

Like, a Whole Thing

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He is a standard patient with a week of shortness of breath. He smiles at me pleasantly as I walk into the room and introduce myself. He has 3 small boys with him, all eager to tell me their ages and favorite color as soon as I make eye contact with them. Nine, 8, and 6. They all *really* like blue. Having shared these important facts, they lose interest in me almost immediately and retreat to a corner to a coloring book they have brought with them.

My eyes scan the monitors as the patient tells me his story. HR 111, BP 260/140, satting 92% on room air. His vitals are all the more impressive because he is only 35 years old. “Are you taking your blood pressure medications?” I ask, but I already know the answer.

He does not meet my eyes as he shakes his head no. “Can’t afford it,” he says quietly. This is far from an atypical presentation at our facility, situated to serve a poor, rural community with limited access to primary care.

It is an easy diagnosis and an easy admission. His chest x-ray shows pulmonary infiltrates, his BNP is up, he has a troponin leak. I start a nitroglycerin drip and call an admitting service. Admission orders go in like clockwork; I am grateful for one simple case that night.

Two hours later, I receive a page overhead. I am surprised when the nurse tells me that the patient wants to leave AMA, that she has prepared the paperwork and just needs me to come “have the talk” with the patient. *I knew it was too easy*, I tell myself, annoyed that I had to add another thing to my growing list of things to do.

“I hear you want to go,” I say to the patient as I walk into the room, AMA form in hand. I try to keep my voice from betraying my irritation.

The patient meets my eyes. “I don’t *want* to go,” he says, his voice still quiet. “They won’t let me keep my kids upstairs. I don’t have anyone else to watch them.” I look at the AMA form where I had written the words *heart attack, stroke, death or permanent disability*. The 3 children color quietly in their corner, oblivious. Nine, 8, and 6. Blue, blue, blue.

My mind races trying to find a solution. “You don’t have any family around? A neighbor you could leave them with? Anyone?”

Again, his quiet voice answers steadily. “We don’t live in a neighborhood *like that*.”

I sit quietly for a second, my chest filled with shame. I am abstractly familiar with the poverty and violence that plagues the neighborhoods surrounding our hospital. I have offered a privileged answer to a man who has likely never had much of anything.

“Just...let me make some phone calls. Please don’t go until I come back,” I tell him. “I’m sure there’s a way around this. Just please don’t go.” He nods silently at me, but the lines in his face betray that this is far from the first time the system has failed him, that I am not the first person who has made him a promise she could not keep.

Twenty minutes and 6 phone transfers later, I find myself speaking with a woman whose title is something akin to Grand Pooh-bah of Insincere Apologies. Her voice is bright and cheery, incongruent with the dull gray of that hour of day. I explain the situation to her. We serve an extremely poor, underserved population. Complex social problems are our bread and butter. We are a safety-net hospital. I can’t possibly be the first doctor to have run into this problem.

“Oh my, that *is* a complex situation!” My heart drops. I can hear from her tone that I am about to receive one of the Insincere Apologies for which she has been trained. “But those nurses are right; that is our hospital policy.” The twinkle in her voice is unchanged by the fact that she has just asked me to give this patient a death sentence. “And if what you’re saying is true, if he’s really that sick, what if he needs to get transferred to our intensive care unit? With those kids there, that could turn into, like, *a whole thing*!” Her voice is shaking now, like she can imagine nothing worse than having to deal with the bureaucracy of such a situation.

Fine! I want to say to her. *You come down here, then. You come down and look this man in the eye and tell him that his life is worth less than you having to deal with a completely*

hypothetical whole thing. *Look at his kids and tell them losing their dad would create a mountain of paperwork for you, that it would inconvenience you.*

I try to keep my voice even, polite. “Is there anyone else I can speak to? A social worker or a patient care advocate? Anyone?”

“No, ma’am!” she says with sparkling confidence. “You have a good night, now!” She hangs up. She has done her job.

I feel a sick sense of relief when I look on the track board to see the nurse has left me a note that the patient has left AMA. I am ashamed at the relief I feel to have been spared the experience of looking that man in the eye and explaining that the system had, once again, failed

him. I am ashamed to have become another cog in a broken system, one that has reduced the Hippocratic oath and the complexity of dealing with human beings to, *like, a whole thing.* But the once-empty rooms have filled with patients while I was on the phone, and there are others, always others, that I must care for now. I close the patient’s chart and say a silent prayer for him as I walk into the next room.

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IMAGES IN EMERGENCY MEDICINE

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DIAGNOSIS:

Uncomplicated acute dacryocystitis. Dacryocystitis is an acute infection of the nasolacrimal sac, usually occurring in the neonatal period as a complication of a congenital nasolacrimal duct obstruction.^{1,2}

Dacryocystitis is characterized by erythema and the presence of a tender lesion proximal to the medial canthus of the eye, mucopurulent secretions from the lacrimal puncta, and concomitant conjunctivitis.^{1,3,4} The infection can spread quickly, giving rise to orbital and facial cellulitis or meningitis, requiring prompt systemic antibiotic treatment.^{1,2} Normal extrinsic ocular movements and pupillary reflexes are helpful in ruling out orbital cellulitis, and ultrasonography can be useful to exclude expansive lesions (hemangiomas, nasal glioma, encephalocele, and dermoid cysts) or intraorbital complications such as orbital cellulitis.^{4,5}

In our patient, ultrasonography revealed an abscess of the lacrimal sac (Figure 3). He was treated with intravenous ceftriaxone for 5 days, with rapid improvement and complete healing in 1 week. Seven days of oral antibiotics were provided at hospital discharge. Ocular culture swab was positive for methicillin-sensitive *Staphylococcus aureus*. Blood culture results were negative. Follow-up evaluation of nasolacrimal duct patency was arranged.

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