Dialogues from *Medical Language: Terminology in Context* for Use in Interpreting Training

Contents

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Chapter 3: Physical Assessment

Introduction: Mrs. Loeppky's wound has been stabilized, and her condition is stable (not urgent or emergent). She has had an x-ray taken of her painful, swollen left thumb and hand. The bones are not broken, but she has an ulnar collateral ligament injury. The nurse questioned Mrs. Loeppky about the probable cause of the injury. (Hull, 2013, p. 76)

NURSE	Mrs. Loeppky, as the doctor told you, your thumb is not broken, but it is injured. It's going to require a splint to immobilize it. Do you know what happened to it? How you injured it?
PATIENT	Please, call me Glory. I'd like it if you just called me Glory. All I can remember for sure is that we were driving along and I was uncomfortable with the seat belt on. But I wanted to keep it buckled. I know it's important to wear a seat belt. So, it was bothering me on the left side of my belly. I hooked my thumb inside the seat belt to keep the edge of it away from my skin a bit so it wouldn't feel like it was cutting into me That's the last I remember about my hand.
NURSE	I see. Well, there are a couple of things that might have happened. In the force of the accident, that thumb might have remained hooked in the belt. It would have been pushed and pulled with a great deal of force when you were hit and then again as you came to a stop. That's usually how these types of injuries occur. You've damaged what are called the ulnar collateral ligaments. Is there any possibility that you might have torn the ligaments by reaching out to brace the dashboard?
PATIENT	No, I don't think so. I don't remember doing that, because we got hit on my side of the truck. I remember a loud bang and being pushed toward Gil.
NURSE	I see. Well, as Dr. Abrams pointed out, the good news is that the ligament did not tear completely, and you won't need surgery for it. Luckily, you didn't dislocate the joint, either. Dr. Abrams will be back in a little bit to apply a thumb spica cast: that's really just a type of splint. In the meantime, I'm just going to wrap that thumb securely against your hand. Immobilizing it like that will protect it from any further injury and help you to avoid any extra pain and discomfort.
PATIENT	It's really turning black and blue now, isn't it? Is that normal?
NURSE	Yes, discoloration is quite normal, Glory. And it will be very sensitive to touch right around the middle joint. That's why well splint it. The splint will also prevent you from trying to use it to grasp things until the ligament heals and the thumb is strong enough to do so. That's going to take 3 to 6 weeks. It's susceptible to reinjury when it's healing. The thumb won't be strong enough to hold any weight.

(Hull, 2013, p. 77)

Chapter 5: Laboratory Diagnostics

NURSE	Hello, Mr. Davis, I'm Roxie, one of the nurses here. Please don't pull on that tube. We've inserted a catheter, sir, to help you void. I know it might be a bit uncomfortable just now, but it's important that you leave it in place. [*Nurse moves Patient's hands away from catheter.*]
PATIENT	Huh? What? What's going on?
NURSE	Sir you are in the ER of Okla Trauma Center. You've been in a motor vehicle accident, and we're taking care of you. You were incontinent of urine on your way here, so we've put in a catheter to help you with that for the time being.
PATIENT	Catheter? What do you mean? [*Patient fumbles with his oxygen mask.*]
NURSE	Mr. Davis, that's your oxygen mask. You need to keep it on right now. Just relax and take a deep breath. You're in the hospital, and we're here to help you. [*Nurse moves Patient's hands away from oxygen mask and holds them for a few seconds.*]
PATIENT	I have to pee. Let me go now. I have to go to the bathroom. I have to go. Please help me. [*Patient tries to sit up and moves his legs.*]
NURSE	No, sir, you've got to lie still a bit longer. [*Nurse restrains Patient with assistance.*] You've been in a car accident, and we're doing some assessments to see if you're okay. You have a urinary catheter in place. It's a small tube that we've inserted up through your penis, through your urethra, and into your bladder. It will drain your bladder for you. You don't have to worry about going to the bathroom. Just relax when you feel that need to void, and the catheter will take care of emptying your bladder for you. It's hooked up to a bag here; there's a catheter bag hung just at the side of your bed, below you.
PATIENT	Yeah ... yes, okay. Oh, I know, I know what you mean now. I know. I've had one before, I think. [*Patient lies back on bed.*]
NURSE	Sir, I'm just going to take a quick urine specimen from this bag before they wheel you down to have a CT scan. [*Nurse drains some urine from bag into a labeled cup.*]

(Hull, 2013, pp. 191-192)

Chapter 7: Mental Health, Drug Use, and Endocrine Assessment

Introduction: Mrs. Davis has risen from a short nap and is disoriented and unsure about where she is and why she is there. She recognizes that this is a hospital and draws some conclusions. She gets up and steps into the open area near her bed, and she reaches out toward a nursing assistant who is coming her way. (Hull, 2013, p. 256)

PATIENT	Oh, you there! Nurse! There you are. Why did you let me sleep? I thought I heard helicopters. Why didn't you wake me? Where's Dr. Morgan?
NURSING ASSISTANT	[*confused*] Can I help you, ma'am?
PATIENT	Well, yes, of course you can help me! Help me find my shoes and get the rest of the nurses up. They'll be in their tents. Tell them to get a move on, we've got in-coming. Nurse, what is that civilian doing here? [*Patient speaks authoritatively and heads to the nursing station.*]
NURSING ASSISTANT	Ma'am, my name is Sandra. You are in Fayette General Hospital. You've been in an accident, and you're confused. Let me help you.
PATIENT	What ... what are you saying? [*Patient pauses to think.*]
NURSE	Hello, Mrs. Davis, how are you feeling?
PATIENT	[*sharp retort*] **Lieutenant** Davis.
	[*Nursing Assistant explains the situation to Nurse. Nurse reorients Patient.*]
PATIENT	[*confused*] I'm in the hospital. Here in the States.
NURSE	Mrs. Davis, do you know where you are right now?
PATIENT	Yes, I'm on leave in Hawaii. I must have been dreaming. I thought I heard helicopters, and I though I was back with my Unit.
NURSE	Ma'am, do you know what year it is?
PATIENT	1971.
NURSE	Mrs. Davis, you are in Fayette General Hospital. It's 2015. You've been in a car accident, and we're taking care of you now. I'm your nurse, Caroline. Come with me, Mrs. Davis. Let's get you back in bed for a bit. You seem a bit confused, and I want to help you with that. [*to Nursing Assistant*] Sandra, can you tell Meagan that Mrs. Davis is awake now if she'd like to talk to her?
PATIENT	Oh, this is a hospital. I'm not in Hawaii. I don't know why I thought that. It must have been a dream.

