2014 Intern Impressions

The Light at the End of the Tunnel by Rachel Chung, August 5th, 2014

If this internship has taught me anything, it is that linear, logical thinking has a limited role in any career having to do with humans. The human body, when confounded with the human mind, presents so many conflicts that one finds oneself skating back and forth across the same issue a thousand times before getting anywhere near a solution.

Learning from an internship is startlingly unlike learning from a college course. The lessons come backwards–do first, explain later, if at all. In fact, sometimes it seems that not even the professionals have a firm grasp on what their jobs really entail. And I could not love it more. Instead of being spoon-fed (in some cases force-fed) demarcated information, this internship has been an all-you-can-eat buffet of every kind of knowledge. The interns have made personal strides in every field, from physiology to emotional maturity. And, as a product of some of the most important lessons I’ve had at TCC, I can sum up the bulk of these ten weeks into one sentence:

To really care for people, a physician must understand his or her charge as a person first and a patient second.

This is the universal trait imparted to me by the physicians at Terence Cardinal Cooke. While it is clear that many physicians at TCC, namely Dr. Lechich, have thought long and hard about this, it is also clear that many of the younger physicians at TCC have only a sense of it as an innate quality of their interpersonal skills. Not only has this principle done wonders for my bedside manner, but it has fundamentally altered the way I view patients at the ends of their lives.

Because of this revelation, it is impossible for me to distinguish between my emotional and academic development. The resulting paper (linked above) is an intense, melodramatic,
even frantic shot in the dark toward synthesizing my new knowledge into something useful. You don’t have to enjoy it, but you should know that I did.
Courage by Rachel Chung, July 16, 2014

When Rent was made into a movie, I was too young to understand. Rent, by writer and composer Jonathan Larson, is in many ways the only connection people of my generation have to the AIDS crisis of the 80s and early 90s. To me, Rent was pretty good. Catchy tunes, emotionally compelling relationships, the works. It was everything a young teenager wants in a rock musical. But when Angel died in the arms of his partner Collins, my mother turned off the television. I looked at her in surprise, and saw tears streaming down her face.

“Rachel, I’ve seen this a thousand times. I can’t watch this. I’ve seen it a thousand times.”

My mother, now a doctor of internal medicine, did her residency at St. Vincent’s hospital in the early 90s. Right in the middle of the AIDS epidemic. Right when Rent was written. To me, Angel and Collins are fictional characters—their story is representative of a closed chapter in history. My mother lived that chapter. It unfolded before her eyes when she was eight years older than I am now. No amount of medical training can equip someone to see that happen a hundred times a day for two years.

The patients on the discrete unit here at TCC are the survivors, the living evidence of an era that now exists primarily in off-Broadway revivals. Listening to their stories fills me with that unnamed emotion that overtook my mother the first time we saw Rent. I cannot name it, and yet these people exude it in their stories, in their lives.

The stories we weep over in Rent are real. Today in group therapy, patients shared glimpses of their lives, one thousand times more potent than any musical. The musical numbers that once seemed so grand and lively now seem dilute in comparison with what these people have experienced. For every patient that spoke there were several more dead in the wake of drugs and disease. The residents supported and encouraged one another to rise against their once inescapable dependence on substances, to live with the aftermath that landed them in this institution and become functional again. To have a normal life.
I cannot with reasonable accuracy portray the wisdom and insight of those who have lived the equivalent of my life one hundred times over. For these residents, hindsight is more than 20-20. Their support not only for each other, but for the interns, who have just begun our journey into adult life, is greater than any program administered by a university, greater even than any lesson taught us by our parents.

“I trust my soul, my only goal is just to be,” is not just the ingénue sharing her love of life with the embittered male lead. It is the insight achieved by a person who doesn’t know what tomorrow will bring.

“Forget regret, or life is yours to miss,” is not the end of a rhyming line. It is a direct quote from the annals of history; it is every thought of every survivor who sees with earth-shattering clarity how much power we have over our own lives.

“No day but today,” is not just a catchy tag-line—it is a thesis. It is the first line of the manifesto written by the ever-dwindling population of those affected by HIV and AIDS.

