

Thoughts at the Groin

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The dreaded sheath pull, bane of every interventional fellow's existence. A maligned but critical necessity, it inevitably engenders a visceral sense of discontent amplified by the fact that nurses are unhappy because it disrupts their workflow and patients are certainly not pleased at the prospect of another 4 to 6 hours of recumbence, having already endured a stranger mashing down on their nether regions for 15 to 30 minutes. The only solace may be the certainty of burning off a few calories in the tetany-charged upper body workout achieved by the process.

I was surprised then, to find myself looking forward to pulling the sheath of a particularly ornery patient around 11 PM one evening. My eyelids trying hard to betray me as I drove back to the hospital, I wondered aloud, why? This woman had recently signed out against medical advice, was threatening to sue the staff for defamation (she deemed certain diagnoses offensive), and to be her nurse meant certain accusation of theft. Frankly, it had been difficult to focus on our procedure through her ceaseless diatribe about the individuals who had scarred her life. And did I mention she had *Clostridium difficile*—equating to a veritable silo of those lovely yellow gowns we so adore. To that end, she was quite adept at calling out the minute her nurse had left the room, degowned and hand-washed. Reentry was met with further caustic autobiographical details and a disheartening sense that you had contributed to her tragic life story.

But, could I blame her? Effectively homeless, she had been left penniless by her daughter and sister, was abandoned as a child by her mother, lost contact with her pedophile father at a young age, and had a host of chronic ailments she could not afford to manage. By right, she was angry at a life that had never really given her a chance. And *then*, came the week just passed: she had been diagnosed with locally invasive lung cancer, had fallen and fractured several thoracic vertebrae, and had amassed a reputation that precluded physicians from believing her back and chest pain were genuine. It was at this juncture that her entire anteroseptal myocardium fell prey to an

occlusive coronary thrombus. This pain was real; electrocardiograms rarely lie.

That was when I met her.

Now, driving back to the hospital, the following questions ricocheted through my mind. What could I tell her? Would I be just another suspect face? Would she respond to encouragement? Would she care that anyone cared? Why should she—who was I to her anyway? We had the ability to treat her heart. But the heart of the matter lay in her broken spirit. Could we do anything for that? She had shouted sincerely at the start of the case that if God wanted to take her, she was ready. And as we wheeled her out after the heart catheterization, she said emphatically, “I hope God blesses you all.” Of course, our role was to fulfill our duties irrespective of what God or fate or the mysteries of physiology had in store for her. Is it not privilege enough to be entrusted with the responsibility of negotiating the fate of another's life, or being granted the resources to pursue this role with perseverance? Do we need any further blessing?

Now at the bedside, I settle into my familiar stance, hands secure over her femoral arteriotomy. “Ma’am, you wanted God to bless us—I couldn’t help but wonder, despite all that’s happened this week, do *you* feel blessed too? You had said you were ready to go. Yet, here we are talking to each other because maybe he wasn’t ready for you.” I could see her thinking, and continued: “You had that pain in your chest that led them to find the cancer, which prompted a transfer to our facility. You tried to leave us, but were made to return after fracturing your spine, bed bound, perhaps to assure that you could not escape us again. It was then that you had this massive heart attack just a short elevator ride away from us. The cancer is removable, the spine will heal, the cigarettes you’ve left behind, and social services have found you a roof under which you can mend. But, had you been anywhere else—even at your local hospital for that matter—this heart attack could have killed you. That didn’t happen, did it? Maybe the blessing you sought for us, ma’am, has been bestowed on *you* too.”

I gave her a minute to process this internally. “Tell me, ma’am, what makes you happy? What do you like to do?” She started her story again, but this time, the tone was different. She was intently working through several word game books to improve her

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spelling and was worried the nurses would misplace them from her purse. She was quite proud of her electric cigarette and was determined to stay smoke free. Whether her daughter cared or not, she was determined to remain present and supportive of her only child. She had been upset at her social worker's indifference, but was now grateful for the lodgings arranged for her. Ready to turn a corner in her life, she wanted to proceed without being deemed limited by various agencies. Before either of us knew it, 20 minutes were up. She had hardly been aware of what I was doing.

"Sleep well tonight," I said at the door after handing her a word game book.

"Not yet, I've got a game to finish here!"

Every patient has a story—a constellation of life experiences through which they can meld personal reality with the pursuit of better health in a way that is uniquely meaningful to them. Ultimately, our patient was able to project a positive trajectory that she could recognize as her own best outcome in illness and well-being. My role was simply to catalyze the conversion of her perspective from one of tragedy and pessimism to that of renewal and determination. While my numb hands might argue otherwise, my time at the groin has become a prized opportunity to do just that.

For that half-hour, the patient and I are stranded on an island, with no choice but to be each other's lone support. The stark lack of elements customary to most patient encounters—the white coat, examination table, or aesthetically arranged seating—is rendered immaterial. I ask about factors that make compliance challenging. They ask about challenges in reducing national medical expenditure. I describe the

purpose and process behind our procedures and therapies. They describe alternative therapies, what works and what doesn't. I ask about their families and proudest moments. They remind me to take pride in the possibility that every patient interaction can be a life-altering moment. I suggest ways to balance lifestyles. They make me rethink the state of my own work-life balance. I ask them what they would like to watch on TV. They ask my opinion on which celebrity chef should be sent packing on the latest cooking challenge. I ask them to share the secret to longevity. They ask me how I am finding happiness in my present. I tell them what questions to ask their physicians during follow-up. They tell me about the physicians they have admired most. I ask them to find that one thing that makes them happiest when they get home and do it. They've asked me to join them!

Admittedly, this exchange has the practical benefit of prodding the clock along just a bit faster. But the beauty of its effect lies in its simplicity. No special skill, insight, or predefined point of congregation is required—just 2 people reciprocating acknowledgment of their own humanity, listening and responding in kind. It's an opportune interplay that can transform a seemingly mundane task into so much more than just holding pressure amid thoughts . . . at the groin.



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