

Conversations that keep up

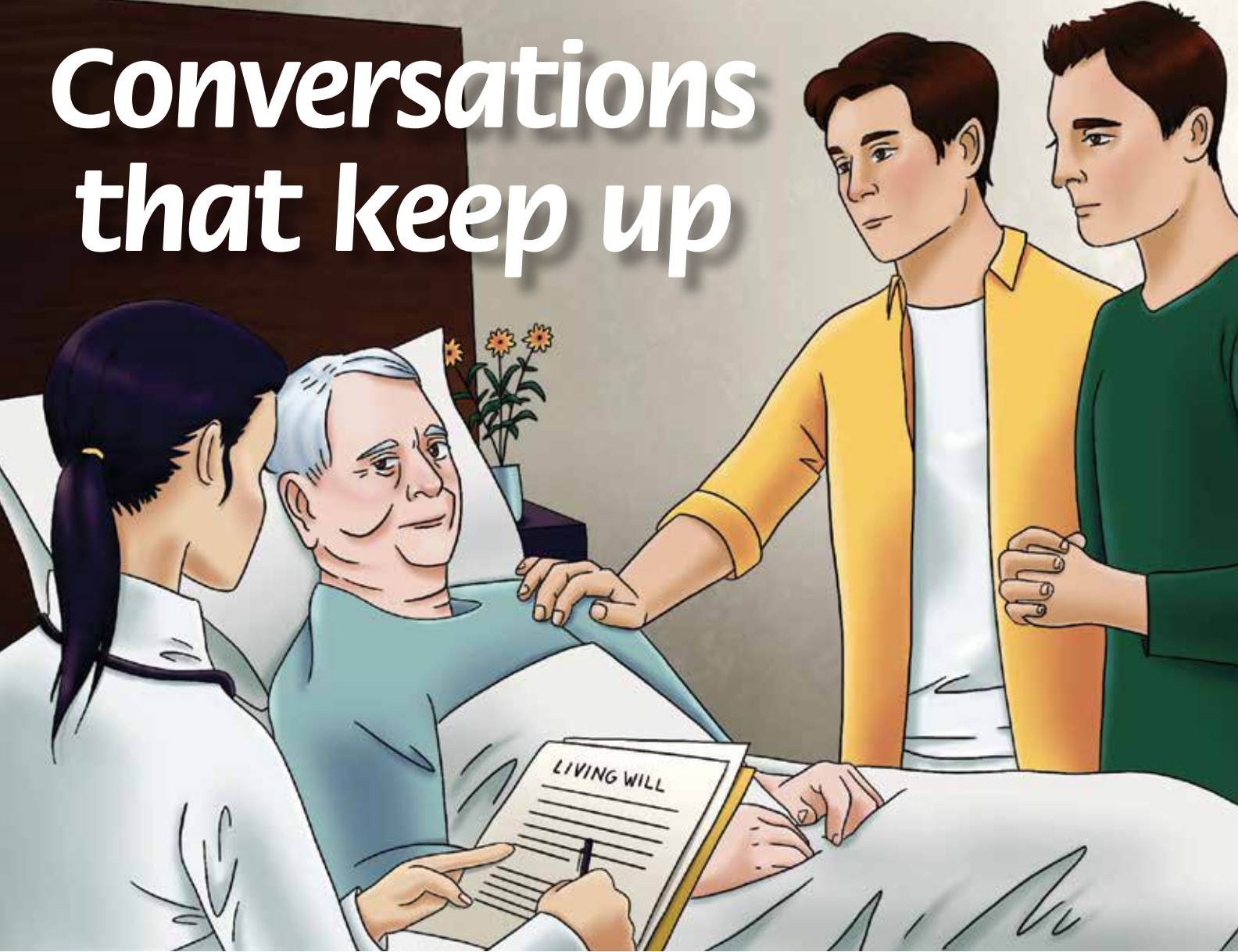


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Mr. Perry sees himself as a healthy 77-year-old. No prior hospitalizations, no medications. He smokes a pack of cigarettes a day and drinks alcohol nightly, but he doesn't see these activities as health issues. He only sees doctors for annual physicals, if at all. He is now experiencing his first hospital admission.

Mr. Perry presents to the emergency department with dizziness, some difficulty walking, and double vision. An initial CT scan of his head is normal. He is placed on a heart monitor and told he will be observed for the night and that they will schedule an MRI of his brain. When asked by the admitting doctor if he would want to be resuscitated if his heart stops beating or if he stops

breathing, he says "of course." He quickly returns to feeling fine, and asks when he can be discharged.

