

Case 13

A Personal Memorandum on Hospital Experience

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Recently, I spent some 17 days in a hospital of very fine repute, indeed, one of the finest medical centers of the East. While there I underwent two surgical assaults on my system and had sufficient time to do some observing from a patient's point of view.

I occupied a semiprivate room and enjoyed the company of one roommate during my entire stay. My roommate was a man 72 years of age, in the hospital receiving treatment for metastatic carcinoma of the esophagus. While he had been in this country for some 30 years, his command of the English language was not good; indeed, he was most comfortable speaking in his native German. He was fully ambulatory and received cobalt therapy daily. His esophagus was somewhat obstructed so that it was necessary for him to subsist on a bland and liquid diet.

In contrast to my own situation he was very much alone. His wife had passed away four months earlier. They had been childless. A dog which they had had for 16 years had died about five or six months before his wife passed away. He had a sister in New York, a brother in Florida, and a brother in Australia. His sister visited him once a week, and he received mail at least every other day.

This, then, was the environment in which I resided while recovering from two operations performed a week apart. These observations are in no way meant to suggest that the situations I encountered were the case in all situations, or were necessarily typical throughout this one hospital. I was stimulated, however, by this experience to reflect upon the meaning of hospital care for some patients and the impact of various aspects of hospital operation on the consumer of hospital service.

On Admissions

I had been told that I was to be at the hospital at 10:30 a.m. to be admitted for hospitalization. I arrived shortly before that only to learn that hospital admissions were scheduled for 11:00 a.m. I was asked to have a seat in a very pleasant lounge, and I thereupon waited for about an hour before I was called by an admitting clerk. The admitting clerk took the usual information and received the customary authorizations for treatment, waivers, etc. She was most pleasant and told me that it would probably be some time before the room would be ready. In this case she suggested that I might want to go down to the snack bar and have a cup of coffee and otherwise relax. I took her advice, and about 45 minutes or an hour later my name was called and I was escorted to my room.

Upon arriving at the room I found that the bed was not made, the floor was not swept; indeed, it was visibly dirty. I was told I might want to go up to the lounge and wait, which I did. Subsequently I returned to the room and found the bed had been made. The floor was still dirty. I asked the nurse if I should change into pajamas and was told to do so. At no point did anyone tell me what the routine might be that first day or ask if I had any anxieties about my hospital admission. There appeared to be no awareness of this by anyone on the floor. It would seem to me that there are a number of patients who arrive at their hospital room quite anxious about what is going to happen, perhaps somewhat awed and afraid of this new environment, who could benefit substantially by having a nurse come in, introduce himself, and explain what the general routine for that particular day might be, including the request for specimens, the taking of blood, when the physician would visit, some explanation about meal service, and some offer to explain whatever the patient might not understand. It may be thought that the very nice brochure that the hospital had prepared was sufficient. However, I would venture that the personal contact, and whatever suggestion of reassurance might be offered, would be helpful to many patients.

On Design

I was struck by the severe inadequacies of design in this facility. The room, which had been designed for two beds, as manifested by the two fixtures for piped-in oxygen, the recessed cubicle curtain rods, and the

two call bells, was decidedly undersized. I learned this, to my discomfort, upon my return from surgery on two occasions when an inordinate amount of jockeying and bumping of the surgical litter took place to put it next to the bed. To make room for the litter, several pieces of furniture had to be moved: my roommate's bed, my bed, my roommate's bedside table, and one of the two easy chairs in the room. The only pieces of furniture in the room that were *not* moved were the other easy chair and the two bedside cabinets.

Apart from this inconvenience, I would point out that my bed was generally no more than a foot and a half away from my roommate's. The other side of my bed was about three to four feet away from the adjacent wall. My bed was the one located closest to the door. If I, or a guest, were sitting in the easy chair located at the foot of my bed, it was impossible for anyone to pass between without either bumping my bed or asking the individual to move his chair. While the hospital has very liberal visiting hours, it would have been impossible for my roommate and me to have had more than one visitor at a time.

It was equally surprising to find the toilet fixtures in the bathroom without any kind of adjacent hand rails. Indeed, there were no hand rails of any kind in the corridors or any place else that I was able to observe.

