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Patient's Plea—Look Closer, See Me

Viewing patients as unique individuals affects attitudes and behavior.

As many of you know, I have authored this column for several years and am quite passionate about the topic. But what you may not be aware of is that I make ICU ethics rounds at two hospitals where I sit on their ethics committees. It is during rounding that I am reminded even more of the influential position we as healthcare executives are in to create and sustain an organizational culture that ensures patients are treated with respect.

The topic of rounding has been covered in this magazine many times, most notably in “Patient-Centered Care: Rhetoric or Reality?” (Sept./Oct. 2011), in which most executives asserted they simply did not have enough time to conduct patient rounds, considering their full schedule of meetings and other commitments. I contended this was a convenient rationalization for deciding not to devote at least one hour three to five times a week to this activity because of “higher priorities.”

Regular executive involvement with patients and families conveys an unambiguous signal to physicians and employees that senior executives genuinely care about patients, their families and the hospital experience by spending time with them. It was

this point that Derek Feeley, PhD, president and CEO, Institute for Healthcare Improvement, Cambridge, Mass., and an ACHE Member, conveyed during the IHI's Annual National Forum in 2016. He said that when we fail to treat patients with dignity and empathy, we are doing just as much harm to those we serve as if we were committing a physical medical error. He also urged attendees to understand that safety is more than just the avoidance of physical harm.

Leaders must be deeply committed to learning what is going on in the care process of their organization and then have the humility, clarity and courage to set in motion the changes to improve them. Many resources exist to help you achieve this aim. One in particular is an article I authored in the Jan./Feb. 2006 issue of *Healthcare Executive*, “Becoming More Effective Patient Advocates,” which is still relevant today.

Patients as Individuals

In addition to traditional care-process resources, patient anecdotes are an effective means of reinforcing the importance of viewing patients as individuals. The following stories include reflections by a physician, an excerpt of a poem from an elderly

patient to her nurse and comments on staff insensitivity by a professor. These are powerful illustrations of why we must recognize patients as unique individuals and focus *not only on who patients are but also on who they have been.*

A Physician's Lament

In the March 7, 2016, issue of *KevinMD Stories*, Edwin Acevedo Jr., MD, a surgical resident, vividly described his feelings when realizing a sobbing older man had just lost his wife. Acevedo acknowledged how he would never know her “when she dressed up for a ball, or how her husband had asked her to marry him, or how it felt to be part of their first family picture, or how it felt to buy their first house together, or how they ended every single day with a good night kiss.”

His poignant description was a powerful reminder that staff members know the patient but usually not the person.

An Elderly Patient's Plea for Recognition

Over 40 years ago, I was fortunate to learn of an anonymous poem discovered among the belongings of a hospital patient who died in Scotland. It was titled “What Do You See?,” and its message is just as relevant today as when it was written. The patient begins by asking, “What do you see nurses, what do you see? What are you thinking when you're looking at me? A crabby old woman, not very wise, uncertain of habit, with faraway eyes?” Then, she eloquently reminds the nurses of why they should recall her as a child of 10, a young girl of

16, a bride at 20, a mother at 25 and a grandmother at 50.

She concludes by writing, “I remember the joys, I remember the pain, and I’m loving and living life all over again. I think of the years ... all too few, gone too fast, and accept the stark fact that nothing can last. So open your eyes, nurses, open and see, not a crabby old woman, look closer ... see ME!!”

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Comments on Staff Insensitivity by a Professor

Invariably, when visiting a physician’s office or observing hospital staff interacting with patients, I still sadly recall a college professor’s letter to the editor of *The New England Journal of Medicine*, published in 1983. She expressed her discomfort about a common, and some might suggest unimportant, practice of calling patients by their first name. The last three paragraphs of her letter should be required reading for everyone who works in a hospital. She wrote:

“[B]eing on the examining table or undergoing diagnostic procedures can be a scary business. It feels as though more than clothes have

been stripped away; there is loss of confidence, of dignity, and of one’s sense of individuality. As a patient, your name is one of the few unique descriptors left to you. It should be yours to ‘give away’ only if you wish ...

“[T]he issue may go far deeper than courtesy or dignity. The physician’s role includes the task of enlisting the patient’s own healing powers. Any procedure that increases confidence and inner energy will be important; any procedure that disempowers or diminishes the sense of self may impede the patient’s progress. An insidious effect of the automatic use of the first name is to make the patient a child again. By reinforcing dependency and passivity, you have stolen power from your potential ally.

“My plea to the medical community is to call patients by their full names until you can ascertain their preference. The skillful use of names can be a powerful instrument indeed, but you squander its effectiveness by the present practice.”

Critical Lessons

If healthcare executives are uncertain about how to motivate staff to be more empathetic, they should read “A View From the Edge—Creating a Culture of Caring,” authored by Rana L.A. Awdish, MD, in the Jan. 5, 2017, issue of *The New England Journal of Medicine*. As the result of her own experience as a patient, she describes how new employees at Henry Ford Hospital, Detroit, where she specializes in pulmonary, critical care and internal medicine,

are “taught to recognize different forms of suffering: avoidable and unavoidable.”

When hospitals sometimes seem like institutional pressure cookers and lengths of stay continue to fall, it is understandable that physicians, nurses and other caregivers have minimal time to acquire meaningful insights about the individuals they are treating. This is particularly true for hospitalists who often have had no contact with their patients prior to hospitalization. In the Jan./Feb. 2017 *Healthcare Executive* cover story, “The Care Continuum Universe: Delivering on the Promise,” the author writes, “Many of us now know the most effective way to care for patients is when *they* are at the center of care, not the hospital or health system.”

The article also highlighted Catholic Health Initiatives as one of three health systems delivering on the promise of the care continuum universe, stating that CHI “views the continuum of care as centered on the ‘person’—as opposed to the ‘patient.’”

It is regrettable that we must be reminded of this essential truth. ▲

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