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REPORT FOR THE PERIOD ENDING

JULY 1979

TECHNICAL ASSISTANCE: HOSPITAL ADMINISTRATION

REFERENCE : CONTRACT NUMBER: AID/NE-C-1441

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## INTRODUCTION

This report constitutes the seventh quarterly report for work accomplished under the terms of the referenced contract. The report is presented in three sections: Part I: Objectives Obtained During the Report Period; Part II: Problems Encountered; Part III: Objectives to be Implemented.

### PART I OBJECTIVES OBTAINED DURING THE REPORT PERIOD

#### Completion of Salmaniya Medical Center (SMC) Accreditation Standards.

- 1.1 During April (1979) four additional chapters of the accreditation manual were completed: Emergency Services, Medical Records, Pharmaceutical Services and Infection Control. During June five additional chapters were completed: Anesthesia Services, X-Ray Services, Governing Body, Nursing Services and the Medical Staff. As Chairman of this committee I coordinated the discussion of the proposed standards with each of the cognizant department heads and effected modifications to the standards where such modifications were indicated.
- 1.2 Following final compilation of the standards, MADGE consultant staff developed a checklist covering compliance with the standards developed for each substantive area. By the end of June the manual was completed. MADGE had the manual printed and copies were provided to each member of the Governing Body. During its meeting of July 8th, the Governing Body accepted the manual as a statement of the goals it desires to see implemented in the future.

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1.3 The accreditation manual will establish definite goals to which SMC can be directed. Moreover, the manual can serve as a guideline for other hospitals not only in Bahrain but throughout the Gulf region.

2. Replication of the Previous Quarter's Study on the Functioning of the Accident and Emergency (A&E) Department.

2.1 Resulting from mounting patient complaints and observations of crowdedness and congestion in the A & E Department, I requested MADGE consultants (March 1979) to conduct a study of the volume and flow of patients through this vital service department. Some of the results, compared with the March study, follow:

21.1 During March a total of 260 visits a day were established; the May study revealed an average of 254 daily visits.

21.2 The breakdown of visits by department, while showing some variation, does not appear significant.

<u>DEPARTMENT</u>	<u>(%) MARCH 1979</u>	<u>(%) MAY 1979</u>
Surgery :	31	29
Pediatric :	30	27
Medicine :	22	23
Gynecology :	16	20
Other :	1	1
	<hr/>	<hr/>
	100%	100%

- 2.1.3 Emergency and urgent patients are seen in less than 10 minutes. Non-emergency patients wait longer until seen, an average of 19 minutes, indicating that a screening system is operative.
- 2.2 A & E physicians appear to decide within a fair lapse of time whether the patients require laboratory and x-ray investigation. However these time lapses were unaccountably long during the third shift (11P-7A) at 28 minutes as compared to the time lapse of only 22 minutes during the second (3P -11P) shift.
- 2.3 The study confirms the impression that the major load of work in A & E is during the second shift (3P-11P) during which 64% of visits are made while the load of 8% during the third shift (11P-7A) is almost insignificant.
- 2.4 As far as the level of urgency is concerned, 62% of the patients seen were classified as non-urgent indicating a significant load of patients who did not actually need A & E Department attention.
- 2.5 Surgical cases followed by medical and then pediatric cases formed the bulk of the sample.
- 2.6 Almost half of the Gynecology cases in the sample were admitted to hospital; 17% of Eye cases and 11% of Pediatric cases required admission. In medicine 9% and in surgery 6% of the cases required admission.

2.7 A number of objectives emerge out of this study.

Briefly stated:

- 2.7.1 The excessive load of non-urgent cases must be coped with and the best mechanism appears to be a combination of extending health center working hours and development of an SMC "drop-in clinic" within the hospital complex.
- 2.7.2 Following proper physician screening, patients not requiring immediate or urgent care should receive an explanation of their condition and be referred to their area health centers; no definitive treatment should be provided.
- 2.7.3 Existing delays within A & E can be significantly reduced through establishing a procedure whereby the specialty consultant, or department duty physician, is routinely called within 15 to 20 minutes for all urgent and emergency cases (the current average delay now is about one hour); that both lab and x-ray studies be ordered by the A & E doctor as opposed to awaiting the arrival of the specialty department physician or consultant; that a decision to admit urgent and emergency cases be reached in a shorter period of time (average decision time for surgical cases is 110 minutes and 85 minutes for medical cases) by having both lab. and x-ray results sent directly to the floor thus avoiding the existing delay.

