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EDITORIAL

Grandmother Rules: Crucial Conversations with Patients and Families

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INTRODUCTION: IT'S WHAT YOU SAY AND HOW YOU SAY IT

Perhaps 35 years apart, my father and I might have done the very same colectomy, but if I am doing something important, the sense is far more abstract for me than it was for him. We can fix the hours all we want, but unless we find a way to revive the relationship between resident and patient, and thus the dedication and purpose that fuel imagination, then the quality will not be what it was, let alone what we want it to be. —Atul Gawande [Am J Surg 2001]

I matriculated at the same medical school from which my father graduated 22 years earlier. This coincidence gave me the opportunity to use his advice, based on his experiences as a student, to seek out some of the school's best and most memorable teachers. One such teacher was an eccentric and engaging professor of neurology named Bertran Sprofkin, who taught a class one day a week that first-year students could elect to take. One of Dr. Sprofkin's most memorable admonitions to us was that we should, in any meeting with a family, sort out who the grandmother of the clan was. And, once that person was identified, he advised that the top priority was to listen to and win over this matriarch. He emphasized this sage advice by stating emphatically that "the only reason you're here in med school is so that you will know just a little more than a grandmother." I have found, in the ensuing 40 years, that Dr. Sprofkin's advice is as valid now as it was then. I have, therefore, continued to pass along to my residents and students what I have dubbed "Grandmother Rules." Following these Rules entails not only sticking with common sense ideas but also being sure that conveying these ideas is done in the vernacular of the audience at hand, in order to make them understandable and acceptable. I have done my best to follow these principles in talking with patients and their families, particularly in the most crucial conversations that I, as a thoracic and cardiovascular surgeon, have had with patients and their families. These conversations include those that occur prior to an operation, immediately after the operation, near the time of discharge, and during follow-up clinic visits. Of course, what I like to say in these important conversations has been honed over the years, based not only on new medical knowledge but also on how I sensed what the patients and their families understood and how they were influenced by what was said, or what was asked, at these important times.

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WE'LL HOPE FOR GOOD THINGS: THE PREOP TALK

I haven't believed in statistics since I heard about a fellow who drowned in a river where the average depth was only three feet. —Woody Hayes, former Ohio State football coach

The first priority in any discussion about a major operation with a patient and the patient's family is to find a way to sit down. One should strive in all such situations to be in a position to be eye to eye with these folks [Meador 1992]. One should also strive to use the words and phrases, and even the accents, of the people to whom one is speaking. My residents have often chided me for sounding like the patients with whom I am talking. My retort to them has been that this just comes naturally to me, having had the great privilege to have worked and lived with and around many different kinds of people. And, it works.

One must not only describe to the patient and family the reasons for the planned operation but one must also acknowledge the risks. However, one does not need to be overly precise in quoting numbers to them under these conditions. After all, the primary experience most folks have with statistical predictions is weather forecasts. As a sage observer once noted, if one asks most people what it means when the weather forecaster says there is a 20% chance of rain on a given day, they'll say something like "if it rains in 100 cities, 20 of them will be our city." I have found it better to note that no mortal condition can be treated without risk and that those risks are sometimes substantial. Perhaps a better way to talk about risk in an understandable way is to say that "the vast majority of the patients we operate on for this condition do well, though not by much"; or, to use another favorite line, one can say that "the odds are certainly in your favor." In this way, one can express appropriate optimism, while conveying the reality that there are real and substantial risks associated with many, if not most, of the operations done in our discipline. It is essential to have addressed these risks, as there are few words one would rather hear from a patient or family, if difficulties do arise, than "you told us that this might happen."

I like to shift these preop conversations, as soon as practical, from the discussion of risk to a discussion of what they will do when they are well again [Tribble 2016]. This discussion has several valuable aspects including conveying a sense of optimism on the part of our team that we expect them to get well. It also shifts their focus to something that they can start to use, almost as a form of self-hypnosis, to allay their understandable anxiety about their impending operation. I specifically like to give them the assignment to send me a picture of themselves doing whatever they have told me that they are going to do when well. I have found this request to be a powerful antidote to their focus on the operation and the early perioperative period.

