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NARRATIVE MATTERS



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‘Nothing Is Broken’: For An Injured Doctor, Quality-Focused Care Misses The Mark

When a physician winds up in the emergency department, providers put quality metrics and testing before her actual needs.

BY CHARLOTTE YEH

It was just after 6 o’clock in the evening on Wednesday, December 7, 2011—Pearl Harbor Day—when I left my organization’s Washington, D.C., office to meet a colleague for dinner. It was dark and rainy, and I had one more intersection to cross to get to the restaurant. I was about a third of the way across the intersection when I heard a loud “thump” and felt a sharp pain squarely

in my backside. A dialogue unfolded in my head: “Wow! I wonder what that was.... I think it was me. No, I don’t think it was me. Wait...I think I just got hit by a car! But there’s no way!” Before I could even make sense of the situation, I had flown through the air and landed on the street.

“Are you OK?” a man frantically asked me. I was so stunned that I said nothing—highly unusual for me. The man

called for an ambulance. I feared I might be run over, lying there where drivers couldn’t see me. Two other men approached, keen on moving me out of the street. But as an emergency physician, I knew that trauma training tells us never to move victims. You’re supposed to splint a victim where she lies so as not to injure her back or neck. But I also remembered that personal safety comes first. In those fleeting moments lying there on the pavement, I debated whether to stay where I was and risk being run over or allow myself to be moved and risk further injury. I chose personal safety. I tried to mentally assess the damage to my neck and back and asked the two men to get me off the street.

They carried me through the pouring rain into a nearby restaurant, where I waited for the ambulance. When the EMTs arrived, they placed a C-collar around my neck and positioned me on a backboard for the short ride to the hospital, a Level I trauma center.

I was wheeled into the hospital’s ambulance entrance, where the triage nurse met me and confirmed that I could speak English. An EMT briefed the nurse, noting that I had been hit by a car.

“Where were you sitting?” the nurse asked.

“I wasn’t sitting in a car,” I said.

“Were you in the passenger seat or the driver’s seat?” she continued.

“No, I wasn’t sitting in a car,” I said. “I was walking across the street.”

It took several rounds of back-and-forth before she understood that I was in an “auto-ped” accident, as they call it in emergency department (ED) lingo. Perhaps the nurse thought I looked too “whole” for this to be true.

The admitting ED team scurried me into an examination room, where they asked if I was having any pain. It seemed an incongruous question, seeing as a car had just plowed into me. Yes, I was in considerable pain, I told them. An IV was inserted, and morphine began to flow.

A doctor came in and commenced the “primary survey,” an initial exam to detect any risk of life- or limb-threatening emergencies. Then came a brief evalua-

tion to ensure that I could come out of the C-collar and off the backboard, a visual inspection for external bleeding or misaligned bones, and an assurance that my heart and lungs were functioning normally. I told the doctor that I had severe pain in my knee and backside. “OK, we’re going to need a CT [computed tomography] of the abdomen, CT of the pelvis, and x-rays of the chest,” she said. Something didn’t seem right to me. Wasn’t she going to examine my knee and backside?

When the tests were completed, I was wheeled out of the exam room, still flat on my back. By this time, roughly three hours after the accident, the ED was chaotically busy and all of the rooms were filled, so I was parked in the hallway. A new round of clinicians—presumably the admitting trauma team, although I wasn’t sure—stopped by my stretcher. “Well, everything looks fine on your tests,” the head clinician informed me. “There’s a little bleeding in the muscle around your hip area. We just don’t know if that’s going to continue, so we want to watch it. We’re going to admit you.” I gasped. I was still in denial that I had any serious injuries.

An inpatient bed wasn’t available yet, so I would be “boarded” in the hallway until one opened up.

I lay there on my gurney all night—nearly fifteen hours—with my work BlackBerry, my personal cell phone, and a morphine drip, watching the bustle of hospital traffic around me. Several times during the night, my blood pressure was taken. When the pain returned every two or three hours, I caught the eye of hassled staff members and had them tell the nurse, who would come by to give me a quick infusion of morphine.

