
FOREST FOR THE TREES

Top 3 Overall Winners

OUT OF CHANCES

By: Dr. Graham Block
University of Colorado Internal Medicine Residency Program

“Well I have a lot of dreams,” D hesitantly started. For the first time in the meeting, all eyes in the room shifted toward the sullen 29 year old sitting in the corner who, although the subject of the meeting, had allowed his mother and father to speak on his behalf for most of the time. In the room were 4 members of the palliative care team as well as me, representing the primary cardiology team. His eyes slowly rose and a suggestion of a smile came over his face. Over the course of the hospitalization, he had lost a significant amount of weight, and his growing beard barely covered the newly sunken recesses of his face. “I’m only 29. I’m still looking to meet someone. I’d like to start a family.”

My contact with D during his 3 week admission had thus far been fairly limited to the medical realm. I had pre-rounded on him every day, dutifully paying careful attention to the level of his jugular vein. We had rounded each day as a team and sidestepped the hard questions. When I had walked by D several times a day as he stared from the hallway out toward the Rocky Mountains looming over the city of Denver to the West, I had trouble looking him in the eye. The week before, I had informed him and his mother (always at his bedside) that the cardiology team had decided, after another multidisciplinary discussion, that they were not going to replace his flailing aortic valve. “Without a new valve, you have a high chance of dying in the next few weeks to months from heart failure.” I said in my best straightforward language; I was careful to avoid any false hope.

D was previously admitted for a month in the medical and cardiac ICUs, brushing perilously close to death for almost the whole duration of his stay. He had raging bacterial endocarditis, most likely caused by his struggle with heroin abuse and the unclean needles he used to get his fix. A miracle surgery restored him to some semblance of health. “Like seeing God…” his mother referred to her feelings of seeing the cardiac surgeon leaving the OR after the surgery.

Back at the meeting, his mother gazed at him intently. “He was all any mother could have hoped for.” D blushed and looked at the ground, the exemplar of an embarrassed young adult whose mother will not shut up. “A model student. Polite. A great athlete. All the other mothers loved him. I couldn’t have been more proud.” “He loved all things outdoors,” His father chimed in. “He’s a great uncle. I just can’t understand why he got into that stuff.”

D left the hospital the first time with a stern warning. “This is your only chance for a new valve,” the surgeon told him. He did not leave with a prescription for suboxone or a referral to a methadone center.

Despite engaging in community resources, faithfully attending his appointments at the CEDAR center and eventually starting on suboxone (“The best thing that ever happened to me,” he said), at some point in the year following year, D relapsed. Most people with opioid use disorder do. “When I get out of here,” D said, “I want to work on my addiction.”

He returned to the hospital in cardiogenic shock from his failing prosthetic aortic valve. The echocardiogram revealed a large vegetation. After his pre-operation evaluation with the anesthesiologists, his urine toxicity screen came back positive for heroin. The surgery was cancelled. He was informed by the surgeon, and then again by me, that he would no longer be a candidate for surgery.

“Won’t” or “Can’t?” His mother asked, tears welling in her eyes and eventually spilling forward onto her floral-printed dress. “They won’t do the surgery, or they can’t do the surgery. Won’t or can’t.” D sat and stared at the ground. I did the same.

The answer was won’t. He was out of chances.

I was left with questions that kept me awake night after night.

What does it mean to be out of chances, to have scratched every box on your lotto ticket? And who gives out the tickets?

How must it feel for the surgeon, to have reconstructed a model house with hundreds on hundreds of toothpicks and perfectly placed drops of glue just to have the patient smash that house with a powerful fist? How to approach that patient again with empathy and love?

How do we see the patient struggling with drug addiction? As a personal failure, a drop out, a victim of a disease? Or as “all any mother could have hoped for?”

CROSS COVER

By: Dr. Jason John
University of Colorado Internal Medicine Residency Program

“28-year-old woman with decompensated cirrhosis and hepatorenal syndrome complicated by hypervolemia and encephalopathy admitted for transplant evaluation. You might want to lay eyes on her at some point; she’s definitely a watcher.”

Victoria was one of 53 patients I was cross-covering for my co-residents that night. As one of the sicker patients on the hepatology service, however, I knew I would be paged about her before too long. Not half an hour later, the first came through.

“Victoria looks really uncomfortable,” the nurse said. “She’s due for Tylenol but I’m not sure it’ll do much.”