3. Implementation of Improved Methods and Procedures in Materials Management.

- 3.1 Ministry of Finance reductions in personnel approvals for 1979, a 70% reduction, have impacted on the development of the Materials Management function originally planned during

1978. In a number of instances I have allocated members of the MADGE consultant staff to a direct assistance activity in Materials Management. During the past quarter the following accomplishments have been achieved in this vital area:

**3.1.1 Equipping and stocking of substores (five lines):**

Substores have been equipped and stocked for the following lines: surgical dressing, CSSD supplies, cleaning materials, stationery, hardware and crockery, and linen. Stocking and stock level control have been initiated but work is being delayed by the lack of Ministry manpower and distinct stock shortages at the Ministry operated Central Stores.

3.1.2 In addition, substores for pathology, radiology and food supplies have been allocated and equipped. Stocking and inventory control are still underway. These stores have both a central store function and an SMC substore function, which must be reviewed.

**3.1.3 Development of stock control and usage reporting systems:**

Basic stock level control in the substores for the above five line items (l.a) has been established and will function satisfactorily if followed up. Proper inventory control with reconciliation of issues with input and physical inventory, as well as the implementation of a Kardex System, cannot be done at this stage due to the absence of qualified Ministry manpower. Records of the issues of the stores exist in proper files but they remain not summarised. Monthly total cost

report of materials delivered to Salmaniya Medical Center is being prepared for each material budget line; this constitutes basic information for budgeting and local financial control, i.e., material lines that are showing budget discrepancies can thus be investigated.

3.1.4 Organization of delivery to demand points:

The supply of materials to the various wards, paramedical and administrative departments has been organized and run in an efficient and reliable manner as evidenced by the absence of user complaints.

The training of the Material Management Offices in maintaining this reliability has been started but several months of close supervision are still required. A detailed job description has been prepared and is with the Civil Service Bureau for grading. I have also arranged for the incumbent to attend a three month training course in the U.K. for materials management

3.1.5 Control of inventory at demand points:

This control was done in collaboration with Nursing and there is, at present, no significant overstocking at ward level. This, however, implies that the reliability of the supply system be maintained.

As data on patterns of consumption emerge, minimum and maximum stock levels in the wards and other usage points will need to be established and controlled. This function is included in

the job descriptions of the various Ministry staff involved.

**3.1.6 Monthly usage reporting:**

Monthly reports on global usage for each supply line are being prepared regularly and are available for budget control and for investigation of discrepancies. A further requirement, when additional positions are approved, include development of a departmental usage reporting system.

**3.1.7 Development of procurement specifications for standardization of stocks.**

A comprehensive listing of the items used in SMC has been prepared for surgical dressings, CSSD supplies, stationery, linen, hardware and crockery, and cleaning materials. The specifications and unit definitions have been clarified for about 85% of the items. A review of these lists must still be carried out by Central Stores to finalize and coordinate the proposed letter numbering and regroup some items which may still be duplicated or substitutable.

**3.1.8 Finalize material budgets for 1979:**

Budget finalization has now been completed and the figures seem to be adequate. Some supply items are running high but this is balanced by other lines which are running low. The usage data now being accumulated will enable us to determine a more reliable projection for each line separately thereby enabling Central Stores to stock needed requirements for the balance of the year.

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3.1.9 Adjustment of 1980 yearly tenders based on required specifications and anticipated usage:

The Director of Material Management expects to receive by July 20th, 1979, recommendations for the adjustment and preparation of the 1980 yearly tenders. He has indicated that he needs to issue these tenders before the end of September so that supplies will be available by January 1, 1980.

3.1.10 By the end of July I anticipate having sufficient data on actual usage (for the first six months operation) to establish 1980 budget requirements.

4.0 The Medical Audit.

4.1 During January 1979 a medical audit system was commenced. The purpose of the audit was viewed as two-fold: first, that of providing a mechanism of quality control of a doctors results and secondly, as an heuristic device to point-out methods of providing improved patient care methods. Our objective during January was that of conducting one audit in each of the nine clinical departments prior to July 1979. This objective has been attained and exceeded in the Department of Surgery in which two additional audits were carried out: A re-audit of appendicitis and a newly formulated audit on renal colic.

4.2 The initial audit of physician handling of appendectomy cases was revealing in that it disclosed a less than optimal diagnostic work-up (an overall departmental rating of 55% was attained).

4.3 MADGE Consultants have now installed a computer in their offices and data from the medical records is fed in continuously thereby permitting a continuous audit of all studies in progress.

