

# Elizabeth McCarthy's Story

***The Painful Education of an Intern***

by Dr. Gene Lindsey

Author of

"The Healthcare Musings Newsletter"



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## **Elizabeth McCarthy's Story, Part 1**

I was an intern in the distant past when we worked every other night. The 48-hour cycle usually consisted of thirty six to forty hours at the hospital followed by eight to twelve hours of recovery before it started all over again. Those were the days when I took naps at stoplights and learned to love coffee. I thrived on coffee and beepers and was sustained at times by the adrenaline stimulated by the fear that the message announced by the beeper would be a challenge that exceeded my skill and knowledge.

For the first twenty-four hours I admitted new patients and cared for the ones who were already on my "service". The day after my night "on call" I would try to get the issues on all my patients stabilized so that the nurses could watch them without much help from my fellow intern who shared the every other night cycle with me. After thirty years I can still picture the various places where I was standing when my beeper went off to announce that I had a new patient, a patient that I might never forget, a patient to whom I would always be in debt for having given me more than I ever gave them.

It was that way when the beep announced Elizabeth McCarthy. I was sitting at the nursing station on F2 with a pile of charts and an order book in front of me. It was sometime after midnight three or four months into the "year". Outside the early fall air had a damp bite and I had just walked out into the courtyard off the "Pike" to use its nip as a kicker to my most recent cup of coffee. I knew I had enough work to keep me busy writing notes and orders until after three. Each night I was on call I maintained the hope that if I got my work done by three and the EW remained quiet, I might get almost four hours of sleep before I had to get myself ready for rounds at seven. It rarely happened that way but I was eternally optimistic. I always started the evening with optimism and held on to it as long as possible. Miracles do happen. Ask anybody who ever took care of sick people.

In those days beepers just beeped. There was no screen on the beeper with numbers or messages as we have now. A beeper was a little metal and plastic box on your belt that had just one note. It was a strident signal to call the operator who would then announce who was looking for you. I really did not need to call the operator. I knew it was

the EW and my fantasy was dead for another night. I called the operator to get the message because if I did not call her she would keep at it until I responded. I mimed the words as she said, "Dr. Lindsey, the EW is looking for you." "Thank you, I'll call them." I said. I was always courteous to operators. They were just the messengers. It was suicide to anger nurses or operators. Many an intern was "beeped" with a "message" an hour or so after going to sleep. Control was a big issue in the hospital culture.

I called the EW. My hope now was that my "hit" was a simple "rule out". We would call our new patients "admissions" or even more expressive of the pain they produced in our sleep-deprived lives, they were called a "hit". Sometimes the new patient was named by the slang for their presumed diagnosis, which in retrospect was obviously a way we turned them into objects or problems rather than the sick, frightened people that they were. The slang used for the presumptive diagnosis of a possible heart attack was "rule out MI". Ninety percent of patients who are admitted for observation for heart attacks have something else less serious than myocardial injury, so it is often true that they are just "put to bed" and there is not much real work to be done. I wanted a "rule out" because by the fourth month of my internship that was work I literally did in my sleep. I had a template "work up" and set of orders that were drilled into my head like a cherished family recipe handed down from generation to generation of bleary eyed future Oslers. I could do the drill in less, much less, than an hour and with the patient comfortably tucked into bed, I would head to my bed in the "on call room" down the hall. With luck I might salvage three hours of sleep, which would not be too bad.

Once again a few words were enough to dash my hopes. It was going to be a long night. I hated the voice of this particular "admitting physician", the senior resident who made the decision to admit a patient and to whom. This one was a cowboy. "Gene, it's a zoo down here and I've got one maybe two hits for you. You're up for the next admit, right?" I politely answered, "Yes, I'm up. Who do you have for me?"

"I've got a sweet old lady who was in pulmonary edema when the EMTs brought her in. She tuned up quickly with O2, MS and some tourniquets. Her rales are down to mid chest now and she gotten 40

of IV Lasix. I think we'll roll her through x-ray and up to you, or you can come and get her." His crisp words transmitted a familiar mental and tactile image. She would look like my grandmother and would have wispy white hair. She would be a little over weight with puffy cheeks bulging around the facemask delivering O2. Her skin would be a pale blue and have a cold moist feel. She would speak in little breathless bursts, with a background rattle and would look very scarred with the darting eyes of a person on the brink of disaster who was having trouble with the wash of stress hormones over her oxygen starved brain.

I liked pulmonary edema. Death clearly was lurking just outside the door but ninety-five percent of the time a few quick maneuvers chased him away. His flight was dramatic. The meds usually worked fast. In a half an hour or so things were often so much better that you wondered, "Was there really a problem?" Pulmonary edema can hit like a storm. When it came on like an unexpected late summer afternoon storm we called it "flash pulmonary edema or just said, "the patient flashed". I thought that there was no problem that was more serious or dangerous that an intern could single handedly drive away than pulmonary edema. It was amazing to watch as the cheeks became pink, the skin dried and the breathing became less labored in a few short minutes; just because you knew what to do. It was like hitting a home run.

Over the year I would admit many similar men and women, but I remember Mrs. McCarthy best. I helped her that night but I failed her big time later.

I met her in the EW and picked up the process of her care from the team. It was like the passing of a baton. I noted her IV lines and quickly assessed what her veins looked like after she had been attacked by my colleague. He had earnestly and enthusiastically tried to get in a good IV in the midst of her gasping and struggling for air. It must have been a frantic effort. He didn't have the touch to do it when a patient was comfortable and certainly lacked the dexterity to do it with a patient who was moving about on a gurney in a desperate search for air. He had botched the antecubitals and the best forearm veins. There was a pathetic butterfly IV hanging from the back of her right hand. It was beginning to infiltrate and the hand was swelling.

“Nice work”, I said sarcastically for the pure relief of expressing my generalized frustration at some legitimate target. I resented him because I knew he was just paying his clinical dues before fading into a lab for the rest of his life to write papers and advance the science of medicine. Our internship group had several like him. Some of them are famous now. A few could start IVs. This one never could. He mumbled something as he backed through the curtain that served to provide a little privacy for the cubical.

I automatically picked up her left hand and pulled a rubber tourniquet from my belt and cinched it around her upper arm. In one smooth automatic move I began to pat her forearm looking for an overlooked vein into which I might slip a more stable IV before she flashed again. I’d seen a person die for lack of an adequate IV access. A good IV was something you always were sure you had before you needed it. She was still fresh from her ordeal and I was not at all sure there would not be an aftershock. I introduced myself, discovered a good vein, reached for an angiocath IV and checked her vital signs and rhythm on the monitor in one continuous move that lasted less than fifteen seconds.

