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Case Reports

Psychiatric Consultations in Less-Than-Private Places: Challenges and Unexpected Benefits of Hospital Roommates

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Introduction

Hospitals are the sites of some of life's most intimate moments. More often than not, however, hospital business is conducted in less-than-private places. Whether in the emergency department or on an inpatient unit, discussions between patients and providers are often overheard by others (e.g., patients, staff, and visitors). This is particularly true for patients in multibed rooms, where another patient is almost always on the other side of a curtain. As psychiatric consultants, we are often involved in scenarios where confidentiality is expected, as reflected by the increased stringency of federal law as it pertains to certain mental health issues.[1] Here we explore the ramifications of having hospital roommates, providing case studies to illustrate the challenges and potential benefits, as well as recommendations for psychiatric consultants who examine patients in these settings.

We present several short case vignettes to highlight the issues (both positive and negative) that may arise when consulting on patients in multibed rooms.

Case Vignette #1

Ms. A, a middle-aged woman with chronic pain and anxiety, was seen by a psychiatrist 5 days after having a spinal fusion. The consulting psychiatrist provided strategies to improve her daily functioning despite her pain. The following day, the consultant asked Ms. A about their previous discussion. She had forgotten details of the interview and the advice offered. However, a voice rang out from the other side of the curtain: "I remember exactly what you said, doc." Ms. A's roommate went on to recount what had transpired the day before (with a large degree of accuracy), noting that the consultant had emphasized the importance of the patient's function.

Here, the roommate was a boon to patient care. The psychiatrist may have been unaware of the roommate's presence the previous day, but she had been listening intently. She was then in the position to reinforce the message delivered to Ms. A for the rest of their hospital stay. By listening and reminding, the roommate likely enhanced the efficacy of the information transferred from physician to patient. Incidentally, she may have also gained useful recommendations for her own medical care.

Case Vignette #2

Mr. C was a young man admitted for osteomyelitis in the setting of intravenous drug use. His roommate also struggled with substance use and abuse. One afternoon they decided to leave the hospital together for "a smoke." They each returned several hours later with pinpoint pupils and an altered mental status.

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Here the roommates goaded each other to partake in behaviors that endangered their health. Although roommates can provide compassion and support, they can also be subjected to peer pressure. If both patients share a particular tendency, they can increase their risky behaviors synergistically. This can make it more difficult for their physicians to ensure adherence to medical recommendations.

Case Vignette #3

Mr. B, a middle-aged man with coronary artery disease, was admitted for coronary artery bypass grafting. Overnight, his roommate (a physician with paroxysmal atrial fibrillation) observed that Mr. B had significant sleep apnea. The roommate provided this information to Mr. B, who shared it with his physicians. A new diagnosis was made and treatment was provided.

In this case, the roommate acted as a concerned and knowledgeable observer. Through hours of close contact overnight, he discovered a previously undiagnosed condition in his roommate, prompting better patient care. A similar situation may arise when a patient falls on his way to the bathroom and the roommate is the first to call for help. The presence of a roommate offers the potential for increased safety through close observation.

Case Vignette #4

Mr. D, a newly homeless young man, was admitted with pneumonia after being kicked out of a sober house where he was struggling with alcohol and cocaine use disorders. On psychiatric interview, he appeared uncomfortable and gradually became withdrawn, eventually saying, "I can't really talk here" (while looking at the curtain that separated him from his roommate). When the interviewer found an empty conference room nearby, Mr. D opened up and began to cry when recounting the havoc caused by his substance use disorders.

This case illustrates the often heightened need for privacy when discussing sensitive issues and the consequences of mental illness. Mr. D was ready, willing, and able to discuss his substance use, but he did not want his roommate to listen in. Had a private room not been available, a significant barrier to appropriate care would have been difficult to overcome.

Case Vignette #5

Ms. S, a 60-year-old woman with a history of anxiety, was hospitalized for a workup of syncope. Late in the evening, her older roommate went into cardiac arrest. Owing to space constraints in the room, the curtain was pulled back to allow sufficient staff to participate in the ultimately unsuccessful resuscitation. Ms. S witnessed both the medical code itself and the distress of the roommate's husband, who was at the bedside when the arrest began. She later described trouble sleeping, with the scene replaying in her mind over and over throughout the night.

Ms. S' roommate experienced a fatal cardiac arrest, which was understandably traumatizing to witness. Ms. S found herself perseverating on this event, to the detriment of her own care. This is an example of a common scenario in which vulnerable patients are paired with roommates who intentionally or unintentionally exacerbate their affective dysregulation. In these cases, it is crucial for the patient's nurses and physicians to realize the effect of the event on the patient and to provide reassurance and support. It is also incumbent on hospital staff to try to prevent these events by placing the sickest patients in private rooms. In nonemergency settings, patients should always be moved before invasive procedures on their roommates. During a code, if a responding clinician lacks an active role, he or she should attempt to remove the roommate to mitigate the trauma.

Discussion

Hospitals have never been private places.[2,3] In the ancient Middle East, hospitals were set up in open courtyards; in medieval Europe, they operated out of chapels. By the 19th century, many hospitals, built for care of the underserved, comprised large open wards with dozens of beds in a single room. On occasion, curtains separated the beds; often, there was not even a visual barrier. In the aftermath of World War II, American patients gained some privacy, as modern hospitals were designed with 2-bed and 4-bed rooms

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