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A CONSUMER BASED STUDY TO IMPROVE THE TREATMENT OF PATIENTS IN HOSPITAL

by

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A Consumer Based Study to Improve the Treatment of Patients in Hospital

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This report is of a study started in 1976 which was planned to seek views of patients about their treatment in hospital with the following objectives:-

1. To identify the deficiencies in communication between patients and the medical and nursing staff.
2. To identify instances of words or actions which unnecessarily distress the patients or relatives.
3. To discover patients who have been given inaccurate information or advice.
4. To expose the difficulties of communication between relatives and patients and staff.
5. Where possible to remedy the deficiencies of communication, correct inaccurate information and allay the anxiety of those patients interviewed.
6. To seek ways of improving the relevant aspects of patient care and to encourage staff and students to adopt them.
7. To inform our medical and nursing colleagues of the results of our investigations and where appropriate to discuss individual patients' problems.

Although various enquiries have been conducted into the satisfaction of patients with their treatment, there is remarkably little information available about patients' views of priorities in the National Health Service and about the aspects of treatment which they find least satisfactory. Understandably, the majority

of human beings do not seem concerned about the general standards of care while they are fit. These only become a matter of concern when people have contact with the service either personally or indirectly through a friend or relative. The recent organisational changes in the National Health Service (NHS) and the reduction in some services have not come about as a reflection of public opinion but by political decision. The media have shown considerable interest in some aspects of medicine thereby drawing attention to specific deficiencies but in general they have concentrated on the more dramatic or "frontier" aspects of medicine and on the "newsworthy" shortcomings.

Complicated complaints procedures have been evolved, partly in response to a need indicated by dissatisfied complainants and perhaps also as a buffer for the political and administrative structure of the NHS. The community health councils do not appear to be fulfilling a representative role for patients and there are indications that in some areas they are viewed as part of the administrative structure rather than as a consumer voice. The introduction of behavioural sciences into the medical curriculum and increasing attention to the problems of communication indicate some awareness of the need for changes in relationships with patients. There is a great need for the policy makers, politicians and administrators to hear patients' views.

Method

Information was obtained by semistructured interview and observation with one of the team working full time on the project and the other part time in association with his normal clinical duties. 302 patients were interviewed under the care of four

gynaecologists and obstetricians, one general surgeon and one orthopaedic surgeon in the Middlesex Hospital, the Hospital for Women, Soho Square and the Central Middlesex Hospital. The interviews were conducted in outpatient clinics and in the wards. Many patients were given follow-up interviews in the ward before and after surgery. Particular attention was paid to patients who voiced complaints about their current or previous treatment (wherever it had taken place) and to any who volunteered opinions or suggestions related to their treatment. The sample included patients admitted for hysterectomy, for which leaflets were offered prior to surgery, (Steele 1975) and the study includes information acquired in assessing the value of these leaflets and others on cone biopsy of the cervix. Observations in clinics, wards, theatres and other departments were made throughout the year and patients' views were sought when there was any indication that they had received (or thought they had received) unsatisfactory, discourteous or confusing treatment. The method of informal semi-structured interviews and observation was adopted as the best method of obtaining spontaneous views and information from patients. The use of a questionnaire was rejected because this pre-selects the type of information to be obtained. It was felt that a constructive, sensitive interview with open questions and conducted by a doctor or nurse would be more beneficial to the patient.

The patients were told that the objective of the study was not to elicit complaints, though we were ready to listen and explore any that the patients chose to convey, but to seek ways to improve the care of patients in hospital.

The selection of a nurse as research assistant was deliberate in order to maintain the relationship between patient and professional. A nurse is familiar with the environment and is used to talking with ill and anxious people. In addition, she has the knowledge to answer many of the patients' questions. Above all the nurse is usually seen as a friend and natural confidante.

Gynaecological patients formed a large proportion of the patients partly because it was convenient to interview patients under the care of this department, but also because of the emotional significance of problems related to this speciality. The spread of diagnoses includes a variety of acute and chronic disease, including carcinoma, non-malignant conditions leading to hysterectomy, pelvic inflammatory disease, infertility and spontaneous and therapeutic abortion.

Results

The study proved acceptable to patients and was remarkable in that every patient approached agreed to help. With some patients the initial response was marginally cautious. They felt they were being asked for complaints and feared their subsequent care might be adversely affected but this hesitation rapidly subsided when the purpose of the study was clarified. Some patients were reluctant to elaborate on specific incidents which had upset them. The patients appreciated the interest taken in their problems and the way in which many of these were sorted out. Letters from a number of patients record this appreciation, including some who had expressed dissatisfaction with some aspect of their treatment.

The interviewer inevitably fulfilled a counselling role and once the relationship was established, many patients were enthusiastic to continue.

The demand for further communication proved that there is a great need for the provision of counselling, continuity of interest and support. The nature of the study imposed a state of isolation and detachment from the medical team on the research worker. Professional staff are not generally keen to accept scrutiny or criticism, whether it is positive or negative. It took some time to gain their trust.

It is mentally and emotionally exhausting interviewing tense and anxious patients especially in the gynaecological wards and clinics. It proved to be more stressful than anticipated from previous experience with those specifically undergoing hysterectomy.

