

Stephen Prosser

# Mit den Augen der Patienten

Für ein Spital lohnt es sich, die einzelnen Abläufe auch aus Patientensicht zu analysieren

**Patienten reagieren sehr empfindlich auf Leistungsschwankungen einzelner Dienstleistungen im Spital – und setzen sie häufig mit einer ungenügenden Qualität der gesamten Klinik gleich. Deshalb sollten Prozesse auch immer aus dem Blickwinkel der Patienten betrachtet werden, damit die Versorgung auch als optimal empfunden wird.**

When I worked in the National Health Service (NHS), one of my colleagues told amusing tales about her days as a trainee hotel manager. One of her responsibilities was to check that each room was in pristine condition; after all, this was a hotel with aspirations of five-star status. The hotel's general manager said there was only one way to maintain standards: you had to lie on the bed and in the bath, to have the same view as the guests. So she laid down in sixty baths and beds, regularly. You will see the relevance of this anecdote immediately. Between 1996 and 2006 I was an inpatient in six hospitals and an outpatient in two others.

I am a very grateful patient – my life was saved on two occasions – but I remain surprised by the many examples of unplanned and unacceptable variations in practice I experienced. Although an NHS employee for almost twenty years, it was only when I lay in hospital “beds and baths” that I gained the valuable insights only patients obtain. I have seen it all: the good, the bad and the just about acceptable and this account, by a former healthcare manager and current academic, is above all the account of a patient – using a relevant diagnostic lens; one who believes that the patients' perspective can identify major improvements in service, typically without financial cost. In what is written the dedication and accomplishments of clinicians and others are readily acknowledged.



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## Abstract

Der Autor Stephen Prosser arbeitet seit zwanzig Jahren im englischen Gesundheitswesen. Seine eigenen Spitalaufenthalte nutzte er, um aus Patientenperspektive die einzelnen Abläufe im Klinikalltag zu analysieren. Den Autor interessierte in erster Linie, welche Faktoren dafür verantwortlich sind, damit sich ein Patient in einem Spital optimal versorgt fühlt. Die markanten Unterschiede und Schwankungen zwischen einzelnen Spitälern, Abteilungen und Mitarbeitenden führt Prosser grundsätzlich auf Schwachstellen in folgenden sechs Bereichen eines Spitals zurück:

**Patientenakte:** Für einen Patienten ist es sehr angenehm, wenn seine Krankengeschichte nach der Identifikation zentral abrufbar ist. In vielen Spitälern sind die Systeme der Administration jedoch so archaisch, dass der Patient seine Krankengeschichte pro Tag mehrfach erzählen muss.

**Abteilungen:** Der Informationsfluss zwischen den einzelnen Abteilungen muss lückenlos sein, damit «die rechte Hand weiss, was die linke tut».

**Arzt-Patient-Beziehung:** Die Patienten reagieren sehr sensitiv auf individuelle Eigenarten der Ärzte. Deshalb sollten die Mediziner den Patienten generell mit viel Nachsicht und Einfühlungsvermögen begegnen.

**Fachkompetenz:** Die Patienten erwarten beim Personal eine hohe Fach- und Sozialkompetenz und eine fürsorg-

liche Einstellung. Dadurch fühlt sich der Patient gut aufgehoben und sicher.

**Kommunikation:** Es gilt festzulegen, durch wen, wann und wie Informationen an den Patienten weitergegeben werden. Es darf beispielsweise nicht passieren, dass ein Patient nur zufällig von einer möglichen Operation erfährt oder nach einer gravierenden Diagnose sich selbst überlassen wird.

**Spitalverwaltung:** Patienten und Personal haben eines gemeinsam – die Arbeit der Spitalverwaltung ist für sie nicht fassbar. Deshalb ist es wichtig, dass das Management regelmässig auf den einzelnen Abteilungen präsent ist und so aus erster Hand über die Bedürfnisse des Personals und der Patienten informiert wird. Somit kann gleichzeitig das Risiko reduziert werden, dass neue Konzepte vom Personal nicht akzeptiert und umgesetzt werden.

