



1st Place Overall Winner

MR. DENVER

By: Whitney Sumner
University of Colorado School of Medicine

I met Mr. Denver on May 4th while on a rural internal medicine rotation. I will always remember this, because as I left his room he said, “May the 4th be with you.” I had just finished taking a haphazard H&P on my first week of 3rd year and I was grateful for his humor to ease my anxiety. In the weeks that followed, the prior theories of a curable pulmonary infection dissolved and we were left with the devastating diagnosis of stage IV angiosarcoma. In the meantime, he had also become my favorite patient. At 44 years old, he was a Hurricane Katrina transplant who played classical music throughout the day and sifted through the photographs. He was a phenomenal photographer and taught others how to use cameras and technology with a penchant for detail that a type-A medical student could certainly relate to. This passion for detail extended to his healthcare, as he kept a detailed notebook of every H&H, medication, dose, etc. Each day he would ask for my differential diagnosis and complete honesty, which I promised and provided; always keeping malignancy on the list.

On the day his pathology report came back, we went to his room and the oncology team shared the news we had dreaded. Up to this point, he had refused to receive medical information with any family in attendance. So when the team had left, he asked if I could stay to help him tell his mother.

This was the beginning of many months of “real talk” that I would have with Mr. Denver. We returned to Denver almost simultaneously; I was finishing my last month of internal medicine and he was continuing chemotherapy, though we knew it had little value. His motivation was that if more chemo meant more data for research then he wanted to continue. Through our near-weekly visits, I came to find that he was the perfect thread to tie 3rd year together. On medicine, I learned how to treat his intractable tachycardia and shortness of breath. On emergency, I learned to read CT scans so that I could go over them with him. On psychiatry, I learned not only about medications to recommend for anxiety and insomnia, but also the ability to counsel him that he should focus less on his notebook and more on those around him. It was also a time sprinkled with meaning-of-life conversations and many donuts.

During my rural family rotation in Greeley, he contacted me that he was going in for an

emergent MRI due to new cognitive symptoms. He described deficits that meant he almost certainly had disease in multiple areas of his brain. I pulled up his scans and found several lesions. That night I drove to Denver and met him at the hospital. He greeted me with a hug and we spent a few hours with his family discussing his scans and trying to keep the conversation light. He was experiencing aphasia and it was clear how much this frustrated him – a man who took tremendous pride in his words.

By the following week, he had an emergency craniotomy following a seizure. Over the next two days I would meet all of his sisters he had told me so much about and his father who had flown in from New Orleans. At this point, he was entirely paralyzed and had lost most functions. He could, however, blink his eyes to answer yes or no questions: a blink for yes, nothing for no. When I said my final goodbye to him, I explained what was happening and asked him if I could have a blink goodbye to make sure he understood. He blinked twice, because he was not the type to miss a syllable. His family decided to remove respiratory support the following day. They asked if I would listen to his heart as he passed away so that we would know when he was gone.

I am not a religious person. I don't even know how spiritual I am. But when Mr. Denver died, there was an instantaneous release. A month or so before he died, he told me that he had cried for me. When I asked him why, he said it was because he knew that he was the first patient that I cared greatly for and that he was going to hurt me when he died. It was typical, selfless Mr. Denver to say such a thing. But until the moment he was gone, I had given little thought to what it would really be like.

I have cried immensely for Mr. Denver. I have prayed for him despite no real belief that anyone has heard me. I have felt anger that he declined so quickly and that we could do nothing. I have felt incredible love from his family that is certainly mutual. Many people told me that to become so close to a dying patient would yield certain emotional destruction. In some moments, I believed that. But those moments were fleeting and they were quickly replaced with a sense of pride, compassion and absolute joy that my chosen profession allowed me to cultivate such a meaningful bond. On one of my last visits to Mr. Denver's chemo appointments, we had a medical discussion and he said, "You know, you're a lot more confident these days. You used to be pretty awkward!" He was my built in direct observation form to (brutally) honestly tell me how I was improving as a future physician.