These deficiencies in room size and design are all the more surprising when one considers that this building was constructed within the last five years.

The lounge on this floor, which is the only place where a person can go if he wants to walk outside of his room, was located at the extreme end of the floor. Its design and furniture layout were such that it was virtually impossible for two or three people to gather in a knot to talk. It is a large room with some couches and chairs placed around the periphery with a television set at one end. There is nothing there to invite three or four ambulatory patients to sit in a small group, or for a patient who may have a couple of visitors to go to the lounge and sit in a way that the three people might face each other. The lounge is windowless and dimly lit. It seemed, in all respects, a place that would tend to deaden socialization or the opportunity for patients to converse together. Indeed, as some of my comments below will indicate, many things in this hospital seemed to conspire to keep patients very much alone.

For the lonely patient, and particularly the elderly patient who may be facing a terminal illness or an illness that threatens to change his lifestyle, loneliness can be a very destructive force. With increasing numbers of elderly making use of our hospitals, I would venture the suggestion that just as we encourage nursing homes to take into account the social needs of their patients, so we must encourage our hospitals to recognize the social needs of their patients.

On Medical Surveillance

I could not help but be enormously impressed with the medical surveillance extended to me and to my roommate. Our physicians and the residents assigned to us were in to check with us no less than twice a day and more typically three and four times a day. The residents gave every appearance of competence, concern, and conscientious attention. They were alert and were careful to explain what they were about to do, what it was that was going to happen to us, etc. They were ready to answer questions.

I must comment, however, on one instance concerning my roommate. In the course of making the diagnosis of cancer of the esophagus, it was necessary to insert an instrument into his esophagus to secure a sample of tissue. He told me if he had to undergo it again he would prefer to die.

One day when his physician was inquiring about how he was eating and whether the food was adequate and whether he was able to swallow, he complained that he was having difficulty. His physician explained that the cobalt treatments might tend to inflame the esophagus somewhat, cause swelling, and thereby make swallowing a difficult procedure. However, if it became too difficult, the physician went on to explain, it would be a small thing to insert a plastic tube through which he could be fed. It was evident, almost at that moment, that my roommate equated the insertion of this plastic feeding tube with the examination he had undergone earlier. He had no opportunity then and there, and he was not quick enough, because of his language problem, to complain about this possibility. All through that day the man worried himself almost into a great state of anxiety. Finally, in the evening he could bear it no more and he asked the nurse to call a physician. When the physician came, one of the residents, he told the resident that he would not permit the insertion

of a plastic tube. The resident said, "I thought you didn't understand it when your doctor told you about it," and he then went on in a very calm, kind, and humane manner to explain to my roommate that this would be a very simple and painless procedure that had no relationship to the examination he had undergone earlier. This came as a great relief to my roommate, but he had spent a day torturing himself over the chance and, indeed, innocent remark of his physician.

The point here is that physicians must take great care, particularly with the elderly, the uninformed, and with those who perhaps have language difficulties, to explain in some detail what it is they might do, how much pain may be involved, how difficult the situation is, etc.

Perhaps the thing that is worse even than pain in a hospital is not knowing. It is the not knowing when something is going to happen, or the not knowing what is going to happen, how much it will hurt, how long it will hurt, what has been done to you, why your body is or isn't reacting in a certain way, what the chances are that things will get better or not get better, how serious some development is, what medication is supposed to do, etc., that is difficult to endure.

On Nursing Service

Perhaps the most noteworthy comment I can make on the nursing service is its variability in the face of extraordinarily conscientious supervision, hard work, dedication, and attentiveness to duty. The level of discipline appeared high—and I use the word discipline in the sense of adherence to routines, safeguarding the issuance and handling of medications, recordkeeping, shift-to-shift reporting on each and every patient, etc.

1. The numbers of staff seemed to be adequate but certainly not excessive.
2. All staff were uniformly pleasant, jovial, and apparently interested.
3. The nursing assistants did their work well and with dispatch.
4. Nurses receiving additional training were very good.