“Mrs. McCarthy, I’m Doctor Lindsey and I will be helping to take care of you while you’re here.” Truth be known, it would pretty much be me. She had no private doctor. She was being admitted to the “ward” service. I was supervised by a senior resident and a distant “attending physician” who was technically responsible for her but showed up five days a week for teaching rounds. Assuming she survived, I would be discharging her with the invitation for follow up in my outpatient “clinic” where I saw patients one afternoon a week under the supervision of another “attending physician”.

“Are you feeling better now?” Her response startled me. “Aren’t you such a nice looking young man? You have such wavy hair. It’s a shame some girl didn’t get it, and isn’t that a pretty tie”. I stepped back. “Well thank you”. I was not to be deterred; I had things to do if I was ever getting to bed. There was a liturgy of questions to be asked and answered. I was the one to be determining the pace and direction of our conversation. My hair was pretty close to my shoulders and my tie was a broad bow tie with pastel flowers on it. It



was 1971. My generation was protesting a war and making love on the grass in Golden Gate Park. I was not there but that's probably a longer story.

"Have you had chest pain? Are you short of breath when you walk? Can you sit for me, please? Do you have a doctor? Can you take a deep breath for me? Again, please. Are you being treated for any medical problems? Squeeze my hands. Have you ever been in a hospital before? I was rattling off the questions as I looked at her neck veins, percussed her chest and rapidly did my "physical". I noted a loud murmur consistent with mitral regurgitation associated with a summation gallop and recognized evidence of an old myocardial infarction on her EKG. I pretty much had the situation sized up and all I had learned from her was that she liked my hair and had been dwindling.

"I think I've been in a little de-cline lately", she finally offered in summation of her recent medical history with an emphasis on the first not second syllable of the directional word. "I don't have much energy anymore. I've moved in with my daughter and her husband. I'm sort of in the way." I think I said something trite like, "I think it's nice that your daughter can help you. That's what families are for." I was too busy to note that her daughter was nowhere to be seen.

The nurse and I rolled her to x-ray. I was not about to wait for the escort service. I was fifteen minutes into the process and was falling behind. I knew the situation but the history was limited to the disclaimer "The patient is an elderly woman who is a poor historian and presents in acute pulmonary edema. No prior history of chest pain or MI", which I began to scribble as she was getting x-rayed. No moment was to be wasted.

I was not surprised by the x-ray. Her heart was enlarged. She had what we call a "wall to wall heart" with vascular redistribution and bilateral pleural effusions, the fluid on the right greater than left. Which translates to "a large failing heart with lungs engorged by blood that the heart is too weak to pump". The x-ray picture fit with a "de-cline". She'd been in the dwindles for a while. There were old scars in the upper lung fields. A "bad cold" decades ago had probably been TB. I was guessing the labs would reveal an anemia and some

renal failure. She would probably have pneumonia before long. At least she wasn't in AFib, yet. I guessed in the end she would "rule in for an MI". The elderly never have crushing chest pain with their MIs. They just "don't feel quite right", then go into pulmonary edema.

I rolled her down the long connecting basement hallway between the EW at one end of the hospital and the open ward that was our destination a city block away. I felt vulnerable. I hated this part. I always imagined a cardiac arrest with just the nurse and me in the basement 200 yards from the EW and 200 yards from the tiny elevator to the second floor of the "F" building that was our destination. "Lord be with me." The elevator moved inch by painful inch and then we emerged into the damped yellow light of the hallway in front of the nurse's station. I announced our arrival by saying to the floor nurse, "Martha, meet Mrs. McCarthy, our new patient. Which bed would you like her to have?"

The two beds in a small room across from the nursing station were traditionally occupied by the patients who required the closest observation. The room was a sort of mini ICU. Sometimes I imagined it as the launching pad to the afterlife. It seemed that most of its patients were discharged to mortuaries. One bed was occupied by a desperately ill young mother who was "bottoming out" after her first round of chemotherapy for her acute leukemia. The only thing the drugs seemed to have done were kill off the few good white cells she had. Her blood was still populated with "blasts". She would die of infection and uncontrolled bleeding the next night when I was "off duty". The other bed had a woman who looked elderly but was actually in her mid-forties. They must have been hard years. Her arms were restrained by leather cuffs. She had the DTs and pneumonia. Not a happy combination of issues but rather common on the "ward".

The rest of the floor consisted of one large rectangular room with ten beds in a line on each side separated by a few feet and curtains. The nurses usually moved the beds around so that the sickest patients were closest to the nursing station. There was a corridor down the middle of the room about eight or ten feet wide. In the afternoon the patients were often up in chairs at the foot of their beds. The nurses would wrap them in soft white cotton bath blankets and sheets and

turn them so that they were all in a line on either side of the corridor looking toward the nursing station which was the center of activity.

Someone would usually tie bright colored ribbons in the wispy white hair of the frailest and most dependent women. I would occasionally stand at the nurse's station late on a fall afternoon with light coming in through the floor length windows that were at the heads of the beds. There was a halo around each of the bobbing heads and the thought would pass that it looked like a bus ride to see the leaves in New Hampshire, or maybe a bus ride to eternity. I was surrounded by people in various stages of actively dying. I thought about death and "the quality of life" a lot.

I was a dedicated warrior against the inevitable and had statistics to prove it. For some reason I kept a list of all the patients I admitted to the wards during that year. Patterns soon became obvious. Almost every patient I admitted had been admitted before. If you were admitted once there was a high likelihood you would be admitted again and again. If you were admitted at all you had almost a fifty-percent chance of dying before the year was over. It looked like we were trapped with the patients in an endless cycle of spiraling disease.

We admitted them and treated them. We discharged them and then they came back sicker than when they came in the last time. It was the natural history of chronic degenerative disease encased by the limits of poverty, social isolation and the recurrent behaviors that had often caused or contributed to the disease. When we presented our patient at rounds the usual chant went something like, "This is the 8th Peter Bent Brigham Hospital admission for this 72 year old woman with a long history of diabetes, chronic lung disease and atherosclerosis now status post MI times two who was recently admitted with pneumonia who now presents with a two week history of increasing shortness of breath and edema."

The first bed on the left was ready for Mrs. McCarthy. It was the bed most visible from the nursing station. Martha was always thinking. I was the doctor but she ruled F2. She had worked the night shift for twenty years. I never ever questioned her judgment. The practice of medicine is heavily dependent on experience. She was the pro and I

was the novice. As we did the doctor/nurse dance, she let me look like I was leading but we both knew I was always glad she was there. She knew the tune.