Ultimately, there is no test that prepares you to confront mortality, unfairness, anger and peace all at once. We can learn the limitations of modern medicine, but do not understand it until we truly bear witness. Mr. Denver was the best teacher that I have had in my medical education. I believe he represents the greatest gift that our patients can give to us and I am forever grateful.

2nd Place Overall Winner

BOURBON

By: Ajay Major

University of Colorado Internal Medicine Residency Program

It's my first day on a new rotation -- rheumatology clinic, with the attending who I hear crafts awful puns on the fly and lives for his so-called "no-delta" visits, his social time with his endless panel of stable arthritis patients. I log in to the health record, with the MS-DOS interface that harkens back to my days as a 5-year-old booting up our computer with those big floppies. I'm greeted by a few notifications on the patients I cared for last month on the wards. A few consults completed, a few labs that I forward to the inpatient team. One notification catches my eye, a canceled lab order for C.diff. I chuckle -- we all knew he didn't have C.diff. With the chemotherapy regimen that he was on, he had plenty of other reasons to have diarrhea. I double-click, curious as to why it took this long for the lab to finally cancel this weeks-old order.

The screen flashes to his chart, and I see on the display:

Reason for Cancel: <death>

I knew he was going to die. When I admitted him to the hospital for hyponatremia, we knew his cancer was terminal. I remember meeting him for the first time, the furrowing of his brows that spoke of the deep, bony pain that pierced through his ribs. His wife was there in the room, her hands clasped a little too firmly in her lap, donning that sallow yellow gown of contact precautions. He wanted the chemo, he said. He was a fighter, he said, as his wife rolled her eyes and scoffed, muttering under her breath. She stopped me as I was leaving the hospital that day, and she confided in me that she didn't want the chemo for him, that he was too sick, that she had known him every day for 40 years and she could tell that he was in pain. He always says it's a four, she chides, but I know it's a seven. But it's his body, she tells me. He wants what he wants.

So, he gets his chemo, and he tolerates it well. I convince him to actually take his oxycodone when he needs it, rather than when his wife says he needs it. I remember the tears in his wife's eyes when he looked at me from his chair, a thin smile on his face, and told me he felt no pain for the first time in months. His wife asks if he can have a beer when he gets home; he gives her a sidelong glance and says what he really wants is some bourbon from his favorite bottle. Not after all that chemo, but I'll ask the cancer doctor, I say. He looks up at me and smiles, the corners of his eyes wrinkling from decades of laughter and the joy of a life long-lived.

I also remember the tears in his wife's eyes when he came back to the hospital just two days later, diaphoretic and lethargic and with a new evil humor growing in his blood. Delayed-onset gut mucositis and subsequent bacterial translocation from his chemo, the infectious disease

fellow tells me. It was the worst night of my few short months as an intern, not knowing whether he would live or die, and not knowing if I was the one who put him there. Should I have kept him the extra day? Did we give the chemo too early? I went home after that long night and tumbled into a dreamless sleep, dreading my morning alarm.

But, he's a fighter, after all, and with a few days of antibiotics and a few boluses of fluid, he's back to his normal self, watching golf on the television and complaining at length about the hospital food. It's worse than when he was in the service, he says. We discharged him to an inpatient hospice on our campus, to a place that we promised would have better food, unlimited access to the outdoors, and all the golf he could ever watch. He asks me on the way out the door if he can finally have that bourbon he asked about before. We'll see what we can do, I say, and his wife gives me a private smile.

I visited him once in the hospice center, a few weeks after he was discharged from the hospital. He was sitting in his chair, his legs like mottled balloons from the proteinaceous edema that had plagued him for the past few months. He gasps when he sees me enter, those wrinkled eyes wide. He shakes my hand, his strong, military grip in defiance of the tumors that litter his bones. His favorite golf show blares on the television.

His nurse comes in and asks him if he's ready for his pain medication, her brows tight with the expectant look I gave him time and time again when he said no to his oxycodone in the hospital. Without missing a beat, he says, "Ask this guy over here. He knows best," and he turns to me, his face a mask of honest inquiry, and he asks, "What do you think, doc?"

A few minutes later, I sat on the bench outside, the setting sun in my eyes, and I cried.

