

# Hospital Experiences and Observations

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In the last 20 years, I can recall visiting the emergency ward of University Hospital in Edmonton only two or three times, but in 2008 I equalled this total within six months. I was hospitalized for bleeding in my right lung in April and in May, and then in October for chest pains. There was some question about whether the bleeding involved a blood clot, and Coumadin was introduced. It further complicated the situation.

There are only three places within University Hospital (a teaching hospital) that consider taking a ventilator user, and these include intensive care, the emergency ward and the pulmonary ward. In the April hospitalization, I spent two days on the emergency ward until a bed opened up on the pulmonary ward, where I spent another two days before being discharged.



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On the emergency ward I found that it was quite easy to get a nurse when requested but that emergency is not set up to house a person like me with a pre-existing and chronic condition for any longer than a few hours. If it hadn't been for my beautiful wife, Valerie, and my regular personal care attendant taking care of my daily routine (including eating, toileting, dressing) during waking hours, it would be very easy for someone like me to be totally forgotten on the emergency ward.

On the pulmonary ward, I fared somewhat better in terms of daily needs, but I still found that my daily personal care would have been lacking if not for my wife and attendant.

When I revisited the emergency ward in May for a second lung-bleeding episode, I never did transfer anywhere else in the hospital, due to a lack

of beds being available for someone who was a ventilator user. Therefore, I spent four days and four nights on the emergency ward, and I am sure that I collected enough material and recollections to write a book that would be both tragic and humorous at the same time.

Bleeding from the lung was thought to be caused by damage to the lung from fighting infections over the years. To prevent further episodes of bleeding, two invasive procedures were suggested. One involved insertion of coils or beads into the problematic blood vessels to deaden them, and thus prevent future bleeding. The other involved removal of the lower lobe of the right lung. I opted for the coils in an angioplasty-type procedure that was successful.

In April and May, I was able to use my LP10 ventilator in the hospital. In July, I received a new ventilator, the Legendair® ([www.puritanbennett.com](http://www.puritanbennett.com)), through the Home Respiratory Care Program in Alberta.

October has been my most difficult medical month since contracting polio on October 2, 1955. I finally realized a few years ago that problems in October were deeply embedded in my subconscious mind because I often wound up with a severe chest infection in that month.

This time it was different. I first experienced chest pains after going to bed on the evening of October 14, 2008. I began to wonder if I was not experiencing some sort of a psychosomatic symptom, but in a different form when compared to a chest infection. However, after continuing to experience some chest pain off and on during the next day, October 15, I again went to bed, but the constant and severe chest pain required some priority attention.

By way of personal history, on October 15, 1955, I was transferred by ambulance from the Royal Alexandra Hospital (under the excellent care of Dr. Russell F. Taylor who later became one of the top cardiologists at University Hospital) to the University Hospital. Fast-forward to the afternoon of October 16, 2008; as I am being transferred from the emergency ward to the CCU, I looked up to read a sign that said, "Welcome to the Russell F. Taylor Memorial Intensive Cardiac Care Unit."

Coronary blockages were found in the left anterior descending (LAD) artery and in another artery branching off from the LAD. The cardiologist thought I was a good candidate for bypass surgery, but considering my high-risk status as a ventilator user and after many tests, he and his colleagues decided on angioplasty with stents to clear the blockages. A mild sedative was administered, and I used my new Legendair ventilator. This procedure was successful.

I received excellent medical care in the CCU, but again I had to rely on my wife and attendant for my daily requirements, particularly as I re-

gained my strength and was able to get up in my wheelchair on a daily basis.

I now take a cocktail of heart medications that are supposed to lessen the workload on my heart, and I have resumed normal activities.

In conclusion, I have come to the realization that anyone with a pre-existing chronic condition is at peril within our high-tech medical care system of today. Yes, the medical care can be and often is excellent, but that same care could turn out to be lethal when administered to someone like me.

When a person with a chronic condition enters the hospital, either for emergencies or elective procedures, and needs daily personal care, he or she had better be prepared for all possibilities. In my experience, even if the nurses have the time, they often don't have the expertise or the necessary training. And if they have the necessary expertise and training, they are very unlikely to have the time to deliver quality nursing care due to the shortage of nurses.

I highly recommend that ventilator users utilize **Take Charge, Not Chances** (downloadable from [www.ventusers.org/vume](http://www.ventusers.org/vume)). It is also available in Spanish.

Audrey King, my friend and fellow polio survivor, summed it all up, "Isn't it ironic that ventilator users have a terrible time moving out into the community and, once there, have an equally difficult time trying to get back in when hospitalization is required?" ▲