I find myself at a loose end. Dr. Rodriguez, a perfectly capable man, was staying behind for a minor wound revision. He offered to look in on my earlier craniotomy. *Going home would give you a chance to think about things*, he said. I hesitated at first. How would it seem for a senior consultant to leave long before his junior doctors? But the previous operation had unnerved me, and there was an insistence in Rodriguez's face.

I surprise myself when I decide to leave my car at the hospital and walk. It is early evening. Elizabeth, I knew, would not be home. She would still be at chambers, hunched over case-notes, enraptured by her point of argument. Usually her work resembles output from an electrocardiogram with steady peaks and troughs. This week, however, she is riding the crest of a tachycardic wave with the Rainier case going to court on Monday. There was no rush for me to get home. No-one waited for my arrival. Before today an empty house seemed innocuous. I would even relish the solitude. But now it sits in wait for me like a threat. A state of mind, I'm sure, that has been largely caused by the events of today. Will retirement feel like this, I wonder, large stretches of time weighted with emptiness.

My work can pull me from my bed at 2 a.m. when Elizabeth is just entering it, then I may not return again until 10 p.m.. This stage of our lives has been our pinnacle. Everything culminating in an extraordinarily productive and ambitious mid-life that without it, without work, it can seem like there's nothing else. There is terror to be found in considering who we are once what we do is taken away. Divorce rates among retirees is on the increase, I'm told. Although a worry, this is not something I expect for Elizabeth and I. I fully expect her to continue working. Nothing will change for her, there is no reason it should.

Walking home, I choose residential streets. Although the route is more circuitous, the roads are quiet and there are hardly any people. It makes the journey less fraught. The rows of houses soak up the roar of distant main road traffic making it pale into white noise. An office-worker strides toward me then takes a sharp right, through his gate and then his front door. Momentary light escapes on to the pavement, as does a woman's voice singing out *Is that you love?* There is a vague smell of cooking which sends a message to my autonomic system reminding me I haven't eaten for many hours.

The cold doesn't bother me after the first half-mile of walking and I like the way my body adapts, becomes lubricated and warm. I place my hands gently in the pockets of my woollen

overcoat and can hear my mother's voice travel all the way across the decades telling me to remove my hands from my coat to avoid misshaping it. I do not. The wind has a sting and my gloves are in the hand compartment of my car. Although sensitive, my hands have been strong and dextrous. Hours of enforced piano practice as a child was excellent preparation for my profession and has made me very skilled at what I do. Patients, I notice, often scrutinise my hands. They are looking for assurances of my competence - are they clean, steady? Do they look like they're capable of saving lives? It is for them I push my hands deeper inside my pockets against the chafing of the wind.

The evening is not unpleasant though it feels unhappy. There's a sense of gloom tonight from the homes around me. Lights are switched on in the houses and often the curtains remain open. The rapid arrival of darkness seems to have caught everyone unawares. It creates a zoo-like sorrow. I am compelled to look inside. I notice how most houses I pass contain people lounging on the sofa watching television. Nowadays the screens are so large I can easily join them, viewing from across the street. I stop to watch a man in smart attire twirling a woman in a pink dress. Her skirts spin out full circle. Round and round she goes as if she's floating. He lifts her above his head and she is suspended horizontally in a perpetual mid-dive. The two never stop smiling, even though the effort of such a movement must be punishing. In the end, maintaining a rictus under such circumstances seems more impressive than the dance moves. Minutes later they stand arm in arm, chests heaving, sweating and, of course, smiling. I notice this is showing in most houses I pass. And the people are supine, stacked bones on their sofas. More often than not the rooms are dark and the inhabitants are only visible through the flicker of light from their televisions. Their faces are pale and grey and remain inert, unmoved by the superhuman prowess they've just witnessed. Contained in their bodies is a sedative calm not unlike the anaesthetised patient prepped for surgery. Not for the first time today I feel godlike. Watching people without their knowledge allows me access to a certain kind of denuding. Though they are doing little more than lying in passive repose, there is a vulnerability about the situation that, perhaps, given the choice, they would not want me, a stranger, to see.

