

Experiences in an Italian Rehabilitation Hospital—Two Stories

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Perm J 2017;21:16-175

E-pub: 04/05/2017

<https://doi.org/10.7812/TPP/16-175>

INTRODUCTION

In Italy, mainly in the south, public hospitals are very crowded and offer very limited and sometimes hasty assistance, so that patients are too soon sent to rehabilitation centers, very few of which are public. This almost entirely private field is financially sustained by the National Health Service, which pays a per diem for a patient's clinic stay. If a patient still needs rehabilitation after 2 months in a rehabilitation clinic or center, reimbursement from the National Health Service will be *in any case* cut

by about 40%. Private insurance is very rare and usually is not involved in rehabilitation.

In private rehabilitation centers, physicians often have to deal with overworked nurses and angry, worried patients and relatives. Although the two following stories take place in the same setting, they are quite divergent and show two very different approaches toward patients and nurses: The thoughtful one is by Dr Arnone, and the angry one is by Dr Crisci.

Professional Satisfaction

by Biagio Arnone, MD*

For a couple of months, this mature and healthy woman had been complaining of frequent but migrating headaches, with or without “aura,” mild depression, anxiety, occasional dizziness, vague visceral symptoms, and recurrent fatigue. She had been visited by an illustrious neurologist, quickly sentenced as “a hysteric neurotic,” and given anxiolytics. Because this prescribed therapy had not succeeded and the dizziness and headaches were growing more frequent, she came to me (perhaps because I am ten times cheaper, or maybe because others were too busy).

The patient's neurologic examination was *almost* normal, but I prescribed a magnetic resonance image, on an inexplicable instinct that she could not be just neurotic or maybe because I just wanted to appear scrupulous. A couple of days later, she returned with the magnetic resonance image report. She had several cerebral metastatic lesions from an otherwise silent neoplasia.

Right! I was right! Oh, damn . . . My enthusiasm lasted a fraction of second; hopefully the patient and her relatives had not noticed my half smile. My instinct had done better than the illustrious specialist, but my brilliant diagnosis condemned the patient. And my moment of perverse satisfaction now worried me.

I think I am a decent man and a decent neurologist, and I have always been proud of my empathy with patients and their families. But now I had half-smiled in front of a tragedy. How could I be satisfied by such a bad diagnosis? Had I inappropriately and inadvertently smiled at other times, in similar situations? Was it that my enthusiasm for a new discovery, a right diagnosis, and a well-done job might have nothing to do with its consequences? Or, as often happens to me, was I being too hard on myself?

I talked with my fellow colleagues and expert nurses, hoping, asking for some comfort. Nurses gave some thoughtful answers; their daily experience at the bedside allowed a deeper sensibility.

They explained that patients perceive almost any change in a physician's voice, but obviously tend to interpret it in a personal way. For instance, my moment of enthusiasm could have been because of relief because I knew the diagnosis and consequently the therapy. Anyway, the nurses told me, no patient would think physicians are happy because of a bad diagnosis.

I am reminded of several situations when colleagues had forgotten they were in front of patients and had spoken inappropriately: “Look, what a magnificent case of Friedreich's ataxia!”; “Have you ever seen such a gorgeous tumor?” The worst was a professor who had asked the patient permission to do an autopsy because his case could be published in a scientific journal after his death. The professor did not understand why the patient had answered in a rude way.

My physician colleagues were quite superficial in their responses to my search for solace: “After all, it's not your fault she is ill,” said one; “You neurologists are strange. A right diagnosis is always a professional satisfaction,” argued a cardiologist; “The satisfaction of the cuckold husband . . . happy to have been right in his jealousy,” answered another; “Yeah, a sh---- satisfaction . . .” No one has taught me how to give bad news, and this crude expression actually defines how I felt, probably like others in that circumstance. To be sorry to be right is a kind of dissociated, disturbing thought; my left brain was satisfied while my right brain would have preferred to say: “I am happy to inform you that I was wrong, you are just a flaming neurotic.” Satisfaction for a well-done job is a natural feeling, no matter what kind of job it is (killer, tinker, thief, or physician), and we should not feel sorry about this, but rationality, culture, religion, conscience, compassion, and empathy should help us learn to mask instinctive pride . . . most of the time. ❖

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Burnout

by Claudio Crisci, MD

“Burnout” syndrome makes physicians frail and paranoid. Thus, medical rounds can be a kind of safari in which you, the burned physician, feel like the target for patients’ parents and nurses.

