HEALING ARTS

Materia Medica

Two Creams, Three Sugars

Michelle Izmaylov, BS

Vanderbilt University School of Medicine, Nashville, TN, USA.

Rain on a sunny day. A new admission with unkempt purple hair, lying on her side and facing the far wall. I stand in the doorway and stare at her bare back. The records in my arms are white paper and black ink. The black is: she is a homeless woman with a facial droop.

The black is: newly diagnosed lung cancer already metastatic to her brain.

It's afternoon in June and the sky outside her window is cerulean cored by gold. There's sunlight on her bed. The sun clings to her wet eyelashes. Warm light mixed up with warmer water.

I say *hello* while standing next to her bed. I say something small in a smaller voice. I feel my lips move and hear no sound. Some silence is a vacuum in which humans can't survive.

I default to something easy and expected. I ask if I can listen to her lungs, even before asking the chief complaint. I lay my stethoscope on her back but focus on her prominent shoulder blades instead, white bones that shift under her skin with every breath. I ask if she has been having headaches. I ask about blurry vision. I ask a few more technical questions to extract information in the scalpel-precision manner for which my medical education has prepared me. She answers with smaller and smaller words while staring at untouched, cooling coffee on the table beside her bed.

I leave because the room is cold, and her shaking spine is not the only one. Because her tumor is terminal and the stethoscope in my fingers feels like a useless toy. Because in my mind the words *crushing headache, the worst headache of my life* are synonymous with a non-contrast CT scan. My resident nods absentmindedly while she listens to the patient's story. I am praised for an excellent presentation. Praised for telling a patient story that doesn't hold any of the patient's story at all. We get the CT scan. My fingertips trace six high-resolution masses on a too-bright computer screen. No bleeding. Not even increased edema. The headache is new but the objective data remains unchanged.

Prerounding on her the following morning echoes the prior afternoon. I greet the patient with a forgettable comment about the untouched pancake on her plate. She remains lying on her

side, facing the clean white wall. My hands go through the rehearsed motions of a neurological exam. I expose the unchanged strength deficits in her right arm and leg. I learn that her pupils are still equal, round, and reactive to light and accommodation. As I listen to her heart, I realize I didn't notice the color of her eyes. I realize I am not listening to her heart. What I hear is the closure of four valves. I haven't heard her heart at all.

I check my watch. If I stay any longer, I will be late for rounds.

I sit on the edge of the patient's bed and notice her staring at another cooling cup.

Do you like coffee?

The patient finally looks at me. *What?*

Looks like they brought you some coffee, but you didn't drink any.

Oh. Yeah, I drink coffee every morning. But I can't have any today.

Why not? This automatic response buys time while I scour my brain for reasons why the patient has been made NPO. Also while I panic about what else I apparently missed during chart review this morning.

There's no liquid creamer.

My brain pauses. This doesn't fit into my generated differential. Perhaps I misheard through her slurred speech. I wonder if I should note this finding when presenting her exam.

They just have the little powder packets, she explains.

No liquid creamer? In the whole hospital?

None, she says in a stronger voice.

I check my watch again. I am twenty-seven seconds late for rounds. *I'll check back on you in the afternoon. Around here, there are secret ways of getting anything*, I say as I jot down exactly how she likes her coffee.

The secret is: there's no liquid creamer in the hospital, but there are a few crumpled dollar bills in my white coat pocket.

I return several hours later to practice some of the many things medical school does not emphasize enough. That UWorld is not a mirror of the real world. That a patient lying in bed with a terminal diagnosis will look a little better sitting up in a chair. That there is a reason *subjective* comes first in SOAP note format. That the chief complaint introducing every patient should be stated in the patient's own words, in quotes. That bringing a patient liquid creamer for her coffee is not a requirement for being a doctor, but it is a requirement for being a human being.

I watch as she swirls a spiral of white cream into black coffee, recreating the Andromeda galaxy in a cup of Styrofoam. As we wait for the cup to cool, she tells me about her purple hair. How her daughter chose that color for no reason other than thinking it was a pretty color.

How her daughter's gloved fingers helped rub dye into her mother's hair. She holds out two barrettes because her hair keeps getting in her eyes. I help secure her hair in place. She lifts her chin and studies her reflection in the still surface of a swirl of cream and coffee. *The headache feels better*, she says.

She takes a sip and reaches out to hug me with her one working arm. I feel her fingers on my shoulder blades. Gently. Gently. *That's strange. Just bones*, she says. As if she had been expecting something else. As if bringing creamer was something more than the ordinary actions of a human life. Or perhaps a reminder that ordinary actions can sometimes mean more than all our medicines combined.

I watch a dying patient drink coffee and smile for the first time.

Sun on a rainy day.

Corresponding Author: Michelle Izmaylov, MD Vanderbilt School of Medicine 300 11th Avenue North, Apt. #431 Nashville TN 37203 USA (e-mail: michelle.Lizmaylov@vanderbilt.edu)