Sabir, Patient 4914*

“Shukren le linqathi.”

“He says, ‘Thanks for saving me,’” explains the interpreter as we approach the bedside of patient 4914. His name, which we usually remember to use, is Sabir. Sabir, the Iraqi policeman who has been with us longer than any other patient in the short history of our facility, is the last patient to be seen on ICU rounds in the Air Force Theater Hospital at Balad Airbase, Iraq. He received a gunshot wound to the abdomen and currently suffers from “abdominal catastrophe,” an uncomplicated term to describe a complicated medical and surgical course that has resulted in an open abdomen, limited enteral function, and a dependence on parenteral nutrition. Bed-bound and weighing about 100 pounds, he is not nearly the man he was when he arrived here.

With an awkward feeling of undeserved praise, I ask the interpreter to tell Sabir, “You are welcome,” and looking at my notes, begin Sabir’s daily presentation to the other physicians of the ICU team. “No significant events in the past 24 hours. Vitals stable. Exam unchanged.” I don’t have a chance to get to the rest of my brief presentation before approaching helicopter, its conversation-deafening and air-reverberating presence easily drowning me out through the tent walls of our hospital, signifies the arrival of yet another trauma victim. We finish rounds on Sabir quickly, examine his abdominal tubes and dressing, write a few orders, and prepare for the arrival of the next patient.

I am a military internist deployed to an expeditionary hospital that cares for injured American and Iraqi military and police members. Most patients here have suffered some combination of burn, blast, or penetrating trauma from gunshots or improvised explosive devices. U.S. troops are treated and removed from the Middle East theater of operations within hours of arrival to our hospital via the medical aero-evacuation system; they leave us with a sense of mission accomplished, perhaps because of assured outcomes at other U.S. hospitals. The relevance of the care we provide to our Iraqi patients, however, is less certain. Iraqi patients usually remain with us for a week or so of stabilizing surgery and ICU care before being transferred to the Iraqi health care system, and we do as much as we can to maximize the long-term chance of success for these patients. We make an effort not to transfer patients until we are confident that the Iraqi medical system can provide adequate care, yet we recognize that medical capabilities in this war-ravaged country are limited. The reality is that the outcome for many of these injured Iraqi soldiers and policemen once they leave our care is uncertain; we rarely learn their fates.

Despite spending more time with our Iraqi patients than we do with our injured American servicemen and women, we are often less familiar with them. Most Iraqi patients arrive at our facility with neither a name nor a background and are assigned a 4-digit identifying number. Sadly, because of injuries, language, and the usual ICU impediments of sedation and mechanical ventilation, many Iraqis are known only by this number during their stay. Patient 4914, Sabir, is an exception to the usual course of Iraqi patients under our care. Sabir has been with us for over 5 months, and his prolonged stay has broken through the common barriers of injury and culture. Many of us, myself included, have come to know Sabir as a person, and his daily presence and the strong feelings that he elicits in those who care for him have made him a fixture of this experience. I have had conversations with Sabir, discovering his past and his personality, and learned that we are the same age. I have even met his family, who travel over dangerous roads to visit him regularly. Through caring for Sabir I have learned a few words of Arabic—“Alam” (pain), “dawa” (medication), and “shukren” (thank you) are often heard from him—and he has learned a smattering of English. Sabir is the most personable Iraqi I have cared for in this often impersonal environment. Unfortunately, our shared knowledge of each other does not transcend the reality of the situation in Iraq. Sabir’s inability to tolerate enteral nutrition makes him dependent on our resources. Transfer to the Iraqi health care system, which cannot provide extended parenteral nutrition, would be a death sentence.

Our ICU rounds deliberately end with Sabir every day, ostensibly for infection control purposes, since Sabir is colonized with a multidrug-resistant Acinetobacter species. However, he is also the last patient seen every day in unspoken recognition that we struggle to care for him—he requires nearly constant attention. His debilitation and inability to do much for himself, and his abdominal wounds that require frequent assessment of drainage and dressings, are significant nursing issues that are physically demanding and that detract from the ability of the ICU staff to attend to other patients. The healing of patient 4914’s abdominal wounds is an arduous process, one that requires frequent trips to the operating room for enteral revision, skin grafting, and drain placement. Separate from the physical burden of his care are the reservations about the therapeutic course we are following. Reluctantly expressed, as if the thoughts should never have entered our consciousness, is the recognition by his American caregivers that patient 4914 consumes a large amount of limited U.S. military medical resources, which are provided via airlift and vehicle convoy through hostile territory for the care of our injured soldiers. In addition, there is a sense of futility to our care, in that the progress of patient 4914 has been slow and troubled by setbacks, such as hospital-acquired pneumonia and catheter-related sepsis. We know he lacks the means by which to leave his home country for care elsewhere, and the care he needs will probably not be available from in-
digilous resources in Iraq for some time to come. We see
in front of us a greatly diminished person, with an open
abdomen, tracheostomy, and unnaturally thin arms and
legs devoid of muscle mass, who consumes much of our
energies, and whose road to recovery, if ever achieved, will
be long. We keep patient 4914 alive for the time being
with our knowledge and capabilities, but to what end? Will
our efforts and use of limited American medical resources
ultimately result in a meaningful life for this Iraqi patient?
Although we struggle with these same questions with our
other Iraqi patients, they are for the most part strangers to
us, numbers without voices, who quickly leave our sight
and our thoughts. Sabir, with his prolonged stay and de-
velopment of a persona, has become an emotional liability
for his caregivers.

Sabir remains with us and continues to become more
of a unique individual, and although he is making progress,
his care remains taxing and his future unknown. In this
trauma hospital, amidst the chaos of helicopters, opera-
tions, and critical care, we keep the wounded alive, both
American and Iraqi. But when the chaos clears, reflection
inevitably occurs. In caring for patient 4914 and others like
him, I have learned that in this war zone medicine for our
Iraqi patients is most safely practiced as a myope, well-
intentioned but short-sighted, to concentrate on the imme-
diate surgery and medication and remain blind to the con-
text of our efforts. While removing pieces of shrapnel,
closing bullet holes, and resuscitating those in shock, we
can feel content in the knowledge of saving lives but can
avoid the unanswerable questions that patients like Sabir
make us ask. Sabir, not patient 4914, has forced us to look
up from our work, through his dogged presence and force
of personality, and see our frustrations and his uncertain
future. As healers, we face the uncomfortable realization
that we are asking ourselves, “Are we truly saving you?”

*Patient name and identifying number have been
changed.

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Disclaimer: The opinions expressed here are those of the author and do
not reflect the views of the U.S. Air Force or of the Department of
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