The object and plan of this study had been explained to medical and nursing staff in our own department and it received a sympathetic and co-operative response. We were not surprised, however, to find that it provoked an air of hostility and detachment in some members of staff. The information obtained was classified under headings related to aspects and episodes of treatment and these are presented in detail. The proportion of patients making comments favourable or unfavourable is set out in Table 1. Of the total (302), 110 (36.4%) expressed total satisfaction and 192 (63.6%) some level of dissatisfaction.

TABLE 1

	%
Staff attitudes and opinions	22.1
Conflicting information	6.6
Teaching with patients	7.9
Lack of multi-disciplinary co-ordination	4.6
Attitudes to information Negative (Ostrich)	4.0
Use of technical language (jargon) by staff	4.0
G.P.'s referral, other hospitals, other specialities	9.9
Effects of media on patient anxiety	6.2
Administration	15.9
Hotel qualities of hospital (Toilets, privacy, catering)	5.0

110 patients (36.4%) expressed total satisfaction
192 patients (63.6%) expressed some level of dissatisfaction

Percentage of total number of patients (302) commenting on specific aspects of care and services.

COMMUNICATION

Communication deficiencies between doctors and patients both in hospitals and in general practice have been recorded by many writers, notably Cartwright, Duff and Hollingshead, Lay and Spelman, Korsch and the Health Service Commissioner. There is insufficient recognition of the difficulties both by the profession and those who criticise (Fletcher). Among the failures in communication reported to us, many could have been avoided by forethought, self-control and consideration for the patient.

The most common failing among health professionals is understatement. Over optimistic forecasts relating to aspects such as the delay before admission, duration of stay in hospital, degree of discomfort and alternative methods of treatment, caused considerable frustration. Anxious patients tend to latch on to key words and phrases, and comments such as 'only for a couple of days' which subsequently materialised into four, five or ten days, created anxiety, depression and inconvenience. Patients who had to cater for young children and families emphasised that the understatement of time was particularly unhelpful. Over-simplified explanations also caused distress.

One patient was told that her womb had been removed and that her vagina had been sealed up. Understandably she interpreted this to mean that the whole vagina had been closed, and that intercourse was no longer possible. She was 34 years old and in considerable distress.

Patients often complained of having received conflicting information and instructions. In their anxiety, patients tend to ask anyone and everyone, from chaplain to consultant and ward

maid, for advice and information and this is a potent cause of confusion.

Many factors affect the quality of communication. Clear and simple explanations are not always understood, and sometimes the patients claim wrongly they have not been told anything. Fatigue, pain, anxiety, dependency and drugs reduce the patients' ability to give, receive or recall information. Other factors which inhibit communication include extraneous noise, for instance the sound of pneumatic drills, ambulance sirens, coughing or indeed any other distracting event in the vicinity.

Time is a potent factor in consultations. Patients are responsive to the obvious pressures of busy clinics and wards and often refrain from asking questions deliberately or are unable to do so. The behaviour of sick people is often atypical and quite irrational. They frequently misinterpret facial expressions, posture and silence. Anxious people also tend to jump to conclusions. We observed several defence mechanisms of which the most common was the denial of reality. (Kübler-Ross). Professional staff often have to repeat themselves to encourage patients to accept the news of prognosis and future potential. To deny bad news makes it more difficult for the patient to accept later and destroys confidence in the staff responsible. Anxious people register key words in consultations with doctors and certain words have a "shock" effect and inhibit further assimilation of the conversation. Words such as tumour, operation, cancer, hysterectomy, mastectomy and twins caused instant hesitation and loss of concentration.

In the ward nursing staff are constantly changing, and at night patients are particularly lonely and vulnerable. There is a greater need for reassurance at night. A number of careless

comments caused infinite distress. One foreign pregnant patient was refused further analgesia, "No, you can't have any more aspirin, you have probably damaged your baby already."

Patients tend to look towards nurses for constant support. Individual relationships often flourish, but with the constant turnover of staff there is an increased risk of communication breakdown. Temporary relief staff were at a serious disadvantage when challenged with questions by patients. The consultation is a stressful time for a patient, and it can be very helpful if the patient writes down important questions and dates of previous illnesses beforehand so that they are not forgotten. We were saddened however, to find that this sensible preparation by the patient to make the best use of the doctor's time and expertise seemed to antagonise some staff.

Communication is a two-way process, and the quality is largely dependent on individual personalities and modes of self expression. Good feedback is essential for motivation: there is a very real need to encourage doctors and nurses to spend more time listening and talking with patients, and for the inclusion of counselling skills in the training of junior staff. We feel it is important to focus on how to avoid erecting barriers in interpersonal communication. (See Cartoons by Calman.) The importance of communication was emphasized by the time and effort required to solve the relevant problems of the patients who took part in the study. The majority of patients required a forbidding amount of emotional support and counselling.

Summary of factors which adversely affect communication between patient and professional.

Limit of consultation time (particularly when there is an atmosphere of haste).

The roles and number of people present.

Lack of privacy or confidentiality.

Noise or other disturbance or distraction within the environment.

Interruption of the consultation.

Anxiety.

Pain.

Emotion.

Dependency situation.

Embarrassment.

Shyness.

Fear or apprehension.

Fatigue or illness (in either party).

Cultural differences and language barriers.

Deafness, blindness or other handicap.

Individual idiosyncrasies.

Personality differences.

Failure of the professional to listen or inability to identify the real problem.

Failure of the patient to reveal the real problem or cause of anxiety.

Exaggerated or understated history from the patient.

