A sacrifice greater than lunch

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Our initial clinic visit had run long, as usual, spilling over into the traditional lunch hour. (I have yet to meet a cognitive neurologist who runs precisely on time or a physician who has the luxury of adhering to a timely lunch break.) His was a complicated case: Mr. X was a 51-year-old white right-handed engineer with cognitive deficits persisting almost a decade after a prolonged ICU stay secondary to septic shock from an injury sustained at his work, further complicated by ARDS and pulmonary emboli. He developed ICU delirium and ICU psychosis, ranging from hallucinations that a black couple visited him in the hospital and told him they were his real parents to thinking he was in a war zone. He subsequently suffered PTSD, reliving those hallucinations, which at times felt more real to him than his everyday life. He also had spells of "zoning out" of unclear etiology. I spent a long time talking to him and his wife, trying to cobble together an outline of events without the benefit of any of his hospital records, although I was thankful I did not have to weed through more than the 1-inch stack of notes from his psychiatrist. He had never seen a neurologist before, so his psychiatrist made the referral to me after years of working with him to determine if there was a neurologic reason for his cognitive deficits.

When I first saw him sitting with his wife, I could not believe he was my patient. As the only notes I had to review were from his psychiatrist, it was hard to believe the baby-faced gentleman with the shock of floppy brown hair was the referral: his youthful appearance belied the description of the distressed middle-aged man listed in the chart, who had suffered PTSD for years, with delusions of the black couple and war stemming from those hallucinations he had from his ICU hospitalization. I couldn't picture him intubated, surrounded by the beep and whir of machines in the ICU. I could not picture his harried wife, a nurse by training, sitting at his bedside, reacting to the news about the troponin spike that indicated a myocardial infarction. I could see him sitting at the kitchen counter, taking apart a broken blender at his wife's behest, and putting it together like new. I could see him restoring an old car with his son, elbow deep in engine grease. I could see him teasing their daughter about her messy bedroom.

Next it was time to address any underlying neurologic component to his cognitive deficits, which was the reason for the referral to me. I tested his visual fields, elicited reflexes, and administered a cognitive screening examination. He was engaged and put forth full effort. There was something incongruous and unsettling watching this engineering PhD puzzle over how to calculate "5 times 13." I knew he knew he was struggling with certain questions, but I did my best to be reassuring and encouraging. He had obviously been through a great deal, but his wife was extremely supportive. The psychiatry notes I read reflected progress in sorting through his PTSD and getting his symptoms under better control, and I felt like he was getting excellent care. His pleasant demeanor and gentle smile appeared to reflect that.

I ordered additional tests: serologies for reversible causes of memory loss, an MRI brain, EEG, sleep referral, and neuropsychological testing. I promised to discuss his case with colleagues who are world experts in ICU delirium and its aftereffects. As he was leaving, he had a very good interaction with our clinic scheduler, whose optimism is infectious and whose warm personality is instantly welcoming.

Days later, in conversation with his wife, she told me that on their drive home, he enjoyed talking in particular to me and to the scheduler, appreciating our positivity. He wondered, "Why are not more people like that in the world?" He'd also felt bad about taking so much of my time and wanted to buy me lunch. Given that they were well into their 10-hour drive back (they'd traversed several states to see me), they joked that if they'd bought something then, by the time

they returned to my office, the lunch would be cold so I wouldn't enjoy eating it. During that telephone conversation with his wife I learned he had committed suicide.

In retrospect, it pained me to reflect upon his comment. If everybody could exhibit compassion and care to all those they met, would anybody feel suicide was an appropriate option? His wife thanked me for making his last medical encounter a positive one, in light of his complicated history. She felt he unraveled because of additional employment-related events that unfolded after their clinic visit. While he had been able to do a modified version of his job, he was not functioning anywhere near his previous level and he was still embroiled in the medico-legal consequences of his on-the-job injury.

Upon arriving home from their journey to see me, they were greeted by a stack of boxes on their front doorstep, in which all his work possessions had been packed and shipped to his home. The unceremonious stripping of his office seemed emblematic of the loss he felt with the struggle of the personal, professional, legal, and financial consequences of this injury. His wife felt this was the final blow. I was devastated to think that while I was searching PubMed and emailing colleagues about optimizing his care, he was likely reflecting about how to end his life.

I wish I could have done more to help the thoughtful man who was kind enough to think of me working through my lunch break and want to buy me a meal. I would gladly have sacrificed more than my lunch.

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