Mrs. McCarthy was one of those people who is pathologically polite and deferential. Even in the aftermath of the trauma of the EW she began to apologize to Martha about being so much trouble. The diuretics were beginning to work. She was speaking less breathlessly and without many rattles. She needed a bedpan. She hated to be a bother. I realized I had gotten to the EW before she was completely rigged by the nurses there with the prerequisite Foley catheter. Martha gave me a look that said, "I have enough to do. Why didn't you let the nurses in the pit [hospital slang for EW] do their work?" To Mrs. McCarthy she politely said, "It's no bother, you've had a hard night. Let's see if we can make you comfortable".

Suddenly I had the feeling that my services weren't needed. Martha was in charge. I retreated to the ward kitchen to forage for something to eat. I came up with a cup of the hospital custard, which I hoped would give me the energy to finish writing my work up and her orders. There was no coffee so I settled for a ginger ale. Custard, ginger ale, coffee, and little cups of orange and raspberry sherbet sustained me in the wee hours when there was work between the bed and me. I sat down to write and soon realized I was too tired to make sense. I scribbled rudimentary orders. I wondered for a second if I should call the resident who was downstairs helping out the intern on F Main, the men's ward, but decided against it. He trusted me but would feel obligated to review the case in search of something to teach me. I did not need more education. I needed sleep.

## Elizabeth McCarthy's Story, Part 2

I called the operator and asked her to call me at six. It was four. I'd finish my notes and orders before rounds. I slept in my clothes. Mercifully the phone did not ring until six. After the two seconds it took to figure out where I was, I thanked the operator and briefly wondered what had happened to that other "hit" in the EW. Maybe the patient had a doc and ended up on the private service or was young enough or sick enough to get one of the precious beds in the CCU. Mrs. McCarthy did not meet any of those criteria.

I was amazed when I saw her. The Lasix and digoxin I had ordered had transformed her in a few brief hours. Martha had "installed" the Foley catheter and the bag hanging from the bed frame was bulging with pale yellow urine. Urine always made me happy. If your patient can make urine and has a little bit of blood pressure you can work with there are miracles in the making. I said, "Good morning Mrs. McCarthy", as I slipped my stethoscope under her Johnny.

The nurses always called the patients by their first names but I was raised to address older people by their surnames. My tongue would have gone into spasm if I had tried to say "Good morning Elizabeth" or "Good morning Betty" which sounded fine coming from Martha. Besides, she looked like someone who might have been an authority figure earlier in my life. I could see her as my elementary school teacher or a librarian at the public library who would be watching if I tried to find something racy like *Marjorie Morningstar* or *The Naked and the Dead*. At the least, she was a lot older than I was.

I was filled with awe once again with the power of the processes that were under my control. Where just three hours earlier there had been a loud murmur and a galloping lub double, lub double, lub double at a rate of 110, there was now a gentle lub push dub, lub push dub, lub push dub at a pedestrian rate of 76. The bases of her lungs were almost clear. Her respiratory rate was 16 despite the fact that the oxygen mask was delivering O<sub>2</sub> to her forehead. She was still dull to percussion at both bases and her ankles and lower legs were still pitting to the pressure of my thumb. It would take a few days of continuing treatment for the edema to clear.

“Well don’t you look good this morning Mrs. McCarthy”, I crowed. I had something to show for my lost night’s sleep. I was a little full of myself. Things got even better as I looked at her lab work. She had a crit of 35. Her creatinine was only 1.4 and she was not a diabetic. The cardiac enzymes were normal so far. She had not had an MI.

In the morning light I could see that on my exam the night before I had missed the arcus senilis. It’s a faint, milky, circular deposit of cholesterol around the outer part of her iris. I covered up my discovery by saying; “Don’t you have pretty blue eyes”. I was guessing that her cholesterol would be 300.

Rounds started a few minutes late. My counterpart showed up shaved and refreshed from his twelve hours at home. I became aware of the metallic tasting film that coated my own mouth and I wished that I had taken fifteen minutes to brush my teeth and step into the shower. Unfortunately, the showers were at the other end of the building about a quarter mile away where the residents slept and not worth the effort. I had settled instead for coffee and custard.

Rounds began with Mrs. McCarthy and I suddenly became aware of how little I really knew about her. I knew everything about the last four hours of her life and next to nothing about the previous 79 years. I finessed the history with medical clichés but realized that it would never fly for “attending rounds”. The resident was in the moment. He didn’t care where she came from or what series of events had led her to our ward. He took all that for granted. He was focused on what we (I) were (was) going to do for (with) her. He wanted to discuss whether I thought we ought to tap off some of the fluid from her chest. He was an invasive guy who liked nothing better than to do a thoracentesis or a spinal tap. It seemed like a lot of unnecessary work to me.

The “attending” would want information. He would be looking for all sorts of minutia. What was her family history? Had she ever been a smoker? Does she drink? What work had she done? I had work to do. After rounds I would have a few minutes to fill in the gaps.

The day nurse was just finishing Mrs. McCarthy’s bed bath when I

returned from rounds. I sat down on the metal chair next to her bed and tried to quickly glean the information I needed. I wanted a two or three word answer to each of my questions. Now that she could talk without gasping for breath she wanted to tell a story as the answer to each question. Without a little discipline the process could take hours. She wanted to talk.

I learned that her parents had “passed away” rather young. Her mother died during childbirth in her thirties and her father a few years later of pneumonia. She was the oldest of five and had gone to an orphanage when she was twelve while the younger children were dealt out to various relatives. A sad story that got worse but it did not illuminate her current problem. She became a domestic servant when she left the orphanage at sixteen. She married “late” to a man who drank too much and died in an industrial accident in his early fifties. She had three children, only one of which, her youngest daughter, was in Boston.

When I asked her about her medical history, I learned that except for having children she had “never been sick a day in my life”, or at least did not recognize that she was ill. It had been years since she had seen a doctor but over the last year she had not gone out much and had moved in with her daughter “for a lot of reasons”. She did not go out much because “coming home you have to walk up a hill and I get short of breath and have to stop”. “Doctor, I’m getting old but I wasn’t sick. I’ve just been slowing down”. As I expected, she admitted to a significant weight gain over the last few weeks and a crescendo of her symptoms that she had not recognized until she sat up at night unable to breathe.

It’s an old old story. It was called the dropsy when in seventeenth century England Dr. William Withering first wrote about the powers of a tea made from the leaves of the foxglove plant by old rural women. The tea was an effective treatment for what we call congestive heart failure. It was a struggle but I filled in all the blanks and was ready for the attending rounds before the team tromped off to X ray rounds.

