The Value of Compassion and Forthright Communication

BY RICHARD TIPPERMAN, MD

Mrs. K is a patient I remember well, mostly for her kind and gentle smile and the life lessons I learned from treating her.

BACKGROUND

I met Mrs. K more than 20 years ago when I was fresh out of residency; she was in her 60s at that time. Her ophthalmic history was notable for high hyperopia, narrow angles that had been treated years earlier with peripheral iridectomies, and dense anisometropic amblyopia, with a visual acuity of 20/400 OS. Her right eye had a visual acuity of 20/30.

Mrs. K had lived her entire life as a functionally monocular patient without difficulty. She worked, raised a family, and was fortunate to enjoy good health, travel with her spouse, and the delights of her grandchildren. Approximately 1 year before I met her, she began to experience increasing difficulty with the activities of daily life secondary to reduced vision in her left eye. Although she had never had good vision in that eye, she told me her sight had gone from bad to worse and that she was plagued by problems with peripheral vision and depth perception. She was not comfortable moving about in her environment.

Upon examination, the patient had clear corneas bilaterally, shallow chambers, and large surgical peripheral iridectomies. The crystalline lens in her right eye exhibited minimal changes, but there was a dense brunescent cataract in her left eye (Figure). A fundus examination of the patient's right eye was unremarkable. I could not obtain a view of the left fundus, but B-scan ultrasonography was unremarkable.

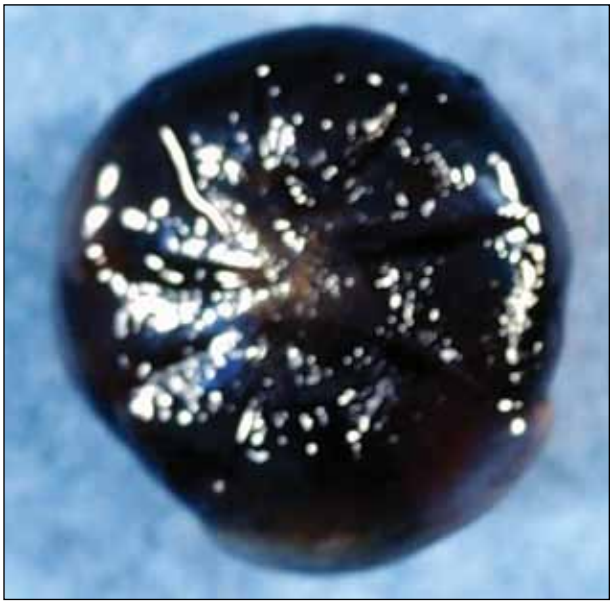

Figure. A photograph of "cataracta nigra," a dense, black cataract that was found in Mrs. K's eye upon examination.

Mrs. K had realistic expectations regarding the visual status of her left eye. She understood that her vision would not return to normal, but she hoped it could be improved to what it had been "a few years back." I discussed with her my concern that the dense cataract might necessitate an extracapsular cataract extraction (ECCE) rather than phacoemulsification.

SURGICAL COURSE

I performed the patient's surgery in 1991. Because of the possibility of converting to an ECCE, I administered a peribulbar anesthetic with facial block and fashioned a superior scleral tunnel. (I had not yet converted to either temporal or topical cataract surgery.)

Initially, the cataract surgery proceeded unremarkably. Even though the red reflex was poor due to the dense cataract, I created a 360º capsulorhexis. I began phacoemulsification with a state-of-the-art phaco unit for that era. Despite using 100% ultrasound power with panel control, the phaco needle barely removed any nuclear material. I had the impression that the zonules were becoming progressively weaker. I decided to convert to a manual ECCE (small-incision cataract surgery had not yet been described).

I converted the continuous curvilinear capsulorhexis to a can-opener style capsulorhexis with a cystotome. To facilitate the expression of nuclear material, I changed the surgical peripheral iridotomy to a sector iridectomy. Next, I enlarged the scleral incision and placed temporary silk stay sutures. I expressed the nucleus as I had been taught in residency, with a lens loop and muscle hook. The procedure was proceeding well, but once the lens was fully delivered, it was apparent that I was dealing with an unplanned intracapsular cataract extraction.

I instilled acetylcholine chloride (Miochol-E; Bausch + Lomb) and performed an anterior vitrectomy before placing an ACIOL. As I positioned the lens on the scleral spur, the patient reported significant pain. In what seemed like milliseconds, the retina was at the level of the pupil, and blood was filling the anterior chamber. I pulled the preplaced silk sutures and quickly closed the incision.

After the surgery, I placed a patch and a shield over Mrs. K's eye and went to the family waiting room to speak to her husband. I explained that she had experienced a major intraoperative complication and that the prognosis was poor. I told Mr. K that I would do all I could to help his wife, but that, in the near term, I wanted her to be evaluated by a retinal specialist.

