Illustration by Jim M'Guinness.

He trusts us

"The best way to find out if you can trust somebody is to trust them."

—Ernest Hemingway

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My wife and I sat in my father's hospital room. He had pneumonia and was not improving after three days of treatment. I sat on his bed, my hand touching his as I looked at his face. His mouth was wide open, gasping for breath, his face was drawn and ashen, and he was minimally responsive to my voice.

He would not eat, not even his favorite Iraqi dish of stewed okra over rice that I cooked for him that morning, following the exact specifications from the recipe book he had written and given to me many years before. The photographs of his brothers and sister, his parents, and his favorite picture of my mother were around him. But even they were unable to arouse his listless body.

I had been here before, needing to make decisions about how aggressive to be with his care. This time seemed different, and the prognosis more critical. In the past, he would improve by the second day of antibiotics and hydration. During this stay, what little energy he had left seemed to wane with each passing hour. I called family in the United States, Canada, and England to inform them of his condition. I even called his rabbi from his synagogue in Maryland where he had been a founding member and congregant for more than 40 years.

As a general internist and educator with more than 30 years of clinical experience, I have counseled countless patients and families through terminal illnesses. I felt that I usually had a good sense of prognosis and could guide people to make decisions using understandable language. I always found this easier from the perspective of an objective third-party, seasoned in both clinical reasoning and shared decision-making.

However, when a relative falls ill, I have always found it to be very difficult to serve in the role of decision-maker. Despite knowing the objective facts of the disease and its prognosis, it takes on a different meaning when it strikes so close to home. I play a dual role: physician and family member, with added pressure to be "right" in terms of making appropriate medical and ethical decisions. This makes the process that much more difficult as the physician in me knows likely outcomes as well as the complications that may arise.

My father, now 99-years-old, moved to Connecticut to be closer to me. He was always an independent man, having left his native Baghdad at the age of 18 to study civil engineering in the United States, finally making America his home a decade later when he returned with my mother and my older sisters. Prior to moving to Connecticut, he had been in surprisingly good health, suffering only from mild cognitive impairment.

Not surprisingly, at age 98, he began to experience progressively serious afflictions: first an upper respiratory infection with vertigo and falls, then urinary tract infections, a hip fracture complicated by pneumonia, and an aortic rupture, all of which he survived and was able to return to a good baseline and enjoy a good quality of life. I would have thought that his advanced age and full life would have made it less difficult to witness his illnesses and easier to come to terms with his impending death. I never felt either of these emotions. He was still my father and friend so each moment together was precious.

For me, one of the most difficult aspects of being his son, as well as a physician, was to relinquish his care to others. It made me realize in a very personal way the trust that our patients place in us, and the responsibility that comes with the title of physician.

This was made even more complicated by the fact that he was cared for at the hospital where I practice and teach.

For this admission, it even came down to making a decision with the emergency department staff about the floor where he was to be admitted. Would he go to the hospitalist or the housestaff service? The latter would place him under the care of the trainees I oversee on the ward where I attend and have an administrative role.

I decided to place him under the care of my housestaff. I had worked with them and trusted that they would take outstanding care of my father. I knew that I had made the right decision when one of my senior residents told me on the night of admission, "Dr. Sofair, understand that we are here for you. You can call us any time." This gave me tremendous comfort that my father was in good hands.

I realized that this could be a difficult position for the housestaff, caring for the father of one of their attendings, delivering prognoses to their teacher, and assisting in making very challenging decisions. Having cared for health care professionals and their family members as a houseofficer and as an attending, I knew that position to be stressful, and I would spend extra time with the patient during their stay. Perhaps the housestaff felt the same way toward my father. With that in mind, I wanted to keep the appropriate level of involvement to maintain communication yet allow them the freedom to care for my father as they would any other patient.

I think that the comment that summarized it for me was when one of my senior houseofficers told me how initially they were nervous caring for my father, but they knew that the fact that I put my father on their service meant that I trusted them, which I did. After all, what higher compliment could I pay to my housestaff than to place my father under their care?

As I sat at my father's bedside and tears welled in my eyes, some of my housestaff came into the room with the attending physician. The intern looked me in the eye, took my hand, and gave me an embrace. The group sat down, reviewed the events of the night, and listened carefully to my dilemma regarding whether or not to continue treatment. My father had been through so much and at this moment could not speak for himself. The attending, offering me a glimmer of hope, said that he thought that we should continue antibiotics and hydration for one more day to see if there might be some improvement by morning.

Considering his age and how poorly he looked, combined with my fatigue from a lack of sleep over the past few days, I had a difficult time arriving at a decision regarding what to do. The team certainly had more optimism than I did. After they all left, I spoke with my wife and decided to stay the course. There was no harm in continuing fluids and antibiotics. I knew the outcome if I withdrew support. I spent that night sleeping in the recliner by his bedside fully anticipating that it would be our last night together.

Surprisingly, conversations about these issues with my housestaff felt natural and unencumbered. At our medical school and in our residency program, we pride ourselves in our emphasis on bedside teaching and role-modeling; we highlight small group teaching on professionalism and doctor-patient communication. We hope that this will translate into our housestaff becoming independent and empathetic patient-centered physicians.

Over the four weeks that my father spent in the hospital for several prior admissions, he was cared for by many attendings and houseofficers as well as nurses, physical and occupational therapists, clinical technicians, discharge planners, and dietary staff. I can say that to a person they worked together to provide state-of-the-art care delivered with kindness and respect, and communicated with us clearly, consistently, and professionally. We never felt that we received different messages from the various providers, or that we were rushed to make decisions or transition to another level of care. I am also proud to say that I do not believe that we received care that was any different from other patients.

That next morning, I awakened early to find that my father's eyes were open and brighter. He said that he was thirsty and asked for something to drink. He even asked for soft-boiled eggs, one of his favorite dishes. Later that day, he asked to get out of bed and sit in a chair. Strengthening gradually over the next week, he was able to leave the hospital to continue his recovery, with assistance, at home.

More than any accolades one may receive as a physician-educator, none compares with the knowledge that you have had a role in the training of physicians who you feel are competent to care for the dearest ones in your life, as well as all of the patients under their care. These days, as I push my father in his wheelchair along the flower-lined paths by his home, and talk about his grandchildren and days gone by, I am overcome by the gift of time we have been granted—given to us by my housestaff through their outstanding care and support over many admissions.

I have learned the lesson of trust—trust of those junior to me who helped me to see a clearer path when my vision was obscured.

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