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THE ORGANIZATION AND ADMINISTRATION OF THE OUTPATIENT DEPARTMENT OF THE AMERICAN UNIVERSITY OF BEIRUT

By

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Submitted in partial fulfillment
for the requirements of the degree
of Master of Arts in the Public
Administration Department of the
American University of Beirut,
Beirut, Lebanon.
1955

THE ORGANIZATION AND ADMINISTRATION OF THE OUTPATIENT DEPARTMENT OF AUB

Afaf Sabi

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CHAPTER I

INTRODUCTION

HISTORICAL DEVELOPMENT AND FUNCTIONS OF THE OUTPATIENT DEPARTMENT

During the Greek and Roman periods, hospitals were temples dedicated to the god of medicine, Asclepius, in which the care of the sick was accompanied by magical, mystical, and religious practices. With the rise of Christianity hospitals increased in number and became integral parts of the Church organization. However, hospitals of this early period were concerned with healing the soul, not the body. The middle ages mark the dark ages of hospitals in so far as scientific treatment of patients is concerned. During the renaissance a revival of hospitals began as a counterpart to the revival of learning. Faith healing was dropped, medications and treatments were re-introduced, and surgery was improved.

Hospitals of the Greek and Roman periods treated all patients who came to them. Their organization was simple and unplanned. After the Middle Ages hospitals were divided into a number of departments, one of which was the outpatient department. The stimulus for the growth of outpatient departments was the need to treat poor patients. Before their establishment poor patients either were treated free of charge in the private offices of the physician or were admitted to

the hospital. This gave rise to two problems: first, the private physician's time was occupied with patients who could not pay for their treatment; and second, hospital beds were often filled with patients who did not need to be there. Thus the establishment of an outpatient department was a means of relieving the hospital and private physician of the burdens of caring for needy patients whose illness did not require hospitalization. Hence, hospitals and private physicians cooperated in the establishment of the outpatient department. The hospital provided space and equipment for the treatment of ambulatory patients and the physicians gave free professional care.

When outpatient departments were first established, they were exclusively concerned with caring for needy patients. Today, however, outpatient departments provide education for medical and nursing personnel, conduct research, and assist in public health functions.

The outpatient department is an integral part of the hospital. It treats patients unless hospitalization is needed, in which case they are referred to the hospital. After discharge from the hospital, the patients are referred back to the outpatient department for follow-up care. Hence, the length of hospitalization is shortened, and private physicians are relieved of the burden of treating poor patients at their private offices. The term "outpatient department" refers only to clinics connected with hospitals, whereas "dispensary" is more inclusive and refers to any clinic whether connected with

a hospital or not.

Current literature makes clear that the modern outpatient department originated during the Roman and Greek periods. The Romans had clinics, known as tabernae medicae,[1] where only the ambulant sick were treated. After this period there is no evidence of the existence of outpatient clinics until the seventeenth century in Europe, when such clinics with, however, limited functions, were established by religious orders.

Following the initiative taken by the religious orders, the governments of Europe gradually started to build dispensaries. These dispensaries were not linked to hospitals, but were usually run independently. If a patient needed hospitalization he was either referred by the dispensary to a government hospital, if one existed, or to a private hospital with which the government has an agreement. This type of dispensary still exists; although, in recent years, some hospitals established their own dispensaries.

In the United States, the origin of the outpatient department goes back to the eighteenth century. They were first established in connection with county government controlled hospitals. For example, the New York Dispensary was founded in New York City in 1791. When large private hospitals such as Johns Hopkins in Baltimore Maryland, St. Luke's in New York City and others were established, the governing authorities felt the need for a dispensary. Since these hospitals were

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1 M.T. MacEachern, Hospital Organization and Management (Chicago: Physician's Record Company, 1951), p. 3.

linked with medical schools, and since the outpatient department provides ample opportunities for the training of medical and nursing students and technicians, such hospitals have a special interest in dispensaries.

The first outpatient clinics in the Middle East were started in the twelfth century. It was estimated that there were as many as sixty dispensaries and infirmaries in Baghdad alone in the twelfth century.[1] This development subsided but was revived in the middle of the nineteenth century in Lebanon, and at the beginning of the twentieth century in the other Arab countries. Lebanon had an earlier start because of the many foreign missions which were established here.

Lebanon has two kinds of dispensaries, those run by the government and those by private hospitals. The government dispensaries are under the control of the Ministry of Health, and were established after Lebanon got its independence in 1943. There is one government dispensary in each Muhafaza of the five into which Lebanon is divided for administrative purposes. The other type of dispensaries, which we call outpatient departments, are linked to private hospitals. In Beirut there are outpatient departments in Hotel Dieu de France, Sacre Coeur, and St. Charles Barromé.

Evolution of the American University Hospital's Outpatient Department

The American University of Beirut was founded in 1865,

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1 Ibid., p. 5.

near the present American Press. Two years later it moved to its present site, which had accommodation for a small hospital and a clinic.

In 1867 the Medical School was established. The need for a hospital and an O.P.D., then, arose. In 1871 an agreement was reached between the American University and the Johanniter Order, a Prussian religious order that established and runs the hospital of St. Charles Barromé. By this agreement the doctors of the University's Medical School would provide professional care for patients at its hospital and clinic, and in turn the doctors of the University would use the patients for demonstration purposes to medical students. This agreement was terminated when the United States entered World War I in 1917.

Through an endowment fund given by Dr. A.C. Post, in 1873 the American University Hospital and O.P.D. grounds were purchased.[1] When the agreement with the Johanniter Order was terminated the School of Medicine used an apartment house for a small hospital, and a few wooden rooms for a clinic.

There were, however, no funds available for the erection of the hospital and clinic buildings. In 1929, a Rockfeller Foundation grant of $250,000 permitted the University to build the present O.P.D. building.[2] The O.P.D. was initially controlled by the hospital, and was primarily used

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1 S. B. L. Penrose, That They May Have Life (New York: Princeton University Press, 1941), p. 32.

2 American University of Beirut, Description of Its Organization and Work, Autumn, 1934, p. 31, and Penrose, op.cit., p. 228.

for the instruction of fourth and fifth year medical students. In addition to the O.P.D. clinic services, the building accommodated the Health Center, a number of private offices, and the medical library. The third floor was used as dormitory for fifty medical students. At present, the O.P.D. offers treatment facilities in addition to the basic diagnostic techniques for medical, surgical, and other specialty cases. It has an x-ray fluoroscopy machine, and a laboratory service which does routine tests.

Purposes and Functions of the O.P.D.

When the O.P.D. was first established, its purpose was to train medical students. Today it has three-fold functions:

1. To develop a teaching center for medical and nursing students and technicians.

2. To care for the ambulant patient by curative and preventive measures.

3. To integrate public health concepts into the O.P.D. clinics through research and investigation.[1]

The O.P.D. as a training center

The American University Hospital is a teaching hospital. It is, therefore, necessary to provide facilities for the training of medical and nursing students and technicians. The O.P.D. provides a variety of cases for their training. Students are given practical experience in the O.P.D. under the supervision of specialists which will prepare them for future prac-

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1 O.P.D., Department Information Report, November 30, 1951, p.2.

tice. Since the income of the O.P.D. does not balance its expenditure non-teaching hospitals cannot undertake the expense of establishing such a department.

The O.P.D. is a training center for fourth and fifth year medical students, nursing students, and members of the house staff. Each year medical students work in the O.P.D. under the direct supervision of doctors, thus securing valuable training on the one hand, and on the other, rendering a service to the public. Demonstration cases for the training of these students and medical personnel are chosen from the O.P.D. Resident doctors and interns get their practical experience in this department. Student nurses also use the O.P.D. as a place for practice and experience. An undergraduate nurse serves in all the departments of the Hospital inpatient service. She receives part of her practical experience at the O.P.D. under the supervision of graduate nurses and the supervisor. This education is not limited to the student nurses of the American University of Beirut, but is available to other nursing schools which are affiliated with the American University Hospital.

The educational function of the O.P.D. enables students to come in contact with social and economic problems of patients; and develops an appreciation of the interrelationship between public health, social work, and medical services. In this was the students understanding of the value of preventive and curative medicine increased, they became acquainted with the other health agencies in the community, and finally they gain

an opportunity to see the total medical care picture, through interchange, discussion and integration of theory and practice in the O.P.D. and in the hospital.[1]

The O.P.D. as center for the treatment of ambulatory patients

The O.P.D. treats ambulant indigent patients who are admitted after paying a nominal fee of two Lebanese pounds for the first visit and one Lebanese pound for any subsequent visit. If they are unable to pay, they are referred to the social worker, who determines their financial status and adjusts the fee accordingly. They are then sent to the Group Clinic where they are examined and given treatment and medication. Those patients who need hospitalization are referred immediately to the hospital. In the diagnosis of the diseases of patients the O.P.D. staff use the O.P.D. laboratory and x-ray fluoroscopy facilities as well as the adjunct facilities of the Hospital. After a patient is discharged from the Hospital, he is referred back to the O.P.D. for follow-up care, if necessary.

When a patient is admitted and is found to have a disease, he will be told how he may have contracted this illness, and how it can be prevented. The attending staff and the public health nurses, who make home visits talk to the patient and his family about hygiene, sanitation, and aseptic techniques.

Since 1936, the department has conducted well-baby

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1 Education Program for Visiting Students and Personnel, A Plan for a Good Teaching Program in O.P.D. Conferences and Orientation.

clinic and mothers' class. Poor babies in need of nourishment are given powdered milk by prescription, free of charge, from the O.P.D. Pediatrics clinic. The mothers' class is a recent innovation. Young mothers meet together and discuss child care problems. During weekly sessions public health nurses demonstrate baby's care, preparation of baby's food, bathing the child, and other aspects of child care. The department utilizes visual aid means for the instruction of people who cannot read.

