

Health Care Left and Right

Experiencing and witnessing the health care system over a 24-hour period led me to treasure social work's commitments to confidentiality and to question how the medical profession deals with it. As I witnessed blunders in the medical care of the poor and the rich I felt even more strongly about the need for professionals to advocate for more adequate resources, greater accountability, and enforcement of standards. It also made me think more about the profound changes that have taken place that cry out for a system of universal health insurance.

by
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How much more mundane can we get than a nosebleed? It began at 10:45 at night as I was preparing for the morning when I was to meet my friend at 7:30 across town at the hospital where her husband—I'll call him Bob—was having life-threatening abdominal surgery. They both had put on a stoical front, but I knew there was hidden turmoil and I told my friend I would stay with her during the surgery. By 11:15 I had to admit to myself that the nosebleed was out of hand and that I would need to get help to stop it. I decided to go to the nearest hospital, which was just seven blocks away. I grabbed a blazer which I figured would cover at least some of the stains on my clothing, a small towel which I was holding up to my nose along with a wad of tissues, a backpack with more tissues in it, and my pocketbook. Fortunately I found a cab quickly and although I had some difficulty talking because of the dripping into the back into my throat, the driver and I agreed on the nearest hospital. He refused to turn onto the street to the emergency room entrance; he thought it was a one-way street. I was having too much difficulty talking and was not about to argue.

I was immediately greeted by a guard at the door. He summed up the situation quickly, said "nosebleed," I nodded, and he motioned me to a window. Behind the window was a male triage nurse interviewing a patient who was sitting next to him on a small chair on wheels. The nurse did not look up until the guard came over and called to him. They quickly agreed that I should come into the room behind the window and wait there for my interview. The guard showed me the way and motioned me to another small chair on wheels.



A Challenge to Confidentiality

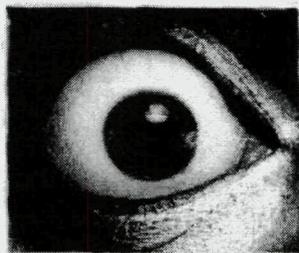
Being interviewed was a large, disoriented man. He announced to the interviewer that he was "a junkie." He seemed to take pride in this, and went on to say heroin, which he articulated very slowly, almost lovingly, as though he were saying "sweet as huunneeey." He gave his name, explaining the significance of his middle name; the whole process was very slow. He interspersed his answers with long and repeated demonstrations and reports, not complaints, of swelling on his leg and arm.

Why was I hearing the intimacies of this man's story? I felt like an intruder overhearing a private conversation. I have been teaching social work students for many years and in our Program we talk about confidentiality in every course. We take it seriously and we want our students to take it seriously. We find situations where confidentiality is challenged and try to figure out the best way to handle them. Some situations are baffling, but we think of confidentiality as one of the cornerstones of the profession (Goldmeier, 1984). I wondered whether we were alone in this thinking. Why wasn't anyone concerned about it?

The bleeding was not letting up and during a lull between repetitions I asked the nurse for some tissues. He quickly got up to give me a gauze pad. The interview with the man continued; the nurse continued to listen patiently and

respectfully to the repetitious statements. Only when he was sure there was nothing else to add did he take his blood pressure using a blue plastic sleeve and also his temperature. The interviewer then pushed some papers to an opening in the wall leading to the next office and told the patient to wait in the waiting room.

Several people were sitting in the waiting room. A little girl of about three years in a pretty pink dress was dancing around. While the interview with the man was still going on a young woman came in holding a washcloth to her left eye. She, too, stood at the window for quite a while, as I had, until the guard came over and called the nurse's attention to her. What happened, the nurse asked. I was fixing a fan with a stick and the stick got pushed into my eye. The same question was asked several times, with the same answer. Are you tak-



ing any medications? She answered, I just had an abortion and I'm taking some antibiotic. What kind, he asked. I don't know, she said, and repeated that she had just had an abortion. Let me see it, he said. She removed the washcloth revealing a huge tear on the eyelid. All right, sit down, he said kindly, motioning her to the seats in the waiting room.

