Berkshire

davidoliver372@googlemail.com Follow David on Twitter @mancunianmedic

Cite this as: *BMJ* 2023;380:p712
http://dx.doi.org/10.1136/bmj.p712
Published: 29 March 2023

ACUTE PERSPECTIVE

David Oliver: Reflections from a hospital bed

David Oliver *consultant in geriatrics and acute general medicine*

Just before Christmas I was struggling to complete my ward round, as I was increasingly breathless and trying not to cough. I went to the acute medical unit to get checked out. I soon discovered that, despite having no history of smoking or lung disease, my oxygen saturations were worryingly low.

Within hours I was on a 40% venturi mask with my saturations stubbornly refusing to increase, and I discovered that I had both respiratory syncytial virus and pneumococcus. I was admitted to hospital for only three days, but the whole episode made me reflect on the patient experience.

I realise that I'm not exactly a "mystery shopper" when admitted to an acute medical unit, given that I've worked on it as a doctor for two decades and know most of the staff. And understanding the terminology and procedures takes a lot of anxiety out of the situation (although insight isn't always reassuring—such as when my National Early Warning Score was triggering alerts).

But I did learn a few things. First, in any open ward area—curtains or not—it's hard to maintain anything like confidentiality. In my first few hours, before moving to a side room, I heard every clerking of every patient in intimate detail, all the conversations doctors were having about patients, and the conversations patients were having about doctors and nurses. There was no privacy. I even found out about my own investigations before I was told. More broadly, noise pollution with phones, alarms, buzzers, chat, and arrivals makes sleep or rest hard. Sleep is important, and between my endless coughing and the noise I snatched a half hour here and there, at best.

Second, the vast majority of your contact time as a medical inpatient is with nurses and healthcare assistants. Between observations, medicines, blood tests, and food and drink, they're the staff you see right through the 24 hours, shift after shift—so the quality of interactions you have with them is crucial. My own experiences were great, and as an aside, they really emphasised to me just how much our system relies on staff trained overseas or from ethnic minorities. Our system would be lost without them, and they need more respect.

I did note that, even with the best will in the world, these staff have so many tasks to deliver that the time for more personalised care is limited. The thing that most bothered me (and clearly some fellow patients) is that I couldn't stop having prolonged coughing fits, sometimes panic inducing. Nor could I get comfortable as a fairly tall person on a hospital bed, so I slept all night in the chair. These kinds of problems are often low priorities for busy clinical staff (as I know from my own day job), but they can be more distressing for patients than we realise, and we rarely have time just to sit with people and reassure them.

Professionalism

Third, the doctors I heard and saw in action with other patients were uniformly so diligent, conscientious, and patient that it made me proud to be a colleague. If you've ever doubted the "microaggressions" experienced by ethnic minority doctors, even in my three days I heard repeated examples of them trying to assess patients, being asked which country they were from (or "really" from), and reacting with resigned patience.

Often the doctors and nurses assessing patients had to field a whole list of resentments about things the patients were unhappy about in the system that were nothing to do with those clinicians. But they carried on with good grace and professionalism, when in the same situation I know I might have pushed back fairly assertively about the problem not being in the gift of frontline staff to solve and other patients' needs also being important.

Fourth, I learnt the importance of visitors. Once I moved to a side room my wife was able to spend hours with me, and it made a huge difference to both of us. I heard other patients around me constantly asking when their families would see them (even though no visiting restrictions were in place).

Fifth, while I wasn't really interested in eating, reheated hospital food really does leave a lot to be desired and seemed worse than meals from the same kitchen that are made for staff.

Sixth, although you're busy being ill and worried, boredom can be a real issue in hospital without decent access to media or wi-fi.

Finally, when leaving hospital and still feeling rough, it turns out that coping with a lot of unfamiliar technology that you have to set up yourself for home monitoring isn't that easy, and assumptions shouldn't be made, even when the user is fairly conversant with tech. The simpler and more user ready, the better.

I don't claim that spending three days in hospital makes me any kind of expert patient, and I've known medical colleagues with long term conditions or serious illness who have been NHS inpatients for weeks, not days—and several who never made it home. But it will definitely change the way I approach patients when I'm on the other side of the relationship.

Competing interests: See bmj.com/about-bmj/freelance-contributors

Provenance and peer review: Commissioned; not externally peer reviewed.