Wie in einem Hotel erwartet auch der Patient in einem Spital ein gleichbleibendes Qualitätsniveau. Dazu braucht es Rahmenbedingungen, die verhindern, dass unerwartete Leistungsschwankungen diese Wahrnehmung stören. Anpassungen in den genannten sechs Bereichen haben einen beachtlichen Einfluss auf das Qualitätsempfinden der Patienten und können relativ einfach und meist ohne zusätzliche Kosten im Klinikalltag umgesetzt werden.

### The curse of variation

The greatest obstacle to consistent first-rate services is the curse of unacceptable and unplanned variation: sometimes the service is excellent, sometimes mediocre; sometimes staff perform superbly, at other times they are ordinary or inadequate. For some reason, one part of the organisation delivers excellence in everything it does, whilst other parts are inconsistent in meeting the needs of its clients.

As a patient, I was surprised by the unacceptable and unplanned variations existing between hospitals, within the same hospital, occasionally between and within the same professions, and sometimes on the same ward. A number of questions illustrate this variability:

- Why are some administrative services highly efficient and others consistently poor?
- Why are some receptionists pleasant and helpful and others miserable and grudging?
- Why don't equally-skilled people undertake tests?
- Why don't all staff realise how vulnerable patients feel?
- Why do some doctors believe the less a patient is told the better?
- Why are some nurses unfriendly, and only make the patient comfortable when asked to do it?
- Why can one hospital provide nutritious and edible food, whilst another offers poor food?
- Why are some bathroom facilities dirty and unacceptable?
- How can the same hospital contain world-class standards in some services and poor standards in other services?

These unplanned and unacceptable variations are widespread and if eradicated would substantially improve the quality of health services, benefiting the patient significantly. Most of the improvements – shown as six key issues – are cost neutral and an essential component for patients in a future hospital.

### Recording of information

We live in the information age. If I *google*<sup>TM</sup> my medical condition, 900 000 references appear instantly; if I buy over the telephone, my postcode allows the supplier access to immense information; and when I buy books from Amazon, my password initiates invoicing and mailing systems.

Information in the health service is a source of amazement to the patient. Hospitals are not made up of technophobes – the clinical equipment bears testimony to that – it is just that so many of the administrative systems are archaic. There are reams of papers, bulging files, and a plethora of sometimes-indecipherable hand-

written comments. All of this would be fine if the systems were highly efficient but the concern is that the systems lack the effectiveness necessary for the patient's best interests.

The patient's experience would be improved substantially if a record of their medical history were available to clinicians once the patient is identified. Without such a system the patient is relied upon to describe not only current symptoms – which is perfectly reasonable – and the his-

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tory of treatment in other hospitals. This history of treatment has to be given repeatedly to various clinicians, as they appear unable to share the first description, and to repeat one's story at a time of severe pain, possible confusion and worry about the future is not a pleasant experience. There is also the concern that the efficacy of one's care might depend on how well one is able to draw on powers of memory and articulation during a time of stress.

Then there is the issue of sharing planned diagnostic information. Most patients are willing to travel for treatment by the most appropriate clinician. This willingness to travel is not always extended to the matter of routine and planned diagnostic tests. Why is it necessary to undertake long round trips to be x-rayed, CT-scanned, MRI-ed, or have blood taken? Why can't those tests be undertaken in the patient's local hospital and the "raw" results, even if not the definitive interpretation, be sent electronically to the other hospital's clinicians?

### Services connected one to another

It is a first-class experience when the components of the hospital system allow the patient to move seamlessly from one department to another. There will be occasional delays, to allow for emergencies or difficult schedules, but generally the patient feels expected and the members of the department know what test or treatment to give. It's a case of the "left hand" of the system knowing what the "right hand" is doing, and the patient benefiting.

