

File

HOSPITAL SUPERINTENDENTS' MEETING
10 a.m., October 11, 1957
Fergus Falls State Hospital
Fergus Falls, Minnesota

Present: Mr. Hursh
Dr. Cameron
Dr. Patterson
Dr. Donald Peterson
Dr. Hutchinson
Dr. Sheeley
Dr. Grimes
Mr. Henderson
Mr. M. Krafve
George Schaekel
Dr. Bradley
Dr. Williams
Dr. Wadsworth
Dr. Adkins
Dr. Vick
Dr. Hoffman
Mr. Johnson
Francis Stevens
Conrad Peterson

Absent: Dr. Magnus Petersen
Dr. E. J. Engberg
Miss Jean Conklin

I. Consideration of Minutes of September 6th, 1957, Meeting.

Dr. Donald Peterson mentioned that the last paragraph on the item "Maintenance Control" in the minutes of that meeting were over-simplified. The paragraph reads as follows:

"Mr. Hursh suggested that each institution start and work with the forms and if any revision was necessary later it could be done."

Mr. Hursh said that the statement in the minutes was correct and that was what he meant -- that if there are certain parts that are found to be unnecessary, the superintendents could make suggestions for revision later. However, there are certain items in the maintenance control forms that are necessary for the development of budget preparation.

II. Mental Hospital Institute.

The following reports were made by those attending the Mental Hospital Institute held in Cleveland, September 29 -- October 3rd, 1957. The various persons attending got together to decide on which portion of the institute they would present. The following are excerpts from the notes submitted by persons from the State of Minnesota attending the institute.

Dr. B. P. Grimes, Superintendent of St. Peter State Hospital made the first presentation which follows:

"The first presentation by Dr. O'Neill on 'Laying the Foundations for an Open Mental Hospital' was a report on a visit made by a number of superintendents from the State of New York to Great Britain during the past summer, to review the various open hospitals in Great Britain, particularly that of

Dr. Reese at Warlingham Park. Dr. O'Neill indicated that while Warlingham Park was enthusiastic about the program, there were others in Great Britain who were not as dedicated to this principle and who found some difficulty in trying to operate on the same basis. Other hospitals in Great Britain did not agree with the principle at all.

"A definition of an open hospital was that for a period of 8 hours during the day, the patient was free to come and go on his own initiative, without a check by an attendant or a request for information at the time that he left. It was reported that patients in an open hospital increase their activity during the day, and they present fewer problems at night. The total amount of sedatives used was considerably reduced in open hospitals.

"Dr. Simon, reporting from a small private hospital said that he did not use a receiving ward service, but admitted all his patients directly to the hospital population. It was pointed out that a half-way house was desirable, but this was undoubtedly a community responsibility and not a responsibility of the hospital. There was considerable discussion of a half way house called the 'Portals' in Southern California. Mention was made of the fact that the patient seen in the community was not the same as the patient currently in the community who was actually a post-hospital patient.

"The medical-legal implications of the open hospital were discussed at length. It was pointed out that the open hospital routine required extensive records to justify the actions taken at the open hospital in the event of accidents or pregnancies.

"Dr. Duval of St. Elizabeth's talked about two suits for suicide. One case in which the depressed patient actually hung herself using the belt sewed onto a bath robe. However, the action was brought on the ground that the patient had suicided with the belt, which was an instrumentality for suicide furnished by the hospital. In the event that this is upheld, it is difficult to see how there can be any defense against any action of the hospital which might result in an accident.

"Dr. Simon set forth the thesis that no consent was required for Electric Shock Therapy, since this was standard routine treatment, not a special treatment and was an accepted practice.

"Dr. O'Neill pointed out that while Warlingham Park was completely open, Dr. Reese has spent 20 years in the process of achieving this result. He pointed out that Dr. Reese had a staff of about one psychiatrist per 100 patients, and had the advantage of using the registered medical sister to supervise these patients. This was an extremely competent and well trained person, for whom there is no counterpart in this country. Dr. Crawfis pointed out that mal-practice

insurance was quite necessary in order to provide the services for the defense of any suit.

"The next topic was on Community Facilities and Changing Hospital Functions. Dr. Felix recommended the use of hospital staffs for out-patient clinics, in order to broaden their experience and make their hospital practice more interesting in terms of its variety. Dr. Krush talked on Community Clinics wide spread in Nebraska. He advised that a local physician be used to provide leadership for the community public health nurses that were actively engaged in the clinic facilities.

"During the day there was considerable discussion of open ward techniques and the size of groups of patients that could be used effectively in open ward techniques. One physician pointed out that on an open ward, 6 or 8 patients were identified together, and used in all activities. If one patient wanted to go to the canteen, the entire group had to go or the entire group was taken to the X-ray department in the event that one patient had to have an X-ray.

"Mike Gorman talked about the size of units for such a hospital, and eventually concluded that 20 patients in a unit was about the desirable size.