(Hull, 2013, pp. 256-257)

Chapter 8: Obstetrics, Labor, and Delivery

Introduction: On the antepartum unit, some of the nurses are taking advantage of a quiet moment to catch up on charting and other duties at the desk. Other staff members are busy with patient care. It's late in the afternoon now, and visitors are beginning to arrive. (Hull, 2013, p. 316)

PATIENT'S MOTHER	Nurse, nurse, come quick! [*Patient's Father pushes call button.*] Nurse!
	[*two nurses enter*]
PATIENT	Oh, hi ... um ... my belly hurts.
NURSE 1	What sort of pain are you having?
PATIENT	Ooh....
NURSE 1	[*to Nurse 2*] UC. I'm going to take another nonstress test. [*checks fetal vital signs*] Brenda, please take care of Glory. I'm going to page Dr. Bedard. [*exit*]
NURSE 2	Well, Glory, it looks like you're having some changes happening here. Laura's gone to get Dr. Bedard to come see you. In the meantime, I'll stay here with you. Are you feeling any pain or discomfort anywhere else?
PATIENT'S MOTHER	Why does she need the doctor? What's happening to Glory and the baby? [*to Patient*] Glory, are you okay?
PATIENT	I ... I don't know, Mama. I suddenly don't feel so well. It sort of hurts here, but ... well ... I don't know what it is, but I just don't feel well.
	[*Doctor and Nurse 1 enter.*]
DOCTOR	Hello, I'm Dr. Bedard. Hello, Mrs. Loeppky. We haven't met yet, but I'm going to be looking after you. [*makes a few checks*] [*to Nurses*] We'll need an ultrasound STAT. Do it here. Get the OR on standby for a possible STAT C/S, too. [*to Nurse 2*] Say, Brenda, see if Frank Jasper's around, will you? Ask him if he'd like to scrub in.
	[*Nurse 2 leaves to complete directions.*]
NURSE 1	Mrs. Loeppky, when I looked at your ultrasound a short while ago, I found evidence of placental tearing; this means that the placenta is coming away from the wall of the uterus. There is a hematoma forming under the placenta where it is separating from the uterine wall. This can cause internal bleeding, and it is unsafe for the fetus. It looks like we may have to deliver your baby.
PATIENT, PATIENT'S MOTHER, and PATIENT'S FATHER	**What?!**
	[*Nurse 2 enters.]*
NURSE 1	In the case of a placental abruption, which I think is what we have here, the fetus's life may be in jeopardy. A Cesarean section is the only answer.
	[*Sonographer enters and performs ultrasound, then exits.*]
DOCTOR	All right. It's confirmed. There is an abruption of the placenta. We'll prepare for OR. Don't worry, Mrs. Loeppky. You're in good hands, and we're going to do everything we can to make sure you and your baby have a healthy delivery.
	[*Doctor exits, followed by Patient's Father*.]
PATIENT	Laura? Is may baby going to be okay? Brenda?
	[*Nurses try to reassure Patient.]*
PATIENT	But my baby isn't old enough! I'm only 7½ months pregnant. That's too soon, it's too early! I'm afraid.

NURSE 1	Babies can be born preterm, Glory. Your baby is about 30 to 32 weeks old now. It will be small, but we have a wonderful modern neonatal intensive care unite here at Fayette General. After the birth, your baby will receive extra special care while he or she continues to grow and develop.
PATIENT	But ... but ... what about Gil? What about Gil? Wait, we can't go. Gil has to be here! We planned this together. He wanted to be here. I want him here. Oh, please! I want him here. This is not the way it's supposed to be. Mama, Daddy, what about Gil?

(Hull, 2013, pp. 316-317)

Chapter 9: Medical Records, Test Results, and Referrals

NURSE	Hello, Mr. Davis, I'm Jenny, your nurse here on 8B. How are you feeling?
PATIENT	Honestly, I feel like I've been hit by a bus, nurse. I don't know why. I'm not injured. I just feel beat. Pooped right out. Maybe it's all the excitement and worrying about my family. But I'm not sick. And I'm not injured.
NURSE	Well, sir, you do have a urinary tract infection. That's why we inserted your catheter. But sometimes these problems are the result of previous conditions. Have you had any urinary, bladder, or kidney problems before now?
PATIENT	No, nothing like that. How'd I get an infection anyway? How does a person get a ... what do you call it?
NURSE	A urinary tract infection, sir. We call it a UTI for short. Bacteria is the cause of this type of infection. It enters your urethra and travels up it, blocking the flow of urine out of your body. That's when you'll notice difficulty urinating or pain when you urinate. Any time that urine cannot flow out of the body, the system backs up and the bacteria multiplies, which causes the infection to get worse or to spread upward into your kidneys and bladder. [*pause*] On the other hand, sometimes something like a kidney stone or an enlarged prostate can impede the flow of urine. Have you ever suffered from anything like that?
PATIENT	No, not that I'm aware of.
NURSE	When you were admitted, you were incontinent of urine. Has that ever happened to you before, Mr. Davis? Urinary incontinence?
PATIENT	[*looks at Nurse silently]*
NURSE	Urinary incontinence is nothing to be ashamed of, Mr. Davis. It can happen to anyone. But I need to know if this is a pattern for you or a one-time event. It may have something to do with your infection, or it may not.
PATIENT	Oh, for heaven's sakes. Yes ... well ... oh ... You know, I'm 74 years old. For the last couple of years, I have had to go a lot, if you know what I mean.
NURSE	Go a lot, sir? Do you mean that you have had to urinate frequently?
PATIENT	[*nods*]
NURSE	Well, urinary frequency can be a normal part of aging for people, that's true. But urinary incontinence is something a little different. Let's talk about that for a minute.
PATIENT	Well ... I've *almost* been incontinent a number of times over the past year or so. I have to be careful how much liquid I drink each day so that I won't have to worry about not making it when I have to go. [*pause*] And the need to go has also been waking me up during the night more and more often.
NURSE	Do you ever have difficulty starting a urine stream? Or stopping it? Or do you ever find that you dribble a bit when you think you've finished urinating but you actually haven't?
PATIENT	[*nods*]
NURSE	Well, Mr. Davis, these are symptoms that you should talk to your physician about, and they should be assessed so that they can be treated. I'm going to tell Dr. Jackson about them on your behalf. In the meantime, have you experienced any pain while urinating during the last couple of days?
PATIENT	[*nods*]

