Special Article

AN AMERICAN COMMUNITY HOSPITAL

BY

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AND

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Since there has been much discussion about the place of the British general practitioner, it is felt that a description of a typical American community hospital and the general practitioner's place in it will be of interest.

General Arrangements

Brookhaven Memorial Hospital is a modern community non-profit-making general hospital in a small town about 70 miles (112 km.) from New York City. It has 150 beds, including 30 in the maternity wing, plus 35 bassinets. The wards are arranged in two- and four-bed rooms and each room has a telephone.

The operating-suite has two major operating-rooms, one minor operating-room, a cystoscopy room equipped with x-ray apparatus, a plaster-room, recovery room, and a doctors' changing-room. This latter rather cramped room also serves the very important function of an informal meeting-place for the staff members. With a supply of coffee on tap, doctors wander in and out all the morning before and after making the rounds of their patients. Discussions of interesting and difficult cases are constantly going on, and if a doctor has a problem he can always find someone there to give advice. These casual discussions have great educational value, quite apart from their social aspect.

A cardiac defibrillator and a cardiac pacemaker are on hand in the operating-suite, set up on a mobile trolley. The emergency department is next to the operating-room.

The maternity department is in a separate wing of the hospital. The delivery suite has three labour rooms, two delivery rooms, and nurses' and doctors' rooms. The doctors' room has beds for doctors who are doing deliveries at night. Most caesarean sections are performed in the delivery room. On the obstetrical floor there is a circumcision room, as practically all male babies are circumcised.

The x-ray department has two diagnostic x-ray machines, one of which is equipped with a Schoenander unit for doing aortograms and carotid angiograms. It has equipment for deep x-ray therapy.

The laboratory has two part-time pathologists, who together give full-time coverage. It is staffed by technicians on a 24-hour-day basis. It is equipped for all routine investigations, including flame photometry and pregnancy tests. Automation is emphasized and an auto-analyser is used for blood sugars and blood urea nitrogens. A Sanborn cell-counter is used for total white-cell counts. Each year 3,000 surgical specimens are examined, 250 radioactive iodine uptakes are performed, and 2,400 Papanicolaou smears from the cervix are reported on. (The latter are practically all slides sent in by the local doctors but do not give an accurate reflection of the total number of exami-

nations done in the hospital catchment area, as some doctors send their cervical smears to private laboratories.) The laboratory runs the blood bank and 1,200 pints (680 litres) of blood are given each year. In an attempt at improving accuracy, several thousand dollars are spent each year on control sera, methods, and standards.

There is a small physiotherapy department staffed by one part-time physiotherapist.

All instruments, gloves, catheters, dressings, and other sterile equipment are distributed through the central sterile supply department and no sterilizing is done in the wards. There are sterilizers in the operating and delivery rooms. Disposable sterile gloves are now being used. Linen is supplied as required to the wards from the hospital house-keeping office. The quantities used are accounted for daily. All laundry is done on contract by weight by a local laundry. Linen for the nurseries, however, is supplied, owned, laundered, and sterilized under contract with a baby-linen supply company.

Oxygen is piped throughout the hospital and the tents are supplied and serviced by a local company specializing in this service. The company sends a technician to set up each tent as required, giving a 24-hour-day service. A liquid-oxygen tank was installed recently outside the hospital.

There is a paging system based at the switchboard, and loudspeakers are distributed throughout the hospital. In each ward and in the doctors' rooms there are special telephones linked up with dictaphones so that histories, physicals, operation notes, and summaries may be dictated. Considering the illegible handwriting of many doctors, this is a distinct advance.

Afternoon and evening visiting is allowed daily for all patients except those in the paediatric department, where visiting is from 2 to 4 p.m. During the first 24 hours after admission and when the patient is critically ill visiting is completely unrestricted. Portable television sets may be rented by patients.

When a patient leaves the hospital he is given a card with a number of printed questions on how he felt about his care in the hospital. There is also space for further comments and suggestions. The average length of patients' stay is 5.7 days.

