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VIEW FROM THE HOSPITAL BED

A New Perspective

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I lay tossing and turning in the uncomfortable bed; the strange room with cables and stands strewn everywhere was very familiar but at the same time alien to me. I lay there thinking how I ended up here. Only a few short weeks ago I was on my way to a successful career as a hospitalist. I had just finished my chief residency, confident in my skills as a clinician. I considered myself to be a strong patient advocate and felt proud of the fact that I kept the patient above everything else. But I had no inkling of what the future had in store for me. I was not supposed to be a patient, I was young and healthy; surely this had to be a mistake. I realized that I just wasn't ready to handle the situation from the other side!

My nightmare started about a week before, when I woke up with excruciating abdominal pain, too weak to even call out for help. I eventually mustered enough strength to call Emergency Medical Services (EMS), the differential diagnosis of my symptoms going through my head. "Surely I had perforated an ulcer!" "The increased proton pump inhibitor consumption wasn't just because of the rigors of the chief residency."

At the triage station, I could see the nurse looking at me, I knew that look, "Great! She thinks I am a pain medication seeker." Even though it was a rude awakening, I realized I was disheveled, unkempt, and looked like anyone else on the street. Between spasms of pain and nursing my bruised ego, I blurted out, "Can I have something for this pain!? I can't take it any more." All I got back was a blank stare and a dry, "We will have to wait till the doctor sees you."

The Emergency Room (ER) physician recognized me as one of the new hospitalists. The demeanor of the staff changed perceptibly; I got the pain medications and the nurses paid close attention to my overall comfort. A battery of tests was ordered and an abdominal computed tomography (CT) scan revealed acute cholecystitis. I underwent an emergent cholecystectomy. On the third postoperative day I developed a nonproductive cough. The fever started within the next 24 hours. A CT scan revealed a large left lower lobe pneumonia.

"God, why is this happening to me?" I was in a daze while arrangements were being made to admit me. It was a different hospital, but here the treatment from the nurses was completely different. They had known me for almost 4 years, and had followed my progress from a green, wet-behind-the-ears intern, to a chief resident, and eventually to an attending physician. Over the years they had learned to trust and respect me, but more importantly they had a bond with me that had developed over the years. This familiarity affected their interaction with me in this different role. I was astonished by how different our behaviors can be, based on our perception of the patient. As medical professionals we want to think that we look at people through the same lens, but our biases can creep up on us without us even realizing it.

I required a week of intravenous (IV) antibiotics before I was discharged home. Multiple blood draws, sometimes scheduled an hour apart; nurse evaluations in the middle of the night; and the nurse call light for the entire floor waking me up at odd hours exposed me to a new dimension of being hospitalized. This incident opened my eyes to a power differential that exists between patients and the healthcare providers. I realized that we are very quick to point out that we are doing what is best for a patient, even if it is uncomfortable or downright scary—without ever considering the emotional and physical turmoil a patient is going through. My experience changed me; I recognize the anger a patient feels because of multiple blood draws every day. I now understand how the constant interruption of sleep cycles because of laboratory draws and vital sign monitoring would inexplicably make an octogenarian lose all bearings of time and place when hospitalized. I find myself asking if I really need to make my patients go through an entire battery of tests, or is there something else that I can do to make their hospital course any easier. I feel the need to sit down with my patients and ask them about small things, their pain control, and their sleep patterns during the hospitalization. I have realized that these small gestures can make a significant impact in the interaction between a physician and a patient.

As physicians and medical professionals, we come with our own set of biases, but our profession further jaundices our opinions about patient needs and demands. Biases are not just based on age, sex, or socioeconomic background, but also on our perception of the severity of a disease process. Perhaps words like "frequent fliers" and "gomers" are just a manifestation of this prejudice. We are taught to be objective in our daily interactions with patients, but this also indoctrinates a degree of cynicism. Slowly, this

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cynicism creeps into our daily patient interactions. We forget that patients with multiple medical problems and frequent admissions also need our help. A lack of tangible diagnosis does not mean the absence of disease. As physicians, we need to evaluate our interaction with patients closely. It is the "frequent fliers" and the old and debilitated individuals that need the closest scrutiny. If a patient with multiple admissions for pain has come in, we need to give them the benefit of the doubt when we address their complaints. I have realized that the occasional manipulative patient will let me down, but in order to practice this profession I have to leave skepticism out of any patient interaction. I recognize that I am not going to transform patient behavior, but I can try to give them the advantage whenever I can.

Our education system values compassion and professionalism, and we try to inculcate these values in our young physicians. Our curriculums try to incorporate compassion in our daily patient interactions, but I feel that simulated patient encounters and checklists make patient contact mechanical. We develop skills to diagnose diseases through repetition, but we fail to teach our students about the individuality of a patient. In the age of quality improvement and patient safety, the ethics and basic decency of our profession has taken a back seat. My illness has forced me to consider my role as a clinician-educator. I feel that this experience was as important as any training I received in my journey as a physician. Looking at the spectrum of disease from the other side has opened new avenues for me as a physician. I have come to realize that as educators we have the responsibility to teach our students to become empathic and considerate healers.

Feedback surveys and simulated patient encounters give us an inaccurate assessment of student interaction with patients. These controlled environments can never take the place of a real patient. Time spent at the bedside with a patient or a family is becoming scarcer because of time constraints and work hour rules. But despite these changes we can devise new ways to stimulate critical thinking. Interaction of residents with patients can be outside of their daily responsibilities. Perhaps a rotation in which the residents review charts and interact with patients in a purely nonclinical role will force them to look at people as individuals rather than just patients. A desensitization at the end of residency to make them think as human beings first and physicians second might modify their decision making. Role reversals can serve as a valuable tool to achieve this goal. Perhaps our evaluation system needs to change from a retrospective subjective scrutiny of resident performance to a more objective analysis of patient care.

I strongly feel that we need to instill these virtues in our trainees. Perhaps they will never fully grasp the vulnerability a patient feels while lying in a hospital bed, but it is neither naive nor overly optimistic to suppose that this education can have a constructive effect on their behavior.

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