


du poids. Elle s'est affaiblie. Elle a contracté la pneumonie... quelques fois. Une fois, j'ai pensé pneumocystose... mais elle s'en est rétablie. Je l'ai convaincue de prendre des antibiotiques, mais ce fut une bataille. C'était une bataille de la convaincre de vivre. Je ne comprenais pas. Je croyais inhérent à tout le monde de vouloir vivre.

Puis un jour, j'avais une clinique en soirée. Il était tard. Je suis sûr que j'étais fatigué...enfin, je le blâme sur le compte de la fatigue. C'était ma dernière patiente de la journée. J'ai à nouveau tenté de la convaincre de prendre des médicaments. J'ai fait mon numéro gagnant d'optimisme, même si je savais qu'il ne me restait plus grand-chose en réserve. Et encore, elle a simplement refusé. Et puis, une autre bombe... elle m'a dit qu'elle quittait le Canada pour retourner dans son pays natal. Elle m'a dit «préférer mourir là-bas». Mon cœur s'est serré. Les larmes me sont montées aux yeux et je me suis retenu pour ne pas laisser les écluses s'échapper devant elle. J'avais échoué. Après son départ, la porte enfin close, je me suis mis la tête sur mon bureau... exaspéré. Je me sentais battu. Le sentiment que nous avions toutes ses choses pour l'aider à vivre... et... rien. À mon insu, elle était revenue et avait entrouvert la porte. Elle m'a vu dans un état dans lequel, selon moi, nos patients ne devraient jamais nous voir... sans espoir. De sa voix douce et calme qui, elle, n'a jamais changé, elle m'a dit: «Juste que vous le sachiez, je sais... je vous ai entendu. J'ai entendu chaque mot que vous m'avez dit. Tout. Tout le temps. Et je vous remercie d'avoir

essayé. Ça n'a rien à voir avec vous... c'est avec moi». Elle est partie. Les écluses ont débordé.

Je n'aurais jamais cru entendre parler d'elle à nouveau. Il semblait que des années s'étaient écoulées, mais en fait, ce n'était que quelques mois après, j'ai reçu d'elle une carte postale. Elle était en Afrique, de retour auprès de sa famille, où elle voyait beaucoup de personnes dans son entourage mourir du même virus. Et, parce qu'ils mouraient, elle avait l'impression qu'elle ne méritait pas non plus de vivre.

La carte postale était petite. Elle ne pouvait pas en écrire bien long. Mais, ce n'était pas nécessaire. Elle a écrit qu'elle a éventuellement suivi une thérapie. De fait, elle a écrit «des médicaments contre le VIH». Elle l'écrivait enfin par son nom. Il y avait quelque chose de spécial dans son écriture, comme si je pouvais entendre les mots qu'elle écrivait sur le papier. La même voix douce, le petit accent. Encore calme, mais comme si elle souriait quand elle a écrit les mots. Ses yeux encore ravagés profondément par la mort, mais capables de voir le monde sous un nouvel angle. «Je vous entendais, écrivait-elle. Je vous ai compris.» Soudainement, je comprenais l'espoir. 

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Best story by a resident

Thanks for the orange juice

Geneviève L'Écuyer MD

My biggest challenge, when I started my family medicine residency, was managing my insecurity. This was a challenge all the time, but it was particularly hard during on calls. When the phone rang at 3 in the morning and it was the nurse calling to say that she needed me to certify a death, I felt incredible relief. And when the family was not present and I could be back in the on-call room within 10 minutes, I felt relief mixed with guilt.

Having said this, I never felt that I was a bad resident. It was just that handling emergencies and working for long stretches of time had not been part of my career aspirations. Mental health and providing patients with follow-up care were more what I had in mind; I liked to think that I had good relationships with my patients.

And then, at 1 o'clock one March morning on the last night of a really grueling week of on calls, it all fell apart. I was called to the side of a patient in cardiology: the attending physician had prescribed metoprolol IV while she was still at home for rapid atrial fibrillation. The patient was an 83-year-old woman who had been admitted for a massive left-sided stroke, with AF de novo and urosepsis. I opened the patient's record and scanned it for the information I would need for my note. Then my eye was drawn to the upper right-hand corner of the most recent entry. Mrs Masson—my Mrs Masson!

