BEN

HOBa

VISIT TO THE U.S.A. AND CANADA WITH MR. R.A. MICKELWRIGHT

APRIL 7TH TO MAY 15TH, 1959

by A.J. Bennett.

My visit to the U.S.A. and Canada with Mr. R.A. Mickelwright originated in a conversation I had with Mr. A.G.L. Ives in Lisbon in 1957. We had heard a very interesting paper given to the International Hospital Congress there by Dr. Albert W. Snoke, Executive Director of the Grace-New Haven Community Hospital, New Haven, Connecticut, on hospital administration, and I commented that his approach appeared a refreshing one and was worth pursuing. Mr. Ives took the same view, and so the suggestion that I accompanied Mr. Mickelwright to the U.S.A. came about.

In the tour of the U.S.A. and Canada the approach has, therefore, been to look rather at administrative organisation and procedures and the various training programmes in hospital administration, rather than at hospital buildings and equipment, though so far as time permitted, this has been done. In five weeks we travelled 2,500 miles by train, visited ten different hospital areas, met and talked with nearly 100 people (see appended list) and we have collected a great deal of information.

Our principal objectives can be summarised as follows:-

i) To look at the training for hospital administration and business management which is taking place at Universities in the U.S.A. and Canada.

ii) To look into the structure and working of the Accreditation Scheme and to enquire as to any other research projects related to methods of improving hospital efficiency and techniques, with emphasis on management.

iii) To see a number of hospitals with emphasis on organisation and management rather than buildings and equipment.

(1) University Programmes in Hospital Administration

Some sixteen Universities in the United States and Canada provide what are, in effect, post graduate courses in hospital administration, either associated with Schools of Public Health or Business Administration or varients of both. These courses, with the single exception of Toronto, where a diploma is awarded, provide a Master's Degree. At least one is long established, the University of Chicago School, which is part of the School of Business, recently celebrated its silver jubilee. The University of Toronto School, which is part of the School of Hygiene, has been running for 10 years. We visited the schools at Columbia, Yale, Toronto, Ann Arbor and Chicago, and attended a two-day conference of the Association of University Programs in Hospital Administration at Pittsburgh where we met representatives of all the centres including those which we had not visited.

There is no lack of graduates coming forward for these University programmes. Although there can be, by the nature of things, no career structure in the vertical sense in hospital administration in the United States, it seems quite well-known that many posts carry salaries ranging from $10,000 a year to $25,000 a year and some considerably higher salaries, and a number of the former posts are obtained by new graduates, i.e. on completion of two years' training.

The very wide range of subjects in which a university degree may be obtained in the U.S.A., much wider than exists in Great Britain, means that graduates may be forthcoming for hospital administration courses from a wide range of studies. Thus graduates in Business Administration, in Pharmacy, in Nursing, in Physical Therapy and in Economics may all be candidates, and we have met students on courses from each form of study. There is a number of Doctors, too, but the numbers are falling. The higher figures of doctors since World War II are said to be a consequence of the interest of Veterans in hospital administration but this source of supply is falling.

With one or two exceptions, the programme is a two-year course - one year at the University or "on Campus" and a year as an "intern" with a chosen hospital administrator (known as a preceptor). The candidate is required to produce a thesis for the second year, at the end of which he receives the Master's degree (with the exception of Toronto as mentioned above). We were shown some of these theses, and they appeared to be most competent and serious studies of hospital and allied matters, and suggested that students had profited from the theoretical part of the course at the University.

The academic year is almost universally devoted to theoretical subjects, though occasionally short visits to hospitals are arranged. The curricula contain a number of common features, such as business organisation and management hospital administration and statistics. Some programmes include accounting, others require it of the graduate in his baccalaureate course, i.e. before entering the hospital administration programme. If the programme is oriented towards Public Health, then there will be more emphasis on subjects such as epidemiology. At the University of Michigan, for example, the required subjects are:-

Principles of Accounting
Modern Economic Society
Personnel Administration
Principles of Organisation
Hospital Organisation and Management
Hospital Problems
Hospital Accounting
The Hospital and the Community
Medical Care Administration
Principles of Public Health Administration
Statistical Methods in Public Health

and at Toronto:-

Hospital Organisation and Management
Departmental Management
Business Management
Personnel Management
Social Welfare
Medical Care
Public Health
Medical Science Orientation
Administrative Practices

There is a long list of elective subjects.

Teaching is by lecture, seminar and occasionally case study, and for the most part the programmes are limited to a small number of people, usually 12 to 15, to facilitate teaching. The exceptions to the rule of a small number per course were considered to be somewhat unsatisfactory.

There was much interest in the National Selective Recruitment and Training Scheme in the United Kingdom, and the residential aspect and advantages of the Hospital Administrative Staff College clearly attracted much attention. One of the most frequent questions put to us was the nature of the curriculum in the British programme. This is probably a consequence of the universality of the University programme in the United States, and we noted at the Pittsburgh conference a general anxiety to maintain status with the other Faculties at the respective Universities. There was, therefore, considerable pressure to keep the course acceptable to the Universities.

One other subject which featured prominently in these courses was sociology. My short experience of the reaction to lectures on this subject given to a post-entry group in the North West Metropolitan Region convinces me that the subject is of value to hospital administrators in training or as part of a refresher course programme. The many practical problems confronting a hospital administrator clearly cannot be solved by a sociologist, but an appreciation of the philosophy may well be an advantage.

Columbia University and Toronto University (in association with the Canadian Hospital Association) run post graduate courses for hospital administrators. Columbia have aimed exclusively at the administrators of hospitals of under 100 beds, of which there are many in the United States of America. The courses consist of

1) theoretical work by correspondence;
2) association for the period with the administrator of a large hospital who acts as preceptor; and
3) a six-week period on campus.

The Toronto course is similar in general scope, and both Universities were most pleased with the keeness and enthusiasm shown by the participants. They attend the short University courses often during their own annual leave period, and occasionally at their own expense.

(2) Organisation and Management of Hospitals

It was interest in this subject which prompted my association with Mr. Mickelwright on this visit and, as I have already mentioned, the inspiration was Dr. Albert W. Snoke's address in Lisbon in 1957. It was natural, therefore, that we should spend some little time with him and his organisation. In looking at other hospitals and in talking with other executive directors we endeavoured to make comparisons with Dr. Snoke's pattern of organisation.

With one exception, all the hospitals we saw were large teaching hospitals associated with Universities. Our impressions were, therefore, necessarily very specialised and, whilst we tried to keep this fact in mind, our study was in consequence only of a part of the picture.

With this cautionary note, perhaps one can make a few comments on the principal parties in the hospital organisation. They are

The University
The Board of Trustees
The Medical Staff
The Nursing Staff
The Administration.

