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SURGERIES FOR THE 1970s

Ombudsman is middle man between clinic patients and hospital

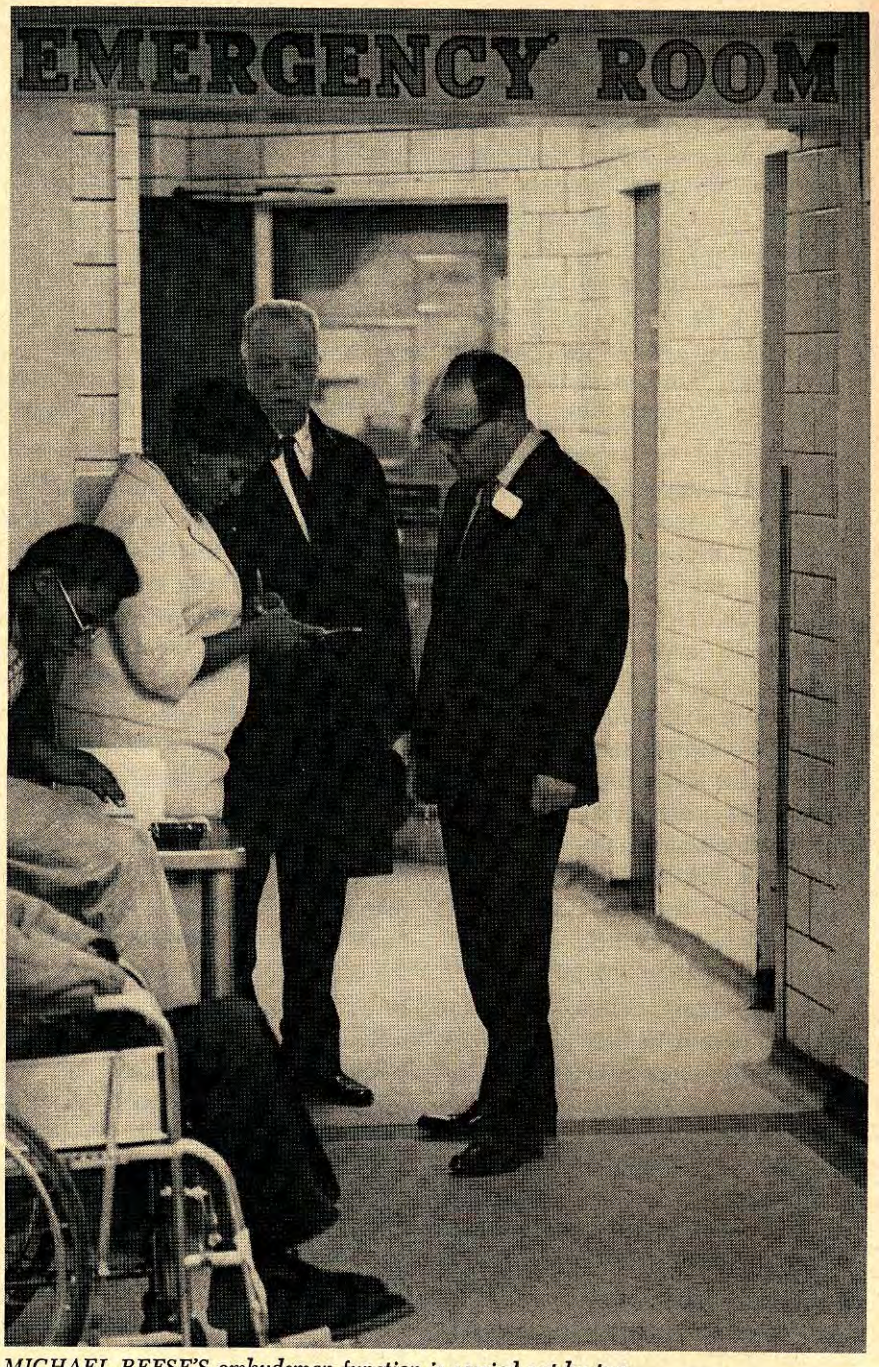
Richard Cavalier

The ombudsman at Michael Reese Hospital, Chicago, interprets the doctors' and pharmacists' orders and sees that the patients aren't forgotten

Who speaks for the patient? Doctors have their professional association, as do administrators, nurses and technicians. But who really knows what nonmedical aid the patient requires? At Michael Reese Hospital in Chicago, the ombudsman knows and speaks up. In a sense related to the Scandinavian ombudsman — who investigates citizens' complaints against the government or its functionaries — the ombudsman at Michael Reese keeps one eye on the patients and the other eye on the clock.

