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Creative Writing

End of Life Conversations: The Medical Student's Role

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Mr. A is a 71 year old gentleman with a past medical history of diabetes, chronic kidney disease, obstructive sleep apnea on CPAP, right sided heart failure (ejection fraction of 51%), depression and a recent diagnosis of lymphoma. He presented to the emergency department following a fainting episode in which he had fallen, hitting his head and briefly losing consciousness. He required transfer to the CCU after he became unresponsive, hypotensive and bradycardic (30). He had described worsening dyspnea at rest and upon exertion in the week preceding his fainting episode as his chief complaint upon arrival to the hospital.

We spent all of our energy and time caring for Mr. A's near total body failure. In the midst of this mayhem, I was caught off guard when he described himself as depressed. This claim came out of the blue. "I'm depressed" is all he said. I felt as though I had overlooked his most important organ. I found myself wondering whether depression could suddenly descend upon a person. Had he been free from depression yesterday, and had only become acutely depressed today? When I asked him to tell me more about this, he said, "I'm depressed because my life is ending." I was surprised to hear this claim since I didn't consider him a patient who was about to die. But this was a naïve and uninformed assessment. He was dying. His heart failing as it battled against his damaged lungs. His CPAP machine broken. His body riddled with lymphoma. Chemotherapy had made him near deaf, forcing us to shout back and forth at one another. His belly so full of ascites that his lungs could not fully expand. His respiratory distress had likely overpressured his weak heart creating an arrhythmia or acute hypotension as the cause of his "fainting" episodes.

"Well I died three days ago, so I'm trying to wrap my head around that. And if I died recently then I'm definitely going to die again soon," he said next. I had read the notes on his inpatient code in the CCU, and obviously he had not died. His heart never stopped, and the code was called for non-responsiveness and a heart rate in the 30s. I explained to him, that, "You in fact did not die but came close to dying; the code was called in case things went in the wrong direction. We like to be extra careful here in the hospital." He said, "I thought code meant death." I thought that, too. He seemed pleased to learn that he had not died on Monday and would be discharged on Sunday.

We moved on to the larger topic of his being close to death but not dead. "I was 35 yesterday. And now I'm here and I'm 71. Where did the time go? I always thought I was young and now all of a sudden, I'm old and dying. I'm so old I can't even hear. I guess this whole thing has made me think about my mortality." I thought about making a joke, saying something like, "Yes, but 70 is the new 50, Mr. A," but decided against it because he was close to death. So, I tried to explain it from our perspective. "I think there is hope in the fact that we know what brought you to the hospital, what caused the two fainting episodes, and how to treat you so that they do not recur. The fluid in

your belly is causing your lungs to work too hard. Your sleep apnea and broken CPAP machine is overworking your already damaged heart. We can take some of the pressure off our hearts and lungs with medications, and that should help a lot. It is true that you are getting older, and you have several serious medical conditions, but many, many people have these conditions. We know how to help you continue living the life you want to live. Not like you're 35 again, but like you're 71 and want to spend time with your family and do the things that you enjoy."

He was quiet for a moment and so was I as I wondered if he had heard a word I had just said. Does he know how his heart and lungs work or fail as one? Is this conversation over? I felt an odd feeling of guilt, as I genuinely wished the conversation was in fact over and I could finish his notes before going to an EKG lecture. "Well what about the lymphoma?" Not over I thought. I knew little about his lymphoma diagnosis or prognosis. I didn't even know if he had Hodgkin's or non-Hodgkin's lymphoma, and as he stared at me, I was trying and failing to remember which one had the owl's eye nucleus. So, I pulled out a trusty line, "Well, you're in the right place to have your lymphoma treated." He kept staring me. "You've had only one cycle of chemotherapy and you're scheduled for your next cycle next week. It's going to be a long journey and this current hospitalization is a bump in the road, but together we're working to get you better."

I then remembered some medicine that might return some of my credibility after that non-sense answer. "Your regimen is called CHOP. It's an acronym that stands for Cyclophosphamide, Doxorubicin is the H for some reason, Vincristine is the O for some reason, and Prednisone is the P." 50% of my credibility returned I thought to myself. "That is the appropriate therapy for lymphoma, but those medications have some serious side effects. You mentioned your hearing has decreased since the first round. That is possibly due to taking cyclophosphamide, which can harm your ability to hear. Additionally, you have heart failure and doxorubicin can harm the heart and exacerbate your heart failure." He asked the most logical and difficult question to answer, "So what am I supposed to do about that?" I visualized one of those old fashioned scales and put his heart on one side and a lymph node full of lymphoma on the other and watched it bob back and forth as I thought about what to say next. "I think we need to talk with your oncologist. You are on the best regimen for lymphoma, but maybe it is not the best regimen for you. Does that make sense?" He said, "Yes. Maybe I can be on a regimen that doesn't accelerate my death, that would be nice." He laughed, and I forced a laugh so I could join him.

I spoke next, "I'm going to be here taking care of you for the next few days as you continue to build your strength. Can we keep talking about all this? Your mood and your psyche are just as important as your lungs and your heart." Was that even true I thought to myself. What did that even mean? "That's true," he said and I felt good. Then it occurred to me that, "Can we keep talking about this?" actually means, "Can we stop talking about this right now and maybe talk about it tomorrow?" But we did keep talking about it tomorrow and every time I saw him after that.

He was discharged several days later. In writing up my experience with him, I opened his chart to see that he has returned with "Worsening weight gain and increased work of breathing." I start on the psychiatry consult service tomorrow. I hope he calls me, but also I know nothing about psychiatry. This is life as a medical student. We have incredibly powerful, consequential conversations about medicine, life and death with what sometimes feels like the artillery of a Canadian national park ranger. However, I think our strongest ally is our youth in end of life conversations. As an elderly patient talks to us about death they are talking to someone who is hopefully so far from their experience that they are doing more than just relaying a medical history. They are giving advice to the next generation. They are telling us, and their former selves, what it is like to die. All we have to do is be there to listen.