When was the last time you spent 3 hours with a patient?

For me, the answer was never.

As a first-year medical student, I spent 2 hours taking my first history. As a resident, I led a family meeting for 1 1/2 hours. But I never spent 3 hours with a patient.

That changed during the first year of my nephrology fellowship.

In our hospital, the fellows’ computer workstation is located in the dialysis unit. After I gather data and round on patients, the majority of my time is spent on the electronic health record (EHR): writing notes, checking dialysis prescriptions, ordering appropriate doses of recombinant erythropoietin and vitamin D analogues, and communicating recommendations to teams. But rather than working in an isolated workroom, as I had throughout medical school and residency, I instead work alongside patients as they receive hemodialysis.

Quickly, I could see the difference. The difference between asking an elderly man admitted for pneumonia about his symptoms, versus hearing him cough up phlegm for 3 hours while asking for a basin and more tissues. The difference between seeing a patient dry heave over 3 hours, with ondansetron and metoclopramide attempted without relief, versus asking, “Any nausea?” and writing “Subjective: Patient reports nausea.”

Most of our time in the dialysis unit is spent in parallel, physically present in the same space. When a patient wants to talk to me, there is no need for pages, waiting, phone calls, and elevators. They just yell, “Hey doc!” and I am at their bedside within seconds.

I write consult notes while they watch television. Eat their meals. Read. Call their family. Walk to the bathroom. I am given a 3-hour window into their 24-hour lives. Caregivers and nurses already know the crucial importance of time. They know how time transforms knowledge into understanding and empathy.

One day, I listened to a patient who suffered a subdural hemorrhage gagging on his thick secretions. We called the respiratory therapist who performed deep suctioning, but the gagging persisted. I paged the team: “Our patient in dialysis has a lot of secretions, RT suctioned, consider more frequent suctioning. Thanks! -Renal.” How can a 117-character message convey the experience of listening to him struggle with his secretions for 3 hours—an experience that the family must endure for 24 hours?

Co-location and observation have led to fortuitous opportunities to improve care. Another time, I overheard a patient on the phone bemoaning the lack of parking at his outpatient dialysis unit. Within hours, the social worker was able to arrange parking vouchers for him, and he stopped missing dialysis. Another patient, an elderly woman with a hip fracture, was crying out in pain for the duration of dialysis. The orthopedic surgery team had recommended hip replacement the day before, but she had chosen nonsurgical management. Because we had time with her, chatting on and off for 3 hours, she was able to tell us that she had changed her mind about the surgery, and later that day her hip was replaced.

What if hospitals were designed this way, with physicians working on the EHR in the presence of their patients? In his 2015 book The Digital Doctor, Dr Robert Wachter discusses the transformation of workflows after EHR adoption. Physicians no longer have to travel to wards to review physical charts, and increasingly spend their time in sequestered workrooms. Geographic localization of care teams may be a start, and studies suggest this can increase time spent communicating with patients, improve nurse-physician communication, and affect provider satisfaction and productivity.

The Accreditation Council for Graduate Medical Education (ACGME) “Back to Bedside” initiative tackles this very question of the separation of patients and physicians, and has funded innovative solutions to foster the therapeutic connection. Working on computers or portable workstations in patient rooms may allow other physicians a glimpse of my experience in the dialysis unit. While inertia and privacy concerns may cause physicians to pull back to their isolated workspaces, this would at least make an alternative possible.

Not all physicians have the luxury of spending 3 hours with their patients in a dialysis unit. But given the chance others may find, as I did, that charting alongside patients can improve care and bring unexpected meaning to work.

Sri Lekha Tummalapalli, MD, MBA
San Francisco, CA

Sri Lekha Tummalapalli is a nephrology fellow at University of California, San Francisco researching quality of care and healthcare delivery in kidney disease.

Address for Correspondence: srilekha.tummalapalli@ucsf.edu
doi: 10.1053/j.ajkd.2018.08.018
© 2018 by the National Kidney Foundation, Inc.