My work entails contact with people when they are at their most vulnerable. I regret to say I am often the cause of their feelings of vulnerability. It is the narrative of diagnoses that, for all concerned, tends to be the most challenging. But often, at the crucial point of giving the diagnosis, I study their faces for evidence they understand. The patients give me no

response, just a deadpan face. I may briefly see the horror in their eyes, a current of shock and realisation, a fleeting gape of fear; then nothing. We humans have an unrelenting capacity for self-delusion and disbelief and I wonder, are they hiding away inside their incredulity? Does ignoring reality make life palatable for the time they have left? Or is their lack of reaction due to propriety and correct manners, even now in this most unimaginable of circumstances? I've heard that the prospect of death intensifies the living and, over the years, I've wanted to know what that must feel like. Looking at their unmoved faces I've wanted to ask them what they are really thinking. But I am a neurosurgeon, not a shrink, so do not. I am left sitting on the outside while the world, it seems, is happening inside of them. Their face, probably more a shield than a mask, is unchanged which, I'm sure, takes just as much effort as the forced smile of a dancer.

I find it important to get straight to the point during these conversations with my patients. My first encounter with this type of exchange, imparting devastating news, was almost thirty years ago. I was a Senior Houseman on surgical rotation with a cardiothoracic surgeon. Mr. Drayton's skill and precision with the scalpel was unparalleled, and I felt privileged to work with someone so accomplished in the early stages of my career. But he was much better with the patients while they were unconscious. During one of his outpatient clinics a 60 year old woman arrived with her husband. She had a life-long history of asthma and believed she was there for stronger medication. I settled them into an examining room and assured them Mr. Drayton would be along in a couple of minutes. Taking an unobtrusive seat, I was ready to watch and learn. The irritation across their faces was evident. A closer look told me they were overdressed for the appointment. He was wearing a suit and seemed unused to it, constantly fingering his collar or his cufflinks. She wore a long floral dress and was doused in perfume and layered in makeup. It became clear to me that they had planned to be somewhere else and did not want to be delayed here any longer.

Minutes later the small, mole-like figure of Mr. Drayton entered the room. He didn't have the typical surgeon's stature. Our bodies tend to be from a similar mould - thin framed and scrubbed, often associated with the tight control and perfectionism of a surgeon, though probably more related to the endless hours spent in surgery with little time for food. Mr. Drayton was round like a beachball with four skinny limbs. His dark greasy hair contained a dusting of dandruff. Without saying a word he went straight to the sink and washed his hands. We silently waited watching him dry each digit thoroughly with a paper towel. Then

he perched on the edge of his desk in front of the couple. It gave him a physical authority over them as they looked up to him from their seats. Mrs. Powell's handbag was balanced on her lap, her painted fingernails seeming to grip it defensively.

I remember there was a pause, and now I wonder if Mr. Drayton was thinking how he was going to proceed. It's not something we're ever taught; benefits of pregismoid over retrogismoid surgical approach, yes; understanding the six grades of the House-Brackmann scale when measuring severity of facial palsy, yes; being deeply empathetic in order to give people the worst news of their lives; no. In Mr. Drayton's defence, he did the best he could.

'How did you get here Mrs. Powell?' he asked. The question took us all by surprise. Husband and wife looked at each other searching for an answer as if it were a trick question.

'My husband drove me,' she said.

'Ah, and where did you park?' Again, looks of bemusement.

'In the carpark,' said Mr. Powell.

'The one directly outside?'

'No, that one was full. We had to park in the one across the road,' said Mr. Powell.

'Really? Astonishing!' Mr. Drayton pushed his circular spectacles back up the bridge of his nose. There was another pause. 'And did you walk from that carpark to here Mrs. Powell?'

'Yes.'

'How many times did you need to stop and rest?'

'None,' she said.

'None? Any breathlessness?'

‘Not really. None more than usual.’

