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# My First Patient

**By Casey Means**

Ms. K presented with ten out of ten right upper quadrant pain and a bad mood. Relegated to a corner alcove in the emergency department for a full GI workup, she spent the night writhing, with doctor after nurse after phlebotomist after machine stopping by to talk, listen, image, poke, and palpate. I saw her during her thirteenth hour in the ED. She was not thrilled to meet me, and my frenetic enthusiasm (which stemmed from it being my first on-call night as a clinical student) was met with the stark reality of this patient's pain. As a med student, however, I had ample time to listen, and after she realized that I wasn't going to rush or hurt her, she began to open up.

In that first conversation, I learned she was 91-years-old and living alone in a trailer park, which she loved. Having been a magazine reporter in Kansas in the 60s and raising children on her own, she was a progressive and fiercely independent woman. With her neighborhood friends, she now passed days playing bridge, pushing carts through Target for 2 hours a day for exercise, and driving around town to check in on her children and grandkids. She'd had a hysterectomy and her thyroid taken out in the past but was otherwise quite well. Earlier in the evening, she'd eaten an English muffin with jam and butter, and two hours later was buckled over on her knees, calling 911.

As I completed my extensive interview and exam—peeking into her ear canals and verifying that her toes could sense vibration—I could not have expected that over the next 21 days she (with her tummy pain) and I (with my enthusiastic naiveté) would share what we would: life, sickness, despair, and hope. Today was not the day she would tell me that one of her daughters committed suicide that year. It wasn't the day she would go into an unexpected arrhythmia, and we would electrify her heart. Nor was it that day we would discover she had a time-bomb in her abdomen that a brief and punishing pathology report would call: "Gallbladder carcinoma, advanced."

It wasn't until about the fourth hospital day that she even knew my name. There is a distinct transition point at about day 4 when patients seem to realize that you, the medical student, are actually going to keep coming back every single morning. Unlike the consult team that briskly pops by to sign off on one specific body part, or a nurse who happens to be working one shift on your hall, or a phlebotomist who will only perform one poke, the medical student on the Internal Medicine team is a steadfast boulder in the sandstorm of a hospital stay. After 4 days of waking the patient up to pester them about their symptoms, interrogating them about the timing and appearance of their bowel movements, bugging them at lunch to see how their appetite is, and saying goodnight to them before heading home, they realize you are in it for the long haul, and they choose to remember you.

A couple well-timed favors go a long way in this endeavor; for Ms. K, it was earplugs. Each patient's desired favor will be different, but the simple act of making note of a patient's wishes and bringing it to them does wonders in creating a trusting relationship

that facilitates good patient care. I bought the earplugs at the gift shop when Ms. K couldn't sleep due to all the beeping and yelling in the ICU. The very next morning, Ms. K and her daughter would start addressing me by name and looking at me when they asked questions in team rounds.

Each morning of Ms. K's hospital stay played out similarly: At about 7:15am, I would knock on her door and enter to find her lying in bed, alone, staring at the ceiling. "Hi Ms. K, it's Casey, the medical student. How did you sleep?"

"It's the end. The nurses are trying to kill me. There is a man standing at the end of my bed at night. I'm dying."

I soon learned not to panic from these comments; delirium is a common phenomena in elderly patients and that frightened and depressed mood can only get better from there. After trial and error–hand-holding, tough-love, Ativan—I learned there was only one thing that could get her off the cliff of morning despair: sneaking oatmeal with 2 sugar packets and milk to her before breakfast. As an anti-depressant, oatmeal for a carb-restricted patient works miracles. After a few bites, she would permit me to do the physical exam, palpate her pained tummy, and hear about her symptoms, which allowed me to then report these findings to the team. Right before she was discharged, she took my hand and told me that she looked forward to her morning oatmeal everyday. The look in her eyes when she said it made me believe her.

On her first day in the hospital, it was discovered by CT that Ms. K had severe choleycstitis, so her gallbladder was immediately taken out laparoscopically. The gallbladder was huge and inflamed, and arrhythmias, pneumonia, abdominal abscesses, and delirium complicated her post-operative recovery. When the pathology report came back a week post-op as gallbladder carcinoma indicating she was not a good candidate for surgery, chemo, or radiation due to her age and deconditioning, things got worse. With a parade of oncologists, hospice representatives, and social workers coming through her room, she became increasingly depressed. After two weeks in the ICU, with antibiotics, heart monitoring, and physical therapy, she started making a comeback, and eventually on day 21 was ready to be transitioned home under the care of her children. She walked into the hospital a fully independent 87-year-old woman, and she left a cancer victim in a wheelchair with an early death sentence.

As I reflect on why my work with Ms. K was so meaningful to me, I keep coming back to what she and I shared. This is a woman whose hand I held when the oncologist told her she had cancer for which we had no good treatments. I suctioned her throat when it filled with pneumonia's yellow mucus, and I woke her up every morning. I knew the exact number of white blood cells floating in her blood each day and could draw a perfect graph of her temperature progression over 3 weeks. I gave a teaching session to my team on treatments for loculated abdominal abscesses based on her CT scan. I'd listened to her heart and her bowel sounds dozens of times and knew exactly where to hear the crackles in her lungs. Each time she got a chest x-ray, I reminded the team that the haziness on the film was not effusions but rather the shadow of her antiquated breast implants. This woman took my hands and told me I'm beautiful. I saw the skin of her abdomen cut open with scalpels and saw bile mixed with hundreds of gallstones spill into her abdominal cavity. I cleaned out her belly button with hydrogen peroxide and watched years of accumulated dust bubble out. I'd seen her breasts, her vagina, her urine, her tears, her children, her blood. There is no other human on this planet who I know quite like this. Not my mother, a lover, or a friend.

The privilege of practicing medicine is a gift. I couldn't have imagined that any job would allow me to witness such a full gamut of human experience every day—and that I would like it. Back when I saturated my medical school applications with the theme of wanting to "serve others," I could never have imagined how much the training would serve me. I guess that's what it is to be both a doctor and a patient: you enter through the sliding doors of the hospital, not sure what to expect, not even knowing what you need. Eventually, you both will leave through those hospital doors, changed inside in ways you couldn't have predicted.

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