EDITORIAL

What a surgeon goes through when managing a complex case: An account of a surgeon's compassion for his patient

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East Cent Afr J Surg. 2023;28(1):1-3
https://doi.org/10.4314/ecajs.v28i1.1

Introduction

Surgeons encounter numerous challenges and clinical situations that cause emotional distress; however, few patients and caregivers are aware of such. The loss of a patient or the development of an unfavourable outcome can be devastating to a surgeon. A personal account of such is given in this narrative based on my interaction with a patient under my care.

Medical treatment

A 38-year-old infertile woman was referred to our hospital after a myomectomy resulted in complications that required the expertise of a consultant general surgeon. This arose after a myomectomy procedure complicated by the development of peritonitis secondary to anastomotic leakage. A second operation was necessary, so she was referred to us. The referring general surgeon contacted us during the second surgery for peritonitis, and we went to the district hospital.

The atmosphere in the theatre was tense: The theatre team did not seem to think that the patient would survive this second operation. The consultant anaesthesiologist stabilized the patient; her vital signs and urine output improved. The theatre nurse set up the instruments for the operation, and I began. The patient responded positively to the stabilization interventions.

I had enquired further about her. She had been married for 9 years and, in addition to being infertile, was HIV positive. Her CD4 count was low, indicating that she had AIDS, which increased the risk of serious infection, delayed wound healing, and could lead to death. Ideally, the initial operation should have been delayed until the CD4 count had improved. The goal in such patients is to perform damage control surgery. I was confident of a good outcome because I had successfully performed this operation many times.

With permission from the anaesthesiologist and nurse, I performed damage control surgery with a right hemicolectomy, abdominal lavage, end ileostomy and colostomy, inserted abdomen drains, and closed the abdomen in layers.

The patient recovered in the intensive care unit and was on appropriate treatment, including mechanical ventilation. She responded well to treatment, was extubated, and was moved to the general ward. Commencing oral feeding was a challenge because she had short bowel syndrome, and her abdomen was only just recovering from sepsis. As a result, she developed intestinal failure causing malnutrition and anaemia, worsened by her advanced HIV/AIDS. Her CD4 count dropped further. We began the recommended treatment for her condition, but the response was minimal.

Usually, the small intestine absorbs a large volume of intestinal juices. A total of 11 L per day passes through the intestines, and all of it is absorbed except for about 300 mL, which is expelled as stool. The patient had an active ileostomy, and fluid was replaced intravenously. She lost a lot of water, salts, enzymes, and proteins, resulting in malnutrition, anaemia, and delayed wound healing. The loss of fluid resulted in kidney failure, which was difficult to manage. Normally, an ileostomy is closed after a total duration of 6 to 12 weeks (as standard; however, early closure at 2 weeks is now considered safe and is practised at our centre).

We attempted early closure of the stomas at 3 weeks, but the abdomen was hostile. The stomas were finally closed during the eighth week after her second operation. Postoperatively, she recovered well, had normal bowel habits, and went home 2 weeks later.

She was readmitted with kidney failure 10 weeks after her discharge. Her entire body was swollen, and she was put on dialysis. Unfortunately, she died after her first session of dialysis.

Personal history

Nosiku (not her real name) became so comfortable with me that she would demand that I see her every day. I obliged, including on weekends.

I spent time counselling her on her situation and telling her to remain positive throughout her admission. As we interacted more, I found out that she was Lozi by tribe and was married to her traditional cousin, a Tonga by tribe. We spoke Lozi. I would greet her in Lozi, '*Mucwani ka fo? Mwai kutwa cwani kachenu*? (How are you? How are you feeling today?)'. She wanted a child because infertile women have low status and are ridiculed by the community for not being woman enough—for being failures. A real woman is one who can bear children. Nosiku's education and relative wealth were no comfort to her; she needed a child.

Nosiku was the firstborn in a family of 6 children. She struggled to complete her education with the little support that her parents could provide her. Government bursaries later enabled her to go to university. She sold scones in the street to help pay her own school fees and to help at home. Her father worked, but his pay was not enough to meet all the necessary expenses.

Upon finishing university, Nosiku found employment at the biggest mine in Zambia, where she worked as a senior executive officer. She supported her siblings with her salary. She followed the Lozi custom of giving her first pay cheque to her parents and spending the earnings that followed on supporting her siblings so they could finish school and find employment. She worried that, without her, they would not cope. If she died, what would become of them?

She told me about how she met her husband and the events that led to their marriage. She told me how, as a young and naïve woman, she prayed for relief in the form of a rich man who would notice her and marry her. As it turned out, the man she described as the most handsome on earth, kind, funny, and supportive of her endeavours, whom she married 3 years later, came from a background as humble as hers. They were childless.

