



Stories in Family Medicine Récits en médecine familiale

These stories were collected as part of the Family Medicine in Canada: History and Narrative in Medicine Program, an ongoing project of the College of Family Physicians of Canada (CFPC), supported by donations to the Research and Education Foundation by Associated Medical Services (AMS). The program collects stories and historical narrative about family medicine in Canada for a publicly available online database. The AMS–Mimi Divinsky Awards honour the 3 best stories submitted to the database each year. Information about the AMS–Mimi Divinsky Awards is available under “Honours & Awards Program” on the CFPC website, www.cfpc.ca. The Stories in Family Medicine database is available at <http://cfpcstories.sydneyplus.com>.

Récits en médecine familiale

Ces récits ont été présentés dans le contexte du programme Histoire et narration en médecine familiale, un projet que poursuit le Collège des médecins de famille du Canada (CMFC) sur une base continue, grâce à un don versé à la Fondation pour la recherche et l'éducation par Associated Medical Services Inc. (AMS). Le programme recueille des récits et des narrations historiques au sujet de la médecine familiale au Canada qui sont inclus dans une base de données en ligne accessible au public. Les Prix AMS–Mimi Divinsky sont décernés aux rédacteurs des trois meilleurs récits présentés chaque année. Pour en savoir plus sur les Prix AMS–Mimi Divinsky, rendez-vous à la section du Programme des prix dans le site Web du CMFC à l'adresse www.cfpc.ca. La base de données sur les récits en médecine familiale se trouve à <http://cfpcstories.sydneyplus.com>.



*Best English story
by a family physician*

Hearing hope

Charlie Guiang MD CCFP

She was a nursing student, in her early 20s, when she started as my patient. Diagnosed HIV-positive when she arrived in Canada a few years before. Family in Africa and surviving in the city on her own. I remember her—gentle, soft spoken with a bit of an accent, almost a little scared when I saw her. I got the sense that she wondered why I was helping her, without needing anything in return. Like she'd never been taken care of by someone else, and it was new to her. She seemed almost a little paranoid.

It took a while, but she warmed up to me ... and I to her. She started to make more eye contact. The more that happened, the more I saw something. There was something sad in her eyes. No, she wasn't depressed. I think her eyes saw things I could never imagine in my 33 years of life. She said at one visit that many around her in Africa died of “it.” “HIV, you mean?” I asked. She could never call it by its name. Like when you were mad at someone, you'd say “that person” or “it,” rather than calling the person by his or her real name. I got the sense, after some conversations, that she felt she didn't deserve to live, if others had died.

Her T-cell counts dropped with time, and I suggested she start meds. She would have none of it. And I recalled one of our initial visits, when I explained to her what to expect with time—that her counts would drop and that we would have to treat her before her immune system suffered, before she suffered. I think I remember her saying that she wouldn't go on medications—but I

respectfully ignored it. I thought, as with most, I would be able to convince her, in time, that medications were necessary. I was still a little naïve ... and seemingly wrong.

Visit after visit, she declined to start antiretrovirals. I explained in as many different ways as possible why she needed to start. I tried different techniques. Again ... and again. I even questioned her competence to make decisions ... but I was reaching. She *knew* what she was doing.

I questioned myself. My inexperience. I had only been practising HIV care for a couple of years, after all. My experienced colleague told me it was normal for him to carry, and use, death certificates at one point, when he cared for those dying of HIV and AIDS. And I started my career when really good, tolerable treatments existed. When patients lived. Thrived. Survived. Patients went on medications, sometimes begrudgingly, sometimes welcoming it, most times embracing it once they started to feel physically better. Then they saw their counts rise ... and they noticed that their spirits did the same. What was I doing wrong with this patient? What was I missing? What did I say? What didn't I say? Did she *hear* me at all?

And then, she got sicker. Her skin, once beautifully smooth and black, had more acne, looked rougher, more uneven in colour. She lost weight. She got weaker. She developed pneumonia ... a few times. Once I thought PCP ... but she got through it. I convinced her to take antibiotics, but it was a struggle. It was a struggle to convince her to live. I didn't understand it. I assumed everyone, inherently, wanted to live.