NURSE	Well, you are being treated for a UTI. The doctor has ordered an antibiotic to relieve the infection, and you can also have some ibuprofen if you need it. It has anti-inflammatory and analgesic properties that can alleviate some of that pain for you and make you more comfortable.

(Hull, 2013, p. 355)

Chapter 11: Postoperative Nutrition and Healing

Introduction: Seven-year-old Clay Davis is now recovering from maxillofacial surgery for a symphyseal fracture midline on the lower mandible. Because of the instability of this type of fracture, Clay's fracture was surgically reduced and fixed with titanium mini-plates to achieve rigid fixation. There was no need to wire his upper and lower jaws. The oral and maxillofacial surgeon, Dr. Sandor, has left the operating room to speak with Clay's parents, who are nervously awaiting the results in the OR patient waiting room. (Hull, 2013, p. 447)

DOCTOR	Mr. and Mrs. Davis? [*shakes hands with Patient's Mother and Father*] We met downstairs in ER. I'm Dr. Sandor, an oral and maxillofacial surgeon here at Okla. Your son is fine. It's been a long operation for a child, but he's doing just fine.
PATIENT'S MOTHER	Can we see him?
DOCTOR	Not just yet. Clay is still in PAR recovering from the anesthetic, and we need to leave him there with the nurses for about another hour, I'd say. Then he'll be moved to Pediatrics and back to Dr. Lincolns care. That's up on the fourth floor, in the west wing. I believe you met Dr. Lincoln earlier today in the ER?
PATIENT'S MOTHER	Yes, but we don't know where Pediatrics is located.
DOCTOR	Don't worry about that right now. One of the nurses will come out to speak with you when the time comes, and he or she will tell you how to get there.
PATIENT'S FATHER	Doctor, what exactly is happening with Clay? We don't have a lot of information. When we got here, our son was already being rushed up to surgery.
DOCTOR	As you know, your son was in a motor vehicle accident, and he received a traumatic injury to his lower jaw. His injury is called a symphyseal fracture. To stabilize and repair that, we attached a titanium metal mini-plate across the fracture line.
PATIENT'S FATHER	A plate. I though he was going to have his jaw wired shut. How long will he have a plate in his mouth?
DOCTOR	Your son's lucky. His jaws were not broken or dislocated at the condylar region, the joints. If that had been the case, we would have had to do a maxillomandibular fixation using wires, and he would not have been able to open his mouth for at least 2 weeks. Since the injury was only to the symphyseal region, we did not have to wire the jaws in place to stabilize them. [*pause as Patient's Parents sigh in relief*] Even so, Clay won't be able to speak or eat for 5 to 7 days as we wait for the healing to begin. He will be able to open his mouth ever so slightly in the meantime, but that will be quite uncomfortable for him for a while yet. In the meantime, he'll have a feeding tube for nutrition. We'll remove the tube in a few days, if all goes well. We'll have a dietician consult with the treatment team and with you as well so that you, too, can support Clay through this difficult time. Your help is going to be very important to his recovery. The dietician will be able to tell you more about how we're going to feed Clay to ensure that he receives adequate nutrition. We'll get a speech pathologist in here, too, to help Clay with chewing and swallowing.

	Usually, the NG tube is removed in 5 to 7 days as well, after primary healing of the surgical wound has begun. The plate itself could possibly be removed in about 6 months. We'll talk about that much later in his recovery, all right?
PATIENT'S MOTHER	And his teeth? Are his teeth okay?
DOCTOR	[*nods*] Yes, your son was lucky in that respect, too. None of his teeth were damaged or knocked out by the impact. He did have some movement in the central and lateral incisor teeth of the lower jaw, however. The plate will help to stabilize those, too, and we will keep an eye on them to ensure that nothing untoward occurs. We'll also be monitoring his airway. You'll notice when you see him that we have him propped up in the bed. He is in this position to prevent any impediment of the airway. [*pause*] After an accident like this and surgery, it's possible that Clay's tongue will become inflamed or swell up in response. We don't want it to block the air passage at the back of his oral cavity. With his altered levels of consciousness postoperatively, we don't want to risk laying him flat to avoid the risk of the tongue falling back into the pharynx and impeding his airway. Finally, we want to avoid the risk of pulmonary aspiration. That means accidentally sucking things into his lungs. This can happen when the tongue is not able to move materials toward the throat correctly, and fluids, mucus, or foods are suddenly moved into the trachea and lungs rather than the esophagus and stomach.
PATIENT'S PARENTS	[*nod*]
PATIENT'S FATHER	And his burn Doctor? What about that? We have no idea what's happening with that, either. We only know that he has a scald on his chest. What can you tell us about that?
DOCTOR	Yes, that's correct. He has a second-degree scald burn across his chest, more prominently on the left upper torso near his collarbone. We had that covered with a special dressing while we were operating. The burn will now be taken care of by the nurses and the pediatrician assigned to your son's case. We've had Dr. Lincoln assessing and consulting on this burn, and you will be able to speak with him over on Peds.
PATIENT'S MOTHER	Thank you, Doctor. You've been very helpful. We can't thank you enough for what you've done.
DOCTOR	You're very welcome. I'll be checking in on Clay tomorrow, and of course, because I'm his surgeon, the nurses have my pager number and will contact me if the need me to look in on him sooner for any reason.