Relationships with the University varied from a direct control of the hospital to a business partnership between the University and the Board of Trustees. The Boards of Trustees are in many ways similar to voluntary hospital boards in the United Kingdom before 1948. Thus some are chosen from a larger body of subscribers, many are self-perpetuating, some include among their members holders of public office for the time being. In all cases an executive body had been chosen from the larger group for management purposes. They are fully responsible for their hospitals and one of their prime considerations is hospital solvency. The frequency of their meetings varied from once a month at least to once a year.

With few exceptions (The Henry Ford Hospital, Detroit, being a notable one) the medical staff are unpaid, except for university appointments, the interns and residents. Some of them are university professors, others are associate physicians in practice in the community. There are, of course, variations of this pattern. Whilst these medical staffs have their own committees, e.g. Medical Records, Drugs, Tissue, etc., the Chief of Service principle, which is the practice on the Continent, is almost universal in the U.S.A. and Canada, so that policy formation was effected partly by the Committee system and partly by chiefs of service.

In each major department there is at least one chief of service who is clinical and administrative head, and we were led to believe that they exercised a responsible discipline over the medical staff in their service. The Chiefs of Service usually have a liaison committee with the Board of Trustees and meet regularly with them and the Executive Director. It is, however, rare for these senior medical staff to sit on the Board. For the associate physicians the arrangement between them and the hospital is that in return for treatment of ward patients and out-patients they admit their own patients freely to the private and semi-private parts (a substantial portion) of the hospital.

The patterns of administration in the larger hospitals which we saw have many common features. The executive director or superintendent or chief administrator is the chief agent of the Board of Trustees. He may be a medically qualified man or a layman, but if the former he devotes his whole time to the administration and is completely identified with the business side of the hospital. The administrative organisation follows the line and staff principle, well understood in British industrial management and taught in the University programmes as part of the organisation of management subject in the curriculum. In accordance with this principle the heads of special hospital departments are staff appointments, and they report at various points in the line administration. Thus in some hospitals the Director of Nursing (the Matron) is a staff person reporting to the Executive Director. Other staff appointments of this kind include the Chief Engineer, the Business Manager (Controller or Accountant) the Purchasing Agent (Supplies Officer), the Head of the Dietary (Catering), the Housekeeper. There was also a Personnel Officer, again a staff appointment who was normally responsible to the Executive Director and who dealt with staff matters of all kinds. He or she did not engage staff, but performed all the necessary preliminary steps for a selection to be made by the Department Head.

The Executive Director usually had a deputy, known as an associate director, and then a number of assistant directors. This was the line organisation, and the heads of the departments reported to and received instructions from one or other of these officers.

At the Grace-New Haven Community Hospital one of the assistant directors to Dr. Snoke was a doctor in charge of the ambulatory and emergency departments, (out-patient and casualty departments). There was a similar arrangement at Montreal, Toronto, and Detroit. The Director of Nursing was also occasionally of assistant director status.

The detail of the pattern of organisation changed with each hospital which we saw, but the general pattern was the same and can be briefly summarised bystating that all the hospital services were clearly under the control of the executive director and he was responsible to the Board for every branch of the hospital's activity. Within this general framework the medical staff treated their patients on a private contractual basis, and clinical matters were directed by Chiefs of service and they in turn were answerable through their committee to the Board of Trustees. The link between the executive director and the medical staff was clearly a vitalone; it was evident in some cases that it was the one which caused most anxiety. We were impressed with the organisational procedures in force to ensure that lines of command were understood, and we noted with interest that "case studies" of situations where lines of command were confused were used for instructional purposes in the graduate programmes.

At New Haven the Executive Director held a meeting twice weekly with his associate and assistant directors when each in turn referred to matters of interest in his own bailiwick which he considered to be of general interest. Also at weekly intervals at this Hospital the Executive Director held a meeting with his associate and assistant directors and all department heads, when the same informal procedure was followed. This meeting was attended by 29 people. It was claimed for this somewhat time-consuming practice that everyone was "in the picture" and grievances and misunderstandings were reduced to a minimum. At the Henry Ford Hospital there was a much more personal direction of affairs. The Executive Director with his associate and three assistant directors, were in regular daily contact (this was in part due to office layout) and it was claimed that any department head could bring a problem to anyone of them and feel confident that it would receive proper attention.

Whatever system was in force, often related to the personality of the Executive Director, we felt that in most cases all the necessary steps had been taken to make it clear to all as to where authority resided, and the systems were designed to reduce, in a complex organisation, areas of unspecified authority and responsibility to a minimum. This has been at the price of making certain professional departmental heads directly responsible to the administration. This certainly makes for clarity, but our stay was not long enough to assess its more deep-seated results.

(3) The Accreditation Scheme, Research Projects, etc.

The Accreditation Scheme

We discussed Accreditation with Mr. Stuart W. Knox, Director of the Connecticut Hospitals Association, and in Chicago at the American Hospitals Association. Reference was made to it at a number of places, and particularly in Toronto, where a Canadian Hospitals Commission has recently embarked on a separate Accreditation Scheme for Canada. Previously the Joint Commission on Accreditation of Hospitals in Chicago covered the United States of America and Canada.

Briefly, the Accreditation Scheme began with the American College of Surgeons who ran it from 1918 to 1953 and whose nominated inspectors visited hospitals to inspect standards and if appropriate awarded an accreditation certificate. This gave the hospital status, and equally lack of it was a serious disadvantage since the hospital's financial success depended on public confidence. Lack of this might set off a number of unfortunate events such as failure to recruit staff, refusal of recognition of training facilities, inability to secure state or federal assistance for capital development and - ultimately - closure.

The scheme is now controlled by a Joint Commission consisting of the American Colleges of Physicians and Surgeons, the American Hospitals Association and the American Medical Association. The Commission has headquarters in Chicago and it has a permanent staff of physicians as inspectors. Its strength lies in the fact that it was instituted by doctors themselves, that it is sponsored by the leading professional bodies in the country, and that the accreditation certificate is necessary for a hospital's success.

The Commissioners visit a hospital and put a substantial questionnaire to the Hospital Board and its officers and examine their answers to the questionnaire. The questions are divided into the following broad heads:-

1. Physical plant.
2. Administration.
3. Medical Staff Organisation. (This is a most detailed section of 12 broad sub-heads on type of staffing and methods of appointment; medical control and committee structure; review of clinical work done; liaison with the governing body; intern and resident services)
4. Medical Records.
5. Clinical Laboratory.
6. X-Ray Department.
7. Nursing Service
8. Dietary Department.
9. Complementary and Service Divisions:
    i. Medical Department
    ii. Surgical Department
    iii. Obstetrical Department
    iv. Anaesthesia Department
    v. Physical Medicine Department
    vi. Occupational Therapy Department
    vii. Pharmacy.
    viii. Out-patient Department
    ix. Medical Social Service Department.

