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## The Hospitalized Patient

1. A 42-year-old married woman was admitted to the hospital for an elective gallbladder operation. Her attending physician greeted her on her arrival at the hospital, and she was assigned a private room and a private-duty nurse. The hospitalization was not going to be as bad as she thought; the large donation her husband had made to the hospital last year had been very well advised.

2. The nurse phoned the intern on call at 3:00 A.M.

NURSE: Doctor X, I am sorry to call you at this time, but Mrs. Smith's IV infiltrated, and she needs her IV antibiotic. . . .

INTERN: Oh, hell! Why don't you go ahead and restart the IV? I know that you can do it as well as I.

NURSE: I am sorry, Dr. X. I'm not allowed to restart an IV unless I am in the ICU.

INTERN: Come on! I saw you starting an IV on Mr. Jones only this morning.

NURSE: Yes, but that was in the ICU. Remember, I sometimes work two shifts. I will get into trouble if I start an IV on a regular ward. Rules are rules.

INTERN: Oh, OK. I am wide awake now anyway. There should be a hospital rule that says IV's are not allowed to infiltrate after midnight!

3. During the first few days of hospitalization in a typical teaching hospital, a typical patient with low back pain has the privilege of meeting the following persons:

1. Receptionist and admitting office personnel
2. Ward secretary
3. Head nurse and one or two additional nurses (take vital signs)
4. Intern (does a history and physical exam)

5. Medical student doing clerkship (may be more than one) (history and physical exam)
6. Resident (history and physical exam)
7. Attending physician (brief history and physical exam)
8. Dietician
9. Maid
10. Nurse's aide
11. Lab technician—blood team
12. Radiologist and technician when X rays (at least routine, probably more) are taken
13. Consultants: Usually, at least one or two consultations are given each patient. For example, in this case, the consultation may be with an orthopedic or neurosurgeon, with a psychiatrist if the patient seems to be anxious, and, finally, with an anesthesiologist if an operation is being considered.
14. Possibly a social worker or the clergy
15. Other patients on the same ward

During his hospitalization, the patient may have to make the acquaintance of a whole new set of medical students, interns, residents, and even attendings as they rotate off the particular service. The same is true of the consulting teams, which, in turn, consist of residents, attendings, and students.

The hospital is a microcosm with which most of us have intimate contact. Most of us were born in a hospital, have some contact with one during our lifetime (if we do not actually work in one), and usually can expect to die in a hospital. Hospitals are seen by society in many different ways—as a necessity, a frightening place, a source of community pride or shame, an important industry, an employer, and in other ways.

Many of those who are ill either are already in the hospital or will be admitted to one sooner or later. We will consider the hospital as a social system and then the environment of the hospital as it pertains to the patient.

## THE HOSPITAL AS A SOCIAL SYSTEM

### Kinds of Hospitals

Hospitals can be classified on the basis of the length of stay of patients, the kinds of services provided, and the type of management. Thus, we can consider short-term vs. long-term, general vs. special, and community vs. noncommunity hospitals. The most common type of hospital

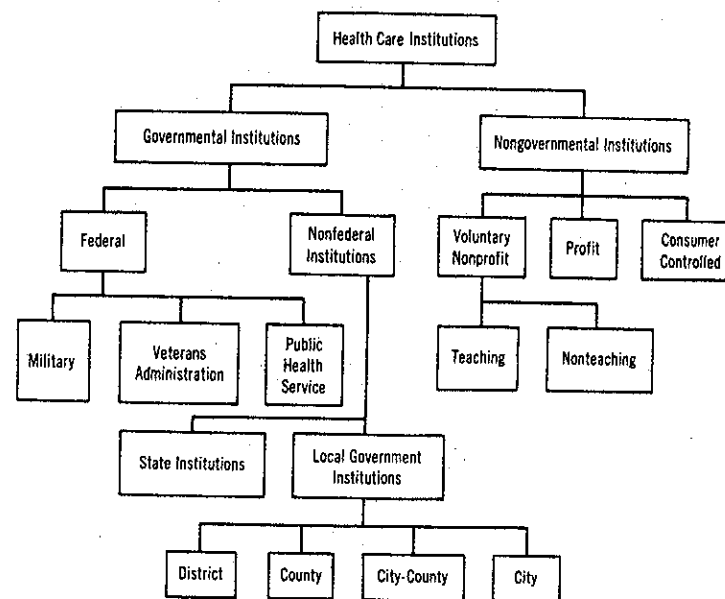


Figure 31. Classification of health-care institutions by control. (From Freeman *et al.*, 1972. Copyright 1972 by Prentice-Hall. Reproduced with permission.)

in the United States is the short-term general hospital (see Figures 31 and 32).