Mr. Perry has two sons. They visit him in the hospital the next morning, with coffee and bagels that clearly didn't come from the cafeteria. They are happy to hear the MRI was normal, except for the arteries in his neck have some plaque. That's odd though, they think to themselves. Why is their dad having trouble holding his phone and why can't they understand what he is saying?

An urgent repeat CT scan is ordered. There are now multiple strokes not seen in the previous brain scan. It's possible that plaque from Mr. Perry's neck arteries are breaking off and traveling to his brain.

I'm the resident physician working in the intensive care unit where Mr. Perry is transferred for closer monitoring. He may also receive intravenous alteplase to break up the blood clots in his brain.

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While his nurses are calling the new nurses, and his medical team is documenting on the computer, I go meet him. I stand in the room as the neurologist tells him all the things we will do—more imaging, more therapies, more exams. The neurologist ends explaining that we will figure this out and get him better.

Working in a hospital, I am constantly reminded of how rapidly someone's health can change. It's possible that suddenly, a seemingly healthy man or woman will become disabled or even face death in the near future. As doctors, we learn how to quickly adapt and provide available medical therapies. We can quickly transfer someone to an intensive care unit or an operating room, and we can start medications that work within seconds. But we often don't stop to help the patient catch up and have the conversations that acknowledge that a change has occurred. I've had too many experiences of pushing this important conversation off until it's too late for a patient to communicate.

I tell Mr. Perry, "I want to acknowledge that your clinical situation is touch-and-go, and may change moment by moment. Hopefully, your brain will stop forming new strokes, but there is a real chance you will continue to have more strokes and it will become even harder for you to communicate." I go on, "You are very sick. It must be terrifying to live with so many unknowns. Is it okay if we pause for a moment and talk about what we are hoping for, but also what we are worrying about? Have you ever thought about what is important to you in life if you are seriously ill?"

He stares at me blankly, trying to figure out if he heard me correctly. "No," he responds.

"Who are you as a person, Mr. Perry?" I ask.

He's skeptical of me at first, but with more questions I'm able to learn that he loves his independence.

"How do you feel about asking people for help?" I ask. Both his sons burst out laughing. Mr. Perry tells me he would never want to rely on people to eat, go to the bathroom, or get dressed. He needs to talk and walk to live meaningfully. He would never want to depend on people or machines.

His sons look surprised that their dad is capable of having this kind of conversation. Perhaps he was always capable, but no one ever asked him these questions. By simply asking him for permission, and by asking open-ended questions, Mr. Perry explored both his hopes and worries about his health.

I thank him for sharing with me, and tell him, "If the worst happens, if your strokes get bigger, if you lose more function, it may not be within your goals to be resuscitated. I hope this does not happen, but it might."

He nods in agreement. I feel his skepticism toward me dissipate. I say, "I know this isn't easy to talk about, but you have given your sons the gift of knowledge. They won't be left making difficult decisions alone. And I am now able to understand and care for you as a person, not a generic patient."

I walk out of the room and inform the nurses of the change FULL to DO NOT RESUSCITATE/DO NOT INTUBATE.

"What?" exclaims the nurse, before I can even explain. "He's just 77!"

Only until recently did I think this way too. If a patient is less than 85-years-old they are young and should be resuscitated, if not, it's their time to go. However, it turns out there are old young people and young old people. What matters are the details—diseases, how they change quality of life, how a patient wants to live, and what they want to do when life no longer feels like living.

I rotate to a different hospital service the next day, leaving me with fragmented patient narratives. Even though those minutes with Mr. Perry and his family were the most meaningful and important of my day, I soon forget about him. Months later, in a moment of fate, I see Mr. Perry's name on one of my patient lists in the electronic medical record. I must have forgotten to remove it. I see the word deceased next to his name.

I read that he survived that hospitalization and went to rehab. At rehab he had another larger stroke. He was not transferred back to the hospital, but transitioned to hospice care and died within days.

I'll never know, but I can hope that our conversation helped provide his sons with the guidance needed to navigate those last conversations with him. I reflect on how too often these conversations are missed at critical moments. Perhaps because we generally avoid difficult conversations, we don't know what language to use, we think we don't have the time, we have more important work, or we have our biases about age and our own end-of-life wishes and fears.

Mr. Perry is a reminder to me that when we believe these conversations are essential, and we make the time for them, we can have a profound impact on the care our patients receive, now and in the future.

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