CONSUMER HEALTH PERSPECTIVES

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WORKPLACE AND HEALTH FACILITY INSPECTIONS IN THE PUBLIC INTEREST

The two articles in this issue of *Consumer Health Perspectives* make evident how invaluable active consumer/worker participation is in enforcing government regulations requiring a safe and healthy environment in patient care facilities and in workplaces. In addition, each of the articles points out the importance of having government rather than private, industry-controlled inspection procedures.

The first article relates the real experience of a hospital Community Board (CB) which, even with limited responsibilities and no authority, was able to cause significant improvements in the cleanliness and maintenance of their hospital. Without the persistent and intelligent efforts of this Community Board neither the State Health Department nor the Joint Commission on the Accreditation of Hospitals (JCAH) would have taken action. In the end, much to the chagrin of the industry-controlled JCAH, the CB was able to bring to bear the authority of a minimally functioning but potentially powerful State Health Department and to effectively utilize a friendly City Health Department with which they had connections, to enforce the sanitary regulations.

The second article concerns Occupational Safety and Health Act (OSHA) inspection procedures. Workers (consumers) have played an essential role in this government inspection process since 1970. Industry, through its friends in Congress, is currently seeking to amend the worker/consumer role out of the OSHA legislation. The high incidence of occupational disease and death uncovered and documented by the government over the last ten years, shows the tragic results of having permitted industry to control workers' safety and health. During this time workers/consumers have been learning how to effectively use the OSHA inspection process. Unions, communities and environmental groups have begun to unite in an effort to eliminate workplace hazards which frequently spill over to surrounding communities. Now as workers/consumers are becoming stronger and more organized, industry is moving to turn the clock backward, to eliminate government inspections and to prevent any public knowledge or control over industrial hazards and their outcomes. It is imperative that the proposed OSHA amendments be defeated.

Both articles in this issue show the importance of maintaining and extending the consumer/worker role in government inspection processes. Consumers and workers have a very personal and legitimate self-interest in assuring that workplaces and hospitals are healthy and safe environments. The greater their involvement, the more likely that regulations and codes will be enforced and standards met.

Even with no authority, as in the case of the CB in the first article, active consumers have been able to make changes happen. If they had real, mandated authority to monitor workplaces and hospitals for compliance with government requirements, there is no doubt that factories and hospitals would be safer and cleaner.

IN THIS ISSUE

Community Boards Can Wield a Big Broom in Their Hospitals

by Zita Fearon

Summary

The following article is a true story about how one voluntary hospital community board used the government's hospital inspection system to force the hospital to adopt effective measures to clean and maintain its Emergency Department (ED), Out-Patient Department (OPD) and laundry facilities.

The article demonstrates the point of the accompanying article in this issue (the threat to OSHA and OSHA type inspections) that government inspections, with penalties for non-compliance with codes and standards, are the most effective tools consumers can use to make hospitals clean, safe and organized to give good care.

The names of the hospital and the people involved have been changed.

The Setting

Vesalius Hospital is a voluntary, community, teaching hospital with 400 beds, an antiquated OPD and a fairly modern but extremely overutilized ED. When the story opens in 1975, the hospital had just submitted plans to the appropriate agencies for renovation and new construction. The plans called for a sizable portion of hospital resources to be devoted to ambulatory care.

The governing board was invisible to the community. The administration was conservative, and though reasonably honest, often unnecessarily aggravating in its slow recognition and resolution of problems. Vesalius Hospital had a non-governing community board (CB). This was a condition for hospital participation in a state aid program which provided funds for ambulatory care. The CB, with a consumer majority, had a legal mandate for its existence and its general responsibilities in the regulations for the state aid program. One general responsibility was to monitor the services. Two of the CB activities covered by this responsibility, which are relevant to the issue of uncleanliness, were 1) solicitation and resolution of patient problems and complaints, and 2) physical review of ambulatory and related services. The latter was done on a periodic rather than a continuous basis.

The Problem(s)

This story concerns two related problems which the CB worked on from 1975 to 1977. The first problem was a substantial lack of cleanliness in the ED and OPD areas. The CB was repeatedly made aware of this problem through personal observation and review of patient complaints. There were dirty floors and furniture. Dirt was embedded along walls and in corners under the wax. The areas were littered with paper, cigarette butts, spilled coffee and soda, etc. Dust was evident on furniture and even on some walls. Bathroom fixtures were never washed, with the obvious result. There was peeling paint and flaking plaster in several areas.

