Term Paper

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The Situation

Very recently I had an experience with a patient that left a lasting impression on me. My assigned patient was an English speaking American male in his late 40's who was in the hospital with terminal cancer, awaiting hospice placement. The cancer has spread to all his organs including the spine and bones. He was gaunt and his skin grayish. He had a colostomy and a condom catheter and therefore there was not much care to do for him. The patient was alert and oriented times 3 but very withdrawn and difficult to communicate with. It did not seem as if he had totally accepted his illness. "Illness acceptance was found to have an independent positive effect on subjective health. Furthermore, acceptance was found to mediate the effects of hospitalization stress on subjective health measures." (Harrigan, 1996, p.1). My patient seemed depressed and mostly sleeping. I did my routine whereby I came in to his room to introduce myself but he barely acknowledged that he heard me. I have dealt with this type of patient before but I found the silence a bit unnerving although not unusual. My inner thought was "Why is he ignoring me?" I left the room but in a while I came in and found him very restless. He started complaining that he felt uncomfortable and hot. I decided it was time to do something for him. I got a basin of warm, soapy water and told him to turn. He had trouble doing that so I helped him. I washed his back and then took some cream and gave him a back rub. I took my time since it was a quiet day and I had time. I felt sorry for this man, so thin and lost in that hospital bed. He seemed to really enjoy the feel of the cream being massaged into his back. His complaints ceased and he relaxed. After I finished he thanked me and drifted off to sleep.

Later on dinner arrived. I brought it in to feed him but his family had arrived. They told me they would give him the food. I left and returned after dinner only to see that he did not eat anything. The wife stated he did not want to eat and I observed her holding his hand and

massaging the area between the thumb and forefinger. I realized that the patient was experiencing discomfort and pain and did not eat anything because of that. He was on a PCA pump and I told him to press the self administration button which is something he kept on forgetting to do. I left the room and continued with my work. Around nine, as I came back from my break I heard moaning coming from his room. I went inside. His family had left and he was in a lot of pain. The PCA medications he was getting were not helping him. I quickly went out to find out if there was anything else he could get to relieve his pain. I spoke to the new nurse who came on shift and she said that the doctor had ordered a third medication but there was a problem. His wife told him he should not take the medication because it would have an adverse affect on his kidneys. I found that puzzling because he was DNR/DNI and at this point in his illness the kidneys were the least of his problems. His pain had increased to the point that he was yelling and crying for help. In the chaos of the moment all the nurses started going in to comfort him. The clerk was out on a break and it was decided to page the doctor. While waiting for the doctor I went in and took his hand. He held on tight and kept on crying out for help. When the doctor came he went to speak him but the patient kept on saying the wife told him not to take the medication. The doctor called his wife and gently told her that her husband needed the medication. The doctor told the wife that at this point her husband desperately needed pain relief. Finally the wife agreed to the administration. The doctor went in and informed the patient of what his wife said and the patient then agreed to take the extra pain medication. I stayed with him until the nurse came in with the medication. Later on in the evening when I came back to check on him he was calmly lying in bed. He looked at me and when I asked how he was he said much better and once again said thanks for helping me. I then helped him turn on his side and he went to sleep.

Done Well

This patient needed a lot of emotional support in addition to some serious pain management. I was not trying to bond with the patient but just did what I thought was the most important thing. The wash and backrub were meant to relax him and to ease his pain. He was not dirty, just restless from the illness and being bedridden. Holding his hand and staying with him till the medication came was to let him know he was not alone. According to the National Cancer Institute in order to provide comfort to dying of cancer –"Keep the person talking. Talk, watch movies, read, or just be with him or her." Staying with him, holding his hand, massaging his back were my ways of trying to ease his discomfort.

My patient was not very verbal but I noticed through his limited verbal and non-verbal signs that he was experiencing pain and discomfort. He never directly asked me to intervene and to do something. However, by being attuned to his behavior I was able to try and help as best as I could. The restlessness, the wife massaging his hand, his moaning all showed that he was in pain that was not being managed. By not being interested and ignoring him I would not know any of this since he would not have asked for anything. Nonverbal behavior means facial expression, looks, body movements and gestures. The quality of the voice, the speech qualities such as interruptions, mistakes in speech and pauses are also indicative of the person's mood and feelings about a situation.

