



**Mount
Sinai**

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Albert Lyons: This is April 11th, 1995, in the archives of the Mount Sinai Medical Center.

We're interviewing Ruth Ravich, RAVICH. This is Albert Lyons. There is Florence Daniels, and perhaps Richard Steele, the archivist, who will be coming in from time to time. When did you first come to Mount Sinai?

Ruth Ravich: In September 1958.

AL: 19?

RR: 58.

AL: 5-8. Yes.

RR: 5-8.

AL: How did that happen?

RR: I was a housewife. And we had lived, my husband and I and my children, had lived in Roslyn, Long Island. And we moved.

AL: Where in Long Island?

RR: Roslyn, Long Island. And we decided we really wanted to bring our children up in the city. My husband also had had it up to the ears in commuting back and forth from the city to Roslyn, Long Island.

So, we decided one Sunday that we were going to move, and we sold our house the following Sunday and bought an apartment in New York. So, when we got here, after

several months, my husband, who was in cancer research, decided that he was not going to be able to do cancer research anymore. It was too mentally difficult for him, and he was going to go into psychiatry. So, he took a residency in psychiatry at Columbia, at Psychiatric Institute. We had two children in private school. We had a cooperative apartment, and his salary was now going to be \$6,000 a year. So, we decided that I had better get a job.

I didn't know what kind of job I could get, but while my husband had been in medical school, I had been administrative assistant for the professor of pharmacology at PNS. So, I thought, "Well, the only place I could go was some kind of a medical center." So, I came to Mount Sinai, and through Bob Siffert, who was at the time, the head of the children's orthopedic pediatric clinic –

AL: S as in Samuel, I, F, F as in Frank, E R T.

RR: I spoke to him, and we decided that I'd come up and try to write for a grant to do some sort of work improving clinic services for orthopedically handicapped children who were at Mount Sinai Hospital. And I did that. We got a grant from the New York Fund for Children for a five-year project.

And I worked in the clinic as an administrator. We had freed the nurse up to do the nursing, and the doctor to do the doctoring. And we put in all sorts of systems and conveniences for the mothers and the children. For instance...

Florence Daniels: Why did you pick that field, orthopedic?

RR: Because I knew Bob Siffert, and he was the head of the pediatric orthopedic clinic. And he was interested in improving clinic care, because the clinics at that time were monstrous.

FD: Okay, go ahead.

RR: So, we wrote, and we got this grant, and we did everything we could think of, to make it better for the children, and for the parents. We instituted an appointment system, there had never been one, we instituted a system where the mother could call and say, "I can't make that appointment. Can you give me another appointment?" And they could change their appointment.

We had a recreation area manned by an ex-student [?] who was a volunteer, to play with the siblings while the mother was in with the doctor. And we had a very nice project, which we wrote up. Some of the appointment things, and some of the progress we made, were later incorporated into Mount Sinai clinics in general, and then eventually they stopped being incorporated.

That led to another project, which looked at multiply handicapped children. And we worked with the schools for these children, who were Mount Sinai patients and were multiply handicapped. And that was jointly with the orthopedic and the pediatric department under Dr. Harris Holtz. And that was a three year project. At the end of that time, Helen Rehr, who was associate director of social service –

AL: R E H R.

RR: Approached me and asked me to go to lunch. I had worked with social service workers on both projects I had done. And she very tactfully said, "I had this idea." Mount Sinai was starting with a medical school, Medicaid and Medicare were coming in, and this was in 1966. And although people from the east Harlem community had always been welcome at Mount Sinai, and at that time, a clinic visit, I think, cost 50 cents, or nothing if you couldn't afford it. The people didn't really feel that this was their hospital. They tended to go to Metropolitan Hospital. And we were going to reach out, and would I take the job in reaching out to the community? And facilitating entry into the hospital. And doing whatever I could to make people feel more comfortable. And I said that I didn't want to work medicines. And Helen Rehr said, "Well, try it for six months." And that was in 1966. I'm still here full time. And I must say, it's been a really rewarding experience.

AL: So, it's not just what she asked you to do at that time, it's changed since then, your work?

RR: Well, yes. It's changed. Because I also – I started in the clinics. If a patient was admitted into the hospital, I would follow them into the hospital. But my main job was with the outpatients. In 1977, I took over the inpatient piece which had been run by nurses.

AL: By the "inpatient piece", what do you mean?

RR: I mean, there was a person here who was called patient representative, patient coordinator, and she had been visiting – actually, that project started with Sheldon King back when he was a resident. An administrative resident. And he was appointed by [unclear] to visit the VIPs, and make sure that they were satisfied with the services. That

service blossomed into a person who was here as a coordinator, to try to make things better for the patients. And she expanded from the VIPs to other patients in the clinic.

AL: These were nurses [unclear]?

RR: Yes. Sheldon King was an administrator, but then the other people were nurses. There was also a person who assisted her, also a nurse. In 1970 – and this was run under

AL: When you say her, “assisted her,” –

RR: That was Mary Ellen McGahan.

AL: Spell it.

RR: M C G A H A N. Mary Ellen McGahan. Worked there for many, many years, first as a nurse, and then as the coordinator for patient services. The other person who joined her after some years, was Nina Auscsik, A U S C S I K. Who is still in my department. In 197– this department was run under nursing by Gail Weisman, who was the director of nursing in 1977. And I was asked to join the departments together. One was sort of focused on the outpatients, one on the inpatients, and to take over as director of – of director of both departments.

AL: That was about what year?