Since its establishment as a teaching health center, the O.P.D. has conducted a home visiting and social medicine. "It is needless to mention that the O.P.D. should be more emphasized as a community diagnostic center with its one foot in the family and the other in the hospital; hospital beds should also be increased to cope with the added load."[1]

In the discharge of its public health functions the O.P.D. cooperates with two agencies: the Health Center, and the Department of Public Health. The Health Center cooperates with the O.P.D. in its public health functions, by teaching mothers how to care for their children and babies, and by examining well babies and children. It supervises mothers' instruction through classes held both in Arabic and Armenian. The Department of Public Health (now the School of Public Health) was established with the financial help of the Technical Cooperation Administration in 1951, to train public

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1 Medical Dean's Office, Report of a Special Committee, June 13, 1952, Curriculum of A.U.B.'s Medical School as Related to the Middle East.

health nurses and laboratory technicians.[1] Public health nurses make home visits on O.P.D. patients as well as home deliveries and participate in child and mother care. Although public health nurses worked cooperatively with the O.P.D.; they were administratively independent of it. However, in 1951, the Home Delivery Service was transferred from the Public Health Department to the Obstetrics and Gynecology Department. Administratively it then became responsible to the O.P.D. Director. The Home Delivery Service is still financially supported by the Public Health Department, to the extent of paying the salaries of public health nurses who work in the service.

The integration of public health concepts through research and investigation

The integration of public health concepts through research and investigation is heavily stressed. It was necessitated by the introduction of public health nursing and modern diagnostic and therapeutic facilities aiming at the prevention of illness. All records and data of the department are available for the use of doctors and other persons for study and research. The role of research is considered mainly in relationship to teaching of medicine, and the investigation of regional disease.

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1 The Technical Cooperation Administration (now called the International Cooperation Administration) is commonly referred to as "Point 4".

CHAPTER II

THE ORGANIZATION OF THE OUTPATIENT DEPARTMENT

The O.P.D. of the American University Hospital was established in 1873. Its purposes are to serve as a training center for doctors, medical and nursing students, and technicians, to provide facilities for medical care of ambulatory patients, and to develop a public health program in the community.

The organization of the O.P.D. has an influence on the success with which it fulfills its purposes. Until 1954 no major administrative changes had been made in its organization. By that time, however, it had become apparent that its former organization was inadequate for its increased responsibilities. Consequently in 1954, a committee was established under the chairmanship of Dr. Leland E. Powers,[1] to reorganize the O.P.D. The Committee suggested changes in the department to emphasize its function as a diagnostic unit for patients and as a teaching unit for medical students. It was hoped that the reorganization would enable the O.P.D. to cope with the recent advances in medical science, and hence better fulfill its objectives.

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1 Dr. Leland E. Powers has been director of the School of Public Health of the American University of Beirut, since 1953, and since October 1954, Medical Director of the O.P.D.

Reasons for Reorganization

The main reason behind reorganization has been the change in the medical curriculum of the School of Medicine, which in turn was a reflection of the change in medical science and technique. Medical science is now commonly divided into general medical practice, specialized medical practice, and preventive medicine. The O.P.D. clinics were reorganized in accordance with these categories. They will be discussed more fully under the reorganization of the clinics.

The second reason for reorganization was to reduce the time spent by patients in being referred from one service to another. Under the former system no patient could be referred from one service to another on the same day, consequently his treatment was delayed.

Thirdly, the different services in the department were not coordinated and each service functioned as an independent unit. All clinics and services were to be reorganized in such a way that they would function as one unit.

Fourthly, public health nurses were not integrated with the work of the department and were responsible to the School of Public Health rather than to the O.P.D. although they worked on O.P.D. patients.

Section A

The O.P.D. Before Reorganization

Although originally the O.P.D. was a small department, its organization was complex. It was divided into two major divisions, the Business Section and the Professional Section. Each of these divisions was subdivided into smaller units. This set-up of the O.P.D. functioned smoothly for many years since its establishment in 1873. As the department grew steadily both in size and importance with the passing of time, however, a stage was eventually reached when the O.P.D. had to be reorganized.

Before reorganization in 1954, the department was responsible for care and treatment of medical, surgical, and other cases in the various specialties of medicine. It was in a peculiar position to contribute to the control of diseases by providing treatment of patients while their illness was more easily curable. The administrative organization of the department consisted of a director as chief administrator, admission service, clinical services, medical staff and diagnostic facilities, such as laboratory, x-ray, and others.

Business Sections of the O.P.D.

The Director of the O.P.D.

The Director of the O.P.D. was always a nurse. She selected and supervised all employees of the department, who consisted of nurses, social workers, and administrative and

clerical personnel.[1] She had final authority regarding working hours of all personnel, and made the final decision on vacation schedules and the closing of clinics. She received all complaints and referred them to the responsible person for action.

The O.P.D. Director controlled the finances of the department through pre-auditing of expenditures. She was responsible for the preparation and execution of the department's budget, as well as for the maintenance of the building and property, along with the Hospital Building and Grounds Department.

The O.P.D. Director also supervised and directed the O.P.D. clinic services. She assisted in establishing clinic policies and procedures, and reviewing clinic activities, and was responsible for the planning of clinic sessions.

O.P.D. Committee

The O.P.D. Committee was composed of members appointed annually by the Dean of the Medical Division from the medical staff. The O.P.D. Director was a member of the Committee which met monthly.

The Committee advised the Director on professional and administrative problems. It studied suggestions for change in organization, fees, number of patients admitted daily, etc; and made nonbinding recommendations to the Director.

Medical Social Service

In 1953, the Medical Social Service Section was estab-

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1 There are three types of employees in the department; full-time, part-time, and volunteers. The latter perform clerical duties.

lished. It was staffed by one employee, who was appointed and paid by the School of Public Health to whom she was professionally responsible. Her appointment had to be approved by the O.P.D. Director, however, and she was administratively responsible to her.

The functions of the Social Service Section were: first, to determine whether or not patients should pay the regular O.P.D. fees (this is very important because no patient should be refused treatment for inability to pay for his treatment and medication), second, to cooperate with other health agencies in the community, and advise the family of poor patients as to other available agencies and services, and third, to counsel patients in social problems that might be affecting their physical illness. In addition, the Social Service Section was interested in home visits and follow-ups.

Admission Section

This Section of the O.P.D. consisted of a chief clerk, and his assistant, both of whom were responsible to the Director of the O.P.D. The chief clerk was in charge of admitting new patients and the assistant clerk of admitting return visit patients. In addition, the admission clerks collected all fees. The chief clerk prepared a record of daily admissions to the department which was tabulated in weekly and monthly accounts. He also prepared daily, weekly, and monthly statements of income.

Supply System and Stores

The O.P.D. used a large variety of equipment and supplies.

These include medical instruments, and soap, stationary, paper forms, sheets, medications, and other supplies which are used by the O.P.D. clinics and offices.

Supplies of the O.P.D. were divided into two categories; Group I and Group II. Group I included all medical instruments and medical supplies. Group II included all other supplies used at the O.P.D. such as stationary, housekeeping supplies, and linen. Supplies of each group were requisitioned every two weeks from the Hospital Stores. All requisitions were countersigned by the O.P.D. Director who authorizes them. When the supplies were delivered the Director or the secretary certified their receipt.

The O.P.D. Store was opened twice per week, so that the various clinics made requisitions and got the supplies they wanted from the Stores. The exchange system was used so that if any service had anything broken like syringes, it had to give the broken one in replacement for a new one. This was followed in the case of other supplies as well to assure that more than was needed was not to be taken.

Professional Services

Medical Staff

The medical staff of the Hospital has the responsibility of seeing that patients are given adequate medical care. The professional staff of the O.P.D. was drawn from the Hospital since the O.P.D. has no separate medical personnel. The chief of each service in the Hospital was also in charge of the corresponding service in the O.P.D. He was responsible for

carrying out the medical policies and maintaining the working standards of the clinics which he supervised. Medical students, interns, residents, and other subordinate medical personnel, were assigned to duties in the clinics under the supervision of the chiefs of the medical staff.

The number of physicians in each service varied. They consisted of the teaching staff of the University Medical School, practising physicians and specialists, senior residents, residents, and assistant residents. Supplementing the work of the medical staff were the interns and medical students, who took all medical histories, and conducted the physical examination. Their work was closely supervised by the senior members of the staff. The medical staff was not effected by the reorganization except the addition of two posts that of Medical Director and Associate Medical Director.

Nursing Staff

The O.P.D. had its own nursing service. Although their salary was paid from the O.P.D. funds, the O.P.D. nurses were professionally responsible to the Hospital Nursing Director.

Prior to 1953, the nurse in charge of the O.P.D. nursing service was the Assistant Nursing Director.[1] Administratively she was responsible to the O.P.D. Director, and professionally to the Director of Nursing of the Hospital. All important administrative problems were reported by her to the Director of the O.P.D. She was responsible for the quality of nursing

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1 The position is now entitled the "Nursing Supervisor".

and orderly service at the O.P.D.; and approved all requisitions for supplies from the clinics. One of her duties was to follow-up on procedures and policies newly introduced into the department. She supervised nursing students' instruction at the O.P.D. and conducted the orientation period. She also supervised nursing techniques and procedures.

In addition to the nursing supervisor, the O.P.D. nursing service consisted of head nurses, staff nurses or graduate nurses, and student nurses. All these nurses worked under the supervision of the supervisor to whom they were responsible. Each clinic had one nurse who was responsible for the routines.

After 1935, when the O.P.D. assumed an independent status from the Hospital, O.P.D. nurses were on vacation when the O.P.D. closed. But later in 1948, a closer relationship developed between the Hospital and O.P.D. specially in respect to nurses. Since then, the O.P.D. nurses have worked in the Hospital.

In addition, the O.P.D. had public health nurses. These were the regular public health nurses and midwives who work in Home Delivery Service. Public health nurses were appointed and paid by the School of Public Health. Administratively they were responsible to the O.P.D. Director; but professionally they were responsible to the Director of the School of Public Health.