(Hull, 2013, pp. 447-448)

Chapter 11: Postoperative Nutrition and Healing: The Language of Nutrition and Diet

Introduction: It is early morning, and Mickey Davis is sitting at her son's bedside, where she spent the night. Clay had been awake for short periods during the night, tut he was very groggy. He tried to speak, but of course he could not; his lips are swollen from the trauma that he endured. His lips are also very dry; throughout the night, his mother gently applied a lip balm to keep them from drying out completely. Clay's jaw remains swollen and bruised. His left upper torso is not covered with blankets, but with a light gauze dressing to protect his fragile, scalded skin. Mickey spent the night crying off and on. When Clay opened his eyes occasionally during the night, Mickey did her best to remain strong so that she could comfort and reassure him. However, when he drifted back off to sleep, his mother cried softly again.

Both parents are present now. Clay's father is holding Mickey in his arms as she cries. He, to, is trying to remain strong, but he has tears in his eyes. (Hull, 2013, p. 471)

PATIENT'S FATHER	Mickey, it's going to be all right. The doctor said everything went well last night in surgery, and Clay's going to be all right.
PATIENT'S MOTHER	I know, Steve, I know. It's just that I can't stand to see him like this. My poor Clay. Oh, Steve, it must hurt so much.
DIETICIAN	[*knocks*] Hello ... Mr. and Mrs. Davis? I'm Takeisha Cameron, a registered dietician here at Okla Trauma. How are you doing today? [*pause*] I've come to talk with you about Clay's nutritional status and whatever needs he may have as he recovers from his jaw surgery. [*pause*] Please, please sit down. As you can see, your son has an intravenous line running there, in his arm, and a couple of tube-like devices inserted into his nostrils. I'm wondering if you know what all of these are for?
PATIENT'S FATHER	We understand that the nasal prongs are to give him oxygen. And the IV inserts medicine and fluids into his blood stream. However, we only know a little about the other tube. The nurse referred to it as an "NG tube" and we know that it's supposed to feed Clay, but that's all. We were very much looking forward to discussing that with you.
DIETICIAN	Thank you. And you are correct: Clay is receiving oxygen through those little nasal prongs that are inserted just to the inside of his nostrils. You are also correct in saying that the other tube, going into this right nostril, is an NG tube. That stands for *nasogastric*. The tube extends through the nose and the nasal cavity, down the esophagus, and into the stomach. That is how your son is going to be receiving his daily nutrition for a while. His status is NPO: nothing by mouth.
PATIENT'S FATHER	I though it was possible to feed people intravenously. Wouldn't that be easier for him?
DIETICIAN	You are correct that intravenous feeding exists, which we call *parenteral nutrition*, but it is not as effective as the NG tube. Parenteral nutrition is designed only to supplement what a patient is able to ingest by mouth. As you can see, Clay is not able to ingest anything by mouth. Although this complicates his care, the insertion of a nasogastric feeding tube allows us to supply most of his daily requirements of vitamins, carbohydrates, and

	dextrose, a type of sugar, through a highly specialized formula that the nurse administers into the tube on a scheduled basis. Nasogastric intubation is a type of enteral nutrition that involves feeding directly into the stomach or intestines. It is not always possible when the face is injured, because access to the nose and throat are necessary. However, in Clay's case, his nose and the supporting bones of the cheeks did not suffer any trauma.
PATIENT'S MOTHER	What would you have done if you could not have put the tube down into his stomach this way, through his nose and throat?
DIETICIAN	That's a very good question, Mrs. Davis. We may have reverted to something we call *total parenteral nutrition*. In that case, a new intravenous line would be started, perhaps in a large vein in the chest, with a larger-sized tube and an intravenous catheter to facilitate the administration of nutrition by that route. Then again, for cases in which longer periods of assisted feeding are required, the doctors may even decided to surgically create an opening called a *stoma* directly into the stomach of jejunum of the small intestine to create a port through which a feeding tube can be inserted. [*Patient's Parents look concerned, Dietician continues quickly*] Not to worry; this is not going to happen with your son. The surgery that he had to repair his jaw is quite standard, and we all expect a good recovery.
PATIENT'S FATHER	So you're saying that Clay will have to be tube fed for awhile but that this will be through that NG tube only?
DIETICIAN	[*nods*]
PATIENT'S FATHER	How long can we expect that to continue?
DIETICIAN	Your son is going to receive his nutrition by NG tube for about a week. Then, if the swelling has receded in his mouth and along the site of the surgery and if he is able to open his jaw even a little bit on his own, we will be able to start him on a liquid diet by mouth. He'll need to stay on a liquid diet for about another week, and then we can move on to soft foods. We don't want to risk reinjuring that fracture line by having him chew down on something.

(Hull, 2013, pp. 471-472)

Chapter 12: Diagnoses and Medication Administration

Introduction: Soon after Mrs. Stevie-Rose Davis was admitted to the hospital from a motor vehicle accident, she struggled with some bouts of confusion. Specifically, she was not oriented to time and place. Dr. Jenson in the emergency room (ER) ordered a battery of tests to determine if the patient's state of confusion had a medical cause. As evening approached, Mrs. Davis's daughter Angie arrived and was able to remain with her mother until she settled down.

