
FIELD NOTES | FALL 2020

The Right Choice

By Vanessa Van Doren

It was around hour 18 of a 28-hour shift in the intensive care unit, or ICU, when my pager went off for what felt like the thousandth time. I was cross-covering the old patients and admitting new ones to both the medical and cardiac ICUs as well as covering emergencies in the surgical ICU. It had been a rough night, with old patients decompensating as several new patients rolled in from the emergency department or the general floors over the course of the evening.

I pressed the button on my scuffed-up pager, and the little screen lit up in neon green: “Family here for rm15, pls come to bedside.”

I rose from the computer and painfully stretched my stiff back. I had been hunched over in this dusty, windowless call room for the past 30 minutes, furiously writing notes. I grabbed my stethoscope and headed down the hall to the medical ICU.

The unit is laid out like a horseshoe, with the nursing station in the middle and the rooms lining the perimeter. I knew room 15 quite well by this point in the evening, as I had been in and out all night checking on a very sick patient.

The fluorescent lights throbbled into my retinas as I looked around the cramped room. A mess of antibiotics and fluids hung from an IV pole to the patient’s right, partially obstructing my view of his deteriorating vitals. Everything glowed a sickly yellow. There was no clock on the wall.

I took a deep, steadying breath of faintly stale air and directed my eyes towards the bed.

Every time I’d checked on him that night, he seemed to recede into his environment more and more. His skin glowed the same color as the walls around him, a thin sheen of sweat sticking sparse clumps of hair to his forehead. His head lolled back on the pillow. His frail body was engulfed by the hospital bed, sheets crumpled and twisted around his scattered limbs. Tape, tubes, and lines slithered out of his body in all directions. We had spoken just a few hours before, but he was now well past talking. His gaze hung on a woman to his left, eyelids fluttering with exertion.

She sat stiffly in an uncomfortable-looking plastic chair. We had spoken on the phone earlier that evening when I asked her to come in. She was improbably dressed for the late hour and urgent visit; hair done, makeup perfect, clothes ironed.

“He used to bring me little gifts,” she said, blue eyes filling with tears behind dark eyelashes.

“Little ceramic deer, one time. I got gifts from other boys too, but his are the only ones I still have. We’ve been best friends since we were 9 and 11.”

She opened her phone to show me a picture of herself smiling next to a dark-haired, bearded man with chiseled features and a kind smile. “That was about a year ago,” she said, eyes drifting back and forth between the man in the picture and the husk in the bed in front of us. “He had to grow his beard when his platelets got low because he couldn’t shave. I did love that beard, though.”

A look of consternation crossed her eyes suddenly. “Can we make sure no one shaves it?”

It was 3:04 am when together we watched her best friend’s soul leave his body. I say it that way because I really don’t know how to describe what I was witnessing on these long nights, sitting with patients I knew only from sign out and their loved ones whom I had just met. I usually started off desperately trying to figure out how to save the patient’s life as they spiraled into VTach and shock. Nearly inevitably, it would become clear that their cancer or sepsis or cirrhosis was making its devastating last stand, and that the person who was still in there, the one who gave his best friend two ceramic deer 60 years ago, was trying desperately to kick free of his wasted body.

It is so hard to make that call, in the middle of the night on a patient you’ve hardly met, when his best friend is quietly sobbing in the corner and your pager is going off constantly - more orders, more admissions, more inhuman demands. You’re forced to choose between spending the time at the bedside of a dying man, trying to ease his passing and the impact it will have on the loved one who is there with him, and delaying care for the dozens of other very sick patients who also need your attention. There are too many patients and only one you. So how do you choose?

The easy answer - the move of self-preservation - is often to do everything. Second pressor, third pressor, amio, cardiovert. Put the crash cart in the room for when the pulse is inevitably lost. Take five minutes to place the orders and call the nurse while you run down to the emergency department to evaluate your next admission. The signout you received says “full code,” and you don’t have time to think about whether that makes sense right now. Complete the algorithm, and on rounds in the morning, you can say that you did your best. Move the loved one, and the feelings and ambiguity and general shittiness of a man dying of cancer while his best friend in the world watches helplessly, outside the room and outside your scope.