The second problem was "hospital foot dragging." The issue of uncleanliness was raised time after time at monthly CB meetings at which time, Mr. Wilson, the hospital administrator habitually responded in a vague way, "We'll look into it." However, there were no observable changes in the state of hospital uncleanliness as a result of his "looking into it."

The Community Board Gets Serious

In *October of 1975* the CB decided to make the uncleanliness problem a major project. The Joint Commission on the Accreditation of Hospitals (JCAH) had scheduled its periodic two year survey at Vesalius Hospital for the end of October. The CB chairperson, Ms. Farrell, made a presentation at the Public Information Interview portion of the JCAH survey. One of the major concerns raised by Ms. Farrell was the lack of cleanliness and she asked the JCAH surveyors to give this matter special attention. She dramatically demonstrated the point by displaying a wet paper towel which she had just used to wipe a small area of tile wall in the OPD ladies bathroom. The paper towel was almost black with dirt.

The CB decided to follow up on the matter itself rather than just rely on the JCAH and its survey report, which would take months to arrive, anyway.

The main obstacle to progress in the matter was that hospital administration asserted that their hospital was no dirtier than the average hospital, that the hospital was reasonably clean, and that they couldn't help it if those areas were dirty, because they were high traffic areas.

Mr. Smith, the head of hospital housekeeping, was invited to the CB's *January 1976* meeting. Consumer board members presented the problem and asked Mr. Smith if he was satisfied with the OPD and ED's state of cleanliness. He admitted he was not and said he could correct the problem within 30 days. The board therefore gave him 30 days to clean up. In actuality,he got twice as long since the board became so involved in other work that it was unable to follow up until 60 days later.

JCAH Makes a Boo Boo

In the meantime (*February 1976*) the JCAH summary report was received by the board. Much to the board's disgust, it contained almost no mention of housekeeping and cleanliness problems.

Documenting The Dirt

In *March*, two months after speaking to Mr. Smith, two consumer board members conducted a formal, unannounced inspection of the ED and OPD to determine if it had been cleaned up. They were so dismayed with what they saw that they decided to prepare a written report detailing and documenting their findings. They presented their 19 point report to the March CB meeting,

documenting the location, degree and type of dirt throughout the area. In addition to the general lack of cleanliness and maintenance which the CB had been complaining of, the consumers also found the following:

1. There was no toilet paper or paper towels in either the OPD or ED ladies' rooms.
2. The Gynecology (GYN) Clinic's ceramic tile walls had been painted with a flat unwashable paint. This made them look clean, but of course, they could not be washed when they got dirty, as they could have been before they were painted.
3. "Clean" laundry was stored in an open bin in a thoroughfare between the ED and the ED cast room. This was also where the ambulance cases were brought in. The bin interior was covered with a fine film of lint and dust.
4. The most serious problem uncovered was that the OPD cast room which was used in the mornings to remove plaster casts, was then used in the afternoon to do minor surgery. Everything—walls, furniture, floor—was covered with a layer of plaster dust and the examining table was especially dirty. There was no air exchange system in the room.

In light of this documentation of some really serious conditions, the CB rquested that a thorough cleaning be done within 30 days, that they be notified when the cleanup was completed, and that they be invited to inspect the job with hospital administration. The response of the hospital administration continued to be very noncommittal.

Ms. Farrell made weekly spot checks of the ED and OPD, and informed the hospital administration and the chairman of the hospital infection control committee, Dr. Baker, of her findings. In the course of one of her visits, a hospital employee said to her, "If you think the clean laundry gets contaminated by being in a dirty open bin in the ambulance passageway in the ED, you should go down to the laundry and see what happens there."

No sooner said than done. Conditions in the laundry were so appalling that the board added the laundry to its area of concern.

By *May*, the thorough cleaning requested by the CB had not been done. Finally, Ms. Farrell persuaded Mr. Smith and Mr. Wilson to accompany her on an inspection of the ED, OPD and laundry. While there was agreement on what they were seeing—dust on walls and furniture, peeling paint and flaking walls, caked dirt and wax on floors and furniture, roaches in the laundry, "clean" laundry being dragged on the dirty laundry floor, the practice of doing minor surgery in the same room where casts were applied and sawed off, etc., etc., Mr. Wilson did not agree that the problems needed immediate and special attention.