Thus, it is so surprising in retrospect the neglect with which I was treated on my return from surgery the first time. I was brought back from the recovery room about 1:30 p.m. From that time until 9:15 the following morning, with the single exception of responses of nurses to give me painkilling shots, I received no attention from any nurse—

despite the fact that the room was beastly hot and my wife and I had complained about the heat. Because of the heat I was drenched most of the time with perspiration, particularly through the night during which I endured the discomforts of a Foley catheter. Nobody washed my face or offered a cool washcloth, nobody suggested or advised me that I might have a pain shot sooner than I had requested it. Nobody, in fact, even inquired as to whether they could do anything to make me more comfortable. No one came in to straighten a sheet. No one offered to change the position of my legs although it was difficult, if not impossible, for me to move them without some help.

Early in the evening of the day of my first operation, I was visited by a member of my staff who is a registered nurse. In talking with me, she observed that the IV fluid was infiltrating. She brought this to the attention of an orderly, who recognized the situation for what it was immediately, and advised the nurses who subsequently called a physician to reinsert the IV. It appeared this had been infiltrating for some time. Apparently the IV had not been adequately checked.

During that first afternoon and night following surgery I think I had more attention and time from physicians than I did from nurses. On that day and the day or two following, but at no other time during the rest of my 17 days of hospital stay, I found the response to the call button singularly bad. It was not uncommon to wait 20 minutes or more for someone even to come over the enunciator system to ask what it was I wanted. In that first day or two following surgery it was not uncommon to wait an additional 15 minutes or so after I had made my wants known. I think this bothered me most when I asked for some relief from pain. It wasn't the waiting so much as the feeling that perhaps they were insensitive. I am sure that this is not correct. It would have made waiting much easier if someone had answered the enunciator and had said, "It's going to take us ten or fifteen minutes to get to you. We're in the midst of trying to give somebody a treatment," "We're in the midst of preparing our medications," or, "Everybody is out in the rooms trying to serve the patients," or something of that sort. At least I would have known that they were trying, which I am sure they were.

As it turned out, on the second day after surgery I had a chance encounter with the field representative from the State Department of Public Welfare, which supervises and approves the hospital. She was

making rounds with a representative from the administrator's office and she encountered me quite by accident. I explained to her what I had found at the hospital and what my experience had been. Following that encounter the nursing service visibly improved. I don't say this to suggest that there was a connection. Frankly, I do not think there was. I don't know what the problem was the first day because as I was better able to get about, I observed the nursing activity on all shifts. They were busy, conscientious, dedicated, and very serious about taking care of medications, checking orders, passing on bits of information to each shift. I can only guess that there is some problem somewhere in the systems review that could make it possible for a post-operative patient not to get some kind of regular checking every hour or two, and some kind of special attention, or at least inquiry, as to well-being and comfort.

One final little note, which perhaps should have some cross-reference to housekeeping. On the Sunday before I was discharged I happened to make use of a urinal during the night. Having partially filled the vessel, I placed it on the floor next to my bedside cabinet. Monday morning I was amused to find the housekeeping service sweep around this partially filled urinal. Members of the nursing staff came and went without paying any attention to this partially filled urinal. On Tuesday morning I observed the same thing with the housekeeping staff, and through Tuesday another three shifts of the nursing service passed over the urinal's presence. On Tuesday evening, a female visitor carefully averted her eyes from this partially filled urinal until I pointed it out to set her somewhat at ease, explaining that I was then in the midst of an experiment. I was discharged from the hospital Thursday morning and at about ten o'clock I confessed to the nurses on duty that I had not said anything to anybody about this partially filled urinal, which had stood there since Sunday night, but that I felt compelled to do so at this juncture since it might conceivably upset any patient who followed me into that room if that urinal was still there. The nurses were visibly upset by this. It was certainly not my intent to upset them and it was not a perverted sense of whimsy that led me to leave the urinal there. It does indicate, however, that there is some confusion about responsibility between the nursing service and the housekeeping service or else the nursing staff is either unobservant or embarrassed. I can't believe either of the latter and must confess being baffled as to how this could occur.