I am sitting in the rheumatology clinic, remembering those wrinkled, warm eyes as I absentmindedly flip through the daily progress notes in his chart, as if those black-and-white words will bring color to my memories of his life: his sickly-green hospital sheets, his grey-white wisps of hair, the sallow yellow of our gowns, reliving each and every memory for fear that I might forget those little details. I do a double-take as I come to one entry by the palliative care physician, dated just a few days ago. It reads:

"Approached by patient's wife. Patient may drink bourbon, 1 ounce, as needed at bedtime."

3rd Place Overall Winner

A FEBRUARY TO REMEMBER

By: Clare Prohaska

University of Colorado Internal Medicine Residency Program

A FEBRUARY TO REMEMBER

February is the worst month of residency. Warned during interviews, cautioned early in the academic year about burnout, the fact that I would never be outdoors during sunlight hours, and that I would not quite be independent enough to function on my own but know enough to be dangerous in February, it was not a month about which I was particularly optimistic. I progressed through the months of wards, ICU and outpatient clinic. Then came February and VA wards.

I took over a team that appeared to be rather dull. The fourth day of the rotation one of my patients, Mr. M, had a new oxygen requirement. Mr. M was a patient with MRSA discitis, who was receiving IV antibiotics and was scheduled to get a repeat MRI done the following Monday to help guide future antibiotic therapy. I was surprised by this news, but not entirely—this was a gentleman who lay in bed all day, grumbled about getting up with the therapists and was consistently asking for more pain medications. I ordered a chest x-ray that showed a new infiltrate, so we started antibiotics, thinking this was aspiration. I left that day feeling good out my plan.

The following morning during my pre-rounds, I saw on the computer he was on a non-rebreather requiring fifteen liters of oxygen to maintain a barely adequate oxygen saturation. The VA maintains an open ICU, so I put in orders for him to be transferred. I went to see Mr. M, who was pale, working hard to breathe and looking scared. I tried to be as reassuring as I could; channeling my inner Osler, I was striving for equanimity. This was no time to be anxious, lest my patient think me hyperactive, overly emotional or incompetent. This was the time for action.

Mr. M was transferred to the ICU. He was stabilized, but had an insidiously increasing oxygen requirement. I went to talk to him about what the next step could be—if he needed to be intubated, would he want this? I went to see him in his ICU room, where he was watching TV. It turned out that he was originally from Colorado Springs but grew up in North Carolina, and was a huge Carolina Panthers fan, who he was watching that day. I muted the TV, put my hand on his hand and asked him this question. “I don’t know, better call my wife,” he said gruffly. As I went over the question again with his wife on the phone, tears rolled down his cheeks. He agreed to an elective intubation if necessary, trying to keep his voice steady so his wife would not know how much it scared him to be asked this.

Mr. M was electively intubated two days later. We struggled to find the balance between

treating what we thought was ILD with the ongoing infection in his back. During this he was awake, alert and interactive, giving me a thumbs up daily, walking with physical therapy with his ET tube in place down the halls of the ICU. My opinion of this man totally shifted—he was fighting for his life, motivated to get out, and wanted a return to normalcy. I met his wife and daughter, who were both beautiful and terrified, and became very close to this family.

Eventually, his lungs recovered enough to where he was able to be extubated. He required high levels of oxygen, but was dead set on going home. He was incredibly weak, despite his physical therapy. Given his high levels of oxygen, we thought that he might need to go to rehab prior to returning home. At this point, it was known that the Broncos would be playing the Panthers in the Super Bowl, and he told me how much he wanted to be home for this game. “I don’t know if we’ll be able to get you back home in time,” I told him. The same tears I saw only a few weeks ago rolled down his face. “We have to do what’s safest for you,” I told him, trying to reassure him once again. He nodded.

It turned out he was able to go home on his high oxygen requirement. The arrangements were made, and he was discharged the day prior to the Super Bowl. I went to say goodbye one last time, only this time I saw the tears again in his eyes. “I’ll miss seeing you every day, girl.” This time my eyes were also full, and I was the one who had a hard time getting words out. I told him what an honor it had been taking care of him, and he went home jubilant.