The ombudsman's task is one of human relations. Because any emergency room is geared for trauma, patients queued up for routine treatment are moved aside in crises, and occasionally they feel forgotten. That's where the ombudsman steps in to explain hospital procedure to the patient; to call the staff's attention to a patient who might have come to the emergency room on a routine visit but who is in pain; to get attention for another patient who might actually have been forgotten. But the assistance goes further. The ombudsman interprets prescription directions. He explains in ordinary terms what seems to be the problem and how soon it should disappear — if the doctor's orders are followed.

The ombudsman is already a much liked and respected member of the Michael Reese emergency room staff, a positive start for a



MICHAEL REESE'S ombudsman function is carried out by two persons: Mrs. Christine Leak, shown taking notes in the emergency room, and Mr. Mahon Washington (far right).

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OMBUDSMAN'S MAIN job is one of human relations. Mrs. Leak and Mr. Washington function as intermediaries between patients and the hospital's busy E.R. staff.

program which started in 1969.

Actually, the ombudsman is two individuals, Mr. Mahon Washington and Mrs. Christine Leak (pictures). They were recommended by the community organization of the area — a wise move from the standpoint of ready acceptance by patients. In a pilot project scheduled daily from 4 p.m. to midnight, Mr. Washington works five days; Mrs. Leak works two. He's a businessman who's short on medical knowledge and long on compassion — his neighbors trust him. She's a registered nurse with three teenage children, also a member of the local community; a student of social work at the University of Illinois, she speaks in a voice of gentle authority. Together they have forged a significant new link between the hospital and its community.

There was a definite need for the Michael Reese ombudsman. This need was pointed up by the work of the "crisis minister" (page 94). In interviews with patients following their medical treatment, the hospital staff found that while all patients were satisfied with the quality of medical care they received, many of them complained about the delays, lack of information and attention, and even their impersonal reception at the hands of a harried staff. Few saw their reception in terms of the hospital's problems — they knew only that they had problems of their own, and that they were not always accorded the dignity they felt their due.

As an inner-city facility, the

Another kind of ombudsman: the "crisis minister" in the emergency room

Michael Reese emergency room functions as an around-the-clock clinic. The hospital knew that about 60,000 patients would be treated in 1969, most of them routine clinical calls. A crush of 80,000 emergency room visits also had been predicted for this year. Those statistics, combined with a memory of the long, hot summer of 1968 called for critical appraisal and swift action. On July 1, 1969 – anticipating a peak load on the July 4 weekend – the ombudsman program went into effect.

There were problems. For instance, what was the ombudsman supposed to do, and for whom? To whom did he report, and what was his authority? Did he ask the E. R. staff for assistance, or could he order it? Did he have an expense account? All anyone really knew was that the ombudsman was needed to interpret doctors' orders and institutional policy to the patients. And the ombudsman was to talk back to the institution about mutual problems.

Two weeks of orientation preceded the July start. Each ombudsman met with nursing supervisors, nurses and doctors working in the emergency room, various department heads, and administrators: everyone whose responsibility could have an effect on E.R. services. The theory was that the ombudsman must understand the system before he could steer patients through it. As a result, friction among staff members, even at peak pressure periods, was minimal especially considering that there was not time to gain the full ac-

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As hospitals everywhere in the nation strive to bring themselves closer to the communities they serve, several hospitals in central Chicago are being assisted unexpectedly by a Presbyterian minister without a permanent congregation, the Reverend Robert A. P. Holderby, D.D.

Although emergency rooms of the inner city hospitals are the scene of his pastorage, the orientation is *people* – not hospital. People respond, and the hospitals find that they are credited with the good will he generates.

Mr. Holderby has been working nearly two full years on his ministry, which has evolved out of his effort to find the greatest need during the night hours, when social and charitable organizations are closed. This work, in turn, parallels his assignment as Protestant Chaplain to the Chicago police force from 1960 to 1967.

As a police chaplain, Mr. Holderby became acquainted with physical trauma as a way of life in the hospital emergency room. He had already become familiar with emotional trauma through clinical training in psychotherapy. He tends the human needs of the patient, or victim, and the family, to whom the emotional trauma of a hospital is a first-time and often terrifying occurrence. He's not soul-saving in the conventional sense of ministry. His "crisis ministry" differs from even traditional hospital chaplaincy. It's unique in Chicago.

