



Writing | Symposium 2021

Mija

By Tasnim Ahmed

Mrs. Gomez calls me *mija*. She's my first patient on my medicine rotation. With a mixture of broken college-level-now-forgotten Spanish and an interpreter on speakerphone, I ask her how she's doing. She answers *bien* with a smile so gentle I almost believe her. When I ask if she's had any trouble breathing, if she has pain, any diarrhea, constipation...she replies in a high-pitched "no!" with a smirk on the edge of laughter that I could possibly ask something so ridiculous.

Her yellowed eyes follow my stethoscope to her heart. Her entire abdomen is bloated, jaundiced. I ask her to hold her arms out straight, hands bent up at the wrist. They flicker like a hummingbird's wings and she smiles back at me again. The skin of her shins dimple under my thumbprint. I reach for her hands and she curls her fingers around mine with the grasp of a newborn, and with that tenderness I don't want to let go. I linger to tell her the teams' plans. She says *gracias* before I leave and tells me she likes my blouse. I tell her it would look even better on her.

By the time I had met Mrs. Gomez, she had been in the hospital for two weeks, deemed to have end stage liver disease. My intern warned me that I'd caught her at the tail end of a merciless disease process. Despite all the interventions attempted on her, Mrs. Gomez's condition only seemed to worsen. Whereas once she was oriented to time, place, and person, we were lucky if she could recall two of the three. Each day that I rounded on Mrs. Gomez, she answered my questions just the same, and always with a mischievous smile. No pain, no fatigue, no dyspnea. She didn't seem to think anything was wrong with her. A naïve tourist in the hospital, I was buying whatever Mrs. Gomez was selling, easily convinced that she probably was doing well.

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On my third day with her, Mrs. Gomez’s liver condition had started to affect her kidney function, resulting in hepatorenal syndrome—a condition in which 50% of patients die within two weeks of diagnosis. This hadn’t surprised the rest of my team—they’d seen this trope play out before. I was only privy to the versions of liver disease in textbooks, unaware of just how diverging the pathology could be. This would be one of the most poignant lessons I learned in patient care as a clinical student: knowing when things were going to be bad before they actually got bad. In my training prior to beginning clerkships, we are taught to raise alarm when a patient “looks sick.” This initially seemed silly to me—was not every patient “sick”? What other reason is there to be in a hospital? But I soon realized that “sick” is codified differently in physician-speak and is rather a euphemism for “dying.” Mrs. Gomez was sick.

I had not expected dying to come with smiles and compliments on my blouse. Dying was meant to be grisly, desperate, and most importantly, obvious. It is the subtlety with which dying proceeds that gives us the hope to stave it off. This hope doesn’t just infect knowledge-compromised medical students, but also has its way of convincing trained physicians and residents. Mrs. Gomez was on the list for a liver and kidney transplant—a choice that she’d deferred to her children, who were eager to try every possible option. We’d replace her broken organs with a healthier set and presumably the dying would stop. Of course, this is an oversimplification that trivializes the high propensity for complications associated with transplantation, but it was a solution, and it seemed at that point that any solution was worth trying.

The day we were meant to have a family centered discussion to receive consent for the transplant, Mrs. Gomez’s oxygen saturation dropped. Her stat chest x-ray clouded with pneumonia? ARDS? A pulmonary hemorrhage? It was hard to tell, and at that moment it didn’t matter as a nurse turned the knob on the oxygen liter by liter, while the rest of us watched her pulse oximeter in anticipation, willing the numbers to change direction.



I stood by the doorway, provoked by curiosity and concern; apprehended by lack of utility. It was the first time I really noticed the photos adorning the door to Mrs. Gomez's room. They were of a middle-aged woman with her arms around a young man and woman to either side. In another, the same woman is smiling from inside a car, her arm resting outside the car door frame. I realized that they were all the same woman. Mrs. Gomez, on the beach, holding a baby, sitting on the couch, and unrecognizable to me without her hair thinned, abdomen distended, or skin yellowed. These photos weren't for Mrs. Gomez; they were too far beyond her line of sight.

I imagine they were placed on the door as a reminder to us, her medical team, that before she became Mrs. Gomez, our patient with decompensated hepatitis, she was Mrs. Gomez, mother of four, with grandchildren, lover of beaches who always smiled with her teeth in photos. I'd like to think we don't need these reminders, but in my limited experience, I've witnessed how often we get consumed in getting a patient to live we forget what it is they live for.

With her newfound lung disease, Mrs. Gomez was no longer a candidate for a liver and kidney transplant. She was wheeled off to the ICU, taken off our patient list, and passed off like an unsolved puzzle. Her name was no longer mentioned during morning rounds, but occasionally in passing when someone opened her chart, with a brief skim of vitals and labs comprising a check in.