### The People in a Hospital

The hospital is an open system and is influenced by the culture of the greater society and community of which it is a part. The social status of the people in the hospital, to a large extent, reflects that of the larger society, although there is also a hierarchical social structure within the hospital. This is so because, to a great degree, the hierarchy in the hospital is parallel to that of the larger society. Those high up in the hospital hierarchy are also likely to have high status outside.

One possible exception here is the patient. In terms of the hospital hierarchy, the patients find themselves at the bottom rung—they are the least familiar with the ethos and culture of the hospital. And, as transients, they are more likely to “put up with” inconveniences and occasional mistreatments than to make an issue of them. But here, again, the social status of the patient in the larger community plays a role. The

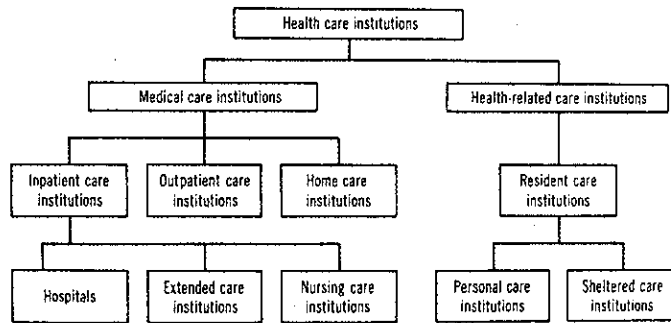


Figure 32. Classification of health-care institutions by function. (From Freeman *et al.*, 1972. Copyright 1972 by Prentice-Hall. Reproduced with permission.)

VIPs are more likely to insist on, and receive, better personalized service than the "charity patients." Patients with high social status, patients who have professional ties to the health community, and those who had families who were willing and able to intercede for them with the health professionals have been shown to receive the kind of care that meets their expressed needs (Roth and Eddy, 1967; Scott, 1969) (vignette 1). The differentiation between the charity patient and the paying private patient is rapidly disappearing, thanks largely to the widespread family insurance coverage of the working population. Psychiatric patients, however, still tend to receive different diagnoses and treatments and assignments to different types of hospitals (state hospital vs. private hospital) depending on social class (Hollingshead and Redlich, 1958; Myers and Bean, 1968). Psychiatric patients from the higher classes have lower hospitalization rates and, once hospitalized, tend to be discharged earlier.

Patients in hospitals may also be informally classified according to their attractiveness and interest value for the staff. Thus, there are the "fascinomas," that is, the most interesting patients, on the one hand, and the "crocks," that is, the most undesirable patients, on the other. The degree of attention, sympathy, and support the patient receives often varies in accordance with this informal classification.

The personnel in the hospital are formally organized in a hierarchy. The general hospital's hierarchical structure is often very complex, with competing lines of authority and priority. Figure 33 shows a typical administrative organization. An important feature of the organization is that there are *two lines of authority*, as in Figure 33. The physicians are organized in a collegial fashion, although there is a stratification according to the specialty and status of the physicians into attendings, residents,