5.0 MADGE CONSULTANT CONTRACT: 1979-1981

5.1 Following five months of negotiations between the Minister and the Civil Service Bureau, the MADGE Consultant contract was finalized during June. The new contract is for a two year period. MADGE's fundamental objective will consist of implementing the accreditation standards developed during the first six months of 1979. A second objective is that of providing an inservice training program, based on a hospital residency program, for the three members of the administrative staff: Mr. A.R. Bu Ali, Hospital Administrator; Mr. Sadiq Shehabi, Associate Administrator; and Mr. Faisal Mskata, Assistant Administrator. Mr. Bu Ali and Mr. Mskata each have their Master's in hospital administration from the American University of Beirut, Mr. Shehabi has his B.A. from Cairo.

5.2 In developing the MADGE terms of reference I worked very closely with the Minister in the development of the training component. Rather than talking about the needs of the administrators I found myself having to speak about program training requirements in order to maintain a semblance of diplomacy, i.e., it wasn't that the staff lacked capabilities, its just that the program should be arranged in a manner that would take account of various facets of

an administrator's duties and responsibilities, etc.

5.3 In a more candid sense then, the following four dimensions are those along which I believe the training program will have to address itself in order to effect improvements in the hospital's administration. The below listed areas are those which proved to be the most problematic characteristics of my staff.

5.3.1 Failure to anticipate. The members of staff each manifest this also within in direct relationship to their rank, with the hospital administrator showing it less than the associate and staff. In general however, they possess no techniques for seeing a problem on the horizon or evaluating symptomatic representations of system breakdown or failure. Typically a problem must become acute or critical before they will initiate action. This of course leads in most instances to administration by crisis and "fire-fighting". The solutions which emanate from these situations are typically *ad hoc* in nature and related only by chance to the existing body of operations' policies.

5.3.2 Unable to define problematic situations in appropriate or actionable terms: Problems are viewed in a piece-meal fashion so certain elements of the problem are given an undue sense of importance. The expression of: "let's get our priorities right", must have emerged out of a context much like this. Actions taken on their perceptions oft times appear to be erratic: precipitously sending some over 20 members of staff for not wearing their I.D. badges before

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the circular had been out for distribution 24 hours; or to constitute overkill: instructing the switchboard operators to listen-in on calls they believed were personal and cut the line they believed the call were a personal one, this action taken resulting from complaints that outsiders could not easily contact hospital on routine (non-emergency) lines.

**5.3.3 Failure to initiate action:** Numerous complaints regarding the non-responsiveness of ambulance crews finally eventuated in the death of a patient. The administrator in-charge had taken no action on the previous complaints which were in letter form through the news media. Shortage of supplies will be blamed on the Ministry located Director of Materials Management; shortage of staff on the Director of Finance and Personnel; and non-functioning equipment on the Directorate of Services, etc., and as a consequence no action is taken.

An interesting variation on the failure to take action was during the time I instituted a hospital-wide incentive award program. Neither the associate nor the assistant would select anyone to receive the award (a step increment) because if they selected same and not the others, those who were not selected would be angry and upset and make a scene. And so it goes ...

**5.3.4 Failure to effect completed staff action on an assignment:** 80% of any assignment is readily accomplished; its the last 20% which is typically problematic. This administrative truism is exemplified in our hospital administrative setting. While the volume of work is there, or failure on the part of staff to complete an assignment yields a multiplier effect in volume of future work. Failure on the part of the Chief of

Staff to insist on the payment of overtime to doctors providing overtime services during the 1978 cholera outbreak have led to their refusal to lend assistance in this year's cholera outbreak. The Chief of Staff is now trying to determine how many hours each doctor worked, where the Ministry overtime records are kept, and whether or not a special fund was in fact allocated for such expenses. The point is the doctor's complaints were registered, superficial inquiries were made but the matter simply was allowed to drift with the result the Chief of Staff is now learning the meaning of the multiplier effect of an uncompleted task.

- 5.4 In spite of these shortcomings there have been improvements effected during my assignment here. On arrival my three musketeers each did the identical work, i.e., there was no differentiation between and among them as to specific areas of responsibility and the like. Any department head coming to the administrative offices would approach any member of the staff, explain his problems, and await results. In the event no results were forthcoming the department head would perhaps return the following day and if the same administrator was not available would seek assistance from one of the other administrators. This sequence of events could continue until the problem disappeared or became acute and demanded attention at which time the three administrators would like a body-corporate all focus their attention on to effecting a solution. I realized I was making progress when only two administrators would depart on an errand rather than all three.

