A PIECE OF MY MIND

Extraordinary

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In my dreams, Mr Smith always looks the same. He sits at a table with a green-and-white checkered tablecloth, a pale blue hospital gown around his skeletal frame, shadows gathered behind his collarbones. His forearms are a mess of bruises—purple, blue, and a fading yellow-green—though he gestures with them wildly and easily. His amber eyes match the color of the root beer in the glass before him. Arthritic fingers close around the glass, leaving their imprints on its frosted surface. He lifts the glass to chapped lips, taking a big sip.

"Nice and cold," he says, winking at me. This is the only time I've ever heard him speak coherently. Each time, I wake up just then, sweating, disoriented, unsettled.

I met Mr Smith in the emergency department two years ago, on a rainy Wednesday in mid-April. He was the tenth patient I admitted to the hospital on a busy call day. The ED resident described him nervously, in a tone distinctly different from our prior nine conversations about patients.

"This sounds bad," I said.

"Yeah, he's got metastatic esophageal cancer, now has a huge blood clot in his lungs. Notes say he's DNR/DNI but he's disoriented and can't say much about his wishes. His labs are a mess, and he's got a terrible oxygen saturation. He's not looking good."

"Are you giving him anticoagulants?"

"One of his notes says he had a big bleed in his belly about a month ago. Unclear cause. No bleeding since, but if we start heparin, he might bleed out. But since you are admitting him, that decision is yours."

"And he's totally out of it?" I asked.

"He's talking, but he's so disoriented that he's trying to eat his oxygen monitor."

I walked to the ED slowly to give myself time to think. Mr Smith had incurable cancer of his esophagus. The blood clot in his lungs deprived him of essential oxygen and strained his heart dangerously. The clot was almost certainly caused by his incurable cancer. The dilemma he presented was both typical and acute: without blood thinners, the blood clot would kill him. But with blood thinners, and a recent history of abnormal bleeding, he could suffer a fatal bleed into his head or his gut. The question was not *if* he would die, but how, and how quickly.

But he's a textbook case, I thought to myself. He's got cancer and a related blood clot. I've treated so many blood clots. It would be easy to treat this one.

Hold on, said another voice, something deeper, calm yet firm. Something ancient yet enduring, a precious heirloom in a mahogany closet. A familiar, gentle hand on my shoulder.

Go see him first.

The room was dark except for the green glow of Mr Smith's heart monitor and the flash of a red alarm, drawing my attention to concerning vital signs: a heart rate in the 120s, a blood pressure in the 90s, and an oxygen saturation in the mid 80s. I pressed a button to silence the alarm and heard a broken voice. "Darlene, Darlene, Darlene," he repeated weakly, to nobody in particular.

"Mr Smith?" I said, hesitantly.

"Daaarrrleeeeeene," he responded, stronger.

I kneeled to examine him. Tangles of matted brown hair outlined his fragile face. Deep wrinkles gathered at the corners of his eyes. His ribs protruded like speed-bumps along the narrow path of his torso, which led to a concave belly. On his right arm, I saw serpentine veins, the pull of flesh against bone, a faded green tattoo that read, "Where there is light there is darkness." ECG leads, oxygen tubing, and three intravenous lines tethered him to his bed. His skin was covered with bruises from multiple attempts at blood draws. A white device was taped around the first finger of his left hand, monitoring the amount of oxygen in his blood. He gnawed on it and stared past me.

I listened to his heart, a flutter in the great hollow of his chest. His breath was shallow and quick, a distant whisper. He coughed when he tried to swallow. His saliva couldn't slither around the tumor in his esophagus. His body told me a story that he couldn't. His chart filled in some details.

"Patient would not want extraordinary measures," his most recent oncology note said. "No known family or friends. Cannot name a decision maker. Code status: DNR/DNI."

I looked at his CT scan. It was difficult to tell where he ended and where his cancer began. Tumor glowed throughout his body like a macabre Christmas tree. My gut told me he was dying, but my head changed the subject.

Giving anticoagulants for blood clots isn't an extraordinary measure, my textbook voice said. It is possibly one of the most ordinary things I do in internal medicine. But, a deeper voice inquired, is treating *his* blood clot extraordinary? That is a different question. He could bleed and suffer more than he is currently. He also might not bleed. Would that result in a better life, or a more drawn-out death? What risk was he willing to live with, or die with? None of the 2500 notes in his electronic chart provided any answers. The only documentation that really told me anything about his perspective on life was his tattoo.

