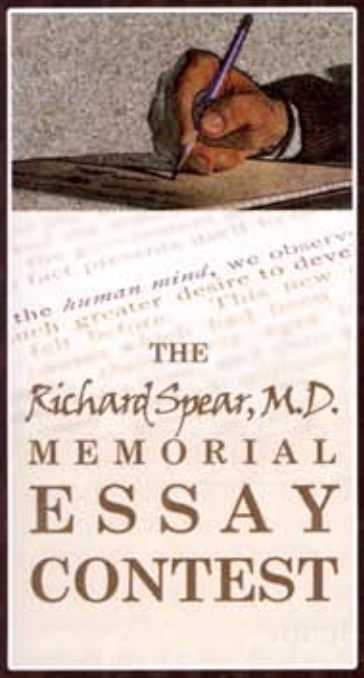


**RESIDENT CATEGORY WINNER**

# A Chance Encounter

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At four o'clock on a Friday afternoon, my intern and I were called to the emergency department to evaluate an open call patient. Open call patients are those who do not have a designated primary care provider or whose primary provider does not have privileges to admit to this particular hospital. The patient awaiting our care typified the former group; in fact, she had only two encounters with organized health care in the past 60 years.

Ms. M presented to us as an 82-year-old woman with abdominal pain. The pain, more discomfort really, had been bothering Ms. M for several weeks. She waited until Friday afternoon to come to the ER because she first wanted to finish her work week. This charming 82-year-old worked as a cashier at a small grocery store, and she did not like missing days. Ten years prior to our encounter, she had undergone a total left hip replacement, and five years prior to that, her husband died in a hospital. Otherwise, Ms. M got along quite well away from doctors and health care in general.

As an upper level resident, I sent the intern in first to perform a history and physical exam. Over the next 10 to15 minutes, I reviewed the vital signs, lab work and imaging studies already completed by the ER physician. Before I even saw her, I knew that Ms. M was very sick. Based on the data in her chart, her stomach discomfort was due to an unknown primary carcinoma, which had multiple widespread metastases to her liver and colon. Her prognosis was poor.

Friday afternoon is a busy time in a hospital. I knew that things would have to move quickly in order to get a fine needle biopsy or my patient would have to wait until Monday. I immediately discussed the necessary orders with the charge nurse and made a call to interventional radiology to ask about their queue. I then politely pulled the intern away from the bedside and met my new patient.

Ms. M's story never grew more complex. She simply had abdominal discomfort. The intern and I could elicit no other signs, no other symptoms and no other complaints. She was planning to return to work the following Monday, as the grocery store stayed busy and had little help. Her son would be in shortly. She joked and laughed, and her face held an easy smile.

If Ms. M was going to undergo a biopsy within the hour, she would have to know the results of her imaging. The intern and I pulled two plastic chairs to her bedside, and in a loud, chaotic ER, I held Ms. M's hand. I told her that she likely had cancer. I sensed that she was a lady of great strength when I first saw her, and now I was convinced of it. Her sparkling eyes watered in the following silence, and she stared at me. Then as quick as the pain came to her eyes, it was gone. She smiled and asked about the "next steps." As the astute intern proceeded with a thorough exam including evaluation for breast masses and lymphadenopathy, I told the patient everything I knew about her health and all the things that I did not know: the things we would have to find out together. She agreed with my plan with one caveat: she wanted to be back at work by Monday.

I was unable to get Ms. M her biopsy on that Friday afternoon. She spent the night in the hospital with us and was "very ready!" to leave the following morning. Her son was

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at the bedside when our team rounded on Saturday. He was a tall man with dirt under his fingernails, a sharp eye and the good fortune to inherit his mother's smile. Ms. M was walking the halls, eating well and her lab work was relatively normal other than a mildly symptomatic urinary tract infection. We arranged the biopsy as an outpatient and discharged her home with antibiotics.

The following day Ms. M's son returned to the hospital with his mother. He had found her down in her home, unresponsive. He also brought with him her living will, which she had completed 15 years ago after the death of her husband. According to her wishes, we were to do nothing "extraordinary." No intensive care, no drips, only antibiotics. Beyond that our hands were tied. The resident on call talked to the son and provided comfort measures through the afternoon. Ms. M died later that evening.

Over the past 20 years physicians and other health care workers have broken fantastic new ground in end-of-life care. Instruction and encouragement to initiate discussions regarding living wills and dying wishes are incorporated into our learning curriculum. These sensitive interactions may always be challenging, but my education facilitated the conversation that memorable day in the emergency department. I wonder if Ms. M's husband had experienced a peaceful end, one that prompted her to delineate her end of life wishes, or if they together suffered through a frightening death 15 years ago. Tragic events can unfold quickly, and physicians must remember the importance of foresight and planning as we counsel our patients.

Ms. M spoke with the strength of one who is at peace with the world. I know I felt great relief upon seeing Ms. M's wishes on paper when she was unable to verbally communicate them. Relieved of demanding decisions, her son also seemed comfortable and free to grieve. As I reflect on the events from Friday through Sunday, I am thankful that everything went so smoothly, and I fervently hope she and her son agree. I can imagine that those who knew her well were deeply saddened by her passing but that they also celebrated her life as a blessing to all of those she touched. $L_M$