"The afternoon discussions started on legal implications in the open hospital, and repeated some of the information given previously. Dr. Felix talked about local public health services and the various techniques that were used to develop community interest in the hospital. Various techniques of securing community cooperation, getting community organizations to take the patients out into the community for picnics, etc., were discussed.

"The annual banquet on Monday evening was presided over by Mr. Robinson. Judge Bazelon talked about some implications of the Durham Decision and a necessity for considering the mental status of the patient in connection with his comparative responsibility.

"Awards were given for the 4 hospitals listed in the program and Dr. Harry Solomon talked about his impressions of the progress of mental hospitals. Among other things he recognized that the treatment of acute illness was becoming a function of community facilities and that the mental hospital itself was taking on a secondary function of the care of individuals who had pretty well been screened through by other facilities. Because of this secondary function and the limited goals possible, Dr. Solomon felt that the picture for recruiting was not hopeful as far as physicians and psychiatrists were concerned.

"On Tuesday the 1st of October the first talk was on Revision of Commitment Proceedings. Dr. Guttmacher presented a statistical review of commitment procedures and the problems and drawbacks it had.

"One technique, 'Non-protesting involuntary admission', was apparently available in Maryland for the patient who came to the hospital for voluntary admission, but appeared to be indecisive and unable to sign an application. In such a situation, the accompanying relative was permitted to sign the voluntary admission blank provided the patient understood what was being done and did not make a protest against this procedure.

"Dr. Rud of California pointed out that the sexual psychopaths in California were convicted of their crime before they were referred to the hospital. The patients were then selected and were confined in a prison if they were considered able to conspire among themselves against the security of the hospital. He pointed out that the hospital was considered to be secure against the individual, but would not provide group security, as group security was a function of a prison unit. It was pointed out that the California youth authority was given the problem of delinquents and problem children; these were not pushed onto the mental hospitals in California.

"Dr. Duval discussed the plans for a Security Hospital at St. Elizabeths, and pointed out that they hoped to operate a fairly permissive hospital with peripheral security. Later he explained that this involved a peripheral wall which did not project very far about the surrounding land with a deep ditch on the inside. This construction was quite similar to that used in the zoo at St. Louis.

"The last talk on Tuesday was by Dr. Blasko on 'The Fallacy of the Per Diem Charge'. Dr. Blasko pointed out that he had arranged in Connecticut for legislation so that all liability suits directed toward any mental hospital function were actually brought against the commissioner rather than any other personnel in the hospitals. Various people discussed the per diem cost, pointing out the fallacies of the variable factors in terms of the work week, maintenance costs, overhead charges, and in general pointed out that the existing per diem costs publicized have little value since they are based on various types of foundation.

"On Wednesday morning the first paper raised the question of securing outside physicians for mental hospitals. The question was raised as to whether an out-patient clinic should be established, or whether it would be possible to provide payment for management of the individual patient by the private psychiatrist. Welfare sources might very well be utilized to provide for payment of cost for the individual patient. There were a number of suggestions about securing the services of University or private clinic facilities in the vicinity of the hospital. One hospital in Arkansas which was quite behind on its records was able to interest the County Medical Society in providing rotation assignments to various members to process all of the patients in the hospital. Dr. Simon pointed out that a large number of outside physicians and

consultants presented a problem in maintaining hospital policy. This was met in his hospital by providing that the permanent staff wrote the orders for treatment. The consultant provided the directive for the permanent staff, but the permanent staff was responsible for the orders. Other suggestions such as County Medical Society meetings at the hospital, lectures to County Medical Society, etc., were offered. Various problems of referral of the patient on provisional discharge were suggested. One hospital was using telephone contact with a local physician when the initial work up was made and subsequent contacts for follow-up.

The last half of the morning on Wednesday was devoted to group sessions. I attended number 13 on Communications Between Hospital Staff and Architects and Contractors. The original discussion was by the business manager and architect for the Institute of Living on a rehabilitation project. There was considerable discussion by the architects from Florida who were developing site plans for a new hospital in Western Florida. The architect, Mr. Fleck, of Indiana discussed problems that they had met in various ways particularly with the development of feeding facilities. Mr. Applegate of California discussed building programs and the techniques that were used in California for the development of plans for the new buildings in that area.

Mr. Hatfield, secretary of state for Oregon raised the question of the desirability of a state architect. I discussed the question with him personally and suggested that he contact Mr. Stevenson, Assistant Commissioner, whom he knew.

Dr. Duval emphasized the need for securing information from many sources prior to the development of plans. He spoke of the availability of information from the hospital architecture service, and the American Psychiatric Association. Dr. Duval strongly recommended that the information in this source be used to develop tours to visualize places that were being developed in order to secure new ideas and review on possible mistakes. He strongly suggested that the chief engineer, the architect and the superintendent personally visit places that were being selected for the development of the new areas.