Here, too, I came back to think about confidentiality. Standing on the other side of the glass window she had to tell her story to everyone in the waiting room, as well as the three of us in the room. Surely the medical professions accept confidentiality as a value—but a value is only as good as its implementation and it seemed to have the lowest priority.

Dying to Get Through the Paperwork

The nurse then motioned me to the chair for my interview. We talked about how and when the nosebleed started; he asked few but relevant questions. He helped me get one arm out of my jacket sleeve so he could take my blood pressure. The blue plastic blood pressure sleeve that he had used on the previous patient was filled with air and would not stay on my arm. Several times he removed it and punched it but the air remained. Grumbling, he went to the back of the room, returning after a few moments with another. He continued to grumble that this was supposed to take just a few seconds. Some minutes later, when the blood pressure and temperature were done, he took my papers and pushed them to the same opening. I asked if I could see a doctor and he said first we had to do the chart. He motioned me to return to my first chair to wait there, and replaced my gauze pad. My voice was leaving me as I started choking and coughing from the blood dripping into

my throat. Several minutes later the door to the adjoining office opened and a man sitting at a desk took my papers and started asking me the expected questions. I told him I couldn't talk loud and rolled my chair closer. Name, address, phone number, insurance cards, the works. By now I was sweating and beginning to feel very sick. He wanted to know who to contact in case of an emergency. I told him I wasn't feeling well, but we continued until we were finished.

Can Anybody Help

Finally the triage nurse led me into the emergency room. It was not frantic like the TV programs, but it was busy, with many patients in small cubicles and lots of staff clustered around the center of the room. He helped me get off the rest of the jacket, which he put on the bottom of a large plastic bag, and then put in the backpack and then my pocketbook, and placed the bag on the bed with me. I thanked him and told him he was very kind.

I had expected to see a doctor as soon as I actually got into the emergency room but I was mistaken. Feeling extremely sick, with no improvement, and coughing and choking more, I began to worry about fainting or bleeding too much and wondered why I had come here. Only the triage nurse came by to say that they were very busy. Later I called out in whatever voice I had left, "Can anybody help me." I did this several times, and finally caught the eye of a young man who

might have been a resident. I motioned to him with a slight wave. He came over and told me to squeeze my nose, which of course I had been doing for well over an hour. I told him it wasn't helping and he showed me how to do it—under the bone at the top of the nose, not at the bottom. He told me to continue doing this for 20 minutes. I had to hold it like that for over two hours before it stopped but during that time it started to get better.

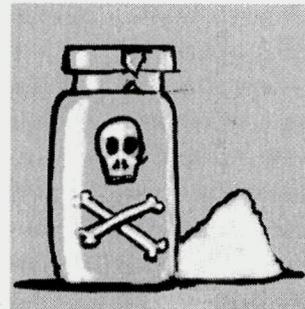
I called out to a nurse's aide who was walking with great energy, asking if I could get a glass of water. She questioned another woman who shrugged and said why not. The first woman got a foam cup and returned to a desk to continue the work she was doing. Disappointed and uncomfortable, I waited, not with patience but hope. Finally she brought it over—not only were there ice cubes in the water, but she also gave me a box of gauze pads. I realized how small kindnesses could go such a long way.

Drugs Left and Right

The resident came back. The bleeding had subsided a lot by now but I was fearful that it would start again, especially if I breathed through my nose. I was still coughing a great deal because of the drip. He said I could stop squeezing it now, that it looked red, like it was

about to fall off. I could take a joke. Then he told me that they wanted to put cocaine in my nose. I was sure this was a joke, or I heard it wrong. Did you say cocaine, I asked, and he shook his head and smiled a bit. The irony of it, I thought. For the past six months one of my major activities was work on a grant our Program had received to expand the substance abuse content in the baccalaureate Social Work Program. For much of our winter break the faculty had been writing curriculum and searching for materials for classes. Days were spent together screening videos to show in classes on the use and abuse

of alcohol and other drugs. We struggled with how to infuse the content into the program so that every student would be exposed to the material. We



organized a conference to learn more about what social workers needed to know in order to work effectively in agencies with drug abusers and others affected by them. We gave pre-and post-tests to students to see what they had learned. Now we were writing the final report on the project. And here I was being instructed to put cocaine into my nose.

