

The
Surprising
Lives *of*
Small-Town
Doctors



edited by Dr. Paul Dhillon

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...

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University of Regina Press

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SASKATCHEWAN

To my Sarah

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Foreword

It is estimated that nearly 60 per cent of humankind will live in an area defined as urban by the year 2030. Not unsurprisingly, there has been a growing focus on the relationship between urbanization and health; our cities are busier, more auto-dependent, and more isolating than ever, which has driven up rates of chronic disease, mental health concerns, and societal upheaval. As economic and cultural drivers, cities attract enormous amounts of attention from governments to ensure that their contribution to nation-states continues uninterrupted.

Yet for countries like Canada, it is impossible for us to forget the swathes of population that live in remote and rural areas. From the vast frontiers of the Arctic and the North to the lush farmland of southern Ontario and the Prairies, Canadians by and large are defined as much by the hardy men and women in Prince Rupert and Cape Breton as they are by the frenetic pace of Toronto and Calgary. History, economics, and policy continue to sculpt the flows by which Canadians migrate, work, live, and play in our vast and diverse country, and these factors in turn influence their health and the nature of the health care they receive.

As a third-year medical student, I drove through northern Ontario to a rural rotation in family medicine and public health in Kenora, Ontario—a beautiful town where Winnipeg was the city, and where you could follow up your suspect flu cases just by shopping in the local Safeway. Rural living provided me with a different perspective on Canadian culture, history, and potential,

and also on the essence of human nature. I imagine the stories in this book will do the same for you.

We are fortunate to live in a nation that, for those of us who call it home, affords us the freedom to choose from any number of tapestries on which our lives can unfold—from Arctic tundra to untouched coastlines, from boundless prairies to concrete jungles. The stories in this book celebrate not only our national identity but the national spirit that drives us ever forward, believing that in diversity lies our strength.

—*Dr. Lawrence Loh*

Associate Medical Officer of Health, Peel Public Health
Adjunct Professor, Clinical Public Health, University of Toronto
Director of Programs, The 53rd Week Ltd.

Message from the Society of Rural Physicians of Canada

A need to tell and hear stories is essential to the species Homo sapiens—second in necessity apparently after nourishment and before love and shelter. Millions survive without love or home, almost none in silence; the opposite of silence leads quickly to narrative, and the sound of story is the dominant sound of our lives.

—Reynolds Price, *A Palpable God*

Rural Canada is a breeding ground for stories. Rural medicine is a fertile breeding ground for stories. When rural doctors and patients get together, stories abound. When rural doctors get together, the telling of stories becomes epidemic.

Patients use stories to illustrate their problems. An old trapper once told me, “I can still write my name in the snow when I pee, but it’s awfully close to my toes!”

Doctors use stories to help patients understand their diagnosis, treatment, and recovery. Inuit relate easily when told, “If your son stops barking like a seal, his croup is getting better.”

Doctors tell stories to other doctors to share adventures and experiences. The Society of Rural Physicians of Canada (SRPC) is the national voice of Canadian rural physicians. Founded in 1992, the SRPC’s mission is to provide leadership for rural physicians and to promote sustainable conditions and equitable health care for rural communities.

On behalf of its members and the Canadian public, the SRPC performs a wide variety of functions, one of which is fostering communication among rural physicians and other groups with an interest in rural health care.

Stories are the best way that I know of to communicate, and the hallways and lecture halls at rural conferences are alive with the sound of stories. We are always amazed at how well we can relate to other rural docs, whether Australian, South African, Kiwi, Pacific Islander, or many others. It is shared experiences and shared stories that make this happen.

I trust the stories in this book will contribute to the great practice of rural medicine and the even greater practice of storytelling.

—*Dr. Braam de Klerk, CM, MB, ChB*
Past President
Society of Rural Physicians of Canada

Preface

For a writer, where does the physical book emotionally begin? In the case of this book, I remember the moment exactly.

It was a chilly but clear-blue-sky day in rural Saskatchewan. A phone call from the nurse had awoken me from my Saturday morning slumber and I trundled over the short drive to the hospital to see the patient who needed some care.

“It’s really nothing,” I overheard the sprightly ninety-two-year-old state emphatically as I was ushered into the examination room. “I don’t see why you had to call back the doctor.”

