Appendicitis—a bad experience

When a physician becomes a patient, he is shocked at the quality of care he receives.

Ed Pankratz, MD

I read with interest Dr Richardson's "appy" experience (Self-delusion and self-care. *BCMJ* 2008; 50[8]: 433). One statement in his article I agree with: "we don't take care of each other." I would also add that in some instances the care of other patients is at best mediocre.

My experience differs from that of Dr Richardson in that I knew within about 6 hours what my diagnosis was, but relaying this to the emergency doc was a big mistake.

My pain started at about 2 a.m. as a generalized abdominal pain, which I interpreted as an upset stomach. A cup of tea did not help; neither did a Tylenol. I tried to sleep but could only doze a bit. By 6 a.m. my pain had localized to my right lower quadrant; I had some nausea and felt warm. To me the diagnosis was 100% clear, and I asked my wife to take me to the emergency of one of the valley hospitals. When we arrived, one of the two nurses in the triage area was chatting with a woman; otherwise there was no one there. In spite of this, I was kept waiting for 15 minutes, and when my wife pointed out to a nurse that I was not feeling well, she was told that there was a wheelchair at the end of the hall!

Eventually I made it to an emergency bed, was promptly and briefly seen by a nurse, and fairly soon by an emergency doc.

Had he done a proper examination, the only tests he would have needed would have been a white count to arrive at the diagnosis.

This is where my fun began. When asked by this doc what the trouble was, I told him, "I have acute appendicitis." This was apparently the wrong response, as he lifted his nose up and said in a voice dripping with condescension, "Well sir, that remains to be determined."

He did not elicit any other history and his supposed physical consisted of listening to my chest briefly.

He did not check for rebound; he did not examine my abdomen; he did not do a rectal—all things that I was taught would aid in the diagnosis of acute appendicitis. Had he done a proper examination, the only tests he would have needed would have been a white count to arrive at the diagnosis. A chest X-ray and an ECG would have been advisable in view of my age but would not have been needed to make the diagnosis.

This so-called emergency doctor proceeded to order almost every test known to medicine, and only after 6 hours did he call a surgeon! The surgeon came promptly and booked me for the OR as the diagnosis was now evident even to the floor sweeper.

The surgeon later told me that my appendix had been "a mess," but this was not the end of my fun. On Christmas evening, my second post-op day, I started to get short of breath and called for a nurse.

After a while a young nurse, all dressed up in Christmas finery, sauntered in and asked, "What seems to be the trouble sir?" I told her of my shortness of breath, whereupon she replied, "I guess we will have to investigate that in the morning." No listening to the chest; nothing else. I informed her that I was short of breath now and did not feel I could wait until morning. Then she went away and returned with a Cepacol. I told her that would not do, whereupon she said, "Suit yourself," and went away.

Fortunately I had my cell phone with me and phoned my wife. My daughter, who had been a critical care nurse for many years, called the nurse in charge and explained the situation to her. After that, several things happened in quick succession: the head

---

Originally from the Ukraine, Dr Pankratz came to Canada as a displaced person in the 1950s. After graduating from UBC's medical school, he was a GP in New Westminster for 7 years. He went on to specialize in obstetrics and gynecology, which he practised for many years in Langley. He was medical director at Langley Memorial Hospital for 2 years and vice president of medicine at the South Fraser Health Region for 2 years. He is now retired.

nurse came and saw me and called the hospital doctor, who was there very quickly, and who in turn called an internist, who was there equally quickly. After an examination I was sent for a contrast scan as an embolus was suspected, but it turned out to be pneumonia, for which treatment was started. The ventolin inhaler gave almost immediate relief. Such was my 2007 Christmas. The rest of my care was no great shakes either, but I survived and am now fully recovered.

Two things became apparent to me. First, there is a general lack of spirit in this hospital; there is no empathy that I could detect. It is sad to see what was once one of the best hospitals in the valley slide to this level. Second, the emergency docs have been instructed to do all the tests they deem required before calling a specialist. This not only results in unnecessary testing, thus increasing costs, but it also is a major factor in the long wait times in the emergency. If a specialist comes in to the case when the diagnosis has been made, why does he get the big consultation fee? Should he not do the investigation? This would expedite care in the emergency, result in fewer tests, and very likely in better care.

Thus my tale of woe.

icbc

Continued from page 25

or comments regarding the treatment of MVA patients or other ICBC-related topics, please let me know.

—L.A. Jensen, MD
ICBC Medical Community Liaison

The opinions expressed in this article are those of the author and do not necessarily represent the position of the Insurance Corporation of British Columbia.

New preferred life insurance rates

The BCMA Term Life Insurance plan has introduced lower rates for nonsmokers and two new underwriting classes—Preferred and Elite. Members and their spouses who practise a healthy lifestyle are rewarded with lower premiums.

To be eligible for the Preferred or Elite class, you must be in very good health and lead a low-risk lifestyle, and your term life insurance coverage must be a minimum of $250 000. Through the normal medical underwriting process, other factors will also be examined, including:

- Tobacco use
- Physical build
- Cholesterol level
- Blood pressure
- Recreational activities
- Driving record
- Personal and family medical history

As an example, the accompanying tables illustrate the cost savings between the new and the standard rate classes for women and men, age 40.

Underwriting class	Annual premium for a female, age 40 for coverage of:		
	$200 000	$250 000	$500 000
Elite	Not available	$110	$220
Preferred	Not available	$115	$230
Standard nonsmoker	$96	$120	$240
Standard smoker	$192	$240	$480

Underwriting class	Annual premium for a male, age 40 for coverage of:		
	$200 000	$250 000	$500 000
Elite	Not available	$130	$260
Preferred	Not available	$140	$280
Standard nonsmoker	$128	$160	$320
Standard smoker	$264	$330	$660

To find out more about the new underwriting rate classes or to request an application, contact the BCMA Insurance Department.

—Sandie Braid, CEBS, BCMA Insurance

Pulsimeter continued on page 28