Having spent many years serving in EDs as an emergency physician, I took comfort in being left in the hallway. It meant that I was OK, that the hospital staff wasn’t so worried about me. As a patient, though, I felt alone. I was struck by the demeanor of some hospital staff who rushed by. It seemed as if they were deliberately avoiding eye contact with any of us poor souls waiting in the hallway, lest they be interrupted and asked for help. I wanted contact. Even after assuring my long-distance daughters by phone that I was OK, I wanted someone present, looking out for me.



Good To Go?

In the morning the day crew appeared, taking over from the night crew. Residents went from gurney to gurney, sorting out patient dispositions. Around this time, the day crew learned that I was an emergency physician and, out of deference and consideration, they moved me out of the hallway into a private room, assuming this is what I would want. The private room was darkened so I could sleep, and the door was shut. Now, instead of feeling safe in the controlled chaos of the corridor, I felt abandoned, clutching my nurse call button, a lifeline to the world.

A new admitting trauma team stopped by later in the day to review my case. Because I had been stable all night and no major injuries had turned up on the CT scans, they decided I was ready for discharge. “Nothing is broken; you can go home now,” said one of the team members.

I was stunned. I was still in excruciating vice-like pressure pain, and my knee and backside still hadn’t been checked. The “good patient” in me wanted to please the doctor and saunter out of the room, but the real person in me was scared. I told the team that I wasn’t able to walk after the accident and wasn’t sure I could walk now. I was traveling on business and staying alone in a hotel room, so I might not be able to care for myself, I said. Again, they told me: “Nothing is broken, so you can walk.”

By now, no one had examined my swollen right knee or left hip area to determine the extent of my injuries beyond broken bones. I knew that serious

ligament or cartilage injuries can be sustained without broken bones. No one had talked with me about whether I would be able to function safely at home, or about follow-up care, either.

But the “good patient” won over, so with trepidation, I said I was happy to go home. “Do you think I’ll be OK at the hotel?” I said. “My knee is swollen, and I’m not sure I can walk on it.” “We’ll just send in physical therapy to get you up and walking,” the resident said.

A short time later, the physical therapy staff came in and looked me over. “We’re supposed to get you up?” one of them asked. They attempted to stand me up, and I nearly crumpled to the floor. I couldn’t support my weight, let alone walk. They helped me back onto the gurney and then left the room to go brief the admitting team.

The resident returned. “There’s no medical reason to admit you,” he said, “but if you can’t walk, we’ll just have to.” The “good patient” in me felt embarrassed that somehow I had failed the “test,” and was now an unnecessary admission, maybe taking the place of someone who needed the bed more than I did.

Diagnosis, Piece By Piece

The resident’s comment struck me as callous, as if addressing my basic need to function and recover after the accident had nothing to do with the care he and his colleagues were there to provide. The team returned a bit later to tell me that a bed had opened up—in the maternity ward.

On that first day in the maternity ward, nurses came in and out as I asked, over and over it seemed, “Is anyone going to look at my knee?” By the end of the day, an orthopedic consultant appeared. He determined that I had a medial collateral ligament tear and recommended putting me in a splint and getting a formal magnetic resonance imaging (MRI) when I returned home to Boston. Finally, I had a partial diagnosis.

During that first day as an inpatient, I experienced increasing lower abdominal pain and told the staff a few times. I suspected a catheter malfunction. “Something feels wrong,” I said. “Is my catheter working? My lower abdomen hurts, and the catheter doesn’t feel

Policy Checklist

The issue: Health care quality measures are designed to improve care, but they too often focus on clinical processes, rather than what patients say they want or need. Methods for measuring the patient experience, including patient-reported outcomes, should be included in standards of care to improve patient-centered health care.

