Newer Dimensions of
PATIENT CARE

This is the first of three discussions concerned with psychosocial and cultural aspects of patient care in general hospitals. Each discussion deals with a different topic, none of which has received systematic examination by most hospitals of this kind. Hence, it has been decided to publish these papers separately as small monographs under the generic title *Newer Dimensions of Patient Care*. The second paper, planned for publication late in 1962, will discuss psychological support of hospital staff as a means of increasing motivation and competence. The third, tentatively scheduled to appear a year later, will present facts and concepts drawn from the sociological and anthropological literature that may help personnel in their understanding of patients.

Newer Dimensions of

PATIENT CARE

Part 1

The Use of the Physical and Social Environment of the General Hospital for Therapeutic Purposes

Esther Lucile Brown, Ph.D.

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"To understand the human condition" might be viewed as the goal of all health personnel.

EDWARD J. STAINBROOK, M.D.

PREFACE

IN RECENT YEARS emphasis has been shifting in the medical and other health professions from almost exclusive concentration upon the diagnosis and treatment of disease to the diagnosis and treatment of persons in their totality. This shift in emphasis is being reflected in fresh consideration of how patient care should be provided to the sick or injured who are obliged to go to a hospital. In any such consideration the psychosocial, as well as the technical, aspects of patient care assume importance.

The writer has attempted to explore some of these psychosocial aspects as patient care is now provided or might be provided in general hospitals. In this monograph, designed to be the first of three proposed publications, attention is devoted to one direct and obvious way for facilitating the treatment of patients as persons; namely, through the planned use of the physical and social environment of the hospital.

Relatively few studies have appeared of patient care in general hospitals that were concerned with psychological and social factors when compared with similar studies of psychiatric hospitals. The very fact that some of the latter institutions have been attempting to establish a "therapeutic community" or introduce other changes of a behavioral nature has created much interest among psychiatrists and social scientists alike.

At the same time, however, that changes in attitudes and environment have been occurring in mental hospitals, alterations of a scarcely less significant kind have been taking place within the pediatric and some maternity services of general hospitals. In many institutions these services present a radically different appearance today from that of a generation ago. The new re-

habilitation units opened since World War II, moreover, have generally demanded from their inception a greatly enriched physical and social environment and opportunity for a wide range of activities quite unlike the traditional aspects of general hospitals. Their staffs deem such facilities and activities essential for moving patients toward recovery. These appear to be the "growing edges" within general hospitals in experimenting with more flexible kinds of patient care, and reference will be made to them and also to the experience of psychiatric hospitals for illustrative purposes throughout the monograph.

Although nothing comparable has been instituted on the medical and surgical units for adults, it is our assumption that these patients also want a different kind of patient care from that now being given in most hospitals. A different kind is obviously required, moreover, if the health professions are to progress in the treatment of the person, which they have avowed to be their goal.[1]

The thesis presented in this monograph is particularly applicable to those adult patients who spend longer than the "average length of stay" in the hospital. Regardless of the fact that institutions operated expressly for long-term patients generally attempt to provide some recreational and social activities, hospitals that think of themselves as serving only acute illness make little or no provision. However, the number of patients who are obliged to spend several weeks in them is often surprisingly large. Finally, this monograph is directed especially to those vast institutions, whether operated by city and county governments or not, where patients are so numerous and patient care is so largely provided by ward and house staffs that little individualization of attention is achieved. In such places a supporting physical and social environment of the strongest possible kind is needed as a help both to patients and to staff.

No attempt has been made in this study to examine systematically the changes in patient care of a psychosocial nature that are going on in various parts of the United States, or to recom-

[1] Steiger, William A., Francis H. Hoffman, A. Victor Hansen, and H. Niebuhr, "A Definition of Comprehensive Medicine," *Journal of Health and Human Behavior*, vol. 1, Summer, 1960, pp. 83–86.

mend specific changes that would be appropriate under specified conditions. Even if it were possible to present such facts and conclusions, the purpose of this monograph might be less well served. Its sole intention is to suggest directions along which the reader may look in attempting to discover what the psychosocial needs of patients really are, and whether there may be ways, not now in common use, of responding to those needs. In spite of the fact that continuous references are made in hospitals to the necessity for "meeting patients' psychological needs," action seems to be predominantly confined on medical and surgical services to repetition of this admonition.

Since this study is of a sensitizing kind rather than one designed to present a body of data or theory, many subjects that might appropriately have been discussed are scarcely mentioned. Others that seem on the surface to be of minor significance have been given extended attention because they are culturally so interwoven with the average person's life experience that to disregard them may be a serious error. Numerous illustrations are presented, not necessarily for their value as models for action but as recordings of perceptions, attitudes, and undertakings that might broaden and enrich discussion.

The subject matter itself deals with the customary things and the everyday practices, attitudes, and opinions characteristic not only of the hospital but of the home and community that are used for comparative purposes. Because the content is largely concerned with the obvious, it is easy to read. But the very fact of the *obviousness* of the practices and attitudes mentioned may be one of the reasons so little change has been achieved. Many of the practices and attitudes have existed so long that few in daily contact with them are even aware of them. Many of the omissions are not noted because no one has made an assessment within a frame of reference that would bring them to light. Besides, it is often easier and seemingly more rewarding to examine new and distant problems than to try to define and seek to solve those closest at hand.

Part II of the study as projected will consider the changes that could be made in the social system of the hospital which might

tend to increase the motivation, competence, and productivity of staff working directly with patients, and which might facilitate the flow of ideas throughout the social system and the implementation of those ideas in behalf of improved patient care. Part III is planned to draw upon knowledge and methods of research developed by sociology and social anthropology that might supplement those developed by psychology and psychiatry and that could be used in determining what sociocultural factors were important in individualizing patient care.

Because no attention has been given in this study to technical procedures that rest upon a knowledge of the physical and biological sciences, some readers will conclude that we have completely ignored their contribution to patient care. Our competence does not extend beyond behavioral aspects. We wish to say, however, as emphatically as possible that we recognize the basic and indispensable role played by technical knowledge and skill; we appreciate the fact that procedures need to be carried through with fine precision and sometimes fine timing, and that an important psychological factor is involved in how and when they are used; and we consider technical proficiency a prerequisite for permitting staff freedom even to examine the broader aspects of patient care. Unless staff have the training and ability necessary to handle procedural problems with facility and assurance, they will scarcely be able to give attention to coping with still more complex problems.

This monograph has been written with those persons in mind who direct the policies of hospitals and also those who are in direct contact with patients and are interested in meeting the psychosocial needs of the latter more fully. Persons concerned with hospital, nursing, and medical administration, we believe, will wish to give increasing attention to this important, although neglected, dimension in patient care. But so will nurses, physical and occupational therapists, social workers, patient-centered physicians, dietitians, and any other categories of professional personnel that maintain day-by-day relationships with patients. They are in an incomparable position to discover what the

individual patient wants and thinks he needs, and to institute or make suggestions for instituting more satisfactory social and living conditions.

The book has also been written for the many lay persons who are interested in hospitals as members of boards and committees, as volunteers or financial contributors, or who see themselves as past or prospective patients. Some of these persons are profoundly disturbed about existing conditions in hospitals or are bewildered by the bitter attacks that have recently appeared in magazines and newspapers. This interpretation, it is hoped, may provide them with some further insight into how they may recast or extend their own role to be of greater assistance to these troubled but indispensable social institutions.

Much of the material in this small volume rests upon the observations of the writer and the discussions she has had as she visited hospitals and medical centers of many different kinds in many places. Her interest in the mental hospital as a social institution began in college. A professor of sociology and the superintendent of a state hospital were exceptionally skillful not only in portraying the problems of mental illness and institutional care, but in emphasizing a dynamic approach to mental health and to the hospital as a therapeutic rather than a custodial institution. Her later sociological studies of the medical, nursing, and social work professions, as well as participation in various groups interested in medical care plans, brought the writer into direct contact with many practitioners and professional schools, as well as general hospitals where care has been progressively provided by the health professions to sick persons.

In recent years the opportunity to "walk" hospitals throughout the United States has greatly increased. *Nursing for the Future*, which the National Nursing Council had requested, could not have been written if extensive provision had not been made for the author to see hospitals as they existed and new hospitals as they were being built at the close of the 1940's. Since then lectures, participation in workshops, or other contacts have taken her to some sixty Veterans Administration hospitals alone. In them she has observed the advantages accruing from the exten-

sive provision of physical and social facilities, a diversified staff, and a psychological approach to the training and use of the auxiliary personnel.

Most recently seminars of two or three weeks, offered the nursing leadership in different areas of the United States, have provided her with valuable attitudes and opinions, some of which are referred to in the text. From these seminars she has gained cues about the direction in which nursing is currently moving and the part it may possibly come to play in connection with the environmental aspects of patient care.

Finally, a word must be added about the most significant opportunity of all for the writer to extend her acquaintance of that area where the hospital as a social institution and the social sciences converge. Since 1948 Russell Sage Foundation has attempted to stimulate behavioral research and teaching in the health field, as well as in other fields of social practice. It has sponsored experimental projects in schools of public health, nursing, medicine, and social work, and in teaching hospitals. These projects have provided opportunity for further examination of how hospitals, as well as health agencies, perceive their role in relation to sickness, rehabilitation, and the protection of health; and the effect social science theories may have upon those perceptions.

Chapter 1

PATIENTS ARE PEOPLE IN TROUBLE

PEOPLE WHO GO TO HOSPITALS are not only sick; they are often in trouble, sometimes in serious trouble. Everyone who gives direct care to patients knows this to be true. Unless hospital staffs frequently resensitize themselves to the nature and meaning of trouble, however, this fact can be easily forgotten in the day-to-day routine of looking after large numbers of patients and in the "busyness" of "keeping up with the system." In order to consider whether patients need a physical and social environment that is different from that now provided by the average general hospital, a brief summary is necessary of the kinds of psychological and social troubles from which patients suffer.

ANXIETY INDUCED BY ILLNESS AND THE "SICK ROLE"[1]

Almost no one arrives at the hospital without some degree of anxiety. Even the diagnostic "workup" is feared because of what it may reveal. The tonsillectomy is likely to be a traumatic experience for the child, if not for his parents. For those patients requiring long-term treatment the hospital experience is frequently viewed with dread, if not despair. Severe pain, perhaps surgical intervention, perhaps permanent disability or even death, may be their lot. A favorable prognosis, moreover, does not guarantee freedom from anxiety. Probably most doctors and nurses have seen patients like the man who strenuously objected to undergoing very minor surgery. In that instance a nursing

[1] Roles are the patterns or types of behavior that a person builds up in terms of what others expect of him. They are literally the "parts" a person plays in the drama of life.

student finally discovered that some years earlier the patient's wife had entered a hospital for minor surgery and had died; he was convinced the same thing would happen to him. There are even patients so laden with neurotic anxiety that they interpret an angry-looking swelling of the big toe or an unimportant wart on the elbow as a sure sign that gangrene or cancer is developing. Physicians and nurses, often knowing nothing about the patient's particular anxiety but perhaps annoyed by his constant complaints or demands, may give him so little attention that he does not dare tell them what he fears. Hence, his anxiety is likely to become acute.

The hospital and its equipment are themselves anxiety-inducing for many persons, particularly those with limited education and life experience. X-ray machines can be truly frightening. They were so frightening, in fact, to many of the inexperienced Italian-Americans referred to the x-ray department of one city hospital that a young technician of Italian background decided that something must be done. To his surprise and gratification he discovered that, if he devoted perhaps five minutes to explanation and reassuring conversation, fear largely vanished. His success was the first step in persuading him subsequently to become a hospital administrator. In her much used book *Patients Are People*, Mrs. Minna Field summarizes in one paragraph the psychological plight of many patients who do not know the nature of hospital procedures or are afraid to ask the results.

> The patient is subjected to examinations and tests, the purpose of which he does not understand and the results of which are not explained. A nurse comes in and sticks him with a needle, another puts a thermometer in his mouth; a strange-looking machine is wheeled to his bedside and connected with his arms and legs; he is put on a stretcher and wheeled through long corridors and passageways. Some of the tests to which he is subjected are unfamiliar, some are painful, many are frightening, but nobody tells him what they mean. And nobody tells him whether the results are favorable or unfavorable. The patient is afraid to ask questions because everyone seems so busy, so intent on what he is doing. Or, perhaps the patient is afraid to ask because he is afraid to know the answer. Whatever

the reasons, the unasked questions remain unanswered, and uncertainty and fear prey on his mind.[1]

Another aspect of hospitalization that is a cause of apprehension to many patients, including nurses and physicians, is being obliged to assume what the social scientists call the "sick role," with its loss of customary rights, privileges, satisfactions, and the symbols of status. For the person who has spent years developing independence of judgment and action, to find himself suddenly reduced to the anonymity of a horizontal position between white sheets is generally a severe shock to the ego. That shock may be intensified upon discovering that even his name is unknown to some of the staff who attend him, and that he is designated as "the occupant" of a particular bed or room, or by the technical term for his pathological condition or the treatment he is receiving. The following story of the patient who called himself "Submucous Resection"—a story that could be duplicated with only minor changes many times over—will permit the reader to imagine how upset Mr. A. must have been before he even reached the room assigned to him.

> Mr. A. went to the admission desk of a general hospital, gave his name and said he was Dr. S.'s patient. The clerk answered, "Yes, you are the submucous resection." This clerk called another clerk saying, "Here is Dr. S.'s submucous resection." The second clerk asked many personal questions and then without looking up said, "Go through the door and up the stairs." Mr. A. did not know which door but proceeded to the nearest one. He did not find a stairway. He went through another door and found himself in a private office. He returned to the clerk for help. Evidently she had made a mistake, for this time she said, "Go up the stairs and through the door." He reached his destination and was greeted with, "Oh, yes, you are the submucous resection."[2]

The new patient quickly learns that he has been robbed of all responsibility for making decisions. He is told when to get into

[1] Field, Minna, *Patients Are People:* A Medical-Social Approach to Prolonged Illness. 2d ed. Columbia University Press, New York, 1958, p. 57. Chapter 5, The Meaning of Hospitalization, is recommended to all persons wanting to get deeper understanding of this problem.

[2] Render, Helena Willis, and M. Olga Weiss, *Nurse-Patient Relationships in Psychiatry.* McGraw-Hill Book Co., New York, 1959, p. 75.

bed and when to get up; even though he is accustomed to having his dinner at seven o'clock, the requirements of kitchen staffing are likely to demand that he be served at five; whether he will be permitted privacy or not, or permitted companionship should he desire it, is determined by the medical and nursing staff, hospital rules and customs, availability of beds, or his own pocketbook. He is reduced to the state of psychological dependency of a young child to such a degree that he often does not dare to ask that a window be opened or that his bed be moved in order that he may look out-of-doors. Dr. Henry B. Richardson once remarked, "It is a startling comment on the hospital environment that going to a toilet is regarded as a 'privilege.' "[1]

Two comments sent to the writer by nurses who were hospitalized for tuberculosis suggest how greatly they suffered from loss of self-identity or autonomy. The first remarked that a patient ought to put in his locker all his "gray matter in excess of what is needed to be docile, say 'yes' and never question anything, and above all be unconscious of inconsistencies or act as if unaware of them." What was hardest "to stand with equanimity" for this patient, who is nationally known in public health, was the frequent recounting of the public health aspects and dangers of tuberculosis, "as if I didn't know and respect them." Her comment closed with the exclamation, "I wonder where I have been and what I have been doing all these years." The second nurse wrote as follows:

> I have just spent the past year trying to find my way back to my place in the world. The year before that I spent "resting." Resting? Far from it. I had an exceedingly rough time accepting the medication-rest treatment for tuberculosis when there was no bacteriological proof of the disease.
>
> I was a patient for six months in the hospital where I had worked for six years in a most satisfying, challenging job as operating-room supervisor. The medical staff I knew well. I respected and trusted the doctors who advised me about my care. I also knew many on the

[1] Committee on Public Health Relations, *Proceedings of the Conference on Convalescent Care*, New York Academy of Medicine, New York, 1940, p. 144. See Dr. Richardson's discussion of Dr. G. Comby's paper, "Psychosomatic Factors in Convalescence."

nursing staff. I entered the hospital with my eyes wide open but I really did not know what was coming.

Everyone was wonderfully kind and good to me but after one week of resting in bed twenty-two hours a day, I was ready to kick down the door. *I had lost my independence.* I had nothing to say about noise, dirt, heat, strangers coming into my room, dessert brought before my food tray arrived, and so on. I became physically ill and emotionally upset. If the Chief Surgeon had not visited me *every* day and *talked* with me, I honestly think I would have left the hospital. It was a traumatic experience and one I shall not soon forget.

In both instances the nurse-patients were in relatively good hospitals. They received a great deal of individualized attention, far more than was available to many of the patients. Under other circumstances the public health nurse would have been gratified that hospital staff were so diligent in their teaching of "health principles" to patients. But under the strain of being a long-term patient, their disregard of her knowledge and experience only contributed to her sense of lack of identity. The operating-room supervisor, accustomed to the large authority that goes with that position, was robbed of the very autonomy that had been professionally of great value to her. It is from situations such as these that we begin to perceive to how limited a degree, as Dr. Erving Goffman has cogently remarked, can a self-image be sustained in the sudden absence of the setting that usually supports it.[1]

WORRIES ABOUT FAMILY, JOB, AND FINANCES

We have spoken of the troubles that patients experience through anxiety about themselves, fear of the hospital, and being obliged to assume the sick role. In addition, there is a category of troubles that almost all patients bring along to the hospital. These are worries about what is happening at home and in the community from which they have been cut off, sometimes so abruptly that they had neither time to plan for separation from family and job nor to accustom themselves to the fact that they must enter a hospital. Staff are, of course, acquainted with the

[1] Goffman, Erving, "The Moral Career of Mental Patients," *Psychiatry*, vol. 22, May, 1959, p. 141.

possible existence of such problems in their patients. It is often hard, however, for doctors, and particularly nursing personnel who work exclusively in an institutional setting, to appreciate the degree of discomfort that patients may be experiencing because so few of the causes of trouble are visible within the largely self-contained and highly controlled world of the hospital.

During a seminar designed in part to resensitize health personnel to the meaning of trouble, a nurse was asked what *she* would do if a physician told her that she must spend three weeks in a hospital for treatment of a cardiac condition. She replied that she would probably "reject the idea as utterly impossible at present." Where would she find a reliable person, she queried, to care for her two children aged four and five? Even after someone supposedly reliable had been found, how many mothers are there who would not worry about the kind of care being given? Many mothers would be disturbed, if for no other reason, lest their children should become weaned away from them during the period of separation.

A great many women patients are naturally worried about their husbands' welfare, sometimes to such an extent that relatively small readjustments assume large importance. In response to the same question asked above, a second nurse wrote that for her own peace of mind she would have to go to the hospital with the "knowledge that my poor helpless husband, who cannot fry an egg, has a place to go for his meals. Since he hates to eat in restaurants, I must arrange with a neighbor for him to join her family for meals." Hospitalized husbands, in turn, fret about how their wives are getting along at home, particularly if the latter do not know how to drive the car or attend to necessary business matters. Some husbands and wives even worry for fear their partner may be going out with "another man" or "another woman" in their absence.

There are other problems that appear as troubles indeed. Can an important job be left at short notice? Will it still be waiting for him, the patient wonders, when he has regained his strength after hospitalization? If not, what will he do? And what will he do if he is sufficiently disabled to prevent his returning to his present

type of work; if he cannot work at all? Many of these worries are unquestionably realistic. Others are not but they are nevertheless very real. They are the product of the way Americans have been conditioned to view work. Although it is less emphasized as a virtue than formerly, work still assumes great importance psychologically as well as economically in our culture. For the average person much of his time and perhaps major interest are invested in work and work relationships. Many persons achieve a sense of power through work quite as much as through money and the display of consumer goods. Even those in relatively unimportant jobs that could easily be filled by others frequently view themselves as irreplaceable and indispensable. When, therefore, sickness breaks the work tie, if only temporarily, the psychological reaction may be profoundly disturbing.

Financial problems are certainly a basic source of trouble. In spite of the appreciable help now afforded by various kinds of hospital and medical insurance, only persons of large private means feel confident that they can weather prolonged hospitalization. Others see illness eating up their savings, causing them to go without the new car the breadwinner so badly needs in his work, or curtailing the education of their children. Sometimes these worries are imaginary but a considerable part of American society still does not have the degree of prosperity generally regarded as universal. Upper-class physicians, particularly, have difficulty in appreciating how inadequate are the reserves of working and lower-middle-class families who are not eligible for medical care at public expense. Among persons with adequate resources worries about money matters generally stem from the influence of a predominantly middle-class American value system. That system has rigidly maintained that the family should pay its own way through life and have at least a small residual amount of money. Persons brought up to accept such an attitude are likely to experience acute anxiety when faced with expenses that are unexpected and unpredictable as to total amount.

Chapter 2

PATIENTS' PERCEPTIONS AND EXPECTATIONS

THE LIST OF TROUBLES PRESENTED in the preceding chapter could have been greatly extended and elaborated upon. It is more than adequate, however, to suggest that patients would like to find in the hospital help for their troubles, as well as treatment for their disease or injury. Many realize, of course, that there can be no solution of some of their problems, but for staff to recognize them as individual persons, to show interest in and sympathetic understanding of their difficulties, and to make their hospital stay as little frustrating and tedious as possible—these are forms of help they both desire and believe capable of achievement.

The health professions maintain that help should be given not only in order that patients may be granted respect and individualized consideration, but in order to maximize the benefits of the medical or surgical intervention. The result of extensive research and clinical observation has been the progressive realization that body, mind, and the emotions are a unity. Hence, to treat disease while neglecting the man may not even produce cure of disease, where cure is potentially possible. The present philosophy of the health professions, therefore, stresses restoration of the patient physically, mentally, and emotionally; it also stresses the importance of providing health guidance designed to help the patient minimize his handicaps, prevent sickness, and protect his health.

To accomplish any such undertaking even very imperfectly, the hospital, including much enlarged and developed outpatient, self-help, and home-care services, will of necessity have to undergo

drastic changes in its handling of patients. Though there be broad general agreement on the part of patients and health personnel that the function of the hospital is to diagnose and treat persons rather than disease, these institutions are still ill-prepared to undertake so comprehensive a task. Significantly, the criteria they use for judging themselves deal almost exclusively with matters pertaining to plant and equipment, finances, and organization of staff. In administrative offices one hears continuous discussion of such subjects as the following: number of beds and average length of patient stay; physical condition of buildings and furnishings; kinds of diagnostic and therapeutic machines, number of operating rooms, and utilization of a "central supply"; number of departments and services; administrative policies; and, particularly, questions of budget.

Staff meetings and informal gatherings of physicians, nurses, and other members of the health professions are similarly devoted to a great variety of subjects, except patients as people. Disease and its treatment, new technical procedures, drugs, and appliances, changes in staffing patterns, professional training, medical care plans, and so on are discussed at length. "We seem to talk about everything else but we never mention patients" was the comment made at a session of the representatives of a medical center who had met regularly for several years to discuss the roles of the health professions. "It isn't possible to talk about patients because everyone is different," came the quick reply from a member of the group. That every physician, nurse, or hospital is different from every other one is equally true, but the similarities and common problems so far outweigh the differences that profitable discussion and planning are a commonplace occurrence, as evidenced by the meetings of this group.

What patients want and hospitals must be able to provide, if patient care is to extend beyond the treatment of disease and disability, are criteria of performance based to a considerable degree on psychological and sociological considerations and not so largely on statistical averages, organizational charts, and overall procedural policies. When people are ill, they are rarely interested in such measures of proficiency. Once in the hospital they seek

emotional reassurance as well as relief from pain, and a physical and social environment that is as little upsetting as possible. "But the full meaning of the hospital experience to the patient has not yet been approached directly. This state exists primarily because of a lack of understanding of the basic psychological factors involved."[1] Elsewhere in his report on patient care, Dr. Dichter makes this significant remark: "We are today in the age of the extensive utilization of trained psychological insights. They are at work industrially, commercially, at the military level, in the political and propaganda sphere, as well as clinically and therapeutically. It is therefore odd that in the profoundly emotional and complex world of the hospital, psychological 'self-evaluation' should begin so late."[2]

PERCEPTIONS OF PATIENT CARE

Before we can begin consideration of what changes might be made in behalf of providing emotional reassurance and a more satisfying environment, some further examination must be given to how patients perceive the hospital in relation to the kind of care that they believe they need and should receive. In the first of three brief paragraphs that we shall quote, a psychiatrist has answered this question in part by summarizing the complaints from patients that are heard over and again. He then turns to problems of the social organization of the staff that lead, in his opinion, to decreased incentive among many of the workers and to inadequate patient care. In Part II of our study as projected, and noted earlier, the nature of that staff organization and its consequences will be explored in some detail. So important is its impact, however, upon determining even such simple questions as changes in ward furnishings and facilities that reference to it is included here.

Common complaints about the experience of being a general patient include: (a) The patient feels lost, he has a minimum of

[1] Dichter, Ernest, "How 'Secure' Is Your Hospital?" *Modern Hospital*, vol. 83, November, 1954, p. 63.

[2] *Idem*, "What the Patient *Really Wants* from the Hospital," *Modern Hospital*, vol. 83, September, 1954, p. 52.

information, he knows little about the meaning of things that are done to him; (b) during much of the time he has nothing to do—he is left to pass the time in whatever way he can with minimum activity, which promotes a kind of tense boredom; and (c) probably the most strongly felt criticism of all is that the hospital environment is cold and impersonal, with a lack of consideration for each person as a human being. The upshot of all this is that patients in general hospitals often feel lonely, frightened, and depressed.

From the viewpoint of social structure, general hospitals tend to be quite authoritarian. There is ordinarily a rigid hierarchy with physicians at the top. Even within the physician group there is a hierarchy based upon rank of appointment. Nurses are in an intermediate position in the hierarchy and nurses' assistants (aides) are near the bottom. Administrative policy is made by one or two senior physicians and/or nursing administrators. The views of those lower in the hierarchy are seldom obtained even in an informal way, despite the fact that these individuals usually have the most prolonged and intimate contact with the patients. There is a tendency to make policies on a hospital-wide basis insofar as possible. Uniformity is looked upon as desirable.

All of these factors contribute to a situation in which decisions are likely to be made on the basis of inadequate information. Not only is the informational basis inadequate, but the emotional overtones of a system in which decisions are imposed from above are often quite distressing to people who value democratic processes. These are conditions under which the hospital's personnel are likely to care little about their work, to avoid participation with patients, and to displace resentment onto patients.[1]

To many physicians, nurses, hospital administrators, and other personnel who have come to take the physical structure and the social system of the hospital almost for granted, Dr. Hamburg's statement may appear unduly pessimistic and grossly exaggerated. They point to the fine new buildings that have been constructed since World War II which are bright and cheerful and have sometimes been expensively furnished under the direction of interior decorators. They recall the carefully prepared literature given to patients telling about the hospital and its resources.

[1] Hamburg, David A., "Therapeutic Hospital Environments: Experience in a General Hospital and Problems for Research," *Symposium on Preventive and Social Psychiatry, 15–17 April 1957*, Walter Reed Army Institute of Research. Government Printing Office, Washington, n.d., pp. 479–480.

According to their perception, the hospital is a place of great activity. Instead of being concerned about patients' inactivity, some staff members have been heard to say in moments of exhaustion that they envied patients who "don't *have to do* a thing." Hospital workers must often wonder how patients can possibly be lonely when one person after another is running in and out of their rooms. Patients testify, however, that the almost endless number of persons and their continued "running" do little to allay loneliness and often accentuate it.

Many doctors and nurses undoubtedly view themselves as constantly giving interested attention and psychological support to patients. How then can the climate be cold and impersonal? There are certainly such doctors, nurses, and other members of the staff, and patients rarely fail to appreciate their interest and support. But observation reveals that a great deal of the time and energy of hospital staff is devoted to keeping an elaborate system in operation rather than doing something directly for, or with, the patient. Recent nursing studies show, for example, that the average registered nurse spends only eighteen minutes with each of her patients during her eight-hour tour of duty.[1]

Other professional persons may feel that regardless of the validity of Dr. Hamburg's statements, there are unexplored factors that might alter the implications of what he wrote. They point to the assumption that sickness itself tends to make a person egocentric, constricted in his interests, dependent, anxious, and depressed.[2] If these be natural concomitants of sickness, why should great effort be spent on reorganizing patterns of patient care for possibly small gains?

Finally, some staff members might reject the foregoing conclusions because it is emotionally too taxing to look closely at the experience of being a patient. The hospital is so anxiety-inducing an institution that the best possible interpretation must often be put on conditions within it. Thus, staff will speak of a patient who

[1] Abdellah, Faye G., "How We Look at Ourselves," *Nursing Outlook*, vol. 7, May, 1959, p. 273.

[2] Lederer, Henry D., "How the Sick View Their World" in *Patients, Physicians and Illness*, edited by E. Gartly Jaco. The Free Press, Glencoe, Ill., 1958, pp. 247–256.

is near death as "doing poorly." In a particular cancer hospital recently a physician categorically stated that its patients "do not think of such things as death."[1] Yet at that very time one patient is known to have called in a psychiatrist privately to help him face the likelihood that he could not live, while another patient, who had only a few days to live, was pleading through her visitors for the kind of staff care and attention that would afford her some sense of psychological support. The word "death" is, in fact, rarely heard in some hospitals. Staff members speak when necessary about "terminal illness" and "expiring." The physician quoted above may have used the word only because he was answering the direct question asked him by someone outside the hospital.

Obviously, two sets of perceptions can exist parallel to each other, those of patients and those of staff. Dr. Goffman's theory about psychiatric hospitals has appreciable validity for general hospitals: patients and staff live in two separate social worlds, although both groups spend much time in the closest proximity.[2] Under such circumstances it might indeed be easy for the staff to refuse to accept conclusions such as those set down by Dr. Hamburg, were it not for the fact that many of them have been ill and hospitalized, or have heard about the experiences of their colleagues. Once they are obliged to undergo bed care their perceptions are likely to change drastically. Some become exceedingly critical. Various members of the health professions have told the writer that prior to their hospitalization, they had thought her statements about the psychosocial aspects of patient care extreme. Subsequently they concluded that she had been guilty of grave understatement. Following such introductory remarks, these persons frequently have given a detailed account of their experiences that only served to illustrate the generalizations made at the beginning of this chapter.

