FOREST FOR THE TREES
By: Kim Chen, MD

It was a decade ago when I first met DH, an unassuming Vietnam veteran seeking treatment for GERD, onychomycosis, and PTSD. It wasn’t until the second visit, though, when I realized how profound DH’s issues were. While reaching across the triangular shaped room to get a blood pressure cuff, I accidently kicked a rolling stool. In less than a split second, DH, who had been resting easily in his chair, was sprawled on the floor on his hands and knees, tense and hyper-alert. I apologized profusely for alarming him, and after a few deep breaths he responded, “It’s ok. I do this all the time. I can’t help it.”

I eased DH back into his chair, and we continued our discussions. A few minutes later, a nurse walked down the hall and dropped a folder into the bin of my closed office door, a signal that the next patient had arrived. The light snap of the plastic hitting the wood was enough to launch DH out of his chair onto his knees as if a bomb had exploded beneath him. It took him a couple minutes before he could retire to his chair. I offered DH a wheelchair so he could safely navigate the landmines in the VA hallways, but he declined. I asked him if he would prefer telephone visits so that he could avoid the VA chaos, but he shook his head. Before he departed, he pulled out earplugs and stuffed them into his ears.

On successive visits, DH revealed to me that he sold wood flooring for a living. He told me his favorite wood was Brazilian cherry and raised his eyebrows when I told him I liked hickory. When I inquired how he liked his job, he told me times were tough between the economy and his uncontrolled startle responses. A few days earlier when his company entertained clients, someone accidentally dropped his fork. Before he knew it, DH was lying on the floor, struggling to get up. His boss explained to the clients, “It’s just his P-T-S-D. You know, shell shock.” DH saw a psychiatrist who initiated different types of medications—antiepileptics, antidepressants, antipsychotics—none of them effected DH’s startle response. He was hopeful when he was finally admitted to the VA’s inpatient PTSD unit. After three weeks, his startle response was unaffected, but the nursing staff had learned to close doors gently, and cleaners made sure his earplugs were inserted before they clanged their mops and ran their vacuums. Other patients in the unit oriented new members to ensure that they did not drop books, slam doors, or use entry/exit buzzers.

Hoping to find a solution to DH’s debilitating startle response, I obtained a referral to a behavioral neurologist, who asked a lot of questions, but did not propose any solutions and did not feel he needed to return. A second referral to a different neurologist resulted in the diagnosis of “PTSD and exaggerated startle.....low concern for a neurologic cause.” A year later a continuous EEG was unrevealing. DH found the results of the consultations frustrating and discouraging.

When DH turned 60, his girlfriend made reservations at a nice restaurant. The appetizers and wine were delightful, and the conversation was wonderful. Unfortunately, a waitress dropped a glass, and before he knew it, DH was sprawled on the floor looking for a foxhole. His heart
raced, his body trembled, and his limbs were locked. He was too weak to get up, and his girlfriend was not strong enough to lift him. After a few minutes, he mustered all the energy he could and crawled out of the restaurant. His girlfriend sat with him as he lay in the parking lot for an hour, before he could finally lift himself up and walk to the car. Not surprisingly, DH lost his job. His boss was sorry to see him leave, but needed to put the interests of his struggling company first.

DH’s startle responses occurred a few times most days. Between my visits, he was seen a couple times in the ER, with x-rays documenting both new and old rib fractures. He never sought pain medications for the fractures, nor did he complain about the injuries he suffered. A few years ago DH asked me if he should go scuba diving given potential risk to his aortic aneurysm. I researched data regarding aneurysms and scuba diving, but information was scant, with only recommendations to err on the side of caution. I asked DH why he wanted to scuba, and for the first time I saw him smile. “Because it is so quiet and serene. I don’t have to worry about anything or anyone under water. It is my escape.” Together, we discussed the risks and benefits and came to the same conclusion—to go scuba diving as often as his personal economics would allow.

