

THE MEANING OF MONEY LAUNDERING IN BUSINESS LIFE AND THE PREVENTION OF IT

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ABSTARCT

Money laundering is the process whereby the proceeds of crime are transformed into ostensibly legitimate money or other assets. The actuality of the subject derives from the Select Committee on the Evaluation of Anti Money Laundering Measures aided by the Financial Action Task Force. Money obtained from certain crimes, such as extortion, drug trafficking, illegal gambling and tax evasion through off shore companies as "dirty". The reason of the Committee program is to give aides to those countries which were not FATF members as money laundering is the most profit yielding business on the world with it's 2800 milliard USD turnover. This organization controls Hungary by supervising the law and overall actions giving a so called Progress Report about the achievements.

In aspect of criminal affairs Money laundering includes all activities which achieve to transform the origin of funds coming from criminal activity as well as tax evasion activity into a legalized form. Money laundering as a phenomenon became a global problem in the second half of the 20th century parallel to sudden increase of drug trafficking. In the past few decades money laundering and the chain of criminal activities as underlying offences got into the scope of the leading economic states. Those activities of money laundering maximally exploit the free movement of capital and financial services. In both the economy and political life there is a need for having laws and regulations against money laundering which rigorously regulate the different financial, bank supervisory activities. According to estimations in the nineties three hundred billion dollars were circulating annually across the world in order to be laundered. Nowadays this figure is well over thousand billion dollars.

Keywords: money laundering, financial action task, terrorist financing

1. INTRODUCTION

Anti-money laundering (AML) is a term mainly used in the financial and legal industries to describe the legal controls that require financial institutions and other regulated entities to prevent or report money laundering activities. Anti-money laundering guidelines came into prominence globally after the September 11, 2001 attacks and the subsequent enactment of the USA PATRIOT Act.

Today, most financial institutions globally, and many non-financial institutions, are required to identify and report transactions of a suspicious nature to the financial intelligence unit in the respective country. For example, a bank must perform due diligence by verifying a customer's identity and monitor transactions for suspicious activity. To do this, many financial institutions utilize the services of special software, and use the services of companies such as C6 to gather information about high risk individuals and organizations. United States federal law for example related to money laundering is implemented under the Bank Secrecy Act as amended by anti-money laundering acts up to the present. Many people have confused Anti-Money Laundering (AML) with Anti-Terrorist Financing (ATF). Under the Bank Secrecy Act of USA, Money Laundering and Terrorist Financing are classified when financial institutions file Suspicious Activity Reports (SAR) to Financial Crimes Enforcement (FinCEN) which is a US government agency. To effectively implement AML and ATF measures, The US government encourages financial institutions to work together for AML and ATF purposes in accordance with Section 314(b) of the USA PATRIOT Act. However, since financial institutions are required by law to protect the privacy of their clients, section 314(b) cooperation has not been generally adopted by financial institutions. To overcome this obstacle, the United Crimes Elimination Network (UCEN) has been established by AML and ATF professionals to achieve this global cooperation goal in compliance with the privacy laws of most countries.

Different countries, depending on the activity, demand different actions [1], [2]. For example; in the US a deposit of US\$10,000 or more requires a CTR (Currency Transaction Report), in Europe it is EUR 15,000, and in Switzerland it is CHF 25,000 in Hungary it is 3,600th HUF requires full identity control. In some countries there is no CTR requirement. Suspicion of ML activity in the US requires the submission of a SAR, while in Switzerland a SAR will only get filed if that activity can be proved. As a result, thousands of SARs are filed daily in the US, while in Switzerland the rate is much lower.

2. FATF: FINANCIAL ACTION TASK FORCE AGAINST MONEY LAUNDERING

Formed in 1989 by the G-7 countries, the Financial Action Task Force on Money Laundering (FATF) is an intergovernmental body whose purpose is to develop and promote an international response to combat money laundering. In October of 2001, FATF expanded its mission to include combating the financing of terrorism. FATF is a policy-making body, which brings together legal, financial and law enforcement experts to achieve national legislation and regulatory AML and CFT reforms. Currently, its membership consists of 31 countries and territories and two regional organizations. In addition, FATF works in collaboration with a number of international bodies and organizations [2.] These entities have observer status with FATF, which does not entitle them to vote, however permits full participation in plenary sessions and working groups. FATF's three primary functions with regard to money laundering are:

- i. Monitoring members' progress in implementing anti-money laundering measures
 - ii. Reviewing and reporting on laundering trends, techniques and countermeasures, and
 - iii. Promoting the adoption and implementation of FATF anti-money laundering standards global
- The Financial Action Task Force on Money Laundering (FATF), also known by its French name Groupe d'action financière sur le blanchiment de capitaux (GAFI), is an inter-governmental body founded in 1989 by the G7. The purpose of the FATF is to develop policies to combat money laundering and terrorist financing. The FATF Secretariat is housed at the headquarters of the OECD in Paris. FATF Associate Members include

The FATF currently comprises 34 member jurisdictions and 2 regional organizations, representing most major financial centers in all parts of the globe. – Argentina, Australia, Austria, Belgium, Brazil, Canada, China, Denmark, European Commission, Finland, France, Germany, Greece, Iceland, India, Ireland, Italy, Japan, Netherlands, Luxembourg, Mexico, New Zealand, Norway, Portugal, Russian Federation, Singapore, South Africa, Spain, Sweden, Switzerland, Turkey, United Kingdom, United States.

The Financial Action Task Force (FATF) is an inter-governmental body whose purpose is the development and promotion of policies, both at national and international levels, to combat money laundering and terrorist financing. The Task Force is therefore a "policy-making body" which works to generate the necessary political will to bring about national legislative and regulatory reforms in these areas.

Since its creation the FATF has spearheaded the effort to adopt and implement measures designed to counter the use of the financial system by criminals. It established a series of Recommendations in 1990, revised in 1996 and in 2003 to ensure that they remain up to date and relevant to the evolving threat of money laundering that set out the basic framework for anti-money laundering efforts and are intended to be of universal application.

The FATF monitors members' progress in implementing necessary measures, reviews money laundering and terrorist financing techniques and counter-measures, and promotes the adoption and implementation of appropriate measures globally. In performing these activities, the FATF collaborates with other international bodies involved in combating money laundering and the financing of terrorism..

3. HISTORY OF THE FATF

In response to mounting concern over money laundering, the Financial Action Task Force on Money Laundering (FATF) was established by the G-7 Summit that was held in Paris in 1989 [3]. Recognizing the threat posed to the banking system and to financial institutions, the G-7 Heads of State or Government and President of the European Commission convened the Task Force from the G-7 member States, the European Commission and eight other countries.

The Task Force was given the responsibility of examining money laundering techniques and trends, reviewing the action which had already been taken at a national or international level, and setting out the measures that still needed to be taken to combat money laundering. In April 1990, less than one year after its creation, the FATF issued a report containing a set of *Forty Recommendations*, which provide a comprehensive plan of action needed to fight against money laundering.

In 2001, the development of standards in the fight against terrorist financing was added to the mission of the FATF. In October 2001 the FATF issued the *Eight Special Recommendations* to deal with the issue of terrorist financing. The continued evolution of money laundering techniques led the FATF to revise the FATF standards comprehensively in June 2003. In October 2004 the FATF published a Ninth Special Recommendations, further strengthening the agreed international standards for combating money laundering and terrorist financing - the *40+9 Recommendations*.

4. BACKGROUND ON THE MONEYVAL

In 2002, the PC-R-EV formally changed its name to MONEYVAL. MONEYVAL was established in September 1997 by the Committee of Ministers of the Council of Europe to conduct self and mutual assessment exercises of the anti-money laundering measures in place in Council of Europe member states, which are not members of the Financial Action Task Force * (FATF). The effort includes encouraging jurisdictions to improve their anti-money laundering measures in keeping with the FATF Forty + 9 Recommendations and to enhance international co-operation. Currently 28 Council of Europe member States are evaluated by MONEYVAL. In 2006 the Committee of Ministers accepted the application of the State of Israel to join MONEYVAL's terms of reference and Israel has since been evaluated by MONEYVAL. MONEYVAL also engages in a regular typologies exercise focused on the methods and trends of money laundering activity.

