Good evening and thank you for coming. It is an honor to share a story from my medical school days and one I have reflected on multiple times.

I was on call and asked to see a patient with leg pain. It was no diagnostic dilemma; he had pain because of arterial disease in his leg, a combination of his age and aversion to any prior medical attention. He had ischemic leg pain.

We hit it off. He was an interesting man, independent, stoic but not stand-off, insightful, and he’d had a myriad of interesting occupations speaking to his creativity. We developed a bond that night, at 2 am in a busy emergency department. He was the type of patient with whom you linger on the social history, just because you want to.

I felt compelled to provide reassurance, that everything would be ok.

But his management proved difficult. Over the coming days I made him my personal project – pushed for multiple re-evaluations by our surgical colleges, dwelled on his case at rounds, expedited radiologic investigations, liaised with our physiotherapist and other allied health about his progress. In medical school we have assignments to write about the non-medical expert roles – the timing worked out that I wrote about being this patient’s advocate, as an example of a job well done.

One afternoon, away at clinic, I received a text from my senior resident. He told me that my patient was deteriorating and required an emergent amputation. I still remember my text “oh, well that just ruined my day”. Those traumatic moments are always engrained in memory. Not sure why I was concerned about the effect on my day – but I think it was the best way I could express my grief.

I went to the ICU post-operatively; but couldn’t bring myself to go up to the bedside. I hadn’t seen a lot of poor outcomes at this point in my training, and this was a tragic to me. I felt like I had failed him.

When he returned to our team, it was clear he was devastated at the loss of his leg. And I was no longer his friend, not because I didn’t want to be, but because I was the face of the medical team that had failed him. He actually asked that I no longer be involved in his care.

The care team told me to pay no attention, he was “delirious”, still recovering from his surgery. But he was grieving.

And I was hurt by this. I became defensive. For our team he became a “difficult patient”. I think we all have had experiences with patients who have felt difficult to work with at times. As a result, his care became fractured. He was seen by someone new each day. Without conservative measures he did become delirious, he had a fall, he fell behind with his physiotherapy. When the time came those rehab applications took a few extra days to get filed.

We likely couldn’t have done anything to prevent the amputation. But afterward, when my patient was grieving, we could have done lots to heal his future –that was the true failing in this story. And at this junction – more than ever – he needed an advocate.

The reason I share this story, is because it is easy to care for a patient when the therapeutic relationship is strong. I still have that medical student reflection saved on my computer about advocacy when I thought I had it all figured out. Before things went awry. Before he really needed me. We often cherish the bonds we develop with patients with whom we have a strong relationship, who we enjoy being around, but I would argue that success in caring for patients with whom our relationship is strained, can and should be equally rewarding. And I hope that by sharing my experience, and my regret for how this case unfolded, we can all have a heightened awareness as future advocates for future patients – during the good and the bad times.

Thank you.