Two months later, the pulmonary fellow who had been at the VA in February texted me. “Did you know Mr. M died?” It turned out he had a flare of his ILD, had an increasing oxygen requirement but this time he had elected to be a DNR. He passed away shortly after arriving at the Denver VA. “His wife told me to say hello, and to thank you for all the care you gave him.”

I was incredulous and heartbroken at the news of Mr. M’s passing. I reflected more on my relationship with him; during our nearly four weeks together, I began to care deeply for this man and his disease. I was rattled—I had recently gone through a burnout phase of my own. I had recovered, and at that point I realized that equanimity is not something given from on high, but something that must be learned. I did not make it out of February unscathed in the end, but I learned that equanimity takes a lifetime and that caring for patients is never a wasted effort.

Other Top Stories

TO WALK A MILE IN SOMEONE ELSE'S SHOES

By: Theodora Tran
University of Colorado School of Medicine

Empathy comes from walking a mile in someone else's shoes, but in the hospital, I noticed something: patients don't wear shoes. My father wore socks.

Christmas morning of 2012, I woke up to find the evergreens drooping under the weight of the fallen snow. I went downstairs to meet my mother and brother, and we looked uncomfortably at the presents wondering what to do. "Let's take these to dad," my brother finally said. Without knowing whether it was appropriate to celebrate Christmas in a hospital, we grabbed some gifts and piled into the car. As we plowed through the snow, we wondered: would dad be tired today? Do you think they do the test last night? Would the doctor be there to talk to us?

When we arrived in the ICU, we found ourselves surrounded by machines. My father was in the corner. His feet were stuffed into oversized socks, and the hospital gown swallowed him whole. "We brought your Christmas gifts," my brother managed to say. As my dad continued wheezing into a ventilator, I averted my eyes into the hallway. It was empty because most people were with their families for the holidays. My brother looked at me, and we realized: this is our family, and we were with our family too.

When we pulled into the garage that night, the doctor called. My mom spoke to him for a few minutes before handing over the phone, asking if I could understand. As the doctor's words poured over me, I scrambled to follow and was quickly overwhelmed. The doctor paused. "I already explained this to your mom," he said impatiently. "It must be the language barrier." Never had words stung deeper. I fell silent as he sped through everything else he wanted to say, and I feigned comprehension when he was ready to hang up the phone. My mom looked at me hopefully, but I had never felt so hopeless. "We just have to let him do his thing," I said, feeling tears leak into my eyes.

After New Year's, my father finally came home. He had several scars from his surgery, and we were all emotionally bruised by the situation. Yet with time, things went back to normal. I returned to my life in college and started working on a medical device project. I spent several months working as an engineer, where I helped build a temperature management system and designed slip-on booties that patients would wear on their feet. In the summer, I implemented the system in the hospital O.R. where I found ways to improve the design for the patient, doctor, and nurse. I went back and forth, from the O.R. to the engineering lab, trying to incorporate what I saw in the hospital into the design of the system.

As I spent more time in the O.R., I became inspired to consider my role possibly as a physician. On midsummer morning, I was at the patient's feet with the device when the doctor came over. "Do you want to be my translator?" she asked. I shrugged, as I'd hardly spoken to a patient in my life.

I walked to the man's head and looked down at his closed eyes. In Vietnamese, I slowly asked, "Sir, do you understand me?" His bloodshot eyes opened. "Do you understand?" I encouraged him. He nodded fervently. I said, "I can't speak much Vietnamese, but the doctor asked me to stand right here."

Moments later, the doctor needed to take an X-ray, and she told the man in English, "Sir, I need you to hold your breath." He looked at her without comprehension. My mind went blank. I opened my mouth, my brain scrambling to translate. "Hold your breath," the doctor went on to command him. He looked at her helplessly. I didn't know those words but managed to mumble something intelligible in Vietnamese. The patient looked at me with understanding, and together, we found the right words. "Nin tho?" he asked. "Nin tho!" I said. "Nin tho!" the doctor repeated after us, and the man held his breath.

