إتحاد المستشفيات العربية
ARAB HOSPITALS FEDERATION

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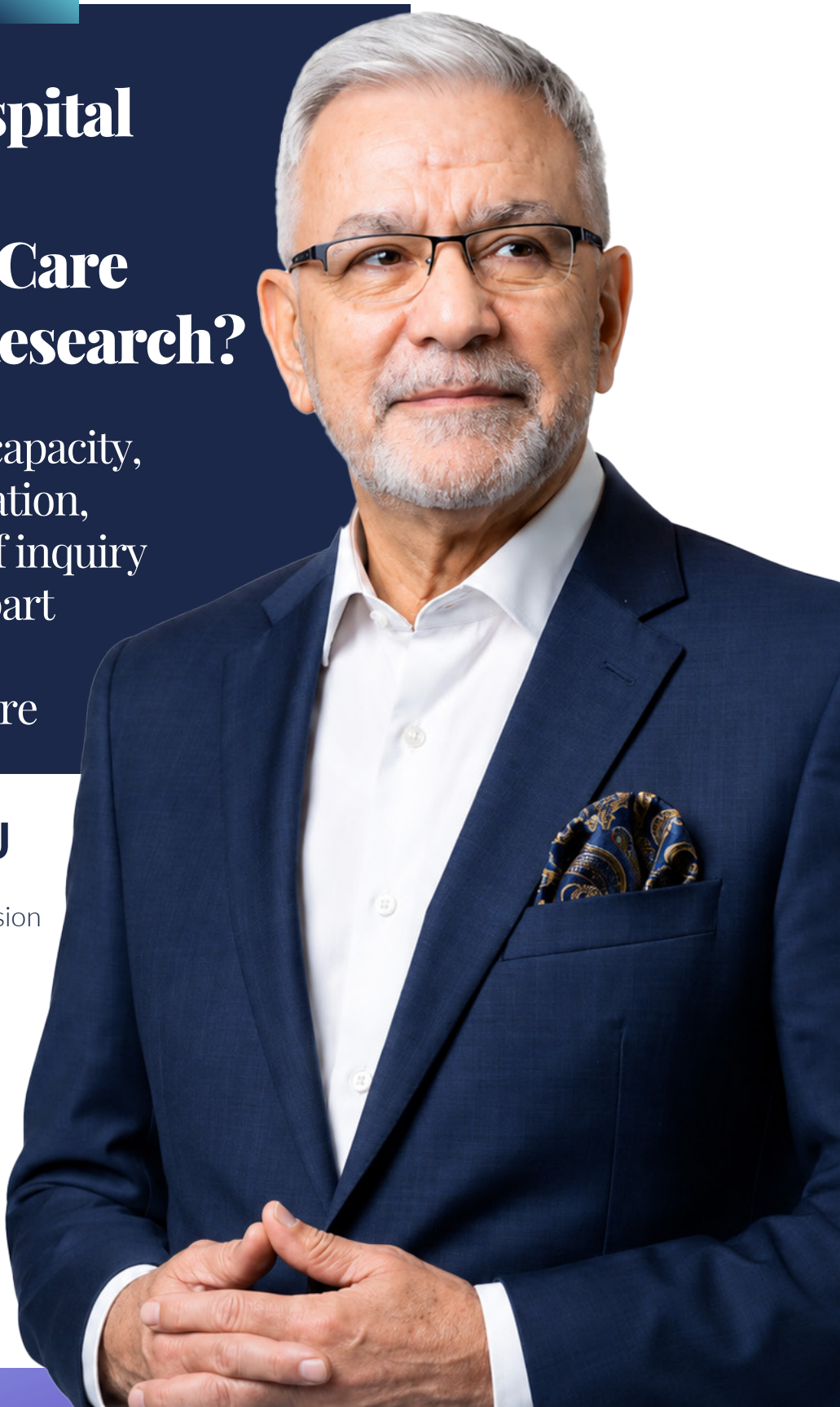
A JOINT INITIATIVE BETWEEN
AHF & WHO - EMRO

Can a Hospital Deliver Excellent Care without Research?

Why research capacity, academic affiliation, and a culture of inquiry must become part of the region's healthcare future