Accustomed to meeting profoundly ill people in the hospital, I was still taken aback by how sick Victoria looked at such a young age. She was lying in bed, eyes closed and grimacing, her face seemingly vacuum-packed over the skull beneath. Her belly appeared as though she was nine-months pregnant.

“Hi, Victoria. I’m the doctor taking care of people overnight. How are you feeling?” The question felt stupid as I asked it.

Victoria briefly opened her eyes to acknowledge me, but quickly closed them. Tears began to stream down her face.

“I’m so uncomfortable,” she whispered softly.

“I know. I’m going to give you some stronger pain medication.”

“Thank you.”

“I’ll try to take the edge off, but we may have to tough things out a bit tonight. Your primary team needs to be able to wake you up in the morning.”

“I understand.”

The medication didn’t help. The next night, Victoria’s nurse again paged me within the first hour of my shift.

“Victoria got a paracentesis today, but now her blood pressure is pretty low. She was in the 90s/60s during the day, but now she’s staying in the 70s/40s.”

“How are her other vitals? Is she symptomatic? Any evidence of bleeding?” I asked, thinking on my feet.

“She looks good and nothing else has changed. The numbers are just lower than they’ve been.”

“Alright. I’ll order albumin and some labs, and be over shortly”

The scene was immediately reassuring as I entered the room. Victoria was sitting in a chair, her belly now tiny like the rest of her, and…smiling?

“Hey, Doctor!” she merrily proclaimed.

“Hi, Victoria. Wow, you look great! I heard they drained your belly today.”

“Yup! Twenty-five pounds!”

“I came by because your blood pressure is a little low. Any lightheadedness?”

“I don’t know, maybe a little. I feel so much better though, and I might actually be able to sleep tonight.”

I got paged two hours later. The albumin infusion was complete, and Victoria’s blood pressure hadn’t changed. She was sound asleep. The nurse asked me what I wanted to do. I told her to let Victoria sleep.

After a night off, I returned to the hospital for my first night doing admissions. At the beginning of the shift, I read through Victoria’s chart from the previous day.

The hepatologists had determined she was not a transplant candidate, and they were not optimistic about her becoming one. Victoria was just too sick to tolerate such a major operation. She had been tearful during rounds that day and didn’t want to participate in a family meeting planned for later that week.

With the admissions pager bound to go off any second, I wondered if I had time or if it was even my place to go visit Victoria. I wrestled with the idea for a few minutes, but finally yielded to the inexplicable something calling me there. Maybe a familiar face and distracting conversation would cheer her up a bit. But that hope was vanquished as soon as I entered her room.

Victoria was once again sitting in her chair, now angled away from the door. Her head was tilted downward, and as I walked around to face her, I discovered that her belly was larger and more distended than when I first met her.

“Hi, Victoria.”

She didn't respond, but instead softly wept. Her cheeks were red with discomfort and frustration.

"I heard you had a bad day, and I came to visit." I hoped my presence wasn't making a bad situation worse.

"I don't understand why I'm not getting better," she replied with univocal anger. "I do everything I'm told, and nothing changes."

"You're really sick," I replied as gently as possible.

"I know that!" Victoria opened her eyes and glared at me.

Disarmed and speechless, I knelt at her side as she continued.

"I know I'm sick. I just want to be able to sit and watch TV without so much pain, and to sleep. I don't even need to watch TV. I just want to sleep!"

I reached out to pat her shoulder, but merely felt a skeleton draped in a hospital gown. Victoria went on.

"I have a daughter, and I'm scared of her seeing me like this."

I remained at Victoria's side for the next ten minutes while she vented. Eventually, her nurse came in to hang another unit of blood and my pager went off. As I rose to leave, Victoria clutched my arm with surprising force.

"Thank you," she mouthed, the vexation subsiding for a fleeting moment.

The further I go in my medical training, the more I learn about the vast resources we have to help patients. But as mortal creatures, all human beings eventually develop a problem that a physician cannot solve. There is no formula for these situations. I educate and empathize. I hold hands and pat people on the back. I say sorry for things out of my control and listen as people take out their frustrations on anyone within earshot. One way or another, my message is always the same: I cannot fix you, but I am with you. Delivering it has been my most difficult task and sacred honor.

Victoria, whose real name is not Victoria, died a couple months after our last encounter. By that time, as it turns out, she didn't need a doctor. She needed a human being to stop talking and start listening. Though I met her in the waning days of her health and life, I choose to remember a different person that I came to know through social work notes, her family, and Victoria herself. Victoria was funny, she was a fighter, and she was a loving and devoted mother.

