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A hospital is an important component in a system of medical care. In a system that is operating efficiently, workers know how their work fits into the system. Everyone would feel important, and would work with people that likewise feel important.

Hard work and best efforts are not sufficient for optimization of a system. A system must be managed. The administrator of a hospital knows a lot about what happens in the hospital. So does a head nurse. A head nurse, for example, knows a lot that the administrator cannot see. Likewise for any nurse that works there. The physicians that attend patients know a lot about the hospital that no one else knows. A patient in the hospital sees what no one else sees.

All these different observations, from different points of view, were they known, might be helpful to the management of a medical care system.

The notes attached were written by an observing, grateful patient. They show how best efforts of nurses, with their special skills and knowledge, are to a large extent squandered. The nurses must be discouraged, seeing a large portion of their efforts as fruitless. How can a nurse feel important under such conditions?

The author has hopes that publication of these notes written from a patient's point of view may make a contribution to improvment of the management of medical care.

A HOSPITAL PATIENT'S NOTES

Well, here I am—flat on my back, literally and in other ways, right ankle resting on three pillows. Elevation is vital to treatment.

My nurse of the moment (R.N.) came in at about one o'clock to wrap my leg from the knee down in a hot towel and insulator. As a first step, she turned on the hot water in the washbowl, as she needed hot water for the towel (some nurses use the microwave oven for this purpose). She then departed, saying, "I'll be right back." A social worker dropped in about a half-hour later. I asked her if she would mind turning off the hot water to avoid more waste of water and energy. She did. In another half-hour, the nurse came back to put on the hot towel, turned on the hot water, and completed the job.

Dr. Sch ordered from the drug store (in the hospital) a paste for the itch caused by the sore leg. The drug store was out of one of the ingredients: must order it from the wholesaler, and can not make up the paste till Monday. As this is Saturday, no delivery from the wholesaler till Monday. I need it tonight. On prodding from Dr. Sch, the drug store sent someone out to another drug store to fetch the missing ingredient. The paste came up that evening.

It may seem unbelievable, but the same scenario took place some days later. My nurse of the afternoon ordered from the drug store a refill for the paste. No problem, except that there would be a delay, as (again) the drug store would have to order from the wholesaler one of the ingredients. Tomorrow will be Saturday, next day Sunday, Monday a holiday. They would send up a substitute, which would be in the form of a lotion, not paste.

On another day, my nurse of the moment (R.N.) came in three times between 8:30 a.m. and 10 a.m. to say that she would be right back to make my bed. I offered to get out of it so that she could make it up straightaway, but she may not have heard me. Each time: "I'll be right back." Anyhow, near noon she came back and actually did the job. Of course, I'll live, bed made or no.

I wonder: Why is a registered nurse making beds? It seems to me that making beds is not good use of her time. Her education and skills could be put to better use, so it seems to me. Are there not helpers to do this kind of work? But maybe there are reasons that I don't understand.

All the while, nurses are on a dog-trot, panting for breath, working at top speed, losing time, not for start-up, but for no start. I know all about it; this is my way.

I was wondering about these thermometers with a heavy electric cord attached. Speedy, yes, but impossible for a patient to hold correctly because of the heavy cord. The patient can only hold the thermometer against his cheek. The reading could be a whole degree low, I surmise. The aide that records temperature seemed to be totally indifferent. A reading, after all, is a reading.

The wash basin in my room has not enough space on it for a shaving mug, barely enough for a shaving brush. Bought at lowest price tag, I surmise.

The man that designed the shower had obviously never used one. The shower head, when not held by hand, can only dangle and flood the floor. There is a tiny shelf in the shower big enough to hold only a wafer of soap. There is only one bar to hold on to. Use of this shower would be a risky business without a friend close by for rescue. Somebody sold somebody a bill of goods.

Intravenous diffusion due at 6 a.m. The nurse came at 5:05 a.m. to insert the needle into the more or less permanent spigot, known as a Heparin Lock, in my left arm and departed. The infusion would run around 90 minutes. Meanwhile, some time after she left, in reaching for something on the shelf, I reached too far and pulled the needle out of the Heparin Lock. The nurse, when she came in around 6 a.m., saw what had happened. She was startled, but said not a word. She merely carried everything away, liquid and tube. I supposed that she would return and start over. Time went on. No return.

At 8:30 a.m. I reported to Meg, head nurse in charge of the shift, that the intravenous diffusion had not been given. It might be important to me, and important to Dr. D., else why bother with it? Meg's first impulse was to call (at home and maybe asleep) the nurse that left the job undone. It seemed to me, I told her, that it matters not what the nurse might say. I know what happened, and what did not. I called Dr. Sch. His secretary said that she would notify him at once and that he would call Dr. D.

The infusion came straightaway. The head nurse returned to say that the nurse that was to give the infusion had recorded the infusion as given. It is possible that she recorded it in advance, with the intention to give it, and did not correct the record. Is this the regular procedure, to record intentions? Who would know?

An unsuspecting physician, looking at the record for his patient, would assume that the infusion had been given, and could draw wrong inferences about how the patient had been doing on the drug. In my case, as it turned out, no harm. But how would he know? A nurse, or a physician, has a right to suppose that the medication was de-

livered as ordered and as recorded.

What is the purpose of the record? To inform the physician about intentions, or to tell him what happened?

