Reflections

Doctors as patients

A view from the receiving end

ANONYMOUS

In the first article of a new series, an eminent specialist explains how being on the other side of the doctor–patient relationship can be most enlightening.

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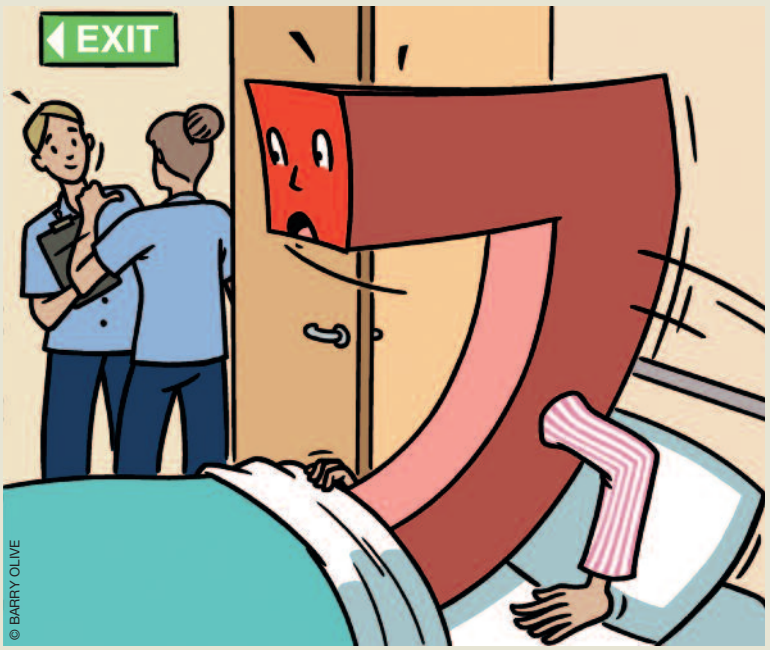

I was amazed. A routine prostate screening suggested cancer. A biopsy confirmed that treatment, rather than watchful waiting, was necessary. Until then I'd imagined I was invincible.

The surgeon explained the options carefully and listened to my concerns. I felt confident I'd be in good hands.

My experiences in hospital had been extensive – daily ward rounds for over 30 years, knowing the ins and outs of the system, feelings of control and of being very at home in the environment. Sound familiar?

But my experience at the receiving end was nonexistent. That was about to change.

FROM THE PATIENT'S SIDE

On the morning of surgery I was shown to my room to await the anaesthetist. As I was reasonably well known there, I was kindly upgraded to a more 'upmarket' room. What they omitted to record was that the patient who had previously occupied that room had gone home. I slipped into the bed. Thirty minutes later a nurse came in and asked me to roll onto my side so that she could check my back. A soft alarm went off in my mind. I asked 'Why?', but a stern look from the nurse made me decide compliance was the wisest option. So I obeyed and displayed my back. The nurse gasped, 'I thought you'd had a laminectomy!' A case of mistaken identity with potentially serious consequences. Come in for a prostatectomy, go home with a laminectomy.

Mistaken identity can be quite common in hospitals. It can easily be prevented if the patient's ID is always checked, and their identity is confirmed by asking the patient, not just by stating their name as in 'You're Mr Smithers aren't you?' A compliant Mr Smith – possibly a little hard of hearing – is likely to say 'Yes' and receive haloperidol instead of flucloxacillin. Imagine how confusing and potentially dangerous it could be with sound-alike names of people from non-English speaking backgrounds, where the patient's command of English may be poor, and the staff member's pronunciation of the name may be worse. Better to ask the patient to state their name and spell it if necessary, and to double check by also asking their date of birth.

Postoperatively my body was doing well. Pain management was excellent, and I was soon on food and oral medication.

But in medicine we often forget how difficult it can be for patients when they suddenly have no control over events and have difficulty maintaining their dignity: the shapeless gowns that don't do up properly at the back, the assumption that you want to be called by your first name, the conversation that drifts in from the corridor 'Bed seven is going home tomorrow', and the sudden realisation that you are no longer a person, just 'bed seven'.

