THE Richard Spear, M.D. MEMORIAL ESSAY CONTEST

PRACTICING AND LIFE MEMBER CATEGORY WINNER

The Fawn

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She strikes me as a little too calm. I like her immediately. It is my third month of internship, a brand new United States Navy doctor. My newness does not seem to matter to patients, mostly military dependents (wives, kids) and retirees. I am the doctor, their doctor. People do not understand the whole hierarchy of residency. Words like "intern," "resident," "chief" and "attending" do not betray the sublime wholeness of "doctor."

She is wearing a plain, soft, cotton, flower-pattern dress. Nice figure. There is a pink ribbon in her curly auburn hair. A little shy, she makes eye contact rarely, mostly maintaining her gaze downward and to the right or left, except when I speak. Then her eyes fix on mine. Like a fawn, her countenance is intensely vacant, vulnerable.

I am assigned to the Internal Medicine outpatient clinic for only one afternoon a week. I always welcome it as a much-needed break from the perpetual grind of chasing down lab slips, writing progress notes, dictating discharge summaries, drawing labs, doing exams and basically functioning as the chief resident's smart phone. The outpatient clinic is never too busy, never too dra-

matic, and is a safe place where I can play doctor and probably not hurt anyone.

My patient is a 32-year-old white female, the wife of an active duty petty officer with two young children at home. But today she has come by herself to follow up on her breast biopsy. Already aware that she probably has some form of cancer and will likely need surgery, the specifics are not clear to her. But I will find out. After all, I am her doctor.

"Well, what's the path say?" demands my attending supervising physician from his centralized station in the hallway.

"Inflammatory breast cancer," I report, not fully understanding what it means.

"Not good," he groans with a half-grimace. "She needs chemo. Get her hooked up with Oncology right away." And away he goes, leaving me holding what has suddenly become a heavy bag.

Back in the room I waste no time. "The biopsy showed cancer. You will need to see an oncologist right away."

There's a quick breath in and out. A fawn breath. "OK," she monotones, looking down. I think she is taking this well. Then her eyes, without blinking, fix on me. "Am I going to be all right?"

"You are going to need chemotherapy" ... pause ... swallow. I am aware that I am not answering her question.

I give her the forms she needs to get her appointment, and she leaves. She will not be coming back to Internal Medicine. She is an Oncology patient now. I wonder how she will do. I don't expect to see her again.

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March 31, 1986

I am next to be assigned an admission to the hospital. It's only 10:30 p.m. My "hit" will not likely be my last. The night is still young, the ER is packed, and the admitting resident is not known for being a "wall." He freely admits patients from the emergency room rather than treating them and sending them home.

The pager goes off. Even though I know it is inevitable, my heart sinks a little. I am given the room number, last name and chief complaint. "Breast cancer, terminal." I would rather have asthma, diabetes, pneumonia, something I can fix. I tread the long linoleum corridors to the nurses' station just outside her room. There is commotion going on. I enter the room and into a tempest.

It is the fawn. In severe distress now. Groaning. Panting. Painful noises from deep beneath her vocal cords. Sounds that would be screams were they not buried in rapid, frothy gasps. Her eyes are wide and crazed, unfocused, her skin pale and edematous. Her hands grasping at bedsheets.

How do I manage this catastrophe? She is my admission, my patient. But I am so peripheral to this unfolding tragedy. Present are three doctors, two nurses, a respiratory therapist and me. We need an IV. No success. Not by anyone. I try five times. No success.

"Anesthesia is here!" announces a nurse. And the masked man proceeds to prep, drape, then stab her undulating chest until finally dark blood fills the syringe. The central line is placed. Fluids and morphine are given. And we enter the eye of the storm.

A second-year resident pleads, "She needs to be intubated. Anesthesia should do it now while he is here." And with that cue, the doctor known only as "anesthesia" moves like a cat to the head of the bed, brandishing his flashing laryngoscope and plastic endotracheal tube.

"NO! You can't," barks the chief resident. "She's a DNR – DO NOT RESUSCITATE!" And with that realization, the participants collectively exhale, begin to collect belongings and throw away the piles of disposable wrappers, used IV catheters, tape, tubing and other compulsory medical paraphernalia.

Realizing I have done nothing but jab this poor creature numerous times while failing to get her IV started, I decide I might as well begin the paperwork. I do not have the luxury of too much reflection. There will be more patients, more admissions and more paperwork as the night wears on. I go to get my clipboard, "Scut Monkey Handbook," and some fresh air.

When I return to the ward a half-hour or so later, I immediately notice things are way too quiet. I enter the room and find what I expect to find. She is still. Cold. Gone.

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How can the first patient to die in your care not leave a lasting impression? How little can I alter the inevitable? I am a doctor, but a doctor is not all that I am. I am also the fawn. We are all fawns. LM

Note: Dr. Murphy practices Pain Management with the Murphy Pain Center.