Personal life and care of patients are inextricably interwoven

The written word, like any art form, has meaning based on the author's intent and experience—but also on the experience and emotions of the reader.

One reader's favorite poem is something another reader finds incomprehensible or, worse, boring. The book that changed one person's life is a book another can't read into more than 10 pages before giving up on it.

None of the 2019 writing submissions to *Minnesota Medicine* were incomprehensible or boring—all were worth reading and thinking about—but the reviewers were impacted differently by each of the pieces done by physicians and physicians-in-training. Four reviewers found 11 different writing submissions (out of a total of 14) to be of particular merit—with only a few that were at the top of more than one judge's list. Two submissions stood out, however, and several more were of note.

The reviewers were Dan Hauser, director of Communications, Education & Events at the Minnesota Medical Association and a novelist with several books under his belt; Chuck Meyer, MD and MFA in Writing, former editor of *Minnesota Medicine*; James S. Rogers, poet, essayist and editor of *The New Hibernia Review*; and Patricia McMorrow, former newspaper journalist, content editor and writer and content strategist at CaringBridge, where she is working on a long-term project, "How We Heal."

TOP SUBMISSION

Experience

By Daniel Plack, MD
Second-year resident in anesthesiology at Mayo Clinic (after completing a transitional internship at HCMC)

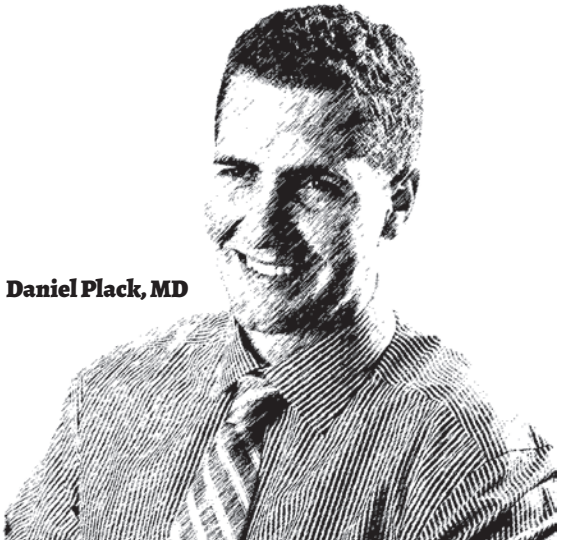
Lights off, shades closed, lying on my bed. I could hear my wife playing with my son in the other room. It was about 6pm. I had to be back at the hospital in two hours. My heart was racing, and I felt like running away. Like any good doctor, I had already diagnosed myself with an anxiety attack. Not being prone to such things, it caught me by surprise.

"I thought you trained for this?"

"You just graduated medical school. That means you're a doctor. Shouldn't you know how to do this?"

"He almost died and it would have been your fault."

I had never treated someone in DKA before. I could hear the nurse's words on repeat in my head as she stormed into the medical ICU workroom the night before, "What's the plan here? A pH of 6.85 is not compatible with life." He had come in with pancreatitis and a past medical history including diabetes, but his sugar on admission was 125.



Daniel Plack, MD

It was my second day, or should I say night, of residency.

Name: Daniel Plack. Degree: MD. Experience: one day.

As Saturday nights can go in the ICU, my senior resident was somewhere, far off, in this dark, quiet hospital, probably in the Emergency Room picking up yet another admission, and she wasn't answering her pages.

What does a pH of 6.85 mean? Certainly, it's bad. But how bad? Isn't there some equation, change in pH of .08 means some change from PaCO2? No. This partial formula was a useless fact now taking up precious, conscious effort in the heat of the moment. My patient was on death's doorstep, or so it felt to me; it was all my fault for not checking his glucose more frequently, and now the nursing staff is asking me what to do.

"Do you want to intubate?" Still no senior. How ironic it was in that moment to have worked so hard for so many years with the goal of being exactly there, and yet wishing I was anywhere else in the world.