[1] Boley, Jean, *A Little More Time.* Houghton Mifflin Co., Boston, 1960, pp. 227–255. Mrs. Boley not only writes about the meaning of cancer and imminent death for her, but mentions her impressions of how cancer is viewed and cancer patients are handled by physicians and hospital personnel.

[2] Goffman, Erving, "Characteristics of Total Institutions," *Symposium on Preventive and Social Psychiatry, 15–17 April 1957,* pp. 46–47.

In addition, accounts of this kind and particularly statements made by patients generally, while being interviewed by psychiatrists and clinical psychologists, have often provided some indication of the profound psychological changes that sick persons may undergo during illness. In psychiatric terminology, emotional regression is likely to occur, perhaps to such a degree that the patient obviously behaves very much like a child in his dependency upon parental figures, in his frequent complaints and insistence upon service, and in his generally noticeable satisfaction if warm personalized attention is given him. Fear, worries, loss of self-identity, discomforts and deprivations, ennui, and embarrassment because of aspects of the physical care he must accept may all combine to reduce him to psychological childhood. At the same time, he is aware that he is an adult and should not act like a child; this realization can well create considerable conflict within him.

Doctors and nurses know about emotional regression and observe its manifestations daily, but many of them do not know how to deal with it. Often, moreover, they are so overwhelmed with the seemingly unending complaints about food, noise, temperature of the room, expenses, boredom, and so on that—consciously or unconsciously—they give the "demanding" patient less attention than they give to more "cooperative" patients, or they reprove him by word or gesture for his immaturity. Thus, his insecurity and inner conflict are likely to become intensified.

As the result of depth interviews, conducted through the use of projective tests in several different kinds of hospitals, Dr. Dichter concluded from his study that the greatest need of patients is for security.[1] The research findings indicated that predominantly sick persons were searching for two comfort-creating symbols: the reassuring equivalents of the "father" and "mother." In the interviews the physician took on the attributes of a strong, capable, and dominant father; there was almost universal emotional dependence on "my" doctor. The nurse took over the reassuring qualities of an idealized mother, being in the patient's

[1] Dichter, Ernest, "How 'Secure' Is Your Hospital?" *op. cit.*, pp. 61–63.

mind understanding, sympathetic, tender, and "firm but gentle" as one patient expressed it. If she were not, the feeling was that she "should" be.

The study indicated further that the patient sought to adopt the hospital emotionally as a kind of temporary "step-family," but in this he was often thwarted by the institutional attitudes and practices. Where the atmosphere was warm and friendly, he tended to feel secure; where it was one of cool efficiency at best, he felt that he was only a cog in the wheel. He might be as lonely and empty as an orphan receiving institutional care.

The conclusion reached was that the heart of hospital service, apart from the primary medical function, should be to tide the patient through his many stages of insecurity and adjustment: upon entry, postoperatively, and in convalescence. Few hospitals, however, have attempted the task of coping with this emotional need. The interviews, in fact, ran into contrary attitudes toward the patient. Some members of the hospital staffs were not interested in "service." One doctor said, "Too bad about them, if patients can't stick it out for a week or two." When a hospital administrator was asked about patients' emotional needs, he waved the subject away with the statement, "Coffee is 90 per cent of our complaints—and coffee is unimportant."[1]

EXPECTATIONS OF PATIENTS

As seen in the foregoing pages, hospitals are a radical departure from the customary social environments and value systems in which people, no matter how diverse, have been reared and in which they live. Even the "culture of illness" as learned in the home is different from, and in conflict with, that experienced by the patient in the hospital.[2] Many of the complaints uttered by patients are due to their inability, when they are already under considerable stress, to adjust to the degree of variation between normal living and institutional care. Complaints often appear to

[1] *Ibid.*, p. 61.

[2] Readers will be interested in seeing Dr. Leo Simmons' statement in Appendix 1 about this cultural difference.

be about relatively unimportant items, such as the temperature or strength of the coffee to which reference has been made. As a consequence, the staff tend either to disregard them or to interpret them literally and seek some improvement, if possible. The interesting fact is that, even when complaints are manifestations of deeper and more serious difficulties, they are frequently expressed in the simple and socially acceptable terms of details of daily living.

In the preceding discussion of emotional regression we have seen, furthermore, how the experience of sickness and hospitalization tends to throw patients back to earlier psychological stages in their development. Many appear to want reassurance similar to that provided by their erstwhile parents; they want also a physical and social setting that reproduces some of the symbols of the things and associations that have long given them support and comfort. Again the family, the home, and normal community activities seem to furnish a frame of reference against which they measure or seek to interpret many aspects of their hospital experience.

The hospital has a function so distinctively different from that of the home and other social groups, and its system of customs, values, and expectations is also so different that one might logically assume that it would be viewed as standing outside comparison with these other institutions. Some patients are so ill that they are glad to receive care and to be relieved from responsibility and from having to make decisions; they appear to accept the hospital gratefully as it is and try to do what is asked of them. Their expectations regarding what they want the hospital to provide them, and its expectations regarding how patients should behave, are largely in conformity.

Even these persons, however, unless they are naturally dependent, may be less accepting of hospital mores as they begin to recover. The majority of persons who are hospitalized are probably less able than they to accept that institution on its own merits without comparing it critically with other institutions and situations familiar to them. How could it be otherwise when one recalls that everyone has long since been conditioned by forces

within the family and the community to certain kinds of expectations about how persons should behave and how things should be done?[1]

Almost every child is born into a family and most persons spend the greater part of their lives within it, whether the family be that of their parents, their own, or relatives. The commonly held perception of the family is of a sheltering, nurturing, and emotionally satisfying social unit. Although many individuals undoubtedly look back on their childhood as a period of unhappiness rather than happiness, they rarely blame the institution of the family, so strongly is it embedded in the mores of most societies. Instead, they blame the accident of having been born to the wrong parents or of having been brought up under unfortunate circumstances. Orphans from an early age or others who have had an emotionally disadvantaged childhood are likely, all their lives, to yearn for the protection, warmth, and affection that they never had but that they associate with "home."

But the family is also the social unit that generally assumes the major role in preparing children for adult life. Through a variety of means, such as coaxing, rewards, coercion, and serving as a model to be imitated, it teaches children what to do and how to do things, and how to behave. It also teaches them what and whom to accept and reject, and what attitudes to have toward various groups of people and toward things and situations. This process is carried farther by the schools and, largely through the remarkable efficacy of play, by the child's peer group. By the time young people have reached late adolescence, an elaborate system of value judgments and expectations has usually been well established which determines how most life situations will be looked at and evaluated.

These expectations the individual will carry along with him to the hospital, as well as elsewhere. To the degree that his expectations of how staff should act in their relations with him are met,

[1] Considerable variation in attitudes, values, and expectations exists, of course, among the several social classes. In this monograph the middle class has been used as the frame of reference. In Part III of the study as projected we will give detailed attention to social-class differences as a basis for further examination of how patient care may be made to serve the needs of various groups.

he is likely to feel comfortable and secure. To the degree that his expectations are not congruent with those of the staff, he is likely to suffer frustration, if not anxiety.

It therefore becomes the therapeutic task of those persons caring for him—if they believe that they should treat him in his totality and not merely his disease or injury—to attempt to discover what his expectations are and how they can be handled constructively. This is anything but an easy task, since it requires much careful listening, judicious questioning, and both willingness and ability to use one's self according to the needs of the patient. For such a task most physicians and nurses are only now beginning to have even elementary professional preparation.

Psychiatry is, however, currently devoting much attention to this undertaking, and the results are being reflected in the broadened frame of reference that psychiatrists, psychiatric nurses, social caseworkers, clinical psychologists, and other health personnel with psychiatric orientation bring to patient care. In the meantime sociology, social psychology, and social anthropology have been developing a body of content concerning human behavior. Some of this content already is of use to health personnel, and more of it undoubtedly will be as rapidly as it can be selected, organized, and interpreted in language understandable to the helping professions.

It is not only problems of interpersonal relations between staff and patients that make the task of meeting the expectations of the latter difficult. As noted earlier, the hierarchical structure of the hospital, with its rigid status symbols and its inadequate channels for communication, contributes greatly to the difficulty. This structure has received relatively little attention, and in most places has undergone but little change of a liberating nature. Few hospital administrators have had any training for looking at other than the more traditional patterns of organization, or for having systematic studies made of the social structure of their institutions. In the meantime as hospitals have become larger and more complex, authoritarianism has tended to persist; inflexibility in application of rules and regulations may have increased; and the addition of more categories of staff, some of whom have very

limited prestige, has often resulted in decreased incentive to work and to give personal attention to patients.

At the very time that general hospitals have produced slight constructive change of a behavioral kind, social and economic forces have been at work that have so modified the nature and purpose of family life that sharp incongruencies tend to exist between the expectations of the hospital and of the patients. The lessening of the struggle to make a living, the broadening of occupational opportunities for women, the assimilation of the large groups of peasant immigrants with their pattern of the father as the authoritarian family figure, and the development of habits and customs appropriate to a more comfortable and perhaps egalitarian society—these and other factors have contributed to greater equality for all members of the family and for increased emphasis on psychological and social goals. Large segments of the population view the home of today as a place where love between husband and wife and parents and children can manifest itself; interests and companionship and responsibilities and decision-making can be shared; sympathy and understanding can alleviate disappointments, insecurity, and suffering; and progressive freedom for the children can strengthen their sense of identity and autonomy.

Persons who have been accustomed to living in this kind of psychological environment are likely to have difficulty in adjusting to the average general hospital where the patient may well consider himself unnecessarily robbed of independence and opportunity to make decisions for himself; where care is provided largely, if not almost entirely, on the basis of impersonal procedures and orders; and where formal rules and regulations determined on the higher administrative levels are applied wherever possible to the entire hospital.

Chapter 3

"THINGS" AS FAMILIAR AND COMFORTING SYMBOLS

CLEARLY, CARE DESIGNED TO MEET PSYCHOSOCIAL NEEDS which rests primarily upon dynamic interpersonal relationships between staff and patients is exceedingly hard to achieve. This is particularly true at present when training in such relationships is only beginning, and when hospitals are increasing in size and complexity and are still procedurally rather than psychologically oriented. Hence, it becomes exceedingly important to seek other instrumentalities that may exist that could supplement what is achieved through relationships. One of the most obvious of these instrumentalities appears to be the planned use of the physical and social environment of the hospital. Environmental changes are relatively easy to achieve and, if they can be geared to the expectations of patients, they are capable of providing sick persons with appreciable comfort, reassurance, distraction, and relief from boredom. Often, moreover, they can give overworked staff some relief from feelings of guilt about neglecting patients as well as from so many demands and complaints.

An increasing number of psychiatric and other long-term hospitals are paying considerable attention to how they can create and consciously use a physical and social environment for therapeutic purposes. Interestingly, general hospitals for acute disease and particularly their medical and surgical services have largely neglected this possibility. They have, in fact, often permitted environmental factors and social situations to exist that run so counter to patients' expectations as to be antitherapeutic. Because of the potential importance of the subject, the remainder

of this monograph will be devoted to a discussion of some of the ways whereby the physical and social environment of the general hospital might be altered to conform more nearly to patients' value systems. This chapter will consider personal possessions and "things" in their psychosocial significance for those who are ill. The three following chapters will discuss social situations and activities.

THE IMPORTANCE OF "THINGS"

In order to emphasize their relevance as integral parts of patient-care plans, something must be said initially about the role played by "things" and the meaning that they come to hold for most persons. Almost everyone has observed how, as the house or apartment is transformed into a home, it becomes filled with things around which sentiment and affection grow. There are the wedding and anniversary gifts, the pictures of the children and their toys. The furnishings of the kitchen are a source of pride to many a housewife, as are the tools on the workbench to the man of the house. A piano, a picture on the wall, or particular books may seem like living friends; without the old rag doll or the cloth horse Mary and Johnny refuse to go to sleep. Then there are the individualized toilet articles, pieces of jewelry, and clothes that become so identified with the personality of the owner that without them the woman, and sometimes even the man, feels naked status-wise. All such things are symbols of normal living that may become invested with almost personal qualities.

With the passing of years "you can become so attached to material things, great or small, that they take possession of you. There comes a time when you can no longer part with them; it's then that you are their slave."[1] Even if this does not occur, interest in things is likely to continue although the particular things a person finds interesting may change. After the children have left home, affection may be transferred to a Siamese cat or a flower garden that had formerly been neglected. As friends scatter and die and perhaps only one of the married couple remains, books,

[1] van Velde, Jacoba, *The Big Ward*. Simon and Schuster, New York, 1960, p. 79. By permission of Simon and Schuster, Inc.

television, a coin collection, or a bird in a cage are called upon to fill some of the void. A certain chair or a comforting old footstool may assume an importance that a young physician or nurse could scarcely understand.

So much theoretical attention has been placed by psychology and psychiatry upon the importance of interpersonal relations and so little upon the relationships between persons and things that one can scarcely overemphasize the significance that things have for many people.[1] America has long been viewed by other countries and views itself as machine and gadget-minded. Machines are understood, admired, often given a name, and sometimes treated with affection. Conversations which Professor David Riesman once had with men who drove the great electric cranes indicated that they found their jobs highly satisfying in spite of being spatially cut off from contacts with other workers. Their relations were with those extraordinary machines over which their dexterity permitted them to exercise superior power.

Animals, even turtles and white mice, are fascinating to children, while dogs are a great source of satisfaction to persons of all ages. Indeed, it is generally recognized that there are individuals for whom a dog is more of a source of affectionate attention and gratification than any human being. When this remark was made to a psychiatrically trained social worker, she quickly said that she could not accept its validity; human relations were unquestionably more important. Suddenly, however, she began to ponder her own relationship to her French poodle. Since the loss of her husband, she admitted, the poodle had had first place in her affections. She concluded that in the future she, as a social caseworker, must give sharp attention to *what* relationships had special meaning for each of her clients, since therein might lie important cues for helping them. We shall see later that the subject of *what* relationships is equally important for those members of the staff who care for patients in hospitals.

[1] In England recently the word "chosisme" has been coined to suggest the great emphasis placed upon things and objects in some current French fiction. This abstract noun is derived from "chose," the French word for thing, and is used because of the awkwardness of the English equivalent which would be "thingishness."

INFLEXIBILITY IN THE USE OF THE PATIENTS' ENVIRONMENT

Against the background of familiar things and the associations that persons develop around them, we must take a more critical look at the physical environment of general hospitals.Those that have been built or reconstructed since World War II have usually drawn much favorable comment from visitors and staff alike. Enthusiastic remarks are heard about the disappearance of large open wards and the great increase in semiprivate rooms, which often resemble double rooms in hotels with their pastel-colored walls, harmonizing draperies and bedspreads, and private baths. Visitors admire the beautiful lobby and lounges, the cheerful coffee shop, and the attractive gift shop. Staff are gratified with the progress that has been made by specialized architects in constructing hospitals that are more functional. That many of these changes are little short of revolutionary is apparent when one compares them with still existent old hospitals that customarily used only white paint and seemed to pride themselves on the sparseness of the furnishings and the inconveniences of the work areas.

In spite of these changes, however, there appears to have been inadequate analysis of what things might give *patients* the greatest comfort, and what provisions might be made to relieve monotony and foster the maximum amount of social life. Besides costs, appearance and utility seem to have been the primary considerations in the minds of architects, boards of trustees, hospital administrators, medical chiefs of service, nurses in administrative positions, and others who were responsible for the planning of the new buildings. They brought to their task upper-middle-class perceptions of what were appropriate standards for a modern general hospital; they also brought with them many remnants of traditional ideas to which they had been conditioned. Probably they rarely had studies made of what patients would recommend in the construction and furnishing of a new building. Under such circumstances it is not surprising that lobbies may exhibit beautiful walls of marble or fine woods while patients' rooms lack basic items of convenience; that dining-rooms and coffee shops are

operated for staff and visitors but dining areas are rarely found on the patient floors for persons who are ambulatory; or that the hospital for acute sickness generally has no organized recreational program for those many patients able to profit from it.

It is our contention that the physical environment of the general hospital is still inadequate, and its use too inflexible and tradition-bound to meet the psychosocial needs of patients to anything like the degree possible. For illustration, let us examine the semiprivate and private rooms, since they are the place where a considerable proportion of sick persons begin their hospital stay and where they spend most of their time. These rooms are set up initially to be convenient for giving nursing care. Once arranged, a bed or table is rarely moved, even though with some small change the patient might be able to look at trees or enjoy the sunset. If the bed could be turned around, long-term patients might almost have the sense of going on a journey. The recent increase in number of wall plugs for suction, oxygen, and so on makes flexibility in the use of room space progressively difficult. Even now, however, the more important problem perhaps is that of rigidity in thinking about what changes would give some relief from boredom, or some comfort and satisfaction to the patient. Admirers of Josephine Tey (Elizabeth Mackintosh) will remember her paragraphs from "The Daughter of Time"[1] that recall the unrelieved preoccupation many patients have with a crack in the ceiling, the design on the wallpaper, or a pipe in the corner from which the paint is peeling.

> Grant lay on his high white cot and stared at the ceiling. Stared at it with loathing. He knew by heart every last minute crack on its nice clean surface. He had made maps of the ceiling and gone exploring on them; rivers, islands, and continents. He had made guessing games of it and discovered hidden objects; faces, birds, and fishes. He had made mathematical calculations of it and rediscovered his childhood; theorems, angles, and triangles. There was practically nothing else he could do but look at it. He hated the sight of it.
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> He had suggested to The Midget [the "very nice five-feet-two" Nurse Ingham] that she might turn his bed around a little so that he

[1] *Four, Five and Six by Tey:* The Singing Sands. Macmillan Co., New York, 1958, p. 3.

could have a new patch of ceiling to explore. But it seemed that that would spoil the symmetry of the room, and in hospitals symmetry ranked just a short head behind cleanliness and a whole length in front of Godliness. Anything out of the parallel was hospital profanity.

Staff become so conditioned to the unchanging arrangements, the type of furnishings, and the upkeep or lack of upkeep of hospital rooms that they rarely seem to consider how space and its contents can be used for therapeutic purposes. When nurses were asked, in one of the writer's seminars, what they would like the hospital to provide were they to spend two months in it as patients, they described in detail the desired furnishings of private rooms, but they made almost no mention of the possibility of rearranging the furniture or changing the location of the bed during their stay. Two nurses suggested instead that they would like to be moved from one room to another at frequent intervals to relieve the monotony.[1]

When staff members actually become bed patients, their perceptions of room limitations are quickly sharpened. One nurse spoke recently of the beautiful grounds surrounding the hospital, but complained that from her bed in a private room only the "midriff" of one tree was visible. She also complained about the fact that the walls had been redecorated with a kind of paper to which Scotch tape would not adhere, and hence it was impossible to have her brightly colored prints where she could see them. By contrast, another nurse spoke glowingly about the care and attention she had received in a community hospital. Much of her report centered around her having been asked upon admission which of the two beds she would prefer. She requested the one next to the window in order, said she to the nurse, that she might look out into lovely trees which were a particular joy to her. The next day the window washer came so that she "might see the trees better." That gesture of thoughtfulness endeared the hospital to her, and the trees and their birds rarely failed to hold her attention during the two weeks she was a patient.

[1] Nurses may be interested in reading the analysis that was made by the writer of a sample of the material submitted by members of this seminar. It appears as Appendix 2.

If anyone still questions whether patients are subjected to unnecessary deprivations in the hospital, the absence of clocks and calendars in rooms furnishes a specific answer. Time is so important a feature of American culture that we are spoken of as living "by the clock." Calendars and time pieces are scattered generously through the average home and are consulted frequently. Some patients are fortunate in having their watch or a traveling clock with them, many more are not so fortunate. The average hospital room provides neither clock nor calendar. And yet patients often need, far more than do well persons, to orient themselves time-wise. Some are brought into the hospital unconscious; many others lose consciousness as the result of the general anaesthesia administered during surgery. When they regain consciousness they may be like the old lady in *The Big Ward*, who asked herself in great mental stress, "But what has happened to me? Is it winter or summer, autumn or spring? Evening, midnight, or early in the morning?" Days later she could say to herself, "It is now ten o'clock I—I would think. The time passes terribly slowly."[1]

Why is it that so little attention seems to be given to the importance of measures of time for patients in general hospitals? In psychiatric hospitals where disorientation regarding time is recognized as a not infrequent occurrence, the subject is receiving merited examination. A psychiatrist, speaking recently on the rehabilitation of chronic patients, not only advocated that a large calendar be displayed on the bulletin board of each dayroom, with the day, month, and year clearly visible, but also that the present date should be indicated. He suggested, too, that the calendar might be given more relevance by entering on it items of the program of social events in the hospital. Clocks, moreover, should be of a size and in a location where they could be seen from different parts of the dayroom.[2]

[1] van Velde, Jacoba, *op. cit.*, pp. 3, 10.

[2] Cumming, John, "Communication: An Approach to Chronic Schizophrenia" in *Chronic Schizophrenia: Exploration in Theory and Treatment*, edited by Lawrence Appleby, Jordan M. Scher, and John Cumming. The Free Press, Glencoe, Ill., 1960, p. 115.

THE USE OF FOOD AND DINING-ROOMS AS SOCIAL THERAPY

Eating together around a table is one of the symbols of family life so taken for granted among middle-class persons that students in the helping professions have sometimes been surprised and shocked when they discovered from their field work that in economically disadvantaged homes the members might never sit down as a family. This eating together, whether in a dining-room, living-room, or kitchen, has long been a well-established folkway for large sectors of the population. "Breaking bread" with persons outside the family is often viewed as a sign of friendship. Within a caste system the very thought of persons from different castes eating together is generally abhorrent. Picnics, neighborhood barbecues, kaffeeklatschs, luncheons, cocktail parties, church suppers, and formal dinners are among the chief social activities in which adults and often children participate. Around the preparing, serving, and exhibiting of food, moreover, much of the social life of the family and community is organized.

Food and eating are, in fact, so tied into the experience of the individual from birth, and are so determined by the practices of the group in which the individual grows up, that anthropologists consider them among the last habits to change as persons become assimilated into another culture. If Americans, for example, were obliged to eat Chinese food exclusively, they might yearn for ham and eggs, doughnuts and coffee, or apple pie, even though the Chinese kitchen is objectively regarded as the world's great cuisine. What is served, therefore, and how and where it is served, may be of signal importance to the welfare of sick persons. Much emphasis is placed in hospitals upon "diets" that have been individualized for medical and nutritional reasons, and some hospitals also emphasize the attractiveness and quality of the food served, as well as the privilege given patients of making selections from a menu card. But hospitals generally have failed to use anthropological knowledge, to whatever extent possible, about variations in food according to the ethnic and social-class

backgrounds of their patients, and about where and when it should be served and with whom it should be eaten.

The writer recalls seeing spaghetti and meat balls listed on the menu card of a hospital where many of its ward patients are Italians and Italian-Americans from the spaghetti-eating parts of Italy. Because of her anthropological background, she took it for granted that the dish was being served as a gesture of friendly recognition of those particular patients. Upon sampling the dish, she discovered that it bore so little resemblance to what would have been prepared in a South Italian cuisine that she concluded that it was probably put on the menu only as another item. Had the spaghetti and meat balls been cooked in true South Italian fashion, and had the Italian patients been told in advance that the dish was being served with them expressly in mind, it might have brought appreciable comfort and satisfaction to a group that finds sickness and hospitalization very trying ordeals.

Probably no single food item in the American hospital is as important as coffee. Some institutions have learned that early morning coffee, served attractively and very hot an hour before breakfast, is greatly appreciated. Patients may even mention it to their friends long afterward as "one of the nice things" at the particular hospital. The administrator, as quoted earlier from Dr. Dichter's report on medical care, who said that 90 per cent of all the complaints in his hospital were about coffee and coffee was unimportant, did not realize how many associations are attached to it. A survey that the Institute for Research in Mass Motivation had made prior to the study of hospitals convinced Dr. Dichter "that the cup of coffee is more than 'just' a simple drink. It has indeed, a deep symbolic meaning."

He continued as follows:

> To the American, coffee has come to mean congeniality and friendship. It has the aura of "home," of warmth and security. It was found, in addition, that the cup of coffee was a symbol of maturity, since in our culture children do not drink it. The man whose wife makes a "good cup of coffee" is a "good little housekeeper."
>
> The cold cup of coffee, then, has deep emotional meaning. To the insecure patient it is a sign. Good hot coffee is symbolic of the home

away from home, of being welcome. Bad coffee is the perfect symbol that he is a stranger, that he is receiving what amounts to the orphan's negligent care. The patient who complains that the coffee is bad, is probably complaining about more than the flavor.[1]

The following brief sketch, as reported to the writer by a very busy woman pediatrician, suggests that Dr. Dichter's interpretation may not be so overdrawn as skeptical readers might believe. It introduces another important element, namely, the sympathetic understanding of "the doctor" and the probable therapeutic effect of that understanding in a moment of great anxiety for the patient's mother.

A young girl complained of abdominal pain in the right lower quadrant. Though her condition was only slightly suggestive of appendicitis, a decision was made to operate, chiefly because of the mother's extreme nervousness and worry. After some thirty telephone calls by the mother to the doctor's office, the girl was admitted to the hospital that very evening and in the morning was taken to surgery. I went to see how everything was going, and found the mother walking up and down outside the operating room in a nervous frenzy. After I had talked to her for a few minutes and she seemed a little more quiet, I said, "Now, if you will please sit down in the room in here, I will ask one of the nurses to bring you a cup of coffee. I am sure you did not even have breakfast." A cup of coffee was brought on a tray. When I saw the mother again after a few hours she said, "Listen, I want you to give me the prescription for the sedative that you put into the coffee." She could scarcely believe me when I said that no sedative had been used, that the drink was plain hospital coffee.

Quite as important as the food itself perhaps are the time and place of serving it. So many complaints have been heard about the inappropriate meal hours that nothing more needs to be said. Less attention has been given to the place. Few Americans have breakfast in bed; only very poor people generally eat in the room where they sleep; and almost no one likes to eat alone. Yet the folkways of most hospitals for acute sickness violate customary patterns of preferred behavior even when patients are able to

[1] Dichter, Ernest, "How 'Secure' Is Your Hospital?" *Modern Hospital*, vol. 83, November, 1954, p. 61.

leave their rooms. In some hospitals there is no provision for ambulatory patients to have their meals except by getting into bed again. As a result of this divergence between practices outside and in the hospital, an occasional patient finds it impossible to eat the food he needs, while many others complain about the food served or about loneliness.

For the very reason that dining-tables and eating with the family, friends, or colleagues at work are such distinctive features of American life, it is surprising that more general hospitals have not capitalized these symbols in recent years when medical staffs have successfully emphasized early ambulation. Persons who have had an opportunity to visit Veterans Administration hospitals, which make extensive use of physical facilities, are impressed by the number of patients who can get to a common dining-room with or without assistance. Going to the dining-room three times a day bears considerable resemblance to normal community life and must do much to reduce boredom. Even more impressive is the number of such patients, again perhaps with the aid of canes, crutches, wheel chairs, or even self-propelling stretchers, who get themselves to the canteen where they while away the time in informal groups over coffee, ice cream cones, or potato chips.

Here and there one finds experimentally minded departments in general hospitals that are making use of customary eating habits for socially therapeutic ends. Attached to one maternity service is a small room with a large old-fashioned dining-room table where mothers may go for a "coffee break" in the morning and again in the afternoon. They so greatly enjoy the acquaintances they make there while they have coffee and cigarettes, and perhaps play cards, that their subsequent enthusiastic reports to friends have done much to promote use of this particular maternity service.

Pediatric services not infrequently arrange for children to eat together. Visitors are often surprised by the ability and willingness of sick or physically handicapped children to feed themselves and to eat more readily than if they were alone with the nursing staff or their own mothers. Their peer group appears to provide

enough stimulation and competitive spirit to encourage independence and normal behavior.

In the light of what is now known about the social meaning of food and the significance of the small group as a strong support for the individual, it would seem highly desirable that small dining-rooms with table service be established on the patient floors. They would permit many patients in dressing gowns who are not able to go to large and distant cafeterias to escape from their rooms and to eat with other persons.

THE POTENTIALITY OF PATIENT LOUNGES AS SOCIAL SITUATIONS

Equally, provision needs to be made for adequate lounge space to serve a variety of purposes. At present the observer generally finds that it is so limited there may not be adequate opportunity for ambulatory patients to visit with their families in some privacy, or to escape from a raucous television set. Or he finds attractive lounges and sun porches with fine views that may be rarely used, although patients are anxiously pacing up and down in front of the nursing station or standing around the elevators.

Persons who have seen the dayroom off the ward that is found in rehabilitation units, in psychiatric services, and in many federal general hospitals must wonder why it has not been made a feature of all hospitals for acute sickness. The writer has been in Veterans Administration hospitals where this room was used as the place in which patients stayed much of the time from the beginning of early ambulation until they were able to go to the dining-room, canteen, library, recreation hall, and elsewhere. Here they could drink coca-cola or coffee, smoke cigarettes, talk and gripe, listen to the radio or watch television, play cards if able, look at magazines, and eat their meals either from trays or at tables. Here the "buddy-system" could readily work as a supporting, integrating force. Because of it, they were perhaps less in need of attention and entertainment from staff than adult patients who have not shared a major common experience.

The basic question is whether lounges can be set up, equipped with familiar symbols of normal living, and used as social situa-

tions to relieve patients of the "tense boredom," as well as some of the loneliness, fright, and depression of which Dr. Hamburg spoke. Another question is also relevant. Can these lounges serve additionally to protect overworked nursing personnel, in hospitals seriously understaffed, from harassment by ambulatory patients seeking attention because of emotional regression or sheer ennui? In an attempt to emphasize the importance of these questions a situation will be used as illustration that is typical of some of the floors in many voluntary hospitals, as well as city and county hospitals for acute sickness.

The setting is a surgical floor for approximately thirty patients in a teaching hospital where much "heavy surgery" is done, and where the average length of patient stay is proportionately longer. The building is old and although redecoration has improved the appearance of the cramped rooms primarily of four or two beds, the physical setting is not conducive to comfort and relaxation, and is extremely difficult for staff to work in efficiently. Storage space is so meager that the long corridor is lined with stretchers, wheel chairs, and treatment tables. The floor is said to be chronically understaffed. Nurses question why they should work so hard under such adverse conditions for less pay than can be had in more modern hospitals close at hand.

