Stethoscopes and stories

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The stethoscope is a simple, elegant technology invented by French physician René Laennec in 1816, but in 21st-century medicine its value is not always appreciated, especially in the care of the elderly. The stethoscope is familiar; it is relatively unobtrusive. It allows us to listen to crackles at the base of the lung, which might suggest pneumonia, and to hear a diminished sound in the bowel, which might suggest the early stages of bowel obstruction. Yes, I will order an ECG or MRI if it can help me refine my diagnosis. However, these technologies can sometimes cause stress for many frail older patients.

In our technology-driven age we seem to naturally default to using our smartphones, tablets, the Internet, or EMRs. We have goals of care and quality of care, as well as the science of efficiency and metrics to measure them. New technology is valuable, but it must do a better job of helping doctors practise patient-centred medicine.

For me, the stethoscope symbolizes our challenge as physicians to balance the use of technology in the care of patients, especially the elderly, with giving them the attention they need so that we can build a bond with them and help improve their sense of well-being. The rapid growth in the number of people older than 65 in Canada makes finding the balance increasingly important; Statistics Canada recently reported that in 2016 people aged 65 or older comprised 16.9% of the population.[1] Technology used wisely for the right patient is appropriate; however, used poorly, it can have a detrimental effect on quality of life and affect morbidity and mortality.

I also value my stethoscope because it represents bonding—the gateway to the soul. Using the stethoscope helps us listen; caring for the elderly demands that we listen. Listening takes effort, especially at a hurried hospital. It requires us to slow down and be attentive. It tells patients that we believe they are valuable. Patients and their loved ones want us to hear their stories. They want to know we care, which is vital to their building trust with us. Dr Howard Brody wrote, "Stories, that is how people make sense of what happens to them when they get sick. They tell stories about themselves."[2]

Many of our elderly patients are frail, suffering from chronic disease and dealing with social and functional challenges. Social isolation is a new epidemic among our elderly patients. Technology alone might not provide the answers to the challenges of our hospitalized patients. It is much better to ask our elderly patients "What matters to you?" rather than "What's the matter?" Asking patients "What matters to you?" empowers them because the answers reveal what is important to them, what their priorities are.[3] If we fail to communicate properly, we run the risk of unintentionally conveying the message that the patient's story of suffering is not important to address in our daily schedule.