"Certainly not," I said. I wanted to tell him about the work we had been doing at school but I didn't think he would be interested. The nostril is directly connected to the

brain, I told him, and why would he want to use cocaine, of all things. I was also worrying about being able to get across town to meet my friend and wondered if I could be of any help to her. He told me that cocaine has lots of medicinal uses and is used frequently in the hospital. "Uh-uh," I said. It will constrict the blood vessels and will also anesthetize the area so he could look at it better and maybe cauterize it, he told me. "Why don't we just put ice on it," I said, "that will constrict it." He laughed and said no, they had to look in it. "What can you see? It's all clogged. Anyway, no cocaine." You think about it, he said, and left.

I wondered what would happen if this were offered to someone in recovery. Or someone flirting with using drugs. I thought about my friend and Bob. Were they sleeping now? Were they crazed with hidden anxiety—how could they not be. I was supposed to be the strong one, and here I was in the middle of the night having an outrageous discussion about cocaine. Little did I know that 24 hours later on the other side of town Bob would fall victim to a similar abuse.

I watched as the self-proclaimed junkie was rolled by my cubicle. He was admitted to the hospital looking quite peaceful. Attention was paid to the woman who had the abortion and the injury from the fan. I heard them say her vision was okay but I could not see whether or not she was admitted. The triage nurse came by again and told me I would be all right.

I was happy to stay put, partly because I was afraid the bleeding would start up again, partly because by now it was so late I wasn't sure there would be any cabs cruising the streets—the early morning hour might be better than the late night. But mostly I wanted to stay because the scene in the emergency room was so absorbing.

A middle-aged man with graying hair was being wheeled into a cubicle directly across from mine. There was an immediate flurry of activity around him and the monitors were turned on. It looked like an emergency room response to a heart attack but I thought he looked too good as he came in to be having a heart attack—his eyes were bright and his complexion was rosy.

To my left was a man with gray-black skin who looked very ill. He was taken out of the emergency room in a hospital gown and then came back, probably from x-ray. Four doctors clustered together in the center of the room the entire time I was there looking at his x-ray and debating his condition. They kept referring to him as the man with the glass eye. But that was not the problem. His stomach was in the wrong place, they said. They couldn't figure out what the condition was and thought they will have to puncture the stomach. Finally one of the doctors went to talk to the patient. He was articulate and explained that he had had an operation to repair an ulcer.



He also said he was beginning to feel less pain. By the time I left they concluded that he was constipated. I wondered why they waited so long to talk to him. And again I wondered about confidentiality. I was able to overhear the entire discussion of the doctors.

They took the rosy-cheeked man out; by now he was in a hospital gown and probably going to x-ray; a woman who was with another patient kept walking back and forth, looking at me each time, as she did with all the patients; I found it intrusive.

I decided to treat myself, surreptitiously removing a small ice cube from the foam cup, wrapping it in a corner of a gauze pad, and sneakily holding it against my nose, hoping it would constrict the blood vessels so we could end the struggle over the cocaine. I felt foolish, a little like a naughty child. I asked for more water, but this time the person who heard me call out said I shouldn't be having water. Puzzling to me—I was thirsty, choking, and most of all, running out of ice.

Now there were intermittent visits from the resident. He put the flashlight into my nose, peered into my throat, and told me he ordered "the tray" with the cocaine and I should wait and see. I agreed only to wait. He asked me when I had my last tetanus shot; I couldn't remember, it was a long, long time ago. He told me that they give tetanus shots with nose-

bleeds and I said fine. I was getting tired but it was too uncomfortable to lie down and I didn't want to miss anything.

The man in the cubicle across from me was brought back from x-ray, still looking good. A nicely dressed woman, probably in her 40s, was brought in with a bandage on the side of her forehead. She was wearing a business suit with a short skirt and high heels; she had a big smile that never left her. From time to time she walked back to the nursing station, questioning when she would see a doctor. They told her they had a lot of emergencies.

