When Worlds Collide

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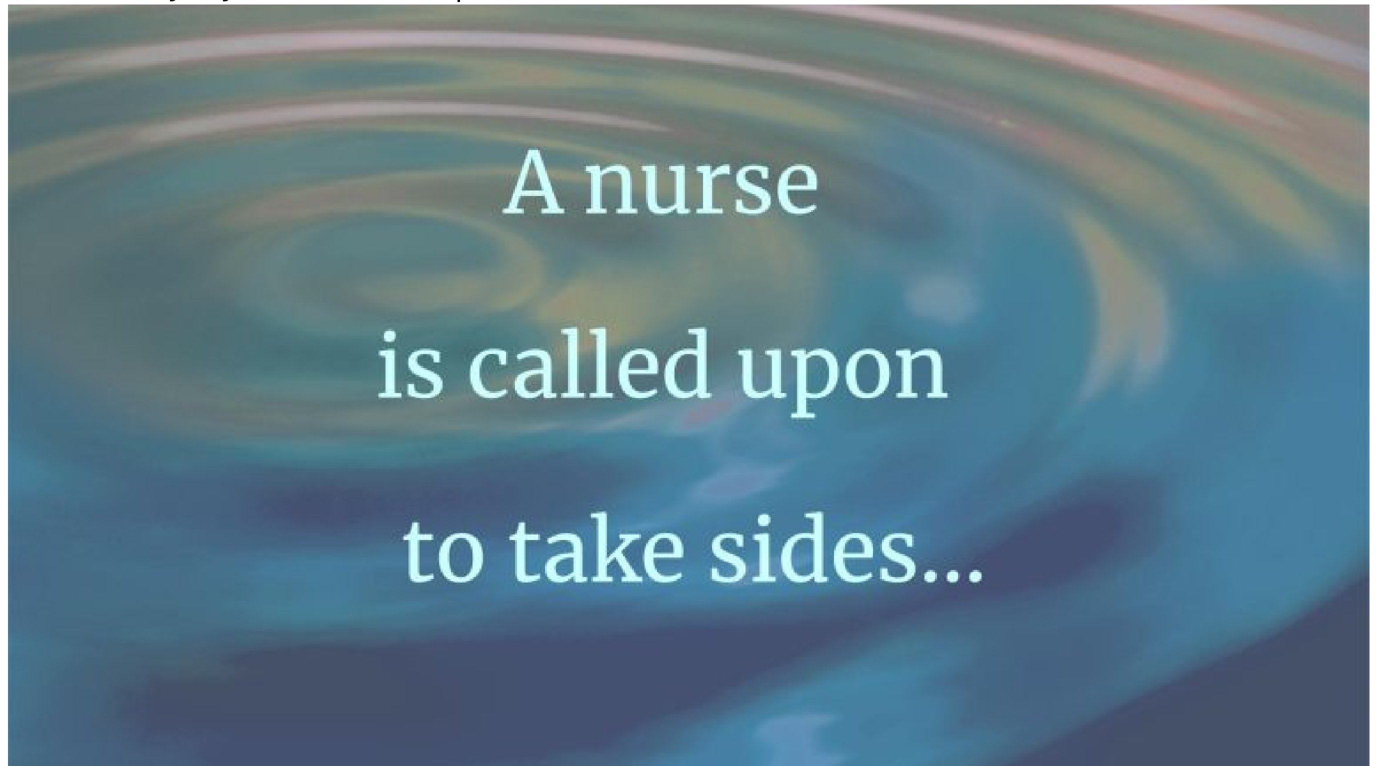
written by Cynthia Stock | March 4, 2022



Malcolm sat in the ICU bed, propped up on pillows to ease his breathing. At seventy-five, he had suffered respiratory complications after open-heart surgery. He'd been on a ventilator for several weeks before gradually being weaned from it.

Malcolm's blue golf cap hid a bald pate surrounded by a fringe of silver hair. He always seemed to be smiling, comfortable with himself and what life had thrown his way. His smile had grown even warmer over the past weeks as we'd gradually formed a bond of intimacy.

Malcolm's cardiothoracic surgeon, Dr. Thompson, had proposed a tracheostomy (a tube in his windpipe) to make it easier for him to breathe. But I knew the procedure was no cure—that it would only prolong death and steal the last remnants of dignity and moments of joy that Malcolm might share with his soulmate, Natalie.

As an ICU nurse for more than twenty-five years, I knew that the responsibility of speaking to Malcolm and Natalie about this was mine.

I sat down next to his bed, with Natalie on the other side. We discussed the tracheostomy details, then segued into the most important question.

"Tell me what *you* want," I said to Malcolm, hoping that this invitation would help him find his way to someplace besides the OR.

Natalie spoke first.