Clinical Services

The O.P.D. had the following clinical services: first, the Medical Service which consisted of the following specialties:

syphilology, dermatology, psychiatry, chest-clinic, cardiology, metabolic clinic, neurology, and gastro-enterology; second, the Surgical Service, which had clinics for plastic surgery, urological surgery, chest surgery, orthopedic surgery, and general surgery; third, the Obstetrics and Gynecology Service, which had clinics for gynecology, obstetrics, sterility, and home delivery; fourth, there was the Eye, Ear, Nose, and Throat Service; and fifth, the Pediatrics Service, which included: general pediatrics, neurology pediatrics, well-baby clinic, and mothers' classes. A final service provided by the O.P.D. was the Public Health Service which had a communicable disease clinic. There were also a distributing clinic, a general practice clinic, and a dentistry clinic.

The clinics functioned in three capacities: first, they provided, on an ambulatory basis, complete diagnosis and therapy. Second, the clinics were utilized as a means for follow-up care of patients discharged from the Hospital who might require prolonged observation or treatment. Third, the clinics provided a way for the follow-up of patients with chronic illness requiring prolonged treatment.

Other Diagnostic Facilities

The O.P.D. had an x-ray fluoroscopy machine used to screen most of the O.P.D. patients and a laboratory to examine stools, urine, blood count, and chediak VDRL. If other tests were needed, patients were referred to the Hospital Laboratories.

Records and Charts Section

Treatment records were kept on all patients coming to the O.P.D. Prior to reorganization, the O.P.D. maintained its

own records, which included the patient's history, diagnosis, treatments, the results of laboratory tests, and x-ray diagnosis reports. Whenever a patient returned to the O.P.D. all new treatments and diagnosis were entered on his record.

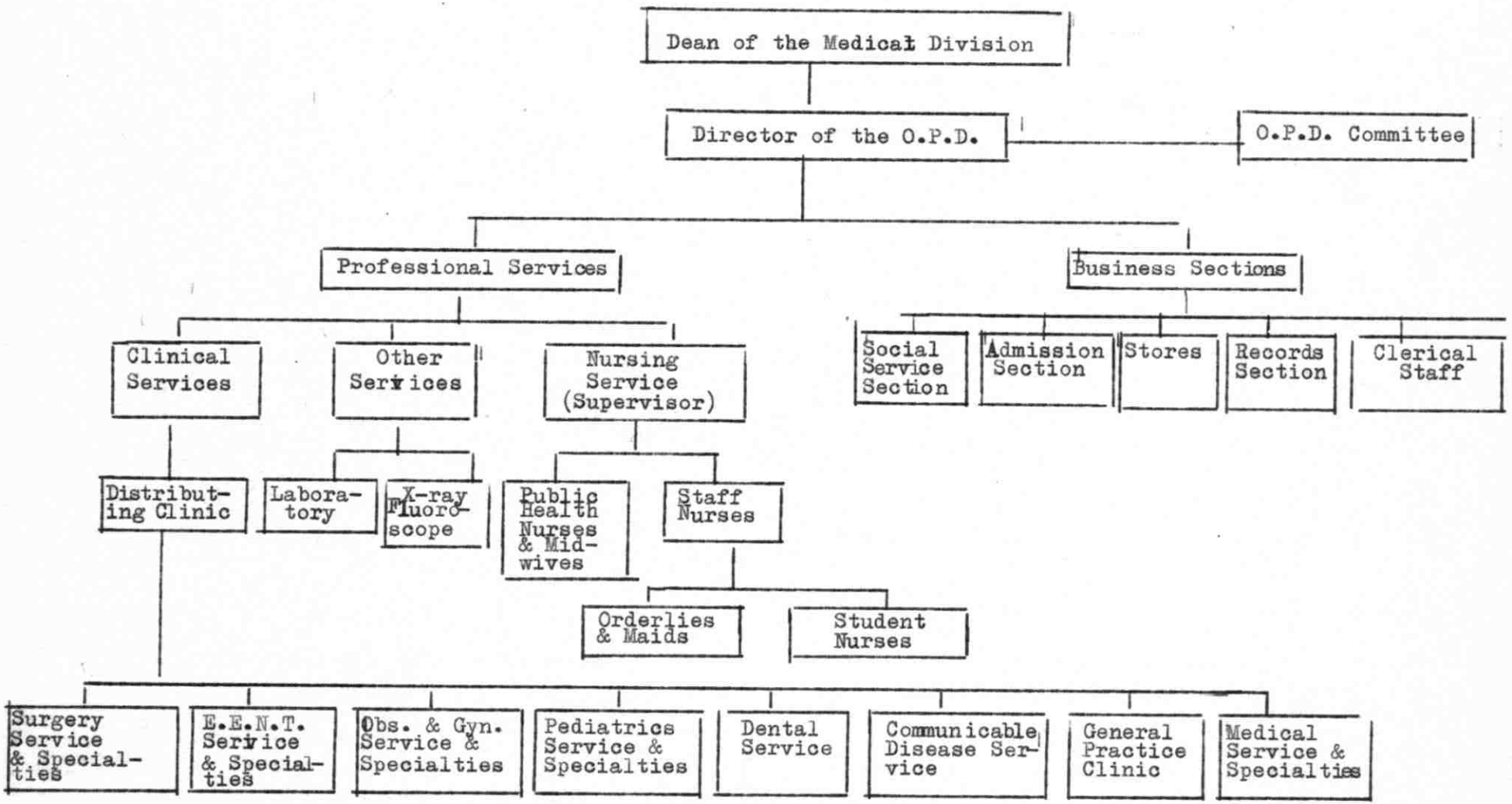
Before 1950, when a patient needed hospitalization his O.P.D. chart was taken to the Hospital and was used as a basis for further treatment and diagnosis, but a new chart was made for him while in the Hospital. He was given a new admission number, and the O.P.D. admission number was not used. Thus, there were two sets of charts, one kept in the O.P.D. and the other in the Hospital, and two admission numbers. This caused some confusion and in 1949, a special committee was set up to study the record system. It recommended that the O.P.D. and Hospital charts should be combined. This recommendation was put into effect in January, 1950. This system was not effective in the case of Hospital and O.P.D. records of patients in the remote past; or those who had charts in both the Hospital and O.P.D. prior to the institution of the new system, except after the patient returned for additional care to either the O.P.D. or the Hospital. The O.P.D. continued to follow its own numbering system, however, until 1954, when the unit system of numbering was introduced, and the O.P.D. was supplied with admission numbers from the Hospital's Admission Office.

After combining the records, certain difficulties arose. These were: first, in some cases charts were not available because interns were using them; and secondly,

there was undue delay in getting the charts from the Hospital to the O.P.D. when needed. It was hoped that by the reorganization of the record system in 1954 these two difficulties will be overcome.

All O.P.D. records were kept in one record room. They were filed in numerical order. In order to facilitate handling, index cards were kept on which were written the names of patients in alphabetical order, according to the first name of the patient. These were cross-indexed with the O.P.D. admission number. If a patient returned, they would get the chart number, and then they would go ahead and pick his chart.

Chart I. Organization Chart of the O.P.D. Before Reorganization



Section B

The Present Organization of the O.P.D.

The Administration

As a result of the reorganization, the O.P.D. Director became the Assistant Hospital Administrator. This change was caused by altered administrative relations between the O.P.D. and the Hospital. Before reorganization the O.P.D. was administratively independent of the Hospital; today it is an integral part of the Hospital. The change in title also indicates the desire to relate the work of the O.P.D. more closely to that of the Hospital. The O.P.D. Director is now responsible to the Hospital Administrator for the coordination of the administration of the O.P.D. with that of the Hospital on such matters as personnel, purchasing, and finances including budgeting. Before reorganization the proper channelling was from O.P.D. Director to the Dean; after the reorganization the proper channelling is from O.P.D. Director (Assistant Hospital Administrator) to Hospital Administrator and to the Dean of the Medical Division.

The administrative functions of the O.P.D. Director remain the same. These are preparation and execution of the budget, purchasing, maintenance of buildings and grounds, and supervision of the admission procedure. He is still responsible for personnel practices in the department, and for the work of all non-professional personnel such as secretaries, clerks, orderlies, maids.

A new post has been added to the Social Service Section as a result of the reorganization. At present the "Social Service Section" has two employees, a social worker, and a social admitting officer. Their main job is to determine a patient's ability to pay. The social worker recommends admission charges for poor patients referred from the O.P.D. to the Hospital. She also initiates and approves requests of expenditures from charity funds. Administratively the Social Worker is responsible to the O.P.D. Director; but her salary is paid by the School of Public Health.

The Admission Section was not changed. However, the quota of admissions to the clinics has been increased as a result of the change in clinic structure and organization.

Medical Staff

Two posts have been introduced as a result of the reorganization. One is the post of medical director and the other the post of associate medical director. Otherwise the organization of this section is unchanged.

The position of Medical Director of the O.P.D. is presently occupied by Dr. Leland E. Powers. He is responsible for the functioning and coordination of the medical services of the O.P.D. He supervises the heads of the various divisions, the medical, nursing, and social service. He also coordinates the O.P.D. services with the Hospital diagnostic and therapeutic facilities. It is his job to provide maximum teaching facilities in the O.P.D. for medical students, nursing

students, and technicians. Thus, he works closely with the Medical School and with the Hospital.

The Associate Medical Director is the second post introduced by the reorganization plan. He is in charge of medical services at the O.P.D. He prepares the schedules of medical personnel and checks on their attendance and approves their distribution. Any misconduct or unethical practice is referred to him. He also checks the laboratory, x-ray, and other services at the O.P.D. The laboratory technicians, however, are still under the supervision of the Hospital Laboratory Director.

All requests for heavy equipment which originate in the medical services are referred to him for approval by the O.P.D. Director before they become valid. He sets the limit of the number of patients to be admitted to each clinic daily in consultation with the O.P.D. Director.

Public Health Nursing Service

The reorganization plan has provided for a new public health nursing post. This post is known as the "Supervisor of Public Health Service"; and she is responsible for "training programs of Public Health Nurses and Public Health teaching programs in the O.P.D. through and in cooperation with the Supervisor of O.P.D. nursing service."[1]

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1 O.P.D. Annual Reports, minutes of the O.P.D. Committee, December 18, 1953.