In the ten years I’ve known DH, we have made no progress on his startle response. We have tried a multitude of medications, cognitive therapies, EMDR, prolonged exposure therapy, battlefield acupuncture, and marijuana. Each new treatment or subspecialty referral brings the prospect of a normal life, but ends in futility and discouragement. I am uncertain about what the next decade will hold for DH. As he ages, I worry that the startle responses will lead to fractures, concussions, and internal injuries. The possibility that DH will become the man he wants to be—easy going, calm, unflappable, and at peace—will likely elude him in his lifetime. The chance of finding a treatment that mitigates his startle response seems remote. It is not easy to balance the hope of finding a new therapy against the probable inevitable disappointment that no effective treatment exists. But although it is unclear who the enemy is or what weapons we have at hand, we will continue to fight the battle.
BEING COMFORTABLE WITH THE DARK

By: Tuong Phan
University of Colorado School of Medicine

KM was my first “rock,” a patient who was due for a lengthy hospitalization. It was 5:30AM when I first stepped into her room. KM had recurrent pancreatitis and had been in and out of several hospitals, but it was her first time in this hospital, her first time being visited by a medical student. I stumbled throughout our interview, trying to make sense of her complicated medical history.

“I’m in so much pain… I just want it to stop.” She closed her eyes.
Mentally preoccupied with figuring out how I was going to present her extensive history to my team, I ignored her and walked towards the door.
“I will relay what we talked about to my attending. Would you like me to leave the lights on?”
“No. Please turn it off. I’d like to go back to sleep.”

That afternoon, I reviewed the 126 pages of her scanned transfer documents: HIT, multiple abscesses, bowel obstruction, high-output fistula, ruptured cyst, and hernias, all on top of a history of RA, AI, and depression with suicide attempt. I pieced together some pertinent details to convey to my team, but as I spoke, I saw it glossed over their eyes. It seemed to be as overwhelming for them as it was for me.

On her 4th day, KM cried.
“No one seems to know what to do with me. You have all these doctors but no one can tell me what’s going to happen.”
The complications of her pancreatitis had completely warped her abdominal anatomy that even after multiple imaging modalities, our specialists were still uncertain of how to put her back together. However, even when she was angry, KM’s voice remained soft.
“I don’t want these holes in my stomach. My husband doesn’t look at me the same way. My daughter is acting out because her mother is never home. I just… I just don’t know what I’m living for anymore.”
KM’s dark room suddenly felt metaphorical. This darkness had been creeping up to us over the past few days, and soon, it was going to drown us. What could I do? What were the right words to say?
“I’m sorry. I can’t pretend to know what you’ve been through… but I do see an end to this dark tunnel, and I hope you will see it too. In time.”
I handed her a box of tissue and went to pre-round on my next patient. But deep inside, I knew those words weren’t enough.

On her 8th day, KM lashed out. My attending had approved of my suggestion to consult Psychiatry, but KM did not receive them well.
“I’m tired of all these doctors. You’re the only one that’s been really talking to me.”
Again, I did not know how to respond. I could have answered any of her questions about medicine, but it was these emotional statements that left me speechless. I was worried that her
growing sense of frustration and isolation would lead her to hurt herself. I had to do something, and in that moment, doing something meant telling the truth, the truth about why I was really struggling.

“Mrs. KM, I’m pretty sure I’m not supposed to say this... But I too have depression. Although in a different way from yours, my past year too had been hell. And I too have been struggling with it.”

Her eyes widened. I continued on as quickly as I could, before I could regret my decision.

“I never knew what to say in our conversations, because I never knew what I would say to myself. The hopelessness, the tears, the self-hatred and self-pity, this darkness that we’re sitting in right now. I am all too familiar with it.”

I stuttered through those last words, unsure of how she would react. She reached for my hand.

“Come here.”

It was the first hug I had ever gotten from a patient. Her frail, malnourished body felt as light as a feather, but her tears carried weight. My shoulders remembered their cool sensation all throughout rounds that morning.

KM was hospitalized for the entire month I was there. I met her daughter and her husband. KM and I would spend at least an hour every afternoon talking, most of the time about things completely unrelated to her medical problems. There were days when she was so fatigued that she asked to only listen while I talked. There were days when she had an infection and we felt estranged, separated by gowns and masks. There was an afternoon when we thought she wouldn’t make it, and I sat there with her family in silence. She and her family became the rock that grounded my decision to continue medical school.

KM was a person before a patient. She did not have holes in her abdomen before her illness, the holes that she was always too ashamed to show her family. She was not on 10+ medications before this past year. And I was a person before a medical student. I listened and saw KM for more than those holes. I did not have the power to prescribe medications, but by being present, I helped calm her anxiety and pain.

Until meeting KM, I had never realized how glaringly bright my white coat was in those dark rooms; we all had been looking like knights in shining armors charging in to rescue these patients from the evils of illness. The challenge lay in being a doctor even without these coats on. The challenge lay in guiding patients through their darkness even when we don’t know the way. The challenge lay in admitting we are human.