Dr. Sch assured me that he is running this lapse down in every detail, and that nothing like it will ever happen again here—the usual supposition: working on only an actual defect, not on its cause.

A little figuring told me that insertion of the needle at 5:05 a.m., for infusion to start at 6 a.m. (if she came back on time) would tie the patient in bed for over 2 1/2 hours: the first hour tied in bed, then 1 1/2 hours for the infusion, plus time added for the nurse to come to take the needle out of the Heparin Lock and take the whole thing away. This long time in bed, with 3/4 cup of liquid infused, could create great discomfort for a patient.

She (R.N.) would "be back in 20 minutes," to take the wrapping off the hot towel and insulation that she had just wrapped my leg in, and would apply the cream prescribed. One hour and five minutes later, almost time for my IV, I rang the bell to call her. She returned in 15 minutes, unwrapped my leg, and started the IV just about on time.

The food is superb. The lasagna yesterday noon was the best that I have had since the days of Iacominni's Restaurant in Akron. The baked chicken today was superb: wing attached, browned to perfection, and the sweet potato, all steaming hot. Excellent beef and barley broth.

Such food in a fine restaurant would cost $20. If only the food came on dishes with a white or light colored moulded pattern, instead of on battered brown. These trays and dishes were purchased at lowest bid, I surmise, or maybe were donated by a soup kitchen on purchase of new ones.

The Fettuccini Alfredo for dinner Monday night was the best ever, with three packets of parmesan cheese, as good as any Fettuccini Alfredo that I ever had this side of Rome. The broccoli soup was delicious. The beautiful looking apple dumpling was hot and tempting. I had already eaten enough food, but with one taste, just for trial, the dumpling was irresistible, so I finished it whether I needed it or not.

Fifteen hours elapse between dinner and breakfast. I was hungry in the middle of the night, first night. Fortunately had candy bars on hand.

I have learned how to acquire and store up food like a squirrel if I get hungry during the night. I order for dinner milk as well as coffee, set the milk aside for use during the night. On hand, from friends, I have wonderful Scottish short bread from Scotland, Waverly crackers, and candy bars. Also, I order a ripe banana for breakfast every day, and put it in storage. I now have two bananas on hand, the number that I started with, but not the same bananas. FIFO is my system, first in first out.

An aide comes along around 9 o'clock at night to hand out juice or (I surmise) soft drinks, or milk, but I now have my own food.

The chair in this room is huge, would seat two people, takes up an exorbitant amount of space, heavy to move. Somebody had good intentions. It can be adjusted to go back as a foot-board moves into place, but need it be so big and heavy? Why not have a movable chair?

The coat hangers here are that maddening kind, found in most hotels. How I wish that I had known about them before I sent that check to this hospital a year ago: I should have designated $10,000 of it to go for new racks and honest coat hangers in the rooms.

I had a new full-size bar of good soap on the wash bowl. The girl that picks up trash must have thought that this kind of soap is not suited to my kind of skin. Anyway, the nurse of the moment brought to me for replacement a new bar of soap, tiny but appreciated.

My nurse of the moment put on a hot towel this afternoon. "I'll be back in 20 minutes, and if I don't come, please ring." Sixty-five minutes later I pressed the button . A helper came in and explained to me that this was not her kind of job, so she cancelled the light for the nurse and went off. Thirty minutes later I rang again for the nurse. The same helper came and observed again that the job was not in her line of duty, so again she cancelled the light and went off. The solution was simple, for me—merely discard the towel and insulation myself, with the rules or against the rules. The same event recurred another day.

This experience leads to questions and guidelines. Why should an aide, unable to perform the task, cancel the light? The nurse on duty for that light would not know that her patient needed a nurse. What if a nurse was suddenly vital to a patient? If he was in a single room, he would be left stranded. His nurse would not know that he had rung for her. In a room with two patients, the other patient might be able to fetch a nurse. Moral: If you are acutely ill, don't go into a private room unless you have your own private nurse on duty at all times.

Shirley, a registered nurse, came to see me as a friend. She made the remark that a Heparin Lock ought to be examined at the end of 48 hours and maybe changed. It has now been in eight days. Later, I asked one of the nurses how long it should stay in one place. A nurse came and changed it from left arm to right arm.

What is the moral of all this? What have we learned? One answer: the Superintendent of the hospital needs to learn something about supervision. Only he can make the changes in procedure and responsibility that are required.

Talks between physicians and nurses, even with the head nurse, accomplish nothing. The same problems that I have noted will continue. A physician can not change the system. A head nurse can not change the system. Meanwhile, who would know? To work harder will not solve the problem. The nurses couldn't work any harder.

Ceil, my secretary, runs back and forth from here to my study only a mile away, to try to keep work moving. I have accomplished work on manuscripts due soon, and have caught up with a number of letters that have been dangling, also with some reading and re-reading in *Harper's Magazine*, the *Atlantic Monthly*, and others. It is not easy to read and to write while in bed with leg up. I violate instructions now and then, in order to write or to sign a letter, sitting up on the side of the bed, leg dangling.

I estimated, on my prescribed four walks per day up and down the corridor, that from half to a third of the beds were unoccupied. Saturday and Sunday could have been even lower and with less bustle. Vacant beds raise the cost per patient.