The Clinical Departments

The reorganization dealt primarily with the clinics. More clinic space has been provided as a result of changing the shape or structure of the clinics and affording more examination cubicles. Therefore, a larger number of patients can be admitted. It will also give medical students additional experience in treating patients.

Prior to reorganization there was a Distributing Clinic and a General Practice Clinic. These have been replaced by the two clinics called the Group Clinic, and the Overflow Clinic.

The Distributing Clinic was formerly run by interns. It was only a screening place from which the patients were admitted to the specialty clinics. However, referrals of patients screened to specialty clinics was not possible on the same day, since the specialty clinics were not opened daily, and no consultations were possible. Hence the treatment of a patient was delayed.

After reorganization the Group Clinic replaced the Distributing Clinic. The Group Clinic is a diagnostic clinic, in contrast to the Distributing Clinic, to which all patients are admitted and given treatment, and only in case of need are specialists called for an opinion. Thus under the new set-up daily consultations in all specialties are possible. Referrals of patients to specialty clinics can take place on the same day, since most of the specialty clinics are held daily, and hence the treatment of the patient is not

delayed. The Group Clinic is run by fourth year medical students under the supervision of staff doctors. Under the new procedure, each doctor supervises six medical students. Every day each medical student in the Clinic gets a new case for which he is responsible. He examines the patient, and writes the history and diagnosis, which are then checked by the staff doctor. A medical student follows his patient to whichever specialty he is referred, and through the Hospital until he is cured or discharged. This procedure not only gives the student practice in treating patients on a general medical basis, but it enables him to see the effect of the prescribed treatments and to observe the development of the disease. The Group Clinic occupies thirty-six cubicles, of which twenty-four are for adult patients and twelve for children.

The General Practice Clinic was a place to which six patients were sent daily to be screened and treated irrespective of their disease. Fifth year medical students ran this Clinic under the supervision of resident doctors. The General Practice Clinic has been replaced by the Overflow Clinic. In contrast to the former clinic there is no limit on the number of patients admitted daily. Fifth year medical students conduct the examination, but their diagnosis is carefully reviewed by the residents.

The reason for this reorganization in the clinics is the new outlook on medical practice. Medical practice can be divided into three general types: First, general medical

practice, which deals with all routine cases and emergencies, and which is provided by the Group Clinic. Second, specialized clinics that handle problem cases needing further investigation by a specialist. Cases for clinical research are covered in the specialty clinics. Third, the public health or the preventive aspect of medicine, that is concerned with the prevention and treatment of diseases.

The Group Clinic represents the general medical practice division of medicine. In this clinic routine cases as well as emergencies are treated. When the case needs a thorough investigation by a specialist it is referred directly to the proper specialty clinic.

This arrangement benefits the patient because immediate treatment is provided. He will be seen in the Group Clinic and then referred to specialist consultants if necessary. If a patient is a surgical case he is referred immediately to the surgery clinic on the same day. Under the old procedure the patient might have to wait several days before an appointment could be made to the surgery clinic.

The new procedure is also advantageous to the medical students. It provides the increased opportunities for students to be trained in the various aspects of medicine through follow-up of their cases to the specialty clinics. Fifth year medical students practise in the Overflow Clinic. This gives them an idea of the office practice as a preparation for their future work. It will also benefit fourth year medical students because they will be better trained, than

under the former procedure, in the methods of making thorough investigation of problem cases and thus deepens and broadens their knowledge of medicine.

The new clinic plan provides a means of integrating public health medicine in the various clinics, through the complete follow-up and home visiting procedures. This makes preventive medicine more useful and practical. Also it helps to promote a spirit of cooperation and team work between the various services that is of inestimable benefit to the patient, the physician, and the department as a whole.

The Record System of the Department

As a result of the reorganization of the O.P.D., the record system has been changed considerably. A centralized unit system of records has been established in the Hospital. Under this system all records of patients from the Hospital and the O.P.D. are collected in one file and are in the custody of a central office. Centralized record keeping was recommended because the record of the patient is a continuous history and should be available for the treating physician whether the patient is in the Hospital or in the O.P.D.

In a centralized unit system when the patient is admitted to either the Hospital or O.P.D., he is given a number. Every day the record librarian will supply the Hospital Admission Office with a list of new numbers. The Admission Office will then send some of the numbers to the O.P.D. admission service. This leads to a combination of the numbering system, which makes easier the transfer of

patients from the O.P.D. to the Hospital and vice versa.

A daily list of the names and numbers of the patients with appointments for the following morning is sent by the admission clerk to the record librarian. The charts of these patients will be sent to the O.P.D. admission service. Before closing the O.P.D. in the evening, all records of O.P.D. patients will be collected by the nurse in each service and returned to the record room in the Hospital.

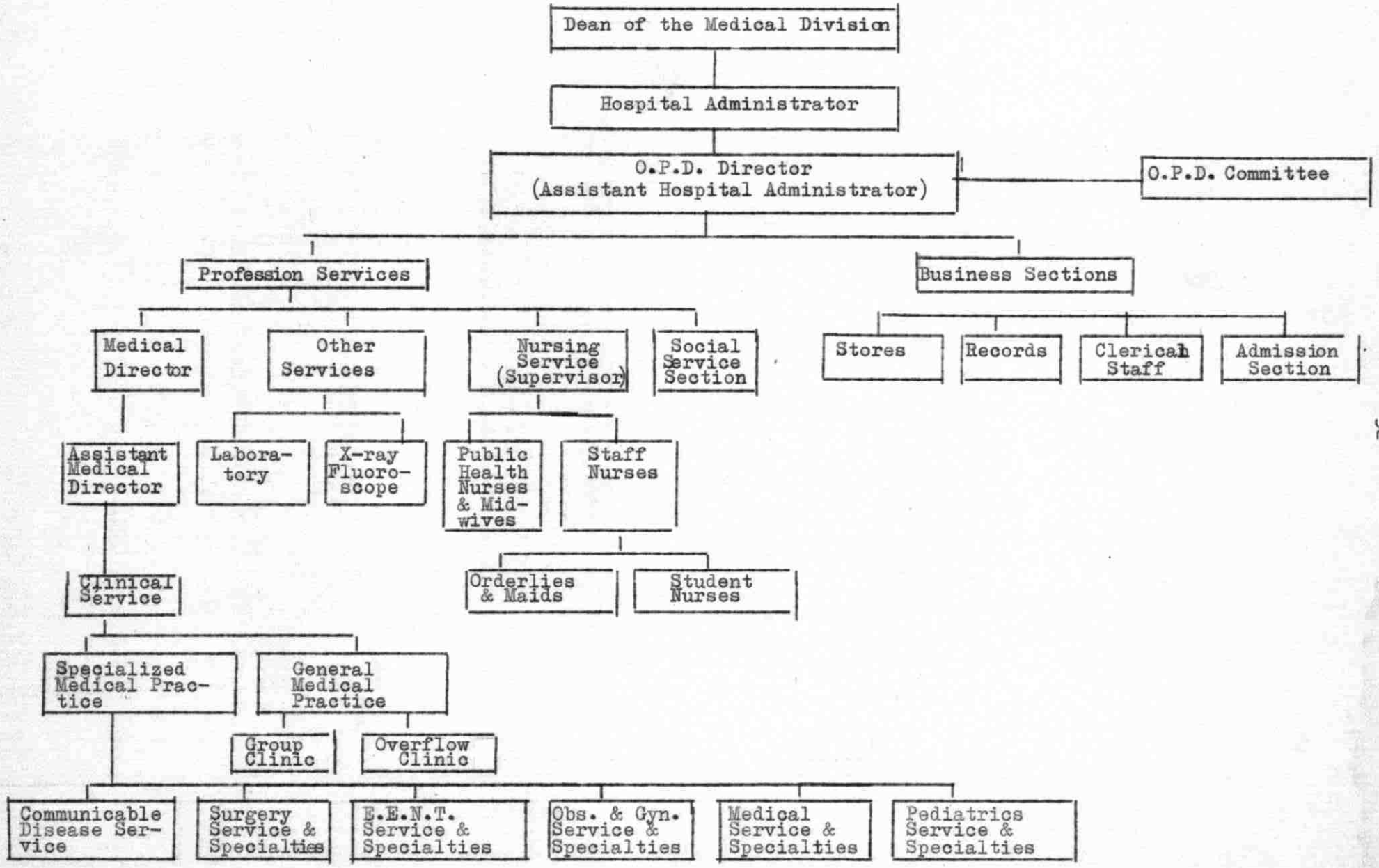
The new system has eliminated the O.P.D. record section since records are no longer kept in the department. Thus space was provided for an additional clinic. The present system, however, works imperfectly as records are sometimes misplaced and lost, and time is consumed carrying records back and forth from the O.P.D. to the Hospital.

The reorganization of the department has placed increased emphasis on its public health function. Medical students are given practical experience through follow-up procedures and home visits of patients. The public health services are integrated with the various clinical services of the O.P.D. A complete follow-up system of the medical clinic is now in force. As a result of the reorganization of the clinics a larger number of patients can be treated every month. The treatment of patients is not delayed since there are daily referrals to specialty clinics and consultations are possible every day. Hence we see that the treatment of a patient is more rapid under the new organization.

Every fourth year medical student today sees one

new patient daily and follows the treatment of his old cases. This procedure gives him ample experience in medical practice. Under the former clinic organization and procedure fourth year medical students spent a certain number of days in each specialty clinic examining only a limited number of cases and not following them through to the clinic to which they were sent, therefore not discovering the effectiveness of the treatment prescribed. Fifth year medical students also see a larger number of cases in the Overflow Clinic than the limited number alloted them under the General Practice Clinic. Hence the reorganization is of considerable help to both patients and medical students.

Chart II. Organization Chart of the O.P.D. After Reorganization *



*This is a chart showing the administrative organization of the O.P.D.