A full copy of the questions under these broad headings is attached. It will be seen that the enquiry purports to be very searching indeed and one of the most interesting series of questions from a British point of view is the attention given to analysis and reports on clinical work and the work of the pathologist on tissue examination.

It will be noted that there are no references to finance and costing. The cost of running the scheme is about half a million dollars a year.

It should be emphasised that accreditation is not compulsory but all hospitals with any desire for local standing will aim to achieve it. We were told that one of the by-products of the post graduate refresher courses for administrators of small hospitals at Columbia University and Toronto University was a new awareness of the advantages of accreditation. The

Commissioners visit about once in three years and accreditation is for three years' duration. It sometimes happens that a hospital is given temporary approval, which means in effect that the hospital is "on probation."

We were led to understand that hospitals make every effort to meet the Commissioners' requirements and if these result in increased running costs they are passed immediately on to the patients.

The Canadians, who have recently introduced their own national hospital service, have also introduced their own accreditation scheme. The two stages are related, and the files on Canadian Hospitals in Chicago have been passed on to the new Canadian Commission. Some 150 hospitals will have to be surveyed by the Commission, and they are planning to cover them also over a three-year period, and because of the rigours of the North American winter, this will have to be done during the summer months.

It is, perhaps, relevant here to refer to the Canadian National Hospital Programme. With the exception of Saskatchewan, which has had a Provincial Hospital Programme since 1948, the rest of Canada, with the exception of Quebec, has been making preparations to take advantage of the Federal Government's legislation to provide free patient care based on an insurance principle. The exact method of implementation is left to the Provincial Governments, but if they take advantage of the Federal Government's action they may receive Federal aid for hospital development. This takes the form of a maximum capital grant of $2,000 dollars a bed towards new hospital provision which is intended to match equal or greater contributions from the Provinces and other sources. The present cost of providing a new bed varies between 12,000 and 15,000 dollars.

In Ontario a new body has been set up to administer the service, called the Ontario Hospital Services Commission. The Chief Commissioner has the rank of a Deputy Minister in the Province. Staff have been drawn from the ranks of senior administrators, medical and lay, nurses and other professional staff in hospitals in the Province. The organisation divides into two, the business side, dealing with the insurance and financial aspect and the hospital planning and consultative service. It was interesting to learn that they relied on the work of the Joint Commission on Accreditation and expected to continue to work closely with the new Canadian Accreditation Commissioners.

On payment of an insurance contribution, the public are entitled to free board and lodging and hospital services, with a small payment for the semi-private and private rooms. It does <u>not</u> cover medical treatment, and the private contractual arrangement between the patient and his doctor is fully preserved. The patient may, of course, additionally insure himself for this. Out-patient treatment is also excluded.

For 4.20 dollars a month, however, the basic coverage is achieved, for a family, or 2.10 dollars for a single person. The effect was brought home to me by a man whom I met, who told me that his wife had been in hospital for years with disseminated sclerosis. Before January 1st, he had been paying 64 dollars a week for her care. Since January 1st, under the new scheme, he had been paying 4.20 dollars a month.

The Ontatio Hospital Services Commission are planning a scheme for detailed examination of hospital budgets and statistics and a programme of hospital building. The organisation may well resemble in some ways the Regional Hospital Board organisation in the United Kingdom. Its development will be a most interesting study.

Other Research Projects

One word, more than any other, seemed to be in use wherever we went and to whomsoever we talked. Research. Often the term was used to describe the search for new data on the frontiers of knowledge. At other times the word was used to mean a study into existing situations where data were inadequate or uncertain. We were given to understand that those engaged in research of one form or another were unable to take up all the money which could be made available either from Federal sources or from private charitable organisations, of which there are many. Indeed, we got the impression occasionally that it was only necessary to have an idea to get access to funds to pursue it. This is an exaggeration, but sometimes one felt that a close examination into the proposed methodology and the likely outcome of a project were not always made. In contrast we were very impressed with the work and publications of the Health Information Foundation in New York. This body is financed by a number of leading drug houses in the U.S.A. Their publications are the result of sound investigation and study and are most attractively presented.

It must be made clear that what has been said on research is an impression after a brief tour and after many talks with many people, and the talks were often of short duration, but in the field of research which one was perhaps most qualified to understand - administrative and managerial research - one was conscious of the fact that the most prominent and promising hospital administrators were active. The stimulus is in line with the very nature of the American approach to all forms of activity but one felt that some of it arose because some of the Universities were playing an active part in the training of hospital administrators, and the background of learning and research had taken root in the schools of hospital administration. The curricula were by their very nature designed to stimulate inquiry and careful statistical study into health problems. The philanthropic foundations (notably the Kellogg Foundation) frequently helped to found these schools and they were very active in promoting and helping in research.

One was reminded of recent comment in the United Kingdom on the need for more research. Whilst it is clearly the business of the Ministry of Health to undertake research, it is equally important that hospital workers in the field should do so as well. It is not enough that all the thinking should be confined to the highest levels.

It is, therefore, important that centres should exist where such work can be fostered and guided, and fundamental that resources should be available for it.

To illustrate this somewhat generalised account, perhaps it will suffice to mention two particular areas of study.

At the University of Michigan at Ann Arbor we met Mr. Walter J. McNerney who was in charge of the school of Hospital Administrators which is linked with the school of Business Administration. Although his principal duties were in charge of the School, Mr. McNerney had with him a staff of experts in various fields, such as sociology, economics, statistics and demography. They were engaged in studies similar to the Nuffield Provincial Hospitals Trust work on hospital provision for a community, and in experiments on Regionalisation, a suspect word in the United States of America.

In addition, and in association with Dr. Virgil Slee, an analysis was being made into patient care. With the co-operation of hospital medical staffs examination was being made of sample admissions, enquiry made into diagnosis and need for admission; the subsequent treatment and results of the treatment. The study was similar in scope to the National Morbidity Enquiry being conducted by the General Register Office in this country. The study was also associated with the work of the tissue committees of the hospitals in question. The information was being handled by the statisticians demographers and economists and it was hoped that much new knowledge on the incidence of disease, treatment and results in a sample population would follow.

The second case was explained to us briefly at the American Hospital Association in Chicago. The study arose out of comments on results of some accreditation reports where it was felt that the quality of management was indifferent, but precise measurement of it was lacking. The American Hospital Association obtained financial support from the Ford Foundation to carry out a management audit enquiry. The enquiry was directed at the efficiency and responsibility of Boards of Trustees, their relations with their officers, the degree of delegation of function and the associated delegation of authority and so on. It might be supposed that this would be a very sensititve form of enquiry and we suggested that volunteers for it might be hard to find. We were assured that this was not the case. The three investigators, all hospital administrators with Master's degrees, had work enough to last a year. They were still engaged in improving their techniques after a number of pilot studies. We were promised more information when it was in a suitable form.

