An Interesting Case

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My patient had just coded. His chest wall rose and fell in sync with the ventilator as he laid otherwise motionless. A missed call on my phone followed by a text message came bearing the words, "I'm so sorry," from my cross-covering coresident.

I was heading home after spending Christmas morning rounding and writing notes in the hospital. It was a dreary, dark, wintery day. At home there was a solemn echo in the hall, followed by an eerie silence. I felt lucky I could leave the hospital.

Earlier, my patient had lain bedbound, cycling total parenteral nutrition and trialing the latest chemotherapy regimens on the fifth floor with one window facing the gray, concrete parking lot. I had promised him we would have a good Christmas Day. I quipped that we were bonded together. Not only had we already spent weeks together, but now we would spend Christmas. We were on track to spend New Year's Eve together, too. I recognized that was little solace for him—he just wanted to be home. That's really all I wanted for him, too. But every day, as a resolution came to one problem, a new setback emerged. His was a complicated, advanced hematologic disorder that had affected all his organ systems. Throughout the medical record, from every subspecialty consult, was riddled the word *interesting*. "Thank you for this *interesting* consult." "This is an *interesting* presentation of. . .." "We will follow along with you on this *interesting* case. . .."

Sitting at home as I anxiously called, paged, and texted my coresident for details, I began to write his transfer note to the medical intensive care unit. This responsibility did not fall on me, but I felt a need to represent him in this note. I did not want him reduced by the next primary team who would meet him—intubated, sedated, and neurologically compromised—to *an interesting case*.

Before he coded, I had already felt bothered by our use of the word *interesting*. Now, it weighed even heavier on me. In medicine, *interesting* becomes a morally neutral, noncommittal word with the suggestion of the unknown, of a surprise to come, a word to capture our attention before the presentation begins. As a noun, *interesting* characterizes a state of curiosity; as a verb it arouses one's thoughts; and as an adjective it catches one's attention. A PubMed search of "interesting case" yields more than 1000 hits, including "An interesting case of pacemaker endocarditis,[1] . . .brucellosis aortitis,[2] . . .eosinophilic meningitis,[3] . . .fishhook ocular injury,[4]" and on and on. My complicated, long-suffering patient was definitely *interesting*. He was also a father. His daughter and I were the same age.

How could I make sure that the ICU knew him as someone, something other than *interesting*? How could I balance presenting my patient as an opportunity—as my fellow trainees no doubt would learn an immense amount from our patient—and also as a person in pain, enduring a dire situation?

In my transfer note I highlighted the salient pieces of his hospital course, the diagnoses, interventions, consultations, and current assessment and plan. I distilled his hospital course down, problem by problem, highlighting the important points one should not miss in a thorough and thoughtful sign-out. Then I called the resident and intern taking over his ICU care to tell them that, just that morning, the patient expressed hope. He had spoken to his wife and daughters. They were coming to see him. This diagnosis was new, devastating, and raw. Two weeks ago, he was walking. Now, he was unable to lift his legs from the bed. I told them his own story.

Part of his story—why he had such *interesting* disease manifestations—was a profound delay in his diagnosis. I had sat by his bedside, listening to him contemplate this delay. He had wondered whether his dark skin and underprivileged status had led others to dismiss his symptoms of pain and unsteadiness. Yet on Christmas Day he was hopeful.

The next day, I carved out time to go to the ICU with my 2 interns. We looked at his vital signs, the intravenous medications going through his central line, the ventilator settings breathing for him. We talked through his cardiac arrest and considered what led up to the sentinel event: his code. I didn't know if he could hear us, but I thanked him for letting us care for him, for trusting us, and I lamented that he was now in a room with the same window view, but in a

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much different place. The interns stood along his bedside opposite me, listening. I wondered, again, am I doing this right?

We returned to the medical floor together as the admission pager went off. A new patient was assigned to his room. We looked through the patient's chart while awaiting her arrival. As we entered the room, I looked out the window at the gray, concrete parking lot. I watched in awe as the intern asked the patient about herself, her favorite hobby, and what life looked like prior to presenting to us, all before the usual "What brings you in today?" We concluded our interview with an understanding of this interesting person—a water-color painter and proud grandmother who was admitted with acute respiratory failure. Through the window, I turned my gaze toward the ICU pavilion. He could not hear me, see me, or possibly know, but I promised to use our time together to care for this new patient with an open mind and heart. I felt a sense of peace. I knew there was much medicine to learn from this interesting case, but even more to honor about this interesting person.

References

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