In this way, residency quickly hammers us into efficient machines that let nothing - sleep deprivation, grief, personal or human circumstances - hinder our ability to execute tasks. Early in our training, we learn to move on with ruthless efficiency. Complete the death packet, sign the notes, update the sign out. Move on to the endless stream of pager beeps. We have carried on this way for years before the pandemic, but the increased demands of the past six months, and the widening gulfs between hospitalized patients and their fiercest advocates, are making it much more difficult.

Since the pandemic started, our intensive care units are busier than ever, and the patients are

far sicker. With rare exception, there are no more visitors. When our patients are dying, as so many of them are now in ways that are beyond the reach of our current medical knowledge, we cannot bring their family in to see and understand the depth of their loved one's illness. End-of-life discussions usually happen over the phone. Family members see their loved one via an iPad in a Ziploc bag, surrounded by faceless staff in head-to-toe PPE. There is no holding your friend's hand or speaking private last words.

It is hard enough to choose a natural death for a loved one who has battled cancer for years, even when you know their wishes, and even when you can verify with your own eyes and hands how close they are to the end of life. It's a process that takes time, support, and trust. This decision is unimaginable for the families of people who were healthy last month, whom they cannot see and touch, and whom they are unable to shepherd out of this world when the time comes.

Throughout this pandemic, our hospital leadership, program directors, and chief residents have gone to great lengths to try to take care of us and make sure that we are able to provide the care our patients need, but there is only so much that they can do. Every year, each program in the country receives a certain number of residents to do a huge amount of work. That work, and the emotional toll of it, has increased this year, but our numbers have not.

I see this impossible choice in the eyes of the new interns as they describe their first month in the ICU. These new doctors just finished four years of medical school, where they were taught the importance of the human connections we make with our patients and their families. Their work hours and patient loads are quickly teaching them otherwise. They are already feeling the pull to spend less and less time with patients and their families in an attempt to offload some of the impossible weight of their work. They are learning not to process the frequent deaths they see because there is simply no time.

The harder, slower, more painful thing to do for our patients is to try, in the chaos and fear, to ask their families about them. Not "what are his goals of care" but "tell me about him," as you hang another medicine and smile and hold his hand. "He was so happy when I said you were coming. He said you met when you were 9 and 11! How did that happen?"

Even now, when these conversations are much more likely to happen over a call room phone than at the bedside, we have to try.

On that lonely night in the ICU last fall, I got lucky. COVID-19 did not yet exist, and so my patient's most trusted person was there with him. My pager quieted down, and admissions came to a halt for a few precious hours. Instead of rushing out of the room and back to my notes, I asked my patient's friend to tell me about him. Through her stories, the voiceless, nearly-motionless man in room 15 took on new life. His fading body was replaced by a rich, complex picture painted by the person who loved him most. After a while, she got to the cancer that had plagued him off and on for years before settling in for good over the past few months. The way the hospitalizations and chemo dimmed him. And the clarity that, no matter what miracle may happen that night (and we all knew how likely that was), this man's life was over in all the ways that held meaning for him. He knew it, she knew it, and they were able to

help me know it in a way that the notes and sign out could not get across. This is knowledge I could only unlock by sitting with them and listening. When we decided together to take the pads off - no cardioversion attempts or chest compressions - and just be with him, it felt like the right choice.

Vanessa Van Doren is a current internal medicine resident physician in Georgia. She started her career as a primatologist but eventually found her way to clinical medicine. She plans to pursue an infectious disease fellowship with a focus on HIV. She lives in Atlanta with her husband Dan and their cat Beau. Her non-fiction essay “The Right Choice” appears in the Fall 2020 *Intima*.

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