On that 8th day, as I was leaving the room, KM asked me to turn the light on. On that 8th day, we shared a smile.
THE EFFECT OF THE LITTLE MERMAID ON IDIOPATHIC PULMONARY FIBROSIS

By: Robin Harland
University of Colorado School of Medicine

From behind the BiPAP mask, JC’s devilish smile shone through an unhopeful situation. His black glasses framed his eyes with the hint of a professor’s scholarship. Rather than accentuating his older age, his untamed white hair gave him an aura of wisdom and perhaps attested to a lifetime of experience. As I entered the hospital room for the first time, I held my breath, not sure what to expect from him. Mr. C was the first patient during my second week of internal medicine, and his chart had my mind whirling.

“And who might you be, ma’am?” He asked with a tone of feigned trickster masking true curiosity. I gave my usual introduction as a third-year medical student (translation: I have no power to help you, despite my official-ish appearing white coat.) Mr. C was staying in the ICU for COPD complicated by idiopathic pulmonary fibrosis. To make matters worse, he had just been incarcerated a few weeks prior to his admission, where he had experienced tear gas and pepper spray as forms of punishment alongside his fellow inmates. His CT had looked disastrous, showing widespread honey combing in both lungs. Even as a new third-year student, I could tell right away what my attending would later define as “inspiratory crackles” sounded very abnormal. What puzzled me was the troubling adjective that so mockingly decorated the name of his condition: idiopathic. That was for me to explore in my subsequent discussion with the attending.

After taking my best stab at presenting Mr. C to my attending an hour later, I started leaving the room and paused for a moment. “Excuse me, is that a Little Mermaid blanket?” I inquired. “As a matter of fact, it’s my granddaughter’s!” We both agreed that Disney Princesses have healing powers no medicine can quite match.

I thought for a moment on one of drugs I had seen on Mr. C’s chart, a benzodiazepine for treatment of intense anxiety he got using the BiPAP mask periodically. Yet here he was sitting before me, so calm and collected. I asked him, “Mr. C, how’s your anxiety been lately?” It was his fifth day in the hospital.

He began to recount to me his experimentation with meditation. “I actually found this goofy recording of a voice that takes me through breathing and mindfulness exercises. Listening to her, my sats were higher than they’ve ever been, even without oxygen! I couldn’t believe it.” I started pondering how Josh’s mental state seemed so intertwined with his physical state. Hospitals are frightening places alone, even without a face mask to make you feel trapped. I congratulated Josh on his success at mindfulness and left his room to write my note.

As the week passed, I started learning more about JC. He had lived in Denmark and all around the United States, for example, and had done everything from construction to military work. He began to call our daily sessions one of his “favorite parts of the day,” which flattered me but
offered some insight into his monotonous days and dismal prognosis. Mr. C knew that his condition was not promising. The pulmonologist had thrown around some possible etiologies from his IPF but ultimately decided he was not a great candidate for biopsy. I had fun explaining “pulmonary Langerhans cell histiocytosis” as a possible cause of Mr. C’s plight, and he taught me how to air drop web sites onto smart phones. One day I found him celebrating his 64th birthday overjoyed by a piece of pecan pie brought to him by his family. His gratitude and optimism astounded me. Although I learned more about him as a person every day, my attending decided his case was growing to be less of a learning opportunity for me and assigned me to another patient. I feared this meant Mr. C’s situation was stagnant without hope for improvement.

One week passed, and I received an email with a patient room number for weekly professor rounds. Showing up I was delighted to see JC, who had moved out of the ICU and onto to the regular floor. As we walked through a comprehensive lung exam in our group of ten, I wondered what he must feel like to be examined by students. Does he feel like a specimen under a microscope? Much to my surprise, he ended our teaching session with a speech thanking all of us. He concluded with “I’m just so grateful to you all for taking the time to learn this and to provide great care. It means the world to me.” Again, I was left baffled by his thankfulness.

Moreover, his health had improved tremendously since I had seen him the week before. “Mr. C, you sound a little better.” I remarked.

“A LITTLE?!” he retorted with a grin. “A LOT if you ask me.” He was now off the BiPAP completely and was being discharged to a skilled nursing facility that day.

“But how are you doing, Robin?”