Apparent insensitivity or lack of interest in the professional.

Misinterpretation by the patient of the doctor's attitude (including facial expression, posture, "body language") or use of vocabulary.

The use of technical terms.

Conflicting information from different people.

Misinterpretation of comments or instructions to staff.

STAFF ATTITUDES AND OPINIONS.

In hospital, as in general practice, patients rarely meet doctors or nurses until they have been received and registered by receptionists, porters or clerks. First impressions are important and the initial reception of patients and their relatives may reflect the general approach to the patients within the hospital. While these people may be selected for their interest in people, and their ability to treat them sympathetically and efficiently, this is not always evident. The intimidating and sometimes hostile barrier erected in some general practices, has caused considerable resentment among patients and damaged the quality of the relationship between doctor and patient.

Reception areas in hotels are specially designed to be attractive and welcoming to clients, but some hospitals have uncomfortable, unattractive waiting areas which do not contribute to the calm and efficient atmosphere needed to reassure patients and their visitors. This can be contrasted with the waiting rooms of private practices and nursing homes.

In emphasizing the need for administrative staff in contact with patients to show courtesy and consideration, it seems only fair to record the pressures under which many work, often in inadequate premises, and the frequency with which they themselves are treated rudely or with open hostility by patients. It is important that those working with the public should be prepared to deal with people exhibiting some of the less attractive aspects of human nature and to remember that these are most in evidence at times of fear, anxiety or stress. The care and consideration shown by some porters is humbling to the professional staff. Their approach, particularly in transporting patients about

hospital can be immensely cheering and reassuring, whereas carelessness particularly with trolleys and wheelchairs can cause considerable pain.

Abrupt, discourteous or inaudible commands can be embarrassing or distressing. One lady with a leaking vesico-vaginal fistula and in considerable discomfort, while waiting for guidance in the outpatient reception area was humiliated when a receptionist said loudly "Tell that woman to sit down, she is getting in the way." It is indeed salutary to stand in any reception area and see the interaction between patients and staff. Perhaps every health service recruit should experience the admission procedure and sample the intimidating feeling of being in a large, unfamiliar place, queuing and being directed along unfamiliar corridors, finally to be deprived of his or her clothes, separated from relatives and settled into a ward with strange people.

In-patients have ample opportunity to observe professionals at work. The major misdemeanour mentioned was discussion at the end of the bed thereby excluding the patient from the conversation. The broadcasting of personal information during rounds or by audible history taking was understandably said to be offensive. Inter-personal relationships among staff are closely observed. Conflicts and power play attract attention and reduce patients' confidence. Correction of staff errors should be handled with discretion away from patients. Basic courtesy appears to be on the decline, introductions are perfunctory and junior staff sometimes launch into a history or progress report on a round without even a nominal greeting to the patient. Patients appreciate physical contact with professional staff and the British are typically reticent in this respect.

People with rigid scientific, social or moral views are not generally empathic, and open disapproval or judgment of patients' life-styles or motives can be inhibiting and painful. Understanding, acceptance and sincerity are important qualities for both doctors and nurses. Junior staff in particular tend to offer opinions and value judgements based on inexperience and limited knowledge rather too readily. A 90 year old lady who was about to have radiotherapy for uterine carcinoma was advised by a nurse that she would refuse the treatment if she were the patient; this caused considerable distress and confusion.

Temporary staff are relative strangers to the patients with whom they may have little opportunity to establish a relationship. Individual ward routines and patterns of medical care usually require time for acquaintance. The resulting pressure on patients and staff can have an adverse affect and is not sufficiently recognised.

The "routine" approach to investigations concerned both patients and us. For instance we found several instances of patients undergoing repeated chest x-rays at short intervals just because it was "routine". Most investigations cause some inconvenience if not discomfort or hazard, and this attitude is inconsiderate to the patients and wastes valuable N.H.S. resources.

During the study we found considerable evidence of undesirable attitudes and conduct by both staff and patients. Incidents which would not normally come to the attention of senior staff gave us greater insight into standards of care from other members of the team, and a better appreciation of the general atmosphere and quality of patient-staff relationships.

TEACHING.

The majority of comments on teaching related to the ward rounds. In the relevant out-patient clinics patients generally saw one student fulfilling an active role by taking the initial history. One student per patient is usually acceptable and less disturbing than a large group.

The complaints centred around ward teaching sessions, which often excluded the patient from the discussions and were described in the Lancet by Steele and Morton (1978). Staff talking at the foot of the bed, or out of hearing, increased anxiety. Some patients were most concerned by the apparent lack of respect for confidential information elicited during the history and broadcast not only to those on the ward round, but to an attentive audience of neighbouring patients. It should be customary for patients to be included as a member of the health team and to take an active role.

Some patients found the teaching sessions most informative and enjoyable, while others were worried by the discussions of diagnosis and investigations. The reactions are perhaps representative of the spectrum of human behaviour in such circumstances varying from the desire to make decisions to the desire to have them made by someone else in authority.

The reactions of students and their behaviour with patients are unpredictable. It should be part of the medical education course to teach students to be selective with their vocabulary, and to be more sensitive to the way patients may misinterpret words and behaviour when under stress.