The CB was quite upset and shocked by the ensuing report of these persistent and growing problems, the more so because hospital administration so calmly admitted the problems and considered them "not serious."

The CB decided that it had exhausted its persuasive techniques with the hospital. It had been very responsible and reasonable in its approach to hospital administration. It had been patient for half a year to no avail.

The Community Board Gets Tough

The CB decided to take the following actions:

1. Write to the State Health Department requesting an immediate unannounced hospital inspection, attaching to the letter copies of the board reports documenting the cleanliness problems. While the State Health Department was supposed to inspect the hospital every two years, it had been five years since the last inspection. (The State Health Department had accepted JCAH accreditation in lieu of its own inspections.)

2. Write to the JCAH, indicating that the CB inspections and reports had uncovered serious matters, which either were not observed by the JCAH survey team, or which they had no interest in. The letter also reminded the JCAH that the problem of lack of cleanliness was brought to their attention by the CB at the Public Information Interview, and that they chose to ignore the problem. The letter, in part, said, "Our own inspections . . . have led us to determine that the JCAH survey and subsequent report are not adequate to the job of helping hospitals maintain standards of quality and environment. It is clear to us that the role of the consumer is increasingly more crucial to make sure that hospitals are clean, safe and effective in the delivery of quality care. . . " Copies of the CB reports and the letter to the State Health Department were also sent to the JCAH.

3. Contact the local press about conditions in the hopsital and the CB's effort to improve conditions.

A Partial Victory

As a result of the CB actions, the following occurred:

1. The State Health Department made an unannounced inspection. Substantial violations were cited in the ED, OPD and laundry. The hospital spent most of its efforts trying to show that most of the violations could not be addressed until they built their new and renovated facility.

2. The JCAH made an unannounced 15-20 minute visit to the ED and OPD areas. The hospital was informed that their previous two year accreditation was reduced to one year and that they would be re-visited at the end of the one year period, i.e. in several months. At that time the hospital received another one year accreditation. At no point did the JCAH address itself *concretely* to the uncleanliness problem.

3. The hospital administration warned the CB Chairperson that going to the press as the CB had directed, would severely impair the board's relationship with the hospital, making it difficult to work together in the future. However, Ms. Farrell decided the relationship they had at the time was neither productive nor useful, and that it couldn't possibly be harder to work with the hospital. She went to the press. The administration was quite angry but mainly confined their remarks to accusing her of exaggerating, and assuring the public that improvements had been made, etc.

As a result of all of this the only measurable thing that happened was the OPD being painted in very pretty pastel colors, in flat, non-washable paint.

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NEW OSHA LEGISLATION WILL END WORKERS' INSPECTION SYSTEM

by Zita Fearon and Frank Goldsmith

In January the American Iron and Steel Institute, an industry organization, called on Congress to "minimize the unnecessarily burdensome impact of OSHA." Five United States Senators, Richard Schweiker (R.-Pa.), Orrin Hatch (R-Utah), Harrison Williams (D-N.J.), Alan Cranston (D-Ca.), and Frank Church (D-Id.) responded by introducing S.2153, a bill currently before the Senate Labor and Human Relations Committee, mislabelled the "Occupational Health and Safety Improvement Act of 1980."

An Im(modest) Proposal

If enacted, S.2153 will destroy the effectiveness of the 1970 Occupational Safety and Health Act (OSHA) by:

1) exempting 90 percent of the presently covered workplaces from OSHA safety inspections, until one or more workers is killed or seriously injured,
2) virtually eliminating comprehensive, preventive inspections,
3) abolishing workers' statutory right to an inspection based on their valid and formal complaint, thus violating the strongly preventive intent of OSHA.
4) Futhermore, the scope of all OSHA inspections would be severely limited because the inspector would be able to look *only at the conditions in the plant relative to the complaint,* that is, the death or injury.

By eliminating OSHA's duty to respond to worker complaints with inspections, as now required, S.2153 will not only weaken the inspection process but will also make it more difficult for workers to obtain compensation for injuries. Under the proposed new OSHA regulations, inspection decisions will be based soley on company compensation records. If there have been no compensated serious injury cases in the last year, there will be no inspection. Even under the present system there is considerable incentive for industry to keep workers from being awarded compensation benefits. The proposed changes will increase industry's stake in fighting compensation cases—the more compensation cases management wins, the cleaner their records, and the less likly that future complaints will be responded to by OSHA.

