administrator will need to be especially sensitive to the many opportunities for fatal errors of judgment in any period of rapid transition. It will be most difficult to turn the focus of a hospital out toward the community until the hospital has established identity as a professional service center, dedicated to quality and to institutional medical care objectives. Development of professional institutional identity has involved a turning-away from the community, a loosening of the influence of community physicians who have expected the goals of the institution to be identified with their private practice, rather than vice versa. If an effort is made to turn the institution outward to the community before there is a strong nucleus of institutional commitment, the result may be retrogressive, should those interested in nothing more than a doctor's workshop regain ascendancy and control. In most institutions, hopefully, potential conflicts among institutionally-oriented physicians and private practice-oriented physicians can be resolved in terms of a common interest in optimum health services for people. Professional administrators will need to encourage more formal and informal involvement of medical staff in broad poli-

cy-making and administration, ever sensitive to the delicate balance among various points of view on the medical staff.

An important function of the professional hospital administrator will be to arrange for exposure of consumer and medical spokesmen to each other's points of view. In general, consumer representatives will be more than happy to leave the initiative with health professionals if they feel that the health professionals are sensitive to consumer interests and objectives.

PROFESSIONAL EDUCATION FOR TOMORROW'S HOSPITAL ADMINISTRATION

The issue that has been traditionally posed for the Graduate Programs in Hospital Administration is "institutional management emphasis or medical care–patient care emphasis." The issue for the future is emphasis on management of a patient care institution or management of an institution for optimum health services for people–including patient care services.

Like university administration, hospital administration involves certain basic institutional responsibilities: housekeeping and plant maintenance, feeding, record keeping, budgeting. The complexities of internal management are reasonably well known. The additional knowledge required by tomorrow's hospital administrator grows out of the added responsibility to the community and to the health professions to assist in the provision of optimum health services for people.

AREAS OF CONCERN

This added knowledge involves three general areas. First, tomorrow's hospital administrator needs systematic knowledge about the *community:* community organization and process, community patterns of health services, community based health care indices. Second, he needs to be well grounded in the characteristics of *personal health care:* the elements of comprehensive health care, the changing doctor-patient relationship, methods of organizing and financing health services, characteristics of health manpower with special emphasis on physicians. In particular, he should be knowledgeable about the history of personal and public health services throughout the United States as

well as in foreign countries. Third, tomorrow's hospital administrator should be knowledgeable about the new field of *change process* as it is evolving in the study of community organization, administrative science, behavioral sciences, and other interdisciplinary groups.

Professional education must be concerned with attitudes and behavior as well as skills and knowledge. I must admit that my confidence in the ability of educators to transfer knowledge is greater than any confidence in their ability to improve or change attitudes, behavior and even skills.

Presumably, men and women best qualified to administer tomorrow's hospitals will be produced by some combination of (a) a sound selection process, (b) a well balanced curriculum, and (c) a well supervised field training experience or residency.

THE SELECTION PROCESS

Of these three aspects of a professional education program, the selection process is probably the most crucial. Hopefully, educators have devised reasonably reliable techniques for identifying a superior group by weeding out those who lack necessary basic attitudes and qualities: intelligence, honesty, idealism, and commitment to lifetime learning. If the selection process can be initiated two or more years prior to selection, it should be possible to attract superior candidates for entering classes with tested skills and a demonstrated ability to absorb desirable knowledge. It seems desirable that every student have some sort of hospital placement (if only summer employment as an orderly) prior to starting the graduate program. The admissions committee should be in a position not only to suggest hospital placement, but to arrange such placement in a supervised setting. In addition, if the admissions procedure starts early enough, it should be possible in many cases to guide the undergraduate program. Sound grounding in administration, economics, statistics, accounting, behavioral and biological sciences prior to graduate school will free class hours for thorough coverage and deeper probing in more specialized subject matter.

The selection process should also involve active and continuous seeking for candidates from among mature, experienced and talented

workers in the fields of health and community organization. With these individuals, too, the selection process should be unhurried and viewed as a productive period in itself.

The curriculum in a one-year graduate program should concentrate as much as possible on change process, community organization, government, and organization and financing of optimum health services, with special emphasis on manpower and international developments in health service.

The residency period seems to me to be a most important phase of the education program. As I see it, the residency should be lengthened, and more closely supervised by the university program. A significant proportion of the residency should be spent at a first-class hospital, but the majority of the time should probably be spent outside of the hospital at such locations as a hospital planning agency, a hospital association, a labor health program, a governmental agency, a prepayment program, etc. In all likelihood, much more adequately compensated second, third and fourth year residencies should be developed, permitting identifiable specialization in administration of medical school hospitals, regional hospitals, community hospitals, entire hospital systems, prepayment plans, planning agencies, etc. Finally, top hospitals should be encouraged to provide administrative staff sabbaticals, and the equivalent of Nieman Fellowships should be provided by some foundation to enable a few promising graduates of programs to return to school after eight to ten years of experience for preparation for national leadership. Presence of a few such individuals at each school would also be most stimulating to the students as a supplement to interaction with the faculty.

ASSOCIATION TIES

In the absence of some experienced students, the graduate program is well advised to develop a close geographical affiliation with a hospital association, following the example of the Pitt program and the Hospital Council of Western Pennsylvania. Such close affiliations can become the basis for a program of community service by the graduate program, with the important by-product of helping to keep the faculty in touch with reality.

Almost all of the graduate programs are now associated with universities with medical schools and medical school hospitals. Eventually, as the university's medical school hospital complex develops a network of services dedicated to optimum health services for an area, the university's graduate program in hospital administration should develop an affiliation with it and concentrate its residencies in the many hospitals in the complex.

Continuing education and tests for residency preceptors appears to be an essential element of a sound program of professional education. Preceptors should be discouraged from using the rotating residency approach and should substitute the "alter ego" approach. Those who are not comfortable with an alter ego should be weeded out.

Professional education along these lines would help each graduate to be an effective planner in whatever setting he finds himself. Those with special interest in planning could take their residencies in planning agencies and find many opportunities for careers in the planning field.

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The doer and the planner are closely related. One works from the present to the future; the other from the future back to the present.

The *doer* concentrates on the decisions that must be made to solve day-to-day operating problems, but with a keen sense of the future implications of alternative decisions.

The *planner* concentrates on the shape of the future and what must be done currently to bring about a desirable future.

The ideal administrator is neither one nor the other, but rather a proper mixture of the two.