

# Discharge Summary

Bailey Fitzgerald, MD

I recede into the corner of the stairwell, sitting on the second-to-bottom stair of the flight. I tell myself I will be less in the way there. It isn't true.

If anyone walks through, they will still have to step around me, but that is not likely to happen at this hour. It has been a busy call day in the intensive care unit. Now, around 4 AM, this is the first calm moment I have had. A young man I cared for died only a few hours into my shift. He was my patient for less than 24 hours. I ran the code blue, even though I was afraid. I would have preferred to sit on the floor in the hallway with his daughter. He died. She grieved. I learned.

After he died, his memory followed me around for the rest of the day. I ran through my list of patients reflexively, checking for lab results and reviewing vitals. Each time I saw his name, I tried to avoid looking at the 4 new letters that had appeared where his age should have been—"dcsd." My priorities shifted throughout the day, but those letters reminded me that I still needed to document the last chapter of his life.

This stairwell is the warmest place in the hospital, which is partially why I choose it. It is a sort of greenhouse; the glass walls trap the sun's heat during the day. I find it hard to maintain a reasonable core body temperature this far into my call, despite the fleece I wear over my scrubs. I can see the sun coming up now, which is the other reason I choose this place. Panoramic views are soothing. I watch as the people on the street start their daily routine and the world keeps spinning.

My patient's family had the body taken away this afternoon, but he is still under my care. He needs a discharge summary. This note will summarize his hospital course, from initial presentation for an outpatient procedure, to a catastrophic complication, and finally intensive care unit admission. It will summarize our efforts as we tried to avert his death. I have been suppressing the urge to think of discharge summaries for the patients who die under my care as "dead people notes," but for some reason the inappropriate phrase is the one that keeps sticking in my tired mind.

I sign into the electronic health record from the laptop on my knees. Template open, I fill in the blank spaces with his story. I do not know who will read this. Perhaps staff in coding or billing. It is easy to see burdensome clinical documentation as a source of physician burnout. Discharge summaries written after a patient's death may seem like overdocumentation. My note is not necessary for continuity of care. This man will never have another physician.

But I am writing the story for myself. In this act of reflection, I reclaim a situation that seemed outside of my control. This is my way of examining the day, of asking what happened, of seeking learning from a terrifying experience. These notes, often rushed through at the end of the day, are some of the most powerful teaching tools. They require a second-order act of synthesis and weighing. They force me to ask myself, *What was important?*

I read nursing notes, searching for what I missed, for warning signs. I transpose the chest x-ray results while thinking about his daughter, who also works in a hospital. I sift through lab results. In life, his vital signs were volatile, the oxygen saturation numbers jumped up and down with each breath. Now on the screen I read the fixed and static entry, showing a number far too low. In the template there is a space to transcribe the physical examination at discharge. I fill in my examination from the morning: pupils fixed and dilated, heart sounds absent.

These are our last moments together. This is my eulogy, my final thesis, my mourning ritual. I feel his ghost beside me on the stairs. *I am so sorry*, I think. *I didn't mean to let you down*. Finished now, I click "sign," and we both are released.

He is laid to rest now, discharged to death. I stand and climb the stairs, off to prepare for morning rounds.



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