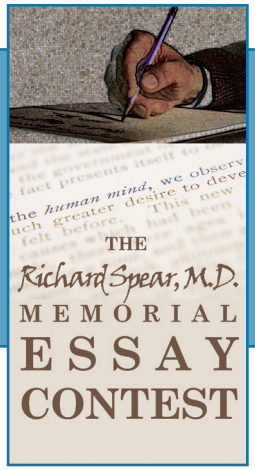
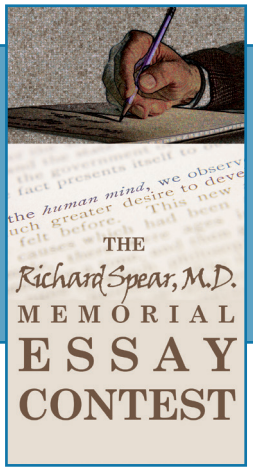


PRACTICING AND LIFE MEMBER CATEGORY

WINNER

2015 RICHARD SPEAR, MD, MEMORIAL ESSAY CONTEST



THE UNEXPECTED IN FRONT OF US

Nina Vasavada, MD

I pick up the manila chart from the rack outside the examination room and read the chief complaint, "Headache." It is a Thursday afternoon, a few weeks into my third year medical student internal medicine rotation. The newness of it all and the breadth of disease processes still overwhelm me. I tap on the door twice and open it, cautiously and apologetically. I suspect that many patients are politely tolerating my novice and amateur inquiries until they can see the attending physician, their consultant, confidante, and dare I say, friend.

The patient is a young woman, just a few years older than I. She notes the frequent onset and worsening duration of migraine headaches, and has been requiring high dose pain medicines to provide relief. I ask questions which might be pertinent to a neurological illness, and conduct a focused exam. We come up with a satisfactory plan for her chronic headache management. I step out of the room while the attending physician speaks to her alone. Soon after, she thanks us as she leaves the office. I muse at how straightforward the case was, and then go pick up the next patient chart. Friday is another pleasant yet busy workday full of varied clinical dilemmas. Having no major responsibilities other than my own education, I enjoy a relaxing weekend studying at my favorite coffee shop and spending time with my equally responsibility-free roommates. It is truly a wonderful phase of life.

Monday quickly passes, filled with simple and complex medical challenges. At the end of the day, I sit down at the nurses' station to navigate the tidal wave of new facts and illnesses. The attending physician energetically and emphatically barrels through his dictations; then, he unexpectedly pauses. His demeanor and expression shift to a somber and pale sadness. He passes the day's newspaper to me. I gleefully take it, looking for a literary reprieve from detailed and fact-filled medical texts that require intense concentration.

My heart sinks as I read the article that he points out. It is the obituary of my young patient with chronic headaches whom I had only met five days prior. She had died over the weekend, the victim of traumatic domestic violence. I contemplate if her office visit was a cry for help, a hope that somehow a discussion of violence would have changed the course of her too-quickly ended life. I learn that her office visit was similar to prior visits, during which the recurrent conversation of abuse and advice of potential options for leaving the harmful situation had been discussed in detail but not heeded. I am devastated by the unforeseen abruptness of her death. I take the article, and reexamine my short visit with this patient over the next few days. I save the obituary in a file folder, dwell on the tragedy for a short while longer, then continue the daunting task and workload of a third year medical student in the midst of introduction into clinical medicine.

* * * *

Several years later, as a young, energetic, medical fellow, night call came with a combined sense of dread and adventure. On a fairly typical call night, I heard my pager chime, and learned that there was an emergency consult from the detention area of the public hospital emergency room. A young man, barely an adult, was diagnosed with severe life-threatening kidney injury. As I drove into the hospital parking lot, I considered the expected possibilities. Perhaps he had an overwhelming infection, a new diagnosis of a worsening long-term illness, or an ingestion of a recreational or environmental toxin. I prided myself on what I thought was a thorough and complete differential, arrived to find the young man, and started the medical interview. He looked disheveled, traumatized, but appeared to have

been healthy prior to this illness. He reported no prior known diseases, no recent fevers or illnesses, no toxic ingestions.

"Truck surfing," he stated, rather plainly. He neither made eye contact nor volunteered other information. I gathered from the emergency room team that he had been competing with a friend to see who could hold on longer to the side exhaust stack of a moving semi-truck travelling on the highway. When the truck driver realized this, he applied the brakes, and the young man fell at full speed onto the asphalt concrete highway. The young man suffered intense trauma, with resultant severe muscle breakdown and kidney failure. He required intensive care for several days. Afterwards, he recovered, with normal kidney function and no long term physical injury to remind him of his extremely poor judgment in recreational activity. I wondered what motivated him to carry out such a dangerous action. Was it depression, ambivalence about his future, or simply impetuous and foolish decision making? I reflected how unexpectedly fortunate this young man was, to walk away from such intense trauma with minimal physical wounds, whereas similar situations have resulted in dramatically worse outcomes.

* * * *

In clinical practice now, I find myself in a marginally comfortable space: somewhat at ease with recurring patterns of health and disease, but still regularly caught off guard by new presentations of illness, unexpected complications, and diagnoses that were only remotely considered. The disconnect is often between the provider, who wants better clinical outcomes, and the patient, who may seek higher quality of life, better sexual function, and energy to complete the work day without medication side effects. Several patients have explained that part of the joy of taking a vacation is taking a "vacation" from their medications. Medication holidays, such as missing diuretic doses so as to not interrupt Thanksgiving holiday visits, make for predictably busy office and hospital services after the holidays have passed. It is remarkable how expectations for plans of care differ greatly between provider and patient.

* * * *

It has been 19 years since I was that third year medical student reading my young patient's obituary. I recently found her news article in a file folder, stored with an assortment of evaluations, presentations, and buried under current life souvenirs of preschool hand-prints and treasured stick figure drawings of family members holding hands. I reflect upon the horrific circumstances of her death, the years of joy and personal growth that violence stole from her. I had only focused on what I expected, the organic and neurological causes of headache with a narrow differential. Sometimes recognition of the unexpected is almost too much to bear.

These varied experiences show me that there is always a third entity in the physician-patient relationship. It is the subjective, personal part of health care, the underlying struggles that each patient brings into the equation. These distinct and unseen concerns have a penultimate impact on the need for patient support, delivery of health care and patient outcomes. My professional aim is to recognize that the hopes, fears, and concerns of patients do not automatically get discussed in between blood pressure, glucose control, and blood chemistry results, yet they play such a pivotal role in the overall effect of care. My goal is to recognize that in every patient encounter, the unexpected is right in front of us.

Note: Nina Vasavada, MD, practices as assistant clinical professor at the Division of Nephrology at the University of Louisville.