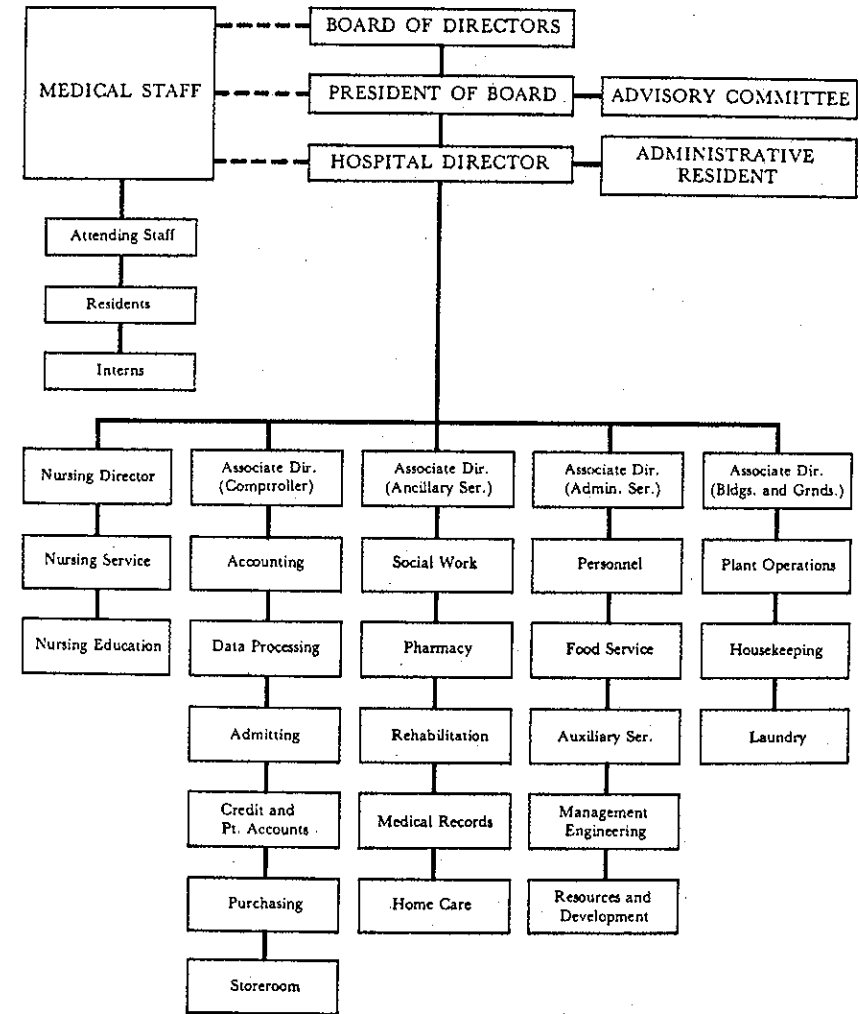


Figure 33. Administrative organization of a general hospital. (From Coe, 1970. Copyright 1970 by McGraw-Hill. Reproduced with permission.)

interns, and students. This collegial organization of physicians is an outgrowth of the historical position of the physician as "visitor" or "guest" in the hospital (Coe, 1970). Of course, without these guests, the hospital cannot function. All other employees of the hospital are organized along another administrative line.

This dual line of authority is very different from almost any other kind of organization. In the customary single-line-authority organizations, like business, government, and the military, decision-making powers rest in the offices of the managers who direct the activities of the workers. In the hospital setting, however, the administrative managers have little authority concerning patient care, while the members of the medical staff, who are akin to consultants in single-line-authority systems, actually make decisions. The administrators' authority is often restricted to matters concerning the provision of means by which the doctors' orders may be successfully carried out (Coe, 1970). A potential conflict arises from the different sets of values: For the administrators, the primary concern is money, for the physicians, it is patient care and sometimes teaching and clinical research as well.

The dual-authority system can have major consequences in regard to *nursing*. Unlike physicians, nurses are directly responsible to the administrative structure of the hospital. In terms of professional activity, however, they are the recipients of the doctors' orders and share with the physicians a primary commitment to the patient. On occasion, this results in a "double bind," a conflict between a nurse's professional role and her role as a hired employee of the hospital subject to the rules and regulations of an employee (vignette 2).

The hospital system is also characterized by an *extreme division of labor*. The professional, administrative, and nonprofessional staffs have clearly distinguishable and separate tasks, orientations, and loyalties. The stratification of occupational levels is rigid, and there is a "blocked mobility" in each level (Smith, 1955). Personnel cannot be promoted from one occupational level to another in the hospital without first resigning from their present position and obtaining further education. For example, without further schooling, a nurse's aide cannot be promoted to a registered nurse, and a janitor cannot be promoted to a hospital administration post. However, the physicians can and do become promoted to a higher rank, for example, from intern to resident to attending physician, without further formal schooling. A floor nurse can advance to being a head nurse, but not to being a physician.

This blocked mobility often results in the formation of cliques and special interest groups that are organized along occupational lines. Thus, nurses are more likely to talk with nurses most of the time, and physicians with physicians. One study showed, for example, that a doctor is three times more likely to speak with another physician than with a nurse and that his interaction with personnel in other occupational groups is minimal. The frequency of conversational interaction of a nurse

with other nurses was twice that of a nurse with other occupational workers (Wessen, 1958).

This same phenomenon is observed with respect to speciality lines even among physicians. Thus, a surgeon is more likely to talk with another surgeon than with a dermatologist, and a psychiatrist probably interacts with other psychiatrists most of the time. An obvious side effect of this *group formation* along occupational and specialty lines is the development of communicational barriers between occupations and specialties, and these can give rise to misunderstandings and mutual suspicions. This problem is especially acute if communication between nursing staff and physicians is blocked. It may take days for the nurse to communicate to the physician that his patient has been ruminating about depressive topics and not eating, even though other nurses may have known it all along. For example, in the case of the "sick Tarzan," the doctors were not informed directly by the nurse about his agitation and attempting to lift up the bed until the fifth day of hospitalization.

Another characteristic of the hospital organization is that it is *authoritarian* in nature. This is especially so concerning matters of patient care. The administrative authority is of the rational-legal type, based on the power residing in a particular office and concentrated at the top of the hierarchy. The nature of the physician's authority is more prestige-oriented and charismatic, related to the heavy responsibility of "saving people's lives," than rational-legal, related to the primary goal of the hospital—patient care. The dual line of authority, however, results in conflicts between the lines, the most common type being between physicians and administrators.

