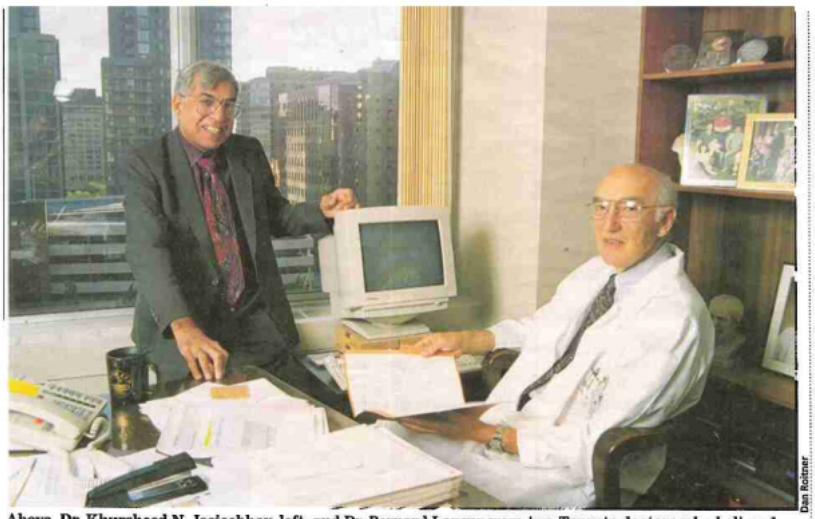

Above, Dr. Khursheed N. Jeejeebhoy, left, and Dr. Bernard Langer were two Toronto doctors who believed more in saving lives than in dying with dignity. Below, Judy Taylor at Toronto General Hospital in 1971.

Dan Roitner

An extraordinary will to live

Judy Taylor was the first person in the world to live without ever again eating a morsel of food, thanks to an as-then-untried technique of artificial feeding developed by a Toronto internist, Dr. Khursheed Jeejeebhoy

Courtesy of Shireen A. Jeejeebhoy

By SHIREEN A. JEEJEEBHOY

"I have no problem going in the ambulance. [But, if] you turn that light on, you turn that siren on, you're to stop, pull over, and let me out!"

Blood and excreta seeping out of her abdominal wound did not stop Judy Taylor from telling the ambulance drivers not to make a fuss. After all, she had never done so: "I had developed some pains in my stomach and, you know, like anybody else, put off going to the doctor, until I nearly passed out in the grocery store."

It was September 1970, and suddenly this ordinary housewife was in the operating room at Scarborough General Hospital having a small section of necrotic bowel removed. In Judy's words, "that should have been the end of things."

But, six days later, the surgeons re-operated and found a previously healthy bowel now grey and friable. They excised her intestines from her duodenum to her descending colon. Unfortunately, they no longer knew how to save her, only how to muffle her pain. Yet her embarrassing, terrifying and fatal condition could not dim Judy's spirited grasp on life. And so they searched for a saviour—and found one at Toronto General Hospital, to where she was dispatched quickly in a last-ditch effort to help her.

Dr. Khursheed N. Jeejeebhoy, my father, an innovative junior internist, had been experimenting with an intravenous feeding system. Upon seeing Judy's emaciated and disembowelled body, he told her husband Cliff, "it's a very dangerous thing. I don't think she will survive." Yet he shared her love for life and understood her need to raise her three daughters and to be with Cliff. He gave her hope, and she christened her new doctor "Jeej" and left everything in his hands.

But, unknown to her, others questioned the wisdom of her decision. Even if Jeej succeeded in salvaging her, what kind of existence was she going to have, with no ability to eat ever again? They worried that he would create a human being with no quality of life.

Not all talked of dying with dignity, however; some believed fervently in saving a life that very much wanted to live. Among them was Dr. Bernard Langer, who explained: "the concern was that she might die of what she had currently. But we knew pretty soon we were going to have to make some decisions about long term."

Despite the challenges—nourishing Judy and curing her oozing abdominal infection—they didn't see any technical or physiological impediments to eventually returning her home.

Those who believed in saving Judy became pioneering members of Jeej's core team and carried out the practical aspects of his vision: a home version of parenteral alimentation that would nourish her completely and revitalize her. Dr. Langer, a general surgeon at TGH, was a key member. In the weeks ahead he resolved two problems: closing the bowel stumps and creating a permanent central line.