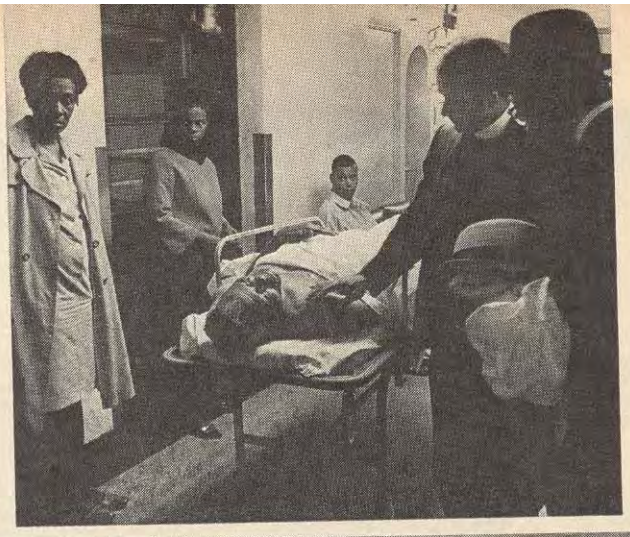
About 10 o'clock each night (following late afternoon ministering and counseling), Mr. Holderby begins his rounds of the inner-city hospitals, working until 2 or 3 a.m. and later at Cook County, Michael Reese, and Provident hospitals, which receive the brunt of patients involved in violent events in Chicago.

At the admissions desk of one hospital emergency room, he checks with the head nurse. In a few words she pegs the situation – a busy night, although at the moment, routine. For a girl with a head wound, he has a smile and enough small talk to help her ignore the doctor working on her scalp. She stops fidgeting, and the doctor relaxes. The men exchange a greeting, and Mr. Holderby moves away. For a young woman with a cast, the offer of a ride home fetches a shy "Thank you." Her family doesn't have a car, and she doesn't have carfare.

Then a huge man with gunshot wounds is brought in on a stretcher. The family is notified. The woman with a cast will have to wait longer.

The family of the gunshot victim begins to arrive. Signatures are obtained to authorize the activity in progress. Routine police questions come next. Then Mr. Holderby offers the family comfort, diversion and prayer, as the victim is wheeled upstairs to the x-ray department.

The pressure is off, for now. The minister exchanges a few words with the staff and the police. He assures other patients



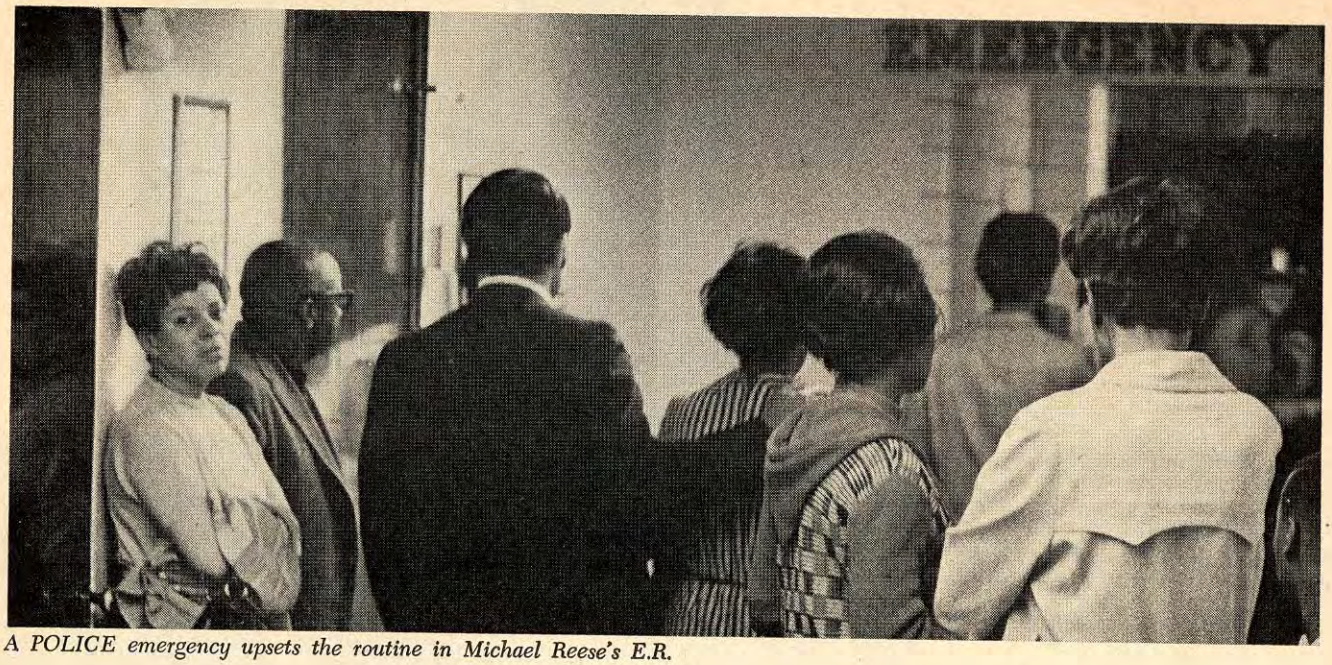
in the waiting room that, although they've waited longer than expected, they haven't been forgotten. It is time to push on. He guides the woman with a cast to his car and drops her at home deep in a ghetto.