History taking is an essential part of medical practice, and if it is done with care and sensitivity the patient need not feel

embarrassed or concerned about confidentiality. Personal histories in the gynaecological field can be fraught with distress and sometimes guilt, and patients may resent any intrusion by students. Clumsy physical examinations also caused distress, especially among older, unmarried women. Staff and students frequently approached patients without introducing themselves or making any attempt to gain rapport. They then proceeded to take a factual history and make a mechanistic examination, so that patients complained of the impersonal approach. Establishing relationships is a very important part of working with people, and time spent initially in establishing a good relationship with a patient serves as a good investment for the future.

Some patients were delighted when a student took a real and continued interest in their problems and maintained it throughout their admission. It gave a feeling of continuity in an alien atmosphere where there was a constant shifting and changing of staff. There is a tremendous value in members of staff spending time talking with patients. Not only does it have considerable therapeutic value for the patients who value the interest and support, but it gives the staff an opportunity to learn the fuller dimensions of their patients' problems.

Some students and doctors in an attempt to outshine their colleagues, were witty or clever at the patient's expense. This does not go unnoticed and some of the patients were distressed by it. Student ignorance is equally upsetting; one patient was alarmed to find a young student in charge of her delivery, albeit under supervision, when a few hours earlier he had been unable to demonstrate any knowledge of the normal course of labour on a teaching round. Tact and diplomacy are required when

handling student error at the bedside. Patients also expressed a loss of confidence in the team, and personal embarrassment, when a member of staff was reprimanded in front of them.

It is easy to become absorbed in teaching and to forget the patient. Teaching by example is crucial and it is salutary for the students to wait while the senior doctor first greets the patient and establishes contact. It has been advocated that teaching rounds be separated from the medical care rounds of patients. We feel this would tend to emphasize the role of the patients as exhibits and deprive the students of opportunities to witness daily spontaneous interaction between staff and patients.

DIFFICULT PATIENTS

Observations.

Have the ability to irritate professional staff easily,
Demand excessive attention,
Expect spontaneous response to requests,
Behave immaturely under pressure,
Are emotionally unstable,
Have difficulty in conforming to a hospital or clinic routine,
Have a personality which requires extra time to establish rapport,
Ignore common courtesies,
Have different cultural, ethnic and religious backgrounds which are not familiar to the staff,
Have a disclosed or undisclosed psychiatric history,
Do not have their emotional or physical needs met by the staff,
Are frightened, guilty or confused.

The staff tend to prefer cooperative, friendly and appreciative patients, who help themselves and have a sense of proportion and humour. They tend to dislike over-emotional, aggressive, hostile, dirty patients who are unreasonable, demanding, fail to cooperate or are inconsiderate towards other patients.

DIFFICULT PATIENTS.

This term is often used by people who work with patients. Patients can be awkward for many reasons, and the staff are not always aware of and are not coping with the real problem of the individual concerned. Some people tend to expect or demand preferential treatment and their aggression may lead to alienation and less attention or to better care which sometimes antagonizes other patients. There are similarities with the difficult customer in the commercial world. Individual patients have different expectations and some of their wishes may not readily be attainable, while the outcome of a patient's request may depend on the doctor's personal views and mood. We have recorded elsewhere the curiously obstructive attitude amongst G.P.s about problems in the reproductive field (p.2[illegible]). Some men and women were difficult because their earlier experience had been unfortunate (for example long delays in clinics, rudeness or unsympathetic handling by a receptionist, nurse or doctor).

Although the frontiers of medicine continue to advance, standards vary enormously and there is ample evidence of unsatisfactory patient-staff relationships. We deliberately studied the patients who made excessive demands on the time and attention of the staff. It is easy to understand why the cooperative, friendly and appreciative patients become popular and receive more attention. The common factors among the unpopular patients were:-

Over-emotional behaviour, aggression, hostility, poor hygiene, lack of cooperation, lack of tact and rudeness.

Some people find it easy to irritate the people around them, particularly those with psychiatric disorders. Others are

totally egocentric and expect spontaneous gratification of requests or priority in any queue. A primitive instinct 'survival of the fittest' was very much in evidence.

People tend to behave awkwardly when their emotional and physical needs have not been met or fully understood by those responsible for their care. It requires sensitivity, perception and insight to recognise the various dimensions of human unhappiness. Underlying guilt, anxiety and confusion are not necessarily divulged in the initial stages of any patient-professional relationship. The confusion may be enhanced by different and conflicting information from members of staff, which predisposes to a loss of confidence.

Cartwright has confirmed the common experience of doctors that increased anxiety levels reduce the amount of information a patient can recall. Patience is required to repeat and restate information in order to allow the patient to assimilate the news.

The special problems of communication with the dying have been well documented by Kübler-Ross, Saunders and Brewin. Anxiety and sometimes guilt, lack of understanding, sincerity or confidence in their medical advisers accentuate the uncertainty they face.

ADMINISTRATION.

16.0% of patients in the study mentioned problems they had encountered through poor administration. It is inevitable that in a large organisation some people will suffer from inefficiency, poor coordination and communication breakdown. The efficient passage of information and coordination of treatment is easily disturbed when several different people and departments are involved in the care of individual patients.

Delays in clinics were a source of frustration for many patients. Missing notes, queue bunching, protracted interviews caused by complicated problems and doctor delay through emergency or sickness were some of the causes. It seems fair that a conscious effort be made to explain the reason for the delay to waiting patients. In our experience, patients have willingly accepted explanations and apologies, but have rarely received them. Waiting in itself adds to the anxiety and pain. It was observed that some patients failed to advise the hospital of cancellation of appointments, and some general practitioners failed to mark urgent correspondence appropriately. On some occasions doctors attended their patients when the medical notes had been mislaid; this is never satisfactory and is potentially dangerous. The doctor, however, is responsible for treatment and remains so even though vital information is not available.