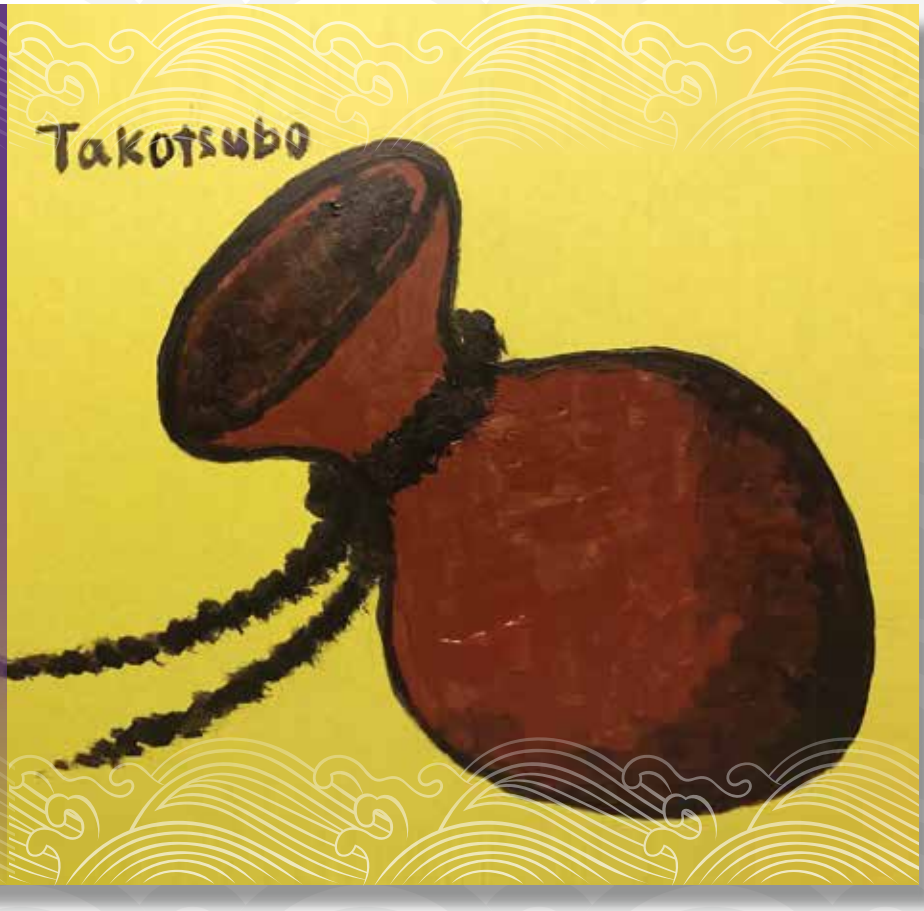
Heart to heart

I think my reflection on my stethoscope and patients' stories was triggered by a recent event with a frail 70-year-old patient named Martha. My resident examined Martha with his new stethoscope and reported that he had heard a faint systolic ejection murmur. He said, "And she is full of crackles at the base of both lungs. She really is very short of breath and she can't make a complete sentence." He told me she had presented to the emergency department with shortness of breath and cough that would not go away. Martha's history, results of her physical examination, and the murmur and crackles suggested heart failure. Martha went through the routine tests for this sort of problem. An angiogram revealed clean coronary arteries. The valves in her heart were functioning well. Puzzled, we continued to investigate what could be behind her sudden heart failure.

Further investigations led us to suspect takotsubo cardiomyopathy, also called *broken heart syndrome*.[4] With this condition, first described in Japan in the 1990s, the heart loses the strength to pump blood owing to severe stress. People with it tend to have high levels of stressors in their lives or in their surroundings.[5]

On day 3 Martha was less short of breath and was responding to treatment but she seemed to be depressed. I told her she had takotsubo cardiomyopathy. When I explained the condition was also called *broken heart syndrome,* she sobbed. She knew the cause was the unbearable grief she carried. She told me that she had been having coffee with her loving husband, a morning ritual for more than 40 years, when he collapsed. Her story of grief had started much earlier though, with fleeing her home country during wartime and leaving family members behind, many of whom later died. Her husband, who was targeted as a radical politician, had had to use a wheelchair because he had been shot in the spine. In Canada, through struggles, she made a life for herself and her family. She built a home, adopted a new culture, learned a new language. She was an author and a professor. Grief continued when she lost a daughter to cancer, and in the months before her husband died, she lost her son and sister. Martha suffered from so much loss: a home, identity, and loved ones. The death of her husband overwhelmed her with stress, which must have contributed to her heart failure and made it hard for her to breathe.

Takotsubo cardiomyopathy, also *broken heart syndrome*, is often associated with physical or emotional stress. It is a syndrome characterized by transient regional systolic dysfunction of the left ventricle, mimicking myocardial infarction, but in the absence of angiographic evidence of obstructive coronary artery disease or acute plaque rupture. In most cases of takotsubo cardiomyopathy, the regional wall motion abnormality extends beyond the territory perfused by a single epicardial coronary artery. The term *takotsubo* is the Japanese name for an octopus trap, which has a shape that is similar to the systolic apical ballooning appearance of the left ventricle in the most common and typical form of this disorder.[4] Here the author presents his painting of a takotsubo.



Listening to Martha's story not only confirmed her diagnosis but also triggered flashbacks of my own hardships of political dislocation in fleeing Marxist Ethiopia as a child with my family. At the time many were killed in the revolution. My heart felt her pain because I could understand; my feeling heart responded to her suffering. In empathizing, I too felt a healing presence—healing is never complete when you are uprooted from your homeland. As I shared some of my story, our hands held in healing. I thanked her for her courage.

By listening to our elderly patients, we honour their battle to live a dignified life. These patients might have outlived most family members. They have overcome struggles, failure, and difficult periods in history. Their resilience and qualities have enabled them to survive this far. We, too, are healed by hearing the stories of resilience and by offering compassionate care and treatment. Showing empathy enables us to develop empathy. But we must allow it; we must give it time and space.

Heal and hear

Our ability to treat and heal is bound up in our ability to accurately perceive a patient's story. Stories save lives. Dr Rita Charon argues that the narrative medicine movement is the basis for a whole-minded approach to medical care. She contends that physicians need both narrative and scientific competence.[6] So when we ask patients to tell us where it hurts, we are also saying, "Tell me about your life; tell me your story." From Martha's story I learned that she was grieving the loss of her husband and what she built: her artwork of recreating her life in Canada.

Martha's prognosis is good. Any damage to the heart caused by takotsubo cardiomyopathy is generally reversible. She had diuresed and responded to medications, but she still needed to heal and that started at the bedside when we used our stethoscopes to listen to her heart and lungs and we bonded and listened to her story. Without knowing what had broken her heart, we could not have helped her; without listening, we could not have helped her. The medication alone would not have been enough. The story mattered.

Dr Germa is a hospitalist at Brantford General Hospital in Ontario.

Competing interests
None declared

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