It is now the following day, and Dr. Jensen has arrived for his morning rounds. He has spoken with the nurses caring for Mrs. Davis, and he is aware that her glucose levels have been erratic since her admission. A pattern is emerging that concerns him, and he worries that the patient may no longer be able to manage her diabetes without medication. He is going to speak to Mrs. Davis about this, as well as about her lab work and her other assessment results. (Hull, 2013, p. 499)

DOCTOR	Good morning, Mrs. Davis. Do you remember me?
PATIENT	Yes I do, Dr. Jensen.
DOCTOR	And who is your guest, Mrs. Davis?
PATIENT	This is my daughter, Evangeline.
PATIENT'S DAUGHTER	Please call me Angie. Everyone does, even my mother, from time to time. [*laughs*] Pleased to meet you, Doctor ... Doctor ....
DOCTOR	Dr. Jensen. Now, Mrs. Davis, how was your night? Were you able to get any sleep?
PATIENT	Yes, I did. The sedation you ordered worked quite well. I did have to get out of bed to void at least five times, though, and I felt quite dizzy and unsure of myself at those times. I was unusually thirsty, too. I was wondering if that could be related to the medication you prescribed.
DOCTOR	Mrs. Davis, it seems that you are quite clearheaded this morning. You have just given me a very clear account of your activities overnight, you're able to recall my name, and you remember that you were given some medication to promote sleep.
PATIENT	[*nods*]
DOCTOR	When we admitted you yesterday, you had some bouts of confusion. Do you recall any of that?
PATIENT	Vaguely. I remember that I was in an accident with Zane and Clay. We were bringing Clay to the hospital because of a scald. My daughter says that Clay's at the Okla Trauma Center and that he may have a broken jaw! [*pause*] And my husband has been released home. But Angie told me all of that stuff. While I was here in the ER, though, well, I have to admit it was kind of a blur for awhile, although I do remember speaking to a nurse who did some sort of mental or psychiatric assessment on me, I think. What was that all about?
DOCTOR	You did incur a mild concussion in that car accident yesterday, and we wondered for awhile if that was causing your confusion. Because of your concussion, I asked the nurses to monitor your mental and neurological status until around 9 p.m. But what I'm really referring to is something else that happened. There was an incident last evening where you were disoriented to time, place, and person. Do you recall that?
PATIENT	Not really. What did I do?

DOCTOR	You thought that you were a nurse in a combat zone who was about to receive casualties. You wanted to organize a couple of the staff to prepare for that. What can you tell me about that, Mrs. Davis?
PATIENT	Well, I was a military nurse serving in Vietnam years ago. I must have been dreaming or sleepwalking.
DOCTOR	Mrs. Davis, I am quite concerned that you may be experiencing the effects of post-traumatic stress disorder from your days in the military and from any traumatic events that may have occurred in Vietnam. Have you sought any counseling for that?
PATIENT	I do not have anything mentally wrong with me. I just have some bad memories, that's all. They come and go from time to time. I don't need any help. So let's drop that now! [*crosses arms across her chest and her breast rises in anger*]
PATIENT'S DAUGHTER	Mom. Mom, please hear the doctor out.
PATIENT	Evangeline! We will not discuss this. Leave it be.
DOCTOR	Well, Mrs. Davis, I can see how sensitive you are about this subject. This tells me that you are indeed bothered by some of your bad memories. However at this time, I can only offer you encouragement to seek some help, if you'd like—counseling or other therapies. You do not have to carry this trauma with you all of your life; there is a way to deal with it when you're ready. [*pause*] I wonder if you'd be willing to discuss the option of medication?
PATIENT	[*looks at doctor angrily*]
DOCTOR	Mrs. Davis, post-traumatic stress disorder can manifest many years after a trauma. Anti-depressant medications can relieve some of the symptoms that you might be experiencing.
PATIENT	Like what? I don't need any medications like that. I'm not crazy, and I'm not depressed. How dare you!
DOCTOR	PTSD is a disorder that is well researched and well treated. I wonder if you ever have difficulty falling asleep or staying asleep? Do you have problems with concentration?
PATIENT'S DAUGHTER	[*nods*]
DOCTOR	Perhaps you experience irritability or mood swings?
PATIENT'S DAUGHTER	Mom ...
PATIENT	[*withering look at Her Daughter*]
DOCTOR	All right, then, I can see that this is a conversation you are not ready to have. Let's go on to other things. An x-ray ruled out any neurological injuries for you. That meant we could give you just a little bit of medication last evening, an anti-anxiety drug to help relax you. You were quite restless. [*pause*] I ordered a rather wide battery of tests so that we could get a better picture of your condition. The results of your lab tests are quite good. A glucose test was done upon admission, and you were slightly hypoglycemic at the time. The team was able to remedy that in a short time, especially after they learned that you have type 2 diabetes. We found out that you were taking ibuprofen and glucosamine. Since we weren't sure what other medications you might be taking, I ordered a drug screen and toxicology test to rule out the influence of any adverse medication

	interactions that may have contributed to your confusion. These tests were negative. We also learned that you were taking levothyroxine, so we ran a thyroid function test. That was normal.
PATIENT	And so, what have you decided, Doctor? I was under a good deal of stress from that accident. Was it simply my diabetes giving me trouble? Is that why you kept me here overnight?
DOCTOR	Perhaps. Your blood glucose levels have been quite erratic since you've been with us. For reasons that are not yet clear to me, you have had more evidence of high serum glucose levels than of moderate or low levels. This concerns me. I've ordered a few more tests for you this morning, but I want you to prepare yourself for the possibility that you may need to take some diabetic medication or insulin to control your condition.
PATIENT	Insulin? But I'm able to manage my diabetes by watching my diet and getting the right amount of exercise.
DOCTOR	Although this is effective treatment for many people who are diagnosed with type 2 diabetes later in life, Mrs. Davis, there is no guarantee that the disease will not progress. A period of medication or insulin use could be temporary, just until we can determine exactly what is happening to you physiologically. I have asked an endocrinologist to stop by to see you today, and we will know more after he has made an assessment.
PATIENT'S DAUGHTER	Mom, I thought you said you were just a borderline diabetic. [*to Doctor*] My mother has type 2 diabetes?
DOCTOR	Yes, It does seem that way. It may be that her condition requires much closer monitoring than it has received in the recent past.
PATIENT	Phooey! Just what I need!

