The Journal of Emergency Medicine, Vol. 57, No. 1, pp. 119–120, 2019

0736-4679/$ - see front matter

https://doi.org/10.1016/j.jemermed.2019.04.016

Humanities and Medicine

RUNNING IN CIRCLES

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Reviewing a list of medical record numbers was not the way I had pictured spending the night before my last shift of emergency medicine residency. I was in charge of morning report the next day and I needed to find an interesting case. I considered repeating a previous case, but I refused to succumb to senioritis.

Yet, the minutes were passing by and I remained uninspired. Nostalgia for my program diluted my concentration with the memories of residency retreats, midnight pizza, and once-in-a-lifetime cases.

I tried to think back to my first experiences as an intern, but the days blurred together. I tried to remember my first patients, but I couldn't. A small idea popped into my head. Could I find the very first patient I treated as a physician? I didn't have a clue how to look that far back through our electronic medical records. I crossed my fingers and texted our vice chair of clinical operations with my outlandish request. "Hey, could you find out who my very first patient was? Ever?"

The response was quick: "I'll try."

I wondered who my first patient was. Male or female? Young or old? What was wrong with them? Back pain? Chest pain? Likely it was a gentle case that would be ideal for a first-day intern. I was a little nervous. I hoped I hadn't missed anything. After all, this was the first person I ever introduced myself to as "Dr. Garcia."

Thirty minutes later, the vice chair told me to check my e-mail for a medical record number. I started by reading my own note from the morning of July 1st. Good, I thought to myself, this is a perfect case to adapt into a morning report. A 44-year-old woman with chronic obstructive pulmonary disease (COPD) on home oxygen, right heart failure, and an opioid addiction would have all the making of a good morning report: a wide differential, chest x-rays, electrocardiograms, and, of course, management pearls.

When I took care of her that July, she was admitted for an exacerbation of COPD and heart failure. The presumed cause was medication non-adherence. Relief! It looked like I didn't miss anything. I continued to scroll through her chart. She had a lot of visits to the hospital but her name wasn't ringing any frequent flier bells.

I started to tally up my findings. She spent 74 days in the hospital across 15 separate visits in 2014 alone. Her visits in 2015 were similar. Over those 2 years, she had been seen by 80% of the residents in my program, sometimes in the emergency department, at other times in the intensive care unit. She had been seen by almost every attending as well. At our hands, she had been intubated four times, had two central lines placed, and countless bedside echocardiograms performed. Sometimes we turned her around in the emergency department; sometimes she required admission.

Social work notes described a difficult home life. She was estranged from her adult children. She was supported by her mother and Supplemental Security Income. In 2014, her utilities were shut off multiple times for nonpayment, which prevented her from using her home oxygen machine and forced her straight to the hospital.

Received: 31 March 2019;
Accepted: 5 April 2019

Thankfully, social workers were able to help pay her bills before discharge each time. I was embarrassed that I didn't know that home oxygen required electricity and I was literally one day away from completing residency.

She struggled with addiction. She had insufflated heroin for most of her life and bought methadone off the street in an independent attempt to discontinue her habit. Several inpatient physicians documented providing drug counseling, but, sadly, no emergency medicine provider recorded an attempt to address this part of her illness.

As I looked through her chart, medication nonadherence and opioid abuse were her two constant companions. Conspicuously missing from her chart were any outpatient clinic notes. Likewise, the importance of keeping clinic appointments was never documented by emergency department providers. After reading so many similar notes, I felt like we had been running in circles the whole time.

I didn't know it at the time, but one morning during my second year of residency, she was found by her mother in cardiac arrest. Although she was initially resuscitated, 3 days later, she was transitioned to comfort care. One year and 11 months after I first saw her, my first patient died. She was 46 years old.

Two years after her daughter died, I tracked my patient's mother down to a nursing home not far from the hospital and called to offer my condolences. She was in good health but could no longer manage living alone after her daughter's death. She was elated to hear that her daughter had not been forgotten. She told me that her daughter had been her only companion. I was her first phone call in 2 years. She had never had a visitor.

I realized that my morning report was not about COPD or pulmonary hypertension or opioids. It was about her, my first patient. I wanted to share her life and her struggles with my colleagues. I wanted to point out our shortcomings as her providers. I wanted to share her impact on our emergency department and hospital.

My first patient had taught countless residents and students about COPD and heart failure. She had taught them about critical procedures and end-of-life discussions. Even 4 years after I treated her, she allowed me to reflect on my vital role as a physician.

During my initial review of her chart, I had been relieved that I hadn't missed anything, but, on second thought, maybe I had. If I had known that she would die so young, would I have taken the time to counsel her? Would any of my colleagues have counseled her? Would we have tried harder to make sure she kept her outpatient appointments? I will never know the answers to those questions, but I do know that I will have many, many more patients like her and I must strive to act sooner for them.