My attending was a well-known cardiologist whom I greatly respected because he was not only a significant contributor to medical science but he was also a master from the old school of bedside clinicians.

Each morning we would try to pick a case from the previous day's admissions that would be interesting for him to use as the focus of teaching us. The intern or a medical student would present the case and then be drilled for information that was missing or not recognized as important. The teaching was usually Socratic, which can sometimes be annoying. Why does the person who knows the answer ask the question? The person who does not know much and would therefore benefit by being able to ask questions is the one who must produce the answers. Socrates was a sadist. Just ask medical students and interns who are educated by constantly struggling with questions they can't answer. I guess it gets you ready for the practice of medicine, which is often about knowing what to do when you do not know what to do. Mostly it's about controlling your anxieties until you know what to do.

Dr. Dexter loved it when I presented Mrs. McCarthy. He was a pillar of the Boston medical establishment and had been seeing older women with CHF for more than thirty years. He was also a grand old professor and loved his role. He was to Boston medicine as Cardinal Cushing was to Boston Catholicism. He had flair and loved the act of charming older women like Mrs. McCarthy. When he took her history he started off with a dignified, "Good morning Mrs. McCarthy, I hope that you are feeling better this morning!" and in a few short minutes she was laughing at a little joke he made and he was calling her Elizabeth. With a gesture he asked and was invited to sit on the edge of her bed. Now she was looking at him on the same level and not up at him standing with a crowd of young doctors behind him. I had the flash that they were both in a position and relationship that they intuitively understood. There was mutual respect but social deference. She might well have been a valued and respected domestic servant who had loyally worked in his home for forty years and took great pride in considering herself a part of his household.

All attendings eventually work the discussion of any case around to a medical subject that is comfortable turf for them. Mrs. McCarthy's history, physical exam and management were home turf for Dr. Dexter. He had an international reputation for his pioneering work in the development of cardiac catheterization techniques to understand valvular heart disease, congenital heart disease, right and left heart failure and pulmonary emboli. He was off and running as he talked to



her and then would look over his shoulder and make some charming remark about her wonderful exam to us. She was his partner in our education. In his hands she was not an object for teaching. Through him she was sharing these wonderful things about herself. When he talked her murmur was characterized as a beautiful sound. He transformed it from something that was a worrisome sign of disease to something that was fascinating about her. I almost wanted one of my own.

Mrs. McCarthy was having the time of her life. I doubt she had ever had so much focus and attention from such an obvious gentleman; or if she had, it had been a long time. As I watched them I was fascinated to see how the color of her cheeks improved as she laughed with him. He brought her to life. He got all the information that I had wanted to get in an easy flowing conversation that did not feel like an interrogation. He knew her neighborhood, some of its shops and the hill she could no longer climb. It sounded like they were neighbors but I knew that they were not. He connected. I was instructed.

As he lead the team away from her bed back toward the larger hallway in front of the elevator, the obvious pleasure he had experienced from the conversation lingered on his face for a moment before his tone became analytical and didactic. He could have talked hours about her murmur and what it meant, not to mention the edema, the possibility that she might also have a pulmonary embolism or be at risk for one. I was relieved. There would be no more questions for me. I relaxed a little.

Over the next few days Mrs. McCarthy gave up 15 pounds of urine to her Foley bag. She took her place on the bus in the afternoon sun. After the Foley came out she walked, at first with a little help from nurses, and then on her own. We struggled with the question of whether her mitral valve needed to be replaced but eventually reasoned that she was doing well with medical management. The decision was based on an increased operative risk because of her age and the fact that she also had significant lung disease, not to mention the fact that she said she wanted no part of surgery.

On the day she was discharged I sat at her bedside. I could not be

comfortable with sitting on her bed. It seemed like her space. We carefully reviewed all of her new pills and for the umpteenth time I gave her my speech about the evils of salt and cholesterol. She understood. Thou shall never eat canned foods, especially soups. Do not partake of processed meats, cheese, beef, ham, eggs or any item upon which you can see salt, like potato chips or saltines. Never ever again put your hand around a saltshaker. Never eat fast food, pizza, or worst of all, Chinese food. Weigh yourself every day and call me if you gain five pounds.

She smiled and said she would do her best. I said to myself, "I better double her Lasix dose and see her back in a week" I excused myself to rewrite her Lasix prescription and reschedule her appointment. She was all set to go. I had never seen her family but apparently someone was coming after work to pick her up. It was my evening off. I was tired and wanted desperately to leave and did. I never met her family.

## **Elizabeth McCarthy's Story, Part 3**

She was discharged on Friday evening. My clinic was on Thursday afternoons. Clinic days were always a stress. Clinic started at 1:30. If you had been on call the night before it was quite possible that your last hour of sleep had been between five and six AM the previous day, thirty plus hours earlier. When you finished clinic three or four hours later, there was still the usual ward work that needed to be done before you "signed out" to the intern who would "cover" your patients for the night. If clinic fell on a day when you were on call, work was accumulating on the ward while you were seeing your six to eight outpatients. Either way, "clinic day" loomed as a distortion in the seemingly endless cycle of days on call and a few hours off.

Despite the stress I always looked forward to my clinic. It was a window to the future for me. Hospital work is episodic. If your practice is limited to the hospital, you see a patient for a few days in the middle of an ongoing process and then return them to the community, hoping that they will remain well and never need return again. If they do return, there is no certainty they will come back to you. I do not pick up a novel and read a random chapter and then return it to the shelf never to look at it again. Even as I began my career in medicine, I intuitively knew that I wanted to be someone's doctor for the long term. If you become my patient, I'm your doctor until you leave the relationship.

Part of the joy of practice is the diversity of patients. It is exciting and challenging to try to understand and help people from all races, all educational backgrounds, all age groups, all cultures, all sexual preferences, and all social situations. I am fascinated by the lives of people. I draw inspiration from the privilege of observing their lives as life goes on day after day and year after year. Years ago I saw the play, "Same Time Next Year" which followed a couple as they conducted an affair seeing each other for a weekend once a year over decades. Practice can be like that. The doctor and the patient become part of each other's lives and go forward together, often not seeing each other for a year or so but immediately renewing the relationship on the next encounter.

Well, it had only been six days and I was eager to see Mrs.