Medical Staff

There are 91 doctors on the active staff. The specialists usually hold appointments in a number of hospitals and several are on the staff of different teaching hospitals in New York City. Most of the general practitioners are on the staff at Brookhaven only, but some at the edge of the district are on the staff at the next nearest hospitals, 13 and 15 miles (21 and 24 km.) away. All patients are admitted to the care of their own doctors, not merely to the service of the hospital. This includes welfare cases, where the physicians are paid a minimal fee agreed to by the County Medical Society on a per-visit basis by the Welfare Department.* Patients admitted to the hospital who have no regular doctor on the staff—that is, those admitted as emergencies—are assigned to doctors from the list for emergency calls maintained by the medical, surgical, and obstetrical services. One of us (M. G. J.) is on the call list for medical cases. The hospital also maintains a list of the doctors in the area for police emergency calls; all the

*Only 4 of the 62 counties in the State of New York have this system. Usually welfare cases are referred to State or County institutions or to the ward services of the voluntary hospitals, where the resident staff (registrars or housemen in England) care for them under the supervision of the visiting physicians on the service.

doctors, including even the pathologists and radiologists, are expected to assume responsibility for this. This entails availability for emergency call one day every two weeks.

Staff appointments are open to all physicians in the district on the recommendation of the Medical Board to the Board of Directors, and in actual practice no doctor is ever turned down if he is satisfactorily qualified. All specialties are covered, including thoracic surgery, plastic surgery, neurosurgery, and psychiatry (psychiatry is on a consultant basis only, as there are no psychiatric beds).

Doctors join the staff initially on a courtesy-appointment basis, during which time they are subject to supervision by their respective chiefs of service, usually for about a year. If found competent in their field of choice they are promoted to associate attending, and finally to full attending. All appointments, in accordance with the recommendation of the Joint Commission on Accreditation of Hospitals, are made on an annual basis and must be renewed each year. This includes even the chiefs of service. Any physician whose standard of clinical work is not considered satisfactory may not have his appointment renewed.

General practitioners are permitted to do minor surgery, which includes simple fractures, and they assist at major surgery performed on their patients. Twenty-two general practitioners may do D. and C.s after prior gynaecological consultation (this obligatory consultation is done at no charge to the patient, which is in keeping with the recommendations of the Joint Commission on Accreditation of Hospitals); twelve general practitioners do tonsillectomies.

Anaesthesia is provided by a partnership of six full-time anaesthetists who cover several hospitals in the area. A nurse anaesthetist covers the delivery room for several nights each week.

The chiefs of service exercise broad supervisory powers, but, generally speaking, do not interfere with the treatment of individual cases. However, if the treatment of a case is considered to be unsatisfactory the chief of service will discuss the matter with the doctor in charge. If the doctor is unwilling to change his line of treatment the chief of service may then take over the case personally.

The following consultations are obligatory, in keeping with the recommendations of the Joint Commission: (1) first caesarean sections; (2) curettages or other procedures by which a known or suspected pregnancy may be interrupted; (3) operations performed for the sole purpose of sterilization on both male and female patients; (4) cases in all services in which, according to the judgment of the physician (a) the patient is not a good medical or surgical risk, (b) the diagnosis is obscure, or (c) there is doubt concerning the best therapeutic measures to be used. A consultant must be well qualified to give an opinion in the field in which his opinion is sought. The status of consultant is determined by the Medical Board on the basis of an individual's training, experience, and competence.

The medical staff meets once a quarter and hears reports from all committees. It also controls the following: Formulary Committee, Infection Committee, Good and Welfare Committee (which acts as liaison between the medical and the nursing staff), and the Medical Library Committee. One thousand dollars a year is donated by the medical staff to the Library Committee for journal subscriptions and the purchase of new medical textbooks.

