

## Errands

I SPENT A YEAR IN GREECE AFTER COLLEGE TRYING TO BE Raymond Carver. I drank Teacher's whiskey, which thankfully my local supermarket stocked, and had a poet girlfriend who was flirting with alcoholism herself. I wrote very short stories about down-on-their-luck people who also drank Teacher's whiskey and had unhealthy relationships. My dream was to sell a collection of stories and become a new voice in American writing; like Carver, once I'd achieved success, I'd become more responsible and cleanse my life of all my prior vices. When my year in Greece was through, I had about nine or ten horrible stories on my laptop computer and the remnants of a very messy breakup hanging over me as I returned to New York to start medical school. I hadn't written anything worth a damn, but, like Carver, I was about to become a responsible adult.

During four years of medical school and one year of internship, I continued to write whenever a free moment presented itself. I had even managed to find what I considered my own voice, one that didn't tell stories about alcoholics trying to find enough money to fix their broken cars or pay for their children's school lunches, but rather one that explored the feelings of my patients and my own reactions to their struggles. As I neared the end of my intern year, I felt that I had fully completed a transformation from being a bad writer who was just studying medicine as a sidebar to a physician who occasionally wrote as a complement to his profession. In fact, after a year spent traversing the steepest learning curve I'd ever been on, I felt confident enough to say that I was becoming a good physician.

Then I met Chris Morgan (not his real name). My first encounter with Chris, a 25-year-old with epidermolysis bullosa, was in April, when he was admitted to the general medicine service for refractory nausea and vomiting. As with all patients I admit to the hospital, before meeting Chris, I spent some time performing a "chart biopsy" on the computer, reviewing his most recent clinic notes and hospital discharge summaries. Chris had what one dermatologist called "end-stage" epidermolysis bullosa, an inherited disorder that manifests itself as blistering or erosion of the skin and, in some cases, the epithelial lining of other organs. Over the past year, he had been hospitalized four times, for a total of 15 weeks, for a complicated urinary tract infection (he had bilateral nephrostomy tubes and a suprapubic catheter due to the erosion of his urogenital system), a central line infection (he had a Hickman catheter for delivery of both his medications and his parenteral nutrition), hypertension-associated seizures, and another urinary tract infection. In his last clinic note, written just before sending Chris to the

emergency department for admission, Chris' primary care physician wrote that he suspected another urinary tract or line infection as the root of Chris' nausea and vomiting. He also wrote that given Chris' painful medical course over the past year, this upcoming hospitalization might be an appropriate time to address transitioning his care to comfort measures only.

I headed to the emergency department, juggling this information in my mind, wondering if I was going to be the doctor who would suggest hospice care to a 25-year-old. I introduced myself to Chris and his parents, soaking in his very unique appearance. Most of his body was wrapped in bandages; the parts of his arms and legs that were exposed presented a confluent trail of fresh blisters alternating with crusted scabs. His limbs were contracted from scarring, and his face was a sea blue, a discoloration that had resulted from 25 years of applying silver-containing ointments to his skin. On his lap sat a basin of fresh, blood-tinged emesis, and on his lips was a surprisingly broad smile. "I haven't met you before," Chris said cheerfully. "I thought I'd met every doctor in this hospital."

Over the next two weeks, our team placed Chris on intravenous antibiotics and coordinated the changing of his nephrostomy tubes, suprapubic catheter, and central venous line. With the help of the gastrointestinal consult team, we devised an antiemetic regimen that maintained Chris' nausea at an acceptable level. With his infections under control, it became clear that a large component of his nausea was due to inefficient control of pain, and Chris' private anesthesiologist guided us in essentially tripling his regular narcotic doses. In the second week of his hospitalization, when Chris' clinical improvement proved solid and discharge planning was set to begin, I sat by his bed one afternoon and said, "I'm happy you turned around so quickly and that this subject hasn't come up until now, but I feel like I wouldn't be doing my job if I didn't address the question of long-term goals with you and your family." I looked at Chris and his parents; they looked at each other and then back at me. "We already talked about it before I came into the emergency room," Chris said. "He's not ready for that just yet," his mother said with a smile. "We're all not ready for that," she added.

A month later, I had moved on to the geriatrics service and had just finished admitting an 81-year-old woman with new-onset atrial fibrillation when the senior admitting resident paged me back to the emergency department to admit

a 25-year-old man with line sepsis. "I'm on geriatrics," I reminded the resident. "It's Chris Morgan," she replied. Because Chris' medical history was so complicated and I was the only intern on service who had taken care of him before, she felt that he would be best served under my care. I was flattered. I felt like a real doctor with his own patients. I *did* know Chris very well, and not just the complications of his epidermolysis bullosa but also the breed of his dog (border collie), the name of his favorite science fiction author (Neal Stephenson), and the number of key chains in his world-famous collection (24,810, according to the *Guinness Book of World Records*).

The senior admitting resident had told me that Chris appeared quite ill—he was febrile and hypotensive, although his blood pressure had responded relatively quickly to fluid resuscitation. His serum creatinine was also about double the level usually seen with Chris' chronic renal dysfunction. She told me to admit Chris to our stepdown unit and reminded me that he had an advanced directive not to be resuscitated or intubated. I knew about Chris' wishes, of course, and agreed with them wholeheartedly—he would never be able to survive one of our hospital codes; still, I headed down to the emergency department fully expecting once again to fix Chris in two or three weeks' time. His mother, waiting outside Chris' room in the emergency department, smiled when she saw me. "They told me you'd be taking care of Chris again," she said. "He doesn't look very good, but you know Chris—he's asking whether or not he'll be discharged in time to see the new *Star Wars* movie on opening night."

