EDITORIAL

Healing our health "system"

My father lies in the CCU. The steady rhythm of the dialysis machine and the occasional chirp of an alarm are all that suggest the location deep within a large University Hospital. A personal encounter with the health care system makes you aware of its achievements—and lacunae. While these observations may be personal and idiosyncratic, I hope you will consider their application to your own institution.

The warmth and dedication of my father's health professionals show they clearly care: freely providing home phone and cell numbers, braving a major Nor'easter to get to work, explaining the medical circumstances in patient detail. The staff, from housekeeping to clerical, have gone out of their way to be supportive and understanding. They arrange transportation and laundry; remain calm amidst dire circumstance and frayed nerves; and do the best to maintain personalized attention. Clearly, our health care system does not suffer because of the quality of our people.

Our technology and therapeutics are amazing too—the intricacies of management of advanced heart and renal failure, the dazzling information afforded by PET scans, the marvels of artificial kidneys and ventricular assist devices. What was unimaginable even 5 years ago becomes routine. We should all be proud of such innovation and creativity.

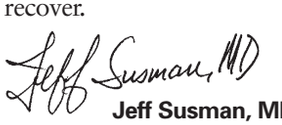
But you don't have to scratch the surface of this story too deeply to uncover substantial failings.

We communicate ineffectively interprofessionally. Basic patient information is neither portable nor readily accessible. Each transfer and consultation entails another elaborate information session. Vital bits of information are missing or inaccessible. Though clinicians try to communicate with one another, it's akin to the game, "Operator," wherein a message passed around a circle becomes garbled. In an age where hotels can track our preference for pillows, health care information system is an oxymoron.

Coordinating care, particularly in our special care units, remains a challenge. Intensivists are great at treating life-threatening chaos, but don't seem to be very good or interested in coordinating more routine care. The lack of continuity and effective leadership (that's the EP team's issue, the hematology team's call, the renal failure fellow's job) leads to lack of clear goals, redundancy, and occasionally errors. Moreover, no one is very good talking about, let alone coordinating, end of life care. We are much better at lysing clots than planning palliative care.

Finally, provision for families is rudimentary. A hotel of sorts is attached to this University Hospital, but there is no place to eat, have one's clothes cleaned, or buy a few essentials. Waiting rooms are cramped, and patient rooms small. Especially at our large academic hospitals, where patients come from all over the country, you might expect we could better consider the needs of families.

The saga of my father continues, and while my family and I know that his problems are largely irreversible, the prognosis grave, and death near—I trust we have the wisdom to help an ailing health system recover.



Jeff Susman, MD
Editor, *JFP*