I called his oncologist, his internist, and his nursing home, looking desperately for guidance. Nobody quite remembered him. His nurse told me, "All I know is that he always asks for root beer, but he can't swallow it so he coughs. It makes him happy though."

And so, I remained exactly where I started, looking at the sweetly disoriented man before me, the nontextbook case, wondering whether to treat his blood clot and

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risk causing a bleed, or get him back to the nursing home with hospice services the next morning to keep him free of pain and shortness of breath during his final days. It was obvious he was dying. I just didn't want to expedite it.

On afternoon rounds, I discussed Mr Smith with my attending physician. "I don't think there is an easy answer here," he said, after hearing about the details of his case. "Think about what you are treating and to what end. I think Mr Smith's in good hands."

I was acutely aware that my whole team was staring at me. Interns and medical students watching my decision-making process, my attending studying my development as a physician, our pharmacist waiting to tell me what dose of heparin to give Mr Smith if that was how I chose to treat him. I felt as though I oozed unacceptable uncertainty, that its scent overpowered the stench of hand sanitizer and stale chips that permeated the hospital.

After rounds, I stared at the computer screen intently, as though the intensity of my stare could produce the clarity of the right answer. It was second nature for me to treat a blood clot, and my fingers started to fill out the order set. I made it halfway through the order set. Then pressed Delete. I started it again, then paused. Looked at the screen. Pursed my lips. Was I a fraudulent physician because I wanted to forego treating a blood clot? Because I thought treating a blood clot wasn't necessarily treating Mr Smith?

And so I wrote in his chart: "Risks of anticoagulation outweigh benefits in a patient with recent GI bleed and limited life expectancy. Will arrange discharge back to nursing facility with hospice services." Instead of ordering medications to treat his blood clot, I ordered medications to ease his shortness of breath. I spaced out the checks of his vital signs to minimize disturbance of his sleep. I requested no further lab draws. I signed these orders.

I looked at the computer screen, my textbook self horrified. The deeper voice was quiet, peaceful.

It was 11 PM when I retreated to my overnight call room. I had not been paged for 30 minutes, the longest stretch of respite that day. I lay down on the saggy bed and closed my eyes. I could still see the image of the computer screen in my head, the orders I had signed seemingly pinned to the lining of my eyelids.

Shortly, my pager let out a series of beeps from Mr Smith's nurse. "His breathing has changed," she said worriedly. "Please come evaluate him."

Dying has a certain cadence and tempo, a recognizable prelude to an infinite stillness. At first, Mr Smith looked like he was sleeping. His chest rose and fell intermittently, then more slowly. His eyes remained closed even when I shook his shoulder. His heart rate slowed. The tempo increased.

There was nobody to call on his behalf. There was nothing to do but be there. If he was resting alone in his deathbed, a bed whose pillows I had fluffed, then I was going to sit with him. He shivered, and I covered him with warm blankets from the ICU. I moistened his steadily drying lips with artificial saliva. Remembering a note referencing his love of folk music, I used my phone to play bluegrass tunes, dispelling the heavy silence around us with banjo, guitar, and pensive lyrics.

I sat for Darlene's absence, and reread his tattoo: *Where there is light there must be darkness*.

The dark of night slowly gave way to the navy blue of early morning, dawn's turquoise, and the day's first blush. As the sky brightened, Mr Smith's breathing slowed. At 6:37 AM, it stopped entirely. His body remained, but he had quietly and comfortably moved out, leaving behind his tattoo, his bruises, his clot, his cancer.

Rounds in the morning were somber. It was my custom to have a moment of silence to remember a patient, but the silence only added to the obvious discomfort of the team.

My attending finally spoke: "I'm surprised he went that quickly."

My intern responded, "Me too. I wonder if maybe we treated that clot, he could have gotten a little more oriented? We could have asked him exactly what he wanted done."

I remained silent, but within me my textbook and deeper voices began again to have a conversation. I quieted them both and went on with my day.

That night I couldn't sleep over the din of their ongoing argument. Maybe I expedited his death, I thought, an act of omission being just as deadly as an act of commission. The weight of my decision sank into my chest, my throat tightening. I heard my attending's words: "Remember what you are treating and to what end." I saw my intern's eyes full of doubt.

And I saw Mr Smith. Silencing my textbook self, I simply looked at him from a bird's-eye view, from the inner perch where I now know that deeper voice resides.

I started to imagine that, wherever he was, he was wide awake, seated at a table with a checkered tablecloth, breathing without oxygen, taking in his surroundings with wild amber eyes, raising a glass of root beer, relishing it without coughing. Perhaps that in and of itself is what he would consider acceptably extraordinary.

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