Part 2: The realities of life as a patient

This article continues on from last month’s Doctor’s health. The author discusses events proceeding from injuries he received from an electrical accident.

Hugh Grantham, MBBS, FRACGP is Medical Director, South Australian Ambulance Service.

The trip in to hospital started off as an almost academic exercise. I could see the index finger of my right hand was burnt, but a pink colour was still evident, making it easier to believe that it might be all right. I became aware that there was some burning in my feet. The burn appeared to have exited through the gaps in my open sandals.

As the situation sinks in

It also seemed a good idea to let the ambulance communications know a bit more about what had happened. At this stage they did not know who had been burnt, or how. My right hand and arm were also beginning to throb and I pointed this out to the operator on the radio.

I’m still the doctor here

The ‘doctor in charge’ coping mechanism was still firmly in place. I did not want to think about anything more demanding than getting the next step organised properly. By playing ‘doctor in charge’ I was able to continue to involve myself in the immediate problem, which prevented me from worrying too much.

We met the ambulance about half way in and I was willing to lie on the stretcher as a patient. The ambulance officers who I had trained were a bit awkward with the situation until they saw that I had some significant injuries. They attached me to the monitor, at which point I had a good look at the strip and decided that it showed sinus rhythm and was therefore OK. Not long after this, the ECG sported an array of ventricular ectopics. Perhaps they weren’t there when I first looked or perhaps I was simply denying them.

The pain which until then had been mild, now really got going. The only analgesic on offer was penthraine which I accepted when it was suggested. Even though I know how to use the equipment in order to get the best out of the analgesic, the penthraine did nothing. This meant that I became distracted by the pain and so let the ‘doctor in charge’ mantle slip. I don’t remember much about the trip except the report which confirmed the situation and that the patient says he is in sinus rhythm and does not want to be touched.

Emergency care

The next stage in the whole weird process was being admitted to the hospital where I worked, through the emergency department that I was very closely involved with. The ‘doctor in control’ came to the fore again as I found a good vein for the resident to get a line in. I think I even told him to insert a 16 gauge cannula. I was at least being consistent with my own practice for other people. There seemed to be a lot of people in that emergency room with very little for any of them to do except check that I was all right and offer slightly stunned sympathy. I had some IV morphine for the pain which did nothing. Further morphine also did nothing. The pain in my forearm was now becoming unbearable. I can clearly remember stating that it still hurt and that I was showing no signs of respiratory depression and was still very conscious. An increasingly nervous and reluctant medical and nursing staff gave me more morphine. After what must have been half an hour we got the dose up to 70 mg IV and I was still awake and struggling with the pain. At this point my wife Pat, came in and I was able to talk to her. I needed to talk about the future and the arrangements that would be necessary for me to manage my recovery. I was still minimising the extent of the damage but had accepted that some surgery on my hand was on the cards. One of the thoughts I had was that I wanted my painting things, as I was already thinking of rehabilitation.

Dealing with the doctor-patient relationship

I was still trying to plan the treatment even though I could not control it. Everyone was concerned and helpful, but unable to speak to me about the future or the informed medical consent issues that they all assumed I realised. It was awkward for them to treat a colleague as a patient but I doubt I would have been able to let go and be a patient anyway. Eventually Arthur, an anaesthetist colleague of mine put in an axillary block and put the arm to sleep. Without the terrible pain I was able to relax a bit but still...
not lose consciousness despite the large dose of morphine.

The time in intensive care was all a bit of a blur. There were a lot of decisions and consultations going on around me that did not include me in the loop. In part this may have been because they felt that I was not sufficiently clear from the effects of the morphine, and in part because it is difficult to decide whether to talk to a colleague as a patient or as a doctor. My friends and medical colleagues who visited me in the intensive care were also somewhat stuck as to how to talk to me. The first reaction was to express surprise and concern, but when the obvious topic of ‘what now?’ came up, they all felt awkward and found other places they had to be.

Assuming life as a patient

The trip to Melbourne by air was relatively unremarkable, except the pain got steadily worse as the trip progressed.

We arrived at the private hospital on Sunday afternoon. The staff were pleasant but were unable to give me any pain relief without medical authority. This presented a dilemma as the plastic surgeon was not in the hospital and would not be in for another hour or so. A phone order for 10 mg of intramuscular morphine proved as useless as I predicted it would be. By the time the surgeon arrived I was becoming quite distracted with the pain. I was not really able to concentrate on the issues at the time until we had gained some pain relief, with regional anaesthesia.

