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Humanities and Medicine

UBI SUNT? REMEMBRANCE OF PATIENTS PAST

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Like so many of my colleagues who are nearing the ends of their careers, I am spending a fair amount of time lately reflecting on some of my past patients. And when I do, I find myself asking, "Ubi sunt?," meaning, "Where are they?" in Latin, with "now" implied, as in "Where are they now?"

"Ubi sunt?," a literary device going back hundreds of years, refers to the futility of imagined permanence, the fragile remembrance of even famous men and women and the ephemerality of fame—theirs and, for that matter, everyone's. For example, in Baruch, 3:16–19, in the Vulgate Bible, we read:

> 16 Where are the princes of nations, even those who ruled the beasts that were all over the earth? (Author's translation from the Latin) (1)

Thirteen hundred years later, in a well-known poem to his father, Jorge Manrique asks an Ubi sunt?, which Longfellow famously translates as,

> Where is the King, Don Juan? Where
> Each royal prince and noble heir
> Of Aragon?
> Where are the courtly gallantries?
> The deeds of love and high emprise,
>
> In battle done?
> Tourney and joust, that charmed the eye,
> And scarf, and gorgeous panoply,
> And nodding plume, -
> What were they but a pageant scene?
> What but the garlands, gay and green,
> That deck the tomb? (2,3)

Marcus Aurelius is also fond of "Ubi sunt?," reminding the reader that famous historical personages like Caesar are now, as their fame will one day soon become, dust:

> The customary expressions of long ago are now unfamiliar. So too are archaic, in some sense, the storied names of those long ago days: Camillus, Caeso, Volesus, Dentatus, a little later both Scipio and Cato, then too Augustus, then too Hadrian and Antony. For all legendary names quickly perish, and quickly does forgetfulness wholly overtake them (4). (Author's translation)

And so I ask myself, "Ubi sunt?," with respect to a host of memorable patients.

Where is that 20-something-year-old man his friends brought in, early in my career when I was only 10 years older than him, for pouring half a bottle of ketchup into his soup at lunch in front of them? A few more questions elicited some headaches in his history. His CT scan showed a glioblastoma multiforme. I hope he is ok but I fear he is not.

And where is that high school senior? The local high school football team's fullback whom I had instructed to scrub the blisters on his hands himself, blisters he had gotten from using a lawn mower that summer. I told him he could do the same job as I at the sink in room 8A—this was five or six ED renovations ago—but more gently. I watched him scrub his hands at the sink. As he turned around and came back to me, he became ashen and began to faint. He was a big 17-year-old, but I was able to catch him before he hit the ground.

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While still in my arms he began to have what appeared to be convulsive activity.

An old-time neurologist happened to come by, both to his aid and mine. This neurologist, whom I knew well, had trained at Columbia (where I had attended medical school) under the great Houston Merritt, the researcher who had put Dilantin on the map. Tommy re-assured me, as only an old-fashioned (read "clinically experienced") neurologist could, that this was not a seizure but—and I do not remember his words precisely—what is often mistakenly referred to in the literature as a "syncopal seizure," or "convulsive syncope." And thus began my love affair with that benign phenomenon, which is really myoclonus, reading dozens of papers to research a paper I would never write. I wonder where that man is now, in his late 50s probably, most likely still residing in West Hartford, and how he is doing. No—I did not think then to write his name down for follow-up, not realizing that some 40 years later I might be writing this essay and asking that question. I hope his blisters healed okay.

And where is, and how is she doing, the woman I fell in love with 20 years ago, albeit transitorily and unbeknownst to her, and only poetically, who came in with a sewing injury to her finger? Her name was a variant of Green so I began a series of three poetic riffs—since I happened to see her twice more for follow-up—on her name and Lorca's wonderful poem "Verde que te quiero verde" (5).