Subsequent to my reorganization however definite organizational responsibilities have been allocated and the concept of management accountability is large. Improvements while modest are nevertheless in evidence and continued improvements, particularly with the MADGE tutelage, can be expected to continue.

5.5 This section would not be complete without noting that when the MADGE advisory/consultant staff come on-board they are going to be complete strangers to Bahrain and the folkways of the country and the hospital. And the folkways here take some adjusting to. The point of this being that during the first several months the teachers are going to be sitting at the feet of the incumbent administrators who will be facilitating the transmission of the accumulated folk wisdom of the centuries to the new staff. A lot of the wisdom is Asian in nature: "don't break someone else's rice bowl"; "don't step on the lowly earthworm else you have a cobra coiled round your leg", etc. If this folk wisdom is taken into account but does not deflect or impair their judgement, I believe the one-on-one counterpart relationship MADGE establishes will be a productive one.

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## PART II PROBLEMS ENCOUNTERED DURING THE PERIOD

### Chief of Staff Change

As reported in my report for the previous period (January thru March 1979) the incumbent Acting Chief of Staff, Dr. Ahmad Ahmad, resigned his post over conflict with the Minister's brother, Dr. Hassan Fakhro. Dr. H. Fakhro was mixing male and female patients on the same ward (not the same room) which, in view of the wave of conservatism precipitated by the Islamic revolution in Iran, was perceived by the Minister, and presumably his colleagues in the cabinet, as unacceptable. Because Dr. Ahmad and I both realized that if the situation were going to be brought in line with the Minister's policy decision, the Minister was the one who was going to have to effect it. As no action was forthcoming, Dr. Ahmad signalled his dissatisfaction by not convening the two-weekly Medical Board meetings and not attending Governing Body meetings. The Minister, on receiving the message, had a private talk with Dr. Ahmad. As Dr. Ahmad believed the Minister was still not prepared to take action himself or to delegate it, Dr. Ahmad resigned and the Minister, against the advise of both Dr. Ahmad and myself, appointed Dr. Ibrahim Yacoub, his Assistant Under Secretary for Technical Affairs (AUT). The AUT has his position as his mother is a wealthy Saudi and his wife comes from the wealthiest merchant family in Bahrain.

- 1.2 Dr. Yacoub was appointed Acting Chief of Staff during late March. By late May the Minister summoned Dr. Ahmad to his office and as Dr. Ahmad stated it, "... pressure was brought ...". Dr. Ahmad accepted the Deputy Chief of Staff position.

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He was unable to function however, because of being overridden by the Acting Chief of Staff. The Minister arranged for the Acting Chief of Staff to attend the annual WHO meeting in Geneva for six weeks which gave us a respite during late April and May.

- 1.3 In the meantime, the Bahraini who had been trained during the period September 1977 thru November 1978, by the American University of Beirut physicians, but who had resigned over personal greivances regarding salary matters and unsatisfactory housing, was queried by the Minister regarding his interest in becoming Chief. Dr. Akbar Moshin Mohammad, a University of Missouri graduate, accepted the appointment June 1st. Dr. Ahmad remains Deputy Chief of Staff and the previous incumbent, Dr. Ibrahim Yacoub, remains in Europe on tour. He is expected to return to Bahrain at the end of August. The new Chief of Staff is a capable physician, realizes his administrative shortcomings, and moves into new areas cautiously. He is a sheite Moslem heading a Medical Board composed of seven other sheite Chairmen and three expatriots: 2 Indians and 1 Lebanese. While Dr. Moshin is fundamentally anti-establishment he is able to keep his personal feelings removed from day-to-day business and reach decisions objectively. While he is not innovative he has a good practical intelligence and I believe good quality decisions will result from his deliberations, etc.

- 1.4 Dr. Ahmad has stated to me his belief that sooner or later the new Chief of Staff will come head-on with the Minister's brother at which time Dr. Moshin will end up in the same position he (Dr. Ahmad) found himself in and will probably resign, again.

2. MANPOWER REDUCTIONS: 1979

- 2.1 Seventy-one beds out of 620 in the new medical center remain unopened as a result of Civil Service Bureau manpower reductions. Resulting from staff realignments I have been able to open sixty-nine new beds during the past quarter.
- 2.2 As a result of this shortage of staff the Materials Management program is more of a caricature than a well developed program; elective surgical cases are being wait-listed up to three months, and the CCU remains unopened.
- 2.3 This situation will continue for the remainder of fiscal 1979 and into the 2nd quarter of 1980 due to time-lags in authorizing new recruitments during each new fiscal year.