I also like to give the patient and family some specific instructions to prepare for their period of recuperation at home, such as stocking the house with appropriate food, rounding up over-the-counter pain relievers, being prepared for the inevitable disruption of their bowel habits, and other mundane, but often overlooked activities of daily living. Not only is such advice useful, but these kinds of instructions also continue to reinforce the notion that we expect them to come through the hospitalization in reasonable shape.

Finally, it is useful to tell the family that the operation itself will "take forever." They will frequently be told that these cases will take much less time than they really take (or seem to take). We must remember that their perception is that the operation will start moments after they last see the patient in the preoperative holding area, when in reality it often takes quite a long time to get the patient safely and completely anesthetized in order to start the actual operation.

THE MOST CRUCIAL CONVERSATION: THE FAMILY CONFERENCE AFTER THE OPERATION

There is no greater teacher of life than the practice of medicine but none greater than the place where life and death are most precariously balanced. —HJ Warraich, MD [Circulation 2016]

The conversation with the family immediately after the operation is completed is one of the most important of all the conversations one will have with a patient's family. One reason these conversations are so crucial is that this is likely to be the one time when most of the concerned family members and family friends are all together in one place.

You must take as much time as is necessary in these conversations, recognizing that they almost always take more time than you wish that they would. You just cannot seem to be in a hurry. It cannot be overemphasized that you must be in a quiet, private place where most or all can be seated. If there are not enough seats for everyone, you must be seated yourself. And, you should do your best to sit as near to the matriarch of the family as is feasible. Privacy is not only mandated by HIPPA regulations, it is also necessary to assure the family that they have your undivided, and unhurried, attention. Most, if not all, who are present will likely remember both the content and the tenor of these conversations forever.

If you are in an academic setting, you should always try to get the resident with whom you did the operation to join you for this meeting. There are several reasons for this strategy including the fact that, if you wait to have this meeting until that resident is available, the patient will have generally made it from the operating room to the intensive care unit and therefore, most likely, be fairly stable. There are few situations more frustrating than having to have a second family conversation, if the patient's condition has changed in this period. Furthermore, the family is fairly likely to see more of the resident than they have of you; having the resident in on the postop family conference, and treating that trainee as your partner, allows that resident to be seen by the family as your valued colleague. Even if I am doing most of the talking, I always ask my resident about his or her opinion on something substantial, such as getting them to offer a prediction on when the patient is likely to be extubated. In this vein, it is also worth noting to the family that about 100 people, on average, will play a substantial role in the patient's care while in the hospital, and that each member of this team can answer the majority of the many questions that will arise during the early postop period.

It is important to read the crowd in the room where the postop conversation occurs. The first person to identify is the matriarch of the clan (that is, the grandmother), as this person will almost always be the highest-ranking member of the family, so to speak. The next person to identify is the out-of-towner, as this person will almost always consider themselves to be more knowledgeable than the "less-experienced" members of the family. You can usually get this person on your side by acknowledging their supposed wisdom and asking if they can, while in town (which is usually a very short period), help you explain things to the family. I have found that families rarely take exception to this strategy and taking this tack will generally decrease the ability of this relative or family friend to disrupt your relationship with the rest of the family.

Once you have worked on crowd control, you can launch into your standard postop talk, which should begin with a description of what you did and an accurate assessment of how you think the patient is doing at this juncture. Then, you need to list the issues that might arise in the next 12 to 24 hours. These include bleeding, unstable blood pressure, and arrhythmias. I like to point out that we have to thin the blood while we work and, though we have an antidote for the blood thinner, it does not completely reverse the effects of the blood thinner. I tell them that we may need to give blood products or other medications while the ability of the blood to clot returns over time. And, I like to point out that even when the postop oozing subsides, some patients will need to have residual blood clot washed out. I tell them that hearts after operations are irritable and, therefore, serious arrhythmias can occur and may even require shocks to restore a normal rhythm. I also use this occasion to note that less ominous arrhythmias may also occur during the hospitalization, such as atrial fibrillation, which will require focused attention. Next, I mention that the patient's blood pressure may be labile for a while, requiring minute-to-minute attention, perhaps even until the next morning. Finally, I acknowledge that a stroke may have occurred during the operation but that we have no way of knowing about that until the patient wakes up.