This type of conflict may become especially pronounced when planning for changes or renovations of a hospital. A study in England on four general hospitals asked the patients, staff, and administrators, "What is most important to alter in this hospital from a patient's point of view?" Each group had differing ideas about what was of primary importance. The administration emphasized physical change of the hospital, such as the provision of dayrooms; the doctors and nurses wanted to improve patient care, for example, by increasing the number of nurses; while the patients wanted to improve the quality of life in the hospital by improving the food, providing television sets, and in other ways (Raphael, 1965).

A more complicated authority relationship exists, especially among the medical staff, in a teaching hospital. The attending staff may be subdivided into the elite, university-affiliated professors and the private practitioners in the community. Some hospitals have separate units, one for the academicians and another for the private physicians. Members

of the academic attending staff are subject to dual roles, that of the clinician in the *hospital* and that of the teacher-researcher in the *university*, each of which has its own reward (promotion) systems based on different criteria. In some teaching hospitals, the house staff (interns and residents) may have conflicts in dealing simultaneously with the community attending physicians who are their patients' primary physicians and with the academic attending physicians to whom they are also responsible.

An interesting feature of the hospital as a hierarchical system is that somewhat as in the military, one can *identify* the *status* and *rank* of a person by *dress*, *speech*, and, to a lesser extent, *habits and manner*. Usually, the least neatly dressed, most disheveled people are the patients, and the most well-dressed and well-groomed people are the attending physicians and hospital administrators. Physicians are often recognizable by the lab coats and uniforms (including the rank; e.g., attendings wear suits or long lab coats, while residents' and interns' costumes are usually different, as are the nurses'). Registered nurses wear uniforms different from those of practical nurses or nurse's aides. Some patients and outsiders take advantage of this and may "pass" for a doctor or nurse with appropriate dress and manner in the hospital, to leave without permission or even to steal drugs or equipment.

In recent years, rapid development in medical technology, the proliferation of for-profit hospitals, simultaneously with the growth of health-care maintenance organizations (HMOs) and Medicare's prospective payment system, have resulted an unprecedented cost-consciousness among hospital administrators and rapid changes in the organization of hospitals in the United States (Starr, 1982; Vladeck, 1984). In general, the health-care financing system is moving away from fee-for-service to prospective payment and managed care. To adapt to the changing political and economic environment, novel ways of organizing hospitals have been described, e.g., an integrated inpatient management model in which a clinical department actively assumes the operational responsibility of an inpatient unit, thus blurring the boundaries between the hospital administration (McMahon *et al.*, 1989).

### ORGANIZATION OF AN INPATIENT UNIT

A typical inpatient unit of a general hospital consists of the following: beds, patients, nursing staff, ancillary staff, supporting staff, and physicians. Usually, all but the physicians and patients are more or less

permanent; patients are transient, and the physicians generally rotate on and off inpatient units.

The number of beds usually determines the number of nursing staff to which the unit is entitled. Beds may be subdivided into private, semi-private, and ward beds.

The nursing *staff* usually consists of a head nurse, an assistant head nurse, registered nurses, licensed practical nurses, and nurse's aides. Depending on the hospital, several nurses may be jointly responsible for the care of a number of patients ("team nursing"), or one nurse may primarily care for one patient ("primary nursing"), with the help of other nurses. The licensed practical nurses and nurse's aides assist the registered nurse. They are all responsible to the head nurse, who in turn is responsible to the nursing supervisor of the division of nursing (e.g., medical or surgical) or to the director of nursing of the hospital. The head nurse and the registered nurses are also the recipients of the doctors' orders and are professionally required to carry them out competently. Nursing care, however, is not confined to carrying out the physicians' orders—it also includes interacting with the patients and providing comfort and evaluating distress when it occurs. It is obvious that good communication between the nurse and the physician is essential if the nursing care is to be coordinated with the therapeutic management plans of the physician.

The *ancillary staff* consists of the professionals related to patient care in a specialized area, such as dietitians, social workers, clergy, and the administrator (or the administrative intern) of the ward. They have liaison relationships with the nursing staff and sometimes with the physicians.

The *supporting staff* consists of the ward secretary or unit manager, who answers the telephones, makes sure that all the forms are in stock, and performs other duties, and the maintenance staff, including the janitors. Members of the supporting staff are usually responsible to a separate hierarchical administrative structure.

The physicians usually found on an inpatient service are the attending physician(s), the residents and interns (house staff), and the medical students. In teaching hospitals, the house staff is usually in charge of the patient, supervised by the attending and aided by the medical students. The physicians usually form a team around the patient, the team consisting of an attending physician, a resident, an intern, and a medical student. However, if the attending physician is not a full-time hospital or university physician, the house staff may have divided loyalties between the community-based attending and the full-time university-based physician supervisor to whom the house staff report as well.