One day, I was running an evening clinic. It was late. I'm sure I was tired ... at least I'll blame it on that. And she was my last patient of the day. Again I tried to convince her to go on meds. I put on a winning act of optimism, even though I felt I had little left in the tank. And she still, simply, declined. And then, another bomb ... she said she had decided to leave the country, to go back

to her homeland. She said she “preferred to die there.” My heart sank. My eyes welled and I fought to keep the floodgates from opening in front of her. I had failed. She hadn’t heard me. As she left, and the door to my office closed, I lay my head on the desk ... exasperated. I felt defeated. Feeling like we had all these things to help her to live ... and ... nothing. Unbeknownst to me, she had returned and peeked her head through the door. She saw me in a way I thought our patients should never see us ... without hope. In her soft, gentle voice, something that had never changed, she said, “Just so you know, I know ... I heard you. I heard every word you said. Everything. All the time. And I thank you for trying. But this isn’t about you. It’s about me.” She left. The floodgates opened.

I never imagined I would hear from her again. It felt like years, although it was actually months, later that I received a postcard. It was from her, from Africa, where she was back with her family. Where she saw many around her die of the same virus. And because they didn’t live, she felt like she didn’t deserve to live either.

The postcard was small. She couldn’t fit a lot on it. But she didn’t need to. She wrote that she eventually went on treatment. It actually said, “HIV medications.” She could now write “it.” There was something bright about her writing, like I could hear her saying the words she wrote on paper. The same gentle voice, slight accent. Still soft. But like she would have been smiling if she had said the words. Her eyes still ravaged deeply by death, but able to see the world with a new perspective. “I was listening,” she wrote. “I heard you.” All of sudden, I was hearing hope. 

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La traduction en français de cet article se trouve à www.cfp.ca dans la table des matières du numéro de janvier 2012 à la page e72.

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*Meilleur récit rédigé
par un résident*

Merci pour le jus d'orange

Geneviève L'Écuyer MD

Le plus gros défi qui s’est révélé à moi au début de ma résidence en médecine familiale fut de gérer l’insécurité. En toutes circonstances, mais surtout lors des gardes. Quel n’était pas mon soulagement, lorsqu’extirpée de mon fragile sommeil à trois heures du matin, l’infirmière au bout du fil me demandait pour un constat de décès. Soulagement doublé d’une satisfaction coupable lorsque la famille n’était pas au chevet; retour à la chambre de garde garanti en dix minutes.

Ceci étant dit, je n’avais jamais pensé être une mauvaise résidente pour autant. Simplement que la gestion de situations urgentes et les longues heures consécutives de travail ne faisaient pas partie de mes aspirations professionnelles. J’étais plutôt du genre à aimer le suivi de clientèle et la santé mentale; je me plaisais à croire que j’avais de bonnes relations avec mes patients.

Mais bon, voilà qu’à une heure du matin sur ma dernière nuit de garde d’une dure semaine de mars, tout chamboule. On m’appelle car un résident doit être au chevet d’une patiente en cardiologie: le médecin traitant a prescrit du métoprolol I.V. du domicile pour une fibrillation auriculaire rapide. À mon arrivée, je feuillette

le dossier et relève les informations pertinentes pour ma note. Dame de 83 ans, admise pour AVC sylvien gauche massif avec FA de novo et urosepsis ... Puis, mes yeux sont attirés par le coin supérieur droit de la dernière note: M^{me} Masson. «Ma» M^{me} Masson!

La dame est une patiente à domicile que je visite depuis huit mois à la suite d’un AVC qui lui a laissé une importante hémiparésie gauche, elle qui était jusqu’alors en parfaite santé. C’est une gentille dame, un peu frêle et très attachante. Devant encore travailler mes habiletés à recadrer mes entrevues, je connaissais l’histoire de sa vie, sa famille et les anecdotes derrière chacun des «portraits» de la maison après trois visites. En novembre, elle avait écrit «Bonne fête D^{re} L’Écuyer» sur son calendrier après que j’eus mentionné à la blague que je me ferais un cadeau en la visitant le jour de mon anniversaire en décembre. Elle avait insisté pour m’offrir un jus d’orange, se confondant en excuses de ne pouvoir m’offrir un cadeau. Son mari et sa fille étaient présents aussi, et je m’étais attardée un peu plus.

Depuis deux mois, M^{me} Masson se plaignait de brûlure mictionnelle atypique et vague. Tous les tests et examens s’étaient avérés normaux et les symptômes s’étaient passablement amendés sans traitement. La semaine précédant l’appel fatidique, elle se portait à merveille, présentait des signes vitaux en béton (plus beaux que les miens que je lui avais dit) et un examen des plus rassurants.

M^{me} Masson était méconnaissable lorsque je suis allée la voir. Non seulement avait-elle maintenant une «double hémiparésie», mais ses traits avaient changé; elle avait ce je-ne-sais-quoi que les patients, toute