Dr. B. P. Peterson of Knoxville had an exhibit of a 400 bed continued treatment facility which provided for a sheltered work shop and activities building, an infirmary and clinic, 2 practice houses and a number of 20 bed units for a small group living. Dr. Peterson pointed out that he planned to have this particular unit for those patients who are probably going to go into the community. He said that he was placing a limit of 1 year of residence in this facility. During this 1 year, the patient would either improve his ability and move back into the community, or would revert back to the rest of the hospital, if the patient was unable to make adequate progress. A copy of his building program for this unit was

available and a copy was secured. Mr. Applegate indicated that copies of the building programs might be available from California sources.

"Smith, Klein and French had taken an interest and made some financial contribution to the development of the plans for Dr. Peterson.

"Tours were arranged on Wednesday afternoon to various hospitals in the immediate vicinity of Cleveland."

Mr. Krafve of Faribault State School and Hospital reported on the following two topics presented on Tuesday, April 1st.

"ACADEMIC LECTURE, PRINCIPLES, SKILLS AND TOOLS OF SCIENTIFIC MANAGEMENT. Prof. James L. Hayes, St. Bonaventure University, New York. Prof. Hayes was introduced by Dr. Duval, St. Elizabeth's Hospital, Washington D.C. who had attended a seminar in which Prof. Hayes lectured, and was very impressed by him. Prof. Hayes outlined the basic principles of good management - planning, organizing, motivating, co-ordinating and controlling. He stressed that a good manager must have the ability to know how to get things done through other people, and by development of other people.

"PLANNING. You must know your objective whether you are planning a short range or long range program. Your people must understand your objectives, if you are to successfully carry out your program - they must know what you expect to achieve.

"ORGANIZING. Organize your staff so that they know the line of authority and who is responsible and accountable. Set up your organization chart so that there is no question of responsibility for the various functions of your organization.

"MOTIVATION. Tell your people of the results expected of them, treat your people humanly, treat people as people, avoiding suspicion, build your people for the job they are to do, make an appraisal of each individual, know what they are capable of doing and develop their capabilities.

"CONTROLLING. Develop a reporting system. Reports should be used with judgement, not as a tool for discipline or as a target for leveling your 'big guns'.

"CO-ORDINATION. Bring people together and talk to them face to face, taking time to discuss plans with them and seeking their point of view. Exchange of ideas is helpful in co-ordinating your staff and to instill the feeling of accomplishment and participation. He discussed the use of informal organizations, and an informal news organ within your institution. He cautioned that good judgement be used so that you do not develop a 'buddy-buddy' system.

"OTHER AREAS.

"COMMUNICATIONS. Use such devices that will bring the best results. Personal contact many times is better than a written memo which is cold and does not always convey intent as writing lacks inflection and expression. He stressed bearing in mind that some people read well, others listen well, we do not all understand words the same way.

"DEVELOPMENT OF YOUR PEOPLE. Select your personnel objectively, select people who can be developed, training them for the job they are to do. Train them to make decisions and to accept responsibility, develop good judgement in them. Each job should be described in writing, setting up standards, for the job so that your people will know when they have done their job. Instill in your people the need to meet your standard of performance, they will obtain a great deal of satisfaction in knowing that they have met your standards. Build your people to do a job rather than continually substituting people to do the job.

"MANAGEMENT PRINCIPALS APPLIED TO A MENTAL HOSPITAL. Dr. Lee. G. Seevall. V. A. Hospital, Perry Point, M.D. lead this discussion. He stated that a mental hospital is authoritarian rather than democratic and that this serves to identify responsibility. Dr. Duval indicated that management improvement must start with the superintendent, and suggested that it may have been better if his superintendent rather than he had attended the seminar at St. Bonaventure. Mrs. Scruggs, of the Enid State School, Enid, Oklahoma, emphasized the need for workshops on administrative procedures. Prof. Hayes stated that every organization is authoritarian, but that the delegation process must be followed to develop a good organization and good management. Industry has an executive office who is responsible to the board of directors, the same as a hospital superintendent is responsible to his department or board, industry does not hesitate to set up an organization with proper delegation of responsibility and authority. He stressed that the development of a good organization must begin with the hiring of good personnel who can be trained and developed. Dr. Duval, suggested that the A.P.A. investigate to determine if seminar type or courses in management can be arranged for. Those present were unanimous in desiring such courses. Prof. Hayes suggested that the institutions acquire the following texts to assist them in management problems. 'Principals in Management' and 'Administrative Action'."

Mr. Conrad Peterson of the Department of Public Welfare reported on the lecture Inventory Controls and Warehousing.

William Brenizer, Business Administrator, Richmond State Hospital, Richmond, Indiana, acted as discussion leader for this topic. Mr. Brenizer opened the discussion with a detailed description of warehousing procedures and inventory controls as they now existed at his Indiana institution. It was quite apparent that Indiana was still following exactly the

procedures which have been followed by other states for several decades and in later years improved upon.

"The Indiana plan emphasized the use of the 'Bin Card' with ancillary use of departmental requisition forms. Considerable time was spent in discussing the receipt of shipments, checking quantities against purchase orders together with case lot issuance of medical supplies to the pharmacy. In the operation of an inventory control system, it was pointed out that an actual physical count was used as the beginning. Charging of inventories was then made against using departments rather than as a blanket stores account. A daily check of receipts and disbursements was essential to the system. Spot checks were taken periodically as a means of verification of the record keeping.

