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Clinician Narrative
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Working full time on a busy medical unit you see a variety of patients, some of which have an impact on you. For me, Sister A was that type of patient.

It was the morning of my first shift of a long stretch for me when I admitted Sister A. She was an 80-year-old with a history of CKD, COPD, asthma, a prior CVA, baseline tremor and non-ischemic cardiomyopathy s/p heart transplant who presented from her assisted living with a persistent cough despite a recent antibiotic course. The chest XRAY in the ED showed evidence of pneumonia, and therefore Sister was admitted for IV antibiotics and further monitoring.

I knew from the moment Sister got off the stretcher that we would get along. She was a petite woman with a large personality. Much of her admission process was spent talking about her love for knitting , how If she was not knitting something was wrong, her love for God, and her willingness and love to help those in need. She spent her first and second day in the hospital calling other people on her roller dex who needed an inspirational talk and telling me stories about her interesting life. Sister always told me that God had a plan for her and she was ready for whatever her plan was.

I left my second shift looking forward to taking care of Sister the next morning but what I found when I walked into her room was a completely different person. Sister was altered, not able to respond to commands, writhing in bed, tachypneic with a constant non productive bark-like cough. On a general medicine floor we often think about hospital acquired delirium and how it can affect a patient. Sister's age and infection definitely put her at risk for this, but my gut and experience with declining patients was telling me something more acute was going on and given our day yesterday I was concerned. Knowing this was far from Sisters baseline, I immediately paged the intern to come assess her. When the intern arrived, she seemed a bit overwhelmed, so I asked if she could page her JAR, so he could get his eyes on her. Because it was the weekend, there was a covering supervising junior resident who had never met sister before. Luckily I had admitted and taken care of sister now for 2 days prior to this event, so I felt confident I could describe clearly these acute changes. I knew her story, her baseline mental status and was confident in my knowledge and therefore was adamant that though she was hemodynamically stable, this was far from the patient's baseline and she could quickly go downhill. Because I wanted more eyes on her, I notified the nursing supervisor of Sister's instability and she came up to assess her. We sent off multiple stat labs including BMP, CBC, VBG, lactate, blood cultures, flu and the entire viral panel. Patients can become septic and rapidly decline leading to shock and death. Early detection and treating sepsis quickly and aggressively decreases a patient's risk for mortality. So, because of that we were making sure Sister didn't have another infection somewhere that we were missing. As time went on, Sister was looking more tired and increasingly tachypneic and I knew she would not be able to sustain her constant coughing as it was not allowing her to take a full breath. I paged

respiratory to see if they had any advice to offer regarding her cough and lack of deep breathing. We tried humidified oxygen, but it didn't seem to make anything better and she kept pulling it off with her constant writhing. The lack of abnormal information (all of her labs came back within normal limits), yet obvious instability was puzzling to both me and the doctors and therefore I asked if we could huddle and come up with a better plan. With a prior CVA, I was worried that maybe Sister was having another stroke. During the huddle, I advocated for a head CT and/or a neurology consult for which the team agreed. Because of her instability and drastic mental status change, the priority now was to get the patient down to a CT of her head, chest and abdomen to see if there was something we were missing like a stroke, bleed or worsening infection. She was writhing in bed, constantly coughing and I was unable to settle her. In order to get adequate imaging patients have to be still in the CT machine. With Sister's current mental status I predicted this would be a problem and we would have to premedicate her for the exam to be successful. The JAR was hesitant to sedate her because of the mental status change, but after explaining that the technician would refuse the patient he was willing to try. With Ativan in my pocket, I travelled down to CT with my patient. In the meantime, transplant cardiology and Infectious disease both saw the patient and felt we needed to be more aggressive with our approach. At that time, I remembered our several conversations regarding wanting to be a DNR/DNI, having a funeral already planned for her and wanting to follow "God's plan". I paged the JAR and asked him to call her HCP to update him on Sister's decline in health, confirm her code status and clarify whether the ICU/pressors etc were part of her ultimate wishes. Ultimately it was decided that a transfer to a higher level of care or aggressive management (including intubation and/or compression) was not part of Sister's plan.

The next day, neurology had consulted and felt that her mental status change could be Cefepime induced delirium and therefore discontinued the medication. After a few days Sister's mental status was back to her baseline. Sister was sitting in a chair knitting, asking how I was, much like the woman I admitted. That afternoon, Sister started to complain of abdominal pain and I noticed she had not voided in 4 hours despite adequate fluid intake. I bladder scanned her and noticed she was retaining >600cc of urine. Unfortunately, after straight catheterizing her, the abdominal pain did not improve, and she started having multiple bouts of loose bowel movements. Because of her immunosuppression (on daily Tacrolimus for history of heart transplant) and prolonged antibiotic course, I asked the team if we could send off a sample for CDIFF. Unfortunately the stool sample came back positive for CDIFF and we started her on appropriate coverage. Sister's abdominal pain was persistent despite the antibiotic course, and she was now requiring IV pain medication despite disliking the sedating effects. Sister abruptly began vomiting coffee ground emesis. To assure we were not missing anything, sister had a KUB which showed a small bowel obstruction despite her multiple bowel movements. I gathered all of the supplies necessary and assisted the doctor with placing a nasogastric tube to decompress her stomach. Placing a nasogastric tube can be incredibly uncomfortable, so I held Sisters hand and encouraged her to take big gulps of water during the process to make it more natural. Once the tube was advanced into her stomach I secured it, so it wouldn't budge. I could see the look of frustration in Sister's face. It seemed like with every step forward we took we then would take five steps backwards. The next day, Sister had multiple extra-large black bowel movements followed by sudden hypotension. We drew a CBC which showed a large

Hematocrit and Hemoglobin drop. We transfused multiple units of packed red blood cells and consulted the GI team who recommended an EGD to locate the source of the bleed.

At this point, Sister was visibly tired, pale faced, lying in bed and feeling short of breath. Sister had a lot of questions about what an EGD would entail and how invasive the procedure was. I sat with her and educated her to help her understand what to expect. That evening, Sister requested a meeting with the doctor, me and her brother (her HCP) and verbalized she wanted to stop with aggressive treatments and focus on ending her life comfortably. Respectfully, we made Sister comfort measures only and pulled back from aggressive treatment. Religion was such an important part of Sister's life, so I asked if she wanted to speak with a chaplain. When he came to see her Sisters face was full of excitement. We spent the next few days, much like the first few days of our relationship, chatting with each other, laughing and listening to music. In fact, one of the last memories I have of sister is her dancing with a smile on her face (as best as she could) in her bed to gospel music as I held her hand. Within a week of making her comfort measures only, Sister passed away peacefully, comfortably and with her rosary in hand.

SAMPLE QUESTIONS:

Clinician-Patient Relationship

1. In your narrative, you state, "I knew from the moment Sister got off the stretcher that we would get along" Can you describe your feelings and thoughts here and how you knew this?

Clinical Knowledge & Decision Making

1. Regarding the story in your narrative, it seems like you spent much of the time chasing symptoms with her sudden mental status decline, her change in respiratory status, her abdominal issues. Can you walk us through what you thought might be ultimately going on with Sister?

Teamwork & Collaboration

1. In you narrative, was there any other care teams such as chaplaincy involved with her end of life. How did you help develop and coordinate these teams?