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Sitting

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Sitting

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During a local COVID-19 surge in late 2021, salaried health system leaders were asked to volunteer for nonclinical hospital shifts to help alleviate staffing shortages. The author, a family physician by training now working largely in a population health administrative role, signed up to serve as a patient sitter. This story explores how taking on the vantage point of a sitter enabled the author to reflect on the premise of watching and being watched, the diverse team that keeps an emergency department running, and how human connection may even contribute to normalizing heart rate. (Note: Pseudonyms are used in place of actual names and some details withheld to protect the privacy of the individuals involved.)

I arrive in the emergency room to begin my shift as a patient sitter, feeling as awkward as my first time volunteering here as a college freshman nearly 40 years ago. The stressed-looking charge nurse points down the hall and tells me to relieve Natalie, who has been sitting there for the last 8 hours. Natalie hands me a clipboard with a patient sticker and a lengthy chart on it and points out what to fill in. I make myself as comfortable as possible, sitting in the emergency room hallway outside my assigned patient's room. She has immediately become "my patient" even though I don't have any information other than her name and age. I know that she has a sitter and 15-minute safety checks, so I can assume she had some sort of self-injurious behavior. She is sleeping, has IV fluids running, and is on a heart monitor. I wonder about my patient: Why is she here? What is her life like? Then I wonder if this curiosity to know is shared by others on the care team.

I notice over the first couple of hours that I'm sitting with her that her heart rate has slowly decreased from 109 to 81 bpm. That seems like a good thing. I remember quizzing medical students about the many causes of sinus tachycardia — pain, fever, blood loss, stress, dehydration, drugs — and making a comment that it is perhaps the most common heart rhythm seen in the emergency room. One job for emergency clinicians is to help get the heart rate back down. On the other hand, a heart rate going to zero is also an outcome that is a very real possibility in an emergency room. Perhaps

achieving *normocardia*, not too fast or too slow, is very much a metaphor for the methodical, ceaseless work of the emergency department?

In some ways it's the strangest job I've ever had. The role is literally to simply be there doing nothing, only observing. No phone, laptop, books, magazines, headphones. Just sitting. Every 15 minutes I write a code for her behavior on a paper form. So far it's been "sleeping in bed," coded as "S/B." It occurs to me that it's a terribly inefficient use of health care resources to have a live person doing this and that this a place where technology could do the job much more efficiently, with perhaps one staffer monitoring multiple patients remotely.

I'm struck by how many people it takes to keep this enterprise running. A guy whose jacket reads "Facilities" comes by to check the hallway doors. He tests to make sure that the doors open and close correctly and that they stay tightly closed, both using the remote door paddle and pushing/pulling manually. He checks off items on a form as he proceeds. I imagine there must be a regulation somewhere dictating how often this must occur, an internal policy and procedure, updated annually, that defines how we maintain compliance with the regulations and some documentation and reporting process that ensures it happens. I can envision an inspector demanding, "Show me your ER door check log." Security personnel march through, always moving briskly toward some unseen need. Patients are constantly wheeled by in chairs and carts. Motorized portable X-ray machines whirr past and return. Environmental services staff pick up the trash and soiled linens several times during my shift and, once, parade through on a Zamboni-like floor cleaner. Three different phlebotomists draw my patient's blood. I notice a trend that while many of the

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other staff say hello or at least nod or smile, most of the clinicians — doctors, nurse practitioners, and physician assistants — rarely acknowledge or even seem to notice me. How many sitters have I breezed past?

I wonder what it is like to be aware of being watched, to feel the presence of another person just sitting there and observing you. And I realize that it is a feeling that most of us probably should have frequently. Indeed, as I sit there I can see the security camera that is possibly viewing me. I can't see the person on the other end; is he or she watching me on a screen? What is he or she thinking? I recall that someone once defined integrity as behaving the same whether or not someone was watching. How little most of us are aware of how often, or in how many ways, we are being watched.

A welcome break in the routine occurs when my patient is awakened for a remote psychiatric interview. I'm not sure about the ethics of overhearing (or is it eavesdropping?) the conversation, but I rationalize that it's my job to stay present. I cannot hear the psychiatrist's questions but can hear my patient's replies. I learn that she recently moved to this area, that she has been in a long series of mental health treatment programs, and is on many different medications. She is here today because of an overdose on lithium. Medically, I know lithium can be highly toxic but rarely kills. Judging from her current condition, I would guess that my patient is likely to recover, and I feel oddly relieved and happy to learn that. After a while my patient replies "I understand" to multiple statements in a row, and I am guessing that the psychiatrist is telling her about the strained and limited options for further mental health care.

When the interview ends, I enter the room and introduce myself, ask if I can get my patient anything. She requests a water refill, which Doug, the nursing assistant, brings. Unfortunately, the lid is not tightly on the ice water and it dumps onto her bed. Doug goes to get some dry linens while I try to scoop up ice. I tell her that I feel like I've been doing a lot of cleaning up lately since we have our daughter's puppy staying with us and show her a picture of our dogs. She opens up with that and tells me a little bit more about her life, and we chat for a while. It feels a little weird for me to talk to her completely as a person and not as a professional. I notice that when she stands up for us to change her sheets, her blood pressure drops and her heart rate skies, and I point this out and encourage her to keep drinking water — back to the safety of my caregiver role. Then there's an awkward pause and she graciously excuses me from the room with a "I think I'd like to order some food now." I code her as "A/B," awake in bed.

I pop into her room a couple of times over the next few hours to see if she needs anything. I get her a warm blanket at one point, happy to be able to do something. When my replacement arrives, I stop in to say goodbye and wish my patient well. She says "Thank you. It was nice to meet you." It feels much more genuine than usual. I'd like to think my presence provided some measure of comfort, maybe even made a small impact on her condition.

Before leaving, I glance at her monitor; her heart rate is now 65 bpm.

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