

SPECIAL ARTICLE

To Be a Patient

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For a second-year resident in Internal Medicine, the hospital is home. When he is not working or studying, he is trying to come to terms with the experiences lived. He is constantly trying to cope with the multiple decisions he is forced to make and with the outcome of those taken. Each patient is challenge. While concurrently creating a rapport with the patient, he tries to place his illness in any of the many medical algorithms memorized. He asks the “why” of everything and connects every finding as if it were a giant puzzle. Then, he studies every aspect of the situation and commits himself to a diagnosis in which everything must fit. The patient with his family at bedside accepts his decision with faith. The assurance of the resident ensures the patient and family that everything will be better. But, what happens when the resident is in a position in which he is the one who has to have faith and accept the decisions made by others?

This is my story.

While participating in a windsurfing competition, I tore the anterior cruciate ligament of my right knee. I asked for advice from my most trusted attending physicians and one of them referred me to an orthopedist who specialized in knee surgery. I also visited eight physical medicine and rehabilitation specialists and seven of them suggested surgery if I wanted to return to my previous level of activity. I reviewed four surgical textbooks and watched a video of the procedure: “The successful repair of the anterior cruciate ligament”. I was told surgery would allow me to regain full use of my knee in six months. Three months after my injury, I decided to undergo anterior cruciate ligament repair surgery.

The surgeon I chose had performed this procedure over 200 times and had a complication rate of less than .01% (a complication rate similar to the one described in Campbell’s operative orthopedics textbook). I fully understood the mechanics of the procedure and logic behind the surgical correction. But, as I soon found out, I was most ignorant of what I was about to go through. The chosen surgeon in the metropolis two hours away told me that I would need two weeks of complete rest after the surgery and a month on physical therapy. Therefore, I scheduled the first two weeks to harmonize with my vacations and planned with my Program Director and fellow residents a rotation in a place that did not require me moving around the hospital the following month: the Intensive Care Unit. I also made arrangements for a place to stay for the two weeks after the surgery in the metropolitan area so that I could be close to my surgeon’s practice.

On the day of surgery, I arrived early with the knee area completely cleaned and shaved; I was carrying the thickest Internal Medicine review book I could find. This, I thought, would ease the tension, since there is never enough time for all the reading to be done. My surgery was delayed, so I read for two hours. Then it was time. After a little conversation with the anesthesiologist, I was given spinal anesthesia and the surgery began. Sedation wore off in the middle of the procedure. I opened my eyes and found an unknown anesthesiologist looking through an Avon catalog. Tense, I tried to read my vital signs from the chart to see if anything was awry but, unable to do so, I requested them. I asked to see the anesthesiologist by the anesthesiologist put me to sleep without a word. I woke up in the recovery room; orders for my discharge had already been written which included instructions of complete rest for two weeks.

The day after the surgery, I woke up with pain in my knee and low-grade fever. I called the surgeon and he reassured me that my surgery was done without any complications and that everything was going as expected. Moxifloxacin 400 mg and Celecoxib 200 mg were prescribed. I was accustomed to the mild persistent pain, but I also felt a bit weak which seemed unusual. Despite feeling feeble, after two weeks I returned to work.

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I was tired all the time and my right knee hurt whether I was at rest or limping around. My surgeon reassured me that rehabilitation would take time. I knew there was nothing I could do but follow instructions. The doctors at the hospital saw me limping and asked about my pain management; they each had a different idea as to which analgesic I should take. The infectious disease specialist looked at my knee and frowned when he heard about the antibiotics I was taking. I thought it was time to worry when he told me I should talk to the surgeon about changing the therapy. At the end of morning rounds, during my second day in the Intensive Care Unit, the pain was intolerable. I was forced to seek help from an attending physician who prescribed Oxicontin 10 mg every 4 to 6 hours. Although the medication offered relief, I took only two tablets that day; I was worried that the pain medication would impair my judgment while dealing with patients.