Pity the Poor Plant Owners

Even with the "unnecessarily burdensome" inspections currently conducted by OSHA, more than 4,500 workers from private industry were killed on the job in 1978, and another 9,500 from the public sector died from job related injuries, an area still exempt from OSHA coverage. It is estimated that 100,000 workers also die from job related diseases each year.

Current Workplace Inspection Procedures

The 1970 law provides "an effective enforcement program which shall include a *prohibition against advance notice* of any inspection and sanctions for any individual violating this prohibition." (Emphasis added.)

Part of this "effective enforcement program" requires OSHA inspectors to make periodic unannounced comprehensive health and safety inspections of workplaces. The frequency of these inspections is determined by the severity of the hazards in a given industry. In addition, workers and unions can obtain an inspection by phoning or writing the local OSHA office. An OSHA inspector must then, without prior notice to the employer, travel directly to the plant to conduct an inspection. Upon arrival the inspector must ask to see a representative of the employees, usually the union president or the shop steward, and then together with the plant manager, they inspect the plant. The participation of the union in both the inspection and employer appeals process represents a sharp departure from previous inspection systems. In New York for example, prior to 1970, only management accompanied the state inspector. Worker representatives were excluded.

Under the recent Supreme Court "Barlow" decision, an employer may request a search warrant of the OSHA inspector. An administrative search warrant takes from 7 to 14 days to obtain, (often more in rural areas) thus giving the employer advance warning.

Burden of Proof

The current inspection system places the burden of proof on the employer. He must prove that the plant is safe and in compliance with OSHA health and safety standards. If an OSHA citation is issued for violating job safety and health rules, a penalty must be paid by the employer. In 1978 these penalties amounted to $19.8 million.

Clear and Impending Danger

S.2153 represents a dangerous precedent for all concerned consumers, in and out of the labor movement. The current OSHA system of including worker representatives in unannounced inspections and putting the burden of proof on the employer has provided a working model for consumers interested in health facility inspections and surveys.

Government Rights/Responsibilities for Hospital Inspections

There are four basic types of inspections/inspection agencies in the health facility area: federal, state, city/county and the Joint Commission on the Accreditation of Hospitals (JCAH). These agencies have the right to inspect health facilities either because inspection is a requirement of programs for which they provide funding, or because federal, state and city/county health and hospital codes require inspections.

Hospitals can choose to document their compliance with federal government standards (and therefore become eligible to participate in the Medicare and Medicaid programs) *either* by a federal inspection using federal standards (the Medicare Conditions of Participation) *or* by a "survey" (*not* an inspection) by the JCAH.

When an Inspection is not an Inspection

The JCAH is a private agency, whose Board of Commissioners is composed of representatives from the American Medical Association, the American Hospital Association, the American College of Physicians and the American College of Surgeons. It is financed by charging hospitals for its surveys. Nevertheless, most medium and large hospitals prefer the JCAH to the free government inspections. This is not surprising since the JCAH looks upon its activity as educational and supportive of hospitals' best interests. It develops its own "standards" which are looked upon as goals, rather than as codes for compliance.

To be accredited by the JCAH all a hospital has to show is that it is trying to meet these goals. JCAH reports are secret on the grounds of confidentiality. Neither the hospital paying for the survey, nor the federal government using the survey as a basis for reimbursing the hospitals are sent a full JCAH report. Only the *summary* of the report is available to the hospital. Others, including the federal government, may obtain copies of these relatively innocuous summaries only if the hospital is willing.

The Difficult Path to Public Participation

There is a poorly publicized and limited way that consumers and the general public can be involved in the JCAH survey process. The hospital knows the date of the survey about a month in advance and at this time is supposed to post a public notice in the hospital announcing the survey date and notify the hospital's Community and Governing Boards. Anyone wanting to provide information to the survey team must then write immediately to the JCAH in Chicago and ask for an opportunity to speak at the Public Information Interview, which takes place just prior to the hospital survey. The JCAH informs the hospital of these requests and the hospital contacts all those wishing to participate in the Public Information Interview, telling them when and where it will take place.