How am I doing? Here was a man with lungs deteriorating by the day, and he had the selflessness to ask me how I was doing. As much as I wanted to cry out that med school was hard and the hours were long, I kept my mouth shut. I stood in the presence of a man who had taught me how to see the best in every situation. He was more than just my teacher on idiopathic pulmonary fibrosis, he was a reminder that gratitude is a choice. JC didn’t live in a naïve world of rainbows and unicorns, he was fully aware of his situation and the gravity of his condition. But he chose to find the good in all of it, and this vantage point influenced him not just mentally, but I believe physically as well. He lived life with purposeful positivity, and he has inspired me to do the same.
“You are entering the chart of a deceased patient. Proceed?” The computer flashed the warning at me mockingly. Did it really think I didn’t already know? I clicked ‘Yes’ automatically and scrolled back to the discharge summary dated December 31st, 2016. I read my words over and over imagining my last memory of him. His heart rate raced into the 180s, and he sat there playfully jeering with his sons. I silenced the monitor while my insides screamed, “convince him to keep fighting, you’re giving up on him!” It would take months before I could silence the voice of my guilt.

I took care of him for four weeks, an uncommon feat in a revolving door of admissions and discharges that residency can come to personify. The day I started was the morning following his admission. My second to last day on the wards, I discharged him to hospice. Every morning in between, I walked into the call room, fearing that he was newly intubated, or in multi-organ failure. I recall the overnight team handing me the sign-out one morning. “He is really sick, Deepa. What are you going to do?” I shrugged and turned my eyes to my patient list in a gesture of shame. “I don’t know.” We moved forward each day with a litany of tests. I caught myself thinking begrudgingly, “to what avail?” We had no idea why he was in decompensated heart failure and every measure we took to control one symptom elicited a new one, more difficult to manage than the last.

I walked into work on New Year’s Eve, a Saturday. The hospital was a ghost town. I began my pre-rounds as I had grown accustomed to doing, with him. “Good morning!” The lights were off and his somber eyes stared back at me blankly, lit only by the orange and green of his bedside telemetry monitor. Maybe I pretended not to hear his words because I didn’t want to hear them. Then, a little louder, “Deepa, I’m done. Get my kids in here as soon as you can. I want to go home.” The sensation of defeat was palpable. “Would you mind explaining to me what you’re feeling?” Why do we feel the need to ask additional questions until we have a satisfactory answer? He didn’t want to go there. “I told you, I’m done. We tried our best, and now it’s time to stop.” I said I understood and respected his wishes. I walked out of the room in shock. His nurse saw the look on my face. “He has been talking about this for days, you knew it was coming.” Maybe I did, and maybe I didn’t want to believe it. I thought back to my nihilistic attitude regarding our aggressive measures and instantly felt my conscience in my throat. Was this transference of my bias somehow?

We are transient beings in residency. One evening we stand in the intensive care unit, clutching the hands of a dying patient’s daughter. The next morning, we walk into clinic to discuss contraception with a healthy 27-year-old. Is there a switch? Do we learn how to turn it on and
off so easily and frequently, that the sentiment of each conversation escapes us completely? We move from one interaction to the next in a superficially seamless fashion, and then we go home. We think about each patient, each interaction, replaying the decisions we made. As we perseverate, we may miss the silver lining, often wedged between the challenging patient interaction regarding pain control and the 8th admission of the day.

At some point, we realize how our thoughtfulness humanizes us. We make clinical decisions based on our knowledge of the human body and pathophysiology of disease. We proceed with standard of care as able, with modifications based off of unique patient experiences. And yet we second guess these decisions, we feel defeated with the weight of failure, and we feel in sum, imperfect. Moving back and forth between one complicated patient and the next, we forget the importance of our complex ability to see the grander scheme, to see who is the patient is, not just what is their disease. It is our moral will to face grave illness and take the hopeful route. We try every option available, to fight for time, for relationships, and for future experiences. That is easy. For us, the road less traveled is accepting defeat. But how do we cope when the patient welcomes the process of dying? We may not necessarily be ready for this. Does it mean our patients have given up on us? Or did we guide them to a point of fulfillment and acceptance? How do we proceed?

I sent him to hospice that same afternoon. I thought I had failed them. The tears in his daughter’s voice when I called her on my walk home from the hospital that night have flooded my memories of their family. “Thank you, Deepa, for everything. He made up his mind and whether or not we saw it coming, I think we all realize this is what is best.” I thought doing this over the phone would make it easier. Wrong again. I choked through the words “it was my pleasure taking care of you all.” Months later, I opened his chart to see that he died one week after New Year’s. I breathed a sigh of relief. In that moment, my guilt was silenced. Stopping our aggressive interventions was the right decision, at the right time, and it was as simple as that. I needed to distance myself from those feelings of defeat to understand it. He was at peace in that moment, and I had the privilege of journeying with him to get there. That was the silver lining. I purposefully opened the schedule for the list of clinic patients for the day. We proceed.
BETTING ON DRINKS

By: Clare Prohaska
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I feel most comfortable in clinic. This is something that I realized about myself during my second year of residency; doing medical school at an institution that emphasized primary care has ingrained this in me for probably the rest of my professional career. This fact is part of the reason I still say that I want to specialize in an area that will allow me to take care of patients in both the inpatient and outpatient setting. One of my patients in my primary care panel is one reason that this is still the case.

