

Humbug, health and humanity: A patient's tale of care in a public teaching hospital

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Foreword

The author of this article claims it is a fair description of her recent experience as an inpatient in an unidentified major public teaching hospital. The name of the hospital has been withheld at our request. The Australian Health Review has no reason to believe her account is inaccurate but readers will draw their own conclusions. The comments of the Chief Executive of a similar hospital are appended, but it is not the hospital in question – which will remain nameless.

Don Hindle, Editor, *Australian Health Review*

Humbug is the word used by traditional Aborigines in the remote communities of the Northern Territory for anything that goes wrong. Red tape, any contact with any sort of government organisation and just plain old bullshit.

Late last year I found myself in one of Australia's public hospitals and humbug was everywhere: in the endless filling-in of forms, in the frame that can never be comfortable, in the unnecessary needle piercing so the doctor will not have to come back. It was in non-adjustable bedpans, in the malfunctioning electronic monitors (which require missing medical expertise from some mysterious source yet to be summoned), in the loud intrusive purring of a mattress inflator. And in bells in toilets which sound and flash but are not answered, in the X-ray technician unable to cope with the instruction 'also do the other foot for comparison', in the nurse who is 'only the messenger' so cannot be right or wrong. And in call buttons that hang tantalisingly out of reach or, if pressed, result in painful waiting and eventual reprimand. In the tidy nurse who shoves belongings into inaccessible drawers, in the clumsy nurse who runs into the broken foot, shoves the tube in the wrist the wrong way, spills the bed pan and leaves me in the mess after forgetting to dispense medication. In the smiling registrar who delivers reality like an advertisement for seafood laksa. So much to look forward

to, like 'months of disablement' and being 'in the risk zone for blood clots'. And it was in innumerable people who tell a person with a broken ankle (or with a glass-filled face, or with a broken neck, a bed-sored body, a heaving stomach, or the waiting, exhausted relative) how lucky they are.

As part of research for a book I am writing I had been trekking in one of the most remote and beautiful parts of Australia, central Arnhem Land in the Northern Territory. During an overnight camping trip in the company of a local Aboriginal guide and two others I had fallen and broken my ankle on a rock platform beside a waterfall.

After spending a cold and painful night in the bush I had been piggy-backed out across river, sands and rocks by my brave and caring companions. I had endured a bone-jarring four-wheel-drive journey across ravines and rivers and been kindly treated by a nurse in a remote Aboriginal community. I had been miraculously transported 400 kilometres by a tiny single engine plane of the Flying Doctor service to Katherine Hospital. Here my leg was X-rayed and placed in a cast so I could journey by road the remaining 350 kilometres to Darwin. Two days later (unable to get an earlier flight) I endured two uncomfortable commercial flights home.

The next day my local doctor was unable to cut through the interstate health humbug to get hold of my X-rays from Darwin. But the report given to her over the phone convinced her it was a serious fracture which would require surgery. This was becoming more urgent as each day went by. More humbug was encountered as we tried to keep an appointment with a highly recommended private orthopaedic surgeon. But he was unable to stay an extra hour in his rooms that night to see me when I rang in desperation to tell him the ambulance had been delayed, even though I had arranged a disabled cab and two strong men to get me there.

Finally, when told of my dilemma, another surgeon put me straight on his list that week for the operation which now seemed inevitable. So I had to get into hospital to have another series of X-rays and to allow the leg to be elevated in preparation for the operation. This was no mean feat. My local doctor, experienced in the state of the public health system, coached me in what I had to do: insist I was a patient of Dr X, and that I could not go home but needed to stay there for the operation on Friday.

That day the casualty department was a battle zone. I was told the hospital was on some sort of alert, accepting only life and death cases. After my X-rays I lay in hiding for six hours in the plaster room, nursing my now exposed broken ankle. A physiotherapist looked after me whenever she could. A young and sympathetic doctor found and examined me and I discovered she was a school friend of my daughter. When it was near 5pm and I was all alone thinking 'what bliss', two nurses rushed in and grabbed my bed. They remonstrated with me. 'You cannot stay. There are no nurses here.' 'But I have been here for six hours, and I'm OK', I protested vainly.

As they pushed me back into casualty I asked if I could at least thank the physiotherapist who looked after me while she organised a busy plaster room. She appeared and reassured that me this was the only way I could get a bed in the ward, and to just 'hang

in there'. This I did surrounded by the misery of an over-full casualty ward. There was elderly man vomiting, a young man with acute appendicitis, a crying girl in a neck brace, a screaming baby. Nurses and occasionally doctors rushed in and out. Everyone appeared bewildered and upset. But at last I had a bed in a ward where I naively anticipated I might have some care at last – and maybe even some warm food and a wash – as I remembered my happy days as a patient in this hospital over twenty years earlier.