It is, indeed, difficult to understand the variation of level of service among this group of bright, alert, pleasant, and conscientious professionals. Indeed, I would not hesitate to employ any of them to pursue duties in my office or in any institution for which I might have some responsibility. How and why these things can occur is a matter that deserves considerable study. Indeed, it is a matter that requires more study than chastising. My guess is that a look at the work of the nurses would indicate some fault or deficiency with the systems that have been designed for them to follow.

On Food Service

The food service at this hospital had an error incidence of between 20 and 30 percent, which is almost beyond belief. Certainly no less than one in five meals, and more likely one in three meals, was served with either small or great errors. These errors included no meal being served at all despite the fact that no stop had been ordered; dry toast being served my roommate, who was on a very strict liquid diet; failure to include part of my roommate's meal, although his caloric intake was a matter of grave concern to the physicians; minor absurdities such as soup being served to both of us with no spoons on either tray and none available on the floor; the use of a palatized system for keeping hot things hot with a palate omitted from under the plate; or the sending up of a plate with a hot palate under it and nothing on the plate; and on to inappropriate silverware, no silverware, the almost unbelievable use of picnic-type plastic ware for eating, etc.

One obvious difficulty, in my opinion, lay in the nature of the form used for selecting menu items. While this form was adequate for telling the cooks what they had to prepare on the following day (it was a mark sensed form that could be run through an IBM machine to calculate how many portions of each item were necessary), its layout was such that anyone trying to check the trays on a trayveyor system against the form would either go blind or out of his mind after looking at about ten of these.

Another problem, I believe, lay in the inadequate communication between the floor dietitians and the kitchen dietitians. While my own situation was not terribly important so far as diet was concerned, that of my roommate was. He was on a very strict liquid diet. He was

losing weight steadily. This was a matter of considerable concern to his physicians. It was not until his physician complained bitterly about the inattention to his patient's food that the dietary service made some sincere attempt to develop foods my roommate might conceivably enjoy. Some of the choices that they gave him can only be described as almost vile. While taste is a personal matter, it is hard to believe that anyone who has ever tasted liver baby food would try to offer this as being a tasty dish. Despite the fact that my roommate had indicated he could not abide a bacon flavor in blended eggs, he was served blended eggs with bacon. I had to protest this kind of neglect and oversight to two dietitians and a physician before I felt any impression had been made in the dietary service.

I cannot believe that an error rate anywhere close to that which the dietary service produced would be tolerated for as long as 24 hours in the hospital's pharmacy or in their central supply, or if operating rooms were inappropriately prepared for scheduled procedures with improper tools, or instruments, available for the surgeon. I would feel that the situation in the dietary service in this hospital is so bad as to represent a virtual crisis because it is so close to almost total breakdown. I have no doubt that there are patients being hurt, and seriously hurt, because of this high error rate. I observed this with my own roommate who, because of errors in one day, suffered a higher weight loss than any other day during the time that I was there. How much of his weight loss was caused by error, lack of imagination, or lack of concern on the part of the staff, is hard to assess, but I am convinced that some of his weight loss must be ascribed to the inadequacies of the dietary service.

On Housekeeping

Perhaps the best and worst that might be said about the housekeeping service, at least so far as my room was concerned, is that it was lackadaisical and unenthusiastic. I only saw people dry-mopping the room during my stay. At no time was the floor of the bathroom wet-mopped, much less the floor of the room I was in. I did observe walls and the corridors and some other rooms being scrubbed down. This appeared to be on some kind of schedule. However, so far as room cleaning was concerned, it was not much

I would comment on one other minor point. My room was located just outside the service closet. Housekeeping personnel apparently gathered there at 7:30 in the morning to pick up their supplies preparatory to emptying wastepaper baskets or doing whatever they had to do. They made no effort whatsoever to modulate their voices. The gathering was apparently a noisy, social occasion. They frequently called to each other halfway down the hall and at that hour this was somewhat disturbing.

