FOREST FOR THE TREES

Top 3 Overall Winners

NOW YOU SEE IT, NOW YOU DON'T

By: Dr. Rush Pierce

It must have started some time before, but I assign the beginning to a sunny August day, auspicious at the time for another reason. I was looking forward to hiking with my daughter, now grown and living far away. Our fun day together ended with a strange comment: "Daddy, your left calf is smaller than the other one."

Some months later I noticed difficulty using my left leg to climb a steep ledge. I recalled my daughter's comment and thought, that's odd, stepping up is mainly a function of quadriceps muscles, not gastrocnemius. Then I fell during my morning run. That evening, I measured my calf circumferences by palpating my tibial tuberosities, measuring 10 cm inferiorly, drawing a line, and then circling my calves with a measuring tape. Indeed, there was a 3 cm difference. I recalled a colleague saying they no longer teach medical students this technique because calf swelling has low likelihood ratios for diagnosing deep vein thrombosis. Oh well, I thought, I'm not trying to diagnose DVT. I looked up the causes of painless calf atrophy in a 63-year-old man and found a short list of mostly bad diseases.

I saw my primary care physician. I was pleased when she measured my calf circumferences like I had. "There's a 3 cm difference, I want you to see a neurologist." This took a few months. By then I had observed occasional twitching movements in my leg. In 40 years of practice, I had observed fasciculations in just a handful of patients, is that what I was seeing? I watched YouTube videos of ALS patients who had filmed their fasciculations and became more worried.

I saw the neurologist, who detected hyperreflexia. My EMG was markedly abnormal in three motor groups, classic for ALS, a disease with a median life expectancy of three to five years. I had suspected this diagnosis but was still stunned, in part because I felt well and was so active. My children urged me to get a second opinion. I saw a specialist at one of the national ALS Centers who confirmed my diagnosis.

I thought I would feel anxious and depressed, but mainly I experienced something else. Previously I had been drifting along, enjoying my life, thinking I would live to at least age 85. Now I was facing just a few years of life, half with significant disability. Suddenly, my life came into focus. My daughter had been urging me to join her in walking the Camino de Santiago. Four months after my diagnosis, I traveled to Spain for this very special father-daughter journey. Without the urgency created by ALS, I doubt that I would have made time for this. I spent more time with family and friends. I connected with long neglected high school classmates. I became interested in mindfulness mediation, and though never a regular practitioner, I often found myself focusing on the present moment and finding joy and meaning in what was right in front of me. I enrolled in a clinical trial. I had been able to be such a better doctor because thousands of patients had volunteered for such trials. Now I could be one of those volunteers and perhaps help other doctors' evidence-based practice. If I hadn't gotten ALS, I would not have had that opportunity.

Together, my wife and I made a number of decisions: retire early, move closer to our kids, build a handicapped accessible house. We felt that this was the best way to address a difficult future. Though it took over a year, we built a handicapped accessible home, I retired, and we moved to another state. Amazingly, through all of this my health prevailed. My muscle weakness did not worsen, I packed and carried heavy moving boxes without falling. I developed no bulbar symptoms.

It was now over two years since my diagnosis. Our move necessitated that I see a new neurologist. He was surprised by the lack of disease progression and repeated many tests. My exam and EMG were now nearly normal. Somehow my disease had gotten better, something ALS never does. I had no doubt about my previously diagnosis, I had had classic signs and symptoms and met the standard diagnostic criteria. But now, inexplicably, I no longer had ALS!

As one with a twenty-first century scientific world view, how do I understand this? Some of my church friends say it was the power of prayer, but I don't think God really works that way, answering some prayers while ignoring others. My daughter thinks that the Camino de Santiago cured me. After all, thousands of pilgrims attest to the healing power of that spiritual walk. Maybe it was the investigational drug that I might have taken during the clinical trial. Perhaps it is just heterogeneity of ALS, an incompletely understood disease for which diagnostic criteria are still inexact. To me it doesn't matter, it is simply one of life's mysterious, awesome gifts.

