finding and photocopying the latest journal article to present to their colleagues at rounds — will have learned that, to the extent that control is at all possible in our lives, it is at home, or at least away from the hospital, that it can and must be exerted.

We are necessarily a driven cohort, we physician-types. We jump hurdles to get through training and are daily swung from one trapeze to another. I think of Peterkin's book as a series of suggestions by means of which we can render residency training a little less like working without a net. Although his advice on how to navigate a number of common, difficult situations in the machine (or monster) that is the modern health care system is solid and almost certainly helpful, more important is the notion, implicit and explicit throughout his book, that if one works in a dangerous environment, one must necessarily be fit, careful and prepared.

Although I was initially disappointed by the relatively short shrift given by Peterkin's little survival guide to the many problems with how "the system" operates, I see now that this is yet another way in which he reminds us of the importance of understanding and accepting the distinction between those things we can change and those we cannot. Having said that, and at the risk of cliché, if we're not part of the solution, we're part of the problem.

Ted St. Godard
PGY1
Family Medical Centre
University of Manitoba
Winnipeg, Man.

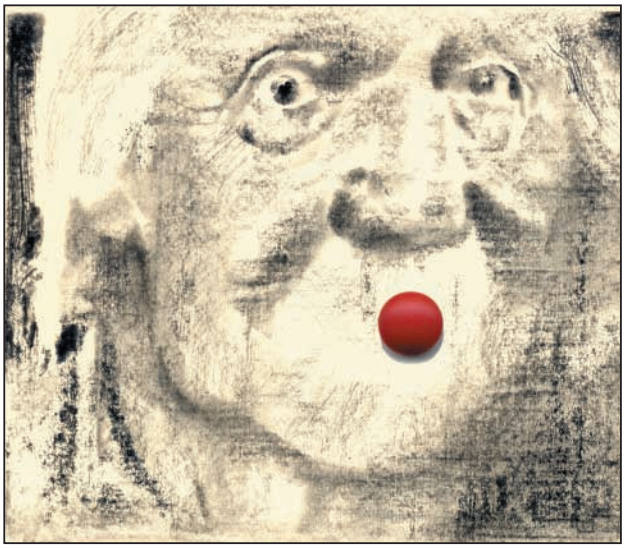
Room for a view

For whom the bell tolls

It is a long drive to this small town, so we wait until there are enough new referrals to our geriatric psychiatry service to make the trip worthwhile. It has been six weeks since we were last here at the nursing home, and we have four new patients to see. Mary, the outreach nurse I work with, places her black briefcase on the desk at the nursing station before going down the hallway to find someone who can take the time to speak with us. I settle into the creaking chair behind the desk and consider whether to open the bag to look again at the charts we have brought with us. I reviewed them in the car as Mary drove us out here, but the view of the open water running endlessly beside the road distracted me, and all I can remember are fragments of the questions we are being asked. Someone cannot sleep. Someone else wants to go home. Thank you for seeing.

Mary comes back with Sandra, the nurse who works on the unit. We make small talk, taking our time before getting down to the list of patients. This man, poor old soul, fell out of bed and broke his hip. He was transferred to Halifax and won't be back for a while. This other man keeps hitting out at staff, they've tried everything, do we have any suggestions?

I like coming up here. At these rural nursing homes the staff know all the residents. They've known them their whole lives, in fact, and can tell you what they were like twenty years ago. This is why families want their loved ones admitted near home; not just so they are closer and easier to visit, but because the community stretches right into the nursing home and doesn't end at the door as it often seems to in the city. The residents are real people, not characters half-constructed from a history in a chart, or from stories told about them by others. There is no urban multitude of elderly demented patients in their wheelchairs and geri-chairs surrounding the nursing station like older-model vehicles in an enormous parking lot. There is no television endlessly looping the news of the day. In fact, the hallway is deserted except for one older gentleman leaning on the handrail attached to the wall, slowly wandering with the purposelessness of senility.


Fred Sebastian

After we have finished going through the new referrals, I remember a question I had wanted to ask. "How is Mr. Zwicker doing? Did that new medication make any difference?" I am curious but not hopeful. We had sent some samples up a few weeks earlier in an off-label attempt to manage his intractable screaming. I hadn't really thought it would work, but you never know.

"He never got the medication," Sandra replies. "He died before it could be started."

