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INTRODUCTION:

This report constitutes the sixth quarterly report for the referenced project. The present report covers the time period: January 1979 through March 1979. The report is presented in three sections: Part I: Objectives Obtained; Part II: Problems Encountered; Part III: Objectives to be Implemented.

PART I OBJECTIVES OBTAINED DURING THE REPORT PERIOD

A. Development and Implementation of Hospital Accreditation Standards

1. During January (1979) the Accreditation Team was created. As Chief Executive Officer of the centre I chair this newly formed committee.
2. The purposes of the committee briefly stated are:
 - a. To establish standards for the operation of the hospital.
 - b. To promote high quality of health care in order to provide patients with the optimal benefits that medical science can provide.
 - c. To apply certain basic principles of physical plant safety and maintenance, and of organization and administration of function for efficient care of the patient.
 - d. To maintain the essential services of the hospital through the coordinated efforts of the organized hospital staff and the Governing Body.
3. It is through the structure and function of this committee that articulation between the hospital consultants (MADGE S.A. previously American University of Beirut - AUB), Salmaniya Medical Center Administration and the Governing Body is effected.
4. An Accreditation Manual based on the American Joint Commission on Accreditation of Hospitals Manual was developed and modified for the particular social and legal requirements of the Middle-East. As a case in point the section on Patient's Rights which started out as a one and one-half page statement (50 lines) was, following extensive discussion, relabelled "Patient's Privileges" and abbreviated to a one page (25 lines) statement.

Some of the changes were:

American version: Equitable and humane treatment at all times and under all circumstances is a right of all patients.

Bahraini modification: The principle of safeguarding all the patient's privileges shall be adhered to.

Comment: Discussions between and among the Bahraini members of the committee revealed difficulty with the use of the term "right" and "equitable". The consensus which developed among them was that if these "rights" became known to Bahraini patients they would not be understood, i.e. it would create additional difficulties for hospital staff in having to instruct them in their meaning and appropriate application. The problem with the use of the term equity is that it brings to the surface the differences between the ruling Sunnites and the ruled Sheitas, wherein the former have greater equity (Orwell's: some are more equal than others) in the functioning of the society than do the Sheite population who constitute the majority in Bahrain. It should also be noted that this matter was discussed during the period of the Iranian upheaval which to a certain degree polarized the postures between and among the Sunnite/Sheite members of my staff.

The two following paragraphs were revised as indicated below:

American version: Where the patient's care is performed by more than one physician, the patient has the right to know the identity of the physician with primary responsibility for his care. Additionally, he has the right to be informed of the nature and purpose of any technical procedure to be performed upon him and by whom it is to be carried out.

American version: It is the patient's right to communicate with all those participating in his care and to receive from them adequate information concerning the nature of his medical problem, the planned course of treatment, and the prognosis.

Bahraini modification: In order to foster the patient-doctor relationship, communication between the patient and his (or her) treating doctor shall be encouraged to include such matters as the nature and purpose of any technical procedure, information concerning the nature of the medical problem, the planned course of treatment and the prognosis of such treatment.

Comment: It is common practice for a senior member of the surgical staff to work-up a patient for a surgical procedure but for a junior member of the staff to do the actual surgery. Thereby making it difficult to provide assurance that a specific surgeon would be doing the procedure. Again, with the patient's right to communicate with all those involved in the provision of treatment, it was believed by members of the committee that many patients would abuse this right by insisting on discussions with all hospital personnel involved in the case irrespective of their direct treatment contribution. The inclusion of the bracketed (or her) was innovative particularly in a society in which women are not entitled to sign legal forms including hospital release forms. In any case in which a woman seeks a surgical procedure, her father, husband or elder brother must sign such a release for her.