It was probably an hour later that the tray arrived, a large tray wrapped in more blue plastic. The resident brought it over and unwrapped it near me, revealing numerous items. I thought again about the Social Work Program at school, about the struggles we were having with substance abuse education and the difficulties some students had in talking about abuse in classes. I thought about the mixed messages we give and get—drugs are bad for you, they're illegal, say no. And then drugs are good for you, they're legal, agree to the treatment. I said absolutely not. He insisted that he had to look in my nose, and I reminded him that he had been doing that. When he returned the next time he said that they had to do something for me because I couldn't remain there so long; it would get busy again in the morning and they would need the space. If I don't want the cocaine, he said, then they would use something else.

What is it? He mentioned a drug and said that it had epinephrine in it. I wondered why he had not suggested this in the first place. But I am allergic to epinephrine, and I told him I wasn't trying to be difficult, but when I go to the dentist I can't take long-lasting Novocaine. He said he never heard of that.

I wanted to tell him that he should have, but instead I told him he is not a dentist.

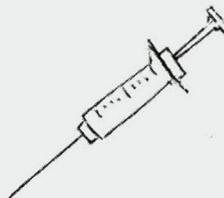
He disappeared again, and came back with another doctor—one of the four who were still discussing the man with the stomach in the wrong place. She peered into the nose and told him to go ahead and cauterize it. I thought he might have done that five hours ago. He hesitatingly said that I wouldn't be anesthetized. She said that if I didn't want to take drugs, then to go ahead and do it anyway. She never spoke to me. He followed her away and talked to her again.

Who Pays For Education?

Later he returned with two slender wooden sticks, about the size of incense sticks, with some brown stuff on the ends. I was enormously relieved; I thought cauterization required a mini-torch. "Will it hurt?" I asked more for his sake than for mine. He said just a little. I asked how long it would take and he said 30 seconds; I suggested he make it a little less. I asked why he needed two

sticks, and he said he always brings two. Okay.

He was holding one of the sticks and a flashlight and kept shifting each from the left hand to the right hand, from the right hand to the left. He seemed reluctant and could not position himself. I knew this was a teaching hospital and I felt respect-



ful and patient with that, particularly as I knew that my troubles were trivial related to almost anything at all. I asked if he had done this many times before and he assured me. Finally I asked if he wanted me to hold the flashlight for him and he said no, the problem was that he didn't have the right tool. "Why don't you get it?" I asked encouragingly. He said he would and left.

I thought about our social work students as they begin in field placement. Surely this is how some of their clients feel. I didn't think much damage could be done here so I didn't worry about it too much. But what if it were something serious, the way students work with clients who have serious problems. Are the supervisors always available? How do clients feel when they experience the students' insecurities and blunders?

He returned with a tool that looked like a guide for the stick. Now he was holding three items, the stick, the flashlight, and the new tool, and again he juggled them, moving them from hand to hand, left to right, right to left, two in one hand,

two in the other. In the end he asked me to hold the flashlight which I happily did as I was sure it would distract me from whatever pain there might be. He finally began the procedure and made it clear to me that he was not at all sure he was on the right spot. It felt to me that he was and I told him that, but just in case he wasn't I counted to 30 very rapidly and when I was at 28 I told him okay, he had his 30 seconds and he took it out. It didn't hurt much and I wondered again why he had made such a big deal about the cocaine.

Near the nursing station there was a discussion about the need for tetanus shots with nosebleeds. I overheard someone say, "why would you do that?" and my doctor's response was that you were supposed to. This one I could stay out of—I didn't care. I assumed it was off, but soon a nurse came with the shot for me.

Before I left, the man across the way emerged from his cubicle dressed, looking as healthy as he did when he came in, and walked out. The woman with the patch on her forehead went back to the nursing station to tell them she was leaving. She was told she needed to have stitches, to wait, and she went back, still smiling.

