

the same as the doctor on Friday. I want to be able to choose whom I see, the person who will listen, and with whom I will feel less lonely.”

And I think that is what Leonard tells us in *Awakenings* when he says,

I have no exit. I am trapped in myself. This stupid body is a prison with windows but no doors I am what I am. I am part of the world. My disease and my deformity are part of the world. They're beautiful in a way, like a dwarf or a toad. It is my destiny to be a sort of grotesque.³

In a way we are all grotesques who can find and feel our beauty in relationship to others who are willing to listen, reflect, and bear witness to our humanity. It is our challenge as physicians to see the grotesque, to

look beyond it, and to see the beauty. That is what our award-winning storytellers have modeled, and I thank them for it.

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Competing interests

None declared

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THE COLLEGE OF
FAMILY PHYSICIANS
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MÉDECINS DE FAMILLE
DU CANADA





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 and Awards” 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 Prix et bourses 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*

Premature

J.P. Caldwell MD CCFP FCFP

A 2:30 AM phone call; pregnant, only 28 weeks, cervix fully dilated. “Come quickly!” I jolt out of bed, downstairs and outside, just remember to go back inside to void. It’s a warm August night in our small town, moonless, with empty streets. I’m impatient at the red lights—all 4 of them—between

me and the hospital, and I wonder if I can go through them. My heart races as I wait for the lights to turn, tapping on the steering wheel to hurry them up.

Twenty-eight weeks—it’s impossible. This baby can’t survive—no matter what you do. I park in the special spot by the OBs’ door, although the hospital is deserted. I race up the stairs.

Our obstetrician is already there. We have no pediatrician in town, so I am the one looking after the infant. It’s a young mother, only 17, and she’s had pain since

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yesterday, leakage of amniotic fluid since then. She didn't realize she was in labour—but now she has to push. She lifts her head up off the bed, holds her breath and grunts, her face turning red. Quickly the baby comes, slipping out in a gush of bloody fluid, slithering onto the bed between her legs.

It's so small.

It's hard to hold, so slippery with the greasy fluid. I suck it out gently, the cord is cut, and I lift the tiny thing up to the resuscitation cart. The nurse and I carefully dry it. It's so fragile, so tiny—eyes closed, spiderlike limbs. It's not breathing, a mottled blue colour.

This is certainly a forbidden sight—looking at human life this young—it's not permitted, almost sacred. It is so close to that fine line between complete dependency and life on its own, that single frightening moment of transition. Tiny, perfectly formed hands grasp vainly at the unfamiliar air, opening and closing in breathless agony.

All pressure is on me. I try to breathe oxygen into the infant with a bag and mask, but the plastic mask is far too large, half covering those closed eyes. The heart rate is 60. It's obvious this baby needs intubation. Intubation! The back of this infant's throat is going to be infinitesimally small—I'm going to try to put a laryngoscope in there? What are my chances? What if I don't? There is no delaying—I extend the head; I lift the tongue forward with the laryngoscope, the blade impossibly huge in that tiny mouth.

I teach neonatal resuscitation—I have been so impressed with it as an essential skill for any family doctor doing obstetrics—but those full-term babies are giants compared to this.

I'm trying to find my way—the infant isn't breathing. That makes 2 of us. My stomach hurts. I am aware of the obstetrician, the nurse, the mother, all watching me. I suck out mucus, try to identify structures—it's hopeless. And I think, how can I possibly do this? I'm not a pediatrician. I'm not a neonatologist. I'm just a family doctor stuck in a very difficult spot. And then I recognize a familiar feeling. This breathless baby is a set-up for failure once again—and it returns, that hollow emotion of inadequacy that family docs know only too well. I can't do it. I'm not trained enough. I don't have the experience. It's too difficult. I'm already disappointed in myself. Again.

What an awful job this is.

I see the base of the tongue—that tiny thing must be the vallecula. I lift it up. There they are—I can see them—that tiny white-rimmed opening—the cords! The tube, the tube—give me the endotracheal tube. The nurse hands me the smallest one we have—but when I put it in I can't see anything else. The nurse pushes on the infant's neck, pulls down on the corner of the mouth—the tube is too tight; it won't go in—it's the smallest one

we have. What else can I do? I can't believe I could be this close and still fail. I can't fail—this baby is dying, right now. No, it's going in; it's slipping in! We quickly take out the laryngoscope, hook up the oxygen; the CO₂ monitor turns colour—we're in—the tube is in the trachea—in a flash the infant turns from blue to pink. The heart rate is up to 110. I hold the precious tube with my fingers to ensure it doesn't shift.

"Good work," says the nurse—but she's not nearly as impressed as I am.

"Good? That's fantastic!" I say.

Things settle down. We weigh the infant—1050 g. X-rays are done; orogastric tube placed; blood pressure recorded. I put an IV in the umbilical vein, and we give dextrose and water. I speak to the Hospital for Sick Children—yes, they will come to transport the baby to Toronto.

"How are you doing with the baby?" the neonatologist asks.

"Good," I say. ("Unbelievable!" I think.)

We bring the mother over—she reaches from her bed to touch her newborn baby, all head and gangly limbs, eyes closed, this alien spacelike creature that has touched her for 28 weeks from the inside out. She smiles, looks from her baby to us, her eyes open in awe.

It's 4 o'clock in the morning. The nurse, at my insistence, makes us all coffee. I'm still holding the tube. We are all giddy with excitement (except, of course, the baby, who is giddy with life). I'm bagging the infant with one hand, holding that delicate endotracheal tube with my other hand, and Mum is still caressing her infant. The nurse, bless her, brings the cup of coffee up to my lips so I can sip away at it. It's a wonderful moment.

What a great job this is.

And then, bagging this baby in the early morning, I realize that there is not a lot of difference between terror and joy—the same intensity, the same power to lift you up or to destroy you. Sometimes they are simply different sides of luck.

The pressure on me was intense—it wasn't the nurse that created this, or even the mother—it was me. I know I will never be able to touch another human being with more potential, with more of a future, with more possibility, than this infant. That's what made the pressure on me so great.

And in that moment I realize how lucky I am—not only lucky enough to be able to help in such a difficult circumstance, but also lucky enough to be allowed to be that close to the elemental forces of life—breathing, living, developing—the very beginning of life, the very essence of being. It's a good moment.

I ask the nurse if I could have another cup of coffee. 🌸

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