Mr. Drayton nodded, never taking his eyes off Mrs. Powell.

‘And the stairs, Mrs. Powell, you managed the stairs okay?’

‘Yes.’

Again there was a pause. Mr. Drayton walked slowly to the consultant side of his desk, removed an x-ray film from a folder, placed it on the light-box behind him. He switched it on revealing Mrs. Powell’s lungs.

‘Mesothelioma,’ he said, and it tumbled innocently from his mouth like any other word. ‘You’ll see from the x-ray here, here and here,’ and he pointed to areas of white, as if part of the lungs had been wrapped in a shroud, ‘is pleural thickening giving you less than 50% of your lung capacity. It should, if it’s not already, make even the shortest walk feel like an expedition to the top of Mount Everest. I’m afraid it’s terminal. We wouldn’t expect you to live beyond 9 months.’

The diagnosis was a shock to me as well as the Powells and I felt myself being pulled down, as if getting caught by undercurrents that I had been unaware of, until that moment. I am not one for the hysterics of superstition and the supernatural, but there was definitely a shift of energy in the room. People can cope with the symptoms, the discomfort and pain of an illness; the horror lies in being introduced to it and knowing its name. At that point terminal conditions become unbearable.

The Powells, I seem to remember, looked at each other while Mr. Drayton rumbled on about palliative care and getting one’s affairs in order. Mr. Powell took his wife’s hand, the only detectable gesture of compassion I saw all afternoon, but they remained plain-faced as if they were standing in line at the supermarket.

On removing the x-ray from the light-box and placing it back into the file, Mr. Drayton said:

‘Ah! I see it’s your birthday today Mrs. Powell.’ I tensed for a moment thinking he was going to wish her a happy birthday. Taking the faint cheerfulness from his voice he said, ‘well my advice to you is to carry on with life as normal as possible. Go out tonight, if that’s what you had planned.’ The Powells just looked at each other.

When the consultation had ended I excused myself, went to the toilet and cried. It shocks me to think of the young man I used to be. Back in those days I would cry at the least amount of urging - a Valentine’s day card from a girlfriend, a sad song or story, feeling tired - all of it had the possibility to make me blub. Although I was embarrassed and angry with myself at the time, I look back now and I’m impressed with my emotional honesty, the ability for my feelings to agree with my actions and behaviour. It’s taken a lot of effort over the years to unlearn this skill.

I quickly realised cardiothoracic surgery was not for me; too much machismo. A cardio surgeon’s response to most things is to crack open a chest and rummage elbow deep until a problem is found then fixed. They do this in a hurry with the screech of a flatline in their ears and colleagues looking on shouting statistics which only mathematically reaffirms what they already knew - their patient is dead. But they are the resurrectionists, bringing people back to life. It’s why they walk with a swagger. And there are cures in cardio surgery, actual cures. You can have open heart surgery and be home a week later feeling like new again.

Death, to a cardiothoracic surgeon, is failure; death is the enemy. But to a neurosurgeon death can often be the preferred outcome. You see, when it comes to the brain, when considering loss of physical and mental capacities, there is clemency in death, a mercy. Over the years I have seen talented neurosurgeons spend hours excising tumours only to have their patients wake as nothing more than zombies, or not even wake at all. *Tiger Country*, we call it. Those areas of the brain responsible for language, memory or our very sense of self are dangerous territories. You have to be careful what you’re cutting and suctioning. A memory or a feeling, they can be gone in one tilt of a surgeon’s wrist. And there is not a surgeon alive or dead who hasn’t learnt this lesson the hard way. Unlike a heart or a lung, the brain contains everything that makes us human, and so our stakes are higher and our victories, real victories, are few. Deciding when to operate, now that’s where the true expertise lies; the art of knowing when to do nothing. I was more suited to neurosurgery in the way that it’s a

thinking doctor's occupation. And if, like cardiothoracic surgeons, there is a swagger in the way we walk, or an arrogance to how we speak, it is a lie. Because foremost a surgeon must always seem confident. There is nothing more frightening to a patient than an anxious, doubtful doctor. And so there is an act we portray that, as a doctor, just like the superhero and the saviour, we have signed up to; it's a hoax that must be perpetually and convincingly performed.

