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**INTRODUCTION:** From emoggy Kuwait to ~~Qaid~~ Oman the patriarchal rulers of the Arabian Gulf States are daily being confronted by the disruptive impact of cultural innovation as a result of technological development. In large measure their difficulties emerge out of the absence of skilled planners to articulate a development framework of prioritized objectives. On the operational side of the equation the problem is much the same: execution of complex projects oft times goes awry as a result of the absence of nationals trained to effect systematic project implementation

This article focuses on one side of the equation: the implementation side.

Preliminary discussions held between the Minister of Health and the writer during mid-1977 revealed the Minister's priorities: reorganize the administrative management of the existing 430 bed hospital; coordinate the commissioning of the new 620 medical center and, finally, manage it.

This article details the administrative framework in which the project was initiated, the steps taken to execute the administrative reorganization, and the impact of these changes on the structure, function and attitudes of participants.

It is believed that this report can be viewed as a handbook for effecting a hospital administrative reorganization in virtually any developing country in the world which is undergoing rapid technological development and in which exists a realization on the part of the country's leadership of the need for trained managers to create the organizational conditions required to effectively utilize the new technology and control its outcomes by means of integrating elements of cultural innovation into an orchestrated administrative process

**PART 1 THE ORGANIZATIONAL STRUCTURE AND FUNCTIONS OF THE MINISTRY OF HEALTH  
PRIOR TO REORGANIZATION.**

The Minister of Health: As the Hospital Administrator is the head of his hospital, the Minister of Health sits as the head of his Ministry. As the Administrator is responsible to the Governing Body and the community which he serves, the Minister is responsible to the Council of Ministers and the nation whose interests he serves in the provision of health care services. As an administrator, the Minister of Health must coordinate and execute all functions of his Ministry through his two Assistant Under Secretaries and the Directors of Divisions reporting to them. In brief, the Minister initiates all major activities and undertakings, is responsible for overseeing follow-through on the part of his two Assistant Under Secretaries and lastly, he is the final authority, short of the Ministry of Justice and Islamic Affairs, on matters of policy formulation and interpretation.

The Assistant Under Secretary for Technical Affairs (AUT), is an American educated, board-certified Pediatrician. His responsibilities include policy recommendations to the Minister for Ministry staff from technicians thru nursing to members of the medical staff. Categories of staff who are not defined as technical include food service workers, cleaning staff, linen-laundry personnel etc. The bulk of the AUT's time is devoted to effecting promotions for members of the medical staff and advising the Minister on expatriate doctor contract renewals.

The Assistant Under Secretary for Administration and Training (AUA), occupies a key role throughout the Ministry system. AUA directs the activities of the Directorates of Personnel, Finance, Materials, Nursing, Training (College of Health Sciences), and General Services (Ministry-wide engineering and maintenance services).

The Director of Finance and Personnel (DFP), a certified public accountant, occupies the single most powerful operational position within the Ministry structure. All financial matters must pass through him; all personnel matters likewise must pass his review and approval. While he is a qualified

professional, his perception of his function is primarily that of saving the government money through demanding stringency in effecting new personnel budgets and then impacting more heavily through non-implementation of recruitment for newly approved positions.

The DFP, responsible for maintaining an accurate manpower count, is unable to provide these figures. The manual system he maintains enumerates 3,375 positions Ministry-wide but he is unable to state where the personnel are located, i.e., hospital, maternity hospital, public health, etc. This lack of detail combined with the personnel budgeting system leads to continual disputes over what positions have in fact been approved. The DFP maintains one set of records, the Civil Service Bureau another and finally the Ministry of Finance comes in with yet a third listing of 'funded' positions. The lists typically do not agree, one of the reasons being that translators will make different interpretations from Arabic, the official government languages, to English, the functional language. Perhaps the most salient observation regarding the personnel budgeting process was made by the DFP: "It doesn't make any difference what limits the Ministry of Finance imposes on me because they have no way of knowing how many people I have. You see, they only know the gross amount of funds I require on a monthly basis and this doesn't tell them anything about numbers...we're O.K. until they get their computer next year".

The Director of Materials Management(DOM), is assigned the responsibility for purchasing supplies and overseeing their distribution throughout the Ministry system. Aside from a chronic slowness in delivery of annual stocks (they normally arrive mid-way through the year for which they were intended) the more serious problem was represented by a wholly inadequate hospital stores arrangement. The existing stores area(located about nine miles from the hospital) is too small to provide a breakdown area for supplies arriving in connexes, etc., and space was too limited to place these items on shelves enabling timely access for filling supplies requisitions.