Patients who had two or more medical problems were frequently subjected to delay and frustration in both wards and clinics. This was largely due to poor coordination between all those involved, both lay and professional. Diabetic in-patients often had to wait for fasting blood tests and hot meals were often eaten cold, if at all. One diabetic patient awoke from her anaesthetic

to be served with curry and rice.

There was evidence of both good and poor communication between hospitals and general practitioners, and between specialists within one hospital. Delays in executing correspondence with appropriate details of treatment, drugs and advice caused further waiting and frustrations to escalate. Time and skill, two very valuable resources, were wasted in correcting administrative inefficiency. This was most in evidence when both professional and secretarial staff had to pursue administrative personnel to obtain necessary action or clarify misunderstandings. The philosophy of treating every patient as an individual is highly commendable, but it is important to establish and adhere to a policy for administration. Lack of management policy leads to inconsistency and further communication and administrative breakdown.

The patients' stories of difficulties in relation to general practitioners centred around unsympathetic attitudes towards their problems, particularly those with infertility, or those seeking sterilisation, abortion or relief of menopausal symptoms. It was only after much persistence that some patients were able to obtain a specialist's opinion.

THE MEDIA.

It would require a specialised study to measure the impact of the media on patients accurately. However, enough mention was made by patients during the study to justify recording some examples.

The need to inform and educate the general public about advances in medicine and health matters, is undisputed. The press, radio, television, cinema and theatre contribute largely to this objective. Attention is also drawn to the deficiencies and problems in the health services available. As a result of sensational and news-worthy coverage we found several patients who had been most alarmed, or who had had their hopes raised unjustifiably.

1) One patient postponed her admission for a year following adverse publicity in the press about sterilisation procedures.

2) Another patient was so concerned after reading an article on hysterectomy in a newspaper, that she refused to be referred to hospital with heavy periods, anaemia and large fibroids.

3) A popular serialised drama showed a young mother's sudden death from a pulmonary embolus. This created considerable anxiety in some women in the later stages of pregnancy.

4) Health visitors reported an alarming increase in confused calls following a television programme which discussed the "pros and cons" of breast and bottle feeding.

5) The widespread coverage of the complications following vaccination against whooping cough created considerable alarm and despondency.

6) A recent programme on the use of the drug Bromocryptine was technically suitable for a post-graduate medical course. It raised the hopes of many women who consequently flooded units such as ours with telephone calls and letters requesting a prescription for "the new fertility drug". When the position was clarified, many women voiced their anger and disappointment.

A letter, from consultant psychiatrist Dr. J.F. Anderson, and others, published recently in the British Medical Journal, lucidly described the adverse effects of both the press and television coverage of electro-convulsive therapy, (E.C.T.) on patients and their relatives.

It is interesting that much of the feedback is directed towards doctors and community health workers, who regularly receive confused calls and correspondence following the broadcasting of "fashionable" medical topics.

It would seem reasonable for those responsible for mass medical education to work in closer harmony with those actively involved in health care, to avoid creating needless anxiety and confusion among the general public.

PROBLEMS ENCOUNTERED DURING OUR RESEARCH.

In the introduction we referred to the general interest and cooperation of the majority of staff. We feel it is important, however, to record the reactions of those who did not welcome the project or were suspicious of the objectives. Some staff felt that the interview was an invitation for patients to complain and that it would cause antagonism. The hostility was probably due to personal feelings of insecurity and a fear of the consequences that might arise from complaints. Research which allows the patient to voice his views, and prompts positive action by the staff, is rare.

People in hospital recognise those who appear in uniform. The wearing of a white coat gave immediate access to patients and notes, but sometimes it created an initial barrier when trying to establish an informal atmosphere for interviewing patients. The research worker felt a degree of isolation, because, although well qualified, she held no specific clinical position.

In seeking permission from doctors to interview their patients, some were readily cooperative, whereas others were distinctly unenthusiastic. Not surprisingly we received more encouragement and interest in areas where the staff-patient relationships were good, than where they were less satisfactory. It is of interest that some of the staff were sceptical or showed frank disbelief when some of the more disturbing events were discussed at meetings.

The complicated complaints procedures evolved by the D.H.S.S. cause apprehension among health professionals. We found, in cases where there was genuine cause for complaint, that our attitude and response was appreciated. The fact that we were willing to spend time listening, offering explanations and apologies, and then

attempted to put matters right was readily accepted by most patients and their relatives. The remote bureaucratic procedures established for investigating complaints are a poor substitute for immediate action, taken by those closely involved in the patient's care.

There was a readiness to attach blame to the research worker if a patient was upset. Some interviews provided an excellent opportunity for the patients to release their personal frustrations and anxieties. One elderly man burst into tears and explained how distressed he was. He felt sure that he had cancer, and there had been recent traumatic events in his family, (his niece was killed, and her husband permanently injured, in an I.R.A. bomb blast, and his nephew had been killed Kenya in a car accident. He had no children of his own and they had been very close). The ward sister, unaware of the background, however, reproved the research worker for upsetting her patient.