After introductions were exchanged, and sleep was wiped from my eyes, the story leading to the patient’s arrival at the emergency department became clear. She was simply chasing away some stray cats from the milk she was putting outside for her cats and had slipped and fallen on her wooden steps. The resulting fall had not broken anything but had shorn a large area of tissue-paper skin off of her shin. As I was crouched down on the floor, carefully examining the large defect, I began some peripheral chatter about her living conditions and social circumstances. Surely she was not living out in a small wooden home in the middle of the prairies on her own at her age?

She continued her story as I patched and quilted my way around the wound, trying to repair the damage. She had been a war bride, had a life full of harsh winters punctuated with mosquito-ridden summers, had experienced immigrating to a new land, with all its pain and suffering and loss, and now had children scattered across Canada.

While doing my mending work, I realized in that moment that, as alone and isolated as a new rural physician can be, it is a gift to be able to share moments in the lives of Canadians, both recent arrivals and the long-established, that are shaping this great nation. Canada is a vast country, and as rural physicians, we are blessed with the challenges that this environment provides, in that we are given an opportunity to provide care for those that are the stitches and thread that bind together the patches of humanity that together make up Canada. In that moment I realized we are not the same without each other, and that without each other we cease to exist as a nation from coast to coast to coast.

That moment—when my patient shared her stories with me—is the place where this book emotionally began. And as I wrote out on her preventative medicine prescription, “stop chasing stray cats,” I wondered if elsewhere there were physicians that felt the same way I did.

As it turns out, there are. There are physicians across the country silently sitting and listening to their patients’ stories, empathizing with their pain, and then smiling at the successes of their quiet daily work. Unnoted beyond their communities, they continue silently. It was only after searching hard that I was able to find and pluck these individuals away from their work and to convince them to write openly—to share their secret fears and their individual moments of clarity and victory over the scourge of disease and the misfortune of injury. It took the guts of a year to find them, representatives from every province and territory of Canada. In some cases it was more happenstance than hard work that allowed this book to become the collection of experiences that it has become—such as a chance discussion with an American in the United Kingdom who happened to be married to a rural Quebec physician.

Now, almost three years after treating my elderly patient’s shin, we have this wonderful tapestry of stories. Forty physicians in Canada, both old and new, have provided a pivotal piece of

the ongoing narrative of what it means to be a rural physician in Canada.

Ultimately, however, the question must be asked—but why? Why is it important to share these stories? Are they of any value?

That question begins in the mind of the physician-writer and is answered by your thoughts today. Personally, I believe there is an intrinsic and therapeutic benefit to the physician as a human being to be able to express and share their thoughts with the interested public, which allows for both internal and, much needed, external reflection. Physicians are sometimes seen as being above the remit of normal emotions and life; should we not cry every single time we deliver bad news? In reality, though, we are human and suffer from pain like our patients. We have doubts and fears. We don't know everything. And we are tasked with some very difficult decisions.

Hopefully, through this book we are able to not only share those feelings and emotions with others in the healing professions but also with our most gifted assets, our patients. This book would not have been possible without the trust our patients place in our hands each and every day we go to work. Thank you for sharing your moments, your pain, and your stories with us; together, we are richer for the experience.

This project also would not have come to fruition without the thoughtful and respectably harsh comments provided by Dr. Tommy Gerschman. His comments are a reminder that behind the stories told by each physician lays a network of friends and family without whom these stories would never be told.

Lastly, names, identifying details, and places may have been fictionalized and/or changed in order to protect the privacy and rights of individuals throughout the book. In lieu of any royalty payments, the editor and the authors have agreed that all such proceeds shall go to *Médecins Sans Frontières/Doctors Without Borders*.

—Dr. Paul Dhillon



YUKON

Dr. Aedes Scheer

Aedes Scheer was raised on a farm in southern Alberta and decided to become a veterinarian rather than a doctor after watching Star Trek and seeing the character Dr. Leonard McCoy treat multiple species. She became an animal health technologist, obtained a B.Sc., then tacked on a professional teaching certificate. She taught high school math and science for a few years and during this time she went to the Yukon Territory for a six-week vacation. Twenty-five years later, she still calls the Yukon home. While living in Dawson City, she provided veterinary assistance to the community, as there was no local vet; worked as a mosquito biologist (earning the nickname “Aedes”); served on city council; volunteered for the ambulance service; and started a humane society. She decided at age forty-two to go to medical school and began working as a GP in Dawson City in January 2013.

