Reflections

Doctors as patients

On the other side of the bedside: a cautionary tale

ANONYMOUS

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When a doctor is related to the patient, their medical opinion may be dismissed as biased or irrational. Can there be no way to use their clinical expertise, a doctor asks.

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As a doctor for over 35 years and a specialist physician, I have often been asked for a medical opinion by people I meet socially or through work. There has been the odd success story and, of course, many failures. Most opinions were ignored – they were free, after all. The fact that full formal assessment, including examination, is not possible does make these situations tricky, and the sages would be quick to advise against giving these opinions. Not having clinical and legal validity can also make things difficult for both the doctor and the patient.

The author, who wishes to remain anonymous, is a specialist physician and the husband of the patient.

I have also had occasion to offer medical assistance on aeroplane flights and in other public places, and interestingly nowhere was I asked to prove my credentials. Claiming to be a doctor seemed good enough, even if the problem was one where I had no expertise. But what if you happen to be trained, qualified and experienced in managing an acutely unwell patient but you are a close relative of the patient, who is in hospital?

I cannot be the only person who feels that the presence of a medically qualified relative at the bedside is generally unwelcome to treating teams, who may become antagonistic, to the potential detriment of the patient. Whether this reflects a lack of confidence (mostly in the junior team) or whether medical relatives are usually meddlesome, I am unable to say. Perhaps it is both.

A doctor becomes the patient's relative

My wife, a fit 53-year-old with no significant past medical history, recently underwent elective abdominal surgery. The surgery was successful, and her blood loss was estimated as less than 400 mL. On postoperative day 2, her haemoglobin level was found to be 70 g/L (preoperatively it was over 130 g/L), and she was transfused with two units of blood. Otherwise she made good progress until the evening of day 5, which was a Sunday. That night she collapsed, hypotensive and unconscious, three times. The third time led to a 'cardiac arrest' call.

I found it difficult to convince the treating out-of-hours team that they should actively rule out bleeding, sepsis, hypovolaemia

(requiring more aggressive fluid resuscitation than the treatment ordered – a small bolus of normal saline followed by 1 litre over 12 hours) and pulmonary embolism, and also that they should discuss the case with a senior doctor. It is likely these diagnoses were considered, but the possibility of bleeding was not pursued because of a haemoglobin result of 110 g/L on an arterial blood gas machine. It had been 90 g/L the previous day.

My suggestion to order a blood culture was refused on the basis of a normal white cell count and C-reactive protein level and lack of fever (my wife had become hypothermic and was being warmed up). At my insistence, fluid administration was speeded up to 1 litre in eight hours. Pulmonary embolism was ruled out on clinical grounds. The senior doctor (an anaesthetist) was contacted and apparently agreed with the management plan. No other action was taken that night.

I had sat with my wife at all hours from day 1, except overnight and compulsory lunch breaks, and was allowed to stay with her on the Sunday night she collapsed, perhaps as a 'perk'. It was harrowing to watch her and the heart rate/blood pressure monitor – something that causes me distress even as I write this. Her systolic blood pressure hovered always under 100 mmHg, sometimes as low as 85 mmHg (it had been near 140 mmHg that afternoon), her heart rate around 100, and up to 115, beats per minute, and she remained clammy, cold and obtunded with a low urine output throughout the period midnight to 9 a.m.

The next morning, thankfully a Monday, my wife collapsed unconscious again when she was sat up. This was paradoxically fortunate because it led to action – central and arterial lines (again), blood transfusion, aggressive fluids, return to the intensive care unit and a CT angiogram. The previous night's haemoglobin measurement on the blood gas machine was discovered to be incorrect. The actual result on a venous sample taken that night was 70 g/L, but I assume this was either not seen until the next day or ignored. My wife's collapse was finally attributed to blood loss. No infection was identified. No tests were done to rule out pulmonary embolism. My wife made a hesitant recovery but is now terrified of hospitals, even though she found the surgeon's care outstandingly good.

What do I conclude?

The team may have known that I was a doctor, but I had mostly kept out of the way until the night of the arrest call. I do not believe I was rude, but concerned and frustrated. The on-call doctors and critical care nurses appeared defensive and intent on not doing anything I suggested. Despite being a person who supervises, trains and teaches similar doctors, I was unable to contribute anything to the situation, where the team seemed ill at ease.

Of course, a doctor's medical opinion can become biased and irrational when dealing with a close relative, but on the other hand can there be no way to use the expertise of a person who happens to be there? Recently, there was a news report about an airliner that was landed with the help of a passenger who was a pilot, after the original pilot became incapacitated. The airline later claimed that the crew would have managed even if that help had not been available! Hospitals will probably make similar claims.

I cannot help feeling that I was that day a 'prophet without honour … in his own town'. In the same health service that recognises my expertise, it was not wanted and seemed in fact to be considered a hindrance and positively ignored. I suppose I should be grateful that people elsewhere still consider my opinion worthwhile, and more importantly that my wife is still alive. MT

CONSULTANT'S COMMENTS

This story highlights a couple of lessons about compromised patient safety. The first lesson is that day 5, when the problem occurred, was a Sunday. It is well documented that weekends are potentially dangerous times for patients, particularly those in hospital. Their usual medical or surgical team is not present, residents and registrars may be covering several teams and have a heavy workload with less time for each patient, the information given about the patient at handover may be inadequate, nursing staff may be from agencies and less familiar with the situation and the consultant on call may not be the patient's own doctor.

What is the answer? Until the system of out-of-hours cover can be improved, all staff providing this cover should be aware that this is the time when patients are most vulnerable and staff need to be extra vigilant.

The second lesson is that the staff were not prepared to listen and give credence to the husband's observations. Sadly, some medical professionals become defensive when patients or families question them or make observations. This may be partly because we do not want to look as if we need help (particularly from a patient) and partly because we confuse the patient's observations, which are generally accurate, with their attempt to make a medical interpretation, which is often inaccurate unless they have a medical education. In becoming defensive, we throw the baby out with the bath water and lose valuable information. Patients are good observers about what they are experiencing. Our job is to listen respectfully and to make the interpretation.

The best doctors regard the patient and family as part of the medical team. They encourage them to ask questions and report events because they know these are valuable. There is a growing literature on the benefit of including the patient as part of the medical team, and there are also studies showing that patient-initiated rapid response calls are not overused and save lives.

So whatever our type of clinical practice, remember that weekends and nights are times to be extra vigilant. Patient care is enhanced when patients and immediate family are included as part of the care team.

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