CHAPTER III

THE BUDGETARY AND PERSONNEL SYSTEMS OF THE OUTPATIENT DEPARTMENT

Section A

The Budgetary System

The O.P.D. has its own budget, which is part of the Hospital budget. The budget is a classified budget divided into income and expenditure sections. On the income side there is only one item, income from admission fees. This income is very low because the O.P.D. is a charitable institution. The admission fee is L.L.2 for the first visit, and L.L.1 for a return visit and even this is waived if the patient cannot afford to pay. A second source is grants and donations. But this is not constant nor is it included in the income of the O.P.D. The O.P.D. receives grants from several sources, one of which is from the American University Hospital Women's Auxiliary which gives each year a sum of money earmarked for O.P.D. Charity. In the fiscal year 1954-55, it granted the O.P.D. the sum of L.L.600, which was used for x-ray, hospitalization and medications for indigent patients. The Medical Students' Society also raises money each year which it gives to the O.P.D. in monthly instalments of L.L.50 to L.L.75 each month. This fund is earmarked for the purchase of medicines for poor patients. Finally, poor patients receive help from

the O.P.D. Social Service Fund which in 1953-54 amounted to L.L.2,000. The Social Service Fund is for the Children's Christmas Party, treatment and medications of children and poor children's schooling. The Social Service Section is the only service in the O.P.D. authorized to spend from these donations and grants. But all expenditures from these must be approved by the O.P.D. Director. The deficit must be met from the annual appropriations approved by the Board of Trustees.

On the expenditure side of the budget, salaries and wages are the largest single expenditure item. In the year 1954-55, L.L.63,850.00 were spent for this item. General maintenance, and supplies and equipment account for the remainder of the expenditure sections. In the fiscal year 1954-55, L.L.5,107 were spent for general maintenance, and L.L.36,643 for supplies and equipment.

Below is a comparison of the income and expenditure of the department since 1950-51.

Year	Income in L.L.	Expenditure in L.L.	Deficit in L.L.
1950-51	20,003.25	98,105.57	78,102.32
1951-52	35,075.00	71,459.00	36,384.00
1952-53	34,654.00	106,336.00	73,971.00
1953-54	35,395.00	108,506.00	73,111.00
1954-55	43,424.00	95,040.00	51,616.00

Preparation of the Budget

The budget is prepared each year by the Director of

the O.P.D. six months prior to the beginning of the fiscal year. He makes his estimates for income and expenditure by considering the income and expenditure of previous years, and anticipating unusual expenditure or income. Building improvements are put on the Hospital capital budget.

After the Director estimates the income and expenditure for the year, the budget is forwarded to the Hospital Administrator. The Hospital Administrator reviews it in detail with the O.P.D. Director and approves it. The Hospital Administrator with the help of the Hospital Business Manager (chief accountant) compiles the budget of the entire Hospital, which is forwarded by the Administrator to the Dean of the Medical Division of the University, who may recommend changes.

The budget is then placed in the hands of the Comptroller of the University, who studies the budgets of all the Divisions of the University and consolidates them into the University budget. At this stage the budget is studied more fully than before. Then the Comptroller passes the budget to the President, who forwards it to the Board of Trustees for approval.

The Board of Trustees has the right to decrease or increase only the total figures. They rarely use this power because the budget is carefully gone over by the Hospital Administrator, Dean, and Comptroller before it reaches the Trustees.

After the Board approves the budget, it is returned

to the President, who is responsible for its execution. The President then delegates the execution of their particular budgets to the deans of the different schools (divisions), who in turn re-delegate this authority to the chairmen of the various departments.

Budget Execution and Audit

The O.P.D. does not follow an allotment system. Each month the Director spends on the account of the department. However, the Director pre-audits all accounts. All requisitions must be signed and approved by him. He cannot authorize a requisition if funds are not available. Hence his signature implies that the O.P.D. has enough funds for the particular purpose under consideration.

The department's accounts are also at any time subject to examination by an outside auditor. The American University has an agreement with an auditing firm (John Russell and Company), which annually audits the accounts of all University departments, usually at the end of the fiscal year.

Every month the Hospital Administrator sends financial statements to each department of the Hospital. These statements include the expenditure incurred by the department during the month and the balance on hand. The Comptroller, assisted by the University accounting office, issues account flimsies monthly. On these is entered the amount the department has spent, the purposes for which it spent the money, the date, and the voucher number of every account. Thus every month the Director of the O.P.D. knows the financial condition of

which more revenue can be brought to the department; thus decreasing the unfavourable balance.

Section B

Personnel System

The success of any organization is more dependent upon the competence of its personnel than upon any other factor. Therefore, sound personnel policies and procedures are necessary pre-requisites to the improvement of administration and organization.

The O.P.D. has both professional and non-professional employees. The department has gradually grown in recent years from twenty-three employees in 1951 to thirty-one in 1955. This figure includes the O.P.D. Director, but does not include medical personnel. The number of employees at the O.P.D., excluding doctors, are as follows:

Position	Number of Employees
Director	1
Nursing Supervisor	1
Head Nurses	3
Staff Nurses	4
Senior Clerk	1
Clerks	2
Secretary	1
Social Workers	2
Orderlies	4
Maids	2
Midwives	3
Public Health Nurses	4
Technicians	3
Total	31

The employment policy of the O.P.D. is governed by the University regulations; and it follows the Hospital's procedure. All personnel, other than professional people, are employed by the Hospital Personnel Officer, upon the recommendation of the O.P.D. Director. All employees must pass a physical examination before being placed on the payroll. No discrimination in employment is made on the basis of religion or race.

Recruitment

Employees at the O.P.D. are divided into professional and non-professional personnel. In the former are included doctors and nurses. In the latter, there are two sections: staff employees and workers.

Medical Personnel

Medical personnel practise both in the O.P.D. and in the Hospital. They can be divided into three categories: teaching staff of the Medical School, attending physicians, and house staff. Attending physicians are in turn divided into chief of service (department head), attending, associate attending and assistant attending. The house staff is subdivided into senior resident, junior resident, assistant resident, and intern.[1] Members of the Medical School are graded into five professional ranks, professor, associate professor, assistant professor, instructor, and assistant

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1 Guide for Personnel, General, p. 2.

instructor.

All medical personnel must have an M.D. from a recognized medical school. Other qualifications are good health, honesty, integrity, and other personal qualities. The attending physicians and the staff of the Medical School should also have practical experience.

Chiefs of services (department heads), and attending and teaching doctors, are engaged by the central administration upon the recommendation of the Dean for a specified period of time or under an indeterminate contract. In contrast members of the house staff are appointed by the Medical Dean upon the recommendation of the service to which they are applying and the approval of both the Hospital and Clinical Committees. The appointment is for a twelve months period beginning July 1.[1] Employment of the house staff is for graduate training that is beneficial to the appointee and to the University. "The house staff is responsible to the Hospital Administrator for all matters pertaining to the administration of the Hospital. For matters pertaining to the professional care of patients, the resident staff is responsible to the departmental chairman."[2] Disciplinary problems and other matters dealing with professional conduct are brought in all cases to the attention of the particular service concerned.

The Guide gives detailed rules for the conduct of the

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1 Ibid., p. 16.

2 Ibid., p. 2.

medical staff. Discourtesy towards superiors or to those in subordinate positions is forbidden. Matters of discipline on service beyond the regularly assigned duties are brought to the chief of the service.[1]

Hospital personnel, including physicians, are expected to refrain from accepting any presents or gratuities offered them for their services. Also members of the house staff are not permitted to engage in private practice while holding appointment at the Hospital.

Each service of the Hospital is required to formulate rules and regulations for the medical and surgical work of the O.P.D. and Hospital, setting forth organization, duties, responsibilities, and procedures in each department.

Appointment of Nurses

Nursing personnel at the O.P.D. are part of the Nursing Department of the Hospital. They are administratively responsible to the O.P.D. Director and professionally responsible to the nursing Director. There are two categories of nurses: first, those in public health, including midwives, who should have a diploma in public health; and second, those in the O.P.D. nursing service, including the nursing supervisor, head nurses, graduate nurses, and attendant or practical nurses.

The qualifications for O.P.D. nurses vary with the grade. A head nurse usually has a Bachelor of Science Degree in nursing, or has been promoted to that post on the basis of

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1 Ibid., p. 4.

merit. A graduate nurse must be a graduate from a recognized nursing school. An attendant needs only to be literate and receives practical training in the wards. Since O.P.D. nurses have the same qualifications and salaries as nurses at the Hospital, inter-departmental transfers can be made between the Hospital and the O.P.D.

When there is a nursing vacancy in the O.P.D. the Director of the O.P.D. informs the Director of Nursing. Applicants submit applications to the Nursing Director, who judges their qualifications. Appointments are made by the O.P.D. Director. The salaries of the O.P.D. nurses are paid from O.P.D. funds.

The same procedure is followed in the appointment of public health nurses. They are appointed on yearly basis by the Director of the School of Public Health, to whom they are professionally responsible. They draw their salary from the School of Public Health.

Recruitment of Staff Employees and Workers

The O.P.D. staff, in addition to the Director, consists of a secretary, a senior clerk, two technicians and an assistant, and two social service workers. There are four categories of staff employees; the senior clerk is of the fourth, the secretary of the third, and the clerks and technicians of the second.[1] On the other hand, workers are divided into two main subdivisions: orderlies which are in turn divided into senior, and junior grades, and maids.

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1 See Appendix.

Staff employees apply for employment to the Hospital Personnel Officer and are interviewed by the O.P.D. Director, who makes the selection. The files of the balance of the applicants are returned to the Personnel Officer. The person selected for employment must then pass a physical examination.

Probationary Period

All O.P.D. personnel are placed on probation for three months. At the end of this period, an employee is either retained or dismissed, depending on the recommendation of his superior. Following this period, and until the completion of one year's service, a worker can only be dismissed after one month's notice. He, also, is entitled to an indemnity of four weeks' salary.

Salary Scale And Working Hours

The salary which an employee receives varies with the category and grade. The salary of each doctor depends on his position. The salary of members of the house staff starts at L.L.100 per month for the intern and increases with promotion to the other grades of the house staff. The salary of the attending staff is confidential.

