Thinking Out Loud... A New Year's Resolution

"Things should be made as simple as possible, but not any simpler."

—Albert Einstein

The close of 2002 is almost here. What a year it was and still is. As the New Year approaches and 2003 lurks in our mental byways, many of us hope for what is not—or for what glimmers as a better possibility of what is—often drawing us into a web of resolutions we design in order to make our hopes real.

I am one of those, however, who is determined not to make New Year's resolutions. I hold steadfast to this decision in the belief that New Year's resolutions interfere with timely adjustments that can improve personal behavior. I believe that, while I cannot change some things, I can choose my frame of mind as I react to them. It is for that reason that—since the beginning of this year—I chose to write of my experiences as the personal caretaker of my mother in the hopes that they would stimulate others to view our system of medical care on a more personal basis.

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Although in the future I will continue to write of my experiences, it will be done with an expanded perspective. A reason for making this decision is embedded in the vignette presented below... a small slice of reality that reveals the "every patient" in us all.

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An Event Writ Large

The day that Mom fell—August 16, 2001—was a day that, for me, stood still—its significance branded on my mind as I assumed a new role as her personal caretaker. I vowed that I would perform its responsibilities as best I could. It was not until the end of her first Emergency Room (ER) visit, however, that I had a better understanding of the challenge. It was at that time that I first internalized the real meaning of shareable information, i.e., communication among the care team (the patient, caregivers, the patient's family, the administrators and billing personnel, the dietitians and social workers) and its relationship to a patient's safety.

The precipitating event was a relatively small one when compared to the whole context of her care. It was a request that I had made as her personal caretaker during the admission process. The request was to use the services of a Board Certified plastic surgeon to suture Mom's face—a request the admitting clerk stated she would personally communicate to the care team; a request that apparently was never handed off to those doing the work.

At the time the assurance was given, I felt relieved. I also felt a relative calmness enter my mind. I turned from the admission desk and went into the waiting room on the other side of the glass wall that separated the admitting area from the bank of chairs standing guard outside the ER.

To wait is perhaps one of the more difficult activities humans must endure, especially when it takes place outside an ER early in the morning before full light breaks day... a lonesome time at best. The main occupants of the room were the cleaning crew, who prepped it for the next day's influx of new

patients. I felt a vestige of days past as the cleaning crew tried not to disturb me and respectfully circled my feet with their mops as if I were royalty. I moved to another chair so they could more easily finish their job. As I did, I heard my name and knew it was time to visit Mom. I walked to the admission clerk before doing so and asked the inevitable:

"How is she?" "She's fine."

"Was the Board Certified plastic surgeon there?" "No."

"Did you tell them my request?" "Yes."

"What happened?" "I don't know."

I walked to the ER and waited to be admitted, mulling over the sequence of events. I knew I could not change what happened. The recurring question was, "Why?" I suppose I shall never know the complete answer. However, when I entered the room where she lay—her nose widely bandaged with a tape so white that her pallor seemed as if an eggshell lined her face—I at once visually understood the impact of an action not taken on her behalf. As always, she smiled and extended her hand to me in welcome, more concerned about my comfort than her own.

Let's Be Practical and Dream

Let's dream that Admission's communication had connected appropriately with the care team, and that at the point-of-care they had seen an alert displayed on a bedside care station (which was *not* there) to use a Board Certified plastic surgeon for suturing. If this had occurred, I would now feel that all that could have been done on her behalf had, in fact, been done, instead of feeling that the scar that marred her face was there because not enough had been done... a reminder of a request run amok. The question was, and still is, "Why?"

Communication: Our Future

Perhaps the answer is that *collectively* we overlook communication as an integral part of our own lives, whether we leverage technology to this end or not. Hence, integrating communication into something else—i.e., the care process—is a double hill for us to climb; it is both personal and institutional.

Or, it may be that, because of its simplicity, we regard the idea of communication as simplistic rather than as a unifying concept that has the potential to energize and organize complex ideas into coherent action.

Sound too much like a textbook? I think not. Review in your mind three companies that the market regards as successes. Then, read their cornerstone documents, such as their mission, vision, and value statements... *their* drivers. Look at their accomplishments and draw your own conclusions.

My company, Healthcare Informatics, Inc., under whose corporate umbrella AMI Healthcare Systems Group (AMI) and Healthcare Management Group (HMG) operate, identifies communication as a driving life force when it states, "*We connect more than systems. We connect people.*"

During my tenure as the personal caretaker of my mother, I learned how important communication is to quality patient care. I learned that partial information not only creates ambiguity, it encourages a dependence on those providing care that is at odds with the patient's best interests, many times transforming trust into mental backwaters that lap doubts over the flow of care. By virtue of feeling one's way through unclear facts instead of clearly thinking through them with a care team, we can at times become our own source of the doubt we hope to avoid. As a result, we run the risk of weakening the bonds of the care team instead of building them to be stronger for the good of the patient. In my journey as a personal caretaker, I have also seen firsthand how the practice of information is becoming a guide to medical care and how each of us is more than a human experience wedged in the core of science. I will build on these themes in the future with ideas "as simple as possible, but not any simpler."

Conclusion

Therefore, in contradiction to the beginning of this commentary, I *will* make a New Year's resolution. Beginning in January 2003, "Thinking Out Loud" will branch into broader topics of medical informatics... a branch of learning that has been defined as "the theoretical and practical aspects of information processing and communication, based on knowledge and experience derived from processes in medicine and healthcare."[1]

This column will discuss topics that relate to financial issues such as those stated within the Institute of Medicine (IOM) 2001 report, "Crossing the Quality Chasm: A New Health System for the 21st Century"—namely, rewarding performance and innovation in healthcare. It will consider topics such as merging information technology into clinical processes, and then using clinical processes to drive the financial ones. It will explore why clinical and financial system integration is pivotal to the provision of quality care at less cost. It will inspect the principles of structured data collection—principles often regarded as mundane in the full scheme of technology, but which are actually the backbone of dependable information so necessary to accurate analysis and to the practice of information in medical care.

I believe that we are poised for a better possibility of what is today. Let's explore and experience it together... *thinking out loud.* The best of the New Year to my fellow travelers.

Reference

1. Van Bemmel JH. The structure of medical Informatics. Med Inform 1984; 9:175-180.

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