DAY 1. IT IS 4 PM ON THE STROKE REHABILITATION UNIT as I walk into a room to find my new patient, Mr Burton, lying in bed. He appears fatigued but alert. Having reviewed his transfer summary from the acute-care hospital, I already know much of his medical history, including his right hemiplegia. I extend my right hand to his left in an awkward variation of a handshake. “Good afternoon, Mr Burton. My name is Dr Stein.” I introduce myself, deliberately trying to inject a tone of optimism into my voice.

“Mike Burton,” he replies. “The nurse told me you’d be coming by.”

“I’ll be your doctor while you are here,” I explain. “Tell me about your stroke,” and he does just that. Familiar themes of an unexpected medical catastrophe emerge. Active, feeling well, then a sudden difficulty speaking clearly, and a feeling of heaviness in the arm and leg. Rushed to the hospital by ambulance, fearing the worst, and then having those fears confirmed. Whisked through the whirlwind of acute care in three days, Mr Burton has arrived here at the rehabilitation hospital, trying to make sense of his nonfunctional right side.

We finish our duet of the history and physical, and then we really meet for the first time. “How long am I going to have to stay here?” he asks, as though his rehabilitation were a prison sentence to be served. “How long until my arm gets better?” he asks, with hopeful eyes. I am ready for his questions, having heard them many times before. Having reviewed the data and examined him, I know he is unlikely to recover much use of his arm. I couch my answer carefully, full of caveats and uncertainty that I do not completely feel. My noncommittal choice of words must leave him thinking he has a politician caring for him instead of a physician, but I stick to my rehearsed speech about the unpredictability of recovery, and the need to give the brain a chance to heal. He accepts my answers for now, preferring the predictability of recovery, and the need to give the brain a chance to heal. He accepts my answers for now, preferring my ambiguous statements about the future to the alternatives.

“I’m walking!” he tells me when I stroll into the room. Indeed, he has been walking after a fashion for almost a week, but now he recognizes he has been making progress. I arrange to see him in the gym with his physical therapist later in the day. His mood is lighter, more likely due to his restored ambulation than to the antidepressant medication he is now receiving. “What do you think, Doc?” he asks me, and this time I know just what to say. I am genuinely enthusiastic, applauding him for his perseverance and hard work. “You will walk out the door soon,” I prophesize, and he seizes on these words. “How soon will I get out of here?” he asks almost before I have finished my sentence. “Another week, more or less,” I tell him. “That sounds great,” he rejoins, leaving me feeling a bit like the parole board. “How about my arm?” he persists, hoping to keep up the momentum of good news. “The arm may not recover as much as the leg,” I tell him, confirming his fears. Still, he accepts half a loaf today—perhaps I am wrong. Af-

A PIECE OF MY MIND

A Fragile Commodity

DAY 4. “What can I do to get better?” he asks. “Exercise,” I promptly reply, despite some unspoken reservations. While the overall benefits of stroke rehabilitation are well established, there are clearly limits to what we can accomplish. Nonetheless, exercise will help make him more functional, I reassure myself, and perhaps enhance neurologic recovery as well. He takes my answer as a prescription for cure, and works diligently both during and after his regular therapy sessions to exercise his weakened limbs.

DAY 6. Nearly a week has passed, and Mr Burton’s rehabilitation is progressing steadily. I round in the morning, and he relates his successes and frustrations. Today I remind him of the progress he is making with his standing, and tell him he will undoubtedly be walking with assistance soon. I see the hope rise in his face, then fall as I describe his need for a leg brace. “It’s a lightweight plastic brace to help you with your walking,” I tell him. I proceed, almost pleading with him, to accept this blow. “It will fit in your shoe, and be invisible under your slacks.” He grudgingly accepts the plan, but his disappointment is evident. By prescribing a brace, I have informed him indirectly that he will not regain full function in his leg.