After at week a work suffering from general malaise, tiredness and knee pain I returned to the surgeon in a state of pure exhaustion. As soon as he saw me, he had a worried look even though he had not seen my hot and swollen knee. His face became somber after he looked at the turbid and serosanguineous sample of the synovial fluid. He asked two other orthopedic surgeons to take samples and look at my knee. Then he told me I must go to surgery at once! It took me three months to prepare for the first surgery, and now I only had three hours to come to terms with this one. The worried look on the surgeon's face did little to relieve my anxiety. My mind began to work overtime and wonder, but I did not dare to ask what had gone wrong. The first thing that came to mind was the number of times I had told my patients about their active role in the patient-doctor relationship. And now I was mute.

I was admitted to a university hospital at 4.00 p.m. My first contact was a first year surgical resident who, fortunately for me, had rotated with me the prior year as a medical student. A bed was finally freed up on the floor at 2.00 a.m. I proceeded to narrate my own history; he skipped the physical, I was glad to turn my attention to my review book once more. By three a.m. my right knee became swollen and painful; the intern was called. Two hours later he prescribed Oxycodone 5mg + Acetaminophen 325mg. The medication did not work and I became progressively anxious, I could not sleep. I felt worried, tense and helpless. The situation seemed to be completely out of my hands.

By the time I was delivered to the operating room, at 7:45 a.m. the pain was intolerable. The operating room nurse looked at me with disbelief, as if I were a drug addict. After all, had I not received 50mg of Demerol one hour earlier? Four minutes later the anesthesiologist

approached me with a 60ml syringe and large bore needle and, without a word, administered something intravenously that put me to sleep. I woke up once again in a recovery room, naked, cold, and covered only by a thin blanket. I had a Foley catheter in place and my knee was hurting once again. I could not move my legs either. Could the reason for this be simple fear? My knee hurt so much that I began to wonder if I had a low threshold for pain.

As I was moved to my room, I felt myself becoming more upset every minute. Upon arrival at the ward, I requested more medication -nicely, with unbelievable restraint. The nurse's reponse was, "the medication nurse is giving medication, you will have to wait". I called a doctor friend with my cellular phone searching to diminish my rising anguish, the phone in the room was out of order. He dissuaded me from the politically incorrect idea of making arrangements to transfer.

The next day the Director of the Orthopedics Department and the surgeons came to visit. "Everything went well". Went well? Not for me. They gave me a short explanation of the relationship between range of motion improvement after physical therapy and long-term consequences of the procedure, some percentages, and open-ended possibilities. Questions were answered much too briefly, but adequate pain relief was prescribed. From that moment on a resident came to visit every day. It would take him one minute to look at the knee area and thirty seconds to look at the IV bags at my side. There was no time to start conversation; he was always in a hurry. The patient in the bed next to mine was a quiet agricultural worker on traction from a broken leg who had no family with him. He was stoic enough not to complain at all. His surgery was cancelled three times in two days. That meant a "nothing by mouth" (NPO) order placed and retracted three times. No food was brought for him when he returned (were diets given only at specific hours?). From my perspective, he was being surprisingly agreeable to the situation. Since I had no appetite, I offered him my food tray which he reluctantly accepted.

The next time my doctor came to visit, I tried to discuss my neighbor's situation and his reply was that I needed to stop thinking like a doctor. Impossible! The learned experiences of a medical resident are so deep and emotionally charged that it would be impossible for me not to be moved by the unwarranted distress inflicted on my neighbor.

Six months have passed and I am now able to look at the experience in a different way. It seems a miracle: I am now able to walk without pain and without a limp. But, most importantly, my relationship with my patients has become more intimate; and I am now much more sensitive to their

real or imagined complaints. The nurses around me and my house staff companions are quickly becoming experts in the effective management of pain. Although I do not wish a similar experience to anyone of my colleagues, I truly believe that being a patient totally changed my perspective. I listen more carefully to the needs of my patients, I have become more caring.

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