I met Mr. L, a middle-aged black man with a history of PTSD, hepatitis C and type II diabetes, early in my intern year. During our first encounter, he sat for thirty minutes mumbling in my office about how terrible his home health nurse was, why he didn't trust her, and how she kept calling him Eddy. “My name isn’t Eddie! It’s Mr. L! She comes in acting all like she knows me!” I sat there, unsure of how to proceed, and politely asked if he wanted me to put in a request for a different home health company. He declined, but frankly stated that if the same nurse came to his house a second time he wouldn’t let her in.

Our subsequent visits were very similar, and I typically inwardly groaned to see his name on my schedule. More paranoid ramblings, how his blood pressure was usually elevated when nurses came barging in, how his sugars were elevated when they checked them. After inquiring about his eating and drinking habits, the subject of alcohol came up.

“How much do you normally drink?”

“Not that much, I’m cutting down.”

“But how much do you drink when you are drinking?”

“One shot, one shooter and one beer. Used to be way more.”

After discussing that this is likely affecting his sugars, I discussed cutting down, and he agreed. We went through this routine every visit, and his ramblings began to make more sense. I started to understand his sense of humor, and started looking forward to seeing his name on my schedule on the Friday mornings we saw each other in clinic.

During my second year, on routine labs he had elevated LFTs as well as a more markedly elevated A1c. He refused to go on insulin, so I sent him to the clinical pharmacist, who was able to titrate oral medications more quickly than a typical resident schedule would allow. I also discussed that since treatment was now indicated for all patients with hepatitis C, we should try to start treatment. He agreed and we sent off a battery of tests. Part of the initial screening included a liver ultrasound, which showed a cystic lesion, for which radiology recommended a follow-up CT of the abdomen. This showed a mass on the head of his pancreas, so he was referred to GI for an EUS. Prior to his EUS, we had a routine visit, at which point he confessed he was terrified of what this lesion could mean. “Doc! I don’t have an appetite! Look at my legs! They’re like chicken legs!” I gave him my cell phone number, told him to call me at any time and I would try to talk him down. I did my best to reassure him, saying that this was likely an
incidentaloma, but he knew as well as I did that this was only speculation.

We talked the night before his procedure, and I could tell how anxious he was. He called me a few days after his procedure asking about his results. I was not at the VA to see the pathology report, but I told him to call to ask about the results. When I went to the VA the following week, I saw that his pathology was negative for malignancy. I saw him later that week, and he was ecstatic. His A1c was better, mostly related to his weight loss surrounding his anxiety about the test, he had a new lady friend, and we were going to try to cure his hepatitis C. He was still drinking about 3 drinks a night, so I wrote a taper down on a piece of paper. “I’m going to hang this on my fridge!” he told me. I was not satisfied, however. I volunteered to bet on it. What to bet on though? Obviously not alcohol, baked goods were out, what else was appropriate for a provider and her patient? “How about a nice… juicy… sandwich?” he offered. We shook hands, discussed where we wanted our respective sandwiches from, and agreed that at our next visit one of us would pay up.

Our next visit was reminiscent of our original visits. He was upset about things in his personal life—his lady friend left, his children were causing problems and again he was having problems with home health. When we finally got into my office, I was attempting to log on to the computer when he took out a Subway gift card, placed it on my desk and stealthily slid it over to me.

“Oh no! What happened?”
“Girl, I couldn’t do it.”
Despite our bet, he has since been referred to hepatology clinic as they began treating everyone regardless of ongoing alcohol usage. We continue to discuss that it is in his best interest to quit drinking. However, as I write this, his last viral load was negative and his liver function has normalized.

