

Measuring the immeasurable

The human aspect of medical care that statistics ignore

HISTORICALLY, hospitals have acted as a refuge for the sick, the frail, the elderly and the infirm. In some instances, hospitals have been the last option for the less fortunate members of our society seeking help. Hospital emergency departments (EDs) are now one of the few agencies available 24 hours a day to assist people in crisis. But the ED is often stretched to the limit providing its services to all and sundry — encapsulated in the story of a composite patient, “Harry the Hobo”. It is a difficult working environment, in which the prevailing orthodoxy of economic rationalism focuses attention on funding measurable outputs. But our experience suggests that some “outputs” are difficult to measure and, indeed, shouldn’t be measured.

At last year’s ED Christmas party, someone noticed that Harry hadn’t yet appeared in the ED. Harry *always* dropped in during Christmas week. In fact, it was in late November of that year that he had last visited. Some Good Samaritan passer-by had alerted the ambulance to a seemingly unconscious old man lying against the wall in an alleyway. When brought into the ED, he was immediately recognised by the triage nurse. “Harry, what have you been up to *this* time?” She knuckled him in the sternal area, to check his level of consciousness, and Harry roused with a “F... off!” before slipping back into oblivion. He reeked of stale beer, and pieces of his last meal were spattered down his front, making the hospital gown he was wearing almost unrecognisable. But his tweed cap remained glued to his head, and his brown jacket and socks were on, the latter recognised more by odour than colour. “Put him on that trolley in the corridor there”, the nurse directed the ambulance staff. No observations were done. Why would you? This was Harry.

The ED on that night in November was bursting. There were no beds in the hospital, but no one bothered any more to ask why. The only reason the department was not on ambulance bypass was that every other hospital was on bypass already. To move to bypass would create “gridlock”, a consequence that could not be contemplated.

So Harry wasn’t very welcome that night. Mind you, he had been only begrudgingly welcome for some years. He was a source of frustration nowadays. Years ago, when his name came up on the screen, the cry of “there’s a good patient for the Intern” would come up. On this occasion, the Emergency Consultant was beckoned by the Nurse in Charge to come and “get rid of him”. Harry’s history notes arrived, or at least the last two volumes of them.

Harry’s presentations actually seem to have shortened as the years have passed. His diagnoses have included chronic “burnt-out” schizophrenia, head injury from falls and assaults, atypical chest pain that had been investigated relentlessly, atrial fibrillation for which he was once taking warfarin, haematemesis, melaena and alcoholic liver disease. But few of these have been active components of his presentations in this, his eighth decade of life. Mostly he wakes from his ethanol-induced stupor, and shouts a few

expletives relating to his desire for the bottle (urine) and for sandwiches and a cup of tea. On this occasion, he was rehydrated with normal saline. As he had no fixed abode, and given that it was 11 pm, Harry slept on his trolley overnight and left in the morning. His cap stayed on throughout.

Over the years, Harry has spoken to many psychiatric triage nurses and many social workers. He used to stay in a men’s boarding house, but was evicted on multiple occasions. Now he sleeps “rough” and his patient registration details record him as being of “no fixed abode”. With no living or caring relative, no general practitioner that he bothers to visit, and no regular publican to have a yarn to, he has nominated the hospital as his next of kin. His most frequent ED diagnosis these days is loneliness.

Harry may be lonely, but he is not alone in this regard. For people at the margins of society, the local ED can be a place of solace. Maybe this is more pronounced since the reduction of institutionalised accommodation for people with chronic psychiatric conditions, maybe not. Either way, no manner of community follow-up and support networks can fill the void of loneliness. So into the ED comes a group of people seeking aspects of attention that are often disregarded when assessing clinical workload. They may be young or old, male or female. One study of “unnecessary” ED attendances at a tertiary hospital in Melbourne found that 41% of repeat attenders were homeless.¹ They may present with atypical chest pain, a conscious collapse in front of the triage nurse, a request for a repeat script for “sleeping tablets”, or a rash of 6 months’ duration. In the waiting room they may chat to fellow patients or catch up on the football displayed on the television. Often they “entertain” the security guards. Once they “break through the department gates” they may get a trolley, where they can choose to sleep or sit up and observe all the activity around them. The place is warm and active. The frowns or firm words of the staff don’t seem to bother them. Being woken up does though, and their colourful vernacular adds to the



liveliness of the work environment. A warm cup of tea, some carrot-filled sandwiches, even a shower and some clean striped clothes from the cupboard — these are some of the “perks” of a visit to the ED.

This type of patient challenges doctors and nurses alike. They are an ever-present nuisance, a source of frustration. Trolley space, nursing and medical assessments, food and toileting — these resources are already heavily stretched but nevertheless expected to repeatedly cater to the needs of Harry the Hobo and those of his ilk.

Medical care is now heavily regulated and constantly measured. In the ED we must measure waiting times, length of stay, complaints and adverse events, which are then benchmarked against key performance indicators. Workload indices, such as attendances adjusted for casemix, need to be calculated. Patient satisfaction surveys are scored and the results compared with those of other health services. Registries keep a record of outcomes for trauma and other diseases, and various surveillance agencies monitor the incidence of injury and infectious disease. Staff morale is measured by staff turnover, staff satisfaction surveys, and days lost due to sick leave. On the basis of these numbers, management is rewarded or punished and hospitals survive or perish.²⁻⁵ With all these measurements and management reviews being conducted, surely a proportionate degree of funding and resources is being allocated to providing “tender loving care” to Harry the Hobo and others like him. Well, no, it isn’t.

How do we begin to incorporate such care packages into our workload indices? Should we begin by measuring the vocabulary score? — that is, how many expletives were uttered that we really didn’t wish to hear. Or maybe by Harry’s aroma score and its effects on the environment we work in? Surely showering time, undressing and redressing time are easily measurable. Department “warmth” consumed by the patient might be difficult to measure, as would the pleasure felt by the patient in being recognised by staff. At the very least, though, we should have an index for the number of carrot sandwiches consumed.

In mediaeval times, the burden of care for the “not unwell but merely unfortunate” fell on the Church. In 19th century Europe, the mass urbanisation associated with the Industrial Revolution increased the marginalisation of the dispossessed, with the concurrent expansion of multiple secular charities.⁶ Today, the “Salvos” and the Red Cross Society are just two of the many organisations that serve the so-called “castoffs” of modern-day society. And, despite the economic rationalism of the 1980s and 1990s, health services have attempted to maintain some flexibility in catering for those “consumers” who do not fit neatly into an “illness category”.

The ED provides 24-hour access and, thankfully, can refuse admission to nobody. For many people it serves as a refuge, a source of basic comforts and basic human values. It becomes their family. We cannot and should not even attempt to measure the delivery of this service. Indeed, any measure would devalue its true worth to the beneficiaries themselves and to the staff who provide it. One could imagine a situation in which hospitals might adjust the

“loneliness score” or manipulate the “compassion index” to maximise income. But the service that is being provided is one of human kindness and compassion — the basis of a civilised society. This human aspect of medical care should be acknowledged and celebrated, rather than measured.

Harry the Hobo did eventually visit the ED on Christmas Eve. He had been found cold and unconscious, and on this occasion wasn’t moving his left side. In addition, it appeared that he had subsequently aspirated and now was in respiratory distress. It was clear that this would be Harry’s last visit. He was taken inside immediately, and when the treating nurse saw the tweed cap beside him on the trolley, she realised who this dying man was. The cubicle was quiet and respectful, and the doctor and nurse applied some oxygen, delivered some hydration, and ensured that Harry was comfortable. He died several hours later. Harry was at home with his family for Christmas.

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