The Easier Thing to Do

By Dr Lo Hong Yee

All names have been changed.

Tan Ah Moi has an adopted son who lives overseas. Not much is known about their relationship but it is said that he was responsible enough to settle her into a comfortable nursing home before he left. She has $4,000 in savings which she has willed to the home. At 100 years old, she has outlived many of her relatives and friends. Her eyesight, hearing and memory are also beginning to fail her. She keeps $200 in a purse which she hangs around her neck all day. She spends most of her time thinking, although nobody knows what is exactly on her mind.

One day, Mdm Tan stopped eating. Usually quiet, she became more withdrawn and lethargic. The nurses who looked after her decided that she was ill and required hospital treatment. This is a common occurrence at nursing homes. Many residents spend their last days in these facilities. For some, they just do not wake up in the morning. For others, a brief illness occurs, they are sent to the hospital and usually do not return. It was unspoken, but the nurses knew that this might be the last time they would be seeing Mdm Tan, as they helped her into the ambulance. She is, after all, someone who has lived through both world wars and probably sang four national anthems – "God Save the King" (British), "Kimigayo" (Japanese), "Negara Ku" (Malaysian), and finally, "Majulah Singapura".

At the A&E, the VHF radio crackled with information about an elderly lady with severe infection who would be arriving within ten minutes. At 42 km east to west and 35 km north to south, it does not take very long to get from point A to point B in Singapore. After a routine handover by the paramedics, the treatment that followed was almost mechanical. It did not resemble any of the dramatic loud and chaotic scenes in the TV drama *ER*. Unlike *ER*, the best A&E departments in real life are calm, quiet and organised places. Unfortunately, most A&E doctors also do not look like George Clooney. They are, nonetheless, decent folks who look after the hordes of patients to the best of their abilities. Mdm Tan underwent a thorough physical examination, and IV cannulas and a urine catheter were inserted. She received much needed antibiotics and fluids. Routine x-rays were done and the on duty surgeon was summoned.

Dr Yi and I were the surgical registrars on call. Dr Yi placed her hand on Mdm Tan's abdomen and elicited a grimace on the wrinkly old face. The diagnosis was apparent – an infection that originated from the abdomen. A CT scan showed the exact source of her infection – a perforation in the sigmoid colon. Faecal peritonitis is a surgical condition that warrants a priority one flat out emergency operation. Every surgical registrar knows the consequences of delay for such a condition – a dead patient and a gruelling M&M session the following week for the registrar involved.

Once the diagnosis was made, the remaining decision making pathway became like a corner kick in soccer – a set piece, something that can be practised and rehearsed. Mdm Tan had a hole in the bowel which needed to be fixed. Yes, she was 100 years old with dementia. But she was still reasonably healthy and could brush her teeth and feed herself. In Medicine, the chronological age is less important than the biological age. A 45-year-old patient with end stage renal failure, uncontrolled diabetes and three previous strokes which left him completely bed bound versus an 80-plus-year-old man who is still writing books and enjoys his daily exercise – you get the drift?

Mdm Tan was resuscitated with intravenous fluids and soon after, whisked to the operating theatre for the surgery.

The anaesthetist on duty, Dr Lim, was a senior consultant who has been in the system for some time. He goes about his tasks with a serenity that says "been there, done that and bought the t-shirt". Nothing fazes him, and certainly not this extremely sick centenarian. He dutifully went through Mdm Tan's laboratory results, completed the mental checklist for a safe general anaesthesia and spared no time in "putting the patient under". While doing all that, he was chatting nonchalantly with the nurses and surgeons. Having spent more than 10,000 hours "putting patients under", it has become reflex for him. Like chess masters, top athletes and elite pilots, senior clinicians can sense that there

is trouble brewing, although they are unable put a finger on it sometimes. This comes from 10,000 hours of pattern recognition.[1]

Just as he was about to intubate Mdm Tan, he mentioned, almost in passing, that perhaps, the easier thing to do was to operate on her. I gave it a thought and agreed that indeed, it would be more difficult to make the call that the surgery might not benefit her. Having lived for a century, staying alone in a nursing home with no kith or kin, demented and dependent on nurses, Mdm Tan might have spent her time thinking about the misery of her existence. We also know from experience that many of these patients will end up staying in the ICU for a long time. And when they cannot come off the ventilator, we pull the plug. In effect, we merely prolong her misery. If she does make it, she might end up with a hole in her throat, a tracheostomy, to help her breathe. Her nursing home might not want to take her back since nurses there are not trained to handle tracheostomies. She then ends up as a ward of the state, breathing through a hole in her throat, fed through a tube in the nose, and totally dependent on nurses to care for her. Most of us wouldn't look forward to such a state of existence. Why then, do we "inflict" this on our patients?

