

# To Cure Sometimes, To Relieve Often, To Comfort Always

By Dr Tan Yia Swam, Deputy Editor

I am not an expert – the other writers of this theme issue are far more qualified than me! I'm just sharing stories of some of the patients who have left a lasting impact on me, and I hope that I have "done right" by them, and their families too.

**The first death:** I remember the first patient who died while under my care. It was the start of housemanship, in Obstetrics and Gynaecology. Madam A was admitted with a huge distended abdomen and loss of appetite over a period of months. The workup confirmed metastatic cancer of the ovary – she was in her early 60s, and simply couldn't accept the diagnosis. She did not want any treatment, yet she was not well enough to be discharged, having significant shortness of breath, and minimal oral intake. I remember making a referral to palliative medicine, to one of the most-feared doctors then (but that's a story for another time). Before the blue letter could be replied, Madam A died. I was on the way home post-call, and the ward called me to tell me she was not responsive, and there was no pulse. I remember my shock, and my sense of helplessness; why couldn't we have done more to "save" her.

Over the next few years, I think I have become more mature in patient management, and am starting to appreciate the truth of my article title, *To Cure Sometimes, To Relieve Often, To Comfort Always*. I have chosen to train in surgery, to be able to cure patients, to be a "cancer warrior" as one of my consultants put it. Yet, I'm learning that sometimes there's no cure, but we can aim to relieve symptoms;

for example, bypass operations for obstructive tumours in the GI tract or biliary tree. That said, there are times when there is also no more role for palliative procedures, be it surgery or chemotherapy, and all we can do is to help patients die with some peace and dignity. I have also learnt that what I can offer to patients and their families is to ease the transition between life and death, to take away some of the fear and mystery of the process of dying.

**The first open-close:** I was a first-posting general surgery medical officer, and was assisting in the operating theatre on my first night call in the posting. A patient with an acute abdomen, suspected ischaemic bowel was brought in for an exploratory laparotomy. On entering the abdomen, a sickening rotten stench filled the air, and what we saw was frankly gangrenous bowel, both small and large, and even the stomach was an unhealthy white. My registrar then immediately called in the senior registrar, to confirm his assessment that this was incompatible with life, and all we could do was to close up, and send him up to "pass away". The anaesthetist that day was very good. He noted the operative findings, and informed us that the patient was on the verge of crashing. My registrar did the fastest closure I have ever seen. The anaesthetist continued inotropes and escorted the still-intubated patient out to the ward, into a single room and only then, in the presence of the family, did he stop the inotropes and let the patient pass away, surrounded by his loved ones. To the family, it meant a world of difference, to be there with him in his last moments.

**The first terminal discharge:** This was during my neurosurgical posting. An old man, Mr B was admitted for stable head injury. To cut a long story short, his stay became complicated by fluid overload post-transfusion, hospital-acquired pneumonia, acute-on-chronic renal failure and NSTEMI. Two ICU consultants had independently reviewed his condition, and deemed him unsuitable for further ICU admissions, especially since he refused dialysis. After staying for close to three months, over which he got more and more drowsy, breathless, and had increasing oxygen requirements, my consultant told me to tell the family to “take him home”. It took me a while to realise that, this actually meant “take him home *to die*”. At that time, in that hospital, there was no palliative team, or palliative nurse; so somehow, I ended up coordinating the discharge planning and follow-up care. Thank goodness he had a large and supportive family who attended the family conferences, and came to a consensus regarding extent of care, and chipped in money to buy the hospital bed, oxygen supplies, and transport home. I called his eldest daughter one week after discharge to ask if they were coping and to my surprise, she laughed and said, “Dr Tan, don’t worry. My father died in peace three days after coming home. He woke up towards the end, and asked for his favourite *kueh*. We made some and fed him. He played with his grandchildren, and then went to sleep that night, and never woke up again. Thank you very much for encouraging us to bring him home. I was afraid that we couldn’t cope, but I think it made him very happy.”

**The first (and only) post-mortem surgery:** This was really odd. In the later part of my surgical training, there was a patient who died while I was on call. Madam C was known to have metastatic colonic cancer, and was admitted for LOW (loss of weight), LOA (loss of appetite), lethargy and so on. Her symptoms of progressive disease were likely pre-terminal, and the family was ready for her demise. However, when I went to sign up the death certificate, one of the sons firmly requested that I remove her stoma! This was an end-colostomy from her Hartman’s operation.

It was the first time any of our on-call team members had such a request. He explained that Madam C had always hated the stoma, and had often asked if there could be an operation to re-join her bowel. Of course, for a patient with such advanced disease, we seldom perform a reversal of Hartman’s. After checking with my registrar, and explaining to family that all I would do was close the skin over the stoma, I proceeded to do just that. I made a silent apology to Madam C, quickly stitched up the stoma, and then said a simple prayer that she would now be at peace. The family was very happy, and her brother thanked me for doing such a beautiful job, and that, “She is now back to normal.”

**The most intense grief:** A man in his 50s was admitted after being found unconscious at home. CT scan showed a diffuse subarachnoid

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haemorrhage, with gross cerebral edema. GCS was 3 at point of presentation to A&E, and his pupils were on the way to becoming full-blown. My registrar admitted the patient to the general ward and instructed, “DIL (dangerously ill), DNR (do not resuscitate). To sign up as SAH (subarachnoid haemorrhage).” When I went to clerk the patient, I had the sad duty of explaining to the wife regarding the diagnosis, and the grave prognosis. It was terrible. The man had previous hypoglycemic episodes, and she thought that this was yet another one. I have broken bad news before, “*I’m sorry, you have a lump and the report shows that it is cancer...*” or “*I’m sorry, the scans show that the cancer has come back*” and so on, but there is always a treatment option that follows,

“...*but we can still operate...*” or “*but we can still try chemotherapy.*” There was no way out of this. Can you imagine the horrible sinking feeling as you are told that your spouse is going to die in a matter of hours? She broke down, cried, clutched at the body and wailed out her grief, “Why are you leaving me? We worked hard, we saved up, and we are going to tour the world! Our daughter is getting married next year! You cannot leave me alone like this!” I was very affected. When the patient passed away a few hours later, I signed up, and instructed her sister to keep an eye on her, and to get professional counseling help if necessary.

Over the years, I have encountered more and more patients with end-stage disease. In my field, I usually see those with metastatic cancer, or those with post-op complications of AMI (acute myocardial infarction), pneumonia or sepsis requiring prolonged ICU stay, then eventually going down the route of terminal extubation, or sometimes simply not recovering and passing away in the general ward. I feel the loss of every patient as sharply as the first. One learns facts from textbooks, clinical acumen from seniors and human relations from the patients. The bonds of husband-wife or parent-child are the same regardless of age, gender, culture or religion.

I am truly thankful that palliative care is now getting well-established, and that the government has also raised general awareness. I hope that as a surgeon, I can continue to improve my own skills to cure more patients; as a person, I will continue to grow in my compassion and understanding of the ethereal nature of human existence.

Remember: love yourself, love one another, and live every moment to the fullest, because one never knows when it’s the last. **SMA**



Miss Tan is happily settled into her current job. She still meets her fill of rude and nasty people (not all of them patients or their relatives), but somehow, she manages to handle it with a bit more equanimity. Life is too short and precious to waste being upset with people who have unhappy lives and taking it out on everyone around them. She tries to bring a bit more cheer to friends and colleagues, by helping them see the humour (or tragic comedy) in kind of work we do. She welcomes comments at [tys@sma.org.sg](mailto:tys@sma.org.sg)