



# I Didn't Know Jack

Arindam Sarkar, MD

(Fam Med. 2020;52(2):140-1.)

doi: 10.22454/FamMed.2020.975663

It was my second day with Mr Duran. I had to gather myself for the dreaded code status discussion. It was also my second day as a doctor. I believed that patients came to hospitals to get better. Patients' families must detest feeling that not only is their loved one dying but doctors are now refusing to try everything possible to help! Aside from participating in one contrived simulation lab, I had never led a goals-of-care conversation. According to that experience, it was not supposed to be hard: sit down, break the bad news, offer empathy and document the new code status. Something in me suspected it would not be so straightforward.

Mr Duran was in his 60s but appeared far older. A recent massive stroke had eliminated his ability to move his arms and legs. The tracheostomy tube in his throat echoed a nonstop whirring of airflow from the ventilation machine. The combination with his facial muscle paralysis rendered his speech completely unintelligible. Mr Duran was of average weight and sported glasses that were likely fashionable three decades ago. He checked into the hospital over 2 months ago and was repeatedly struck with infection after infection. He remained on powerful antibiotics without any sign of improvement. His organs were failing, one by one.

Mr Duran's unassuming and earnest wife spoke only Spanish, and I

patiently did not (beyond *empuje* or "push" from my obstetric training). Interpreter services at our hospital were scant and I frequently resorted to communicating exclusively with the patient's spirited 20-something daughter, Lucia. Each day I'd give her a few minutes to relay an abridged version of my update to her mother, and then I'd offer Mrs Duran unrestricted time for any follow-up questions. She never had any. She only expressed gratitude that her husband looked comfortable.

Mr Duran communicated with us using an antiquated apparatus on which he could point to simple pictures and common phrases. His marked finger tremors yielded frequent, and for him likely infuriating, misunderstandings. On the first few days of the rotation, I honestly did not try very hard to understand his fragmented, indiscernible speech. In my mind at the time, it wouldn't have made a difference. We weren't going to change any medications or improve his overall outcome based on those words.

When I revealed to Mrs Duran during our code discussion that patients with prolonged ICU stays often have serious setbacks, I expected her to sigh. When I said her husband's pneumonia showed little sign of improvement and now his other organs were declining, I expected her to cry. When I explained my recommendation that if his heart

stopped we should not perform rib-crushing or heroic interventions, I expected protest. I turned to the interpreter to ask if they could understand me. Mrs Duran and Lucia at first said very little. Then, looking at her husband, Mrs Duran confidently stated in English, "We don't want anything." They had discussed it before. They knew he was suffering. That he was dying. They did not want resuscitation. They understood (long before I did, apparently) that this was the end. They understood that comfort and joy are to be cherished while they last, but that life is finite.

As the days went on, Mr Duran experienced progressive deterioration. Yet, after the code talk, I recall a vastly different sensation of calm and relief in my daily conversations with him. At times, even when our team wasn't rounding on him, I'd pop my head in and say hello. Instead of discussing drugs and labs, I found myself spending time in Mr Duran's room adjusting the curtains, flipping the television channel and changing the height of his bed. I don't remember if his speech eventually got clearer or if my spending a few extra minutes each day with him made him more understandable.

---

From the Baylor College of Medicine, Department of Family and Community Medicine, Houston, TX.

On the last day of my rotation, I walked into Mr Duran's room and told him that he had left a lasting impression on me. I sat down on his bed next to him, shook his hand and wished him the best. As I stood to leave, he unexpectedly asked me for a picture. I knew my risk-averse, senior resident would sternly warn me not to, but I chose to smile ear-to-ear in the selfie. Was I violating my privacy? His privacy? Who knows? While Mr Duran's phone was out, his family showed me photos and videos from 3 months earlier. Then the stories came pouring out. What I saw and heard, took me aback. He was jogging around the backyard and passionately describing types of tequila.

My goodness, I thought. If we hadn't taken this photo, I would have never caught a glimpse of the real Mr Jack Duran. Mrs Duran showed me dozens of pictures and regaled us with tales of a bilingual truck driver who loved college basketball and eating *pupusas*. Evidently, Mr Duran was a romantic charmer who had somehow convinced her within a month of meeting each other to marry him. By this time, Mr Duran preferred I call him Jack and I insisted he call me Rindy. I had never gone by that nickname professionally, but it felt right.

I realized that code talk was my first time trying to be a doctor. About a month later, I got a Facebook message request from Lucia. I

didn't want to open it. She'd probably ask me questions about her father's health, ask for advice on getting into med school, or blame me for his code status decision. Five months later, when I finally clicked on that message, it read, "My dad passed away yesterday. He thought the world of you. You were our favorite doctor." I did not reply.

Jack was the second patient I cared for that passed away. The first gentleman had been critically ill at the outset of my rotation and his departure was expected. I had conveyed to Jack's family that our team's best estimate offered several remaining weeks of life until the seemingly incurable lung infection resulted in respiratory failure. Despite this, news of Jack's death felt viscerally unsettling. I wondered if the next team got to know Jack or if his final doctors would refer to him as a critically ill gentleman whose departure was simply "expected."

I regret not opening Lucia's message earlier. In retrospect, waiting 6 months portrayed a lack of emotional fortitude on my part and a missed opportunity to preserve a powerful connection. I realized that my reluctance to acknowledge her message stemmed from fear that communication outside the hospital would entail an unnecessary emotional risk for me. If presented with the same opportunity today, I would strive to close the loop with Jack's family so

that they, too, would know that they were important to me.

Although I knew healing in medicine would involve recognizing and minimizing suffering for individual patients, I now better understand that a physician's personal connection often extends to a family or even an entire community. Upon hearing of Jack's death, I made two pledges: (1) treat a person and not just their pathology, and (2) always attend to the suffering of the family as well as that of the patient. I never saw our picture together, but I will never forget the man. Thank you, Jack, for teaching me to be a doctor.

**ACKNOWLEDGMENTS:** The author thanks his wife for encouraging mindfulness in medicine, his family for fostering interest in creative writing, and his teachers for granting career perspective.

**CORRESPONDENCE:** Address correspondence to Dr Sarkar, Resident Physician, Baylor College of Medicine, Department of Family and Community Medicine, 1100 W 34th St, Houston, TX 77018. 281-650-3221. arindams@bcm.edu.