Seeing Mr. F, whose strong features are softened by decades of unimaginable difficulty and sadness, silently rejoice as we, the interns, expressed how humbled and inspired we were by their stories gives away how devoted these people are to sharing their experiences—to sharing their courage. The closing words of one patient will always stay with me:

“Y.F. is staying clean, day by day.”
Today was another unique day as we sat in on a care plan conference with Mr. M’s mother, Ms. M, (random initial chosen to represent resident and family) in the Huntington’s Ward. She was very concerned about her son’s treatment, and she expressed her frustration at what appeared to her to be a lack of care for her son. First of all, she was not always aware of changes in medication and what they meant. This was often due to lack of communication with the physician. This problem was rectified during the meeting itself when the physician came and spoke with her, answering her questions about the medications. There were other similar issues that came up, but they seemed to contain the general theme of miscommunication. The mom would interpret something as lack of care, while what actually happened was simply a change in routine or care plan.

One of the attendants of the meeting stood out. He was a volunteer at TCC who spent lots of time with Mr. M. Throughout the meeting, the volunteer, let’s call him J, continued to make sure that Mr. M’s mom was satisfied and that she understood what was happening. He would repeat things that had been said already, but things that she might not have heard. It was clear that his focus was not on figuring out details of care, but he cared about making sure that Ms. M was satisfied and happy.

At one point, the conversation turned to walking. Physical therapy (PT) had written a report saying that it was unsafe for Mr. M to walk, but his mom refused to believe that that was the best option for him. The care plan team tried to tell her that it had to do with the PT order, and though they could attempt a reevaluation, as of now, the CNAs could not legally help him walk. Like many other residents’ families, Ms. M did not want to give up on her son. It seemed to her that not letting him walk was giving up on him.

J took this opportunity to explain to Ms. M that Huntington’s is a deteriorating disease and that residents will ultimately die from it. At some point, Mr. M would not be able to walk, and he would eventually pass away. His manner was particularly noticeable as he called Ms. M endearing terms such as “love” and “sweetheart.” J elaborated and spoke about the many residents with whom he visited. He also talked about his family who, themselves, were residents in the Huntington’s unit. Suddenly, he burst out in tears and could barely continue talking about them. Ms. M felt much better after his intervention.
J represents the ideal person to be at these meetings. He can not only sympathize, but also empathize with the residents and their families, being that he, himself, suffered through the same tragedy that Ms. M is suffering through now. He is also incredibly close to residents, and I would guess that he would have this feeling, even if his family never was affected by the disease.

I wonder, however, if the staff here at TCC can ever express that kind of empathy. Firstly, they are limited by the fact that this is their job. It is difficult to make something you do for work into something so meaningful. Secondly, often does not have the time to spend with residents, at least not as much time as J does. Finally, there may always be a barrier between physician and patient. No matter how much TCC tries to break that distance by calling family members and the patient part of the team or by calling patients “residents,” the distance between healer and injured, between staff and client, those who are serving and those being served. Even pastoral care, a group that can form the most intimate bonds with residents, is separate from the patient to some degree.

There have been times at TCC when I have questioned my desire to become a physician because of this barrier between physician and patient. Part of the reason I wanted to become a physician was in order to promote and create bonds like those, bonds that J exhibits, bonds that I have had the privilege to form during my time here. Perhaps I will have to accept that this may not practically be possible.

What I realized from this encounter, however, is that what soothed Ms. M was not the work of the nurses, not the physician explaining the medical decisions, but someone showing that he truly, truly cared about her son. That he visibly cried over his death. I think that even if as a physician, I won’t be able to spend as much time with residents as I do now, I hope to be able to consider their care from the perspective of someone like J, to care for them as they wish to be cared for.
Juxtaposition by Joseph Quintas, July 10, 2014:

Juxtaposition is a powerful rhetorical device, often used to compare or contrast words, phrases, situations, etc. This summer, I discovered its use as an emotional tool. This week, two residents, two roommates, were discharged from the hospital, but their situations could not have been more different. I found the juxtaposition of their beds, these two souls, to be extremely powerful.