I then generally suggest that the family consider not staying in the hospital overnight, since they likely will not be able to

spend much time with the patient in the early postop hours. Therefore, they should take advantage of this opportunity to get some rest, especially since we will undoubtedly need their help later when the patient is out of the ICU. Most families appreciate being given permission to take the rest of the day off.

In all aspects of this postop conversation, you should start your answers to almost all questions by saying "now, that is a very good question," as doing so will be seen as a sign of respect. After all questions that arise have been answered, I tell the family that they will be able to see the patient once our conversation is finished and once the patient is settled in the ICU. At this time, I remind them that, while the patient may look awful to them during this first postop visit, they should remember that the patient is comfortable and doing, usually, as well as we could hope. I also take this opportunity to note that many patients, when awake later, will frequently be somewhat confused, and I point out that some degree of disorientation is to be expected from someone who has not had truly restorative sleep for several days—as they likely did not sleep well the night (or nights) before the operation and the drug-induced sleep of the operative day does not really count as sleep.

These postop talks are truly crucial conversations. Pay close attention to how the families react to the things you say and how you say them. Learn from these reactions. You'll get better at it. The return on the investment that will come from taking your time with these conversations is quite substantial, as it is this conversation that most in the family will remember most clearly.

THE LIVER IS THE HEAVIEST ORGAN: CONVERSATIONS ON DAILY ROUNDS

You should do your best to see the patient each day after the operation while they are still in the hospital. So should the resident who did the case with you. Again, try to sit down when feasible during these visits. An old adage holds that patients and their families believe that your visit was about twice as long if you sit down than if you do not. You should examine the patient, at least to some extent. Try to do some small favor for them if you can, like rearranging their pillows, sheets, or blankets. If you have time, offer to get them a warm, wet washcloth or something to drink. Patients who are "on house arrest" will always appreciate these small gestures. It is also worthwhile to note that they can expect to sleep better at home than in the hospital. An effective move that reinforces your preop conversation about what they'll do when they're well is to write something about that activity on the white board that is in most patient rooms these days. Such a note will generate further discussion between the patient and the patient's family and the rest of the healthcare team.

Another worthwhile bit of advice to the patient and families at this point is to suggest that family members and friends postpone their visits until the patient is home again. This strategy recognizes the reality that the patient has to act as host or hostess when visitors arrive, which can be exhausting, and it acknowledges the reality that, once home, a postop patient may be lonely and would also be much more able to interact with and appreciate visitors.

I also like to offer some suggestions to the patient and family about getting their breathing back to normal, such as standing when feasible (since the liver is heavy and will "pull the lungs down and open them up"); using their incentive spirometers ("you need to suck on that device, not blow on it"); clearing the throat frequently (knowing that coughing, as many will advise, can be somewhat, or even significantly, painful); and asking when the supplemental oxygen can be discontinued (since oxygen can actually contribute to atelectasis by reducing "the nitrogen stent" [Elefteriades 2012]. It is also worth coaching the patient and the family on strategies for getting some sleep in the hospital, such as taking pain medicine when ready to sleep, using ear plugs or headphones to control ambient noise, and focusing on the activity that they've told you they plan to do when well again. Some advice on managing the GI tract is warranted, such as not eating too much if not hungry (which may lessen the likelihood of nausea) and asking for help with restoring normal bowel function (such as stool softeners or even suppositories or enemas, when necessary). Finally, it's worth suggesting that the patient and family do whatever else they can to make themselves feel more normal, such as shaving (preferably with an electric razor since hospital-issue razors are often downright dangerous) or putting on makeup, reading a newspaper, keeping their glasses on, and wearing something that makes them feel less like a patient such as a bathrobe from home.