I had been visiting this patient at home for 8 months, following a stroke that had left her with major left-sided hemiparesis. Prior to her stroke, she had been in perfect health. She was kindly, somewhat frail, and very engaging. Because I was still working on my interviewing skills, within 3 visits I knew the history of her life and her family and had anecdotes for each of the “portraits” that hung on the walls of her home. In November, she had written “Happy Birthday, Dr L'Écuyer” on her calendar, after I mentioned, jokingly, that my birthday

Cet article se trouve aussi en français à la page 69.

present to myself would be to visit her on my birthday in December. She insisted on giving me a glass of orange juice, apologizing profusely for not having a present for me. Her husband and daughter were there and I lingered for a while.

For 2 months, Mrs Masson had been complaining of an atypical, vague burning sensation when she urinated. All the test results and examination findings had been normal, and her symptoms appeared to be improving without treatment. The week before the fateful call, she was doing very well, with rock-solid vital signs—"better than my own," I had told her—and the examination was most reassuring.

And now, before me, was a woman I hardly recognized. Not only did she have "double hemiparesis" but her facial features had completely changed. She now had the look that all patients, regardless of their pathologies, have when they are hours away from death. I asked her if she recognized me. Although her voice was unrecognizable, she said yes. When I asked her if she was comfortable, she said that she was. As I left the room, the nurse turned to me and said, "She answers yes to all of our questions."

One of the notes in the file left me stunned: "Talked with family. Patient has had urinary symptoms for 2 months that have not been treated by the family physician. Urosepsis, secondary AF, and embolic stroke."

Still in shock, it was not until the next day that I questioned my judgment. Was I a bad resident? Had I done a poor job of assessing her condition? I pictured a heated discussion with the family—even a lawsuit. I pictured my supervisor criticizing my lack of attention. Without being able to say exactly why, I felt helpless in the face of her rapidly deteriorating condition.

When I returned to the office on the Friday after my on call, there was a note saying that Mrs Masson

was in palliative care. With a knot in my stomach, I picked up the phone to call her daughter. I was not sure whether I was afraid of reprisals or whether I felt inappropriate sympathy for this gentle old lady with whom I had shared a glass of juice. As it turned out, her daughter's voice was warm, almost overly so. She was very happy with her mother's care and relieved that her mother was no longer suffering. I was puzzled, yet I was beginning to understand the value of the relationship of care that I had created with the patient and her family over the months. They trusted me. There was nothing I needed to criticize myself for. I had not overlooked anything.

The following Monday, there was a note saying that Mrs Masson had died. Without quite knowing why, I thought of the resident who would have been called to certify her death. Had she been disappointed to see the family around the deathbed, as I would have been? Was she disappointed that she would have to sympathize with them? Would she have preferred to hurry back to her warm bed? And here was another lesson for me: it is easier to keep a distance. It takes time to transform one's sensitivity into professional empathy.

Just before I wrote this, I called Mrs Masson's husband. He was calm and glad to hear from me. He asked me to be his home physician and to fill the void left by his spouse. And then he started to talk about the weather. I now understood that Mrs Masson and her family had already grieved, after her first stroke. I understood something that my medical training had not enabled me to grasp: people can become serene when faced with death. How lucky I was to have treated this woman. Thank you for these lessons, Mrs Masson. And thanks for the orange juice! 🌻

Dr L'Écuyer is a resident in Saint-Jérôme, Que.



Best French story
by a family physician

The connection

Stéphanie Perron MD CCFP

February 1, 2011

Dear Matthieu,
I am writing this letter to you because I am very touched by your situation. Even physicians who have practised palliative care for 10 years feel sadness when one of their patients begins to deteriorate. This is especially

Cet article se trouve aussi en français à la page 70.

true when the patient has amyotrophic lateral sclerosis and is only 34 years of age. We are taught that we should feel empathy, not sympathy, and yet we are only human and sometimes feel a deeper connection with our patients.

I met you 7 months ago at your home. You asked me if we could call each other *tu*, because you found the more formal *vous* awkward. In your wheelchair, your legs were not working the way you needed them to and your left hand was very weak. Your 2 big dogs wanted to welcome me but because I thought they might be heavier than me, I asked your friend Jessica to let them out the back door while I came in the front door. I found myself standing in front of a charming young man, with bright green eyes and a friendly smile. You are only a few years younger than me. You have a tattoo on your right arm. You have the body of an athlete.