The Directorate of Services(DOS), function incorporates the Ministry's efforts to effect a public relations activity, arrangement for expatriate housing and provision of linen and laundry services throughout the hospital and health care center system and, most importantly, execution of the Ministry's engineering and maintenance requirements. Stated briefly, few of the functions are organized and managed effectively. Hospital engineering constitutes one of the major life-lines to effecting a smooth operating facility.

The quality of work carried out by this group was illustrated one day when the Chairman of the Dental Department called me to come over and stop maintenance staff from their efforts to repair a dental x-ray unit with a wooden mallet.

The Directorate of Nursing Services (DON). The Director of Nurses previously served as the Principal Nursing Officer (Director of Nursing in American Terminology) at the hospital. She is responsible for establishing nursing policies throughout the state. She is Irish and was trained in the United Kingdom; accordingly the hospital abounds with Sisters (staff nurses), Departmental Sisters (nursing supervisor) etc., all of which are led by the Principal Nursing Officer and Deputy Principal Nursing Officer.

On arrival at the hospital I realized within the first twenty-four hours that I had virtually no significant interface with the Principal Nursing Officer in terms of establishing policies, recruitment or discipline. The Principal Nursing Officer perceived herself, as the British system specifies, responsible directly to the Ministry-located Director of Nurses.

As an outcome of this arrangement, the Director of Nurses recruited nursing personnel, hired them, promoted them and disciplined them entirely outside the hospital functional structure.

This area was the first one which underwent a pervasive restructuring when the reorganization was initiated.

The Directorate of Training (DOT), is composed exclusively of the College of Health Sciences which trains nurses, laboratory and x-ray technicians. New programs are modular and other specialities are taught from time-to-time such as plaster technicians, dental assisting and inhalation therapy. While the impact of the college on the hospital is a favourable one, discussion of its role will not be carried beyond these comments.

The Director-General for Curative Medicine (DGCM) The incumbent of this position is administratively responsible to the Minister for the conduct of all hospital and health center activities. On appointment as Chief Executive Officer I reported to the DGCM.

My primary point of contact with the D.G occurred as the result of disarray in the interface between the hospital and the 14 outlying ambulatory health care centers. Analysis of the problem revealed an almost inoperative referral appointments system between the health centers and the hospital, a patient-record transfer system from the health centers to the hospital consultant which was about 50% effective, and a practice by hospital consultants to go beyond diagnostic work-up and prescribing to following the patient's progress over an extended period of time thereby substantially increasing the numbers of patients seen in any clinic on any given day.

Immediate efforts were directed toward the resolution of these problems: An ambulance was stationed at each major health center for the transport of emergency cases to hospital and a dispatch system from the hospital for the smaller centers. Once the Medical Board commenced its routine meetings, Chairmen were made aware of the problems caused by their staff serving in the capacity of the primary care physician by retaining the patient for a prolonged period of time rather than doing a diagnostic work-up, prescribing a course of treatment and referring the patient back to his primary health care physician.

Unwrinkling of the movement of patient records between health centers and the hospital for referral appointments and their eventual return to the health center was organized by assigning two transport department drivers to patient record pick-up and delivery duties. As some of the drivers were not literate, color coding of boxes for pick-up at the health center or return to the health center proved successful.

The greatest success in organizing the referral system occurred in the development of a central appointments desk in the new medical center. Previously, patients obtaining a referral appointment from a health center had to come to the hospital in order to locate the specialty department Chairman's secretary who would book the appointment. More frequently than not, a patient would fail to make the appointment and simply show-up on the day of the appointment. The new system centralized all specialty service appointment books and had four incoming telephone lines for use only by health center staff in making their appointments.

While problems remain with the consultant following the patient for too long a period, Medical Board efforts to reduce the number of times a patient returns has nevertheless met with some success.

The problems noted above had been in existence for years. Because there had never been a single administrative head at the hospital who perceived board-scale organizational problems and could effect changes across all departments, the problem had lingered and become dramatically worse as population increases, swollen by expatriot labors, almost doubled the country's population.

Following the first few months on assignment, and the development of a close working relationship with the D.G., it underwent significant reduction as his functions were absorbed by the Governing Body following implementation of the administrative reorganization.

**PART 2 THE HOSPITAL ADMINISTRATIVE STRUCTURE AND INTERFACE WITH THE MINISTRY  
PRIOR TO REORGANIZATION**

Prior to the administrative reorganization of the hospital, particular difficulties occurred with the management of matters constituting the life-lines of the hospital: personnel, finance, materials management, engineering and nursing services and both short-term and long-range planning efforts.

