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Creative Writing

The Veteran and the Rookie

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On the first day of medical school, we watched Abraham Verghese's TED talk about the physician's power of touch in caring for patients. He stated, "I'd like to introduce you to the most important innovation, I think, in medicine to come in the next 10 years, and that is the power of the human hand – to touch, to comfort, to diagnose and to bring about treatment." Now, almost three years later, I still remember how that talk affirmed my desire to enter the medical profession – to touch people's hearts, minds and bodies and have a meaningful impact on their lives. What I did not expect was for patients to touch my life more than I could hope to touch theirs.

One afternoon during the second week of my third-year internal medicine clerkship, my team admitted Mr. H, a 96-year-old World War II veteran, for severe anemia in the setting of gross hematuria. When I asked him his secret to living nearly a century, he replied humorously, "I survived Prohibition in the '20s. I can survive anything."

As I took his history, I learned he enjoyed going to the bakery every morning, driving around town, visiting the salon, and reading the New York Times daily. He found delight in his sense of independence, ability to socialize while running errands, and comfort of his home. However, for the past week, he felt, "blah, just blah."

His children lived a few states away, so he had a caretaker – a neighbor who checked in on him daily. His neighbor had become like a daughter to him over the years. She joined him for lunch and a few hours of good company each afternoon, but noticed he had become increasingly pale, weak and tired. He had lost interest in performing his normal daily activities. When he hadn't shaved his face in three days, the caretaker knew something was wrong and brought him to the hospital. Upon admission, he received several units of blood. A bladder ultrasound revealed a large mass that was highly suspicious for malignancy.

On rounds the next day, I updated Mr. H's caretaker on his ultrasound results while my patient slept comfortably in bed. She listened carefully, then shared with me what the patient had said when he awakened that morning.

Mr. H: "I beat the odds."
Caretaker: "What do you mean you beat the odds?"
Mr. H: "I beat the odds."

The caretaker explained to me that this was his way of saying he recognized the end of his life was near, and knew it was a gift to live one more day.

The urologist saw him that morning, and determined that the only way to stop the bleeding would be to perform invasive surgery. However, he felt that putting a 96-year-old patient through surgery, with the accompanying morbidity during post-operative recovery, was not conducive to maintaining the patient's quality of life. The urologist recommended diagnostic cystoscopy, which could not be scheduled until one

week later.

Herein lies the first fundamental mistake in our care of the patient. As medical providers, we live by the principle "first, do no harm". Why pursue a diagnostic test, with its associated risks and potential complications, if the follow-up surgical management and treatment would ultimately not be performed? Sometimes the best approach is to do nothing at all. Although the patient should have been discharged at this point, the patient received continuous bladder irrigation and several additional blood transfusions while awaiting cystoscopy.

Over the course of the next week, Mr. H put down the New York Times crossword puzzle each morning and pleaded, "This catheter is bothering me. I want it out. Let me go home." I reassured him we wanted to make sure he was stable enough to go home.

In hindsight, from the first moment he expressed his desire to go home, I wish I had asked the patient about his goals for treatment. When I asked about his code status on his initial admission, I only confirmed he was DNR. However, I should have inquired how much, or in fact how little, medical treatment he wanted to pursue, well before extreme measures would be required to sustain his life. With each passing day of his admission, the patient had made it increasingly clear he wanted to go home.

To better gain Mr. H's trust, I spent time hearing about his family, his work as an accountant, and his life as far back as an NYU college student in 1935. Through our conversations, Mr. H and his caretaker came to confide in me when they felt uncertain about the course of his care and had doubts about proceeding with cystoscopy. I updated them on the results of any tests performed that day, clarified recommendations different consulting physicians had made, and relayed conversations we, as a medical team, had regarding his care. They looked to me as their primary means of communication, not only as their messenger helping to coordinate his care, but also as their advocate.

In the evenings, I stopped by Mr. H's room before heading home. When I asked if I could do anything else for him, he continued to reiterate his desire to return home. Each night, I reassured him I would relay his concerns to my attending and update him first thing in the morning. As I bid farewell to Mr. H for the night, his caretaker always reached out to embrace me in a goodbye hug. I soon realized we had all developed a special bond.

Two weeks after the patient's admission, a new attending physician joined our team. I presented the patient's hospital course during rounds, emphasizing the patient's discomfort throughout his prolonged hospital course:

Stephanie: "He complains of a lot of pain. He wants the catheter out and he wants to go home."
Attending: "Why don't we give the man what he wants? Let's send him home."

I felt relieved. I had communicated the patient's desire to go home to the previous attending each morning for two weeks with increasing frustration and desperation. However, the team had charged on actively pursuing medical treatment for Mr. H. Fortunately, the new attending put the patient first. He listened and heard the patient's concerns, recognizing what this proud man already knew early on when he expressed that he had "beaten the odds". I regret that it took us two weeks to respect his wishes, but did finally accept that it was okay for this man to return home to live his final days on his own terms, with autonomy and dignity.

We, as the medical team, should have paused to identify and address our patient's hopes and fears much earlier in his care. Had we listened to his pleas to go home, this patient could have been discharged two weeks earlier. It was our own anxiety and discomfort with recognizing the limits of medicine that kept us from listening.

On the day of Mr. H's discharge, he looked at me with imploring eyes as he asked, "Can I go home?" Finally, I could tell him we had canceled the diagnostic cystoscopy and were making the necessary arrangements to send him home.

Mr. H was sitting up in bed as I stood at his bedside and leaned over to talk with him. My ID badge dangled in the air from a lanyard around my neck,

and he took it in his hands to look at my picture more closely. After a few seconds, he dropped my badge and raised his eyes to meet mine with a warm expression.

Mr. H: "Stephanie, it was a pleasure being here with you. Everyone took good care of me. Thank you."

Stephanie: "No, sir, it was a pleasure having you as my patient and getting to know you. It really was a privilege. I wish the best for you at home."

He smiled, slowly reached out, and gently touched the palm of his left hand to my right cheek. He held my face in the palm of his hand for a short moment, then blew me a kiss. Instinctively, I smiled and blew him a kiss back. I then said goodbye for the last time.

I won't ever forget the feel of my patient's gentle touch. By placing his hand on my face, my patient led me to consider, reflect on, and internalize what it means for a human being to approach the end of life. He knew the end of his life was near, but he felt at peace knowing he would spend his last days in his own home.

We learn in school it is a privilege to practice medicine because we have healing hands that can care for those who cannot care for themselves. I now know our patients have hands that also heal. Mr. H and his gentle hands calmed my anxieties about the limitations of medicine in the face of aging, frailty, and death.

My patient touched me, physically and emotionally, in a subtle but powerful way that has shaped the way I hope to practice medicine. I hope to be direct, respectful, and honest with patients and encourage shared decision-making. I hope to feel less vulnerable and become more comfortable with having conversations about end-of-life care. I hope to treat my patients, both in life and near death, with dignity. Thanks to this dignified veteran, a rookie learned a very valuable lesson.

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