Patients were frequently emotional at interview and their views and stories sometimes varied after a second and third visit. Much of the information was opinion and hearsay which is open to misinterpretation, and as an outside observer one has limited access to the facts. However, every effort was made to ascertain the true facts and eliminate bias. Classification of the information was difficult because of the enormous number of variables. In interpersonal communication emotion and personal feelings can alter the emphasis so as to lead to a radical distortion of the facts.

Many of the patients were depressed and anxious. It would be difficult for any sensitive person to spend a considerable time listening to human unhappiness without absorbing some of their distress. Support from the other members of the team is essential,

but is not always forthcoming. Balint group meetings have been shown to provide guidance and support for those heavily involved in the counselling profession and offer one way of reducing this stress.

(Suggestions for change or improvement were received with mixed reactions).

Annexure indicates 50 of the more common responses.

FOLLOW-UP

The second part of our study was devoted to finding ways of achieving the following objectives:-

1. Greater awareness of the needs of patients by those involved in their care.

2. Achieving changes in professional attitudes towards patients.

3. Improved treatment of patients and relatives particularly by better communication.

4. Recognition of the need to educate staff about patients' needs.

5. Informing our professional colleagues and students, of the results of our investigation.

The study has been conducted at the same time as the series of meetings attended by health care staff and representatives of patients' associations at the Kings Fund Centre. These were initiated to hear the consumers' view and to facilitate and investigate communication between patients and staff and we have been closely involved with the planning and organisation since their inception. Many of our findings have been confirmed repeatedly at the meetings and our goals are broadly the same; in particular we share the conclusion that there is a real need for a change of attitude towards patients among many health care professionals.

Interest: This varied from disbelief and boredom on the one hand to genuine interest and concern expressed in varying degrees by the majority. Staff working in our own department were

interested and there has been an increased recognition of the social and emotional problems of obstetric and gynaecological patients though much remains to be achieved.

Medical Students: In the course of small group teaching throughout the year and also in larger scale teaching for the annual intake (approximately 100) of students, we have increased active patient participation and greater emphasis on courtesy, communication and deliberate discussion with patients. These have been accepted readily by most students and commented on spontaneously by some visiting students from the United States of America.

Students on our firm have spent more than sixteen months in clinical work before coming to us, but there has been ample evidence of the need to provoke thought about courtesy, attitudes and behaviour. We feel that this aspect of medical education should be a continuous process, but to a very large degree it must depend on the example set by individual medical teachers in their own conduct towards patients.

Nurses: Lectures were given to the tutors and student nurses, who were responsive and enthusiastic. We also took part in post-graduate study days. It is intended that all student nurses in the school should have a lecture primarily devoted to communication. The nursing staff attending these sessions showed interest in the problems we have described and were very keen to discuss them. We have made some progress in arranging joint sessions for medical and nursing students - an experiment which we plan to extend, hopefully, with the assistance of some of the patients' associations.

Doctors: We have lectured at two other hospitals on our findings and found very different responses. At our own departmental meetings our findings have been described and some of the teaching material shown with a good response.

Audio-Visual Aids: We have had a number of photographic slides taken to illustrate specific points and have obtained relevant slides from other sources such as Journals, T.A.L.C. (Institute of Child Health).

Cartoons were prepared by Calman, and photos of these are attached. Other suitable cartoons were also collected and we found this medium useful /for stimulating thought and discussion, thought the impact was reduced if more than one or two were used at a single session.

Video-tape interviews with patients who had suffered unsatisfactory treatment of a type which merited dissemination were shown to be useful and were particularly effective and sometimes disturbing for those who had known the people concerned.

Conclusion.

The lectures, discussions and demonstrations were effective but reached only relatively small audiences. The students presented the best opportunity to improve standards since it was possible to bring influence to bear on a whole intake of future doctors and nurses at one time. The aids prepared for us are useful but this approach can only have a small impact on overall standards of staff behaviour and patient care. To bring these matters to wider attention requires assistance from the media and we are confident that a well produced, humourous teaching film of the type produced by Video Arts would be the most effective way of conveying the appropriate messages to students and qualified professionals. Through the further generosity of the fund we have commissioned a script for such a film and feel that this may be a forerunner of a series designed to improve relations and communications between patients and staff. We have recorded our suggestions for improvements and developments in the future and hope

that publication of this report, resilience and devotion to the objectives, and the maintenance of our interest with the ongoing working party on Communication between patients and staff, will ensure wider recognition and a continuing process in this field.

Publication is a good method of reaching a wider audience and attracting attention to the work. We have published one article in the Lancet on the Teaching Round and hope that this report or parts of it may be published as well to generate enthusiasm and interest among the wide potential readership of the Kings Fund publications.

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Annexure 'A'

FIFTY EXCUSES FOR A CLOSED MIND

1. We tried that before.
2. Our place is different.
3. It costs too much.
4. Leave it until we are not so busy.
5. We don't have the time.
6. Our place is too small.
7. It's too big a change.
8. The staff associations will scream.
9. The staff will never accept it.
10. We've never done it before.
11. It's against hospital policy.
12. Run up our overheads.
13. We don't have the autho rity.
14. We like change - so long as it involves no alterations.
15. That's too ivory tower (theoretical).
16. Let's get back to reality.
17. That's not our problem.
18. Why change it, it's working all right.
19. I don't like the idea.
20. You're right - BUT.
21. We're not ready for that yet.
22. You cannot teach an old dog new tricks.
23. It isn't in the budget.
24. Good thought - but impracticable.
25. Let's hold it in abeyance.
26. We'll be the laughing stock.
27. Let's give it more thought.
28. My mind is made up - don't confuse me with facts.
29. Not that again.
30. We'll lose money in the long run.