During the afternoon which the observer spent on this floor, the head nurse, supposedly the most competent in the hospital, was so overwhelmed with work that she actually ran up and down the corridor. With the best efforts she and her limited staff could put forward, they could scarcely attend to the urgent medical needs of patients who had recently returned from the recovery room. There were nine ambulatory patients with no one to give them attention, with nothing to do, and nowhere to go except into the corridor or the tiny lounge designed for visitors that was scarcely large enough for two couples. The impression which that surgical floor left with the observer was depressing indeed. Was this the best that could be done for patients who had undergone major surgery? Why would a truly able head nurse continue to work under such conditions? How many floors were there across the United States where conditions were no better?

A potential solution to part of the problem lay in the fact that adjoining the surgical unit was a room that would comfortably hold perhaps a dozen persons and that had been originally intended as a room for visitors. Because the surgical house staff had no place to use as a lounge or for case conferences and staff meetings, they had long since appropriated it. Crowded though it was, could the hospital not find some other place for them? Could the room not then be converted into a cheerful lounge, well provided with equipment for occupational and recreational therapy, where patients would be expected to spend their time when out of bed?

Because these patients were still ill physically and extremely nervous, besides being diverse in age and background, it is doubtful whether without some assistance they could use this lounge and the contacts with one another for constructive purposes. Under such circumstances the lounge would need to be staffed by an occupational therapist, group social worker, or, if necessary, a volunteer. Since the number of persons trained in working with groups is sharply limited and since few hospitals would think they could afford a professional person for nine patients, the solution would probably have to lie in expecting the occupational therapist or social worker to divide her time among several groups. Part of that time, moreover, would need to be spent in teaching volunteers what to do in her absence.

On floors where staffing presents a less serious problem than on this particular unit, the head nurse might be able to arrange the schedule so that her nurses and nursing aides could replace the volunteers. Many head nurses maintain that more might be done generally to entertain patients if the floors were provided with cards, games, drawing paper, paint boxes, and other supplies. The patients need an appropriate setting, however, and nursing staffs that have as yet received only a limited amount of training in working with groups need the guidance of persons more experienced in using the social milieu to help patients move toward emotional self-sufficiency and independence.

This discussion of the use of the lounge as a social situation has been written with hospitals for acute sickness in mind. Hospitals

and nursing homes for long-term patients have made much more provision for lounge space. The way in which that space is used varies greatly, however, from institution to institution. In some long-term hospitals a relatively rich and varied recreational program is provided. The greater problem perhaps for patients in these institutions, who do not have single rooms, is the lack of opportunity for privacy, for being alone sometimes, and particularly for entertaining relatives and friends without others watching or sharing in the conversation. No theme recurs more frequently in *The Big Ward* than this. When her mother has to go to a nursing home that has only wards and a common lounge where all the old ladies who are not in bed sit all day, Helena asks bitterly:

> So merely because she is short of money she is compelled to sacrifice her privacy forever? Don't you realize that is the most dreadful thing that can happen to anybody? Whatever she does, there will always be people watching her. Everyone feels the need to be alone at some time or other. Even an animal can creep away into its lair.[1]
>
> [And after Helena has gone to say good-bye to her mother before returning to her home in Paris, she lives over the scene in her mind.] What a sad parting! She [the mother] tried so bravely to hold back her tears—right up to the very last moment. And all those people who were sitting around us! Why didn't they have the decency to go away? They can't, of course, they only have their dormitory. "I shall try and come again soon, Mummy," I said. "To be sure," put in Miss Laus, "she'll be coming back. You don't need to upset yourself so much." "Naturally, it's terrible for your mother that you are going away," whined Mrs. Jansen. "When are you due in Paris?" asked Mrs. Blazer. I cursed them all. I should have loved to scream at them, "Go to the devil!" But I said nothing. I sat in front of my mother on the high plush chair; we loved each other helplessly.[2]

THE NEED FOR OTHER SOCIAL FACILITIES

In addition to dining-rooms, canteens, and lounges many other facilities can contribute to the comfort of patients. A pleasant library, attractively furnished with comfortable chairs,

[1] van Velde, Jacoba, *The Big Ward.* Simon and Schuster, New York, 1960, pp. 51–52. By permission of Simon and Schuster, Inc.

[2] *Ibid.*, p. 80.

is an asset for persons who have had considerable education and who like to read or chat in such a setting. Chapels, where religious services are held and which are open at all times to patients and visitors, have increased in number in recent years and appear to have met a considerable need. Occupational therapy rooms, as well as physical therapy units, have also been increasing in general hospitals. Unfortunately, they are still viewed too exclusively as places where patients are sent on doctors' orders to receive specific treatment for specific physical limitations. Because these rooms frequently provide a warm and supportive atmosphere and place emphasis on patients doing something or making something, they are of great potential value in reducing "tense boredom" and increasing self-reliance. Hence, they might well be viewed as psychosocial facilities that would benefit a wide range of patients besides those needing physiological assistance. They might also be viewed—and featured—as offering an intermediate step in the patient's progress from his room to the outside community.

One facility that is found in relatively few general hospitals is a warm-water swimming pool. (Psychiatric hospitals seem to have fared only a little better, although there has probably been much wider consideration of the utility of the pool by psychiatrists than by other clinicians, except those specifically trained in physical rehabilitation.) With the marked interest that is being placed on rehabilitation, it might have been assumed that more swimming pools would have been built in connection with new hospitals. As a matter of fact, they have not begun to keep pace with the increase of private pools for purely recreational purposes. The Hubbard tank and other smaller tanks still continue to be installed almost exclusively, for purposes of rehabilitation, although some medical specialists, as well as physical therapists, have spoken enthusiastically of the value of the swimming pool. We certainly can pass no judgment on the relative merits of the pool versus the Hubbard tank in connection with physical rehabilitation *per se*. But there are psychosocial considerations about which we may be permitted an opinion as the result of both observation and the extensive use of a therapeutic pool.

To a remarkable degree the pool permits the patient, as the tank does not, to associate himself psychologically with health and normal living. Even though he may have to be lowered into the water on a stretcher, he often has the sense of considerable freedom of physical movement and release from nervous tension. He may almost believe he is in a "regular" pool. The illusion is intensified by the fact that there are other persons in the water with whom he may chat under conditions very different from those on the patient floors. The success of the pool as a social and recreational facility was clearly evidenced by the extreme frustration the writer suffered when it was closed for five days at a time upon three occasions.

Another behavioral aspect is of equal or greater importance. The pool provides a possible social milieu where patients, *if they become a peer group*, can apparently succeed to an extraordinary degree, through praise, competition, criticism, or ridicule, in encouraging each other to exercise regardless of severe pain. This influence of the peer group is perhaps of a different order from that exerted by a physical therapist in a one-to-one relationship with a patient in a Hubbard tank. Relatively little seems to be known in any systematic way about the manner and the extent to which patients help other patients in the swimming pool, or elsewhere in the general hospital. Daily observations of a group of post-polio patients, who had been kept together continuously since the beginning of their illness, suggested that the psychological help they gave each other while in the water was large in amount and seemingly indispensable. On the other hand, a number of long-time arthritic patients, who also used the pool through being referred by the Outpatient Department, did not constitute a group during our observations. It seemed unlikely that they would ever become one unless they received active and prolonged help from the physical therapists.

Let us turn now to a last item in this long list of "things" that are more often conspicuous by their absence than their presence. The failure of the general hospital to have a large auditorium or recreational hall that can be used for a diversity of social purposes, and that will readily accommodate wheel chairs and stretchers, is as surprising as the absence of patient dining-rooms.

This country is still close enough to its Puritan heritage to keep many adults from admitting that they *play*, that they like to play, or that play is a more effective instrumentality for learning than is work.[1] Play is intended, they insist, for children. But behind the mask of "recreation" or "social activities" a never-ending stream of hopefully pleasurable pursuits is engaged in that yield enough of the satisfaction of play to ensure their continuation. Without these pursuits it would be difficult for the average person to imagine that life could be interesting or stimulating. Yet he may find himself obliged to spend several weeks in a hospital cut off from customary pleasurable pursuits, though not necessarily because of his physical condition. Among passive activities, motion pictures and stage entertainments of many kinds are widely popular. They would seem to be particularly valuable for patients since they require little expenditure of energy, they often furnish an easy escape from immediate realities, and they are a symbol of the well person's going to "a show." Television is not an effective substitute.

As an example of how "movies" and a social hour can be used to give patients a distinct change of setting, we shall describe the practice observed on a hot Saturday evening in a Veterans Administration general hospital. Already on Friday a visitor could hear the staff saying to patients, or patients telling each other, "You know tomorrow is Saturday Night Out!" On Saturday it was easy to sense the ripple of anticipation and excitement that ran through the wards. After supper the long procession began moving along under the arcade from the main building to the auditorium. First came the men who could walk, push their own wheel chairs, or be assisted by other patients. They arrived very early. Then came the men in chairs who needed the attention of the nursing assistants. Finally came the patients—many patients—on stretchers accompanied by nurses and assistants. When everyone was in the auditorium a motion picture was shown. Immediately afterward the stretchers began to be moved back to the hospital floors. For those patients able to stay, there was a social hour with refreshments, cigarettes, and im-

[1] Foote, Nelson, and Leonard S. Cottrell, Jr., *Identity and Interpersonal Competence*. University of Chicago Press, Chicago, 1955, pp. 144–157, 167–169.

promptu music. Members of all categories of the staff moved around, laughing and joking with the men. The "buddy-system" was very much in evidence.

Saturday Night Out may have been poor in freedom of choice and movement as compared with "real life," but most patients in the average hospital who are beginning to convalesce or are not acutely ill would probably view it as a life saver. Many hospitals question how it is possible to get a large percentage of all patients to a motion picture at frequent intervals. The practice, except at holiday seasons, has now unfortunately been given up in that particular hospital because the bed capacity has been doubled. Such a practice requires, of course, extensive planning of staff schedules to assure the presence of adequate numbers of nursing personnel. It requires many stretchers and wheel chairs, besides several elevators and arrangements for their most efficient use in moving the stretcher patients. It demands much patience, and also the occasional sacrifice of Saturday evening on the part of every member of the hospital staff.

But more than this, it requires the conviction that if the philosophy of the treatment of the *whole man* is important, the treatment must be interpreted in realistic ways that have meaning for patients. Once such conviction exists, and an evening program (or other symbolic activity) is considered to be as significant as many other therapeutic undertakings, the problem then becomes one of seeing if and how staffing patterns and the use of facilities *can* be arranged. Even more, it becomes one of helping all staff members to realize that they will need to use themselves in many ways that are distinctly different from those associated with the traditional treatment of disease.

ANIMALS

Two of the most common signs of family life are children and animals. Around them great affection centers. Unfortunately, both children and animals are in very short supply in hospitals. It will presently be seen how rarely children are permitted even to visit sick members of their family. Children who are them-

selves ill are customarily segregated in a pediatric service and, hence, are scarcely ever seen by other patients. But the situation concerning animals is even more unlike life. The general hospital was completely devoid of them until small birds in cages and gold fish in glass tanks began to appear on children's wards. Such living amenities have perhaps now arrived in occupational therapy units or hospital lounges, but only rarely on the adult patient floors. Almost no consideration, moreover, seems to be given to whether their usefulness could be extended to other animals such as dogs, which are far more important psychologically in bringing distraction, comfort, and affection to patients.

Unlike the general hospital, the question of dogs and cats is currently receiving some attention in psychiatric hospitals. Psychiatrists, who have treated patients whose closest tie was with their dog, have concluded in some instances that that tie should not be broken because of hospitalization. Hence, they have promoted the idea of the joint admission of patient and dog. Other staff personnel, who thought that playful or cuddly dogs would bring pleasure particularly to withdrawn patients, have sometimes tested their assumption by taking one of their own dogs to a floor. In a hospital where this occurred, patients and dogs got along so well together that some of the staff complained because the patients seemed too much interested in the dogs! Around large psychiatric hospitals with extensive buildings and land, dogs and cats appear unexpectedly, make their home, rear their young, and provide much entertainment for patients who have the freedom of the grounds. Cats were purposely brought to one hospital to kill the rats and mice in the farm buildings. The patients fed the cats food taken from their plates at the table until the cats were worthless as hunters, but they served to give patients a purpose in life, however unimportant that purpose might seem to well persons.

How little attention has been given the subject in general hospitals is evident whenever a speaker includes it in a discussion of the therapeutic use of the symbols of normal family life. No part of the talk or the following discussion arouses so much excitement or so many quick rationalizations as does the question,

"Would it be possible to permit a patient's beloved dog (or cat) to visit him?" Interestingly, the rationalizations sound very much like those used in a discussion about members of a minority group moving into an upper-middle-class, white neighborhood. To hear the first reactions to dogs, one might conclude that they were all slum products that had never been housebroken, were noisy and disruptive if not vicious, and were covered with vermin. To think of them as well-behaved, patrician animals being brought on a leash to call on a patient in his private room or a lounge is often not quickly possible, so new is the idea. Yet after the very meeting where the audience has sat in stunned surprise or has reacted with strong negative statements, a nurse will perhaps slip up to the speaker with a story of how she once could not resist smuggling her "darling little Pepi," concealed in a pillow case, into Mrs. T's room and the extraordinary pleasure and comfort Pepi gave Mrs. T.

More than almost anything else perhaps, reaction to the question of the admission of children and animals as visitors provides some clue of the rate of change with which a hospital is throwing off the heavy hand of outworn rules and regulations, and is exhibiting flexibility in thinking about *how* patients' emotional needs can be met.

DISCUSSION

In this chapter, long as it is, we have discussed only a few of the "things" that might provide comfort and distraction for patients, help to check emotional regression, and promote a more optimistic outlook. No attempt has been made even to enumerate scores of things, many of them very small but useful, that immediately come to mind as valuable assets. We have chosen instead to devote more space to the few subjects discussed in an attempt to emphasize their psychosocial significance. It is only within this frame of reference that most things take on importance as contributing to the therapeutic process.

Even though they may accept the premise that the general hospital exists to treat *people* who are carriers of sickness, many

hospital directors, as well as administrative physicians and nurses, are likely to come to one or more hasty conclusions upon reading these pages. They will reject the discussion as inapplicable to *their* institution because of the brief hospitalization of their patients, the increased danger of infection, or the expense involved in initiating and operating such a plan. Some brief answers must be given to these issues.

One figure is known precisely by almost every hospital director and all members of the staff who are concerned with planning. It is the figure for average length of patient stay. Ask a director and he will tell you instantly that the figure for his hospital at present is 6.8, 7.6, 8.3, or whatever the number of days maybe. A continuous effort is being made, moreover, in many institutions to reduce the figure. Because average length of stay is so brief and has become progressively briefer in recent years, it is extremely easy to fall into the error of the doctor quoted earlier, "Too bad about them, if patients can't stick it out for a week or two." The question is, "What *is* a week?" To a well, active, and happy person, it is at most seven short days. To persons in deep trouble, it may be months or even years if human feelings rather than calendar time be used as a measure. Among the most frequent complaints of patients not under heavy sedation is how slowly time moves; that it seems as if one had been in the hospital "forever."

Average length of patient stay provides a misleading base for considering social needs of patients. In commenting on this formula two physicians have written that averaging length of stay is "similar to averaging the weights of a 200-pound pig, a 20-pound turkey, and a 5-pound chicken. Their average weight would be 75 pounds, which would be a stupendous chicken, a tremendous turkey, and a small pig: in each instance the figure bears no resemblance to the original article."[1] In many hospitals the figure is very low only because of the large number of persons who are admitted for diagnostic examinations, tonsillectomies, or other procedures of brief duration. These same hospitals may have a

[1] Myers, Robert, and Vergil N. Slee, "How to Make Length of Stay Make Sense," *Modern Hospital*, vol. 93, December, 1959, p. 91.

surprising number of older people with cardiovascular conditions, cancer, or broken bones that necessitate long stays. Ask the hospital director how many patients there are in the house at present who have been there for three weeks, a month, or more than two months, and he will not be likely to know. He may not even have statistical reports in a form whereby he can assemble the figures readily. Medical chiefs are generally unable to be much more precise about the patients on their service. They may show the utmost surprise if someone gives them a breakdown of the figures on a floor-by-floor basis. When one chief of medicine realized that 50 per cent of the patients on a private floor had been there more than twenty days and that the count might not be appreciably different on several other floors, he immediately commented on the fact that there was no social program available for these patients. He also remarked that the proportion of such patients was likely to become larger in the future with the increasing age of the population.

Any reply to the second issue falls outside our area of competence, except for the general comment that it is hard to see how the introduction of further things and social situations would be more likely to increase infection than many hospital practices now current that are taken for granted. If it is reasonably safe, for example, for patients on stretchers and in wheel chairs to be transported in elevators so crowded with personnel and visitors in street clothes that even standing room is not adequate, the use of symbolically important things in patients' rooms and of a wide variety of social situations would seem possible. It is assumed that careful consideration should and would be given to specific situations, but that the patients in an entire hospital should not be subjected to an impoverished environment because the exigencies of some patients' diagnoses require that they be kept under careful control.

We can only conclude that many rules and regulations that governed the needs of earlier days but are less applicable to present conditions have deterred hospitals from periodic reassessment of what can and what cannot safely be done, and what "calculated risks" should be taken in the interest of broader

therapeutic goals. We can only conclude, furthermore, that the tendency to make rules applicable wherever possible to the entire institution has severely crippled consideration of what can and should be done for individual patients, or for those who are in areas of the hospital that are relatively safe infection-wise. Individualization of patient care has been the goal of therapists, but many of the hospitals' administrative policies run counter to this goal.

In answer to the statement that the hospital cannot afford the expense of installing and operating a greatly enriched physical setting, it should be noted that dozens of small items such as calendars, bedside clocks, and occupational and recreational supplies that would be of great benefit to patients are relatively inexpensive. The women's auxiliary of many hospitals or interested church groups, businesses, and department stores could often be persuaded to keep the hospital supplied. Other things, such as dining-rooms, an auditorium, and a swimming pool, constitute a very different problem. They require not only considerable money to construct but space that can rarely be used for income-producing purposes. In this connection several important issues merit attention.

Modern hospitals have generally been very generous and also experimentally minded in purchasing expensive medical equipment and very large or highly complex machines. A good case can often be made, for instance, for purchasing a new sterilizer for the operating room because it would be "so much more convenient." Are changes in the physical environment that would supposedly benefit patients not worthy of being tried experimentally and of receiving somewhat comparable generosity? Which is more important: a handsome lobby with fine marble or teak and mahogany walls, or an auditorium for patient use? Would hospital directors not be willing to sacrifice a beautiful board room in behalf of some modest dining-rooms for patients? When John M. Glenn, who had served as general director of Russell Sage Foundation for a quarter of a century and as a member of the Board of Johns Hopkins Hospital for perhaps even longer, was past eighty he made an emphatic remark. It was

unexpected because the Foundation was housed for over forty years in a beautiful building of Florentine architecture. Said he, "Hospitals become nonfunctional in ten years. I am in favor of their being constructed as temporary buildings with the least possible money spent on construction. But inside the buildings I want to see money *lavished* on facilities and personnel."

To a considerable degree the basic question is one of relative values rather than money. But that question cannot even receive proper consideration until hospitals give far more attention to discovering what are the psychological and social interests and needs of patients. In this connection it was gratifying to hear a group of nurses in administrative, supervisory, and teaching positions report in one of the writer's seminars on an exercise that had been given them. The group had been asked, supposedly by a new hospital director, to advise him as to how they thought the fifty-year-old buildings of a fine voluntary hospital could be rebuilt to provide patients with the best possible physical environment and the staff with the best working conditions. They prefaced their report with the following:

> We realized that our conception of ideal remodeling of the fifty-year-old building and that of the patients who would use the building might be considerably different. We therefore decided not only to present to the director what we, as the hypothetical nursing staff, considered a sound plan for improvement but also to make two recommendations. The first was the formation of a committee, whose constituents represented the best resource people in the community, to work with us in an advisory capacity. Sociologists and anthropologists would be a "must" on this committee, even though we had to reach beyond the immediate city to get them. The second recommendation was that a questionnaire, carefully prepared by qualified persons, be sent to all patients who had been hospitalized here during the past three months, as well as to present and future patients until we were satisfied that sufficient data had been assembled. Tabulation of data and preparation of a report summarizing their suggestions would again be done by qualified persons. We concluded that there was no need to start remodeling next week. We had better know for sure what the patients and personnel wanted. After all, we had gone along like this for fifty years. Deep down inside we fervently hoped that in the final analysis there could be agreement between patients and personnel.

Chapter 4

RECEIVING THE PATIENT INTO THE HOSPITAL

WE TURN NOW TO THREE CHAPTERS devoted to a discussion of social situations and social activities that have the potential for playing a significant part in any broadly conceived plan of patient care. The first of these, the admission of the patient, is particularly important because it is at the admission desk that a person, often acutely sensitive to every cue about the place to which sickness or injury has brought him, gains an initial impression of what that place will be like. This one brief experience may set the tone for acceptance or rejection of what is to come.

The patient, as has been seen, is likely to be seeking a "home away from home" with the psychological assets generally associated with the word he has known since early childhood. Being received as a guest in friends' homes has probably been a satisfying experience for him. He has responded warmly to the pleasure expressed in his hostess' voice upon his arrival and to the cordiality of her handshake. Her preparations for his coming have made him feel that he is most truly welcome. This is how he perceives being received into a home. Unfortunately, such symbols of hospitality are lacking in most hospitals. Even institutions that attempt to provide some social amenities as part of the admission procedure rarely offer enough of a warm welcome to meet his expectations and hence relieve some of his dread. In many institutions the procedure is so trying an experience that it intensifies dread on the part of the patient and may even create a feeling of hostility.[1]

[1] No attempt has been made to discuss the difficult question of hospital bills, which make admission psychologically hazardous for the patient even if he carries

Were the literature not replete with them, countless examples could be given. One illustration will be offered, however, for the express purpose of indicating that failure to individualize attention may be found at the admitting desks of fine voluntary hospitals and not exclusively, as many persons might assume, in public, overcrowded institutions. If we mention the fact that the following incident was clearly recalled ten years after its occurrence, the illustration will also serve to substantiate the observation of various persons that the emotional impact of entering a hospital is pronounced.

> A patient slowly and painfully dragged himself up to the admission desk in the private pavilion of a nationally distinguished hospital. Said the well-dressed, fine-appearing receptionist in a matter-of-fact manner with scarcely a glance in his direction, "If you will sit down, I will take the information." Replied the patient, "I cannot sit down." When he failed to comply with the receptionist's request, she responded exactly like an annoyed schoolteacher or mother reproving a disobedient small boy. "I *said*, if you will sit down, I will take the information." Replied the patient, "But I said I could not sit down." This time she heard his answer, but instead of expressing some sympathy for his plight or apologizing for her having missed his explanation, she looked at him incredulously. Her face seemed to indicate that she wanted him to know that she understood that he was only being difficult and was trying to put something over on her. His pain was so acute that he did not attempt to explain that he had a ruptured vertebral disc and had had his choice of coming to the hospital on foot or on a stretcher. Had he arrived by ambulance it would have been obvious that something serious was the matter. But for her to imagine on that particular day that someone standing in front of her fully dressed could not sit down was impossible, even though she worked in a hospital!

This patient's reception to the hospital was far from being a good one. Hospital administrators deplore such conduct—if they hear about it. They make apologies or try to excuse it as very rare; they perhaps employ skilled public relation writers to at-

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insurance. American middle-class folkways consider it poor taste to discuss money matters when hospitality is being extended. Hence, it is hard to see how a warm, supportive welcome can be given the incoming patient unless financial considerations are handled separately.

tempt to offset the effect of such occurrences; they reprimand or may even dismiss the "guilty party." But such unfortunate occurrences continue even in the finest hospitals, and will continue, if psychological theory be valid, until positive steps are taken to help staff minimize recurrences. To pass moral judgment on behavior such as the receptionist's is generally worthless, and even harmful if used as an escape from attempting to analyze the basic problem.

In Part II of the study as projected an effort will be made to discuss in detail the nature of help that might be given the staff. Hence, we shall raise only a few seemingly pertinent questions here. Had this receptionist ever been made to feel that she played an important role in the therapeutic process? Had she been given an opportunity to understand how much her therapeutic effectiveness would be lessened if she permitted her own difficulties and "bad days" to come between her and the patients? Was she included in some staff group where such matters were discussed, where frustrations could be freely "aired," and where praise was used as an incentive for improvement? Or was she only an attractive, well-dressed woman with sufficient technical skill for her job who was left quite alone to face daily a succession of sick patients and worried families when they were least able to give *her* as much as a cheery nod or tell her an amusing anecdote?

EFFORTS TO IMPROVE ADMISSION PROCEDURES

Some attempts are being made by parents and also by hospitals to create a favorable image of that institution in the minds of children before they enter it. As an example of what parents can accomplish, the experience of one father and his young son is instructive.

> Almost from the time the boy could walk the father began taking him on exploratory tours of the city. The father would point to a church, fire-station, postoffice, private home, or apartment house, and explain the purpose of each. Whenever they came to a hospital the father would say, "That is a place where people go when they don't feel well. There are nice doctors and nurses in that building who wear white clothes and who make sick people feel all better."

> From time to time for two or three years the little boy heard the same story about every hospital he and his father saw on their walks. One day the youngster suddenly began to run such a high temperature that the doctor rushed him to the hospital before the father was even notified. The first thing the father said as he hurried into his home was, "We didn't have time to prepare Georgie for going to the hospital." Georgie had, however, been well prepared. He was *so* relieved to see those nice persons who wore white clothes that were going to make him "feel all better"!

Pediatric hospitals or services are occasionally conditioning children with excellent results to think of hospitals as interesting rather than frightening places. Many nurses will recall the article, "They Learn About Their Community Hospital," describing the tours of the Children's Hospital in Oakland, California, which Miss L. Louise Baker, the nursing director, has run for several years for boys and girls of nursery school age.[1] The children usually visit in groups of 12 or 15 accompanied by some of their mothers and the nursery school director. (Earlier, the mothers have had an evening meeting with Miss Baker, who explains what the children will see.) They are greeted by a nurse in uniform who asks them if they know what she is and what she does. The boys and girls can then talk all they wish about nurses, doctors, and hospitals in general. Afterward they see a bed that they may crawl into, food trays, an x-ray picture, a stethoscope through which they listen raptly. They may walk by the porch windows and see the patients, *who like their visits.* The laundry with its mountain of linen is a popular spot. So is the kitchen to which they are taken at the end of the tour and where they are served fruit juice and crackers. If anyone doubts that one way to a child is through his stomach, it should be noted that at the end of the first tour a disappointed little boy said, "I don't ever want to come to this hospital. They don't eat here." Since then refreshments have always climaxed every visit.

[1] *Nursing Outlook*, vol. 7, October, 1959, p. 572. See also "Almost All's Right with Their World," *Nursing Outlook*, vol. 7, January, 1959, p. 31. In it Catherine J. Patton and Virginia Barckley describe the procedure whereby children with congenital or traumatic amputations and their parents are invited to visit the Crippled Children's Home in Pittsburgh before any decision is made about their admission as patients.

The remark was made earlier that it has been much easier to think creatively about the needs of children than those of adults. In recent years, however, psychiatric hospitals have been demonstrating the same kind of creativity. They are now attempting, in several places at least, to give prospective patients and members of their family an explanatory tour prior to hospitalization. Psychiatric institutions, moreover, are paying considerable attention to tours for persons from the community at large in the hope that attitudes toward mental hospitals may be changed. Both mental and general hospitals encourage lay persons to volunteer to work a few hours each week. These volunteers not only learn much about hospitals in this way, they also interpret what they have seen and heard to their acquaintances. Unfortunately, they come predominantly from the upper-middle class and their interpretations rarely reach the very groups in the population that need orientation the most.

Here and there a welcoming hand is extended to patients with surprising warmth and seeming spontaneity at the moment they enter a general hospital. One obstetrician is known, for example, to have made it a practice to appear in the hospital lobby, dressed in his street clothes, to greet the woman patient and her husband when they arrived for the delivery. He would help the patient register and escort the couple to the room assigned, exactly as if he were welcoming them to his home. He did this in spite of the fact that, already early in pregnancy, he had shown them through the maternity service and had described every procedure in detail.

In a relatively small community hospital that has received more than local attention because of the friendliness and informality of its patient care and the progressive nature of its medical program, every incoming patient is greeted in a pleasant setting either by the admitting officer or the superintendent of the hospital, both of whom are nurses in uniform. One of them then escorts the patient and members of the family to the designated floor where they are introduced, as if old acquaintances, to the charge nurse. When the superintendent was asked why she and the nurse responsible for admissions wore uniforms, she replied

that she believed patients who were afraid of the strangeness of the hospital would be reassured upon seeing a symbol that was familiar to them.

Recently considerable interest has been shown by some psychiatric hospitals in the question of whether enough individualization of attention can be given patients during the first few days to help them adjust to institutional living and be responsive to treatment rather than become more hostile, aggressive, or withdrawn. This interest bears directly upon how patients are received into the hospital and their introduction to life on the admission ward. In spite of many experimental changes that have been made, perhaps no psychiatric hospital in the United States, and almost certainly no general hospital, has consciously attempted to model its practices after customary methods of welcoming guests to the degree that has Dr. Paul Sivadon, the French psychiatrist. In the following quotation we present that portion of one of his papers in which he briefly describes "Technics of Admission and Welcome" as utilized in the public mental hospital in Paris, with which he was associated for more than ten years.[1]

> One of the critical moments in the community treatment is the admission of the new patient. Because of his emotional regression he needs to be accepted, or still better, to be desired by the new society of which henceforth he will be a part.
>
> In my service I have had for the past ten years a psychologist who functions as a hostess to welcome each new patient. [In one of his addresses in France he speaks of her as specifically assuming the role of a mother.] She is the first person with whom the patient comes in contact. Instead of taking away his personal effects she gives him whatever he needs: toilet articles, cigarettes, writing paper, and so on. She introduces him to his fellow patients, to his attendants, nurses, and doctors. She tries immediately to make him feel that he

[1] A decade ago that French hospital was much like a rundown state mental hospital in the United States. It was vastly improved by the introduction of an active treatment program based in considerable part upon the therapeutic use of the physical and social environment of the hospital. Figures for length of treatment required and for annual admissions and discharges came to compare favorably with the results of some small teaching and treatment hospitals in this country. Unlike these hospitals that tend to accept predominantly "acute cases," however, Dr. Sivadon accepted everyone sent for hospitalization exactly as does a large state mental hospital.

was expected and that he is needed, and that his help is needed, perhaps with a party that is being prepared, with a game, or with some little service which no one else can render (as repairing a bell or a broken chair).

