THE PRESENT STATUS OF HOSPITAL STANDARDIZATION AND ITS VALUE TO THE PUBLIC

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For those not familiar with the Hospital Standardization movement, I wish first to present a brief history of its development.

A large number of national organizations interested in hospitals have become increasingly more concerned in the betterment of hospital service. However, before 1915 practically nothing definite had been evolved from the large amount of data which had been gathered on this subject by these organizations, the most active of which were The American Medical Association and The American Hospital Association.

The Hospital Standardization Conference held in Chicago, Oct. 20th, 1917 marked the beginning of active Hospital Standardization. This meeting brought together many of the leading hospital and medical men of the United States and Canada, including the presidents of the American Medical Association, the American Hospital Association and the American College of Surgeons. After considerable discussion of the various problems involved, Dr. Bevan recommended the creation of a general committee of twenty-five to bring together all the factors interested in the problem of Hospital Standardization, such as; The American Medical Association, the Association of the American Medical Colleges, the American College of Surgeons, the American Hospital Association, the State Licensing Boards, and all other large associations interested in this work.

At the close of this meeting a general committee was appointed to work out a definite questionaire and schedule for an extensive study of hospital conditions. This general committee was made up of the leading physicians, surgeons and hospital superintendents of the country. They met in Washington in December of 1917, and worked out a questionaire which was sent to all

the hospitals and on the basis of the information thus obtained, the minimum standard was determined. Obviously, hospitals exist primarily for rendering the highest service to the patient, and this idea has been uppermost in formulating the minimum standard as will be seen by the following requirements:

THE MINIMUM STANDARD

1. That physicians and surgeons privileged to practice in the hospital be organized as a definite group or staff. Such organization has nothing to do with the question as to whether the hospital is "open" or "closed", nor need it affect the various existing types of staff organization. The word staff is here defined as the group of doctors who practice in the hospital inclusive of all groups such as the "regular staff", the "visiting staff", and the "associate staff".

2. That membership upon the staff be restricted to physicians and surgeons who are (a) competent in their respective fields and (b) worthy in character and in matters of professional ethics: that in this latter connection the practice of the division of fees, under any guise whatever, be prohibited.

3. That the staff initiate and with the approval of the governing board of the hospital, adopt rules, regulations and policies governing the professional work of the hospital: that these rules, regulations and policies specifically provide:

(a) That staff meetings be held at least once each month. (In large hospitals the departments may choose to meet separately).

(b) That the staff review and analyze at regular intervals the clinical experience of the staff in the various departments of the hospital, such as medicine, surgery, and obstetrics; the clinical records of patients, free and pay, to be the basis for such review and analyses.

4. That accurate and complete case records be written for all patients and filed in an accessible manner in the hospital, a complete case record being one, except in an emergency, which includes the personal history;

the physical examination, with clinical, pathological, and X-ray findings when indicated; the working diagnosis; the treatment, medical and surgical; the medical progress; the condition on discharge with final diagnosis; and in case of death, the autopsy findings when available.

5. That clinical laboratory facilities be available for the study, diagnosis, and treatment of patients, these facilities to include at least chemical, bacteriological, serological, histological, radiographic and fluroscopic service in charge of trained technicians.

These standards have been made high enough to protect the patient and low enough to be reached by the majority of hospitals, whose motives are high. The college sums up the "Minimum Standard" in the following statement: "It grew out of the straight thinking of the clearest minds in medical and hospital work on this continent. It is practicable, workable and constructive. It costs effort rather than money. It safeguards the care of every patient admitted to the hospital by insistence upon competence on the part of the doctor, by thorough study and diagnosis in writing of each case, and by a checking up at least once each month of the clinical service of the hospital. It fixes responsibility through-out the hospital. It defines the minimum service to the patient which beyond all debate is considered essential".

In an article published in the Word's Work in June of 1920 on the effect of this standard among hospitals, Mr. Hawthorne Daniel says in part: "The statement is simplicity itself, and yet with all its simplicity it contains just the suggestions that go to make good hospitals of mediocre ones; just the suggestions that lead to the conservation of lives and the elimination of unnecessary operations; just the suggestions that bring about the conscientious care that every patient in every hospital has a right to expect."

Within the brief period of three years, practically all of the national associations interested in hospitals have

accepted and endorsed the "Minimum Standard". These include the following:

The American Hospital Association.
The Canadian Medical Association.
The Catholic Hospital Association.
The Conference Board of Hospitals, and Homes of the Methodist Church.
The Medical and Surgical Section of the American Railroad Association.
The Methodist Hospital Association.
The Protestant Hospital Association.
The American Conference on Hospital Service.