At this point the role of patient became much more real. I was no longer in my own hospital, being treated by the people I knew. I was no longer treated as someone with a medical presence. The surgeon made it obvious that the decision as to when to operate was his and I was quite happy to leave that decision to him.

Two anaesthetics in 24 hours and a constant infusion of pethidine did a lot to dissociate one from the world outside. The first operation removed the finger and debrided the skin on my forearm as well as taking skin for grafting from my legs. A second anaesthetic was needed to lay the graft on. In the more conscious hours came an attempt at a shower and a total loss of dignity as the patient role became a reality.

Images of illness

The surgical experience was one of repeated returns to theatre for successive debridements, and although I took great pains to view them as a clinical problem, they became a succession of impressions rather than a distinct picture.

One impression was the rather depressing tendency to come back from theatre with a bit less than one went in with. No one actually said quite what was going to happen each time and a sort of role call of my parts was part of waking up. This role call was made all the more difficult by phantom sensations that tended to be very real and painful, particularly in a state of half sleep.

Once awake the logical mind then translated the implications of the role call into clinical problems. Would I walk? Could I write left-handed? Would a patient find the damaged hand off putting?

Pain relief

Another impression of those trips to theatre was that they always stirred up the pain. At this stage I was on a continuous infusion of pethidine. One of the most frightening things for me was a well meaning night nurse who was determined I should not have too much analgesia. Like many doctors and nurses, she knew too much pain relief caused addiction, or perhaps she was worried about respiratory depression. At this stage I was emotionally exhausted and physically in poor shape and would have loved to sleep through the night. It is interesting that I refused any sedatives however. I used to wake up in intense pain and look at the pump settings to see she had turned it down as soon as I was asleep.

After several episodes of this I would get to the stage of asking who was on that night if I was going to theatre. I didn't ever voice my fears and now it seems ridiculous how frightened I became and yet felt trapped from doing anything about it.

Pain was a constant part of the deal at this time and I became quite desperate to escape the phantom pains. Ordinary pethidine seemed to do little, adding an anti-inflammatory didn’t help much but did give me some idea of having influenced my own treatment. The major breakthrough was the addition of the antiepileptic drug Tegretol. Tegretol was a major step forward but unfortunately affected my bone marrow, causing anaemia and further worry. As a doctor, the concept and consequences of aplastic anaemia were all to well known to me.

On one occasion I tried some basic alcohol in the form of scotch. After two good tumblers full, as well as my base line analgesia I achieved the double satisfaction of pain relief and panicking my adversary night nurse.

The fears of addiction proved totally unfounded. Once clear of the acute operational setting I managed to go from an intravenous continuous infusion to nothing much more than a paracetamol and the odd glass of scotch. Even at repeat operations I have not felt the need for anything much except in the actual operation phase. The lack of problems with addiction in cases of severe pain was something I understood intellectually, but it was interesting to observe it from the other side.

Ambivalence to the sick role

Another interesting psychological phenomenon was the sick role. For the first time I let go and decided that it was a bonus not having to care for others. The sick role was very tempting, to sink into the genuine sympathy and pity of friends, family and treating staff. However, accepting the sick role was very frightening to me.

To this day I have refused to talk to a lawyer about compensation, as I have
seen the way this can subtly complicate the recovery process. The great advantage is that I can admit when I am feeling better without any subconscious reservation.

**Lessons learnt**

I now take the issue of analgesia very seriously and tend to give far more analgesic than I used to. Interestingly I have never caused a problem by overdoing it. The conclusion is that my past attitudes to pain relief, which were typical of many of us, must have been way under the mark.

That night nurse taught me something. Now, after I ask a patient if they have pain or other worries, I stop. If they say no, I have learnt to wait and then either ask again or keep quiet long enough for them to mention that there is actually something that they wanted to say.

Treating a colleague is the other lesson. Presumed understanding and embarrassment make good communication difficult. But I wonder if the impression I had of not being part of the decision-making isn't the same for all our patients. Certainly when the surgeon had time to sit and talk for a moment, it improved things considerably for me.

Dr Grantham’s story will conclude next month...

**Conclusion**

This is my outline of a simple approach to a common problem, the ‘difficult’ patient. There are other variations on this theme. You can BATHE the patient12 (ask about the Background, what do you feel about it (Affect), what Troubles you, how are you Handling it and show Empathy), or you can find a Dozen Good Questions and Three Good Answers for All Seasons.12 What is important is that you have a plan for how to approach these patients, remembering that they have the same right to good medical care as any other patient.

**References**