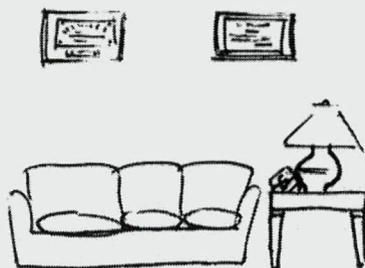
It was five a.m., and I asked an aide if I could wash up before leaving. Again I experienced the vast pleasure of small kindnesses when she brought over several towels and a washcloth. I went over to the triage nurse to say

thanks and he told me someone else had just come in with a nosebleed. I thought that if the same resident will treat that patient then he will have done it at least once before. I wondered what that patient would do with the cocaine.

Across Town: Medicine for the Rich

At 7:30 in the morning, with one restless hour of sleep, I left home to meet my friend in the hospital across town. Like the hospital I had been at, this one was also voluntary. But the one I was headed for is one of the most sophisticated medical centers in the world: large, organized, well-planned; well-endowed; a leader in medical science, they say.

The Family Waiting Room was perfectly designed with nice sofas you could almost stretch out on, cozy chairs and roomy tables, a staffed desk to transfer messages to the waiting families, telephones for in-hospital connections. It had the



needs and comfort of the patients' families in mind; nobody had to sit on small chairs on wheels. There were lots of plaques on the walls honoring

the philanthropists. And the layout offered some privacy for family members to talk and to talk to the doctors when they came after the surgeries. Maybe social workers also came but I didn't see any. There also was a conference room with a door where one could anticipate full privacy when talking to the staff.

Stories about my night's adventure provided some distraction during the otherwise tense three and one-half hour wait. We ate breakfast and returned to the comfy room where we snoozed and talked. Finally the doctors arrived—the second surgeon and the cardiologist who also was present during the operation. This was a very complicated medical situation—they probably don't get much more complicated or risky—and on top of it all Bob had long-standing problems with his heart. In addition, while Bob was having this most drastic surgery, he was also scheduled to have a routine but much needed procedure—a simple hernia repair.

Blunders on Both Sides

The surgeon wore his operating room garb including the booties over his shoes, the cardiologist was in a fashionable suit. They looked as finished as the room we were in. They remained standing throughout the conference. After a lengthy and informative discussion about the abdominal surgery, which reportedly had gone very well, my friend asked about the her-

nia surgery. Both doctors looked puzzled and there was silence. Oh yes, well, uh, they're doing that now. They left immediately, with the agreement that the chief surgeon would be down very shortly when all was completed. We were both convinced that the hernia surgery had not been done as planned.

An hour and a half went by, with several phone calls by my friend to the doctor's office on the in-hospital phone. It was a worried and impatient time. The woman at the waiting room staff desk was as helpful as she could be. Finally the chief doctor arrived, still in scrubs. He too remained standing. Yes, he said, the hernia surgery was being completed "as we speak." But they told us an hour and a half ago that it was being done then. Oh, it is a whole other surgery, blah, blah, blah, blah, he went on with so many reasons why it took this long. My friend and I were stunned. It was crystal clear that in spite of all the amenities of this famous hospital with its beautiful appearance, and in spite of fact that the doctors were the most prestigious, they had forgotten to do the surgery and it took this much time to get him back to the operating room. This too was a teaching hospital, but these arrangements had been made with the staff, not a groping student. In fact they were made with the chief of the service.

The next day I heard that during the night Bob had a heart attack. Bob had several organs removed and he also had a morphine pump so he could self-administer the drug for post-

operative pain. Without those organs the morphine affected his heart, particularly as he already had serious heart problems. He was treated and was okay. The doctor acknowledged that it was an oversight.

All's Well for Now, or Is It?

In spite of the incompetence and mistakes, both Bob and I are well. Ten days after this incident, mercifully after my college graduation was over, I came down with a raging infection which may or may not have come from the ER; in any event I recovered. Bob was back at work and on the golf course within a few weeks—a remarkable recovery under any circumstances.

But what about the problems that were so obvious in just 14 hours of observation. I had witnessed violations of confidentiality without anyone even acknowledging that there was a problem, an understaffed emergency room with patients neglected, abuse of drugs by the medical care system, incompetent and unsupervised treatment by a resident, and incompetent treatment by a chief of service. And within another twelve hours Bob had a heart attack as a result of further errors in medical care.