MONEYVAL takes into account the practices and procedures of the FATF in its work. MONEYVAL is a sub-committee of the European Committee on Crime Problems of the Council of Europe (CDPC). Each of its member countries is entitled to appoint three experts to MONEYVAL [4]. These individuals are selected based on their expertise in legal issues related to national and international anti-money laundering instruments, supervision of financial institutions, and law enforcement matters. There are thrice-yearly Plenary meetings of the Committee at which the national experts consider and adopt draft mutual evaluation reports and follow up reports of evaluated members of members. Additionally, the MONEYVAL membership also includes experts from the past and current Presidency of the FATF and four scientific experts appointed by the Secretary General.

When MONEYVAL (then called PC-R-EV) was formed in 1997, a document containing the terms of reference for the Committee was agreed at the same time. The Terms of Reference have since been amended to extend the mandate of the Committee until 31 December 2010. The amended Terms of Reference also permit FATF member countries to participate as observers in the work of the Committee.

5. ASPECTS FOR EU MEMBER STATES

The European Union is also active in the formation of institutional system against money laundering [5]. On the basis of the FATF recommendations it has adopted its directives that have to be implemented by the EU member states. In Hungary the Parliament adopted the Act CXXXVI of 2007 on the Prevention and Combating of Money Laundering and Terrorist Financing (AML/CFT Act) that implements the Third EU AML/CFT Directive (Directive 2005/60/EC of the European Parliament and of the Council on the prevention of the use of the financial system for the purpose of money laundering and terrorist financing) into the national legislation. The EU directive 2005/60/EC "on the prevention of the use of the financial system for the purpose of money laundering and terrorist financing" tries to prevent such crime by requiring banks, real estate agents and many more companies to investigate and report usage of cash in excess of €15,000. The earlier EU directives 91/308/EEC and 2001/97/EC also relate to money laundering. The European Union is currently negotiating a New 4 th Anti – Money Laundering Directive that will change the nature of anti-money laundering compliance across the European Union.

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THE OPERATION OF AN EMERGENCY MEDICAL DEPARTMENT IN A COUNTY HOSPITAL FROM A LOGISTIC POINT OF VIEW

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ABSTARCT

The purpose of this article is to give an overview of the actual emergency medical attendance through an exemplary hospital in Hungary, highlighting its possible imperfections which could perhaps be improved through further structural developments. In order to be expressive, the article follows through the journey of two nominal patients who turned up in the emergency department of the hospital. The importance of this topic is expressed by the fitful judgment of the emergency attendance. Emergency service had already existed in the United States, only later then did the one-entrance service system start to develop Hungary. In some places this system has been working well for decades, but for instance at the University of Szeged – due to the uncertain judgment of the system – the construction is just being finalized, right at the time when such studies are published that question the reason of existence of the emergency departments – at least in their actual form.

Keywords: emergency, logistics, hospital, Székesfehérvár, medical care, SBO EMD

1. INTRODUCTION

The annual patient traffic of the department of emergency medical care at Fejér Megyei Szent György Egyetemi Oktató Kórház (Fejér County Saint George University Teaching Hospital) [7] in Székesfehérvár is 33.000 persons, as it can be read on the hospital's website.



Figure 1. Fejér County Saint George University Teaching Hospital [7]

The source states that the total number of the population attended by it is 420.000 persons. It can be concluded from these two numbers that each twelfth person of the population concerned, which is 4,2% of the country's total population visit the emergency unit every year. According to the data it means 92 patients daily, around the clock, let it be a weekday, weekend or holiday. However, this number is experienced to show an outdated state. In the last six months or year there was hardly a day when the patient traffic was under a hundred. The number of the staff for this number of patients is distributed in the following way. Three of four surgeries work steadily. There is a doctor and an assistant in each of them. As a regular basis, in the fourth surgery there is a doctor in the most frequented period from the aspect of patient traffic: between noon and eight p.m. This time one of the assistants, for practical reasons the one in the middle surgery, works both in his/her own and in the fourth surgery, too. To understand this logic we are sketching the spatial location of the department, especially the surgeries. Coming from the entrance the doors of three surgeries open on the left, while the fourth from the right. The three surgeries on the left are joined by doors. So, when the fourth surgery operates actively, the temporary lack of the nurse in the middle surgery is compensated by the two assistants in the side surgeries. The triage nurse (expert in the first-aid rescue who assesses the general status) is the organic part of the staff. Besides doctors and nurses,