On the near side of the room was Ms. R. Ms. R was an elderly woman. She mostly spoke Spanish, but she knew enough English to say that she was alright, or that she was in pain. When I first met her, it was with a palliative care consult. She looked like she was nearing the end of her life, but she kept holding on. Although bedridden, she was taken outside every day, and she was awake enough to speak briefly to me.

Her roommate, Ms. C, was a relatively young woman, a nurse at a hospital in Harlem. She was here because of an issue with her foot, and just needed a stop at TCC for rehab. All the while, she was knitting blankets, watching TV, and wishing to leave.

I visited Ms. C the day before her discharge. She was so excited to be able to leave, so ready to go home. She really wanted to get back to work at the hospital. She spoke enthusiastically about her family and about her neighborhood, spending a lot of time talking about the problems with the public school system. It was refreshing to meet someone who was able to leave and someone who could recuperate.

As I was leaving Ms. C’s room, I glanced at her roommate. Ms. R had been sleeping every time I checked in on her, even at 10 in the morning, yet she was generally weak. I did not think that this was a sign of anything to come. I thought she was just generally tired.

The next day, Ms. R passed away. Perhaps I could have recognized that her sleeping was a sign of her getting weaker, but I failed to notice that. Her passing came as a great shock to me. Although I barely spoke to her for more than a minute each time I saw her, I held her hand a few times a week and heard her frail voice speak to me in indecipherable Spanish. Now she was gone. I didn’t know what that meant. I still don’t know what that means.
What made the moment all the more poignant was the fact that Ms. C was going home. While her roommate would never see light again, Ms. C was going back to her neighborhood, to her family, to her life again. There was so much going on, conflict between life and death, between going home and passing on.

Two more residents passed away that day. One of them was mentioned during morning report. Just the day before he was speaking to his family, and now he was suddenly gone. My friends and I were also following a Mr. R, who was in steep decline. Last week, he had been weak, but he was speaking. This week, we witnessed his quick decline as he stopped responding until this day when Dr. Lechich predicted his passing within hours. Sure enough, as we were preparing to leave that day, Dr. Lechich told us that he had passed away. We went to see him, or his body. Who knows if it’s really him. He looked exactly the same as he had been before: mouth open, eyes open. He just wasn’t breathing.

I don’t think I could’ve made it through that day if all I have reported so far was what happened. But I also spent time with another resident, Mr. B. I sat with him for an hour or so as we discussed music and poetry. He shared some poetry from his favorite poets, read their beautiful words to me. I listened to him gasping as he read, but he put so much life into those words, that everything he read sounded beautiful. Finally, he shared some of his own poetry with me, and that was just as, if not more, beautiful. This man has so much to offer, so much to give to the world despite his current situation and inability to move. He can still produce art and give it life.

Despite the tragedies that surrounded this reading session, my spirit was lifted by Mr. B’s verses. I still wonder about the lives that were lost and still don’t know how to contemplate them, but I do know that there is positivity from this place. It sometimes seems like there is no hope here, and the work here is doing the best that can be done, but I believe that there are positive aspects that are inherent to the work here, not just positive to be gleaned from the negative. Mr. B exemplified what life can come out of such a place as TCC. It does not make the pain of the deaths go away, but it helps to maintain my belief in the work that is done here. The juxtaposition of the three deaths that day with his poetry made this point clear.
End of Life Meetings by Joseph Quintas, July 2, 2014

In my experience at TCC, I’ve sat in on two End of Life (EOL) care plan meetings, each with its own different atmosphere. The first meeting concerned a Mr. W, who was perhaps days away from death. Mr. W had lost mental capacity, but he had previously appointed one of his coworkers as his Health Care Proxy (HCP), a person predetermined by the patient to make health decisions for him after he had lost capacity to make those decisions himself. I sat on the side as the physician and nurse practitioner explained the situation and centered the discussion around whether or not to continue dialysis. The TCC team suggested ending dialysis treatment, and while the nurse practitioner merely hinted to this idea, the physician strongly suggested it, although he was careful never to say that this is what the HCP should do. In this case, the HCP was willing to listen to advice, but he seemed to be strongly influenced by the physician’s input.