YOU CANNOT WEAR YOUR PAJAMAS DURING THE DAY: THE DISCHARGE TALK

It is important to issue some marching orders when patients are ready to go home after heart surgery. One of my favorite mentors when I was a resident used to start this conversation by saying "the most important thing I can tell you about what to do when you get home is that you cannot wear your pajamas during the day." I have loved this admonition ever since, as the take-home message conveyed is that "you are not a patient anymore once you're home." A corollary to this advice is that one must get back to one's daily routines, which I describe as "getting back to where you once belonged." I tell patients that if their usual daily schedule was to get up in the morning, drink some coffee, and read the paper, then get back to that routine immediately. Eat with the family. Get out of the house. Go to church or to other familiar places. The downstream effect of pushing to get back into those daily rhythms is that other aspects of one's life will tend to get back to normal as well. Everything from sleep cycles, bowel function, appetite, energy, and mood will tend to fall in line. As an aside, patients will often be told that coffee is not good for them, but there is no data to support that assertion. It is now known that coffee doesn't affect the likelihood of arrhythmias. And, it's a diuretic, which can be good at this stage of recovery. Besides, it's a plant juice that is full of antioxidants. [Ding 2014]. I also like to "prescribe nature" [Reimers 2016]. I tell them to get outside, sit on the porch, go for a walk, or at least get to where they can look out a window, if conditions aren't optimal for being outside.

Though most patients won't still be having significant pain, not everyone will be so lucky. By this time after their operation, however, most patients can manage their residual discomfort with over-the-counter medications, such

as naproxen (Aleve) or acetaminophen (Tylenol). I like to suggest that the patients start their day with their morning cardiac medications, including their daily aspirin (taking the aspirin prior to taking non-steroidal pain relievers will insure that the aspirin is affecting the platelets before the non-steroidals get on board, which some say is the optimal sequence for taking these medications). And, the patients need to be cautioned about overdosing on acetaminophen, which is a concern if they are still taking narcotic preparations that often also contain acetaminophen. And, it's worth telling the patients that they should use their narcotics only for pain uncontrolled by the non-narcotic medications, as this strategy will aid in restoring normal bowel function.

While patients should be told that they cannot drive a car for about four weeks after their operations, they can ride in a car. And, they should be able to use shoulder harnesses and sit anywhere in the car they want (not worrying about air bag deployments, as they will not hurt a sternotomy incision). Furthermore, getting out for car rides can be part of your nature prescription.

It is also worth telling the patients and their families that the patient's mood may fluctuate. It is not uncommon for patients to have some emotional lability, but if such mood swings occur, all involved should resist overreacting, such as by using medications, as these mood swings are fairly common and will pass with time. I suspect that at least some of this moodiness arises as patients who may have had a steely resolve realize, subconsciously at least, that while they were prepared for the worst, they were unprepared for this turn of events, even if still doing reasonably well. It is also worth noting that exercise and activity can be a powerful antidote to mood swings [Reynolds 2016].

While virtually everyone will tell a patient who has had a sternotomy not to lift anything more than 10 pounds, few tell the patient what they might do to help work their way back to a state of fitness. I like to tell patients to round up 2 empty gallon jugs, which can serve as modifiable dumbbells, as they can gradually add water to them to increase the weight of these jugs, which, when full, will weigh only 8 pounds. The patients can be encouraged to move these jugs around to gradually increase muscle tone and flexibility. I never tell the patients that they cannot lift their arms over their heads, though this restriction is not an uncommon one in some practices. After all, folks have to be able to brush their hair and put on shirts. I like to refer to the studies done by the physical therapists in the Baylor Hospital system in Dallas [Adams 2016], who recommend that the postop patients keep their arms relatively close to their trunk during their early recovery period, which they describe as "staying in the tube."