RR: 1977. And since then, we have expanded, and we have gone back. I've had as many as 13 people. I now have eight people. I've been promised more people in the emergency room. 4.4 people started in January, and now it's put on hold, so I don't know what's going to happen with that part of the project. We basically look for or are – have referred. And

about 30% of our referrals come from staff. Medical doctors, nurses and administrators. People were having problems negotiating. Either they can't find something they need; they don't feel that doctors are speaking to them properly or giving them enough information. They have several doctors, and each doctor is giving them different information. We try to straighten out whatever is the problem they are presenting.

We keep our statistics, and I'll tell you about that later. Very, very carefully, try to keep the statistics from the patient's perception. We don't feel that the patient is always right. But we're dealing with the patient's perception, because if they're perceiving something wrong, then we've done something that makes them have that perception. So, we keep track of what things inpatients are talking about. And we report back to the appropriate administrator. Either Head of the Medical Department, the Head of the Nursing Unit, or a director of some other Ancillary Service.

As to the number of complaints we're getting. The location of the complaints, and what the nature of the complaints are. So that they, basically, can start to look at their services from the point of view of the patient. So that we have two functions. One is to find the patients who are in trouble, to get them through the trouble, to resolve their problems as quickly, and as effectively as possible. We work in as non-adversarial a position as we possibly can. Sometimes that gets a little sticky. But usually, we can manage to smooth that over.

FD: How do you find these patients that have a problem?

RR: Oh. The patients are informed about the patient representative department in several ways. It's written on the patient's bill of rights. Which is given to every patient when they come into the hospital. It's on the proxy, that they have the New York state healthcare proxy that patients are asked to sign. Now, this is a relatively new board that would designate someone to speak for them, if they were no longer able to speak for themselves. And automatically, if you have any questions, you call the patient's representative.

FD: Is it user friendly language, or is it more legal?

RR: No, it's user – it's user friendly. Some people feel it is user friendly at a level that is a little higher than some of our users. But it is written by lay people. It is not legally at all.

AL: What else? There are other methods too.

RR: Yes. We have a video that is shown on all patients' TVs, that talks about patients' rights and the patient representative. And the offer is that any problems that other staff are unable to resolve call the patients' representative. So it's as loose as that. And we get approximately 50 to 80 calls a day, on a patient hotline, which is a direct dial – two-digit dial –from the patient's room to the patient representative.

That's only for the inpatients. The outpatients have got an equal number that we are handling all the time. But mostly people who come into the office. For the people who are in the hospital, we usually take the information. Someone at our call center will take the information. There are many things that can get handled over the phone. If the nurse hasn't come in to take the patient off the bedpan, we can usually call the nurse, and get

somebody to come in to do that. But if the patient seems quite upset, or if the same patient calls three or four times, with what sounds like a minor problem, a patient representative will go up, and listen to the patient and see what it really is that is bothering the patient.

And very often it's fear. Fear of retaliation of the staff, and afraid to say that they're not satisfied. It can be that they're in more pain than the doctor – than the doctor thinks they're in. Whatever it is, we will speak to whatever people we need to speak to, just to straighten out the problem for that individual. And then we will keep track of the current problems, so that we can bring that to the attention of the higher ups.

FD: Is all this done in English?

RR: It's English and Spanish. I have a Spanish secretary who will help translate. We have several people. The people in the outpatient department are all Spanish speakers. I have a volunteer who speaks five languages and is in the outpatient department and goes into the inpatient department when necessary.

AL: What is the name of that volunteer?

RR: Esther Bigel.

AL: Spell it.

RR: B I G E L.

FD: [unclear].

RR: We have. And I started getting together a list which is called Interpret Team. And I think I can tell you a story about that too. My first week here I was called down as a patient representative. I was called down to the emergency ward. And there was a Chinese man there who had obviously just been discharged from the hospital the day before and no one to find out why he was presenting in the emergency Room. I was called in. Well, I didn't speak Chinese, either. But my husband, at that time, worked down, worked part-time down at Gouverneur Hospital, on the lower east side. And I knew that they had a Chinese interpreter down there.

So, I made a telephone call. And set up a three-way conversation, and decided what our patient needed, and the doctor examined him, and gave him some medication. And I took him to the pharmacist, because I knew he wasn't going to be able to speak to the pharmacist. But low and behold, the pharmacist spoke Chinese. So, I decided at that point that I would try to get whatever staff we had, who spoke foreign languages, to sign up in something that we called Interpret Team. And we have kept that up to this day. And that was 1966 [unclear].

AL: Is this staff mainly voluntary or paid?

RR: This is paid staff. This is our Mount Sinai staff who are doing other things but are fluent in a language other than English. And can be called on if necessary, to help them.

AL: Yes, but your staff is paid?

RR: My staff is [unclear].

AL: You have no volunteers?

RR: No. I have five volunteers. I have three volunteers who work in the outpatients, besides the one who does the interpreting. She works three days a week. I have one volunteer in the outpatient department who works five days a week. I have two who work two days a week each, and those people have all [unclear]. I have two patient representatives on the inpatient side, who handle the hotline. Four days per week. And two days.

AL: Let me just insert here, that when I became a patient at the hospital in 1986, somebody came to me, right after I [unclear], to do what I'd already done, and asked me whether the pictures in the room, because it was a private room, were satisfying to me, or whether they should change any of them. Cause if I did, they would bring others in.

RR: That was not my program.

AL: That was not your program?

RR: That was an amenities program that was put in by the administration, in an effort to please the people who were paying for private rooms. And they did, they had special snacks, at different times of the day, they had the pictures that you could change if you wanted to. They had several people who would do errands for the patients on those wards.

AL: I was under the impression that they were volunteers.