These two illustrations and this section are not specifically for the purpose of suggesting exactly similar studies in the United Kingdom. They are rather in the nature of a plea for a greater spirit of enquiry into our own service for a readiness to admit deficiencies and seek to improve them, and as an appeal for the wisest use of the slender non-exchequer funds which are available for our service.

Efficiency Methods in Hospitals

Coming fresh from the United Kingdom where work study and organisation and method are current topics of interest, we observed that neither expression aroused much interest and we could not detect that the same procedures under another name were in active operation. Yet the United States and Canada have their manpower problems and they are faced with high and increasing costs and the influence of both is being taken into account in design. The view could be held that if the cost of a service is automatically passed on to the patient and the cost is automatically met then the problem is not likely to be tackled on a cost reduction basis. This is not in fact true, for wherever we went we detected an anxiety about costs, and many were concerned as to the best methods of reducing costs whilst maintaining the level of efficiency of service.

There was, however, no special philosophy on work study and organisation and methods so far as they related to simplification of procedures, economy in manpower and elimination of unnecessary work. Much more attention was given to mechanisation and automation; occasionally one could not escape the feeling that the gadget was preferred for its own sake.

Our experience, perhaps, led us to add another cautionary note in our approach to work study. On the financial side it seems evident that no great savings can be achieved and such savings as are made must inevitably be ploughed back elsewhere. This is the general experience of those who have had the advice of experts in the field. On the oganisational side the need for a new species of hospital administrative officer (work study) has certainly not been demonstrated in the U.S.A. On the other hand, the view is held strongly in some quarters that heads of departments (e.g. laundry, catering) should be trained or versed in the principles of efficiency techniques and positively encouraged to keep them in mind at all times, both in planning their departments and running them. The use of the expert consultant from time to time is a common practice and is clearly an advantage.

(4) Some Impressions on Hospitals Visited

All except two of the hospitals we visited were teaching hospitals. We were aware of the dangers of coming to any conclusions from such a narrow study. Something like 30% of the hospital beds in the United States are provided directly by the Federal Government, and a substantial number of these are the Veterans' Hospitals, built to serve the needs of ex-service men, and they are reputed to be of very high quality. A large number of smaller hospitals have been built by States and local authorities under the Hill-Burton Act, whereby federal aid is available for such construction in under hospitalised areas. We were told repeatedly of the many small hospitals - over 50% of all hospitals in the United States have less than 100 beds - particularly in the south and west and away from the big cities of the east.

The two exceptions mentioned above were the Henry Ford Hospital in Detroit and a 150-bedded community hospital at Battle Creek, Michigan.

Most of the hospitals we saw were new or contained substantial new construction. They were without exception built on the vertical principle. The chief impression which one had was that of space. We did not have time to judge whether the space was effectively used or had been designed to secure the maximum economy in staff movement. The lesson for British constructions seems to be that it is false economy to reduce space to minimum figures. Experience in this country has repeatedly shown the need for expansion, and particularly for reorganisation of space, and neither of these is possible if the original design is on minimum standards.

The patients' accommodation is provided almost universally on the continental pattern, that is single rooms, double rooms and rooms for four. The design was of three general types; the most straight-forward was to have the rooms on one side of a corridor and the service rooms on the other with the Head Nurse's station at the end or half way along the service. The L design which is the feature of the Slough hospital development was also used, and particularly in the psychiatric units and we were told that it worked well. Another design provided for the service and utility rooms in a central block and with a circulating corridor around and the patients' rooms on the outside. This was a most interesting design, since it required greater overall width of building and meant necessarily that some rooms continually needed artificial light. They also needed ventilation and air conditioning. In a country where the latter becomes essential during the summer months, we were advised that it worked well and the staff were happy with it - unless, of course, there was a plant breakdown. The pattern was in use at the Henry Ford Hospital, Detroit; it had been completed and was being brought into use at the Toronto General Hospital and was in the course of construction at the Royal Victoria Hospital Montreal. The possibilities of internal replanning were, of course, greatly increased because of the increased room for manoeuvre made possible by greater width.

Most of these patient units contained about 24 to 30 beds and almost invariably the Head Nurse had a clerk sitting at the nurses' station. With a system where almost all items of service (e.g. pathology, X-ray, drugs, special nursing) ultimately appear for payment on the patient's bill, clerical help of this kind is a necessity.

The ward kitchens were, for the most part, liberally provided with space and equipment. They included provision for light meals and among the

common equipment were a dish washing machine, ample refrigeration and ice-making apparatus. It was a common practice to present patients with a menu offering a choice of food, so that the extra space was very necessary for the preparation and sorting out individual patient's requirements.

For the most part food was brought to the floors in heated trolleys from the kitchens, though we did see the tray-veyor system in action. This system is possible in a vertically designed building where the kitchens are either directly above or below the patients' accommodation. The tray-veyor is a continuous vertical transporter and a tray placed in the shaft at kitchen level would be removed at the appropriate floor. We were told that six minutes was the average time between kitchen and patient. The possibilities of mechanical breakdown were not remote, and with all the other hazards, including infection, present, the heated trolley service seemed the best.

Other mechanical devices which attracted our attention were the pneumatic tube system of communication between floors and other departments, linen chutes, a liberal distribution of vacuum points in corridors and rooms, a liberal supply of mechanical cleaning appliances, and the call system between rooms and the nurses' station.

The one common feature on all items of equipment is that they are subject to mechanical breakdown and human error, and it is most important to have an arrangement whereby immediate expert advice could be obtained when faults occurred. On the tray-veyor system, for example, the hospital concerned had a contract with the manufacturer for an on-call service. We were told that the cost of this service was very high.

Another feature of the hospitals we saw was the role played by the out-patient and casualty departments, normally described as the ambulatory and emergency service. It was here that the words "indigent patient" were most frequently heard and these words were reminiscent of a vanished past in British ears. In the big new hospitals which we saw these departments often occupied the less favourably placed spaces in the buildings. The waiting accommodation was frequently reminiscent of what we are trying to get away from in the United Kingdom. There were rows of benches in depressing waiting areas where the patients were usually waiting to see a registrar (a social worker) who made a fairly extensive preliminary investigation into the patient's history, circumstances and means. From this point they would be referred to "residents" who would attend to their medical needs. Another feature of these departments was the accounts office, where patients paid, on the spot, for the treatment provided and drugs received.

Generally speaking, we were surprised at the smallness of the load on these out-patient departments. For example, at the Grace-New Haven Community Hospital of 600 beds the total attendances were less than 150,000. We were advised that most people would see their physician at his private office and he would arrange any necessary treatment there or admit them to the private or semi-private parts of the hospital. Almost all such patients would have some form of insurance which would at least cover part of the cost of hospitalisation. Thus only patients whose means were inadequate or non-existent would tend to use the out-patient departments.

Generally speaking, the clinic areas were extensive and waiting provision in each area adequate. Again, however, the hospitals we saw

were mainly teaching hospitals and the areas were designed having regard to the amount of teaching to be done.