"A workable inventory control plan would result in good purchasing procedures. Records would be readily available showing source of supply, cost of items, established usage, and would determine the reorder dates. Institutional waste would be eliminated as a workable condemning system would be possible, the per person usage would be stabilized, computation of per capita cost could be readily ascertained, the requisitioning system would be standardized, and theft would be discouraged.

"A number of states reported that in addition to the quantity check, various quality checks had been instituted. Several state Purchasing Departments have developed standard specifications for purchases which were used by receiving clerks as a quality control. State-Federal inspection service on perishables such as fruits and vegetables was now being supplied for quality control to institutions. An increase in the utilization of price contracts entered into with vendors was noted.

"Illinois reported that they had established a pilot demonstration at one of their hospitals for a complete utilization of I.B.M. for all paper work of requisitioning, receiving, issuance and inventory control. Institutional periodic needs were submitted to the central procurement division through the sending in of the appropriate punch cards. Purchase orders, in turn, were produced as a machine operation."

Mr. George B. Schaekel, Business Manager of the Sandstone State Hospital reported on the presentation of "The Importance of Sanitation in the Hospital". The report is as follows:

"This discussion confined itself almost entirely to the dictionary definition of sanitation, i.e. 'the science of sanitary conditions' with the meaning of sanitary - 'Free from, or effective in preventing or checking, agencies injurious to health, especially filth and infection'. When the job class Sanitarian was used it was also used as defined by

Webster: 'An advocate of sanitary measures; one especially interested or versed in sanitary measures, or, specifically, making a profession of the application of such measures for the public benefit.' (benefit of the hospital). To insure that all areas in the hospital were sanitary, many methods were mentioned. Different hospitals in different states have used or are now using all the following delegations of responsibility and all try to have regular inspections:

- (1) In charge of custodial workers.
- (2) Delegated to the head housekeeper.
- (3) Delegated to the head nurse.
- (4) Delegated to the chief engineer.
- (5) Delegated to the staff physician.
- (6) Turned over to the Department of Health.
- (7) Coordinated between the housekeeper and the head nurse.
- (8) Depend on contracts with exterminator companies.
- (9) Various combinations which would include outside contracts on pest control, Department of Health, Department of Agriculture, with Department of Welfare or individual hospitals.
- (10) Responsibility delegated to a sanitarian reporting directly to the Superintendent.

"The ideal situation was considered to be No. 10. New Jersey has such a Civil Service class, paying \$4,560 - \$5,490. Other states are using the class Sanitarian but no statement was made as to their salary. Minnesota falls in group No. 9 - various combinations.

"No. 1 apparently was the most generally used organization and probably the most unsatisfactory.

"Reports from the floor indicated that wherever responsibility was placed in the hands of the head housekeeper, the engineer, the head nurse, or any one below the responsibility of the superintendent, had failed.

"Dr. O'Neill of New York stated that he started in Laboratory Medicine and at one hospital the job of sanitary officer was turned over to him and he felt very inadequate. He gave the opinion that it should be considered unsatisfactory to delegate responsibility for sanitation to one of the staff physicians. A sanitation officer would be better qualified in his opinion and be able to spend his full time at it. Discussions from the floor indicated that where responsibility was turned over to the Department of Health the results over a long period of time were unsatisfactory.

"California reported they had some of their responsibilities coordinated between the housekeeper and the head nurse, with coordination between the business office and the medical staff, which had given good results.

"As to depending on contracts with exterminator companies, the reports from the floor were controversial; Pennsylvania found that their services were unsatisfactory and they probably would be discontinued. Others found exterminator companies were doing a very good job on the entire sanitation problem. Minnesota reported that the Department of Health and the Department of Agriculture cooperated with the Department of Welfare in making inspections and helping to solve difficult problems, and that Minnesota hospitals use contracts with exterminator companies.

"There seemed to be general agreement that each hospital should have a full time sanitarian and that, (1) This individual should be a trained public health officer or equivalent, hired as such or trained after hiring. (2) He should be responsible to the top administrator of the hospital. In Minnesota this is the superintendent. In the discussions, areas where difficulties had been encountered in maintaining sanitary conditions include:

- Raw food inspections.
- General housekeeping.
- Epidemics. (Difficulty in locating and eliminating source)
- Inoculations. (As to necessity)
- Cleanliness.
- Appearance.
- Milk and Ice Cream.
- Garbage handling and disposal.
- Food management.
- Geriatric ward.
- Laundry.
- Bakery.
- Pests, such as flies, cockroaches, mice and rats.
- Dishwashing.
- Electric Clocks.
- Water supply - P. H. factor.
- Pipe space behind toilets.

