Necessary conversations

Medical drama script excerpt

Scene 1: Quiet post-op hospital room where healthy 60-year-old marathon runner lies post uneventful appendectomy. Enter stage right, extremely handsome, intelligent physician bathed in a heavenly light of healing.

"Bob, we need to talk about a serious matter," states the angelic physician. "If your heart were to stop what would you like us to do about it?"

"What do you mean?" asks the concerned patient.

"Well, would you like to be resuscitated?" questions the physician.

"What are you trying to tell me?" stammers the increasingly alarmed patient. "Didn't my appendectomy go well? Why would my heart stop?"

"It went fine, but we have to fill out this form regarding your wishes, which we keep on your chart," explains the calm physician.

Fade to black

I think we can all agree that having advanced directives for end-of-life care is a good idea. Previously, many elderly patients with numerous medical problems underwent unnecessary resuscitation attempts as this delicate subject was never discussed with them prior to their life-ending illness. Sometimes when one of these patients started to fade the nurses would add a note on the chart that would say something like, "code status?" This really meant that they didn't agree with the current status of full code and wanted to ask you if you were out of your mind to try and resuscitate this 90-year-old with end-stage lung disease.

In my health region we have a document called Medical Orders for Scope of Treatment (MOST), which outlines the patient's advance directives for CPR and range of desired medical treatments. It seems that the pendulum has swung a little too far in the other direction as this form appeared on my healthy 60-year-old athlete's chart to complete when he presented with appendicitis. However, the trend toward advance planning is a good one, as I can remember being part of many apparently inappropriate resuscitations through the years. The MOST form has been a good reminder for me to discuss end-of-life planning with my patients.

Probably the best place to discuss this issue is in our offices. I attended a GPSC PSP seminar on palliative care recently where GPs were encouraged to talk with their patients regarding their views on death, dying, and resuscitation. If you wouldn't be surprised if a patient were to die in the next year, it's likely time to have this discussion. I find that patients respond well to this dialogue, particularly if I present it as a routine part of my care plan for my elderly patients with complex medical problems. Many patients fear they will be kept alive on machines without consent and appreciate having their wishes heard.

I am often surprised by the acceptance patients have about their possible impending death and their desire to be left alone in dignity while they die. Their biggest concern is that they might suffer needlessly, and once this fear is allayed they become very calm and rational about their plans. I would encourage each of you in primary care to start talking with patients about death and dying as, let's face it, we are all going to be there one day.

—DRR

Surgery

My first serious surgical experience was on my second day as an intern (or "junior resident," as we were called then). I was on call for the surgical unit in a regional referral hospital, and my surgical consultant had just returned from a tour of duty in Vietnam. He was always full of adrenaline, and to underline this fact wore his army camouflage suit around the hospital. I was just slightly afraid of him.

I was called to the emergency department in the early afternoon to assess a 9-year-old boy who had been brought in after a two-wheeled cart tipped over on his abdomen. There was no penetrating injury, but the boy looked bad—pale, sweaty, and scared. We stabilized him and arranged for him to go straight to the operating room for an exploratory laparotomy, suspecting that he had a ruptured spleen. Captain Camouflage was in his element, and more so when we identified that the boy had not ruptured his spleen but had somehow torn some mesenteric vessels. They were bleeding at an alarming rate, and as I was trying to clear the suction tubing I started to feel dizzy.

You can probably guess the rest. To my credit I didn't faint, but I certainly wasn't much help for the rest of the procedure. Fortunately the surgical cavalry arrived, the bleeding was stopped, and the boy recovered nicely—faster, in fact, than my pride. Captain Camouflage never let me forget the episode. So he was mildly surprised when I told him that I had decided to go into a surgical specialty, and I didn't do so to prove that I could handle five-alarm bleeding. I just liked obstetrics and gynecology. So I became an obstetrician-gynecologist.

I wasn't too far advanced in my career when I began to enjoy performing microsurgery, and before long I was simply a gynecologist. The reconstructive work that we did was effective if done right, and there was professional satisfaction in seeing women benefit from their surgery. But selfishly, the real joy for me was the technical satisfaction of completing a complicated surgical procedure that few other people could actually do. There was also the whole ritual aspect of surgery—something that people outside surgical specialties cannot really grasp.

Performing surgery involves multiple rituals, each of them reassuring to the surgical team and, for the most part, to the patient. Entering the operating room, with its smells, its scrubbed cleanliness, its sounds, and its masked occupants, is a quasi-religious experience. The double-checking of the patient, the chart, and the equipment to be used, as well as the hush in the room as anesthesia is induced—all of these have a steadying effect on the surgeon and the team, and reassure the patient that all will be well. There is the professional satisfaction of being part of a skilled team, wherein everyone has a role and respects everyone else's role. There is camaraderie and there is warmth. There is the glow of satisfaction when the procedure is successfully completed and the patient wakes up and is wheeled from the room.

I'm going to miss all of this, because I have decided to stop performing surgery. It's important to know when the zenith has passed, and I think mine has. A mentor once told me, "Get out while you can still do it." So I will—but with more than a tinge of regret, and nothing but good wishes for the next generation of surgeons. Lucky them.

—TCR