RR: No. They were paid.

AL: Was that discontinued?

RR: Yes, with the opening of 11 West. Where they have amenities people who do this kind of thing.

AL: Explain that to me. 11 West?

RR: 11 West is the floor for VIP. The rooms are very expensive. They run from – well don't quote me on this, but there's something like \$350 to \$790 a day over the price that the –

AL: So they have this amenities program on that floor?

RR: Yes.

AL: But not on the other floors?

RR: They do have somewhat of an amenities program, on one of the maternity floors. On page [?] five. And I'm not sure what has happened to that, because they've mixed up page four and page five now. And they may not have it. But they do have... A Stork Club, which is a very fancy club for the mothers and fathers, if the mother is in a private room. I don't know how that works, because the people – the maternity patients are getting out so quickly now. They're out in less than 24 hours, and it's more like 12 hours [unclear]. That I don't know, that that's what really happens. I'm not –

FD: How did you start the Columbus [?] Patient Activist Program? How did that come about?

RR: Well, it came about through Helen Rehr's suggestion, and I was going to start working for six months. I came into the hospital. I met with the heads of all the different departments, and I told them I was there to help them with their patients that had problems. This was mostly outpatients. I met with many people – Church groups, [unclear] groups, some of the schools, to offer our services to patients coming in that we thought might have a problem getting in [unclear]. We had some Spanish speaking person at the door. And I just worked... Solving whatever problems I could solve as they came along. And keeping track of what they were. So that I could immediately start keeping track of the recurring problems and try to do something about them administratively.

FD: Referring to that, what were the most prevalent ones?

RR: Appointments, [unclear] appointments, inability to pay, and the clinics. Long waits. Terrible ambience.

FD: But all these are correctable.

RR: Well they're correctable if someone feels that they have priority to correct – to correct them.

AL: But they have not been corrected.

RR: That's not so. We have brand new buildings in the clinics. Annenburg was a new building. It was in a shambles two years ago. They've really done a very nice job in all the clinics. I'm sure the ambience is better.

AL: Improved considerably.

RR: Yes. Except that some of the waiting areas are so crowded, that people are sitting on top of each other. It really is again, needs to be expanded. And they're expanding, into a new building now.

AL: Staying with the outpatient department for a moment. Have there been problems in relation to particular patients that there used to be complaints about? Has there been improvement there? Or about the same?

RR: About the same. There are still problems with treatment. People don't feel the doctors are treating them properly. The doctors sometimes don't show up for the clinic. And this has been going on all along. The residents may be, for instance, the surgical residents are in surgery. The ophthalmology residents are in surgery, and they may come down very late, and the patient is waiting, and there has been no appointment system. So, every patient is given an appointment at 12 o'clock and some of them are still there at five o'clock waiting to see the doctor.

AL: You think that could be improved?

RR: Yes. And there are plans to improve that, because the plans, they have this new IBAX system. I-B-A-X, which is a computer system to give appointments. And supposedly, this will solve some of the problems that have happened with appointments. At the moment, it's impossible to get any clinic on the telephone to even make an appointment. So, it has been solved –

AL: You mean the line's busy?

RR: The line is busy, or the clerks are so busy that they don't have time to answer the phone. They will put the person on hold, or they will say, "Call back after four o'clock." And there is no...

AL: How would you correct that?

RR: Well, the IBAX, the way they have planned to correct it, well, I would correct it by having enough help to do what has to be done.

AL: Like what?

RR: Like having enough people to answer the telephone. The way they plan to correct it. And it's been in the works for several years, at least a year and a half, is to have a central telephone line, that anybody could call for any clinic appointment and they would get the appointment, and someone would get back to them with the appointment. Now that's pretty difficult though. Some of the people don't have telephones. Some of the people don't give you the right address. There are all sorts of problems involved with it. But at the moment, we do not have enough help to really take care of the number of patients we are seeing.

AL: Now, what about the inpatient complaints, the types of things that you hear about?

RR: Well, I just happen to have my annual report. And I'll tell you some of the recurrent problems. Medical record problems. To get back to the clinics. The medical record problems in the clinic have been enormous. The records do not arrive in the clinics on time.

AL: You mean in time for the same for the patient?

RR: For the patient. They can't, many of them can't be found. Sometimes that's because they have been asked for by another clinic and the doctor has decided to take them all to do the research. Sometimes because they're filed incorrectly when they get back, and they don't get back. Medical records department is working on that. There has been some small increase in satisfaction in that medical records department. But the state regulations were changed recently. And they now require that medical records of deceased patients be made available only to an – be made available to an attorney for an estate. Our legal department read that to mean that they could not release them to anybody except an attorney for the estate. And many of our patients had deceased people who didn't have estates or didn't have an attorney. And other hospitals, including some of Mount Sinai attorneys, were releasing these records.

And we were not releasing the records. So, we brought that to the attention of the legal department, and the medical records department. And they revised it, and they said it didn't have to be an attorney. It could be another qualified person. If they looked at the record to make sure that there was no problem. Problems could arise, because for instance, there was someone who was deceased, who had had HIV – was HIV, had AIDS. And the person asking for the record did not know the person had AIDS, and you were stepping on their confidentiality by telling somebody else they had AIDS. So, each one of these is now carefully looked at, to see whether or not it should be released. So, that was one way.

AL: Right. That's the records. Now where are we in the inpatient department? Go ahead.