it would be fairly difficult to define the number of staff because they do not belong to the department directly. The hospital porters are assigned centrally but they, together with the cleaning staff, work in a continuous shift of 0-24. In case of a patient traffic of this kind it can be stated with reason that the department can work only in a well-organized structure which has not only financial and human resources conditions. It is also a fluently operating logistic system which, in this case, is not employed in securing pharmaceutical products and appliances though it is of the same importance, it is not specific from the view of the department of emergency medical care-but it sorts out the patients coming. The importance of the topic is emphasized not only because of the suitable use of hospital resources but it is underlined from the patient's aspect, as well, since the emergency unit – 'nomen est omen' – gives a quick treatment, even though originally the name itself would not refer to it. It can be concluded that it generates of dissatisfaction of high level if the patient has to wait long hours in the department waiting room.

2. THE SUBJECT IN DETAILS

The task of the Emergency Medical Department /EMD/ (in Hungarian Sürgősségi Betegellátó Osztály /SBO/) [8] – which has been formulated by themselves for themselves, is 'to accept patients with or without a referral, arriving either on foot or in ambulance twenty-four hours a day. Regardless of the referral or the way of the arrival the EMD complete an assessment of general status.' It also means that for the department this assessment, apart from the patient's status (explained later), is absolutely a loss of resources either in money, in human resources or in time, even though it is not in unit or the same degree. To sort out the cases which are more urgent than the other urgent or the totally groundless ones it requires highly-qualified experts with serious experiences. First, we are aiming to show the way in two separate fictitious cases which the patient go through until he/she leaves the department [5].



Figure 2. The entrance to EMD [8]

2.1. The first case

The first case is a young female patient in her thirties whose stomach starts to ache at home on Friday. The painkiller stops the stomachache at home but it reappears again and again during the weekend. The pain is durable first with one dose of painkillers and then with a double dose, so she spends her time with her family comfortably in an armchair. Then, on Monday morning when she wants to go to work her pain is still there which disturbs her in her activities so the 'well-informed' woman, who knows the tasks of the emergency department fairly well, decides to go to the EMD of the hospital. She leaves her home accompanied with her partner by car; the parking lot is about 150 meters away from the hospital, so they have to walk to the entrance. Entering the building they go to the reception right next to the entrance. Here, the patient gives her social security card to the officer sitting in front of the computer, and then they are asked to sit down in the waiting room. At 8.30 a.m. on Monday morning there are around 10-15 patients together with their relatives in the waiting room. In the meantime, the details about the patient are entered into the computer. So far, there is no information about it, it should be waited. The door of the triage room opens, the patient is called. The woman enters, and the assistant there asks her what the matter is. Her name, the date of birth, the security card number are written on the left upper corner of an envelope, which will contain every single document of the patient, the arrival time in the middle, while the complaint in the