3. Further Notes on Being and Expatriot in Bahrain.

- 3.1 In my previous report I noted that as a result of the Islamic revolution in Iran that attitudes of Bahrainis toward expatriots had undergone a marked deterioration. This acute period of deterioration appears to have abated during April and to have in fact improved during the period May thru July, but to remain less favorable than previous to December 1978. In large measure, the reason for this turn about is probably due in part, to the adverse reports coming out of Iran through the news media. In the hospital context however, the cause is a more immediate one: During July two key members of the medical staff (Sheite Moslems) visited their relatives in Iran and came back with reports of the country being in "a total shambles".

The comment: "It's awful", will be heard repeatedly. Each doctor I spoke with characterized Iran as a country composed of approximately 60% peasants who support the Islamic revolution with the remaining 40% opposed to it in varying degrees. Among the 40% it was reported, there is a serious desire to have the Shah return to take charge of the country again in order to stabilize it. My impressions of the conversations I had were that among these 40% there are distinct efforts to bring this about but that the society is so fragmented and factionalized that development of consensus leading to action is simply not possible. In the event action were to be forthcoming it is believed by observers that it would in all probability be the military establishment which would seize the reins of government in an attempt to implement corrective stabilizing action.

- 3.2 On the other hand, the acute response on the part of Bahrainis with whom I am associated on a day-to-day basis toward the Israeli-Egyptian peace treaty have softened. Although many still believe that Sadat could be assassinated at any moment, by his own people for the most part, an acceptance of the situation is noticeable and accommodations to it are being made. Our Ministry has resumed sending students to Alexandria for extended training courses and the expatriot Egyptians in our Ministry are again able to surface.
- 3.3 Polarization of attitudes toward the Iran regime continue on the part of Bahrain's Sunnite and Sheite population with the preponderant part of the Sheite population supporting Khomeini's efforts toward effecting the spread of an Islamic State beyond the borders of Iran. There are some fears on the part of Bahraini Sunnites that Iran may be providing organizational impetus to this development

4           The Principal Nursing Officer (Acting)

4.1       With the termination of the previous Principal Nursing Officer during April, her deputy, Miss Irene Kerrison, assumed an acting capacity. I explained to her the system I was working toward implementing (the American system) and asked whether she believed she could work constructively within it. She admitted that the system was new to her but that she would like to try it. She has done well in working within the system but unfortunately is a light-weight with problems in taking a leadership role. She was informed by me that her first three months would be a trial period during which she could determine whether or not she could function comfortably within the system, new to her coming from a British training and work background. While she has done well in terms of working within the system she does not possess the leadership skills required by the position. She is quite content to do the day-to-day routine administration called for but does not seem inclined to take an active posture toward development and upgrading of the nursing service organization. In effect she is a maintenance-lady, quite capable of operating the existing system but not equipped to design, build or implement an explicitly upgraded nursing service program. Accordingly, the Minister has approved my recruiting for a new Principal Nursing Officer with the qualification that she be British. In attempting to understand this qualification H.E. stated his belief that American nurses are good engineers, i.e., they can operate all kinds of equipment but they lack compassion, that British nurses are more patient-care centered and less skilled in reading dials and setting parameters for buzzers and bells to go off.

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4.2 This point was discussed with him but I am not able to evaluate his current position on the matter. He is returning to Bahrain from a vacation in the U.K during mid-August. His decision may depend in some measure on whether or not he had a good leave in London !

5. Cholera 1979

5.1 During late July six cholera cases developed in Bahrain but a break of seven days occurred but two additional cases were identified during the second week of August confirming the general outbreak of cholera in Bahrain. Government has decided not to notify WHO or to make the matter known publically. This decision has upset the Chief of Staff for several reasons: doctors should be alerted to the epidemic so they will take fecal swabs for microscopic examination, patients suffering from cholera will linger at home and possibly not reach hospital for treatment until serious dehydration and electrolyte balance has occurred, and finally, by having cholera cases in association with non-cholera patients in the Accident and Emergency Department contamination of other patients and staff can more readily take place.

5.2 The issue remains unsettled and will remain so pending the imminent return of H.E. from the U.K. We all believe H.E. will declare the epidemic as he has done so readily in the past realizing the consequences of holding the announcement in abeyance.