We see therefore that this modern movement for hospital betterment and classification is not the work of a single organization, but represents the ideas and aims of all the large organizations interested in hospitals. Endorsing the "Minimum Standard" in 1919 Father Chas. B. Moulinier, President of the Catholic Hospital Association, made the following statement: "I pledge to the American College of Surgeons with my personal honor and all the official capacity I have, that the Catholic Association with whatever force and power it has, the clergy of the Catholic Church and that great body of twenty or thirty thousand sisters working in Catholic hospitals are going to co-operate with the College to the highest point."

The American College of Surgeons made a survey of all general hospitals of 100 or more beds in the United States and Canada in 1920, and they are now making a survey of all general hospitals between 50 and 100 beds. All hospitals which conform to the "Minimum Standard" will be rated as Class "A".

The progress of the movement has been rapid. In 1918, only 89 of the 761 larger general hospitals met the "Minimum Standard". In the next year, 198 fulfilled the requirements. In 1920, 407, and in 1921, 579 or 75% of the larger general hospitals had conformed to this standard. 25% of the 764 smaller hospitals already visited were found to meet the standard.

In expressing his opinion on the rapidity of this movement, President Henry S. Pritchett of the Carnegie Foundation said: "From coast to coast the idea is changing the conditions in hospitals. Everywhere there is the ferment of development, the activity of improvement. In great centers of medical affairs the changes have been startling. In Baltimore, there is not a hospital of 100 beds or more that has not put into effective operation the "Minimum Standard", and in New York and other cities the hospitals have made almost as great an advance. The world of the hospital is changing. An advance normally to be expected in twenty years has come in three." The change in Canada has been just as rapid. In five provinces not a single large hospital remains unclassified.

No movement is destined to contribute more to the conservation of the public health of the country than the hospital standardization movement.

In 1917, the records kept in 75% of the hospitals of this country were practically valueless. No examinations were made of the patients on admission. No diagnosis, no family history and no physical examination were recorded.

Figures from two prominent hospitals prepared on similar cases before and after standardization show that the percentage of operative cases was reduced from 44 to 30% in one hospital, and in another from 62 to 47%, and the mortality was reduced about 1%. This represents the prevention of 15% of unnecessary operations and the saving of one in a hundred of all patients admitted.

Again, a comparison of a standardized and a non-standardized hospital in which 100 appendectomies were done showed the following:

	S	N. S.
Complete physical examination and blood count	100	14.
Consultations held	41	2.
Working diagnosis reported	100	0.
Progress notes recorded	100	0.
Infections following operation	3	12.
Incorrect diagnosis	4	14.
Patients relieved	94	77.
Deaths	2	9.

These figures show in end results in favor of the standardized hospital a 7% lower death rate, and 17% more of relieved patients.

Our community of about 90,000 people is cared for by 310 general hospital beds. Last year 7,628 patients were treated in the three local hospitals. Of these, 4,106 or 53% were surgical cases and 1,753 or 23% submitted to major operations.

Conservative estimates show that the application of the principles of standardization reduces the death rate at least 1% and unnecessary operations at least 5%.

This would mean the saving of 76 lives and the prevention of 381 unnecessary surgical operations each year in Winnebago County alone.

As applied to Illinois, this would mean the annual saving of 4,000 lives and elimination of 20,000 needless operations.

About 6,000,000 people are treated in the general hospitals of the United States each year. Based on the above percentages, standardization will mean an annual saving of 30,000 lives and 300,000 needless operations in the United States.

During the twenty months of our active participation in the recent world war, about 80,000 of our soldiers died of disease or wounds received in battle. According to our figures, more than half as many lives will be saved in an equal period through this hospital movement.

Nothing has been said about that large number of obscure surgical conditions which will be discovered and corrected by a more efficient diagnosis and treatment. Most of these border-line cases have here-to-fore received very poor medical care or no treatment at all.

We can easily comprehend the far reaching results of the application of the principles of standardization to all the hospitals of the country.

1. It will result in abler diagnosis and more intelligent treatment by a more efficient medical profession.
2. It will help greatly to eliminate incompetent operators and unnecessary operations.
3. It will do more than legal enactments to abolish the evil of fee-splitting.

4. It will produce a better trained nursing profession and will help greatly to disseminate useful knowledge of disease and its prevention and cure to the public.

5. It will lower the death rate, reduce the number of post-operative complications and lessen the period of disability of the sick.

6. Indirectly, the influence for good will extend far beyond the walls of our hospitals into the homes of all of our people.

7. It will change many of our hospitals from poor boarding houses into scientific institutions.