Back to Article Click to Print

TIME IN PARTNERSHIP WITH CNN

Monday, Oct. 15, 2007

The Ethics of Erasing a Bad Memory

By Scott Haig

She was worried about the lump and worried about the children who were worrying about her. She was, however, most worried about the anesthesia. "What if I don't wake up?" just wasn't a question I could answer sufficiently for her. Some people take no solace in statistics (that, for example, there are two or three deaths per 1 million patients anesthetized) — these patients are the medical cousins of the folks still crossing the country by train or bus rather than "risking the airplane." So I warned her that there might be a little pain and agreed to do her biopsy under a local anesthetic — but only if she would allow an anesthesiologist in the room, just in case.

The lump was growing near — maybe on — the inner end of Ellen's collarbone, meaning that during the biopsy I might have to use a tool that goes, "crunch." It's pretty hard to numb-up bone with a local anesthetic so I was glad to have Frank, the anesthesiologist, there at the head of the table with some IV sedatives, in case Ellen got panicky or was in too much pain. She was adamant about not going under, but agreed to "some sedation" if we thought it was necessary.

I can understand not wanting to lose consciousness. It's arguably the most precious thing we have. And although serious complications from anesthesia are truly rare these days, so are bone tumors — and she clearly had one of those. Ellen had a history of cancer too — it had not been a cancer that was likely to spread to the bone and there hadn't been any sign of it for years, but it had been a malignancy. This lump was growing at the end of the clavicle, in the place where arthritis often produces a lumpy enlargement. But Ellen's lump had come on too fast; it felt fleshy and, most significantly, unlike arthritis, it wasn't tender at all. As hard as I pressed on the lump that day in the office, it didn't hurt. That's why I booked the biopsy.

I've been in many operating rooms over the years, with the highest-tech, ultrahigh-quality equipment

around, but I don't think I've been in one where the intercom, a low tech app if there ever was one, really worked. And we found that was true in our room that day.

Ellen's procedure got off to a fine start. She was O.K. with the needle-sticks for the lidocaine and she stayed calm and collected under the layers of paper and plastic that we used to drape-off the surgical site. When I got in there, I saw that the lump was growing from the bone. I warned her it might hurt but she didn't make a peep when I used the tool that crunches and bit off a piece of bone for the pathologist.

I ordered up a touch prep — a quick microscopic look at the cells of the specimen. We would know in 15 minutes if there were cancer in the lump. While the specimen was in the pathology lab, we washed out the wound and started to sew it back up, layer by layer. The inch-long incision was on a very conspicuous part of this youngish woman's body, right where a necklace or the neckline of a fancy dress might lead the eye. I sutured slowly. We were still waiting for the pathology report anyway. It was quiet in the room. I made small talk with Ellen and the nurses. Ellen was O.K. but nervous. She talked about her kids, about how much driving she did everyday shuttling them around. The topic of the tumor, and what it had looked like, was given wide berth by all of us. I finished stitching, but I had to stay scrubbed — we couldn't take off the drapes until pathology told us they had a sufficient specimen. There wasn't much else to discuss; it was real quiet and, rare for the OR, a little bit awkward.

"Dr. Haig?" A voice over the intercom, harsh and loud.

"Yes," I said. "Is this path lab?"

"Yes, can I put on Dr. Morales?" the voice replied, referring to the pathologist looking at the microscope slides of Ellen's specimen.

"Have him call in on the phone," I said. The drill, which everyone knew, was that the circulating nurse would hold the phone to my ear while the pathologist told me what he saw.

But instead of an "O.K." there was silence, and then, "Scott, this is Jorge, can you hear me?"

"Yes, but hold on, we're under local in here," I said. "You'd better call the desk and have them put you through to the phone in the room."

"Scott, I can barely hear you but, listen, this is a wildly pleomorphic tumor, very anaplastic. I can't tell..."

"Hold on, Jorge — let me use the..." But he couldn't hear me and kept on talking.

"...what the cell type is, but it's a really, really, bad..."

The circulator was moving toward the intercom on the wall, but she wasn't going to make it.

"...cancer."

Ellen's shuddering gasp, then shrieks came from under the drapes: "Oh, my God. Oh, my God. My kids. Oh, my... my arm..."

The burning pain in Ellen's arm was due to the rapid application of propofol, a paper-white liquid medication, which the perceptive Dr. Frank had plugged into Ellen's IV the second he heard the c-word. When he saw her reaction, he pushed. The drug, sometimes called "milk of amnesia," stings some patients sharply in the veins, but what it also does is erase your last few minutes. (Think of the "neuralyzer" from the *Men in Black* movies.) Oh, and it puts you to sleep. An amazing molecule, a great anesthesiologist and a great save.

Not everyone agreed. I looked up at three sets of eyes, the nurses' eyes, that bored into Frank and me accusingly. *How can you do that?* they demanded to know. *Don't you need consent or at least fill out some kind of form before you steal a patient's last 10 minutes?* But all I could say was, "Awesome job, Frank." Somehow with that, and with the calm sleep on their patient's face, we were given not forgiveness, but a reprieve.

Ten minutes later Ellen woke up, happy and even-keeled, not even knowing she'd been asleep. From the recovery room she was home in time for dinner. "The procedure went smoothly, but we'll have to wait for the final pathology reports," I said, which was not exactly the whole truth, but it let me get the oncology people cued up, a proper diagnosis, and Ellen herself emotionally prepared. I would give her the bad news at a more appropriate time.

The ending was not quite happy; it was a recurrence of the cancer she'd had years before — fairly rare for that type of tumor. Ellen died of it about six years later. I confess I never told her about the incident with the intercom.

Over a decade later, I'm still not sure that was right.

Questions of withholding bad news, wiping out bad memories — plastering-over wayward cracks in our minds with chemicals — are answered thousands of times everyday, without ever being asked. Ethics

committees and experts exist in our hospitals, but what they have to say counts precious little down in the trenches, where intercoms fail and human minds treat human minds, in real time. You would think, by now, that the distinction between treatments using words (or ideas) and chemicals (or electric currents) is starting to blur. (If an hour of psychotherapy accomplishes the same thing as 20 mg of Prozac — that is, a boost in mood and serotonin levels — is there a difference?) But it is not. Everyone I know who deals with medicines that affect minds seems to operate with a very clear functional distinction between personhood — the realm of virtue, vice, responsibility and creativity — and brain chemistry. That distinction was clear in the eyes of my nurses that day. Something more important than a chemical balance in Ellen's brain had been violated — only a little and, obviously, with benevolent intent. But it hadn't been as simple as pushing a rewind button. Something there had borne the unmistakable quality of *wrong*.

As mundane, as miserably human as a soccer mom "dying young" of cancer might be, I found such value and such meaning in the way Ellen clung to her consciousness, the personhood she needed to care for her family. Much of what we read about brain science in the media today would have us believe that we're nothing more, really, than very fancy machines. And surely what we're learning about the physical brain is exciting and powerful — but thinking honestly, it remains so limited. We can trace the brain pathway of a drug "high," we can call it pleasure, but that tells us nothing about what so many people choose instead — deeper things that somehow beat out mere pleasure as the reasons for doing what we do. Those comforts — of ultimate meaning, virtue, peace and joy — have little to do with molecules.

Dr. Scott Haig is an Assistant Clinical Professor of Orthopedic Surgery at Columbia University College of Physicians and Surgeons. He has a private practice in the New York City area.