Room 1: The 95-year-old woman is almost independent after 2 months of rehab, but none of her siblings can (or wants to) take care of her at home. It is August, and they would like to spend a quiet summer, and then they will look for a good, not-too-expensive hospice. *Can she stay in your center for another month?* No, she can’t. There is no medical reason (and the Health System would not pay). Anyway, here is the phone number of another center where there may be a bed free.

Room 2: This 24-year-old drug addict will never recover from his last trip; now he is in a persistent vegetative state. His admission was a struggle for nurses and administrators: Too great of a commitment and waste of money, they said, while his relatives prayed for help. *Can’t you doctors give him something to wake him up?* the relatives asked. They had heard on television about stem cells, and television always tells the truth.

Room 3: This youngster is always trying to look in the nurses’ shirts or to touch their butts. He is aggressive, and bulimic. *Can’t you scold or, better, dismiss him?* He is recovering well from a head trauma—his disinhibited manner is just part of the frontal syndrome—but he is disturbing nurses too much, and they will soon unleash their advocate against you. Burn, physician, burn.

Room 4: *Why is that lady always screaming and asking for help?* She is just another old, fat woman with a broken hip; she can’t control her bowels and can’t roll in the bed, and she is very disturbing, especially at night, when the underpaid nurses on duty would like to have some rest. *Why don’t you send her home? Then her snob daughters will have to take care of her and soil their hands instead of giving us orders and protesting everything.* Be careful in your answers; you are a little hysterical these days.

Room 5: Bed no. 1 is too dirty; he needs a bath. Bed no. 2 is too unstable. It takes you a moment to understand the nurse is not talking about the furniture but about patients. Nurses will take care of them, sooner or later.

And so on it goes ... for 40 more patients.

You feel like you are the only one to take care of patients and to remember their name, age, and story; to other physicians patients seem to be just occupied beds, waiting for a turnover (you are not the only one burning). In other divisions, nurses are not as busy as in yours; you are too precise and demanding: *Do you really need to know daily blood pressure and temperature of all patients? Are laxatives really necessary? Patients get dirty and need to be cleaned too often.*

Those two patients are arguing about the air conditioner; one wants it on, the other obviously off. You, physician, are supposed to solve the conflict in some way (Change the room for one of them? Sedate both? Break the air conditioner?).

Almost completely in ashes, you try to maintain an ethical and professional approach, rejecting compromises and wondering why you didn’t continue your neurophysiology research instead of choosing rehabilitation. Your fellow colleagues, former students in your research lab, are now distinguished professors who sometimes call to recommend one of their paying patients to your attention. After all, you are still a master in what you do. Do not forget to take ranitidine today or your ulcer will kill you ...

You sit at the computer, fantasizing about a better job (Switzerland? Dubai? With your curriculum you could go anywhere, or could you?). In an e-mail, clinic administrators warn you to control nurses’ use of too much soap, latex gloves, and diapers; and to change that useful but expensive antibiotic with that cheap one donated as a “bonus” from a drug company for having consumed a ton of diapers and a million bottles of laxatives.

The e-mail continues: *At present no money can be put into your project for better occupational therapy.* They have already spent it on new desks, armchairs, and other furniture for the administration offices, and the Public Health Office is late with payments (a more-than-20-month delay). Why don’t you go on with the old stuff? You are doing a good job, and patients and administrators are satisfied with it. As a friend says: You are frying fishes with water. Still no answer to your request for a couple of new wheelchairs or a direct telephone line; when you need an ambulance for an emergency, you will have to pass through that nice lady operator, waiting until she has finished chatting with her boyfriend. Another e-mail tells you that your paper (you still try to write one every year) is very interesting but quite unusual, and unsuitable for publication. You feel stuck in a burning cage; talking with colleagues would perhaps make you feel better (a problem shared is a problem halved) but you never succeeded in expressing your feelings, especially with fellow colleagues as stressed as you.

At last, another day has gone. Maybe you are the last physician leaving the center, as always; but then they call you from another ward: Your colleagues, equally almost burned out, forgot to put on therapy a patient who arrived this morning, a very difficult one, obviously. *Could you please come and solve the problem?*

Yes, I’m coming. After all, to be a good physician is the only thing that still makes you feel well. ❖

^a Claudio Crisci, MD, provided translation and editorial assistance for “Professional Satisfaction.”

Disclosure Statement

The author(s) have no conflicts of interest to disclose.

How to Cite this Article

Crisci C, Arnone B. Experiences in an Italian rehabilitation hospital—two stories. Perm J 2017;21:16-175. DOI: <https://doi.org/10.7812/TPP/16-175>.