The difficulties were a many sided phenomena resulting from lack of planning within both the hospital and the Ministry and a further lack of communication and coordination of efforts within and between both spheres.

Personnel: As a case in point: prior to the writer's arrival the Director of Finance and Personnel had submitted a two-year personnel budget covering the years 1978 and 1979 to the Ministry of Finance. In his budget requests he did what he had been doing for previous years: requested an overall 10% increase in positions. Normally such a rule of thumb can be effectively utilized in a relatively static setting. But the setting he was budgeting for was far from static with a new medical center scheduled for opening during late 1978 and three new health centers scheduled for completion during the period 1978-1979. The salient point is that his personnel allocations were done in an administrative vacuum without consultation with cognizant Ministry spokesmen or hospital representatives.

Finance: The DFP's performance was considerably improved in the finance area as he was guided by equipment tender costs in effecting appropriation of funds for the 20 million dollars of equipment.

Nevertheless, resulting from his lack of experience in dealing with this large scale operation, he neglected to include funding for the ubiquitous unanticipated event through placing funds in a contingency account in his

**budget.** Failure to allocate such funds caused grave concern when it was learned there were no available spare parts for the building or the new medical equipment and no funds available for their purchase.

**Materials:** Materials procurement throughout 1977-1978 functioned well. The Director of Materials Management used formulas he had developed over the years for forecasting requirements. Distribution of materials to user-points however, constituted a chronic problem.

**Engineering:** Engineering services, as noted above, were centralized at the Ministry with a small work force stationed at the hospital to repair refrigerators, windows, air-conditioning units, replacement of washers in leaking sinks and the like. Steam generation was overseen by two long term employees who constantly coaxed the ailing equipment along.

To get action on a water outage during the midst of surgical procedures, for example, required a telephone call to the Ministry-located Chief Engineer's office and, if he was in, a direct request for assistance in response to which he would locate a member of the engineering staff and dispatch him to the scene of the problem. The occasions when the Chief Engineer could not be immediately located are too numerous to mention.

**The Medical Committee,** an unofficial hospital committee later to be replaced by the Medical Board, had no organized access to any Ministry official. While the Assistant Under Secretary for Technical Affairs was concerned with the doctors and their practice of medicine, there were no standing or ad hoc committees involving participation between him and the medical staff. In the event a staff doctor needed Ministry guidance it would entail telephoning the AUT, setting-up an appointment, and working through the problem on a one-to-one basis. AUT's role was later to be formalized at hospital level by the appointment of a Chief-of-Staff.

Resulting from the lack of scheduled or planned meetings between hospital and Ministry staff, it was exceptionally difficult to routinely obtain direct access to the Minister by either hospital doctor or hospital administrator. One had to proceed, the etiquette had it, from a Ministry superintendent to a Director and finally to an Assistant Under Secretary who, if he could not solve the problem, would make an appointment with the Minister. Unofficially however, the situation was considerably different for the country's nationals: favour seekers in a small scale society have no reluctance to approach a prominent figure directly -- particularly when in all probability they grew-up together, attended the same schools in a setting in which their families were socially active.

The problems generated by the lack of organized communicative access to the Minister were many: communications ascending and descending the administrative hierarchy were routinely garbled or filtered; response time to queries was extensive; by the time a query reached the top and a response commenced its return trip to the originator, the shifting priorities of a fast moving situation would cancel the value of the original query and the data received.

Further problems arose as each member of the medical staff believed that only the Minister could solve his problem.

On the other hand, frustrated and recalcitrant members of staff would periodically create an issue for purposes of initiating direct and personnel contact with the Minister. All things considered, the system was inefficient and urgently in need of restructuring through implementation of an effective system of communication within a policy and procedures framework.

Hospital Nursing Administration structure and function was modeled on the British system. In terms of structure, the top Nursing position in the hospital was the Principal Nursing Officer. Immediately below her was the

Deputy Principal Nursing Officer followed by three Assistant Principal Nursing Officers in charge of in-patients, out-patients and special projects.

Because the Ministry-located Director of Nurses had previously served as the hospital Principal Nursing Officer, her familiarity with hospital requirements kept her activity involved in hospital matters even though she occupied a policy position at the Ministry.

As a result of this involvement, the hospital Principal Nursing Officer perceived herself as reporting to the Director and handling all recruitment, promotion and disciplinary matters through nursing channels rather than hospital channels.

