



## **Under the Blanket**

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I'M GOING TO WAIVE MY HIPAA RIGHTS, whatever they may be, and tell you what I saw on the other side of the syringe, scalpel, oxygen mask, and the rest of the gadgets we physicians use with patients. It's a personal story, but I hope it transcends the self-indulgent hospital tale we all prefer to avoid. My professional and personal worlds collided and gave me some thoughts as a practitioner.

In February I responded to an advertisement seeking normal controls for an MRI study sponsored by vascular surgery. Since I was older than 55, without aneurysm or spinal cord disease, I was eligible to have a free MRI of my abdominal vasculature. What a deal. Why would I not do this? (By the way, they may still need some "normal controls.")

So, I signed up and got the contrast injection MRI. When the researchers finished the study, I learned I was no longer a "normal control." First, the good news was that there was no obvious adenopathy or renal vein invasion. My CXR was normal. The bad news: I had a large (6-7 cm) left renal cell carcinoma, and in an instant I went from being as healthy as possible for 67 years to the victim of a potentially lethal cancer.

Symptoms? I had no hematuria (the most common symptom). I did have left back pain, more severe after working a full day in the OR, but otherwise, I had nothing that would have made me seek medical help. So, in late February, I elected to have surgery and underwent a radical left nephrectomy. The final cell type turned out to be a chromophobic carcinoma instead of the more common and more lethal clear cell carcinoma. But before that answer came down, I learned a number of things about Stanford patient care delivery: in the clinic bed, but not bedside.

### **Customer Satisfaction**

I was very impressed with the efficiency and attention I experienced in the Stanford Clinics and from the outpatient labs. The new facilities in the Cancer Center are especially impressive. And the personnel all seemed to enjoy their jobs.

### **Internet Access**

Why can't we finally have access for patients? We have the wireless infrastructure, and surely our need to communicate while hospitalized remains stronger than ever. Also, Lucile Packard Children's Hospital has had free Internet access for a year for patients and visitors.

### **Protocol Compliance**

Lying in bed, you focus on funny things sometimes, so I wondered just how well the protocols we are being taught to follow are being carried out. I had time to watch the nurses and aides wash their hands, and generally compliance with our hand hygiene protocols was excellent; in fact, almost compulsive. Are we as physicians doing as well,

showing leadership? Another current patient safety rule calls for checking patient identification in two ways - usually a wristband check and a verbal inquiry as to name or birth date. I may have missed a double check or two when I got my meds, but my mental scorecard ticked off full compliance with the labs.

### **Noise and Sleep and More**

The complaints I've heard from other patients seemed to be true. I was in a double room converted to a "private room" by installing a plywood panel and door so thin you could easily hear quiet conversation on the other side. And overall, the alarms going off continually, conversations, footsteps, motors and the like persistently inhibited any attempt at solid sleep. But the distractions didn't stop there. I had the misfortune to wear compression boots from foot to knees. These inventions of the devil at first seem like a good idea (after all, who wants to get DVT?). However after several hours, the constant inflation deflation cycle coupled with the noise of the compressor motor started to drive me crazy - not to mention contributing to sleep deprivation. The incessant noise, however, is a serious problem, and perhaps we should take a look at some corrective measures.

I was placed on a hydromorphone PCA, and at least this component of my stay was quiet - but only at first. I was offered from 0.2 to 0.4 mg of hydromorphone with a lockout of 10 minutes and no basal rate. This is where the rubber hit the pavement for me as I transitioned from anesthesiologist to patient. Although I should know better, I hit the button whenever I felt any pain. I became confused and had a number of very bizarre dreams and nightmares.

Yet, whenever I awakened, I hit the button again. Then it got noisy. Strangely, I discovered that whenever I took off or lost my nasal oxygen cannula, the pulse oximeter alarm would go off and wake me up. Fortunately, I could stop the alarm by keeping my nasal oxygen cannula in place. The next morning I felt absolutely terrible - confused, disoriented, nauseated, with pain. That's when I figured out that PCA was to blame, so I decided to stop using the device. Things cleared rapidly after I made that decision.

But even after discovering the truth about PCA, I continued to play doctor. I turned the pulse oximeter around so I could see it. My saturations were not good. On room air, my sat would drift down to the mid 80s. With supplemental oxygen, they came up into the mid 90s. If I used the incentive spirometer vigorously (and that hurts), I could get the room air sat into the low 90s for a short time. It took me concerted effort with deep breathing for several hours to get rid of the atelectasis I had developed during the night and maintain room air sats in the mid 90s. Good thing I know what I'm doing, I guess. Most patients would simply lie there and be miserable. Interestingly, a recent article by the Anesthesia Patient Safety Foundation points out a high incidence of morbidity caused by hypoventilation with atelectasis, hypercapnea, and respiratory acidosis from the effects of PCA and epidural narcotics. The APSF says that monitoring oxygen saturation with a pulse oximeter gives a false sense of security when supplemental oxygen is administered. The O2 sat will be OK, but everything else is going south. The bottom line is that the APSF will probably recommend that exhaled CO2 monitoring should be added to pulse oximetry as mandatory monitoring for postoperative patients receiving narcotics. Unfortunately, our technology is not quite good enough yet to do this well on nonintubated patients.

Playing doctor on myself probably contributed to stress, but I'm convinced the stress would have been worse if I had remained ignorant. Think of the anxiety a patient without a medical background must feel. Trust the doctor? Easier said than done when you are feeling terrible in a noisy bed.

So after one night as an inpatient, I decided if I were to get some sleep, I'd have to leave. Fortunately, I was able to do so.

### **VIP Status-The Red Blanket**

Stanford gave me a red blanket, telling everyone who came in my room and saw it that I was a "VIP" patient. While I felt honored, my caregivers weren't so sure this was a good

idea. Some of the nurses and others asked if the blanket meant they should treat me better or differently, and if so, whether this sent the right message to patients. Maybe this concept needs to be evaluated.

### **Nurses and COWS**

I have only the deepest appreciation for the nursing staff and nursing aides I came in contact with. They all were genuinely concerned and helpful. However, they did seem to be struggling with the new wireless mobile data entry devices, called COWS, which they wheel from patient to patient to use in lieu of carrying a clipboard. Fancifully, I imagined we could put a bicycle seat and pedals on the COWS so the nurses could maneuver them more easily.

### **Psychological Impact**

The biggest impact of my hospitalization was psychological. I have had deep thoughts about what to do with the rest of my life, accompanied by a fair amount of depression and fatigue. I'm more optimistic now that my diagnosis is actually quite favorable.

An earlier than previously planned retirement from clinical medicine may be in the cards, since I have discovered that daily high stress in the OR is not necessarily a good thing. Coming face to face with your mortality is a real eye opener.

More important, I hope that I can transcend the clichés and truly be more empathetic with the experiences patients have. I hope I can find ways to put that knowledge to work in practical ways that will incrementally improve the hospital experience for those patients who can't read a pulse oximeter. They're scared in a noisy environment and trust us to do what's right both on a hospital-wide basis and in the patient room itself.

We need to make sure we do just that. Thanks very much for reading. Go ahead and use my thoughts to apply to your more general musings and discussions. I welcome your comments about this article.

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