Letter from . . . Chicago

Inspecting the hospitals

GEORGE DUNEA

As the recession lingers and the entire health-care establishment is encountering growing financial difficulties, increasing irritation is being felt about the Joint Commission on Accreditation of Hospitals, the body that inspects hospitals, sets standards, makes rules and regulations, and drives up the cost of health care by millions of dollars.

The Joint Commission on Accreditation of Hospitals is the offspring of a review programme set up by the American College of Surgeons in 1918 to assess the quality of patient care in hospitals. The basic requirements, listed at the time on one page, were minimal and emphasised the need for an organised medical staff that should meet monthly and have appropriate professional qualifications and ethical standing. The hospitals were also required to apply basic principles of plant safety and maintenance, conduct research and educational programmes, and operate properly supervised laboratories and *x*-ray facilities. Yet of the first 700 hospitals inspected only 13 were found to comply with even these simple requirements, leading the regents of the college to burn quietly the records of the surveys to avoid embarrassment. In subsequent years, however, the programme gained widespread acceptance. By 1951 over 3000 hospitals had become accredited, but by then the requirements had expanded from one page to 147 pages. The job had clearly become too big, leading in that year to the formation of the Joint Commission on Accreditation of Hospitals, incorporated in Chicago, with the American Medical and Hospital Associations, the Colleges of Surgeons and Physicians, and the Canadian Medical Association (until 1959) as corporate members (the American Dental Association joined in 1980). By 1960 the Joint Commission on Accreditation of Hospitals had revised its standards to a 210-page book, and by 1961 it began to develop its own staff. Rapid growth took place in the mid-seventies, so that currently the Joint Commission on Accreditation of Hospitals has a budget of $185m and 400 employees, including 185 field surveyors. It has accredited 5000 out of 7000 of the nation's hospitals (the others being too small, unable to comply with the standards, or not interested) as well as 1200 psychiatric, 1100 long-term, and 125 ambulatory-care facilities.

Major interactions with the government began in 1965, when under the newly promulgated Medicare Act the hospitals approved by the Joint Commission on Accreditation of Hospitals were to be deemed to comply with Federal conditions for participation without need for a further State inspection. There was trouble almost immediately. Activist consumer groups filed suit, challenging this delegation of authority to a private organisation as being unconstitutional. Hostile elements complained that inspectors of the Joint Commission on Accreditation of Hospitals were not stringent enough; and in 1972 Senator Edward Kennedy held congressional hearings and made widely publicised disparaging remarks about the conditions in hospitals tolerated by the Joint Commission on Accreditation of Hospitals. Later the administration sent large teams of non-medical personnel to conduct validation inspections of facilities already approved by the Joint Commission on Accreditation of Hospitals. These teams spent many days looking for deficiencies, and deficiencies they found, leading to sensational newspaper headlines of "Lives too dear to risk," and "Two-thirds of accredited hospitals flunk Federal exams." Then followed a fight over confidentiality when the government released the Joint Commission on Accreditation of Hospitals reports to the press, and a further threat arose when the Professional Services Review Organisations, now about to become extinct but at the time mandated to conduct quality assurance programmes for the government, looked as though they would squeeze the Joint Commission on Accreditation of Hospitals out of the inspecting business. For a while the Joint Commission on Accreditation of Hospitals was clearly an endangered species; but later its relations with the government improved to the extent where in 1979 it won the praise of the General Accounting Office, which recommended that it should continue to be awarded the contract for carrying out accrediting and certification functions. Yet another potential problem lies in its relationship to its parent organisations, which tend to view with suspicion excessive signs of growth, independence, or assertivity in their offspring. Yet when in the face of criticism the Joint Commission on Accreditation of Hospitals fought for its life by becoming more catholic than the pope, the parent bodies lay back in the supine contentment that they had begotten a bureaucratic Frankenstein that would surely keep the government off everybody's back and prevent the "Feds" from taking over.

How long, oh Lord, how long?

Yet anyone doubting that young Frankenstein has got out of hand should listen to the complaints of a harassed chief of surgery, as described in an editorial in the March 1981 issue of *Surgical Rounds*. "How long, oh Lord, how long?" he asks, describing how each week he reviews all deaths and all interesting or suspicious cases; conducts ward rounds, clinicopathological conferences, mortality conferences, and meetings with the pathologists; goes to the operating room to observe personally what is going on; and receives further information from the students and residents with whom he conducts teaching conferences. Yet inspectors of the Joint Commission on Accreditation of Hospitals have been regularly dissatisfied because there is not enough documentation, and have required more committees, more minutes, more reports, more procedure manuals and bylaws, which have resulted in more and more time being spent in doing paperwork, so that "there is a scurrying all over the hospital, by people who should be busy caring for patients, to prepare procedure books, so each area can have a book to go by and the inspection team can see if they go by the books."