WHAT IS RIGHT AND WHAT IS EASY

By: Dr. Prashant Parmar
St. Joseph Hospital Internal Medicine Residency Program

"We must all face the choice between what is right and what is easy" -Dumbledore.

Choosing the right path can be exhausting and frustrating, miring you deeper into the worst parts of humanity. But we still choose it; sometimes because of our colleagues. Sometimes because people are watching us. Sometimes we are being evaluated. We sometimes choose the right path so that we are recognized for doing a good thing. The need to be recognized is part of what keeps us going.

But this is what I teach my interns: there will be times when no one is watching, when it won't hurt to walk away, and when the easy path will make you feel better. At those times, they are the only one and there is no reward seen on the other side.

It is easy to say that you will choose the right path in front of an audience. Through the exhaustion, burnout, and anger, it is hard to do.

This is my story of that choice.
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In the EMR, notes are neat, distilled paragraphs summarizing an entire person. Patients, of course, are not charts. Sometimes their bodies or brains decide to misbehave with the plan outlined in a beautiful note (in my case, that the intern writes and I take the credit for with my addendum and signature).

Young. DKA. Homeless. Frequent flier. Frequently AMA. Any internal medicine doctor can fill in the blanks of her story. Add to this: Angry. Distrustful. Grating. Bitter. Hopeless. We both knew our scripts.

This time, though, there was more to her story than DKA. Prior to admission, she had been raped. And she knew that no one cared. She had walked out of Denver Health before coming to us without time to make a plan. The easy choice was to continue this trend; my hospital didn't have the SANE nurse, the kit, or the training to handle this story.

I, however, clearly cared. I wouldn't be the one to choose the easy path. And upon learning this story a well-connected friend gave me a local crisis line for her to call. I left the day satisfied; I went beyond treating her DKA..

I checked the next morning. Her lights were still off (like yesterday), blankets over her head (like yesterday). She refused to call the number, refused care, and followed the script of her story exactly.

I couldn't understand what went wrong in my plan, so I accepted her refusal and moved on.

At the end of the day, though, I broke my script. In between telling me to leave her alone, came the phrase "Why should I care. No one cares about me, and you don't either, so why should I bother".

Doctors operate in a world where we are trained to know the right thing. Our perspectives, therefore, can overlook or override others. Here is what I missed: a male authority figure just told her what to do and expected her to do it. Her power and choice had been forcibly taken, and my decisions on her behalf reinforced that world. In my desire to be a rescuer, I had almost once again made a choice that was easy for me but not right.

My script was not her script.

This was where I faced the easy path alone: I had tried and could walk away.

Instead, I tried something new. I asked permission to call for her and asked her for help. Maybe, I told her, we could figure this out together. Her "sure" was dismissive, defensive.

In the room, I pulled out my phone, called my wife and told her I wasn't joining her for dinner, called my intern and told him good luck for the next 4 hours (I assume his scared yelp meant he was totally ready for this). She listened to these calls. I dragged a stool next to her bed, picked up the phone and called the Blue Bench. I explained that my hospital had no SANE nurse, no kit, and no protocol.

She put me on hold.

I turned to my patient, who was staring at me completely baffled, and told her "I don't know what to do, and I need your help". And things changed from there.

One minute into the now-held call, my patient was talking to me. Five minutes in, she was laughing. She sat up, smiled, and started asking me about her options. When the advocate returned, she started telling her story.

Calls to the charge nurse, the case manager, and the house supervisor revealed that while I didn't have access to a SANE nurse or resources, I could coordinate with Denver Health.

I went back to ask her permission again. She was back on hold, but the room had hope. She told me about a women's shelter that the group could get her into and a way for her to report her story to the police.

Instead of undermining my patient's world, I found how to support it.

After four hours, a plan. The next day we would discharge her to Denver Health. There, a SANE

nurse, police officer and the Blue Bench representative would be waiting. Then, arms full of resources, she could go to the women's shelter.

"Thank you for caring," she said.

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Scripts go awry. It is easy to walk away when no one is watching. Not every path ends in a victory or a change.

When you are the only one who can, when you don't know the end, and when you don't know what to do, it takes strength to choose the right path..

I teach my interns this choice. Not for themselves, and not because other people are watching, but because when we are alone, it is still the right thing to do.

The Blue Bench is dedicated to changing the conversation about sexual assault. Their 24-hour crisis number is 303-332-7273.

Other Top Stories

HEY SHORTIE!

