Peggy’s Grapes
Elizabeth Grant, MD

“You were an exotic dancer?”

This is not a routine inquiry for morning rounds, but Peggy (name has been changed) is not a routine patient. Our team needs a little boost, no matter how unconventional. It is one of those months on the inpatient teaching service where each patient is sicker than the next. We rush around putting out fires and rarely find time to connect to our patients, let alone each other. Our team includes an attending who works so much she longs for duty hours, a third-year resident whose husband lives 1,500 miles away, a second-year resident with two young children at home, and a brand-new intern who finds his excitement about being a doctor already waning. As the senior resident I find myself in survival mode with little in my reserve tank to share with others. Residency training seems to promote a state of starvation. We are stretched so thin that we hunger for the nourishment Peggy’s generous sense of humor offers. “It was the 70s and it was Las Vegas,” she coyly continues without prompting.

Whether through a story, a joke, or just the twinkle in her eye, every interaction with Peggy provides fuel to fortify us for the next patient on our list. Peggy’s history unravels during our daily visits, but her diagnosis remains a tightly concealed mystery. Despite our best efforts we cannot help Peggy in the way we think we should: with a diagnosis and a cure. Though we continue to run tests, engage consultants, and ask the same dead-end questions, we come up empty handed.

As her condition worsens, and we exhaust our diagnostic and therapeutic options, all Peggy can eat is grapes. She asks for grapes at each meal of the day. She calls the cafeteria workers and requests grapes between meals. After a few days she can no longer speak, but the team collaborates to make sure that there are always fresh grapes on her bedside table. This unspoken effort occurs as we subconsciously realize that although we cannot save Peggy, we can provide the most basic nourishment as a means of acknowledging the way she has fed our souls.

One evening I am about to rush past Peggy’s room, but an instinct makes me pause and look inside. The realization hits me like a ton of bricks: Peggy may die tonight. I sit down and start speaking softly to her, or maybe I am speaking softly to myself. As I whisper words of comfort I realize that I am calming myself as much as I may be soothing Peggy. I begin to see the invisible boundaries I have cultivated to survive the strain of residency; the walls that have been separating me from the ability to authentically connect with patients start to crumble.

Peggy died that night. When I arrive the next morning to the team workroom I see a blank space where her name used to be. This is a common gesture made by the frenzied night float resident that conveys the loss of a patient overnight. Often the resident later scrawls a new patient’s name in that same slot. We are trained in medical school to deliver bad news to our patients, but how do we communicate about grief and loss with our colleagues? Last year I found out one of my dearest patients died when I opened her chart in the electronic medical record and an alert popped up with the sterile emotionless message: “You are entering the chart of a deceased patient.” Just hours following Peggy’s death I struggle to find a better way, though I feel unprepared to face the rest of the team. Self doubt creeps in as I start perseverating: Do they already know? Do they care as much

“...the sun, with all those planets revolving around it and dependent on it, can still ripen a bunch of grapes as if it had nothing else in the universe to do.”—Galileo Galilei

From the University of New Mexico.
as I do? Or worse, do they care more? I stumble through the summary of last night’s events, I ask my team how they feel, and I acknowledge the important role Peggy played on our team.

Often I rush past an emotional moment just as I sprint to a hospital code, but this serves as an ineffective attempt to escape my feelings. I thought the barriers I built would shelter me from the suffering encountered each day as a resident. I now realize I was hindering my ability to process and move beyond the pain, anger, sadness, and grief. Despite myriad challenges, we should strive toward growth, whether personal enrichment by reminding ourselves of our own humanity, or professional fortification of our colleagues by sharing bad news in an honest and respectful manner. Experiencing and processing the human emotion of grief restores our empathy and lessens the dehumanizing impact of our demanding training. Mindfulness and self-care during times of stress may help us avoid the cycle of burnout. To grow rather than stagnate, we must savor the sting of grief. Only then can we indulge in the feast of life. Each time we gave Peggy grapes we evoked the purpose of our profession and felt the gift of a deep human connection.

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References