I have experienced mixed, confusing emotions about all of this. I am overjoyed that I can anticipate a longer life with a different ending. I awaken every day, still astonished about this incredible turn of events. Strangely though, I also feel guilty. Friends in my ALS support group are still burdened with a horrible disease, and for no understandable reason, I escaped their inexorable fate. In many ways, my life was more focused, immediate and real when I had ALS. I connected with family and friends in meaningful and joyous ways, this now somehow seems less compelling and less urgent. When I had ALS, my life came into focus. I could really see it. I felt alive and authentic every day. Now I often feel less vibrant, less attentive to the joy of everyday things. While I am so thankful that I no longer have ALS, I desperately hope I can hold onto the part of that terrible disease that unexpectedly added focus, meaning and joy to my life.

BRINGING HOME THE BACON

By: Dr. Cassandra Duarte
University of Colorado Internal Medicine Residency Program

“Your promises aren’t good for much” he told me, straight faced and slightly disappointed as he glanced longingly at his cup of Starbucks coffee. Mr. O had been admitted overnight because of increased shortness of breath in the setting of metastatic prostate cancer. He had been made NPO overnight because the resident was concerned that he had aspirated on some water in the Emergency Room. This morning I had told him he could have some coffee, mistakenly interpreting his nursing dysphagia screen for the official speech and swallow screen.

I apologized profusely and asked him to hold off on drinking his coffee for just a short bit of time until the team had a chance to come talk with him. “This is already off to a bad start” I thought as I foamed out and walked away from his room. I brushed the encounter under the rug as another small stumble in my first month of intern year and hoped that Mr. O wouldn’t hold this against me. During rounds we had Mr. O take a sip of his coffee to do our own bedside speech and swallow evaluation. He passed with flying colors and eagerly started drinking his coffee.

The next day I came to pre-round on him and saw him struggling to reach something in bed. I said hello and he mentioned that he had dropped his hearing aid. I saw a little flesh colored object just out of reach of his hand. I wandered over and picked it up, and then (poorly) helped him fit the piece back into his ear. Jokingly I said “my promises may not amount to much but at least I was here when you needed some help!” He laughed with me, forgetting that he had made fun of me and my empty promises the day before.

Though we spent a very short amount of time together I found him a wonderful person to speak with. He was always warm and welcoming in the mornings and I’d make a joke with him about how we both needed coffee. Countless times during his hospitalization I would peek my head around his curtain and see him sitting up, bright blue eyes behind his large wire rimmed glasses. Often they were wet with tears. It was during this admission that he and his family were starting to come to terms with his terminal diagnosis and were considering a hospice referral. Usually when I saw him upset I’d come over and sit with him, plopping myself on the edge of his bed. We’d chat about different things in our lives and without thinking I’d reach over and hold his hand or rub his shoulder during our conversations. I’m not sure why I didn't think twice about physically comforting him; perhaps it was in an effort to replicate an experience that I had never had with either of my grandfathers. W hen I got up to leave I would inevitably set off his bed alarm and would think to myself, “another intern faux pas.”

The last few days he was with us he mentioned that he wanted bacon for breakfast but his diet wouldn’t allow him to order it. I didn’t understand why since I had put him on a regular diet as he had made the decision to go home on hospice. But, low and behold, the nutritionist kept changing his diet to a mechanical soft in the setting of his official speech and swallow evaluation. Angrily I called them on his last day and begged them to allow him to get bacon - after all, we were sending him home to be comfortable.

On his last day, we rounded and after the medical student gave his presentation, the attending asked me if I had anything to add. I turned to Mr. O and asked him if he got bacon with his breakfast. His blue eyes sparkled and he said “Yes! But when it came it wasn’t crispy enough!” I laughed, gave him a high-five and squeezed his shoulder.

I came back later that day for one last visit. Though I'm still early in my intern year, I tend to enjoy the big, meaningful, meaty conversations with patients about their life and death. I sat on his bed one last time and asked if there was anything else I could do for him. As I held his hand he started to cry saying that he would miss me and that he appreciated the care that we had given him. The most surprising thing he mentioned was that he valued that I wasn’t afraid to touch him. He felt that other providers had treated him at an arms’ length and he wondered if his prostate cancer diagnosis scared people from physically interacting with him. For the first time, his eyes weren’t the only ones wet with tears during our conversation.