A few days later, on my day off, I'd conduct my daily visit to Mrs. Gomez's chart, only to find the word *Deceased* following her name, where her age once sat. I read the post-mortem notes with the haste earned for the last few pages of a novel. She was extubated. At her side were two of her children and a chaplain. I thought about how before I began my clerkship, I could count on one hand the number of people I knew who had died: people I had spoken to, touched, experienced alive. And then suddenly in only the span of a few weeks, that number would double. It shocked me how quickly I had become accustomed to death on the wards. Yet



there I was, legs outstretched on my couch, learning about Mrs. Gomez's death from the *Epic* app on my phone, the same way I might find out about a TV show being cancelled while scrolling through my newsfeed.

I thought about her children without their matriarch, and that one would have to explain to her grandkids that she had passed. The memory I could not shake was Mrs. Gomez calling me *mija* in the morning. I felt undeserved of the grief that overcame me. I was just another fleeting body to her, but she was still a warm hand that I held at one point.

After Mrs. Gomez's passing, I listened to my team discuss her poor prognosis, which was already predicted within her final days. I wondered why we decided to keep her admitted, knowing she would eventually die on a hospital bed in the ICU, a ventilator stretching thin the last moments of life just enough for her children say their goodbyes. If we had discharged her earlier, could she have died in her own bed, surrounded with friends and family who could hear her last breath, a breath that didn't emerge from a plastic tube or become muted by mechanical whirs? Instead, Mrs. Gomez spent her last days surrounded by foreign and identical scrubs, with her visitations strictly limited due to COVID restrictions.

"Nobody wants to die in a hospital." I no longer remember if it was a patient or a doctor who told me this, but it has become one of my mantras. To the credit of extensive medical research, there are now calculators and scores we use to determine a patient's prognosis, turning doctors into clairvoyants. I do not know the details of Mrs. Gomez's status when she was first admitted, but it's fair to say that during my time with her, our medical team had expected her impending death. Her process of dying began much earlier than the moment her oxygen saturation dropped. On one hand, I wish our foresight persuaded an earlier discharge for Mrs. Gomez to initiate comfort care, but on the other hand, I realize that without concrete evidence that we had hit the point of no return, it would have felt like we were surrendering to the disease. Unfortunately, once patients do hit their point of no return, the process of dying accelerates such that it's undeniable.



Still, regardless of the calculators, scores, and lab values, perhaps the most important aspect of Mrs. Gomez’s medical decision making was the wishes of her children, whom she had assigned her alternate decision makers. While alternate decision makers are reserved for patients who are incapacitated, even when she was alert and oriented times four, Mrs. Gomez always deferred her judgment to her children. And as children that wanted to see their mother live, they were confident about the capacity of our medical interventions. “We want you to do everything you think is best for her to get better,” her daughter once told me during one of our daily phone calls. Her optimism struck me with nostalgia for a time, only two weeks prior even, that I too saw medicine as a definitive fix for sickness. I wanted to believe that if we knew enough about the pathophysiology behind a disease, we could surely intervene, stop it, reverse it. Yet within my first two weeks on the job, I had learned that our limitation in medicine was not always our knowledge, but the untellable whims of the human body.

Her daughter’s request to me was a paradox—what we thought was best likely would not make Mrs. Gomez “better,” just comfortable. Like war veterans, we’ve seen the ugly. We are intimately aware of the dirty secret that our medical interventions often fail. It is perhaps a consequence of the success we’ve had selling modern medicine that so many of our patients place romantic ideals of high survival benefits on hospitals. And I know that most of the time, hospitals work. We help people survive, but for the first time, as I struggled to search for the right response to Mrs. Gomez’s daughter’s request, I was confronting the cost of our interventions.

This controversial pessimism I hold toward aggressive medical treatment lies in direct opposition to the optimism I typically carry with me to most patient encounters. Usually, I am reassuring patients when they are given a diagnosis. Most of the patients I see have benign illnesses—a UTI, gastritis, peptic ulcers—benign in the relative sense; that in the gamut of fatal disease processes, these illnesses rarely lay claim to a death. They have straightforward fixes with little room for caprice. As such, my job is to translate offensive medical terms to

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nonthreatening laymen's terms. In those situations, my knowledge feels like a saving grace as I quell my patients' fears of the unknown, exonerating the medical field. Yet, with patients who have poor prognoses, my medical knowledge feels almost cruel, as if I am betraying their hope.

The conversation on death of a patient often starts and ends with code status—a decision that applies only when patients are at the cusp of life and death, dying only in the most immediate sense of the word. Yet in the treatment of chronic conditions, sometimes physicians sense a patient is dying far earlier than we let on, disguising our discovery out of fear—or out of hope—that we may be wrong. However, perhaps it is a discovery we should be more transparent about with our patients, because how a patient wants to die is also how a patient wants to live.

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