In most of the new construction provision had been made for psychiatric units and we saw a number of them at New York Hospital, Montreal General Hospital and the University of Chicago Clinics. The units varied in size from 30 to 100 beds. Each of them maintained a day hospital and in some cases the unit was combined with a night hospital. Patients who were well enough to go to work and not well enough to go home were treated at the Hospital and slept there. There was much stress on the informality of the atmosphere and in the University of Chicago Clinics the staff did not wear uniform. In each case the average length of stay was about six weeks; admissions were, as far as possible, restricted to cases with a good prognosis, though there was no social bias. Each unit was said to be too small and the general hospital side referred from time to time to the psychiatrists' increasing demands for space.

They all said they would welcome access to grounds or gardens for the psychiatric units; in all cases they occupied floors of large blocks.

Perhaps the most interesting unit was the Massachusetts Mental Health Centre in Boston, the creation of Dr. Solomon, now State Commissioner of Mental Health for Massachusetts. The unit is under the energetic direction of Dr. Jack Ewalt and forms part of the Harvard Medical School. It has 150 beds, and a special research unit of 10 beds for children. The 150 beds include 11 beds for a night hospital. Because of its research and teaching activities, it has over 100 medical staff, and Dr. Ewalt freely acknowledged their good fortune.

Cases are referred by physicians, the courts, by other hospitals, and others arrive on their own accord. They confess not to be selective. Each arrival is received by a nurse and a social worker in a charming room with a completely non-institutional atmosphere. Coffee is provided, and after an appropriate interval a doctor arrives.

The cases are allocated to units in the care of a psychiatric team and not to a particular psychiatrist. Thus all the patients in a particular unit would be in the care of the same team.

We were impressed by the informal and friendly atmosphere. The entrance lobby was made like the lobby of an hotel, with a shop in a corner presided over by a patient. (Patients also run the cafeteria service at which all persons in the building eat during the day). Visitors, patients and staff mixed freely and cab drivers arrived and departed with people and their belongings.

The patients' accommodation was a dormitory pattern with divan beds and the ward atmosphere was completely absent. The rooms were mainly open to the corridors; they contained occupational therapy work, books and television. Occupational therapy had been decentralised to the patients' rooms, since expansion of the unit had precluded appropriate expansion of an occupational therapy department. Provided the necessary staff were forthcoming they favoured taking occupational therapy to the patients.

One could not fail to be impressed with the atmosphere of this unit; with the friendly spirit and the almost complete absence of institutional

surroundings. To the tidy mind it might give offence because of its seeming lack of order, but one could not but feel that there is room for much experiment in the United Kingdom on this type of institution.

There are one or two other general impressions which might be recorded here.

The universality of the cafeteria system in all the hospitals, big and small, new and not so new, which provide large, open, cheerful spaces for staff and visitors. All staff, Board members and visitors take a tray and join the line and take their choice - paying (except for special guests) at the end of the line. The one concession occasionally seen was to the medical staff who were permitted a recess in the main room to talk over their subject at lunch.

A lack of accurate knowledge of the British hospital service was generally evident, and when it was mentioned it was mentioned in the sense of it being something which must inevitably happen in the U.S.A.

We felt that the British hospital service needed more active and informed propaganda in North America. Perhaps a more regular exchange of men and women working in hospitals on both sides of the Atlantic might help to bring this about.

Frequent high praise for British nurses and nursing was expressed. Contrary to the impression gained in England one found that, whatever the formalities might be in reciprocity, the standard of British nursing remains as high as ever it did. A midwifery sister in New Haven was nostalgic for the British way of doing things. She had, by some special arrangement, been able to run the obstetric department at the hospital without getting the necessary post graduate certificate. She told us that she would have to go back to "school" if she sought a similar post elsewhere. The nursing profession in the U.S.A. seems to share the universal passion for the University Degree in the subjects of the chosen profession as being an essential prerequisite for employment; which accounts for the extremely wide range of available courses of instruction, unheard of in British Universities.

In conclusion, I should like to thank all concerned in the U.S.A. and Canada for the tremendous hospitality and kindness which we received; it would be difficult to single out any particular hospital or individual since wherever we went we were most warmly welcomed and generously treated. I should, however, like to pay special tribute to the Kellogg Foundation and Dr. Andrew Pattullo in Battle Creek, and the American Hospitals Association and Dr. Edwin Crosby and his staff in Chicago.

June, 1959.

A.J. BENNETT

Visit to U.S.A. and Canada. April-May 1959

People met during Visit

NEW YORK CITY, N.Y.

Dr. Ray E. Trussell	Associate Dean (Public Health)	Columbia University School of Public Health and Administrative Medicine of the Faculty of Medicine.
Raymond P. Sloan	Associate Professor	- do. -
Harold Baumgarten, Jr.	Program Director, Hospital Administration	- do. -
Dr. Clement C. Clay		- do. -
Dr. E.M. Bluestone, M.D.		Columbia University and New York University.
Dr. Sterling D. Spero	Dean	New York University, Graduate School of Public Administration and Social Service.
Professor Frank Cohen		- do. -
Troy Westmeyer		- do. -
George Bugbee	President	Health Information Foundation.
Dr. Odin W. Anderson	Research Director	- do. -
Dr. August H. Groeshel	Associate Director	New York Hospital.
Dr. Hamilton		Psychiatric Op. Dept., New York Hospital.
Dr. E. D. Rosenfeldt, M.D.	Consultant	Hadassah Hebrew University Medical Center, Hadassah.
Dr. Hadyn Nicholson	Director	Hospital Council of New York.
Harvey Schoenfeld	Director	Barnet Memorial Hospital, Paterson, New Jersey.

NEW HAVEN, CONNECTICUT

Dr. Albert W. Snoke, M.D.	Director	Grace-New Haven Community Hospital.
John T. Law	Associate Director (Administration)	- do. -
Dr. Raymond S. Duff, M.D.	Assistant Director (Out-Patients)	- do. -
Miss Anna E. Ryle	Assistant Director and Director Nursing Service & Nursing Education	- do. -
John E. Ives	Assistant Director (Administration)	- do. -
Alfred H. Marshall	Public Relations Director	- do. -

NEW HAVEN, CONNECTICUT (Contd...)

Dr. Hiscock	Chairman	Public Health Department, Yale University.
George S. Buis		Hospital Administration Program, Yale Universi
Robert J. Pelletier	Research Assistant	Brady Memorial Laboratory Yale University.
Dr. Lepage	Dean	Grace-New Haven Community Hospital Medical School
Stuart Knox	Executive Director	Connecticut Hospitals Association.