Public—Keep Out

Members of the general public do not accompany the survey team on its survey of the hospital. However, in a few places, certain hospitals allow the active members of their Community Boards (in a clear distinction from the general public) to accompany the survey team. Sometimes, they are even permitted to be present at the Exit Interview where findings and recommendations are informally discussed. It must be stressed that this involvement of Community Boards in the JCAH survey is rare. The general practice of hospitals is to forbid "outsiders" from participating in the JCAH survey. There is also no requirement that the hospital share the JCAH summary report with anyone, including its Community Board. The report, which usually takes several months to be sent to the hospitial, may be treated as confidential information if the hospital so desires.

The JCAH Bombs Out

Since 1972 HEW has been authorized to do validation surveys of hospitals which have been previously accredited by the JCAH, either on a sample basis, or as a result of a substantial complaint. In 1974, 67 percent of the hospitals surveyed through the HEW validation process failed to meet federal standards for participation in the Medicare and Medicaid programs.

The Government Sells Out

Despite the federal government's experience, state

governments continue to delegate standard setting and inspection duties to the JCAH. New York State is most notable in this respect. Until 1977, New York had one of the best hospital licensure and inspection programs in the country. In that year, the State Health Department, which is obligated by State law to inspect New York hospitals every two years, completely scrapped the excellent state codes and standards, revising the hospitial code to accept JCAH standards and accreditation in lieu of state inspection.

Now only those hospitals which fail to receive two year JCAH accreditation are inspected by the state. State inspections are made on the basis of the weak federal standards for participation in the Medicare and Medicaid programs. At least, state inspections continue to be unannounced and community health activists and consumers can cause an inspection to occur by writing and asking for one based on a substantial complaint. On the other hand, consumers are not informed when the inspection will take place and are not included in the inspection. However, the state inspection reports are available to the public, on request, at a nominal cost.

In light of their favorable experience with New York State, the JCAH and hospital trade associations are pressing other states to delegate their statutory responsibility to the JCAH.

Local Health Departments Hang in There

City and County Health Departments across the country also do inspections of health facilities based on individual City and County Sanitary Codes, their provision of about a quarter of the Medicaid funds paid to local medical practitioners and health care facilities, and their funding of specific programs in full or in part. Sanitary inspections will be unannounced. Other inspections may be announced ahead of time. It is usually not customary for consumers to participate in city/county inspections, unless it is an integral part of the program they are funding, e.g. Ghetto Medicine.

Consumers, Know your Stuff

It is important for consumers to understand the codes, standards, programs and contracts so that when a specific problem arises at a facility, they will know which agency to contact for an inspection.

Industry Learns a Bad Lesson from the Hospital Sector

The weakening of health facility standards in New York State came about in much the same way that the OSHA inspections are being threatened. The Hospital Association of New York State (HANYS), a trade organization representing hospitals, carried on a campaign to "lighten the hospitals' burden of having to deal with so many standards and inspections." Their "burden" was "lightened" without public hearing or public comment.

Getting Clout: Consumers Have Their Work Cut Out for Them

Consumers and the general public are unable to force government to protect their rights to health and safety. Unlike unionized workers, they are not organized. They only use health facilities when they really have to, and frequently use a variety of health facilities, depending on where they live, the nature of their medical problem, or how much money or medical insurance coverage they have. On the other hand, workers go to the same workplace every day and become familiar with its hazards, and with each other. Unions provide classes to help workers learn about health and safety standards, their rights and how to get an inspection. The union offers legal protection and provides leadership when there are legislative or other threats to their rights.

Health consumers have no such organizational protection. The few consumer health advocacy groups that exist have constant financial difficulties, receiving little or no government funding. Private groups like to fund studies and pilot, one-time-only, projects. The public who needs them most cannot afford to fund them out of their own pocket anymore than they can afford to pay for health care or medical insurance out of their own pocket. Consumers have difficulty in finding the advocacy groups because they have very little money to publicize their existence. Another problem is that consumers need this kind of help on a very sporadic basis, unlike workers, who need it every day on the job.

The only consumers who have any kind of a crack at using and shaping government standards and inspec-

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Community Boards . . . continued from page 3

The City Health Department Comes Through

In *December, 1976*, the CB decided to contact the City Health Department and ask for a sanitary inspection. This inspection would restrict itself to problems of cleanliness. If the claims were substantiated, fairly concrete and rapid corrective actions would be required. The hospital was informed by the City Health Department that an unannounced inspection would take place in the near future. (Even then, there was no evidence that the hospital was concerned and trying to clean up.) Although Ms. Farrell was informed a day in advance of the inspection, and invited to participate in it with the City inspectors, the hospital was not informed of the time of the inspection.

