
# EP 01:
# The Genesis of the *Guidelines*: Doug Erickson
## —Transcript—

## Opening

**Doug Erickson**
I like to lead by getting good people in place and letting them do their thing. OK, I don't have to be recognized as. You know, Doug Erickson, you know, father of the *Guidelines*. I don't care about that stuff. It really has to do with the end product and the good that we have done.

**[Intro music: "Skip to My Lou" by Neal Caine Trio]**

**Bridget McDougall**
Welcome to *Between the Lines with FGI*, the podcast brought to you by the Facility Guidelines Institute. In this podcast series, we invite you to listen in on casual conversations related to health and residential care design and construction. Coming to you from Washington State, where the state dance is the square dance, is John Williams, FGI's VP of content and outreach and chair of the 2026 Health Guidelines Revision Committee.

**John Williams**
Yeehaw!

**John**
And joining from the great city of St. Louis, the first U.S. city to host the modern Olympics, is Bridget McDougall, associate editor with FGI. And we're both here because when we talk about designing construction of places where folks receive care, we've got a lot of questions and from what we've heard, you do as well.

**Bridget**
That's because there's a lot to be curious about under the umbrella of health care design and construction. We've got the codes that tell you how to build these spaces, right? But there's more there, between the lines, so to speak. And that's what we'll be exploring on this podcast with the help of invited guests and you along for the ride.

**John**
So, thanks for finding us, and let's get ready to read between the lines with FGI.

**[Music fades out.]**

## What are the *Guidelines*? Who is Doug Erickson?

**Bridget**
OK, so chances are your state has adopted some edition of the *Guidelines*, even if you're not entirely familiar with them. These minimum code standards have been around in some form since 1947, when they were called the General Standards for Hospital Construction and were part of the federal regulations of the Hill-Burton Act. I *am* curious as to why it's called the Hill-Burton Act, by the way, but I will look that up later.

**John**
Named after two senators, Harold Burton and Lister Hill, actually.

**Bridget**
Well, that's a great name. Lister. I do love it.

**John**
Isn't that the best? Fun fact: Lister Hill was named for Joseph Lister, pioneer of antiseptic surgery and who also had something else named for him. Care to guess what that was?

**Bridget**
I so badly want it for it to be Listerine.

**John**
Bingo!

**Bridget**
Really?

**John**
You got it. So, to the Hill-Burton Act itself, it was one of the most influential pieces of health care legislation of the 20th century. And although that act has effectively sunsetted, it's cast a

really long shadow. At one point, it had funded construction of a third of the hospitals across the entire country.

**Bridget**
And those general standards for construction, as they were called, have morphed and changed names over time to what is now the FGI *Guidelines*. Today, the *Guidelines* are still the most widely recognized guidance for planning and design health care facilities, and that includes hospitals, outpatient, and residential facilities.

**John**
In our first episode, we're so excited to tap into the history of how we got here with a guest that many of you know well, if not by name only, Mr. FGI himself.

**[Music fades in: "Skip to My Lou" by Neal Caine Trio]**

**Bridget**
Doug Erickson, the man whose name is synonymous with FGI and the man responsible for hiring me after we both served on a jury in 2019. True story. I am really looking forward to hearing from him.

**[Music continues then fades out.]**

## Welcome, Doug

**Bridget**
Welcome Doug Erickson. We're so glad to have you here.

**Doug**
Hey, Bridget. Hey, John. How are you today?

**Bridget**
Hey, doing great. Thank you.

**John**
Doing great.

**Doug**
It's exciting to talk about some of the beginnings and how we kind of came about to where we are today. I look forward to it.

## How did the *Guidelines* shift from a federal document to a privatized one?

**John**
We do too, Doug. So, let's start out by talking about how the *Guidelines* made that shift from a federally led document to a more privatized and privately led document that gets regular revisions based on public input and consensus voting.

**Doug**
Well, back in the mid-80s, I don't know, it was '84, '85, during the Reagan administration, they were deregulating a lot of things across the board. Well, one of the things they deregulated was by taking away the minimum construction requirements for hospitals and medical facilities. So, in 1985, I believe it was, '85, '86, Joe Sprague, Armand Burgun, and myself went to Washington, DC, met with the Public Health Service who was responsible for the document, and asked them if we could take the content and privatize it. If we didn't, they probably would have just gone off into neverland and we wouldn't be here today.

**John**
Was that the point where you came on board?

**Doug**
I actually started when I was with the Joint Commission back in 1978. It was a 15-person committee, mainly made up of regulators, either federal regulators or state regulators. And then as a result of my being with the commission, they asked me to join the [Health Guidelines Revision] committee.

## What could the dangers have been of not saving the document?

**Bridget**
So, what do you think the dangers could have been of not saving that document?

**Doug**
[The] danger would have been the fact that every state and every federal agency would have had to write their own standards, their own guidelines, their own minimum construction requirements. And we didn't want that. We wanted the consistency. We wanted to continue the trend of having one standard that states could adopt if they wanted to—or federal agencies could adopt.