Whilst proper to assume that each service in the hospital works with precision, professionals and services operating efficiently within their departments, it is important for those individual services to be fully connected, as it is the patient who experiences the disconnected parts, those parts not properly joined together. For example:

- One day patient experience stands out. The procedure was undertaken in modern facilities, the nursing care was excellent, I cannot praise the doctors highly enough for their skill and how they spoke to me throughout the procedure. And yet, I was asked to change into a surgical gown in the nearby gentleman's toilet – a room that was small and smelly, and near the reception desk so somewhat public.
- My worst experience took place in a highly-regarded hospital, with top class clinicians and management. I needed a test urgently and was taken in my bed to the diagnostic facilities by two porters. On arrival I was told there was a delay of forty minutes. The porters parked my bed in the corridor, outside the suite, and left as they had another patient to move. I was on my own, in a corridor that was, in effect, a public thoroughfare as outpatients and visitors had access. I had been given pain killers on the ward and shortly fell asleep, waking up about 90 minutes later, still unattended, to find my wife sitting at the foot of the bed. She'd been there for about 40 minutes, meaning I had been on my own for 40 or 50 minutes. Eventually, the nurse and consultant greeted me and treated me wonderfully.

This is a perfect example of lack of connectivity: doctors and nurses on the ward had done their job expertly, send me on my way; the porters were excellent, wheeling me and avoiding the bumps to ease my pain; the diagnostic staff could not have given me better care. Yet there was a

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yawning gap in the overall system that allowed me to lie in a bed, in a public corridor, in pain and on my own for over an hour (if my wife hadn't turned). To be charitable, it is possible that someone was keeping an eye on me, but my wife and I were not aware of it.

Problems arise in the "white space" between teams and there are times when patients fall between two or three "stools". Ensuring the whole system works effectively is a key management task and if hospitals have an organisation chart, or set of flow diagrams, where every box is square, every circle round, every line straight, and each part of the organisation joined to some other part, then management should be alarmed: they should throw away the charts and diagrams and walk around the hospital and talk to the patients. The charts and diagrams are misleading – everything is certainly not symmetrical and smooth from the perspective of the patient.

### Relationship between the patient and the clinician

Take nursing, for example: typically, they are expert, hard working and willing to answer questions and allay fears. However, there is also a kaleidoscope of different *cultures*, *personalities*, *organisations* and even *practices*.

Diversity is an apt word to describe the individual *cultures* found on a ward, especially in larger city hospitals. I overheard one sister explain that her six staff nurses for the night shift came from six different countries.

Every *personality* type can be found and there are occasions when a patient's inability to "read" the best way to ask a nurse for something can be disadvantageous. This is why patients in some hospitals wait eagerly to see which nurses will care for them on the next shift.

Then there are the different *organisations* and these can differ quite markedly with key individuals on the ward establishing the tone, or the organisational culture, of the place: some manage to be professional and friendly; others manage only the professional side of that equation.

In terms of *practice*, some nurses function at the cutting-edge of technology and clinical practice; some appear solely to perform administrative tasks on behalf of doctors; and some combine various nursing activities to benefit the patient: one nurse, who had provided me with "high tech" care, made drinking chocolate and toast at 3.30 in the morning, a meal that signalled I had just turned the corner in my recovery.

However, it is difficult for patients to comprehend the subtleties of different *cultures*, *personalities*, *organisations* and *practices*. Most patients feel vulnerable: they are in a strange environment, away from their families, potentially embarrassed, possibly in pain and anxious about what the doctors will tell them. Patients, in such a state, need to be treated with kid gloves.

### Ongoing training and development of staff

The patient has three main requirements of those charged with taking care of them:

#### A professional and practical competence

One assumes that the uniform worn is an indication of the person's competence. It means they are professionally qualified, have been accredited, are subject to regulation, are committed to keeping knowledge and skills up-to-date, and can apply knowledge practically.

The patient does not believe that all professionals are, or need to be, equally qualified or equally competent; but patients do believe there is a basic level of qualification and competence below which no person caring for them is

allowed to fall. It is a reasonable assumption and fundamental area of trust to expect those caring for the patient to be competent. The patient does not want to be looked after by a surgeon ten years out of date, or a nurse who fails to keep up with latest practice, or a hospital manager who resembles an old-fashioned bureaucrat.

### A compassionate and caring nature

There is a great difference between a clinician reacting to a request for care and one taking a proactive role in making the patient comfortable, ensuring their needs are met where possible. A patient understands quickly: some clinicians should only be asked for help when absolutely essential; others are happy to help with every reasonable need.