RR: Advanced directives, which are the proxies where people can say who they want to make decisions for them if they can't make them for themselves. The nurses would not witness those proxy forms. Because nurses traditionally have not witnessed wills, because they did not want to be called to court. And they were taking care of the patients. And there was some reason for it. With the proxy there didn't seem to be a reason that they couldn't witness. It was only witnessing the signature. Not anything else, just that this was the patient who was the person who was signing was the person, but they were quite reluctant to do that. So, I asked nursing administration to send a memo around. And the memo went out, and they were still reluctant to do it. So, another memo went out about six months later. And now, finally they are really, when it's necessary, doing it. The forms, this is back to, there is a non-understanding of the proxy, by a lot of people, including the medical people.

This is a big problem. They don't understand where to look for it. They don't understand what to do if a patient becomes incompetent. They don't know who would have the priority. The proxy, sometimes there's a proxy and a living will, and the medical staff gets very upset about who they should talk to.

Some of the doctors are quite willing to go along with a patient's family when they say, "This patient is on a respirator, and is not expected to recover, and we're going to give them a morphine drip, or we're going to make them comfortable, or we're just going to let them go." And some of the doctors are quite reluctant to do that. They might say, "Well, I'm not going to kill that patient." So, this is an explanation, something that has to be explained over and over again. And indeed, the head of – the Dean for Hospital Medical

Affairs, actually, Dr. Gelernt, has said that he was going to try to set up appointments with all the medical departments, to go over the proxy and the information.

AL: Dr. Gelernt. G E L E R N T.

RR: We, my department and the ethics department, Rosamond Rhodes, have – we set up with the medical department, a grand rounds, for the doctors in the medical department of medicine –department of medicine. And we went over the whole proxy and that was very well received.

AL: Rosamond Rhodes, R O S A M O N D, Rhode, R H O D E S?

RR: It's M U N D. I think her name is an O? O N D? Sorry about that. DNR orders, which were changed by the state from three day renewal of orders to seven day renewal orders.

AL: C and R?

RR: D N R. Do not resuscitate.

AL: D and not resuscitate.

RR: Changed. And there's a sticker that goes on the chart. And everyone thought they had to be changed every three days. It was changed to seven days, but the three day stickers were still on the floors. And it took some time to get them off and replaced by the seven day stickers.

We had some problems with amenities. The patients were informed at admission, that if they took a private room, if they paid for a private room, they could have someone stay over with them, and a cot would be available. But there weren't enough cots, so that they

would come and there wouldn't be a cot for the patients. That was taken care of. They ordered more cots. We had a terrible time with KCC, particularly the floor Five South, which was in really in disrepair.

FD: What's KCC?

RR: Klingenstein Clinical Center. That's the building on Madison Avenue. Some of the – it's old building, and the furnishings were terrible, and the ambience was terrible. It was dirty. We brought – several people complained about it to us. And we brought that to the attention of Support Services.

AL: This Klingenstein Clinical Center was one of the very new buildings in my time, because it was there that the psychiatric department was to be housed, as well as various medical services and beds.

RR: And I remember when they were building the KCC building, and they had an underground river, and it held up building for a long time, because they had to dam up that. I think it was the old Harlem River as a matter of fact. That's something that came out. So that was a long time ago. My department has been very active with compliance for the Americans with Disabilities Act. So that we supply, in addition to the interpreters, and to get back to that Interpret Team, we have over 200 staff members who speak 55 different languages, that we can call on, to interpret for the patients. And we also have access to AT&T language line, which gives us, I think they have 155, or 160 languages, that you can set up a conference call.

FD: What is that? Employees of AT&T that will interpret for you?

RR: It's yes. Well, you pay for it, per call. You call a number. You give the Mount Sinai, we have our own code number, and people can give that number, and they will set up a conference call, with someone speaking practically any language in the world. But in compliance with this, with the language requirements, we have arranged for, since 1994, over 3,300 Spanish interpretations for patients, over 350 interpretations in other foreign languages, and over 200 sign language interpretations, for our patients. In addition, we have in this department, we have made up, we've produced Communicard, which you'll be interested in looking at.

FD: What does the card show?

RR: This card shows...

AL: You're holding up a big card.

RR: Yes. The card shows.

FD: In Spanish.

RR: Well, it's in Spanish, and it can be converted to any language.

FD: And you can [unclear].

RR: It has colorful, easy to understand pictograms, which illustrates symptoms, medical, physical, and emotional needs, as well as healthcare professionals, to whom a patient might want to speak. They're color coded for quick recognition. The patients can communicate with staff members, or families, by pointing to a need, or responding even

by a nod or a blink, if a nurse or a staff member points to one of the symbols. The card is 13 by 22 inches and it's laminated, so it can be used again. It has holes punched, so it can be hung at the patient's bedside. It's easy to store. The hospital has made about \$100,000 on these cards since they were first brought into commission.

AL: What do you mean by "made \$100,000?"

RR: We sell them.

AL: To whom?

RR: To, I would say, probably two thirds of the hospitals in the United States have them. When they...

AL: They bought from Mount Sinai?

RR: Bought from my department at Mount Sinai.

AL: I see.

RR: So, there are two versions. There's the one that is for critical care areas, and emergency room. And the one that is more general. This was made through a grant given to me by the Robert Wood Johnson foundation. So, it didn't cost us anything to produce. All the production costs came from the Robert Wood foundation, and we were free to do whatever we wanted with them.

AL: And so, you were free to charge for it? Okay. Now tell me some more of the types of complaints. And problems.

FD: Sounds like most of this is intelligent housekeeping, really.

RR: Well.

FD: I mean, they're solvable with the right person doing something about it.

RR: It depends. Yeah. With the right person doing something, most of them are solvable. Some of the doctor's problems are well, the housekeeping ones are all solvable.

