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National Health Care: Dangerous or Necessary?

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My husband and I crouched near the speakerphone, stunned by the urgent words coming from my sister-in-law in England.

"Dad has been admitted to hospital because his leg pain can't be controlled with medicine. They are planning surgery for tomorrow. He will probably lose his leg. He says he doesn't want to wake up if he has to live with so much pain!"

The words came quietly and impassively, spoken by a seasoned nurse. Having married into an English family, I have learned that they say the least at the most critical times. Amputation is major surgery, and any major surgery is dangerous if you are frail and 96 years old. My father-in-law Harry survived Dachau, took a bullet during WWII, and even recovered from childhood asthma in the days when it could kill you. We knew the man with nine lives was again tempting fate - this time with an impending hospitalization. Thus, we decided to put our lives in Philadelphia on hold, send our son to his best friend's parents and join the old man. Thirty six hours later, we arrived in Manchester airport, bleary yet determined to support Harry.

Hospital visits can be, and often are, unsafe in the U.S. So much so that a private and extraordinarily reputable group was formed, the Institute for Health Improvement (IHI), to campaign for greater safety and quality. IHI's careful research demonstrated that hospital carelessness has killed more than 100,000 people in the U.S. yearly. According to IHI, improvement in the basics: infection control, clinical documentation, drug management, surgical safety and team communication could save 100,000 lives in the U.S. In other words, the lack of attention to these basic practices killed 100,000 people per year in the U.S.

Although staggering information to the lay person (or potential patient at an American hospital), this information is old news to hospital executives. More than 400 hospitals in the U.S. subscribe to IHI's approach and are attempting to live up to the Hippocratic Oath: Do No Harm. In fact, building on its success, IHI is now staging another campaign: the "Five Million Lives Campaign" intended to protect 5 million people from incidence of hospital-induced medical harm.

Think about it. You or a loved on goes to a hospital and has a good chance of coming home with a problem not there to begin with. Yet we claim to have the best health care system in the world.

The World Health Organization country evaluations ranked U.S. health care systems 37th in the world - well behind such countries as France, Italy, Spain, Austria, Singapore, Colombia and yes, the United Kingdom (which came in 18th). In fact, life expectancy in the U.S. is 24th worldwide. We spend the most money per capita, yet achieve average results. Doctors are aware of the risks in hospitals. Assuming that communication and coordination breakdowns occur, my dearest physician friends in the U.S. are always available and ready to help when someone we love goes to a hospital.

Armed with this knowledge of U.S. practices, I expected to be a lioness when we got to the hospital in the U.K. Wasn't "socialized medicine" inferior, as American media and politicians assert?

Wouldn't Harry have interminable waits for critical care, be shortchanged the best care in favor of wealthier people who could pay for private hospitals and the best doctors? Wouldn't he be neglected somehow when it came to rehabilitation and social services for the elderly? Before I left, a woman on my tennis team asked with great concern, "Aren't you terrified that something will happen to him? We've all heard how socialized medicine is so horrible!"

She believed that a national health system would deliver inferior care, fraught with huge wait times, archaic practices (due to underinvestment and minimal staffing) and poor follow-through.

To be particularly well-prepared, I e-mailed questions to a physician friend who is the head of critical care medicine in one of the top hospitals in the U.S. He advised that, in addition to proper medical care, my father-in-law would need psychological and social support as well. These were rarely provided in the U.S., but necessary for healing, he said. He also had clear advice about pain management.

When arriving at the hospital in central England, the first difference we noted was the openness of the facility. Unlike American hospitals, we didn't sign in. We arrived during visiting hours and walked through well-signed corridors directly to the surgical recovery area. Prior to entry, we used sanitary hand gel from a dispenser for visitors, which was also clearly visible. At my father-in-law's bedside was a chart initialed every four hours by a "sister" - the senior nurse in charge, with documentation of all medicine, food and procedures done at bedside. It was easy to know what had happened and who was in charge.

Although the med-surg unit had six beds separated only by curtains, privacy was maintained when it was needed. More importantly, critical patients were always within view of the nurses. All staff wore badges, and the hallway showed photos of all the types of staff so we could differentiate nurses from aids from attendants by uniform and know whom to ask about what.

We were there for five days, during which time my father-in-law had exemplary care. Pain was managed with the most minimally invasive methods. His surgeon used an epidural rather than general anesthesia - best practice for geriatric amputees - making his recovery much smoother. Infection control was done properly, and his leg healed well. When my father-in-law couldn't adjust his hearing aid, the chief nurse agreed that using acupuncture to help his arthritic hands would be in order. Mild bronchitis, cause by an tube down his chest for breathing during surgery, cleared quickly. In addition, an entire coterie of support professionals came. There was a nutritionist, rehabilitative specialist and even a psychologist who arrived on day three to help my father-in-law understand that as a new amputee, he was likely to have feelings that might be big and uncomfortable, and that she'd help him cope with them.

At the bedside! Trauma recovery! By a trained psychologist! All part of the package of what I was prepared to believe would be inferior care!

Beyond the care coordination, the social service agencies had already been notified by the hospital and arranged to visit Harry's home to determine its suitability for wheelchair access. Years earlier, they installed a chair lift to help him ride from his first floor to the second floor in the home in which he has lived for 55 years. This was done rather than him suffering the indignity and isolation associated with moving from his home to assisted living with strangers.

The National Health Service provided excellent care, case management and continuity, and clearly understood that the story of this patient would not be complete until he returned home. Reintegration into the community is highly valued and is considered part of the responsibility of the care team, who have since recommended modifications to Harry's bathroom so that a wheelchair is

accessible there.

The key word was *team*. A team took care of him, planned his future care and seemed ready to talk to one another without being pushed. We did not need to advocate.

As the family, there was enough else to do - taking care of his bills, his home and his cat. We trust that the care and rehab will be done properly by the professionals. These circumstances are never easy, but I was aware that we had it much easier than I had with hospitalizations of either of my parents in the U.S., where I forcefully advocated for simple dignities and was left, along with other wildly frustrated family members, to organize care and support once my parent left the hospital. Here in the U.S., there were no helpful social service agencies and each doctor seemed to know only about their particular specialty with no clear overall plan. The segmentation was maddening, myopic and took a huge amount of energy.

This episode makes me wonder, if we in the U.S. chose to save all this energy; the worry, the time, the money and the poor outcomes that are endemic in a fractured health care system, what could we do? There is $634 billion earmarked for health care reform, but the "single-payor" option seems to have lost credibility. Yet national health care systems rank way above the U.S. system and cost less. National health care systems outshine ours in many ways. Why, then, is this option off the table in this age of "change?"

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