IT was 12:00 PM, Sunday afternoon. I was reviewing a busy operating room schedule with trauma cases left over from the night before and a list of procedures requiring Anesthesiology assistance when my phone rang. It was David from the primary service asking to schedule an anesthesia assisted procedure for a patient who required a lumbar puncture.

“Is this Dr. Vavilala?” he asked. I was not sure whether he required my assistance with the LP or sedation for the procedure. He told me that Mr. O, a 75-yr-old Cambodian patient who was admitted with altered mental status, and who was now receiving treatment for meningitis, had been rather uncooperative the last two nights when the procedure was attempted. “So, you need me to help you with sedation and confirm treatment effect …?” I asked.

At 6:00 PM, the postanesthesia care unit was full of recovering patients from general anesthesia. Mr O., a small-framed, frail, and bald gentleman, lay supine on the hospital stretcher, covered with a plain white hospital blanket over his chest and abdomen. Barely visible, a saffron shawl peeped out from under his shoulders. The nurse asked me if she should give Mr. O some sedation.

David assembled his procedural tray and the nurse asked a series of questions:

“Should I give him some versed?”

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“Should I give him some propofol?”

“Should I hook up the monitors?”

“Should I access the peripheral IV?”

“No,” I replied, feeling unable to prevent the naturally and rapidly occurring chain of events that I felt were premature. The questions kept coming. The flow of events, I could not slow down.

I said hello to Mr. O and he smiled back peacefully. Then, aah, the interpreter! I had worked with this particular interpreter many times … we learned that Mr. O was oriented to person, place, and circumstance … so, what was the issue, I wondered, standing at the foot of the bed. Over the next 5 min, Mr. O had surprisingly but willingly moved himself into the fetal position, ready for his LP. But, “He won’t hold still,” they said, seeming to not notice the fact that he had already achieved this goal.

“He’s elderly, and I want to give this procedure a try without sedation,” I said. I was thinking about trying to prevent delirium and confusion by avoiding unnecessary medication, but somehow was not able to get this message through.

“You aren’t Buddhist, are you?” joked David.

“Let’s just leave him alone and see what happens,” I responded, aware that my approach to Mr. O appeared, to the others, unnecessary and maybe even wrong.

I wanted to talk to Mr. O. I leaned over to ask him some questions when, suddenly, the interpreter’s hand stopped me.

“You know he is a monk and women shouldn’t touch him, right?” queried the soft-spoken interpreter, with brows slightly furrowed. In fact, Buddhist monks are forbidden to touch or be touched by a woman, or to accept anything from the hand of one. If a woman has to give anything to a monk, she must first hand it to a man or put it on a plate provided. I apologetically moved back, and asked Mr. O to tell us the details of the attempted and failed procedures yesterday. It was true! Most of his healthcare providers during the last 2 days were female, including the anesthesiologist who had performed a history the day before. He said he tried to tell them not to touch him but they thought he was confused. Who knows, maybe he was confused, maybe there was no interpreter, or maybe the right questions were not asked. Although I had managed to not touch him, it was unclear to me how many people had done so, and today, he almost received unnecessary sedation for his LP.
We collected 4 ml clear cerebrospinal fluid and an opening pressure of 11 mmHg, no increased intracranial pressure, and presumed treatment success. All through the LP, Mr. O had dozed off. He slept all the way back to his room.

The candida meningitis was likely due to his uncontrolled diabetes, I concluded. I asked the primary service to order Mr. O a meal because he could officially now eat. With amazement, the interpreter stated, “Monks don’t eat after 10:00 AM.”

As an Indian immigrant with some cultural similarities—perhaps it is that background that stopped me from sedating Mr. O—yet, even I did not make the connection that the saffron shawl that was visible had signified something more special. In the rush of it all, I had leaned over a bit too much and a bit too fast, and had made him uncomfortable. Had it not been for the interpreter, I would have violated some very important boundaries.

Children, the elderly, and patients with limited English proficiency are all vulnerable populations. Mr. O, a patient, spiritual person, was nearly assaulted by the need to move things along and get things done. I had the following thoughts:

What must Mr. O have felt? Should I dare ask him?

How easy would it have been for me to just sedate him for the LP?

How many violations have occurred?

Did he get to eat or drink the day before or was his tray of lunch delivered at noon, just like everyone else’s?

I share this as an example of the powers of language and interpreters—what vulnerable patients would do without them, that and cultural awareness.

As an anesthesiologist who spends much time “doing,” it was an important reminder that many times, it is better … to not do.

Onto the next case.