right upper corner. According to the patient's story the following sentences are written there: 'Stomachache for 3 days. No vomits. No diarrhea [3]. After a few compulsory questions or in the meantime, regarding the number of patients in the waiting room, the nurse does the ECG which she puts into the envelope, measures the patient's oxygen saturation and blood pressure which values are written on the envelope. Then it is followed by the most important mark which is written next to the previous data, under the arrival time: IV. It is the triage nurse's task to sort out the patients on the basis of the questions and basic parameters. The cases which need immediate treatment belong to group I, while the not so urgent ones to group IV. Cases between them belong to groups II or III. After that our female patient is asked to take a seat in the waiting room while the triage nurse carries the envelope into one of the central surgeries. By 'central' I mean that from this surgery the doctors can enter two of the four ones, so it is easily accessible for them. Here, the nurse puts down the envelope on the pile of the ones marked with IV. The patient has to wait until one of doctors seizes the envelope with her name on it and takes it into his/her own surgery and asks her to enter there. So, it is important to know the logistics of envelope picking. From this aspect the complaints written on the envelope, blood pressure, oxygen saturation or the age of the patient are not important. There are two factors which the doctor weighs: the number which shows the state of urgency and the arrival time. To make the things simpler, we disregard the case that if there is a cardiologist working in one of the surgeries, it is obvious that the patient with complaints in the chest will be examined by him/her, in spite of fact that a case like this can be treated by everyone working there. So we suppose that each doctor going to the table with the envelopes has a specialist examination on emergency medical treatment. The selection in the first round is done by the HiFo system so the doctor chooses the case with the highest emergency grade. It is a small but solvable contradiction that the highest grade is the grade I and as this number rises so the grade of the emergency decreases. What happens in case of equal points? Then they change to the FiFo system which means from cases with the same emergency grade they choose the one which arrived earlier. Our patient who has a stomachache and was sorted to the grade IV has to wait until each case with grades I, II, III and also those who arrived earlier are examined. Naturally, each patient with grades I, II, III who arrives in the meantime changes this potential order. After our patient gets into the surgery which actually takes around an hour the doctor queries her, uploads the anamnesis into the computer, examines her and then takes notes about the present status of the patient. Then, he/she tries to arrange the necessary examinations. While the assistant takes a specimen of her blood, the doctor orders the laboratory tests via the computer system. It is the hospital porter who carries the test-tubes with the blood to the hospital's central laboratory from where the results will be shown for the doctor on the computer. Besides, the doctor sends the woman to an abdominal ultrasonic examination because of the pain in her stomach. He/she orders the desired examination via the computer network, the patient is accompanied by the hospital porter to the hospital's radiology where they complete the examination, and then the doctor can see the results on the monitor, ideally even when the patient is again in the waiting room of the department. Obviously, during these examinations the doctor begins other cases, as well, since there should be no dead time, so it can easily happen that the doctor treats five or six patients at the same time. Obviously, it means that the female patient with a stomachache cannot enter to the doctor immediately after arriving back from the ultrasonic examination, since he/she queries or examines the other (third or fourth) patient and arranges the next steps of his/her diagnostics. For the patient it is naturally a wasted time and probably not the only one. When she enters to the doctor again, he/she knows the results though he/she cannot close the case and asks for a medical consultation with a surgeon. While she waits for the specialist, she sits in the waiting room and the doctor is occupied with the next patient. When the surgeon arrives, the woman enters the surgery again; they examine her stomach, but do not find a severe, urgent inflammation or intestinal obstruction. The patient takes a seat in the waiting room again. Her emergency practitioner is aware of each information after the surgical consultation to state that the present menstrual spasms, revealed at the time of anamnesis, are in the background of the symptoms, so after the necessary documentation the patient can leave for home.

2.2. The second case

Our second patient is a man in his sixties whose side, while raking in their garden in Dunaújváros, weakens unexpectedly and then he falls down. His wife runs to him but the man can neither understand her words nor talk though he is seemingly attentive. She calls the ambulance that arrives to him in a short time. After assessing the patient's status they have to decide where to take the man. Before the era of emergency departments, the one-gate patient traffic the paramedics had to decide which hospital and which department they should take this man. It is an easier decision where the out patients' departments were within the same

building, or in a fortunate case, next to each other but for example, in the clinic of the University of Szeged the department of neurology is not even in the same campus than those of surgery or internal medicine [6]. The system of one-gate emergency departments surmounts this situation where, regardless of what symptoms the paramedics observe, they take the patient directly to the EMD and the specialists are asked to go there to examine the case. Anyway, it is only the psychiatry which does not belong to this system for several professional reasons. In the present case, in this system, which does not cover the whole country, the paramedic has to decide where to take the patient for completely another reason. Using his professional experience and knowledge he/she assessed that the man has stroke. While the general neurologic care is accessible in most hospitals countrywide, so is in the hospital of Dunaújváros, but the stroke centre which gives a specific therapy – using systematic intravenous thrombolyses – can be found in Székesfehérvár, as the nearest. So the paramedic decides and goes directly to the Town of Kings. At the arrival the paramedics say that they have brought a patient and the triage nurse immediately sorts him as grade I. After a doctor examines him and ascertains that the symptoms started fifty minutes before, he starts to arrange the aforementioned lyses which has to be given to the patient within 4,5 hours. It is when the logistic race with the time starts. Preparing for the lyses, the patient is taken to the intensive department of the EMD. It is important to mention here that the process detailed as follows is accomplished even though a part of the candidates for the lyses does not get the treatment because of the contraindications revealed during the process. Now, I will not detail these professional principles. They take a specimen of the patient's blood for the further laboratory tests in the intensive department of the EMD. Meanwhile, a cranium CT-examination is asked in agreement with the cardiology, where the hospital porter takes the patient and the doctor working in the intensive department calls the neurologist working in the building three hundred meters away from him/her. By the time the neurologist finishes the call, the CT-images are in the computer system, in an ideal case, so he/she can observe them. If he/she sees bleeding, the lyses is contraindicated and order the patient to the department. The hospital porters take the patient with vehicles for ambulance service between the buildings, so he leaves the emergency department. If no bleeding can be seen on the CT, the neurologist heads to the emergency department. He/she examines the patient and the laboratory results and decides if the lyses can be started. If so, the patient will stay in the intensive department of EMD for the following 24 hours. The dosage of the specific medicine is followed by the time of observation of this length. Then, a new cranium CT-image is taken then the patient is taken to the neurology department by the aforementioned hospital porters and their vehicle.

