

A Teacher in Pain

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“I will not talk to you, or anyone else,” she sighed emphatically and with a disgruntled expression on her face.

“May I just ask you a few questions and listen to your heart and lungs, ma’am?” I politely asked.

“I told you, I am not talking to you or anybody else. I want out of this crazy house,” she fired back sternly. Stunned, I glanced at the nursing aide seated at the bedside to seek his reassurance and support, but he returned my look with a silent, blank expression and shrugged his shoulders.

At a loss for words, I immediately began to rapidly triage what might have gone wrong. Was this the wrong patient? Did I fail to explain my role as the medical student? Had this patient lost trust as a result of a previous experience with a health care provider? Or, I hoped, was this simply a prank, a way to welcome me, the third-year medical student, to the inpatient unit? However, when no other members of the team entered the room with “gotcha!” smiles on their faces, I realized that none of the explanations running through my head were helpful. I knew this was the correct patient, Ms. S, a woman in her mid-70s who had

recently had a hip replacement but had been readmitted the evening before with an acute change in her mental status. I had reviewed her chart prior to entering the room and had asked her to verify her name when I introduced myself at the bedside. In my introduction, I clearly identified myself as the medical student working with the family medicine team.

Shocked by my initial encounter with Ms S, I paged my supervising resident, an experienced PGY-III, to seek guidance about how to proceed. When we entered the patient’s room, the resident was met with even greater hostility from the patient than I had been. Ms S again repeated that she wanted “out of this nut house” and asserted that we were lying to her about several aspects of her care. Her additional ramblings further confirmed her altered mental status, and she refused our attempts to further examine her. Unable to obtain a review of systems or complete a physical exam, we left the room and consulted our family medicine attending who had provided regular care for Ms S. He agreed to see the patient later that day to evaluate her and to speak with her family.

And so began my first day on the family medicine inpatient service as a third-year medical student—a morning filled with feelings of doubt about my clinical communication skills, disappointment in my inability to complete a physical exam and document the patient’s progress, and, quite honestly, frus-

tration with the patient for refusing to cooperate with the clinical exam. Little did I know that this initial encounter with Ms S would evolve into several valuable lessons that will accompany me throughout my career as a physician. The patient with whom I had this first, negative interaction would ultimately become my teacher and instruct me, perhaps unknowingly, as I followed her progress during her inpatient stay.

When the attending physician who was the Ms S’s usual provider discussed her case with the team later that first day, he noted that she recognized him but that her behavior was very uncharacteristic. He stated that Ms S was usually very pleasant and had been looking forward to returning to her previous activities following her hip replacement. The attending had also spoken with Ms S’s daughter, who noted that her mother was confused and unusually upset and complained primarily about severe pain in her hip.

Our team considered a broad range of differential diagnoses in an attempt to explain Ms S’s apparent delirium, including a urinary tract infection, cardiac events, drug interactions, stroke, and hypoxia, among others. All the preliminary results were normal, although an acute stroke could not be definitively ruled out because Ms S refused a CT scan. Her inpatient medication list included no deviations from the outpatient regimen. Because Ms S consistently expressed a complaint

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of pain, we decided to increase her pain medications.

When I saw Ms S the following day, she remained hostile, albeit less so. Her mental status improved markedly, and she became oriented to person, place, and time. She agreed to allow me to complete a physical exam. For the first time, Ms S opened up to me and expressed to me that she was in a great deal of pain. She explained that the degree of the pain far exceeded what she had expected from her pre-operative conversations with the surgical team and was also much worse than the pain that she had experienced daily from degenerative arthritis of the hip. Further, she told me that she had previously had a knee replacement that did not cause as much pain as the hip replacement. I assured Ms S that the team would make every effort to manage her pain. This conversation gave me hope that Ms S now trusted me and the other members of the team enough to allow us to help her.

By day three, Ms S agreed to have a CT scan performed but only because it could potentially hasten her discharge. The bedside nursing aide was discharged, and Ms S was transferred to another inpatient unit with broader rehabilitation capabilities. However, we received word from the charge nurse on the new unit that Ms S had refused the CT scan after all. When I saw Ms S later that day and inquired about why she did not agree to the CT scan, she informed me that she was not able to lie flat on the scanner table because of pain. She mentioned that if she could have tolerated the pain, she would have gladly had the CT scan completed. As we talked and I completed the physical exam for that day, her focus shifted from her pain to her discharge. Ms S expressed a strong desire to have her pain relieved so

that she could be discharged to a skilled nursing facility where she could regain her strength and return home. She even demonstrated to me her ability to transfer from her bed to a bedside chair. For the first time since we met, Ms S smiled.

The following day, Ms S noted that her pain was better controlled, and she had slept nearly the entire night. The reduction in pain allowed her to flex and extend her leg with greater range of motion than the day before, and she was able to tolerate ambulation to the doorway of her room and back to the bed with the assistance of a walker. Ms S then reflected that she felt her pain had made her very frustrated and angry and that the pain was initially so severe that she had forgotten some of the events since her admission. By now, Ms S's delirium had resolved, and she was discharged to a skilled nursing facility later that afternoon, with more optimal pain control. Prior to her discharge, I told her "I am happy for you, and I know you will do well."

The primary lesson that became apparent to me as I observed Ms S's progress during the course of her hospitalization is never underestimate the deleterious effects of pain as described by the patient. Ms S had experienced pain from a previous knee replacement surgery as well as from the daily agony of degenerative joint disease. However, her expectation was that her post-operative hip replacement pain would be less than either of those. Pain is alternatively regarded as the "5th vital sign"¹ or a subjective symptom rather than an objective sign. However, Ms S taught me that pain can be so severe and distracting to the patient that it causes additional clinical complications (in this case, delirium) that can mimic life-threatening pathologies. Ms S had repeatedly expressed her pain and discomfort, and despite revi-

sions to her analgesic orders, we continued to search for other etiologies to explain her delirium. However, it was her pain, not hypoxia or cardiac events, that precipitated her delirium. I have now learned firsthand what has been suggested by several authors: that inadequately controlled pain can cause elderly patients who have undergone recent surgical procedures to be up to nine times more likely to develop delirium.²⁻⁴ I am confident I will not forget this important medical lesson.

I learned more from Ms S than medical management. Her patience for my learning and for her own improvement has already influenced my development as a physician and has renewed my appreciation for patient-centered care. I hope that someday I will be able to thank her for the lessons that she taught me through her pain—lessons that have already made me a better medical student, a better person, and, some day, a better physician.

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