Whether on the left side of town or the right side, whether on the political left or right, the need for competent health care that is accessible to all remains the single most important item on today's national agenda. Lack of such care re-

sults in physical harm; demoralization of patients, their families, and communities; and emotional harm to poor and rich alike, to savvy people and innocents, to individuals, family groups, communities, and societies.

We have passed the time when medical services could be made available for particular groups—the rich, the elderly, some of the poor. Baffling medical conditions such as TB, dementia, Alzheimer's, HIV/AIDS, substance abuse, mental illness, and the elusive killer viruses, are not diseases of one group. We are at the point that any plan for health care for one group will not be acceptable politically or socially, let alone morally—for the reason that the need is now more recognizably universal. It is no longer a matter of a benevolent society, but a shared effort for survival. Also affecting every income group is the higher cost of care, the need for long-term care, and the absence of medical insurance to pay for it. These medical conditions know no economic or cultural boundaries. These are health problems that touch every person and every family and community, the privileged ones and the disenfranchised.

That Medicare and Medicaid have resulted in a narrowing of the gap between medicine for the rich and medicine for the poor is not surprising. With universal need there must be universal solutions. While we cannot mandate integrity, as a society and a profession we can insist on adequate resources, accountability, and enforcement

of standards (Atherton, 1990; Van Soest, 1994).

The need goes far beyond the furniture in the waiting room, whether in the emergency room, which generally is used by the poor, or in the decorated waiting rooms of the well-dressed hospitals. In both hospitals the staff and patients represented the diversity of the city and I noted no biased behavior in either. For the poorest of the poor the night before there had been endless acts of kindness and respect as well as troubles

with equipment, understaffing, lack of supervision, and disregard for confidentiality. Cocaine as a treatment of choice, particularly when it was clearly not needed, must be questioned. For the rich the doctor still got it wrong during the surgery, and the doctor and staff missed the danger of self-controlled morphine intake. These issues affect everyone in every medical setting. We are left with the need for advocacy on the part of all helping professions so we can get it right. □

REFERENCES

- Atherton, C.R. (1990). Liberalism's decline and the threat to the welfare state. *Social Work* 35(2), 163-167.
- Goldmeier, J. (1984). Ethical styles and ethical decisions in health care. *Social Work in Health Care* 10(1), 45-60.
- Van Soest, D. (1994). Strange bedfellows: A call for reordering national priorities from three social justice perspectives. *Social Work* 39(6), 710-717.

Conference:

ORGANIZED RELIGIONS' 1 INFLUENCE ON POLITICS AND GLOBAL SOCIO-ECONOMIC ISSUES: CAUSES AND CONSEQUENCES

To be held at **The Point at the Pyramid**, California State University, Long Beach on **Wednesday, April 21, 1999**.

CALL FOR PAPERS: The organizers of the conference invite proposals for papers, panels, workshops, and round tables for possible inclusion in the program. **SUBMISSION DEADLINE IS MARCH 1, 1999.** Potential presenters should submit a one page abstract to co-chairs. Final papers should be edited, double spaced and considered "camera ready." All accepted papers should be submitted in final form by April 21, 1999. These papers will be published under conference proceeding.

CONFERENCE OVERVIEW: With the end of the twentieth century rapidly approaching, we are inclined to seek, reexamine and understand the major events and movements of the past decades. For instance, the voices of religious leaders have permeated the arena of politics. The conference will provide a forum to discuss and debate the philosophical, political, and historical roots of these religious groups. It will examine the causes of the current resurgence of the neoconservative emphasis on religious values and traditional virtues. Furthermore, it will analyze social complexities at the end of this century including ethnic cleansing, culture wars, and intensified xenophobia. The dynamics of regional conflicts and the patterns of international conflicts have often been associated with religious organizations, among other causes. Civil wars, refugees and genocide are the result of channeled opposition activities through the medium of religion. In summation, this conference will focus on contemporary issues of vital global concern on human rights, development, and the reawareness of religious diversity.

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