Each of the nursing grades has its own salary. Below is the salary scale for nurses:

Position	Monthly Salary in L.L.
Nursing Supervisor	415.00-475.00
Head Nurse	360.00-415.00
Staff Nurse	280.00-360.00

The salary scale of workers is as follows:

Position	Monthly Salary in L.L.
Orderlies	45.00-75.00 plus maintenance
Maids	35.00-55.00 plus maintenance
Drivers	125.00.200.00 no maintenance [1]

Workers not living in the Hospital receive a maintenance allowance of L.L.10.00 for room and L.L.40.00 for board each month. Workers with families are entitled to a family allowance of L.L.10.00 monthly for the wife, L.L.10.00 for the first child, L.L.7.50 for the second and third children, and L.L.5.00 for the fourth and fifth children. Family allowances are granted on presentation of an identity card for each family member. These allowances are for children under sixteen who are not working and under twenty-three if they are going to school.

The employees work from thirty-nine to forty-eight hours each week, and are governed by the Lebanese Labour Law. However, working hours may be increased above these limits for certain jobs; thus the working hours for messenger boys, orderlies, and maids range between forty-eight and sixty hours per week. In addition, employees are entitled to thirty-six continuous hours of weekly leaves; and time and one half for overtime work.

Vacations and Leaves

The members of the medical staff, nursing staff, and

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1 Workers Payroll, Salary Scale, July 1, 1952. Also see Appendix.

employees of the third and fourth categories, are entitled to thirty days vacation annually with full pay, whereas employees of the first and second categories are given fifteen days vacation with full pay. Workers are given six paid holidays annually. These are two days on Christmas, and single days on New Year's, Easter, Good Friday, and Independence Day. For non-Christians, the six days vacation may be interchanged with their own holidays. According to University rules, vacations are not cumulative and no extra pay is granted an employee if he does not take his vacation and remain at work.

After the employee has been on the job for one year he is entitled to fifteen days sick leave with pay. Sick leave is not deducted during the first year, if it is apparent that the individual was ill as a result of his work. Thus sick leave for the first and second years are fifteen days, and after that the Lebanese Labour Law applies. According to Article 40 of the Law: "In case of sickness, not caused by work accident, the employee is entitled to the following:

If he spent in the service	Sick leave with full pay	Sick leave with one half pay
2-4 years	1 month	1 month
4-6 years	1 1/2 months	1 1/2 months
6-10 years	2 months	2 months
10 years and over	2 1/2 months	2 1/2 months"

Sick leave is based on medical reports from the Infirmary, and can be renewed during the year until the maximum set above is reached. "If the total days exceed

one month, however, the employer will have the right to reduce the vacation leave to eight days."[1]

In addition, an employee is entitled to two days leave with full pay in case of the death of his father, mother, wife or husband, children and grandchildren, grandfather, or grandmother.[2] Moreover, a worker when working overtime on emergencies or otherwise, has a right either to a leave equal to the hours he worked, or to compensation for the hours.

Promotion and Transfer

Promotion depends on several factors, one of them being seniority. Other factors of importance are character, efficiency, merit and usefulness of the employee to the department. The O.P.D. Director recommends the employees for promotion. His recommendation is based on a "Job Description and Efficiency Report"[3], filled by the Director himself in case of administrative employees and by the head of the other sections for the rest. To become effective, promotions must be approved by the Hospital Administrator and the Medical Dean.

Staff employees and workers are promoted upon the recommendation of the O.P.D. Director to the Hospital Administrator, who has to approve it. Any increase in the number of personnel of the O.P.D. must be approved by the Hospital

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1 Lebanese Labour Law, Article 41.

2 Ibid., Article 38.

3 See Appendix for the form, and items used, in the "Job Description and Efficiency Report".

Administrator and the Medical Dean.

Transfer of personnel between the Hospital and the O.P.D., and the O.P.D. and the University, is effected after securing the consent of the O.P.D. Director, and the chairman of the department to which or from which the transfer is made, and the approval of the employee.

Termination of Service

An employee's employment may be terminated by death, resignation, superannuation, and discharge. In case of death of an employee his dependents or direct relations are entitled to an indemnity and the balance of his salary. When an employee resigns, he submits his resignation in writing to the O.P.D. Director, which is then sent to the Hospital Administrator and to the University Treasurer. Acceptance of resignation depends on the O.P.D. Director to whom all O.P.D. personnel are directly responsible. In 1950 only two employees resigned from the O.P.D., and in 1952, three nurses. Permanent employees are entitled to a pension after they reach the age of sixty-five years or have worked for thirty-five years. At present there is no employee on pension.

An employee is discharged upon notification by the University Treasurer. No employee can be discharged for unsatisfactory work unless he has received two warnings from the Treasurer's Office. A discharged employee is not entitled to an indemnity but he is given one month's notice before dismissal. All discharges are proposed by the O.P.D. Director

and must be approved by the Hospital Administrator.

An employee may be discharged for several reasons; one of which is for unsatisfactory work; from 1948 to 1953, five employees were discharged for this reason. A second reason for discharge is misbehavior, no one has been dismissed for this reason. Thirdly, an employee may be discharged for inability to get along with the people with whom he is working. Only one employee has been dismissed for this reason since 1948. Finally, an employee may be discharged for disability, in this case too only one employee has been dismissed since 1948.

A discharged employee is entitled to an indemnity paid on the basis of the last monthly payment made to him. Indemnities are paid as follows: for less than one year's service, half a month of indemnity is due to the discharged employee; for one year's service, one month of indemnity is paid; for the first five years of service an employee is entitled to one month of indemnity for each year and half a month for any year thereafter; any year which the employee has just started is considered one year and thus he is entitled to the indemnity due to one year of service.[1]

Before an employee may be discharged he must be given a notice in writing plus compensation for the period he served. The limit for notice is fifteen days for employees who served more than one half year and less than a year; thirty days for

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1 Policies, Instructions Concerning Discharged Personnel, November 7, 1944.

those who have worked more than one year and less than three years; and two months for those who have served for three years or more.[1]

Disciplinary Provisions

There are three types of disciplinary action taken against employees: first, is verbal warning or reprimand. If an employee does something wrong he is called into the office of the chairman of the department where he is reprimanded for his actions and his mistake explained to him. Secondly, if an employee makes the same mistake or one similar to the one for which he was reprimanded, he is served a first written warning which the employee signs. In case he commits the same fault a third time, he is served a second written warning. The third form of disciplinary action is discharge. This is the severest form of discipline. Discharge is resorted to in case the above mentioned methods fail to give a satisfactory result. If an employee is found guilty of stealing, he is automatically discharged without indemnity. The penalty for misconduct and non-conformity to Hospital rules and regulations is also discharge.

Turnover Rate

Turnover of personnel in an organization is defined as the "shift and replacement of personnel, incident on its maintenance."[2] The turnover rate shows the rate at which

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1 Ibid.

2 Mosher, Kingsley, and Stahl, Public Personnel Administration, 3rd Ed. (New York: Harper and Brothers, 1950), p. 185.

employees move in and out of the organization. In addition, the turnover rate shows the effectiveness of the methods of recruitment, the personnel procedures, and the working conditions. A high labor turnover shows either unhealthy working conditions, or ineffective personnel procedures or both. Thus the chief administrator of an organization should record the factors that lead employees to leave either voluntarily or involuntarily.

The turnover rate for medical personnel at the O.P.D. cannot be determined, because they work on a part-time or on a voluntary basis. But the separation rate[1] for the other employees in 1953 was 13.95 per cent, and in 1954, 8 per cent. In comparison the accession rate[2] in 1953 was 13.04 per cent,

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1 Separation rate: is defined as the number of separations over a certain period of time per 100 of the working force. The separation rate was calculated as follows:

1953: The total labor force was twenty-three at the beginning of the year three left the service

$23-3 = 20$

$\frac{20+23}{2} = 21.50$ (average of the labor force at the beginning and end of the year).

$S.R. = \frac{3 \text{ times } 100}{21.50} = 13.95$ per cent

1954: Similarly the separation rate for 1954 was calculated and to be 8 per cent, twenty-six was the labor force at the beginning of the year, and two left the service.

2 Accession rate: proportion of those who join or enter the service.

1953: three acceded to the service
twenty-three was the labor force

$A.R. = \frac{3 \text{ times } 100}{23} = 13.04$ per cent

1954: four acceded to the service
twenty-six was the working force

$A.R. = \frac{4 \text{ times } 100}{26} = 15.38$ per cent

and in 1954 it rose to 15.38 per cent. The net turnover rate in 1953 was 13.04 per cent (or the least of the two, considering the separation rate and the accession rate); and in 1954 it was 8 per cent. Thus we see that the net turnover rate for the O.P.D. is not high. It is held by some authorities that a 10 per cent is the optimum rate, which for the last year the O.P.D. has not exceeded. This conclusion is based on the fact that the turnover rate should be large enough to prevent stagnation and small enough to reflect healthy working conditions.

Efficiency Rating

Every year an efficiency rating report is made on each employee. The efficiency report is considered the basis for future promotion. The efficiency form is prepared by the University Personnel Office. It is divided into six sections. The first section is a description of the type of work done by the employee. The second deals with the chief administrator's judgment on certain characteristics of the employee, such as dependability, adjustment to work, initiative, cooperation and disposition, regular attendance, punctuality, and health. Each of the above items has three degrees one of which is only checked. The third section indicates whether or not the employee is obliged to work overtime, and, if so, the reasons for it; and the number of hours. The fourth section encompasses the employee's strong points and most satisfactory jobs done, and if he could be improved. In the

fifth section, the recommendation for promotion, demotion, raise in salary, termination, et cetera. The sixth section is left for general remarks.[1] All information contained in this report is confidential.

To enable the personnel to feel that they are contributing to the department, a suggestion method was employed. A suggestion box was placed in several places where the employees drop in slips on which they make suggestions for improvement of the functioning of the department. These slips might be signed or not, at the employee's discretion. Good suggestions were to be taken into consideration and the initiator given credit for them. This method was used in 1952, but the employees' were apathetic. Since then no efforts have been made to use it again.