As an intern there are many days when I feel like I’m a baby bird stumbling out of the nest and plummeting towards the ground, figuring out how, at the last minute, to save myself from crashing. I still set off bed alarms. You’d think that for someone who has been through over 20 years of formal education I’d be able to figure out how to disarm these things. There are days when I wake up in a cold sweat, questioning if I am doing the right thing. When I start to doubt myself I think back on tender moments like those with Mr. O, and and tell myself it’s okay if I haven’t read the most recent clinical trial, or have memorized the laboratory findings of a certain disease process. Because sometimes, to a patient, all that matters is bringing home the bacon.

THE EASY ONE

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

It's a familiar routine for the medicine intern.

We arrive at the hospital early in the morning, receive sign-out, furiously mine clinical data, and run around seeing patients before rounds. We are expected to know "everything" about patients. We prioritize the newest and sickest. But things come up, priorities replace priorities, and we frequently find ourselves running behind. During our most chaotic mornings, we find solace with the Easy One.

The Easy One is alert and oriented, and not acutely ill. His or her plan of care is well-established, and often near completion. In fact, we usually aren't doing much for the Easy One aside from addressing frustratingly non-medical barriers to discharge.

For a time, my Easy One was a pleasant elderly gentleman. Admitted for a COPD exacerbation that responded beautifully to treatment, he was stuck in "antibiotic jail" after one of his blood cultures drawn at admission grew MSSA. The Easy One was one of my favorite patients. He was nice and nonchalant, and his mannerisms made me laugh. My team got a kick out of our interactions, which were always the same.

"Good morning!" I'd proclaim entering his room.

The Easy One sat on the edge of his bed with his back to me, gazing dutifully to the northern window like a compass needle. A cheerful tone always replaced his wistful appearance.

"Gooood MOR-ning!"

I heard my attending giggle from her office across the hall.

"How was your night?"

"Pretty good…can't complain. My breathing feels better. I slept okay, not great."

"Yeah, it's almost impossible to get decent sleep around here."

"I know, I know."

"Alright well order some breakfast. We'll see you during rounds."

"Okay, see you later!"

After rounds, we wouldn't see the Easy One until the next day. The newest and sickest would occupy our afternoons just like the mornings, and my duties mostly involved sitting at the same computer in the same windowless workroom, coordinating care with consultants, putting in orders, answering pages, following up on data, and writing notes.

One day, I was struggling with these tasks. One patient was sick. Another needed a lumbar puncture. Another had a poor long-term prognosis, and I had to discuss this with him and his family. I was starting to experience all the symptoms of burnout we discussed during intern orientation – emotional exhaustion, depersonalization, feelings of ineffectiveness and lack of accomplishment, compassion fatigue, moral distress, etc. I was working so hard to do what felt like a mediocre job, salvaged only by the more experienced physicians supervising me. Furthermore, the Easy One's new nurse was paging me what seemed like hourly that afternoon.

"I'm taking over for the Easy One and I noticed you haven't ordered labs. Were you going to order any?"

"The Easy One says he's not sleeping well. Can we increase his melatonin?"

"The Easy One seems depressed. Can you come see him?"

I promised to see the Easy One before I left but was certain he was fine. He had been doing fine since I met him. On a day I thought I'd be working late into the evening, I managed to wrap up by six o'clock. As I bolted for the exit, I remembered my promise.

"Hey there! I just wanted to check in. How are things going?"

"Pretty good…can't complain. My breathing feels better."

I walked to the window and enjoyed a moment of the diminishing sunlight before sitting down. Then I stretched out my legs and let my body collapse backwards into the chair. The Easy One and I were face-to-face.

"I was hoping to get to know you better," I said.

"Sure. We see each other every day so that would be good."

"Where are you from?" I asked.

"New Mexico. Lived there until I joined the Navy. Then I traveled all over."

"Oh yeah? Tell me about it."

We talked for half an hour. I learned all about the Easy One, and he learned about me too.

Given a transcript of the dialogue, one would never guess the conversation had occurred between a doctor and patient in the hospital.

Eventually, I noticed the pitch darkness that had surreptitiously swept in behind the window. I told the Easy One that his nurse was worried he seemed depressed. I discovered he was grieving the recent death of his daughter from a drug overdose, but that things were getting better. I assured him that we would support him in any way we could.

“Well, I have to go, but hopefully you get some sleep tonight.” I stood to leave.