FD: Yeah.

RR: The, well, some of them cost money, because some of it is because the facilities are in poor shape.

FD: Yes.

RR: The doctor and the nurse problems are not quite so easily solved. Some of the doctors have differences of opinion. They don't get along with the particular patients.

AL: They don't get along with the patients?

RR: They don't get along with the patients. The patient doesn't like them. And they're reluctant to refer the patient to someone else.

AL: You're talking about attending physicians or house staff?

RR: I'm talking about both. Mostly attending physicians.

AL: Attending physicians?

RR: Yes. We have more problems with attending physicians.

AL: And they will. You mean patients, the doctors that the patients have actually brought with them?

RR: And they would like to change.

AL: Yes. And that they're afraid to talk, or unwilling to talk to the doctor about?

RR: They're unwilling to talk to the doctor. And sometimes the doctor is not very gracious if they do talk to them.

AL: Does this happen often?

RR: Well. I don't know what's often. If it happens twice a month, it's often.

AL: Yes. That's often. Let me ask you this. As far as you know, you may not be able to answer this. Are the physicians on the attending staff in this institution subjected to, or presented with, what I could call professionalism, and the nature of professionalism, and what that means. And why the idea of not getting along with a patient, there's something unprofessional about.

RR: Well, I would agree that was something unprofessional, but I'm not...

AL: No, I mean, is anybody – is any of this dealt with, as far as you know, with the attending staff?

RR: Well, I report to a director of a service, if a patient is having a problem with a staff person who I – where we cannot resolve. And sometimes, we would have to go to the director of a medical department, to ask for change of physician.

AL: Well, when a patient complains that way, and one of your staff, or you, see the patient. How do you handle that?

RR: We would first go to the physician.

AL: Yes.

RR: And try to discuss it with him and see what he has to say about it.

AL: And what usually happens?

RR: Usually what happens is the doctor will go back to the patient or will go to the patient with the patient representative. And this would happen with a nurse too, whether it was a misunderstanding or a dissatisfaction, and talk out what the problems are. And almost always, it can be handled.

AL: So it does get handled?

RR: It usually gets handled. Almost always. I don't think I've had to take things to a head of the department more than five times in the years I've been here. It almost always gets handled. We have a problem now, where the family feels the patient is in terrible pain, and needs more medication. Would like to have the patient put on a morphine drip. The nurses agree. The patient seems to be in terrible pain.

The doctor on the case, one doctor has come in and said, "Yes, I would agree." But the other doctor is the attending doctor. The attending doctor comes in and says, "I don't think she needs any more. And I'm not going to help her expire." So, actually, he called one of my patient representatives last night at eight o'clock. To discuss this case, because he couldn't get to her during the day. And the discussion was, "Well, if that doctor thinks that the patient needs to be on a morphine drip, why doesn't he put her on the morphine drip?" I don't think so.

FD: Do you find that there are the same few doctors that there are complaints against? Does it begin to be the 80, 20 syndrome? 20 percent of the doctors cause 80 percent of the problems?

RR: I think, we don't have enough really. It's usually, it's across the board. Sometimes you'll get, we do have a few doctors who, and this would be a matter of communication, who do not communicate with their patients. And a couple of services where the doctor almost never comes in after surgery, to see the patient.

AL: Which service is that? You would like not to say.

RR: Don't put me on the spot.

FD: No. We're not. [unclear] oral history.

AL: One of the departments in which that probably happens is in the cardiothoracic department. Because having been a patient there, I know how that works. The problem with that is, that the surgeons are not only occupied for all of the day, but even after the

day. And that is why that department has put together a very extensive physician assistance group.

These are physician assistants who see the patient often, and they do. And even the residents don't get a chance to come down, but the physician assistants do. They see the patient often. I can testify to that. They are highly knowledgeable. And while I, myself, had no particular problem that required the immediate attention of the surgeon there, I understand there have been. In which case they get somebody who is able to see the patient.

My surgeon did see me. He saw me at intervals, but he didn't see me every day. And I just want to indicate that to have it on the record. And that is the reason they put it that way.

FD: How?

[Tape Two]

AL: We are now on another tape because something went wrong with the machine while we were interviewing Ruth Ravich. This is April 11, 1995. And so we just have to switch to this other tape and we will continue.

FD: I noticed in your CV that you talk about the East Harlem community.

RR: Yes.

FD: Is that all that Sinai concentrates on, or was that your outreach program or what?

RR: That was my outreach program at the beginning.

FD: Right.

RR: Sinai has two communities, really, the East Harlem community and everybody else, the Downtown community, the Upper East Side and people from all over, but the East Harlem community, when I started were the people we were reaching out. And I became quite active in the East Harlem Health Council, which at that time was trying to put together what health facilities were available for the people in the East Harlem community.

FD: Okay. I'd like you to trace sort of the progression of patients' rights and this whole area that you're involved in. I think you mentioned that this was the first hospital that did patient advocacy and then it spread. Can you tell us about that?

RR: We were the first hospital to have a patient representative program that really was making an effort to change the systems.

AL: That's in the city.

RR: No, in the country.

AL: In the country.

RR: Probably in the world. Our program has become a model for patient representative programs throughout the United States and abroad. There are programs now in Israel, Germany, Australia, Sweden. Mostly modeled after our program. Our program was modeled after an ombudsman program, the Swedish ombudsman, the information and referral services that grew up in London after WWII, where people were bombed out of their homes and they needed to find other places and they needed to find their people so that we became an information and referral source. And we're still an information referral source. And of course, the American legal system. The differences are that the

ombudsman, as set up in a governmental ombudsman, only gets cases after every other avenue has been exhausted. So there is nothing that can be done at the time.

