Art of medicine

It's about time

I work in a government-funded health-care system that is the envy of many countries. The dismal state of indigenous health notwithstanding, Australia typically features at the "good" end of graphs that depict important health-care statistics. Yet at the teaching hospital where I work, each day of my oncology and internal medicine service starts with a reminder of just how tight the bed status is and how important it is to consider who really needs to remain in hospital. Ward rounds must start early; discharge scripts must be punctual; transport must be booked speedily. Every day starts the same way, with the pressure to do things better, faster, cheaper. If these are carrots meant to drive efficiency, the stick is that hospitals incur a government-imposed penalty for delayed care.

The notion of cost-effective care is difficult to convey anyway but when a system is purely government funded, it is nigh impossible. The average resident has no idea about the difference between the cost of clavulanic acid and penicillin or the difference it makes to administer intravenous rather than oral omeprazole. The average specialist would be hard-pressed to approximate the cost of a week's stay on a ward versus a high-dependency unit. Even the medical student shows little hesitation in wasting common resources such as bandages, plasters, or electrocardiogram rhythm strips. Scores of investigations are never checked. Patients leave, die, or just become lost to follow up. Mostly, those tests were inconsequential in the first place.

How much do these observations affect the individual clinician? Very little. At the end of my month of service, I have no idea how much expenditure I had created for my hospital or the taxpayer. With no bills to pay or insurers to haggle with, the patient is equally oblivious to the cost of care. Did it matter that I didn't order a scan for the patient with cancer bound for a hospice? What difference did it make to wait for sensitivities before prescribing antibiotics? Did rationalising an older woman's 20 pills change anything other than her smile? It's hard to know for sure.

In a public system, there is no patient to complain about the cost of drugs that are either highly subsidised or available at a flat nominal rate. There is no insurance company to veto therapeutic decisions. There are no bureaucrats directly questioning a clinician about individual expenses levied on the system. This may sound like a heaven-sent blessing, but governments are fast realising that exponentially rising health-care costs are unsustainable.

Doctors have commonly held the view that what matters most is service to an individual patient, achieving the best outcome for the patient before you. But laudable as the notion sounds, it causes unease to many. You only have to walk past Emergency to find eager eyes watching out for their turn to be helped. My patients with cancer who have not survived remind me that many might have died more peacefully were it not for the futile intervention that only served to exacerbate the family's grief.

The tension of adequately caring for the individual while serving the population is growing. Perhaps it is with this in mind that our medicine service has introduced a measure for physicians. It's called the length of stay and at the end of a month of service, provides a numerical estimate of how long each patient stayed in hospital under a physician's care. Presented only as an item of interest—anonymous and attached to neither reward nor retribution—the length of stay figure serves as nothing more than temporary fodder for reflection. Administrators would like to use it as a marker for efficiency, reminding us of the shrinking budget and growing needs. But clinicians argue that lengthy hospital stays often reflect the jammed MRI queue, the lack of nursing homes, inadequate rehabilitation beds, and deficient community mental health care—in other words, things that the average clinician doesn't control. One way to reduce the burden on the public health-care system might be to use the flourishing private facilities, but to discuss this with our patients, many of whom can barely afford their groceries, seems unethical to me. It is also fair to say that, where it exists, universal access to health care is sacred to most people—and hence to many politicians.

I have often wondered then how the actions of an individual physician could even begin to make a difference in this environment. Should one just accept the "system" for what it is and acknowledge that any personal change would only ever be the proverbial drop in the ocean? Tired of passively observing, I mused how I might reduce my patients' length of stay without compromising their care. What I found surprised me.

At the start of service, I sit down with my junior staff to discuss how we will manage our unit of up to 25 patients. Placing the emphasis on clinical medicine, I remind my team that we will make decisions the "old fashioned way"—with a good history, a thorough examination, and judicious investigations. I tell them that the power of their signature is great and they can order any test provided they can justify its need. I ban terms such as "routine bloods" or "regular scan". I tell them that they must understand how a test they order will alter management because I will quiz them. It always surprises me how quickly the investigations diminish with a reminder about accountability. The welcome reduction in time spent chasing tests translates directly to increased time for bedside teaching, something that recalls to harried doctors the joy of clinical medicine.

Our conversations with patients are a critical part of this bedside care. During the patient's stay, I believe that two conversations are sentinel: the first and the last. Although I often stand during rounds, I make it a point to sit down for these conversations, which has an immediate effect of reassuring the patient that I am there to listen. It's hard to look rushed with your feet planted on the ground, and even if we don't get through every issue, patients seem to respond better when my body is not half-turned towards the door as we talk.

The student or resident presents the case in the traditional way with one important difference: we begin with the social history. An 80-year-old volunteer lifeguard may warrant a different approach to her pneumonia than the elderly patient with dementia who has been progressively declining in a nursing home. I remind my team that we will practise the holistic medicine that we all learnt at university but later seem to have lost sight of. Where possible, I invite patients to complement the history. This frequently adds useful information but always has the effect of making the patient feel respected. After the history and examination, I spend time on the explanation. Many patients undergo a battery of tests in Emergency. I explain what the results mean and how we might use them to establish a diagnosis and guide treatment. I also talk about how long the patient is likely to stay in hospital, and which other professionals he or she can expect to see at the bedside. The patient is invited to ask questions or write them down for the future. At this first visit, we establish key relatives who we will contact. Sitting down; exchanging, not just delivering information; formulating a cogent plan with the patient where practicable; and allowing time for a few questions—these are the focus of the first visit.

I find that this first visit goes a long way towards smoothing out the rest of the patient's stay. While it doesn't take nearly as long as I had feared, the benefits that flow from the dialogue are undeniable. It allays anxiety, especially since we top it up with small parcels of updates on other days. This approach also means that residents don't get cornered by uninformed patients and relatives and protects them from the stress of reassuring people of our good intent. Crucially, all this actually feels like patient-centred care.

Whereas the first visit sets the tone of the hospital stay, I use the last visit before discharge to tie up loose ends and, importantly, to define future expectations. Again, I sit down to discuss the diagnosis, what we could and couldn't fix, and solutions for any of the patient's concerns. This is also time to explain drug changes since non-compliance is a key reason for readmission. The last visit, arranged with a relative present, provides an opportunity to anticipate some of the predictable problems that might cause the patient to return to hospital, a major factor in escalating health-care costs.

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A common problem in public hospitals is that the revolving doors keep seeing the same patients in and out. We manage acute presentations without tackling the bigger issues, especially if the same team is unlikely to see the patient again. But it is important for the patient's journey to define the goals of care and help put any unrealistic expectations into perspective. Patients and their families are grateful when we take the time to do this. Sitting down at the bedside; tying up loose ends; defining what lies ahead—these are the tasks at the end of a hospital stay. The first visit and the last with the patient are important bookends that set the tone of experience, for the patient and doctor.

I have experimented with my style of practice to be a responsible user of the health-care system. But I was surprised to discover that these small steps during the past 2 years have led to a consistent reduction in the length of stay without a corresponding increase in readmission rates. While there have no doubt been savings as a result of this change, simply reclaiming bedside medicine has been my greatest reward. It's wonderful to be a clinician again and find that such anachronisms as sitting with the patient, listening more and talking less, and careful deliberation about the need for tests are a genuine part of the solution to the woes of modern health care. Sure, there are entrenched deficiencies with the "system", but as an individual physician who doesn't just want to feel helpless against them, it is empowering to know that care—cheaper, better, faster—is possible, one patient at a time.

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