McCarthy. Four months into my internship I had admitted dozens of patients but there was something that seemed especially interesting about her. What was it? Was it that I was the first doctor she had seen in many years and was therefore a different, “fresh” patient, “untainted” by the work of others? She was not like so many of the other patients who seemed to be professional actors who let us “play doctor” with them in exchange for the care they so desperately needed. They would put up with the endless stream of medical students, interns, residents and “attendings” all asking the same questions, doing the same exams. We would argue the findings and observations seeking to demonstrate superior knowledge and insight. We often had our debates at their bedside as if the patient were in a coma or totally uninterested in what seemed to the medical personnel to be so fascinating a problem. In the tradition of the medical wards of city “teaching” hospitals they bartered their “teaching value” for their health care. This transaction had been the backbone of medical education in Europe and America for over two hundred years. It was not immoral; it was perhaps insensitive and impolite. We thought we were benevolent with the patient’s best interest as our motivation. It was the way we trained doctors. Mrs. McCarthy was new to this transaction and I was the only “young doctor” she had experienced. Maybe there was some other explanation. Perhaps I just really was interested in knowing how she was doing. I wanted to read the next chapter in her story.

I had thought about her frequently during the six days since she had gone home. I was worried that I had increased her diuretic too much as she left and as a result her potassium could be dangerously low. If I over diuresed her, perhaps her renal function had deteriorated and now she would not “clear” her digoxin and would be poisoned by excessive accumulation of the drug in her blood. I was sure she would have difficulty following a low salt diet. Perhaps she would have retained fluid. There were a thousand things that could have gone wrong. Seeing her was the treatment for my anxiety. What if she did not keep the appointment? I could have called her but that would have exposed my uncertainty. I was just as sure that she would be well as I was sure that something bad had happened.

The clinic was housed in a wing of the old student nurses’ residence at the opposite end of the hospital from F2. Sometimes when I

walked the quarter of a mile to the clinic I would revel in the thought that I was walking the same path of many famous Brigham doctors. As I walked past the door to the operating room, I knew Harvey Cushing, a pioneer of neurosurgery, walked this same hall on the way to remove a pituitary adenoma that was causing Cushing's disease. Joseph Murray walked into the same OR to transplant the first kidney. Just above me Sam Levine, one of the greatest of all clinical cardiologists was brave enough to get people with heart attacks out of bed and up in a chair when common wisdom kept them in bed for weeks. Soma Weiss the brilliant young physician whose last diagnosis was his own exploding aneurysm must have walked this hall on the last day of his life. George Thorn, who was retiring as chief of medicine this very year and was a pioneer in endocrinology, sped up and down this route everyday checking out research on E Main that was supported by his famous patient, Howard Hughes.

The Peter Bent Brigham Hospital was built in 1913, the year we invented income tax, a death and taxes connection? The hospital was spread out behind the new (1903) site of Harvard Medical School. It is a perfect example of how the solutions to today's problems are tomorrow's problems. The Brigham was built before the era of antibiotics when infectious disease was the most dreaded enemy. The new hospital won architectural awards for its revolutionary design. It was a campus. There was a central administrative building with Grecian columns at the end of a park like drive that passed through decorative iron gates leading to Brigham Circle and Huntington Avenue. On the right side of the drive parallel to Huntington Avenue which flowed from Olmstead's Emerald Necklace toward the Museum of Fine Arts and Brahmin Boston's Symphony Hall were the nurses' building and the clinic. To the left was the "A" building for private patients. The other buildings spread over the acres to the west. They were lettered "B", "C", and so on down to "F". Over the years other buildings appeared like metastases between letters and along Shattuck Street, the alley way between the hospital and the Medical School, the Harvard School of Public Health and Children's Hospital.

The original idea was that disease would be confined to a single building and the doctors would have to walk through fresh air and sunlight as they went from one building to the next. I do not think it

took many Boston winters before the buildings were connected by a covered walkway, which became “The Pike”, and below that ran the subterranean tunnel through which I rolled Mrs. McCarthy on the night she was admitted.

I liked “The Pike”. Running to a “code” or walking fast to get to clinic on time was the best exercise I got in the five years of my training. On this day I was hurrying to clinic not wanting to be late and in a state of great fear and anticipation of what might await me. I ran up the stairs to the second floor and there she was sitting on a metal folding chair along the wall of the corridor that served as a waiting room. She looked like a well person. She was dressed in a simple cotton print dress with blue and pink flowers and wore a slate gray cable sweater that looked hand made. It had pockets that looked useful. She wore laced black two-inch heeled shoes which as a child I had called “old lady” shoes. My grandmothers and all the older women at church wore them. I noted little mother of pearl earrings and she looked like her hair had an added wave. It had a faint blue tint.

I sang out to her, “Hello Mrs. McCarthy, how are you doing? You certainly look nice today.” I was delighted with her answer; “I’m very well and thank you Dr. Lindsey”. I collected her record from the clinic office and escorted her into my “office”. I spent the next thirty minutes asking her all the right questions. I reviewed her physical exam. I talked with her about her diet. I was pleased with my management of her congestive heart failure. She was doing well. I asked her to wait for a few minutes while I walked down the hall to review my plans with the clinic “attending” who was hanging around chatting with the clinic secretary and drinking coffee. He seemed a little annoyed with my intrusion and quickly signed off on my assessment and treatment plans.

When I walked back into the room she was staring out the window at Huntington Avenue and the people waiting for the trolley. She looked a little sad. I had not seen the look before. I asked her if she was feeling well. She quickly composed herself and said that she was fine. “I was just thinking about the trip home. I hope it doesn’t rain.” I asked her where she lived and did she ride the Green Line. “I used to have a nice apartment of my own in a “three family” just up the hill. She pointed to Mission Hill, which rose out of the eastern side of

Brigham Circle. The Robert Breck Brigham Hospital sat on the crest of the hill like a medieval castle, which looks down on the peasants in the town below. "Now I have a room in my daughter's home in Jamaica Plain." Her tone and inflection communicated loss and an unwelcomed transition. It sounded lonely and isolated. I had a "nice apartment" contrasted with "now...a room in my daughter's home."

I asked if she still visited friends on Mission Hill or went to the Mission Church. "Most of my friends are gone and I just don't get out much." I remembered the hill she had to walk up to her daughter's house and now to her "room". I started making clumsy suggestions about meeting new friends and finding a senior center. She listened politely. I eventually talked long enough to bore myself and recognize the futility of the situation and finished with the thought that maybe before long she would feel well enough to ride the trolley all the way into Filene's Basement and would not that be great? I guess that my thought was that Filene's Basement must be every woman's idea of a great day out. She told me that she did not get much Social Security and that was why she lived with her daughter. I got the message. If you do not have any money to spend, why would you want to go downtown?

"Well now, let's figure out when you should come back". I suggested a month would be about right and then realized that would be Thanksgiving Day. "Well why don't I see you the first Thursday in December."