5. To date over fifty percent of the Accreditation Manual has been drafted, discussed, modified and distributed for implementation to the cognizant hospital administrator and specialty service department head. Current planning calls for completion of the manual by June 30th. Effective July 1st, efforts will be directed by the committee to facilitating and evaluating the implementation of the standards outlined in the manual.
6. Upon completion of the manual and the implementation of the standards contained therein, Salmaniya Medical Center will be the only similar sized Persian Gulf State which will have developed and implemented American Accreditation standards. In Saudi Arabia there are two hospitals which have developed these standards and have successfully gone through the Accreditation Survey: ARAMCO and the King Faisal Referral Hospital, both of which are American operated.

B. Implementation of a Hospital Budget and Financial Management System

- I. Effective January 1st, records of all revenue and expenses were for the first time maintained per the 1978 development of the hospital budget and budget reporting procedures.
2. To date, reports on January and February 1979 operations have been completed. The single most revealing factor is the magnitude of expense characterizing hospital operations. Operation of the medical center accounts for over 65 % of the total Ministry of Health budget. Previously these expenses were estimated to be somewhat over 50 % of total Ministry costs. In spite of the existence of a hospital budget, its actual success or failure is related to whether or not the Ministry of Finance will fund it per program requirements. For 1979 for example, only 30 % of the new staff positions required for total hospital operations were approved. This means that existing programs will remain essentially static and new programs will be delayed until 1980 or 1981 when appropriate funding levels may be provided.

C. Development and Implementation of Personnel Management System

- I. Effective January 1st, 1979 efforts to obtain a Personnel Officer to complete hospital administrative staffing was approved. With the arrival of the incumbent, efforts are being directed toward effecting an accurate count of personnel assigned to the hospital. The Ministry of Health located Director of Finance and Personnel's records are, for practical purposes, non-existent and those he has are totally inaccurate. We believe we have positions filled in the magnitude of 1,402 personnel as of December 31, 1978, but this figure requires further verification. From all appearances I believe we should have a final accurate count sometime during September 1979. These figures are essential for purposes of forecasting personnel costs and new manpower requirements and for accurately staffing existing service functions and planning and implementing new service functions.

D. Implementation of a Materials Management System

- I. Personnel requirements for 1979 were completed during late 1978 as were organization charts, job descriptions and materials budget. Due to the severe reduction in staff (a 70 % cut was announced March 15th) full implementation of objectives will be curtailed throughout the remainder of 1979.

2. During the period under review however, progress was made toward the finalization of the development of a master list of all seven (7) lines handled by the hospital substores: surgical dressings, stationery, linen, hardware, crockery and cleaning materials.
3. Based on these master lists the substore shelves were tagged and appropriate items placed in their designated locations.
4. An inventory of both substore stationery items and cleaning materials was completed.
5. The satisfactory delivery of substores items to users functioned well throughout the report period.

E. Development and Implementation of a Medical Audit System

1. Effective January 1979 Salmaniya Medical Center Administration in conjunction with MADGE Consultants organized and implemented a medical audit system. The purpose of this audit is two-fold: first, that of providing a mechanism for quality control of a practitioner's results and secondly, as an heuristic devise to point-out methods of providing improved patient care. The medical audit is derived from the Joint Accreditation's standard which states:

The medical staff organization shall strive to create and maintain an optimal level of professional performance of its members through the appointment procedure, the delineation of medical staff privileges, and the continual review and evaluation of each member's clinical activities, (page IO8 JCAH Manual - 1976 Edition)
2. The medical audit is organized as one of the functions of the medical staff's Quality Assurance Committee (QAC) which reports to the Medical Board. The responsibilities of the QAC related to the conduct of the audit are:
 - a. Overall supervision of the audit
 - b. Coordination of the specialty department audit committees
 - c. Formulation of recommendations to the Medical Board regarding the improvement of standards of professional practice, based on audit results.
3. Established specifications require that there shall be an audit subcommittee for each major clinical department: Accident and Emergency, Anesthesia, Internal Medicine, Obstetrics and Gynecology, Ophthalmology, Surgery, Otorhinolaryngology, Pediatrics and Psychiatry. Each subcommittee is to be composed of two to four members, selected by the Chief-of-Staff and the respective Chairman of the Department. A medical records analyst is to be a member of each subcommittee.