Most staff did introduce themselves, but only by their first names, and it was hard to tell who was an agency nurse, a nursing assistant or a hospital-employed RN. The only person who didn't introduce themself was a young male doctor who breezed in and immediately started asking a rather personal question. Was he a courier, a nurse, a technician, or just a curious passerby? I had the temerity to interrupt and suggest he first tell me who he was. This wasn't comfortable for me, lying there in a gown with a drainage bag and catheter. Would many patients outside the health professions be confident enough to ask?

Apart from the first episode of mistaken identity, patient identification was generally good. I was always identified before being given medications, but the busy staff generally left the room before I actually took them. For all they knew, I could have been saving them up for a suicide attempt or a drug deal with 'bed 26'.

Thirty-six hours after surgery a pleasant young nurse came in and announced she was going to shower me. So there I was, wearing nothing but a urinary catheter and bag, being led into a shower, soaped, washed and rinsed. Only one party seemed to be embarrassed and it wasn't the cute nurse. Hard to retain one's dignity in that situation.

Later that morning my blood pressure was low and, when my normal antihypertensive medication was brought in, I said I'd rather not take it in view of the low BP. 'So you are refusing to take your medication' was the response. My recalcitrant behaviour must have been recorded in the notes as the next morning another nurse handed me the drug and asked whether I was 'going to refuse the medication again'.

I was aware of multiresistant organisms in hospital and concerned about adequate hand washing. I wondered how best to handle this. It's not easy for a patient to ask a health professional whether they have washed their hands before they touch you. It wasn't easy for me, and I belong to the same club. I decided to put my own bottle of alcohol-based hand wash on my bedside table with a sign 'Please humour me and give your hands an extra wash'. I might be regarded as neurotic, but no one seemed to notice it anyway. I did pluck up the courage to ask some staff whether they had washed their hands – most had and none took offence. But again, it's not easy unless we tell patients that it's OK to ask.

Then there was the surgical complication. Within a week of surgery I was having quite unpleasant and rather unusual pain. I emailed the surgeon who thought it couldn't be related to his surgery and suggested physiotherapy or, failing that, a referral to a neurologist for neuroleptic pain relief.

Many doctors don't have a GP. They should. Fortunately I do and he's very good, so I asked what he thought. He did a thorough physical examination, thought a postoperative pelvic fluid collection was the likely cause and ordered an ultrasound, which confirmed his diagnosis, so appropriate management was set in train.

WHAT DID I LEARN?

There were lessons in my experience for myself and for us all.

Firstly, patient misidentification is a problem in the health system. It can occur for many reasons, such as the patient being in a different bed from the one organised – as in my case – or from look-alike or sound-alike names, or from simply not checking thoroughly. It can always be prevented, by careful checking in *all* cases.

Secondly, as health professionals we pride ourselves on our communication skills. But communication means more than talking – we need to listen to what the patient says. Patients are good observers of their experiences. They don't have the medical background to interpret what they observe, but if we don't listen carefully we may miss important information.

Thirdly, loss of power, control, dignity and self-esteem are common in hospitalised patients. This would occur far less often if we put ourselves in the patient's place and asked, 'How would I like to be treated and communicated with if I was the patient? Or if it was my mother, my spouse or my child?' Our attitude might change considerably.

Fourthly, we need to encourage patients to ask questions: 'Have you washed your hands?', 'Are these my tablets? They look different from the ones you gave me yesterday', 'Do you want to check my name first, just to be sure this procedure is for me?' This is difficult for patients. We need to give them permission to ask such questions and to teach our staff that these questions are to be expected and shouldn't cause offence.

Fifthly, errors occur in between 8 and 9% of patients admitted to hospitals in Australia.[1] Overseas results are similar.[2] Some of these errors cause permanent disability or death.[1] We have excellent knowledge and technical skills in Australia, but errors occur through miscommunication, not following correct procedures, and working in environments that don't have a culture of actively trying to understand and prevent errors.[3] This is where we can make major advances. Every health professional can play a role in reducing error.

There were other lessons too, but a final one is that I found I wasn't invincible after all. MT

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