## How do states adopt the *Guidelines*? Who uses this document?

**Bridget**
Can you describe a little bit about the adoption process and how the *Guidelines* are adopted for those who might not know?

**Doug**

There is no requirement for a state or federal agency to adopt the *Guidelines*. However, I think they recognize that since this is a national committee of experts, whether it's 110, 145, based upon the cycle that we're dealing with, a lot of states that participate on the *Guidelines* or that know about the expertise that goes into designing and developing the *Guidelines* kind of look at this and go, "Why would we not want to adopt yours?" And if we do adopt it, maybe there's a couple of amendments we have to make because of some state-specific requirements, whether it's in a weather-related modification that needs to be changed, whether it's a state legislature requirement that needs to be changed because there's something within the state that has to be accounted for.

**John**
Or maybe you live in a state with a lot of volcanoes, like Washington State, or a state with a lot of hurricanes flying over like Florida.

**Doug**
Yeah, exactly, John. It's the regional or the state-specific amendments that really make it, I think, even a stronger series of documents because you got the baseline and then you throw on whatever those states have that is unique to the state. Then, of course, we've got the Indian Health Service that adopts our *Guidelines*. We've got the VA that uses it as another set of requirements; DOD, the same way. They don't officially adopt, but you can pretty much say that when the architects and engineers get their request for proposal, it does say follow the *Guidelines*, even though it's not in a federal law for DOD, VA, et cetera.

## What are some of the significant topics you've seen addressed in the *Guidelines*?

**Bridget**
So, Doug, talk to us about some of the most significant topics that you've encountered over the past 50 years, specifically things that have impacted the patient experience—how the patient experience has improved due to adoption of the *Guidelines*.

**Doug**
Well, I think that the biggest one and the one that I will never, ever forget is, of course, going to single-bedded medical surgical rooms. And the fact that it took us 10 years, three cycles, with a lot of debate on both sides as to whether or not we should make that leap and actually codify going to single bedded medical surgical bedrooms.

I can tell you that there was significant discussion on both sides. I can hear Mr. Burgun saying right now from the front of the room, "How many of you—raise your hand please—how many of you would accept going to a hotel, checking in, and being told, 'Well, John Williams is going to be your roommate for the next couple of days?'"

**John**

Right, because I snore, and nobody wants to hear that.

**Bridget**
[laughs]

**John**
However, to your point, patient safety and the patient experience is improved when rooms are not shared. And regardless of whether you're sharing that with a snorer or a sound sleeper, still, that was a pretty big shift back in the *Guidelines*, as evidenced by the 10 years that it took to reach consensus there.

**Doug**
Oh, we probably killed thousands of hours of discussion, looking at both sides of the coin, and it was finally decided—and it was a consensus, of course—to go to single-bedded rooms.

**Bridget**
So, you make a good point about things that patients experience that are a direct result of the *Guidelines* that perhaps we don't think about that as we're a patient in the room. We're not sitting there in a single patient room thinking, this, thank goodness, this is because of the *Guidelines*. But what are some other things that patients might be experiencing that are a direct result of the changes in the *Guidelines*?

**Doug**
Oh gosh, there are quite a few of them. I mean, the whole thing with the safety risk assessment, getting it right for both mental health, for patient falls, for patient movement. I mean, all these things, noise and acoustics. . . .The *Guidelines*, through the development of the acoustic requirements in the chapter on acoustics, has significantly raised the bar. I mean, these are all things that enter into that patient experience.

In the safety risk assessment, the couple of ones that really stand out, of course, are infection prevention, in which I do believe the *Guidelines*, and along with some of the other societies, such as the American Society for Health Care Engineering, et cetera, and APIC and some of the others have really gone after.

## When did the infection control risk assessment (ICRA) enter the picture?

**John**
Nobody had heard of infection control risk assessment or ICRA back in the '90s. What's your memory of how that whole risk matrix came to be?

**Doug**
Well, it was about 1988 and Judene Bartley, Andy Streifel, and myself were doing a lot of road shows together. Judene talking about, of course, infection prevention; Andy talking about

water quality, air quality; and myself talking about all of the codes, the standards, life safety code, et cetera. And it was just, we were probably sitting around having dinner and it was, we really need to do something—[such as to] put together a national program on trying to reduce the nosocomial infections, they called it back then, now health care-associated infections today.

And a lot of it has to do with modifications, of course, to the physical environment, and then also modifications to how we construct, whether it's renovation or new construction that's being tied into or attached to an existing facility even within air; you know, the infiltration of dust as a result of a building going up adjacent to or in the case of Riverside, California, it was one of the universities had a field directly across from the hospital. And they would plow that field two or three times a year. And they lost eight patients because the building was under negative pressure, and they were pulling in the dust from the plowing of the fields across the street from the hospital.