BOSTON (AND CAMBRIDGE), MASSACHUSETTS

Professor T. North Whitehead	Lately Director	Radcliffe College, Harvard University.
Professor Fritz Roethlisbruger		The Harvard School of Business Administration.
Mathew Roberts	Associate Director	Management Training Progr Harvard University.
Dr. Jack Ewalt	Professor of Psychiatry and Director	Harvard University Massachusetts Mental Health Center.
Dr. Greenblatt	Deputy Director	Massachusetts Mental Health Center.
Dr. Solomon	Commissioner of Mental Health	Massachusetts.
Dr. Hugh Leavell	Professor of Public Health Practice	Harvard School of Public Health.
Dr. Philip Bonnett, M.D.	Director	Massachusetts Memorial Hospital.
Dr. Dean A. Clark, M.D.	General Director	Massachusetts General Hospital.
Miss Ellen Adam	Personnel Director	New England Deaconess Hospital.

MONTREAL- CANADA

Col. Ogilvie	President	Montreal General Hospital.
A. H. Westbury	Executive Director	- do. -
Dr. Storran	Medical Director	- do. -
Dr. James D. Conant	1955-57 Ambassador Extraordinary and Minister Plenipotentiary of U.S. to Germany. 1953-55 U.S. High Commissioner to Germany. 1933-53 President, Harvard University.	
Mr. Hogan	Business Manager	Montreal Neurological Institute.

MONTREAL - CANADA (Contd.)		
Dr. J. Gilbert Turner	Executive Director	Royal Victoria Hospital, Montreal.
Ray S. Clark	Assistant Director	- do. -
TORONTO - CANADA		
Dr. Doug. Piercey	Director and Assistant Professor	Canadian Hospitals Association School of Hygiene University of Toronto.
K. S. McLaren	Professor and Director	Kellogg Residence Research Project, School of Hygiene, University of Toronto.
Dr. D.L.Maclean, O.B.E.,M.D.	Secretary	School of Hygiene.
Dr. N. E.McKinnon, M.D.		Department of Epidemiology and Biometrics, School of Hygiene.
Mr. Builder		Department of Hospital Administration, School of Hygiene.
Dr. Noonan		Ontario Hospital Services Commission.
Dr. Stocker		- do. -
Dr. Peters		- do. -
Dr. Sharpe	Director	Toronto General Hospital.
Dr. Doyle	Assistant Director	- do. -
DETROIT, MICHIGAN		
Dr. Robin C. Buerki	Executive Director	Henry Ford Hospital.
David Everhart	Assistant Director	- do. -
Dr. Howells	Assistant Director	- do. -
ANN ARBOR, MICHIGAN		
Walter J. McNerney	Professor of Hospital Administration and Director	Program in Hospital Administration, University of Michigan.
E. J. Connors	Assistant Professor of Hospital Administration	- do. -
BATTLE CREEK, MICHIGAN		
Dr. Emory W. Morris	President	W. K. Kellogg Foundation.
Andrew Pattullo	Director, Division of Hospitals	- do. -
Mr. Roote	Administrator	Community Hospital

CHICAGO, ILLINOIS

Richard Johnson		American Hospitals Assoc
Jack Owen		- do. -
Robert C. Borczon		- do. -
Dr. Anderson		- do. -
James A. Connelly	Associate Director	University of Chicago Clinics, Billings Hospital.
Vernon Forsman		Hospital Administration Program, University of Chicago.
Mrs. Sophie Zimmermann	Co-ordinator	- do. -
Al Van Horn	Assistant Director	American College of Hospital Administrators

PITTSBURGH

Conference of the Association of University Programs in Hospital Administration. In addition to many of those listed above, we met many others, including:-

Dr. Harvey Agnew		Department of Hospital Administration, University of Toronto.
Keith Taylor	Professor of Hospital Administration	School of Public Health, University of California.
Dr. McGibony		University of Michigan.
Jim Stephan		Program in Hospital Administration, University of Minnesota.
Roger Klein	Director	Graduate Program in Hospital Administration, Emory University.

ESSENTIAL DIVISIONS

PHYSICAL PLANT

Part 1 - (1)

1. Is the physical plant,
   a. Fireproof construction?
      Type of construction:
      Date of completion:
   b. Protected against fire hazards?
      Note if fire drills are held and if fire extinguishers are present, in good order and tested frequently.
   c. Equipped and designed for quick evacuation of patients?
   d. Clean and sanitary?
   e. In good state of maintenance?

2. Are there facilities for,
   a. Segregation of patients by services?
   b. Isolation of patients?

ADMINISTRATION

Part 1 - (2)

1. Does the method of selecting members of the governing board assure the best type of representation?
   a. How often does the board meet?
   b. What committees do they have?
   c. Do the trustees value their position as such?

2. Is the general atmosphere of the hospital,
   a. Pleasant with cheerful wards?
   b. Suggestive of a reasonable amount of interest shown in the patient?

3. Is the administrator trained and experienced in hospital administration?

4. Does personnel take advantage of organized institutes, national, state and other meetings?

5. Is there overcrowding that is detrimental to patient care?

MEDICAL STAFF ORGANIZATION

Part 1 - (3)

1. Is medical staff organized on the
   a. Open plan and not controlled?
   b. Open, but controlled?
   c. Closed plan?

2. Are the by-laws, rules and regulations acceptable?
   a. Enforced? When Revised?
   b. Signed by all members of the medical staff?

3. Are written applications for staff membership required?
   a. Complete for all members?
   b. Do they contain the principles of financial relations in the professional care of the patient?
   c. Are members selected for the medical staff only after submission of written application and credentials?
   d. Are appointments made by the board only on the recommendations of the medical staff?

4. Is the membership of the medical staff restricted to,
   a. Graduates of approved medical schools?
   b. Licensees of the state or province and in good standing?
   c. Members of, or eligible for, the local medical society?

5. Are medical staff appointments made annually?

6. Are the medical staff groups clearly defined as to their privileges and duties?
   Honorary Consulting Active Associate Courtesy Other

7. Is there a chief or president of the medical staff? Name:
   a. Active departmentalization with duly appointed heads, as follows?
      Medicine Surgery Obstetrics and Gynecology
      General Practice Dentistry Other
   b. Essential committees of the medical staff? Executive Credentials
      Joint Conference Program Other

8. What is the net death rate?

9. Is there a thorough review and analysis of clinical work done monthly?
   Are minutes of the medical staff meetings recorded?
   Do they show a thorough review and analysis of the clinical work?
   a. Review of selected patients in the hospital at the time of the meeting?
   b. Review of selected cases discharged since the last meeting?
   c. Analysis of clinical reports from each department?
   d. Reports of committees?
   e. Discussion and recommendations for the improvement of the professional work in the hospital?

10. Does the medical staff maintain satisfactory liaison with the governing board?

   a. Is the administrator the official contact between the two?
   b. Does the governing board exhibit due care in the approval of recommended new members of the medical staff?

11. Does the hospital maintain intern and/or resident services?
   Interns.
   Number: Length of service: Type:
   Residents.
   Number: Length of service: Type:
   Are they graduates of approved medical schools?