While Jeej marshalled his forces, Judy clung to life. As Cliff told Bill Trent of *Weekend Magazine*, "Every night she'd say to me, 'Don't let me die. Please don't let me die.' " Cliff could comfort her, but no one could ease his fears. Every night he left, he "didn't know whether she'd be alive the next day."

Judy also took hope from Jeej and his team members like head nurse Pat (Walker) Little, who changed Judy's putrid, acidic dressings hourly, monitored her alimentation, and spoke soft words. And Judy communed privately with God, which she credited above all else for pulling her through.

I first came to know Judy when she gave my father a highly symbolic guinea pig, which my brother promptly adopted. Later we looked forward to her barbecues; I remember most her laughter and fabulous cookies. She was my father's special patient and I was honoured years later to have her attend my wedding.

Judy first went on alimentation on Oct. 7, 1970, the day after she arrived at TGH. Jeej favoured an alimentation formula that would provide her with all the required nutrients through a permanently embedded catheter in her superior vena cava. But the problems were that researchers knew more about trace element requirements for animals than for humans, and the accepted model of alimentation then was glucose solutions or "hyperalimentation" (hypertonic intravenous alimentation).

However, this American-based model did not fulfil all Judy's nutritional needs. Instead, Jeej chose to put fat, glucose, protein, vitamins, trace elements and electrolytes in her alimentation. "I spent quite a bit of time deciding what people required, based upon what their oral absorption was, what their requirements were, and we converted it all to intravenous form," said Dr. Jeejeebhoy, now on staff at Toronto's St. Michael's Hospital.

He came to call this formula "total parenteral nutrition" (TPN) because, as he explained in the September 1974 issue of *Modern Medicine of Canada*, "intravenous nourishment of a patient can be undertaken ... also with isotonic solutions, in the form of lipid."

This assertion challenged conventional wisdom. The Americans shunned intravenous fat, because the product they had used had been toxic. But the award-winning Swedish researcher Arvid Wretlind had developed a safe intravenous fat emulsion made from soyabean oil, which had been used for several years in Europe. Pharmacia manufactured it as Intralipid. The burning question in Jeej's mind, though, was would Intralipid lead to a fatty liver?

He had to wait three months for the answer. In the meantime, he ordered megadose multi-vitamin injections every three weeks to help heal Judy's malnourished body and daily blood tests (necessary because heparin blocks on central lines did not exist at that time) to ensure her TPN was feeding her properly and keeping her in electrolyte balance.

"Oh God! Not again. You took some this morning!" The hapless nurse bearing the tray of tubes only smiled at Judy's sense of mischief. She knew that despite her fears, Judy always co-operated.

"She had an uncanny survival code," Little explained, and sore arms, black-and-blue buttocks, operations and near-death hallucinations were not going to kill her.

Judy was probably barely aware of the doctors' efforts during this time to help her combat her infections. Eight days after admission, Judy received five days of massive doses of antibiotics. But she continued to drift downward until she had no pulse and no blood pressure when she entered the operating room 15 days after admission.

An infusion of blood raised her pressure, and Dr. Langer and Dr. K. Wayne Johnston, chief resident of surgery, re-incised her abdomen longitudinally. Dr. Johnston recalled: "we were sitting there saying this is the most bizarre thing we've ever seen."

Her duodenum was at one end, a stump of large bowel at the other, both infected and scarred. They were so far apart, they wouldn't meet. The previous surgeon had attempted to sew the stumps together, but they were unhealthy, ischemic, and had fallen apart. All they could do was to oversew them with wire sutures and insert a gastrostomy tube and four drains, the latter to drain the congregating pus out of her abdomen. The drains cured her infection.

In November, Dr. Langer tackled the conundrum of the permanent central catheter for her feeding. He was aware that neurosurgeons were using silastic catheters for patients who had hydrocephalus. They placed these tiny catheters into the ventricles in the brain, tunnelled them down under the skin into a neck vein (or abdomen) and thence into the vena cava or the atrium. "So I knew ... they could stay in the venous system a long time," he said. They were ideal for Judy.

Seven weeks after admission, she again went into surgery. Under X-ray control, Drs. Langer

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