Then she shows him around the grounds and buildings, the workshops, the reception room, the bar and the hairdressing parlor. Very quickly, often by joining in a game, the patient makes the acquaintance of two or three comrades with whom he will soon work in the shops. The welcome is rounded out by introducing the patient at the weekly meeting of the committee of patients. [The committee is composed of one delegate from each of the six pavilions. They meet once a week with the medical chief and the hostess to discuss the patients' grievances about the hospital.]

Finally, each week there is a friendly gathering at which the medical director and the hostess meet with the patients who have been admitted in the past seven days. We find out whether they are provided with everything they need, and we solicit their criticisms and their ideas. Then each one is given a brochure with his own name printed on it in which he finds, following some words of welcome, the principal kinds of information that are likely to relieve his anxieties. In particular, he finds there the name of his personal physician and of his social worker. He is also given some visiting cards with which he can introduce himself to his comrades and which he can place at the head of his bed or at the entrance to his cubicle.

These technics of welcome, as well as others which will occur to you, turn out to be of considerable importance in promoting the rapid participation of the new arrival in the community. In effect, the more one wishes the patient to allow himself to slip quietly into the communal life in a relaxed way, the more important it is to individualize him as much as possible and to make him feel himself to be a person. It is for this reason, namely, to counterbalance the communitarian atmosphere into which he is plunged, that the patient is at first seen privately by his personal physician, who gives him an appointment by a written personal invitation.[1]

DISCUSSION

Can anyone doubt that the manner in which a patient is received when he enters the hospital may have a profound effect upon his perception of whether he is welcome as a human being or is only the bearer of a disease to be treated? Before he even

[1] "Technics of Sociotherapy," *Symposium on Preventive and Social Psychiatry, 15–17 April 1957*, Walter Reed Army Institute of Research. Government Printing Office, Washington, n.d., pp. 459–460.

gets to the designated floor of the institution, a level of expectation may already have been set in his mind of the care and attention he will receive.

To provide an admission service that attempts to maximize its therapeutic potential on a day-by-day basis, however, is a difficult task. Even to attempt to achieve such an end requires that more attention be given it than at present, not only by hospital administrators but by medical social workers, nurses, physicians, and any clinical psychologists or other social scientists on the staff, who are interested in how every part of the hospital can be used to lessen patient anxiety and frustration and furnish positive psychological aid. To achieve this goal also requires that those members of the staff charged with responsibility for the daily reception of patients and their families receive help and recognition if they are to be able to maintain a climate of genuine interest and sympathetic understanding.

The writer's own experience in visiting hospitals leads her to inquire whether sitting for a couple of hours at a time watching admission procedures and particularly patient and family reactions might not be of appreciable profit to those interested in possible changes. Such persons probably hope to rely on journal articles or papers read at conventions, but such literature is likely to be more procedurally than psychologically and sociologically oriented. We would suggest that visits be paid not merely to the admission service of one's own hospital, but to hospitals that are distinctly different in size, organizational control, and kinds of patients served. Not to be neglected are the great city or county hospitals where patients of the most diverse backgrounds pour in; the nondenominational, voluntary hospitals that often pride themselves on their skill in interpersonal relations; the famous Jewish hospitals to be found in very large cities; the community hospitals where staff and patients may be acquainted with each other; and the hospitals run by Catholic religious orders, Seventh Day Adventists, Latter Day Saints, or other groups who have a "mission" to care for the ill.

Such observational visits would serve, we believe, to resensitize hospital staffs to what admission means for the average person.

No matter how well one knows this intellectually, only periodic resensitization is likely to keep persons in administrative and supervisory positions alert to the need for continuing reexamination of the process, and keep the staff of the admitting office from unconsciously reverting to depersonalized routines. Other ends would also be achieved from observation. Visits would provide a basis for comparison with what is being done in the home hospital, as well as many fresh perceptions or totally new ideas. Observation in hospitals admitting patients of diverse racial, ethnic, and social-class backgrounds might serve to emphasize how acceptance or dread of the hospital is related to the ways in which these groups were socialized as children. This emphasis would perhaps lead finally to recognition of the need for learning to use different methods of welcome and reassurance according to what is familiar to each group.

Chapter 5

VISITORS AND VISITING HOURS

Through the large glass doors of the lobby a mother and son could be seen hurrying toward the fine new hospital. They were almost gay as they entered hand in hand somewhat breathlessly. Obviously, they had visited the hospital before because the mother stepped without a moment's hesitation toward the elevators, while the boy went immediately to sit on a lounge in the lobby. Since this is a hospital for veterans, it may be assumed that the woman was going to see her husband, who was probably also the father of the charming lad of twelve or thirteen. For strangers to hospital folkways who might have wondered why the boy did not accompany his mother, the answer was abundantly clear. Directly over his head was a metal sign fastened securely to the wall, "No children under fourteen years allowed above the lobby floor."

Across the United States in hundreds of hospitals hang similar signs that differ only in the fact that the stated age is often twelve and sometimes sixteen. These signs have belonged to the furnishings of hospitals until they are generally taken for granted. So much a part of hospital culture has it been to forbid children to visit parents, grandparents, brothers and sisters, or anyone else that a boy and a sign in juxtaposition are almost required to cause one to reflect on the significance of that prohibition. It was once considered very dangerous for children who supposedly contract and distribute diseases readily to be allowed on the wards. In the days when the open ward might boast of thirty or more beds, it was also taken for granted that children would disturb patients and be a nuisance. But times have changed. Knowledge of asepsis has made great strides; the new hospital architecture has replaced the open ward with semiprivate accom-

modations or at least with glass partitions; and early ambulation permits many patients to see their visitors in lounges or elsewhere.

One can only conclude, therefore, that this sign, like many other hospital prohibitions, has not been scrutinized in the light of modern conditions or of current psychological ideas. The basic consideration today would appear to be whether patients *need* to see their children and grandchildren, and whether children *need* to see their parents or other members of their families. To deprive a mother or father, when sick, of even a glimpse of what may be most dear and important in life runs counter to the current philosophy of the therapeutic value of meeting patients' psychological needs. To prevent every child by fiat from seeing his parents or other persons to whom he is psychologically tied, may be to do him severe damage.

> Lest anyone consider this last statement extravagant, we wish to give two illustrations. A man in middle life commented to the writer recently, "I hate those signs." When he was ten years old his mother was taken to a hospital where she later died. From the time she entered the institution he never saw her again. The memory of the trauma still persisted thirty years later. The second instance is of a girl whose father developed multiple sclerosis. For a long time he was obliged to stay at home, getting about the apartment with canes and later in a wheel chair. His young daughter had ample opportunity to see that he became progressively more helpless. When she was fourteen he was obliged to begin five years of hospitalization. Although she visited him a few times at first, she was not encouraged to continue because of the distance of one hospital and the mother's perception of the depressing aspect of subsequent neurological services. During this time she developed the fixed idea that her father was not really sick, but had gone to a hospital as a way of deserting her and her mother. A few weeks before he died, when she was nineteen, she went to visit him. Seeing his physical regression was a great shock. Shortly afterward she entered a private psychiatric hospital where her delusion about her father's desertion was worked through in many painful psychotherapeutic sessions.

Some changes are being made, at least in removing the sign about children from its conspicuous place on the lobby wall. Often the board that carries announcements about visiting hours includes at the bottom the reference to children. In some places

there has been relaxation of the rule, although the privileges accorded are few and small when compared with visiting privileges for adults that have been greatly extended in recent years. The announcement of a new policy at Research Hospital in Kansas City in August, 1959, is characteristic of the kind of change being introduced. Its monthly bulletin stated that children under twelve could visit patients, other than those on the obstetrical service, from six to nine in the evening in a specific waiting-room, provided arrangements had been made with a particular nursing supervisor. On Saturday and Sunday the hours were extended to from two in the afternoon until nine o'clock. The supervisor responsible for arrangements reported a month later that several children had already succeeded in getting above the lobby floor.

It should be noted, however, that Research Hospital had not included provision for children to have even a peek at mother and the "new baby," psychologically important as that might be for many children.[1] In another hospital that has introduced a very progressive maternity service where fathers are present much of the time, the nun supervisor hoped that children might be permitted to visit the "rooming-in" units. Her first step of serving youngsters milk and cookies in an adjoining dining-room met with such a stir among the staff, however, that she concluded that time would have to elapse before she could venture to take any child to his mother's room.

VISITING ON PEDIATRIC SERVICES

Although tentative steps are only now being taken in permitting children to visit their parents in hospitals, something scarcely short of a revolution has occurred in recent years to relax rules about parents visiting their sick children. It was formerly believed that the hospital course was smoother, more effective, and

[1] In her excellent article, "Mothers in Hospital," *Nursing Outlook*, vol. 7, December, 1959, pp. 690–692, Mrs. B. M. Gilbert discusses when and under what circumstances English children might be permitted to visit their mothers who are hospitalized for infectious illness, accidents, or medical or surgical conditions, as well as for childbirth. She notes that in at least three London maternity hospitals visiting is permitted under certain circumstances.

less disturbing if parents were excluded to the limits of tolerance.[1] Only to watch the scene as reluctant and tearful mothers left their screaming children when the loudspeaker announced "Visiting hours are over" was sufficient to convince many pediatricians and nurses that "children are better off without their parents." As a result, visits were sharply restricted in length and frequency.

This practice can still be found, but change has been extensive enough to make it appear somewhat shocking to discover a statement in a hospital lobby that restricts visiting to a mere hour twice a week. The writer recalls seeing a fine new hospital which the community's leading industry had recently contributed, where such an announcement was very clearly stated on a board at the information desk. In reply to her casual question about why time for visiting was more restricted than on the medical and surgical floors, the nurse on duty quickly reiterated the old philosophy in a tone of absolute conviction. She obviously did not know that there are hospitals where parents are now admitted at all hours during the day and may even stay with their children at night, and where the announcement at the entrance to the pediatric service may actually read, "Parents Welcome—Any Hour."[2]

Much of the change that has occurred is the result of considerable theoretical or clinical study of the psychological needs not only of well but also sick children.[3] Child psychiatrists particularly have scrutinized the role played by hospitalization and by staff and parents during the child's hospital stay, while one pediatric nurse has developed continuing research on the meaning of hospitalization for children at varying ages. The books and articles they have written,[4] and the service they often provide as

[1] Hunt, Andrew D., Jr., and Ray E. Trussell, "They Let Parents Help in Children's Care," *Modern Hospital*, vol. 85, September, 1955, p. 89.

[2] Pattock, Sister M. Gwendolyn, "Ad Lib Visiting Works!" *Nursing Research*, vol. 5, February, 1957, pp. 130–132.

[3] Bowlby, John, "Maternal Care and Mental Health." World Health Organization, Monograph Series, no. 2, Geneva, 1951.

[4] As examples see Dr. James Robertson's, *Young Children in Hospitals*, Basic Books, New York, 1958; and Dr. Florence H. Erickson's "Play Interviews for Four-Year-Old Hospitalized Children," *Monographs of the Society for Research in Child Development*, vol. 23, no. 3, 1958.

consultants to pediatric departments have been influential in producing change.[1]

Some of the hospitals that have relaxed their rules about visiting hours have begun a broad consideration of *how* visiting and also symbols of family life can be used therapeutically. If the child is very young, very sick, about to have an operation, or otherwise in particular need of his mother, she may be permitted or even encouraged to spend the night. Some pediatric services provide folding beds or comfortable chairs and blankets. When such services are rebuilt, accommodations for children and their mothers will probably be provided. Pediatric departments that encourage the mother to stay are generally those that attempt to give her sympathetic understanding and support. Nurses teach her how to assist in caring for the child; if necessary, they teach her the sterile procedures necessary in an isolation unit.

Generally only two visitors are permitted to see the child at any one time, and in some places the parents are the only persons who may visit him. In other hospitals grandparents, an aunt, or anyone who has acted as a foster parent may be permitted or cordially invited to pay him a call. Brothers and sisters are sometimes allowed to look in at the open door, and as the child improves are given an opportunity to play with him for half an hour from time to time.

Because children like food from home and because the hospital kitchen does not prepare many of the dishes popular among the different ethnic groups, some children's services suggest that the mother bring food with her. Other services that are equally trying to reorganize their social practices, strongly discourage the mother from doing this. As an answer to the child's insistent demands that he talk to his "Mommy" or "Daddy," booths with low telephones have occasionally been installed. The results were so excellent in reassuring and comforting youngsters at Mt. Sinai Hospital in New York that children who are unable to go to a booth may make a call through the regular switchboard service.

[1] Sylvia M. Barker's "Pediatrics Family Style" in *American Journal of Nursing*, vol. 58, August, 1958, pp. 1123–1125, suggests how closely nurses and child psychiatrists work together at Mt. Sinai Hospital in New York City, and how greatly increased is the place given parents in the care of their children.

Pediatric departments that are truly experimental in outlook are now struggling with physical rearrangements and changes in procedures whereby parents can stay with a child until anaesthesia is administered prior to surgery and again when he regains consciousness in the recovery room. Because children in isolation may be very ill and particularly in need of their parents, while premature babies in incubators may suffer emotional deprivation, efforts are also being made to reduce the handicaps imposed by these special environments in order to permit more parent-child contact.[1]

As illustration of what an institution can accomplish which works progressively to make the hospital experience as comfortable as possible both for the child and his parents, readers of this monograph may wish to turn to Appendix 3. There, in "Rx: Admit Parents at All Times," a mother describes how a community hospital gave physical care to her young son who had poliomyelitis, and simultaneously helped him develop more emotional balance and greater social skill. It also treated her in her anxiety through the complete freedom it gave her to come and go, stay all night, help with taking care of her little boy, and observe the love and consideration that were given all the sick children.

VISITING ON SERVICES FOR ADULT PATIENTS

On hospital services for adult patients also, visiting hours have often been greatly relaxed in recent years, particularly in voluntary hospitals. Hence, hours continue to be more generous than on children's services, although they rarely permit a family member to spend the night with a patient except on some obstetrical services or in the instance of death. Where changes have been made, they appear to have been confined largely to consideration of what hours would be most convenient for staff, visitors, patients, and also for easing parking difficulties. No body of psychiatric and social science theory or experimental data ex-

[1] O'Connell, Elizabeth R., and Brandt, Patricia, "Liberal Visiting Hours for Parents," *American Journal of Nursing*, vol. 60, June, 1960, pp. 812–815.

ists concerning the psychological needs of adult patients in general hospitals comparable to that about children and also adults in psychiatric institutions. Perhaps as a consequence relatively little exploration has been undertaken of how visiting can be used in a planned way for therapeutic purposes. As currently practiced, it presents many unresolved problems that relaxation of hours alone does not solve.

Before turning to these problems, a rapid survey of the present situation is in order. It will begin with a reference to the many hospitals that have not yet modified their visiting schedules. The possible strain upon visitors, staff, patients, and hospital facilities where the old system still exists was demonstrated not long ago in an enormous public hospital of ward patients. The writer was caught up in the stream of human beings that flowed down the long first-floor corridor within two minutes after the visiting hour had begun. The crowd, rushing toward the altogether inadequate elevators, was like that in the New York subway at five in the afternoon. Because it knew that many persons would not succeed in getting into the elevators and to the desired floor within a quarter of an hour, it was aggressive and rude. Even members of the hospital staff dressed in white were scarcely able to move against the current. An hour later the exodus would repeat the experience.

On the patient floors the situation would be only a little better. There was neither enough space on some of the wards nor enough chairs to permit the two visitors allowed to sit down at the same time; there were not nearly enough seats in the corridors for the overflow from the wards. What happened was that seemingly large numbers of persons would stand around beds without comfort or privacy for the time allotted them. Then they would depart and the patients, many of whom read little and were without resources for entertainment, would be left desolate until the next visiting period. In spite of what appeared to be great numbers of relatives, many patients would have no visitors. Can one imagine what this procedure might mean in loneliness and discomfort for them when no one out of all this disruptive crowd came to their beds?

In smaller hospitals that have not relaxed visiting arrangements, the time periods—such as from one to two and seven to eight—are not only limited in length but are often exceedingly inconvenient for urban employed workers where long distances must be traveled, and for those persons who must prepare evening dinner and get the children to bed. For the individual patient in these hospitals, whatever his desires may be, he is likely to be surfeited with visitors who stay until the last possible moment, and then be left to long empty stretches without callers. If he has a private room, however, arrangements for him to see relatives and friends are considerably more flexible.

It is around these brief, patterned visiting periods that present changes largely revolve. Although the laity would assume that lengthening of visiting hours might be instituted fairly easily and readily, few hospitals have been able to accomplish it without many discussions of "all that will be involved." When the decision has been made, moreover, the consequences are awaited with some anxiety. Many hospitals report subsequently that the new schedule was put into operation with remarkable ease and often with obviously good results. The long discussions may have been valuable in giving staff ample opportunity to adjust to the idea that patients *can* be treated and cared for without being so cut off from their former life, and that visitors spaced over a longer time may not be so disturbing to staff as had been expected. What would be most interesting to know is whether this experience in inducing change will facilitate the taking of subsequent steps, such as permitting a family member, when psychologically indicated, to stay all night with a patient.

Some hospitals have gone to surprising lengths in their relaxation of visiting hours. Research Hospital, to which reference was made earlier, added an explanatory note to its new schedule published in the bulletin, *The Researcher*, for August, 1959. The substance of that note is being reproduced here because it is probably characteristic of the reasons that would be given by many other institutions.

> Months of study and research took place before this plan was effected. It will allow more freedom for visitors coming to see their

relatives and friends, and it is anticipated that patients will derive more benefit than under the previous "restricted" schedule. This freedom will undoubtedly reduce the length of visits, which will in turn reduce patient fatigue. Through opinion surveys patients themselves indicated that they would prefer less restriction of visitors. The plan, furthermore, will alleviate the cramped parking situation by spreading the arrival of cars over a longer period of time.

Provisions on the medical and surgical units under the new schedule permit visiting in private rooms from seven in the morning until nine in the evening. In the semiprivate rooms and wards visitors are admitted from seven to eight and again from eleven until nine at night. Visiting is only a little less generous on the obstetrical unit, with the time from 9:30 to 10:30 and again from 4:30 to 5:30 set aside exclusively for fathers. What makes this plan appear almost radical is the provision for early morning visiting before relatives go to work or while en route.

Lack of Individualization of Visiting Arrangements

In spite of the fact that such new arrangements greatly extend the time available, relatively little attention has been given to how visiting schedules might be individualized according to the specific needs and wishes of the patient. Where the unfortunate effects of this failure to arrange for visiting can be seen most conspicuously is on the private floors. Strangely enough neither the nursing nor medical staff ordinarily makes any systematic attempt to arrange visits for private patients according to the latters' wishes or even their physical and emotional condition, except in instances of acute illness. Repeatedly some patient on the floor will have a dozen visitors particularly on Saturday and Sunday afternoon, and often so many at one time that half of them must stand outside the door of the small room. Frequently one hears nurses commenting that the patient will be so exhausted afterward that sedation will be required to get him relaxed enough to sleep.

Nurses themselves, in preparing memoranda for the writer about what they would wish the hospital to provide if they were in the role of patients, have spoken clearly on this subject. They

have noted that they would wish to be consulted about who and how many persons should be permitted to come to see them. They did not want anyone to walk into the room unannounced. Their reports of unfortunate personal experiences indicate that a captive patient is certainly not in a favored position for handling visitors unaided.

Visiting that is determined by rules rather than on the basis of individualization can be nontherapeutic because of its overabundance and its abuse. It is more likely, however, to be nontherapeutic because of the limitations imposed. In the light of what was said in Chapter 1, Patients Are People in Trouble, it would appear essential for staff to raise the question frequently of whether the continued presence of a family member was indicated, even if it meant permitting him to spend the night on the medical or surgical floor. In a recent article Professor Thelma Ingles, who has been attempting for several years to take a sharp look at the total needs of medical and surgical patients, supports this assumption. "A great deal has been written," she notes, "about the need for hospitalized children to have a parent stay with them. Adults, frightened by the uncertainties of an illness, may also feel safer with a family member near. The privilege for this decision should be theirs."[1]

The following illustration suggests that even under very difficult circumstances a patient's psychological needs might conceivably be met with relative ease if rules were flexible enough to encourage staff to think *how* that goal could be achieved.

> A very elderly woman, who spoke only Yiddish with any proficiency, was admitted to a semiprivate room in an excellent Jewish hospital to await major surgery the following morning. At the customary evening hour the members of her family were required to leave. Her fear, as described by the other patient in the room, began to mount and became progressively worse during the night until she was in great physiological as well as psychological distress. The sedation given seemed to do little to relax her or reduce her anxiety. Aside from the few preparations for surgery, she received exactly the same amount of nursing attention as the other patient, who was

[1] "Do Patients Feel Lost in a General Hospital"? *American Journal of Nursing*, vol. 60, May, 1960, p. 651.

about to go home and could have dispensed, if necessary, with almost all evening care. No one stayed with her or attempted to comfort her. Certainly the nurses, predominantly non-Jewish, did not know Yiddish. The other patient tried to reassure her but without a knowledge of the language was able to do little.

On the basis of a considerable body of data about the tight-knit, supporting nature of the Jewish family, it may be assumed that this woman of eighty had perhaps never before had to face a major crisis in life without the immediate help of relatives. She may even never before have been a patient in a hospital. *Why was not at least one member of her family permitted to sit beside her throughout the night?*

Before ending this section it is essential to note that in some rehabilitation centers provision has been made for the patient's closest relative to spend some time with him if his home is at considerable distance. The purpose is not only to give additional support to the patient but to teach the relative how to care for him, if necessary, when he returns home.

In the new hospital construction based on the concept of "progressive patient care,"[1] a unit is being included for the self-help of persons who are ambulatory. These persons may either have been graduated from the nursing care furnished on the medical and surgical floors, or they may have come from a distance for diagnosis and treatment in the outpatient clinics. In its new Health Center, the University of Florida has incorporated a unit of 26 rooms, each with two beds and hotel furnishings, where a member of the family may stay with the patient. The Health Center has gone on the assumption that recovery or adjustment will often be speeded by having the patient in a home-like environment, and that the presence of a relative, particularly in the case of very young or elderly patients, may contribute to a faster and more thorough recovery.

Plans such as these do nothing directly to solve the problem of the continued stay of a relative, where necessary, on an acute service. Possibly, however, if the undertakings in pediatrics, obstetrics, rehabilitation, and self-help are numerous and suc-

[1] U.S. Public Health Service, *Elements of Progressive Patient Care*, Tentative Draft, Washington, February 27, 1959; Abdellah, Faye G., and E. Josephine Strachan, "Progressive Patient Care," *American Journal of Nursing*, vol. 59, May, 1959, pp. 649–655.

cessful enough, they will ultimately make an impact on the whole hospital.

Friendly Visitors

For decades individuals as well as church, club, and other community groups have made it a practice to visit hospital patients, provide entertainment, or do volunteer work. Some of these persons have considerable direct contact with patients; many do not. Clergymen, by the nature of their profession, are frequently found calling on patients. Grey Ladies, members of the Junior League or other organizations that sponsor volunteer service, may sometimes be seen on the adult floors feeding patients, writing letters for them, or reading to them.

In spite of these efforts, however, hospital patients are so numerous and such large proportions of the older and long-term patients have so few personal visitors that all the contributions combined are like a few drops of water in a semi-desert. Veterans Administration hospitals, many psychiatric hospitals, and some institutions for long-term patients undergoing rehabilitation have consistently worked on the creation of recreational programs that included individual and group visiting. Hospitals for acute illness that have assumed their patients would be in the institution only a few days have done relatively little. In Chapter 3 note was made of the fact that this assumption can be incorrect and unfortunate in its consequences. Many patients are so greatly in need of diversion that even seeing children of nursery-school age walk along a porch can be highly welcome!

Recently girls and boys of teenage have been increasingly introduced in some hospitals, particularly during the summer months, to act as paid or unpaid aides. Their enthusiasm, vivacity, and gaiety have brightened up many patients. At an age when adolescents are busily seeking self-identification, an opportunity to assume an adult role and do something for other persons is often very satisfying. The experience of one Veterans Administration general hospital, as reported in *The New York Times*,[1] will perhaps encourage other institutions to try a similar plan.

[1] Issue of August 4, 1958.

The one hundred girls and boys, who constituted the "junior volunteer service," were originally engaged in preparing supplies under supervision which they then took to the various floors. Presently they worked themselves into more important jobs. Once they arrived on the floors the patients were delighted. Men who had never been seen to laugh responded warmly to their humor and bantering. On the geriatric ward one patient said, "Just think, these kids think enough of us old men to give up their own fun and come in and spend time with us. It makes us feel we haven't been forgotten after all." Presently the volunteers were playing cards, chess, and checkers with the patients; were writing letters for them; and were helping them get around the halls and grounds. They took part in educational and corrective therapy by assisting victims of neurological and cerebral disorders to learn to walk, read, and speak again. The director of volunteers declared that the youngsters had accomplished remarkable things in "morale building."

CHAPLAINS AS FRIENDLY VISITORS AND COMFORTERS

An interesting phenomenon connected with visiting is the role that resident chaplains play in some hospitals in addition to their strictly religious functions, and the way in which that role is perceived by staff. Many of them give much time to providing psychological support and comfort. Sometimes they take the initiative for visiting patients generally or those who they think may wish attention. In hospitals with several chaplains they are likely to obtain information from the admitting office about the faith or denominational ties of the new patients and plan their visiting accordingly. In some institutions they wait to be called by nurses and physicians.

Not infrequently one hears members of the staff of crowded public hospitals speak of how generously chaplains come upon call, regardless of the hour, to sit with anguished patients or their relatives to whom the doctors and nurses can give no attention. Some of these staff members who are themselves uninterested in the church and in strictly religious functions, nevertheless speak

of the chaplains' role of comforter as truly indispensable. In the papers written in the University of Minnesota seminar, reported in Appendix 2, many nurses made it evident that, as patients, they would turn largely to chaplains for comfort and support. In some instances it was apparent that they wanted spiritual help from a priest or minister. In a larger number of instances they seemed to be asking for someone who would sit with them at not infrequent intervals, listen to their troubles, express genuine interest, and guard the conversation as confidential. Many appeared unable to think of anyone else who could take this role or take it so well as the chaplain.

In the light of evidence such as this, it is somewhat surprising that chaplains are not thought of more often as members of the therapeutic team, to the extent at least of having their opinions sought about patients' psychological reactions and social problems. Because of the fact that they almost inevitably hear anxieties, grievances, and complaints expressed that may never come to the attention of the staff, they are in an exceptionally good position to offer suggestions about the needs of particular patients or about how better coordination of care might be provided generally. Although they are sometimes viewed as essential allies in psychiatric and long-term hospitals, the idea of a team relationship does not appear to have been considered in most general hospitals. Instead, the chaplains often complain of the very circumscribed role that physicians permit them to assume.

Another aspect of the use of chaplains as visitors merits attention. In some general hospitals not so understaffed and overwhelmed with very ill patients as are most city institutions, there also appears to be a tendency to call the chaplain almost automatically whenever patients are badly upset and distraught. Is it possible that physicians and nurses suffer such a grave sense of inadequacy (perhaps because of lack of psychological preparation) that they have relinquished to the chaplain part of their own responsibility for listening to the patient and manifesting real concern for him and his problems? Or is it possible that the chaplain's services are much in demand because the hospital has failed to build into its social system occupational, physical, and rec-

reational therapists, social workers, librarians, and clinical psychologists, who would be available to a large proportion of the patients, and all of whom would help to provide individualized interest, sympathetic understanding, and a warm social environment?

Many nondenominational voluntary hospitals have no resident chaplain and receive relatively few visits from priests, ministers, or rabbis. Are these hospitals denying to their patients a truly supportive aid; or have they been able to provide such well-coordinated intramural resources that the clergy seem less necessary for other than exclusively spiritual purposes? Have hospitals considered the advisability of having a systematic study made of how many of their patients would like the services of chaplains, how frequently, and why?

HELPING THE VISITORS

Thus far our attention has been focused on visiting hours and visitors in their relation to patients. But the visitors, particularly if they are the immediate members of the family, often need attention and help almost as much as do many patients.

Waiting for a report from the operating room, even more than the father's waiting for the announcement of the birth of a baby, is a terrible ordeal for many relatives. Yet so little study has been given to the needs of families that there are still hospitals that do not provide so much as a little privacy. Many institutions still have their "Misery Row," as Mrs. George Lawton characterized the bench in Philadelphia's Hahnemann Hospital where relatives sat while heart surgery was being done on a member of their family. The bench was directly in front of the elevator; hence everyone stepping off saw the persons sitting there in all their anxiety and grief.[1]

Privacy, or lack of it, can, of course, be of many kinds. One fine hospital, which has a pleasantly furnished lounge partially

[1] Persons interested in the meaning of open heart surgery for the patient and also the wife or husband will want to read *Straight to the Heart*, International Universities Press, New York, 1956. In it Dr. George Lawton, a clinical psychologist, describes vividly his psychological reactions from the time he knew he had a serious heart condition until well after his recovery from surgery. Mrs. Lawton adds a helpful supplement.

shut off from the lobby, announces over the public address system to all persons sitting there the exit of each patient from the operating room. A visitor to that hospital cannot help wondering how many of those waiting persons shudder when a loud, matter-of-fact voice suddenly announces that Mr. Blewett or Mrs. Sullivan or Grace George "has now left the operating room and has gone to the recovery room."

What waiting for a report means even when a suitable, indeed fashionable, environment has been provided, and how comforting a cup of coffee would be, was captured by Niven Busch in his novel, *California Street.* He briefly describes the morning that Anchylus Saxe and two members of his newspaper staff sat anxiously expecting word about Mrs. Saxe.