The operation itself was uneventful. We found the hole in the sigmoid. As the surrounding tissue was unhealthy, the entire sigmoid colon was resected. We did not hesitate in creating a stoma for Mdm Tan. A stoma is a temporary opening in the abdominal wall that allows the faeces to be diverted into a bag. To join the ends of the bowel for sick patients like Mdm Tan is to play with fire because the risk of an anastomotic leak is high. In addition, for bed bound patients, stomas offer a better quality of life than diapers. Imagine a typical bed bound patient who soils himself. It might be hours before his caregiver changes his diapers, leaving him lying in his own faeces for longer than he might want. A stoma bag stores faeces in a bag that can be emptied daily with minimal odour and skin irritation. The patient's perineum remains fairly clean because urine is well absorbed by the diapers.

Mdm Tan taught me a few things. Much as I hate to admit it, it was indeed the easier option to operate on her. To make a clinical judgement that she might not benefit from surgery and let her perish was a more difficult path to take. However, many, including myself, would continue to feel uncomfortable in letting terminal patients go. One reason is perhaps there is a slight conflict of interest in making this decision. If I chose not to operate on Mdm Tan, it meant I could have spent the time resting and sipping coffee. So when I make the decision to withhold active treatment, I need to satisfy myself that it is indeed for the good of the patient. The easiest way to resolve this conflict of interest is to operate. After all, Mdm Tan had all the indications for an operation. I suspect that is the same for many doctors and patients in the hospital. Relatives of terminally ill patients feel the need to do something for their loved ones – the natural thing to do is to admit them to the hospital. Doctors on the receiving end feel obliged to do something for these patients. Admitted to a discipline with go-getters (such as General Surgery), patients are bound to have something done to them. Even now, as I do my daily ward rounds and make decisions to minimise blood taking for some terminally ill patients, it is always tempting to want to do another blood test or another x-ray, just to see how things are. Somehow, to do nothing, also known as masterly inactivity, is not as easy as it seems.

The second lesson I learned from Mdm Tan was found in the sigmoid. Apparently, the hole was caused by a tablet. When we cut open the resected specimen, we found a single tablet with its blister pack intact. The blister pack had been cut and had sharp corners. When swallowed whole, the sharp corners perforated the colon and caused her to become sick. Nobody knows what really happened. It is easy to postulate but getting to the bottom of things requires a full investigation. What was the easier thing to do? To report to the Ministry of Health so officials can do spot checks on nursing homes? Or to ignore it and assume that Mdm Tan was demented and she could have swallowed anything, from safety pins to fish bones? She could have even cut the blister pack herself and swallowed it. Nobody would pursue this matter for Mdm Tan. In my opinion, it is easy to be self righteous and assume that the nurses at the home were careless and therefore, report them to the authorities. It is also easy to ignore it; after all, doctors should just do what they do best – treat the patient. Other departments can handle the social circumstances and investigative work. There truly is no easy answer.

The final lesson I learned from her came as a surprise. She was remarkably feisty. Against all odds, she survived the ordeal and returned to the nursing home with a stoma. This is not so much a vindication of our decision to operate on her, as it is a reminder of our limited role in the grand scheme of things. As healthcare professionals, we make clinical judgements and treat patients to the best of our abilities and conscience. While we can predict the outcomes sometimes, patients surprise us time and again. Without sounding too fatalistic or religious, it feels as if there is a higher being who decides the final outcome. This is not to say we throw away evidence-based medicine. Rather, we should strive to be as scientific as possible, but acknowledge that it is not the pride of knowledge, but humility of wisdom that sometimes guides us best in our practice. As newly minted doctors, most of us started our careers as humble house officers. We quickly learned our place in this hierarchical fraternity – it is good to appear meek and avoid trouble. Hubris sets in insidiously as one advances in his medical career. It is easy to say that we should remain humble.[2] In practice, it is tougher than scaling mountains. SMA

Notes

1. Gladwell, Malcolm. The 10,000 Hour Rule. In: Outliers: the Story of Success. New York: Little, Brown and Company, 2008.

2. Humility is difficult to define. It has nothing to do with being introverted and is not to be confused with a lack of self confidence. The best person to ask if one is humble is the person in the mirror. Introspection is the beginning of humility.

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