4. The duties and functions of the subcommittees are:
 - a. To determine periodically what topics are to be the subject of study.
 - b. To determine the parameters to be studied for each topic and to establish standards for those parameters.
 - c. To assign the medical records analyst the task of abstracting the relevant data from the medical records and comparing these data with a set of standards, and reporting any deviations to the subcommittee.
 - d. To study and analyze the particular medical records that show deviations from the established standard.
 - e. To report periodically to the Q.A.C.
5. Peer review is accomplished through scrutinizing deviations criterion and record by record.
 - a. Analysis may reveal that deviations noted support that actual practice is superior than the established standards or otherwise justifiable.
 - b. Unjustified deviations are to be further analyzed in order to indicate whether they were due to lack of knowledge or to failure in performance.
 - c. To determine whether the noted deficiency is due to failure at the individual physician level, medical staff level (departmental or interdisciplinary) or institutional (i.e. hospital procedures).
6. Actions and recommendations of the subcommittees are initiated when a written report is forwarded to the QAC outlining recommendations aimed at preventing recurrence of the deficiency or deficiencies. Recommendations rely on one of three mechanisms to bring about change:
 - a. Intervention in the individual case.
 - b. Alteration of standard procedures (departmental or staff level).
 - c. Alteration of organizational procedures (hospital level).

7. Documentation of implementation is accomplished through designating one of the members of the QAC (or possibly a subcommittee member) to follow up on one or more of the recommendations verifying that:
 - a. The parties responsible for implementation are aware of their duties.
 - b. The responsible parties did actually implement the recommendations.
8. Determination of the efficiency of the audit committee includes the requirement to perform a re-audit in those cases deficiencies were identified and that the re-audit should occur not later than 12 months from the initial audit.

F. Study of the Accident and Emergency Department

- I. With the appointment of a new Director of the Accident and Emergency Department, I requested MADGE consultants to conduct a study of patient flow through the department.
2. Findings revealed that over 260 visits per day are made to the department and that of these 260 visits over 6 % are admitted to hospital. Admissions followed the pattern depicted below:

Surgery	:	31 %
Pediatrics:		30 %
Medicine	:	22 %
Gyne	:	16 %
Others	:	.74 %
D.O.A.	:	.26 %

While the average in and out time per patient visit (for non-admissions) was slightly in excess of twenty minutes, significant delays in effecting admissions from the department were noted and indicate an immediate need to speed up the evaluation procedure leading to an admit/release decision. Efforts are now under way through the Medical Board to reduce the period the patient remains in the Emergency Room awaiting laboratory and x-ray results determining his disposition.

PART II

PROBLEMS ENCOUNTERED DURING THE PERIOD

A. Termination of the Principal Nursing Officer (PNO)

Per the previous quarterly report regarding this matter, the Principal Nursing Officer when requested to submit her resignation by the Ministry located Director of Nurses refused, accordingly, I notified the PNO of her termination April 1, 1979. She departed the hospital April 12th after turning-over to her deputy; she departed Bahrain April 14, 1979 for Nottinghamshire.

B. Resignation of the Chief-of-Staff

During the period October 1977 through December 1978, the American University of Beirut provided five AUB staff physicians to come to Bahrain for a period of three months each for purposes of training a Bahraini to assume the status of Chief-of-Staff. Four weeks before the Bahraini was to assume his duties he resigned, stating a preference to remain active clinically and in research activities. He was replaced by Dr. Ahmad Abdulla Ahmad, a Bahraini University of California graduate in Ophthalmology. While Dr. Ahmad had neither administrative training nor the exposure to the in-service training period received by his predecessor, he is bright, responsive and he moved into the position easily. His taking over the position was supported by his colleagues because he was Bahraini and his incumbency would put an end to expatriots (Lebanese) serving in this top medical/administrative position.

