Palliative and Supportive Care

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Cross-Cover

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Essay/Personal Reflection

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"Mr. Smith just passed away; can you come declare him?" I read the text scrolling across my pager screen and utter a deep-seated groan.

As the cross-cover resident, I am tasked with managing any overnight events that may arise for the 90 patients that currently comprise the general medicine services, a responsibility I have to this point found thoroughly overwhelming.

It feels as if my pager has not stopped buzzing since I arrived eight hours ago at 6:00 PM. While most pages contain reasonable requests or non-critical information, the constant bombardment I have experienced in my sleep-deprived state has driven me to my wits end. Add to this the 10 or so active "watcher" patients which threaten to decompensate at any moment, and what results is a constant state of frustration, anger, and fear that has me counting the seconds until my shift ends.

It is against this emotional backdrop that I receive the page about Mr. Smith. At this moment I view the news of his demise as merely as another imposition upon my limited time and energy, such precious resources which at this moment are surely best directed toward my patients who remain alive, or so I think.

I pull up the patient's chart and see that Mr. Smith had been transitioned to comfort care earlier in the day. The resident caring for him, normally attentive to detail, had apparently forgotten to pass this along. Even worse, as I pull up Mr. Smith's electronic chart, I see that the hospital course documenting his stay thus far is completely empty.

My baseline stress is now accompanied by heightened anger and a deep sense of unfairness. To walk over to the patient's room, perform the death exam, take time to speak to the family, and document all of this will require a minimum of thirty minutes, very likely more. This means at least thirty minutes' worth of deepening my debt to unread pages, and attending to the accordant small fires that arise.

I sigh deeply and massage my temples, attempting to assuage the pulsing headache I have experienced since the night prior. I wash down three ibuprofen with the remainder of my tepid coffee, grab my stethoscope, and set out for Mr. Smith's room.

When I arrive at his door, I pull up my copy of his chart to look up his first name and "one liner": "Jeffrey Smith, a 72-year-old male with a past medical history of decompensated cirrhosis, type two diabetes, and hypertension, admitted for hepatic encephalopathy, found to be bacteremic, now transitioned to comfort care." Armed with this minimal information to make the acquaintance of his loved ones, I knock on the door before I gingerly enter.

In the sparsely lit room, I can make out Mr. Smith, his head rotated to the side with eyes closed, his skin jaundiced with an ashen tint, his body stiff but in a strangely placid way. By his side, clutching his hand and sobbing quietly, is a woman with grey hair, whose mascara-tinged tears have soaked the mask covering her mouth and nose.

"Hi, my name is Ben, I am one of the resident doctors, I'm very sorry for your loss." My voice is hoarse from fatigue and mechanical from a dearth emotional reserve. As this statement hangs for a moment, I consider how strange it is to offer pleasantries and final condolences in the same monotonous breath.

She looks up at me and sobs more.

"It's just so hard to believe. He has been sick for a long time, but it seemed this time was different."

I nod quietly, staring at my feet.

"We had been together for thirty years, so this is just very hard to process." She hardly finishes her statement before breaking down once more. I clumsily grasp a tissue box and hand it to her, the failsafe practice I have learned to draw upon when words, or the energy to voice them, evade me.

With her free hand, she gratefully accepts the box, dabs her eyes, and clutches the crumpled tissue in her fist, all while maintaining her grasp of Mr. Smith.

As I pull up a chair beside Mr. and Mrs. Smith, I recognize with some relief that my initial sense of annoyance for being called to this room has dissipated in the face of such profound grief. And yet as I consider how objectively painful this experience for Mrs. Smith must be, I find myself immediately aware of the absence of my own emotional response. I sense no gnawing pit in my stomach that typically accompanies my care for dying patients. There is no tearing of my eyes or tightening of my throat which often herald my own physical reaction

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to the suffering I witness. There is not even a fleeting thought that Mr. Smith could very well be my own grandfather, that his death is in any way personal or particular.

Instead, what I feel is what I felt before entering this privileged space; a parched mouth and a sore throat that twinges every time I swallow; a low-level diffuse headache; a strange mix of nausea and hunger that accompanies my sparse nocturnal meals; and a constitutional sense of fatigue that deadens me.

My lack of expected emotional response is now compounded by the guilt I feel when I recognize I am thinking only about me, and not Mr. and Mrs. Smith. This seems like a different type of imposter syndrome than the type I have been warned of, but one more existentially dire.

I turn to Mrs. Smith, and once again tell her that I am "So, so very sorry," for her loss. I emphasize to her that "I cannot imagine how hard this is." This feels true in a literal sense but still disingenuous. I quietly tell her how I will go about the process of declaring death; of auscultating his heart, and watching for a pupillary response, after which point I will allow her more space to grieve. I ask if she would like the chaplain to come by and she nods silently.

I next place my stethoscope on Mr. Smith's wan chest and listen for the predictably absent heart sounds. I pull open his cold, taut eyelids and observe his pupils, refractory to my pen light. I once more pause, beset by how strangely mechanical this feels. Even if I don't feel sad, shouldn't I feel some sense of awe, of gravity, even of fear or discomfort? Whether I should or not, there is nothing there, only the discomfiting sense of absence.

I reiterate to Mrs. Smith how sorry I am for her loss, inform her that I will contact the chaplain, and ask if I can be helpful to her in any other way. She shakes her head silently and thanks me for my kindness, a comment that only deepens my guilt.

As I slink back to my workstation, I am once more bothered by my lack of emotion. How could I feel so empty? Had I now officially joined the ranks of the "burned out," of those suffering from "compassion fatigue," of the emotionally distanced and spiritually calloused lot which I had been warned about from early in my training? Before I can face this prospect head on, my pager buzzes and I look down to see the first of 12 neglected pages awaiting my perusal. I sigh and log into the computer.

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With the benefit of hindsight informing my care for Mr. Smith, I have come to recognize that it is a deep hubris that underlies the presumption that we can always be present emotionally to patients. While we may conceive of ourselves as endless receptacles of energy, ingenuity, and compassion, we are in fact embodied, contingent, limited beings just like the patients we serve.

Thus, when we equate our moral performance with our emotions at any given moment in caring for patients, we consign ourselves to failure and the guilt that accompanies such failure. The fact that we may lack the subjective sense of sorrow, of compassion, of empathy, in the course of our most rigorous moments of care is not surprising. Indeed, given the demands of our work and the consistent neglect of our own basic physical needs in service to this, such responses should be expected.

And yet this *post hoc* rationalization still doesn't satisfy me. I cannot truly know whether Mrs. Smith sensed my subjective emotional barrenness at that moment in caring for her and her husband. But independent of this, I wish I could assure her that both she and her husband were seen and heard, and that is something. And that I am sorry, and that I am tired, and that I wish I could heal myself if I am indeed sick, and that if grace truly abounds then I am glad that we share it.

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