It's only words…

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We continue our series in which Consultant Interventionist Dr Michael Norell takes a sideways look at life in the cath lab…and beyond. In this column, he considers how we talk to our patients.

This article marks a first in the almost 10 year history of *The oblique view*. Thus far my meanderings have been largely generated by ideas I have attempted to develop into readable (hopefully), entertaining (occasionally), interesting (let's not push it) and even informative prose (now you're taking the mickey).

Any particular messages or personal themes that I have felt important enough to transmit, are woven into the fabric of the piece; the hope is that they become more palatable if seasoned with a tad of humour and garnished with a dash of tongue-in-cheek.

In this issue of the *BJC*, the editor (my old friend Henry Purcell) thought it might be novel for this piece to resonate with another article within these very pages. Between you and me, I cannot thank him enough. I have struggled increasingly to contrive new topics to write about and so to be actually handed a fresh subject on a plate was a godsend, and I was delighted to accept the brief.

Part of our professional skill is to be able to communicate sometimes complex or fairly technical information to patients and their carers who will often have little or no medical knowledge. Despite the unrelenting onward march of technology, public understanding of medical concepts that to us are second nature, seems to have altered little.

Mind the gap

See how often the print media report a celebrity undergoing percutaneous coronary intervention as having had 'heart surgery'; how the middle pages are then festooned with cartoons depicting the step-by-step process of stent implantation or how coronary artery bypass grafting is performed. These descriptions and images have not changed over the years. Despite the advent of the internet revolution that places boundless knowledge at our fingertips, it would appear that the gap between our own knowledge and that of the lay public is as large as it has always been.

We should not be surprised. Whilst universal awareness of heart disease generally, high blood pessure, smoking and cholesterol – not to mention appreciation of the many interventions available – continues to increase, so does our own understanding of this science as medical practitioners. Hence the distance between us and the noncogniscenti remains.

In an article in this edition of the *BJC* (see page 39), investigators examined patients' understanding of fairly commonly used cardiological terms such as a 'stent' or 'heart attack'. The results are interesting; essentially we should not take for granted a patient's understanding of the terms we use.

There is an oft quoted phrase, which I have admittedly laundered slightly in order that you can read it before the 9.00 pm watershed, namely "assumption is the mother of all mess-ups". How true that is; in the era of media and public scrutiny, transparency, audit trails and our duty of candour, this reminder is more applicable to modern healthcare than it has ever been.

It is not enough just to inform patients and their families; we must take all reasonable steps to ensure they have understood and then satisfy ourselves that they have done so. The more this process is documented the better.

The age of consent

This is particularly relevant when obtaining consent for a procedure. Cases of litigation are brought against healthcare providers not necessarily because an investigation or treatment resulted in an albeit recognised complication. It is often because the patient had not been made sufficiently aware of that possibility, or the option of an alternative management plan with its own pros and cons.

No longer is consenting just a signature, rapidly scribbled five minutes before an operation; it is a process which must embrace the patient's understanding of what is proposed as well as the demonstration that time – a cooling off period – has been allowed for consideration and discussion.

The findings of this research study will resonate with many of us. We ask our patients frequently questions like, "Have you had a coronary angiogram before?" The subsequent conversation goes something like this:

"I'm not sure; I had a test this morning."

"That was an electrocardiogram; an electrical heart tracing. I'm talking about a catheter test involving a local anaesthetic, X-ray pictures and a thin tube in your groin."

"Mmmm. I'm not sure. I had an X-ray of my chest years ago; is that the one?"

"No; an angiogram gives you moving pictures of the heart."

"Yes, I had a heart scan; is it the one with jelly on the chest?"

"No, that's an echo; sound pictures of the heart."

And so it goes on…

In the old days it was easier. An angiogram would be remembered for two reasons; the left ventriculogram would produce a hot sensation, make you think you had wet yourself and then invariably cause you to throw up. (We used to routinely give metoclopromide before the contrast injection). Secondly, the procedure would be followed by an 18-stone rugby player pressing on your femoral artery. You don't forget that sort of thing.