"Yes, let's intubate."

"Do you want to start an insulin drip?" I knew my patient needed insulin, that much I remembered from that long gap between my real medical school rotations and the start of internship. How do I titrate that? What's my starting rate? Can I just order an insulin drip and let them figure it out?

"Yes, I want to start an insulin drip."

As I walked to my patient's room, one nurse asked another, "Why is it so insane tonight?"

The other nurse turned and pointed to me, "Because it's his second night." A joke, yes, but also an acknowledgment of my floundering. So they did know. Well, even if they didn't show sympathy, clearly they understood I was struggling. That was … mildly comforting. My incompetence must be obvious.

In a flurry, the night ICU nurses took over. They gave insulin, got extra IVs, gave fluids and paged Anesthesia for a STAT intubation. I sat at the desk outside the room, peeking through the blinds, "Uhh, let me know if there's any orders I can put in." No one looked at me, responded or even acknowledged that I was there. In that moment, I was exactly 1 inch tall. But, there is also a glimmer of hope in knowing how small you are—there is only room to grow.

Back home, all I could do was lie there on my bed. I didn't want anyone to die, especially not because of me. I closed my eyes, breathed deeply, and prayed. I prayed for peace in my mind, safety for my patients and an attitude of thankfulness. He survived and so did I.

I still couldn't answer my family's questions. I could barely look them in the eye. I knew they were so proud of me, finally a real doctor, and eager to hear how the first two days went, but I couldn't bring myself to tell them what happened. Not yet. I felt I would only disappoint. They wouldn't understand, and I didn't have the words to explain it. But I could get off my bed, pack my food and drive back to the hospital.

Name: Daniel Plack. Degree: MD. Experience: two days.

REVIEWERS' COMMENTS

"This story captures the fallibility of a young resident: all-knowing but not knowing enough to feel secure."

"Bravo! Just love this piece. You really feel like you're inside the head of a newly hatched doc."

"In this vignette of an anxiety-filled night in the ER, we are brought into the young physician's doubts and worries. But we are also assured of the mandate that physicians must always give their best."

TOP SUBMISSION

Unintended Consequences

By Chuck Bransford, MD,
Retired from general internal medicine, medical director for Lakeview Hospice and Lakeview palliative care at Lakeview Specialty Center in Stillwater

Oh my God, I know this man.

I treated him last year. He seems berserk, running down the sidewalk with a baseball bat hitting everything in sight—car windows, stop signs, mailboxes. Around the corner is an elementary school with kids on the playground. I have to stop him.

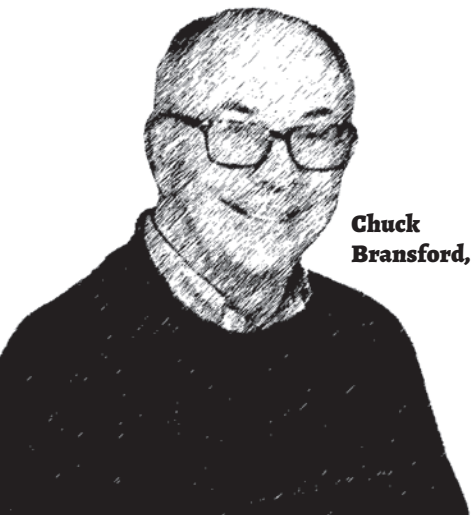
It had all started months before with a simple, happy conversation: feet dangling off the back of a red pick-up truck on a warm fall day, followed by an unexpected bump on the road, and his head crashing down onto the street just a few feet below. The brain injury was severe. Our team had to act fast. I had been waiting for this moment all my life—a pure sudden brain injury in an otherwise totally healthy young man. We rushed him to the OR. Using the head CT as our guide, it became obvious that the only way to save this man was to reduce the pressure on his swelling, injured brain. And so, we did it, using a bone-saw, the procedure I had been researching for years and itching to do. We removed the top half of his skull—about the size of a stocking cap—above the eye sockets of course, about eye brow level. We took the top half of his skull off and placed it in a freezer.