The medical service holds a lecture and discussion at 8.30 a.m. once a week on a prearranged subject. The various services—medicine, surgery, obstetrics, and paediatrics—hold monthly meetings at which attendance is compulsory for the members of the particular service; They may also be attended by members of the other services if they so desire. The meetings on internal medicine, surgery, and paediatrics discuss all deaths and all cases of interest. The meetings on obstetrics discuss all cases of interest, including every complication and every first caesarean section. If good clinical standards have not been maintained in a particular case the doctor in charge can expect considerable criticism.

Nearly half the deliveries in the hospital are performed by general practitioners, several of whom have complete obstetrical privileges, including the performance of caesarean section. There were 1,889 deliveries at the hospital in 1962, of which 759 were carried out by general practitioners. No maternal deaths occurred; there were 23 stillbirths and 27 neonatal deaths. Of 100 caesarean sections performed, 44 were primary and 56 repeat. All deliveries were performed by doctors, as is the custom in the United States. (No deliveries are done in the patients' homes.) The average length of stay of maternity patients is 4.3 days.

Although there are 50 qualified specialists on the staff, the chief of medicine is a general practitioner. (It should be noted that medical specialists in the U.S. do general practice confined to medicine, as well as consultant practice (Jacoby, 1961). The paediatricians likewise do general practice confined to children.)

Medical Board

The Medical Board is the executive committee of the medical staff and is responsible for maintaining the standards of medical care in the hospital. It consists of the chiefs of surgery, medicine, obstetrics, paediatrics, radiology, pathology, allied surgical services, allied medical services, and five general practitioners. The president of the medical staff is a member of the Medical Board *ex officio* unless he already sits on it.

There are eight subcommittees of the Medical Board: the Joint Conference Committee acts as a liaison between the Board of Directors and the medical staff. The Medical Credentials Committee checks the credentials of applicants for positions on the medical staff. The Medical Records and Audit Committee spot-checks patients' records to see that the standards of note-taking and treatment are maintained. The Tissue Committee correlates the pre- and post-operative diagnoses with the pathological diagnosis; It also checks where surgery is performed without removal of tissue. (The Medical Records and Audit Committee and the Tissue Committee together act as controls to maintain good clinical standards of treatment.) The Sterilization Committee must approve all applications for surgical sterilization and abortion. The Medical Board also has medical education, hospital rules, and tumour committees. The Medical Board meets once a month or more frequently as necessary. It has the power to suspend any physician whose ethical or clinical standards do not meet its requirements. It is responsible to the Board of Directors.

Board of Directors

The 24 members of the Board of Directors serve in a voluntary capacity. The salaried executive vice-president is the administrator of the hospital. The directors are responsible for the running of the hospital and receive advice from the Medical Board, but are not bound to accept this advice.

Financing the Hospital

The building of the hospital was covered by private contributions, supplemented by a federal subsidy of 33% of the construction costs through the Hill-Burton Act. Extensions have been financed in the same manner, plus a substantial mortgage (\$400,000 in 1956—now reduced to \$200,000).

The day-to-day running of the hospital is paid for out of income from services rendered. About 70% of the patients are known to have Blue Cross (a nation-wide non-profit-making prepaid hospital insurance) or other insurance. The 5% of patients whose injuries were received while at work are paid for by Workmen's Compensation Insurance. About 11% of the cases are paid for by the local department of welfare and the others pay directly. A substantial number of this latter group have other insurance (unknown to the hospital) which they collect, using the hospital's and doctor's bills as a basis.

At Brookhaven Memorial Hospital the average operating income per patient per day during the year 1961 was \$29.70, whereas the average cost per patient per day, including renewed equipment costs, was \$31 a day, the balance being made up by public contributions. This does not include the doctors' fees. (To give a standard of comparison, a registered nurse is paid \$16 minimum a day.)