My hopes were dashed as I learnt the reality of ward life in the 1990s. Sharing what was to become a miserable post-operative nightmare were three remarkable women braver and stronger than me. Opposite was Margaret with a broken neck. She was the survivor of a horrific encounter with a drunken driver only minutes from her home. She was fully encased in a monstrous head, neck and chest brace so we dubbed her Princess Leia from Star Wars. She had been the principal carer for a severely disabled husband and a 93-year-old mother-in-law. She put up with the pain and indignity of her encasement with gentle good humour and forbearance.

Next to her was Jan, an elderly entirely bedridden Polish woman who spoke little English except to continually apologise to the nurses whenever they finally came to attend to her. Next to me was Trudy, a plucky young separated mother of 15-month-old twin boys. She was having one of a series of operations on her legs which had been completely smashed up in a car accident 12 years ago. Together, in desperation, we forged an alliance to combat the over-stretched, disorganised and consequently cruel system that we encountered.

For the first two days all of us were post-operative except Jan, but we all required drips, antibiotics, painkillers and personal care and, if possible, a modicum of sympathy. What we experienced was chaos. No routine in terms of medication, personal care or sustenance. Tasks would be started and never finished. We became familiar with the nurses' promise to be back in a minute, which would typically mean up to half-an-hour with my broken leg unsupported, curtains left open to reveal all, meals getting cold while out of reach, water jugs empty and so on. The ward lay dirty and unswept over the weekend and the toilet undisturbed with none of us able to clean up after ourselves. Breakfasts arrived before we were woken, toileted or washed. One would usually have to buzz repeatedly for medication to relieve the considerable post-operative pain. Even then it would apparently be forgotten.

Instead of the nurses being in control with standard routines of care it seemed as if they were reacting to whoever persisted the most or whoever they deemed to be more in need. At no time was any explanation given, which increased the sense of chaos and anxiety.

Humour helped to keep us sane, but there were some bad moments. Jan always had to wait for a nurse to come and cut up her food. We were all still bedridden so could not help. She never complained but once in desperation I asked a man who was mopping the floor if he could help. He refused, saying it was not his job. What if she choked? He would be responsible. My patience finally snapped as I yelled, 'what sort

of society do we live in where we cannot help an elderly person eat?' At this point a sister arrived and chided me by way of excuse. 'It's just that this is also our lunch hour so we cannot come and help.'

That night the three of us lay in pain with medication over an hour late. There was no comfort of a wash. When Margaret asked for a back rub, she was asked why she could possibly want it. We felt abandoned. When nurses finally appeared it was not to help us but to reprimand us. I could not bear to hear Margaret treated cruelly and I finally began to weep while she, feeling sorry for me, did the same. I wished I was back on my rock platform in Dalabon country with the three special men at my side and the good spirits to help me. Morning came after a terrible night during which none of us slept and now we suspected nothing would improve. Unable to contemplate another such night, we complained to one of the day staff, who seemed sympathetic. Eventually a nurse came to apologise, apparently oblivious to the impact of her previously unfeeling attitude. When she stopped and listened to Margaret's story she was remorseful. This helped us but the subsequent improvement was only marginal.

On Monday it suddenly seemed as if we were parked on the edge of a health freeway as an endless parade of people entered our ward, no matter what our state, with no apologies or reasons. There were people clutching clipboards, draped in stethoscopes and carrying basins, mops, pillows, drips and catheters. Sometimes they would stop, sometimes continue on their way. There were visitors, lost relatives, pink ladies, chaplains, occupational therapists, social workers, students, physiotherapists and volunteer cheer-uppers. There was the appearance of care but still no coordination or ultimate responsibility for the welfare of individual patients. Promises were made by all with unpredictable results. By now we were past caring and in my anger I was determined to become independent as quickly as possible by first becoming able to get in and out of bed and then to walk to the toilet and bathroom. Once accomplished I achieved the status of a patient who could be sent home and was no longer a burden on the system. My surgeon, a young man with a deserved reputation for both his charm and expertise, had skilfully inserted a steel plate with seven screws to hold the broken bones in place and was pleased with the result.

Now it was a just matter of dealing with the discharge humbug. Unsure about the promised return of an occupational therapist to organise home nursing and aids to living, I used my mobile telephone to ring the hospital OT department to ask them to come to my bed as soon as possible.