"The Central Islip State Hospital, New York, with 10,000 beds and 3,000 employees, tries turning the sanitation problem over to the State Department of Health and found it unsatisfactory. They now employ a full time sanitarian with much better results. At another hospital a full time sanitary inspector was employed for 1,000 beds and 800 employees. They were fortunate in finding a public health officer who cleared up one of their difficulties shortly after he started work. The spray nozzles on the dishwashers were clogged and the water boosters were not maintaining proper water temperature. The clogged nozzles and the low water temperature usually were not noted by the dishwashing crew for extended periods because the washer apparently worked O.K. Daily inspection was set up on this and now no dishes in an unsanitary condition get back on the serving line. It was brought out in another discussion that dishes should never be wiped dry. Pennsylvania wished the A.P.A. to set up specifications for the job of

sanitary officer or sanitarian. In New Jersey, where they have a Civil Service job class of Sanitarian, they have six full time sanitarians who service twenty-three institutions. These sanitarians are responsible to the chief executive officer. Ohio reported that under their tuberculosis control they have one sanitarian working full time out of the central office. He spent a large portion of his time inspecting food management and disposal of food waste.

"The Bangor State Hospital, Maine, found breeding places for pests in the workings of electric clocks. They now have a regular inspection of the electric clocks to eliminate this hazard. In Maine they use the inspection facilities of Wyandotte and Kleensade.

"Dr. Bush, Chief Inspector for the Hospital Accreditation Board, mentioned that in all their inspections they had never found the pipe spaces behind toilets and other pipe tunnels clean. In fact they were generally found filthy even in comparatively new buildings. He also suggested that inspections be made after dark when searching for cockroaches.

"At another state hospital, State of Washington, a diptheria outbreak was laid to mishandling of garbage, which had been in charge of a custodial worker. The organization was changed so that more responsibility could be delegated.

"It developed in the discussion that many recommended that the immunization program should be under the sanitarian. Also cooking and serving schools for the food service employees. At some of the hospitals insect control is also turned over to the sanitarian because control of pests was only a small part of the overall sanitation problem and control of rats was easy if all shelters and sources of food were eliminated.

"Mr. Seaman commented that many people judge a place by what they see. If it looks clean the general impression is it must be clean, and if it looks untidy and dirty it very likely is unclean.

"There was agreement on the fact that maintaining sanitary conditions in a hospital is of extreme importance, requiring steady continuing effort with frequent and regular inspections, preferably by an employee hired as a sanitarian responsible to the chief executive officer of the hospital."

The following joint report was made by Nancy K. Kjernaas, Mental Health Consultant, and Miriam Karlins, Volunteer Coordinator, on the various sessions that they attended.

"OPEN HOSPITAL. The first day's discussions centered around the open mental hospital. Concern was not so much with definition or methods of opening hospital wards as with laying the foundations in the hospital and in the community.

Several members of the New York delegation reported on their visit to hospitals in England and discussed the implications for the American mental hospital.

"Dr. O'Neill, in his opening statement, said that the open door policy cannot be put into effect successfully without (1) a full scale activity program and (2) a full scale volunteer program. The theme of the following discussion was that simply opening wards is not a goal in itself, and that very careful consideration must be given to what the hospital door opens onto. Hence, the two points stressed above. Members of the Institute were urged not to return home and enter into an 'open ward contest' nor to take up this latest banner as another in the long series of panaceas for state hospital problems. However, the general opinion seemed to be that hospitals with all or most of its wards unlocked for at least eight hours a day is a desirable goal, if proper conditions can be provided for the patients. Dr. Reese, who has been the foremost exponent of the open hospital, was quoted as saying that schizophrenic patients do not regress in open wards. It was also pointed out that the idea of substantially open hospitals is not new, and that present policies have evolved during the last 75 years as a result of overcrowding.

"Regarding the importance of public education in laying the foundation for the open hospital, there is apparently a difference of opinion. Some administrators in England feel that a full scale program prior to the policy change is helpful; others do not think it necessary. There does appear to be general agreement, both in the present discussions and on the basis of British experience, that the public should be kept informed as the hospital policy changes. Those who feel that prior information is not necessary, base their opinion on their observation that the idea of an open hospital often seems far less radical to the public than it does to many hospital administrators. Several discussants who have already begun changing to the open ward policy cited favorable public reactions and stressed the value of well-informed volunteers and newsmen in explaining the change to the public, particularly in heavily populated areas.

"Dr. O'Neill pointed out some of the factors that may make a widespread establishment of the open hospital more difficult in the U.S. than in Britain. The only one that he felt might be a genuine problem is the lack of cultural uniformity and the greater variation among hospitals in this country. Other differences frequently cited are the difference in British and American commitment laws and the greater number of trained 'mental health nurses' in Britain. While these may impose added difficulties, they do not -- in Dr. O'Neill's opinion -- present insurmountable obstacles, and may serve as handy 'excuses' for delaying a change of policy.

"The most crucial single factor in laying the foundation for this step is the attitude of the hospital superintendent and

thorough acceptance by his staff. Except in isolated instances, particularly with ward level personnel, staff acceptance has not been difficult to obtain.