Friends and Neighbours

After several years of living and working in Dawson City in the Yukon, I decided to return to school to become a doctor. My accommodating husband and I did the long-distance thing for six years and, as I intended, returned to Dawson City. Prior to

this new career, I had held numerous roles in the community. I was part of the town's fabric and possibly even a member of the heralded "Colourful Five Percent."

Although it was highly discouraged throughout my medical training, I maintained friendships with a large portion of my small community throughout med school and residency. As students, we were warned about the perils of getting too familiar with our patients. Sure, I understand that; I have heard it all before. Medicine is not my first profession. I was not a twenty-something med student—I could have given birth to many in my class—but I tend to view these sorts of things as guidelines rather than rules. I continue to see friends and neighbours in the clinic. I think this gives me an advantage when assessing patients. I know their "normal" because I see it displayed in the lineup at the post office and grocery store. I know sizeable chunks of their histories because I have heard these informally while helping put in a garden with a neighbour or sitting on the bench coaching their kids or standing next to them at a funeral. In my experience, people in small communities are accustomed to occupying multiple roles and while the occasional person wants to discuss a rash or some malady in a public setting, they clue in when I say, "How about you make an appointment on Monday?"

I had volunteered with our ambulance service for several years prior to starting medical school. I saw many excellent doctors and nurses arrive in the community but then leave when the lack of anonymity became too much of a burden, or it was too difficult to find a spouse in a diminishing pool of people not yet seen in the clinic. The flipside was that when doctors and nurses stayed completely apart from the townspeople, they missed out on knowing the people they treated. On more than one occasion I recall bringing a local in to the nursing station and reporting that something was not right with the patient. I couldn't quite put a finger on it, but they were not the person I knew in the

day to day. This was often dismissed as interesting but lacking evidence. And, inevitably, the person was medevacked out for something that just needed time to evolve. It began to dawn on me that because I was comfortable living in the small town, plus my spouse was comfortable living there too, maybe I could learn how to be a doctor, and then possibly become a doctor who did not leave.

Small towns being small towns, Dawson's population is somewhat incestuous. We have a saying, "fall together, spring apart"; relationships often form for the cold months but break up once the light and warmth returns and the greener pastures of transient summer workers appear around town. Consequently, Dawson City is tolerant of nontraditional families and a wide spectrum of lifestyles. I first learned about this when I was providing veterinary services on a house-call basis and was asked to euthanize the aging family pet. I would show up to a diverse house full of grieving people all associated with the doggy I was about to put to sleep. By the time I packed up my bag and expressed my last sympathies, I had some additional insight to all the combinations of couples and kids who had been a part of the dog's life. The years of house calls and comforting pet owners have provided valuable background information, as well as ample bedside-manner training, for me in my current role as a GP.

However, just when you think you have the upper hand, do not get too smug. Medicine is utterly humbling and will remind you how little you really know. Even about yourself.

One day, while newly back in town as a doctor working a twenty-four-hour, on-call shift every second day (a "1-in-2 on-call"), the ambulance pulled up with a good friend of mine on-car. He was weak and short of breath and found to be in a narrow complex tachycardia. Bob is a big guy in his mid-forties with a past history of hypertension, smoking, and heart disease with a stubborn paroxysmal cardiac arrhythmia. His vital signs were still holding strong and we tried a couple of doses of adenosine.

This did not change anything. We were about to try metoprolol, as had been done in the past for him, when his vital signs tanked. Now we needed electricity. I tried to explain to him what was going to happen next as the nurse got things ready for an electrocardioversion, but I was not sure he could hear me. To my surprise, he reached out and grabbed my hand and said, “Aedes, I know you so well I can hear in your voice that you are scared and that is scaring me.” Yep. He nailed it. I was scared for him and I couldn’t hide it, even though he was failing quickly. Tears ran down my cheeks and I could not shut them off. He started to cry too. And then, voila! His heart rate settled, his blood pressure resumed a textbook reading, and he sat up. We were wiping away the tears and grinning sheepishly when the nurse walked in. She sort of squinted and clucked under her breath but announced our patient had spontaneously cardioverted.