Related resources and reading:

- Bate P, Robert G. "Experience-Based Design: From Redesigning the System around the Patient to Co-Designing Services with the Patient." *Qual Saf Health Care*. 2006;15(5):307–10.
- Porter ME. "What Is Value in Health Care? Supplementary Appendix 2: Measuring Health Outcomes: The Outcome Hierarchy." *N Engl J Med*. 2010;363:2477–81.
- Kilo CM, Wasson JH. "Practice Redesign and the Patient-Centered Medical Home: History, Promises, and Challenges." *Health Aff (Millwood)*. 2010;29(5):773–8.
- Porter ME, Lee TH. "The Strategy That Will Fix Health Care." *Harvard Business Review*. 2013;91(10):50–70.
- Basch E, Torda P, Adams K. "Standards for Patient-Reported Outcomes Based Performance Measures." *JAMA*. 2013;310(2):139–40.

right." I was told that catheters are irritating and always make you feel like you have to urinate. Each time I mentioned it, the bag was checked, the presence of urine was confirmed, and I was assured that the catheter was working. It wasn't until six hours later when the admitting team came by that they pulled back my sheets and exclaimed, "Did you know your catheter fell out?" as though it was my fault for not "telling the staff" or checking myself.

Over the next several hours, the piecemeal evaluation continued. That night, I began to experience numbness and tingling in my leg and my hip. I knew these were neurological symptoms, and something wasn't right. Three times doctors or nurses came through, and each time I explained my concerns but was not evaluated. It wasn't until twenty-four hours later, during the night of my second day of hospitalization, that I had a neurological exam revealing contusion of both the sciatic and the gluteal nerves.

On my third day in the hospital, someone asked if the admitting trauma team had done a history and physical, standard procedure following the initial primary and secondary surveys. They had not. A resident then performed a "tertiary" exam—essentially, a repeat history and physical examination—although he and I both knew the prior exams had been incomplete.

By morning rounds on my fourth day

in the hospital, I was both medically and functionally stable, able to ambulate cautiously with assistance and a walker. I insisted on being transferred to a rehabilitation facility near my home in Boston.

The Art of Care

Nearly two years after my accident, after extensive rehabilitation, I am still limping and walking with a cane. I have had to adjust my daily routines. I still need wheelchair assistance at airports and still struggle with my balance on ramps and uneven ground. It is a challenge to put away bath towels on an upper shelf without tipping over. I still can't ride a bike or hike. Even swinging open a door is problematic because I can't fully brace myself against the weight of the door.

The most dispiriting consequence of all, though, is the loss of independence. Every choice I make each day about where I go requires careful advance planning: What's the terrain? Will I need to ask for help? How long will it take for assistance to arrive? I depend on others now.

As a medical professional who became an accident victim and then a trauma patient, I was a participant-observer in emergency care, with a big-picture window into how well our health care system does or doesn't work. There's just something about being boarded on a

gurney in a hospital hallway for fifteen hours that gets one thinking about paradigm shifts.

In my case, I was struck by the uneven nature of my care, marked by an overreliance on testing and a narrow focus on limited quality metrics such as pain management or catheter care processes. Looking back, I believe that this approach fostered an inattention to my overall well-being. Instead of feeling like a connected patient at the center of care, I felt processed and disengaged. This is disconcerting, especially at a time when patient-centered care—that is, care delivered *with me*, not *to me* or *for me*—is becoming the new normal.

The Oath of Hippocrates, the medical profession's ethical creed, reads: "I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone." This vow compels physicians to heed both the "science" and the "art" of medicine. The science often lies in defining the treatment regimens. The art lies in understanding what matters personally to the patient.

Even in an ideal world, this would be a high bar to clear. Despite some national consensus on quality metrics, we have continued struggling to measure "the good of the patient." Still, quality metrics cannot alone advance the good of the patient. Focusing on clinical measures in particular is not enough as long as other measures that focus on patient-desired outcomes are ignored. If we don't understand what patients' expectations are, we can't engage patients effectively in their care.