And where he is now, the 16-year-old high school junior who came into our ED drunk—this in a different city in a different state, in a much earlier lifetime—having decided, since he was drunk and 16, to try his inebriated hand, and feet, at a trampoline. He landed off the trampoline upside down on his head. He came in mumbling, "I am wasted; I can't move anything," having absolutely no idea, since he was drunk and 16, that he had just passed through the one-way turnstile of quadriplegia. I called the neurosurgeon. A young attending only a few years older than me arrived, saw the patient, the C-spine films (this is mid 1970s and pre-CT), and walked out, shaking his head. I waited for the parents to arrive. They did, and were only a dozen years or so older than me. I watched them enter the room with the neurosurgeon and then looked at my watch, waiting for it. [Like Proust's Dr. Bergotte, I could, given a clinical clue, confidently tell the future (6)]. It was a minute, perhaps 2, before I heard his mother's wail. I can hear it now. I'll always be able to hear it now.

Some "Ubi sunt?"s are somewhat pleasant, somewhat mysterious. Take, for example, the middle-aged judge who came in for plain old community-acquired pneumonia about 30 years ago. At the end of the visit, as I was discharging him, I said, not too sternly, "You really should quit smoking"—an admonishment I had uttered only 100 times before and would utter some 300 times after.

About 2 years later I was wandering through the local shopping mall and saw him. We both said hello and then he said, in all seriousness, "You saved my life." I looked at him trying to decide whether he needed an LP or a tox screen. But he meant it and explained: "Because of you, I stopped smoking."

That was when I first learned that our words, coming from us *qua* physicians, carry meaning and force, at least for some patients. And since we cannot know beforehand which patients listen and which do not, it behooves us to give good advice whenever we can. To all.

Unfortunately, I know only too well where many of my patients are. Like the man who came in with AFib and rapid ventricular response, with whom I had a brief discussion, as I ordered the Cardizem, about the unusual spelling of his last name. The nurse, whom I loved to pieces when he was helpful (most of the time) and not so much when he was a pain in the rear (often), asked me a few minutes later if we could move him out of the acute care section of our ED. I remember saying, since it was an expression I had first heard when it was being applied to my dying father when I was 17, "He's not out of the woods yet," meaning my patient's heart rate was still about 140-150 beats/min. And then—welcome to clinical medicine—he arrested. No reason; no warning; no antecedent case like that in my experience; no case like that since. He just arrested and died. I went out and asked the first attending cardiologist I saw in the ED what she thought about it. She just shook her head. I recalled the unusual spelling of his name as I filled out the death certificate. What did I learn from that? About AFib with rapid ventricular response? About medicine? About life? Nothing. Or perhaps I did: Welcome to clinical medicine. But I already knew that.

Or the woman I came to like a great deal—this was in my internal medicine days, some 45 years ago. Not old enough to be my mother, she could have been a young aunt. She was in the ICU for a chest pain admission and was my sixth or seventh admission that night. I walked in about 3 AM—4 hours or more since she had arrived—sat down to take her history and promptly fell asleep. She didn't wake me, figuring, correctly, that I needed it. When I awoke about 40 minutes later, I apologized and admitted her. In the morning, the cardiologist, an incredibly bright but ornery and eccentric fellow Brooklynite, felt that this was not coronary insufficiency pain, pushed on one of her ribs and diagnosed metastatic breast cancer to bone. Over the course of several more admissions, I would always visit her—benefits of an internal medicine program in a small hospital. She was a very spunky lady. Before she died, we became great friends. I miss her still.

Like many physicians, some of my more memorable patients were not even mine. RT was a 65-year-old woman who was always in for bouts of congestive heart failure. Not her fault. Not poor compliance. Poor meds—about all we had then was furosemide and digoxin. (This was the early 1970s, when we still were not sure how nitroglycerin worked, and quinidine for atrial flutter was standard operating procedure.) I may have taken care of her once or twice but we all knew her, always saw her, and, most memorably, would always see her faithful son, always in his U.S. Postal Service mailman uniform, walking the halls at the end of his day in search of his mother's exact location on the third floor of our hospital. (Neither snow nor rain nor heat nor gloom of night stayed this devoted son from his appointed visits.)

Several years ago I did what we all do when we need an answer to an "Ubi sunt?" With a little help from my friends at Google, I found her name in the alumni magazine of my hospital. It was the eponymous memorial fund her son had established for her. God bless him then. God bless him now.