I had assumed that I had the advantage; I know my patients and therefore I can give them better care. The thing is, they know me too. Apparently, I don’t have a “poker face” when it comes to my friends. I could try to fake a brave front, but that does not seem honest to me. I have decided not to bury what I am feeling. It is a better approach, and I am finding that if I am up front with my emotional state and my patients, I am not caught off guard as I was with Bob. Like fraternizing with our patients, in med school we were counselled against being emotionally transparent with our patients. But then, my patients are neighbours and friends, the very group of people my medical school said we were not supposed to see as patients. So maybe two negatives make a positive? I don’t purport to be anything but human and am therefore subject to the weaknesses and strengths of that species. I am finding there may be little difference between these and that an apparent weakness can become a strength.



NORTHWEST TERRITORIES

Dr. Sarah Giles

Sarah Giles is a geographical error—she was born and raised in Toronto—but she likes to say she hides it well! After completing an undergraduate degree and medical school at Dalhousie in Halifax, she moved to Thunder Bay for residency in family medicine at McMaster University. She has spent the past eight years working as a locum in northwestern Ontario, the Northwest Territories, and Western Australia. In 2013, she completed her diploma in tropical medicine and hygiene and almost immediately put those skills to work in 2014 working for Médecins Sans Frontières/Doctors Without Borders in Myanmar, South Sudan, and Pakistan. In 2015 she successfully challenged the emergency medicine exam. She writes a column for the Medical Post called YoungMD and a blog for Canadian Healthcare Network (www.canadianhealthcarenetwork.ca) called Point of Care: where life meets medicine.

In the Middle of the Night

“Doctor Giles! Doctor Giles! Doctor Giles!”

I tried to figure out who was calling my name. Why was someone screaming my name? Where were they? Where the hell was I? It was all too much to process from the depths of my sleep.

Then it suddenly all clicked. I was in a remote Arctic community doing a community visit. It was the middle of the night. Somewhere in the bed and breakfast I was staying at, someone was frantically screaming my name. I don't think I'd ever been called with that sort of urgency before. Flinging my door open, I found a man dressed in winter gear at the bottom of the stairs. "We need you at the health centre right now!" he implored. I grabbed my glasses and hurriedly started to throw on clothes. Remembering that there was a resident doing the community visit with me, I started to yell his name. "Stephan! Stephan! Get up!" Which room was he in? Screw it, it didn't matter, the entire building must be awake. "*Stephan!*" He emerged from his room, his outrageous curls flopping everywhere. "Throw on some clothes! There's some sort of emergency. Let's go!"

In the Suburban, we got the briefing: a woman had fallen down a flight of stairs and the nurses said she wasn't doing well. I was eighteen months into my career in rural and remote family medicine and I was scared. Luckily, though, I had somehow scored a great resident (who felt much more like a colleague than my student). Shit. Shit. Shit. It was going to be us or nobody. I took a deep breath and tried to stay calm. Could I fake the confidence and skills required to save this woman? I wasn't sure.

When we walked into the room, I knew things were bad. The woman was collared and struggling to breathe. ABCs. ABCs. "Start bagging her," I said before even taking off my jacket. Her heart rate and blood pressure were good, but she looked terrible. She was bleeding from the head. "Put in an oral airway." Shit, she didn't spit out the airway—she had lost her gag reflex. "Sarah," one of the nurses said, "check her pupils—they are sluggish." She was right. By this point, I was swearing out loud.

"Have you called for a medevac? Okay, I'll do it," I said as I watched the resident perform the secondary survey.

“We will need to intubate this patient. What drugs do we have?” I had just done the Difficult Airways Course in Boston and was ready to use all the fancy drugs, but none of them were in the tiny health centre.

“Ativan and midazolam” was the reply to my question. Neither of those drugs was on my algorithm for intubation.

As I spoke to the doctor at the referral centre, requesting a medevac, he told me there was actually one on its way to a neighbouring community and that they could reroute it. The critical care nurse and paramedic would have all the drugs we needed. I sighed in relief.

