Learning from patients

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In January 2014 I was on the cusp of beginning my internship. I was nervous but also excited to finally begin full-time work, and in a vocation I was passionate about. It was at this time that I met a friend of a friend at a small lunch gathering. After introductions, he casually asked me what I did for work. I excitedly told him that I was about to start as a junior doctor at a reputable teaching hospital, to which he replied, somewhat provocatively, 'A junior doctor! Well it's only a matter of time until you kill someone'.

This unexpected comment took me slightly aback, and I wasn't sure exactly how to respond. I didn't want to dwell on the possibility that my own limitations might lead to someone's death, but when I thought about it later, I realised that I was about to embark on a career where I would regularly be exposed to death, and would need to recognise this as a natural and inevitable stage of life.

My first death certification

I commenced my internship and waited for one of my patients to die. I started the year working evening and night shifts, covering a variety of wards, including oncology and palliative care. Within a few days, I was called for the first time to certify the death of a patient. When I arrived, one of the nurses beckoned me. She knew that I was a new intern and had probably not done this before. She explained that the patient had been admitted under the care of the palliative care team, and that the death was expected. The family had already said their goodbyes and all that remained to be done was the examination and certification.

When I entered the patient's single room, it was eerily quiet. It felt odd to be in a room with another person but for there to be no audible presence of them whatsoever. I looked over to see her frail body, hardly visible beneath the blankets that covered her up to her neck. Her skin was sallow, her eyes sunken and her jaw slack. I approached the bedside and looked, listened and felt for signs of life. I can't explain why, but I felt slightly uneasy as I did this, as if there were someone in the room watching me. I respectfully and efficiently completed my examination before leaving the room.

Learning from patients and their deaths

I waited for some sort of emotional response to what I had just experienced, but was surprised by the relatively small impact it had on me. All I knew of this woman was a lifeless body lying on a hospital bed. Perhaps I had subconsciously disconnected from this in the way I had already become accustomed when learning anatomy in a room full of prosected cadavers. In an attempt to justify my response (or lack thereof), I reasoned with myself that it would be different if I had known and developed a personal relationship with the patient.

In November I commenced my oncology term. I had been told that the term could be quite challenging, and that I should be prepared for the fact that many of my patients would deteriorate and die during their hospital admission. I sincerely hoped that this would not be due to my limitations as a doctor. Despite this advice I could not have anticipated the sheer number of deaths that I would not only witness, but also be part of, and how different each of them would be. Reflecting on these experiences, I have realised that although death is a natural and inevitable stage of life that we will all eventually experience, it is an area that is often overlooked in prevocational medical education.

But the taboo subject of death is not unique to medicine. We live in a society that is focused on hiding everything that represents our mortality: wrinkles, grey hair, skin imperfections, and even illness. We glorify the field of medicine and idealise doctors as demigods who ‘cure disease’ and ‘save lives’. But at the same time we shy away from discussions about allowing individuals to follow their life trajectory, and forget the medical professionals who offer these people a comfortable and dignified death.

Sharing my experiences learning from patients

As a way of recognising and paying homage to the patients and their families who taught me so much about life and death, I have chosen to write a series of stories based on true events. I hope that these stories, published across a series of blogs, might also provide a resource for fellow junior doctors who may have had their own experiences dealing with life and death.

Learning from patients - *I just want to be left alone*

When I first met Theo he was in his mid-sixties, although to look at him you might have placed him at closer to eighty. He had enjoyed life, with a long history of smoking, drinking and previous drug use but had mellowed in his older years. Theo was known to the outpatient oncology clinic after he was diagnosed with prostate cancer eight years ago. Reviewing his file, we noted that he had declined further investigation and treatment at the time, and had chosen to not follow up with our services.

Theo was brought to hospital by ambulance after he collapsed on the street. On arrival he was noted to have rectal bleeding, and a CT of his chest, abdomen and pelvis revealed a massive tumour of the prostate invading into the rectum, as well as widespread distant metastases. Once stabilised, Theo was admitted to the ward under the care of the medical oncology team.

Theo posed challenges both medically and ethically. For the past eight years he had refused to accept his diagnosis of cancer, and he continued to do so now. Despite the fact that he had collapsed in the street, he repeatedly stated that there was nothing wrong with him and that he did not need to be in hospital. He was in no rush to leave, however, and gladly took advantage of the free meals and clean sheets.

When patients refuse further treatment

The following morning we were called to review Theo for chest pain. An ECG showed signs of acute ischaemia, which had not been present on admission. As we prepared to work him up for possible ST elevation acute coronary syndrome, Theo became acutely agitated. He refused any further observations, examination, blood tests and ECGs. As his treating team, we became anxious. We were acutely aware that without treatment, Theo would die within a few days.

We thought that it might be a good idea to speak to someone who had known him for a long time. Without a next of kin to contact, we decided to get in touch with his cardiologist of many years. His registrar arrived and spoke to Theo about his situation and what would likely happen if he accepted or declined further investigation and treatment. Theo declared 'I'm not having a heart attack. I just want to be left alone'. He declined all medications except for subcutaneous morphine for shortness of breath and pain relief.

The morning after his onset of chest pain, Theo agreed to have a blood sample collected. His troponin came back at seven thousand. We searched for a rational explanation for his seemingly irrational decision. It is possible that he saw this as an easy and relatively comfortable way to die, rather than slowly deteriorate at home. But given that he consistently denied the fact that he was ill, we were also concerned that perhaps he lacked the capacity to make decisions about his medical treatment. We requested a psychiatry review, but when the psychiatrist arrived, he declined interview and was objectively too unwell to participate.

Learning from patients - when you have the ability to save a life but they won't let you

Within 72 hours of presentation to hospital, and within 48 hours of onset of chest pain, Theo died. His death was more abrupt but also more peaceful than I had expected; only two hours prior, I had seen him sitting up in bed eating his bacon and eggs. Despite this, I couldn't help but feel uncomfortable about the whole situation. We had the ability to save Theo's life, but without his cooperation, we were left to watch and wait for him to die. Was this what that friend of a friend had meant when he said it was only a matter of time until I killed someone? Was it our inability to persuade Theo to accept medical treatment that led to his death? Perhaps. But even if we could have persuaded him, would that necessarily have been the right thing to do?

Theo was clearly a unique individual. We will never know why he refused investigation and treatment for his prostate cancer at the time of diagnosis, but regardless of the reason for his choice, it was ultimately his to make. It would be easy to argue that he

didn’t realise the significance of the diagnosis and what could be done to improve his prognosis, but I suspect that he was probably more at ease with his mortality than the majority of us, and considered this just another of life’s journeys. In the end Theo didn’t want modern medicine to save him. He just wanted the autonomy to choose how he lived and how he died.

All names, personal information and clinical presentations have been changed in the interest of protecting patients' privacy.

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