Early adopter

Exposure to comfort care as a child helps a medical student chart his career path.

BY DOMINIC DECKER

At 6 days of age, I made my first visit to a hospice. It was the feast of St. Dominic, for whom I am named. My parents brought me to Our Lady of Good Counsel Home, a free hospice in St. Paul for terminally ill cancer patients, which was staffed by a group of Dominican sisters. My mother and father had been volunteering there for several years. Bringing me to the home during my first week of life served as my birth announcement. It also created a rich image, the juxtaposition of birth and death, and served as a visible reminder of the most profound moments in life.

On that August day, I was placed on an altar and blessed by a woman who had dedicated her life to providing end-of-life care. The Dominican sisters have since turned operations of the hospice over to the Franciscan Health Community, who renamed it Our Lady of Peace Home. But my family’s connections with them endure. While living in New York City, I did fieldwork for my master’s thesis, which focused on storytelling at the end of life, at Rosary Hill Home, another free hospice.

My exposure to hospice made me realize how my preclinical training was almost solely focused on curative interventions. Lecture after lecture would outline disease pathophysiology and follow with slides on treatment modalities. One of those talks stood out. It was given by a pulmonologist on COPD. The treatment slides listed the usual interventions: bronchodilators, corticosteroids and pulmonary rehabilitation. Also included was the option of palliative care. This was one of the only mentions of palliative treatment during my preclinical years.

It wasn’t until I transitioned to the clinical years that the role of the physician was reframed from someone who cures to someone who alleviates suffering.

I spent the first day of my fourth year in orientation for a rotation in a medical intensive care unit. It included a presentation on advance care planning by Honoring Choices Minnesota. This discussion of goal-oriented, patient-centered care shaped my month in the ICU. And it was with this in mind that I met Jim.*

Early one morning, I admitted Jim with acute-on-chronic renal failure in the setting of epistaxis, rectal bleeding and poor oral intake. The emergency department

*Patient’s name has been changed.
note that preceded his arrival painted a grim picture: Emergent hemodialysis was being considered for his significant kidney injury and his hemoglobin was falling, raising the suspicion of an ongoing bleed. When I entered his room, I expected an obtunded patient and limited history. Instead, I found a pleasant man wrapped in blankets and ready to talk.

Jim confirmed what the ED had reported. The past few days had been particularly hard. He was living with a roommate in a nearby duplex and had been trying to return to his hometown, where more of his family and friends were living. He was charming, smart and ornery, a combination of personality traits that could make me laugh at 3 a.m. during my most demanding month in medical school.

Jim was transferred out of the ICU later that day after his condition had stabilized. I assumed I would never see him again.

As my month in the ICU came to an end, I prepared to begin my next rotation, an elective in palliative care. The pulmonologist who lectured on COPD and mentioned palliative treatment options became my attending. And the man I admitted a month earlier to the ICU at a different hospital once again became my patient.

Although Jim appeared more frail and gaunt, he still had a smile that belied his condition. He remembered me from the other hospital. Now, with a second admission in about a month, it was clear his health was deteriorating. The palliative care team responded by discussing his goals of care.

Jim’s hospitalization was lengthy, affording me the opportunity to check in with him frequently and fully realize the medical student’s role: to listen and be present at the bedside, to let the patient be the teacher. Our conversations picked up where they left off in the ICU: We discussed home and family, the reality of disease and the inevitability of death. Jim confided in me that he was concerned about what death would look like for him. I told him how special he was to me and how much he taught me about medicine, something I had never before expressed to a patient.

Jim died on the last day of my palliative care rotation. He was in a quiet room in the hospital, disconnected from monitoring equipment, covered in a blue quilt. Family members were at his bedside and his favorite music was playing.

As I prepare for residency, I often think about Jim. It’s my ongoing tribute to his life and its impact on mine.

Many of my most memorable patient encounters took place during my palliative care rotation. When asked during residency interviews why I wanted to become a physician, or train in internal medicine, it is this field that I refer to—a field that has quite literally been influencing me since my first days of life. MM

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