Deathbed Epiphany

Category: Stories
written by Christina Johnson | November 4, 2016

As a family-practice resident, I've found that a premium is placed not only on my clinical acumen but also on how well I respond to my patients' mental and emotional experience of illness.

Yet the work of learning to be a doctor is just that—work. And in overwhelming amounts. Time management becomes ever more vital: As I take the time needed to gently break bad news and to console a patient, I must also stay conscious of the next patient's appointment, the next phone call to make, the next exam to study for, the next lecture to attend, the next research project to complete and the next practice guideline to learn.

As my residency progressed, I found myself increasingly preoccupied by this aspect of work. I timed my office visits to determine how I could improve my efficiency. I honed my admission-interview shtick so that I could get a comprehensive story in half the time. I learned to elicit the needed information from a patient so that I could make an assessment and get to the treatment plan as quickly as possible.

And, I noticed, I was feeling increasingly disconnected from my patients.

Then, one day not long ago, our team admitted a middle-aged woman with diabetes. Her name was Annie. She'd come to the emergency room with a raging fever and shortness of breath; tests showed an infection in one of her heart valves. She was given antibiotics and sent directly to the ICU where, before long, she was put on a breathing tube and give medications to sustain her blood pressure.

By the time I encountered Annie, two days after her admission, it had become clear that these efforts weren't working. Her organs were failing, and all the signs pointed to imminent death. Reading her records, I learned that she was an immigrant whose parents, uncles and siblings had suffered from chronic illnesses. Desperately wanting something different for herself, she'd done her best to control her weight and blood-sugar levels, but it had always been an uphill struggle.

At first Annie was just another name on my patient list. But over the next few hours, as I reviewed her charts, I discovered more about her.

She was a teacher, and she loved her work. With her own children grown to adulthood, she was looking forward to retiring. She wanted to do something special—something that reflected her unique talents and burgeoning interests. She'd already picked up a part-time job, which meant longer hours but also new experiences. Caught up in planning and preparing for this new stage in her life, she'd felt a nagging suspicion that something was going wrong with her health, but she hadn't gone to get examined.

“I was too busy living,” she’d told one of my team members.

Now, as Annie lay silently in the ICU, my team and I came through on rounds. Walking past her family, who were consoling one another in the hallway as they prepared to say their last goodbyes, we headed into her room.

The attending physician approached Annie’s bed, unsnapped her flimsy gown and listened keenly to her heart. I stopped short, suddenly overwhelmed by the scene before me.

On the wall next to Annie’s bedside hung a picture of her sitting on a couch beside a young child. She wore sunglasses and was laughing, frozen in mid-movement—lifting her arm to wave, or playfully shooing away the picture-taker. It was a photo of joy.

I looked down at this middle-aged woman lying in the hospital bed with its plastic mattress and thin sheets, surrounded by flickering lights, beeps and buzzing. This greedy illness had stolen her body, ended her plans and dreams and would make orphans of her children.

She’s the same age as my best friend, I suddenly realized.

“Have you listened to her heart?” my attending asked. “She’s got an awesome murmur.”

“No,” I said. I found it hard to understand what I was feeling—and even harder to say that, at this moment, I didn’t see a patient in that bed. I saw a young woman who was about to die, whose grieving family we’d just passed by.

I couldn’t say that I felt it was insensitive to use her as a case study at this moment; I felt it wasn’t my place. I’m sure my attending didn’t mean to disregard the moment’s gravity. He was just trying to make a teaching point.

I approached the bed. While he pressed on Annie’s belly and checked the edema in her legs, I took her hand in mine and held it tightly. I couldn’t bring myself to do anything else.

As we left, the attending was still writing his note.

“What else might you look for in these cases?” he asked.

“I’m not sure—”

“Her nail beds! Did you look at her nail beds? Sometimes you can see splinter hemorrhages when the infection is severe.”

“No,” I said again, trying to rally my thoughts.

“This seems so sad to me,” I began. “She’s so young…I just want to make sure all of her comfort-care orders are in.”

I wanted to say that Annie’s death was making this room a sacred space. That

we were sharing the air that contained her last breaths.

That I wanted to remove my shoes and stand in silence, head bowed.

That this was hallowed ground.

Not long after, Annie’s family was ushered into her room. Through heavy tears, they asked that we turn off her life support. She died two hours later.

I left Annie’s room vowing to remember that medicine is not only about accurate diagnosis and efficiency: It is about helping each patient to have both a good life and a good death.

Annie taught me that my true work as a doctor is to honor the space and time I share with each of my patients. Remembering her, I’ve become an active advocate for giving patients the very best medical care, whether that means aggressive medical intervention or aggressive medical comfort. When I recall that moment by Annie’s bedside, I feel empowered to champion the principle of doing no harm, even with something as seemingly minor as a routine bedside examination.

Thanks to Annie, I’ve learned that if I miss out on hearing a heart murmur in favor of honoring a patient’s last moments, then I have done my job well.