By: Dr. Sneha Shah
University of Colorado Internal Medicine Residency Program

“Hey Shortie!” That is how my most frequented primary care patient greets me every time I enter the room.

I first met this 6’1’’, 290 Lb. man as a 5’2’’, 105 Lb. intern – with little gravitas. As many of my patients do, he grilled me with questions like, “Are you old enough to be a doctor?” and “Where is your boss?” Adamant to prove my worth as a physician, I jumped right into bombarding him with evidence-based recommendations. I left that visit quite sure I’d never see him again.

5 weeks later, he returned having completed none of the tests I’d ordered nor having lost a single pound of weight. Frustrating! But this time he was wearing surgical scrubs. So, I abandoned the lecture I was about to launch at him and asked about the scrubs. This simple act has led way to a crumbling of the façade of evidenced recommendations and lectures to a strong therapeutic relationship.

Over that and the next many visits, I discovered the following: my patient used to be a surgical scrub tech but because of chronic knee pain, he lost focus to continue that work. Now, he worked graveyard shifts at Sam’s Club in the meat department (but still liked to wear scrubs occasionally). He is divorced and responsible for his 14-year-old daughter half the time. Recently, he chose to move his sick, elderly mother in with him for whom he is now the sole caretaker. He copes with these stressors by drinking soda and eating junk food. While allowing his daughter to participate in extracurriculars, he has no time to exercise for himself. His previous doctors had never bothered to ask him any of this. And he’d never bothered to continue seeing them.

As the years have gone by, I’ve remained 5’2’’, 105 Lb. but my patient is now 35 Lb. lighter. His blood pressure to entirely under control. He drinks no soda and cooks at home for those who depend on him. And even though we usually debate every recommendation for 20 minutes, ultimately, he does listen.

As physicians, a key strategy to surviving in the medical field is to compartmentalize and depersonalize. Yet, only when I bothered to discover the most intimate details about my patient’s life, we materialized impactful and sustainable therapeutic plans. Because of this patient, I hold myself accountable: Whenever my mind tries to rush past a patient telling me their life story, I stop myself – and I listen! We must regain the confidence in ourselves to humanize our patients again. To find our patience again.

In clinic, I've seen that patient more than any other. We continue to work together. The innocuous "Hey shortie!" disheartened me the first few times. Now those words reverberate the tall impact we've had on each other.

JOY ABOARD A SINKING SHIP

By: Dr. Kristina Barber
St. Joseph Hospital Internal Medicine Residency Program

Perfect, pure white orchids basking in the sunlight on a wooden shelf were the first things I saw as I entered my patient's room at 6:30 in the morning. This day was just like the last few. New issues had arisen overnight, and treatment ideas had already been exhausted. I sat next to my patient with my medical student in tow, feeling completely uncomfortable, pitying myself as I sat in my helplessness. We were all on the same sinking ship, despite my best attempts to plug up the holes.

The neuroticism and diligence that allows us in the medical profession to achieve our academic goals can also be our downfall when it comes to the gray zone and the times when despite our best efforts, patients do not get better. Medical school had not prepared me for times like these -times when I would need to sit with discomfort and not knowing. Over four years, I had memorized a million illness scripts and treatments to make patients better - each multiple choice question answered brought a patient to a better state of health. During clinical rotations, I had seen patients improve, and others who left the hospital to die. However, I had never been the culpable, responsible one because I was the medical student. I was never the doctor. I suppose I expected that having that MD behind my name would usher in more confidence and give me magical powers to always have another answer, another treatment, another idea. However, I have quickly learned that the doctor's white coat is not l ike those white orchids. It is not perfect or meant to be a thing at which to marvel or to be put on a pedestal.

Sitting there in my discomfort that day, I fell back on the thing I know how to do best – to be human. Later that day, my patient and I just sat together and talked for an hour. We talked some about her medical problems and her hesitant acknowledgement of her impending mortality. We talked mostly about her life. She told me about her recent safari to Tanzania with her husband of 50 some years to see the Big 5. She recounted how the lions roared and devoured their prey on the savanna. She talked about her love for gardening, and how she raised orchids like those in her hospital room. She even taught me how to care for them myself when I admitted to lacking a green thumb.

