EDITORIAL

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The Least We Can Do

If you use the letters "TLC" in an emergency department, your colleagues may assume that you're referring to total lung capacity or the thin-layer chromatography results of a toxicology test, or perhaps The Learning Channel on cable television. In New York City, where taxicab seat-divider injuries are not uncommon, they may even think you mean the Taxi and Limousine Commission. Much lower on the differential would be the words "tender loving care."

Although I would never criticize overburdened, underappreciated physicians and nurses who do a heroic job of managing patients in today's emergency departments, I do believe that a little TLC will almost always make the difference between a compliment and a complaint letter for the same expert care provided to the same patient on the same night.

Recently, a colleague from psychiatry told me that the abbreviation TLC originated many years ago as a pediatrician's order at Bellevue Hospital after a study demonstrated that premature infants who were frequently picked up and held by the nurses did better than those who were not. For infants who were not getting that kind of attention, the pediatrician began writing "TLC q_h" on the order sheets.

By recounting this story, I am not suggesting that TLC is the nurses' responsibility or the doctors' right to prescribe. Rather, it should be within everyone's scope of practice and should not have to be ordered by anyone.

I am certain that young physicians, newly infused with the latest medical knowledge and skills and equipped with state-of-the-art technology, must feel that accurate diagnosis and effective cures are more important than empathy and sympathy. We have all known at least one physician who was long on bedside manner but short on everything else. Sometimes, tragically, a physician who is unable to provide even a minimum standard of care but is superb at "handholding" is hailed as a hero by his compromised patient (or surviving family members).

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Now, more often, we see the reverse: a physician or nurse who performs every indicated procedure perfectly, only to be excoriated by a patient for not explaining what is going on, or not providing a bedpan, blanket, or lunch, or for just not "being there" during the many hours that the patient spends in the emergency department waiting for a test result or an inpatient bed.

One aspect of emergency medicine that distinguishes our specialty from others is the close proximity we have to our patients. The most successful emergency department designs are those that facilitate direct observation of all patients. But that works both ways. The patients are watching us, too, and sometimes we walk past them as if we're behind one-way mirrors. Too often we act like restaurant waiters who are oblivious to all attempts to get their attention. We need to remind ourselves that we work in much the same setting as actors who perform in theaters-in-the-round—only our "performances" last 8 to 12 hours at a time.

Thirty years ago, patients spent much less time waiting in emergency departments. If you told me then that I would one day be considering a policy requiring bedside visits and documented progress notes every two or four hours, I would have thought you were crazy. But we live in a different world now, a world of overcrowded emergency departments and long lengths of stay, and providing a little TLC is the least we can do. In some cases, it may be the only thing we can do. **EM**