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Psychiatric consultations in less-than-private places: Challenges and unexpected benefits of hospital roommates

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Keywords

Privacy; Social support

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 multi-bed 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 multi-bed rooms.

Case Vignette #1

Ms. A, a middle-aged woman with chronic pain and anxiety, was seen by psychiatry 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.

Conflicts of Interest: none.

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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.

Here the roommates goaded each other to partake in behaviors that endangered their health. While 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 been 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 work-up of syncope. Late in the evening, her older roommate went into cardiac arrest. Due 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 patient'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 impact 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 non-emergency 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 one 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 on both sides of long corridors. By the 1980s, this trend continued, as consumer-driven healthcare and greater concerns about privacy prompted the development of private and semi-private (i.e., 2-bed) hospital rooms in select pockets throughout the country. Today, almost every new inpatient bed in America is in a single room. In fact, the 2006 guidelines from the American Institute of Architects and the Facility Guidelines Institute mandated that all new inpatient rooms be private unless there is a specific need for a two-bed arrangement.⁴

Despite this history, however, most hospitals retain a mix of private and semi-private rooms. When a patient is housed in a semi-private room, it is not always possible to take the patient to a private office or to a lounge for an interview or a physical examination. Moreover, it is rarely feasible to ask the roommate to leave the shared room during the interview. While physicians receive extensive training on issues of privacy with regard to the discussion of patient information in hallways or elevators, we receive little if any training on how to approach the issue of privacy in shared hospital rooms. Furthermore, hospital roommates repeatedly overhear sensitive information, even though they are not indoctrinated into the mandate for confidentiality. Therefore, semi-private rooms do not provide half the privacy of a private room; they offer no privacy at all. Such breaks in confidentiality and trust are

especially important in psychiatry, where patients discuss their innermost thoughts and where stigmatizing diagnoses are made.⁵

The goal of our five case vignettes was to illuminate some of the many ways that hospital roommates can influence patient care, in both positive and negative directions. Patients and their roommates are privy to intensely personal information, and as a result, they can exercise unusual power over a stranger. Among other things, roommates can listen, remind, observe, diagnose, support, badger, and annoy. They can facilitate treatment or they can exacerbate medical issues. As hospitals move away from multi-bed rooms in favor of units with exclusively private rooms, it is worth understanding the advantages and disadvantages of this shift.

Privacy concerns are one of many arguments in favor of a swing towards single-bed rooms.^{6,7} Single rooms reduce the likelihood of transmission of hospital-acquired infections,⁸ unacceptable and disruptive noise levels, sleep disturbances, stress, and anxiety,⁹ and may increase patient satisfaction.¹⁰ From the hospital's perspective, private rooms reduce operating costs by reducing length of stay and increasing room occupancy, since many double rooms go unfilled when one patient has a hospital-acquired infection or unchecked behavioral issues.¹¹ Finally, there is evidence that patients in multi-bed rooms may withhold portions of their history or refuse the physical exam because of the perceived lack of privacy.^{12,13} Therefore, private rooms may allow for more accurate diagnosis and effective treatments.

However, the possible benefits of multi-bed rooms are often overlooked. In particular, several studies have shown that patients appreciate the social support that roommates provide.¹⁴⁻¹⁶ Roommates help mitigate feelings of loneliness or isolation, provide a ready companion at difficult moments, increase safety by keeping a close watch on the other patient's condition, and may be a source of useful information. Indeed, when patients are asked for their preference (i.e., single room or semi-private room) the majority of patients prefer multiple-bed rooms.¹⁷⁻¹⁹ In one small study, for example, 18 out of 20 Danish cancer patients preferred to be hospitalized in multiple-bed rooms unless they became too ill to interact.¹⁵

The literature, therefore, reveals benefits and pitfalls of having a hospital roommate. As a result, there have been calls to re-examine the wholesale rejection of multi-bed rooms.² If used wisely, they can be beneficial. Several strategies to maximize privacy can be employed to allow for the therapeutic opportunities of roommates. First, physicians should aim to give patients a choice as to whether they wish to engage in a private discussion. Some patients prefer privacy, others will not; giving them the choice eliminates one of the major hardships of being a patient (i.e., a lack of control). This may be impractical (though beneficial) in some circumstances and may require systemic changes to hospital layouts. Second, when privacy is not feasible, physicians should acknowledge that fact and express regret.²⁰ Such statements will go a long way toward facilitating empathy. This is particularly true after an event such as was portrayed in case vignette #5, when a patient is traumatized by an invasive procedure performed on the roommate. It is crucial to apologize for this breach in privacy,

and to make systemic changes to the hospital to prevent them in the future (e.g., keeping the sickest patients in private rooms and moving roommates before any procedures occur).

Third, there are small practical steps that physicians can take to maximize privacy. For example, they can stand closer to the patient, rather than at the end of the bed; they can speak quietly, close the door, and use hypothetical scenarios (so that patients need not confess to something illegal or embarrassing). Even if the roommate is still in the room, it is easier to ‘tune out’ a conversation that is conducted quietly. In qualitative interviews, patients have mentioned each of these measures that they wished their doctors had taken.¹² Fourth, multi-bed rooms could be reserved for those patients expected to stay longer, or who have similar issues. For instance, patients in a rehabilitation hospital following injury or stroke, or patients recovering from organ transplantation, may benefit from the long-term social support provided by a roommate with the same condition. When hospitalized, patients can also express their preference for a single- or multi-bed room, if they are given adequate information on the possible positives and negatives. Finally, when new hospitals are built, rooms can be re-designed so that roommates can still support each other, but have separate toilets and sinks to minimize risk of infection, and movable acoustic panels for soundproofing when desired². The idea here is to maximize socialization and patient safety, but minimize disruptions to privacy.

Conclusion

Hospital roommates act like a double-edged sword. As long as most facilities contain a mixture of private and semi-private rooms, it is vital that physicians and other health care providers recognize the pros and cons of having a roommate, and take steps to capitalize on the benefits while minimizing the harms. As psychiatric consultants, we can model some of the aforementioned techniques for patients and other providers in the hospital and attempt to give patients the appropriate level of privacy for sensitive discussions.

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