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In most hospitals the inspections are conducted by a team of three—a nurse, a doctor, and an administrator—who make their recommendations to the Joint Commission on Accreditation of Hospitals accrediting committee that meets monthly and makes its final decision. The inspections are voluntary—as voluntary as joining the ruling party in a totalitarian State—for loss of accreditation would mean the loss of government funds which nowadays constitute so important a part of a hospital's income. No wonder then that accreditation visits are taken seriously and may be traumatic. There is usually little trouble from the nurse inspector, even in places where you could die from dehydration before a nurse brought you a glass of water. But the administrator may literally crawl through the building, fussing about pipes and fittings and fire escapes and oxygen cylinders, and making suggestions on how to improve the plant. In the past, hospitals have been asked to spend millions of dollars to remodel to come into compliance with the Joint Commission on Accreditation of Hospitals. One hospital was told to build walls separating its lift from the stairwells. Other hospitals have very old buildings that in no way meet the Joint Commission on Accreditation of Hospitals standards, and it is not clear what can be done about this, especially if they are municipal hospitals that accept patients that have nowhere else to go. Yet even more intractable in the past, despite denials by the Joint Commission on Accreditation of Hospitals, has been the medical member of the team—often above retirement age, often from a small town, sometimes out of touch with the realities of clinical medicine, at times grasping at the last vestiges of authority, and seemingly incapable of understanding how things at a large hospital can be different from the Black Creek Hospital. "How come you don't discuss a medical case at your quarterly staff meetings like every hospital in Black Creek does?" You explain that this is a teaching hospital, which has grand rounds, clinicopathological conferences, mortality conferences, teaching rounds—but his eyes just glaze over.

Form rather than substance

It is indeed this excessive emphasis on documentation and paperwork, a preoccupation with form rather than with substance, that constitutes the most irritating aspect of the Joint Commission on Accreditation of Hospitals. Even before the inspectors arrive the Joint Commission on Accreditation of Hospitals sends a bulky questionnaire replete with questions about procedure books, criteria for admission or discharge, mechanisms for formal patient grievances, qualification of personnel, and organisation tables. Enormous attention is paid to the bylaws outlining the relations between the medical staff and the governing board, and there are also reams of forms delineating the privileges of the doctors, so that everyone has to fill in forms and questionnaires and more forms, and a long list to tick off all procedures devised since the discovery of the lumbar puncture. Yet all this pales into insignificance compared with what goes on at medical records, where millions of dollars are wasted as teams of librarians in every hospital work overtime pouring over bulky illegible charts to make sure everything is in order for the next inspection. Signing of verbal and telephone orders constitutes a major obsession, so that not a week will go by without a consultant finding in his pigeon-hole a weightly chart of a patient whom he may not have seen for years and whom he may have long forgotten, with a sign to request the verbal order for aspirin dated 7 March 1977. In every chart there are dozens of little coloured tags for each doctor, the reason for the delay being that for the past four or five years the chart has been making the rounds of the pigeon-holes of all the medical and surgical doctors on the case. Equally important are the discharge summaries, which *must* be completed even if it is five years too late and the patient has long ago died or moved to Texas; but then nobody reads most of these summaries anyway, and indeed one doctor is said to have dictated all his summaries in Spanish for two years before anyone caught on. It has also been alleged that some hospitals have been known to hide their incomplete records before the inspection, and that one prestigious university hospital threw out thousands of records before a visit by the Joint Commission on Accreditation of Hospitals.

An equal amount of busywork and red-tape is being generated by quality assurance, the supposedly realistic exercise carried out in co-operation with other reviewing bodies now that everybody has at last caught on that audits are a waste of time. Medical and clerical personnel who would be better employed in taking care of patients spend their time running around setting up criteria, complaining that gynaecologists fail to carry out pelvic examinations and eye doctors do not look at fundi (of course, the patients had already been examined in the doctors' offices), or fretting about whether anaesthesia is a service or a clinical section, a vital distinction because it determines how often quality assurance reports must be submitted. And the bitter irony of all this frenzied activity is that there is not a shred of evidence that it has done anything really to raise the standards of clinical medicine.

In recent years there have been many complaints about the Joint Commission on Accreditation of Hospitals, both within the American Medical Association and the American Hospital Association. The Joint Commission on Accreditation of Hospitals has responded that it is flexible, is trying only to raise standards, and wholeheartedly supports containment of costs. Already it would seem that the inspections have become more reasonable, but so far nothing has been done to reduce the enormous amount of preparation and paperwork that now goes automatically into the daily routine of a hospital with the aim of securing eventual accreditation. The Joint Commission on Accreditation of Hospitals points out that, as of 1980, out of 100 hospitals inspected, 74 had received two-year accreditation, 25 were approved for one year, and the only one denied certification had right of appeal. Yet more will have to be done at a time when the government has drastically cut its Medicaid programme, is beginning to chisel away at Medicare, and when even the private insurance companies are beginning to worry about the cost of hospital care. Many hospitals that in the past have undertaken ambitious building programmes now have empty beds and are experiencing cash-flow problems. The government is encouraging one-day surgery and cutting back the reimbursement for emergency room visits, which may drive patients to surgicentres or doctors' offices. This winter many hospitals have been forced to close wards and have laid off scores of clerks, technicians, public relations officers, and other personnel, as well as reducing the wages of other employees and asking doctors to accept their remuneration being postponed. It may not be too long before further cuts will become necessary, and a time will come when the Joint Commission on Accreditation of Hospitals will have to restrain its passion for documentation to stop driving up the costs in an already beleaguered industry, if indeed this unique exercise in voluntary self-regulation is to survive.

Should mumps vaccine be given to prepubertal or postpubertal boys who have not had mumps?

There is no reason why prepubertal or postpubertal boys should not receive mumps vaccine. This is a recommended procedure in the United States and the vaccine is usually given in the form of measles-mumps-rubella (MMR) vaccine to prepubertal and postpubertal children of both sexes. In Britain mumps vaccine is available but its administration is not recommended as a routine procedure. Determination of susceptibility or immunity to mumps cannot be made on the basis of a past history as asymptomatic infection is common. Immunity can be determined only by serological tests. If an individual doctor, however, wishes to give mumps vaccine to prepubertal or postpubertal boys there is no reason why it should not be given, even without prior serological testing.—J A DUDGEON, professor of microbiology, London.