(Hull, 2013, pp. 499-501)

Chapter 12: Diagnoses and Medication Administration

Introduction: Late in the afternoon, Dr. Jensen returned on his rounds to see Stevie-Rose Davis. He found her in good spirits, oriented, and eager to go home. (Hull, 2013, p. 535)

DOCTOR	Hello again, Mrs. Davis. You're looking much brighter this afternoon. How are you feeling?
PATIENT	I feel very well, thank you. I'm clearheaded and energetic. When am I going to be discharged?
DOCTOR	Well, I've been reading your chart, and I see that your blood sugars have begun to stabilize since we've put you on a diabetic diet and given you a little Glucophage. I think the combination will work well to settle you.
PATIENT	[*nods*]
DOCTOR	I understand from the notes left by the nurses and Dr. Shawshank that this car accident was not the only stressor you were under yesterday.
PATIENT	[*nods*]
DOCTOR	When you first arrived in ER, your blood glucose was low. What can you tell me about that?
PATIENT	Well, the accident with my grandson ... I spilled the coffee on him. [*pauses and looks nervously at Doctor*] It was morning and I hadn't had any breakfast yet. I was too busy getting Clay's breakfast—that's my grandson—and feeding my husband. I was just going to give my husband another cup of coffee and sit down myself for something to eat. That's when this all happened. So, I didn't get my regular breakfast or even lunch. I'm usually careful to eat right to control my diabetes.
DOCTOR	I see. And then, of course, the accident occurred. Our initial treatment of providing some nutrition to you to bring your glucose levels up worked. However, it seems to have worked too well. After that initial intervention, your levels kept climbing. There were some lapses in there, but, until this afternoon, we weren't able to get your blood glucose down to an acceptable level, where we could be certain that you'd be able to manage again on your own. I expect that a good deal of that fluctuation and the high readings can be attributed to your series of stressors from yesterday. [*pause*] Dr. Shawshank has started you on Glucophage tablets for now. I believe he spoke to you about this?
PATIENT	Yes. He said that I should take this medication for a while, until I can see my primary care doctor or make some arrangements to see an endocrinologist. I have a very good relationship with my own doctor, so I'll just see her again after you release me from here.
DOCTOR	Very good. I can't stress enough the importance of making that follow-up appointment, Mrs. Davis. The goal here is to keep your diabetes at a manageable level and to prevent an escalation of symptoms or pathology.
PATIENT	Yes, I hear you, Doctor, and I totally agree. I don't want my diabetes to get worse.
DOCTOR	And I think I need to add here that I do appreciate that you are under some circumstantial stress right now. I know how much you don't want to consider that this stress might also influence your mental health and any other symptoms that you might be experiencing. I'm not going to go there with you right now, Mrs. Davis. We don't need to talk about that issue. What I was going to suggest was that you take a very small dose of anti-anxiety medication to help you through a stressful time right now. Short-term. What do you think about that?
PATIENT	Well, funny you should say that. My daughter Evangeline and I had a long talk about that today. She made some very good points about my mood. She says that I have mood swings sometimes. And, you know, just between you and me, I think she's right. But maybe it's

	just because I don't sleep so well. I do have insomnia, and sometimes I have some pretty bad nightmares. I thought that this would pass in time, but it hasn't. So, I was wondering if, instead of anti-anxiety medication, might I be able to get a prescription for a sleeping pill?
DOCTOR	I'm glad to hear you talking like this, Mrs. Davis. This conversation and the one we've just had about your diabetes show that you have good insight and that you are taking responsibility for your health. I'm not really an advocate for sleeping medication because some of these drugs can be quite addictive. I wonder if you would consider taking a low dose of anti-depressant medication at bedtime instead?
PATIENT	[*scowls*]
DOCTOR	Wait, wait. I am not talking about anti-depressant therapy of any sort here. Certain anti-depressants are now used to promote relaxation and sleep. They have a sedative effect. An example of this is trazodone. We often use it on surgical units for preoperative patients for just this purpose. We only give it for a couple of days.
PATIENT	Oh, I didn't know that. In my days as a nurse, we didn't do anything like that.
DOCTOR	It is quite common practice now, Mrs. Davis. I'd like to suggest that you take a medication like trazodone for, say, 7 nights and see how it works for you. This would give you time to see your primary care physician and to talk it over with her. Together, you could decide whether there were any benefits of the medication for you. Would you be interested in that?
PATIENT	As long as it is on a trial basis, I'll do that. Who knows, maybe it'll work.
DOCTOR	Very good then. I'll write the order for you, and I'll also write the order for your discharge. How does that sound?
PATIENT	Oh, just wonderful. Thank you so much. Can I phone my daughter now to come and get me?
DOCTOR	[*nods*]
PATIENT	Oh, I've really got to go home and take care of my husband and make sure he's okay. And I just have to talk to Mickey and Steve, Clay's parents, and apologize and do whatever I can to make things right with everyone.
DOCTOR	Mrs. Davis, you cannot be this stressed. It is very hard on your system. You've got to let the other family members pitch in as well during this difficult time. You, too, were in an accident. You, too, have heath issues. You, too, need to rest and recover. Please promise me that you'll try to take it easy.
PATIENT	I will, Doctor. Thank you for your kind and caring words.

