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The Arc of Serenity

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A long, plaintive wail drifted toward the computer workroom. My inpatient medicine team, assembling for our first day together, looked up and straightened like deer hearing rustling in the woods. The wailing turned into shouting, and a nurse rushed by. "Poor thing," my intern murmured, not knowing that he would soon be responsible for taking care of that patient: Serenity.

Serenity -- not her real name -- had been admitted to the hospital with a broken humerus. She had poor underlying health and rheumatoid arthritis so severe that she couldn't even hold a pen to sign her name for a release of medical records.

The first day we rounded on Serenity, she continued to scream no matter what we did. Her wispy braids, someone's attempt at kindness, had unraveled. Her words were garbled by missing teeth and a dry, cracked tongue. Her eyes, full of tears and anguish, darted around the room. I didn't think a small, elderly woman could intimidate me, but I was frightened by her emotional display, and none of us got very far with her that day.

Serenity had been ordered to six weeks of bed rest for her fracture, as one by one, rehab facilities throughout the state declined to take her. She developed a gaping pressure ulcer, intensely itchy skin, and suffered bouts of terror. When she was in pain, which was most of the time, she was inconsolable and could not be reasoned with. Her yelling became background noise as I wrote my daily progress notes. As one of the nurses said, at least Serenity's lungs were still good, which on some level was reassuring.

There was always some issue with Serenity, whether it was inadequate pain control, accusations that the physical therapist had given up on her, or because she just wanted someone to scratch her dry, excoriated back. One day during rounds, she grabbed my hand and pleaded, "Don't leave me!"

Despite her entreaty, Serenity seemed to distrust us—we who towered over her in white coats and spoke too quickly, stabbed her with needles and rolled her broken body over—even as she accepted our care and occasionally giggled and smiled like a shy child.

There was no epiphany, no electric moment of enlightenment. Gradually, however, I found it easier and easier to stop by her room after lunch and teaching rounds. She told me that the highlight of her day was being able to sit in a chair at the window so she could watch the cars move on the highway. Through little stories and asides, I learned about her deep religious conviction and her love of gardening. She was the woman in her neighborhood who went

door to door, offering cassava, fresh corn, bell peppers, and herbs. She was worried about her children, especially a daughter who she thought was irresponsible. Far from being the incoherent, out-of-control woman I'd met that first day, I came to understand Serenity as a lonely woman approaching the end of her life, who knew it but didn't acknowledge it, who had little family or social support, and whose wits were much sharper than she could express.

What Serenity needed just as much as morphine and nursing care was our dedication. There was no evidence-based approach for Serenity, and so we used our most precious resource to treat her: our time. My attending planned her afternoon rounds out so she could linger to chat and make Serenity feel cared for. The intern checked on Serenity frequently, even though she had been on the same medications for weeks and we'd stopped drawing labs on her long ago. The nurses never complained about Serenity, and for my part, I found that despite all of my studying and educational pedigree, I delivered the best care by providing back-scratches and conversation as needed. It took a while, but the whole team eventually understood that what Serenity needed most was the promise that we wouldn't abandon her.

When dealing with patients who challenged me because of their difficult personalities, sociocultural differences, or other complexities, I returned in my mind to the PowerPoint bullet points from my medical school lecture hall: try to understand the patient's perspective, accommodate their cultural or religious preferences, and use a model of shared decision-making. I tried, but as Serenity showed me, in real life there is often lack of clarity, a need for delicate negotiation, messy family meetings, and pressure to provide "high value" care. Bullet points couldn't provide intuition for what each patient wanted and needed — That could only be found through practice and by caring for many, many patients.

As a doctor-in-training, the medical arcs of real, imperfect patients reshaped me. I gained clinical knowledge from my patients' diseases, but also from their suffering and the effect it had on me. The emotional transformation that takes place when we are put in the position of taking care other people cannot be overstated. I have charted my growth constantly and critically. After every patient I cared for, I asked myself how I'd felt about the interaction, and why I'd felt the way I did. Self-awareness is a tool for lifelong learning about oneself and other people and is vital to developing an individualized, emotionally effective practice style. In order to be empathetic, we have to understand ourselves first.

Serenity changed, and I changed, too. I learned to acknowledge when I was happy because my patients got better or because their gratitude made me feel good about myself, but also when my patients scared or enraged me. In Serenity's case, at first I was frightened and avoided her because I didn't have the confidence to tell a person in so much misery that I could take care of her.

Now, when I sit down with patients facing pain from metastatic cancer, family members of end-stage dementia patients, and patients who have lived in the hospital for months suffering setback after setback, I use the arcs I know as guideposts, questioning and listening to refine my approach with each patient at hand. And I know that when I feel relief or injustice or sorrow, that that is what my patient is experiencing, too.

So what kind of comfort could we ultimately provide to Serenity? We continued to search for rehab facilities and reached out to her family, who was not very engaged in her care. After weeks of back and forth and multiple meetings with the palliative care team, Serenity told us that she wanted hospice-level care in the hospital. She didn't want to die, she said, but she didn't want to be in pain. We arranged for her to stay on our floor so that she could stay comfortable with providers she knew. My resident told me that she would probably pass away in less than a week. When I left the wards after two months, though, she was still going strong – and yelling for back scratches every morning.

Joy Liu is an internal medicine resident in Boston, MA. Her interests include speculative fiction, the history of medicine, and health advocacy. She has self-published one novel (so far), *Watermark*, available in the Amazon Kindle store. She maintains a technical medical blog called "The Friendly Intern," and recently retired a reflective blog called "Pathos and Pathology." She plans to write both facts and fiction in the future.