Another socially complicating characteristic of the young physicians, particularly the house staff, is that they wield much power even though they are transient and relatively inexperienced members of the unit. Many members of the nursing staff on the unit may have been there for as long as 10 or 20 years and may be more knowledgeable about procedures and medical problems encountered on the ward than are the house staff, who change every few weeks or months. The mobility of the house staff may be envied by the less mobile staff members.

For a ward unit to function optimally, it is necessary that (1) each staff member has defined, unambiguous, and unchallenged roles, (2) there is effective leadership and cooperation among disciplines, (3) there are smooth and open channels of communication between and among all the persons involved—including the patient, and (4) there is a spirit of commitment to cooperative efforts for good patient care.

To ensure the smooth running of this complex organization, many hospitals now assign *liaison psychiatrists* to inpatient services. The liaison psychiatrist, as a physician who is knowledgeable in psychosocial aspects of patient care and in organizational dynamics as well as biological aspects of illness, is often in a position to understand the dynamics of a ward and the complex interactive relationships between the medical and psychological aspects of patients and the ward problems. He may be in a position to improve and foster good communication between all concerned and to integrate multiple and fragmented observations for the primary physician. He is optimally situated to serve as a catalyst in opening up communications since, *unlike* everyone else on the ward, he does not report to any administrative authority who might take unfavorable action against a member of the ward, such as the nursing supervisor or the chairman of the department of medicine. The liaison psychiatrist may be an independent agent or may himself be a psychiatric resident, reporting to the department of psychiatry. The liaison psychiatrist is often assisted effectively by a *liaison nurse*, a psychiatric nurse with advanced training in liaison psychiatry, who may run liaison meetings with the nursing staff and act as a communicative link between the nurses and the physicians.

The liaison psychiatrist functions best when he forms a team with the primary physician (house staff or attending), the head nurse, and the social worker, in cooperation with the liaison nurse.

In most hospitals, the liaison psychiatrist also does psychiatric consultations on the patients in the unit. These involve evaluation and treatment of emotional or behavioral disorders of patients in the general hospital. Depression, suicide attempts, confusion, delirium, personality difficulties, drug-related problems, and intention to sign out against

medical advice are common reasons for referral of patients to the psychiatrist. The liaison psychiatrist often finds that a patient's aberrant behavior reflects division and conflict among the staff. For example, a patient who receives conflicting information and advice concerning his illness from his attending physician and intern may be understandably confused and may wish to sign out. The liaison psychiatrist may arrange a meeting of the patient, the intern, and the attending to clarify the conflicting information.

## THE HOSPITAL AND OUTSIDE ORGANIZATIONS

Many organizations interdigitate with the hospital in personnel, patients, and material. Others have major impact on the policy decisions of a hospital. Financial support for the hospital may come primarily from the government (federal or local), charities, businesses, or profits.

Laws and regulations at all levels directly influence hospital practices. Examples include the legislative acts requiring nondiscrimination because of race and the formation of professional standards review organizations (PSROs). Insurance companies' policies and practices, such as what procedures are covered, for what types of illness, and for how long, also influence hospitalization patterns and length of stay of patients.

Educational institutions, especially *medical schools*, have major direct influence on hospitals. Many full-time physicians in hospitals are also faculty members in medical schools and are influenced by the values and practices of the medical school. The prestige of the hospital is often directly related to the degree of affiliation with, and the prestige of, the medical school. This, in turn, affects the quality of the hospital personnel. (The more prestigious institutions can attract better-qualified staff.)

Religion and moral standards of the community have an effect on the hospital in influencing the types of patients admitted (e.g., Catholic hospitals have more Catholic patients and are unlikely to have many elective abortions).

The quality of patient care and physical and personnel adequacy of the hospital are scrutinized by such organizations as PSROs, the Joint Commission on Accreditation of Hospitals, and the American Medical Association.

Hospitals generally have intimate relationships with other hospitals, and each may refer patients to the others. Chronic care hospitals and

psychiatric hospitals often receive patients from general hospitals. Clinics and the offices of private practitioners in the community often refer patients to the general hospital for admission.

### THE HOSPITAL ENVIRONMENT

When a patient is admitted to a hospital, he finds himself in a *strange environment* and an *alien culture*. He is usually apprehensive, because he has a condition considered too serious to be treated in the doctor's office. The intensity of his apprehension increases with his uncertainty about what to expect in the hospital. Much of what will happen in the hospital depends on tests and procedures to be done there; for example, laboratory test results may indicate the need for an exploratory operation. Depending on what is found at operation, there may be a need for radical surgery, chemotherapy, or no treatment—possibly the difference between life and death. *Uncertainty reigns*.