Not Done Well

When I first came in and noticed that patient was not speaking to me I did not look closely at his face. He was lying on his side with the face partially covered and the lights were not on. It was partially dark and I could not see very well. I should have turned on the light and

asked him to turn on his back so I could see his face. I believe that I would have observed the beginnings of discomfort on his face and could have probed more to see if he was feeling some pain. Then I could remind him to push his PCA button in case he forgot to do so. Instead I assumed he was only angry which turned out to be a wrong assumption. I felt that he was ignoring me and my reaction was that I would leave him alone and not bother trying to get more information. It would have been more professional to ignore my own feeling of "rejection" and to proceed to more questioning because ultimately it is the patient who was in discomfort and not my own hurt feelings. At that time I forgot that the hospital situation was all about him as a patient and not my own feelings of what I thought he should be doing or not. Later on when he refused his medication I became angry at his wife for telling him that he should not take the new pain medication. I remember thinking that she was being obstinate and that he was being foolish for listening to her advice. Once again I did not take the bigger picture into consideration.

What Could be Changed

I need to work on my own feelings. In this situation there were times when I became very judgmental towards my patient and his wife and the doctor. In the beginning I felt insulted because my patient was ignoring me. That should not have happened since I have dealt with dying patients before. Somehow I let my emotions and feelings take precedence over my professional training. The patient was aware of his impending death and he was dealing with a tremendous amount of pain. As a hospice case his days were numbered. I was dealing with him on my level, as a healthy person expecting him to react to me like as if nothing was wrong. Instead of feeling empathy for him I felt sorry for my own hurt feelings, something I should have known not to do. According to a book about Motivational Interviewing in Health Care "Good listening is actually a complex listening skill. It requires more than just asking questions and

keeping quiet long enough to hear patients replies" (Rollnick, 2008, p.9). I listened but I did not realize that listening also means listening to the silence of a communication, not only the chatter.

When it came to the wife, I realized that I was being even more judgmental and opinionated. Her reaction to not giving the pain medication was one of over protectiveness toward her husband. She did not want him to suffer but was afraid of causing him even more suffering. She had no control over his illness so this might have been her way of having some small control over the situation. I am a hospital worker and I deal with all kinds of illnesses and symptoms on a daily basis. The wife only dealt with her husband's illness and would not be able to make the same conclusions as any one of us in that setting. I realized I needed to work on my own feelings, to become more logical and less self involved when dealing with people. As a member of the human race I know this is hard and I know and acknowledge that I will not always be perfect. However, the only thing I can always remember is to try and if I fail try, try again.

My reaction to the doctor was also one of condemnation. I felt he did not push hard enough to get the patient his medication. I felt that since the man was alert and oriented times three, the doctor should have gone in a pushed harder to convince him to take the pain medication. I felt he was being weak and afraid. The wife had nothing to say because the husband was able to make his own decisions. Looking back I see that the doctor was walking a thin line between the two parties involved. The patient was very dependent on the wishes of the wife and the doctor knew this. From my point of view it was easy to say he should do this and that. However, now I realize the position the physician was in. He did come through at the end but it was also an unpleasant situation for him. He was a mediator and he also felt bad for the patient. His was not enviable position.

The whole situation made me think about how I think about patients and coworkers in general and made me realize how easy it is to get your own emotions involved. This is the fine line between being human and being a professional. It is knowing when to shut down the feelings and think logically that is the challenge.

References

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Harrigan, J. & Rosenthal, R. (1996), *Illness Acceptance, Hospitalization Stress and Subjective Health in a Sample of Chronic Patients Admitted to Hospital.* Applied and Preventive Psychology, 4:21-37 (1995). Cambridge University Press.

www.cancer.gov/cancertopics/factsheet