Taking Care of Ms. A

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I arrived at the first day of my medicine clerkship bright-eyed and bushy-tailed, as the saying goes. I was halfway through my third year, the time when medical students finally stop being nerds who learn only from books and start being nerds who learn by reading at home and by closely following patients in the hospital, focusing on a given specialty a few weeks at a time.

For most students, the medicine clerkship forms the bulk of their learning during third year. It is where you see the bread and butter of the medical world and learn the basics like managing pneumonia, heart failure, COPD, alcohol withdrawal, and kidney injury.

My first day, on Halloween, was orientation and fairly dry. We got our daily schedules and were introduced to our residents and interns. Later in the day, I admitted a patient whose liver was failing and causing a buildup of nitrogen in her blood, which essentially made her unresponsive. Glad to simply have not looked like a fool in front of my resident, I made a quick escape from the hospital.

The next day was my first full day of the clerkship. I made sure I had way too many pens, my penlight, my ID badge, and, of course, my stethoscope. I touched base with one of the interns, first-year residents who are generally overwhelmed with the demands of quickly learning the ropes straight out of medical school. Ordered to talk to a Ms. A, a recently arrived refugee, I pulled out my phone to dial up the hospital's interpreter service and walked to her room, with its view of a dreary New England fall day and its drab vomit-green walls.

The first thing I noticed was how gaunt she was. She had a long, hollowed-out face, stretched and sunken by illness, the strangeness of a new land, and uncertainty about what exactly was happening to her. Something most medical students realize rather early on is that much of what you say as a physician (to be) is conveyed via tone and touch. Talking through an interpreter, literally playing a game of telephone, is often like being a reporter interviewing a subject: you get the facts, but not much else. Slowly, I was able to stitch together her story of being diagnosed with cancer in her native country, waiting four years to immigrate to the United States, and merely days later finding herself in the hospital. I nodded as she told me this, my ears listening but my eyes also reviewing her radiology scans. In medicine too, pictures are worth a thousand words, but, more often than not, the ones a doctor remembers tell terrible stories.

So it was with Ms. A. While she was waiting for her chance to come to America, her cancer knew no borders. It had traveled with little difficulty to her liver, lungs, and colon. How exactly does cancer do its dreaded work? It makes the blood a little thicker, predisposing you to clots which can become lodged in the arteries to your lungs, making it difficult for you to breathe. It can fill your lungs with fluid, drowning you while nausea makes even drinking water difficult. With Ms. A, all of this was happening while the mass in her colon was killing tissue and becoming a hotspot for infection, causing her excruciating pain.

So we went to work. We thinned her blood, drained her lungs, gave her medication to help with nausea, and started her on powerful antibiotics. With her condition stabilized, the experts got involved. Oncologists, colorectal surgeons, gastroenterologists, and palliative care physicians all saw her over the next several days. They ended up confirming what we, the primary medical team, knew from the second we saw her scans.

Many of the hard conversations fell to us. Often Ms. A's sister would say, "But all of this started after she got to the hospital." Her son once indignantly offered, "All you need to do is just eat. You just need to eat more." When offered hospice care, which entails spending the last few weeks in a facility where the focus is on making you comfortable, Ms. A's sister was entirely lost. She once asked, "But it feels like a hotel--how will she get medical care there?" With all that in mind, Ms. A decided to spend the rest of her time in the hospital. She didn't have much of a home, and her family had ruled out hospice.

I had my own way of marking Ms. A's rapid decline. When I first talked to her, the phone interpreter could hear her even as I held my cellphone far away. Day after day, I held my phone closer and closer, with her voice barely rising above that of a whisper. I began to feel guilty doing my morning physical exams as taking a deep breath or turning to one side would produce sharp and excruciating pain.

After nearly two weeks, I stopped checking in on Ms. A every morning. Usually medical students "carry" 2 or 3 patients, hoping to learn from them as they progress in their hospital stay, checking labs, imaging, following up with specialists. Yet at this point, we were waiting for the end, and my team felt I could learn best by picking up a new patient. In the afternoons, after the bustle of activity during morning rounds had quieted down, I would check in. She would be bundled up under a thick layer of blankets, her sister quietly reading a Koran beside her.

Eventually, the resident and interns I was working with had to move on to different rotations, while I was still on the same floor for a few more days until Thanksgiving. On Monday, I spent a little more time in the afternoon with her, telling her that I was grateful to have been a part of her team. As my family will tell you, I'm a bit of a crier and I felt tears welling up, but in medicine you're not really supposed to cry, so I blinked hard and held them at bay temporarily. The next morning, a nurse found Ms. A dead. I've been repeatedly told by older physicians that investing yourself in your patients tends to make you a good doctor. But it also makes it harder when a patient dies or gets hurt. The books never really prepare you for that conundrum.

It's surprising how fast and fleeting death tends to be swept away in a hospital. It surprised me when I first saw it, but it only makes sense. A room is quickly cleaned, the bed remade, the body sent quickly to a funeral home. By lunch, almost every trace of Ms. A was gone, including her sister and her son. I stepped into the room, once again clean and sterile, the only trace her name on a small whiteboard.