To carry the objectives of the O.P.D. the department recruits a number of employees, in the employment of which it follows the Hospital procedure and personnel policy for the recruitment, promotion, transfer, termination of service, discipline, and sick leaves and vacations of personnel. The personnel policy is clearly defined and publicized so that every employee knows his duties and responsibilities.

The O.P.D. staff is a small one of thirty-one employees which does not raise personnel problems. The turnover rate is not high, indicating that the working conditions and personnel procedures are good.

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1 See Appendix for the form used for efficiency rating.

CHAPTER IV

PROBLEMS AND RECOMMENDATIONS

It is now necessary to discuss some of the organizational and administrative problems of the O.P.D. These are fiscal, procedural, and other problems.

Budgetary

The O.P.D. does not follow any allotment system, but the Director spends on the account of the department. Thus he may spend in half a year all the annual appropriations of the department. Such a state of affairs is not advisable, to remedy it the department might introduce a quarterly allotment system, a device of budgetary control whereby the money appropriated for the fiscal year is divided on a quarterly basis into a time schedule of work and expenditures. These quarterly portions of the appropriations can be called the Director's budgets, established for the quarterly spans within the limits of the fiscal year program as authorized and approved by the Board of Trustees. This system has been suggested because of the variation in the work load of the O.P.D. in different seasons of the year, hence the appropriated money will be divided into four equal parts and the Director of the O.P.D. will have the power to apportion the sum alloted for the quarter between the three months that make up the quarter,

as the work load of the department necessitates and the experience indicates.

The advantages of this system are: first, it simplifies the task of repairing allotment schedules and setting controls; second, it will be less frequently necessary to change allotment schedules or to return purchasing requests because no funds are available for the purchase; third, it requires less bookkeeping than the monthly allotment system.

By adopting an allotment system, the O.P.D. will be able to plan its spending so as to have sufficient funds to carry on its program throughout the year. Hence expenditures will be kept within the limits of the amounts appropriated for the year. This system will also give the Director control over the department's expenditures commensurate with his administrative responsibilities.

Records

Another major problem of the O.P.D. is its record system. Before reorganization, records of O.P.D. patients were kept at the O.P.D., and were independent of the Hospital record system. As we have noted, after reorganization a centralized system of records was adopted whereby O.P.D. and Hospital records are combined and the O.P.D. admission numbers are supplied by the Hospital admission service. According to this system, a patient who is admitted to the O.P.D. will be given an admission number that will be used for any future admissions to either the O.P.D. or the Hospital. Although

this system is an improvement over the old, in that it centralizes and unifies the records, thus making it easier for medical people to carry on the history follow-up on their patients, it nevertheless has its drawbacks. The O.P.D. staff complain that records are often misplaced, or lost, at other times part of the record is lost. Also much time is spent in taking records back and forth between the Hospital and the O.P.D.

Although centralization has improved the record system, changes need to be made in the form of the record itself. Today the record of a patient consists of a number of papers of varied sizes and colors stuck together by clips or pins. Generally the record is not kept in a binder. To avoid losing parts of a patient's record, and to have better form, his chart should be a small file containing all the necessary information and data. All other papers within the file should be of the same size and the reports of x-ray, laboratory, and other tests being of various colors with gummed edges making it possible to stick them to their proper places. In this way no parts of the record will be lost and it will be easier to file, and hence there will be less chance to misplace them.

Much time is spent in transporting records between the O.P.D. and the Hospital. There are two methods for avoiding this: first, connecting the O.P.D. with the Hospital by a tunnel, which is expensive and so out of question; second, keeping records of patients who have appointments at the O.P.D. This latter solution is advisable because there is

an empty room on the first floor which could be used as a record room, and also the admission officers or the appointment desk clerk can take charge of it.

The above mentioned problem leads into the problem that some of the employees of the department are not occupied all the time they should be working. The admission officers work in the morning till noon, and then they do little work in the afternoon. In this time they can take care of the records. Another alternative is the appointment clerk. She also works in the mornings and has little to do in the afternoons except on certain days when they have afternoon clinics. She can take care of records. In this way the time spent for getting and taking records will be eliminated. Doctors who need the records of O.P.D. patients can borrow them on loan basis; and when a patient is transferred to the Hospital his record should go with him and vice versa.

Appointment

A third problem of the O.P.D. is delay in the treatment of patients due to the simultaneous arrival of many patients at the same time. When a patient comes in, he is admitted and is sent up to the floor where the clinics are held, where he awaits his turn, sometimes hours and hours, before he is called in. This is the result of the appointment system, by which returning patients are given appointments. The appointment system is necessary, but when patients are given appointments, the appointments are all written for

7:30 a.m. Most of the patients come at this early hour, and thus there is a big crowd at the O.P.D. at this time. Hence, they have a long wait until their turn comes. It would seem logical that appointments be given for different hours as the work load of the clinics permits, so that some of the patients would come at 7:30, others at 8:30 a.m. and two later shifts at one hour intervals or more than one hour intervals could be established as it is found necessary.

On the other hand, if new patients have still to wait a long time after following the above procedure, this time can be utilized for educating them in public health techniques and hygiene. Other than this delay the treatment of the patients is done as rapidly as the present circumstances permit.

The O.P.D. is primarily a place to which poor patients are treated and taken care of. But we see that a number of the patients who come to the O.P.D. are well-to-do and can afford to pay for a private physician. It might be possible to set an admission fee of L.L.5 for the first visit and L.L.2.50 for a return visit to be charged of patients who can afford to go to a private physician, but come to the O.P.D., either in the hope to be seen by a specialist, or because of the facilities available at the O.P.D., not found at the private office of the physician. You can distinguish a rich patient from the poor one by his dress, and by other factors. Such patients should be sent to the social service section to have their financial status determined, in this

case not to reduce the fee, but to raise it.

Personnel

The final problem of the O.P.D. that I shall take up is lack of personnel education and information. After an employee assumes his job at the O.P.D., his education ends; what he learns, he learns on the job. The Director holds no departmental meetings nor do any of the section heads. Weekly or bi-monthly meetings could be held by the section heads, to discuss the existing problems; and to divulge pertinent information. Moreover, the Director should hold a monthly departmental meeting for the same purpose on a departmental scale. In this way attitudes of employees will be noticed; problems will be discussed, and solutions suggested. New procedures and rules will be publicized and the employees will be educated into the procedures of the department and they will be up to date in their information.

There has been a growing realization on the part of Hospital authorities that the O.P.D. is extending the usefulness of the Hospital to the community, and that through the O.P.D. services the Hospital has become a more effective force in the preventive and curative aspects of medicine. Looking at it from a broad social point of view it is of equal importance with the Hospital.

The hundreds of patients who come to the O.P.D. clinics go there not merely because of lack of means to

obtain services of a private physician, although this is one of the main reasons; but to a considerable extent they go there because they expect to come under the care of specialists, and because the O.P.D. has the equipment which the ordinary physician is unable to provide for himself. The increased popularity of the O.P.D. clearly demonstrates its usefulness and so irrespective of what the future social provisions for medical care may be, the O.P.D. is bound to play an important part.

APPENDIXES

Appendix I

O.P.D. General-Miscellaneous Business

Strictly Confidential

JOB DESCRIPTION AND EFFICIENCY REPORT

....
Name of employee Date

1. Please describe in detail the type of work done by the employee. (If this space is not adequate, use separate sheet).

2. Check the following to indicate your judgement on the following characteristics of the employee. (Check I if above average; II if average; III if below average).

(a) Dependability	I II III
(b) Adjustment to work and adaptability	I II III
(c) Quality of Work	I II III
(d) Volume of work turned out	I II III
(e) Initiative	I II III
(f) Cooperation and disposition	I II III
(g) Regular attendance	I II III
(h) Punctuality	I II III
(i) Health	I II III

3. Indicate whether the employee is obliged to work overtime and state reasons why overtime is necessary:

Never ( ) Occasionally ( ) Regularly ( )

4. State briefly the employee's strong points and most satisfactory jobs done, also in what ways you believe he would improve himself.

5. Do you believe this employee should:

	Yes	No
(a) Be promoted to a more demanding job	( )	( )
(b) Remain in present job but merits raise in salary	( )	( )
(c) Remain in present job at present salary	( )	( )
(d) Be transferred to less demanding job	( )	( )
(e) Be terminated	( )	( )

6. General Remarks:

APpendix II. ANNUAL PERSONNEL RATING

DATE _____

Strictly Confidential

Name of Employee _____

Department _____

Employed _____

Salary _____

Job Title _____

Scale
1. Superior
2. Above Average
3. Average
4. Fair
5. Unsatisfactory

WORK HABITS (Check appropriate point on scale)

	1	2	3	4	5
Knowledge of work	( )	( )	( )	( )	( )
Quality of work	( )	( )	( )	( )	( )
Skill in work	( )	( )	( )	( )	( )
Adaptability to work	( )	( )	( )	( )	( )
Interest in work	( )	( )	( )	( )	( )
Speed in work	( )	( )	( )	( )	( )
Accuracy in work	( )	( )	( )	( )	( )
Neatness in work	( )	( )	( )	( )	( )
Ability to organize work	( )	( )	( )	( )	( )
Ability to follow instructions	( )	( )	( )	( )	( )
Dependability in work	( )	( )	( )	( )	( )
Economy with materials	( )	( )	( )	( )	( )

ANNUAL PERSONNEL RATING (Continued)