"Really?" The medication we sent is expensive, difficult to get covered by the provincial drug plan. And I don't have any more samples left. "He never got it at all? Was the box even opened?"

"I doubt it."

DOI:10.1503/cmaj.1041007

Mary and I look at each other. "Is it still around here somewhere?" Sandra goes to see if she can find the sample. I am a little bit sorry that we didn't get to see if the medication worked. But, I think to myself, we can give that sample to someone else. I can think of two or three people right off who might benefit from it.

I try to remember what Mr. Zwicker looked like. A thin old man, childlike in the final stages of dementia, tilted backward in his geri-chair, eyes closed. It would be difficult to say whether he retained any volition or self-knowledge that day in the sunlit room. He was not screaming when we saw him, but silently opening his mouth and allowing a spoonful of institutional mush to be placed on his tongue, as if he were receiving Communion. There was a solitary calm around him, and not even a gentle shake of his shoulder and the sound of his name could reach the place beyond dignity or indignity where he was adrift.

Sandra arrives with the anonymous brown envelope of interdepartmental mail and hands it to Mary, who pries open the staple to peek inside. "It's still there," she says. What good luck, for us.

But even as I am thinking this I am aware there is something odd, and perhaps improper, about my attitude. Surely it is not right to feel, having just heard of Mr. Zwicker's death, only this cheerful gratitude? Am I supposed to feel sorry? I check my emotions the way you might check a pulse, monitoring for irregularities. I tell myself, *This was a person's life*, trying to kick a bit of sympathy out of my soul, but all I manage is a bit of self-indulgent guilt. *I can't feel badly about someone I've never met*, is the argument I put up.

I seem to remember some quote about no man being an island and how we are diminished by every person's death. But what does this mean for a doctor, especially one who works with elderly patients? Am I to shrink a little every time a patient dies? It seems unreasonable to expect me to give up a bit of myself because Mr. Zwicker, who could open his mouth only to swallow or scream, died while I was hours away. It is only natural that I am more attached to my pills than I was to a shadow of an old man in a small rural nursing home.

We spend the next few hours seeing patients and writing notes. As we are getting ready to go, I look into one of the rooms. It is empty, without the little bits of personal detritus that indicate an inhabited room whose occupant is only temporarily absent. I think perhaps this was Mr. Zwicker's room, although it is hard to remember. These rooms are so much alike. Outside the window, clouds move slowly through the blue air, breaking apart, reforming, changing shape before my eyes, each one passing by unique and unremarkable.

Lara Hazelton
Psychiatrist
Halifax, NS

Room for a view

The eyes

The husband and wife were brought in on a weekday morning. The smell was overwhelming. Despite their years of experience, the horror in the eyes of those around me — firefighters, paramedics, nurses, physicians — was striking. She was completely burned, unconscious and barely alive. The pink cotton underwear that I helped remove outlined the only area spared from full-thickness burns. Her husband had been doing renovations when a chemical exploded. The neighbours told the firefighters that he had originally escaped, only to go back into the engulfed house to bring out his wife.

He was in the next bed with full-thickness burns over ninety percent of his body, evidently in pain and very aware of his surroundings. The darkness of the burns contrasted with the whites of his wide, scared eyes.

There was a different pace in the room than I'd experienced in other trauma cases. The words "palliative now" were whispered. There was an odd quiet as a femoral line was urgently placed. The paramedics had been unable to get a peripheral line, so the patient had yet to receive sedation. The only mercy of a full-thickness burn is that the pain receptors are also destroyed; however; the pain was still so evident in his eyes.

I reflected afterwards that I do not remember anyone telling the patient about the horrific prognosis for him and his wife. We all knew as we sedated him with heavy narcotics that he likely would never wake up. I carry a powerful memory of looking straight into his eyes in those last moments of his conscious life — they were so white, so questioning.

In medical school we are instructed in the art of breaking bad news. We learn to prepare adequately, to allow sufficient time, to gauge how the patient is feeling, how much the patient wishes to know and can understand.

Little of this applies in the trauma suite where more than once I have looked into someone's terrified eyes, only to realize afterwards that I was one of the last people to make contact with that person. I struggle with these memories, and with the question of whether I have the right to tell or not to tell the patient that there is no hope.

Carolyn Snider
PGY-2, Emergency Medicine
University of Toronto
Toronto, Ont.

DOI:10.1503/cmaj.1032027