Our Best at Their Worst

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Tired of being yelled and cursed at, the rest of the team had stopped rounding on Mr. J. For some reason, though, he tolerated me in my short medical student's white coat, so each morning I was his sole visitor. His room was sparse—ever since he had shoved his bedframe at a medical assistant, we had removed his furniture—and Mr. J slept on a tattered mattress on the floor. He wasn't *polite* to me, exactly. Most days he refused to speak at all, barely willing to open one eye for me to check his pupil, but he never threatened me. "I always admire you Orientals," he said benignly in his scratchy, worn-out voice when I asked why. "Your families still teach you courtesy."

From our perspective, Mr. J's chief complaint was a deep vein thrombosis in his left leg, which he steadfastly refused to let me examine, and he was stuck with us taking warfarin until his international normalized ratio (INR) reached a therapeutic level. From his perspective, though, Mr. J's chief complaint was heroin withdrawal. He spent his days yelling that he needed more methadone, but each day I reported back to my team honestly: he had no goose bumps, his pupils were constricted, and he reported no diarrhea. "So his methadone is okay," my resident would reply. "What's his INR?"

Visiting him each morning—and cajoling him not to leave against medical advice each afternoon—seemed pointless. I didn't expect him to comply with his warfarin regimen, much less abstain from heroin, after his discharge. I was relieved to leave him behind when my monthlong rotation ended.

But as my third year progressed, it turned out Mr. J was an incredibly typical patient. Month after month, patients presented with medical problems rooted in poverty, addiction, or personality disorders that our acute care teams were helpless to fix. Many yelled at and threatened me. When my Christmas break finally arrived, I wearily boarded the light rail to the airport and found myself watching a layer of snow painting over the depressed areas through which the city had built its train. It reminded me of the days and nights I spent buffing laboratory numbers pointlessly without making a real difference in the chronic social and medical illnesses that afflicted my city.

Somehow, that was the moment when I heard a voice full of familiar scratchiness and unfamiliar joy, calling, "Doc!"

"Mr. J—," I answered, startled. Half mindful of his privacy on a crowded subway, I cut myself off partway through his name. "How are you doing?"

"2.4!" He laughed easily at my lack of recognition. "My INR! I just got it checked this morning." He grabbed my hand and shook it enthusiastically. "I just wanted to say thank you for everything. See?" He eagerly showed me the leg he had never let me examine before. "Thank you, Doc!" he called out, already walking along—quite quickly, considering his limp—to greet somebody else. "I really appreciate it."

I stood there, dumbfounded, as I tried to reconcile the Mr. J I had known with the mirthful one here. Perhaps his withdrawal had subsided, or perhaps he had found a methadone clinic that was caring for him better than we had, or maybe he was back on heroin. Or maybe he was just relieved not to be locked in a small room with a once-green mattress on a cold tile floor.

I was still standing there wordlessly when another man cleared his throat quietly. "Excuse me," he said. "Are you Willie's cardiologist?" I looked briefly at Mr. J's tattered combat fatigues and then back at this man holding a leather briefcase and towering over me in a navy suit and overcoat.

"No," I stammered. "I was just his medical student."

"Well, I wanted to say thank you," said the man in the navy overcoat, and I found myself surprised for the second time that train ride by an enthusiastic handshake. "You know, he's often the best part of our day."

I blinked.

"He rides the train up and down all day," the man explained, "and he greets all of us with a smile. He asks us how our families are doing. He encourages us." I looked down the train car, wondering whether we were talking about the same man, to see Mr. J clapping people on the back, shaking hands, and issuing alliterative nicknames. "When we saw his leg swell up like that, and then when he disappeared for a few weeks, we all feared the worst. It was

such a relief to see him back here, lifting our spirits again. So thank you—whatever you did for him, you did it for us."

I had visited Mr. J every morning and afternoon for 24 out of 28 days and it turned out I hadn't known him at all. My mechanical conclusion-drawing about his personality—observing, extrapolating, and reacting—had been based on what I saw when he was neglected, in pain, and stripped of any creature comfort. Believing the worst about him eroded my hope in his future and, by extension, our work in his life.

I think of him often, now, as a pediatric emergency medicine fellowship brings me face-to-face with patients at their physiologic and psychological nadirs. If I take an extra moment to listen, I may find that a violent, autistic teenager adores his older sister and only began to act up when she left for college. I might hear a toddler's rendition of *Baby Shark*, sung in perfect English by a child who otherwise knows only Arabic. Or I could see that a patient's delirium is calmed best not with dexmedetomidine but with photographs of his loved ones.

More often, though, the pace of the emergency department leaves no time for those humanizing details. But if I am not to lose hope, I must fill in that gap with a conscientious determination to believe in a patient's best even if my own eyes never see the evidence of it. I must choose, in other words, to have *faith*.

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IMAGES IN EMERGENCY MEDICINE

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DIAGNOSIS:

Paraneoplastic acral vascular syndrome. Paraneoplastic acral vascular syndrome presents as distal digital ischemic changes in the setting of known malignancy and absence of an acute embolic or occlusive cause. Skin changes can range from painful discoloration to ischemic necrosis and gangrene. It can develop before the detection of malignancy and can mimic Raynaud's disease, vasculitis, vasoconstrictive drug use, or thromboembolic disease. Although associations have been made with pulmonary adenocarcinoma, age, and thrombocytosis, much remains unknown about the syndrome, including its pathophysiologic mechanism.[1,2] Occult malignancy and paraneoplastic syndromes should be considered in older patients presenting with acral ischemic changes and significant risk factors for malignancy.[3]

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REFERENCES

1. Le Besnerais M, Miranda S, Cailleux N, et al. Digital ischemia associated with cancer: results from a cohort study. *Medicine*. 2014;93:e47.
2. Gambichler T, Strutzmann S, Tannapfel A, et al. Paraneoplastic acral vascular syndrome in a patient with metastatic melanoma under immune checkpoint blockade. *BMC Cancer*. 2017;17:327.
3. Poszepczynska-Guigné E, Viguier M, Chosidow O, et al. Paraneoplastic acral vascular syndrome: epidemiologic features, clinical manifestations, and disease sequelae. *J Am Acad Dermatol*. 2002;47:47-52.