My first time, a time where I was solely responsible for communicating the indelicate news of a patient's demise, was to a man in his eighties. A small mercy, I told myself back then, since he had already lived a long enough life for it to be referred to as *a good innings*. However, when it came to it, when we were to look each other in the eye so I could tell him he had only a few weeks to live, length of innings seemed irrelevant. Death takes us all by surprise, no matter the age. We all think we know that we are going to die. But with medical advancements, we often don't experience loss and grief until we are ourselves very old. Consequently we have all become profoundly detached from the reality of the end of life. This was the situation I was in all those years ago; mid-twenties and no one close to me had died, so death, to me, was only an abstract idea, nothing concrete.

It was during my early days in neurosurgery, I was called to A&E for a consultation. An elderly man had been admitted complaining of headaches, dizziness and vomiting. He'd mentioned a recent minor fall and they'd sent him for a skull x-ray. That's how they discovered a subdural haematoma and I was called. I was pleased to take this case because I knew a subdural haematoma - a bleed on the lining of the brain, was very operable and likely to have a good outcome. Happy endings in neurosurgery, I'd found in my first few months, were in short supply. I hoped that my consultant would let me perform some, if not all of the operation.

Despite being very ill, the patient was fully cognisant and even cheerful sometimes.

'My God!' he said to me the first time I met him in A&E, 'how old are you? You don't look old enough to have left school, let alone be a doctor.'

I was indeed a young looking doctor and he enjoyed drawing my attention to this whenever the opportunity arose. His gentle teasing, or maybe it was just his age, reminded

me of my own grandfather. I transferred my patient from A&E to McWilliam late that evening and when I visited his bedside one more time before going home he was well enough to continue his banter with me.

'You're here rather late. Do you want me to telephone your parents, tell them you're okay and on your way?'

Or,

'It must be past your bedtime Dr. Fairchild. Isn't this a school night?'

I left the hospital with a good feeling that evening. Tomorrow I will get some operating time and save a man's life.

I arrived early the next morning and sat at a desk in the ward looking through his medical notes in preparation for my presentation at the morning meeting. My younger self felt exhilarated thinking about the day ahead. An inspection of the notes, however, identified a serious problem. I have come to understand that death, contrary to the generally held belief, is not a one-off event. Rather it is a series of circumstances that escalates to the act of dying. Like the smoker who develops a cough, then emphysema then lung cancer, then dies - the pathway to death, perhaps, started with a person's decision to smoke. There in the notes information presented itself to me whereby I could see my patient's successive episodes that would lead to his death. For reasons that remain mysterious to me, the night before I had missed it and so had A & E., my elderly gentleman had recently been diagnosed with aortic stenosis, a narrowing of the valve at the overflow of the left ventricle in his heart. Reading this I felt a strange sense of detachment from myself, as if I were outside my body, floating up to the ceiling. I looked down on myself hunched over a desk full of notes, I looked down at sleeping patients, a man pushing a cart of breakfast cereal, nurses in discussion. Because when I read about the aortic stenosis I realised general anaesthesia would kill him. There was no way he could have the life saving operation.

At the morning meeting my prognosis was confirmed. With complete agreement among my colleagues and superiors we decided this man must be left to die of his injuries. The initiation of death is not always clear. Was his aortic stenosis an inevitable prelude? Or did

he seal his fate when he stumbled and fell? Now I am a much older man this pathway to death has special significance to me. I am always looking for it in my own life, always wary of subtle shifts of wellness. Now, in my late fifties, it is likely I have already joined the path and the first point of death has happened.

That morning, in the morning meeting it was agreed: I was his doctor, so I wanted be the one to tell him.