They can report and they have a very high level reporting usually to Parliament, so they can recommend the changes to be made at that level. But for the individual it's after the fact, and it usually is not very effective. The legal system, of course, is an adversarial system the way it's set up with us. And we try very hard not to be adversarial because I find that the way to get things done for the patients is to make sure that everybody is working together, that you're not working against somebody. They're our patients, not your patients. And the information and referral were just carried on. And we do at least 20-30 cases a day of information. As a matter of fact, people are calling us instead of calling the operator because you can't get the operator on the phone. So, we do a lot of information and referral this morning.

I had someone who was asking for a doctor for a second opinion. Of course, now they have the Mounts and the Sinai mine, but they didn't have that before. So that's the basis of it. And the other programs throughout the United States and abroad have based their programs on mine. In 1971, no, in 1969, some of the patient representatives; three, one from Philadelphia, one from Long Island, Jewish and myself were invited by the United Hospital Fund to come to meet. They thought at the time that this might be a very good place for their volunteers. We all talked about what we were doing and were amazed that the problems we saw in our hospital, which we thought were terrible and were only happening in our hospital were actually happening in the other hospitals too. It was decided that this really, although volunteers could help in the program, this really needed paid staff people to make it effective.

So, we sent letters to hospitals across the Eastern seaboard to see where patient representatives were. And we set up a meeting in Philadelphia and about 120 people arrived. And we all talked about what the possibilities would be. And we started an association of patient representatives based in New York, but none of us had the assistance to do anything more than what we would do with-

AL: When was this?

RR: This was in 1970, '69, '70. '70 to '71. In '71, we approached the American Hospital Association to ask them, could we affiliate with them in some way? Now we were quite aware at the time that if they accepted us and they did, we became the 13th member association of the Hospital Association. It would be because they felt our advocacy role would be less difficult for them to handle. In other words, they were co-opting the advocates.

And we handled that by allowing people who were not hospital employees to be members of what became the Society of Patient Representatives. After that, it was the National Society of Patient Representatives. It is now called the Society for Patient Representation and Consumer Affairs of the American Hospital Association. And there are about 1,500 members. I was the first President of that Society and I've become active – I've been active in it ever since.

FD: Well, is Mount Sinai still the preeminent role model for the rest?

RR: Pretty much. Yes.

FD: Now let me ask you a futuristic question. If we did this interview 10 years from now, where do you think we would be? Would many of these minor things be settled? Would there still be large, large problems?

RR: You know, I was convinced that after I had been here for a year, there would be no more problems. I would be able to solve everything. And as a matter of fact, when Dr. Case came in as head of Sexes and Gynecology before he became the Dean and I went to introduce myself in the program to him and he said to me, "Well, if you are here, I don't see why you can't get everything fixed up." I want to tell you that you can get one thing fixed up and something else is going to break down. I don't really believe in an organization this size, you can ever get everything to satisfy everybody also, that everyone can be comfortable in the facility. It's not a manufacturing automobile. And you can say that we have to handle it. We have to re-engineer. We have to be like any production company. There are too many variables with the patient.

AL: How do you think Mount Sinai stacks up in that respect with the other hospitals in the city?

RR: In being nice to people?

AL: Well in having the patient representative problems present.

RR: I think it's just the same. I think it's just the same. I always feel as though I have the worse or difficult to solve. They're not. We can really solve almost anything, except when we run up against, "we don't have enough help." I mean, I've, I've lost staff. I lost 70% of my staff in the outpatient department last year. And we're doing still doing about the almost half the number of cases.

AL: Is there anything you think the board of trustees could do about this?

RR: Yes. I think they could look at the kinds of statistics that are coming in and see what things we are doing.

AL: Let's have some of the statistics because that might help.

RR: For 1994...

FD: While you're looking that up, let me ask you, this revolution in medical care, will that bring more problems in your opinion or will it take them [unclear]?

RR: I think it will make more problems for the patients. I think people are and will continue to be discharged before they are ready, either medically or socially because people sometimes have to go home and really have no support at home. I think the bottom line, the money line is always difficult when you're trying to provide service and at the same time cut costs.

AL: Are you referring by 'the revolution' to the new HMO type of –

FD: That whole need for more funds and more efficiency in putting people in HMOs and so forth, the DRGs and so on.

RR: Well, the DRGs are pretty standard now. I think the HMOs –

AL: The DRG, meaning Diagnosis Related Grouping.

RR: That's the way the hospital is paid for each patient that comes in. I think the HMOs will be fine for the younger population. People who are relatively healthy. I hope they'll be fine for other people. I'm sure they will be doctors who treat the older people very successfully. But I think the idea of keeping money or being able to have more money, because you do not refer a person to a specialist will tend to have some people who need a specialist not refer.

That doesn't mean that they're not perhaps over referred now, but I think that gatekeeper is going to be a very difficult position for any doctor to have. And I think always when

your bottom line is, you've got to save money. That means you have to not do something else. And that doesn't mean that a lot of the doctors were not ordering too many tests.

They're still ordering too many tests.

They're not using themselves and their knowledge. They're not confident enough about what tests are needed. That doesn't mean that some tests are not needed. And I think the malpractice issue and unless the government makes it go away somehow by capping things at a rate that patients are not going to be recompensed when they really should be. I think that's going to continue to drive up medical cost. The HMO will cut them back. But I think in cutting them back, they'll also be pulling back other things.

AL: How about the statistics you were about to give us?

RR: Yes, we had 7,166 problems last year.