While we talked, my discomfort sat beside me, no longer consuming me, merely a quiet observer of this human connection. A sense of calm, of comfort seemed to fall over the room, as though we had found the silver lining in this terrible situation. We had found joy aboard this sinking ship. When I thought I had nothing left to offer as her doctor, I realized that I had everything I needed already – my human experience, time and compassion. A saying by one of my medical school teachers took on personal meaning that day - "Kindness is easy to administer and exceptionally well tolerated." Although this all did not change the fact that my patient pursued hospice and eventually passed away, she told me that day how that little bit of

extra time, extra care had made all the difference. Short of a complete cure, no lab test, no imaging, no medication that I know of has quite this effect.

DEAR PATIENT, I CARE FOR YOU MORE THAN YOU EVER SEE

By: Dr. Maranda Herner
University of Colorado Internal Medicine Residency Program

Dear Patient,

You see me early in the morning as I wake you up. I ask you a few questions and move your warm covers to examine you briefly. I am often in the room for 30 seconds to a few minutes, and considering the first 10-20 seconds you are only thinking of blinking to adapt to the light, it probably feels even shorter. Then you don't see me for a few hours until the team rounds again, or you may not see us if we happen to come by when you are elsewhere in the hospital getting your various tests. If we catch you, you hear us discuss recent findings and ideas about a plan for the day. Afterwards, we summarize for you, and try to include you in the ultimate decision. Likely we exchange pleasantries at the end, but it probably feels rushed and not enough. Sometime in the afternoon I may pop my head in to see how you are or update you on any changes or knew news. So in total, if I estimate a generous amount, we spend maybe 10 minutes together. How could you feel my dedication to you when you only see so little of me?

I spend so much more time caring for you than you ever see.
I care about you more than you probably know, until now.

I arrive at the hospital early in the morning. First, the night resident tells me about any overnight events. Then I go to the computer and learn about the "chart you." I view your vitals --those annoying checks of blood pressure, heart rate and oxygen that keep you up throughout the night. They are the best warning signs of something going wrong. I really care about them. Sometimes I walk up to the heart monitor machine itself and interrogate it. Next, I look through your labs-- those annoying pokes that wake you up when you had finally fallen asleep. They help me see how your body is responding or changing at a chemical level. I care about them a good deal, some more than others. Finally, I look to see if any of the image studies we ordered were done overnight (guaranteed no sleep now) or if any consultants had left evening notes suggesting we do something different. Oh and I look to see how much you have pooped and peed-- those silly hats in the toilet and urinals are so precious to me. Sometimes I care about these so much that I call the nurse to ask for details. Often times, other student and residents are looking over the “chart you” too, and we talk about “chart you.” Finally, I scurry to your room to greet you. Before you have even woken up, I have already been thinking about you for an hour.

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Next our team rounds on you, as you sometimes see and sometimes don't. Then I call a consultant doctor, a specialist in her/her field, and describe everything I know about you to him/her. We talk about what we think would be most helpful to you. Sometimes I spend hours

hunting down your many consultant doctors, relaying information between them, discussing their thoughts with our primary team, and hopefully ultimately finding a best plan—which I then try to come discuss with you. Afterwards, I likely call your nurse to update him/her on plan changes and ask if he/she has any concerns. Then I write a small summary about you to give to the night doctor. We talk about you briefly, and I let them know of anything I was watching that day.

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At home in the evening, I read medical journals about new studies that guide the best care for your diagnosis, and I try to assure we are providing that most updated care. Sometimes I check on "chart you" to see how your night is going. Most nights I sleep soundly, but sometimes I wake up fearing I forgot to order your morning labs for your surgery or wondering if I forgot to decrease your morning blood pressure medication. Those unfortunate nights, I again check on "chart you" and reassure myself that you are tucked safely in bed with your appropriate plan in place.

I spend so much more time caring for you than you ever see.
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I know you only see small glimpses of me. But please know that I spend lots more time watching you, talking about you and trying to best care for you. The many consultant discussions, the many checks on "chart you", the many relays between me and the nurses, and the many evening panics-- all attest to my heartfelt caring for your wellbeing. I cherish those few moments in the morning as you look up at me, still blinking to wake up your eyes, and the little smiles you offer me between grumbles about not eating breakfast yet. Sometimes I gently touch your hand after checking your pulse or touch your shoulder after listening to your lungs because it allows me to feel connected to you-- too act out a full day's worth of compassion in that minuscule time I have to do so. Can you feel how much I care about you in those simple acts, as I hide so much of my caring from you?

I spend so much more time caring for you than you ever see.
I care about you more than you probably know, until now.
I hope you can feel it someway, somehow.
But even if you do not, I will continue to care for you.

Sincerely,
Your Intern Doctor