> So they waited. All three, from time to time, separately or together, consulted their watches, for all—though their thoughts were otherwise divergent—had in common the strange sense that time had slowed down. The atmosphere in the waiting room altered. Many anxious people had sat in this same crisp and merry room, and the by-gone worries crawled out of the cheerful flowered prints and varnished sticks of furniture and beset those who sat there now and whose waiting had gradually and harshly taken on the feeling of a death watch.
>
> "Have they got any coffee in the place?" Anchylus asked after a while.
>
> Before Matt could answer, Letty said sharply, "All the nurses have it, Mr. Saxe, but they won't give it to you."
>
> She shook her head, condemning the nurses' niggardliness with regard to the coffee. Her eyes invited conversation, but once more none was volunteered.
>
> "Well, I suppose there's a place downstairs, a commissary or something," Anchylus said.
>
> [The two men went to find the coffee. Letty sat down again in her chair.] If the men, by going, had proved they dreaded it—were unable to sustain it—then she herself would, unassisted, see that the watch was observed.[1]

The recovery room furnishes postsurgical patients with continuous observation and highly skilled nursing care in a place where all equipment and supplies are readily at hand and where

[1] Busch, Niven, *California Street.* Dell Publishing Co., New York, 1960, pp. 41–42.

surgeons can be called quickly if necessary. But the several hours of waiting until the patient is taken back to his "regular" room where the family can see him are often acute agony for them. The Parkland Memorial Hospital in Dallas, Texas, has attempted to solve at least part of this problem. A gallery was built around the recovery room, and a small window at each bedspace was constructed in what would otherwise be unbroken wall space. Family members now walk around the gallery until they come to the designated window where they are permitted to observe for a few minutes. From inside the recovery room a nurse raises the blind, and they can see the patient who has been placed in bed in such a position that his face and upper part of his body are clearly visible. By pulling the curtains on both sides of the bed, privacy is ensured to the adjoining patients.[1] This relatively simple provision appears to give as much reassurance perhaps to many families as the provision for viewing new-born babies through the glass wall of the nursery.

Although waiting for a report of the outcome of surgery is a crucial experience for families, there are many other problems with which they need help. They want, particularly, to be able to obtain information and counsel both about the patient's present condition and the extent to which he will recover or be handicapped in the future. To obtain such information and counsel in the busy routine of the hospital is extremely difficult unless the patient is fortunate enough to have a private physician. Mrs. Minna Field has summarized so well the nature of this difficulty and what was done to alleviate it in one hospital, that we quote again from her book, *Patients Are People.*

> Relatives feel, and rightly so, that the physician treating the patient is their most reliable source of information. In reality, however, relatives seldom succeed in seeing the doctor and often find it difficult to secure an understanding of the implications of the patient's illness or to obtain accurate reliable information about his physical condition. Though, theoretically, doctors are available to members of the family during visiting hours, actually they are

[1] Bell, Audrey N., "Visitors to the Recovery Room," *Nursing Outlook*, vol. 6, July, 1958, pp. 402–403; Scheidt, Albert H., "This Recovery Unit Has Room for the Family," *Modern Hospital*, vol. 93, December, 1959, p. 100.

seldom in evidence, being busy elsewhere. If and when the relatives succeed in finding a doctor to answer their questions, privacy and sufficient time are often lacking so that many of the questions that trouble them remain unasked and unanswered. In most instances, they perforce have to be satisfied with the stock replies from the information desk that "the patient is as well as can be expected," or "is resting comfortably." These may sound reassuring, but they certainly fail to answer the numerous questions relatives have in mind, and leave them with a sense of helplessness and frustration.

When these unanswered questions persist, as they usually do, the mounting anxiety and tension are inevitably reflected in the emotional tone of the visits. Presumably, visiting hours are a means of maintaining the patient's contact with those close to him and thus bolster his morale. A relative who is anxious, fearful, and tense, who sits at the bedside with one eye constantly on the corridor trying to catch sight of a doctor, communicates his restlessness to the patient and by so doing negates the beneficial effect of his visit.

The mounting difficulties created by this situation, the dissatisfaction expressed by doctors, patients, and relatives alike, led to the adoption of a new plan instituted at Montefiore Hospital in New York in August, 1948. A special hour, immediately preceding the ward visiting hours, was set aside each week to give families an opportunity to discuss matters freely with the professional team concerned with the patient's care—the doctor and the social worker. These sessions, variously referred to as "Family Night," "Interviewing Night," or "Tuesday Night Clinic," have steadily gained in popularity. Ever larger numbers of members of patients' families have availed themselves of the opportunity for free and unhurried discussion of the problems with which illness confronts them.[1]

When Mrs. Lawton wrote the supplement to her husband's book, she suggested that a counseling service be made available to the relatives of patients undergoing heart surgery. In some respects her suggestion is a further extension of the service provided by Family Night. On the basis of her own experience and that of the relatives of other patients with whom she talked, she concluded that families had two problems that they often could not meet successfully alone. The first was to conceal their anxiety and appear calm and cheerful when in the patient's presence; the second was to be able to attend to practical matters requiring

[1] Field, Minna, *Patients Are People:* A Medical-Social Approach to Prolonged Illness. 2d ed. Columbia University Press, New York, 1958, pp. 199–201.

attention without fuss or panic. In the future when there is more understanding of emotional problems, Mrs. Lawton believes that hospitals will employ a psychiatric resident, clinical psychologist, or social worker who "will interview the close relatives and discuss the whole situation with them, allowing full scope and release for the relatives' feelings, and help smooth out the emotional and practical problems involved."[1] She might equally well or perhaps even better have suggested that a person trained in counseling act as a consultant to staff in order to enable the latter, wherever possible, to provide such help for relatives. Thus, the tendency to divide responsibility among a sometimes bewildering number of persons would not be further encouraged.

In her opinion enough should be told the relatives so that they are not like children left in the dark "whose fear paralyzes every thought and action. Of course, what is to be told and how it is told will depend considerably on the kind of person with whom the worker is dealing, his emotional makeup and the extent of his education."[1] She believes that systematic studies need to be made of how much a relative can be told ahead of time, with estimates made afterward of how well or not this worked out.

Another problem experienced by relatives to which Mrs. Lawton refers is the restlessness that results from tension and anxiety as well as from physical inactivity. She is convinced that relatives would be greatly relieved if they could be doing something. She asks whether a social worker or volunteer could not assign tasks that would make them feel that they were participating in the attempt to help their sick ones or other patients.

DISCUSSION

Chapter 4 was concerned with one component of the social environment of the hospital, namely, that created by the admission procedure. The suggestion was made that its therapeutic potential might be increased if persons in charge of admissions could reproduce something of the warmth of hospitality that is transmitted to guests being entertained in private homes. Here

[1] Lawton, George, *op. cit.*, p. 327.

we have moved to consideration of another aspect of the social environment of the hospital, that provided by visitors under former and now changing conditions. Even in attempting to discuss this subject we have been obliged to give major attention to the way in which rules and regulations and the physical environment limit or support the social environment that visitors create.

Anyone interested in the social system of general hospitals can scarcely fail to speculate on why these institutions have largely limited their examination of the significant subject of visitors and visiting to the procedural aspects of visiting hours and what lounge and dining facilities need to be made available. The slow and painful movement toward study of such questions as the role of relatives and friendly visitors, and the meaning for visitors of hospitalization of a family member, substantiates the thesis of Chapter 2, Patients' Perceptions and Expectations. These institutions are not psychologically but procedurally oriented, and policies are made insofar as possible on a hospitalwide basis because uniformity is looked on as desirable.

That some progress has been achieved in pediatrics and in obstetrics within the general hospital, although these services were rather rigidly closed until recent years, is probably partly the result of the fact already mentioned that more flexibility is encouraged in thinking about the needs of children than of adults. It is also the result of the fact that theoretical assumptions have been developed, largely by psychiatrists or other physicians with psychiatric orientation. These assumptions have provided the basis for action even though no attempt may have been made to test their scientific validity or to evaluate the results of their application. Some rehabilitation units also have introduced greater flexibility as a result of the realization that family members may need help in accepting psychologically the physical disability of the patient, and particularly that they will need to be taught how to care for him when he goes home.

On medical and surgical services there have been fewer theories to provide incentive for action, and the psychosocial needs of sick adults and their relatives are only now beginning to be viewed by general hospitals as appropriate subjects for re-

search. One of the most surprising discoveries for the social scientist is to learn the degree to which hospital staffs take it for granted that they know what a patient wants and needs without even consulting him. The situation reminds one of the remark of the surgeon who spoke about his wife's praise of the excellent nursing care she had received during her two-week hospitalization. He added, however, that it was incredible to her that not once in that time had anyone asked her what *she* wanted or how she would like to have something done. Because decisions are so predominantly made for patients and for their visitors, almost no data have been collected about their perceptions of how visiting should be further developed. Without such data or the systematic observations of trained social scientists, materials are not available on the basis of which hypotheses at least might be constructed.

Chapter 6

THE THERAPEUTIC ROLE OF PATIENT AS HELPER

THIS CHAPTER SEEKS TO EXAMINE still another aspect of the social environment, namely, that created by patients in their contacts primarily with other patients. The purpose of this examination is to initiate more consideration, if possible, of the potential psychological value of having patients assume a role of giving help to, or of receiving help from, other patients. This subject has already been touched on in the references to the "buddy-system" that often operates spontaneously in hospitals for military service men and veterans. Reference was also made to it in the statement about the encouragement that the post-polio patients gave each other in the warm-water swimming pool. It might be added that persons who have been almost destroyed physically in serious accidents are required during rehabilitation to undertake movements, such as walking, that seem virtually impossible to them. The observer sometimes gains the impression that, regardless of the support provided by the physical therapists and the heavy braces, these patients could hardly be persuaded to try to move were it not for the presence of an audience. Other patients and staff appear to wait almost breathlessly, sympathize with the man if he fails initially, and applaud heartily if he succeeds even to a small degree.

So important therapeutically may be the patients' doing something for someone else or at least sharing in common experiences that this subject must now be looked at in more detail and within a broader frame of reference. We shall begin by returning for a moment to Dr. Sivadon's attempt to integrate patients into the

life of the hospital as quickly and easily as possible.[1] When his plan for welcoming them to his psychiatric institution has been presented at meetings, members of the health professions have generally been warmly responsive to his emphasis upon making patients feel that they were not only expected but welcome. His third suggestion that patients be made to feel needed presents difficulties, particularly for the personnel of general hospitals. Often someone asks instantly, "How can patients be needed?" That immediate reaction perhaps indicates the effectiveness of the process of socialization that many clinicians and clinical nurses have undergone in viewing hospital patients as *helpless* persons, much as they may have been frequently when hospitals were used only for surgery and major illness and before many of the present drugs and treatments were known.[2] Unfortunately, the perception of helplessness tends to close the door to careful scrutiny of what patients are able to do, at different intervals during their hospitalization, for other patients, staff, or the floor generally, as well as for themselves. Hence, unless perceptions are altered, an important aspect of the social environment of the patient areas may go uncultivated at the expense of patient welfare.

When the nurses in the writer's seminars prepared their papers on what they wanted the hospital to provide for their comfort and satisfaction as patients during a supposedly two-month hospitalization, several suggested that they would like the opportunity to assist the nurses on their floor in whatever way and to whatever degree possible. They commented on the fact that it would make time seem less long, that they had always worked and it would help them psychologically if they felt they were continuing; it would reduce their sense of guilt about calling for assistance if the floor were understaffed. An occasional person made imaginative suggestions about what she thought she could do for another patient in the room even if she were confined to her bed.

These nurses were often able to visualize and predict the value that work and helping someone else would have for them if they

[1] See pp. 60–61.

[2] Paradoxically, patients in nineteenth-century hospitals were often expected to bathe themselves, help other patients, and do much of the housework if such tasks were not inconsistent with their recovery. Duties to be performed by them were even made part of the hospital regulations.

were ill, because such activities represented the symbolic continuation of their customary role. It is less clear that they visualized the value for "real" patients of helping other persons or doing some kind of work, in part, because they took it almost for granted that the services of members of the health professions are required. One nurse made the significant remark quoted in Appendix 2, "I think health personnel have not adequately considered the significance of work. I believe many hospitalized people, particularly those with long-term illnesses, could benefit from work activities."

Little question of the value of such activities would probably arise among social scientists, or the educated laity generally, who have been conditioned to living and working with supposedly healthy rather than supposedly helpless people. They would go on the assumption that there are innumerable things that many patients are able to say and do to help other patients or staff, and that symbols of work and responsibility may be important props on which patients can lean.[1] Frequently one hears hospital visitors speak not only of the need for recreational activities but for keeping the patient occupied in useful ways. Former patients often mention something that they could and would have liked to do if they had felt free to suggest it to the staff.

> A young man was greatly concerned about having to leave his mother, a widowed teacher who had broken her hip, in order to take a position at a considerable distance. Said he, "Mother will be all right if they will only let her do something for other patients." Months later when someone inquired how things had turned out, he said that the hospital had not made any suggestions, but a role had fortuitously presented itself that she could fill with great satisfaction. The Polish patient in the next bed could not speak or understand English, but she could understand German. His mother could understand Polish and could speak German fluently. Hence, she assumed the function of interpreting to members of the staff what the woman said. Moreover, she spent much time as counselor in explaining aspects of hospital routine that had distressed the patient, and in their long conversations together when one spoke Polish and the other German, she was able to be the "friendly visitor," offering comfort and distraction.

[1] Many psychiatric hospitals have given careful attention to how work can be used as therapy. As illustration of the considerable literature on the subject, see Dr. Seymour Boorstein's "Ego Autonomy in Psychiatric Practice," *Bulletin of the Menninger Clinic*, vol. 23, July, 1959, pp. 149–152.

WHAT PATIENTS CAN DO

Although hospital personnel may not be able to respond quickly to a theoretical discussion of how patients can be given the feeling that they are useful and needed, attempts are made in most general hospitals to encourage them to engage in some social interaction and occasionally to do something specific for another patient. As yet these attempts are usually random, uncoordinated, and rarely part of a nursing-care or patient-care plan. No body of conceptualization or of systematic practice has been developed comparable to what exists in psychiatric hospitals. Regardless of this fact, it is possible to elicit a long list of varied undertakings that *some* patients can undertake *at some time* during their hospitalization.

One nurse working by herself listed twenty items and noted that with time she could think of more. The items and the categories under which we have classified them are purposely being presented in their rough and incomplete form. They are intended only to suggest additional items and categories to staff members who provide direct patient care.[1] Several of the nurse's items could be grouped under the general subject of services to individual patients incapable of self-help: reading aloud, writing letters, doing errands, talking to patients in need of conversation, and feeding a patient or taking him to another part of the hospital "under controlled conditions." Other items were primarily recreational in nature, intended to indicate what a patient could do to enliven the social environment: taking responsibility for games, teaching others or entertaining them with his own professional or occupational skill, interesting them in his hobby. The list was weakest in regard to specific physical services that could be useful to patients, nursing staff, or the ward generally. The one statement read, "A patient may perform simple helpful acts, such as giving out mail or routine supplies in controlled situations." Services of an advisory or counseling nature formed

[1] Many readers will be interested in seeing the memorandum, presented as Appendix 4, that was prepared by a nurse on the basis of the analyses set down in these paragraphs. It carried the investigation much farther, and suggests that planned work activities be made part of a "therapeutic hospital environment."

a fourth category: interpreting for non-English-speaking patients, reporting observations to doctors and nurses that might help them in caring for another patient, or explaining the religious beliefs or ethnic customs of a fellow patient with which the nurses were not familiar.

The final category of five items was of a different kind. It was concerned with the role ascribed to patients, who had successfully undergone surgery, rehabilitation, or several childbirths, of talking to, reassuring, and perhaps giving demonstrations to other patients about to undergo similar experiences. As illustration, specific reference was made to laryngectomy patients who had learned to talk again, and to patients wearing prostheses following breast surgery and the amputation of a leg. This last category is particularly interesting because it results from the conscious attempts now being made, at least sporadically in some places, to have patients discuss their experience, for therapeutic purposes, with other patients. Later in the chapter we shall return to further consideration of the possible significance of these attempts.

Obviously, there are numerous ways whereby patients can engage in social interaction symbolic of normal living that may help to reduce boredom and strengthen their self-respect and returning sense of independence. Much of this patient participation must be carried on in the setting of the ward or the patient floors, and must be planned, supervised, or stimulated by the nursing staff. Unfortunately, systematic consideration of work activities and interaction among patients represents a new aspect of nursing for most staff and head nurses. Hence, training is needed in broadening and deepening their imagination about what patients are able to do, and what kinds of social situations can be created that are within the physical and emotional ability of patients.

A psychological device that is often useful in increasing perceptivity is the repeated listing of all the appropriate items that can be brought into consciousness. This device appears admirable here since it lends itself to practice both by individuals and groups. Lists could be composed under a variety of subject headings that would help to emphasize different facets of the problem.

Valuable, for example, would be lists dealing with what patients having each of several diagnoses might be able to do at various stages during hospitalizations of average length; lists of shared activities that could reasonably be planned for a representative medical or surgical floor; lists of activities such as patients themselves could plan with nursing encouragement and suggestions; and lists of supplies and equipment that would be needed. Some of these lists could be prepared at "brainstorming" sessions of staff nurses, where careful discussion would permit additions to or deletions from the items as well as justification of each one included. Some could result from assignments in schools of nursing where the instructor requested that they be based on careful observation on medical and surgical floors, and also in pediatric, rehabilitation, and psychiatric services recognized for their use of planned patient participation.

KNOWLEDGE OF INDIVIDUAL PATIENTS REQUIRED

To know what patients in general can do in social interaction and in work situations is extremely valuable and a necessary first step, but it is not enough. If concrete opportunities are to be provided them, it becomes imperative that the staff know far more than now about what each patient does in "real" life and what his potentialities, interests, and hobbies are. With such knowledge the staff can often bring together two or more patients for mutual pleasure and benefit.

On many hospital floors there are men who would gladly talk together about fishing, golf, or the mechanics of cars if their interests were only recognized and they were given an opportunity. Two women interested in cooking might enjoy a chance to exchange recipes. If it were possible to put an older and a younger woman together, says Dr. Prescott W. Thompson, director of the Adult Outpatient Service of the Menninger Foundation, the older woman might experience the gratification of feeling that she had something to offer, while the younger woman might learn much of practical value. "If the interest is in knitting, crocheting, or demonstrating card tricks," Dr. Thompson con-

tinues, "surely it is part of good nursing to see that material and patient, or patient and audience, are brought together."[1]

How far hospital staffs may be from making any such provisions was illustrated for the writer by one private floor which she had an opportunity to observe for many weeks. It was composed of enough patients from the academic and intellectual world to form the nucleus of a college faculty; it had a roughly equal number of persons prominent in society. Many of these patients would undoubtedly have enjoyed meeting and talking with others whom they knew by name and field of interest, but whose presence in the hospital was rarely known to them. Assuring privacy for the patient seemed to be the goal of the floor staff. The nurses, in fact, often spoke sharply about carelessness in leaving a door open from the patient's room to the corridor. There is little evidence that patients were ever asked whether they would like to meet others on the floor even though some, when convalescent, were so impatient for social contacts with persons of their own kind that they wanted to leave the hospital before it was advisable.

Medical and nursing staffs have had little orientation toward, or preparation in, finding out about patients' social backgrounds, interests, and desires as a basis for considering how they can be used for therapeutic purposes. Many have never had courses in sociology and anthropology that deal with the social and cultural components of human behavior, to say nothing of courses that attempt to apply these components to an analysis of human behavior under the strain of sickness. Hence, it is not surprising that a biologically based attitude toward patient care continues to be the major frame of reference. Group social workers and clinical psychologists like Dr. Sivadon's "hostess," who have had training at least in the psychological components of human behavior, are better prepared to assess fairly quickly how patients can be made to feel that they are wanted and needed. Such persons are rarely used, however, as consultants on the adult patient floors of general hospitals.

[1] "Let's Take a Good Look at the Aging," *American Journal of Nursing*, vol. 61, March, 1961, p. 78.

Evidence of the degree to which a traditional role concept continues to influence practice even when another type of practice is clearly indicated can be seen in a series of studies that were made at the Massachusetts Mental Health Center when it was called the Boston Psychopathic Hospital. Two of these studies were concerned with what social and recreational skills nursing personnel have that could be used for the benefit of psychiatric patients, and what nursing personnel know about the leisure-time activities of patients prior to hospitalization.

In this particular hospital much emphasis had been placed on the utilization of social and recreational skills in the ward dayrooms as well as in the more exclusively occupational and recreational areas of the hospital. Regardless of the pervasive encouragement that was given nursing personnel in working with groups of patients through the use of varied social situations, the staff had not made any systematic assessment of the social skills they brought to their jobs or skills the patients possessed. When the results of the first study were available it was discovered that the nursing staff had many more potential assets than were being used.[1] A few of them had skills of the utmost importance, such as piano playing, singing, or ballet dancing, about which their colleagues sometimes knew nothing. Even within this permissive climate, nurses still felt it inappropriate to be seen using something like ballet dancing to entertain patients. But undergraduate college students, who volunteered their services on wards of badly regressed patients in a neighboring psychiatric hospital, easily used everything they knew, and kept asking each other whether someone could not do such and such a thing. Piano playing, group singing, and square dancing were stock tools for enticing patients into recreational activities.

When tabulations were completed in the second study for the leisure-time activities of 30 selected patients prior to their hospitalization, it was found that only 23 per cent of these activities were known to the staff. Concerning 3 patients much was known; there was partial knowledge about 8 and disagree-

[1] Morimoto, Francoise R., "The Socializing Role of Psychiatric Ward Personnel," *American Journal of Nursing*, vol. 54, January, 1954, pp. 53–55.

ment about 19. Only two sources of information had generally been used: observation of and conversation with patients on the ward. Rarely had families been asked for information, and social workers and recreational therapists were infrequently consulted in spite of the fact that they were encountered daily in this small and informal hospital.[1]

If nursing staffs are to learn how to obtain adequate knowledge about patients to enable them to initiate plans for, or encourage patients to undertake, psychologically useful activities, there must first be conviction that such efforts are *nursing*. Then staffs must have help in learning to observe patients' social behavior with a degree of acuity comparable to what they have developed in observing physiological symptoms; they must have aid in listening to what patients say and what is not said; and they must be taught how to interview patients in order to get necessary information. Observing, listening, and interviewing are highly complex skills that both merit and require as careful training as do the traditional nursing procedures that have been so highly perfected.

As nurses acquire facility in observing what patients are trying to do and in listening to what they are trying to say or not to say, it will be progressively easier to pick up cues that can be incorporated into nursing-care plans. As illustration of this generalization, the case will be presented of a patient who created a role of vital significance for himself. To it the nursing staff responded warmly. So little orientation had they had, however, in analyzing the meaning of social behavior that they failed to see that this patient was giving them a ready-made model for possible use with other patients.

> The chief nurse of a Veterans Administration general hospital and the writer were spending the morning on a medical floor leisurely listening to whatever patients wanted to tell us. We arrived at the room of a patient probably in his late sixties who had been brought into the hospital several months earlier expectorating great quantities of blood. According to his report he had been a most frightened

[1] Morimoto, Francoise R., and Greenblatt, Milton, "Personnel Awareness of Patients' Socializing Capacity," *American Journal of Psychiatry*, vol. 110, December, 1953, pp. 443–447.

man who was sure he was going to die. Between his fright and what was diagnosed as a lung cancer he had been acutely ill for several weeks. Then he began to improve. When we saw him he was not only ambulatory and moved freely about the entire floor, but he had created a role for himself that was obviously giving him much satisfaction. He had made himself *indispensable*, as he saw it, to the nursing service.

With tremendous pride he recounted to the chief nurse a long list of things that he did regularly or as they were needed. He began with, "I'se deliver the mail every day to the men in bed; I'se feed that colored gentleman across the hall his lunch." As we left the floor the chief nurse commented on how well this man who had been extremely sick, anxious, and difficult to manage was maintaining his morale in spite of the fact that he probably knew he was not going to live.

Because he was articulate and had thoroughly enjoyed showing off to the chief nurse, it was clear that he had himself developed the role of ward helper, but that the nursing staff had responded to his need to be indispensable not only by giving him things that he could do but by giving him many signs of appreciation and warm praise. The writer questioned the chief nurse about whether the staff were consciously aware of the situation and were consciously rewarding him, or whether they were reacting "intuitively" to his behavior. She felt almost certain it was the latter.

If she were right in her conclusion, the staff had gained nothing from this experience that would lead to a generalization about the significance of what had happened and to consideration of its applicability to other possibly similar situations. Had they been aware of what was going on, they might have stated a series of hypotheses in some such terms as the following: It appears possible for a patient to create a role that can give him much psychological support even with an exceedingly anxiety-inducing sickness. There are probably other patients who would benefit if they had something to do whereby they could earn praise and recognition. It should be possible for the nursing staff to help patients create roles, or assign roles to them when they are unable to initiate something, that would have therapeutic value.

With hypotheses such as these the staff would be in a position to consider each patient in turn, attempt to decide what patients might perhaps benefit from this kind of intervention, and then

try to determine, often in discussion with the patient, what kind of role would be possible, appropriate, and satisfying. Such action would represent a major forward step in thinking about the use of the social environment of the floor for purposes of helping patients to feel wanted and needed.

If the staff concluded that they could go still farther, this kind of undertaking could readily be made into a research project. Careful notes could be kept about each step taken, when and why it was taken, and what the results seemed to be in each instance. Finally, when notes regarding a considerable number of patients had accumulated, they could be analyzed to obtain possibly useful knowledge about any one of several questions: What results had been achieved as a whole? Had expertness in creating roles and rewarding performance been increased? How did patients vary in their reactions to this particular aspect of nursing care?

THE THERAPEUTIC IMPORTANCE OF THE PEER GROUP

Before ending this chapter we should like to describe a remarkable organized effort of patients in aiding other patients: Q.T. Inc. in Boston, the members of which are exclusively persons who have undergone ileostomy surgery. It is an effort centered both in the hospital and in the community that was designed to assist a specific group of persons. It provides visitors for the patients prior to surgery with whom they can identify psychologically and who will help them subsequently with their postsurgical and post-hospital adjustment. Hence, the service which begins in the hospital and outpatient department furnishes a bridge between that institution and the family and community club. Many similar groups now exist elsewhere that may or may not use the same name, but the Boston organization was the first to be established and is one of the largest and most active.

An appreciable proportion of the persons who have been obliged to undergo ileostomy surgery are relatively young. Questions of marriage, ability to have children and to lead a normal life assume great importance for them. If they can be given sufficient reassurance, teaching, and guidance for a considerable

period of time, Q.T. Inc. maintains, the chances are good that they will be able to face life without serious psychological disability. The surgery and the resulting physical disability are so threatening, however, that few persons can be expected to emerge from the experience successfully without help.

In Boston, at least, it is customary for members of Q.T. Inc. to visit ileostomy patients prior to surgery, and it is now frequently taken for granted that they will help to prepare the patients psychologically. They are the visible manifestation that it is possible to "come through" and without their physical disability being apparent. The women visitors, for instance, take great pains with their grooming and appear in tight-fitting dresses in order to allay the anxiety of patients who have assumed that they would have to wear loose, baggy clothes for the rest of their lives. Following surgery, members visit at whatever frequency seems indicated to provide the psychological support and guidance deemed necessary. They follow the patients to the home and visit them there until the latter are able to attend the regular club meetings of the group. Some postpatients come to the meetings for only a few months, after which they attempt to get along independently. Not all succeed and hence an effort may be made to encourage them to return. Some who feel the need for continuing support may attend indefinitely. All will be encouraged to be workers in the organization.

One of the chief problems connected with ileostomy surgery has been the difficulty encountered in perfecting or fitting appliances to provide maximum comfort and reliability for each patient. Because of the large personal experience that members of Q.T. Inc. have acquired in the use of appliances, physicians often write on the order sheet that one of them be asked to fit the patient and teach him the use of the appliance. Although the organization views this as a medical or nursing function, it has continued to accede to the request because so much of the success of its role in reassurance is dependent on these aspects of physical care. At present it is sponsoring research that seeks to find more satisfactory appliances than the manufacturers have yet produced.

In addition to its *Ileostomy Quarterly* for the members of Q.T. Inc., the organization has been trying to prepare literature that the medical profession has said it needed, so that doctors and nurses will have more knowledge about these patients and more understanding of the emotional factors involved. A recent grant from the U. S. Office of Vocational Rehabilitation has permitted it to enlarge and strengthen the study, research, and publication aspects of its program. At present it is seeking a highly skilled surgical nurse who would care exclusively for ileostomy (and perhaps colostomy) patients on an experimental basis in one Boston hospital. Thus, gains might be made in learning what is required in nursing and teaching such patients that could then be reported for application elsewhere.

In summary, it may be concluded that the role this organization has played for several years is the direct outgrowth of the personal experience of its constituents and of competence based upon that experience, combined with the desire of the members to help one another. Its achievement in working with patients and postpatients illustrates once again the potential usefulness of a peer group composed of persons who have shared a common tragedy. Its successful practice tends to support the validity of those undertakings, mentioned earlier, where hospital staffs sometimes request patients to talk to other patients with similar problems. The history of Q.T. Inc.—as well as the experience of the many other kinds of mutual aid groups that are now being formed —makes the concept of patients treating patients appear less radical then many persons would have believed likely.

A decade ago Dr. Robert W. Hyde was already inquiring whether the social system of psychiatric hospitals could not be organized in such a way that patients would treat patients. Although he referred exclusively to mental institutions, his hypothesis may have enough psychological applicability to warrant quoting it here for possible future discussion in general hospitals.[1]

> One point in ward clinical management is still in its experimental phase and has not yet found an accepted place in medical practice.

[1] Hyde, Robert W., and Harry C. Solomon, "Clinical Management of Psychiatric Hospitals," *Connecticut State Medical Journal*, vol. 15, May, 1951, p. 394.

Isn't it possible for us to develop an organization in our hospitals wherein patients are treating patients? Why can't the patients who are convalescing from their mental illnesses assist in the care of the patients much more acutely ill, in an organized directed fashion? It has been noticed by many that there is a phase in a patient's recovery from a psychosis wherein he has a very good memory and understanding of what he has been through—an understanding perhaps deeper than that of anyone who has not had a similar experience. Some maintain this insight even after recovery. Isn't it possible to utilize this special understanding of one patient in the treatment of another?

Further support of this idea is based on the deep involvement of the mentally ill with themselves—an all-encompassing egotism that declines as the patient progresses to recovery, declines as he develops more and more social relationships with those about him. Gradually he thinks less and less of himself and more and more of others. Are we encouraging the patient in his thoughtfulness of others; are we giving him an opportunity to help others as he has been helped; or do we insist on doing things for the patient, on being always the givers of medical help with the patient constantly the recipient and never the giver? Later, at the time of discharge, he is expected to change suddenly into an individual who can again engage in the give and take of life.