I can think of one test I had, one I'd had many times in the same hospital, where the procedures bordered on being farcical. As the needle was inserted, blood from my arm squirted high into the air; the equipment set up for the next stage of the test had been inserted incorrectly and I was sprayed with a harmless liquid. A charming diagnostician, who had not fully mastered the procedures and should have been supervised, was left alone to administer some tests.

### A personality allowing the patient to develop an appropriate relationship

No two clinicians are identical; they have different backgrounds, interests and personalities; what one clinician considers a suitable approach may not suit others, who are more introverted or extroverted. What is true of a clinician is also true of a patient: no two patients are identical and their needs, the ways they express themselves, or the ways they wish to be dealt with, should be taken into account. Some clinicians are expert in the way they treat patients and others treat patients as if they were all exactly the same. Variations occur on the same ward, where one clinician takes into account the preferences of the patient and another fails to see the need for helpful discrimination. This, in turn, makes it difficult for the patient to know exactly how to relate to a clinician and their preferred modes of functioning.

### Skill of communication

Although there is nothing wrong with my hearing or reasoning, there have been times when I failed to understand the significance of an important point being made by a clinician. Normally I would have understood immediately, aware of the nuances and implications, but in hospital experiencing the after-effects of medication and anaesthesia, coupled with fear and pain, there are times when important information is not understood.

These three examples show how the wrong person can make the communication and how poor communication can take place because of unthinking individuals.

- **Example 1** As I was being wheeled out of one hospital, after a long stay, a nursing auxiliary said: *"It's so good to see you going home, especially after you came so close"*. *"So close"*, I thought, *"Whatever does she mean?"* I asked what she meant. *"Well, you know"* she said, *"so close, when you nearly didn't go home"*. This was news to me. No one else had said this, even though it had dawned on me as a distinct possibility, during the early part of my stay. But this was the first time that anyone had said it to me and it came as a surprise. I let the matter drop; I was delighted to be going home.
- **Example 2** I attended outpatients for what I thought was a routine appointment, expecting to be told that the consultant would see me again in twelve months. As I sat in a diagnostic room a nursing assistant took my blood pressure and handed me a manual *"that I give to everyone about to have surgery"*. I was feeling a little tetchy that afternoon; it was warm, I was tired after a long drive through heavy traffic, and said: *"What do you mean surgery? I'm not having surgery"*. She disappeared and an experienced sister appeared and said something about manuals being a routine procedure. Thirty minutes later the consultant explained that I needed surgery and I left the hospital in a daze, with my head spinning.
- **Example 3** demonstrates the power of non-verbal communication. It came at a time when some people thought I was not long for this world. Five doctors stood at the foot of my bed, with the curtains drawn and four of them looking glum. They shared some comments with each other, then spoke pleasantly but solemnly to me, and started to leave my cubicle. As the final one left he turned, gave a large smile and thumbs up signal, and playfully punched my foot. I'll never forget that moment and the feeling that perhaps one doctor thought I might pull through my difficulties. Perhaps he didn't, but his actions certainly boosted my confidence – a powerful example of positive and intimate non-verbal communication.

### Invisible hand of senior management

A typical patient has no idea what hospital managers do. Such a lack of understanding may not bother hospital managers who see themselves as hidden assets, ensuring that a multitude of different components come together,

enabling those on the front line to deliver services. Such an attitude is admirable.

Worryingly, it is not only patients who have little idea how senior managers spend their time: a large number of front line staff do not know either. There is little recognition of the crucial role played by senior management in ensuring the smooth running of the hospital and the wider organisation. This is one reason why some ward staff join conversations with patients eulogising the role of clinicians and criticising the role of senior management. Sometimes it is done innocently or naively; at other times the willingness to disparage senior management borders on disloyalty. Perhaps this is not surprising as senior managers spend much of their time in little direct contact with ward-based activities; however, within the health system their role in strategy, financial management, human resources, dealing with government, and much else, is indispensable. I know healthcare managers are hardworking, dedicated

and caring, but as a patient I believe they should rearrange their priorities to enable them to deal with issues of unacceptable variations in service delivery and to tackle these issues in a manner that shows clearly their contribution to frontline healthcare delivery. Senior managers should be more involved in ward-based matters, in those priorities for patients, and less involved in developing further policies and attending even more meetings.

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