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PART III OBJECTIVES PLANNED FOR THE UPCOMING PERIOD

1. Implementation of Accreditation Standards.

1.1 As noted under objectives attained, the accreditation manual, based on the American equivalent, is now ready for use. Once MADGE is staffed and the counterparts briefed and oriented, I envision maximum efforts being directed to the implementation of these standards. The organizational (committee) structure required is already in place and will constitute the vehicle for planning and implementing the standards. This is a long-term project and if 70% of the standards can be implemented within a two-year period I would accept this as a significant accomplishment.

1.2 MADGE consultant staff provided excellent support during the development of the standards. As they now have an additional contract in Medina, Saudi Arabia, for commissioning a new hospital there, their efforts may now be divided and it is difficult to estimate how much of a thrust we can maintain particularly in view of a number of new MADGE staff arriving on the scene. In any event, I perceive this activity as taking precedence over all other administrative tasks for the ensuing period.

2. Continuation of Development Improvement of the Management Information System: Materials Management, Personnel, Patient Information and Medical Audit.

2.1 Materials Management: efforts toward the further training of the Materials Management Officer will be continued. Emphasis will also be placed on the training of sub-stores clerks in the maintenance of accurate records of items received and distributed. Efforts toward establishing docu-

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mentation for the development of a Kardex system will also continue.

2.2 Personnel: Newly emerging Civil Service regulations requiring documentation of anticipated monthly overtime, a new car allowance regulation, and sick-leave procedure during the previous period have reduced the man hours available for effecting the needed personnel count and development of a control file. I am currently discussing with MADGE the possibility of using their computer to effect a personnel control system. If we can move in this direction it is possible that by year's end we can have the needed personnel accountancy/control procedures in effect and operating. In the event the Civil Service Bureau raises objections to the use of the computer I do not see how when this system will be operative. The personnel coordinator given to us by the Ministry was given the position as a reward for 30 years faithful service as a clerk. And today he remains a clerk in a position requiring a much broader background.

While advances are being made in the personnel administration area the clerical demands on this office are increasing at an increasing rate with each new procedure established by the Civil Service Bureau. The end to these requirements is nowhere in sight.

Unless we obtain Civil Bureau approval to use the MADGE computer, or alternatively, receive approval for staffing the personnel function with qualified staff, our personnel

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data will remain incomplete for the foreseeable future.

2.3 Patient Information: This system has been in effect for over twelve months and provides interesting, if not useful data. While its fundamental use is in health planning for the construction site of new health centers or a new hospital, the information in general has no real bearing on day-to-day hospital operations. I have used it in the context of developing medical specialty staffing patterns for our satellited ambulatory health care centers but aside from this application the bulk of data available through this medium remains generally inapplicable. When and if the Minister's plans for building a medical school in Bahrain materialize, along with the usual para-medical specialties, the report will become more relevant, particularly from an epidemiological point of view. In the meantime the report will be utilized primarily to ascertain ambulatory care center staffing requirements and the location of new health centers.

2.4 Medical Audit: The value of this quality control mechanism has been established in terms of bringing physician diagnostic and treatment practices into conformity with state of the art expectations. I plan on promoting this activity as much as possible during the upcoming period.

3. Coping with the Anticipated Cholera Epidemic through Developing Internal Capabilities and Shared Services with Out-Patient Centers.

3.1 During August of 1978 a cholera epidemic commenced in Bahrain and lasted through January 1979. Over 15,000 patients were

seen at hospital with over 300 becoming inpatients because of the severity of the symptoms. The influx of patients caused serious dislocations within the hospital in terms of cholera victims occupying specialty care beds. As the cholera epidemic continued, and more and more specialty cases could not be handled, the pressure on the physician staff mounted from patients who were denied service. The solution effected was that an increasing number of patients were treated on an outpatient basis with antibiotics and returned to their homes. Because we were able to coordinate effectively with Public Health, staff members not usually assigned to locating contracts were given these duties and successful contract tracing and home treatment was effected with the result that acute care beds were made available.

- 3.2 This year pathology reports the outbreak is again Ogawa type cholera; clinically the virulence appears to be more severe than the previous year which could mean extended hospital stays.

As this situation mounts in severity it will consume a lot of time. As a result, I am not planning anything too ambitious for the near-term future.