We were so proud; the pressure on his brain diminished and he slowly woke up over several weeks. We all applauded our well-researched efforts, took his picture and placed him on the victory wall next to our ICU—another save.

Unfortunately, his cognition wasn't coming back, so we took him back to the OR and unwrapped his brain.

We peeled back the glistening dura and gazed in wonder at the multiheaded gyri of grey matter. We followed the research of Wilder Penfield during the 1930s and attached electrodes to multiple parts of the brain, hoping that brain electrical stimulation might help our patient reorganize his thoughts. We kept him wide-awake (the brain having no pain fibers) and began stimulating different parts of his brain with small electrical shocks, just as Wilder Penfield did. When stimulating areas around his temporal lobe, he began having vivid dreams and memories where he would visit old friends, often those who had died long ago.

At times he would sit up, eyes filled with tears, calling out with such urgency to stop the people of his visions from leaving. Once, he sat up suddenly and began to sing what I believe were ancient Celtic songs in the Gaelic language. He described old relatives going back generations. He said he felt as if he were standing right next to them, sometimes embracing them. The joy was palpable to all of us in the room. We felt so privileged to be part of this adventure. We didn't know what we didn't know. I loved that one specific area of stimulation would produce, say, left finger tingling, but that the memories were freer floating and transient, never producing the same result twice despite us stimulating the exact same spot.



Chuck Bransford, MD

After 30 days, when the swelling was down, we reattached the skull—kind of like fitting in a puzzle with both halves being a little off. The match was not perfect around the jagged temples; parts of the bones had shrunk and other parts had swelled. But it would do. The crazy glue would hold. There were just a few bumps and indentations where the match was imperfect. He was still a bit confused, but was walking almost on his own when we transferred him to the transitional care unit where he would receive the best physical therapy possible. This was the last time I'd seen him. Until now.

I had, however, reviewed over and over again the desperate letters from his wife and family. He just isn't the same, terrified of his own home—positive it was haunted and that someone else was living there waiting to harm him and his family. Every time they came home, he began to shake with terror, pupils dilated. The doctors loaded him with tranquilizers. He couldn't seem to tell his dreams from reality. Past, present and future made no sense. He was trapped in his visions with no grounding available. I explained to the family that we just didn't know how to reattach the mind to the brain, let alone to the heart. We didn't know which nerves to sew together or even if nerves have anything to do with it. Head needs to be tempered by heart, but we hadn't a clue as to how. He couldn't seem to gather a sense of his own self, but physically he could do anything. He was very strong.

So here he is running down the street, baseball bat in hand, swatting at everything in front of him —the unintended consequence of my "well intentioned" efforts. There will be no talking this poor man down, no magic words that can help him make sense of things. In my mind and heart, he is my re-creation—and my responsibility. He and I are paying the price for my reckless exploration into areas beyond current human understanding. I understand now the heady rush of doctor Frankenstein to create life, and then the regret. I race across the street and do the only thing I can—I tackle him as the bat lands and we both come crashing down, heads meeting the sidewalk together. My patient becomes unglued, and me, I wake up surrounded by white-coated ghosts inhabiting a jungle of tubes and blinking lights in a land I cannot comprehend. The doctors see the swelling on brain CT and discuss among themselves whether they should remove the cap. I imagine myself looking up through my brain experiencing the stimulation of the electrodes and greeting my great grandparents and their parents and singing with them the songs of our shared history.

REVIEWERS' COMMENTS

"This was an interesting story, a kind of modern retelling of Frankenstein. What are the odds that this physician would encounter a patient he had saved and then had to restrain him from doing harm?"

"This was a well-written piece that shows the link between imagination—putting one's self in the other's position—and empathy. Plainspoken but powerful, it opens a window on the deep mysteries of the mind."