I was unable to get any answer about when I could leave, so I telephoned my husband and asked him to telephone the nurse in charge. A few minutes later a nurse rushed into the ward to say 'your husband is on the phone and wants to know when you are being discharged, do you want to speak to him?' We took matters into our own hands. I left in my own wheelchair, sailing past the nurse's desk to pick up the discharge papers.

I was pleased to go home. I was sad that this once proud hospital was now full of humbug, dangerous to health and lacking in humanity.

Commentary

MICHAEL WALSH

Michael Walsh is Chief Executive of The Alfred Hospital, Melbourne.

Humbug, health and humanity: A patient's tale of care in a public teaching hospital

Anyone who takes pride in Australia's public hospitals would be perturbed and alarmed upon reading Narelle Scotford's account of her recent admission to a public teaching hospital.

I work in a major public hospital. We admit over 3000 patients per month, as well as diagnosing, counselling and treating around 15 000 outpatients and 2500 emergency patients. From these 20 000 patients we receive around 20 formal complaints and three times as many formal compliments. The complaint rate is around 0.1%.

As with any service industry, satisfaction with hospital care is a mix of personal perception and the objective facts. Personal perceptions often differ between the parties involved in a hospital experience. Hospital stays are usually charged with anxiety and emotion and different people bring different expectations. People who stay for more than one day in a public teaching hospital are pretty sick. All the 'test days' and 'recuperation days' of 20 years ago are gone. Those days are needed to treat other sick patients who are awaiting admission.

Because of this trend, the average 'burden of sickness' of each ward and each bed is higher now than it has ever been, so staff are busier. Notwithstanding this change, with very few exceptions they are all focused on doing a good job for the patients in their care. The patient-clinician relationship remains paramount and is one of the strongest and most rewarding of professional (and personal) experiences.

Concerning the credibility of Scotford's account, it is impossible to assess from only one perspective. I have no reason to disbelieve it, but I would seek the views of others involved in her care. I feel sure that a thorough investigation of matters she raises would reveal a number of areas where patient service should be improved. I have rarely dealt with a complaint that is completely frivolous and offers no opportunity for improvement.

Could it happen in the hospital at which I work? Of course. Fortunately I believe that the chances of such a comprehensively bleak experience are very low. They are never eliminated, however, because we work in a people industry, and individual perceptions and behaviours are the key determinant of service outcomes, such as patient satisfaction.

Of the problems mentioned by Scotford, perhaps the greatest challenge at this hospital is overcoming the loss of integration caused by increasing specialisation of diagnostic and treatment regimes. We have introduced primary nursing, a philosophy and approach that establishes a clinical bond between the patient and his/her primary nurse. The primary nurse is the integrator and the patient advocate, helping to guide the patient through what can be a bewildering array of professional contacts. The primary nurse is also an essential link with the outside world, with responsibility for carer liaison and discharge-planning.

There are no problems that could never occur in any hospital, so it would be folly for me to nominate problems that could not happen here. Suffice to say that we work hard to minimise the risk of such outcomes.

How do we minimise these risks? We monitor patient satisfaction closely through regular surveys, we consider all complaints in detail (I personally meet weekly with our patient representative to discuss all complaints) and we formally review all complaints and incidents once a month at our Patient Services and Care Committee (which I chair). I take complaints and incidents seriously and I like to do something about them.

We are endeavouring to encourage patients to raise concerns with us as we view such feedback as a learning opportunity. There will always be a very small minority of patients who require little encouragement to make complaints, but most patients do not offer constructive criticism until they are asked. However, when asked, they will do so if they feel such feedback is of value to improve services.

More proactively, we have recently introduced a customer-service training module for staff and interest has been very high. Also there are the traditional quality monitoring and enhancement activities such as clinical audit, clinical indicator review, clinical practice protocols and hospital accreditation.

Finally, regarding trends, we simply do not have the information to assess whether things are getting worse or better. At this hospital overall patient satisfaction has remained reasonably stable for the last three years, but we have some stunning areas of success, for example, our emergency department. The work of the National Health Ministers' Benchmarking Working Group is important in establishing some broad standards and consistent performance indicators. Patient satisfaction is listed on their agenda, but data are not regularly reported nationally and standards have not been set.

In my opinion, hospital care is about people. Delivery of service is closely related to the morale of staff and the culture of the organisation. These intangibles (or 'soft issues' as the economic rationalist would refer to them) are notoriously difficult to measure and they are very susceptible to damage through mediocre policy and management!