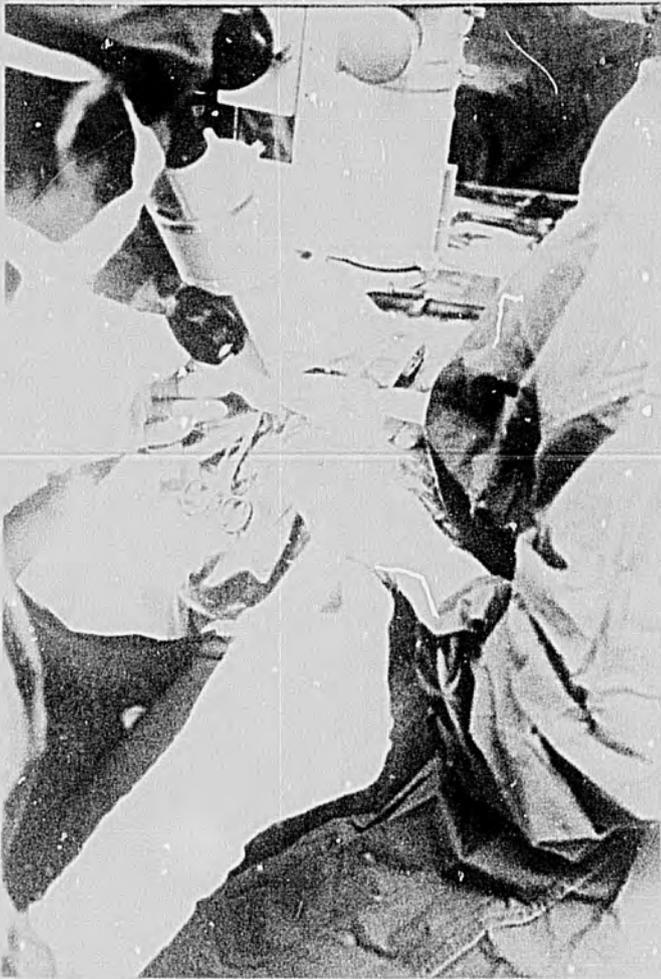
4. Hand-Over to my Successor.

- 4.1 During the ensuing three months I will commence a hand-over of my responsibilities to Mr. Bu Ali, Hospital Administrator. I sit on five Ministry Committees plus the Governing Body and Mr. Bu Ali will have to move into these areas during the upcoming period. As he has taken over my role during previous

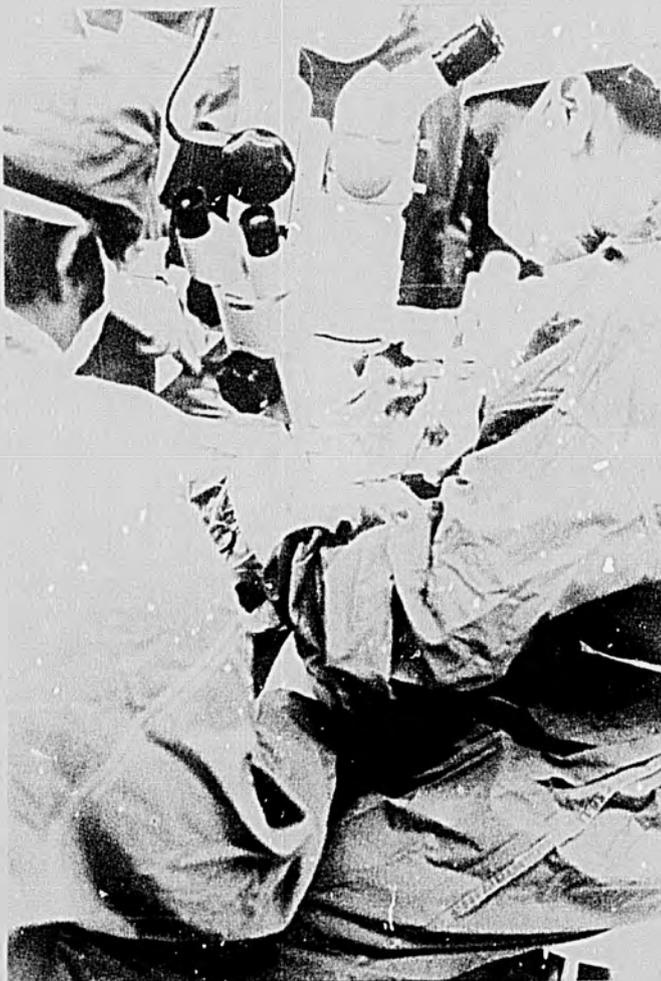
absences, I do not believe that the transition will be too difficult to effect yet maintain continuity.

- 4.2 I would only note in this context that the hospital administrative offices are badly understaffed. Three administrators for a 620 bed acute care hospital in which the staff are at best poorly trained is simply insufficient to maintain the thrust which is required to keep the hospital moving along the way it must go without encountering periodic crises. In brief, I believe the existing staff will be over-extended following my absence and that the standard of planning and output will of necessity suffer.

