FIGHTING a losing BATTLE

Brian Bowden, Class of 2020

The first time I met him was in the emergency department, as the first consult visit of my surgery rotation. Before seeing him, my preceptor briefly described the nature of the consult—an elderly man presenting with an infected decubitus ulcer. As I slid open the door to the room, he was on the bed, facing me in a reclined, uncomfortable position, with a younger man, his son, standing to the right of the bed. I introduced myself to the patient and his son and explained my role. As taught, I addressed the patient first. However, after a few attempts to gain the patient's attention without a response, I turned toward his son, and began to receive a history from him.

My patient had a long history of fractures, nerve damage, and a chronic decubitus ulcer, along with a history of diabetes and hypertension. Due to a complicated vertebral and pelvic fracture, he had been bedbound for the past two and a half years, essentially now a paraplegic.

Something had happened over the past few days, as his son had just seen him the previous weekend. At that time, he was his normal self—alert, oriented, cheerful, and without any sign of acute illness. However, over the last two days, he had progressively declined, becoming more delirious and agitated.

When my preceptor arrived shortly after, we examined his decubitus ulcer. It was pungent, necrotic, and desperately needed debridement. However, this wasn't what was making him septic. His lab results came back with an elevated white count, elevated BUN and creatinine, and urinalysis showing infection. He was treated with fluids and antibiotics, and his delirium resolved by the next day.

I saw him the next morning during rounds. I reintroduced myself, and thought he could recognize my face but didn't seem to remember my name. He was much more alert than he was the day prior in the emergency department, but not to his baseline that his son had described. His labs had improved with decreased white count, and resolved urosepsis. However, he remained tachycardic and tachypneic.

The next day, I again reintroduced myself, still unsure of whether he remembered me. Again I got a vague sense he remembered, but the look in his eyes made me seem unsure. I explained that we would be operating on him later that day in order to clean his wound. He simply nodded, without saying any words.

His surgery was a much different experience than any of the previous ones I'd done before. Those had been elective surgeries that would result in a curative outcome. This one, however, seemed to be making a painful situation only a little less painful, as if what we were doing was futile. During the surgery, we removed a large amount of necrotic tissue, going all the way down to the sacral bone, and even into the edges of the gluteus muscle on both sides. The blood loss wasn't insignificant, and as the minutes passed I felt like I was battling two feelings—one telling me that what we were doing could allow him to be comfortable and back to his baseline, and the other, that we were doing no good whatsoever.

I don't know if anyone else gets a boost of energy and confidence after finishing a surgery, accompanied by the feeling you've accomplished something, and that your patient will be better off than they were before. But I know I do. Well, this didn't feel like that. It felt just the opposite, like I wish I had never scrubbed in. It felt like we had made things even worse, like we were in a lose-lose situation. Don't operate and he'll still have dead, necrotic tissue that is prone to making him even sicker. Or operate, and we'll carve a large hole in his backside, leaving him a long and nearly impossible road to recovery.

Over the next few days I rounded on him in the hospital. He remained on our patient list, but he was now under the charge of the hospital's wound care clinic. He continued to remain tachycardic, tachypneic, and generally did not appear well. Each day I went to see him, I got the sense that he remembered me, that I'd been seeing him for the past week, and that most of the time I had a white coat on over surgical green scrubs. But each time I looked in his eyes, something told me that he didn't really know who I was, what my role in his care was, or the extent of what had been done for him just days prior.

The next week, because of other school obligations, I didn't go back to the hospital until Thursday. When I got to the hospital to see the patients on our list, I didn't see his name. It seemed odd to me, but I didn't think much of it. As a third year medical student, I know nearly nothing about how a hospital system works. I assumed he'd been transferred to another unit, was transferred to a different facility, transferred out of my preceptor's care, or simply not showing up on the list due to an error in the system. I saw the patients on our list and then headed to the surgery center for our morning cases.

As I was scrubbing in for the first case of the day, my preceptor came up and began scrubbing as well. As he started scrubbing, he asked me, "Did you see the patient wasn't on the list?" To which I simply nodded and replied, "Yes." He waited a few seconds, thinking I'd put two and two together. When it was clear I hadn't, he then said, "He died yesterday morning."

My heart sank. Not just from the sadness of a life I knew was now gone. But also from embarrassment, that I had neither realized why his name wasn't on the list, nor tried to figure out why when I first pulled up the list earlier that morning. I quickly refocused in order to finish my scrub and mentally prepare for the first case.

At the end of the day, after we had finished our cases, I began to think differently about his situation. Maybe it was better off that he had passed. I know that sounds morbid, but I think it's right to feel this way based on his situation. What quality of meaningful life did he have? It was obvious he was in discomfort, pain, and who knows how he was perceiving his situation. As my preceptor explained after we finished debriding his wound, his long-term prognosis for recovery was dismal. Even with the best wound care and nutrition, his paraplegia would leave him little chance for complete healing of the area.

My patient's situation, his treatment, and his ultimate passing was unique from anything else I experienced in my third year. It was the first time that I had a patient pass away who I spent a significant amount of time caring for. Even though it took me until the end of my third year, I felt like I finally had a substantial role in the care of a patient. For the most part, all of the patients I had seen this year were healthy—far from their death bed. But he was an exception.

As I continue medical school, and progress into residency next year, this patient will provide a reminder that I will experience more of these same situations. And though they'll have their own unique challenges, and I will learn from past experiences, the passing of any patient will never be easy. ■

BOSS BASE
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