Thinking doctor

The road to healing

William A. Curry, MD, FACP

The author (ΑΩΑ, Vanderbilt University, 1975) is Associate Dean for Primary Care and Rural Health at the University of Alabama School of Medicine.

> This patient needs a thinking doctor.
>
> —Anonymous Neurosurgeon

Thank God there was one patient who didn't need me to think. Nineteen others populated a brutally busy general medicine service, and it was my first day to get to know them. Half had been admitted overnight. Two interns, a senior resident, and a medical student did their best to move us through rounds, while I checked on the notes from my predecessor. They were all sick, these patients, and most of them had tough home situations, if they even had homes. "Challenging psychosocial factors," we like to say. "Rocks," the residents call them, because they never move from the hospital or from the long team list that becomes the reality of a ward service. If we're going to teach, or take good care of them, or have room for more, or get some sleep, or have a life, we have to trim that list.

Mr. B wouldn't help us trim the list anytime soon, but then he didn't demand much. He was forty-seven and hopelessly demented. That was the first thing I heard, and the second was that if you left his meal tray in front of him for too long he would eat the styrofoam plates and cups. Not only was it the stuff of instant legend, it was the ticket to question-free rounding. Bizarre, not typical, a little threatening. Maintain barrier precautions, stay on guard, move on.

He was quiet, entirely mute, sleeping a lot but always arousable and even

Illustration by Erica Aitken.

serene, gazing purposefully at us with no response to our greetings. Neurologically he was intact but for the glaring exception of his mental status. Physically and biochemically, everything else was perfectly fine. The lights were on, but nobody was home. He was "medically stable, awaiting nursing home placement." The only delay was for Social Security to certify him. That would trigger the nursing home's acceptance, his removal from our list, and replacement with a more complex and educational patient.

After four or five days of stopping at his bedside, we discovered that he had a fever. Not much, just a degree or two, below the threshhold of a "significant fever." It was a teaching opportunity, the question of what is a "significant fever." It has to do with the probability of sepsis, blood-borne infection, life-threatening infection. But "significance" is a relative term. The little fever made us stop and examine him a bit more, make sure there wasn't something serious about him. It wasn't much, but it might have been what began to change the way we looked at Mr. B.

Eventually the fever went away with no treatment, and we decided he just had the cold that several team members and patients had suffered. It was the first thing we could see that we had in common with Mr. B. After all, he was a lonely black man with no apparent cognitive function: tragic, sad, hopeless. We were healthy white guys, smart and getting smarter, entrusted with the keys to the kingdom of life and health. In our best moments, we acknowledged our humility and humanity.

I felt compassion for Mr B, at least as much as time allowed, but there didn't seem to be anything we could do but feed and bathe and clothe him, and hope he could get out of the hospital before he caught something more serious than a cold. But the viral bonding was a start. Bidden or not, we had that in common. I tried harder to talk to him. He nodded yes and no to simple questions in a consistent way. There were rare reports of a few words from his mouth, appropriate, to the point, but very simple. Still compatible with severe dementia, but a little more functional than we'd thought. Was he scared, intimidated as demented patients often are in an environment as strange as a hospital? Or had he been pretending some of this?

Then came the call from the Feds. This guy was not at all who we thought he was. He hadn't grown up here, somehow managing to get lost or estranged or otherwise separated from any human support. He was an immigrant, with an invalid Social Security number, an alien. It fit, his being an alien. Not just from Africa as they said, but maybe not from this planet, this solar system. It would explain why he ate styrofoam, or had that faraway look. Maybe he understood everything and this was part of the invasion strategy. What would be next?

Okay, that was ridiculous, but who was this guy? Earlier I had run the record for proof that he really had a dementia. The multi-infarct diagnosis didn't fit, because the strokes on his CT were in the wrong places to affect his thinking. But he did have the loss of brain tissue overall, and dementia was the best description of his state. The tests for treatable causes of dementia had been done, with an exception or two that we added, and all were negative—all, that is, but one. He had not had a spinal tap to examine his central nervous system for infection or other strange causes of his mental wipeout. So we did that too, and it was normal.

But who was this guy? How had a solitary foreigner managed to get along in Birmingham, Alabama, and then end up like this? The little fever had started it but the Feds had fanned the flames. The old records showed that a year ago he had been admitted when he showed up saying he was living on the streets and needing a place to stay. He got IV fluids and was sent back out twice. But—this guy surviving on the streets? That took a lot more skill and smarts than he had now. Obviously he'd lost a lot of function in just a year. How did he get here this time, where had he been?

We found he'd been in a boarding home, and his landlady knew things. He had come to this country for graduate study and taught college mathematics. The rest was still a blur, but somehow, whether it was the dementia or something else, he'd fallen on terrible times that now looked like this. Was there redemption for Mr. B? Would the urbane members of the Faculty Club band together and rescue him? Was there a pot of gold at the end of this murky rainbow? Apparently not. We had come full circle. He was alone, unfunded, and hopeless—if hope is measured in the possibility for recovery of function, autonomous decision-making, or working crossword puzzles. He was after all a problem for the social workers and lawyers, a question of where his disposition for custodial care would be outside the hospital, a "dispo problem." My compassion could not change that—or could it?

Labels help a lot in medicine. They categorize, prioritize, order our thinking. But they can close us off from the truth. Dementia can be reversible, but not for Mr. B. Dementia can be treatable, even for Mr. B. After all, it turns out he can communicate. What about prejudice: pre-judging—is that reversible? Treatable? We can re-examine diagnoses in our patients, but what if the processes already have gone too far for too long? The tissue damage can be relentless and eventually irreversible. What about the tissue of my own relationships, my own life? I can re-examine my attitudes and assumptions, but what if—like for Mr. B—the tissue of my relationships, the synapses of my connections, are far gone? Just as Mr. B is alone without connections, could I find myself cut off from the humanity that brought me into medicine? Why do this alone? What can I do about lost time? Is there a way for a thinking doctor to think about that?

The author's address is:
Faculty Office Tower 720
1530 3rd Avenue South
Birmingham, Alabama 35294-3407
E-mail: wcurry@uab.edu