

MATERIA MEDICA

Vigil

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We pressed our ears against the door. Silence. I looked to B. He knocked timidly.

A few moments passed. B pulled the latch. We entered.

A pause. It was late in the evening, and I was on night call with my intern, B. We had come to visit Mrs. A, a patient of ours on the medicine service.

A faint light suffused the room with a pale glow. Scattered around were Mrs. A's family: children, grandchildren, nieces and nephews. Some were piled onto the empty patient bed next to Mrs. A's; others sat in chairs, bundled in hospital blankets; still others stood silently in the shadowy recesses of the room. Towards the end of this crowd, which must have numbered over twenty, were Mrs. A and her four daughters who huddled quietly around her bed.

We weaved through to reach Mrs. A. Upon seeing us, one of her daughters leaned in to alert her mother to our presence, speaking softly in a dialect of Portuguese that resembled a humming lullaby with its whispered *z's* and *v's*.

Mrs. A lay dying. She had presented to us a little over twenty-four hours ago. The daughters had accompanied her in. Yesterday, they were comfortable. They thought their mother had a minor bleed. *She had had one in the past*, they said. *It had been successfully fixed*. They had been through all this before. They were bringing the family up in a few weeks for the holidays.

They did not understand when we told them we could do nothing for their mother. They were angry when we suggested she should be considered for hospice care. They wept when they learned she did not have much time left.

That night, they sat ashen, staring alternately at their mother, the ground, at us. Their eyes were distant. Lost.

On exam, she was bloated, swollen, and in pain. The skin over her legs looked so taught it could burst at any moment. Her lungs sounded wet. Her anasarca belly gave way boggily under our hands.

We replaced her covers. Lying over the surface of her sheets was a rich embroidered velvet blanket, vermillion, with a golden embroidered trim fashioned in what I assumed was a traditional style. On second glance, perhaps it was a dress? Or maybe a shawl? She could have worn it previously, in happier days.

We asked the family if they had questions. *No*. We asked if there was anything we could do. *No, but thank you*. We left in silence. At the door, I looked back at Mrs. A. One of her daughters was gently stroking her hair. I turned to look at the

family. In spite of the lateness of the hour, in spite of how emotionally spent they must all have been, they were all awake. They were keeping vigil in Mrs. A's final hours on earth.

To be a physician can at times feel unsettling. To perform our duties well, we may be called upon to be present in the most difficult moments in our patients' lives. While they may not be total strangers, they are people whose experiences, history, memories, and families are more unfamiliar to us than not. Yet, our profession demands we flout our aversion to intrusion and our respect for private suffering and delve, unapologetically, into the most intimate and vulnerable moments of our patients' lives.

And what responsibility we must take on in such moments! To us patients and families look for guidance in plotting the course through challenging times. To us they turn for knowledge, leadership, compassion, and reprieve: when B and I entered the room, the family parted way for us. They looked on as we performed the ritual of our exam, the ritual of our evaluation, the ritual of our entrance and exit. As clinicians, we, like the family, were actors in a play. In the final hours of Mrs. A's life, we too had roles to which we were assigned in the sanctitude of that space.

At the end of a patient's life, it is often we who guide them through their final hours on earth. As medical students, we learn about mechanisms, diseases, and differentials. Yet, little are we exposed to the events at the end of life, and ill equipped are we to handle this seemingly superhuman responsibility. Even in our clinical year, when we learn to manage patients and grow in our clinical independence, our experience is sanitized, curated, and filtered. Hardly ever do we see the "difficult" cases. Almost never are we given the patients that are "not a good fit for medical students." Inevitably, some patients will die in the hospital, but by learning in an environment of *PG* medicine, we become woefully unprepared to cope with the experience of death. Is it any wonder then that when we do become residents, we feel uncomfortable and underprepared in managing our patients at the end of life?^{1, 2}

To care for someone nearing the end of life is a sacred privilege which privies us to some of the most personal



facets of the human experience. Being present for the family and bearing witness to their sorrow not only challenges us to be more compassionate and present clinicians, but also can be how we best care for our patients. In order to be present, we must learn how to do so. Should we learn to play our part well, I believe we can make the journey at the end of life less terrifying, less unrelenting, and perhaps, a little less lonely.

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Later that night, I said a little prayer for Mrs. A. I was not sure anyone was listening, but I hoped that perhaps, someone, up there, would. Perhaps too, Mrs. A would know that B and I witnessed her suffering, that we were present in her final moments, that we, however briefly, guarded the embers of her soul—a vigil of our own.

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