AL: 7,100 and-

RR: 66 problems. We had 8,007 other services and that would include patient and family support. These are people who are in trouble and just need extra talking to or extra help in coping with what they're doing. We need staff support. When the staff can't cope with the patient they'll call say, "Please come up and help us." And this patient will not be discharged. Didn't get out of the hospital. We have to get them out. You can call, you can get in there and find out why they couldn't get out. There was nobody to pick them up. There were all sorts of arrangements that could be made. I try very hard to keep my staff part of the team, but a little away from the team. Because I find that when you're an integral member of the team, it's very hard once the decision is made to bring in some other ideas or something else that would make it better for the patient.

So, although we are on the floors and everybody knows us, we're a little bit separate from that team that's making all the decisions. So if we find out that the patient needs something else, we can always go back and they can't say, "Well, you were part of the decision making." Because we were not. So that helps. We had Special Services and that's any kind of arrangements we would make. We've had several weddings in the hospital for instance, we'd make arrangements for that. We had one where mother was dying and the daughter was supposed to be married the following month and they didn't think the mother was going to make it. So we had a wedding in the chapel. We have some where the patient was dying and wanted to get married. We had one where the woman was going to have children, actually was going to be twins. And she wanted to get married before the baby was born. So we arranged that one. So that's kind of a fun thing. We have enormous number of errands and information, 5,100 people last year.

AL: You call that what?

RR: Errands or information. That would be somebody needs something from the gift shop desperately. They don't have a piece of writing paper or they want to visit a relative who's in the hospital and there's nobody to take them. We might even push them a wheelchair to see that other person, whatever. Any kind of special errands we can run. We do notaries and a lot of proxy information about the proxy. Talk about it. We also show a film on the video talking about the proxy. Patients can make up their minds, but this of video was made by the FOJP. That's the Federation of Jewish Philanthropies and it shows the advantages of having a proxy and also shows that it's not that you don't have to have it. It's perfectly voluntary. And that it means you can put down what you want. Either, you

want to have things done or you don't want have things done. And then the interpreter services. And I talked to you about that.

AL: Now the 7,660, I wasn't sure what it referred to.

RR: Problems, problems and complaints.

AL: Problems. Yeah. And the 8,000?

RR: Other services.

AL: Okay.

RR: And 2,500 some odd interpretive services.

AL: Right. Okay.

RR: And I present graphs of inpatient outpatient.

FD: If you wanted to sum up what you needed most...

RR: I want to talk about something else because I want to go talk about Sarah Lawrence.

FD: Just let me speak the one question.

RR: Okay.

FD: If you had to talk about the most serious problems, just like one or two, overall, not just statistically, but how do you see that?

RR: Communication is the most. And that would be communication between patients and families and either physicians and owners. That's most difficult and the most frequent of the problem area.

FD: Right now go on to Sarah Lawrence.

RR: Okay. In 1979, I was on a committee of the National Academy of Sciences investigating the effects of biomedical research on patient care in the Veterans Administrative Hospital. And through that committee, I got to know a woman who introduced me to Joan Marks. Joan Marks was the head and is still the Director of the Human Genetics Program at Sarah Lawrence College.

AL: That's M A R K S?

RR: Yes. She thought it would be a good idea for Sarah Lawrence to have another health related program. And she thought perhaps how advocacy would be a good program. So she asked me to work with her and we got together a plan of how we would present this on a master's level. She got some funding for it. And in 1980, we opened it up. We had our first class, I think, of 17, 16 people. It was in a year and a half course. And the students study economics, health management, ethics, reading a chart, physiology, their whole course that they study and a year and a half, they have a Master's either in a Master of Science or there's another – Master of General Studies or something else [unclear]. But in it, as part of the course, they work for 200 hours in a health facility. And people who have been in interns in my program are the people I have hired as I have had jobs filled. And they are quite wonderful. Marvelous.

FD: Now, was that a pioneering entry –

RR: Yes, that was the first and it is still the only Master level program in health advocacy. There are several colleges that have courses that would relate to, but this is the only one that gives a degree. Now, St. John's College on Long Island is going to start giving some courses in the Fall. One of the things that happens with the Sarah Lawrence and I'm still,

I taught in that program for five years, and now I'm a Special Advisor to it. One of the problems is it does not give night courses or Sundays or Saturdays – weekends.

And there are many people who would like to go, who are working and can't do this program. So, the Sarah Lawrence, although it's not going to be on a Master level, it'll be courses that people who are in the field can take. For instance, they can take the legal course, which is very important.

FD: It was St John's.

RR: The St John's program. This program is really for someone, although people who take it can work, at the same time, they have to take at least a day off a week and sometimes more than that. And it's very downward.

FD: Now in this rather unstructured interview, which is the way we want it to be. What haven't we covered that you'd like to comment on?

RR: Well, I think the Oxford piece is very interesting.

FD: Okay.

RR: We talk about that on?

FD: No we didn't. The Oxford University in England.

RR: Oxford University in England. Some people from Oxford were here two years ago and I spoke at an Oxford Mount Sinai consortium meeting, which have been going on now for four years. One year it's in Oxford, one year it's in Mount Sinai. And two years ago, 1993, it was at Mount Sinai. And I spoke about patient representation. And I was asked to come over to Oxford to tell them about it. Because they are starting to replicate our system as we are going toward their system, which was very interesting.

There's a lot of private medicine going on in England. And they were very interested in the idea of patient representation. So, I went over and I spoke and actually my speech is being incorporated as a chapter in a book that will be published by Blackwell Scientific in January. Last year, the Mount Sinai people went to Oxford. And I spoke again – and I spoke about the proxy and patients' rights and patient care [unclear].