(Hull, 2013, pp. 535-536)

Chapter 13: The Healing Process: The Language of Reparative, Restorative, and Rehabilitative Care: Burn Healing

Introduction: Kuldeep Singh, the physician assistant in Pediatrics at Okla Trauma Center, has come to speak with Clay Davis and his parents about Clay's burn. He has introduced himself and asked the family to call him by his first name. He explained his role at Okla Trauma and his experience with treating children who are recovering from a wide variety of burn injuries. At the bedside, he has donned gloves, and he is preparing to examine Clay's wound. He gently lifts the gown off of the child's shoulder, and he begins removing a very loosely taped piece of cotton gauze. (Hull, 2013, p. 576)

PHYSICIAN ASSISTANT	As you know, Clay suffered a superficial partial-thickness burn across his upper torso. Burns are the result of the death of tissue that is caused by heat. We call that *tissue death necrosis*. You can see here how heat damages the cells of the skin. When that occurs, chemicals stimulate the nerve endings. That's what causes the pain. You can see where the outer layer of skin has burned away. That would be painful for the child.
PATIENT	[*two thumbs up in confirmation (nodding is painful)*]
PHYSICIAN ASSISTANT	Burns begin to heal when new layers of skin begin to grow. That starts at the outer edges of a burn; see here and here. [*as if to himself*] This is healing very well. [*to Patient and Patient's Parents*] Superficial partial-thickness burns, like your son's, are often painful, and they are accompanied by painful blisters that must naturally rupture or degrade as part of the healing process.
PATIENT'S MOTHER	Oh, I can see that all but one or two of the very small blisters have gone and now they're just like flat, empty balloons.
PATIENT'S FATHER	Yes, and others have broken open and are peeling with the rest of the skin.
PHYSICIAN ASSISTANT	[*nods*] These types of burns usually heal over a period of 3 or 4 weeks. We have been keeping the burn site covered very lightly to protect that raw tissue and the dermis from any risk of infection. Without the epidermis to protect it, this layer of skin—the pink skin that you can see in spots—is very vulnerable to infection. As you can see, we have been successful in preventing that.
PATIENT'S MOTHER	His skin does look so raw in some places. Are you saying that's normal and that it will eventually be covered by a new layer of skin in the next few weeks?
PHYSICIAN ASSISTANT	[*nods*]
PATIENT'S MOTHER	And what about the color? Will some of the color be off? Dark or pink or even white?
PHYSICIAN ASSISTANT	I don't foresee any visible scars resulting from the burn, although some pigment changes in the skin might be possible. This would depend on how deep the burn is at various sites and whether the melanin and carotene cells are still producing pigment. To ensure that healing and pigmentation recover optimally, you will have to keep this section of skin out of direct sunlight for at least the next six months.
PATIENT'S MOTHER	Did you hear that, Clay? You're going to have to wear a t-shirt when you're out in the sun and even when you're in the pool or at the lake this summer.
PATIENT	[*groans*]

PHYSICIAN ASSISTANT	Lastly, you'll want to keep an eye on the healing tissue itself. As time goes by, the wound area will start to shrink in size. A complication called a 'contracture of tissue' might occur. It might not happen, Mrs. Davis, but I just want to be sure you are aware of this possibility. If the skin begins to tighten or pull a bit as it heals, you should tell you family physician or pediatrician as soon as you can. He or she can make some suggestions regarding how to keep the skin moist and pliable as it recovers. Of course, gentle exercise involving that area, such as moving the shoulder and neck a bit, will help to maintain healthy circulation in the area and to promote tissue regeneration and pliability.
PATIENT'S MOTHER	Oh, okay. Could I put some aloe vera gel on it to help it along?
PHYSICIAN ASSISTANT	You can, but you should do so sparingly. What is paramount is keeping the wound site as clean as possible and free from further injury. [*to Patient*] Clay, this burn might start to itch now and then. I don't want you scratching it. That could tear that new, fragile skin, and an infection could set in. [*pause*] You won't scratch at it, will you?
PATIENT	What about my cat? My cat climbs all over me sometimes. She likes to climb up and ride on my shoulder.
PHYSICIAN ASSISTANT	No way. No cat on your shoulders, young man. That is just too risky. [*to Patient's Parents*] Cat scratches on new skin would be a very bad idea, Mr. and Mrs. Davis. You'll have to watch your boy to ensure that this doesn't happen. [*pause*] And watch that cat, too! If the skin is itchy and bothering Clay, apply a cool, damp cloth to the area for a while. That is helpful. And, of course, as you said, perhaps a little aloe vera gel, but only a little. Your pediatrician may have some other suggestions for you, too.
PATIENT'S PARENTS	[*nod*]
PHYSICIAN ASSISTANT	Now, you are going to go home today, Clay. I want your mom and dad to take you to a doctor before the end of this week, okay? You need your jaw and burn looked after for quite a while yet. Now, I'm not going to put gauze on this anymore. That skin needs some fresh air. The nurse will come in soon and bandage it again for you so that you can go home safely. You don't have to wear a bandage over it all the time, Clay. Mom, perhaps you can put a clean one on him if he's going to be active for a while, just to protect the site from injury, all right?
PATIENT'S MOTHER	[*nods*]
PHYSICIAN ASSISTANT	Very good then. Well, it's been a pleasure to meet you all, and I wish you all the best in your recovery, Clay.

(Hull, 2013, pp. 576-577)

Chapter 15: Rehabilitation: Physical and Occupational Therapy: Leg Injuries

PHYSICAL THERAPIST	Hi, Gil. I see that it's that time again. How was the ride here in that chair? Did you manage to wheel yourself here, or did someone else bring you and drop you off?
PATIENT	[*proudly*] I managed to do it all on my own.
PHYSICAL THERAPIST	Congratulations! You certainly are determined to get better fast, aren't you?
PATIENT	[*nods*]
PHYSICAL THERAPIST	Have you spoken to your doctor today, Gil?
PATIENT	Yes, and he says that I can go home in 24 to 48 hours. [*pause*] Can you imagine? Finally going home! Sleeping in my own bed, being home with my wife. It's great news!
PHYSICAL THERAPIST	Well, I had heard that from the doctor, so I prepared some discharge plans for you that I'd like to go over today. I'd also like to work through a complete review of your physical therapy needs, and then we can get into some activities for today. How does that sound?
PATIENT	Sounds great. Let's get started.
PHYSICAL THERAPIST	As you know, you had a complex spiral hip fracture at the distal end of your right femur, right where it impacted the acetabulum.
PATIENT	[*nods*] I learned quite a lot about what that means when I was at Okla Trauma Center.
PHYSICAL THERAPIST	That fracture was surgically reduced, and the wound site was covered with a padded dressing that not only protected the incision and the suture line but also the hip area itself, thus preventing skin breakdown and pain along the bony prominences of the hip.
PATIENT	Yes, and the stitches along my hip, as well as those on both sides of my lower leg, were removed by the nurse earlier today. She also applied fresh padded dressings.
PHYSICAL THERAPIST	[*nods*] We've had you sitting up and standing quite frequently throughout the time that you've been with us here at Fayette. You and I have been working on some very gentle range-of-motion exercises for your right ankle over the past week. These have helped to keep the muscles and tendons from stiffening, to promote muscle strength, and to ensure that healthy circulation was maintained.
PATIENT	So when will I finally be able to walk? When will I be able to get back on both feet?
PHYSICAL THERAPIST	Generally, when an internal fixation of a fracture like this occurs, you can expect to start walking on the affected side within 2 to 3 months. In the interim, once you've been able to tolerate those range-of-motion exercises for a bit—as you have—you can be fitted for a short removable brace or a cast to protect and support the healing tibia and the adjacent ankle. I'm not sure if the doctor plans to arrange that for you before your discharge. If not, your physician will be able to plan this transition with you. [*pause*] In the interim, you will be able to use crutches in addition to using a wheelchair.
PATIENT	Well, at least that's some progress, even if it isn't as much as I'd hoped.