And others I do not want to know "Ubi sunt?" Especially the ones so early in my career. Like the 14-year-old with lupus cerebritis—this is 50 years ago now—whose name I still remember as well as my own—to whom—this is decades before the likely assistance of any modern blood tests, or CT scans or MRI scans—we gave industrial dosages of intravenous prednisone as a diagnostic and therapeutic trial. If it was lupus causing her delirium, she'd get better. If it was viral, she'd get worse. She got better.

Welcome to clinical medicine, which is the epitome of a moving target.

Or the young man on a motorcycle who had decided to pass a car on a country road with a bad curve, ramming his left shoulder into the massive driver's side mirror of an oncoming Ford F450 truck. He came in with his left arm—all of it—in a plastic bag. That was the good news. He had also fractured his thoracic spine with a retropulsed fragment now resting in his spinal cord. He left the hospital a paraplegic.

I saw him some months later for a minor injury after doing a wheelie in his wheelchair and tipping over. (Patients like him remind me of James Pethel, in Beerbohm's *Seven Men*, living a life of extreme risk, living it before there were X games) (7).

I can no longer see a Ford F450 truck without thinking of that arm on one side of the trauma room and its former owner on the other. Permanently morbid associations. A professional hazard of being an emergency physician, I guess.

Where is he now? Don't know. I retired from the acute care section of the ED 2 years ago. I miss it but I do not miss Ford F450 injuries.

I shudder to include that cohort of patients who came in incredibly sick. Although we all work in the *Emergency* Department, in fact, 75% of our patients are not all that sick. I mean, you could walk the halls of any ED in the United States, randomly select patients to be sent home and told to return tomorrow, p.r.n., knowing with anxiety-free experience that half of them would be better and not return.

But about 10% are sick, or about to be sick. And probably 1–2% of any big city ED (our census exceeds 100,000 visits a year) are really sick or injured or infarcting or hemorrhagically stroking.

This is the cohort I will never forget, that 1% who, you suddenly realize with chilling clarity, all have the following characteristics:

1. They are really really sick, as in trying-to-die sick.
2. You have minutes to save them. Or not.
3. You have NO idea what is really wrong with them.
4. You've been here before. You didn't like it then and you don't like it now, and
5. You already know the end of this story.

The end is that most of these patients die. You come to understand, later—always later—that they represent a subset of truly desperately ill patients who, had they come in minutes to hours earlier, were salvageable; and, had they waited minutes longer, would have come in DOA. They are on-the-cusp patients, trying to fall off their already razor-thin edge of life.

I remember asking, after the second or third such patient, a much more experienced, and far smarter EM attending than me the following question, "Jack, do you ever have a really sick patient who is trying to die on you and you have no idea what is going on?" Jack looked at me and said, quietly, in all seriousness and humility, "All the time."

These patients put years on our lives and often, sadly, teach us nothing except the simple lesson, as counterintuitive as it may sound, that you can take care of someone without knowing what is wrong with him. But only for so long.

Welcome to clinical emergency medicine.

And the 2—not 1 but 2 (I was going to write a poem after the second, entitled "No one should ever have to see some things twice," until I realized that *I* was not the victim here), I repeat, 2 patients with severe self-inflicted gunshot wounds to the mid-face leaving some orbit and ears and not much else. Face gone. Both with no cerebral injuries so that they were totally aware of the entire incident.

I feel the way my much older cousin must have felt, he who came back from the Korean Conflict and first talked about his experiences only 50 years later. Some "Ubi sunt?"s stay deep within us. And rightly so. My guess is that all of my EM colleagues have their own personal Cabinet of Horrors that they keep locked up. Tightly.

And, on a more trivial note, where is the woman who answered, "Four weeks ago tomorrow" when I asked her when her last menstrual period was. I asked her what she meant. She replied that her last menstrual period had been 4 weeks ago on a Thursday. "My periods are always on a Thursday." I confess: I stared at her. Who is that regular? I had always been taught that nature and the human body abhor straight lines and strict regularity. What else is regular in her, I wondered? Are her hiccoughs metronomic? When she sleeps, is her heart rate a monotonous 62 beats per minute—not 61, not 63—for 8 hours straight?