“Yeah, at least until they wake me up at three.”

“What do you mean?”

“Well, they come do my breathing treatments at eleven, and I go to sleep afterwards. But they come back at three in the morning. It doesn’t really help, and I can never get back to sleep.”

Beginning my trek to the employee parking garage, I felt great. I remembered why I had gone into medicine in the first place: to take care of people during their most vulnerable moments in life. And that night, I felt like I might have succeeded. I heard the Easy One’s story. And I spaced out his breathing treatments so that he would not be woken up at night.

But as I walked, I realized how detached I had become from the people I was supposed to be serving. I was often not the physician I aspired to be, and had little more than my own inexperience and inefficiency to blame.

In fact, I am emotionally invested in my patients. I worry when they are sick. I grieve when they die. I rejoice when they get better. But oftentimes, they would never know from our necessarily brief interactions.

I could have delved into the Easy One’s concerns days beforehand. If I had, a sick, elderly man would not have been unnecessarily woken up in the middle of every night.

It would have been so easy.

Other Top Stories

THE YIDDISH SPEAKING MECHANIC

By: Dr. Victoria Seligman

Mr. M had a spring in his stride as he walked down the long hallway from the waiting room. He exuded pride, in his well pressed mechanic shirt with “David” embroidered above the right pocket. It was his uniform. I never saw him in any other clothes over the almost ten years that he was my patient. I felt an affinity for him from my first encounter, and this would grow.

David worked in his son’s auto repair shop still most days. He was in his late 80’s when we first met. He had been a longstanding mechanic for the New York City (NYC) Police Department and eventually came to Colorado with his family. He recounted tales over the years: of working in New York, of travelling to most of the states in the United States with his wife in a motor home, and of his continued travel. We shared a common cultural bond, both being New York Jews. There was something therapeutic for me as well in his visits.

Mr. M reminded me of my grandfather Joe who was lovingly called Pop by his grandkids. He shared Joe’s gleaming blue eyes. We started exchanging emails for holidays. I was on the list of corny jokes he passed on to family online. Pop and he had a similar the work ethic too and both worked long hours well into their 90s. Mr. M inspired me by his continual pursuit of new education and experiences. A few years ago, he told me with great joy that he had been accepted at his synagogue to a religious spiritual study called Kabbalah that would require daily meetings even earlier than his mornings at his son’s shop.

David would ultimately share some of his more painful moments in life; a privileged revealing. He had lost a son at 21 to leukemia and his wife of 65 years had passed. He had great faith and found comfort in it. When I started to explore his World War II experience, a tremendous story was uncovered.

Mr. M spoke Yiddish as did my grandparents. It was a common language from central and eastern Europe used among immigrant Jews in New York and often not passed down to the generation of my parents. Mr. M spoke enough to converse minimally per his report. He was among very few Jews in his branch of the military and among many fewer who could speak Yiddish.

As it turned out, Mr. M had been a witness to great atrocities during World War II. Drafted in 1943, he was sent to Europe and attached to an artillery unit as a truck driver hauling troops as the Americans began their relentless assault on the home territory of Hitler. Ultimately, they reached Germany and he had already seen great devastation.

He did not recall the name of the concentration camp, just that it was one of the first to be liberated by US troops. He watched with other solders as some of the army’s top generals, including Eisenhower and Patton, toured the facility. The delivery was indelible. I remember him describing in my office the moment of personal and historic significance. I remember him telling me about entering the camp, about seeing the Holocaust survivors. He described the survivors as one reads in books, as skeletons full of fear. He also recalled the corpses. I remember seeing his eyes twinkle as they teared. His story intersected with my personal history, as I am of a generation that still had direct ties to the Holocaust. I had a childhood friend whose parents were smuggled out of France to survive. I had Hebrew school teachers who were survivors. I had seen the numbers tattooed on arms. I was brought up with an obligation to remember.

David had entered the camps as a member of his platoon. He had, however, had the unanticipated experience of being a translator. The wary and traumatized survivors did not trust that the Americans entering were truly there to help. David used his Yiddish, the universal language at that time for Jewish prisoners, to reassure them. I kept his name on my list of incredible stories of veterans for years with the intention of videoing his story. Though, the years slipped away.

