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Passy, France

The "Forgotten" Hospitalized Patient And Modern Medicine

by Joseph G. McCarthy, M.D.

"Make a habit of two things: to help or at least to do no harm." – Hippocrates

CASE REPORT BY PATIENT

In September I arrived at the hospital for major surgery and was brought to my room. A parade of doctors and nurses began prepping me for the operation the next day. I didn't recognize anyone and was surprised that there was no general briefing about my surgery.

The next morning, a nurse told me that, although there was some concern, for the most part everything looked "OK" to proceed. I had no idea what that meant. Another nurse told me that Dr. A, not my doctor, Dr. B, would do the surgery. Neither doctor ever spoke to me before the operation and when there was a three-hour delay I wondered whether something was amiss. Finally, someone gave me an injection; I do not remember anything until I awoke in Recovery.

During the next couple of days, I was pretty groggy, but my wife learned from a doctor we had never met that a pre-op test had shown problems that might affect my outcome. Later she heard from another that the surgery was potentially unsuccessful. That was a surprise, as was an infection with a high temperature that left me delirious. Five or six days post-surgery, Dr. B stopped by; I was pleased to see him because he knew me and my history. He told me that a new team of specialists could treat my complications, but it was clear that he was not responsible for my care anymore. It was confusing. We had no idea who was in charge of my case. If not he, then who?

I asked that question repeatedly throughout the following months, as I descended from confusion to frustration and finally to a sense of abandonment. Various doctors told me that it was a multidisciplinary team effort and that all the doctors on the medical service responsible for my recovery knew my case. Really? Half of them never met me and the rest appeared and disappeared from my room on rotation and shift changes.

In fairness, several doctors and nurses were exceptional even if the system was opaque and faceless. However, I never did find out who was responsible for me, even later when I was running on empty from plasma exchanges, steroids and endless attempts to overcome my complications that ultimately ended in a failed surgery.

Provided by RPA

In the fast moving world of healthcare delivery, the above case report highlights a common complaint of the hospitalized patient: the difficulty of identifying a physician in charge and of communicating with that individual. The patient feels confused and abandoned and comes to believe there is no doctor taking ownership of his/her case. Moreover, the problem is compounded by the fact there can also be miscommunication among the staff members, resulting in the patient being given contradictory information or advice from different members of the hospital team.

How did this problem come about?

In the last 30 years, there have been radical changes in the healthcare delivery system. Scientific medical advances have resulted in an explosion of new diagnostic techniques, lifesaving drugs and treatment procedures, all contributing to the “miracles of modern medicine”. The numbers of medical personnel involved in a patient’s care increased exponentially; the complexity and costs of high tech equipment skyrocketed; more hospitals were built; and drug prices soared into the stratosphere. While patients have certainly experienced better outcomes and life expectancy has made astonishing incremental gains, healthcare costs went out of control. In an effort to contain costs, managed care and other types of health delivery reforms were introduced. In essence, health care delivery was corporatized and many business management techniques were adopted by hospital systems. An example of one of the changes has been the gradual replacement of the independent physician (PCP) by the modern practice model of the "multidisciplinary team". The latter is composed of a broad spectrum of specialists depending on the patient’s health problems and needs.

On being admitted to the hospital, the patient's PCP (Primary Care Physician) is no longer directing care, which is now often transferred to the “hospitalist”, a hospital-employed or “corporate” physician in charge of the patients in a particular section of the hospital. The hospitalist works a defined shift and turns over the care of the patient to another at the completion of the shift. Following admission, the multidisciplinary team is developed and enlarged depending on the patient's problems and requirements.

What results is the lack of a designated leader or captain who knows the patient as a unique individual with personal needs and concerns. What is glaringly missing is single physician ownership of the patient problem. In complex medical problems with a resulting large team of physicians, the problem can be aggravated by “group think” with lack of individual physician decision-making or even accountability.

There are also constraints on the amount of physician time available for talking with the patient. With the corporatization of health care and the development of the EMR (electronic medical record) physicians have work quotas limiting the amount of time available to talk to patients. Electronic communication (texting etc.) is also preferred by younger healthcare workers, a poor substitute for a sit down face-to-face doctor to patient or even doctor to doctor talk.

What does the patient need?

Quite simply, a point person to take ownership of the patient’s problem and captain the healthcare team. This person, in turn, would talk to the patient and be available for communication with a designated family member or healthcare proxy. Although this role may not be clearly defined within the current patient care structure, the hospital’s governing board could easily and inexpensively implement the following workable suggestions:

1. Identify and appoint only one physician who would be responsible for coordinating information among the team members and would be responsible for relaying and discussing

this information with the patient and family. The point person would also arrange a sit-down session with a specialist on the team whose role is especially relevant to the patient's case.

2. Designate the point person, with the patient's permission, to secure the patient's previous medical history and to communicate with the patient's PCP.

3. Prominently display the name of this individual on the door of the patient's room and on the patient's wristband.

4. Establish by 10AM a specific time for a daily talk by the point person with the patient and family representative.

5. Develop a mechanism to complain about communication problems with the point person, recognizing a patient's concern of being labeled a troublemaker. Most hospitals, however, have an ombudsman or patient advocate program.

The implementation of such a program would create a more caring hospital environment, lessen patient anxiety and reduce the stress associated with hospitalization. It would also facilitate communication within the healthcare team and improve patient health outcomes.

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Editor's Note: This essay was written before the current Covid-19 pandemic that impacted hospitalizations and communications between doctors and patients. The author submits that the fundamental points of the essay remain unchanged with the postscript that scheduled virtual communication with family members or designated representatives should be mandatory and would be satisfactory.