2.3. Solutions

In the cases detailed above the improvement of the logistic system is of more components. In the first case, the purpose is to decrease both the waiting time and the burden put on the doctors working in the department. In the second case, the main point is to allow the patient to have the specific therapy as soon as possible due to the extremely time-sensitive factor of the treatment.

Decrease of the waiting time is a crucial issue in other hospitals abroad, as well. Some of them present this data as the most important value of the patient's satisfaction. The Dutch University of Twente in Enschede set as an aim in their 2012 study that they intend to decrease this value in opposition of the principle that development of the network of medical advisers can relieve the emergency departments thus lessening the waiting time. They started from factors which they can influence by the structural and organizational transformation of the local EMD. They found out that a simple method like the practice that it is the triage nurse who orders the necessary laboratory tests lessened the gross (the total) waiting time with almost 9,5 minutes [2]. It increased the time spent at the triage nurse with only one and a half minute. The same study emphasizes the simple fact that the practical outlay of the EMD can decrease the waiting time, too. It is easy to imagine that the neurological consultation is slower in the hospital of Székesfehérvár since the neurologist starts from a street-like distance than if there were a neurologist working steadily in the emergency department. On the basis of similar principles, the Dutch study underlines the importance of surgeons as they have observed that they are needed for the 54% of the cases. [2] Though there is no similar survey in the Saint George Hospital, the workers in the EMD think that this high rate is not experienced there. Forcing the defensive medicine back would decrease the waiting time but it also would have a financial consequence, too. The menstrual spasm of the female patient with a stomachache seemed to be potential even at the time of anamnesis; nevertheless she was given a thorough examination.

In case of our elderly male patient with a stroke the change in logistics may arise in a completely different field, actually in the ambulance level. Since it can easily be asked if the paramedics recognize the situation, namely the patient has embolism in the brain and has to be taken to the stroke centre, why should not they

transport him directly to the hospital? Probably, the requirements according to the professional rules are provided in a better level in the intensive unit of the emergency department. Would not it be worth improving the infrastructure in order to decrease the loss of time?

These are special cases, however, in general we have to refer back to the roots of the problem, namely to the basic health care. The Hungarian studies on this subject claim without doubt that the present emergency service is not efficient the reason for which have multiple sides. Among others, the number of groundless claims is high which happens because the population is under informed and they have a kind of 'I deserve it'-attitude [4]. The professionals often experience parallel alarms when both the doctor on duty and the ambulance are called at the same time. Turning back to the professional field, the study finds the number of the present professional principles low. A well-formed protocol which meets the highest professional requirements can certainly improve the service [1].

3. SUMMARY

The present emergency medical attendance is not efficient enough according to both the Hungarian and international specialized literature or at least it could be organized in other forms. Simple modifications, like that the triage nurse orders the laboratory tests, can improve the efficiency to a greater extent, other developments of large volume like for example, the transformation of the system of family doctors would increase efficiency in an unacceptable degree. We think that one of the most striking problems is that the present emergency departments have been established in old building complexes. It means that the disunity of the specialized areas of medicine – for example the distance of the neurology department from the main building in Székesfehérvár – results in serious logistic problems for both the doctors and the patient.

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