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Hospital Deficiencies:

The Patient Rarely Knows

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How can the public tell just how good or bad a hospital is?

One way might be to call in a group of outside experts, give them the run of the place, then listen to what they have to report.

In fact, something roughly like this goes on each year at about 2,500 hospitals in this country. The process is called accreditation. And it will start today at the Nassau County Medical Center, the county's public hospital in East Meadow.

A survey team from the Joint Commission on Accreditation of Hospitals, a private Chicago-based group that sets national standards and evaluates hospitals every two years, is scheduled to begin its biennial three-day inspection at 9 AM. First order of business will be a public hearing at which complaints and criticisms will be heard from patient and community groups—a new practice begun a year ago by the commission.

To operate, a hospital need only be licensed by the State Hospital Department. So why get inspected voluntarily by the commission.

Some hospitals say they do it because it gives them an objective appraisal of their many departments. "We find the inspection to be fair, thorough and effective," said Jack Gallagher, administrator of North Shore Hospital in Manhasset.

But accreditation also is needed for very practical reasons. The commission's seal of approval qualifies a hospital for Medicare payments, for intern and resident teaching programs, and, in some cases, for Blue Cross contracts.

However, a number of consumer groups are questioning how meaningful the survey is from the public's standpoint. "It [the commission] is a product of the medical profession," said Louise Lander of Health Policy Advisory Center, a New York City-based activist group. "It has never seen its constituents as the general public."

Critics of the commission point out that unless the hospital agrees:

- No member of the press or public may accompany inspectors on their rounds.
- No consumer group may hear the inspectors' informal critique made to the hospital director and medical staff after its tour.
- And no one except hospital officials may read the commission's final report, usually delivered 90 to 120 days later.

As a result, unless a hospital chooses to release the commission's report, no patient can learn in what areas his hospital may be deficient. A few hospitals, for example, Cook County municipal hospital in Chicago, make a practice of publicizing the report. But, a commission spokesman said, even the best hospitals come up lacking in some departments, so most do not make the report public.

"My reaction to all this is that the inspection serves very little purpose as far as the public is concerned," said Joan Saltzman of Community Advocates Inc., a health-oriented consumer group in Great Neck. "There certainly would be more confidence in the procedure if it were not such a closed system."

Requests to three Long Island hospitals for their accreditation report drew various responses. Spokesmen for Long Beach and North Shore hospitals and Long Island Jewish-Hillside Medical Center said they would have to refer the request to their boards of trustees. Dr. James F. Collins, Nassau Medical Center superintendent, made his hospital's most recent reports available after consulting with County Executive Caso's office.

In an inspection, the survey team looks at such things as medical records, laboratories, dietetic services, and nursing and medical services. For example, one standard for medical records is that the record "shall contain sufficient information to identify the patient clearly, to justify the diagnosis and treatment and to document the results accurately." When the survey team fills out its final report, inspectors indicate the degree of compliance for each standard—from full compliance to noncompliance.

The accreditation decision is a three-step process. The inspection team first makes its recommendation. Staff doctors then review the report and agree or disagree. Lastly, a special committee of doctors on the commission governing board makes the final decision. The commission can accredit a hospital for two years, accredit for one year (a kind of provisional status in which a hospital is expected to bring some areas up to snuff), or not accredit.

About three per cent of all hospitals surveyed are not accredited. Another 20 per cent wind up with provisional accreditation. Chief deficiencies found are inadequate plant safety, inadequate nursing coverage, and inade-

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quate functioning of the hospital's medical staff.

But surveyors are not allowed to comment on the quality of medical care. They can only see if the hospital has the proper mechanisms—such as a tissue committee—to do its own evaluation. Some critics quarrel with this limitation saying reluctance to monitor medical care means that accreditation cannot guarantee quality. Instead they say inspection merely adds up to a "friendly, sociable visit."

To this, Porterfield says: "He [the commission inspector] can't impose his clinical judgment on the medical staff's. . . . We want to encourage hospitals to develop their own policies." The commission, a spokesman adds, is independent, objective, free from political domination, and has been established itself as a professionally recognized benchmark by which an institution may be measured in its pursuit of excellence.

Yet, despite the commission's prestige and wide use, there are some who are not convinced of the validity of its survey. Critics point out:

• The commission notifies the hospital six weeks in advance of its visit, enabling it to spruce up for the inspection. Ms. Lander of the Health Policy Advisory Center said when she worked at Bellevue Hospital there was much painting and updating of records just before the survey. Porterfield says he doesn't have the staff to "race around the country indiscriminately." In any event, he added, the commission is not a regulatory body or a policeman, but merely an educational consultant providing a service.

• The survey is paid for by the hospital—to the tune of $350 per inspector per visit day. Some say this puts the team and the commission in a quasi-employer-employe relationship. Porterfield denied that economic considerations are important because the commission gets funds from other sources as well. (The money comes from the four medical groups that appoint the commission's governing board—the American Medical Association, the American Hospital Association, the American College of Surgeons, and the American College of Physicians.) However, 70 per cent of the commission's $3,800,000 income came from survey fees in 1972.

• No laymen work on survey teams. The teams are composed of a doctor and a nurse for small hospitals and a doctor, nurse and hospital administrator for major medical centers. Porterfield says the commission realizes there is a patient's point of view. But he says, "We couldn't charge a hospital for a purely lay person."

Yet, it is just because some people have felt the commission has failed to emphasize the patient's viewpoint in writing hospital standards that a new group, called the Consumer Commission on the Accreditation of Health Services, has been formed. Edward Gluckman, executive vice president of the independent, New York City-based commission, said its purpose is to have consumers inspect hospitals—looking at medical services from the patients' angle. For instance, its inspectors would see what kind of access patients have to medical services or how their privacy and rights as patients are protected.

But this group is still in its developmental stage. Right now it is the Joint Commission that is the national standard-bearer of hospital excellence. And although efforts are beginning for governmental groups to take over this function, some think the commission will continue its long reign. Dr. Edwin L. Crosby, the commission's first director when it was founded in 1952, said before his death in 1972: "No other single idea has done as much over the past decades to upgrade American hospitals."

Still, there are those who remain skeptical. "A hospital uses the commission's accreditation certificate to show the public it has met national standards," said Gluckman of the Consumer Commission. "But in many cases, the commission's own criteria is vague, minimal and weak. And they are certainly not applicable to the needs of the patients." /II