OTHER FAVORITES

Care, Careful, Caring

By Cory Ingram, MD, MS, FAAHPM
Medical director of Hospice and Palliative Medicine, professor of Palliative Medicine, assistant professor of Family Medicine at Mayo Clinic College of Medicine

Commentary

Every day, medical providers and families meet at the maelstrom of end-of-life care, often highly unprepared in the setting of a very predictable clinical trajectory. Like a movie, the disease of dementia plays out in a predictable fashion. The characters are different but are all equally unprepared when time to role the credits.

Goals of Care (Family Perspective)
You say our sister is dying? I don't believe you! How is that possible? Why didn't anyone tell us what was coming? Even the worst movie trailers give a good idea of how the movie will unfold. The movie is ending and now you ask us to explain what we saw? I don't trust you!

Goals of Care (Medical Provider Perspective)
That's right, she's dying. We see this movie playing out almost every day. Dementia is a predictable disease journey. Like a movie set in the forest, we let them wander in the woods at night without a light, treating them as if they are walking on a sunny beach with no horizon in sight. Why?

Goals of Care (Patient Perspective)
I can hear them all talking. My family looks angry and sad. I wish I could comfort them, but dementia muted me. Year after year a bit less me. I experience their love and grief. Too much pneumonia. No fun. I'm okay. Most of me is lost. I'm here. Let the credits roll. Love you!

REVIEWERS' COMMENTS

"Structure feels like it mirrors progression of disease. Clever. Wonderful images and word choices."

"A short but intriguing casting of the end-of-life in terms of differing responses to a film. Clever and thought-provoking."

OTHER FAVORITES

Honoring Her Wishes

By Suliman EL-Amin, MD, MS
First-year child and adolescent psychiatry fellow at Mayo Clinic

On a particularly cold Minnesota day, I was working the night shift in the emergency department. It was fairly quiet that evening, as most people in our small community were asleep, having to work early mornings. Soon into my shift I was informed that that an elderly woman would be coming in from a nursing home. As a budding intern, I was more than happy to be assigned the case because it seemed straightforward.

I kept a lookout for an ambulance from afar. Soon, I could see its ominous red lights flashing against the clear dark sky as the ambulance pulled into the unloading bay. Like a legion of soldiers, the emergency medical technicians marched to the back of the truck and synchronously opened its doors, pulling out a stretcher. As they placed the stretcher on the ground, I got a toe-to-head glimpse of our patient—Ms. B. She was a short, frail Latina woman who appeared to be in her mid-80s. She had almond-colored skin, long grey hair, and a rosary around her neck. She looked as worn as the day and seemed to be fading in and out of consciousness. By her side was her husband, clasping her hands while the EMT pulled her stretcher into the room. He was a retired construction worker, dressed in blue denim overalls and a weathered Carhartt jacket. He stared at Ms. B. with caring eyes and sorrow.

Ms. B. spoke to her husband in short sentences, in between deep breaths. We quickly gave her oxygen and allowed her to rest while we drew some blood. I collected most of her history from her husband. He informed me that Ms. B. caught a cold last week that seemed to linger for a few days before becoming progressively worse.

Ms. B. nodded her head in agreement as her husband narrated her story. It was a story her husband had repeated to physicians several times in the past two years. Ms. B. would get a cold that would progress over a few days and, at some point, she would be taken to the emergency department, treated and sent home to recover. Each time, the ordeal was dramatic and seemed to take an emotional toll on the couple. After one such visit, Ms. B. and her husband decided that they had enough and would not fight the inevitable. This led to a discussion with her primary care doctor about a comfort care plan should Ms. B. become ill again.