Today the interns and I sat in on a very differently run EOL care plan meeting, concerning a Ms. L. We sat with the nurse practitioner, the social worker, Dr. Lechich, and the head nurse as they discussed Ms. L’s condition with her daughters, one of whom was present, and the other was on the phone. Ms. L was unconscious and had lost the mental capacity to make decisions, so her daughter was her HCP. Ms. L’s condition was not improving, and this was her fifth stroke. The TCC team, headed by the nurse practitioner, hinted that it might be best to let her mother go. The NP related that, after all, when not in a hospital setting, the natural way for people to die is to stop eating. Her tone was not forceful, merely suggestive. The daughter, however, wanted to at least try feeding her mother in order to not give up on her.

It seems, based on my limited experience here, that the medical team is generally of the opinion that care should be limited once quality of life has declined to such a state that to keep the person alive is undignified and painful for them. This opinion often contrasts with the family’s wishes to keep the resident alive. What I’ve noticed from the two meetings are very different ways of going about relaying this information. In Mr. W’s meeting, the physician was more forceful in his notion of stopping dialysis, although he never told the HCP what to do. I believe that in some situations, such as this one in which the HCP was not so emotionally connected to the patient, it is the correct decision to use stronger language if you, as the physician, believe that you have a worthwhile opinion. Contrasting, in Ms. L’s meeting, the nurse practitioner may have been hinting to a similar
notion, but she did not put any pressure upon the family members. When the HCP decided to try to feed her mother, despite hinting against it, the NP ultimately agreed. This gentle and understanding tone changed the entire atmosphere of the meeting and made it easier to discuss such a terrible concept.

I was also amazed by the resolve of the daughter of Ms. L. Her daughter was very well informed about the medical situation, and while she did not yet want to give up on her mother, she was reasonable in her decisions. The NP mentioned that sometimes we keep our family members alive, even when their quality of life is so poor. We often do that, not for their sake, but for ourselves because we do not want to let them go. The daughter mentioned that she was really trying to act according to her mother’s wishes, and while she spoke emotionally about the situation, she made the call to cling to her mother’s wishes against her intuition of keeping her alive at all costs. I hope that, when dealing with such situations I can be as emotionally strong as Ms. L’s daughter was.
We began our afternoon today by observing an ethics committee meeting in regards to a particular patient, whom I will call M. The ethics committee consists of the nurses in charge of M's care, Dr. Lechich, our in-house Catholic priest, a Catholic priest from an affiliated institution, M's lawyer, and several social workers. M has been a consistent fixture in our morning reports, so the initial description of our dilemma is brief.

M, a devout Catholic, has been refusing treatment—all treatment. She has a serious wound, which, if left untreated, may cause her serious pain and will eventually cause death. The conundrum we are facing is this: according to Catholic doctrine, it is sinful to allow harm, even passively, to befall one's body. By refusing even the most basic care, some members of the ethics committee believe that M will be committing passive suicide. However, other committee members believe that it is unethical and unconscionable under any circumstances to administer care against the patient's will. While my treatment of this issue may elucidate my personal bias, I will attempt to provide as impartial an account as possible.

M's lawyer and friend was an invaluable member of the committee, as she knows the patient personally and understands more thoroughly M's possible motivations for refusing care so consistently. In the past ten or fifteen years, M has shown almost deliberate neglect for her own care. She lived alone and, though by some standards not self sufficient, followed a strict daily routine of watching television, usually the news, so that she could—according to her lawyer—"comment on the evilness of the world," watching mass, and praying. Even then, M was willfully neglectful of the basic steps of personal hygiene. M was deeply paranoid and, until her attorney managed to convince her otherwise, would not allow any stranger into her apartment to clean or care for her. However, despite being amidst the throws of extreme paranoia and self-neglect, M has been deemed to have the capacity to make medical decisions.