In effect, if I believed it important to increase the nursing complement in the O.R , I would go to my Principal Nursing Officer with the request and she in turn would discuss it with the Director of Nursing who would then request the Director of Finance and Personnel to initiate recruitment action. The system, with all its faults was nevertheless effective. The nursing staff comprized the most disciplined group at the hospital. The removal of authority from the hospital to the Ministry nevertheless functioned to attenuate the authority of the hospital Principal Nursing Officer and delay rapid response to new or emerging hospital operations requirements.

Supervisors of Non-Clinical Service functions maintained a direct liaison with Ministry representatives in finance, personnel, materials management and engineering as hospital administration had no authority in influencing outcomes in these important management areas.

Normally a supervisor, prior to going directly to the Ministry, would seek out a member of the hospital administrative staff for purposes of discussing his needs and obtaining advice on exactly whom at the Ministry could provide the needed assistance.

To complicate the supervisor's situation, there was no organized mechanism providing the hospital supervisor access to a member of the hospital administrative staff. The sole mechanism for effecting contact was to make an effort to catch any one of the administrators in his office and discuss his problem with the administrator in hopes that hospital administrative action could be taken. Once the supervisor would depart, more frequently than not, the administrative officer would not be able to carry the matter any further because of the steady succession of hospital staff coming to his office with requests, demands, etc.

Appointment schedules as we have them in the Western world are virtually unknown throughout the Arabian Gulf. The philosophy behind this is that because the Ruler is always available to his subjects it would be offensive for a government official to refuse to see anyone seeking his assistance. Accordingly, in the midst of an office meeting someone will walk in your office and because he is standing he apparently believes this gives him precedence to explain the purpose of his visit. During his explanation someone else will almost invariably arrive so the standee is invited to be seated along-side the first caller. Upon this signal the third caller commences his dialogue. You listen politely then ask him to be seated, turn to the first visitor and attempt to work through his problem. It is interesting to note that all the visitors in your office will participate in the discussion being conducted. They will ask clarifying questions, give advise or add elaboration to the matter being discussed. While the Westerner would normally throw-up his hands at the very thought of having two or three or more meetings being carried on simultaneously, the fact of the matter is that it can be conducted productively, and further, this is the way business gets done in the Arabian Gulf.

While there was no end to communication activities throughout the

hospital there were few results coming from these activities. As a consequence of the lack of organized communicative liaison between the hospital staff and the Ministry there was a continual stream of hospital staff members coming and going to the Ministry to seek information and action.

The Minister, in the usual Arabian Gulf tradition, would receive all staff desiring to meet with him from cleaners to members of the medical staff.

In a situation like this, where there is an absence of policy or procedure and officers delegated the authority to take action, each administrative matter was handled de novo. The time consumed on very routine matters was incredible. Working through the assignment of a car allowance or telephone allowance would take hours of discussion, eventual documentation and invariably end up with one of the Assistant Under Secretaries for final Ministry action before it was forwarded to the Civil Service Bureau to surface through their administrative hierarchy. The time required to complete any given administrative action was perhaps ten times longer than a similar action in an American hospital.

### PART 3 PREPARATION FOR THE IMPLEMENTATION OF ADMINISTRATIVE REORGANIZATION.

Following a week long series of consultations with the Minister of Health during July 1977, we had reviewed and discussed the available organizational options and methods for their implementation. The Minister was agreeable to a comprehensive reorganization of the hospital and provided assurances of autonomy in implementing new positions and altering existing channels of communication and authority.

General discussions had been held during these consultations regarding the structure and function of a Governing Body and an Executive-Committee. The term Executive Committee had to be laid aside as in Middle-Eastern societies the use of the term 'executive' may be viewed as suggesting a

usurpation of authority normally exercised exclusively by the Ruler. The term Chief Executive Officer on the other hand is acceptable, it was explained, as long as emphasis is placed on the word 'officer', i.e., officer of the government subject to its rules and regulations. These matters having been discussed, including the need for a Chief-of-Staff to head-up the medical component, I found on my October 1977 arrival that the Minister had brought on-board a skilled physician-administrator from a leading Beirut University to serve in this position.

Preparation of the Medical Staff Rules and Regulations and a Hospital Administrative Organization Chart along with an operational policy manual was carried-out by the Chief-of-Staff and the writer for their respective areas of administrative concern.

Meetings were held between us daily for purposes of discussing the objectives being sought and devising the most effective methodology available for reaching them.

Each of these codifications, (medical staff rules and regulations, hospital organization chart and operational policy manual) constituted what were to be major innovative elements determining hospital structure and function once implemented. At no previous time had any of these vital elements of administrative organization been in use. Their application and implementation was destined to revitalize the conduct of hospital affairs.