By the next day, even with broad-spectrum antibiotics and aggressive IV fluids, Chris continued to post fevers while his creatinine steadily rose. We sent his urine off for laboratory analysis but viewed the sediment ourselves under the microscope, confirming our suspicion that he wasn't simply just dehydrated but suffering from sepsis-induced acute tubular necrosis. When the urine laboratories returned the following day, his serum creatinine was already five times higher than his normal range and his urine output continued to drop. Although Chris was becoming sicker and sicker, now requiring a face bucket to keep his oxygen saturations at acceptable levels and a PCA pump to control his increasing pain, the vascular interventional radiologists, who knew him well from his many line changes in the past, agreed to remove his old line and place new access. Despite our efforts, by his fifth hospital day, Chris' overall discomfort intensified while his clinical picture grew grimmer.

When Chris stopped making urine altogether, I went into his room to tell him that he was going to die. Over the course of my intern year, and especially that month on the geriatrics service, I had led a number of discussions about transitioning a dying patient's care to comfort measures only, but I had always had these talks with family members, their relatives far too sick to speak for themselves. Chris, on the other hand, despite being septic and anuric and grossly ana-

sarctic by this time, was wide awake when I told him there was nothing more that I, as his physician, could do for him other than make his last days peaceful and dignified. "I understand," he said. He wiped at his eyes and added, "I'd like to be alone with my family now." It was almost the last thing he said to me.

Over the course of the next eight days, Chris' pain and sedation medications were titrated to his comfort. He was able to visit with his family and his many friends who traveled from all over the state. I occasionally heard laughter coming from his room, which I took to be a good thing. Chris had stopped speaking to me since our discussion about his prognosis. I understood that he needed to channel many of the emotions he must have been feeling—emotions that must have included fear and anger and frustration and helplessness—onto someone; as it was my words that had set off these feelings, I was the obvious target. I would have liked to laugh along with Chris in his final days, but I wasn't one of his relatives or friends. I was his intern.

On my last night on-call for the geriatrics service, Chris' nurse paged me to his room. "He looks like he might go tonight," she said solemnly before I followed her into his room. "And he looks like he's suffering something awful." Inside, Chris was squirming and moaning while each of his parents held one of his bandaged hands. "Whatever amount of Dilaudid he's receiving now, double it," I whispered to his nurse. I sat down by Chris' bed and told him how sorry I was to see him in such anguish. I told him I had promised to make his last moments on this earth peaceful and felt like I was failing to live up to that promise, and for that I was sorry too. "I'm going to increase some of your medicines," I said, "but is there anything you can think of that might help?" He let go of his father's hand and reached out to take hold of mine. "I could really go for an apple right now," he said. And then he chuckled, and so did I. His parents and nurse did too.

I left the room and ran down to our hospital cafeteria, which thankfully stays open through the night. I picked out two picture-perfect Red Delicious apples and brought them back up to Chris' room. With a plastic knife, I peeled the skin off the first apple and cut it into small, bite-sized pieces. I kept the second apple intact. I explained to Chris that the first apple would be easier to eat, but I brought the second in case he had been craving the actual sensation of biting into an apple. I left him alone with his parents, and he died three mornings later, when I had already moved on to the cardiology service for my last rotation of intern year. I don't know which apple he ate.

But I do know this: After leaving Chris' room, I returned to my own call room and lay down on an uncomfortable cot to cry for my first time as a doctor. As I was wiping away my tears, I remembered reading a story about Anton Chekhov's death. He was receiving hospice care in a luxury hotel in southern Germany, and his physician was

summoned late in the night by Chekhov's wife, who reported that her husband was becoming more short of breath and coughing up blood. When the physician arrived, he saw that Chekhov was nearing his end; oxygen might help, but that would have taken nearly five hours to retrieve, and by then Chekhov would be gone. The physician picked up the phone and dialed the hotel's kitchen, ordering up a bottle of champagne with three glasses. Chekhov drained his glass, complimented the champagne, and then passed away.

A month after Chris' death, I was rounding on a patient in our stepdown unit and ran into the nurse who had taken care of Chris for most of his last nights. We reminisced about him and, in particular, about that night when all he wanted was an apple. I went home that night and located where I had read about Chekhov's death, in a Raymond Carver story entitled "Errand." It's one of Carver's last stories, and its subject matter and style is a distinct departure from the minimalist tales Carver is known for, but like all of his writing, he describes human actions—right or wrong—with honesty and compassion. When discussing the physician's decision to order champagne instead of oxygen for the dying Chekhov, Carver writes, "It was one of those rare mo-

ments of inspiration that can easily enough be overlooked later on, because the action is so entirely appropriate it seems inevitable."

Once again, I find myself trying to live up to Carver's example. Chris taught me that the learning curve isn't just about understanding physiology, mastering procedures, or choosing the most effective therapies. The learning curve is about reaching a point where, as a physician, I can feel confident that my decisions, in Carver's words, are "so entirely appropriate." After five years of medical training, and two months with an unforgettable patient, I understand that, very often, the crucial decisions that I will make as a physician—the decisions "that can easily enough be overlooked later on"—will involve simple acts, or errands, like listening to a patient talk about his dog or the last book he read, or running down to the cafeteria so that he can enjoy an apple one last time.

Andrew Bomback, MD  
Carrboro, NC  
abomback@unch.unc.edu

**Editor's Note:** The parents of "Chris Morgan" read the manuscript and gave written permission to publish his story.

I have learned this at least by my experiment: that if one advances confidently in the direction of his dreams, and endeavors to live the life which he has imagined, he will meet with a success unexpected in common hours.

—Henry David Thoreau (1817-1862)