I have met M on several occasions, and in my very unprofessional opinion, she does indeed seem to understand what is going on around her. She understands what she wants, but, in the words of her attorney, "she may not understand the consequences."
By the end of the one-hour meeting, I had devised a list of several options. The options are either supported or restricted by another list of provisions and ultimatums, which seem to be under the most strenuous debate. Our options are these (in order of preference inferred through general consensus):

1. Convince M, probably through a religious argument, that it is in her best interest to accept a minimum of comfort-centered care.
2. Obey M’s current wishes and do nothing to alleviate any pain or infection that may arise.
3. Transfer M to a non-Catholic facility that will not be faced with the same dilemma.
4. Treat M for her mental illness, possibly admitting her against her will to a psychiatric hospital.
5. Treat M against her will.

The order of these ideas is loose, and many may be added, but these five courses of action are those that came up most strongly during the meeting. Option 5 is almost certainly not viable, as nearly all members of the committee agreed that treating the patient against her wishes would be both unethical and would cause further emotional trauma to the patient. Ideally, M will change her mind and agree to treatment for her worsening wound, but the committee agreed that, in her current state, that is unlikely. Her lawyer predicted that, should the wound become infected and painful, she might change her mind and accept pain medications at the very least. The committee also agreed that options 3 and 4, in which the patient would have to be moved, would cause great emotional and physical distress.

The ideals that underlie each of these options stem from the schools of thought I mentioned earlier. As the committee stood at the end of the meeting, there may be conflict between the medical and theological schools. While both parties agree with both schools of thought, each has prioritized these tenets differently. This is why we have option 3. If the Archdiocese cannot condone M’s lack of treatment, our only choice would be to move her to another facility, as all hospitals operate first and foremost under the law of the state, which deems it unethical to administer care against a patient’s will.

The question remains—what do we value most? Is the purpose of healthcare, both religious and secular, to honor the patient’s wishes? Is the purpose to keep the patient
alive? According to the palliative care articles I’ve read recently, it is to keep the patient healthy until it is unviable or overly traumatic to do so, at which point our objective becomes to provide the patient with the most comfortable and dignified death possible.

The study of ethics is applied philosophy. If this were a philosophy treatise, I could go on indefinitely, but because we have a limited number of hours before M needs to eat again, we need to come to a conclusion. We need to take action. We need to solve an unsolvable problem by weighing our pros against our cons. The most difficult part is that when someone has to give in and compromise, we aren’t compromising on a philosophical idea; we are compromising on the matter of someone’s life. We are not the ones directly affected by our own decision, which, in some ways, is more responsibility than any committee of professionals deserves.
Today, for the first time since I got here, I found myself sincerely feeling connected to the patients. I’ve been talking to the residents for the past two weeks and a half, but until today there existed this separation in my head between the patients and me. They were often bedridden, sometimes cognitively impaired, and I was able-bodied, and healthy. The differences between them and me were more than I was used to and it was hard to look past them and focus on the experiences we shared. But today, the interns were invited by Dr. Rybstein to attend a group therapy session and it was there that I started to understand that regardless of how discombobulated or beaten one’s mind or body gets, we still face the same problems that trouble the rest of humanity. In the hour-long discussion, it became apparent that many patients shared a general frustration with their lack of agency, a plight that I understood everyone to experience at many points in their lives. Life often does not go the way we picture it to and there will be things that are out of our control. Job applications get turned away, families are broken, and our health takes a turn for the worse. Of course there are differences in the height of each hurdle, but disappointment and the challenge of how to overcome it is common to everyone’s lives. I still feel this invisible self-imposed distance between me and the residents, but it is definitely closing.
Community by Rachel Chung, June 18th, 2014

Today we attended a group therapy discussion on the HIV unit. Dr. Rybstein, who is a psychologist specializing in patients with a history of substance abuse, led the discussion. As the patients trickled in, they greeted each other and us. Once the group was fully assembled, I observed a few interesting things: every member of the group was a person of color, and only three of the ten or so patients participating were women.

But beyond that, the discussion that unfolded can hardly be done justice on an internet blog. Dr. Rybstein’s first question may have been the hardest:

“Does anyone have any opening thoughts they would like to share?”

While I, like many college students my age, may have been stumped or intimidated, a patient in a rolling bed, whom I will call A, raised his hand and exclaimed, “Thank God for living!” He pumped his fist and looked upward. Off to a strong start.