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The Eye Theatre: The Zeiss operating microscope is being used for a cataract removal procedure by Drs. Sha (left) and Vadiya (right). Prior to the availability of the operating microscope this procedure took almost four times longer to complete.

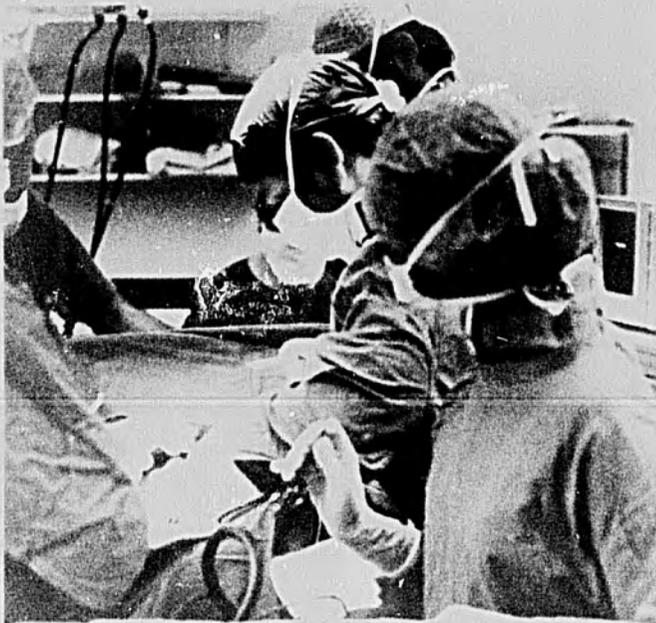




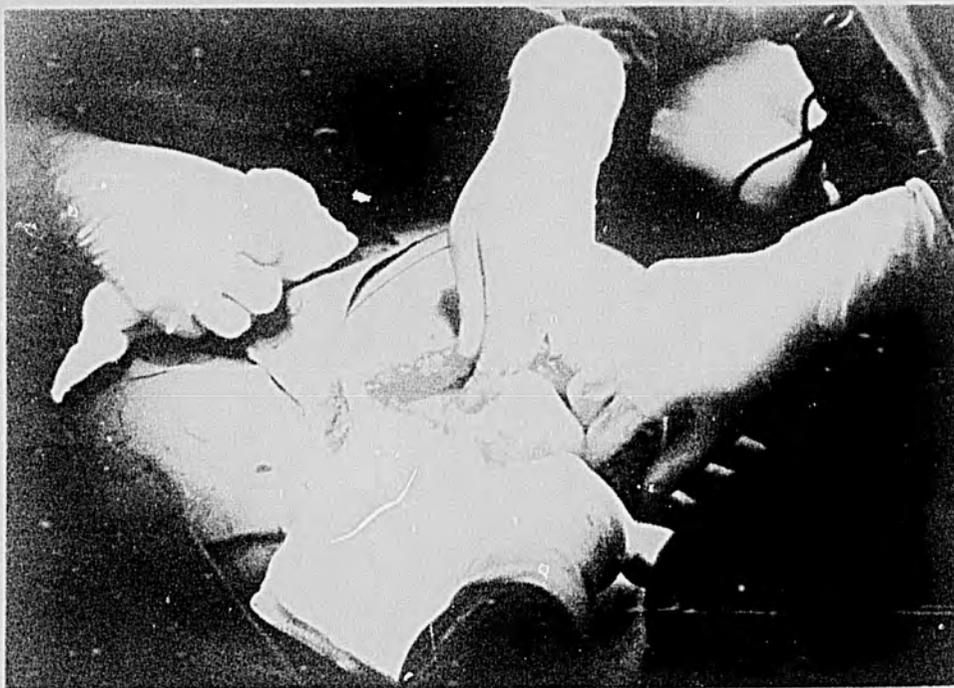
The ENT Theatre: Dr. Ahmad is preparing to remove the tonsils of a 12 year old patient. Drs. Sheed(left) is assisting.



The tonsils removed. From start to finish the patient was in the operating room for 44 minutes. Drs Sheed (left) and Hassan (right) are in the background.



An emergency patient with a suspected bowel obstruction has been brought to the O.R. from the Emergency Room. The first incision in the abdomen is made 57 minutes following the patient's arrival in the Emergency Room by Dr. Patil (right).



Nine minutes following the first incision the lower bowel is exposed and the search for the obstruction commenced.