Dr. Ahmad was in the post for one week when conflict developed between him and the Minister's brother, Dr. Hassan Fakhro, who serves as Chairman of the Department of Medicine. The conflict was due to Dr. Fakhro's mixing male and female patients in the same ward (not room). This kind of proximity of the sexes is strictly prohibited (even medical records are segregated by male/female) by Islamic religion and social custom and it appeared to those of us involved in this matter that H.E. the Minister's brother was making a distinct effort to embarrass him politically and socially. The fact of mixing was made all the more important as it was during this time that an ultra-conservative mood was sweeping Bahrain due to the Islamic Revolution taking place in Iran. The subject of mixing had been discussed and re-discussed subsequent to December 6, 1978, the time of the move to the new center, and a negative decision was taken. Due to increasing pressure through the news media, H.E. the Minister reasserted the negative decision during a February Governing Body meeting: there was to be no mixing of the sexes. H.E. instructed Dr. Ahmad to inform Dr. Hassan Fakhro of the policy decision. Dr. Ahmad did so. In brief the situation prevails: Dr. Fakhro is adamant and will not segregate.

Dr. Ahmad throughout February and March was aware that the Minister knew full well that Dr. Hassan would not change, yet would not himself become involved in order to end the matter. Dr. Ahmad and I both agreed we would not move unilaterally on this matter; that it was between the Drs. Fakhro; that if the matter was to be resolved H.E. would have to become personally involved. H.E. did not take measures to implement his policy throughout February or March thereby precipitating Dr. Ahmad's resignation.

In response to the resignation H.E. attempted to persuade Dr. Ahmad to continue but to no avail. H.E. was forced to appoint his Assistant Under Secretary for Technical Affairs (AUT) to the position of Acting Chief of Staff until a new candidate for the post surfaces. The Assistant Under Secretary is a Pediatrician who was educated and served his residency in Pediatrics at UCLA. His position as Assistant Under Secretary is largely political: his mother is Saudi Arabian and he is related to wealthy Saudis; his wife is from the largest merchant family in Bahrain. He is not a capable administrator and I believe deterioration of the medical staff organization will occur at an accelerating rate of increase as long as he remains in the position. I have discussed this matter with H.E. (who shares my concern) and he assured me he would make every effort to effect a change at the earliest possible time. We also discussed the candidacy of one Chairman in particular, Dr. Jan Al-Safar, but we both realize that a lot of criticism would result if Dr. Safar was selected as he is the Minister's brother-in-law and too many doctors believe the Minister's wife is already too influential in overall Ministry affairs. The picture is now bleak and promises to be more bleak in the near term future.

C. 1979 Manpower Reductions

- I. As noted in the previous section (Part I) the Ministry of Finance effected a massive personnel budget cut for 1979. 70 % of all new positions were stopped. This is particularly bad for the hospital as the move from the old hospital (430 beds) to the new center (620 beds) requires substantially more personnel to operate it. For the remainder of 1979 I will not be able to open the remaining one hundred and forty beds though I know constant pressure will be brought to do so.

D. Airconditioning Problems in the New Medical Center

Predictions by consultant engineers of a summer disaster due to a shortage of necessary air conditioning equipment have failed to materialize in spite of 110° temperature. The situation as of now, appears good, but humidity has remained significantly below annual averages for this time of year. The acid test will be made during July-August when average daily temperatures are in the 100's and humidity readings in the 90's.