PHYSICAL THERAPIST	Gil, we haven't been able to progress to crutches as quickly as we'd hoped to because of the complications of you knee and shinbone injuries.
PATIENT	[*nods*]
PHYSICAL THERAPIST	You're wearing a knee support, and, although that does not weigh a great deal, it still exerts pressure on your quadriceps and on the ball-and-socket joint of your hip. The distal end of your fractured right tibia is only minimally supported by the dressing and the tensor bandage that cover it now. It's absolutely impossible for you to bear weight on that foot and ankle under these circumstances. Even so, you are strong enough now to start walking more independently. Today, I have permission from the physician to try you out on crutches.
PATIENT	[*smiles*]
PHYSICAL THERAPIST	Gil, when you're released from the hospital, you'll need to rent or buy a wheelchair. You'll need to use that for at least the next 3 or 4 weeks. That being said, you will be able to ambulate with crutches intermittently throughout your day, as long as you're at home, where it's safe. As you continue as an outpatient while receiving rehabilitation services, your therapist and physician will notify you when you can use the crutches more often and where. It won't be long until you are weaned off of the chair.
PATIENT	All right. What you're telling me is that I've go a long way to go yet before I can walk without support. I can see that I've go the same amount of time—or even more—to wait until I can drive again, too, right?
PHYSICAL THERAPIST	[*nods*] Today, and after your discharge, you'll need to continue those bilateral leg exercises so that, when you're standing erect, you will be able to maintain your balance and gradually begin to distribute your weight equally on both feet when standing. So, we'll do a couple of warm-up exercises first, to prepare your hip, knee, and ankle for standing. After a few repetitions for each muscle and muscle group, we'll move over to the parallel bars so that I can watch you stand up by yourself, as you've already done now a couple of times. When we get there, you'll be in control. When you're ready to stand, just let me know.
PATIENT	[*nods*]
PHYSICAL THERAPIST	When you're in that standing position, I'll make an assessment of your current postural alignment. Next, Conrad—one of our rehab technicians—and I are going to measure you for crutches. Then, with us standing near at hand, we'll wait for you to get your balance and take your first steps with them.
PATIENT	[*nods*]
PHYSICAL THERAPIST	Afterward, depending on how well you tolerate the activities, we may have you lie down on one of the beds here while we apply some ice to those muscles that have been working so hard.
PATIENT	Let's do it!
PHYSICAL THERAPIST	One more thing, Gil. I have a surprise for you. [*pause*] I've invited your wife to join us today. She's sitting in the waiting room right now. I wanted to bring her in so that I can teach her how to help you with your exercises, applying ice, using the crutches, and so on. I hope you don't mind.
PATIENT	Mind? No, no. This is great!
PHYSICAL THERAPIST	[*to Rehab Technician*] Conrad, could you escort Mrs. Loeppky in?

PATIENT	Does she know I'm going home soon?
PHYSICAL THERAPIST	No, I haven't told her. I thought maybe you'd be the one who'd like to tell her.

(Hull, 2013, pp. 685-686)

Chapter 17: Reproductive and Family Health

Introduction: Glory's postpartum checkup with her family practice physician, Dr. Antoine, is coming to an end. He has talked to her about her mental health and examined her physically. He has one more subject to broach with her: her sexual, reproductive health.

DOCTOR	There's just one more thing I'd like to talk with you about today, Glory. And that is about a return to sexual activity and the risks of pregnancy. Have you thought about your sexual health yet, Glory?
PATIENT	Sexual health? I'm not sure what you mean, Doctor. Do you mean have I thought about having sex with my husband yet? [*pause*] Well, I've thought it was much too early for that, but then again, Gil's not really in any position to engage in that kind of thing. You know, he has all kinds of apparatuses around his knee, pins in his ankle, and ...
DOCTOR	Well, let's approach this one topic at a time. Number one, you can begin to have intimate relations—sexual intercourse with your husband—any time now, if you like. I see from the exam that you're no longer bleeding post-delivery, so I think it would be safe for you. And, of course, you did not have a vaginal birth. Secondly, I was asking about family planning, birth control, and so on.
PATIENT	Well, Gil and I do want one more child. We have always wanted two. I will be able to have another, won't I? Dr. Bedard, the OB, said I could have more children. You're saying that, too, aren't you?
DOCTOR	Yes, yes, I am, Glory. But now that you might become sexually active again soon, it's not too early to start thinking about contraception again. I'm wondering if you know about the relationship between breastfeeding and conception? [*pause*] Well, it's not likely that you'll conceive again while you're breastfeeding—as long as you feed your baby often and feed her breast milk exclusively. And it is up to you to decide when you'd like to stop nursing. I know that I used to prescribe birth control pills for you, and I wonder if you'd like to start them again.

(Hull, 2013, p. 781)