Chapter 7

EFFECTING CHANGE

THE PRECEDING CHAPTERS have attempted to resensitize both reader and writer to the well-known but greatly neglected fact that patients are people in trouble, and if such people are to be helped along the road toward cure and health, their psychosocial as well as their physical needs must be discovered and met. We have proceeded on the basic theoretical assumption that one way of meeting some of these needs is to make the hospital more nearly like the familiar social setting from which patients come and to which most of them will return. The interpolation of a sharp and unnecessarily artificial hiatus between past and future experience leaves the patient unprepared for, and hence anxious about, his stay in the hospital. It may sometimes leave him scarcely less unprepared for his return home than was the man who could not emerge from the sick role and insisted that his meals be served him on a tray rather than at the family table.

To deprive patients at a time of great emotional vulnerability of members of their family, of things, foods, and amenities that have particular meaning for them, of social activities that represent play, sociability, and distraction, is widely assumed, although not yet scientifically validated, to make the healing process longer, harder, or less successful. To place patients in situations where their independence, self-respect, and privacy are needlessly violated is nontherapeutic. On the other hand, to create social situations within an adequate physical setting where patients can sense that their importance and worth as individuals are respected, where they are helped to realize that the physical embarrassments of being cared for like small children are generally only temporary, and where they can measure progress from

psychological and physical dependency to increasing autonomy—this is to use the hospital environment for therapeutic purposes.

Some physicians and nurses, to be sure, still purport to believe that it is necessary and desirable to maintain a social setting that varies radically from that of the home and community; they believe that the patient should be expected "to work" to get well, through active acceptance of a regime supposedly designed for his benefit regardless of how restrictive it may be. Many patients have probably had an experience similar to that of the woman who complained that she could get no rest because of the noise, confusion, early hours for being awakened, and so on. A nurse replied emphatically, "Mrs. N., you are not in the hospital to rest. You are here to work to get well. You can rest after you go home." Since treatment, as seen by Mrs. N., consisted only of medication and an hour of physical therapy daily, she could scarcely understand why she should not also have an opportunity for needed relaxation.

An occasional physician has spoken sharply to anyone who suggested the desirability of broadening the base of patient care to include more environmental comforts and satisfactions. He has insisted that the person did not understand what was involved in the therapeutic process with its requirements of closely controlled management of patients. We believe, however, that such nurses and doctors represent a continuously shrinking number. They are preoccupied with the technical and procedural aspects of treating disease, not with treating persons.

THE CONSEQUENCE OF "WORDFACTS"

It may be assumed that in general all the health professions, including hospital administrators, want to see patients given consideration and help that transcend the treatment of disease. Accomplishment in some directions, however, has been meager indeed. One of the areas in which it has, most surprisingly, been very inadequate is in dealing with such concrete considerations as physical space and things, and provision for social activities. In preceding pages this failure has been attributed to the percep-

tual limitations of persons responsible for planning and running hospitals. Because such persons have not been trained to see the hospital in psychological and sociological perspective, they scarcely view it as an instrumentality that can be used to serve psychosocial ends.

We now want to suggest another possible reason for this failure. It is the error of confusing talk with action—an error that is exceedingly prevalent elsewhere besides hospitals, and is probably most flamboyantly conspicuous in politics and journalism. In his brilliant article, "The Age of the Wordfact," John Kenneth Galbraith writes satirically, "The wordfact makes words a precise substitute for reality. This is an enormous convenience. It means that to say that something exists is a substitute for its existence. And to say that something will happen is as good as having it happen. The saving in energy is nearly total."[1]

In countless hospitals and particularly in hospital conventions across the United States, one hears talk of the beautiful new buildings that have been constructed and equipped and the amenities that have been introduced. The talk frequently sounds as if changes had been designed expressly to meet the patient's every wish. Even more frequently one hears talk about the necessity for "meeting the psychological needs of patients," until the listener agrees with the nurse who remarked that that expression nauseated her. An important psychological concept has been corrupted to the point of becoming a trite catch-phrase, the repetition of which often replaces even attempted application. Such talk, without accompanying action, may be potentially more dangerous than the attitudes of those few therapists who still take it for granted that "patient management" includes restrictive management of environmental resources regardless of whether the patient has congestive heart failure or a broken arm.

In regard to sweeping assertions, that rest on no verified base, of what has been or is being accomplished for the comfort and satisfaction of patients and their families, "the age of the wordfact" needs to be brought to a rapid end, and action substituted

[1] Galbraith, John Kenneth, "The Age of the Wordfact," *The Atlantic*, vol. 206, September, 1960, p. 87.

for talk. The almost endless rationalizations about why proposed action cannot be initiated, as well as the sometimes autocratic assertions that various advocated changes will *not* be made, need also to come to an end. For hospitals to continue to argue about the reasons for not providing facilities for social activities and for keeping patients occupied on adult medical and surgical floors, when they are provided on pediatric and rehabilitation services, may be to court mounting dissatisfaction from the public. For administrators to declare defensively that the sign concerning children that hangs in the lobby "is going to stay there" may have equally unfortunate results.

Of late several unpleasant and largely very unfair articles have been published, particularly in popular magazines with a large circulation. They have been a protest against conditions in hospitals where administrative housekeeping was probably poor, medical and nursing attention inadequate, and the general environment unnecessarily restrictive. If hospitals meet such attacks by attempting to substitute the skillful words of public relations firms for changes that are long overdue, these same persons or groups may consider that Professor Galbraith's prescription for drastic action is as applicable to hospitals as to the political arena. "Elaborate rationalizations of failure should not be met by bored silence or even by a fishy stare. They should be greeted by loud and vulgar laughter, followed immediately by equally uncouth speeches and letters. . . . All who proclaim good intentions should be immediately asked for their program as to performance."[1]

HOW CHANGES CAN BE INITIATED

An attempt must now be made to examine in broad generalization how it is possible to move from wordfacts, rationalizations, or skepticism into experimental action and who might most appropriately be the agents of change. As an introduction to this discussion note should be taken of the fact that almost every object, practice, or program mentioned in this monograph is

[1] Galbraith, John Kenneth, *op. cit.*, p. 90.

already in use or operation in some hospitals and often in many. This fact should give pause to the members of hospital staffs who view these proposals as radical. The very persons who reject an analysis such as that presented here as being only "for the birds" often are aware that other hospitals have instituted some of the changes described. They may even have concluded that the changes are desirable. What is probably most disconcerting to them is the impact of seeing so many of these newer undertakings presented not as individual and isolated instances of change but as illustrations of suggested areas for change or revised ways of looking at the function and use of the hospital.

Hospitals for acute illness, as mentioned before, tend to have the greatest difficulty in finding applicability in a discussion of the value to patients of an enriched physical and social environment. They see its applicability and appropriateness for psychiatric hospitals and hospitals and nursing homes caring for patients with long-term physical illness. Interestingly, they often equate Veterans Administration general hospitals, to which we have referred several times, with long-term hospitals and hence consider the experience of these institutions as inapplicable to themselves. Were they to compare statistics for the same diagnostic and age-groups in their own and the federal institutions, there might be less difference in length of hospitalization than they believe exists. Regardless of this possibility, we can only conclude that many hospitals for acute sickness might be convinced of the need for a richer and more flexible environment were they to have figures prepared for study that would give them a profile of patient turnover on every floor or unit. Were they, in addition, to observe the results achieved in patient satisfaction and motivation on those pediatric, maternity, and rehabilitation services that have made extensive use of things and of more informal social relations, they might conclude that similar changes would be profitable on medical and surgical floors.

Observation and Assessment

This last remark leads to the generalization that observation is certainly one of the potent forces in producing consideration of

change, and hence is heartily to be recommended. Seeing things "with one's own eyes" often makes a stronger impact than listening to or reading a technical paper or even a perceptive work of fiction, such as *The Big Ward*.[1] Frequently, moreover, the observer sees things of great relevance and significance for him that were not mentioned in the paper or book. For observation to be valuable it must not be hurried, and (within the context of this discussion) it must be focused upon psychosocial aspects quite as much as upon the facilities that help to determine them. In the health field rapid acquaintance with new kinds of facilities is common, but there appears to have been relatively little experience in observing how they are used and what they may achieve for other than strictly medical purposes.

The following observation dealing expressly with a familiar type of occurrence, indicates, first, the difference between looking at a social situation and looking at facilities, and implies that conclusions may vary widely according to which is seen. Second, it notes the kind of question that may occur to a person seeing a social situation with fresh eyes. Finally, it intends to suggest that realistic answers to such questions may be essential for providing the foundation on which consideration of improvements can wisely begin.

> In a fine university hospital the writer was invited to visit the department of physical medicine, of which the institution was very proud. The trip to the top floor where the department is located revealed the same crowded elevator encountered in many other hospitals. Two patients on stretchers were being taken by aides for physical therapy. In addition, as many staff members as possible pushed their way into the car. The situation seemed almost intolerable to the visitor who was well and on her feet. She asked herself how the patients reacted to the discomfort of the heat, the opening and shutting of elevator doors, the broken snatches of conversation, and the lack of free space. Did they object to being in a helpless, horizontal position where everyone could look at them? Did they think they had been robbed of both self-respect and privacy? Did their families and friends object to their being handled in this way? (Here is a subject that needs to be studied by watching and listening to the spontaneous reactions of patients and their visitors, and by interviewing both groups.)

[1] van Velde, Jacoba, *The Big Ward*. Simon and Schuster, Inc., New York, 1960.

When the top floor was reached, the stretchers were pushed off the elevator and lined up against the wall of the public corridor leading to the treatment rooms. Four other stretchers with patients were already in position. Everyone who went in and out of the therapy area had to pass close to them. How long had the four patients been there? How long would it be before the last of the six patients was at least wheeled inside the door? Was this their "Misery Row," or were they so relieved to have a change of scene that the situation seemed less humiliating to them than to the visitor? If waiting were unavoidable and interviews of patients revealed objections, could part of the large room available be curtained off and the stretchers arranged in such a way that the patients could talk to each other, besides being given a little privacy?

The visitor felt embarrassed that the administrator who was escorting her should have encountered such unfortunate events when he had a guest. However, he seemed completely oblivious of any lack of consideration for the patients. He was eager to get to the treatment area where he could display the spacious and well-arranged department, the beautiful stainless steel tanks of several kinds, and the generous and varied equipment for strengthening muscles. He obviously understood machines and they won his admiration. He could see them. On the other hand, he had probably ridden in crowded elevators and passed patients lined up against the corridor wall so many times, he no longer saw anything. But let him visit another hospital to which he would bring fresh vision and he could perhaps observe favorable or untoward situations which he then might use for comparison with his own institution.

Observation often leads directly to recognition of the need for making some assessment of situations that may constitute problems or appear so promising that their usefulness should perhaps be recognized and applied elsewhere. Assessment, in turn, generally leads back to further observation, within a planned frame of reference. The purpose of assessment, as viewed here, is to procure data that are more adequate than those generally obtainable from the customary method of pooling knowledge and attitudes at a conference table and that can be used to decide what should be done. Some assessments that yield highly useful results are relatively simple to undertake; others that necessitate great exactness involve complex research procedures and the skill of experienced social scientists. In reference to the subjects discussed in this monograph, even simple studies would yield

data now almost entirely lacking in general hospitals. For the very reason that the field has been so largely unexplored, however, assessment is needed of many situations of different kinds. Several examples will serve to illustrate this statement.

In the earlier discussion of what patients in general are able to do for other patients and staff and what specific patients are able to do, an attempt was made not only to suggest the need for answering these questions but to indicate rudimentary methods for undertaking the assessment. In the observation presented in this chapter, studies of patients' perceptions and feelings in regard to being on stretchers in crowded elevators and public corridors suggested themselves.

Let us turn to a different kind of problem. It may be assumed that a hospital director has received such adverse comments about the prohibition "No children under—allowed above the lobby floor" that he concludes a decision must be made either to maintain the policy or remove the sign. He and his associates agree that even rough answers to questions such as the following might furnish helpful guides to determination of policy. How many patients, at a given time, on each unit of the hospital are physically able to receive visits from their children or grandchildren; how many are likely to be able at some time during their hospitalization? What patients are in a condition that might be traumatic for the children, if the latter were permitted to visit? How many patients are being cared for in a physical environment where semiprivate and private rooms and ample lounges facilitate provision for child visitors? How many patients, when questioned, say that they would like to see their children or grandchildren? How many other patients say they would not object to, or would welcome, having a child occasionally visit his parent in the semiprivate room they share with others or in the lounge? Were children to be permitted to visit on a selective basis, what members of the staff should carry responsibility for making necessary decisions and arrangements?

As a final example of assessment, let us look at some of the items of information needed if a hospital were trying to decide whether to set up lounges adjacent to wards or patient floors and

operate them as supervised social situations. How many patients on the average from each ward would be able to use these lounges? For how many hours a day? Would physicians grant permission for ambulatory patients to spend designated periods of time in them? Would nurses assume responsibility for encouraging patients to go to these lounges for designated periods just as, under other circumstances, they would go to the occupational therapy department? What equipment and supplies would be desirable for lounges serving patients from each of the various services? What provision should be made, and what could be made, for staffing them? Under what conditions could patients be expected to assume responsibility for entertaining and helping each other?

Pooling of Resources in Ideas

Even more important than the obtaining of such factual information as a foundation for deciding what changes should be made, is the need for trying to learn to look at the hospital through the eyes of patients. In a letter addressed to the writer was this statement: "We, as nurses, have become victims of our own situations, for we can see in nursing only what other nurses can and have seen." The statement contains such an element of universal truth that "social workers," "physicians," or "hospital administrators" might be substituted for the word "nurses." The members of every profession are "zipped" firmly into the culture of their particular group. The very process of professional training determines largely what will be seen, what will not be seen, and the right and correct ways of looking at and doing things. Through this process of handing down not only knowledge but attitudes and perceptions from teacher to student, skill and stability are provided. How to prepare the members of a profession to be able to see other than what their intellectual mentors have seen is far more difficult.

Fortunately, each profession working in the health field has been socialized in a somewhat different way. Social workers, for instance, have been trained to observe some facets of patient behavior and many of the relationships between patients and

their families that physicians and nurses often neglect. Occupational, recreational, and physical therapists have had a kind of training and experience in using things therapeutically and in working with small groups that is particularly valuable within the context of this discussion. Psychiatrists and clinical psychologists have learned much in recent years about the manipulation of both the physical and social environment of the psychiatric hospital. This knowledge seems sufficiently applicable to the general hospital to make them valuable consultants. At long last dietitians are beginning to interest themselves in the cultural aspects of food and food service, and they report that they find the subject both interesting and important.[1] Many chaplains have been trained to sit and listen actively to whatever patients want to pour out. As a consequence, they are in a particularly favored position to interpret what patients want and how patients perceive many aspects of hospitalization.

Every hospital has representatives of some or all of the groups mentioned, in addition to its nurses, doctors, and hospital administrator. Together they constitute its internal resources, and consultation can be obtained, as needed, from the health professions not included in its personnel. Within these groups are enough points of view to give some guarantee of a broader approach to understanding and representing patients' interests than has often been true in the past. Anyone who has the opportunity to listen and talk leisurely with members of the various categories of staff is likely to be impressed by the number of "bright ideas" that are expressed within one institution. This may be true even though little opportunity exists for these ideas to be used as cross-fertilization and they do not represent the general climate of opinion of the hospital.

At present "bright ideas" tend to be self-contained within each professional or technical group. (They may not move freely even within one group.) In many hospitals nurses do not know the help they could get from social workers and occupational

[1] As an example of the kind of article that appears with increasing frequency in the dietetic literature, see George H. Fathauer's "An Anthropologist Looks at Food Habits," *Journal of the American Dietetic Association*, vol. 37, October, 1960, pp. 335–338.

therapists, let us say; physicians would be amazed at what physical therapists might sometimes be able to tell them about patients' responses to the encouragement of the peer group, or what nurses have observed that has relevance for patient management; and hospital administrators might be truly surprised were they to hear the comments, often expressed as chit-chat at the coffee break, about what could be done to give patients a better "break."

Obviously, one of the urgent needs, if patient care is to be improved, is to open more channels for communication to flow horizontally across professional lines, and not merely down and sometimes up within each professional group. Unless such channels can be opened and utilized effectively, relatively little can be accomplished in planning for the use of the potential physical and social resources. Many of these resources are not at the command of any one group and no group has the ready competence to maximize their use for the patients' best interests. In Part II of the study as projected, detailed discussion will be focused upon the exploration of ways for increasing horizontal communication.

Patients as Consultants

Unless one understands how firmly professional training conditions its practitioners to assume that they know what patients want and should have, he is continually surprised at their reluctance to consult patients about the success or lack of success of the hospital in providing comfort and distraction from boredom. In Dr. Sivadon's program, to which reference has been made,[1] patients are given many opportunities to express their complaints about the hospital. He believes that complaints (whether about weather, food, traffic conditions, or the like) are a frequent means of initiating conversations everywhere, and that they can be used psychiatrically as the basis for social interaction that is therapeutic.

An internist, who attempts to discover whether his cardiac patients have anxiety that needs to be relieved, frequently asks, "What are your gripes about the hospital today?" This question, which is asked because it is relatively nonanxiety-inducing,

[1] See pp. 60–61.

generally stimulates a quick reply that gives some clue about the possible nature and degree of the patient's anxiety. Upon hearing of the practice of this internist, another member of the staff inquired sharply, "How can he ask that question? Doesn't he know that he is inviting the patient to make unpleasant remarks about the personnel of the hospital?" One might conclude from such a remark that the hospital was composed of two closed and conflicting clubs: the staff and the patients. As a matter of fact, patients' "gripes" are likely to be about cold food, lack of diversion, and general lack of individualized attention.

If sound planning for change is to be effected, staff need the benefit of suggestions from persons of many kinds who have had the experience of being hospitalized. Therefore, it might be considered of immediate and primary importance that patients, and particularly former patients, be consulted.

Consultation can be achieved in a variety of ways. At staff meetings on a particular service or floor called for discussion of patients' wants and whether these wants can be met, the opinions of two or three articulate, ambulatory patients might be of inestimable value. In connection with planning for more comprehensive changes such as have been discussed in this monograph, persons who have had fairly recent hospital experiences could be invited to be members of the committee studying the proposed change. Because needs and satisfactions vary greatly according to the ethnic, educational, and socioeconomic background of the individual, the members should represent a broad cross-section of the community using the hospital. Many institutions take it for granted that they have patient representation through the members of the board of trustees, the women's auxiliary, or other bodies. Even if these persons have been patients, they are almost always drawn from a much narrower sector of the population than that served by the hosptial.

Perhaps more important is indirect consultation when the feelings, perceptions, and opinions of patients and former patients are sought in greater detail or at greater depth through research methods. Recently several categories of staff, including social scientists, have attempted to make some such studies in psy-

chiatric hospitals. In general hospitals nurses particularly are beginning to assess patients' satisfactions and dissatisfactions in connection with a few objective items characteristic of the ward or private floor. Nurses have been reluctant to go far beyond such items because of the newness of the undertaking, their own limited perceptions of the meaning of things and social situations for patients, or their uncertainty about the responsiveness of the hospital administration and the medical staff to their assuming this study role.

Patients, moreover, tend to treat the questionnaire handed them or the request for suggestions in a cursory fashion. They are either afraid of untoward results if they express themselves freely or so eager to leave the hospital that they are likely to be of little help. Perhaps only leisurely interviewing that permits opportunity for confidence to be established, skilled group discussion, or well-designed projective tests will produce materials from patients while in the hospital of sufficient depth to be useful in contemplating changes. The chances of tapping significant data some weeks after the patient has returned to his home are probably higher. He is "out from under" the restrictive atmosphere that often made him guard what he said in the presence of members of the staff, and he has had an opportunity to begin to sort out his impressions of an experience in which he was emotionally involved.

If indirect consultation through sampling the perceptions and attitudes of patients and former patients is to be undertaken, either social scientists or members of the health professions who have learned research methods are necessary, at least in helping to plan the study and in providing instruction in methodology. Repeatedly the discovery has been made too late that time, energy, and money have been wasted on a study that was almost worthless because the sample was not representative, the questionnaire omitted essential topics, or the interviewer communicated attitudes to the interviewee, if only nonverbally.

As an illustration of how much can be learned through a relatively simple method of interviewing about what patients want from staff, *Nurse-Patient Relationships in a Hospital Maternity*

Service may be recommended.[1] A young woman sociologist and a clinical specialist in maternity nursing questioned prospective mothers when they first visited the outpatient department of a voluntary hospital concerning what they expected from nurses during pregnancy, delivery, and after-care. The same women were questioned again while they were in the hospital for the delivery. A few weeks later in their homes they were asked whether they had received the kind of help they had expected or thought they should have. The concluding chapter of generalizations is telling enough, it would seem, to make every hospital in the United States conclude that it should reevaluate its maternity service. The method used is also applicable to every clinical area. Do patients on the other clinical services need support, reassurance, and someone to answer their many questions to anything like the same degree as did these mothers?

WHO SHOULD UNDERTAKE CHANGE?

The answer appears obvious from the foregoing discussion that suggestions about possible needed changes should come from all categories of staff and from all ranks within each category. No one group can believe, if it accepts the general principle of this analysis, that it has a premium on ideas or any exclusive right to the making of suggestions. The best and most creative thinking of everyone needs to be encouraged, and opinions sought well beyond the hospital walls from persons who are experienced and articulate enough to act as spokesmen of patients' interests. Social scientists might also be profitably consulted about whether changes under consideration appear "in line" with the cultural background of the patients served.

Hospital administrators unquestionably have a central role to play in connection with inducing change. Perhaps, however, they do not need to be the direct agents of change to the degree that has often been true in the past. We can assume that they have often found themselves in the unenviable position of being

[1] Lesser, Marion S., and Vera R. Keane, *Nurse-Patient Relationships in a Hospital Maternity Service*. C. V. Mosby Co., St. Louis, 1956.

expected, after only cursory direction from their board and perhaps cursory discussion with some heads of departments, to assume responsibility for changes in physical facilities or in procedural rules that would supposedly benefit patients. Sometimes they must have felt very unsure of their decisions, or of whether the decisions had the support of the staff most affected. With all the multifarious details on their shoulders for running a complex hospital and having no training in methods for assessment of patients' needs and reactions, they could scarcely see how to act differently.

We conclude that their role might better be one of attempting to solicit suggestions from all categories of staff about environmental problems or proposals for change, and also suggestions as to how these matters might be studied and some broad agreement reached concerning the action to be taken. As part of this undertaking administrators need knowledge of how consultation from outside the hospital can be obtained, when it is needed, and its potential assests and limitations. Certainly one of the most important aspects of the administrator's role lies in motivating staff through giving them generous recognition whenever they try to find answers to problems; and in heartily supporting their experimental attempts, even though some of the personnel may be skeptical about the outcome.

If our observations of hospitals have been at all accurate, there is no appreciable shortage of persons who potentially could offer suggestions, or plan for and implement changes designed to enrich the physical and social environment of the hospital. At present, however, such persons, other than physicians, generally consider themselves restricted in what they can say and do by the hierarchical structure of the hospital and by their limited authority. They would feel free enough to express and carry out ideas only under supportive and dynamic leadership, which sought to give them a larger stake in achieving the hospital's goals through making them partners in the undertaking. This statement applies in general to social workers, occupational and physical therapists, dietitians, x-ray technicians, chaplains, and clinical psychologists when employed by the general hospital.

The Role of Nurses in Effecting Change

The statement is also true of nurses and to them some particular attention must be given for two reasons. First, many of the kinds of change discussed in this monograph would supposedly occur within those areas of the hospital where nurses exercise general direction. Second, through a sequence of occurrences mentioned in the Preface, the writer has had an opportunity to observe trends in the nursing profession rather closely. Some of the very recent trends are particularly relevant to the subject under discussion, but may as yet be little known to the laity or even to many persons in the health professions.

Nurses have long held that one of their chief functions was to make the patient comfortable. They have also held that it was their responsibility to maintain a therapeutic environment on the patient floors. These two assumptions can readily be interpreted to encompass consideration of how the physical and social environment can be made to serve the patient in his totality as a person. Thus far nurses have done relatively little to demonstrate, particularly on medical and surgical services, how these assumptions might be applied in a comprehensive way. The creative, understanding, or broadly prepared nurse, to be sure, has been able to translate some of the meaning underlying them into action. She has accomplished it even when external conditions and existing facilities were poor indeed. But the great majority of nurses have not had the educational background or the ego strength, and they have not found the necessary facilities or the interested attention or psychological support of physicians and hospital administrators necessary for permitting them to do much more than maintain the status quo.

Various forces are at work, however, that may enable nursing to assume an appreciably larger role in producing change. Considerable numbers of nurses, as compared with only fifteen years ago, are being given an opportunity for advanced education even on the doctoral level, and some of them are receiving preparation in the methods of research employed by the behavioral sciences. As a result, they are finding themselves in a progressively better position to reexamine the function of nursing and the role of nurses within a broader frame of reference.

They see the degree to which, since the beginning of World War II, physicians have handed over to nurses functions of a procedural and often a counseling or teaching nature that were formerly performed only by doctors. Moreover, the recent results of medical research, the great strides made in rehabilitation, and the growing interest in long-term patients have introduced whole new areas of nursing care. They observe how the exigent demand for nursing services that has continued unbroken for two decades has made it imperative for them to assign tasks, which could be performed adequately by persons with lesser training, to practical nurses and nursing assistants.

For these and other reasons the function of nursing has been enlarged and the role of the nurse has been changed even more sharply. What the nature and scope of both function and role are, the nursing profession has assiduously been trying to define. The subject has received much classroom exploration in the universities as well as discussion at professional meetings, and has been studied through a large number of research projects.

Recently nurses have instituted a new and perhaps more fruitful approach to discovering their role. Instead of emphasizing nurses and nursing exclusively in their exploration, they have begun systematic studies of a clinical and research nature in which the patient is the focus of attention and nursing is viewed as a flexible, multi-faceted instrumentality for helping him, often through coordinating the services of many other personnel. This shift in emphasis appears to the writer of very great importance. It encourages examination of who the patient is as a person with a psychosocial past, present, and future; it centers attention on what the patient as an individual should have, not only in skilled nursing procedures and in health guidance but in comforts and satisfactions designed to check emotional regression and foster progression toward independence. In the consideration of comforts and satisfactions, nurses have begun to open the door to conscious evaluation of the significance of a variety of environmental factors.

Emphasis upon a theoretical and technical approach to the function of nursing rather than upon what could be learned from patients themselves long tended to keep attention centered on nursing procedures and on management of the patient floors. It

also tended to reinforce the separateness of nursing from the other professions. The very efforts of nurses, particularly through research, to define their functions and role often led many persons in the other health professions to believe that they were only seeking to advance their own interests.

The new swing to concentrating attention on the patient permits easier and more spontaneous contacts with the various other persons who participate in his treatment. To the degree that nurses view themselves not as medicine or treatment or head nurses but as representatives of the patient's interests, they feel more free to seek closer relationships with physicians and members of all the related groups. They discover that the patient himself provides a common meeting ground for every kind of therapist who is truly patient-centered, and that that very quality of centeredness fosters the development of mutual recognition, respect, and support.

Recent as is this trend from emphasis on nursing to emphasis on patient care, results of consequence begin to be visible. Articles of a different tenor are appearing in increasing numbers in the nursing journals. Nurses who have developed real competence in the more comprehensive aspects of patient care are in great demand to fill positions where they will exercise considerable influence. Physicians of the patient-centered kind are so gratified by this larger and more professional attitude that they are moving forward to offer their assistance, and to work with such nurses in something approaching a partnership. Social scientists, from whom the nursing profession has already had extensive help in teaching, research, and as staff members of nursing organizations and consultants in many new undertakings, are also moving forward to assist in this trend. For the very reason that their primary interest lies in the psychosocial and cultural determinants of human behavior, social scientists are beginning to see that as they gain larger acquaintance with the general hospital and the requirements of total patient care, their interest may have appreciable direct usefulness.

Because nursing is evolving a role in which professional attitudes and breadth of outlook rather than technical skills assume

progressive importance, larger and more immediate changes can perhaps be made in the physical and social environment of the patient areas of the hospital than would have appeared possible even a decade ago. If this goal is to be achieved, however, nurses will still be urgently in need of two kinds of assistance. First, they should be able to call upon consultation, at least, from social workers, occupational and physical therapists, dietitians, chaplains, and social scientists. Second, and even more important, they should have the support and trust of hospital administrators and doctors.

Nurses are in the ambiguous if not difficult position of working under the jurisdiction of both these groups. Since physicians have final responsibility for patient care, and hospital administrators determine many policies and control finances, justifiable aspirations of the nursing service can easily be overlooked or minimized. In spite of the growing indications of progress, nurses have generally been conditioned and are still conditioned to avoid conflict. As a consequence, they may not have the aggressiveness frequently necessary in a large institution even to make representation of patients' interests. Many sincere efforts have been stillborn because the director of the hospital forgot to show any interest, or because perhaps one physician spoke critically of the effort and his criticism became rationalized as opposition from "the doctors."

On the other hand, persons who have had the opportunity to see what nurses have accomplished in changing the climate of a ward if they had the active support of one physician or one member of the administrator's office, believe that herein lies an essential key to how change can be achieved. "The most important thing a director can give is confidence," said Theresa Helburn after her forty years of experience as a theater director. Nursing needs perhaps more than anything else at present the express confidence of all hospital administrators and particularly all physicians who are patient-centered, if it is to succeed in being the major agent for maintaining a socially therapeutic environment in those parts of the hospital where patients spend most of their time.

APPENDICES

Appendix 1

THE "CULTURE OF ILLNESS" IN THE HOME VERSUS THE HOSPITAL

The following excerpt is taken from the perceptive address made by Dr. Leo Simmons at the Annual Meeting of the National League of Nursing Education in 1951. The address was published under the title "The Manipulation of Human Resources in Nursing Care" in the *Fifty-Fifth Annual Report of the National League of Nursing Education.* The excerpt appears on pages 328 to 330.

. . . When it comes to illness, there is a great difference in whether the patient goes home to *his* bed or to a hospital into one of *our* beds. The prescribed medical care may be about the same, but there is a tremendous amount of contrast in the interpersonal relationships.

In our American traditions, a man's home is still his fortress, if not his castle, and even though he becomes a "patient" there, he still retains a proprietary sense of his rights and privileges, and he can insist on being treated on his own terms. Moreover, he generally is reinforced in these feelings by friends and family sentiments which accord to him special concessions, because of his illness. There is among us in family and community life an attitude and a set of customs which appropriately can be called "the culture of illness" in the home.