I had experience, up until that point, of telling people alarming news. I had told relatives about the death of their loved ones. And as difficult as that was, I didn't feel the same as I did in that moment. Telling someone, you're going die seems very different to telling someone that a person close to them has died. Previously I had painted a portrait of the doctor as hero - we did everything we could to save them but, in the end, despite our best efforts, I'm afraid they were unable to survive their injuries. The relatives depart with the image of a doctor ceaseless in his attempt to save a life. That posture seems necessary for my own comfort as much as the families.

But I was struggling, in part, to know what role the doctor plays in this particular instance. Having come from a morning meeting where, like gods, we decided the fate of a man, I had felt myself turn into a doctor as villain. My tried and tested narrative of heroism was useless to me now, and I needed a different story to carry me through. No words were strong enough, I thought, to provide any real comfort. There were no consoling narratives I could give.

I was distinctly aware that, with the information of his imminent death, my position as his doctor had taken on an omniscient quality. I was about to tell him, with a great deal of accuracy, when and how he will die. It will be very difficult for him to hear. Once heard his life, what remained of it, will be changed forever. Some men would feel a sense of self-importance playing this role, they would feel powerful and divine, but not me. I was burdened by my position and the thought of what I was about to do made me nauseous.

I waited for his daughter to arrive before giving him the news. This involved me distractedly going about my business on the ward, always with an eye on my elderly gentleman so that I could see the moment the daughter appeared. The ward felt oppressive,

my body became clammy, and my breathing shallow. Eventually I saw the daughter, an elderly woman herself, materialise at the bedside and remove her coat. It was my cue.

I had, earlier that week, read an article in the BMJ about new research regarding the psychology of communication. People never hear the first sentence you utter, all important information, it said, should be contained in your second sentence. At the time this seemed a very useful piece of information. It gave me a place to start, all I had to do now was find the rest of the words.

I approached the bed and again, I had that strange sense of detachment. The hospital, the beds, the people around me didn't seem real. I asked father and daughter if this would be a good time to speak to them. My patient's symptoms had worsened overnight and I had to lean in to hear his weakened voice - he was asking me if I was going to be late for school. I saw this as an invitation and pulled the curtain around the bed for some privacy. I took the seat on the opposite side of the bed to the daughter. The patient's hair, I remember, was thin and wispy looking finely balanced on a leathery head. Propped up on pillows with his chin resting on the hospital blankets, the yellow claws of his fingers peeked out from underneath.

'What I'm about to tell you is very important,' I made sure I got both their attention and continued. 'I'm afraid we are unable fix the injury to your brain with an operation. I'm very sorry to say that we fully expect your brain to continue swelling and, we are certain, it will lead to your death. I'm so sorry, there's nothing more we can do.'

My voice broke, so I stopped talking before the rest of me followed.

There was a sharp intake of breath from the daughter as she raised her hand to her mouth, then nothing. My patient blinked slowly and had the look of a man who had been running from this moment all of his life. When the villain catches up with you, best to turn and go willingly.

I stayed and answered their questions and I sat with them in the silences. When I felt it was appropriate I left our little cubicle, keeping the curtains closed. They both thanked me. In my experience, no matter how frightening and terrible the news, they always do. Propriety again, I suppose. Afterwards, when I was in the toilet, I wasn't sure if my eyes

were wet because I'd been crying or because I'd just been sick.

Lately I have become preoccupied, a fantasy almost, of how the medical establishment will address me when it is my turn. Us doctors fail to think about this. We believe our white coats protect us from ever having to don a hospital gown. But for me it's coming, I feel it, it's coming.

That night, after my first inoperable subdural haematoma, I had one of my usual dreams where I wake up and am lying in bed, then at some point I realise I'm still in a dream. This is repeated over and over until I feel the horror of never being able to wake, realising that reality is lost to me forever. On my final false awakening I opened my eyes, looked across for Elizabeth, but lying there was my patient, his grey head on Elizabeth's pillow and his taloned hands holding on to the top of our duvet. He turned and asked me for help. It caused me to wake with a start.