What About Me?

Category: Stories
written by Amy Cowan | January 4, 2019
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It's Monday morning, and I'm the attending physician starting a week of inpatient service in the hospital. On my patient list is a man named Earl, age ninety-one. He's outlived his siblings, his first and second wives and all of his peers. After seven decades of smoking, his lungs are failing; he carries a diagnosis that reads "severe emphysema."

The sign-out note from Earl's previous doctor reads, "Daughter and son-in-law met multiple times with the team last week." As his medical decision-makers, they've been waffling about what to do for him. Last week they said, "Do everything," then "Take a comfort approach," only to wind up back with "Let's get him strong enough for rehab."

I've been putting off rounding on Earl: I'm afraid that these two will hijack rounds by changing their minds again.

Walking into his room, I'm struck by sharp contrasts. Stan and Elise, wearing designer black and Apple watches, work on their iPhones and laptop in the cramped room with its 1980s décor. About the only color is Earl's maroon VA-issued pajamas.

I introduce myself, but don't engage in lengthy conversation—not yet.

As Earl's morphine wears off, he awakens to his own drowning: Gurgling secretions fill his squishy lungs. Too weak to cough, he grimaces, large eyes pleading for help. The nurse and I reposition him. Another morphine dose helps with his air hunger, and he drifts off again.

Throughout the morning, I check in on him. Stan paces; Elise types on her phone. Both seem absorbed and distracted. I wonder what it's like to lose a parent, then quickly shut the thought out.

Around midday I ask them, "How's he doing?" I know the answer: *Comfortable for now, but what about when he wakes up and can't breathe?*

I suggest that we step outside to talk about what's next—specifically, Earl's impending death.

"He was doing so well last week," Elise says. "I guess we thought he'd just walk out of here."

"We know he's tired," Stan picks up. "We can tell he's given up. Do you think he can recover?"

Their faces give away their thoughts: *How long does he have? If we remove the*

oxygen mask and let nature take its course, would he suffer?

I take a breath, quieting my own feeling of loss over Earl's future.

"Your father sounds like an exceptional man," I say. "Can you tell me more about him?"

They go way back, filling me in on his military service, his love for music and dancing, how he met Elise's mother. About his beloved garden; he gave away everything he grew. Moving into the present, Elise and Stan agree that he wouldn't want to live like this.

We discuss what happens next—the mechanics of managing Earl's symptoms without prolonging his suffering. Mostly, they ask questions that I can't answer.

"How long will it take for him to die once the oxygen is turned off?" *I'm not sure.*

"Can he feel anything?" *Not sure.*

"Can he hear us?" *Don't know.*

Earl is their father, and my patient: I want to get this "right."

"We want him to be comfortable," says Elise, now crying.

"So do I," I say. I try to seem stoic, but my heart races. Although I've attended many deaths, this is only my second time taking a patient off supplemental oxygen—a "terminal wean," as it's called.

Before going back to Earl's room, I approach his nurse, Madison.

"Have you ever seen someone die?" I ask bluntly. If she feels moral distress over weaning the oxygen, I need to find another nurse to assist me.

"Once," she says quietly.

"Me too," I want to say, but don't. I feel exposed, like I'm playing doctor instead of being one. My mind races: *Will I be relieving his suffering, or actively killing him? Does anyone die well, or are we just kidding ourselves?*

Too chicken to share these thoughts, I ask, "Are you okay assisting me?"

"Yes," she says. Suffering my own moral distress, I'm not sure that *I'm* okay doing this.

Should I sleep on it, or wait till next week and sign it out to the next hospitalist? I wonder.

He won't survive until next week, my mind reminds me firmly. *Be the doctor.*

I blink hard. I have to get moving.

Madison and I go in together. Tall and blonde, she projects poise and confidence. She’s holding two syringes: one in her right hand, to sedate; one in her left, for air hunger.

“This is the right thing to do,” she says, as if to tell me: *You’re not an imposter. You belong here. You can do this.* “He’s suffering, and we have to help him.”

She turns off Earl’s fentanyl drip and injects each medication. I make the first downward adjustment to the high-flow oxygen, and we watch.

Lungs gurgling, Earl remains in an opioid dream. Across the bed, Elise holds his limp hand.

We’ve each staked out our territory and purpose: Madison gives medications, Elise has a hand, I have the oxygen, Stan paces. Perhaps needing more, I lean over and push Earl’s stick-straight hair toward his right-sided part, wondering, *Did he consider himself lucky to have this full head of hair?*

Over the next thirty minutes, I gradually turn down the oxygen until the machine no longer hisses. Earl holds his breath—and so do we. When he finally exhales, it’s a sputter, while our collective in-breath is deep and full.

I feel for a pulse. Nothing.

Elise looks at me. *Is he dead?* her eyes ask.

I walk around to Elise—her face splotched red from crying, her hands firmly clutching shredded Kleenex.

We embrace. I feel a lump of emotion stuck in my throat. My eyes fill with tears that I won’t let fall.

It’s an honor to be part of this veteran’s death, I remind myself.

“He died well,” I hear my voice say, mechanical and far away.

Next comes a blur of paperwork: death note, organ donation, consent for autopsy.

Casually, I ask Madison how she’s doing.

“Fine.” Maybe sensing my distress, she says, “He was suffering. We did the right thing.” Then she hands me the death certificate. “Could you sign on this line? No, not there, here.”

Time of death. Cause of death. Did tobacco contribute to death? It’s comforting to be able to work again. I’m focused and productive. Tasks getting checked off.

Why is doing task-oriented work easier than being a witness to suffering? I ask myself. *Why is standing silently at the bedside to comfort a patient or family member so exhausting? Shouldn’t it be the other way around?*

It’s been twelve hours since I walked into the hospital. I head back to my office and scoop up my belongings. I hit the lights—and then it hits me.

In the dark, I slide down the heavy metal door and land seated among my car keys, handbag, water bottle and mostly uneaten lunch. Knees tucked under my chin, I sob.

“I just witnessed a person die,” I whisper. Questions tumble through my mind: *What about me? What about my distress? Does being a physician mean that I have to be an emotional robot? Why couldn’t I share my vulnerability with Madison? Why are we taught that showing emotion at the bedside is weak? Why did I feel so uncomfortable?*

I take a few breaths.

Take it easy, I tell myself. *It’s only Monday. You have another six days on service.*

Gently, I remind myself that when I miss a chance to practice self-compassion, I will get one more chance—and a thousand chances after that.

Tonight, in the dark, is my one more chance.

About the author:

Amy Cowan, an assistant professor in internal medicine at the University of Utah, practices as a hospitalist with the VA in Salt Lake City. “Working with internal-medicine residents and taking care of veterans continues to be my greatest joy. Writing helps me to make sense of stories, including my own.”

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