Her response surprised me, "Shouldn't I come back sooner?" We settled on the Thursday before Thanksgiving. She left for the lab to have the EKG and blood tests that I had ordered. After she was gone I sat at my desk trying to write my note about the visit into her chart. I felt a little sad and unsure about what had happened. I was reassured that her condition was stable but somehow I was not at all sure she was well.

There was a time when I would say that I was not drawn to medicine because I was fascinated by the study of diseases. I did not become a doctor to advance the science of medicine. It is was not the challenge of promoting health to people by trying to teach, cajole, or convince them to make healthy choices in their lives that called me to

medicine. I am committed to using any tool, including fear-inducing projections of disasters to come, to promote health, but I didn't become a doctor just to be an evangelist for health. After the list of why "I didn't become a doctor to..." I would facetiously say, "I became a doctor to be a voyeur, a peeping Tom through the windows in the lives of people". I never believed it. I just thought it sounded interesting. It was sort of an explanation for my atypical orientation toward clinical practice in such a specialty and research-oriented environment as Harvard Medical School and the Brigham. I was a student of sick people, an observer who was passive and maybe a little titillated by the excitement and drama of medicine. Sitting there after she left I felt strangely vulnerable. It was not sure on which side of the window I stood.

The next three weeks passed quickly because I was finishing my time on the women's ward and looking forward to my vacation on the "TCC". There were a few easy "rotations" during the internship. When you finished the wards you were given R&R on E Main, which was the previously mentioned research unit of Dr. Thorn that was officially called "The Clinical Center". It was an endocrine metabolic unit. There were also a few cardiac research patients on E Main. Sometimes patients were even paid to be there to participate in research.

I remember almost nothing about the TCC except meeting a very shy young man with a brain affliction that drove him to eat. He weighed almost 700 pounds. I think I slept for most of the month. Mrs. McCarthy was on my mind for the first few days after her visit but then life on the ward and things away from the hospital filled most of my consciousness and Mrs. McCarthy's face popped up in front of my mind's eye only from time to time. I would quickly flip through her problem list in my mind and set myself at ease realizing that each problem was well addressed and then let go of her image for another day or so.

The Thursday before Thanksgiving was one of those late fall days that serve as a preview of the misery to come over the next five months. An intermittent cold drizzle was occasionally interrupted by snowflakes and a penetrating gust of wind. It was so nasty outside that I was surprised to see her sitting on the cold metal folding chair



in the corridor. She still wore a clear plastic rain cap that tied under her chin. Her old beige raincoat was soaked and a plaid umbrella was standing in a little puddle and leaning against the wall.

"Mrs. McCarthy you are soaked! Let's get that coat off of you," I said with genuine concern. "I'm fine Dr. Lindsey. There will be plenty of days worse than this one before long." As I escorted her into the exam room I said, "You must be feeling well to be able to get here." She shocked me by saying, "Dr. Lindsey, I would have to be almost dead before I would miss my appointment with you." I was startled and a little confused. I stammered, "Why that is a real nice thing for you to say."

We had a typical appointment. I was pleased with her exam and decided that I would repeat her chest x-ray. I wanted to see, hoped to see, that her heart was smaller. I was pleased that her heart rhythm was regular and her rate was 75. I sent her to radiology and moved on to my next patient after telling her to come back with the film.

After about a half an hour she was back in the hall sitting patiently with the big manila x-ray jacket on her lap. I walked over and said, "Would you like to see your picture?" She indicated that she would like very much to see the picture. We walked down to the viewing box at the far end of the hallway and I flipped up her current x-ray and the film from the night of our first meeting in the EW. "Wow, look at that," I exclaimed. Her lung fields were clear. The pleural effusions were resolved. The heart was appreciably smaller. "What do the pictures show?" she asked. I led her through the appropriate findings as if she were an eager medical student. A comment my dad once made flashed through my mind. "Give most people credit for the ability to understand anything you're smart enough to explain in plain English". When I was finished with the presentation she exclaimed, "This is so interesting. Thank you so much for showing me my x rays." In reverent silence we stood side-by-side for a moment and soaked in the beauty of our collaboration.

I broke the moment by saying, "Let's go in the office and make our plans." She sat down by my desk as I wrote out refills for her prescriptions and completed the liturgy of the visit by reaching for my calendar to set the next appointment. She seemed very disappointed

when I suggested that she was doing so well that a return in two months would be quite appropriate. Her face had fallen so far in an instant that I quickly recovered by suggesting that she return the Thursday before Christmas. As she left the room she turned around and surprised me by saying, "I'm sorry but could I touch your hair." She was too fast for me. Before I could answer she reached up and patted the hair behind my left ear that hung close to my collar and said, "It is no fair. Some woman should have had that hair. I've wanted to touch your hair for a long time." She seemed very pleased with herself as she left. I called out weakly, "I hope you have a very nice Thanksgiving." Once again I sat down to write up the visit, not quite sure what was happening.

The holiday season and internships don't mix very well. I worked on Thanksgiving, which meant that I would have a couple of days off for Christmas. My wife and two little boys came for the turkey served in the cafeteria to the house staff and other employees. The oldest boy ran up and down the deserted "Pike" while my wife and I bravely tried to remind ourselves just why we were there at all. We lived in expectation. The previous seven years had been one long exercise in delayed gratification. I had the feeling that she had naively hoped that things would be easier after I graduated from medical school and began to earn a small salary. We did have a few more dollars. No one could have prepared us for the stress that the year would bring to every other aspect of our life together. The day itself was one huge representation of it all. Our families were gathering without us a thousand miles away. For the first time the issue was not whose parents do we see at noon and whose do we see in the evening. Those days were finally over. The hospital would be my world for some time and it was not really a family experience.

As I walked them to the car the little one rode on my shoulders and held onto my hair like the reins of a horse. He got great pleasure by turning my head right then left as if controlling my direction. I followed his lead and he was giggling with delight. Their departure was interrupted by the intrusive sound of my beeper. The beeper can kill any conversation or put inflection in any moment no matter how sensitive. It is almost as if someone is watching and then just at the least opportune time from my point of view gives a signal to some cosmic operator or shouts, "OK, hit it now!" Thanksgiving was over

with the beep and they left quickly. I watched them from the sidewalk as they pulled away to go home to Newton in the failing late afternoon light.

The anticipation of Christmas and a few days off carried me over the next few weeks as we used every spare moment like a precious gift. We took bits of time to find and decorate a tree, visit Santa Claus at Jordan Marsh and build the momentum of the season for the boys. I don't remember thinking about Mrs. McCarthy at all.