While these development tasks were being carried out a cholera outbreak in Saudi Arabia and Iraq occurred. The Chief-of-Staff and I developed a Cholera Committee composed of senior doctors on the staff for purposes of planning a response capability in the event of an in-country cholera outbreak. While this committee met daily at the outset, for purposes of monitoring developments, the Chief-of-Staff and I evaluated the performance of the individual participants and listed the names of those staff

We believed capable of becoming Chairmen of their clinical departments and composing the Medical Board.

Development of a medical center budget gained impetus on receiving authorization from the Minister to call in a financial consultant firm for purposes of establishing a hospital budget. The consultant remained on assignment for over two-weeks and developed his firm's proposal based on our detailed discussions of what was perceived as essential components of the budget and financial reporting system.

A project was mapped out and a cost figure determined. Back to the Minister who approved the project and the related cost. Developmental work on the formulation of the budget, including tracking and costing of supplies, commenced December 1978, and continued throughout the year leading to its implementation January 1979.

While budget development was going on, efforts to bring the Director of Finance and Personnel into its development proved fruitless. His objections were stentorian and without let-up. His main objection was that his Directorate could not function on a budget basis as other Ministry components were not on a similar budget basis. Efforts were then made by the financial consultant to help the Director of Finance and Personnel develop a budget for other Ministry components, including taking the Director to the States to show him a hospital budget in operation. But alas, even these efforts proved ineffective. Though the Minister had earlier assured me of the appointment of a hospital controller, a compromise had to be effected: the controller would be on the Director of Finance and Personnel's staff. Once this agreement had been reached, involving over 12 haranging hours in separate meetings, work continued toward development of the budget as originally scheduled, and eventually, the Director of Finance and Personnel made his records available to the budget development consultants.

Development of a Materials Management System was identified as an urgent need the moment the budget development team commenced their work. The materials management system was composed primarily of have-nots as opposed to haves.

The have nots included: suitable receiving area, breakdown area, shelf storage capability, inventory, charge master, policies determining provision of substitute items, or due-out system. At this time I negotiated an extension to the financial consultant's contract to commit some resources to upgrading the materials management system. Again the Minister on becoming aware of the scope of the problem readily agreed to increasing the scope of the consultant's work objectives.

Development of a Hospital Personnel System had been discussed in detail with the Minister during the July 1977 consultations and he gave his blessing to the development of this hospital capability. That it was delayed for implementation until December 1978 reflected again the objections of the Director of Finance and Personnel to "... the fragmentation of his Directorate". The personnel officer, at the firm insistence of the Minister, was finally cleared by the Director of Finance and Personnel.

#### PART 4 IMPLEMENTATION OF THE REORGANIZATION

Implementation of the hospital's reorganization commenced November 25, 1977, a matter of 56 days following the writer's arrival in country. My first act, as Secretary to the Governing Body, was to convene its first meeting. Resulting from previous discussions with the Minister, it was agreed that the Minister would be Chairman, the Chief Executive Officer would serve as a voting member and act as Secretary, that other members (all voting) would be the Assistant Under Secretaries for Technical Affairs and Administration and Training, the Chief of Staff and the Director-General for Curative Medicine.

The first act of business was presentation by the Chief-of-Staff of his nominees for Chairman of the eleven clinical departments who had been selected from among those who had participated in the Cholera Committee.

The Minister accepted the candidates as nominated. By the stroke of his pen the Medical Board, possessing legal status, was created, as was the Governing Body, through the convening of its first meeting.

Convening of the first Medical Board meeting occurred two days later. Cholera Committee members sensing they were to be selected as Chairmen received their confirmation. The newly prepared Medical Center Regulations, comprizing a twenty-four page document, were distributed. The first official act of the new Chief-of-Staff was to appointment members to Chairmanship of their departments and the medical speciality committees (Quality Assurance, Credentials, Infection Control, Operating Room, Library and Research) called for in the new regulations.

Meeting times for these committees, places and dates were established for each committee. Upon completion of these first day activities the medical staff had moved from a state of no formal organization to a state of high formal organization including a legal basis of existence.

The mood throughout the hospital was both optimistic and expectant. Something was being done and results were commencing to surface.