**John**
And that does contain aspergillus and all sorts of other fungi.

**Doug**
That does contain [it]. Yes. Yep.

**Bridget**
So, the infection control risk assessment is a tool to be able to address a situation like that.

**Doug**
Oh, absolutely. It is not something that is just applied when you start construction. It's being applied as you're planning the building.

**John**
And it's funny too, because when people talk about ICRA, most of what they think about are those preconstruction or those construction-based risk mitigations like sticky mats and temporary barriers. But the ICRA is more than that. It's the number of isolation rooms that you need, the number of sinks and locations and things like that: design-based infection control assessments.

**Doug**
Mm-hmm. Right. Where do you put pediatrics in association with chemotherapy or pediatrics in association with maybe other oncology or with the operating rooms? It's that whole flow through the facility of all of the visitors, the staff, and the patients and making sure that one element of your patient population doesn't infect other patients within that patient population.

## What are other areas where the *Guidelines* has had a big impact?

**John**

Is there anything else that jumps out to you as thinking, hey, this is a time where we really move the bubble on patient care and patient outcomes?

**Doug**
I think the most recent one was the whole issue of low acuity pods within the ED. And I think as that starts to become more mainstream, that's going to have a huge effect on the patient population. If you are a low-acuity patient and not being moved into an exam room or a procedure room, I think that has a huge impact on the quality of health care and also the patient experience.

**Bridget**
Yeah, right, because those patients with minor injuries or conditions that don't require gurney or bed don't have to wait around—right—for that gurney or bed or treatment room to become available. So, they can be cared for in a more efficient space.

**John**
Doug, you've talked about several things in the *Guidelines* that directly impact patient experience. You talked about single patient beds, low acuity patient care areas, the ICRA—or infection control risk assessment—noise, acoustics, mobility, safety risk assessments. When we asked about how the *Guidelines* have moved the bubble on patient care and outcomes, that's a significant amount.

## How long does it take to be fluent in the *Guidelines* language?

**Bridget**
You have a ton of knowledge, Doug. You've got the whole history of the *Guidelines* as we know it in your brain, right? For somebody who's new and starting off, it can be pretty intimidating to walk into this environment and look at all the knowledge that's there and all that's going on and wonder, "How long is it gonna be before I get caught up to speed and understand?" So, in your experience, how long does it take to get fluent in the *Guidelines*?

**Doug**
In the past, it would take almost a good cycle for people to get comfortable with participating as an active member of the HGRC. And John serves on a lot of other committees as I served on probably 25 different national committees over the years. And I can tell you the first time I walked into the National Electrical Code, panel 17, it took me a cycle to learn who people were and how to get myself kind of put into the discussions.

**Bridget**
You talk about it taking a cycle—and for those who haven't been involved in the revision process, a cycle is four years, right?—if you include the year that editorial staff is preparing the document for publication. And that's really true for me. It took a good four years for me to feel

like I am finally fluent in the language of the *Guidelines*. So *be patient* is what I hear you saying. Any other tips for new folks?

## What advice do you have for those new to the *Guidelines*?

**Doug**
If I had to say something to an incoming member, it's get with staff, get yourself a mentor, and then ask questions. There's nobody on staff or within the HGRC that won't take time in order to answer your question, deal with your situation, whatever the case might be. So, it's really: be active, and don't let the process scare you. Don't let the people scare you.

**Bridget**
Well, I mean, some people.

**Doug**
Some people, exactly. [laughs]

**John**
Right.

**Bridget**
I mean, listeners can't see that I'm looking at both of you, but there's nothing scary about either of you at all.

[laughter]

**Doug**
Yeah.

**John**
Right.

**Bridget**
You heard it from the man himself, Doug Erickson, as imploring, imploring folks new into their fields to get involved. We're here to help you do that.

**[Music fades in: "Skip to My Lou" by Neal Caine Trio]**

## Wrap up/Goodbye

**Bridget**

Well, Doug, I hope that you know how important you are to all the people that you've been involved with over the years in different committees, and to the patients that have a good experience because of the *Guidelines* that may not know your name or know you personally, but really that in some way, shape, or form, you have been a strong thread in the fabric of this work and we are also appreciative to you.

**Doug**
I appreciate that, Bridget. It's just been such a pleasure and a joy, quite honestly, to have been in this business for 55 years. It has been a wonderful, wonderful career.

## Outro

**Bridget**
Thanks for joining us for this episode of *Between the Lines with FGI*. Have an idea for an episode? Get in touch with us by writing to podcast@fgigidelines.org.

**John**
And if you're interested in becoming a sponsor for one of our episodes or a series of episodes, you can also reach out to us at podcast@fgiguidelines.org.

**Bridget**
Thanks to Neal Caine and the Neal Caine Trio for the use of his song "Skip to My Lou" from the album of the same name.

**John**
Join us next time as we go *Between the Lines with FGI*. Bye, everybody.

Bridget
See you next time!

**[Music fades out.]**