The medical team was unaware of this discussion and subsequent plan, so we sprang to action as soon as Ms. B. arrived. Having already witnessed a number of similar cases, I knew the exact protocol to follow—we ordered a chest x-ray, oxygen, and labs. While I was placing orders and speaking with the nurse, Ms. B.'s husband interjected, explaining that her desire was to have no

Honoring Her Wishes *(continued)*

intervention in her end-of-life care. I was a bit baffled and needed to verify this, so I reviewed her chart further. I saw a note confirming that she did not want any of the customary interventions. With a significant amount of training in patient rights, I was well prepared to respect Ms. B. and her family's wishes regarding invasive treatment. However, I had never encountered this in an emergency situation. In my mind, she was presenting with a common ailment that could have been easily treated in the hospital.

Although Ms. B. appeared to understand the implications of her wishes, I still wanted to discuss her case with the chief resident to confirm the plan. We were concerned that she was going to pass away soon, so we involved the ICU team and talked the situation over with our attending physician. So, there we were—several doctors and nurses, a sizable team, huddled in Ms. B.'s room, trying to figure out the next step.

The doctors then stepped out and stood outside the clear glass door of the room, discussing the quandary and reviewing her documents. Ultimately, the attending physician agreed that the right thing to do was to follow Ms. B's wishes. He then cleared the room to speak with her and her family directly. He was very calm as he spoke to Ms. B., who, despite fading rapidly, was at peace. He then turned to her husband and son, who had recently arrived, to explain the hospital's protocol—in this case, it was to follow her wishes. Their eyes welled up as they began to accept her fate. The nurses were instructed to remove any unnecessary medical equipment from the room and to keep that part of the department as quiet as possible. There was far too little time left to move Ms. B. to a calmer section of the hospital.

The attending physician then asked Ms. B.'s husband if he would like to contact any additional family members about her condition to summon them to the hospital as soon as possible. Meanwhile, the nursing staff added to Ms. B's comfort by placing additional pillows on her bed and partially covering her with a new blanket. With time, she began speaking less and less and fading in and out of consciousness. Each time she went into a state of rest, the chief resident and I would come into her room to check her pulse.

Ms. B. was soon surrounded by an unbroken circle of love made up of her husband, son, sister, brother, and two of her grandchildren. Her sister covered her with a beautiful quilted blanket standing by her bedside as she lay quiet. The curtains of the room had been partly shut with an opening just wide enough for the medical staff to peek in. After some time, Ms. B.'s blood pressure began to gradually drop, and her breathing slowed to a whimper. The chief resident and I entered the room again, and he gently pressed his fingers against Ms. B.'s carotid artery. Her eyes were already shut, her chest was no longer heaving, and her essence had left her body. He then announced the inevitable with a somber look: "Your relative has passed."

Slowly, Ms. B.'s relatives assembled in the family room. The attending physician informed me that he was planning to speak with Ms. B.'s family for a few minutes. He requested that I go with him, adding that he does not bring a pen or paper during these times in order to be fully attentive to the patient's family. His goal was to learn a little about the patient's life, to better understand what they were like before they became ill.

When we entered the room, Ms. B.'s circle of love had transitioned into a circle of mourning. The attending physician and I introduced ourselves to the newcomers and offered our condolences. He explained that he wanted to know what Ms. B. was like before she became unwell. The family gradually began talking about the good times they had shared together. I learned that Ms. B. was excellent at quilting, had immense love for her grandchildren, and enjoyed taking long walks with them to the pond. While they were reminiscing, some of her family members began to smile fondly at those memories. After learning what we could about Ms. B. and sharing the next steps with the family, we left the room.

The attending physician and I quickly returned to our workstation where he taught me a final lesson by displaying a simple gesture of immense kindness—he jotted down what was said in the room for future reference for a card he planned to send to Ms. B.'s funeral. As the day progressed, her life force now departed, Ms. B.'s remnants were removed from the room.

My shift continued and I reflected on what had just transpired. Often, the pace of medicine makes it difficult to adequately capture the vastness of the human experience. Due to competing priorities, there are many opportunities to overlook the details. What appeared simple became complex. However, I learned that when we take the time to honor the values and experiences of our patients and their loved ones, what was initially chaotic can become beautiful and meaningful.