On Social Services

My experience leads me to believe that, at least in this hospital, a new approach to hospital social services may be called for. It is insufficient to rely on the patient to ask for help from social services. The plain fact of the matter is that most patients are not aware of what a social worker can or can't do for them. On the other hand, a social services department has much to offer many patients who need help from a professional social worker. This is going to become increasingly more the case as older people avail themselves of the benefits of Medicare. Take my roommate, for example. This man was hospitalized for treatment of what he knew might be a fatal illness. He was very much alone despite contacts with some relatives and had recently suffered the loss of his spouse. He was a man who, like one-third of all people 65 and over, spoke with a foreign accent and who might have increasing difficulty with English as tension, stress, and anxiety levels increased.

My roommate said to me one day, "I suppose my whole life will have to change now. I will have to get a nurse or a housekeeper in to live with me. I will have to get somebody to prepare my food. Maybe I won't be able to drive any more." He discussed the provisions of his will with me indicating some anxieties about what his relatives might think about this or that provision. He was not a poor man by any means—indeed, he was quite well-off. He had some plans to go to Florida in the fall and then to Israel in the spring to visit a nephew. He was concerned about approaching his physician about what he could or couldn't do. This man was a bundle of anxieties. Many of these things could have been anticipated from his admission form and by some kind of routine communication from the nurses to the social services department.

However, I doubt that there was any provision for communication except in terms of the most overt kind of cry for help from the patient. My roommate was a man who could have benefited from some effort to find him a chess partner. He had brought a chess board and chess pieces and a chess book with him. This was something that meant a great deal to him. He, unfortunately, in me drew a partner who not only did not know how to play chess but, for whatever reasons, did not want to learn. No volunteer came to play chess, no group workers appeared to help this lone person. I wonder how many others on other floors were as ambulatory as he and who were as alone and as anxious, who put up not only with days and days of worry and anxiety, but perhaps with weeks. When I left the hospital he was completing his third week, and would probably be in the hospital a fourth. His days had very little to fill them after his 15 or 20 minutes of treatment and fewer minutes than that of attention from his physician.

I have one other comment that probably is not relevant to social services but does have something to do with accommodating non-medical, non-nursing patient needs. As noted, my roommate was alone and had very few visitors. Rather than wear the unironed hospital pajamas, he changed during the day into pajamas of his own. However, he had no one to make arrangements for the laundering of these pajamas. He was an extraordinarily meticulous and neat individual and this concerned him. It was only when my wife suggested that she would take the pajamas to the laundry and I would arrange for a friend to pick them up that any provision was made for this at all. It is not sufficient to rely on informal methods for this kind of service. It is also insufficient to expect the inarticulate to call for this kind of service or request it on their own. Hospital staffs must be somewhat more sensitive than they appear to be to these kinds of non-medical, non-nursing service needs.

I believe that social services departments in hospitals must look beyond their traditional concerns and begin to look at these elderly, lonely patients who may be facing a health situation that will introduce major changes in their lives, their relationships, and their lifestyles. Much of this can be picked up in very simple ways. However, the relationship that a social worker enters into will not come easy, as those who work in the field of aging can attest. But the older person is captive

and has time, and social service has a great deal to offer in helping him and perhaps his family adjust to altered modes of living, the prospect of death, and of diminished energy and ability.

As a first step, I would urge hospitals to take a hard look at the characteristics of the older people who are coming through their doors, regarding well their length of stay, their marital status, the number of visitors they have, ascertaining on whom they rely, and trying to ferret out what it is that concerns them about their hospitalization.

No one should mistake the purpose of this memorandum. It is not to criticize or complain. I went to this hospital because I sought out a particular surgeon. I secured excellent medical care and, for the most part, excellent nursing care. My goal was to correct a bodily defect through surgical intervention. This goal will have been achieved. Despite what deficiencies may have existed that I have described above, measured in terms of the goal established, one must report success. However, not all cases are that simple and in not all cases are the results so direct. In some cases those good results are achieved only at the cost of a certain amount of anguish and aggravation. Perhaps this memorandum can serve to avoid some of that anguish.

Other cases, however, will not "succeed," and failure may be ascribed to failures in the system. This memorandum is in part addressed to that possibility. Beyond that, I think that all of us have some duty to try to improve on what may already be a reasonably good operation. Here again, this is among my prime purposes in writing all of this down. My main hope is that this memorandum will serve some constructive purpose.