My Toolbox Is Never Empty

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As I pull up to the stoplight, frustrated at the glowing, red circle obstructing my passage, I am conscious of a young man on the corner to my right. He is selling *The Contributor*, a local "street newspaper" supporting the homeless and impoverished. These vendors are not unusual around the city. In fact, they are so commonplace that locals associate individual vendors with specific corners. There is the woman who sits outside of the McDonald's drive-through near the park, the tops of her thighs rosy from hours in the sun. Then there is the bearded man who brings a folding chair to the corner outside of the hospital and gives daily greetings to nurses, physicians, and other personnel.

But as my car comes to a stop, I feel my heart leap and my chest tighten. I recognize this man, but not because I am accustomed to him selling newspapers at this corner. Visions flash across my memory: a dark-skinned man, near-motionless in a hospital bed. He had been brought to the emergency department (ED) by his mother, in a state of confusion. The clinical team was concerned for nonconvulsive status epilepticus.

Then, just as quickly as my heart leaped, I feel it tumble deep into my stomach, and a new image appears in my mind. I see the same man, responsive now, but appearing downtrodden at the news I had just delivered: that he is not permitted to drive for at least 6 months due to his seizures. He is an immigrant from the Sudan who obtained a bachelor's degree in mathematics after arriving in the United States. This degree had given him hope, but he expressed concern about being able to work without a vehicle, to which I provided an inadequate response.

Now, as I sit in my own vehicle at his corner, I am acutely aware of our intertwined but divergent paths. I feel the red heat of shame brush my face as he looks to the cars for potential customers. Will he recognize me? Unsure of what to do next, I turn my eyes to investigate the left leg of my jeans. Mercifully, the light turns green, and I drive forward, staring intently at the vehicle before me.

I was a medical student when I met him in the ED, as well as when I hid my face that day. Three years later, I am beginning residency in emergency medicine, but the moment I turned away from the man at the stoplight still fills me with sorrow and self-reproach. We anticipate having moments that shock or challenge us in the hospital. But we expect them to stay there, enclosed in the whitewashed walls of a hospital room. So when the clinical world visited me on a street corner, I found myself ill-prepared and disoriented. Though several years and numerous clinical encounters have occurred since then, I still find myself reflecting on that day. While the shame persists, I have molded that feeling into an ethic that I hope will guide my actions as a resident and practicing physician.

The man's visit to the ED was not an educational simulation, in which the story neatly concludes in 10 minutes and the patient exists only within the walls of the exam room. Seeing him on the corner, I was ashamed at not having considered more completely what a seizure might mean for him or his family. I sank with guilt for the emotionless manner in which I had told him he could not drive. I felt inhuman for not having explored the impact of his health on his dreams and for not seeking out resources to assist him. I loathed the idea that I had played a role in bringing him to that street corner, so I turned away.

We prefer to think that our interactions with those in the ED produce idealized results: that a patient can afford their medications at discharge, that they will follow up with a primary provider in a week, and that by receiving pages of generic discharge instructions they will be transported forward on the road to a better life. But when we find ourselves shocked to confront the opposite, as I was that day in the car, we must take the opportunity to reorient ourselves to the stories of our patients and the life trajectory that each encounter may initiate. Only then can we look squarely at the suffering we not only seek to ease but also that we unintentionally produce.

As individual physicians, we will not eradicate homelessness, substance abuse, or other major public health crises, but we have an obligation to consider the lives of our patients beyond each individual encounter in the ED

and welcome opportunities to be present in their lives outside the hospital, even if that is a casual encounter on the street. Instead of letting our paths diverge once again that day, I could have spent a brief moment building community, showing him that he is not forgotten. I could have pulled over, reintroduced myself, and asked about the man's health and how he was coping. At the very least, I could have purchased a newspaper that day.

We cannot take it upon ourselves to resolve every individual's troubles, but I enter residency with the determination to place each medical encounter in the context of the patient's greater life narrative. I will not only acknowledge the immediate suffering of their emergency but also the suffering preceding and following my time with them. In this way, I will equip myself to meet their needs more completely. Though at times I may feel there are no more tools in my toolbox, that is never true. What I failed to offer the gentleman—both in the hospital and on the corner—were my time and presence. Even with no medical care to extend, we can create community. And wherever community exists, there is the potential for healing.

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IMAGES IN EMERGENCY MEDICINE

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DIAGNOSIS:

Henoch-Schönlein's purpura. Henoch-Schönlein's purpura is an immunoglobulin A–mediated vasculitis that commonly presents in children after a viral illness. Diagnosis consists of palpable purpura (a mandatory finding) in addition to at least one of the following: diffuse abdominal pain, skin biopsy with immunoglobulin A deposition, acute joint pain, or renal impairment including hematuria or proteinuria.[1] Although common in children, affecting approximately 15 per 100,000 annually, the incidence in adults is far less common, ranging from 0.5 to 5.1 per 100,000 patients.[2,3] It is important to accurately diagnosis Henoch-Schönlein's purpura in adults because nonpediatric populations are at higher risk for disease sequela. Older than 50 years is a strong predictor of severe renal impairment.[2]

Henoch-Schönlein's purpura was suspected in our patient with hematuria and palpable purpura, although his renal function during his ED visit was normal. The patient was referred to rheumatology and dermatology, where skin biopsy confirmed immunoglobulin A–mediated vasculitis. At subsequent visits, the rash had nearly resolved and the patient's renal function remained normal.

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