The *physical environment* of the hospital is not of much help in alleviating admission apprehension and anxiety. Cold, impersonal architectural styles, dark, gloomy rooms, and busy, businesslike, and forbidding staff characterize many traditional, especially older, hospitals. Patients often feel like unwelcome guests who nonetheless have to stay for, and in fear of, their lives.

Once in a hospital room, particularly a multibed room, the patient may be confronted with almost total *lack of privacy*. Conversations can be overheard, and many of the most private functions such as elimination now become public—often patients do not have *control* over when to bathe, urinate, or defecate—sponge baths are given by nurses, intimate parts of the body can be poked, observed, photographed, X rayed, opened, or even cut with little advance warning and, it seems to the patient, by almost anyone wearing a uniform. There is even little control over what the patient can eat or drink.

The *language* spoken by the "people who count" in the hospital, the doctors and nurses, often sounds foreign to the patient—somehow distant and professional. The patient feels too stupid to ask questions—besides, the staff members seem to be so busy. The patient may also be in terror of offending the doctors and nurses—after all, his life *literally* depends on them.

An interesting situation occurs at the time of *doctors' rounds*. The patient's history, often including rather personal and confidential material, is presented to the attending while other patients, their visitors, and

other staff (possibly the janitor and the maid) are looking on. Then, the patient may be undressed to varying degrees to be examined by a number of persons including the medical students. Heated debates concerning the diagnosis and treatment plans may take place among the house staff members and the medical students. The intern or resident who had the closest relationship with the patient may be humiliated by the attending for his lack of knowledge or for (horrors!) stupid proposals about treatment. Occasionally, discussion concerning a patient whom the doctors have already finished seeing continues in front of the next patient's bed. Of course, the patient before whose bed the discussion takes place assumes that the discussion is about him! Thus, sometimes patients get entirely erroneous ideas about their conditions and treatment plans at the time of medical rounds.

Most patients' personal habit patterns must undergo change in the hospital. Their activities change and so do their habits concerning food, routine, and personal hygiene. Patients who like to play golf or work every day may instead have to read or watch television. Patients who are accustomed to sleeping alone may find it hard to fall asleep in a multibed room and annoying to be awakened in the middle of the night for the check on vital signs (blood pressure, pulse rate, temperature, and respiration). One patient's groaning, snoring, or moaning may keep other patients awake. Sedating medications, on the other hand, may keep patients constantly in a daze.

Many patients lose track of time in the hospital, and those who have the vulnerability become confused. Even if elderly patients with cerebral arteriosclerosis have not been confused at home in their usual habitats, in the absence of normal cues to help orient themselves, many such patients become disoriented, confused, and agitated in the hospital, especially toward the evening when fewer cues are available (sundowning syndrome).

It should be understood that patients may become very *self-centered* in the hospital, partially as a function of the anxiety concerning the self and also partially due to the regression fostered by the hospital environment (see Chapter 5). When this happens, a patient may develop a tendency to think that almost anything he sees or hears is somehow related to him. Patients commonly think that conversation overheard between the doctors or nurses in the corridor concerns them; even conversations between other patients may be misinterpreted. The implication of this is that the staff should refrain from saying things within hearing of any patient (especially in the corridors or in the same room as the patient behind drawn curtains) that might be misconstrued in any way.



Certain specialized units in the general hospital present particular problems due to the physical and interpersonal environment. They include the intensive care unit, recovery room, operating room, hemodialysis unit, isolation unit, and cancer ward.

The *intensive care unit*, including the coronary care unit, has been thought to be contributory to a psychiatric syndrome called the "ICU psychosis." This is usually characterized by confusion, agitation, and a florid paranoid psychosis. ICU psychosis is most often considered to be an organic psychosis due to sensory deprivation (monotony), electrolyte imbalance, and multiple medications that are often administered in the ICU. Drug-induced psychosis, especially by meperidine (Demerol) and by antiarrhythmic agents such as atropine, lidocaine, and procaine is also common in the ICU.

The physical setting of the coronary care unit seems to have an impact on the general feeling tone of patients. Leigh *et al.* (1972) studied two types of coronary care units in the same hospital: an open, four-bed type and closed private cubicles. They found that patients were freer to express hostility, were concerned about possible shame, and manifested more anxiety concerning mutilation in the "open" unit, whereas patients in the cubicles were unable to express hostility directly but tended to deny and displace hostility or direct it inward and were more concerned about loneliness and separation. In the coronary care units studied, patients who showed high levels of hostility directed inward, low levels of overt hostility, and high levels of separation anxiety had a higher risk of developing cardiac arrhythmias.