"HOSPITAL-COMMUNITY SERVICES. A number of suggestions for services not now provided in Minnesota's hospitals were brought up during this discussion. There was considerable talk about day hospitals and whether these should be operated as part of the total hospital program or as separate hospitals. The general opinion seemed to be that it would hasten the destigmatization process if patients are admitted for day or night treatment into the regular hospital setting. One superintendent suggested using any empty beds for two week vacations for geriatric patients being cared for at home. Another suggestion for older people was a special residential unit in a public housing project where older persons could live, with baby-sitter service, etc. The need for closer relationships between hospitals and trade unions was emphasized by several speakers. Dr. Tarumianz reported on several years experience in operating a night clinic, open 6:30 - 10:00 p.m. several nights a week, using state hospital staff members. This has the advantage of providing clinic service to working people without taking them from their jobs for appointments, and it promotes more hospital-community integration.

"THE FALLACY OF THE PER DIEM. This subject was of particular interest from the public education standpoint, since Minnesota - in common with many other states - has sometimes used comparative per diem rates to good advantage. Dr. Blasko, leading the discussion, pointed out many respects in which the per diem rates for various states and even for hospitals within a state are not comparable. The general consensus was that this figure should no longer be used in its present form, and one discussant suggested that the NIMH discontinue publishing comparisons of the states on this basis. However, Conrad Peterson and several others pointed out that legislators request comparisons with other states, particularly those nearby, and that some index must be worked out. Until a substitute is available, we will probably have to continue using the per diem rate. Among the substitutes or refinements presented were an index based on the number of staff hours per patient or the cost per patient under treatment.

"'REMOTIVATION' DEMONSTRATION AND HOSPITAL TOUR. This was an optional part of the program, and since nothing will appear in the formal proceedings on it, I (NK) would like to report rather fully on it.

"The field trip to the Cleveland State Hospital was divided into two parts: a demonstration of new 'remotivation' technique to be used by the psychiatric aide, and a tour of the hospital. The tour was very poorly handled. Comments by psychiatrists and others in the group were eloquent testimony to the value of carefully planned and informative tours. This

was rather poorly planned and decidedly uninformative. Although I am sure none of our hospitals would exclude such a group as this from the disturbed wards, for example, this experience has made me feel that we must look very closely at our procedures for all groups visiting the hospitals. Several things stand out as obvious: (1) groups must be kept small (2) volunteers will have to be used to accomplish this objective without taking up an undue amount of staff time, (3) each area visited should show something about patient care or treatment or hospital administration action, there should be an opportunity for discussion after the tour with a staff member. There is no merit in walking miles - as we did - to see an empty room which we are told is used for group therapy!

The 'remotivation' demonstration sponsored by Smith, Kline and French, was far more interesting and informative. We had an opportunity the previous day to attend a private showing of a film made by SKF explaining the remotivation technique. The attached pamphlet gives a pretty good explanation of the origin and operation of the remotivation classes. To summarize briefly, the basic premise is that every patient - no matter how regressed - has some areas undamaged by his illness, and it is these undamaged areas that remotivation tries to reach. Although it may be called 'therapy', it is not intended to serve the same function as regular group therapy in which patients discuss themselves and their problems. Rather, the aide conducts 'classes' on the ward with a selected group of patients, centering around an impersonal topic - such as the seasons, the sea, etc. The aide attempts through questions, poems, and various objects to stimulate the interest of group members, and to encourage discussion of what they know about the world around them and particularly the work of the world.

Mr. Pillanger, an aide at the Philadelphia State Hospital, gave an impressive demonstration of the technique with a group of patients with whom he had been working for only two days. About half of the patients were entirely new to the group at the time of the demonstration. They all participated to some extent in the discussion, and it was interesting to observe their integrated appearance in the group in comparison with some obviously abnormal behavior as they left the room. Mr. Pillanger is clearly a gifted and sensitive person, but he told us that 200 aides have been trained and are using the method successfully at his hospital, so it would appear not to be a technique dependent on the talents of one man. Sessions are usually held twice a week on the ward and periodic records made of each patient's response and progress.

The technique is still experimental, and much remains to be done in working out selection of patients, composition of the group, duration of the 'course', various levels of course content, etc. It would appear to be easier to put into operation in a hospital already organized on a team basis,

and for this reason, I thought it would be of particular interest to some of our hospitals. Aside from its value to the patients, there seems to be a definite morale value for the aides and a general improvement in ward climate, even for patients not participating.

"We also discussed the possibility of incorporating volunteer assistance into the remotivation program, and Mr. Pillanger thought this might be handled in several ways. Volunteers could assist the aide in collecting materials and planning discussion areas; they might assist in the actual classes; or they might be trained to take over classes to extend the program more broadly.

"If there is sufficient interest in trying something like this in Minnesota, I think arrangements could be made for a training course, possibly with the assistance of Smith, Kline and French.