## Elizabeth McCarthy's Story, Part 4

When clinic day before Christmas arrived, I suddenly remembered she would be back. I felt a little guilty knowing that I had not given her a thought for weeks. As I topped the stairs to the clinic, I saw her sitting forward on the metal folding chair in anticipation of my arrival. She had a radiance that was immediately observable. She looked very healthy and happy. A very obvious Christmas gift was only partially concealed in a brown bag, which she held carefully on her lap. She spoke first. "Oh, Dr. Lindsey, I'm so glad to see you", she said. "It's so nice to see you too," I replied. "You certainly look like you have the Christmas spirit."

I opened the door to the office and held it for her as she picked up her things. She collected her black wool coat that sported a Santa Claus pin on the lapel, her "special" package and a large tote bag filled with her purse and sundry other items and then preceded me into the room. We were into the room for only a second before she dropped everything but the "special" package and sat down with a sigh. She reached up to me, held out the gift and exclaimed the obvious; "I've brought you a Christmas present." I raised my voice a half tone and squealed, "What a nice thing for you to do for me, thank you so much." We did the usual verbal dance. "Oh, I hope so much that you will like them. I made them myself." "What do you mean, them?" I said. "Oh, you'll see," she said. "Open it, open it, please open it now".

I carefully removed the ribbon and the paper. Inside the box were three bow ties. She immediately said again, "I made them myself, I so hope you like them. I love your ties and wanted to make you some that you would really like." They were beautiful and I said so immediately. I was impressed. One tie was a dark burgundy Batik print. There was a flower child lavender tie that was wider than the Batik tie. It was a real butterfly. It had yellow daisies with wispy green stems. It was the kind of tie I loved to wear. I would stand at the mirror and tie a bright tie in the early morning light and say to myself, "Do I really want to wear this". A little debate usually ensued and then chances were I'd take the new tie off and go with an old reliable friend. It usually took two or three aborted attempts to get out of the house with a really distinctive tie. When I finally overcame my better judgment in favor of flare and controversy and made it out of the

house where change was no longer possible and I was committed to the new tie for the day, I was always exhilarated.

The third tie was a Christmas tie. It was red with green wreaths and bells. She looked at me with a slightly cocked head and a smile and said, "Merry Christmas." I was flabbergasted. Each tie was a work of art. I found most of my ties on the sale rack at the Coop in Cambridge. Occasionally I would impulsively buy a distinctive tie in someplace like Filene's Basement as I followed my wife around town on a Saturday afternoon with the kids in tow. She was a recreational shopper. The ties that I now held could not be purchased. I was quite moved and very pleased. I did not know what to say so I just turned them over in my hands admiring them. They were individually wrapped in tissue paper. I unwrapped and rewrapped each one as I admired its individual qualities and speculated out loud about where I would wear it and the sort of reaction I would get. The ceremony ended with a final pronouncement, "This is the best gift anyone has ever given me, Mrs. McCarthy", and I meant it. There was something exhilarating about receiving a gift from a patient. It was a brand new experience for me.

The remainder of the visit was downhill. She was doing very well. I reduced her dose of Lasix. We reviewed the lab tests and the official x-ray report which corroborated what we had observed when she had the x-ray on the last visit. No doubt about it she was much better.

I had a dilemma. She was better and really did not need to be seen again in the three or four-week cycle of the last few visits but intuitively I knew that she would be unhappy if I announced that she did not need to return for two months. My clinic schedule was getting heavy. With only one afternoon a week to see return patients, I needed to manage my appointment availability carefully to prevent overloading the schedule. Were the ties a bribe? I did not think so. Would she be unhappy and look downcast if I suggested she should come back in two months? It was a definite possibility. I was losing my objectivity.

"Mrs. McCarthy, you have done a great job with your medications and diet. You really must be watching your salt. I bet you are feeling a lot better. Are you beginning to get out and do things?" She replied, "Dr.

Lindsey, I really don't have anywhere to go. I try to help around the house but mostly I stay in my room where I won't be in the way."

As on a previous visit, I began to try to think of suggestions that might help her break out of her isolation. I knew it was a futile exercise but I tried. I said, "We know that you are able get to your appointment and home again riding the T. It would be the same ride if you were to try to visit some of your old friends on Mission Hill". I gestured in the general direction of the hill. "I bet you have lots of friends you could visit in your old neighborhood," I said.

She looked at me with a skeptical expression that I had never seen on her face, "Calumet Street is very steep Dr. Lindsey, and even if I could climb the hill all my friends are dead or have gone to a nursing home. I told you this before. I really am all alone. My friends are all gone." I decided to hold my counsel. I dropped the fantasy of advising her out of her circumstances. She would have to find her own way to make herself happy.

I changed direction and abruptly ended the visit. I had done all that I could do this day, "I hope you have wonderful holidays Mrs. McCarthy. I decided that I would split the difference. She had waited four weeks from the last visit. Two months was more appropriate. Six weeks would be a compromise that moved the interval toward the more appropriate level of frequency. Maybe next time it would be two months. I announced, "I'll see you back at the end of January in about six weeks. I know that you will do just fine as long as you take your meds and watch your salt. Knowing you, I bet you will have found a lot of things to do with your new energy. I can hardly wait to hear about all your adventures when I see you next time. You can call me anytime if you think your condition is changing."

The appointment was over. Its mood had started high and then swung low. I could not figure out why such a medical success left me feeling like such a failure and why I was so worried about someone who was clearly better in every way that I could measure.

Christmas was a great relief. Half of the interns had three days off at Christmas and the other half had three days off for New Years. It pretty much split along religious lines. My little boys were thrilled with

my continuous presence for such a long time. It was not enough time to fly home to the South. So for the first time we had our “own” Christmas. I wore my Christmas tie to church and it was noticed. People asked me where I got it and I was more than proud to say that it was a handmade gift from a patient. My favorite tie was the Batik. Its dark burgundy and black tones looked mysterious and unusual.

During early January she popped into my head frequently and especially when I wore one of her ties. I thought about calling to see how she was but somehow did not get around to the task. January was very, very cold. For more than three weeks the temperature failed to break the freezing point. It snowed several times. I like snow. It always excites me like a gift. I love the veil it puts over all the ugliness of the tired city when it first falls. Snow creates urban adventures. I feel like a pioneer when it snows. Every task of daily living becomes a little challenge. We had a thaw a few days before her appointment. The temperature was over forty for three days. I thought it was a good sign.