Hackett *et al.* (1968) showed that patients who were able to deny anxiety effectively in the coronary care unit had a better prognosis than those who were unable to deny their anxiety. Witnessing other patients' distress and death is another hazard of being in an ICU. Most patients are able to deny these events effectively, but the next time, they tend to state a preference to be in single rooms (Hackett *et al.*, 1968). Although most patients deny being apprehensive in the coronary care unit, they nonetheless think about rather sad events, such as the death of loved ones in the past. An implication of this is that the physician need not feel constrained to inquire of these patients whether they are thinking upsetting or sad thoughts, lest he "suggest" such thoughts to them.

Psychological preparation is important in transferring patients out of the coronary care unit. Klein *et al.* (1968) found that patients had emotional reactions and more frequent cardiovascular complications (accompanied by an increase in urinary catecholamines) if they were transferred out of a coronary care unit without preparation. On the other hand, when the patients were psychologically prepared beforehand about the transfer,

and when the primary nurse actually accompanied the patients to the new ward and introduced them to the new nurse, there were fewer complications after the transfer and less increase in urinary catecholamines.

The (surgical) *recovery room*, like the ICU, is a very confusing environment. Here, there is a curious and intense mixture of sensory overload and sensory monotony. There is always activity and usually no night-day difference because of artificial lighting and absence of windows. In addition, the patients are, as a rule, heavily sedated and in the process of recovering from anesthesia. Organic brain syndrome due to central nervous system depression brought on by anoxia (operative), medications, electrolyte imbalance, and other disruptions is common. Severe pain can contribute to the disorientation.

Some patients in the surgical recovery room are also unable to talk because of tracheotomies or soreness due to endotracheal tubes. This often results in severe frustration and fear on the patients' part, as well as agitation. For these patients, provision of a pencil and paper is often extremely welcome.

A rather frequent cause of agitation and psychosis during the postoperative phase is withdrawal from alcohol and other central nervous system depressants (see vignette 4 in Chapter 12). Patients' drug and alcohol histories should be carefully obtained at the time of hospitalization to prevent such withdrawal reactions from complicating the postoperative picture. Many alcoholic patients secretly bring alcoholic beverages into the hospital. Thus, delirium tremens can occur three days postoperatively, even though the patient may have been in the hospital for many days prior to the surgery.

A special form of psychosis, called *postcardiotomy delirium*, has been reported after open-heart surgery. Typically, the picture, consisting of illusions, visual hallucinations, and paranoid delusions, occurs after a lucid period of three to four days following the operation. The sensory monotony, sensory overload, amount of time on the artificial pump, and sleep deprivation in the surgical recovery unit have been suspected as contributing factors. The personality of the patient also seems to contribute to the development of postcardiotomy delirium; patients who score high on the dominance scale on Cattell and Weber's 16 Personality Factor Questionnaire have a greater tendency to develop it (Kornfeld *et al.*, 1972). The delirium usually clears within 24-48 hr after the patient is transferred to a standard hospital environment (Kornfeld *et al.*, 1972). This postcardiotomy delirium can be distinguished from the organic brain syndrome some patients have after open-heart surgery in that in the latter, the confusion is demonstrable immediately after the surgery, without any intervening lucid period.



The *operating room* is an environment in which patients often hear more than they see. In the course of the induction of anesthesia, hearing is the last sensory modality to become anesthetized and the first one to return. Even when the patient seems to be unconscious, he may still be able to hear. Conversations before an "unconscious" anesthetized patient, therefore, should be cautious and judicious. Thoughtless joking about the patient or discussions about the serious nature of his disease should be avoided. Special psychotherapeutic measures such as ventilation under hypnosis may sometimes be necessary to work through anxiety and depression resulting from the effects of conversation overheard during anesthesia (Cheek, 1959).

The *hemodialysis unit* provides life support for many patients with chronic renal failure. Being dependent on the machine for life creates a number of psychological problems, including a sense of lack of control and of being dependent on external control. Some patients do not comply with the restriction in salt and fluid intake, and the suicide rate is greatly increased. Electrolyte imbalance and uremia often produce organic brain syndromes and depression. Here, again, successful use of denial has been associated with good prognosis.

*Isolation rooms* are provided in the hospital for patients with infectious diseases or when reverse isolation (guarding against exposure to infection) is necessary, such as in immunodeficiency diseases. The patients are in individual rooms, and everyone entering may have to wear a mask and a gown. There is a reduction in the number of visitors. In extreme cases, the patient may be in a plastic "bubble," totally insulated from the outside, and touched only through plastic gloves at the end of plastic arms built into the walls. Sometimes, individuals dressed in "space suits," wearing gloves, of course, may touch the patient. In this type of environment, the most significant complaint by patients is their inability to touch or be touched by another human being (Holland *et al.*, 1970). The significance of touching in development has already been discussed in Chapter 15.