Her husband's kindness, support, and love showed themselves when she was admitted to hospital. He was always by her bedside, taking care of her. I have not seen many men do this, especially during illness. Usually, women are the ones who take care of their husbands, not the other way around.

Nosiku was a determined woman with a strong will to live and to achieve her dreams, so much so that when she was told that she had fibroids, that this was what was making her infertile, and that surgery could fix the problem, she and her husband were overjoyed and were willing for Nosiku to undergo treatment. Her husband had told her that a child would come at a time appointed by God, and so they had to be patient. Nosiku loved her husband deeply for such understanding.

Nosiku was not on good terms with her mother, and her account made me understand why. Nosiku's mother had given up on Nosiku walking out of the hospital alive; her mother was convinced that it was a matter of time before Nosiku died. She was opposed to Nosiku's marriage. Her mother did not trust Nosiku's husband because she was convinced that he was a gold digger and had married Nosiku for her money. Nosiku held a senior position at her place of work and earned a higher salary than her husband. Her mother had hoped that Nosiku would get a rich man who would solve the family's financial problems.

One day, I found Nosiku in tears because Nosiku's mother had visited her in hospital. Her mother had said, in the presence of Nosiku's siblings and husband, 'My daughter, you are extremely sick, and you are dying. People who suffer from conditions like the one you have never walk out of hospital. Since you are going to die, please share with us your wealth so that your family can benefit from your hard work'.

I stayed quiet and just listened to her story. I was overwhelmed with compassion. There were so many things against her, but we—her doctors—were hopeful. I did not know how to comfort her or what to say, except that if she did not give up on me—her surgeon—I would not give up on her. I promised to do everything in my power to enable Nosiku to go home alive. I told her that there was every likelihood that the treatment would work.

Nosiku learned that her medical insurance and that of her husband put together would not be enough to cover the cost of the treatment she required, and she did indeed get a letter indicating that she had exceeded the benefit limit of her medical insurance and that she must pay the outstanding amount herself. The hospital wrote a letter, drafted by me on behalf of the executive director, explaining the surgical treatment she was receiving and the recovery she was making that would culminate in the reversal of her stomas and, finally, her discharge from hospital. In response, the general manager of the mine, accompanied by other senior personnel, visited Nosiku at the hospital to ascertain the facts. Encouraged by the way she was recovering, the company agreed in writing to pay her bill. This gave her tremendous joy and hope.

In the week of her discharge, I wrote a letter to her employer summarizing the treatment given to her and thanking them for their support of her. The bill for her treatment was substantial and was fully paid by the company. The hospital organized a little send-off for her. She left the hospital in a company car from her workplace. This was the first time that a patient with her condition ever walked out of the hospital. I was a young surgeon, and I was proud of her recovery. I was certain that her treatment would pave the way for many others.

A week later, I rang her to find out how she was doing. She told me that she was doing great! She continued to recover uneventfully at home. I told her that many doctors, along with future patients with similar conditions to hers, would benefit from the lessons learned through her treatment. I suggested to her that I would write about her case and publish it in a peer-reviewed journal. This made her very happy, and she made me promise to send her a copy of the article.

That was the last time we spoke.

The reviews from the district hospital, where she attended the clinic, were uneventful. The last report I received from the district hospital's medical staff, following her recovery from the surgery, indicated that she was doing well. At this point, I did not make further follow-up but advised them that in case of any problems, they could reach me by phone.

According to the attending doctor at the local hospital, the discovery of kidney disease in Nosiku occurred within a short period of manifesting symptoms suggestive of kidney disease. The available kidney function test confirmed kidney failure, which was an indication for referral. When she arrived at our hospital, she was prepared for urgent renal dialysis. Unfortunately, we lost her during the session of dialysis due to severe impairment of kidney function with underlying HIV.

It is not clear what led to the development of kidney failure. Obvious clues were not present early enough for life-saving interventions. However, evidence of kidney disease is detected late when usual kidney function tests (measurement of urea and creatinine) available in hospitals are used, especially with underlying HIV. Glomerular filtration rate measurement, which can detect early kidney disease, was only available for research and not for use in clinical practice in our setting. This was the case for Nosiku.

Conclusion

I have kept my promise and have written a piece about Nosiku for publication in a medical journal. I have also written this account to remind us of the human being who was our patient. Hopefully, it will be published, and I will have fulfilled all aspects of my promise to her.

Editorial

Competing interests: None declared

Received: 1 Mar 2022 • **Revised:** 23 Jun 2022

Accepted: 26 Sep 2022 • **Published**: 29 Apr 2024

Cite this article as: Kazuma SME. What a surgeon goes through when managing a difficult patient: an account of a surgeon's compassion for his patient. *East Cent Afr J Surg*. 2023;28(1):1-3. doi:10.4314/ecajs.v28i1.1