Now the significant contrast is that the sick man's personal prerogatives undergo very important changes when he is moved out of *his* home and *his* bed and into *our* hospital and one of *our* beds. Whereas at home he retained his work-a-day apparel and accoutrements which provided a sense of competence and self-sufficiency, in the hospital all this equipage and the associated

symbols of power are stripped from him and locked away out of his sight and reach—or even sent back home. Now, to the degree that such things are said to "make the man," not much, really, can be said for the patient in our routine institutionalized outfits.

Moreover, at home physical surroundings were familiar and afforded a sense of security. Home is a haven the world over, we are told, even if it is no more than the place where a man routinely hangs his hat. But the hospital surroundings are very different, strange, and disquieting to say the least, and this includes some of the smells and the nuisance noises as well as the unfamiliar routines. Indeed, the contrast between the physical environment of the home and of the hospital may be regarded even by the physician as sufficiently upsetting to justify some prescribed sedation, just to numb the patient's sensitivity to the disturbing ward practice, especially at night. Added to this is the general impression which a patient can easily acquire that something very serious is about to take place to call for such an important move.

The social environment changes even more radically. People in white begin now really to rule this man's life, and, not infrequently, they appear to hold his life, if not his death, in their hands. The resident physician can become nearly all powerful (or at least *next* to God); and a little head nurse is without doubt the boss of the place in all but the major matters of life and death.

Even aides and orderlies find themselves in position to grant or to withhold what are really small but what now become, to the patient, very precious favors. And, incidentally, we know that some of the spoils of the siege, in the form of tips and a certain amount of deep personal gratitude, quite frequently go to these lowly aides and attendants. It was surprising to me to note how often these little people are mentioned in letters of gratitude which patients send to the hospital administrators. It can be observed sometimes, and it is not infrequently reported to me by patients, that the flow of human warmth between these little laymen and themselves can surpass that which is felt between the patients and the professionals. As one patient put it, "Head nurse So-and-So is really a colonel at heart, and, as for Dr. ———,

for all his courtesy, when it comes to treatment he is a cold potato." Perhaps this implies no more than the thought that the *culture of illness* is different in the home and the hospital, and that the little nonprofessionals in the latter are in a position to manifest more of the homely traits. This is not to imply, however, that the milk of human kindness flows not freely between professionals and their patients. It is merely that the above-described contrast occasionally jolts the naive spectator. No doubt, with adequate knowledge and insight, the apparent discrepancy will disappear.

The fact remains, however, for even the casual observer to see, that the social characteristics of the hospital (or its culture) tend to stimulate a considerable amount of dread and apprehension on the part of the patient. And there is no question but that some of the very necessary treatments can come to appear to an ill-prepared and apprehensive person as not far short of unfriendly intent and even torture. However well-meaning the staff, and however justifiable the treatment, if a patient worries about explanations which are never given or fails to understand them if they are, if he is full of misgivings and emotional sets against the procedure, and if he feels that he has been tricked or coerced into something more severe than was necessary, then stressful interpersonal relationships have already complicated the situation, and they may, not insignificantly, affect the course of treatment. It has been my experience that any impartial observer can easily recognize a considerable amount of fear and sometimes panic on almost any one of our typical hospital wards, and that much of this could be avoided or softened through the skillful manipulation of available human resources in therapy. And, as stated before, it is my opinion that much of this anxiety is stimulated by the contrasting "cultures of illness" as manifested in home and hospital.

Symbols of the contrast between independence and a feeling of security at home, and dependence and an air of apprehension in the hospital are easy to spot in prevailing practice and especially in our conventional terminology. In the hospital, for instance, the patient rings the bell and waits prayerfully for nurse or doctor, while at home the nurse and the doctor ring the bell and wait

patiently on the threshold. In the hospital the patient is "admitted" and "discharged" and all the relatives are visitors, if you please, while at home the physician is "on call" and can be "changed," and even the nurse is a visitor. "Orders" are written in the hospital, while "prescriptions" are expected in the home. In the hospital, patients are "pushed" around from place to place with not much time for explanation, but at home they are "led" about with both explanations and persuasions. In the hospital a nurse is "assigned" to the patient, while at home she may be "hired" and "fired." In the home, nurses come and go while the patient stays on, but in the hospital it is just the reverse, with the nurse holding tenure. Perhaps for many people there are few moves in life which are more ominous than the move from the home to the hospital.

An impartial observer of typical ward practice and patient responses to it may have cause to marvel at how docile and submissive our brave, bold, liberty-loving American citizens become when they find themselves admitted to our hospitals and even into some of our clinics. In a sense, it would appear that we Americans are once adults and twice childlike—when we grow old and when we enter a hospital.

Perhaps not insignificant also is the fact that, while the patient was at home, he was obviously the sickest person in the family circle and thus deserving of special attention and consideration. Now that he is in the hospital, especially if on a ward floor, there are others who appear to be more seriously ill than he, and they seem to require much more special attention. And although misery may love company, it can be cold comfort to be told pointedly that some of these other patients are "much worse off" and ever "so much better behaved and cooperative."

This contrasting symbolic terminology could be carried on into further detail, but its purpose here is only to emphasize the principal point that the challenge of comprehensive nursing care needs to be emphasized in the hospital setting even more than in the home, because here the social and cultural forces which call for it are weaker and it can be easily overlooked or forgotten more or less. It can be observed on almost any ward that a staff nurse is

able to rely upon much more autocratic and bureaucratic methods of patient management than she could safely get by with in the home. Indeed, it is possible for her to ignore or to ride roughshod over a patient's apprehensions and resentments and yet be rated as a very efficient nurse who "gets things done." She can become an outstanding head nurse without ever approaching the bedside of a patient except on rounds with the physicians, and she may be all but unaware of what is going on in the heads and in the hearts of the diseased and distressed bodies in her charge. Sometimes it is easy to conclude that "headaches" and "heartaches" in our modern hospitals now surpass the physical pains, thanks perhaps to the almost miraculous "pain-killers." This accounts substantially, in my mind, for the increasing importance of the cultivation of improved interpersonal relationships in the very highly controlled hospital environment. And this is precisely because of the pronounced contrast in the "culture of illness" as we learn it in our homes and experience it as patients in our hospitals.

Appendix 2

NURSES' PERCEPTIONS OF THINGS AND PEOPLE AS SOURCES OF COMFORT DURING HOSPITALIZATION

Health personnel who have had their clinical experience in hospitals and continue to work in them have generally become so conditioned to these institutions as they are that little attention is given to the desirability of appreciable changes in the physical plant and in ways of using existing resources. Suggested changes may, in fact, meet with appreciable resistance. As an introduction, therefore, to discussion of whether the physical and social environment of the hospital might be altered to provide greater psychological support to the sick, some 65 nurses who were members of a three-week workshop being conducted by the writer in 1958 at the University of Minnesota were asked to consider what *they personally* would want if they were ill.

According to the problem presented them, their physician had told them that they would need to spend about three weeks in X hospital, which he had spoken of as being a fine and "very permissive" institution. They were asked to note the physician's supposed diagnosis, had he been able to make one, and then describe what they would wish to take with them to the hospital that would be most likely to provide comfort and satisfaction. In the next problem it was assumed that they were faced with a hospitalization of at least two months. They were asked to consider what, besides good medical and nursing attention, they would wish *the hospital* to provide for their comfort.

The reports from this group, most of whom had had extensive experience in teaching, supervisory, or administrative positions are illuminating. Understandably those who wrote the most penetrating papers were generally persons who had recently

undergone extended hospitalization, or whose husbands or children had been in the hospital. They were still sensitized to the experience. It may be assumed that many of the other nurses had been so long removed from direct contact with patients that they had difficulty in feeling even vicariously what it was like to be a patient. The papers frequently gave the impression, moreover, that most nurses had not attempted to put themselves into the sick role as a basis for deciding what they would need. The psychological difficulty of making a self-diagnosis of sickness, however, must not be overlooked. One writer perceptively remarked, "The diagnosis I can tolerate in reference to myself I find must be medical. Any surgical or accidental mutilation, at least in imagination, is so disturbing that I can think of nothing comforting or satisfying to take with me." It was our impression that as the workshop continued into the second and third weeks, the discussions deepened appreciation of the character and nature of the sick role and served to resensitize the group to a broader gamut of patient needs.

Be that as it may, the papers clearly reflected one thing. Most nurses wanted for themselves a physical or social environment such as the majority of hospitals provide only in part. Yet their demands as viewed by a lay person were on the whole relatively modest and circumscribed in scope. They were asking chiefly for more continuity to the pattern of life including its amenities to which they were accustomed. Perhaps the most interesting paper in its insistence upon amenities as a therapeutic instrumentality came from a male psychiatric nurse, now an assistant chief nurse in a Veterans Administration neuropsychiatric hospital. Because his entire professional life has been spent in such hospitals, he diagnosed himself as a psychotic patient. He then proceeded to list in minute detail the many things (as well as frequent visits from his wife and children) with which he felt the need of being provided. It is doubtful whether any psychiatric hospital, even those that have attempted to restore the amenities of the era of Moral Treatment,[1] gives attention to or permits such

[1] Greenblatt, Milton, Richard H. York, and Esther Lucile Brown, *From Custodial to Therapeutic Patient Care in Mental Hospitals.* Russell Sage Foundation, New York, 1955, pp. 407–412.

extensive use of things. This nurse was convinced that he would not use the articles destructively, but that they would provide a therapeutic link between him and his former life. The intriguing question arises of whether he was unable to cast himself in the role of a possibly destructive patient, or whether psychiatric hospitals continue to be overcautious in what they permit patients to use.

PROPOSED SOURCES OF COMFORT DURING HOSPITALIZATION

Let us begin with the things that these nurses planned to take to the hospital which had been characterized as permissive in atmosphere. Although annotations about things are probably the least interesting portions of the papers written, they furnish clues about what one fairly homogeneous group of persons feel essential for their comfort and satisfaction. In examining these lists two facts should be kept in mind. With one exception, the writers were women and the things noted clearly reflect feminine interests. Secondly, they were middle-class women with the value system of the middle class, often of the upper-middle class. Because they had been asked to concern themselves only with *their* personal desires, they made no comments about the degree to which the things selected by them would meet the needs of persons who had had a very different life experience. Certainly any hospital with a wide distribution of social classes among its patients, which is interested in utilizing the physical and social environment for psychological support of patients, cannot safely rely upon a middle-class value system as its exclusive guide.

Four items were mentioned with the greatest frequency: reading material, radios, lingerie and lounging clothes, and toilet articles. Reading material was defined almost exclusively as books, although one nurse wanted to take the past twelve issues of her *Atlantic Monthly* in order to "catch up." It was generally assumed that magazines, like newspapers, would be available in the hospital. (Several persons who did not make that assumption wanted the hospital to provide them.) Particularly interesting was the specificity about the books that would be selected.

Several writers noted particular authors or titles of fiction; several spoke of study books they intended to take in order to use this time "to improve themselves." The choices tended to be on the heavy side, although one or two nurses mentioned including lighter fare, lest they should find themselves unable to do sustained reading. The Bible or a prayer book, sometimes accompanied by Rosary beads, was often named. Liebman's *Peace of Mind* seemed indispensable to one nurse. The implications of the comments of another were perhaps reflected in several of the book selections. "In particular I would take a book that discussed 'inward peace' or a religious book as preparation for surgery. Even though I am a nurse and know all the procedures, I have had the experience of being apprehensive about anesthesia and felt that presurgery was my period of greatest stress."

Second to books, a small radio would accompany many of the nurses, although one definitely did not want a radio in her room. Instead, she wanted the hospital to provide a piano in a room where she would not disturb other patients, that she could use for playing and singing. Television sets and record players were occasionally mentioned. More often, however, the hospital was expected to furnish them. Some of the nurses hoped to find television in the solarium or lounge; but as frequently they wanted music played only in special rooms where they would not be disturbed if they had visitors or wished to be quiet.

Bed and lounging clothes received much attention. They were clearly viewed as essential for "preserving one's personal identity." Daintiness and attractiveness were often emphasized, if only through references to *shuddering* at the clothing furnished by hospitals. It was in connection with personal toilet articles, however, that luxury received major attention: the finest dusting powder, eau de cologne, soaps, lotions. A few nurses even remarked sharply that they would take their own soap and kleenex because they did not like the quality used by the hospital. An occasional nurse, besides the nuns in the group, stated that personal things were unimportant. For most of these middle-class women, however, individualized clothes and toilet articles had long been indispensable props to living, and they knew they needed the continued use of such props during their hospitalization.

Next, numerically, were writing materials and hand work. Some spoke of the importance of maintaining contacts with their customary life through writing letters; two or three wanted to try a story, a poem, or a fragment of a diary. Sewing, needlepoint, crocheting, and particularly knitting were all noted with frequent comments. A mother wanted to mend some of her children's clothes "as a means of relieving her guilt feelings" about leaving the children to be cared for by others. One nurse commented that it would take the entire bottom drawer of the hospital dresser for the afghan that she looked forward to finishing during the three weeks. Another had packed in her suitcase the material and pattern for making a quilt. Still another nurse, who had planned for herself four projects that would provide a busy and rewarding sojourn (apparently on the assumption that she would not feel at all ill), proposed to take her sewing machine in order to "make more of those fancy little cocktail aprons. My friends enjoy them and I love to make them!" In connection with knitting, someone remarked perceptively, "I would include my knitting with the hope that I would feel like reading instead; but there are times when no other activity is so satisfactory."

Selections mentioned generally by only one or two persons reflect the gamut of interests within the group that were viewed as capable of providing comfort: drawing materials, watercolors, a projector or handviewer and camera slides, globe, "a nice piece of hard, dark wood with good grain for carving," and "fly tying equipment in order to work on new patterns in flies." Also mentioned were the photographs of husband and children, the charcoal sketch of St. Francis, a coffee percolator, powdered coffee, a chess set for playing with other patients and visitors, and a deck of cards for solitaire that "requires no thought and helps to shut out distractions." One of the nuns hoped that she would feel free to "decorate" her room with a picture or a crucifix, while another nurse planned to establish a pleasant environment, conducive to relaxation, that would help her "psychological adjustment to the hospital." For this purpose she was prepared to take scatter rugs, pillows, pictures, cigarettes and ashtrays, a table clock and a reading lamp.

Persons Who Would Accompany Nurse-Patients to the Hospital

An attempt had been made in the assignment through characterizing the hospital as *very permissive* for nurses to feel free, if they wished, to have persons, or even animals, accompany them. The question "What would you take with you?" did, however, suggest things unless they had seen something like the Swiss Air Lines advertisement. "What would you take with you on your second trip to Europe? 1. The family, of course. 2.————." Literal interpretation of *what* may have been the reason for the relatively infrequent references to persons, other than as visitors who were usually considered only in a generic way. Failure to work into the sick role, however, perhaps accounted for not placing more reliance upon the support that relatives and close friends might provide.

Inability because of their own conditioning to imagine a hospital free enough to admit animals, for example, was possibly also a factor. At least one nurse later testified to the fact that her dog was her closest friend. But the only person who so much as mentioned an animal was a nun who cast herself in the role of Jackie, an eight-year old boy. She had him say, wistfully, "I hope my mommy can bring my goldfish and my two mud turtles and my two parakeets, because they need lots of love and just the right kind of food and nobody else knows how to give it to them." This was an appropriate remark because acceptance of small animals, at least, has been won, even if slowly and with difficulty, in the pediatric service of many hospitals.

It was also appropriate, although still surprising, for Jackie to talk about having his mother stay with him in the hospital and having his little brother come as he got better to play with him.

> Dr. Jackson says I have rheumatic fever because my legs ache and my joints are all swollen up and I hurt all over, but I guess I hurt worst of all because I am scared of hospitals. Maybe it's because my Uncle Jack died in one, and because I don't know anybody there. Maybe they won't even let my mommy stay with me and maybe I'll have to have a lot of "shots" . . . I wish they would let my mommy stay with me until I can get acquainted a little, and then let her come

whenever she gets a chance or when I need her most. . . . I hope the doctors and nurses like my mommy and daddy and make them feel welcome when they come. . . . Now since I have to be here another month, Jimmy, my little brother, can come to see me for half an hour every other day because I was so lonesome for him. And next week we are going to have a birthday party for me when I'll be nine years old.

A few nurses specifically mentioned taking their husbands or their children or both to the hospital with them: one nurse definitely wanted her fiancé to go with her. She made much of wanting him also to be permitted to have the evening meal with her as he did customarily. If she had children, said she, she would want them to be able to visit her. Since she had none, she wanted the privilege of seeing her nieces and nephews. One paper revealed how its writer had shifted her emphasis during the writing process. She had listed nine relatively unimportant items, including soap and kleenex. The tenth item read "my very best friend." She later commented that suddenly it had occurred to her that it was a friend that she wanted. Having discovered that fact, she could think of nothing to add to the list.

A married nurse with children gave her entire attention to the importance of family relationships. Because of the inflexible nature of the hospital social system and hence the small likelihood that the family could be maintained as an integral group psychologically during the hospitalization, said she, she proposed that a nurse be given the role of intermediary between the patient in the hospital and the rest of the family in its home setting. She wrote as follows:

If it were necessary for me to spend three weeks in a hospital, I should not worry about my physical needs. I would pack my suitcase with the usual items including reading material; but if I were allowed to bring the thing which would give me the most satisfaction, I would bring my family.

Divorcing a patient from his family causes psychological disturbances which are detrimental to both patient and family, and are, I believe, a definite factor in the recovery of the patient.

In our present hospital setup it would be impossible to bring my family. So my next choice would be a professional nurse who would

act as interpreter between myself, my family, and physicians. She would not administer to my physical needs—technicians can do that —but she would take care of my psychological needs, worries, and so on. She would taxi back and forth between hospital and home, explaining, understanding, reassuring. She would help us make the necessary adjustments.

Provision for Visitors

Several nurses specifically wanted the hospital to make flexible provision for visitors, whether members of the family or friends. Most often they wanted to receive visitors when *they* wished and when it was most convenient for persons to come. Those writers who touched upon this subject at all showed marked independence of judgment and great definiteness about the arrangements they desired made. One nurse did not wish "duty" visits. With unrestricted visiting she would feel, said she, that her friends wanted to see her when they came, and that the conversation would be less likely to focus upon the patient's medical condition. A second nurse noted that restricted visiting hours "compel visitors to stay longer than is desirable or necessary in order to take advantage of the time allotted for this purpose." Hence, she wanted more visitors for shorter periods. Still another writer described the experience she had had of friends, with few common interests, "descending upon me as a group. It was difficult for me to find a topic of conversation which was of mutual interest. Couldn't the hospital let me enjoy these visits over a longer span of time?"

At least a half-dozen persons noted that they wished positive assistance from the hospital in controlling unwanted visitors.[1] Among unwanted visitors in the imaginary situation presented by one writer was "the evangelist who came and prayed over me last week. It infuriated me, but one must be polite. Perhaps if I buzzed twice the nurse would know I wanted her to ask my visitor to leave." Another writer asked whether the Grey Ladies

[1] Two or three persons also wanted the hospital to exercise control over the flowers that arrived. A rosebud on the breakfast tray or a fresh bunch of gay small flowers would please them. No reference was made to wishing plants or large bouquets in the room.

might not be given responsibility for trying to see that visitors were not nuisances.

Several comments appeared about the desirability of pleasant reception rooms for receiving visitors. Two nurses felt that they could not comfortably have guests while they were in bed or in the nursing care unit. They wished a cheerful living-room with privacy. One nurse who had diagnosed her illness as active tuberculosis hoped that she would find some type of visiting rooms where her family, including the children, could visit with her regularly and yet be protected from her infection. She hoped that gowns and masks would not need to be worn. She asked whether a glass partition might be a solution. She hoped that the staff would have enough confidence in the protective measures provided to permit visiting to occur without further restrictions and that there would be no loudspeakers or buzzers to announce that visiting hours were over.

WHAT THE HOSPITAL WAS TO PROVIDE

The comforts and social amenities to which these nurses were accustomed dictated much of what they wanted the hospital to provide. Over and again, for example, they requested that telephones be more readily available, preferably in the rooms; that newspapers be promptly delivered in the morning if not in the evening; that traveling carts with magazines, toilet articles, and other items for sale make frequent rounds; that a traveling beauty parlor permit weekly shampoos and waves; that a circulating library appear often. One writer suggested that a trained librarian, who would have "both understanding of and perceptiveness to my needs," be in charge of the circulating library.

Unlike the nurse who intended to bring furnishings to make her room pleasant, most of the group obviously expected the hospital to offer cheerful, well-furnished private rooms with attached bathrooms. Some of the memoranda described these furnishings, including the use of color in the room and the pictures on the walls. Some mentioned wanting sunshine, others a view of trees or flowers. The sentences quoted below probably recapitulate the

general attitude of most of the nurses except for the nuns who had been conditioned to the relative unimportance of things: "Comfortable, pleasant furnishings within my room and the unit would be desirable. I would not feel so set apart and different if my environment were more homelike and warm. Though I do not personally feel that the environment is the principal factor in motivating people toward health, I do consider it to be a contributory factor."

The importance of attractively served and more individualized food, of occasionally having someone with whom to eat, and of regular dining-rooms for ambulatory patients received frequent reference: "I hope that I will find a food service in this hospital," wrote one person, "that is directed by a creative, imaginative dietitian who enjoys good food herself. If sometimes there is a tidbit I long for, I hope I can get it without feeling guilty for the trouble I have caused." Freedom to have a snack between meals or in the evening without concern about disturbing someone's schedule was reiterated by others. "Why can't supper be served at six o'clock instead of five?" was the query of another writer. "I'm starved by bed time! I should like more salads too, greater choice of foods, *hot* foods, *hot* coffee. Food is so important!" Selective menus were requested by several writers.

"It would be pleasant and satisfying to have a congenial companion, another patient, a nurse, or someone else, eat one meal each day with me. It would be helpful to feel free occasionally to have friends or family members." Much the same idea was suggested by a second writer. "I wonder why meals are served in the privacy of a patient's room. Mealtime would be more enjoyable if I didn't have to eat alone. Why couldn't the hospital let me dine with other patients in the solarium?" Another asked *why* medical-surgical floors couldn't have dining-rooms for persons who were ambulatory.

Still another writer considered the subject of food service within a supporting social environment so important that she devoted her entire attention to it. "I have always disliked the way meals are served to patients. The crowded trays, the lukewarm food, the huge portions, the wilted salads, and so on are

not conducive to enjoyable eating." She recommended well-appointed dining-rooms with linen cloths and napkins, and waitresses. "I have always disliked eating alone," she continued, "and a dining-room would provide company. It would be a social situation that the patient cannot get from walking up and down the corridors or even from sitting in a reading-room." Although she admitted that it might perhaps be unreasonable, she wanted to be able to invite a guest or two occasionally. "This would give me the illusion for a little while at least that I am still part of the outside world. As far as I am concerned, it would create a social situation that would be more therapeutic than medication or treatment."

Aside from pleasant private rooms and a far more flexible food service, including areas for dining, a limited number of other physical facilities were occasionally mentioned. A quiet reading-room with periodicals and books would be welcome. So would a music room but its purpose differed according to the interest of the writer. Some thought of it as the appropriate place for the television set, others wanted it to contain a fine phonograph and records, the nurse who wished to play and sing thought it should have a piano for the use of patients. A solarium with a view seemed indispensable to some persons in order to get away from their rooms, as a place for talking with other patients and friends, and to one nurse as a spot from which she could observe the activities of persons below her, thus helping her to feel that she "was still part of activity outside the hospital." A coffee shop had a few adherents because it resembled normal community life or provided opportunity for talking with other persons.

Provision for religious services was noted but less often than one might expect. Opportunity to attend movies or other entertainment within the hospital was scarcely mentioned. Were these nurses unacquainted with the availability of such resources, particularly in the federal general hospitals, to say nothing of psychiatric and other long-term hospitals? Or did they believe that during even a two months' hospitalization they would not experience an emphatic need for such aids? Interestingly, the desirability of quiet rather than of being part of social situations appeared to be the chief focus of emphasis. The hustle and bustle

of the average hospital unit and the sharp clicking of visitors' high heels on the corridor floors seemed so distracting if not exhausting that one of their chief desires was for quietness. This is the explanation for the amusing postscript that one nurse added to the list of things to be taken to the hospital, "Oh, I think I'll throw in a set of ear plugs in case the noise out in the corridor becomes unbearable."

On the other hand, occupational therapy facilities were vigorously requested and even recreation of an unspecified kind. The phrase used by one nurse, "facilities for choosing some kind of creative work," sums up the expressed need of a half-dozen persons. A handicraft teacher provided with supplies would teach one nurse-patient to make jewelry, weave, or "do something different" with her hands; would let another try using a paint brush to discover whether she had any artistic ability. "With an active, enthusiastic, and creative occupational staff," said one of the writers, "I might be able to discover latent or undeveloped talents and gain satisfactions in being creative. I might even be able to contribute to the community life of the unit."

In contrast to exploration of the new and the untried, emphasis upon assistance in keeping constructively busy and in working also received attention. "I have to have something to keep me busy, where I can see gradual progress being made; I must have a purpose in making the article and a future use for it." A quiet place in which to work with a minimum number of interruptions during work periods and those planned for, was demanded by another writer. "I think health personnel," she added, "have not adequately considered the significance of work. I believe many hospitalized people, particularly those with long-term illnesses, could benefit from work activities."

To these nurses who had generally been hard-working, educationally ambitious, and often overwhelmed with professional responsibilities, there was recognition of the therapeutic importance of recreation but difficulty even in using the term, to say nothing of defining it as play.[1] Perhaps this fact accounts for the

[1] See *Identity and Interpersonal Competence*, by Nelson M. Foote and Leonard S. Cottrell, Jr. (University of Chicago Press, 1955, pp. 144–157, 167–169), for a social psychological analysis of recreation and its importance to the growth and development of the individual and of the family.

paucity of references to motion pictures or other overtly recreational programs. It is evident from the memoranda that occupational therapy often furnished a means of finding play satisfaction. Informal groups and clubs within the hospital were also seen by two or three persons as providing another means. "Why doesn't the hospital staff promote informal gatherings of patients so we could share experiences, ideas, and different bits of information? Wouldn't it be fun, and interesting, too, to know more about our fellow patients?" However, the rationale for the music, poetry-reading, book, and bridge clubs mentioned by another writer was that they would give some sense of a "home away from home."

The two references explicitly to recreation as such are particularly interesting. In neither is there specificity about what is included under the term. In both, occupational and recreational therapy are no more sharply differentiated than they are in many hospitals. Again in both the writers speak for patients generally and not exclusively for themselves as they did in listing what they would bring to the hospital. The first excerpt notes that an adequate occupational and recreational staff would permit "certain hours of the day to be planned" with activities to which the writer "could look forward." Then the observations are added, "Recreation would provide excellent balance, as well as provide an atmosphere in which 'socializing' could take place more easily. The entire program might be enhanced by the inclusion of the patients' visitors."

The second excerpt begins with the personal statement that the writer wants recreation that is planned to meet her particular needs. Then she immediately declares that she is disturbed by the fact that "we have so many patients who just lie or sit. When one tries to initiate occupational therapy, one is told that the therapist is not employed merely to entertain patients. For a nurse to find any kind of suitable recreational equipment for patients is next to impossible in most hospitals." Since so many patients are ambulatory, said she, the facilities could be centrally located. "A little room, plus a little equipment, plus a little guidance by a trained person might be a combination that would thoroughly enrich a hospital experience."

Participation in Planning for Care and in Helping Themselves and Others

Many of these nurses were particularly articulate in stating that it would be easier to accept hospitalization if they were consulted and there were cooperative planning and arrangement of the day's schedule. Even the phrasing of several statements indicated how strong were their feelings. "I should like a sense that I have some 'say so' about what I am going to do or what is going to happen—that I still rule my own life." Hospital facilities, wrote another, "would not mean much to me if I were not consulted or considered in plans that concerned me. I would want to keep my independence and not have to conform to hospital rules and regulations completely."

Some of the comments, particularly when read in conjunction with unsolicited statements about physicians and nurses, appeared as indirectly sharp criticisms of existing hospital conditions. Conversely, an occasional comment seemed to indicate that its author had had experience in a hospital where patients were taken at least into junior partnership in a talking, listening, and planning process. Still others probably reflected the current attempt in nursing education to emphasize recognition of patients' psychological needs and the importance of health guidance and rehabilitation.

"The best thing the hospital could provide for me would be flexibility in its routine." This writer referred, as illustration, to her preference for bathing at night, while many patients would prefer some other time. A little personal interest and inquiry, she noted, would establish the facts. One of the greatest boons to a patient's comfort would be "to treat him with more individuality—to make more effort to find out what he does at home and allow him to maintain, as nearly as possible, his normal daily pattern of living."

"I hope the staff in this hospital is sufficiently oriented toward or interested in rehabilitation and all that it embraces to let me have a share in planning for my own eventual recovery [from tuberculosis], to recognize when I do not have the power to move ahead alone and will quietly take the lead, but will just as

quietly step aside when I am once more headed in the right direction—home."

Closely connected with this desire for some degree of self-determination was the interest expressed by a few writers in being given freedom to *do* more for themselves and other patients. Suggestions ranged from recording one's own temperature and intake and filling the hot water bottle to selecting records to be played on the house station at some time during the day. The nurse who had cast herself as a person who had developed diabetes during pregnancy said it would be satisfying to help with the tasks of the floor. "There are many routine jobs that a patient in bed, in a wheel chair or ambulatory could help with. This activity could provide a fine opportunity for getting to know the personnel on their side of the 'sickroom' door." Obviously some concluded they could gain needed support through identification with members of their own profession or through seeing themselves in the customary role of helping sick persons. One of them expressed concern with how busy the floor staff were; and then commented that she would gain much satisfaction if she could help them, and could keep in contact with them and what was going on. Another declared that it would give her her "biggest lift psychologically" if she could feel that she was a little more than a passive receiver and was contributing to the welfare of other people.

The Chaplain as Comforter

To whom would these nurses turn with their troubles—frustrations, anxieties, fears—that could not be relieved by visitors, occupational and recreational therapy, an enriched social environment, and particularly by their own efforts and activities? They had been specifically asked, it will be recalled, to examine what they wished the hospital to provide other than medical and nursing care. This qualification had been introduced expressly to encourage them to consider additional possible resources, because doctors and nurses are frequently "too busy" to give needed attention. They seemed to have difficulty in finding people to whom they might turn, so much difficulty, in fact, that several insisted in writing about what they wanted from these two

groups of staff that have traditionally been the purveyors of patient care.

