Case Studies from Tasmania by Arthur Dobson

Mrs G. was born in 1936, grew up, worked as a secretary, married at 19 and had a family of 3 children before contracting polio at the ago of 24 years in 1960. The next 10 months were spent in hospital in an iron lung before she regained enough strength and control of her breathing to return home to her family. By her mid-forties Mrs G's condition had deteriorated to a point where she was provided with a CPAP machine to allow her to breathe deeply enough to balance her oxygen levels. This gave her a new lease on life until the late effects of polio started appearing in the 1990s. Her neck, arms and breathing slowly deteriorated until she started taking respite breaks in nursing homes to take the pressure off her devoted husband who had provided the only care and assistance she had received for many years.

On her last period of respite, after failing to receive assistance to go to the toilet because the staff were too busy, she attempted it herself and suffered a very bad fall. An ambulance was called and Mrs G was taken to hospital with no instructions regarding her polio condition. She was wearing a wrist band with an alert spot but no one bothered to check it out and when she was trying to tell the staff that she could not breathe lying down without a respirator the last thing she heard before they injected her with a tranquiliser was "she's only a stupid old woman, just shove it in". This of course stopped her heart and lungs immediately but they were able to revive her only to have the same thing happen again on at least two other occasions in other sections of the hospital before someone finally woke up and checked the reason for the alert spot which had been recorded in her medical history. Incidentally I understand that one of these incidents occurred in the ward with an alert spot clearly visible on the patient identity card above her bed.

It was a miracle that Mrs G survived but she did and was operated on and had a pacemaker inserted which improved her condition quite considerably allowing her to live a number of peaceful years in a nursing home before passing away in her early seventies. Whilst at that nursing home her family took her on regular outings which she thoroughly enjoyed but she felt always safe to return to the one nursing home where the staff understood her condition.

The point I wish to make is that we are not peas in a pod despite the standard practice in the education of doctors, nurses, therapists and carers being to treat us all the same and ignore other conditions that patients may be suffering from. Whilst this may not be the official policy of the education system it does happen

more often that not. This has been admitted to me by a number of health professionals.

Mr D. was born in 1946 on the family farm some 40 kilometres west of Launceston. In 1952 at the age of 6 years he contracted polio and spent the next 2 years way from home, first in the infectious diseases hospital and then a home for crippled children where he completed his first year of schooling. He started at the local area school in grade 2 with short callipers on both legs which were discarded some years later and after leaving school at 15 he went to work on the family property, a mixed farm of dairy cows, cropping and a stud prime lamb sire breeding flock that regularly exhibited and sold sheep at major shows throughout Australia. Whilst he always had minor problems with his feet and poor eye hand coordination he worked happily and competently in his chosen career. Like many polio survivors he fought hard to prove himself as good as anyone else and this caught up with him in his early forties.

A bungled oesophageal hernia operation in 1994 resulted some days in an induced coma on life support after which he suffered horrifying nightmares, an adverse reaction to the anaesthetic. An abnormally long recovery time following the anaesthetic was also noted during which the polio damaged motor-neurons seemed to decide they had had enough and started shutting down leading to a marked decline in his physical ability to cope with day to day life. A marriage breakdown didn't help the situation and the farming operation was gradually wound back. His hips wore out and had to be replaced due to the damage caused by osteoarthritis.

The first of these operations was carried out in March 1998 and whilst the surgery was successful a lack of knowledge on the part of the hospital staff regarding the late effects of polio and slow recovery time led to unnecessary complications and stress. Mr D did take appropriate information on the complications likely to occur following surgery on polio survivors and a number of the staff did take the time to have a quick look at it. The physiotherapist absolutely refused to accept that Mr D was unable to undertake her exercise regime just after lunch due too excessive fatigue following the busy morning schedule that occurs in a hospital and then lunch after which it is normal to have a rest. This was the time she insisted that she worked with him even after he explained the situation to her. She branded Mr D a difficult patient and a very stressful situation developed.

Eleven months later the second hip was replaced and the operation again appeared successful. Many of the nurses were the same and remembered the difficulties which

followed the previous operation. The physiotherapist on this occasion was an older man who had spent some years in private practice and was more used to listening to the patient. On checking Mr D's history he commented that as Mr D had worked with some of the best physios over the years, he knew what he had to do and suggested he undertake the required exercises when he felt comfortable doing them and the physio would check on him every second day or so. This resulted in Mr D being cleared to leave hospital by the physio before he had been cleared by the doctors. Unfortunately it soon became evident that there was something wrong as Mr D was tripping a lot and could not walk at all without the crutches long after they should have been discarded.

What had apparently happened was the accumulative effect of three major anaesthetics over a relatively short time had caused a return of the foot drop that had occurred when Mr D had contracted polio nearly 50 years before. A visit to the Orthotics Department of the Hospital followed where Mr D was lucky enough to find an Orthotist visiting from Melbourne who had experience in working with polio survivors and she was able to provide Mr D with in shoe supports for both lower legs. This worked well but it took over a year before Mr D was able to walk without crutches and several more before he was able discard the foot supports. Whilst he hasn't had to use these supports for a number of years they are still on hand should they be needed. Mr D now ensures that his anaesthetist is well aware of his polio history and insists that he checks his bad history with anaesthetics, which is readily available from the hospital concerned, before undergoing any surgery. Mr D feels lucky to have a GP who is familiar the late effects of polio but gets frustrated when having to deal with other health professionals who don't take the condition seriously.

This is another example of the ignorance of the health profession when it comes to dealing with polio survivors.

As principal contact for the Post Polio Network – Tasmania Inc. I am often contacted by family members of polio survivors in hospitals asking if I can take relevant information to the hospital as they feel that their family member is being ignored or even ill treated by being given inappropriate treatment. This information is usually well received but not always and it must come from a professional source not unqualified people like myself.