Or the woman who casually answered, "I don't get headaches," in the middle of a review of systems. She was roughly my age—35. Between the ages of 25 and 70 I had roughly two to four headaches a week, every week. And a severe one about once a month. Triptans and ibuprofen were my vitamins.

Fortunately, they have mostly subsided, but that day, as one who had no idea what a life free of headaches might be like, I asked her, incredulously, "You never get headaches?"

"No," she said. "I've never had a headache."

I stopped the review of systems for perhaps 30 seconds and stared at her as though a Martian had just registered in my ED. I wonder—is she still headache free?

And, even more absurd, is the lady wearing "Tuesday" panties, whom I saw on a Thursday, still out of sync? I asked her—I could not help myself since I had already noticed, that year, the latest trend of wearing panties with days of the week on them and 100%—okay, it was not a randomized controlled trial—almost all the wearers were sporting the wrong day of the week—I asked her if she was always out of sync? She answered, in a blasé fashion that gave me to understand that this discussion was over, that she did not pay attention to panty-day-of-the-week accuracy. Some research questions go unanswered.

And the humorous or poignant one-liners we all treasure, the wisdom that issues from our patients' mouths—or, as William Carlos Williams put it,

> The physician enjoys a wonderful opportunity actually to witness the words being born. Their actual colors and shapes are laid before him carrying their tiny burdens which he is privileged to take into his care with their unspoiled newness. He may see the difficulty with which they have been born and what they are destined to do. No one else is present but the speaker and ourselves, we have been the words' very parents. Nothing is more moving [(8), p 361].

We get to be there when the words *are* born. They are often so memorable that we never forget them.

For instance, the dreadfully alcoholic woman in her 50s when I was but a 4th-year clerk on the Medicine rotation, a woman whom I had decided I would salvage, putting whole vats-ful of water-soluble vitamins into her in the lost cause of nutritional redemption. One day I caught her trying to climb over the rails of her bed—this was Columbia, P&S, in Manhattan—and I asked her where she was going. She said, in all seriousness, "I just wanted to see what the sand feels like here in Philadelphia."

Or the woman whose first language was German, English her second, and her third, the difficult language of symptom description when the symptom is dizziness, a foreign tongue mutually unintelligible to both patient and the physician. After struggling how best to describe her feeling of imbalance, she suddenly smiled with accomplishment and came out with the wonderful, "The floor attracts you!"

Or the autistic twin men who knew the local weather for each day the past 100 years and could tell you in 2 seconds what day of the week July 8, 2055 would be—this was 1968. When a smart aleck in our first-year medical school class asked, noting that one did more of the talking, "Which one of you is smarter?" our class—all 120 of us—held our breaths as one. After a 3-second pause, the more vocal one said, "We're both smarter." We all clapped.

And then there are the ones I would like to find to offer an apology. Like the woman who rubbed me the wrong way one day—I honestly do not remember the specifics—and to whom I answered, with an edge to my voice, "Yes, Ma'am," And she called me on it. "You are using 'Ma'am' not out of respect but because you don't like me."

She was right. And wherever she is, I apologize. I am a different physician now. I am truly sorry. But as Greg Henry recently wrote, we can't go back and apologize (9). Or, as Robert Louis Stevenson wrote a few years before Greg Henry, life, especially the rapidly paced and stressful clinical life in the ED, is but a "game of consequences to which we all sit down." (10).

Perhaps one of the happier memories of a patient I have, knowing full well where she is now, is Julia. Julia had a terminally aggressive cancer causing her great pain. She was always there with her husband, another narcotic-seeker, he without cancer. We all tried to limit Julia's narcs out of a mistaken sense of duty to the God of Narcotics - Limitation. (This was 25 years ago, before the crusade for responsible pain-management-medications began.)

And then it happened, a veritable Joycean epiphany. With blinding clarity, it came to me one evening, the simple but profound realization that I had been worshipping at the wrong altar. Julia *was* in pain. I knew that. We all knew that. Who cared if she came in for narcotics? She was dying. The only way I could be a physician to her was to relieve her pain. And so I did. And she died. But not before we became patient and physician.

