

HUMAN RELATIONS AND HOSPITAL CARE

ANN CARTWRIGHT

London, Routledge & Kegan Paul, 1964, 262 pp., \$6.00.

At first glance, one is tempted to ask what is so significant in a social survey of hospital care which, like so many social surveys, only confirms in an orderly way what we already knew? Isn't the summation, critical though it is, merely a special case of the general category "man's inhumanity to man"?

Well, not quite. Unlike the functions of some other institutions, that of the medical institution is to *help*—to help people who are in pain, to relieve suffering. Dissatisfactions in the past have derived from insufficiency of *medical* knowledge. What seems to be different today, and what is documented here, is the failure of the hospital to provide the patient with personal attention and understanding: "The successful application of medical knowledge depends on what patients think and feel about doctors, nurses, and hospitals. A patient's decision to become one, his willingness to be examined, his acceptance of treatment, depend on his confidence in the skill and humanity of doctors and nurses and on his feelings about the institution where he may be treated."

It is not the *skill* that comes under attack in *Human Relations and Hospital Care*, it is the *attitudes*.

One would have thought that after more than a thousand years of experience the hospital would have become automatically competent in its helping function, improved, if anything, by the maturing and innovations of technical skill. However, like so many institutions designed to serve social needs, the hospital has become self-serving,

allowing procedures and attitudes that serve institutional needs to take precedence over human needs.

Dr. Cartwright sets out to answer the question: "What is it like to leave your home and family and go into hospital, where you are dependent on strangers for physical care and companionship?"

Dr. Cartwright approached the answer through a survey of a random sample of patients aged 21 or over from 12 areas of England and Wales, who had been in hospital within the six months prior to the inquiry. There were 739 people interviewed in their own homes, over 81 per cent of those eligible.

From Part I, "Admission to Hospital," through "Life in the Ward," "Problems of Communication," and "The Hospital and the Outside World," Dr. Cartwright submits an analysis of how patients and their families react to nurses and doctors, to the anxiety of uncertainty of diagnosis and treatment, to large wards, to lack of privacy, to the prying and exposure imposed by medical education, to deficiencies of communication, to inconvenient visiting hours. The economic consequences of hospitalization and the role of the family doctor in hospitalized illness are also examined. In addition, the author attempts to compare various types of hospitals, and the influence of social class in reactions to these circumstances.

Among the findings, most disturbing is the fact that by far the greatest dissatisfaction among patients stems from lack of information and the inability to find channels for obtaining information while in the hospital: "Whatever the reasons, patients were more critical about the difficulty of obtaining information than of any other aspect of their hospital care. . . . Over half the patients described some difficulty in getting information while they were in hospital."

The information desired was simple, basic, and—by any standard—necessary: the diagnosis, the nature of the treatment, the anticipated length of stay. Yet in the majority of instances, doctors (particularly), nurses, and other hospital workers could find neither time nor inclination to provide the information. Interestingly enough, there is no difference in satisfaction among patients when information is given by a doctor, nurse, or other health worker.

Curiously enough, in the discussions on privacy, it is not the large-

sized ward that patients object to—although distress is generated by too visible evidence of others' suffering. Again, it is the disregard of human need—the delicate adjustment to sensibilities—that stands out, unnecessary exposure to public view, to be talked about in one's presence like an object, that incur bitterness.

Of course, the outrageous barbarism of hospital "routine" should be summarily remodeled. There is no excuse for the 5:30 A.M. awakening (30 per cent of patients in nonteaching hospitals are still awakened *before* 5:30 A.M.!), the rigid meal schedules, preparation for rounds at the attending doctor's whim, the "unwelcome intrusions" of students without a by-your-leave. These can be changed without in any way endangering medical care.

Unfortunately Dr. Cartwright did not direct her inquiries to the area of quality, except for the limited early discussion of delay in hospital admission. More comparative analyses would have been welcome. But even in the discussion of admissions to the hospital, the responsibility for delay seems to fall most heavily on patients themselves rather than on the practitioners. Can this, too, be a defect in communication? The general practitioners are very bitter about not getting old people into hospitals promptly. Is this due to a defect in communication, too? Many questions are raised in this section that would repay thoughtful exploration and analysis. How good are the general practitioners in their diagnoses, and in their referrals? And how well are general practitioners and specialists integrated in their functioning so that illnesses can be promptly and efficiently diagnosed, and patients hospitalized as required? How much effort is extended in *preventing* hospitalization?

Clearly what emerges from the fairly simple formulations of this study is that a more clear-cut definition of what the patients—as people—need must be transmitted to professionals, and that a more effective way of promoting hospital functions to meet these needs is required. Hospital design, administration, and professional function all need intensive study and more imaginative reordering. A precise role for the general practitioner, so clearly lacking in medical care organization at all levels, is also vital in hospital practice. The complaints about lack of information, for example, can easily be over-

come through some such reordering. A personal doctor, well trained, technically skilled, and hospital-associated is a *sine qua non*. The personal doctor who is aware of patient needs in the emotional area, and who is sociologically sophisticated, would obviate nearly all the criticisms.

Within its scope, the book could not include studies of the relation of patients' views to some objective standard of quality. Did the level of professional skill, for example, parallel other satisfactions, or was there no relationship? There is a clue in that teaching hospitals were found to be a trifle more satisfactory than nonteaching ones: patients were more enthusiastic about the nurses, for example. But did teaching hospitals satisfy their patients with a greater degree of information than nonteaching hospitals? We don't know. Certainly patients satisfied with service did not indicate they had had any more information than dissatisfied patients. I suspect professional skill and human relations will not be found to go hand in hand.

As a patient's-eye view, the survey is excellent. And it helps to be reminded that what professionals say patients want or need isn't entirely what constitutes good patient care. The professional commitment must be broadened to include *patient* conceptions of patient need. Dignity and respect for the individual should go hand in hand with technical skill. It may be a relic of the ancient and discarded theory of illness as punishment that incites the practitioners to treat the victims so cavalierly. Shall we bring professional concepts of patient care into the twentieth century along with professional theory?

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