E. Notes on Being an Expatriot in Bahrain

Resulting from the Iranian-Islamic revolution which took place during the period covered by the report, Bahraini's attitudes toward expatriots has undergone a noticeable deterioration. During a January Medical Board meeting here, the assembled Chairmen of Clinical services insisted that the (American) Civil Service Director be asked (summoned would be more correct) to join one of their meetings to explain why expatriot Americans received a 100 % inducement allowance and the British a 75 % inducement allowance, and both groups received both housing and car allowances which they did not receive. (The explanation for the inducement allowances is due to the requirement that both American and British expatriot staff must pay their national income taxes and the size of the inducement allowance is geared to compensate for this requirement) During the meeting comments emanating from the Bahraini members of the Board indicated their unanimous belief that one of the fundamental causes of the Iranian revolution was the dissatisfaction on the part of Iranians with the presence of a privileged group of expatriots who were receiving salaries and inducements far in excess of the Iranian national who, they pointed out, may have been educated in the same school as the expatriot and who may also have been doing the same job. There was a clear-cut consensus between and among the Bahraini staff that these factors were as important in explaining/understanding the cause of the revolution as was the general Iranian dissatisfaction over the Shah's bringing about fundamental social changes from which only the privileged benefited.

With the recent signing of the Israeli/Egyptian peace treaty a further deterioration in attitudes toward expatriots has taken place. While Egypt and the more readily available Egyptian expatriot constitute the primary targets, the diffuseness of the emotions spills over to other expatriot groups. Our Director-General for Curative Medicine is an Egyptian who has been serving the Bahrain Government for over nine years. In an effort to protect him, the Minister has instructed him to confine his activities to only the Ministry of Health and to refer any matters requiring contact with Bahraini staff or doctors to the Bahraini Assistant Under Secretary for Technical Affairs.

As a consequence of this peaking of awareness of the expatriot, renewed efforts are being taken by the Government to Bahrainize throughout. The position is a poorly thought-out one but the response is an emotional one. As a case in point: about 30 % of nurses in Bahrain are Bahraini and it will take until 1992 for the existing College to train sufficient staff to operate the existing health care facilities in existence today.

In summary, it appears that while the Bahraini does not have a xenophobic dislike for the expatriot as such, (assault cases coming to the Accident and Emergency Department involving Europeans has just recently surfaced) he nevertheless does manifest a distinct and abiding dislike of occupying a position in which he must rely on the expatriot; and it is these feelings which have recently been brought to the surface which are functioning to make relationships with Bahrainis more problematic than previous to the Iranian revolution and the signing of the Israeli/Egyptian peace treaty.

PART III OBJECTIVES PLANNED FOR THE UPCOMING REPORT PERIOD

A. Continued Development and Implementation of Accreditation Standards

- I. The move toward implementation of Accreditation Standards is approximately 20 % complete. By the end of 1979, based on progress to date, I would predict that approximately 30 % of the objectives will be accomplished. What has been done to date, i.e. the modification of the American Standards and discussing them with cognizant department heads is the easy part of the project; the difficult part remains their implementation. I would envision the entire sequence taking up to three years to fully implement.

B. Continued Development of the Hospital Budget

- I. 1979 is the first year that a hospital budget has been applied as a management tool. The Hospital is the only government facility in Bahrain having its own budget. Efforts to determine its accuracy (amounts budgeted, etc.) will constitute the major activity for the remainder of the year. Preparation of the 1980 budget will be undertaken later this year.

C. Continued Development of the Personnel Management System

- I. As noted above, efforts continue toward effecting an accurate manpower count. Records are in many cases non-existent and Ministry of Health efforts to accomplish the task are ineffective leaving Salmaniya Administration with the task. Efforts toward effecting this count should be completed circa September 1979.

D. Coordination of the Move of the Central Maternity Hospital to Salmaniya Medical Center

With the vacating of the old hospital the existing maternity hospital (located in Muharraq) will be converted to a small scale maternity dispensary and the maternity hospital transferred to the Salmaniya complex.

Efforts to renovate the old hospital to serve for a period of five years are now underway.

During the above referenced five year period a new 100 bed maternity hospital will be constructed on the Salmaniya site and will, like the temporary hospital, become a part of the Salmaniya complex. Planning efforts are now underway to equip, staff and operate the maternity function for its projected 1980 opening.