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## Rites of Passage

It was the second week after finishing my internal medicine residency. What a daunting experience it was to be a newly appointed attending physician. My hospital rounds were painfully slow because I would consult the Tarsacon pharmacopoeia and Uptodate prior to writing any orders or making clinical decisions. During this keystone phase of my career I had the privilege of taking care of Ms. S. It has been almost 2 years since, and I still think of her and what I learned taking care of her.

Ms. S was a woman in her eighties with end-stage chronic obstructive pulmonary disease (COPD). She was a frequent flyer, as evidenced by the multiple discharge summaries appended to her chart. Her hospital course was predictably punctuated by frequent inpatient exacerbations of COPD, and every time I told her that she'd be discharged the next day I had to eat my own words. After much effort and pharmaceutical gymnastics she finally seemed to be improving. She went nearly 3 days without a significant exacerbation of her condition. I believed that with my medical prowess, I would be mankind's next savior. As I told her yet again that she'd be discharged the next day, she thanked me and said she hoped not to be readmitted any time soon. Making small talk I learned that she had been a nurse at the very same hospital, where she had spent close to 40 years discharging her responsibilities. "We didn't know smoking was bad back then—everybody did it," she said. I commiserated and assured her that she was well on her way to recovery.

The next day as I zealously sauntered into the hospital, I thought of the fantastic job I had done managing Ms. S's COPD. I mentally patted myself on the back; after all I was a smart guy. As I went into her room, I saw to my utter horror that she was in the midst of a severe COPD exacerbation. I swung into action, barked orders to start nebulizers, gave her a huge dose of steroids, and put her on a monitor. Through the clutter of nurses starting their IVs and the beeping of monitors, she said her time had come and she was ready to die. I gently chided her, assuring her this was just another episode, no different from her previous ones. She looked frail and tired, and her eyes appeared sad and forlorn. I departed from her room to call the resident in the ICU, where I thought surely she would be better served.

The unit unsurprisingly had no beds immediately available. She would be moved as soon as the unit had a bed; meanwhile, the pulmonary physician was on his way to see her. I dashed back to her room to check on her. To my dismay she was in respiratory distress, unable to talk and using all she had just to breathe. On the table next to the bed she had scribbled on a piece of scrap paper: "Let me go please, it is OK." Knowing how exhausted she was, it must have taken superhuman effort to write this. She already had advance directives and was a DNR/DNI, but now she

was precipitously declining in front of my eyes. Visibly trembling, I went to the nursing station and called her sister to apprise her of the waning of Ms. S's condition. I had never been faced with a scenario like this before. Taking time to compose myself, I wrote an order to put Ms. S on a morphine drip. All the while I couldn't shake off a sense of being ineffectual. Was modern medicine powerless to help people like her? I hoped I was doing the right thing. The pulmonary physician concurred with what I was doing, giving me the validation I was seeking.

Her sister arrived expeditiously, and I filled her in on what had happened. She nodded in understanding and stated her sister had always said when her time was up, she wanted to be let go. Her next question was the one I dreaded: "How long do you think she has?" I was evasive, reflecting my discomfiture at being totally unprepared in such situations. "It is hard to tell, maybe 24 to 48 hours, but these things are hard to predict," I answered her. Writing orders for comfort measures, I couldn't help feeling unqualified to be a doctor. This wasn't something I thought I'd have to grapple with.

Soon all of Ms. S's relatives near and far came in to see her. They spent time at her bedside, but the morphine had taken effect. She was sleeping and looked comfortable but was unable to participate in conversation.

The next day as I arrived at the hospital, there was a cloud of dread in my mind. Ms. S probably had passed away some time during the night. At the nursing station, I was informed that the predictable hadn't happened. I went into her room to find it full of her loved ones. Her sister looked haggard but calm, and Ms. S was sleeping. I asked how things were, and Ms. S's sister's eyes lit up. "She woke up at 1 a.m. and spoke to us for 2 hours. We were all able to tell her how much we loved her. She asked about all the children in the family and told us how much she loved them. Thereafter she went to sleep. She woke up at 6 a.m., looked around, and said, 'Why the hell am I still alive?' She went to sleep soon and has been sleeping ever since." Laughter broke out in the room. I laughed with them. This was all a new experience. So Ms. S had closure before she died. Her family seemed content in this sad hour.

Ms. S passed away shortly after that. Her family thanked me for making her comfortable. But ini-

tially I felt I had done nothing much. Then the realization of my role as a doctor finally hit home. Sometimes it is apposite to hold a patient's hand and let the inevitable happen rather than fret on the shortcomings of medicine. It is all right not to over-intellectualize every clinical event. After all it is all about treating people, not a constellation of bodily organs. Sometimes less is more and all that is needed. I always look back on this experience every time I feel smug. Since then I have incorporated discussion about goals of care into my repertoire. Patients with multiple admissions for incurable diseases need special attention. I hope my personal growth involves approaching such patients with the empathy and compassion they need. Having such discussions also helps to prevent the frenzied panicking that usually accompanies the inevitable decline of patients with terminal illness. The increasing emphasis of medical school curricula on end-of-life care issues reflects these sentiments. A growing geriatric cohort with multiple and often chronic medical diagnoses makes these skills indispensable.

My personal credo has been profoundly influenced by Sir Robert Hutchison's Physician's Prayer. I first read it in medical school but revisited it shortly after my experience with Ms. S. To my mind, it is still relevant and serves to keep me on an even keel when making difficult decisions.

*From inability to let well alone, from too much zeal for the new and contempt for what is old, from putting knowledge before wisdom, science before art and cleverness before common sense, from treating patients as cases and from making the cure of the disease more grievous than the endurance of the same, good Lord deliver us.*

Sir Robert Hutchison (1871-1960)

### Print and Online Resources

*Oxford Textbook of Palliative Medicine.*

Center to Advance Palliative Care: [www.capc.org](http://www.capc.org).

American Academy of Hospice and Palliative Medicine: [www.abhpm.org](http://www.abhpm.org).

International Association for Hospice and Palliative Care: [www.hospicecare.com](http://www.hospicecare.com).

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