This is a resident case log of a patient encounter in which an "Aware Medicine topic" was central.

Without the Code Chimes

I clearly remember my first night on call as a resident. We've all seen the media portray residency overnight call as sleepless and action-packed. I had my ACLS book ready. I was fired up to receive those 9 overnight admissions that would keep me from seeing the call room. The idea of there being a "code" called was a chance to put my knowledge to the test. A preceptor had told my class that "doctors are supposed to save lives," and I was prepared to do just that. I was energized as the shift started, stimulated with a much more than typical amount of caffeine to keep me up for the night. Then it happened. The pager didn't go off. Hours passed, and it was still quiet. Did word travel that it wasn't worth calling the "new intern"? I called the pager myself, and sure enough it worked. As hard as I tried to sleep I couldn't, out of fear that I would miss something. I would have to wait about 8 hours in to my shift to hear the (what would later become dreaded) beep of the black box, and return the call to the nurse's station. "Doctor, we need you in room # xxx for a pronouncement." "A pronouncement?" I asked. "Oh, yeah, a death pronouncement. The patient just passed and we need a doctor to pronounce him as dead."

I was completely confused; had I missed the code chimes? Maybe it would have been a good idea to call a doctor before the patient died? What am I supposed to do now? I had waited all night - for THIS? When I got to the room, the patient's family had left. It was just me and Mr. S in my closest encounter to death in my short medical career. Moments ago, this elderly gentleman had been breathing, thinking, living. His medical treatment must have failed. Although I had to turn no further than my palm pilot for an outline of the necessary exam and documentation (thanks to a recent orientation lecture), I felt completely helpless and inadequate. The only thing that could have been worse was if I had to confront the family. I can't imagine how disappointed they were that their loved one not only died, but died right in the hospital under what was supposed to be such close supervision with up-to-date therapies.

Over the next 2 1/2 years, the beep of the pager became no stranger to me. I can't think of any particular turning point in my training, or a time that I look back at and can recognize that my views have changed. My experience caring for JP toward the end of my residency made me realize that in fact it had happened. JP was admitted to the hospital for what appeared to be a run-of-the-mill infection. JP would always greet the medical team with a smile, nod, and thank us for the work we were doing. He never uttered a word of pessimism - he was always doing "good" or at the worst, "alright." His eyes glowed every morning when his family arrived to keep him company. His acute status gradually improved, however, his underlying malignancy became more problematic. Despite a life expectancy of a few short months, JP and his family wanted everything done medically to treat him. IV antibiotics, catheters, monitors, blood draws, and imaging consumed his next several weeks. Consultant after consultant met with JP, his family, and the primary medical team to discuss his care. At this point, medical treatments for his conditions were maximized and surgical options were all that remained. As steps were being taken to chose a date for surgery and discuss its risks and benefits, JP started to say "no." While his words became few and far between, the optimism that the staff and family had grown to know from JP was no longer present. He asked us to take the tubes out. When we attempted to examine him, he would tell us "no thank you. In his rare alert moments, he asked for his wife and children. He wanted to see his dog. Despite the challenge of eating it, he continued to ask for ice cream. I will never forget the tears shed by his wife when he told her he had had enough.

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Multi-disciplinary conferences and family meetings ensued. Although JP's dismal prognosis could not be avoided, every discussion led the staff and family to feel a sense of peace in our medical plan. We could do no greater honor to JP than to abide by his requests to focus on keeping him comfortable. After several weeks of maximal treatment in the hospital, JP transferred to hospice. He was made free of the tubes he had fought, with his family by his side. He was able to pet his dog and at last – eat the ice cream he had been asking for. JP died a few short days later, after spending time with his family that they described as "as precious as many years."

My interaction with Mr. S was one that struck me with great disappointment, however, caring for JP was as fulfilling of an experience as I can imagine in the medical world and beyond. By the time I cared for JP, I had come to see that death does not always indicate failure or error. As a medical team, we had no reason to be ashamed of the outcome. Although our initial goal of a cure was not accomplished, by directing care to treat the wishes of the patient and his family, we were able to provide the best form of medicine possible. I regularly encounter a quote that reminds me of JP and the joy that filled his final days – "Life is not measured by the breaths we take, but by the moments that take our breath away."