Surgery: a patient's perspective and lessons learnt

R. Mehdizadeh[1]

IN BRIEF

- Discusses the need for conveying empathy successfully and breaking bad news well.
- Highlights the significance of valid consent and the different levels of consent.
- Illustrates how effective communication may play a role in reducing the anxiety of the patient.

OPINION

This article discusses a hospital experience from the point of view of a patient, in this case a healthcare worker herself – a dental student. The author relates her experience of a three-day hospital stay and appendectomy, during which time she experienced the breaking of bad news, the consent process, and the importance of good communication - all from the patient's viewpoint.

The abrupt nature with which appendicitis presents left me unprepared for my three-day hospital visit and appendectomy. However, it also proved to be an interesting exercise in experiencing the breaking of bad news, the consent process, and the importance of good communication – all from the patient's viewpoint. It is often noted that healthcare workers can be among the most difficult of patients themselves.[1] The increased level of awareness and knowledge they have, or perceive they have, can make the switch from clinician to patient all the more challenging. Despite the short amount of time I have been treating patients as a third year dental student, I still felt this all too well. However, the high level of care I received and parallels with respect to dentistry left me not only feeling a deeper sense of empathy for my own patients, but also inspired me to carry forward what I have learnt in my own work as a future dentist.

Having been rushed to A&E with abdominal pain in the small hours of a working day, I was promptly seen by an emergency doctor. She was left unconvinced of appendicitis on examination as I presented atypically – afebrile and without rebound tenderness. It is thought that only around half of patients will demonstrate 'classical presentation', following findings from Murphy who completed over 2000 appendectomies in 1904.[2] Therefore, when the results of my blood test revealed an unusually high white blood cell count, I was admitted onto the surgical ward with a view to having an ultrasound scan to further aid my diagnosis. As I attempted to get some rest after a hectic past few hours, I couldn't help but feel uneasy. Sadly, I had to swallow the painful irony that my plans for the next day no longer included attending a much-anticipated talk on surgery. This was to be my first lesson – the disappointment, uncertainty, and vulnerability one feels as a patient, wholly in the hands of one's carers.

BREAKING BAD NEWS

Following my ultrasound the next day, a junior doctor came to speak to me and I swiftly found myself the recipient of bad news. As a scenario which had been discussed in theory during dental school, I was naturally intrigued to see how she may go about it. At my insistence the sonographer had already shared her findings with me, hence I was aware that my appendix was acutely inflamed, or in her words: '*...a nice textbook example of one*.' Nonetheless, I appreciated how well the young doctor broke the news to me. She greeted me warmly, introduced herself, and sat next to me at eye-level, before asking me how much I was already aware of. This open-ended question allowed me to give my interpretation of the preceding events. Listening carefully, she then confirmed that I was correct, and explained the next steps in detail. I recognised that the consultation followed the well-known 'SPIKES' format for delivering bad news, an acronym developed by Dr Walter F. Baile[3] ('S—Setting up the interview; P—assessing the patient's Perception; I—obtaining the patient's Invitation; K—giving Knowledge and information to the patient; E—addressing the patient's Emotions with Empathic responses; S—Strategy and Summary'). It could be argued that following pre-conceived formulas and pathways for what are very human situations is too robotic. However, I found that the well-structured nature of the consultation gently eased me into accepting the fact that in a matter of few hours I would be operated on for certain.

Throughout the conversation I also felt a genuine sense of respect and understanding from the doctor. Where clinicians struggle with empathy, it has been suggested that this is often not due to an intrinsic lack of it on their own behalf, but rather a difficulty in relaying that empathy to the patient while attempting to remain objective and able to make clinical decisions.[4] Furthermore, that these skills can be acquired. This includes being sure to pick up empathic cues from patients which are often non-verbal, and acknowledging their concerns after having listened in full.

CONSENT PROCESS

I was also interested to see the parallels and differences in the consent process compared to dentistry. There were examples of implied consent – for example, that by exposing my upper arm I was consenting to my blood pressure being monitored. However, I was always asked for verbal permission before more invasive procedures such as taking blood.

As for the surgery itself and written consent it requires, I was surprised by how brief the entire process was. Although the risks and alternatives were explained, the benefits of the operation were heavily emphasised. Here, with respect to the four principles of bioethics,[5] beneficence and non-maleficence outweighed the latter two of autonomy and justice. It was clear that it was in my best interests to have the operation, and without delay at that, so too much of a focus on any

[1]Third Year Dental Student, King's College London
Correspondence to: Roxanne Mehdizadeh
Email: Roxanne.Mehdizadeh@gmail.com

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unlikely complications would not be beneficial to my wellbeing. Within dentistry such emergency scenarios where informed consent has its limitations are very rare. As has been suggested, patients are fully within their right to make an informed refusal, or unwise decision.[6]

The consent process I was more familiar with related to less involved treatments such as fillings and was based on the principles of shared decision making[7] and obtaining valid consent.[8] I had taken care to explain every possible benefit, risk, side effect and alternative option in meticulous detail, ensuring understanding and appreciating the continuous rather than one-off nature of consent. The elective nature of such treatment allows for the patient to have the autonomy to be involved in this way.

COMMUNICATION

There were innumerable aspects of surgery which I had never previously been aware of. How many times had I asked the question '*have you ever had any operations?*' to my own patients while taking a medical history without truly understanding what that entailed? I had not considered the near-constant suspense and long intervals of waiting for the results of tests and scans to be relayed. Nor the inability to truly rest due to the continuous checking of vital statistics at hourly intervals, even throughout the night. Nor the changing of IV fluids, delivery of medications, and, of course, the general difficulties in sleeping with uncomfortable cannulas digging into one's veins, all while the bustling on the ward continues well into the night. I was extremely well cared for, but these are simply the unavoidable facts of staying in a hospital and requiring 24-hour monitoring. They all contribute to the loss of control and dehumanised feeling one has as a patient.

With respect to the appendectomy itself, despite my ostensible nonchalance during the consenting process, I was in all honesty gripped with anxiety as I lay in the anaesthetist's room one door away from the operating theatre. I had decided that it would be the perfect occasion to mull over the horror stories I had read about anaesthesia awareness. However, the anaesthetists soon dispelled my fears, explaining every step – from the reasoning behind the cricoid pressure, to the ice-cold sensation I would feel as the general anaesthetic travelled up my arm, as well as the sore throat I may experience the next day due to the intubation. Throughout all of this, my dreads and uncertainties were allayed by the constant and high calibre communication from the various members of the team. Within the dental setting, studies have shown that providing such descriptions of what to expect or so-called 'sensation information' reduces anxiety,[9] and that most (although not all) patients prefer a talkative dentist if they are nervous.[10]

Overall, my unexpected hospital stay reinforced my understanding of the consent process, breaking bad news and communication from a patient's perspective. In fact, the whole experience was humbling and taught me that being a patient can quite frankly be terrifying, yet at the same time enlightening for healthcare professionals.

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