Once again I was excited when the day of her appointment came. It would be good to see her. I decided to wear the lavender tie. I had finally made it out the door with the lavender tie still around my neck. I rushed down the pike and ran up the stairs to the second floor where the clinic was located. Then I stopped short. She was not there. Other patients had arrived but she was not in her usual metal folding chair near the top of the stairs. I asked the secretary if she had come and perhaps had gone to the restroom but was told that she had not checked in yet. I waited for fifteen minutes but she did not come.

The second patient was waiting and so I saw him. I kept glancing out the door all afternoon. I would walk to the window and try to spot her on the street coming off the T. Maybe there was one of the frequent interruptions of service further out the line in Jamaica Plain where she lived. Maybe she thought her appointment was next week.

By the end of the afternoon I had considered at least a dozen possible explanations for her failure to show. I had looked up and down the hall between each visit. I thought that perhaps she had fallen on the ice and had broken her arm. She might be in the EW. The EW would never think to call the clinic. They probably would not

call me even if she asked them to do it. I knew those secretaries in the EW. They put people off all the time. The secretary would probably have said, "Sure honey, don't worry. I'll give the clinic a call in just a minute". Then she would forget to do it.

She might even be there languishing in pain waiting for her turn to be seen. She might still be in the EW waiting room. She could be in x-ray. I worried and waited but she never came. By the end of the afternoon I was anxious and unable to concentrate on what my patients were saying. I was worried sick about her. Something must be wrong. I did not know her well but I knew her well enough to know that she wouldn't forget to come nor would she just decide to skip an appointment.

Earlier in the fall I had a patient who did not show up for an appointment and I called his home. His son answered and said that he was sleeping. I asked the son to wake him up so that I could speak to him. The son came back to the phone and said his father was "breathing funny" and would not wake up. We sent an ambulance and the man had a respiratory arrest on the way to the hospital. I could not let myself believe this sort of thing could happen twice in the same year. There was some logical explanation for her missing the appointment. Whatever the reason was, I had not thought of it. It was time to find out the answer.

I sat at my desk for a few minutes looking at my clinical notes. Everything was perfect. All her labs were normal. Her x-ray was improved. Finally I turned to the front of the record where the telephone number was recorded. I was filled with apprehension. I dialed her number.

A man answered. My voice was unreliable and sounded strange to me as if someone else was saying, "This is Dr. Lindsey, is Mrs. Elizabeth McCarthy at home? I missed her in clinic today". There was silence at the other end of the line. After a long time the silence was broken by a matter of fact, flat toned announcement, "She's not here. She has been dead for three weeks." I felt like I had been hit in the stomach with a two by four. I stammered, "Would you please tell me about what happened?"



There was another long pause and then the voice spoke with a little more inflection and a hint of feeling and fatigue as if it was about to tell a story it had told before and was tired of delivering, "She liked you a lot Dr. Lindsey. She talked about you almost every day. We should have tried to call you but we didn't. I guess we've been too upset to try. She just left her room one afternoon without speaking to anyone. She rode the T downtown. Sometime later she must have jumped off the platform in front of the train." I could not speak. After a moment he continued, "We really did not know where she was for several hours but then the police called us. I'm sorry we did not call you. We tried to help her but she was never happy here. She always said she was a burden and that there was nothing in her future. We thought she was just upset about having to leave her apartment and would get over it."

I gave him my condolences and asked him to call me if there was anything that I could do. I sat at the desk for a long time. I could not finish my clinic notes. I could not comprehend what he said. I did not believe it. I could not imagine her taking her own life no matter how unhappy she was. Even if she did choose to end her life, I could not imagine her choosing such a violent form of suicide.

There was some other explanation. It must have been an accident. Maybe she finally decided to try my idea and go downtown. Those platforms can be crowded and tight. Late in the afternoon when people are headed home from work and shopping they shove and push their way to where they think the doors will open so that they will be sure to get on the train and maybe even get a seat. Perhaps she was shoved and accidentally fell off the platform. It was a tragedy but I knew she did not jump. It's possible that she had an arrhythmia and collapsed while standing just at the line on the edge of the platform. As she dropped, she could have fallen off the platform into the path of the oncoming train. There was always a crowd in those underground T stations downtown and anything could happen in a crowd.

Who could know what really happened? I was angry that her son-in-law implied that she had jumped to her death. I had never seen him during the entire time she was in the hospital. Why hadn't he and her daughter made her feel welcome in their home? There was probably

a lot of family tension and perhaps some long held anger over something that should have been resolved decades ago.

I found myself halfway down The Pike and did not remember leaving the clinic. I could not cry but could hardly breathe. I felt weak. I felt lost. I felt so terrible. I had never felt this way before. Halfway down the pike off to the right behind the blood bank there was a dirty room with vending machines and scarred Formica topped tables surrounded by folding chairs in various states of disrepair. The tables and chairs had graffiti scratched into their surfaces. Many of the messages made impolite comments about the hospital management. The escort messengers and dietary workers hung out there during the day. It was one of the few places where they could go to smoke and relax.

No one was in the room. Sometimes I would go there and buy a candy bar or a drink from the machines. It was dark outside and the room was gloomy because it had no windows. The air was stale from old cigarette smoke. I collapsed into one of the chairs and dropped my head into my hands. I sat there a long time. I sat there until my trance was broken by the sound of my beeper.

There was no phone in the room. I did not care. I did not move until the beeper called again. I realized I would never know what really happened. Did it make any difference? I had not really helped her in any lasting way. She was dead. In some way I felt I must be responsible.

I took off the tie and just looked at it for a long time. I can't remember if I put it back on then or not. I needed to answer my page. I had responsibilities. It would probably be a long night. As I walked out of the room and turned onto the pike I saw my resident. He was well on the way to being a famous clinician and scientist. I told him about Mrs. McCarthy. As my beeper went off for the third time he shrugged and said, "Strange, get over it".

I don't have the ties anymore. I don't remember what happened to them. I could not look at them again. Several years later my marriage ended and maybe that's when I lost them. I know that I never wore them again. Mrs. McCarthy's face still pops up before me in my

mind's eye from time to time. I have also seen her looking at me from behind the faces of other patients over the thirty years that have passed.

I guess that I could write a book about what she has meant to me and how knowing her has impacted my practice of medicine. I always have a very full office schedule because I've never learned to manage my schedule well. Perhaps in part because of her, I always try to be available when patients say that they need to see me. She taught me that I should be looking for more than just a disease to treat.

Congestive heart failure is fascinating to treat and over the intervening decades my academic colleagues have added greatly to our understanding and management of the diseases of the heart. Never the less, sometimes the circumstances of life create heart ache in the lives of patients that is often harder to help or treat than angina, edema and shortness of breath.