My Most Famous Patient

Amit V. Khera

As a medical student on a recent cardiology rotation, my attending taught me how to manage postoperative atrial fibrillation, a system for reading echocardiograms, and the nuances of the most recent perioperative cardiac risk management guidelines. Yet his most lasting lesson was one that he was uniquely qualified to provide. For years, he had been asking each of his patients to identify what made them famous. He suggested that we adopt his tactic, hopeful that we would remember patients on a busy service for more than their most recent ejection fraction.

Although initially skeptical, I began to routinely include the question on my initial patient histories. Many were somewhat taken aback, far more accustomed to my lines of inquiry about orthopnea and lower-extremity swelling than a question mandating a much deeper level of introspection. Most insisted that they were not famous for anything. However, given sufficient encouragement and a few additional seconds, every single person came up with an answer. One man had been recently inducted into the football hall of fame in recognition for decades of service as a college referee. Another had founded a barber shop quartet renowned throughout the area. Still another patient described her instrumental role in raising 15 grandchildren. As a team, we collectively took great pride in carefully embedding our patients' accomplishments in the social history portion of our presentations.

A few weeks later, as a member of a renal consult team, I realized how accustomed I had become to the practice. Each morning, we rounded on some of the sickest patients in the hospital. One woman had been in the intensive care unit for months despite universal agreement from the medical staff that no amount of heroic intervention could offer hope for meaningful recovery. Yet each day we soldiered on—supervising the continuous filtration of toxins her failing kidneys were unable to clear. The seeming futility of the process began to eat away at me, leading me to question my desire to pursue a career in a critical care specialty.

I am certain my experiences that morning on rounds colored my approach to my next consult. We had received a brief call from a fatigued surgical intern about a concerning rise in a patient's serum creatinine. My study of the patient's chart revealed that Mrs. E was a 92-year-old woman initially admitted four months prior for severe and symptomatic aortic stenosis. Despite the technically sound replacement of the faulty valve, she never fully recovered from the stress of the operation. I carefully made note of a litany of complications including respiratory failure, multiple episodes of sepsis, and waxing and waning mental status.

I entered Mrs. E's room for the first time to find a minimally responsive, anasarcic, elderly woman with tubing coming out of every orifice. Ventilation was maintained via a tracheostomy, nutrition via a gastrostomy tube, and postsurgical drainage through a chest tube. Her nurses dutifully recorded daily outputs from a bladder Foley catheter and rectal tube. Although my subsequent assessment and medical training had taught me that her kidneys needed to be supported with dialysis, I could not help but wonder whether it was appropriate. My teammates were similarly unenthused. "Why can't these families just let go?" a member of my team wondered aloud. Another cited excess spending in patients' final months of life as one of the primary drivers of our nation's health care financing woes.

The next morning, I was surprised to find Mrs. E alert, interactive, and surrounded by loved ones. I seized the opportunity to obtain the psychosocial history that I had missed out on the day before. An inquiry about her most famous attribute led to

Second-place essay.

Mr. Khera is a third-year medical student, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania.

Correspondence should be addressed to Mr. Khera, 3434 Sansom Street, Second Floor, Philadelphia, PA 19104; telephone: (919) 475-8099; e-mail: (khera@mail.med.upenn.edu).

The Francis A. Velay Humanism in Medicine Essay Contest Presented by the Arnold P. Gold Foundation

The Arnold P. Gold Foundation is a not-for-profit organization founded in 1988 to nurture and sustain the time-honored tradition of the compassionate physician. Today, students, residents, and faculty participate in at least one Gold Foundation program at 92% of our nation's medical schools and at schools abroad. Its programs and projects are derived from the beliefs that compassion and respect are essential to the practice of medicine and enhance the healing process; the habits of humanistic care can and should be taught; and medical role-model and mentor practitioners who embody humanistic values deserve support and recognition.

In 1999, the Gold Foundation instituted the annual Humanism in Medicine Essay Contest as a way to encourage medical students to reflect on their experiences in writing. Since the contest's beginning, the foundation has received close to 2,000 essays from more than 110 schools of medicine and osteopathy.

Contestants for the 2008 Humanism in Medicine Essay Contest were asked to draw on real-life experiences to explain, "How patients teach their doctors about humanism in medicine." Winning essays and honorable mentions were selected by a distinguished panel of judges. For the seventh year in a row, *Academic Medicine* is pleased to publish the winning essays from the contest. The second-place essay by Amit V. Khera appears here.

Winning essays are also published on the foundation's Web site: (www.humanism-in-medicine.org) and in the foundation's *DOC* newsletter. For further information, please call The Arnold P. Gold Foundation at (201) 567-7999 or e-mail: (goldfdtn@gold-foundation.org).

my discovery that she had recently published her autobiography at 91 years of age. Her daughter proudly produced a copy from her purse and insisted that I take it home. In reading the entire book that evening, I began to realize just how incomplete my patient history and initial snapshot impression of Mrs. E had been. I read about her amazing story of surviving the Holocaust in Poland. She described the agony of losing every member of her family in Nazi concentration camps. Determined to fight back, she had played a critical role in the Jewish partisan resistance movement, saving countless people from capture and almost certain death. I learned about her subsequent fight to move past the horrors of the war, her first date with her husband, the challenges of immigrating to America, and the birth of her first grandchild.

I found myself walking to the hospital the next day praying that Mrs. E would be alert enough to tell me more about her life story in person. I found her singing, tracheostomy tube in place, a Yiddish song to her daughter. Both cried when I told them I had already finished the book. Pulling it out of my short white coat, I asked Mrs. E to autograph it. The first line read, "To a friend." As I recounted her story on rounds, my entire team became excited about participating in the care of a celebrity. Our dialogue in the patient's room eventually turned to end-of-life issues, a conversation I could not imagine having without first grounding ourselves in her personal story.

Mrs. E and her family ended up deciding not to pursue the dialysis that might have extended her life. The next day, a do-not-resuscitate order was placed, and arrangements were made to transfer our famous patient to a hospital closer to her home. Despite having provided no medical intervention, moving beyond Mrs. E's anonymity was amongst the most meaningful experiences of my medical school career. I am convinced, now more than ever, that achieving a semblance of understanding of our patients' lives enables us to deliver better care. While committing to read every future patient's autobiography may not be realistic, I have learned that a simple inquiry about their fame is a great start.