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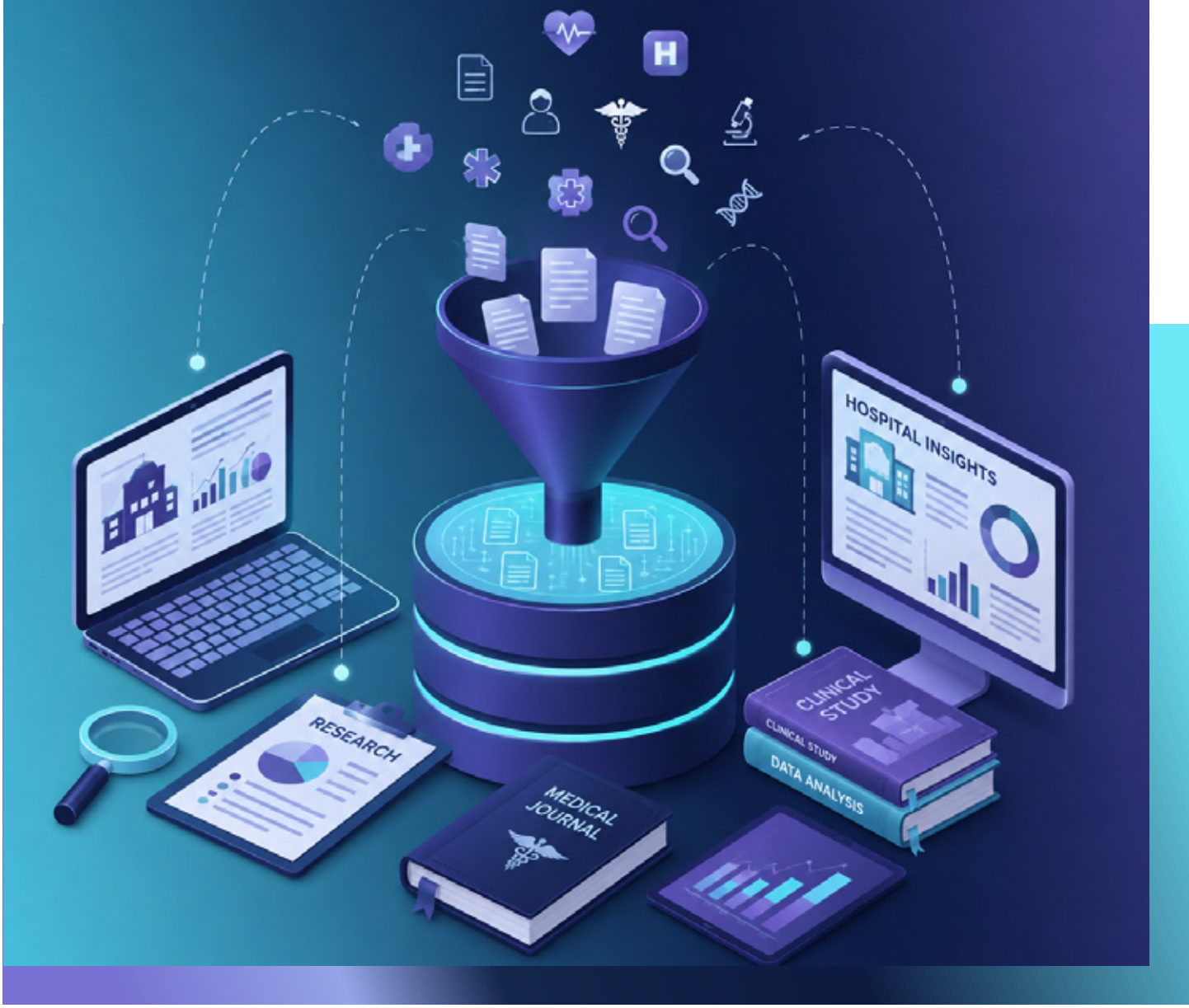

A hospital may have advanced equipment, distinguished physicians, modern operating rooms, and an impressive building. But if it does not ask whether its care is effective, safe, equitable, efficient, and responsive to changing needs, can it truly claim excellence?

This question is becoming urgent across the Arab region and the wider Eastern Mediterranean. For too long, research has been treated as an academic activity conducted somewhere outside the hospital, inside universities, specialist institutes, or journals that frontline professionals rarely have time to read. Patient care, meanwhile, has been treated as the hospital's "real work." That separation is increasingly untenable.

Research is not literally synonymous with patient care. A clinician does not need to conduct a clinical trial before treating every patient, and every hospital does not need to become a university medical center. Yet high-quality care depends on the ability to generate, interpret, apply, and continuously reassess evidence. In that sense, research and patient care are not identical, but they are becoming inseparable.

The difference between delivering care and learning from care

Hospitals deliver thousands of decisions every day: which diagnostic pathway to follow, which medication to prescribe, how to prevent infection, when to discharge a patient, how to organize staffing, and where technology can safely improve performance. Each decision produces information. A research-active hospital transforms that information into knowledge. A hospital without a culture of inquiry often allows it to disappear into disconnected records, individual memories, and unexamined routines.

A hospital that asks these questions become a learning hospital. It does not merely repeat yesterday's practice with newer equipment. It studies its performance, identifies variation, tests improvements, and turns experience into institutional memory.

Do research-active hospitals provide better care?

The evidence should be interpreted carefully. Research activity does not automatically guarantee better care, just as the absence of a university name does not prove poor care. Outcomes are also shaped by leadership, staffing, resources, case complexity, referral patterns, governance, and access to specialized services.

