A Painful Lesson

Vivid dreams tumble through my head in no meaningful sequence. In a half-stupefied state I become aware of the stertorous breathing of the woman in the room next door. Rather than being filtered by the walls, her snores are magnified to a swelling roar that engulfs my small space. I wonder how anyone can sleep here. The next minute, I am wide awake with a stab of pain. I turn gingerly in bed, wincing at the effort. Over the next few minutes the pain escalates in intensity and seems everywhere at once. The fluorescent blue of my watch displays 3 a.m.; reluctantly I press the call button.

I am in the hospital with premature contractions at the beginning of my third trimester of pregnancy. Being a patient is a new experience for me, one colored as much by my own apprehension as that of my obstetrician at the unexpected turn of events.

A bright light floods the room as the nurse flicks on a switch.

"What can I do for you?"

"I woke up with pain."

Without my glasses, her face is a blur. She is tall, with a blunt haircut and a businesslike manner. Pens and other paraphernalia peep from her top pocket.

"Where is the pain?"

I trace a hand over my lower abdomen as her cool hands envelope mine.

"What does it feel like?"

"A constant, dull ache."

"It seems rather localized," she says after palpating my abdomen. "I wonder if it is your ureter."

Thinking I misheard her, I wait.

"Maybe you have a UTI," she says slowly.

"I have no symptoms of one," I respond, puzzled. The pain seems much the same as that which I've had over the past few days since my admission to the hospital.

"You don't *have* to have symptoms."

Bewildered at her line of thought, I take a deep breath, as much to mitigate the pain as my irritation.

"*And* your OB sent off a urine sample," she emphatically adds.

"It was a routine test. She didn't really suspect a UTI," I protest, trying to be helpful without being pushy. Doctors make poor patients, I warn myself.

This is her first shift looking after me. She does not know me as a physician; my work as an oncologist does not bring me to the obstetrics ward. Nor should she need to know my profession, I reason. Through the open door waft the familiar sounds of a busy ward going about its work. Twins lustily cry in unison for a feed, a family noisily celebrates its newest arrival from the delivery suite, and nurses rue the reduced staffing as they rush past each other.

"Well, let's give you some indomethacin for the pain."

"I prefer to avoid it; I am in my third trimester." Nonsteroidal drugs causing premature closure of the patent ductus arteriosus is about the only thing I recall from my pediatrics rotation in medical school. It was also something the OB had touched on.

"It's charted for a reason," she says brusquely.

"Yes, as a last resort," I respond, determined to remain nonconfrontational.

She is clearly displeased with my perceived resistance.

Spotting the hand that rests on the right of my abdomen, she muses,

"Have you had your appendix removed?"

Although part of me feels exasperated, another is fascinated by this seemingly futile exchange. It suddenly dawns on me that exchanges like this must take place every night between patients, nurses, and doctors.

"My appendix is intact."

"Do you want some paracetamol?"

"No, I don't think it will do much. But my OB did suggest earlier that I could have some nifedipine at times like this." The drug had previously relieved my pain, leading my OB to chart an additional dose to be administered on an as-needed basis.

"It doesn't sound as if these are contractions."

"I have felt such contractions before." I wonder how to convince her, without sounding like a hypochondriac, that my pain is real and not unduly tainted by anxiety. I grimace as I discount the most obvious yet worthless explanation, "I am *not* anxious."

I pause, not wanting to further antagonize her. I tell myself that she is not being intentionally difficult, that it is a busy night and her attention is diverted by other events. In fact, the nurses have provided exceptional care so far.

"What do you want then?" she asks.

How many times did I ask a disgruntled patient that question as an irate intern, having readily labeled that patient "resistant"? "Maybe you can assess me again in a little while and see what you think."