Obviously, they did not view other patients as any large support. Almost everyone visualized having a private room. One of the religious Sisters cast a vote for roommates, and so did the nurse who diagnosed her problem as prenatal diabetes. Even the latter added, "provided they had diagnoses for a similarly comfortable sojourn in the hospital." Patients were perceived as persons—hopefully interesting—whom one met in pleasant spots around the hospital and with whom one chatted, played cards, or went to "club meetings." We have seen that they were also viewed occasionally as persons from whom one gained indirect help from helping them. No one testified to direct help actually received from another patient, or to having observed or participated in group activities where patients gave indispensable support to each other.

Persons with occupational and recreational skills and one trained librarian were in demand, as has been noted earlier, but primarily because of their skills with things that might produce therapeutic effects. Interestingly, social workers received almost no attention. One writer observed that with a two months' hospitalization "the chaplain and social worker could assist me in making a better adjustment both in the hospital and upon my discharge. Unfortunately, many hospitals at present cannot obtain or afford a qualified social worker." Her last sentence is factually correct, but this particular assignment did not concern itself with what the hospital was able to provide but with what the nurses *wanted* it to provide for them in sickness.

In a particularly perceptive comment another writer indicated that she hoped her physician, nurses, chaplain, and social worker would hold regular group discussions of her needs and how they might be met. Almost no one else mentioned the social worker by name. Had the majority of these nurses never had any personal and intimate contact with social workers? Did they still assume that the social worker's role should be limited to work with economically and socially underprivileged patients? Or have nursing and medical social work, two professions composed largely of women, tended to ignore the importance of each other?

If so, has the reason perhaps lain in the fact that they were both seeking larger recognition within the social system of the hospital which has generally failed to create enough prestige, except for physicians, to "go around" among the several categories of staff? (In Part II of the study as projected the subject of prestige and other psychological rewards, in their importance for improvement of patient care, will be discussed at length.)

A nurse who had had a recent short stay in a hospital reported that as she began to recover she felt "horrible about being there." She felt guilty, embarrassed, and generally uncomfortable. Hence, she decided that she needed to make preparation for the avoidance of another such experience. "The first thing I would like is to have someone who would help me adjust to the hospital. It might be a chaplain who would listen, but better still, I think, a psychologist or psychiatrist who could tell me why I feel the way I do." She also suggested that a member of the nursing service who would listen "might do," provided the nurse was not on staff duty on, or the head nurse of, her floor. She doubted whether she could express her feelings to someone "who might discuss them with others."

The two references to a social worker, and one to a psychologist, psychiatrist, or a nurse not connected with the case exhaust the suggestions concerning persons to whom to turn, except for the chaplain. Many of the writers revealed that aside from the medical and nursing professions it was the chaplain, exclusively, to whom they would look for support. Clearly for some of the nurses he would meet a spiritual need that was very important. The nuns wanted to participate in daily Mass in a chapel, even from their beds. If that were not possible, they wanted to hear Mass said in their rooms. They wanted a frequent confessor and spiritual adviser. Some of the lay nurses, Protestant as well as Catholic, explicitly stated the need of spiritual help. For a larger number who mentioned the chaplain, however, there was no such indication. They seemed to be asking for someone who would sit with them at not infrequent intervals, who would listen to their troubles, express genuine interest, and guard the conversation as confidential. Many of them appeared unable to think of anyone else who could take this role or take it as well as the chaplain.

Appendix 3

Rx: ADMIT PARENTS AT ALL TIMES

by Miriam Hemmendinger[1]

This is an account of a hospital and a child. The child is mine, and though I am as fatuous as the next mother, I cannot claim he is an unusual child. The unusual part of this narrative is the hospital. I believe it is so singular, its philosophy and techniques have so many implications, that I feel impelled to tell about it the only way I can—through our experiences there when our youngest child developed polio.

Hundreds of children come down with polio every year and countless articles appear about individual cases. Mark's case, a combination of bulbar and spinal, was comparatively mild and simple; and there would be absolutely no reason to dwell upon it were it not for the way he was handled by a hospital which seems to feel that medicine stands on no loftier plane than the patient, and that the reduction of terror demands almost as much attention as the reduction of a fracture.

Mark is seven; a lively uncomplicated seven, though prior to this illness very shy with strangers. He suddenly became ill late on a Saturday night, with some of the traditional polio symptoms: fever, stiff neck, and violent headache. By Sunday afternoon he was no better, and overcoming my ostrich-like impulse to call it a "virus," I took him to our family doctor. He promptly suggested hospitalization for definite diagnosis.

The hospital was the Hunterdon Medical Center, just outside Flemington, New Jersey. This was a new hospital then in its second year of operation; an experiment in bringing to rural

[1] Hemmendinger, Miriam, "Rx: Admit Parents at All Times," *Child Study*, vol. 34, Winter, 1956–1957, pp. 3–10. Reprinted by permission of Child Study Association of America.

areas the same broad range of medical services as are offered in a large city. We knew a little about Hunterdon as Mark had had his tonsils removed there the previous winter. I had been impressed with the hospital then, particularly with the provisions made for parents to spend the night with their children, and with the careful pre- and post-operative care. However, hospital is a horrid word to most parents. We're grateful for these institutions but we dread them for ourselves and, doubly, for our children. The mixture of suffering and fear, the curious withdrawn attitude of the staffs, and false standard of the "stiff upper lip," the lack of real communication all make up the average hospital atmosphere. The sicker a child becomes, the harder it is to relinquish him to those skilled, devastatingly efficient and impersonal hands. Add to this the hated word "polio," and you can imagine my emotions as I put Mark in the car and headed for Flemington, maintaining a calm exterior only because I was too numb to maintain anything else.

As we approached our destination, I explained to Mark that he might have polio and that going to the hospital was the only way to find out. Our family has never talked of this disease as different from any other serious illness, so Mark was not particularly impressed by the word polio, his only anxiety being, "How will they find out? What will they do?" I replied as honestly as I could, explaining about the spinal tap, which would hurt like an injection. He was naturally apprehensive but trusted my explanation. I was also apprehensive, dreading not only the diagnosis but the shock of hospitalization, the treatment and all that might lie ahead. Mark, lying quietly beside me in the car, seemed suddenly very small and unprepared for pain.

The Admitting Office

When we walked into the admitting office (Mark limping stiffly but insisting he could walk, and I too intent on fooling myself to argue) the lady in charge suggested that we go right up to pediatrics and went along with us to record the routine admitting particulars. As she stood chatting with Mark while we waited for the elevator, I vividly recalled another hospital where

I had had to wait one hour with my older boy who had a fever of 104°, before he was admitted and escorted to his room.

Pediatrics, like all other floors at Hunterdon, is a cheerful, non-hospital-like wing which, either by virtue of its newness or some other magic, lacks the usual hospital aroma composed of equal parts of disinfectant, ether and floor polish. The interior walls are finished in natural wood, and all rooms boast large "picture" windows with gay draperies. The isolation room was warm with yellow drapes and a painted wall mural, and Mark was settled there by a friendly nurse. The door was left open and we could see and hear the children across the hall, and watch two lively boys "hot-rodding" in wheel chairs up and down the hall.

Remember, this was a Sunday afternoon when only a skeleton staff is on duty at any hospital. The resident intern who came in was not the one assigned to pediatrics, and from his conversation with a colleague, was clearly being rushed off his feet with emergency accident cases. However, he managed to keep any disturbing sensation of urgency from Mark, patiently taking time with each step. When Mark asked worriedly, "When are you going to do the spinal tap?" the doctor raised his eyebrows at me and replied, "Well, if you know about it, we'd better do it right away, then you won't have to think about it." While he waited for the equipment he explained what he was going to do and how Mark was to lie, impressing upon him, without any threats, the need to lie still. He neither mitigated the fact that it would hurt, nor dwelt upon it. Then they went ahead as fast as possible. Mark howled but he managed to lie still and listen to our encouragement between yells. It was a hard few minutes, but certainly not devastating, and I noted how nurse and intern were quick with praise and no one uselessly urged Mark not to cry. The need and right to cry are respected at this hospital.

"Direct and Honest"

The usual blood tests followed the spinal puncture, and then we could comfort Mark by promising "that's all for today." Everyone had been so direct and honest, he cheered up immediately and followed the rest of the procedures without anxiety.

By this time Dr. H., chief of pediatrics, had arrived from his home, and a technician had been called in to analyze the spinal fluid. It seemed an amazingly short time before Dr. H. reported that Mark probably had polio, although meningitis or encephalitis were still possibilities. (With that "choice" we could only feel fortunate when it was definitely established as polio the next day.) "Would you like to stay with your son?" asked Dr. H. Would I! Nevertheless, I hesitated. Did this mean that I would be isolated, too, for the duration of the contagious period? I had a husband and two children at home to consider. No, indeed; I was told I could come and go as I wished. I had only to conform to the same isolation techniques observed by the staff: the sterile gown to be worn when in the room, the careful washing of hands. I could be with my child, minister to him, comfort him. And comfort myself!

When I expressed my relief and surprise, Dr. H. remarked that although little is known about polio, all experience points to the fact that doctors and nurses caring for polio patients do not carry the disease home to their families. If hospital staffs can exercise the necessary precautions, which are essentially ones of cleanliness, so can parents. I might add here that we obtained Gamma Globulin serum for our other children and two neighbor children, but neither my husband nor I bothered to have the injections, although we were with Mark constantly. Perhaps the most contagious period is over by the time polio is diagnosed.

Recognizing Emotional Factors

Hunterdon's attitude toward polio is not one composed purely of calm common sense. This hospital recognizes the emotional factors in children's illnesses, particularly in the case of hospitalization. They believe that mothers and fathers can play a large role in the recovery of a child. Fear is reduced if a parent is on hand, and the awful feeling of being deserted, and even sometimes (in the child's imagination) punished, is practically nonexistent at Hunterdon.

Think of what this means not only to the youngster but to his mother and father. I have seen anguished parents standing help-

less as their little ones were borne off screaming to a ward marked "Isolation." I have heard doctors tell mothers not to visit their children because the strain of leave-taking at the end of visiting hours would be too devastating for the child. But at Hunterdon *any hour is visiting hour for parents*, and they are encouraged to stay if they can, particularly in the beginning. There is a stack of roll-away beds ready to place in any room, and as there are no more than two patient beds to a room, and four cribs to a nursery, there's ample space.

How do the nurses feel about this parental invasion of their sanctum? Some of them confided to me that they would never have believed that the presence of a parent could make so much positive difference to a hospitalized child. Most of these nurses had trained in hospitals where the very opposite attitude was prevalent and where parents were considered an emotional burden to be endured as briefly as possible. Now they discovered that with some few exceptions parents were really a help. "If anyone had told me I'd *want* mothers around!" one nurse said with humorous astonishment.

As the concept of the value of parent attendance is basic to the hospital's philosophy, there is no charge for the privilege of staying there. I stayed every night of the first week with Mark, until he was out of isolation, and paid for nothing but my meals. There was no fee for my bed and linens, for the coffee and sandwiches the nurses shared with me at night, for the variety of juices put at my disposal. And there could be no price set upon the patient answering of questions, the sharing of information, the way parents are accepted by the staff and allowed to help in the nursing of their children. Small wonder that there is so little weeping. Small wonder that Mark slept, fitfully, painfully, but with complete security at night, and that in between times I slept too instead of tossing in a nightmare of anxiety at home.

An Approach with Many Facets

This consideration of a child's needs in terms of his whole personality rather than in the narrow terms of his specific physical disorder, is apparent in every technique. The record taken by the

resident pediatrician, Dr. T., covers every facet of the child's physical, emotional, and social life. I was asked very careful questions about Mark's symptoms, of course, but I was also encouraged to talk about his behavior at home, his fears, likes, attitudes, relationships with other members of the family, etc. I am well aware that as his mother I was under scrutiny, too!

The nurses keep similar daily records, not only of the child's temperature and other physical data, but also of his emotional reactions, how he plays, how he reacts to visitors, whether he seems restless, angry, fearful, etc. Dr. T. wanders, with deceptive casualness, in and out of the rooms during the day, constantly adding to her understanding of each child through conversation or just observation.

Under these circumstances it is not surprising that nurses and doctors always explain before they do anything directly to their patients. If pain will be involved, they say so honestly, the tone being one of confident assumption that the child will cooperate. But if a child is unable to face the treatment, if force has to be employed, that force is used in a kindly impersonal way with neither threats nor moral persuasions about being "bad" or a "sissy." There is much good-natured teasing and there is also much real loving. Babies are cuddled and held on laps, little children are rocked in understanding arms, older children are held, too, played with and read to. Each child is a real individual and treated accordingly. Of course, there is discipline, the kind of adult control that leads to self-control. Simple manners and courtesy are encouraged in the children, and much consistent courtesy is shown by the staff.

The "Extra" That Counts

But beyond all this, there is an extra sensitivity and perception. For example, from the very first, Mark decided that the bedpan was not for him. Like many youngsters whose toilet-training days still linger faintly in their memory, the conception of being toileted in bed was alarming to him. No doubt he could have been persuaded or forced; in fact, I immediately set about to do so in order to prepare him for what I felt would be inevitable. The

very first nurse who met with his anxiety, however, respected his feeling promptly, and cheerfully carried him to the isolation bathroom. She must have noted his reaction on his record, for the bedpan did not appear again. There was never the slightest indication on the part of any nurse that this was an unnecessary extra burden, which it obviously was, as Mark had to be completely supported and had great difficulties due to his weakened stomach muscles. It was a month before he could sit even partially by himself, but during that period the question of the bedpan was never raised.

Similarly, in the early days of his hospitalization, if some treatment or examination could wait until I was on hand (I went home daily for a few hours) Mark's anxieties were respected and the treatment was postponed. In this way such a feeling of trust was established that Mark began to manage more and more on his own, and needed me less and less.

Another small but telling example of this sensitivity was the manner in which nurses went off duty. Day nurses usually made the rounds and said goodnight to their charges, reminding them they would be back the next day, or not, as the case might be, and mentioning the name of the night nurse and her aide. That nurse in turn would pop in as soon as possible after she took over simply to say "Hello, I'm here if you want me." This must be a big reassurance to bed patients, giving a real feeling of continuing awareness and care.

And a final example on a different level: during that first week, while his body was still reacting to the paralyzing effects of polio, Mark was closely watched, tested three or four times a day, and examined by a variety of doctors. At an early point the orthopedic surgeon was asked to check Mark's muscles. The first time that surgeon managed to get to pediatrics, Mark was attempting one of his first light meals. Dr. K. immediately backed out of the room and said, "Don't bother him now, I'll be back when he's done." He returned within the hour to find that Mark had dozed off. Again, Dr. K. refused to have the patient "bothered." He came a third time . . . Mark was still asleep, and he finally examined him the next day. This was a busy surgeon who left his

quarters in another part of the hospital on four separate occasions, rather than disturb a sick seven-year-old at an inconvenient moment!

As soon as Mark's fever subsided, hot pack treatments were introduced to relax the spasms. This was done three times a day, the period slowly increased from 10 to 25 minutes. I was shown how to distribute the packs along his small body, how to place him, etc., and given that heavenly feeling of really helping when I so wanted to help in the battle. In my absence, one of the nurses set up the treatment and stayed to read to Mark or play records to while away those long heated minutes. And after he was out of isolation there were frequently two or three convalescent children in the room during hot pack time, listening to the story, or singing along with the records.

Setting a Goal

Mark was still young enough not to be frightened by the immobility of certain limbs. He knew this was one of the results of polio, but as everyone was so casual he obviously assumed the helplessness would go in time. As there are no wards at Hunterdon, he was not exposed to some of the more frightening aspects of polio, nor the unthinking remarks of visitors. We told him it would be a long time, made no promise, and set our immediate sights on getting out of isolation. His door was left open whenever he requested it, so he could partially observe what went on outside. There was an older girl across the hall who had been seriously affected by polio throughout her whole body, and a four-year-old who was beginning to walk again. We watched both children, sympathizing with the slow progress of one, rejoicing with the increasing skill of the other, and Mark quite naturally identified himself with the latter. We used to see those two patients go off daily to hydrotherapy, and the therapist and her assistant dropped in at Mark's room taking time and effort to become his friends long before he began to go along. They told him all about the equipment upstairs, and urged him to acquire some water toys to use in the pool. The other two children with their boats and water pistols made Mark anxious to

join them and gave him a simple goal which he knew he would soon reach.

The hydrotherapy room is well equipped with whirlpool bath, Hubbard tank, and a variety of exercising equipment. The room is even better equipped by virtue of its therapist. She knows just how to mix work and fun, praise and discipline, and gets a fine response from her young patients. Many of the stretching exercises are sharply painful, and this pain is fully acknowledged while the need for the exercise is explained. "I'd cry too, if someone did this to me," Miss N. would say with cheerful sympathy. "Come on, we'll do it once more, and you yell all you want." Miss N. loves her young patients and treats them with humorous respect; and as she stretches their limbs she helps them grow with the pain rather than sink into it. Her young assistant sees to it that the trip up and back to pediatrics, whether in a wheel chair or a stretcher table, is an adventure in travel. Erratic speed, stops at points of interest, and general hullabaloo is always part of the journey, and Mark looked forward to those trips as the high spot of his day.

When the Isolation Period Was Over

After the isolation period was over, Mark was moved across the hall and I went back to home routines, visiting him afternoons, while my husband visited at night. Mark could soon tolerate having his bed raised for short periods, and as time went on managed to sit up. Sometimes he was alone, frequently he had roommates; and he who had been so slow at making friends with strangers began to reach out with pleasure. Naturally his pile of gifts increased daily, and the staff cheerfully permitted us to set up an electric train a loving grandmother had sent. Imagine an extra table with an electric train set up in a hospital room! Everyone played with that train and no one seemed to be annoyed because the extra clutter made the room an obstacle course.

A month went by, we were all settling down to a routine between home and hospital. Mark took our goings and comings easily, enjoyed our visits, but was not dependent on them. For a

change of scene he was frequently put on a stretcher table and wheeled into the playroom or—which he preferred—down the hall to the nurses' station. There he would lie on his stomach, absorbing all the activity, asking innumerable questions, getting generally in the way, although no one ever said so. His brother and sister were allowed to visit once a week. It is worthwhile noting here that they had been permitted to stand at his door the end of the first week. Dr. H. evidently recognized the value of relieving the older children's anxiety, and therefore allowed a brief reassuring visit—another example of how the entire family is considered as well as the patient.

Being Part of His New World

New polio cases were admitted after Mark had been hospitalized for some time. Fortunately these cases were mild, and the children were able to leave fairly soon. These early departures could have been hard to take, particularly as the girl who had been most seriously affected had been transferred to Warm Springs, so that Mark was in the position of the "oldest" polio patient. I noticed that no one made useless promises to him about his going home or pretended, with that heavy pretense adults sometimes use, that he was perfectly content to stay in the hospital. However, the morning the pediatric floor was fairly deserted, Mark, graduated to a wheel chair by then, was invited to join the staff in the treatment room where they enjoyed a mid-morning break with coffee, cake, and conferences. Frequently thereafter, if the staff were not too busy, Mark was asked to join them for his share of cake and a couple of games of dominoes with one of the doctors. By such methods, without words, was he comforted and made to feel a real cog in this new world he was inhabiting. Small wonder Mark matured and became friendlier with adults.

Same Treatment for All

None of this "treatment" I have been describing is peculiar to polio patients alone. Every child and parent at Hunterdon receives the same loving attention and respect. Sometimes, of

course, parents would find themselves unable to stay with their children the first frightening couple of days. The nurses would then spend extra time with that child, and children soon identified a particular nurse as their special one. When possible, other nurses would defer to such a preference. "Let so-and-so do it," I'd hear a nurse say. "Jane likes her the best." I have seen lonely children cuddled, played with, read to, settled in play pens, wheel chairs, or stretchers right by the nurses' desks, not as the exception, but as the rule. I have seen nurses making checking rounds with a baby on the hip, for all the world like a mother going about home chores with a fretful baby in tow.

I saw a two-year-old so blistered with some sort of allergy that it was agony for the child to be touched, let alone handled by white-clad strangers. The baby's mother was encouraged to do all the handling, doctors and nurses observing and doing as little directly as was necessary. It was considered as important to treat the child's terror as to locate the source of the allergy.

Another infant was brought in in a coma, needing immediate oxygen. The mother was desperately frightened, and could clearly hardly bear to relinquish the child for treatment. As soon as possible after examination, the infant was returned to the mother's arms, and the mother shown how the oxygen was to be administered. The door to the nursery was open and I stood watching as the nurse went swiftly in and out. When the baby was settled, she brought comfortable slippers and slipped them on the mother's feet. She wrapped a blanket across the shaking thin shoulders. She kept a vigilant eye on the infant, but the mother was in that magic circle of observation and care, not shut out. The following evening, the baby, with the amazing resiliency of infants, was already convalescing and a nurse carried the infant about in her arms in order to permit the exhausted mother to sleep.

I saw countless accident cases brought in, broken bones being the most common emergency. No matter how busy the staff seemed to be, each child was carefully prepared for whatever treatment was in store. The anesthetist came down to the child's room and briefly explained the process and instruments of

anesthesia before the child was taken away into the forbidding atmosphere of the operating room. Whatever could be done to alleviate the terror of the unknown was always attempted, yet no one ever lied to a child to make things easier for himself. How many of us can claim such consistency!

The Underlying Philosophy

Are these nurses and doctors a special breed, the cream of their professional crop? No, I don't think so. Hunterdon pays no more than other hospitals and has the same problems of staffing. The difference lies in the hospital's philosophy which must be well explained to each and every staff member, for everyone seems to practice the same unfailing understanding and controlled tenderness. It is as if the nurses were told not only the importance of the psychological effects of illness and the destructive power of fear, but also as if they were reminded that they are women and potential, if not actual, mothers as well as nurses.

One of the Lucky Ones!

On October 8th, still muscularly weak and in need of future therapy, Mark walked out of Hunterdon Hospital. He was one of the lucky ones—he walked! Because his spine was involved, the possibility of a future spinal curvature and an operation has still to be considered. It may take two or three years before we can be sure one way or the other. But no matter what happens, Mark is lucky! A crippled spirit is far harder to support than a crippled spine, and Mark's spirit is whole and unself-centered. He has learned about pain, patience, and people in a positive way. He has greatly matured in these months, and in a situation which might have been very harmful to his sense of security, he gained both trust and self-assurance. I do not doubt that his physical progress would have been equally good at any number of other hospitals, but I sincerely doubt he would have grown as emotionally healthy in the fairly rigid impersonal atmosphere of the average ward. Yes, Mark is lucky, and we are lucky, for we have access to a hospital where efficiency is never developed at the expense of the patient, where sterile refers only to cleanliness, and where love is a recognized antibiotic!

Appendix 4

PLANNING FOR PATIENTS TO HELP AND TO ENTERTAIN EACH OTHER

The following memorandum was prepared at the writer's request by Mrs. Esther Miriam Blanc, an experienced nurse engaged at the time in graduate study at the University of California School of Nursing in San Francisco. She had been asked if she would attempt to answer the three questions noted in her first paragraph. She did much more as the reader will discover.

In answer to the question "Could you list twenty things that patients on medical and surgical floors could do to help other patients or the nursing staff?" I found that I could list many more, so I simply went on to the next question: "Could you arrange these items in categories?" In answer I decided I could, and so I did. I came to the third question, "Could you then think of more items to list under these subject headings?" I knew I could do that, too, and would end with a paper made up of long lists of items. This line of thinking finally resolved itself into a sort of overall plan which might become part of a "therapeutic hospital environment," where patients would be busy doing all manner of things and there would be a brisk exchange of skills and talents going on throughout the hospital!

It is well known that patients of all classes who must remain in hospitals for any length of time suffer not only from deprivations, but are bored almost to extinction. There are very few provisions on an organized basis to relieve this tedium which we believe slows recovery, tends to make the patient feel very impatient and thus noncooperative, and makes him more critical of the hospital personnel and practices than he might be if his boredom were relieved.

The objectives, therefore, in creating a more therapeutic environment should include the following: to provide the means for relief of boredom by introducing a series of workable exchanges of services between patients; to supply the needs of patients for dependency and independence as they arise by letting them do for others and have others do for them in such ways as are possible; and to consider the feasibility of making these means a permanent organized service with paid personnel and clearly formulated and stated policies.

Essential to my plan for reorganizing the social environment would be a director of nursing service who possessed imagination, spontaneity, warmth of personality, intellectual ability, and a broad liberal education. If possible, she should have had training in interpersonal relations. Most particularly, she should believe so firmly in the necessity for changing the social environment that she would be able to motivate the nursing personnel to want to help with the plan.

Nurses alert to the possibilities for improved patient care inherent in this proposed scheme would observe all they could about each and every patient, both in general and specific frames of reference. Examples of kinds of characteristics and interests to be observed are: outgoing, retiring, hostile, curious; reads mystery stories, can crochet, keeps a copy of *A Passage to India* on the bedside table, cannot read, likes to talk about cooking, speaks Armenian, and so on. The information gathered about the patients should, in my estimation, be *charted* on the nurses' notes, and then cards be made and the data tabulated. Nurses should also note the physical disabilities and abilities of the patient so that no demands would be made that he could not meet.

In addition, we should have lists available of all the things we had been able to think of which patients might theoretically be able to do to keep themselves occupied or help others. The first time anything was tried, careful notes would be kept about how it was arranged, the response of the patient and others involved, and so on.

Now, let us move into a surgical ward and see what is happening as the result of our plan. On this floor we have eye patients

and orthopedic patients. In a four-bed ward there are two patients with corneal transplants; one has a herniated disc and is in traction; and the fourth is an ambulatory eye patient with one eye covered. She will be going home in a few days, but in the meantime she can go from bed to bed and do things for the other three. Because both of her eyes were covered for a long time, she knows how the eye patients feel. She stands quietly at the bedside of each from time to time so they may know she is nearby.

During the course of the day the patient in traction reads the news from the morning and evening paper to the other three. She makes two calls on her telephone for the other patients. (She can dial directly.) The ambulatory patient lifts the telephone from the bedside table for her to use. The two patients with eye bandages find they have a common interest. The nurse has told them, "Mrs. Jones, both you and Mrs. Smith have a common occupation. Why don't you find out what it is, so you can talk about it?"

You see we have begun in a small way to set the machinery going toward mutuality in this four-bed unit. Now let us move to the children's ward. In a wheel chair is a man of more than middle years who is telling the boys from eleven to fifteen about "railroading" and what happened in the blizzard of 1949, while he was a railway engineer on the run between Ogden, Utah, and Cheyenne, Wyoming. In another room there are two persons, a middle-aged man with crutches and a boy of fourteen also with crutches. The man, a professor of mathematics, is helping the boy with algebra.

And so it is throughout the hospital. Here a woman is reading aloud from a newspaper in Russian to another patient, and there a patient is taking around the mail to the entire ward. One of the volunteers is on her way to the public library with a list of books and prints to get for persons who have expressed interest in special things. On another unit a birthday cake is being served. This hospital keeps track of birthdays, and the entire unit is informed in advance. One patient is seen writing a letter for another. In the elevator someone is being taken to x-ray in a wheel chair by an aide, but another patient is going along to help reduce the tedium of what may be a long wait.

In planning for changes in the social environment I have taken into consideration funds needed for materials and supplies, and for the services of occupational and physical therapists, as well as facilities. (Don't worry, we shall have a therapeutic swimming pool, and a good workable arrangement with the available libraries in the community.) Volunteers will be the blessing of the plan. Borrowing books, records, and prints around special interests, as I have suggested, implies a different perspective from going around with a bookcart. Volunteers will be encouraged to do many more things than at present, and to make continuing suggestions about what could be done.

Presuppose, too, that everyone working within this scheme will have an interest in ethnic groups, and an appreciation of the diversity of cultural backgrounds that exist in America and of the richness that results from this diversity. That is why the information card will have room for all of these items: doctor, lawyer, merchant, chief, Armenian, Italian, Indian (American or East Indian). With such information, we might be able to bring together combinations of persons who would not only enjoy each other while they were patients, but might become friends and enrich each other's lives.

Now let us turn to a few examples of categories under which to list things that patients can do to reduce their boredom and give them the feeling that they are not helpless and worthless.

1. Linguistic Skills

a. Translations for the scientists and professional personnel on the staff. If the library, for example, begins to subscribe to nursing journals from other than English-speaking countries, I think patients might enjoy translating some of the articles for the nurses.

b. Helping patients explain things to nurses and doctors and conversely. Let us assume that a small child of recent Hungarian refugees is in the hospital and his mother cannot be with him. A bilingual patient of Hungarian origin gets to the child and not only acts as interpreter but is able to comfort him and allay his fears.

2. *Skill in Arts and Crafts*

a. A patient who lies in bed knitting a sweater that looks like "Joseph's coat" is helping another patient who has recently learned to knit and has expressed a desire to "learn more about it."

b. In the next bed to a young woman who has an interest in cooking, we put a motherly looking Italian woman who knows a great deal about delicious cookery. We know this to be true because her worried daughter had told someone, "My mother makes the best ravioli in the world"; an alert "someone" made this notation on her card!

3. *Ethnic Variations*

Here again, imagination will help us. The average American, recovering from a hernia operation, might find his vision widened by meeting a graduate student from Poona in Central India, and hearing about a pilgrimage the student's parents made to a shrine in the Himalayas and that such pilgrimages by others have been going on for about fifteen hundred years.

4. *Professional Skills*

A lawyer might enjoy talking with a person who either had similar or diverse interests. Perhaps he might like to meet another lawyer or a banker, broker, or biologist, or the Italian housewife, or even the lady who knitted provided she had interests beyond knitting.

5. *Other Categories of Occupations*

Engineering is a broad category; it is essential to find out what *kind* of engineer the patient is. Inquire what the biologist does, and do not neglect the carpenters and plumbers, the schoolteachers, and, of course, the nurses. Nurses are probably the kind of fish most "out of water" as patients. Because the nurse is likely to have a very trying experience, bring her into the "in-group" at once. Do not treat her as if she had parked her knowledge and experience in her locker. She generally has a real need to be useful, as well as to be spared uncertainty. She can be helped to avoid boredom and anxiety, but perceptiveness and effort are required.