

The Clock on the Wall

ROBERT A. SWENDIMAN, MD, MPP

Her plea came through tears. Four white coats hovered around her bed, watching uncomfortably as the words overwhelmed her desire to be a “good patient”—one who does as she is told and never complains.

“You need to understand,” she said. “I only see you at the crack of dawn, then sometimes very late at night. And while I wait for you, I watch the clock. Do you know how slowly the hands move when you lie in bed all day? It’s agonizing.”

“Amelia” was a chronically ill, yet medically stable, patient. She had been very sick early during her admission to our busy surgical service. She had a complex abdominal wound that we were now trying to heal through a variety of therapies and medical appliances. She was not allowed to eat; nutrition was provided through her veins. A large sponge covered her wound, sealed airtight by a vacuum device attached to the wall, pulling her skin and tissues together. She had been operated on more than 20 times in the past few years.

But recently, Amelia had reached a somewhat steady state: not ill enough to warrant frequent physician attention, but still not well enough to leave the hospital. While we waited for her to heal, she awaited “disposition”—transfer to a step-down, long-term care facility.

Healing is a slow process, and Amelia had a front row seat. The staff knew her well, but, since she had few other issues, I seldom received calls from nurses regarding her care. I spent more time with the sicker patients. The team saw her only quickly during morning rounds, and her wound appliance was changed just 3 times per week. Fewer interactions meant progress in our minds. In hers, it meant abandonment. She watched days go by without any of us actually laying a stethoscope on her chest.

While covering 30 patients on the floor, putting out “fires,” or sometimes literally running around just to keep everyone alive, it was easy for us to forget Amelia. Suddenly it was 6 o’clock in the evening, and there were still tasks to complete. Patients were still coming out of the

operating room; orders still needed to be placed. And then it was time to round again. The hands on the clock moved too quickly.

But there she waited, in the room on the corner of the third floor, watching the clock. Its hands moved all too slowly, and she felt very much alone . . .

I was shaken by Amelia’s assessment of our care (*my* care) over the past few weeks. I remembered an article I read prior to starting residency, showing that interns spent only 8 minutes with each patient per shift.¹ Eight minutes. I recalled being horrified by the authors’ findings. And yet I realized that during the past week, I had likely spent less than half that amount of time in her room each day.

I was determined to make up the difference. I began spending as much time as I could with her. We talked about significant others, horses, the beach, medicine, and her condition. Once, I even ate my lunch in her room.

When medical students asked me at the end of the day if there was anything else to do before going home, I requested they spend some time with Amelia, to meet her and hear her story. Just to make the hands on the clock move a little bit faster, even if only for a few minutes.

Before Amelia was discharged, she acknowledged how much it meant to her to have providers spend more time with her toward the end of her stay. I smiled at her, but there was an inner sadness. I walked out of the room and flipped through my list of patients: stroke 2 weeks after surgery (Amelia?), chronic bowel obstruction (Amelia?), anastomotic leak (Amelia?). One Amelia would be leaving today, but others could take her place. I promised myself I would do better.

My phone rang. A patient 2 floors up was in respiratory distress. I looked up at the clock on the wall: 4:30 in the afternoon. My day was nearly spent.

References

- 1 Block L, Habicht R, Wu AW, Desai SV, Wang K, Silva KN, et al. In the wake of the 2003 and 2011 duty hours regulations, how do internal medicine interns spend their time? *J Gen Intern Med.* 2013;28(8):1042–1047.

Robert A. Swendiman, MD, MPP, is a PGY-1 General Surgery Resident, The Hospital of the University of Pennsylvania.

Corresponding author: Robert A. Swendiman, MD, MPP, The Hospital of the University of Pennsylvania, Department of Surgery, 3400 Spruce Street, Philadelphia, PA, 19104, 215.908.1032, robert.swendiman@uphs.upenn.edu

DOI: <http://dx.doi.org/10.4300/JGME-D-14-00788.1>