There are many things that are not perfect in our healthcare system, including both the patients and the providers. Primary care is not my ultimate calling, of this I am sure. However, as I think back through my relationship with this one patient, I am once again reminded of what a privilege it is to be a physician. Indeed, I cannot imagine this job without some continuity in clinic.
On the night of September 10, 2001, I set my alarm to go off extra early as I knew the following day was going to be a day that I would forever remember. This was to be my first day as a primary care provider at the VA. As I was preparing to leave for work that morning, news of the first plane hitting the World Trade Center was just being announced. By the time I reached the VA it was clear what was unfolding. The few people gathered in the waiting room when I arrived were glued to the TV. I went to my office and received a brief tour of the clinic. When I returned to the waiting room I paused a moment to get an update and saw a reporter speaking while over his shoulder one of the towers collapsed. Everyone collectively gasped.

I called the first person’s name on the face sheet and an elderly man stood up, extended his hand and said, “My friends call me Ed.” We went to my office and tried to focus our thoughts on getting acquainted rather than on the national tragedy that was unfolding. Fortunately, he was very healthy was a routine visit. In reviewing his past medical history, the only thing that I felt required further discussion was his 10% service-connected disability rating for tuberculosis. He noted he contracted the disease when he was twenty-years-old while serving in the Pacific during World War II and was treated at a hospital in the Philippines. When I inquired if he recalled his treatment regimen he confidently stated, “streptomycin.” I paused, expecting others to be named, however, he was confident that was his only treatment. We returned to the waiting room, shook hands, said our goodbyes and looked to the TV to see that the iconic towers that helped define the Manhattan skyline were no more.

Ed’s history reminded me how little I knew about TB, particularly treatments from that time period, so I printed out some articles to take home. As I read this material while watching the 9/11 coverage, I thought of Ed as a young man in his late teens being sent to fight a war only to end up hospitalized in a foreign land enduring the lengthy treatment for tuberculosis. Competing for my attention were the many stories coming from he TV that, together with Ed’s story, helped redefined what the word “hero” meant to me. Firefighters, police officers, and countless ordinary citizens displaying innumerable random acts of kindness and self-sacrifice. Some of the most memorable reports were accounts of people leaving goodbye voice messages on their loved ones’ telephones. Hearing both the fear and calm resignation of the inevitable outcome was heart-wrenching.

It was many months before I saw Ed again. I recalled his medical history more than I remembered him or his name. He again requested I call him by his first name like his friends did. I tried to oblige his request despite it going against my inclination to address my elders more formally as a sign of respect. I suspect, as a young physician, I was also still defining my own concept of doctor-patient boundaries. I figured developing anything resembling a friendship would certainly disrupt the formality required to sustain a healthy doctor-patient relationship. Over the next many years Ed remained remarkably healthy and active. He undoubtedly provided more useful tips on improving my golf swing that anything I offered him to improve
his health. I got to hear about his family, his faith, his pride-filled athletic accomplishments during his college days. I serve as a continuity clinic preceptor for medical students and always wanted them to have Ed as one on their patients despite his mundane medical history, perhaps a way of having my first patient be one of theirs.

Several years ago Ed was hospitalized twice with acute renal failure due to urinary tract infections that required brief periods of dialysis. We contemplated the risks-benefits of prostate surgery at his age and opted to pursue a TURP. He did well for a short period of time but seemed to gradually decline. One day he presented to clinic when I had one of my medical students with me. He complained of several nights of drenching sweats, weight loss, and excruciating back pain. On exam he exhibited asymmetric weakness in his legs. While waiting for lab and MRI results, the student and I did what we Internists love to do most, ruminate over our exhaustive lists of differential diagnoses. I thought back to his TB history and began to make a case for tuberculous involvement of his spine, or Pott’s disease. The MRI revealed numerous lesions of his spine. However, the bone biopsy did not reveal a clandestine zebra, but rather metastatic adenocarcinoma of the prostate. With a clean pathology report from the prior year’s TURP and a PSA of 3, how could you his be?

While Ed did opt to undergo treatment, his health precipitously declined. Our clinic appointments became more focused on pain relief and comfort measures. I bought a cake for his 90th birthday and threw a small party for him in the clinic. Typically, when I called to check up on him I would speak to his wife, but towards the end he was alert and in good spirits and I spoke to him. He appeared to understand that his time was coming to an end. We talked about our first meeting on 9/11. I couldn’t help feel the passage of time with the last patient from my first day of clinic now dying. I also thought about those goodbye phone calls by the 9/11 victims that went unanswered. Ed finished our conversation by saying, “Thank you for calling and for the care you have provided me over the years, Dr. Barnes.” “My friends call me Carl,” I replied. After a knowing chuckle he said, “Goodbye, Carl.” “Goodbye, Ed.”

Goodbye friend.