DAY 9. I walk into his room during breakfast. I offer to return later, but he knows that if I do, I will only be interrupting some other activity. He has settled into the rehabilitation routine: a day packed with therapy, followed by an evening with nothing to do. I inquire about his progress in therapy, but his answer tells me more about his mood than about his therapy. “I don’t know why I should even bother with therapy. My arm is just no damn good, and I don’t think it’s ever going to get better.” I think to myself that he has a point, and that his severely paralyzed arm isn’t likely to recover much function. This is clearly not the time to confirm his worst fears, so I carefully phrase my answer, acknowledging the slow progress, but encouraging him to be patient with the process of recovery. I then point out his progress in walking, and his growing ability to perform his own daily activities in spite of his residual weakness. When I am done, I leave a message for our consulting psychiatrist to assess Mr Burton for possible depression.

DAY 14. “I’m walking!” he tells me when I stroll into the room. Indeed, he has been walking after a fashion for almost a week, but now he recognizes he has been making progress. I arrange to see him in the gym with his physical therapist later in the day. His mood is lighter, more likely due to his restored ambulation than to the antidepressant medication he is now receiving. “What do you think, Doc?” he asks me, and this time I know just what to say. I am genuinely enthusiastic, applauding him for his perseverance and hard work. “You will walk out the door soon,” I prophesize, and he seizes on these words. “How soon will I get out of here?” he asks almost before I have finished my sentence. “Another week, more or less,” I tell him. “That sounds great,” he rejoins, leaving me feeling a bit like the parole board. “How about my arm?” he persists, hoping to keep up the momentum of good news. “The arm may not recover as much as the leg,” I tell him, confirming his fears. Still, he accepts half a loaf today—perhaps I am wrong. Af-

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ter all, I have repeatedly pointed out my inability to accurately prognosticate.

Day 23. Discharge day! In spite of the bleak New England winter outside, it is spring for Mr Burton. Home today, at long last. “Are you sure I’m ready to go home?” he asks. In this age of managed care, my patients fear that their discharge date is being determined not by their rehabilitation progress, but by their insurer. And sometimes, to my chagrin, they are right. But today, I reassure him, he is going home because he is ready to live independently again, not because of any less noble reason. He accepts this, then reviews his post-discharge plans with me again. As we review these plans, I see a mix of joy and anxiety in his face. One part of him is shouting, “I made it! I can walk again, I can take care of myself!” while another part of him is whispering, “Will I make it? What if I never get better? What if I have another stroke?” Sensing his anxiety, I reinforce my message: “You’ve done great with your rehab, and you’re going to continue to do great at home.” I remind him of the support of his family, and of the home services we have arranged for him. My therapist and nursing colleagues cheer him on. Finally, the handshake of closure, still my right to his left, but his grip is now firmer and more confident. We part with mixed feelings, a team broken apart by a happy event.

I knew when I met Mr Burton that he would very unlikely recover significant use of his arm. Trained in the era of patient autonomy, I once felt I should share all available information I could provide about prognosis as early as possible. Arguably, unfavorable news regarding arm recovery would be tempered by favorable predictions of a return to walking and living independently. While this portrait of recovery might match my definition of a good outcome, my patients were inevitably hoping for much more—a return to the life they lived before their stroke. When good news is delivered with bad news, the good news often is submerged beneath the bad. It quickly became apparent to me that most of my patients were not ready for the cold hard facts the minute they arrived at the rehabilitation hospital. They needed time to come to terms with the reality of their disabilities, while simultaneously regaining lost function. This is a process that shouldn’t be rushed.

Patients with severe illnesses are looking for a mix of hope and reality, and providing either one alone is a disservice. Hope is a fragile commodity, easily crushed by careless provision of the “facts.” There is a fine line between paternalistic withholding of the truth and leaving some imprecision regarding prognosis in order to maintain hope. In our zeal for patient autonomy, we should not forget the importance of nurturing that hope.

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Write while the heat is in you... The writer who postpones the recording of his thoughts uses an iron which has cooled to burn a hole with. He cannot inflame the minds of his audience.
—Henry David Thoreau (1817-1862)