Residents' page

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Can lack of communication kill?

Life in the emergency department (ED) is never boring; opportunities to learn abound. As a place of transition between admitted hospital patients and those sick at home, the full spectrum of illness that exists within a community can be observed on any given day. On occasion, a patient who visits the ED can be seen to have received less than optimal medical care in the community, or has fallen through the proverbial cracks. The experiences of these patients give family physicians reason to think twice, to learn from the mistakes of others, and to refine their practices accordingly.

This event took place in a tertiary centre ED at around 10 PM. A gentleman in his 80s was brought to the department by a city ambulance. He suffered from an extensive metastatic head and neck tumour, and had recently been admitted to a community hospital to begin chemotherapy. Discharged approximately 1 week earlier, this gentleman had been unable to eat or drink anything substantial during his stay at home due to the compression on his esophagus by the tumour. Obviously very dehydrated and emaciated, he seemed unlikely to survive the evening.

With a sense of urgency, we attempted to understand where this patient was mentally in accepting his illness and impending death. And it was with chagrin that we learned that, at least from the patient's perspective, some of his physicians had led him to believe that he would start chemotherapy, that his tumours would shrink, that he would then eat again and subsequently regain the strength he once had. He immediately took offense at the question about his wishes to have resuscitation attempted should his heart or breathing stop; there was no question that he fully expected many more years of life. Despite many hours of discussions and examinations by many teams from the hospital, there was no convincing this patient or his family that he would more likely suffer than benefit from aggressive interventions. He was ultimately transferred to the medical ward late in the evening "full code," with intravenous drips, catheters, and a mountain of bloodwork pending.

At about 2:55 AM that evening, an all-too-familiar ringing blared from the overhead speakers, followed by an announcement of a "code blue," on one of the medical wards. I heard the clamour of footsteps running up and down the main staircase next, along with the buzzing of the elevator. The unambiguous nature of the overhead announcement was apparent to all in the ED. Patients who were previously complaining they had to wait to be seen quickly fell silent, now thankful that they were well enough not to be first on the list. Fully expecting to hear that the gentleman previously seen in the ED was the one to have coded, a quick phone call to the ward surprisingly revealed that it was not he, but his room-mate. We resumed our work. Quite unexpectedly, less than 10 minutes later, at 3:02 AM another code blue was called, this time in the step-down medical ward. Again, footsteps raced to this new code, while other staff remained behind to finish resuscitation attempts on the first patient. Finally, the nightmare continued with a third code blue announcement approximately 3 minutes later, back at the original medical ward. Some minutes later, a frantic code team member ran into the ED in search of another crash cart. The medical ward had one cart currently in use, while the code team's cart was employed in the step-down unit. A cart was found and quickly disappeared down the hallway.

Two of these patients did not survive their crises; one did: the patient in the step-down unit. Interestingly enough, this patient might not have survived at all if he had coded only 3 minutes later. Had the code team used their last crash cart to attempt resuscitation on the patient previously seen in the ED, who had virtually no chance of recovering

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from a cardiac event, this step-down patient could have been denied the timely resuscitation efforts that ultimately saved his life. He will never know how the lack of honest, effective communication between a patient and a physician, neither of whom he had ever met, put his own life in jeopardy.

Denial can interfere with concise and adequate communication between physicians and patients, particularly in cases where there is a terminal diagnosis. We spend and invest as much energy into seeing things that do not exist as we do in not seeing things that do exist. This refusal challenges any practising physician to break through barriers that prevent proper communication, to keep patients aware of their true state of health so that they can make informed and autonomous decisions. It is not easy to bear bad news, to deal with the emotions involved (the patient's, the family's, and our own), all within a system that encourages brevity and productivity.

It will never be clear how his doctors talked to the elderly gentleman about his disease and what exactly he was told before he came to the ED. We do know for certain, however, that any attempt to talk to this gentleman or his family about his prognosis was not understood by them, the very people who most needed to understand what to expect. This man and his family were denied the chance to do the work of dying: to resolve conflicts, to share feelings and emotions, and to tell all the stories that needed to be told before it was too late. Unfortunately, this scenario is probably not rare. In this case, however, poor communication between a patient and his doctors put another person's life in jeopardy—and that should give us all pause.

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