Mr. Mark’s remarkable good health slowly declined. He was receiving treatment for recurrent prostate cancer. More significantly, he had a series of TIAs and was developing sequelae of ischemia. For his 92nd birthday, he travelled to Israel and then NYC for a family celebration and was so happy to take this trip. He returned with a gift. We had often talked about Jewish food. And, there he was with a dozen NYC bialys. I had told him that after all these years in Denver, I had never had luck finding a good version of this bagel relative.

At one of his last visits, Mr. M asked me what we were going to do to fix his balance difficulties and uncoordinated gait among other neurologic symptoms. I strolled to explain to the mechanic that a fix for him was like an impossible mechanical feat. He passed away shortly after at age 96.

Mr. M remains a symbol of resilience to me. He was one of the few living liberator voices when I knew him. This is my belated tribute.

HOW TO SHARE A HISTORY

By: Nicholas Arlas
University of Colorado School of Medicine

"But you're white," said the little person with a big voice who sat in the bed in Care Unit 2. We had just met for the first time, a patient and a medical student, coming together to share a story sparked by the history of the present illness. In this case, she was here because she awoke at 4am coughing up blood, and had felt like she was going to die.

"I couldn't breathe."

The sound of high flow oxygen whirred through the room in the ED at Memorial, and she sat upright in her bed drinking coffee, black. Her name, which I'd seen in the EMR upstairs, suggested that she was Native. Not the native as in I'm a "Colorado native" who likes to put my kid in a onesie with said label, or who turns up their nose at out-of-state transplants while drinking craft beer in downtown Denver. The Native whose family was here before Colorado was Colorado, before the plains were Oklahoma, the Dakotas, Kansas, Nebraska. Before states were states. To use her preferred term, she was an Indian.

"You don't know how it is for us."

Those are true words. I will never know how it is for a Native American to live in today's America. So what does that mean when it's my job to give voice to her story in the context of a hospital admission? This person is part of a community that has been marginalized through the systemic racism of both the government and institutions like the healthcare system. She was stepping into a world where she would have to give up a fair amount of control. In fact, as her admission was at a teaching hospital, I would be the one to tell her story and provide the first pieces of information about her to the attending physician.

"If I'm not out of here by Friday I'm going AMA!"

The conversation started to flow from the drip, drip, drip, of a faucet left on, into the steady stream of melting ice. I had learned about certain aspects of Native culture from storytellers and great writers. Tommy Orange, in his novel *There There* taught me about the urban Native experience, about regalia, blood quantum, and A Tribe Called Red. Louise Erdrich taught me about the Native American boarding schools in her haunting short story *The Flower*. Rebecca Roanhorse, in her Hugo Award winning story *Welcome to Your Authentic Indian Experience*^{TM}, threw down a layered take on exploitation that still has me thinking. It has been a privilege to read the work of these authors and listen to the stories that have grown out of their histories.

In her seminal work *Wakiksuyapi: Carrying the Historical Trauma of the Lakotah*, Dr. Maria Yellow Horse Braveheart describes historical trauma as “cumulative wounding across generations.” She suggests that collective survivorship can be brought about through commitment to a community’s traditional values and healing.

“I was a nurse for forty years.”

As a registered nurse and a medicine woman, my new patient’s identity straddled modern medicine and Native healing traditions. As a physician in training, I’ve learned to be careful with my words and to open my ears more than my mouth. It is with gratitude that I can say my experience as a reader has opened my mind to issues I never considered, and shown me how much I don’t know. It is with this mindset that I approached her history of the present illness. We say to our colleagues all the time “*take* a history.” I propose we shift our phrasing to be “*learn*” or “*share*” a history, as “*taking*” has a one-sided or even violent connotation. The act of taking has defined much of the historical trauma experienced by my patient and her family, and the way forward in her care was to acknowledge that. So as we settled into our conversation I asked her to share her story, and sat down to learn.

“Can I have another cup of coffee?”