The creation of the Medical Board with a Chief-of-Staff at its head represented a tremendously important innovation within the ranks of the medical staff. For the first time they now had access to the Minister through their Minutes of Medical Board meetings and the Chief-of-Staff who served as a member of the Governing Body. At no prior time was there ever a similar mechanism for communicating with key Ministry officials regarding departmental needs and requirements,

operational frustrations, likes and dislikes, etc. The mood of the medical staff was almost euphoric with the dissemination of information regarding the role of the Medical Board and its interface with the Governing Body.

The implementation of the new hospital administrative organization occurred the day following the convening of the Medical Board, and the appointment of Chairmen. I met with my staff and handed out the first administrative organization chart they had seen subsequent to completing their hospital administrative education. Copies of departmental policies were also given out in sufficient number to enable each departmental supervisor to receive a copy. Thorough discussions involving their use and application were held.

The immediate response from administrative staff was that the new system would not work. As back-ground to their assessment was the fact that none of the three hospital administrative staff had specific responsibility for the management of the affairs of any of the twenty-two departments comprising the hospital service structure. For example, one day a department head, say the Chief Laboratory Technician, would come to administration seeking assistance in having his department airconditioning unit repaired. On arrival the Chief Technician might find the Associate Administrator in office. The Chief Technician would explain his problem to the Associate and go away expecting appropriate efforts to be made by the administrator. If on the second day repairs had still not yet been effected, the Chief Technician would return to administration and this time perhaps find the Assistant Administrator in office. The Chief Technician would explain his problem about the malfunctioning air-conditioner again in hopes that the Assistant would intervene with hospital engineering to effect repairs. On the third day the probability that repairs were still not made was high. Accordingly the Chief Technician would return to administration and perhaps this time encounter the Hospital Administrator. The Chief Technician would repeat his

problem for the third time.

As my administrative staff commented: "... well who can be accountable for lack of action in such a situation, we all are or no-one is". Clearly their response of "sharing of responsibility" in this sense was little more than a protective coloration wherein they could not be singled out for failure to perform. And it was this vagueness that the staff initially fought desperately to retain. Once they realized that they were not going to be ridiculed for poor performance, the potential threat originally perceived receded to a point where they commenced to function within the new organizational context. The administrative staff's response eventually softened and soon they commenced to experiment with trying-out the managerial functions symbolized in the chart and codified in the operational policies. After a very tentative start of about four months duration, each administrator commenced to realize that no longer did they have to focus on all problems at any one time, but rather just those indicated on the chart. At that point the system commenced to take hold and to work for the administrator as well as the department head. Resistance to the accountability role was slow to overcome but increasingly administrative staff could be observed holding their colleagues to the system and challenging one another to take what can only be labelled as appropriate action.

The day following distribution of the hospital organization chart, a hospital department head's meeting was called. It was a very quiet affair. Department heads listened attentively, learned who the administrative officer in charge of their section was and departed with instructions that similar management meetings would be held each two weeks; that they as managers were expected to bring their problems to these meetings for discussion and resolution to the extent possible. At the next meeting all hell broke loose; supervisors were taking other supervisors to task for non-performance or poor performance.

What was being witnessed was literally years of pent-up emotions and frustrations with no arena for their venting and no mechanism for their being remedied. These emotional but realistic outbursts continued over the course of approximately six weeks. The unproductive personnel commenced to be productive and the critics and criticism commenced to ebb and retreat as performance improved. Today these meetings continue to be held each two weeks and the nature of the problems addressed, and the solutions effected, constitute valuable contributions to the integrated and planned management of the medical center.

Included in the reorganization of the hospital was a precise delineation of the role of the Principal Nursing Officer in terms of reporting to the Chief Executive Officer of the Medical Center. While the format was clear, attitudes and habits change slowly. The end result was a request to the incumbent PNO to resign. Following further failure to follow the newly prescribed channels of communication and authority, and continued refusal to resign, she was terminated. With the promotion of her deputy to PNO the new system is commencing to operate as planned: Nursing operational matters, directly under the Chief Executive Officer, are discussed in the Medical Board with the PNO who represents nursing matters in the Board's deliberations, and actions are implemented in terms of hospital requirements and objectives. In the event agreement cannot be effected at Medical Board level the matter is moved to the Governing Body and both the Director of Nursing and the PNO are co-opted to participate in Governing Body discussions and adjudication.

An expanded Hospital Engineering presence was arranged coincident with the commissioning of the complex systems comprising the new medical center. A hospital engineering and maintenance team was recruited and assigned to commissioning activities including a qualified Hospital Engineer to head it up. While organizationally the Hospital Engineer continues to report to the Ministry located Chief Engineer, the Hospital Engineer nevertheless reports to Hospital Administration for the establishment of work priorities and assignments.