The *cancer ward* increases anxiety and defensiveness on the part of both patients and staff. Patients are especially attuned to the doctors' attitudes—for signs of hope or evidence of rejection. Although patients usually do not ask the physicians directly about the prognosis of advancing cancer, they tend to consider the physicians' continuing interest almost as a commitment to cure. The physicians, on the other hand, tend to use the defense mechanisms of denial, isolation, and intellectualization vis-à-vis the patients, concentrating on the laboratory results and tissue findings. It is easier for the physician not to confront the

patient's approaching death and his own impotence in the face of this inevitability (Leigh, 1973).

Doctors therefore have a tendency to minimize their contact with patients, leaving this up to the nurses. The nurses often feel unhappy and angry about having to be the only persons left to deal with the patients at a personal, emotional level. Opening up communications between the nurses and doctors, and showing doctors that their continuing interest is essential for the patients' maintenance of hope, can alleviate this situation. A liaison psychiatrist can contribute to this by being the catalyst for such communication (Klagsburn, 1970).

The hospital environment, in general, is a strange and anxiety-provoking environment for the patient. In the face of such anxiety, the patient responds with an exaggeration of his personality style, habitual coping mechanisms, and defenses. In the case of the "sick Tarzan" (Chapter 16), we see that he was in the coronary care unit, where his anxiety level was increased by the sensory monotony and the need for lying in bed. During the interview, his personality style of exaggerated showing off, dramatizing tendencies, and need to be in control was clearly demonstrated. One also sees evidence of major denial ("Nothing bothers me"), which augurs well for the patient in terms of prognosis, if only it were modulated and he were to stay in bed.

## SUMMARY

The hospital is a *complex social system*, influenced by various factors in the larger society. The formal hierarchical organization of the hospital personnel has *two lines of authority*: the physicians and all the other employees. Nurses, unlike physicians, are directly responsible to the hospital administration and at the same time are responsible to physicians in terms of patient care. Across occupations in the general hospital, there is a "*blocked mobility*"; that is, one cannot be promoted from one occupational level to another without further schooling.

Physicians often have *dual loyalties*: patient care and academic, especially in teaching institutions.

The typical *inpatient unit* in a general hospital is the functional unit in patient care, consisting of the beds, patients, nursing staff, ancillary staff, supporting staff, and physicians. Liaison psychiatrists and liaison nurses can play an important role in the smooth functioning of such a unit.

The hospital environment, in general, is characterized by *uncertainty* and lack of control from the patient's point of view. Certain special areas of the hospital, such as the intensive care unit, have their own special environments and attendant problems.

## IMPLICATIONS

### For the Patient

The hospital environment is a highly anxiety-provoking one in which the patient is threatened with the loss of autonomy and, possibly, life. *Privacy* is often disregarded, and patients feel too stupid to ask questions or make requests. There are particular problems associated with special areas of the hospital. Patients should be *prepared*, if possible, about what to expect in the hospital, including whom to ask for information and other matters.

### For the Physician

For obvious reasons, physicians feel quite at home in the hospital. They therefore tend to feel that patients should share their feeling of ease and familiarity in the hospital. Physicians should recognize how frightening and strange the hospital environment is for the patients. Physicians should make deliberate attempts to *ask* patients about their reactions to the physical and interpersonal environments of the hospital and encourage them to *communicate* their thoughts and feelings. Physicians should also recognize that cooperation among the professions and occupations in the hospital, including nurses and other workers, is essential for good patient care. Doctors should encourage the *nurses* to *report* any new observations concerning patients and to communicate openly about difficulties or dissatisfactions. Doctors should also recognize the "*double bind*" nurses often feel in having dual lines of authority to which they are responsible.

### For the Community and the Health-Care System

Hospitals should be constructed *aesthetically* and *functionally*. Every room should have paintings, calendars, and television or radio. Educational programs should be designed for patients and potential patients about where to get information in the hospital and where to "*gripe*," and the hospital administration and the medical establishment should

encourage communication and cooperation among different occupational groups in the hospital. Medical education should emphasize respect for a patient's *privacy* and the importance of not embarrassing patients (or the medical student, for that matter) on walk rounds. Hospitals should provide *liaison psychiatrists* for patient-care units to foster cooperation and communication among different groups and also to prevent and manage behavioral and emotional problems of patients.

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### RECOMMENDED READING

Coe RM: *Sociology of Medicine*. New York, McGraw-Hill, 1970. A lucid and concise textbook of medical sociology. Has a good chapter on the hospital as a social system, as well as on the development of the modern hospital.

Kornfeld DS: The hospital environment: Its impact on the patient. *Adv Psychosom Med* 8:252-270, 1972. A good review paper on the hospital environment's impact on the patient. Good list of references for interested readers.

Starr P: *The Social Transformation of American Medicine*. New York, Basic Books, 1982. A comprehensive and readable book that describes the remarkable changes that have occurred in American medical practices and institutions.