

ON LIFESAVING CARE AND THE NECESSITY OF DIGNITY

The story of Mrs. Hassan

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As a medical student in your early months, it's difficult to disagree with the notion of whole person care. Of course, all doctors should see the patient before them not as a biophysiological problem to be solved, but as a person with a family, friends, a sense of self, a sense of dignity. This seemed so obvious as to be almost banal, and I often took these lessons for granted. This changed – quickly and dramatically – when I began the clinical stage of my training.

The transformative experience I wish to discuss involves a patient I will call Mrs. Hassan. Mrs. Hassan was a librarian in her early sixties, almost the same age as my mother. She had a reserved demeanor and spoke French with an accent. The first time I saw her, she was unconscious.

One surprising thing about operating rooms is how cold they are. It was my first time on the surgical side of the OR (I had been in anesthesia the month before), and I felt that distinct blend of caffeine-induced focus and early-morning fatigue. I clumsily scrubbed in, amid a buzz of orderlies, nurses, residents, fellows,

and other medical students. In the OR's austere environment, under harsh fluorescent lights, with the continuous beeping of monitors, and, like many junior medical students, in perpetual fear of contaminating the sterile field, I felt a combination of trepidation and excitement. Mrs. Hassan was having a major esophageal cancer removed in one of Canada's best tertiary hospitals – the case was bound to be interesting. The attending surgeon strolled in when everything was ready, the patient under general anesthesia and the trainees eagerly awaiting instructions.

For the first 45 minutes, I watched in awe. For the next four hours and 45 minutes, I tried not to zone out. The surgery was technical, performed with great skill using a relatively new, minimally invasive technique. The operation was successful, the tumour was removed, and when it was over, I watched Mrs. Hassan wake up in the post anesthesia care unit.

A few days later, I was asked to present Mrs. Hassan's case at Friday rounds. Her surgery was the first I had witnessed, and she was the first patient I had ever presented. I summarized the history of her illness, her presentation, the surgery, her status post-op. While I had not contributed to her care in any meaningful way, I felt in some sense responsible for her – I knew her story inside out. She was "my patient."

Mrs. Hassan remained in the hospital, making an uneventful recovery. About a week after the operation, however, her X-ray showed a distended stomach, a common complication but one requiring prompt attention. It was decided that a nasogastric tube (a small suction device passed through the nose and into the stomach) would be placed to relieve the pressure.

A small herd of medical trainees entered Mrs. Hassan's room. There were two fellows, a resident, two other medical students, and me. Mrs. Hassan was discouraged by the news of the procedure but resigned to its necessity. I wheeled in a screen attached to a gastroscope, which would be used to visualize the patient's stomach. Another medical student sprayed lidocaine into Mrs. Hassan's mouth and nostrils, standard practice to mitigate the discomfort of the nasogastric tube insertion.

Mrs. Hassan was alone in her bed, surrounded by observers. I was to her right with the two other medical students. Facing me was the resident, who would perform the procedure under the supervision of a fellow. The resident inserted the nasogastric tube into a nostril, and Mrs. Hassan gagged. This was to be expected, but I assumed the tube would be rapidly placed and the discomfort would soon be over. Quite the opposite occurred. The resident wiggled the tube around, getting it into Mrs. Hassan's throat and aggressively stimulating her gag reflex, but unable to advance it into her stomach. He then attempted the other nostril as Mrs. Hassan heaved. The fellow watched him, providing tips here and there. No one seemed to be paying attention to her.

As a student, I understand that medical teaching is vital, but there is a time for teaching and a time for experts to take over. Despite repeated, failed attempts to get the tube in, the resident continued to try as the fellow observed.

At a certain point, the gastroscope was inserted. The nasogastric tube already in Mrs. Hassan's nose, the thicker gastroscope was shoved down her throat as she violently choked and retched. I will not forget the way Mrs. Hassan began to clutch, with both hands, the armrest on the side of her bed. It was as if she had to grab hold of something to prevent herself from drowning. Shocking though it was, I was less surprised by the brutality of the procedure than by the lack of attention paid to Mrs. Hassan's pain. As the gastroscope went in, everyone scrutinized the screen I had brought in, attempting to discern what was causing the stomach distension. Fascination with Mrs. Hassan's condition seemed to be blinding the medical trainees to her suffering.

In fairness, the young physicians felt they were doing something good for Mrs. Hassan – and they were. The nasogastric tube was necessary to ensure she successfully recovered from the surgery. Rarely had anything been clearer to me, though, that a lifesaving procedure was no excuse to leave Mrs. Hassan writhing without comfort. No one told her it would be over soon; no one held her hand. To say nothing of sedation, which, I later learned, while not routinely used for nasogastric tube insertion, should be standard practice during gastroscopy.

At some point, I instinctively grabbed Mrs. Hassan's shoulder, telling her she was doing great and it was almost over. It didn't feel special; it felt natural. What felt to me so incredibly unnatural was that I was the only one holding her. Eventually, a nurse came in and grabbed Mrs. Hassan's hand. Noticing the pained look on the nurse's face, I knew immediately that she was seeing what I was seeing.

The fellow eventually took over and the procedure was completed. Mrs. Hassan slumped back into her bed, exhausted, her face awash with snot and tears. The fellow, young enough to be her son, rubbed her head and said, "Sorry sweetheart but we had to do this for you."

There was a small chapel in the hospital. I have never been a particularly spiritual person, but after it was all over, I went to the chapel. It was a novel feeling for me, the sense that I needed to be there. I closed my eyes and silently pleaded that Mrs. Hassan would recover, find comfort, find solace.

In the days that followed, I questioned whether I had overreacted to the situation. I was new to hospitals, after all. Maybe this happened all the time. When I brought up my concerns with the surgeon, he politely dismissed them: yes, these procedures are unpleasant, but given a lack of resources, there is really nothing to be done. Sedation, apparently, was out of the question.

Still feeling a sense of responsibility, I opted to visit Mrs. Hassan a few days later. I found her in considerably better spirits, the nasogastric tube still in but set to be removed soon. I apologized to her for her treatment. She told me it was worse than anything else she had experienced – worse than the surgery – and if they tried to do that again, she would refuse. She couldn't understand how the young doctors who performed the procedure could have behaved like that. We spoke about her grandchildren and her immigration to

Canada. I wished her the best and said I would come visit tomorrow, hoping I had conveyed that someone in that room had seen her pain, had seen her.

In medicine, we sometimes feel that patients should realize there will be moments of discomfort and embarrassment and should accept it. We are helping them, and they shouldn't blame us for doing our job. Yet, while there will be moments of discomfort, there should never be moments of indignity. The most skilled clinicians are not those who use brute force and "give it to the patient straight," but rather those who make the moments of unease seem to pass in a flash.

My experience caring for Mrs. Hassan was profoundly transformative, as it showed me the consequences of not treating someone as a "whole person." The failure to recognize a patient's suffering – either because we have intellectualized their pathology or because we tell ourselves we are just doing what it takes to help them – is catastrophic. I will not forget Mrs. Hassan, and I will see her in the patients who come under my care. She will remind me that patients are people deserving of kindness and compassion as they navigate their stay in a place of healing. ■

Biographical note

Alex Stoljar Gold is a medical student at McGill University, where he completed a Bachelor of Arts and Science in Cognitive Science. Alex is passionate about whole person care, with a particular interest in exploring patients' experience of illness through the humanities in medicine. He is also interested in medical anthropology and global health.