Of course, there are those patients one would simply like to ask a question. One question. Like the patient, my age, who looked like a former love of mine, for whom I fancied an imaginary and harmless attachment. The question—okay, two—did I show it? And, was it strictly one-sided or mutual? Some questions fare better in the persistent vegetative state of one's imagination.

And lastly, where is that patient now, and did he ever recover his joy?

I walked into his room—East 15 in the old ED where I worked—the last renovation but one—for what I anticipated was just another cold. And so it was. But it taught me so much more.

As I asked him what his problem was, he told me (perhaps with the same urgency to unload a burden of grief that Iona, Chekhov's carriage driver, had felt), that his wife had recently died (11). I said I was sorry. And then, with the saddest eyes I have—to this day—ever seen, he looked at me and said, "They told me, 'You get over it'." Pause—a George Burns delivery pause for effect, but this one promising not to end with a laugh—"You don't get over it."

I took care of his cold but I never, ever, forgot his grief. That was the day I learned that the tincture of time does not all wounds always heal.

I truly, truly hope he was able to recover a modicum of joy in his life.

I ask myself now: "What do these patients have in common?" A question I have not heretofore asked myself. Upon further reflection, I think they have the following similar aspects:

1. They were highly dramatic, in that they all could have been made, with the proper playwright's hand, into successful one-act plays. Or one-scene plays.
2. They all left a scar in my memory cortex. Not a big scar. But an indelible memory trace that will remain until I forget everything: my mother's maiden name, my birthday, my wife's social security number.

But why did they leave those memory traces? Good question. I do not know. We all have such patients. Did they teach us something? About medicine? About pneumococcal pneumonia? About themselves? About ourselves?

Was it their stories, so neatly encapsulated that they rendered themselves ready additions to the medical lore and narrative each of us carries within herself? Object lessons we feel will be respected at medical campfires wherein such tales are reciprocally traded back and forth with the intuitive understanding that this oral tradition is part and parcel of our teaching each other the simple lesson, "Welcome to medicine," a lesson that never ends, but is to be continued at the next campfire?

Although I am sure this cultural institution of the oral history of medicine is paramount, there is also the paradoxical phenomenon of the pleasure of remembering one's harsher moments, one's having survived *even this*! As difficult as some of these memories of our personal "Ubi sunt?"s were (and I have spared both of us the two tales of horrid infant deaths by vehicular trauma, agonizingly prolonged and in front of large, disbelieving, and emotionally traumatized EM audiences used to such trauma)—despite the unpleasantness at the time, these recollections remind us that we were alive then, vitally important and able to surmount life's toughest hurdles. And although we failed some of our patients, we served many others well. Very well indeed.

Vergil understood this, as he understood so many things, when he composed the following pep talk that Aeneas gives his exhausted men at the end of Book I of the Aeneid:

> ○ comrades—for we none of us are unaware of our misfortunes—
> ○ we who have suffered worse, the god will grant us an end to these as well.
> You, who have experienced even Scylla's rage and her howling rocks within and even Cyclops' boulders,
> Recall your spirit, and dismiss this grievous fear.
> It will, perhaps, be pleasing one day to remember even these miseries.
> Through many a misfortune and many an untoward outcome of events
> We have striven towards Latium: where the Fates
> Have made manifest a resting place. It is meet and right for us
> There to revive the kingdoms of Troy;
> Be brave! and serve the propitious events!
> (Author's translation from the Latin) (12)

He is right. It *is* pleasing to remember even the Scyllas of our internship, the straits of our novice attending years, even the darker moments of our careers when only Rachmaninoff's second piano concerto (preferably played by Sviatoslav Richter and listened to, alone, in the dark) and two fingers of Maker's Mark would soothe the end of a kidney stone of a shift.

"Ubi sunt?" may literally mean "Where are they (now)?" But what it really means is "Ubi sum?" as in "Where am I now?" or, perhaps more importantly, "How did I get here? And did I stay the course?"

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