Through my experience as a patient, I observed a bias in what the metrics track: toward the clinical and away from the personal. To help restore this balance and reassert the "art" of care, I see three areas that the medical community should address.

Beware The Culture Of Testing

When a test, such as a CT scan or a blood exam, is the centerpiece of care strategies, patient care can be compromised. As medicine and technology evolve, we may have become victims of our own success. We have become test-happy and technology-powered. These tools may provide us with good data on the

patient, but this doesn't mean we're serving the good of the patient.

In my case, test-based care, while absolutely necessary, could have been balanced with a better understanding of me as a person and what mattered to me.

The unintended consequence of our current approach is that the clinical measure can become more important than the patient. I am afraid that as a result, we may be training a new generation of practitioners to equate high-quality care with conducting a test. Instead of having the test be used to discover new information about the patient, it is being used to define if one even is a patient.

Personalizing Care

After I'd spent four days in the hospital, it dawned on me that not once had anybody come by to ask how I was doing, what I needed, what I wanted, or whether I had any concerns. I then understood something that my own patients had been telling me all the time: They don't feel *engaged* in their own care. There is nothing personal about it.

Weeks after my accident, I began rehabilitation treatment at a hospital in Massachusetts to work on activities of daily living, such as getting out of bed, using a walker, preparing meals in the kitchen, getting in and out of the car, putting socks on, taking a shower, and getting up and down the stairs. The art of care promised by the Hippocratic Oath flickered back to life. Here, personalized patient care was the rule, not the exception. I saw staff treating every patient with dignity and respect, and listening to what mattered to them.

Each member of the rehabilitation team asked me what "my goal" was—a simple enough inquiry. I told them it

Emergency departments can't hide behind the excuses of "we're too busy" or "it's too chaotic" to avoid connecting with every patient.

was to be able to go up and down the stairs in my house. No one ever asked me this during my acute hospitalization.

During my rehabilitation stay, I witnessed pure encouragement and compassion. Staff appreciated the patient's current capacities, physical and emotional, and showed a sophisticated understanding of the gradations of care and recovery. Care becomes personal when dignity is established, regardless of the setting.

Patient-Reported Outcomes

Patient-reported outcomes are a vital piece of the puzzle and are often overlooked, because of institutional inertia or culture. In my case over those first four days, the management of my reported pain was perfect, a 10 out of 10—but it was the exception. Despite my requests for information and attention, it took a piecemeal evaluation over four days to sort out and diagnose the full damage to my body. My reports about my own condition did not seem to matter to anyone else.

Patient-reported outcomes currently in development, such as asking for the patient perspective ("what do you want," "what are your fears," "what matters to you") and equalizing the patient-provider dialogue, create shared part-

nership in the outcomes and might have made a difference in my care. Going forward, quality metrics should give more weight to patient-reported outcomes, if we want to truly assess care more effectively. As my experience suggests, we're not quite there yet.

The 'North Star' Of Care

If I resolved anything on my care journey, it is that the "North Star" guiding all care must be providers using "any means possible," to know the patient, hear the patient, and respond to what matters to the patient. It should make no difference where you practice; any provider can do this. Emergency departments can't hide behind the excuses of "we're too busy" or "it's too chaotic" to avoid connecting with every patient.

It is time to frame a new paradigm of care, a consumer-driven approach that concentrates attention on the art of medicine. This might begin with a reinvigorated focus on patient-centered care and mastering the skills of listening, empathy, and patient partnership.

The Oath of Maimonides, another code for the medical calling, offers a hopeful note about the physician: "Today he can discover his errors of yesterday, and tomorrow he can obtain a new light on what he thinks himself sure of today." Should this wisdom prevail, the next generation of quality measurement may strike that elusive balance between the clinical and the personal, and the good of the patient will always guide the care we deliver. ■

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