Wound care instructions should be relatively simple. Showers are OK, though hot baths are not, until the wounds are completely healed. Neosporin will speed healing of the chest and leg wounds. ACE wraps are useful to aid in edema resolution and healing of the legs, particularly if a vein has been taken from them.

The most common reason that a patient is readmitted to the hospital after being discharged is fluid overload, leading, inevitably, to some degree of shortness of breath. Thus, some explicit instructions for managing fluid are necessary. First, I tell patients that they should keep a daily log of some of the information that will guide how they manage their fluid status [Latif 2016]. Each day the patient should record three parameters: their weight, the degree of ankle swelling, and how short of breath they feel. If their weight does go up instead of down, their ankles are more swollen, and if they are more short of breath, they need to take more Lasix. They may need to take more diuretic even if only one or two of these things are heading in the wrong direction. I personally believe that these instructions are better than simply having the patient take 2 or 3 doses of Lasix empirically every day for a week or two, though some practitioners do prefer this strategy.

Finally, I tell the patients that they must eat to heal. What they eat in the early postop period should be directed by what they find palatable. The so-called heart-healthy diet (which is increasingly controversial anyway) can wait until healing and recovery are further along. It does seem reasonable, especially for diabetics, to suggest that they limit sugar intake. I also tell patients to get a lot of fiber in the diet, both in the short and long term.

A TEACHABLE MOMENT: THE CONVERSATION DURING THE POSTOP CLINIC VISIT

You don't inspire your teammates by showing them how amazing you are. You inspire them by showing them how amazing they are.
—Robyn Benincase, World Champion Adventure Racer

In addition to the usual issues that need to be reviewed at the first postop clinic visit, such as wound healing, breathing, and medications, there is an opportunity to continue to guide the patient's psychosocial recovery. I like to insist that the patient bring the picture of themselves that they promised to create, the one referencing what they were going to do when they were well again. I have found that virtually all patients and families will eagerly fulfill that assignment and looking at this picture is fun, even inspiring, for all. It's important to convey a positive attitude to the patient at this point by noting how well the patient looks, how well the wounds are healing, and how their chest exam or chest X-ray looks. These sorts of comments reassure the patient and the family that their recovery is on track.

It's also worth noting that this visit is a teachable moment, so reminding the patient to continue to pay attention to rehabilitation, diet, and attitude is important. Patients will almost always seek advice about diet, and I generally start by saying that "we don't need you to eat sawdust and dirt." I note that refined carbohydrates are generally to be avoided, while protein and saturated fats are reasonable, in moderation. I emphasize that they should eat as many plants (vegetables, fruits, nuts, etc) as possible. I decided long ago that I should not ask these patients to eat in a way that I myself would not. For instance, I learned to enjoy eating fish [Sole-Smith 2013]. It did take me a while to get past the recollection of all the fish sticks I ate as a kid. Now, I eat fish preferentially much of the time. I try to encourage my patients to find

some activities that are not only good for them but also things that they will actually do. One line I like to add to this conversation is: "Your heart is in better shape than it's been in years. Now your body has to catch up. Let's come up with a plan that will work for you."

SUMMARY

The affection and respect you will command from this day forward as doctors of medicine—these are not things of your own making. These things have been earned for you by the decency and humanity of countless generations of good [people] of all faiths over the past 3,000 years. These [people] are dead and for the next few years you will hold in your own hands this magnificent heritage. —Charles Dunlop, MD, Professor of Pathology at Tulane University [J Vasc Surg, 2007]

Talking to patients and their families is a crucial skill for all physicians and surgeons, and this skill is often not taught explicitly to students and trainees [NEJM Knowledge+ Team 2016]. Honing this skill benefits from mentorship, takes time to accrue, and requires the practitioner to make observations about how these conversations are received by the entire spectrum of patients and patients' families that all clinicians will encounter in their practices.

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