12. Does the hospital maintain an organized medical reference library current texts and periodicals? Is it used by the medical staff?

MEDICAL RECORD DEPARTMENT

Part 1 - (4)

1. Do the medical records contain the essential information?

2. Who is head of the medical record department?
   a. Registered?
   b. Equivalently qualified?
   c. Provided with sufficient assistants?
   d. A member of the American or Canadian Association of Medical Record Librarians, state or local association?
   e. Privileged to attend meetings-local, institutes or extension courses?

3. Do only attending doctors, residents or interns write or dictate the medical records?

4. Are records written promptly after admission of the patient and are they signed by the doctor?

5. Is there an active record committee of the medical staff?
   a. If active, do they control the quality of the records?
   b. Are all records examined by the committee before filing?
   c. If not, are records checked by the chief of service when making daily rounds?

6. Is the completed medical record always signed by the attending doctor?

7. Are the medical records filed by?
   a. Serial No.:
   b. Unit No.:

   And cross-indexed according to?
   a. Disease:
   b. Operation:
   c. Doctor:
   d. Is the indexing complete to date within normal limits?

   Is the filing system satisfactory? Are number of unfiled records within normal limits? (should not exceed one month's discharges.)

8. What nomenclature is used?

9. Are the medical records used for group studies by the medical staff?

CLINICAL LABORATORY

Part 1 - (5)

1. Is the clinical laboratory operated by the hospital and is the equipment owned by it?

2. Is the location suitable with adequate space?

3. Are there facilities in the laboratory or by arrangement with other institutions, municipal, county or state health departments, for laboratory examinations under the following headings?
   a. Chemical:
   b. Bacteriological:
   c. Pathological:
   d. Serological:
   e. Rapid diagnosis by frozen section:

4. Are there supplementary laboratory services available as follows?
   a. Blood bank:
   b. Donor list for whole blood transfusions:

5. Has the hospital the services of a clinical pathologist?
   Has the hospital the services of a consulting pathologist if no full or part time person is employed?

6. Is there an adequate number of qualified technicians to handle all the laboratory work efficiently?

7. Are all tissues removed at operation examined, reported on in writing, and the report signed by the pathologist?
   a. Gross. b. Microscopic c. Does examination of the pathological records indicate an excess or normal tissues removed?

8. Are the filing and reporting systems for laboratory examinations satisfactory?
   a. Is a copy signed by the pathologist filed with the patient's record?
   b. Filed in duplicate in the laboratory?
   c. Cross-indexed?

9. Are reports of completed clinical laboratory work submitted to the administration monthly?

10. Are requisitions for clinical laboratory examinations in writing?

11. Are routine laboratory examinations required on all patients on admission? (Urinalysis, blood counts, examination for syphilis etc.)

12. What is the autopsy rate for the past year?

X-RAY DEPARTMENT

Part 1 - (6)

1. Is the x-ray department operated, and is the equipment owned, by the hospital?
   a. Is space adequate? b. Is location satisfactory?

2. Are there facilities for,
   a. Radiography?
   b. Fluoroscopy?
   c. Superficial therapy?
   d. Deep therapy?
   e. Bedside radiography?

3. Is the department free from hazards?
   a. Equipment shock-proof?
   b. Department protected by the usual safety measures? Enforced?

4. Is there a radiologist in charge of the department?
   a. Name:
   b. Qualifications:
      Full time: Part time: Time spent:
   c. Has the hospital the services of a consultant radiologist, if no full time or part time person is employed?

5. Are the reports of interpretations in writing or dictated and signed by the radiologist? Are requisitions for x-ray examinations in writing?

6. Is the filing system for x-ray reports satisfactory?
   a. Is a copy signed by the radiologist filed with patient's record?
   b. Is a duplicate filed in the department.
   c. Cross-indexed?

7. Are there a sufficient number of qualified technicians to handle all the x-ray work efficiently?
   a. Registered: Full time: Part time:
   b. Equivalently qualified: Full time: Part time:
   c. Trained or in training: Full time: Part time:

8. Are summaries of the completed work submitted monthly to the administration?

9. Are routine x-rays of chest taken on admission?

NURSING SERVICE

Part 1 - (7)

1. Are there a sufficient number of nurses to give good nursing service to the patients?

2. Is each ward or department under competent registered graduate nurse supervision?

3. Does the graduate nursing staff hold regular conferences? If so, How often?

4. If a School of Nursing is maintained, by whom is it accredited?

DIETARY DEPARTMENT

Part 1 - (8)

1. Is the department organized under a qualified dietitian?

2. Are there sufficient assistant dietitians?

3. Has the department,
   a. Adequate modern equipment?
   b. Facilities for therapeutic diets?
   c. Adequate number of personne
   d. Clean and sanitary facilitie

4. Has the department personnel access to the clinical records?
Is there cooperation with the medical staff?

COMPLEMENTARY AND SERVICE DIVISIONS

MEDICAL DEPARTMENT

Part II (1)

1. Is there a well qualified medical staff? Total membership:
F.A.C.P. or F.R.C.P.: Equivalent qualifications:
Diplomats of boards: General practitioners:

2. Is there active division of the medical department under the following services?
Are heads appointed to each division?

General medicine	Cardiology	Communicable disease	Dermatology
Endocrinology	Gastroenterology	Metabolic diseases	Psychiatry
Pediatrics	Tuberculosis	Other	

3. Do the records justify the diagnosis and treatment,
   a. By a complete history and physical examination?
   b. By laboratory and other diagnostic tests?

4. Are consultations required in all critically ill cases under medical staff rules and regulations? Are they always recorded?

5. Has the department,
   a. An electrocardiograph, with a member of the medical staff qualified to interpret electrocardiograms?
   b. Equipment for the estimation of basal metabolic rates?

SURGICAL DEPARTMENT

Part II (2)

1. Is there a well qualified surgical staff?_____ Total membership_____
F.A.C.S. or F.R.C.S.:_____Equivalent qualifications_____
Diplomats of boards:_____ _____General practitioners:_____

2. Is there active division of the surgical department under the following services?
Are heads appointed to each division?
General surgery_____Fractures and other traumas_____Neurosurgery_____
Ophthalmology _____Otorhinolaryngology_____Orthopedic____Plastic___
Oral and maxillofacial_____Proctology_____Thoracic_____Tumor_____
Urology_____Other_____

3. Has the hospital a surgical department which is
   a. Properly located?_____
   b. Provided with a sufficient number of operating rooms that are adequately equipped?
   c. Adequately staffed with qualified personnel?