"THE HUMAN SIDE. Minnesota's new mental health film was shown four times during the Institute - more than any other film on the program. Comment was uniformly favorable, and a good deal of our time was spent in discussion of the film. Mr. Sareyan, director of the Mental Health Materials Center, has made a proposal for handling national distribution of the film. It appears that a suitable arrangement can be worked out in the near future.

"GROUP SESSIONS. Among the smaller group sessions, those of particular interest to us were concerned with the role of the social group worker in the hospital, management of the geriatric patient, and the role of the psychiatric nurse.

"In the group work session, a number of novel uses of groups within the hospital were discussed, but because of the shortage of trained group workers, very few of these groups are actually under the guidance of a trained worker. One hospital reported using patients to orient new groups of patients. Another reported group sessions for nursing home candidates. The general recommendation was that in view of the scarcity of group workers, they should be used in the hospital for training and supervision of other personnel who conduct the actual group meetings.

"The complicated subject of management of the geriatric patient was divided into pre-hospital, hospital, and post-hospital areas. Mentioned under pre-hospital needs were suitable activity programs, re-socialization programs, and environmental manipulation, including placement in mixed age groups in the community. Basic to any such community organization is a broad program of public education, including preventive mental health education as well as organization for specific projects. Need for an inclusive hospital program was emphasized, including psychotherapy as well as somatic and rehabilitation therapies. Among post-hospital management techniques, the whole battery

of residential treatment centers, family service agencies, half-way houses, day centers, etc. was discussed. Greatly accelerated and coordinated development of all such facilities is necessary, in the opinion of the group.

"PSYCHIATRIC NURSE: The session on 'The Specific Functions of the Psychiatric Nurse', led by Dr. E. W. Busse, concerned itself mainly with the problems and questions confronted by this professional group. Such basic questions as, who is a psychiatric nurse were described. Is she a nurse with experience in a psychiatric setting? Is she a psychiatric nurse because of certain basic preparations and/or special training? What is her preparation - or what should it be? Her ability to function is often related the attitude of the hospital administrator and how he thinks of the psychiatric nurse. The question was raised as to whether or not the psychiatric nurse should define her own role instead of having it defined by others.

"MENTAL DEFICIENCY: A PSYCHIATRIC PROBLEM. This very interesting discussion was obviously aimed at prodding psychiatrists to accept more responsibility for the mentally retarded. Dr. Bair, who lead the discussion, stated that allied disciplines and the community have taken more interest in this problem than have the psychiatrists. Dr. Jolley of Illinois later pointed out that good cooperation has been obtained for the welfare of the severely retarded by parents, biochemists, and pediatricians. In contrast, there is little provision for the higher level mentally retarded - where the psychiatrist could make his most effective contribution. Educators are far ahead of psychiatrists in planning for this neglected group.

"Dr. Jolley and Dr. Bair both stressed the point that 3/4 of all mentally retarded individuals have IQ's over 50 and that relatively few of these are in institutions. Those who are admitted nearly all come in because of an abnormal social situation which makes it impossible for them to remain in the community or because of a psychiatric disorder. Once in the institution, however, there is little, if any, psychiatric treatment available to these patients. Our present methods, says Dr. O'Neill, have actually removed chances for psychiatric treatment for the 50-80 per cent of mentally retarded who have psychiatric problems in addition to their basic defect. Dr. Bair stated that psychiatric treatment has proved surprisingly successful where it has been tried.

"In similar vein, Dr. Bair raised the question of whether it is wise to continue the present practice of separating mentally deficient, mentally ill and socially maladjusted children and adults in separate institutions, because of the frequent difficulty in delineating these conditions. Dr. O'Neill reported that in England there is no separate institution for the mentally retarded and few special schools. There, programs for the retarded are integrated into community day care centers, regular psychiatric facilities and workshops.

He and others predicted that treatment of the mentally deficient will follow the same trend in this country, as treatment of epilepsy already has.

"Dr. Bush, who heads the APA Central Inspection Bureau, says that the Bureau began six months ago inspecting institutions for the mentally deficient, and their preliminary findings would suggest that these institutions are - on the average - 10-15 years behind the mental hospitals in developing effective psychiatric treatment."

III. Payment for Damage to Employees Clothing.

The question has been raised as to whether or not the laws of 1957, Chapter 940, Section 40 authorizing the payment of property damage not in excess of \$25 could be used to pay for damage to personal clothing such as torn shirts, uniforms, and so forth.

The law is broad enough so that payment of property damage up to \$25 could be made. Primarily payments have been made for broken glasses and watches broken by patients in the course of the aide's employment. The discretion of the superintendent in allowing claims such as this will be accepted by the Central Office. It was pointed out that if for instance, a shirt was torn, the total reimbursement for a new shirt should not be made if the shirt had been worn for some time. This is given only as an illustration of the consideration of any claims presented.