Another patient, whom I will call F, was second to speak. He talked about how difficult it is working toward discharge. “Patience is not one of my better virtues,” he said. It was then that a patient I will call B chimed in. B stressed the importance of accountability, even in nursing home care. He said that if a patient isn’t proactive about his or her own care, the patient will not progress toward discharge. B was surprisingly articulate—not just for a resident of a nursing home, but amongst people in general—B went on to lead the discussion in many ways.

After B finished speaking, another patient, S, who also seems to lead the group, expressed his frustration with Housing Works, the organization that assists residents with finding a place to live after discharge. B stressed once again that he has been fairly successful in working with outside organizations because of his proactivity. However, B also possesses uninhibited communication skills, which S lacks.

When another patient, called D, interjected with a complaint about her medication, the conversation became heated. D said that her assigned nurse gives her her medications
after breakfast, but at that time in the day, D's stomach does not have enough food in it. “I've been positive longer than she’s been giving out medication,” she said.

It was here that B took the reigns. With Dr. Rybstein’s help, B explained that the nurse has no control over when medication is administered, and that D should take up the issue with her attending physician. However, D continued to push the matter.

As B reiterated his previous point about being patient and proactive, the conversation became both more heated and more circular. The overarching statement of B’s various remarks was,

“There are people here with great potential to be leaders, but what they choose instead is to be ignorant.”

B elucidated that many patients at TCC are reluctant to hand over control of their care to the interdisciplinary teams here. Patients like D are understandably adamant that the care with which they have provided themselves thus far has been sufficient. They feel that when we take their care management off their hands that we are both disrespecting and usurping their agency.

But what I found more interesting in observing this session are the ways in which patients hold each other accountable and encourage each other to be better. Patients like B, F, and S are evidence of a community that exists completely independently of the outer workings of medical administration here. I hope that in my remaining time as an intern, I have the opportunity to observe more interactions like this.
Today, Zoë and I went searching for Dr. Rybstein, who specializes in patients with a history of drug abuse. When we finally did find her, she was engaged in a meeting, so we set up camp in the adjacent recreation room, which was, for the most part, devoid of residents. We saw a resident we knew, whom I will call C. We asked the basic questions—how are you feeling, what are you up to today, how did you sleep—C told us his birthday was coming up. C seemed excited, so Zoë asked him what his plans were for his birthday.

“I don’t make no plans in advance, you know,” C said, “It’s a blessing just waking up this morning.”

Later on, another intern, Joseph, joined us. C went on to describe the hardships he had experienced. C has seven brothers and three sisters, a mother who passed away when he was three, and a father he is not willing to talk about. C has experienced a stroke and external trauma, leaving him blind in one eye. C has a history of drug abuse and, most importantly, is HIV positive.

“But I’m a fighter…I’m gonna make it.” C’s account was peppered with statements like this one; he made it perfectly clear that he intends to leave this facility alive and in good health. C’s optimism, in spite of all he has witnessed and experienced, was inspirational. He refuses to give up, and at 51 years old he plans to overcome any and everything thrown his way.

It is amazing what people are willing to share with you if you show that you are willing to listen. We spoke to C for roughly fifteen minutes. When people are as far advanced in their diseases as many of the residents here, you find yourself skipping the pleasantries and really focusing on what the resident has to say. “How are you?” is not just a mandatory greeting. You ask a healthy person how they are with the expectation that he or she will say “Good, and yourself?” but here you ask a resident how he or she is expecting to hear the truth—that very few people here are “good.”
However, despite the turmoil and sometimes even depression of living in a long-term nursing facility, residents like C manage to thrive. In the six days I have worked at TCC, I have seen so many types of patients: those who want to leave, those who want to live, those who want to die, and everything in between.

The hard truth of the day is that C, like many of the residents of the discrete (HIV) unit, will die fairly young. But so many residents, especially the ones on discrete, maintain a positive outlook. It seems trite until you see it in action, and I would not have written about it until today, but seeing someone in such dire straits with such optimism is both rattling and uplifting. C gives me hope; because if C can have hope, I can.