31. Where did you dig that one up from?
32. We did all right without it.
33. That's what we can expect from the staff.
34. It's never been tried before.
35. Let's form a committee.
36. Patients will not like it.
37. Has anyone else tried it?
38. We're all too busy to do it.
39. It will not work in our place.
40. Who's trying to teach me my job?
41. That will work in your department, but it will not work in mine.
42. I'm not convinced.
43. Let's sleep on it.
44. Think of the disruption it will cause.
45. It will make equipment obsolete.
46. It cannot be done.
47. It's too much trouble to change.
48. It will not pay for itself.
49. I know a colleague who tried it.
50. We've always done it this way.

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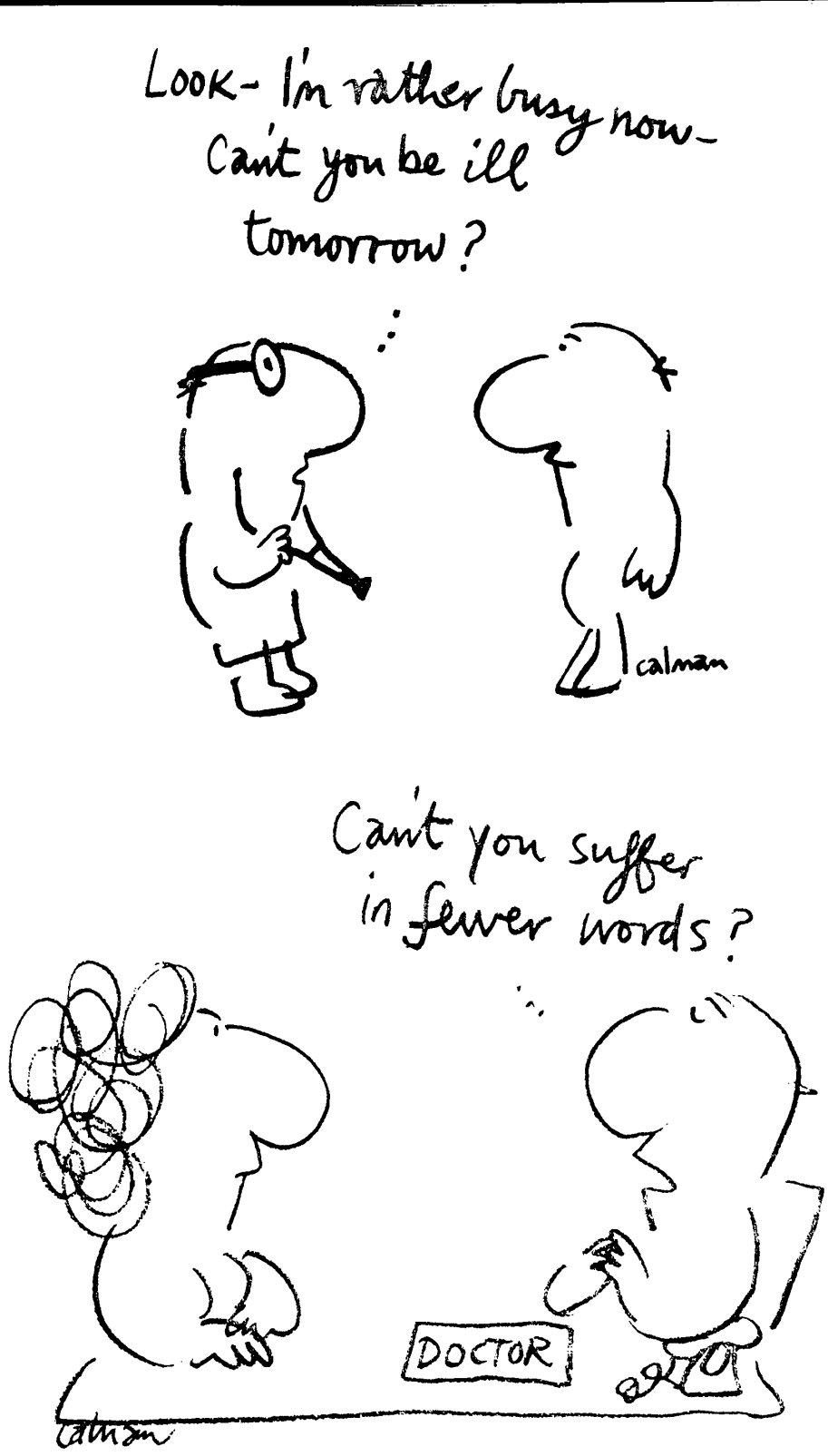

Patient and Doctor

THE WARD ROUND

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WARD rounds and the conduct of those taking part in them are often criticised by patients and staff. When it is conducted without regard for the patient's feelings and dignity, the round can be a potent cause of embarrassment, anxiety, and distress; and it can lead to a loss of the patient's confidence in the staff, to refusal of treatment, or to self-discharge. During a study aimed at improving the care of those in hospital,[1] information gleaned from patients revealed several unsatisfactory but recurring aspects of ward rounds. We have recorded these criticisms and we suggest ways of improving the conduct of ward rounds.