“Sarah, the patient’s blood pressure is getting really high. And have you noticed that one side of her chest is much higher than the other? I think she has a pneumothorax. I can’t hear breath sounds on one side.” I thanked my lucky stars for having an amazing resident. We quickly needle decompressed the patient’s chest—the “whoosh” of air was just like they said it was going to be in the textbooks—and her vitals stabilized.

Within ten minutes of calling for a medevac in a remote Arctic community, I had the flight team by my side with drugs drawn up. “My angels with wings!” I cried as they had entered the building. That sort of response time is unheard of in remote regions of Canada. Perhaps things would be okay after all?

As I sized up the patient for intubation, I knew it was going to be tricky. As a staff person, I hadn’t actually intubated anyone and now I faced a collared patient! Using the bougie and scrounging up all residual courage, I got the tube on the first try. A wave of relief flooded my body. I realized that I had sweat through my clothes.

“Sarah, the patient’s BP is going up again and I can’t find the catheter we used for the needle decompression. I think it fell out.” *Shit.*

“Repeat the needle decompression and prepare for a chest tube,” I told the resident, chastising myself for having failed to better secure the catheter.

I called the regional trauma centre to let them know about the patient I was sending them. “It doesn’t look good.”

With the chest tube, endotracheal tube, Foley catheter, and multiple IVs in place, men from the community carried the patient, on the stretcher piled high with a ventilator and tubing, out to the plane. I breathed a sigh of selfish relief—we had gotten the patient out of the community and she was alive, but I knew that she likely didn’t have long to live. She would get a CT scan and then the doctors in the big centre would deal with whatever needed to be done. I had done my part.

But I wasn’t actually done. A few hours later, I received a call from the doctor at the referral centre. The patient’s injuries were not compatible with life. A decision had been made to send the patient back to her home community so she could be extubated and die surrounded by her family. I begrudgingly accepted the patient—I was not sure what sort of care she would need and I was concerned that the tiny health centre would not be able to meet her palliative needs. Although I understood the desire for the patient to come home, I also desperately wanted to sleep. I wanted the problem to go away. I was exhausted and had used all my skills to keep her alive, and now I was being asked to do the opposite.

As the medevac team touched down in the community once again, people began to flood into the health centre. There were more people than I could count. Once again, they lovingly carried their friend and relative over the snow and into the health centre. I addressed the family, who then asked me to address the crowd.

“Mrs. Smith has suffered a severe brain injury. Right now, she is only alive because the machines are breathing for her and supporting her vital organs. The family believes that she should be allowed to die a natural death. I will give you all time to say your goodbyes to her before we remove the machines. Once the machines are removed, she may continue to live, but I do not

think it will be for very long. Please, take your time.” I felt helpless. I had tried to keep this woman alive, we all had, but I had failed. And now there was an entire community looking at me. I wanted to run.

I removed myself to the corner of the patient’s room and watched as what seemed like the entire community filed past her bed. After everyone had said their goodbyes, a family member asked everyone to gather into the room. “I would like to say a prayer,” he announced. His prayer asked for God to take care of his family member and the usual sentiments one hears in this situation. As an atheist, I listened quietly and respectfully but in a rather detached manner. That is, until I heard the following: “And, God, thank you for Dr. Giles. Thank you for bringing her to us and for allowing her to give our family member a chance at survival. We are grateful for her effort and her compassion.”

I was stunned. The family and the community weren’t angry with me. They didn’t think I was incompetent. They were actually thankful for my presence. I wondered how such grace was even possible.

As I tried to discreetly brush away my tears, the people filed out of the room. Without needing to speak to one another, I quietly stopped the pump for the IV pressors. With that, the patient’s heart rate and blood pressure quickly rushed to zero. We extubated her and removed all of the tubes that had invaded her body. She was returned to her natural state.

I opened the door to the room and informed the family that she had died the moment we turned off the machines. As they filed past me, the men shook my hand. My body shook with attempts to control my sobs. They were, however, no longer sobs of shame and failure but of relief and thanks.

That day, I realized that perhaps there is more to medicine than saving lives, especially in remote environments where physicians usually aren’t present. If we happen to be there and give a

patient the very best shot at survival possible, maybe that's the best we can do. The people in this community appreciated the harsh reality of life in remote regions, but I was just beginning to understand it.