PERSONAL CHARACTERISTICS

Intelligence	( ) ( ) ( ) ( ) ( ) 1 2 3 4 5
Mental alertness	( ) ( ) ( ) ( ) ( ) 1 2 3 4 5
Initiative	( ) ( ) ( ) ( ) ( ) 1 2 3 4 5
Cooperation	( ) ( ) ( ) ( ) ( ) 1 2 3 4 5
Courtesy in meeting public	( ) ( ) ( ) ( ) ( ) 1 2 3 4 5
Courtesy in handling telephone calls	( ) ( ) ( ) ( ) ( ) 1 2 3 4 5
Acceptance of responsibility	( ) ( ) ( ) ( ) ( ) 1 2 3 4 5
Assistance to co-workers	( ) ( ) ( ) ( ) ( ) 1 2 3 4 5
Discretion with confidences	( ) ( ) ( ) ( ) ( ) 1 2 3 4 5
Loyalty to A.U.B.	( ) ( ) ( ) ( ) ( ) 1 2 3 4 5
Health	( ) ( ) ( ) ( ) ( ) 1 2 3 4 5
Punctuality (keeping office hours)	( ) ( ) ( ) ( ) ( ) 1 2 3 4 5
Attendance record (sickness or other)	( ) ( ) ( ) ( ) ( ) 1 2 3 4 5
Personal appearance (well-groomed)	( ) ( ) ( ) ( ) ( ) 1 2 3 4 5

ANNUAL PERSONNEL RATING (Continued)

PERSONALITY TRAITS (Please check those most applicable)

Positive		Negative	
Courteous	( )	Discourteous	( )
Tactful	( )	Not tactful	( )
Quiet manner	( )	Loud	( )
Energetic	( )	Lazy	( )
Helpful	( )	Not helpful	( )
Accepts criticism well	( )	Dislikes criticism	( )
Cheerful	( )	Moody	( )

GENERAL REMARKS AND RECOMMENDATIONS:

_____
Signature

Appendix III. AMERICAN UNIVERSITY OF BEIRUT

Application for Appointment

Date: _____

GENERAL INFORMATION

Full Name: _____
(First or personal) (Middle or father's) (Last or Family)

Position applied for: _____

Address: _____

Date of birth: _____ Place of birth: _____
(Month) (Day) (Year)

Nationality: _____ Religion: _____

Identity Card: _____ Valid to: _____ Issued at: _____
(Number) (Date)
(If U.S.A. citizen, see below *)

Languages spoken: _____

Health: All candidates must pass a physical examination before appointment valid.

Name, relation and address of responsible relative:

_____

FAMILY STATUS

Married or single: _____ If married, give name, age and occupation of wife or husband:

_____

Name & ages of dependent children:

_____

_____

EDUCATION: Name of Institution	Location	Dates attended	Degrees, Diplomas & dates received

* Citizens of U.S.A.: Passport No. _____ Date & place of issue _____

Valid to: _____ Type of visa to Lebanon _____

Social Security No. _____

Address in U.S.A.: _____

Application for Appointment (Continued)

EXPERIENCE Name of organization	Position held	Dates From-To	Salary per mo.	Immediate Superior

REFERENCES:

_____

_____

Appendix IV. EMPLOYMENT APPLICATION

Division and Account to be charged

Name: First or Personal Middle or Father's Last or Family

Title for year applied for School & Dept. Rank or category

Tenure: Indeterminate Classified Determinate 11month 9-month

Other (Describe)

Effective Date Termination Vacation: Months Weeks Days

Salary: per year (Indicate $ or L.Leb.) Per month Total for Budget Year

Full-Time Appointment? If part-time, show full-time Rate If P.T., show hours or proportion

If appointee receives supplement, give amount & describe

Is rent subsidy applicable? Married or single? No. of dependent family

If applicable, allowance for education of ..... children.

Not more than three

Maintenance provisions, if any, room, board, laundry. Describe in full

Will appointee live in AUB quarters? If not, is there a rebate?

If appointee is to supervise dormitory, extra-curricular or other special activities, indicate duties and remuneration

Insurance provision Leb. indemnity U.S.Soc.Security Leb.Teachers fund Other (Describe)

EMPLOYMENT APPLICATION (Continued)

Travel, if any, from where to where? _____ When? _____

Number of adults guaranteed travel _____ No. & ages of children guaranteed travel _____

Is this a new position? _____ This is a replacement of whom? _____ Why? _____

If reappointment, give previous salary, position, dates of previous service and total service _____

REMARKS: _____

I have explained these terms to the appointee, who has accepted them. I have made it clear that the terms become effective only when confirmed by signed contract or agreement.

Date _____ Signature of recommending officer _____

Checked by personnel office

Checked for agreement with budget

Copies: Personnel office
Treasurer's office
Dean's office

Appendix V. AMERICAN UNIVERSITY HOSPITAL

UNIVERSITY INFIRMARY REFERRAL

Date: _____

Please examine:

Remarks:

Referred by: _____

Diagnosis and Recommendation:

Appendix VI. JOB DESCRIPTIONS

CATEGORY I

Junior Technician - Trainee for more advanced technical job; must be willing and able to do whatever menial chores are assigned (cleaning equipment, etc.)

Junior Clerk - Simple office routines, as required by particular department.

Receptionist - Meet visitors; answer phones, no typing required.

CATEGORY II

Assistant Technician - More knowledge of work than required of Jr. Tech. and ability to perform more technical work.

Clerk - Simple bookkeeping; office routines.

Receiptionist-typing - Fairly good typist, meet visitors; answer phones.

Clerk-typist - Office routines; typing incidental to other work; filing, etc.

Typist - Type letters from outline drafts and other copy work, cut stencils use dictaphone.

CATEGORY III

Technician - Proven ability to perform certain jobs, some without direction and ability to assume more responsibility.

Short-hand-typist - Ability to take dictation and transcribe notes; prepare letters from outline drafts, file; other routines with some direction.

Clerk - Same as clerk under Category II but capable of assuming more responsibilities as required by particular department.

Receptionist - Person particularly adapted to meet people who can use judgement in handling them; also intelligent and courteous handling of phone calls, typing and other clerical work.

CATEGORY IV

Senior Technician - Must be capable of administrative work; teach in labs as well as assist in lab work; ability to do research, must be thoroughly familiar and expert in all phases of work involved.

JOB DESCRIPTIONS (Continued)

Senior Clerk - All duties of clerk plus some accounting; supervise and train personnel under his direction; set up and maintain records; procure material, equipment, etc.; inventory of stores, or other comparable duties.

Secretary - Ability to handle with general direction only, routine office administration; prepare draft replies to correspondence; file; handle phone calls and visitors in polite and discreet manner; plan office operations with efficiency and initiative; train office personnel in procedure, etc, skilled in shorthand and typing; maintain confidence entrusted to her by virtue of her position.

CATEGORY V

Administrative Secretary - All duties of secretary, plus added responsibility and use of initiative; capable of performing some supervisory duties.

Accountant -
Chief Clerk - Same as Senior Clerk, but with more scope to work and more power of independent judgement.

Appendix VII. WORKERS PAYROLL
SALARY SCALE
July 1, 1952

Position	Salary		
Orderlies and Attendants	LL.45.00 to 75.00	plus	maintenance
Kitchen workers	50.00 to 100	"	"
Maids	35.00 to 55	"	"
Messenger - Hospital	35.00 to 50	"	"
Cooks and Assistants	150.00 to 250	"	"
Laundry workers	75.00 to 110	no maintenance	
Gatemen and Watchmen	100.00 to 150	"	"
Drivers	125.00 to 200	"	"
Seamstresses	100.00 to 135	"	"
Sewing Room workers	85.00 to 100	"	"

Workers not living in the hospital receive the following maintenance allowance:

Room	LL.10.00
Board	40.00
Total	50.00

Family allowance is calculated as follows:

Wife	LL.10.00
First child	10.00
Second child	7.50
Third child	7.50
Fourth child	5.00
Fifth child	5.00
	LL.45.00

Family allowance is granted on presentation of an identity card for the family member. Allowance is for children who are not working up to 16 years of age or until 23 (twenty-three) years of age if they are going to school.

Five Holidays annually with Pay:

Christmas	- 2 days	)	Christmas	- 1 day	)
New Year	- 1 day	)	New Year	- 1 day	) Non-
Easter	- 1 day	) Christians	Ramadan	- 1 day	) Christ-
Independence Day	- 1 day	)	Al-Adha	- 1 day	) ians
			Independence Day	- 1 day	)

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ABSTRACT

THE ORGANIZATION AND ADMINISTRATION OF THE OUTPATIENT DEPARTMENT OF THE AMERICAN UNIVERSITY OF BEIRUT

The O.P.D. was established in 1875, to fulfill the following purposes: First, to develop a teaching center for medical and nursing students, and technicians. Second, to provide the ambulant patient with curative and preventive remedies. Third, to integrate public health concepts into the O.P.D. clinics through research and investigation.

The organization of the department is made up of the Director as chief executive officer, the O.P.D. Advisory Committee, the medical social service section, the admission section, the records section, and the professional services, which include the medical staff, the nursing staff, clinical services, and the x-ray fluoroscopy and laboratory.

Until 1954 no major administrative changes had been made in the organization of the O.P.D. However, in recent years it became apparent that its organization was inadequate for its increased responsibilities. The reorganization effected the following changes: First, the Director of the O.P.D. became the Assistant Hospital Administrator. Second, the clinical services of the O.P.D. were drastically effected by the reorganization. The Dentistry Clinic was abandoned. The Distributing Clinic and the General Practice Clinic were replaced by the Group Clinic and the Overflow Clinic. Third, a centralized

unit system of records was adopted that enables medical personnel to carry their history follow-up on patients; and also facilitates the transfer of patients from the O.P.D. to the Hospital and vice versa.

Each year the O.P.D. Director prepares the budget six months before the beginning of the fiscal year. He is also responsible for its execution after it has been approved by the Dean, Comptroller, President, and Board of Trustees. During the execution process, the Director pre-audits the accounts of the Department. The accounts of the Department are also audited by an outside auditing firm yearly. In addition, the Hospital Administrator sends monthly financial statements to each department; and the Comptroller issues account flimsies.

The O.P.D. is staffed by thirty-one employees in the recruitment of whom are followed the University and Hospital personnel policies and procedures to a large extent on matters of recruitment, salary scales, working hours, vacations, leaves, promotion, transfer, termination of service, and disciplinary action.

After reviewing the general set up and administration of the O.P.D. as it existed prior to 1954 and after, the following problems are discussed: lack of an allotment system, confusion in the record system, delay in the treatment of patients due to drawbacks in the appointment system, inadequate financing, and lack of personnel education. Solutions for these problems are suggested.