COMMON COMPLAINTS

The Patient Ignored

It is easy to discuss the patient while treating him as if he were part of the furniture. He feels neglected and his role is that of a bystander. This fault can be avoided by greeting the patient and introducing the staff; when many people are involved in treatment, their role should be explained. The gist of any technical discussion should be explained.

The Patient as an Exhibit

If physical examination is likely to be embarrassing, it should be conducted behind curtains in the presence of the fewest people necessary, maybe doctor and nurse. But if there is teaching value in demonstrating a physical sign, the patient should be asked for his consent.

Exclusion

If the discussion takes place at the foot of the bed or out of earshot, the patient feels totally uninvolved and he may worry that an unpleasant truth is being kept from him, especially if the team proceeds to the next bed without explanation. If the team moves away to examine an X-ray, this should be explained and the conclusion passed on when the team returns.

Fellow Patients

Other patients may listen with avid interest to learn all that they can about an individual. Standing too far from the patient concerned necessitates loud talking, but standing fairly close can create a confidential atmosphere without shutting in or "threatening" the patient. Details in the history which may be embarrassing or distressing and which should be treated as confidential should be omitted or disguised (these may be discussed outside the ward before or after the round).

The Patient Who Does Not Understand

Staff should be constantly aware of the danger of unguarded discussion by the bedside of those patients who are apparently unconscious, sleeping, foreign, confused, or of low intelligence.

The Need for Private Consultation

Senior doctors rarely visit the ward unescorted and the presence of more than one person may inhibit the patient who wishes to discuss a worry or problem about which he is embarrassed. The perceptive doctor or nurse will realise that a patient wishes to have a private talk and the doctor can return alone, later. The concept that everything can be discussed on a round is out-dated, especially in gynæcology, where emotional and sexual problems are a frequent source of distress. A solo ward round is something every doctor should do from time to time. Patients appreciate the individual attention and the doctor not only establishes better relations but also learns a great deal.

The Creation of Alarm and Despondency

Terms may be mentioned (especially on teaching rounds and sometimes quite inappropriately by students) without the patient being aware that they are not relevant to him. Certain obvious words such as cancer, amputation, hysterectomy, and twins can cause so much mental turmoil that any subsequent explanation is missed. Failure to realise this causes more distress and, coupled with the failure to listen, is a potent cause of failure in communication. On the many occasions when diagnoses are reconsidered and when measures are mentioned for the first time, those on the round should wait while the position is explained to the patient either by the doctor or a student (a useful way of teaching students to choose their words carefully). When something alarming is inadvertently mentioned it should be immediately explained to the patient either as an irrelevancy or otherwise. Patients should also be encouraged to demonstrate their reactions to student participation in the ward round.

Sensitivity to Interpersonal Relationships and Disturbance of Confidence

Patients are often upset when staff or students are criticised, reproved, or shown to be ignorant on a round. A striking example of the latter situation is that of a patient attending a teaching session at which the students could not answer the question "How do you know if this lady is in labour?" Later that same day, the patient found, to her alarm, one student in charge of her delivery, albeit under supervision. The problem of student ignorance cannot be avoided, but teachers can avoid making the student appear so stupid or incompetent so as to embarrass or worry patients. Criticism or correction of staff or students, and arguments on medical matters or clashes between staff, should take place outside the ward.

Being Taught On

There is a great danger of the patient feeling like an exhibit when he is the focal point of a teaching round, for which it is official D.H.S.S. policy that the patient's permission has to be obtained. It is sad that a ruling is required to carry out what is purely a matter of courtesy. We prefer the concept of teaching "with patients"; some patients find that being involved in discussion and teaching makes them better informed and they therefore feel reassured. A real cause of distress can arise from the desire of a student who wishes to outshine his contemporaries by being witty or clever at the patient's expense

When business and teaching rounds are combined, students should see priority being given to the patient. After good news has been given, care should be taken to avoid raising doubts caused by, for example, discussing technicalities ("What happens if the laboratory results are wrong?"). The delivery of bad news, however, is so personal that it should be done with sensitivity and in private.

Alternative to Ward Rounds

One alternative is to take the patient from the ward to the round held in a separate room. This may be necessary when special instruments or examinations are necessary as for example in otorhinolaryngology, neurology, and ophthalmology, but it generally amounts to making the patient an exhibit. There are no really satisfactory alternatives to the ward round, although there are many other methods of teaching.

Conducting a Round

To conduct a round when more than two or three people are present requires courtesy, experience, appropriate medical knowledge, concentration, and a certain amount of stamina. Some doctors and nurses know intuitively how to behave towards patients and colleagues, whereas others require a change in their attitudes. Students need guidance in their behaviour. Teaching by example and precept must surely have great potential for influencing attitudes. Human caring qualities are not ranked as highly as they should be in the selection of medical students and teachers, and sensitivity is one of the many attributes necessary in a good clinician. There has been considerable emphasis on the teaching of behavioural sciences and this may well provide a basis for preparation. However, the behavioural scientist rarely has any practical experience of a role involving responsibility for patients, and students are likely to be more influenced by the professionals in the role to which they aspire. The doctor who shows that his prime concern is for the patient and treats him with respect, courtesy and consideration, will inspire imitation by the more sensitive students. The consumer voice will certainly be heard more loudly in the future and members of the caring professions should welcome the opportunity provided by ward rounds to reappraise their conduct towards patients.

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