Nevertheless, international studies have repeatedly found associations between research or teaching intensity and improved outcomes. A large United States study of more than 21 million hospitalizations reported lower adjusted 30-day mortality in major teaching hospitals than in minor teaching and nonteaching hospitals. Research in the United Kingdom has also found that greater hospital research activity was associated with lower mortality after adjustment for institutional and patient characteristics. These studies demonstrate association rather than simple causation, but the pattern deserves attention.

Is academic affiliation necessary?

Formal affiliation with an academic institution can be highly valuable. It may provide methodological expertise, research ethics support, access to faculty and trainees, joint appointments, statistical assistance, library resources, grant capacity, and pathways for publication and knowledge exchange. It can help hospitals recruit ambitious professionals and create an environment in which learning is expected rather than optional.

The correct question is therefore not, **"Must every hospital be owned by or attached to a university?"** It is, "How will every hospital gain reliable access to the capabilities required to learn?" For some organizations, the answer will be a comprehensive academic affiliation. For others, it may be a regional research network, shared ethics committee, multicenter study platform, data collaborative, or targeted partnership. The structure may differ; the obligation to learn should not.

Why this matters urgently in our region

Our region also faces a serious evidence problem. Limited publication does not mean limited innovation. Hospitals may be implementing digital command centers, predictive tools, telehealth, smart-energy systems, automated workflows, and new models of care without formally evaluating or publishing the results. Valuable knowledge remains trapped inside institutions. Policymakers are then asked to make national decisions using incomplete evidence, much of it produced in settings with different populations, infrastructure, financing, and regulatory capacity.

AHF and WHO EMRO: building a regional research platform

The Arab Hospitals Federation is bringing this issue forward through collaboration with the World Health Organization Regional Office for the Eastern Mediterranean. This is conceived as genuine co-leadership: WHO EMRO contributes methodological integrity and regional engagement, while AHF brings its hospital network and its focus on smart, safe, and sustainable healthcare.

The starting point is a major scoping review examining the impact of artificial intelligence and digital technologies on hospitals in the region. The review will map evidence across seven interdependent dimensions: hospital design, size, role, workforce, performance, resilience, and environmental sustainability. It will follow established scoping-review methods, including the Arksey and O'Malley framework as refined by Levac and colleagues, PRISMA-ScR reporting, structured eligibility criteria, bilingual evidence identification, and independent screening and charting.

The novelty: studying the hospital as one living system

The novelty of this work lies in moving beyond narrow studies of isolated technologies. An algorithm does not enter an empty room. It enters a hospital with people, workflows, infrastructure, incentives, vulnerabilities, environmental responsibilities, and governance constraints. A tool that improves diagnostic speed may also change staffing, accountability, cybersecurity exposure, energy use, patient trust, and access to care.

The review will therefore treat the hospital as an integrated socio-technical system. It will examine not only what technologies can do, but whether institutions are ready to use them safely; how governance and ethics keep pace; whether benefits are equitable; whether systems are resilient and secure; and whether findings can be transferred across countries and hospital contexts. It will also make visible where evidence is absent, and distinguish, as far as possible, between an absence of innovation and an absence of evaluation or publication.

From evidence to policy

For policymakers, the review can establish a clearer baseline: what is being implemented, what outcomes are being measured, which risks are emerging, where capacity is weakest, and where investment could deliver the greatest public value. It can inform digital-health strategies, workforce planning, procurement standards, research governance, cybersecurity requirements, sustainability policies, accreditation expectations, and equitable financing.

It can also help prevent policy from being driven by promotional claims. Innovation should not be measured by how frequently the word “AI” appears in a strategy. It should be judged by demonstrated improvements in safety, access, quality, efficiency, resilience, sustainability, and patient experience with transparent accountability when it fails.

A call to participate

AHF is also paving a pathway for young healthcare professionals and emerging researchers who want meaningful exposure to research. Clinicians, nurses, pharmacists, engineers, data specialists, quality professionals, hospital administrators, public-health practitioners, and students all have a place in this endeavor. Research is strengthened when the people who understand hospital reality help frame the questions, interpret the evidence, and identify what has been overlooked.

We invite hospitals across the region to participate share evaluated initiatives, identify institutional and grey literature, nominate motivated professionals, support research training, and open responsible channels for collaboration. We invite academic institutions to build affiliations that produce measurable work rather than ceremonial announcements. We invite experienced researchers to mentor the next generation. And we invite young healthcare enthusiasts to step forward, not merely to observe the future of healthcare, but to help document, question, and shape it.

The hospital of the future will not be defined only by its technology, its bed count, or the prestige of its building. It will be defined by whether it can learn. Research is not an accessory to patient care, and academic affiliation is not a decorative title. Both are mechanisms through which hospitals become more self-aware, more accountable, and more capable of improving.

The choice before our region is not between caring for patients and conducting research. **The real choice is between hospitals that deliver care and hospitals that deliver care, learn from it, and make the next patient’s care better.** AHF invites the region to choose the latter, and to build it together.