Comfort Measures Only

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I always thought my first time would be different. I took extra time through first and second year to hear what it was like to have dying patients; going to seminars, hearing from professors, even researching music in palliative care. But when a 42-year-old man with metastatic colon cancer caused by Gardner's syndrome was admitted to my surgery team, I followed everyone else's lead and avoided him. We would look furtively into his room on morning rounds whispering about whether his morphine dose was high enough and how his family had expressed their wish that he die in the hospital. I would pause sometimes, staring through his door at an angle where I could see his legs and body, wondering what he was thinking and feeling. Did he resent having healthy providers, who lacked his intimate knowledge of mortality, coming in and out of his room? Or was he searching for any distraction, however fleeting? Quickly I'd snap out of my reverie and scurry to keep up with "walk rounds;" writing a flurry of progress notes, finding out who had or hadn't passed gas the night before. I felt badly that I wasn't learning about this patient's experience, but I didn't know where to start. Because we weren't surgically treating his colon cancer, there wasn't any surgical protocol to be learned, and we weren't even performing daily physical exams. "Comfort measures only" meant respectful privacy, not bumbling medical student care. I didn't feel that I could casually ask him how he was doing in the face of what he must be feeling. And yet I also couldn't help but ponder what was going on in that room; why, after 2 years of preparation, it felt so very foreign and inaccessible; and what, at the end of the day, did "comfort" really mean? Careful silence? A well-chosen word or two? Simple physical presence? Why was this so hard?

Then one Sunday when I was on call, I answered a page for the third-year resident I was helping. It was a nurse. "Umm, we need your help on the third floor. Mr. M. has, uh...Well, he's passed on and we need someone to examine him." I relayed the message that our patient with Gardner's had died and we needed to see him. I followed my resident into a still, single room with quiet crying. Mr. M.'s gaunt head was turned to the side with opened, searching eyes and jaundiced skin. My resident motioned that I listen with my stethoscope. I gently pulled back the sheets taking pains to avoid touching the cool body and listened, not expecting to hear anything but focusing all the same. With some guidance I felt reluctantly for a carotid

pulse. My resident closed the eyes, said he was sorry, and left to look for a computer. He coolly explained to me the technicalities of a death certificate, and I watched while he asked sheepishly if the family wanted an autopsy. The family thanked us profusely, adding to my confusion. We could only mutter how sorry we were while they shook our hands and talked about how they couldn't have hoped for things to go more smoothly. My resident's pager went off three more times during these 20 minutes, and by the time we were finished we had another admission to the ED on top of the one that had been waiting for over an hour. He asked me quickly if I was okay. I said "I think so." And that was it. I had seen my first death in the hospital.

I didn't know what to make of it. I still don't know. I don't feel sad. Fortunately, I guess. Or actually, unfortunately. There was no meaning to what I did, only motions. There was no enormity, no realization of some daunting task. Just a physical exam, a mumbled apology, and some paper work. How could I spend hours in my first 2 years discussing imagined deaths only to see a patient die and have it feel like one more box on a to do list? I always imagined that my first death would be fraught with crying and twisting emotions. None of that. I read a paper on how to determine death, and wondered at my lack of empathy. I didn't tell many people about it, not because I was embarrassed about being emotional during my surgery rotation, but just the opposite: I had seen something profound with little more than a second thought.

I don't blame the resident. How could he know that he would have to usher a naïve medical student through death and dying during his weekend shift? I don't blame my professors. Several have told me again and again to contact them if something came up and I needed to talk, to shed some burden. Instead, I only think it's ironic that certain parts of our education are so carefully titrated and controlled, while other parts depend wholly on circumstance and what can be fit into an unrealistically busy schedule. Committees discuss how many multicultural patients appear in our tutorial cases; great care is taken to talk about approaching our cadavers first year; I can't count how many times I've been told the latest research showing disparities in our healthcare system. But when it comes to actually living these experiences with actual patients, they happen in rapid fire amongst young resident-teachers who don't have the time to fully reflect on what they're doing and how they are affecting impressionable medical students. After years of discussing the ethics of abortion, I saw three in one day during my OB/GYN rotation. Nobody planned it that way; it just happened.

I'm not saying that I should be shielded from reality. At some point you need to leave the abstract confines of the classroom and see clinical medicine as it's practiced. It would be unfortunate if in an attempt to protect us we were separated any more from patients. Already so much clinical independence and practical knowledge are learned in residency and

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not in medical school. I just think that when administrators talk about curriculum reform they should realize that as students we learn far more about what it is to be a doctor from unscripted patients and residents stretched to the limit than we do from carefully designed syllabi and lectures. Changes made to the formal curriculum during our pre-clinical years are an important start, but real changes need to include thoughtful role modeling and creating space for well-meaning residents to be the best teachers they can be.

When we enter the clinical setting as third-year medical students, we are incredibly impressionable and malleable. We

learn very quickly not only how to conduct efficient clinical exams, but also how to react to the many events that are common in a hospital, but were rare in our previous lives. Perhaps learning to offer “comfort” requires reflective time for patients, students, and doctors alike. Sometimes the most important teachable moments can happen at unexpected times.

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