As the doctor continued working, I stood by the man's head. He looked at me. "Miss, will it hurt?" he asked in Vietnamese. I didn't know. "Is the tumor big? Will they give me the medicine? Does my son know?" As he continued to ask, I started to find the answers. The more I began to understand, the more I wanted to know about his diagnosis. I wanted to tell him what the doctors were saying to each other, and I wanted to assure his family that he would be okay. Throughout the man's operation, I again felt overwhelmed and confused at times, but I was hopeful that I was there for this man to offer my understanding.

Whether it is for a father or a stranger, it was empathy that put me on the path towards becoming a physician. Empathy is powerful. It is inspiration not only to improve the patients' physical conditions but also to care for their emotional states, to discern their personal needs, and to recognize their cultural differences.

In creating the future of healthcare, we can't forget empathy. Yet, how do we structure empathy? How do we fuel connection in clinic but maintain impartiality in diagnosis? I hope to answer these questions during my career, although in some ways, I started on that path even before medical school. Each new generation of the engineering system I worked on in college incorporated a design element that better suited the needs of patients. I used to pull the slip-on booties on the patient and wonder: what would it be like to walk a mile in this patient's shoes—or should I say, their slip-on booties?

COMMON GROUND

By: Nazanin Kalani
University of Colorado School of Medicine

In my second week of my internal medicine rotation, I was assigned a patient that would teach me the importance of taking a step back in order to see the patient as more than a diagnosis. This patient was a young female with metastatic breast cancer. As I looked through her chart prior to introducing myself, I discovered that she was completing her premedical requirements in order to apply for medical school. Being a young female medical student myself, I was nervous that talking with me would be difficult for an aspiring student with a terminal diagnosis. These fears were eased when I first introduced myself and asked permission to speak to her, in which she kindly accepted. Regardless, I approached the situation thoughtfully. Instead of jumping into questions about her diagnosis and her hospital stay, I decided I would sit down and talk to her about something we both loved, medicine. We talked about our motivations for going into medicine, what medical schools she wanted to attend, and how many pages of her organic chemistry book she actually read. Rather than treating her like a patient with a terminal diagnosis, I engaged with her as a fellow student with familiar goals and aspirations that I had just three years ago. When I left the patient's room, her mom followed me out. She told me that her daughter really needed that talk that morning and that she hadn't seen her daughter's eyes light up like that all week.

As the first cohort of students from the University of Colorado that will be spending our third year rotations in Colorado Springs, we have been given the task of choosing 50 panel patients that we will follow throughout our year. The goal of the panel is to follow these patients to the majority of their appointments, from primary care to specialty care and even to their surgical operations. In its most basic form, it is meant to give us an insight into health systems and the complexities and challenges of continuity of care in the healthcare domain. More importantly, I have found these continuity patients allow us to gain a sense of awareness and empathy for the magnitude of impact a diagnosis makes in a patient's life. I learned this lesson through this young patient with cancer.

I was able to follow this patient throughout my week in internal medicine. After each day, our connection was strengthened. I learned she had young children while she learned about my fear of pediatrics. When my week was over, I told her about our patient panel and she agreed to have me follow her throughout her care. While she was in rehab, I was able to see her progress from her hospitalized state, for instance, she could now walk with the help of a walker. Yet even with her encouraging progress, she was readmitted in the following weeks. Again, I went to see her in the hospital. This time I played a unique role in her care. I found myself becoming a liaison between the patient and the healthcare team. Although she had stage IV cancer, her view of her prognosis was hopeful and she wanted to be aggressive in her treatments. I was able to communicate her history and goals to my attending physicians while simultaneously serving as a sounding board for the family at times when they felt frustrated

about aspects of her care.

I have been following this patient for several months now, I have visited her in the hospital, rehab, and even at her oncology appointments. My involvement with this patient has expanded my capacity for compassion and empathy as I have fully immersed myself in her experience. We have built a unique student-patient relationship, one in which trust and respect are balanced with partnership and understanding. This patient has shown me that finding common ground with a patient initially, such as a shared love of medicine, can mold the way a patient views and reacts to you. It has taught me to always remind myself of the patient and their goals of care before I look at their labs and their diagnosis. As I move forward in my career, I know my time will decrease and my responsibilities will increase. This will inevitably make building strong connections with patients more difficult. However, I hope to remind myself every day to sit down when I speak to a patient, to ask them about their hobbies and aspirations, and to demonstrate genuine empathy when I hear about their journey through our complex medical system.