The second hospital is quiet. An elderly man in a wheelchair has been waiting about two hours for transfer to Cook County Hospital. Mr. Holderby wheels him out, lifts him into the back seat of a police squadrol. "Can you take another?" asks the head nurse. Another aging man, whose sister-in-law beat him for drinking, is also going to Cook County.

People in and around the central Chicago hospitals have noticed and have come to accept the effective — if unorthodox — man with a mission. Doctors, nurses, hospital chaplains, and administrators have joined other citizens in underwriting the work of Mr. Holderby. The brand new organization is ecumenical and is formally known as The Crisis Ministry, Inc. Its charter provides for a continuation and expansion of the work through both direct service and educational assistance to all who deal in crises, including policemen and firefighters. — R. C.

TOP: Mr. Robert Holderby's "church" is the E.R., his "congregation," all patients.

BOTTOM: A midnight chat with a patient who needs a ride to Cook County Hospital.



A POLICE emergency upsets the routine in Michael Reese's E.R.

ceptance of the program before it began.

Briefing sessions are now conducted during a two-hour period each week, between the ombudsman, the evening supervisor, the director of community relations, and any department head or doctors the ombudsman invites. The new line of communications appears to be creating better understanding among all of the E.R. teams, quite apart from the ombudsman program.

The ombudsman reports to the director of community relations on the working of the program. On duty, however, the ombudsman is responsible to the evening supervisor. He wears a staff badge and has the right to enter the E.R. at his discretion. He can demand attention for a patient in pain. He can request attention for patients who have been waiting any great length of time. He can order an ambulance for any patient who has waited longer than two hours for transportation to Cook County Hospital.

To date the program has elicited only favorable response from the community at large. Patients queried report satisfaction with both the medical treatment and their reception as individuals. Yet there are no tangible results — no *things* which can be pointed out; so it is on the humanitarian aspects alone that Michael Reese is proceeding with and planning to expand its patient advocacy program. As soon as the budget permits, an ombudsman will be assigned to the midnight-to-eight shift; hopefully the E.R. ombudsman will be available around the clock before too much longer.

By request of other department heads, the concept of ombudsman — or patient advocate — is probably going to be extended into many other areas, including not only the clinic, but also the admitting office and possibly the personnel office.

Already the program has proved that all E.R. staff members — interns, residents and nurses — need more training in human relations than they now get. They are in positions sensitive not only on a people-to-people basis but also on a majority-to-minority basis. And then there's the danger that impersonality will be interpreted as institutionalism on the part of the hospital. The medical staff is not expected to hold hands with patients; it is expected to bend a little when the patient's emotions are involved.

Another significant finding is that patients and their relatives will talk more freely to the ombudsman about their treatment and problems than they will with the professional on the case. While it is not the intention of the hospital to create a middle-man for diagnoses, it is possible that the symptoms described to the ombudsman can be relayed to the professional for comparison with the symptoms formally reported. Most important is the attitude of trust which the patients and their families are showing toward the ombudsman.

By analyzing the calls made for dental care, the ombudsman program has revealed how critical is the need for clinical dental care. No dental service is now available in the hospital's service area; the ombudsman reminds the hospital administration regularly and vociferously that clinical service must be provided somehow.

Newly aware of the sometimes unrecognized delays which can occur outside the active E.R., Michael Reese staff members have taken a personal interest in paring down the routine processing time so each patient can have a full measure of professional care in the shortest time possible. ■