The clock now reads 4 a.m. I lie in the dark fighting a mixture of frustration, discomfort, and vulnerability. Perhaps I should have told her that I was a doctor—that I could tell if I had a UTI or appendicitis; perhaps I should have insisted on her paging my OB instead of dancing around a potentially serious issue. But I felt on principle that I should not have to do either of those things to receive proper care.

Twenty minutes later the door suddenly swings open, the light blazes again, and the nurse smacks some nifedipine on my table.

"I paged your doctor."

"I appreciate it." I am grateful that I cannot see her expression, only sense it.

"I *hate* waking up doctors at a late hour."

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"So do I," I agree, swallowing the implicit accusation along with the pill.

The pain relents, and I sink into a guilty and exhausted sleep. In the morning I express my regret to my OB for the unnecessary wakeup call. She agrees with my impression of the pain and, as she leaves, advises, "Sometimes it is okay to let people know you are a doctor."

Although her words ease my guilt, the ensuing days find me reflecting on my experience. Being a patient marks a vulnerable time in one's life. In the middle of the night it is difficult enough for a physician, let alone an individual unpracticed in the nuances of medicine, to deliver a succinct history. The human body, sophisticated machinery that it may be, does not always behave predictably. Hence the septic patient who cracks hearty jokes until he suddenly arrests, the adolescent whose angry appendix only manifests itself as right upper quadrant pain, and now my own pain, which did not fit the usual description. On a busy night, which describes every night at a major hospital, there is usually a delay in answering a patient's call. Many times a nursing assessment is adequate, but if the night resident is required, there may be another substantial delay before the patient is seen. With skeleton staffing, patients are often assessed with preconceived notions, the emphasis being on tiding the patient through the night until the home team arrives. Conversations are hasty, diagnoses even more so amidst the cacophony of call bells and urgent beeps.

I wonder whether I would have believed the suggested diagnosis of a UTI or appendicitis without the benefit of being a doctor. Would the conversation have reassured me that I was not in labour or heightened my anxiety that there was something else wrong? And even if I harboured doubts about what I was being told, what would have been my recourse? Concerned family members are often the ones who insist on a second opinion while patients seek to maintain goodwill with their caregivers. Although I felt confident about the cause of my pain and knew that I could ultimately request to have my doctor paged, most patients possess neither the detailed medical knowledge nor the conviction to adopt this path.

On many mornings, I have arrived on rounds to hear a patient complain of pain overnight. While eliciting a history, I sometimes flick through the charts to gauge what was made of the symptom, my view colored by the subjective and objective information contained within the rapidly scribbled entry as the patient's sincere voice somehow transforms into a mere backdrop. "*Patient visibly distressed*" conjures a serious image. "*Sitting up despite complaining of severe symptoms*" suggests a disconnect between patient and problem, while "*appears very anxious*" is a pronouncement on the patient's coping skills. As for "*functional etiology,*" the mere mention of the phrase consigns a patient to a multitude of false assumptions even before a history is reestablished. Pressed by multiple commitments, it becomes tempting to rely on codes, numbers, and films rather than the word of the patient—especially in the case of a nursing home resident, who can be placated more easily than a university professor who expects answers. It is something we are taught throughout our training, yet it took my own inpatient stay to underscore to me the importance of listening to, and moreover believing, the patient.

The nurse returns the following night. The pain that has nagged me most of the day now seems quiescent.

"How are you feeling?" she enquires.

"Better, thank you."

She pauses. "I guess I thought it was something else because of the way you described the pain," she offers, "and it was such a busy night."

Grateful to be feeling better, I treat her remark as her way of expressing regret.

Days later, I prepare to leave. Out of curiosity, I pick up my own chart for the first time, and look back at an earlier entry to see how two hours of pain, vulnerability and turmoil were encapsulated. Suddenly penitent for treating chart entries as the immutable truth above what my patients have tried to tell me, I pledge to treat the patient, not the notes, on my next round. Written on the chart is the final seal to my pledge.

"*Patient complained of atypical pain—declined pain relief.*"

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