FD: You say the British system is moving more towards private companies.

RR: Yes, well, the national health is still there and functioning, but many patients are going outside if they can get private.

AL: Now you said the Mount Sinai people went there, which people?

RR: This is a program. It is called the Mount Sinai Oxford Consortium. It is made up of people from ethics, mostly bioethicists.

AL: From the bioethics group.

RR: Right. Run by Roseman Rose again with representation from Princeton Brandeis, CUNY, Mount Sinai, think Williams, there are several more groups included and everybody makes a speech about whatever they'd like to speak about. And we all talk about it. It's very interesting.

FD: I see that you've given presentations on subject to places like the American Jewish Congress and the American Women's Bar Association. Is that the shape of things to come? Most everything else is hospital oriented.

RR: Well, there was the Library Association. That's really only a selection. I've done presentations at other places. I can't really say them all off hand.

FD: But this is consumer information, in other words.

RR: Yes, mostly consumer information.

FD: Is that an up-and-coming field, consumer information?

RR: I would hope so. I think it's very important. We've also done consumer information, particularly in the East Harlem community about the proxy. We've had open meetings and we've gone out to senior citizens groups and to settlement houses. We talk about the proxy and the advantage or disadvantage as you may look at it.

FD: Now does – does the proxy really accomplish what it's meant to do, in your view?

RR: I think it can. But I think it does in some cases. It has not settled down into a system. There's too much play in what the doctors know about it and what they feel obligated to do. Because the whole healthcare profession is set up to save lives. And it's very difficult for doctors to say, "this is beautiful. I don't think we should do it." But with the cost problems coming so prominent, there are going to be more and more cases where it is going to be used and people are afraid that it will be used to end life for cost saving places.

AL: Now, what is it, do you think, the Board of Trustees of Mount Sinai could learn about or could be informed about and could do that could improve altogether the services to patients at Mount Sinai?

RR: That's a hard one now. I think they're very concerned about the bottom line, as they need to be, but they should also, or perhaps also could be a little more concerned about the treatment that patients are getting while they're in the hospital. They do a very extensive patient survey after the patient is discharged. And I think, although there are lots of people who disagree with me because these patient surveys are being done all over the country.

I think that the problems that a patient has when they're in the hospital may not come out once the patient has left. If the patient feels well, they may not want to bother talking about the problems that they had. So unless you look at what is happening to the patient in the hospital, you really don't know what the good things and the bad things are. And if it's good enough to say, well, once they're out and if they have a positive attitude and they're going to refer patients here, if that's good enough, then you have to leave it that way. But if you really want to know what's going on, you have to find out what's happening to the patients while they're here.

AL: Suppose you were a Trustee. And you were an Officer, let's say Board of Trustees, what do you think you could do?

RR: I think you could go and look at the patient representative statistics and see what they're actually angry and what things are coming up, what the patient's perception is of the care, what the patient's perception is of the care they're receiving. For instance, with all this re-engineering. Now maybe the Board of Trustees thinks because eventually the re-engineering is going to lead to better service, which it may or may not. I think it may. That doesn't mean that the patients can be completely neglected and things done around them.

AL: Isn't this report of yours... doesn't that go to the Board of Trustees?

RR: A very small piece of the report goes to the Trustees.

FD: What is this re-engineering? We don't have that on tape any place.

RR: Well, I think if you want to know about re-engineering, you have to get it from the horse's mouth. And I think you have to speak to Wendy Goldstein.

FD: Wendy.

RR: Wendy Goldstein, who is the Associate-

AL: But engineering is a general term. It means re-arrangement and reorganization is really what it means.

RR: And here what it does, very briefly, because I don't want to go into it too much. We are reorganizing so that different services, related services will be managed by the same people. For instance, the cardiac service and the cardiothoracic service will be managed on a business and a clinical level by the same, there happened to be two people there. There will be a clinical person and an administrative person in charge of each of the care centers. And they expect to have seven care centers here. The two that are up and starting to work are cardiothoracic and GI. So that would be GI medicine and GI surgery, which makes a lot of sense because people get referred back and forth from GI surgery to GI medicine. And sometimes what has happened is that, once a patient has had surgery, the surgeon is no longer interested in them. And the resident – the physician of that same service hasn't picked them up. So, there are people who get lost between the cracks in that regard. That may help –

AL: In other words, the medical side, just as an example on the surgical side of gastrointestinal diseases would be into the same overall department.

RR: Right. And hopefully that will improve things. The bottom line for this re-engineering is money. They feel it will save money.

Speaker 4: Excuse me, I'm sorry, Mr. Steele here? Thank you.

RR: Because they are retraining people to do a multitude of jobs. If they feel that if someone has just one job to do, there's a lot of downtime. If they have many jobs to do, they can keep time whether this works or not remains to be seen. It's too new.

AL: Of course, you know, like you should be put on tape here that the surgical department, as just an example, and the gastrointestinal department, the GI department, have always been very close. Not only have the people been close to each other, but there are joint meetings. And I would say of all the departments, the GI department and the surgical department have been so close that it's interesting to me, that it has felt now that it needs even more of this consolidation.

RR: Well, it's a different management effort. And I think the fact that they are so close may make that one of the successful places to join.

AL: Well, then it isn't for the benefit of the patient, primarily it sounds to me, but more as an organizational matter for costs and the ancillary personnel. Is that true?

RR: Costs – no one makes any bones about it. It's the bottom line.

AL: I see.

RR: And it's a way of making things.

FD: Thank you.

[End of Interview]