

MIND TO MIND

Creative writing that explores the abstract side
of our profession and our lives

Stephen T. Harvey, M.D., Editor

Let's Talk

A Breakdown in Communication?

Barbara Fallon, Ph.D., Ann Stewart, M.D.

Every story varies with the teller. This story of a 50-year-old man named John with a subarachnoid hemorrhage is recounted by two voices: first, the patient's wife, and second, a friend who happens to be a family physician. (The friend's voice is italicized.)

"My head feels like it's in a vice grip." On December 15, 2013, at 9:30 PM, my healthy 50-year-old husband suffered a ruptured brain aneurysm. The urgency of Christmas planning and presents, which had weighed so heavily on me at 9:29 PM of the same day, disappeared. I longed for those trivial responsibilities over the next 6 weeks. As John struggled through diagnosis and treatment, I struggled with him, trying to be his advocate. Our friends took over the care of our home and our two children. In the ensuing 6 months, the healthcare system revealed its best and its worst, sometimes both on the very same day. My life was a roller coaster of emotion, and my mood was defined by the variable health of my husband. Despite advice to the contrary, I interpreted any small sign of progress as imminent recovery, and any setback broke my heart.

The textbooks are right—the worst headache of a patient's life can be caused by a bleed in the brain. But this time I wasn't the doctor, and I wasn't trying to make the diagnosis. This time I was the personal friend of the patient, sitting on the sidelines and watching as my son's godfather went through the risky process of brain surgery. I wondered if he would make it. Sometimes having knowledge about the odds, the risks, the benefits, and the possible outcomes can leave you

From the Factor-Inwentash Faculty of Social Work, University of Toronto, Toronto, Ontario, Canada. barbara.fallon@utoronto.ca
Accepted for publication May 8, 2017.

Permission to reprint granted to the American Society of Anesthesiologists, Inc., and Wolters Kluwer Health, Inc., by copyright author/owner.
Anesthesiology 2017; 127:713-5

without hope. I wondered if he would be left with a permanent disability. I wondered if there would be devastating side effects from an experimental drug. I held my breath. And I tried to support his courageous partner, also my good friend, who was at his side through more than 6 months of surgeries and rehabilitation.

There was an alarming lack of communication from the healthcare professionals responsible for his care, and this defined my worst moments. I cried only twice during my husband's 42 days in critical care; both times it was the result of frustration with the method and quantity of sharing information. Days passed without a doctor speaking to me about my husband's condition. When the medical team rounded, they rarely acknowledged my presence. Sometimes two different practitioners told me completely different things about my husband's care. Gradually, I lost confidence that any one person was in charge of my husband's medical care. I grew reluctant to leave his bedside.

The call went out for friends and family who could be with Barb at the bedside. A remarkable team of supporters came forward, and I tried to do what I could. As a physician, I had some insight into the hospital routines and how care decisions are made. I know doctors are aware of the importance of communication with patients. But I also know from my own experience that day-to-day effective communication is harder than it looks, and sometimes what you think you are saying is not what is understood. When teams are caring for patients, it can be challenging to brief all members of the team on individual patient issues. On the flip side, some patients may have limited health literacy or lack skills to navigate the system. But my friends are well educated professionals and have supportive friends and family. Surely, I thought, they won't have a problem understanding the situation and navigating this case.

Close to the end of John's first stay in the hospital, a CT scan showed an accumulation of fluid in his brain at the top of the shunt. Despite this, he was discharged to a rehabilitation hospital. The fluid increased, and 30 hours after leaving the intensive care unit, he was rushed back to the hospital for emergency surgery. Although the increase in fluid had been evident 3 days before, it was not clearly communicated to me. His sporadic confusion was attributed to a urinary tract infection. It is quite possible that the accumulation of fluid was unavoidable given his unusual reaction to the shunt. But the lack of communication and the conflicting messages eroded my confidence in the decisions being made for my husband.

I visited the rehab hospital on the day John was readmitted, and I was with Barb as she watched her husband's intracranial pressure rise and his confusion increase. It unfolded over the course of hours, and it was very frightening. We followed the ambulance back to the hospital together and waited as John went back to the OR. The shunt was adjusted, and the fluid was resolved. John survived and was able to chat with me 36 hours later. He is resilient. Since then I've wondered how our battered healthcare system, still being cut back, can do better with patient communication. It's a subject that Barb and I discuss often. Despite years of education, team training, and mandated discharge protocols, we still haven't quite got it.

John underwent eight brain surgeries to address issues arising from the initial aneurysm and the placement of the shunt. Three months after his "worst headache ever," he went on a skiing holiday and then returned to work full time. But 3 months after that we were back on the rollercoaster when major issues associated with his shunt required several surgeries to resolve. John returned to work full time within 5 days of his last discharge from the hospital and has no deficits or limitations.

As time went on, I became cautiously optimistic. More than 2 years after the initial event, John seems to have beaten the odds. We are grateful for the care he received. As a physician, this experience has changed my practice. I am spending more time in conversation with my patients. Sometimes the extra time slows down the clinic and makes everybody late. But John's experience has reminded me that being heard and understood is part of healing.

ANESTHESIOLOGY REFLECTIONS FROM THE WOOD LIBRARY-MUSEUM

Judge Misjudges: Chicago Edges Out New York for the Columbian Exposition



On the cover of its August 10, 1889, issue, the American satirical weekly magazine *Judge* portrayed Christopher Columbus with his left hand planting an 1892 banner and his right one pointing a sword to a map of Manhattan. Neither depicted act by Columbus would prove correct with regards to the upcoming 400th anniversary celebration of his “discovering America.” Bypassing New York City, the U.S. Congress selected Chicago to host the World’s Columbian Exposition, and that world’s fair actually occurred in 1893. Frankly, Manhattan or Chicago would have suited as an exposition site for the “Master of the Science and Art of Anaesthesia,” Pittsburgh’s Samuel J. Hayes, D.D.S., M.S.A. (1833 to 1897). At “Chicago’s Columbian Exposition,” orange-covered copies of the world’s first anesthesia journal, *The Dental & Surgical Microcosm*, were distributed by Dr. Hayes, the journal’s proprietor and controlling editor. Each journal advertised the nearby Post Graduate School of Anaesthesia, which Hayes had founded. Weekday mornings, physicians and dentists at Hayes’ school learned how to administer anesthesia; in the afternoons, postgraduates were free to attend the Columbian Exposition. (Copyright © the American Society of Anesthesiologists’ Wood Library-Museum of Anesthesiology.)

George S. Bause, M.D., M.P.H., Honorary Curator and Laureate of the History of Anesthesia, Wood Library-Museum of Anesthesiology, Schaumburg, Illinois, and Clinical Associate Professor, Case Western Reserve University, Cleveland, Ohio. UJYC@aol.com.