Nowadays, fewer ventriculograms are performed and when they are done patient-friendly contrast is used. The use of femoral arterial closure devices and more radial access has made the whole investigation better tolerated but, at the same time, less memorable.

Things change

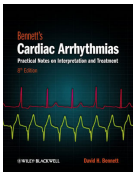
Another term that is in routine use is 'heart attack'. It is surprising that we still find ourselves using it, especially in the modern era of universal troponin testing and thus the occasional need by authoritative bodies to modify the definition of *myocardial infarction*. The pathology is clear but the clinical correlates are variable. As a result, when our patient asks, "So did I actually have a heart attack, doctor?", we sometimes struggle to answer.

"Well, there was no actual damage to the heart muscle that we could detect, but your heart did stop a few times and had to be restarted." I'm not sure how reassuring that is.

We should beware and take pains to be sure that communication with our patients is clear. We learned at medical school that when patients tell you they get migraine, asthma or palpatation, the first thing we do is ask them to describe what they mean. As Humpty Dumpty remarked to Alice in a rather scornful tone (sic) in Lewis Carroll's 1872 classic, *Through the looking glass*, "When I use a word, it means just what I choose it to mean – neither more nor less"

Book reviews

Bennett's cardiac arrhythmias: practical notes on interpretation and treatment, 8th edition



Author: Bennett DH
Publisher: Wiley-Blackwell, 2012
ISBN: 978-0-470-67493-2, Price: £34.99

This 8th edition of *Bennett's cardiac arrhythmias* offers a comprehensive overview of the mechanisms and management of the most commonly encountered types of arrhythmia in clinical practice. A large variety of good quality examples are provided appended with concise explanatory notes, and the layout is uniform throughout. What is particularly noteworthy and different from a standard book of electrocardiography is the fact that not only does the author outline and exemplify mechanisms and types of arrhythmia, but he also provides an introduction to electrophysiological principles and catheter ablation for arrhythmias.

This is particularly important, since ablation procedures have now become part of the standard level of care offered to patients in tertiary centres. Dealing with patients having to undergo ablation requires a multidisciplinary approach: the team includes the junior doctor (the first to assess the patient), the registrar, the anaesthetist, the consultant performing the procedure, cardiac technicians and, in rare cases, cardiac surgeons. Having a basic knowledge on the fundamentals of an electrophysiological procedure is therefore essential. This book provides a very good guide to those involved in the care of a patient referred for radiofrequency ablation, by offering a solid platform covering everything from the recognition of the problem to the most state-of-the-art treatment that can be offered to the patient.

Other commonly encountered problems on cardiology wards today emanate from patients who have previously received implantable devices, either defibrillators or antibradycardia pacemakers. Early recognition of the most common problems, such as under/oversensing, is essential in the post-implant care of the patient. The basic principles of device functioning and programming are beautifully and clearly outlined in their respective chapters and offer a useful guide for nurses and junior doctors dealing with the post-operative care of these patients to identify the problem early.

Chapters focusing on anti-arrhythmic agents, with details on mechanisms, indications, and recently introduced anti-arrhythmic drugs, including those allowed to be used in pregnancy, as well as arrhythmic problems encountered in athletes, add more to the comprehensive nature of this book.

Last but not least, reference is made to the most recent guidelines, especially with regards to management of atrial fibrillation, the most common arrhythmia. Newly introduced risk scores, as well as new oral anticoagulants are covered. Reference to guidelines for device implantation is equally provided, as well as possible interference and regulations regarding fitness to drive in several case scenarios.

This all makes this book a reference for a large variety of health care professionals and a good foundation for those needing a broad and thorough approach to the diagnosis and the most appropriate management of cardiac arrhythmias.

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