4. Which of the following methods are used to prevent unnecessary and/or incompetent surgery?_____
   a. Supervision by the head of the department:_____
   b. Surgical staff committee:_____
   c. Limitation of surgical privileges:_____ _____
   d. Routine tissue examination:_____
   e. Operating room supervisor and/or administrator_____
Do they provide adequate control?_____

5. Does the surgeon have a qualified medical assistant in all operations?____
Resident____Intern____Referring physician____Other_____
Does the operating room register record the first assistants?_____
Is register complete and up to date?_____

6. Is sterilization of surgical supplies and water adequately controlled by any of the following methods?_____
   a. Recording thermometer on the discharge line:_____
   b. Fusion tubes:_____
   c. Color indicators:_____
   d. Periodic cultures:_____How often?_____

7. Do the surgical records justify the diagnosis and operation by:
   a. Sufficient recorded evidence of preoperative study?_____
   b. Record of surgeon's preoperative diagnosis?_____
   c. An operative report describing technique and findings,,written or dictated immediately following operation, and signed by the surgeon?___

8. Are all infections of clean surgical cases routinely recorded and reported to the administration?

9. Is the postoperative infection rate minimal?

10. Is a consultation required under the medical staff rules and regulations? Is it always recorded?
   a. In all critically ill cases?
   b. In cases in which the diagnosis is obscure?

11. Is the postoperative death rate within reasonable limits?

OBSTETRICAL DEPARTMENT

Part II - (3)

1. Is there a well qualified staff to do normal and operative obstetrics?

2. Has the hospital an obstetrical department in which,
   a. The delivery room is properly located?
   b. The patients are completely segregated from other patients in the hospital?
   c. There are isolation facilities for obstetrical patients?
   d. There are isolation facilities for the newborn?

3. Has the department,
   a. Competent graduate nurse supervision?
   b. Completely separate nursing service?

4. Do the obstetrical records contain the essential information?

5. Is the newborn nursery under the supervision of a qualified pediatrician?

6. Is there an adequate review and analysis of selected obstetrical cases at,
   a. Medical staff meetings?
   b. Department clinical meetings?

7. Is the morbidity standard of the American Committee on Maternal Welfare, or its equivalent, used?

8. Is the usual strict nursery technique observed?

9. Are the following statistics within reasonable limits?
   a. Cesarean section rate:
   b. Maternal mortality rate:
   c. Infant mortality rate:

30. Is consultation required under medical staff rules and regulations?
Is it always recorded and signed by the consultant?
a. In all major gynecological and obstetrical surgery?
b. In sterilizations and therapeutic abortions?

ANESTHESIA DEPARTMENT

Part II - (4)

1. Has the hospital a department of anesthesia?
Who of the following administer anesthetics:
a. Qualified medical anesthesiologist in charge:
b. Other qualified assistant medical anesthesiologists:
c. Registered nurse anesthetists:
d. Graduate nurses:
e. Interns and/or residents:
f. Referring physicians:
g. Other than referring phsicians:

2. Are all standard anesthetic agents used? If not, note those that are,
a. Ether:
b. Nitrous oxide:
c. Regional blocks:
d. Spinals
e. Cyclopropane:
f. Ethylene:
g. Sodium pentothal:
h. Curare
i. other

3. Does the pre-anesthetic investigation always include record of,
a. Physical examination?
b. Urinalysis and hemoglobin estimation?

4. Is there a record of post-anesthetic follow-up by the anesthetist?

5. Is there a post-anesthesia recovery room adjacent to the operating suite maintained with complete recussitative equipment?
Is the recovery room under the supervision of the director of the department?

6. Are adequate precautions taken against the usual explosion and fire hazards in the operating suite? It should be noted if,
a. Equipment is shock-proof, i.e. lights, outlets, etc.:
b. There is humidity control in operating rooms:
c. There is careful technique on the part of the anesthetists:
d. Electro-cautery is ever used in the presence of explosive gases:
e. Grounding precautions are taken:

PHYSICAL MEDICINE DEPARTMENT

Part II - (5)

1. Is the department under the supervision of a physician trained in physical medicine?

PHYSICAL THERAPY

Part II - (5a)

1. Is the location suitable with adequate space?

2. Is there an adequate number of physical therapy technicians to carry on the work of the department?

How many are:

a. Registered:	Full time:	Part time:
b. Equivalently qualified:	Full time:	Part time:
c. Trained or in training:	Full time:	Part time:

3. Is the equipment provided consistent in extent and variety with the size of the hospital, department, and the volume of cases treated?
Note facilities and equipment under the following headings:

a. Hydrotherapy:	d. Exercise:
b. Ultraviolet:	e. Massage:
c. Electrotherapy:	f. Heat:

4. Are all prescriptions for treatment written by the referring physician?

5. Are the records of treatment,
a. Filed on the patient's chart? b. Filed in the department?

OCCUPATIONAL THERAPY

Part II - (5b)

1. Is the location suitable with adequate space?

2. Is there an adequate number of occupational therapy technicians to carry on the work of the department?

	How Many Are:	
a. Registered:	Full time:	Part time:
b. Equivalently qualified:	Full time:	Part time:
c. Trained or in training:	Full time:	Part time:
d. Volunteers or untrained:	Full time:	Part time:

3. Is the variety of occupational therapy equipment, and are the programs diverse enough for the number and types of patients treated?

4. Are all prescriptions for treatment written by the referring physician?

5. Are the records of treatment,
a. Filed on the patient's chart? b. Filed in the department?

PHARMACY

Part II - (6)

1. Is the location suitable with adequate space?

2. Does the hospital have a,
a. Well stocked pharmacy with a registered pharmacist? Drug room only?
b. Is the pharmacy well equipped?
c. Is there control of the department in the absence of the pharmacist?

3. Are only U.S.P., N.F. and N.N.R. preparations used?

4. Are narcotics handled under properly controlled conditions?

5. Is there an active pharmacy committee of the medical staff?
Has a hospital formulary been adopted and is kept up to date?

OUTPATIENT DEPARTMENT

Part II - (7)

1. Are there adequate physical facilities?

2. Is the department,
a. Fully departmentalized? b. Under medical supervision?
c. Organized for special services?

3. Are there acceptable medical records,
   a. Filed in the department?
   b. Filed in the central record room?
   c. Correlated with inpatient records when patients are admitted to the hospital?
   d. Summarized and discussed at the monthly medical staff meetings or departmental conferences?

4. Is there adequate personnel to assure proper care of patients?

MEDICAL SOCIAL SERVICE DEPARTMENT

Part II - (8)

1. Is the location suitable with adequate space?

2. Is the department under the supervision of a qualified medical social service worker?
   Name: Qualifications:

3. What is the extent of investigation by this department?
   a. Medical:
   b. Financial welfare:
   c. Follow-up of discharged patients:
   d. Rehabilitation of patients:
   e. Environmental - for information of attending physician:

4. Are medical social service records,
   a. Filed on patient's record?
   b. Filed in the department?

5. Is there cooperation and interest on the part of the medical staff in medical social service?


572 020000 048572


572 020000 048572