Reflections

Prescriptions of sleep

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Only one rule in medical ethics need concern you—that action on your part which best conserves the interests of your patient.

—Martin H. Fisher

At 3 AM it is pretty quiet on the medicine wards. The soft, rhythmic tones of telemetry monitors occupy the background while a sleeping patient's television broadcasts the late, late local news. Bleary-eyed house staff labour over admission notes as nurses and patient aids attend to patients resting fitfully in their beds. Five hours from now the desk where I sit will be buzzing with activity, the relative tranquility of the night long forgotten.

Mr Roberts is an 84-year-old gentleman just starting to rest after an exhausting day navigating the complexities of the admissions process. He probably did not realize what a long day lay ahead when his wife insisted that they go to the hospital because of his increasing shortness of breath.

Mr Roberts is a gentle old man, the kind every resident hopes to meet after picking up a chart or receiving an assignment. He lives with his wife and still enjoys an active lifestyle after a mitral valve replacement 1 month ago. Now he has increasing dyspnea. I worry. As the admitting resident on the case, I feel infinitely more responsibility than I had during my internship year. I consider endless possibilities that might explain his symptoms, reminding myself of the wisdom in the phrases "common things are common" and "deadly things are deadly."

While medical school and internship have equipped me for the challenges of being alone at night admitting patients to the hospital, nothing could fully prepare me for the multitasking I must do while serving as "nightfloat," covering all admissions to the hospital after 11 PM so that my colleagues can sleep. Nor am I ready for the disruptions that I will cause in this patient's nearly sleepless night.

A doctor in the making

Since I was young, when I took pleasure in removing a splinter in my mom's or dad's hand, I have realized that sometimes to help, one must cause hurt, and that part of a doctor's job is to be willing to cause that hurt in the name of healing. With a single focus of removing a tiny piece of wood from my dad's finger, at age 6 I was encouraged by his supportive words to narrow my sights and quickly advance the singed needle while holding his finger still. No amount of dexterity could prevent some discomfort during the process. I was a doctor in the making, guided by a nurturing father who was a doctor himself.

Now, 20 years later, I am shocked by how differently I feel in the middle of the night, when I am the needle, diving into Mr Roberts's world of fitful sleep to perform an examination so that I can "get to know the patient" whom I will care for over the next few hours. His pleas to be left alone leave me struggling for words. How can I explain to him all of my thoughts: that there is nothing I would like better than for us *all* to go to bed, that I wish the *whole hospital* were asleep, that dyspnea after a recent mitral valve replacement can be life-threatening. But Mr Roberts does not give me a chance. He simply insists that he be left alone, and he politely declines my offer of even a brief examination.

No amount of training could have prepared me for the difficulty of bargaining with an exhausted, kind, sensible, but sleepy 84-year-old who probably needs his 3 hours of rest more than he needs me. How many times will I have to cause discomfort or pain in the name of the greater good to which I am

committed? Might it not be enough to check his pulse oximetry, respiratory rate, and let the man rest? Yet in doing so, I would be forgoing the interview and physical examination that my colleagues will expect me to have performed and that could be important for his safety.

Mr Roberts remains in bed. He quickly begins dozing again, as if to prove to me just how tired he is. I move to a bedside chair, happy for the chance to rest my weary feet. After all, I have been awake for as long as he has, and while I am not an 84-year-old man with a recent valve replacement, I feel as if I could use some rest. I listen to his rhythmic breathing, and remarkably, find myself entering into a deeper and deeper state of relaxation....

I leave him alone

My eyes snap awake. I check my pager: 3:45 AM. Incredibly, I have been resting at Mr Roberts's side for almost an hour! He is reclined at a 30°angle and appears comfortable. His breathing is even and unlaboured. I gently approach his side, gingerly adjusting his sheets so I can listen to his lungs and heart. He fidgets in his bed, moving to get comfortable. I step back after my brief examination—observing and wishing I were home in bed. I review his vital signs and the history taken by the emergency room physician several hours earlier. I decide to leave him alone. The irony of having to cause discomfort or to hurt someone in order to help them is something I continue to agonize over—a bitter pill that I would rather not ask my patients to swallow.

I listen to Mr Roberts for a few breaths longer before quietly slipping out of his room, wishing him restful sleep in the few remaining hours of darkness.

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