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HOSPITAL ORGANIZATION AS SHOWN BY CHARTS OF PERSONNEL AND POWERS AND FUNCTIONS

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1 The doctor has so long been used to thinking in terms of one-man-power in his practice, and, in his hospitals on the basis of every service being independent of the others, that he does not take kindly to suggestions that bear on the analysis of his job, or of possibilities of redistribution and readjustment of certain parts of his work in accordance with present day industrial methods. "In this very personal matter of my relation to my people as human beings," says he, "I am the best judge." And he is right. But he wants to let his generally haphazard methods go at that. Perhaps he may, in his house-to-house calls. That is another story which I take up elsewhere. But in his institutional labors we cannot fail to note how often this "individual is lost in a maze of associated effort to meet the communal requirements."

2. This may not be true in some teaching hospitals, such as universities, but it is not an overstatement concerning the average institution. So much has been done on the administrative side to study finance, feeding, nursing, housing, and executive labors in general, and to chart and compare these, that it is time our professional department made an attempt to catch up. When one asks Johns Hopkins or Massachusetts General or the University of Minnesota for a diagram of the personnel or for their chart of the activities on the professional side, they seem to fail to understand exactly what one is after. Somebody, therefore, must construct a framework—however rude—for alteration and comparison. Institutions can start from these diagrams and construct their own. Thus, too, we can enlist the interest of the industrial engineers to help us clarify the situation. Its confusion is due to the necessarily intimate inter-relation between the various parts of the work—the executive with the medical and the various parts of the medical with each other—and to lack of study.

3 For example. Shall the surgeon or the superintendent discipline the house surgeon? Where is the dividing line between general surgery and the surgery of women? Between the ear surgery of the complicated mastoid and brain surgery? Who is to determine that this ear surgeon or this gynecologist has had sufficient drill in surgical technique to qualify for important operations? What department or individuals shall give orders to a nurse or an orderly? These are but samples of every-day decisions, not specifically worked out in most hospitals.

4 There is convenience in diagrams. Charts of a staff, its members and their duties, bear the same relation to the list in the front of the hospital year book and the by-laws as the maps of a property do to the lawyer's description of it. There are drawbacks to diagrams. They involve thinking and some study. Also, no one chart can show all relations and inter-relations at once without being confusing. Wherefore we begin with the most important relations and the details are tackled later. Having settled the main issues, the rest fall into place naturally and by degrees—provided there is patience and judgment and *esprit de corps*. The plan of action once determined, we define the directing authority, together with the subdivision of delegated authority in conformity with the branches of the organization; we recognize areas of discretion corresponding to the subdivision of authority; we stimulate loyalty to the common object, and we welcome inspection and fearless report of results.

5 Chart No. 1 A, shows the larger groups that make up a general hospital. It sketchily indicates the com-

[1] Exhibit before the Harvard Medical Club, New York, 1915, exhibit and paper before the Taylor Society, New York, December 8, 1916. Delay in publication due to the desire to get it before the medical profession. It has been declined by the leading hospital journal and also by our greatest surgical journal.