IV. Caps and Pins for Aides.

This was discussed from two viewpoints. The question was raised as to whether or not it was desirable to have all hospitals require all aides completing the aide training program to wear caps and pins. The next point of discussion was the desirability and feasibility of purchasing these from hospital funds if their wearing is required. A poll was taken of the different institution superintendents as to their handling of these matters. Moose Lake State Hospital reported that the aide gets one cap at the time of the award given at the completion of the aide training program whereas Anoka State Hospital gives a pin. After discussion it was the general consensus that it would be desirable to have all aides wear pins and caps however it was left as a matter of local determination.

V. Handling of Narcotics.

At the last Pharmacists' Meeting there was a discussion of this subject and an indication that the physicians' narcotic number should appear on all prescriptions sent to the pharmacy and the ward narcotic key should be carefully controlled.

It was brought out that there is no need of having a physicians'

narcotic number posted in the pharmacy department as it is not necessary for a doctor to have a narcotic number for use in the hospital. It is only necessary for him to have a narcotic license if he is writing a prescription for a patient on the outside. This matter could be reviewed again by the State Board of Medical Examiners as well as the question of whether or not a physician on limited license can write the prescription.

In the matter of narcotic control it was pointed out that one person should be responsible for that control and the narcotics be counted every shift. This is a practice that is universal in the institutions. It was pointed out that it would be undesirable to order narcotics in large volume.

VI. Use of Physicians' Samples.

At the same meeting of the pharmacists the question was raised as to the policy of dispensing physician samples to patients and employees and the filling of prescriptions of unusual nature -- that is, prescriptions written by consultants and outside medical personnel. It was brought out that all prescriptions should be written by the staff physician.

VII. "Hold Orders" Issued by Municipal Courts.

It has been brought to our attention that in some instances municipal courts have occasionally issued hold orders on which patients have been admitted and the county billed for hospitalization. It was also brought out that counties will only pay on a proper hold order, and they have objected when municipal courts issue a hold order.

The district court can issue a hold order for observation before sentencing. The probate court can issue a hold order. The main purpose of the hold order is primarily for private hospitals, however in mental hospitals, a hold order issued by a court should have prior consent of the superintendent.

It was decided to ask the assistant attorney general to issue a bulletin as to which court has jurisdiction in the matter of issuing hold orders.

VIII. Other Business.

1. Legislative Commission on Welfare.

One of the main purposes of the legislative commission on welfare is to recodify the laws. The first meeting is planned for October 22 at which time Mr. Hursh would like to submit some names for an advisory committee to be created to study the psychopathic law. Dr. B. P. Grimes, and John Hawkinson are already on a committee which has done some work in this area. It was suggested that John Frank and John Gearty, Assistant County Attorneys of Ramsey and Hennepin Counties respectively, have the longest experience in this area and

could be considered as possible members as well as Judge Anselmo of St. Louis County.

Dr. Starke Hathaway, Judge Underhill of Virginia, Minnesota, and Judge Archer were also suggested, as well as Dr. Stanley Lindley at St. Cloud V. A.

2. The Procedure for Handling Isolation for Tuberculosis Patients or Patients who are Suspect.

Mr. Hoffman raised the question as to the proper method of cleaning up a room in which such a patient was cared for. If the room has one bed it is not difficult to clean up. It is not necessary to burn the mattress unless the bed has been extremely soiled. The usual procedure is to sun the mattress turning it over from time to time.

Anoka State Hospital uses soap and water and has an autoclave for mattresses. Hastings State Hospital, when a case is found in a 25 bed ward, uses ordinary housekeeping methods for decontamination and feel it is probably more important to check the other patients for possible infection.

3. Toilet Seats.

Dr. Cameron and representatives of the state architects office looked at toilets and toilet seats with a view to determining which were best suited for institutional use. It was felt that wall hung toilets with a concealed flush valve should be recommended for new construction. These can be obtained suitably drilled for a drop seat. If such were routinely purchased in the future there would be little trouble in shifting from toilets with drop seats to integral seats or vice versa as the changes in patient population dictate.

4. Medical Technologists' Meeting.

Dr. Cameron has received a communication from Dr. Kimball who said that it would be impossible to hold a fall meeting. Dr. Kimball will continue to work with the committee and suggested that they add some physicians to the committee. In the interim there are tentative plans to send two solutions to participating laboratories for checking. One is for glucose determination which is to be tested promptly and a second solution which will contain several components -- urea, chlorides, calcium and phosphorus, which can be tested within two weeks. These solutions and the instructions will be sent to the hospital superintendents attention of the laboratory, giving the name of the senior technician or technologist. It will be valuable to have this evaluation proceeding the workshop on instrumentation which will be scheduled for the spring of 1958.

5. Civil Defense.

Correspondence was had relative to the Civil Defense courses offered at Battle Creek. These courses were found to be geared primarily to public officials rather than hospital personnel.

6. The Role of the Consultant.

There was general discussion as to the role of the Central Office consultants and their relationship with the hospitals. The question of change in requisitions was felt to be a major problem warranting further discussion at the next superintendents' meeting.

IX. Selection of Next Meeting Place and Date.

The next meeting will be held at Anoka, September 15th.

X. Adjournment.

The meeting adjourned at 4:30 p.m.