Two sanitarians spent four hours inspecting the ED, OPD and laundry. Ms. Farrell said, "They were the most professional and knowledgeable inspectors I ever saw. They were non-threatening to the staff and made many helpful suggestions which were very well received by the nurses, laundry supervisor, etc." The Assistant Commissioner of Health, in his covering letter to the City inspection report, said, in part, "I am greatly concerned that your hospital managed to amass eight pages of violations, all of them dealing with sanitary conditions. . . I think you will agree that the report represents an embarassment. . . the hospital [should]. . . take this report seriously and move to correct all the violations, as well as taking steps to initiate and/or change the maintenance program at [the]. . . hospital to assure continued compliance to code requirements. The purpose of this letter, in addition to transmitting the report, is to advise you that a re-inspection will take place at an unspecified time. . . should the situation warrant, staff will be instructed to issue summonses to the hospital for unsanitary conditions. . . "

The re-inspection revealed that only eight deficiencies from the original eight pages remained outstanding. Another follow-up inspection was done six weeks later and only two items remained: the replacement of the vinyl covers for a chair and examination table, and the use of flat instead of enamel paint.

Much later, the CB inadvertantly learned that the head of housekeeping and the assistant administrator responsible for housekeeping were no longer with the hospital.

Eventually, the JCAH gave the hospital a two year accreditation, after lavishing a great deal of praise on the hospital for the great overall improvements. Future JCAH inspections were more thorough after it was put on notice that the State Health Department had to come in and do the job they had botched up.

The CB found the most stunning improvements to be in the laundry, which had new equipment. The walls had been completely cleaned, scraped, plastered and painted and an additional change of linen had been acquired, eliminating the necessity for weekend work.

Although the CB received no credit whatsoever for these improvements, it was their persistence and initiative which started the inspection machinery going, eventually forcing the hospital to clean up.

How to Win

The favorable outcome of this story was due to several crucial factors:

1. The CB had a legal mandate for its existence and activity and could not be dissolved by the hospital.
2. Some of the consumer board members were well informed about health and hospital codes, the responsibilities and authorities of appropriate inspection agencies and knew how to utilize them.
3. The CB had a respect for procedure. It was patient, reasonable, and had an impeccable record of responsible action. The CB documented the problems in writing and followed up on them effectively.
4. Government had a clear responsibility in the area and was willing to work cooperatively with the consumers.

This was a real, not a fictional story. Hopefully, it can serve as a model to help other community boards around the country make their facilities comply with codes and standards. Of course, consumers can only make use of government inspection procedures as long as they exist. It is essential that setting standards and inspecting hospitals not be delegated to the hospital industry or to professional provider organizations such as the JCAH in which consumers have no say and from whose decisions consumers have no avenue of redress.

OSHA . . . continued from page 6

tions of health care facilities are organized consumers already participating in the system through legally mandated boards. These organized consumers are also more likely to be in touch with consumer health advocacy groups.

(See *Consumer Health Perspectives,* Vol VI, No.8,"Health Consumers at the Crossroads," February 1980.)

An example of how one such commmunity board used the standards and various inspection systems available to it, is an accompanying article in this issue.

AT THIS JUNCTURE, AS INDUSTRY AND GOVERNMENT MOVE TO WEAKEN THE OSHA INSPECTION SYSTEM, TURNING IT INTO A WORKPLACE VERSION OF THE INEFFECTIVE JCAH SURVEY SYSTEM, WE RECOMMEND:

1. OSHA should be strengthened, (given the amount of job related deaths, disease and injuries) not weakened, and the current inspection system should be retained, continuing workers' rights to a periodic, unannounced, comprehensive inspection, as well as worker initiated inspections, and

worker participation in inspections and the appeals process.

2. Health facility standards, codes and inspections should be a government responsibility. Degree of compliance should be quantifiable and inspections findings verifiable.

Consumers should have a say about what is included in these government standards. Minimum standards should be consistent across the country and those covering areas of patient safety, cleanliness, professional qualifications, equipment, standards of care, and the like should be quite high.

3. Consumers should be able to initiate and participate in inspections, and obtain copies of the reports from the governmental inspection agency. This is similar to what workers *now have under OSHA.* We can afford no less!

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