“Malcolm and I live just a couple blocks from here.“

I knew their street. Mature trees, manicured lawns and older homes; a neighborhood of history and engagement.

“Every evening, we sit on our bench with cocktails and watch the traffic. We chat with our neighbors walking their dogs.“

“They all know us, and we know them,“ Malcolm interjected. “And we just enjoy life.“

Gently, I explained that a tracheostomy would put this cherished way of life on hold.

“After the procedure, you’ll be back on the ventilator. The weaning process will start all over.“

Malcolm and Natalie looked at each other.

“How long?“ Malcolm asked.

“There’s no definite time frame. There are no guarantees.“

We talked about quality of life; about the difference between survival and recovery. We talked about death.

“We just want to go home,“ Malcolm said.

He and Natalie reached a decision: no tracheostomy. I told them that I’d stand by when they spoke with Dr. Thompson.

I had worked with Dr. Thompson from his first day at the hospital. A lean man with willowy legs, he glided through the unit, his thick black hair slicked straight back from a long, gaunt face. A Southern drawl, courtesy of Mississippi, disguised his ability to shed his gentle, laidback persona and become a human juggernaut.

I’d observed this transformation on one night shift. A new nurse, four years into her career, attentive to detail and conscientious, was caring for one of Dr. Thompson’s post-op open-heart patients. As she carefully changed the incision dressing per protocol, blood filled the glass drainage bottles. This was alarming and unexpected. Dr. Thompson was notified, and someone ran to the blood bank for a unit of packed cells.

Before whisking the patient off to emergency surgery, Dr. Thompson accused the nurse of causing the bleed by her handling of the dressing. We nurses all knew that the amount of bleeding reflected a surgical problem. In his gut, Dr. Thompson knew this, too. Frustrated and disappointed at falling short of his own high standards, he’d lashed out at the closest person.

The patient survived; the nurse quit. Seeing Dr. Thompson’s capacity for rage taught me that each of my professional decisions had consequences—and not just for the patient.

Now Dr. Thompson sauntered in to make his case to Malcolm and Natalie.

“How’s it going?“ he greeted me, then peered into Malcolm’s room. The window’s light cast Malcolm and Natalie in silhouette, their postures resolute and content. I had seconds to choose between actively advocating for them or assuming the time-honored role of handmaiden to the physician.

An “old-school“ nurse, I still called doctors “Doctor.“ I didn’t question orders unless I had hard-core, documentable evidence that an order went against best practice or patient wishes. But I knew that my job also including acting as the doctors’ eyes and ears when, as in this case, they couldn’t be at the bedside. I’d also facilitated many family conferences for patient decision-making. As a professional, I found strength in autonomy.

“Malcolm doesn’t want the trach,“ I told Dr. Thompson.

I could only imagine the thoughts behind the flush of anger that suffused his face. His jaw muscles tensed and quivered. He crossed his arms and looked at me, not saying a word.

The memory of him raging at my former colleague flashed through my mind. By supporting my patient’s wishes, was I putting my job at risk?

“Malcolm just wants to go home,“ I said.

Dr. Thompson entered Malcolm’s room and walked to the foot of the bed. His body formed a sleek S as he spoke to the couple, bobbing his head for emphasis.

I hovered in the doorway, ready to defend Malcolm’s wishes—but I wasn’t needed. His and Natalie’s comments left no room for argument. Minutes later, Dr. Thompson left.

I had several days off after this incident. On my next shift, a new person occupied Malcolm’s room.

Time passed, and although Dr. Thompson maintained professional civility, he didn’t call me by name for months. When he left for another hospital, I felt sad to lose a practitioner with his expertise and presence. I remembered his tender moments with patients, how he’d reassure them with a pat on the hand or a shoulder squeeze. I remembered laughter and camaraderie.

Several years later, I retired.

Shortly after that, I bumped into Dr. Thompson at my gym. Spotting me laboring on the treadmill, he waved and walked over.

“Hey, how’s it going? I haven’t seen you in quite a while,“ he said with a flash of his charming smile.

“Well, you moved, and I retired.“ I paused the machine.

Dr. Thompson looked surprised. “Good for you. I guess it’s not too late to

tell you I appreciated all you did for my patients. You always gave the best care.“

I listened for any animus or sarcasm, remembering the day when I feared my job might be in jeopardy because my plan of care clashed with his. But his voice communicated nothing but good will.

In that moment, I realized that as two healthcare professionals treating the same patient, Dr. Thompson and I had come from different perspectives. He preferred to intervene using a skill set of delicate, complex physical actions. I, on the other hand, enjoyed the luxury and privilege of experiencing the patient as an individual—and this had been reflected in my plan of care.

I hoped that Dr. Thompson had reached a similar insight.

Most of all, I hoped that Malcolm and Natalie had enjoyed at least one more evening together, watching the sunset and greeting neighbors from the bench in their front yard.