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Opinion Open Access

When a Doctor Becomes a Patient: Navigating the USA Healthcare System

Lynn E DeLisi*

VA Boston Healthcare System, Psychiatry Harvard Medical School, USA

***Corresponding author:** Lynn E DeLisi, Attending Psychiatrist, VA Boston Healthcare System, Professor of Psychiatry Harvard Medical School, USA, Tel: +617-432-1000; E-mail: Lynn_DeLisi@hms.harvard.edu

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Opinion

How did I find myself in a busy city hospital emergency room lying on a stretcher in between two elderly men drowsy and groaning from their latest alcohol binges? A woman with a tag that says “RN” walks over with an understanding expression and says “don’t worry, we will be getting you out of here soon”, a statement that I would hear several times repeatedly for hours until it actually happened, and then I am asked in a low voice prefaced by “now I have some questions that we are required to ask everyone”: “Is there anyone harming you at home?, are you being abused?. Do you feel depressed or want to harm yourself? Do you use drugs?”

I am happy that they ask these questions because in my “real life” I am a psychiatrist and know that many people come into an emergency room to whom these questions definitely apply, but not me. My broken ankle was due to my own stupidity and not my spouse throwing me down a flight of stairs. I am amused about how difficult it is for the nurses to ask these things.

The shift changes twice, while I lay in the emergency room watching people scurrying around in all directions, not necessarily knowing what to do and paying no attention to my huffs of impatience. Finally, I am wheeled into an alcove with a curtain, and a smiling young resident approaches me looking at my broken ankle. “Ah” he says, “we are going to have to align your bones” so he begins by telling me he will string my leg by my toes up to the ceiling and keep it tied there for 10 minutes.

This technique is supposed to align bones? “It works” he says “we do this all the time”. I ask what year residency he has reached, and he says, 2nd. I ponder about his boldness and self-assured attitude and think about the 2nd year residents I teach and get a pang of anxiety, knowing they certainly do not know all that they think they do and this guy is pulling on my broken ankle and telling me this is a treatment he “does all the time”? I scream when it starts to hurt, although I realize doctors are not supposed to do that and I have been crying, as I am miserable and uncomfortable as well, but doctors shouldn’t do that either. They will surely think I am feigning being a doctor in real life if I keep crying, so try to bite my tongue.

While recuperating, I notice that some people come into my room and address me as “doctor” knowing my history, while others address me as Ms. and talk down to me like I am a baby or senior person with limited cognition. I do feel helpless like a child in my hospital bed, yet unable to easily assume my role as “patient”. I have somehow lost control of my surroundings and for someone who prides herself in always “being in control”, this is an uncomfortable reversal of roles.

My leg has been very painful and at first when they offer me oxycodone I refuse saying why not try Tylenol first? So, I suffer with pain for a couple of more hours and then give in, the nurses advising me that it is much better taking it before the pain appears, as it doesn’t work so well afterwards. I see now what has happened to the patients I treat. They come to me addicted to their oxycodone. I have had many arguments with patients over this, warning them about the addiction potential of oxycodone and trying to find them something else that can ease their pain. Now I see how readily it is available to me in as a high a dose I want several times a day. I am also sent home with a hefty supply of it on discharge.

I meet up finally while still on the ward with one of the residents who has had contact with me over the past week. He is clearly very uncertain about what will be done to me next. He was the one who contested me post-surgery about my knowledge of IV’s. I was concerned at that time that air could be let into my vein, given the fluid was all gone and a warning bell was loudly ringing.

You are supposed to be a physician” he retorted, “don’t you know that is not how IVs work?” I didn’t try to explain at that point to him that I have been a psychiatrist for 40 years and probably learned about IVs before he was ever born, but rather let him go in triumph that he certainly had exposed me as a sure thing quack! First and second year residents are inexperienced, and certainly have not spent enough time as residents to “do certain procedures all the time”. There is no substitute for practice, but the attitude is what counts. Do they know what they don’t know and look it up or ask more senior doctors, or do they feel they must pretend to the patient that they are the most competent doctor ever? So, when he says I am not to be discharged on an antibiotic and I insist he check this out with his attending, he stalks away, but sure enough the nurse who discharges me comes back with an antibiotic prescription.

On discharge, I have been assigned a visiting nurse service for follow-up. To experience them as a physician takes a lot of strength. I tell the nurse that comes my first day home that I seem to have developed a rash but she does nothing, not even look at it. The rash becomes almost purple within a couple of days, and I attempt as a patient to call the doctor’s office to see if I need to be seen. I try unsuccessfully to reach the doctor.

The clerk who answers the phone would not get the doctor, but only send messages to his assistants. I finally able to use my intuition as a physician and medical school faculty member. I bypass the clerks by. logging into the school intranet and hit “address book”. Sure, enough my doctor is listed. I send him a frantic message with my cell phone number and within five minutes he calls, asks me to text him a picture of my leg and he will reply giving me instructions about what to do. This was the beginning of my second hospitalization for cellulitis and possible systemic infection.

I am home now recuperating, having had several visits by an array of nurses who take my temperature and blood pressure and physical therapists who do the same. I have time in between to ponder my

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experiences on the other side. It is clear that patient's need advocates to help navigate them through any medical crisis and assure that they get the proper care they need.

I don't know why that is, except I see how busy a city emergency room can be and the chaos that ensues as more trauma victims are brought in and triaged among the elderly also in waiting rooms with urinary tract infections, or having drank too much alcohol. The days of my childhood, when a doctor was called to come quickly to the house with his/her black bag and stethoscope is over. Ambulances bring people into emergency rooms and people walk in with a variety of ailments. They don't have any other way to receive treatment. They don't have inside ways to call or email their doctors, and other than googling their conditions on computers, they have no way to advocate for proper healthcare.

I have learned two things of importance about residents in training: (1) that they must learn to know what they do not know and have a clear understanding about what circumstances require a call to the senior doctor. (2) that it is very important as part of any medical school training to teach the interpersonal skills that are essential for dealing with patients who are in acute stress. These are skills as important as learning how to align bones.

What is it about the exchange of roles between doctors and patients? The doctor is perceived as strong and in control of the situation by giving instructions to all that surround her/him; while the patient is no longer in control, but must submit to and trust those around her/him for care. Being helpless in a world where one always provides help is a feeling that can be overwhelming. Ultimately the doctor-patient gains a sensitivity to the barriers and frustrations in navigating the healthcare system in the USA that occur for most ill people who have not gone to medical school and have no insider knowledge or connections.