Outside Control of Hospital Standards

Hospital standards are maintained by inspection by the Joint Commission on Accreditation on Hospitals (a commission set up jointly by the American Hospital Association, the American Medical Association, the American College of Physicians, and the American College of Surgeons). It inspects the hospital every three years, or sooner if it considers it to be necessary. The inspection covers plant, all phases of medical care, including medical records, the Medical Board, the Board of Directors, qualifications of the chiefs of services, x-ray plant, and the pathological laboratory. It makes recommendations, and if the hospital does not meet its standards it may refuse accreditation. If accreditation is refused Blue Cross will decline to pay for patients in the hospital. This hold over the purse-strings is a very potent method of maintaining standards.

The New York State Department of Social Welfare examines all non-profit-making charities, including hospitals. Its standards of examination are similar to that of the Joint Commission on Accreditation. If approval is withheld then public funds for the care of welfare (public charge) patients may not be made available for the hospital.

The County Commissioner of Health is principally interested in maternity and nursery services and inspects them at least once a year. Samples of infant-feeding formulae are cultured each week. All communicable diseases, staphylococcal infections, and cancer cases must be reported. The x-ray department and the use of radioactive substances are checked by a sanitary engineer at least once every two years. The State Health Department checks the quality performance of the laboratory and licenses the use of laboratory animals.

Discussion

In the American community hospital both the general practitioner and the specialist have important parts to play. The general practitioner fulfils himself by following his patients into the hospital. The dichotomy of medical care by which the English general practitioner treats the patient in the home but the specialist cares for him under the

hospital roof is thereby avoided. It should also be remembered that in the English hospital the specialist very often functions by remote control, the actual care of patients being in the hands of junior house staff who are in training to become general practitioners themselves. The concept which has developed is not the general practitioner as a lowly member of a team, but rather the family doctor expanding to his full stature with all the technical aids of modern medicine at his disposal. Patients are happier to have a continuity of treatment outside and inside the hospital. Even if the major responsibility of care is that of the surgeon they are reassured in knowing that the family doctor is also at the operating-table and at the bedside in the stormy post-operative days.

The close day-to-day contact between general practitioner and specialist leads to true evaluation of the latter, who maintains his practice not by virtue of a hospital appointment but rather by constant demonstration of his superior skills. If the general practitioner has problems there are consultants available, and in grave situations consultation is mandatory; but nevertheless he is encouraged to assume responsibility, not as in England to hide behind a collusion of anonymity. Accountability to the Tissue and Medical Records and Audit Committees and to the monthly meetings of the different services encourages consultation whenever there is a need. However, the doctor who uses consultants unnecessarily freely will soon find that his patients will lose faith in him.

All the above have a marked educational value. In such a stimulating atmosphere few men would not continually improve their standards of practice.

Not only does the family doctor keep clinical control of his patient but his status is assured, as beds are allocated on a first-come-first-served basis, no preference being given to the specialists or even to the chiefs of services. High standards of medical care are maintained by a control of the privileges of staff members, whose appointments are made on a yearly basis, automatically renewable only if satisfactory clinical standards are maintained.

The short average length of hospital stay of both general and maternity patients is noteworthy. Particularly in the case of patients admitted for investigation, time wasted by not doing the maximum number of investigations in the shortest possible time may mean excessive time off from work and consequent loss of income to the wage-earner.

Finally, there is firm external control of hospital standards by the Joint Commission on Accreditation on Hospitals, the New York State Department of Social Welfare, the County Commissioner of Health, and the New York State Health Department.

Summary

The workings of a typical 150-bed American community hospital are discussed. Particular reference is made to the position of the family doctor and the internal and external control of standards of medical work.

REFERENCE

Jacoby, M. G. (1961). *Practitioner*, **187**, 792.

The Calouste Gulbenkian Foundation, Lisbon, has made a grant of £6,000 over three years to the Blackfriars Settlement to establish an occupational work centre for people who are either physically or mentally handicapped or infirm from age or other reasons. The settlement is known for the scheme whereby well-known artists contribute designs for rugs to be made there.