The improvement in this service function has now been maximized to its fullest potential under its present form of decentralized organizational placement.

The development of a hospital personnel system, per the specifications contained in the previously noted operational procedures, was initiated during late 1978. The delay was again caused by the continuing objections of the Director of Finance and Personnel. Conflict resolution was achieved in this instance through the Minister's firm insistence.

The old system was organized in such a manner that any non-doctor member of staff would forward his leave request through his department head directly to the Director of Finance and Personnel for approval. Doctors forwarded them directly to the AUI or DFP. In the event the employee had sufficient accrued leave the DFP would approve the leave and return the approved request to the doctor or the departmental supervisor. Hospital Administration in this instance played no role in the leave approval. The same procedures were used for initiating requests for new positions as well as the approval of car allowances, social allowances, uniform allowances, telephone allowances and the like. The system was clearly one of absentee personnel management over which administration had no involvement or control.

With the arrival of the Personnel Officer, efforts to systematize recruitment, leaves and the establishment of criterion for the awarding of allowances were developed. Due to the absence of DFP's personnel statistics for the center, first priority was directed to establishing an accurate manpower count on a department by department basis for the medical center's 1,806 authorized staff.

The inclusion of this key member of staff will more than justify his salary expense through averting the need of hospital staff to periodically leave the hospital to visit the DFP to determine what action

is being taken on requests for leave, etc. More importantly however, were the efforts being directed toward the establishment of hospital-wide manning tables based on staffing requirements as opposed to ad hoc formulas involving increasing yearly personnel allocations by 10%. Increases in efficiency and reductions in staffing costs, while incalculable at this time, are expected to be sizeable.

While the materials management area continues to constitute operating problems the new stores area which is currently in the construction-design phase will alleviate the problems now being faced.

**PART 5**      **SUMMARIZATION OF THE IMPACT OF THE ADMINISTRATIVE REORGANIZATION FROM 1977 to 1979.**

Perhaps the most appropriate method of summarizing the impact of the reorganization of the hospital is through review of concerns articulated by hospital administrative staff and the twenty two non clinical department heads November 1977, and again during May 1979, a matter of nineteen months following the reorganization:

Method: During a meeting with the hospital department heads each was requested to list the five most important problems he encountered on a day-to-day basis. Following this, general discussions were held in an effort to define terms and effect overall agreement on the five single most important problems they faced. The 1977 list was composed of the following items:

1. Insufficient job satisfaction and low pay
2. Not sure where to take a problem; to Hospital Administration or to the Ministry.
3. No delegation of authority from the Ministry.  
It's too centralized.

4. Nobody takes action; things don't get done.
5. Communications between the Ministry and Hospital are poor.

During May 1979, nineteen months following the previous 1977 discussions, the same procedure was again employed. At the 1979 meeting there were three department heads present who had not participated in the 1977 discussions.

The five most important factors listed during the 1979 meeting were:

1. Discrimination in treatment of national staff as opposed to expatriate staff in terms of salaries, car allowances, inducement allowances and housing.
2. Policies issued by the Civil Bureau are done so without study and are changed just as staff become familiar with them.
3. Clashes caused by the autonomy needs of professionals, i.e., managers and doctors.
4. Too much Civil Bureau paperwork required for completing personnel procedures.
5. Inadequate understanding of Civil Bureau personnel rules and regulations.

The shift in problem identification and prioritization between the 1977 and 1979 listing is a striking one. The general movement is readily identifiable as a shift from lack of job satisfaction, tentativeness in how to go about problem solving activities and reflects an administrative structure failing to incorporate an action-orientation. In the 1979 listing these problems can be seen to have receded and replaced by concrete job related concerns. No longer is job dissatisfaction a

major issue nor is the manner of how to go about problem solving. The movement observable in the supervisor's perception and prioritization of problems has undergone a shift from a passive-orientation involving criticism of the failure of others, i.e., the Ministry and Hospital Administration to delegate or take action, to an 'active-orientation' in which they adopt an active management posture through identifying concrete issues toward which definitive action can be taken and problem resolution achieved.

**PART 6 PROJECT COMPLETION** Resulting from the completion of the contract covering this technical assistance program, consultations were held with the Minister regarding the preparedness of the Hospital Administrator to take-over the management of the center. My recommendations concerning his preparedness were favourable. Accordingly, The Governing Body during its September 30, 1979, meeting appointed Mr. Abdul Rahman Bu Ali, Hospital Administrator, as Acting Chief Executive Officer of Salmaniya Medical Center.