OUTCOME

The night after the surgery, I had difficulty sleeping. My mind raced. What would happen next, I wondered. Every time I saw Mrs. K's name on my patient schedule, I instantly became nauseated, and my stomach knotted.

Initially, she had significant pain. During the early follow-up visits, I spent a great deal of time explaining and reviewing her situation, answering questions, and trying to be supportive. After a period of conservative management, the patient underwent a pars plana vitrectomy with silicone oil to manage kissing choroidals. Three months later, the oil was removed, and she achieved a visual acuity of 20/200. The postoperative complications limited her activity and reduced her quality of life for at least 6 months.

REFLECTION ON COPING WITH SURGICAL COMPLICATIONS

Learning to deal with the emotional stress of managing a patient with a complication is one of the most challenging aspects of clinical medicine and one of the least discussed as well. Often, when I work with residents who are managing a patient following complicated surgery, I will mention the emotional stress of dealing with the situation. Many of the residents are instantly relieved, as if my acknowledgement of this normal and appropriate human response validates their experience. We surgeons rarely talk about this aspect of our work.

There are two aspects to dealing with a problem, the intellectual and emotional responses. Residency training, self-study, and participation in courses at ophthalmic meetings can adequately prepare ophthalmologists to deal intellectually with any surgical complication. Ultimately, the appropriate physical response and surgical maneuvers to manage complications become second nature. In any acutely stressful situation, however, an emotional response has the potential to affect one's judgment and decision-making skills. Wind and Rich highlighted the behavioral patterns and personality traits of good surgeons, which include an attention to detail, calmness, logical thought under stress, and effective leadership.[1] In stressful situations, surgeons may experience a surge in their sympathetic nervous system that initiates a fight or flight response that can lead to a rushed maneuver rather than a slow, reasoned, and deliberate approach.

I believe controlling what I term the *acute emotional response* is learned by residents when they work with skilled surgeons. In this setting, residents can directly observe how experienced surgeons respond to surgical difficulties. Control over emotional responses is further strengthened when a surgeon is mentally prepared for surgery and is confident that, if a problem arises, he or she will take the necessary steps to achieve the best possible result. To some degree, it is easier to deal with a poor outcome if the surgeon knows every effort was made to affect a good outcome.

The long-term emotional response of managing complications can be more difficult and disruptive, because it affects the surgeon more than the patient. The surgeon may repeatedly play events over in his or her mind, which leads to increased stress.

It can be upsetting to evaluate a patient with a poor outcome during follow-up visits. This stress often manifests itself as poor communication, which impairs the surgeon's relationship with the patient. He or she might interpret the difficulty in communication as a form of abandonment. Patients like Mrs. K need two things, information and sup-

port. This case taught me the importance of expressing true and ongoing concern in combination with frank and open communication.

Every surgeon develops his or her own unique coping mechanism for managing stress. Unfortunately, maladaptive coping mechanisms can potentiate stress, burnout, impair clinical judgment, and even have negative cascading effects on physicians' personal and family life. Developing positive coping mechanisms to stress is essential to both quality care for patients and quality of life for surgeons and their families. Positive coping mechanisms include talking with friends, colleagues, or family; physical exercise; and engaging in meaningful hobbies.

LESSONS LEARNED

Although I could not fix Mrs. K's expulsive hemorrhage, it was immediately apparent to me on the day of the surgery that she and her family valued and appreciated a clear-cut description of her problem, management, and prognosis. Although she and her family were upset, this eased when they sensed a truly caring attitude on the part of their surgeon. In the weeks and months that followed, I made an extra effort to remain in contact, be supportive, and follow up after her specialist's visits. In retrospect, these efforts probably helped me emotionally as much as they helped her. In dealing with the stress I felt as a result of her problem, I realized that, if I were going to perform surgery for the long haul, I needed to have healthy coping mechanisms, which for me include a combination of physical activities and time with my family.

Approximately a decade after Mrs. K's surgery, she developed a visually significant cataract in her right eye. I performed the surgery, and fortunately, the procedure was flawless. I remain grateful for her confidence in my abilities and also for the life lessons she taught me. ■

Section Editor David F. Chang, MD, is a clinical professor at the University of California, San Francisco, and is in private practice in Los Altos, California. Dr. Chang may be reached at (650) 948-9123; dceye@earthlink.net.

Richard Tipperman, MD, is an attending surgeon at Wills Eye Hospital in Philadelphia. He acknowledged no financial interest in the product or company mentioned herein. Dr. Tipperman may be reached at (484) 434-2716; rtipperman@mindspring.com.

1. Wind GG, Rich NH. *Principles of Surgical Technique: the Art of Surgery*. Baltimore: Urban & Schwarzenberg; 1983.