ACCEPTING

By: Forrest Jespersen

University of Colorado Internal Medicine Residency Program

What can I provide you sir? In my ICU you will continue to suffer from pain. We will put more catheters through your thin, jaundiced skin. You will not eat another meal; they will be delivered through a tube rubbing your nose raw. Your breathing will worsen and we will put a breathing tube into your airway. Is this what you want on your way out of this world? I cannot ask you these questions as your failed liver has poisoned your mind. Do you know that it is now your wife and family who are tasked with helping us guide your dying body through to its final home?

The transferring physician's voice, heavy with exasperation, asked to transfer this 47 year old man to the ICU due to worsening respiratory status. The tumor had completely obliterated his liver and no treatment options remained. His liver, inundated by disease, left him dangerously hypoglycemic leading to days tethered to IV dextrose, further worsening his severe anasarca and ability to breathe. I was being asked to accept the care of a man whose death was clearly imminent from this brief phone call. What could I do for this man without worsening his suffering while attached to machines rendering him that much more departed and alien to his family? Does the family know that hours to days are left for this man? My ventilators and pressors are only temporary measures costing tens of thousands of dollars daily – is this warranted?

I walked into his room not knowing what to find aside from a terribly sick man. What I found made my expectations seem rosy. There he was, reclined in his bed with eyes partially open, focusing on nothing in particular but revealing vibrant yellow sclera. His jaw hung from his head as he took shallow breaths too quickly. His abdomen and legs so swollen he could not move without help. Only once I leaned in close and introduced myself did his eyes move slightly before returning to his former stare. "Sir," I thought, "your body has made its decision, I can do you no good, please do not make me do this to you." I was afraid of the pain and misery I would have to inflict upon him. Though it was clear to me his cancer was bringing his life to a close, his family was not ready to say goodbye and he remained full code. Were they honoring his wishes or pursuing their own? They prayed for a miracle. I prayed I would not have to cor him.

My internal conflict about the appropriateness of this man's care led to multiple conversations with fellow residents, my attending, and the palliative care team. Futility often came to mind. Concerns were raised about whether we should intubate him, or were he to code, when do we call it? When do we say the psychological burden the nurses and doctors bear from doing painful and ultimately fruitless procedures is so great that we do not offer them? How do others grapple with this? Surgeons can refuse to perform surgeries. Oncologists withhold chemotherapies that will expedite death. Where do my interventions fit in the algorithm for a

dying man?

Daily I would speak with his family, reiterating that anything we do would only serve to prolong his suffering and ultimate fate. Where was that miracle? I write this not to speak ill of the family or their faith, but rather about the realization that the miracle they needed was time and that in their minds God provided just a little more through the tools only available in the ICU. His pulse was still palpable and briefly he would stir, but after days of no longer being able to participate with the prayers or interacting with anyone, his family realized they should let go. Time came when we were able to extubate him, remove catheters, and move him to a room apart from the hums, beeps and chaos of a busy ICU. My patient died peacefully in a room surrounded by family, people holding his hands. No code. No machines. No trauma.

Giving his wife a hug prior to leaving his room for the final time included navigating the mass of tight curls orbiting her head. She squared my shoulders and thanked me, asking that I never forget my patient, the time we shared agonizing over how to care for him, or the peace in the room when he finally left. I assured her I would not. As I walked out she caught my glance once more and said with a smile, "Remember the hair!"

I walked out of the hospital exhausted after my 24-hour call shift. In addition to pronouncing this man deceased, I called the coroner for two other individuals that night before transitioning another young man to comfort care early in the morning when his mother arrived from abroad. He died hours later. This was the culmination of one of the most emotionally taxing yet simultaneously rewarding 24 hours I have ever experienced. It left me oddly drained but immensely proud and fulfilled, having in a curious way helped these patients and their families through an inevitable turn for us all. Now, more than a year later, I think of that man with tumor riddling his body, his wife with that amazing hair, and the challenges, the joys and the growth that came with accepting the transfer of a dying man.