In summary then, with the reorganization of the administrative-management of the hospital, the commissioning of the new medical center, the development of accreditation standards, and finally, the appointment of my administrative counterpart as Acting Chief Executive Officer, the objectives codified in contract: AID/NE-C-1441, have been fulfilled in their entirety.

**ATTACHMENT: 1**

**NAMES AND POSITIONS HELD BY PERSONS REFERENCED IN THE TEXT:**

**MINISTRY OF HEALTH STAFF:**

1. H.E. Dr. Ali Fakhro, Minister of Health.
2. Ibrahim Yacoub, M.D., Assistant Under Secretary for Technical Affairs, (AUT).

3. Mr. Mohammed Bahaa Tajir, Assistant Under Secretary for Administration and Training, (AUA).
4. Mr. Ismail Madhaffar Ali, Director of Finance and Personnel, (DFP).
5. Miss Mary Murphy, Director of Nursing (DOW)
6. Mr. Zuhur Hassan, Director of Materials Management, (DOM).
7. Mr. Mohammed Reda Al-Saad, Director of Services, (DOS).
8. Dr. A. Abu Zaid, Director-General for Curative Medicine, (DGCM).

Hospital Staff:

9. George H Jamieson, Chief Executive Officer, (CEO)
10. Mr. Abdul Rahman Bu Ali, Hospital Administrator.
11. Mr. Sadiq Shehabi, Associate Administrator.
12. Mr. Faisal Maskati, Assistant Administrator.
13. Dr. Akbar Mohsin Mohammed, Chief of Staff
14. Dr. Ahmad Abdulla Ahmad, Deputy Chief of Staff
15. Miss Irene Kerrison, Acting Principal Nursing Officer
16. Mr. T.E. Joseph, Personnel Officer
17. Mr. Hussain Al Ali, Materials Officer.

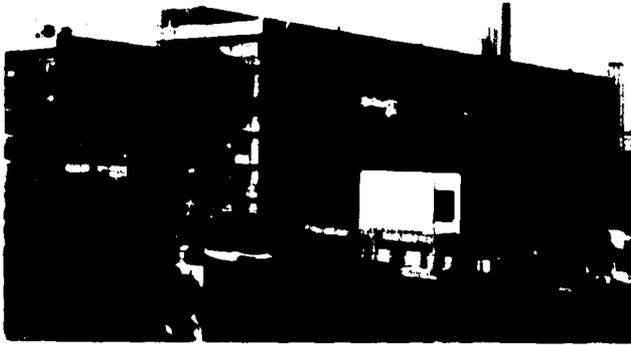
Chairmen of Clinical Departments:

18. Dr. Najeeb Jamsheer, Radiology
19. Dr. Hagop Yacoubian, Surgery
20. Dr. Hassan Fakhro, Medicine
21. Dr. Faik Al Hilli, Pathology
22. Dr. P.K.V. Rao, Anesthesiology
23. Dr. G. Simon, Dental
24. Dr. Jaffer Bareeq, ENT
25. Dr. Ahmad Ahmad, Ophthalmology
26. Dr. Khalil Rajab, OB-GYN.
27. Dr. Akbar Mohsin Mohammed, Pediatrics.

Hospital Department Heads:

28. Mr. Ismail Akbari, Clinical Laboratory
29. Miss Fatima Bin Ali, Social Work
30. Miss J.E. Bette, Domestic and Sanitation
31. Mr. Fred Browne, Hospital Maintenance
32. Miss Marian Dawood, Medical Records

33. Mr Mohammed Ali Eesa, Prosthetic-Orthotics
- 34 Miss Zahra Hussain, Linen - Laundry
35. Mr. Ibrahim Jaffar, Admissions Bureau
- 36 Mr. Mr Doug Kennaugh, Catering
37. Mr. Naje Mohammed, X-ray
38. Miss Layla Abdul Rahman, Pharmacy
- 39 Mr Ahmad Shaffie, Physiotherapy
- 40 Mr Sabot Saloom, Transport
41. Mr. Jawad Sharaf, Hospital Store
- 42 Mr Ibrahim Yacoub, Medical Equipment Repair
43. Mrs. Lynn Yacoubian, Environmentalist- Infection Control Officer.



**OCTOBER 1977:** status of the new Salmaniys Medical Center at the beginning of the writer's assignment.



**OCTOBER 1978:** The writer and his wife outside the new medical center October 14, 1978, the final day of commissioning when the building and patient care equipment were accepted.



**OCTOBER 1979:** The new medical center, fully operative throughout the preceding ten months, is shown at completion of assignment.