WHEN THE DOCTOR BECOMES A PATIENT

By: Dr. Gail Mizner

One year ago, the night I got home from the 2018 CO ACP Chapter meeting, I was relaxing in the bath when my hand swept across my right breast and I felt something hard. I had a moment of dread, but pushed that aside and went to bed. Eight days later, I got a diagnostic mammogram which showed nothing—just the dense breasts that my mammograms had shown for years. The ultrasound was another story. Even I could see, the irregular mass in my lower right breast when I looked up at the screen. Dr A, the very nice diagnostic radiologist who takes turns with her colleagues coming to our rural hospital every Monday and Tuesday, tried to come up with a differential diagnosis, but we both knew I had breast cancer.

The biopsy was scheduled for the following week. I had a talk to prepare and patients to see and an elderly parent just out of the hospital to visit, so I didn't have much time to focus on the breast cancer until Thursday, the day before we were to leave on a one night hut trip. With the living room filled with backpacks and ski equipment, I decided to look up my ultrasound report: 2.0 x 2.4 x 3.0 cms. Three centimeters! I had just moved from what I'd assumed was stage 1 to stage 2. What I had thought was a little "ditzel" of a tumor attached to a cyst was actually a 3 cm tumor encompassing the entire "cyst." My friends asked me if I wanted to cancel our excursion, but I wouldn't hear of it. We went ahead with our plans, and, though not without its tearful moments, the trip was wonderful. My husband and friends enveloped me with love and support and laughed with me as I joked my way through my dread at having to stop HRT. Nature's beauty soothed and strengthened me.

The biopsy went smoothly. It was not particularly painful, and I found it interesting to be in the role of a patient getting a procedure I had ordered for others so many times. The radiologist said she would call me in 2-3 days with the path report. She called the next day while I was at work: invasive ductal carcinoma, grade 2, ER/PR and HER2 testing to follow. Residency training prepares you to work through almost anything, but thank goodness I had a lot of no shows that day. In between patients, I called my husband, Mike, (who works in Phoenix all week long) and my two 20-something sons. Mike and Zach, my youngest son, both arranged to fly in the next day, but I couldn't face the idea of going home to an empty house that evening. I texted about 8 of my friends, several of whom had had breast cancer: "Just found out: invasive carcinoma…I'd like to have a cancer party tonight at my house… Bring food if you can come." They came, bringing a meal so delicious and well balanced it was as if we'd been planning for weeks. We laughed and told stories and those who'd already been through the breast cancer ordeal showed their lumpectomy scars. It was perfect.

The next day, I had to decide where to get treated. I'd been given lots of recommendations, including local options, but I decided I would feel most comfortable at the major medical center where I had trained and been on the faculty so many years ago and where I still had many friends and acquaintances. I called and got an all day appointment in their Breast Center for the following Wednesday.

As the week proceeded, I got the good news that my tumor was ER/PR positive and HER2 negative, and I had a phone call from the nurse navigator at the Breast Center. Perhaps because I told her I was a physician, she flooded me with information. I was eager to have it at first, but she just didn't stop, and she was bouncing around from one topic to the next, talking about chemotherapy and weight gain and diagnostic tests and investigational studies. I've been taught since medical school not to overwhelm patients who've just received a serious diagnosis with too much information, and I'm sure I've violated that rule multiple times. This time the shoe was on the other foot. I got off the phone feeling completely overwhelmed.

Friday morning I had my MRI. Though I had resisted the idea of doing breast MRI screening through the years, knowing the high false positive rate, I didn't think twice when the diagnostic radiologist recommended it after my diagnosis. The exam was awkward and uncomfortable—not the kind of acute discomfort of a squeezing mammogram, but a long, noisy time in a weird position.

Later that afternoon, Mike and Zach and I were getting ready to go skiing when, not having learned from my experience with the ultrasound, I looked up my MRI report: 6 cm tumor with chest wall invasion. A common expletive beginning with f exploded inside my brain. Were we talking stage 3 now? I could not bring myself to go to my husband or son right away with this news. I needed to talk with someone who would immediately understand the implications of the report, so I called one of my internist friends. She reacted with the same four letter word. Finally, I went and told my husband and then my son, trying to reassure them with the most important piece of information I'd retained from that overwhelming phone call with the nurse navigator—that MRIs often make the tumor look bigger than it really is. And then we went skiing. It was a beautiful, sunny afternoon, and I skied like a bat out of hell. I felt powerful and strong, able to face whatever was to come and thoroughly insp ired and strengthened by the beauty around me. I actually felt joy.