A reflection on practising medicine “up North”

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Forgive me for being a cold-hearted physician. I do not think I am, although the following anecdote may convince you otherwise. This week a patient asked me to see her for a medical problem of importance to her and I refused while standing right in front of her. Mind you, I did not completely refuse. I offered the services of the community health nurse or to be rebooked with “the next doctor” the following month. This as I was standing right in front of her.

After spending a grueling three years living and working on one Aboriginal reserve on James Bay in Ontario, I have now chosen to exchange that life for one of being a fly-in physician in the Northwest Territories — a vastly barren, unforgiving and largely uninhabited geographic territory spanning 40 000 km^2 and straddling the Arctic Circle. When I work in the Sahtu region, I am the only physician responsible for all 2500 inhabitants spread across its five communities. I also have the help of competent and experienced community nurses.

While in the region (spanning weeks at a time), I am continuously on call and travelling between the communities. They are fly-in only, and my life revolves equally between clinic and airline scheduling. It is within this context that I experienced the following patient encounter that has left me deflated, feeling guilty and questioning if I did the right thing. It also paints an image of the complex factors that play into the provision of health and social care in northern Canada.

My encounter with her began before I even saw the patient — hours before. I was seeing a police officer as a patient in one of the outlying clinics. Over *her* radio I heard one of my upcoming patients’ names, which I had earlier scanned on my day sheet. I did not know the context but considered it an ominous sign. Later on that day, the patient (Dora) was brought to the clinic by the same officer.

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In the tranquility of my examination room, she explained through her tears that the night before her ex-partner had tampered with the lock into her home, kicked down her door and assaulted her. Not assaulted in the sense of pushing her or berating her, but actually beating her. She presented with innumerable bruises, what I suspected to be a fractured distal radius and abrasions over her entire body. She wore dirty ill-fitting clothes that were too large for her thin frame and gave the impression that this was not her first time experiencing such violence.

I examined her injuries, requested a radiograph (done by the janitor) and splinted her wrist. I asked where she would sleep that night given that she now had no front door. She stated that she would stay at her father’s “camp” in the woods for the time being. Without much to offer, I gave her some analgesics from the nursing station, splinted her swollen wrist and sent a referral to the social worker. This would likely take weeks to make its way through the bureaucratic process. I asked her to return in the morning in two days.

She presented two days later in the late afternoon. My flight was scheduled to leave at 5 pm. Traditionally, in a fly-in community with limited physician access, the last day is the most hectic because requests for prescription refills arrive for review and a signature, nurses request patient reassessments and patients arrive with the hopes of seeing the physician before their departure.

I asked one of the experienced nurses to examine Dora and to obtain the radio-

graph report of her wrist, which had appeared to me to be suspicious for a fracture two days prior. Time evaporated as I continued to work through my patient list and knowing that I was edging closer to my flight time. There were no flights on the weekends, and I needed to be on the only one out that day to be in the next community as scheduled.

The nurse found the radiograph report that had been dictated that morning, which did not indicate a fracture. I instructed him to examine the injured wrist, to consider keeping Dora's wrist in the splint for another week if necessary and to see how she was doing in general. He arranged this, then came to tell me she specifically wanted to see the doctor and was not happy about seeing a male nurse.

I saw Dora in the "emergency department" — a room containing a crash cart and more supplies than the others. I examined her wrist briefly. She appeared inebriated but denied drinking. I explained that her wrist had no fracture, and she was free to leave but could keep the splint on for comfort. She began sobbing, then overtly crying, stating, "But I have bleeding coming out of my bum." This is where I went wrong — maybe. In my rush and exasperation to get to my flight, I explained that I still had booked patients to see and a flight at 5 pm, and simply could not see her for this today. I gave Dora the option of seeing the female nurse or to be booked with the next doctor in one month. Dora kept crying and then said, "But you are the doctor and you're right here." This stopped me in my tracks.

I do not remember the last time that I felt that uncomfortable pang in my stomach. That feeling that I was so deeply in the wrong. I am the doctor. I was right there. While in the region, I was still considered "the one." How could I say that I would rebook her to see the doctor when I was standing right there in front of her?

Needless to say, this one encounter has stayed with me. I feel guilty, I feel ashamed of what I said. I attempted to reason. I attempted to be rational at a time when none of this made sense to a desperate patient frequently in touch with the medical system, yet oblivious to our man-made systematic schedules.

I again offered the options. I again tried to rush the patient out the door. I even opened the door to suggest we were done. Dora asked me to close it. "I deserve some privacy," she said and refused to stand up. She then asked if she could have a hug. Admittedly, after my experiences in remote, sometimes dangerous situations, my first thought was whether this was a veiled attempt to hurt me. Would she strangle me with my stethoscope? I honestly had that fleeting thought.

Part of me is embarrassed, part of me is unapologetic. I was specifically taught in medical school not to hug patients. I was in a room by myself with a patient whom I did not know well. The nurses were in their own rooms with their own patients and no one would even hear me if I was attacked or injured. After a moment, I edged closer and hugged her, gingerly at first. She continued to sob. She smelled of alcohol. Nothing bad happened and, in fact, it seemed that Dora gained her composure and I relaxed.

Thereafter, Dora left. I am not the same physician that I was before meeting her. I learned that the patients I see often seek something other than a medical diagnosis or management plan. They seek compassion, sympathy and reassurance. In coming to see me, patients have hope that I can acknowledge and help to alleviate their struggles, even if this is accomplished by simply listening. In my medical world of scheduling, patient lists, flight times and what seems to be a never-ending carousel of in-and-out, this incident suddenly, unexpectedly, vulgarly highlighted one concept. Somewhere along the path between admission to medical school and three and a half years of practice, I lost my humanity. Not all of it but enough to make me question whether the medicine I practise is even the reason I went into practising medicine at all. Where have I gone wrong? Is it the system or is it me?

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This is a true story, told with the patient's consent. Her name has been changed.

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