Note: This narrative is compliant with HIPAA regulations. All identifying details have been changed significantly to protect patient's privacy.

REVIEWERS' COMMENTS

"This is a considerate examination of what the author calls 'the vastness of human experience.' The many levels of complication and nuance are heightened by the fact that it plays out in an end-of-life setting."

OTHER FAVORITES

Always on Call

By Jennifer Oberstar, MD
Assistant professor in the Department of Family Medicine and Community Health, University of Minnesota

It was Saturday, September 29, 2018, at 5:30pm and it turned out to be the worst day of my life. I, as a sports medicine physician, had been working a high school/college cross-country meet called the Roy Griak Invitational, which is one of the largest meets in the country. Many runners crossed the finish line with labored breathing and pure exhaustion, but the day passed uneventfully.

Covering mass-participation events is often on the list of duties of a sports medicine physician. Routine training for these events includes assessing exercise collapse, heat illness, musculoskeletal injuries, and emergency protocols such as CPR. All this training prepares us for an emergency we hope we will never have to face. Another major race was completed, and I was happily headed home to my family, who had been waiting for mom to finish her weekend's work.

To decompress, I hoped to sit down and watch 10 minutes of college football before dinner. On this beautiful fall evening, my oldest daughter gathered fruit from the refrigerator to make a fruit salad. She cut bananas, apples, and grapes. Not to be left out, my toddler climbed up on her step stool beside the counter to help. She picked up an uncut grape and instantly choking sounds echoed from the kitchen.

My husband shouted, "Choking baby!" and I ran to the kitchen. Assessing the situation, I attempted the Heimlich maneuver and back thrusts, and then shouted to my husband, "Call 911!" As my rag-doll baby hung limply in my arms, her baby blue eyes, which had searched for my face from birth, looked right through me without recognition. A pale face with diaphoretic brow made the physician in me methodically search for all medical possibilities and procedures. My thoughts kept repeating, "I need to establish an airway."

As a last resort I performed a finger sweep and dislodged the grape. At last a patent airway was established and I sat on the kitchen floor rocking my whimpering daughter in my arms. My oldest daughter trembled, shedding uncontrollable tears.

"Thank goodness you were at home," my relieved husband sighed. We had so often discussed the balance between a physician's work schedule and family life.

My husband went to the door after this two-minute traumatic ordeal to greet the EMS crew. The EMS team, prior to getting this call, said they had been discussing a choking baby scenario and then the emergency call summoned them to our home. When they arrived, it was clear to them the medical crisis was over. They asked about my protocol and wanted to know if I was an ER physician. I told them no, but my training as a sports medicine/family physician had served me well. I explained I was sure I had scraped my daughter's soft palate on the finger sweep and asked them to check her out. Her lungs were clear and the sats were 96% room air.

These short evening events seemed to have lasted an eternity.

A telephone call from our concerned neighbor, who had seen the ambulance, helped us verbalize the recent events. I spent an all-night vigil beside my daughter's crib watching her every breath.

This eight-hour vigil gave me time to ponder a physician's extensive training, the people in my life, and life's elusive gift. How thankful I was for my training. Would other mothers have had a mental list of procedures and protocols to call upon? At the time of CPR training, it was just one more required course to be completed. Even the daily typing of charts and electronic records seem like a mundane routine, but I turned to the written word to process this emotional medical event.

Furthermore, my thoughts reflected on people in my life. Our family bonds have grown tighter having faced a crisis and being reminded of how important we are to one another. I am appreciative of the EMS workers, well-intentioned neighbors, and medical colleagues, who helped me debrief this situation. Finally, I have a new appreciation for work/family life balance. I am ever thankful for the time we are afforded with one another and the positive outcome of this event. Every breath is a precious gift.

REVIEWERS' COMMENTS:

"What a great piece of writing. Duel between mom/physician set within the fraught scenario of a baby not breathing … Wow!"

"An account of an incident at home that helps us recognize the unending responsibility that comes with medical expertise."