A Universal Cue

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It was July—the start of my second year as an internal medicine resident, and my first time as a senior resident on inpatient wards. I was excited to transition my time and attention from the "trees"—writing notes, answering pages, electrolyte repletion—to the "forest"—leading rounds, educating our medical students, and fostering a collaborative team culture. On her very first day, our sub-intern, Mary, started following a new patient, Ms A, a 41-year-old woman who had just flown to the United States from overseas for evaluation after a diagnosis of metastatic colon cancer. Ms A had peritoneal carcinomatosis, a sub-massive pulmonary embolus, malignant pleural effusions, and a bowel perforation complicated by bacteremia. She had been a high-functioning, successful businesswoman just 2 weeks prior.

Mary was often the first to arrive at our workroom and last to leave. In addition to our morning pre-rounds, Mary and I spent many afternoons in Ms A's room, providing medical updates and our best efforts at emotional support for our patient and her family as they navigated this sudden, life-altering experience. Mary and Ms A were from the same country, and they often spent time exchanging stories about their shared backgrounds and faith. On Mary's days off, Ms A would inquire about Mary, and Ms A's parents and sister would share how they trusted Mary and appreciated her patience and calm demeanor.

After 2 weeks on our service, and only 4 short weeks after her diagnosis, Ms A was deemed no longer a candidate for surgery, chemotherapy, or other cancer-directed therapies. Her blood pressure became more tenuous, and she grew quiet, lethargic, and intermittently confused. One afternoon, Mary and I sat in a semicircle with her family, each of us with tears in our eyes, and made the collective decision to transition her care to focus on her comfort.

After the meeting, I asked Mary how she was doing. She shook her head and offered the "shrug and sad pursed-lip smile." We exchanged quiet reflections as we walked to the elevator bank, "I think that went as well as it could have," and "I wish there were more we could do." As the busy elevator opened and closed, my mind had already started to wander to our other patients. How was Ms W, who had aspirated earlier in the afternoon? Was Mr S able to lie flat for his CT scan? Did I have time to grab coffee before afternoon rounds? A co-resident I had not seen in several months entered the elevator, and we chatted animatedly about plans for our upcoming vacations.

We entered our workroom, and I shared, "Ms A is in comfort care," with our larger team. Suddenly, Mary's body stiffened next to me. She sniffled, mumbled, "excuse me," and quickly exited the room.

At that moment, I was reminded of a memory from early in my intern year. Near the end of a night shift, a code was paged overhead. My senior resident, Rob, ran it seamlessly and professionally, and we stabilized our patient after a few rounds of CPR—only to find out that the patient had had a DNR order in place the entire time. I had thought that calling family members to inform them of a patient's death was the worst phone call one could make. But this one—sharing that a medical error that caused us to inadvertently disregard perhaps the most personal and privileged wishes of this patient and his family—this one was worse. Demoralized, disheartened, and resentful of what we had done, I returned to our workroom after the call. I turned to Rob and asked, "how are you feeling?" "Hungry," he replied, with a half-hearted chuckle.

I balked. But Rob's response was not that of an uncaring physician; in fact, Rob was one of the most compassionate seniors with whom I had worked; a "doctor's doctor," as his peers often described him. He had experience that I did not have at that time: 2 additional years of residency, filled with many more codes, emergency situations, and complicated ethical scenarios. He had developed his own unique way of coping with challenging situations, and he was able to more quickly channel his energy into helping the rest of us process what had happened. Rob then led us in a debrief about medical errors, communication, and opportunities for quality improvement—all while eating a granola bar.

Back in the present, as the door shut swiftly behind Mary, I felt immense shame. What did it say about me, if I could quickly turn to my phone, or yearn for caffeine, or feel excitement for my own vacation plans shortly after an emotional patient encounter? By the end of my intern year, I had lost

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count of the number of goals of care conversations I had participated in. But this was Mary's first experience with a dying patient, one whom she had grown to know as a person, a daughter, and a sister. Simply asking how Mary was doing was not enough.

Later that afternoon, Mary and I set aside time to debrief on our goals of care discussion and on Ms A's course with some of our nursing colleagues. A few days later, our attending facilitated a team-wide debriefing session led by a palliative care physician for our team's inpatient deaths. Mary and I continued to have frequent check-ins about the emotional toll of our challenging cases through our remaining weeks on service.

I have come to learn that all of us, whether early medical student or seasoned attending physician, have moments where we are "Mary" and moments where we are "Rob." A team member's "shrug and sad pursed-lip smile" nonverbal cue is a potent reminder to pause and debrief, or to arrange time to do so. We have moments when we hide our emotions, reflections, or tears, yet we all need to be able to share our vulnerabilities. All of us benefit from collectively slowing down, in solidarity with one another, to reflect, process, and restore.

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