My Journey from ER to Palliative Care

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My family was braced for this day: the day of my mother's death. It was a sad separation, but it did not feel like a final goodbye. Hers was a better death than what we had prepared for months earlier—it could have been filled with much more suffering. As I held my mother's hand at her last, I wished her well on her journey. She had been a flight attendant for sixty years; for this, her final flight, I hoped it would take her somewhere special, somewhere amazing, to some final destination where we may meet her again. The day was July 1, 2019.

In 2014, my mother was diagnosed with idiopathic pulmonary fibrosis. I remember the call from the pulmonologist. I knew the prognosis and the likely timeline. It was not long before her health was waning—it was time for hospice. I initiated the discussion, and it took many discussions before she accepted hospice and was at peace with the decision. The process took time, quiet contemplation, and compassion.

This event, like so many other life-changing events, made me pause and reflect; that reflection would ultimately lead me to a change of career path. Since 2013, a time span that includes the years of my mother's illness, I've worked as an emergency physician in busy, urban emergency departments. My clinical career has been defined by the adrenaline rush of the medical emergency: the hectic pace, the momentum to push cases through, the chaos of the code. My day-to-day medical environment stood in stark contrast to that of my mother's hospice care.

From the start of my career in emergency medicine in 2010, I knew I did not completely fit the mold of a typical ER doctor. But why? I was highly competent, I was good with the patients, and I could handle the fast-paced tempo of the ER. I had been recognized and awarded for the excellence of my practice. So again, why? Despite my clinical competence, my conscience would cause me to pause because I felt an off-ness: sometimes I would stand, with an ET tube in my hand, and think "this is not right, this is not what this patient wants, this is what not what this patient needs." This put me at odds with my job description, and this was not the first time I had felt this off-ness. Even in residency, attending physicians instructed me thus: "let's just tube them and get them to the ICU, they can talk to the family about their options." I was there to learn, so I would push my thoughts aside, tube and line the patient, admit them to the ICU, and move on. That was what the job required so I made my peace with it, but I sorely missed the opportunity to connect with my patients.

As the years in the ER went by, I tried to soothe my conscience with the following mantra: "I'm not trained for those conversations, this is not in my scope of practice, move on, the waiting room is full, you have metrics to keep up with." Abbreviated conversations, limited scope, churning through patients, metrics being key—these are what the logistics of emergency medicine require in order to operate with efficiency, so I conformed. However, that voice remained—a little voice that grew louder as I gained experience. Clearly, I had not made peace with it.

In 2014 my mother became ill; in 2018, she entered hospice care; in July of 2019, she died. Then, in January 2020, the Covid-19 epidemic hit the United States in full force. Now, in the ER, I was intubating Covid patients on a hope and a prayer; now, the only comfort I could offer them and their loved ones was "it's going to be OK," knowing it probably would not be. It was obvious that intubation was not saving our Covid patients. Now, I watched them say goodbye to their loved ones over an iPad, which I held before them, a stranger intruding on their landscape of grief, a stranger wearing full protective gear so as not to bring such a death home to my own loved ones or the loved ones of others. This vicarious experience of death was a turning point for me: the stark contrast of an often unexpected death in physical isolation from loved ones—as became the emotionally excruciating norm with Covid patients—with the relative comfort of a hospice death—like my mother's recent passing—kicked my conscience into a full, shouting voice. It would no longer be soothed or quieted. I was forced to acknowledge and listen, and then to begin a conversation first with myself, and then with many others around me. What I needed was the ability to treat patients using a whole-patient approach. This is a challenge in the ER, but this was also the answer to the nagging question of "why?"

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With this answer to my conscience acquired, in 2021 I began investigating how to change my career path, learning more about hospice and palliative medicine and opportunities therein. Could I integrate this specialty into my day-to-day practice? The more I learned, the more I believed it possible to integrate the two, and the more motivated I became. I made the decision to incorporate the call of palliative medicine into my current practice of emergency medicine. The first step would be to apply for a fellowship in hospice and palliative care, which would entail some financial loss. I am, however, lucky to have both the financial means and the support of my family and friends to do so. And so, with a leap of faith, I applied for a match to a fellowship in palliative care. I am ecstatic to report that in July of 2022, I will begin a Hospice and Palliative fellowship. Will it be the correct choice for both myself and for my patients? My little voice will be sure to let me know. ●