Narrative Essay

Primary Care Ride

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In this essay, the author describes an experience of attending to the death of a patient that reaffirmed the values that led him to family medicine.

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Pedaling fast to stay warm on a cold morning, initially I did not hear the beeper chirping under my clothes. When it registered, I grudgingly pulled over and peeled layers of clothing to find the device. The chill of late November always comes as a shock, even colder and more biting than once winter has settled in. I dialed the unfamiliar number on the pager into my cell phone. The answering voice glibly slurred:

"Emergency room, St. Blank's Hospital."

"This is Dr Ennis, I was paged."

"Hold on."

On the sidewalk for several minutes on hold, I was getting colder and frustrated. Worried about being late, I clumsily began to pedal my bike, steering with one hand and trying to keep the phone near my ear with the other. This morning, I was scheduled to teach a 3-hour marathon session to 16 third-year medical students on their family medicine clerkship. Finally, while I was negotiating morning rush-hour traffic one-handedly, a woman's voice came on the line.

"Hello, Dr Ennis. This is Dr Brown. A patient of yours was brought in by the paramedics this morning. His name is Jamie Merchant, a 10-month-old baby. His mother found him unresponsive and cold this morning. He had no vital signs upon arrival. We coded him for over an hour but could not bring him back. It's probably SIDS."

Stunned, I stopped the bike. Not sure what to say, I said nothing for what seemed a very long time. Now feeling an entirely different kind of chill, I dry gulped and stammered an inquiry about the child's family. The physician explained that both parents were there.

"As you'd expect, they are very upset."

I asked a few more questions about the circumstances of the baby's death. Dr Brown said the infant had been co-sleeping with his parents, but she did not know much else. I thanked her for calling me and pressed the End button. Getting myself repackaged, I began to ride ever faster toward the medical school.

Not conscious of pedaling, my mind became absorbed in the tragedy. The death of a child always seems so inexplicable, so unfair. This was the absolute worst thing that could happen to a parent. Jamie was so innocent, at that age when infants garner unconditional love from the world with almost everything they do. I wondered what I should do. Go to St. Blank's, a hospital where I had no clinical privileges and knew none of the staff? The event had a sense of finality that takes the wind out of the sails of a doctor's interventionistic bent. My mind kept racing. Doctors save lives; there was no life to save. What was there for me to do as an interloper in a strange hospital? Anyway, there was a conference room full of third-year clerks waiting for me. All the rest of the clerkship faculty were off at a national meeting in a sunny, warm place. There was no one to call to pinch hit. My presence at that class was essential. Despite my rationalizations that directed me toward the medical school, I turned the bike toward St. Blank's.

The emergency room was relatively empty that early morning. As I wandered my way into the clinical area, I could hear the baby's mother sobbing and screaming hysterically. Her uninhibited, raw emotion served as a beacon helping me to navigate to that area of the ER. There were several doctors and nurses outside the room where they had attempted the resuscitation. In a corner, the extended family encircled the mother trying to calm her. Their overtures to soothe her only seemed to agitate her more. Off to the side, pacing back and forth, was the infant's father, looking lost and absorbed.

I approached the doctors first, wanting to get a better understanding of the medical facts. Hesitating,

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I wondered if they would regard me as an intruder trespassing in their domain. They were emergency physicians, and I was a family doctor. They were on their home turf, and I admitted my patients to an entirely different hospital system. I sheepishly said to one of the docs:

"I'm Mike Ennis, Jamie Merchant's primary care physician."

It took a few seconds for him to register that Jamie was the name of the patient with SIDS—realizing the connection, he excitedly said to the other staff: "This is Dr Ennis. He's the baby's PCP." To my surprise, they not only genuinely welcomed me, they seemed exuberant to see me, like I was a long lost sibling who came unannounced to Thanksgiving dinner. The doctors and nurses invited me to hear everything they knew about the infant's story, all the heroic measures that failed in their emotionally depleting near hour-long code. Even though the baby was a little older than typical for the diagnosis, they nonetheless suspected SIDS. The ER staff then seemed glad to surrender the management of the aftermath of the case to me even though I had no official credentials at that facility.

I had known the infant's mother, Amanda, for more than 15 years. We first met when she was a teenager in my early years of practice. We got to know each other over the typical fare that brings teens to the doctor: acne, contraception, mono, a physical exam before enrolling in community college, etc. After a few fleeting relationships, Amanda met Joe. They were married, and he became my patient as well. I delivered all three of their kids.

Amanda's crying was of a pitch and cadence rarely heard in public; it rendered her pain palpable. My mind flashed back to the last time I heard a patient cry like this, when I delivered a stillbirth. As I approached the family huddle and began to gently peel through the relatives enveloping Amanda, I again felt a sense of timidity. What does one say at a time like this? As a doctor, I am trained to act, to do. At least, I should say something thoughtful, definitive, helpful. Instead, I merely said her name, "Mandy…" Before I could offer anything else, Amanda turned and hugged me, really tightly. I awkwardly tried to gauge the appropriate amount of hug to return.

Over many years of practice I have come to accept patients' tears as a regular part of doctoring. But Mandy's rhythmic sobbing, in my ear, grabbed hold of my soul. Mandy would not let go of the hug. Her husband, Joe, stirred from his pacing and came over and joined in the hug. Now I was really uncertain of what to do. When we finally came up for air, I could only clumsily utter how terribly tragic and unfair the whole situation was. Here, as with the emergency room doctors and nurses before, the entire extended family seemed relieved that I was there.

Surprisingly, after our long embrace, Mandy appeared to gather herself together a little. She was still crying, but the tempo was calmer, more in control. She wanted me to go with her into the resuscitation room to see Jamie. There he lay, full of failed lines and tubes, ashen, completely robbed of all signs of life. The jovial, engaged countenance that illuminated his recent well-child visit was gone. Nonetheless, I could still discern the family resemblance to his two older siblings. Mandy then asked, "Dr Ennis, did I kill my baby?"

"What?"

"Did I kill Jamie by sleeping with him?"

This took me aback. Imagining how utterly terrible she felt, I tried to summon the imperturbability that Osler said every doctor needs to call upon to steady himself in times of crisis. I had the impulse to immediately respond with a resounding, "No, Mandy, you didn't." But instead, I asked "What makes you say that?" Mandy went on to tell how some of the doctors and nurses had asked questions about her sleeping with her baby: "Do you always sleep in the same bed with him?" "Did you awaken to find yourself on top of him?" "Were you drinking alcohol last night?'

I suggested we find a place to sit down and talk. Hinging on the faith that our long-established relationship would help us navigate through this difficult terrain, I began with the inquiry primary care doctors fall back on every day, all day: "What are your thoughts?"

Mandy poured out: "Since Jamie was born we had shared a bed without problems. I'm a light sleeper and almost every night I am easily awakened several times by his stirrings and murmurings. Nothing—absolutely nothing—out of the ordinary went on last night."

Somewhat daunted, it was now my turn: "When terrible things happen, we naturally look for reasons. We can't help but think 'what did I do to cause this?' You did not do anything to make this absolutely terrible thing happen. It's like getting struck by lightning. This is not anyone's fault."

I explained that co-sleeping was a minor risk factor for SIDS, but this was more likely an issue when a heavy sleeper shared a bed with a very small baby, like a newborn. It was untenable with a big, strong 10-month old like Jamie. I added that, across the world's diverse cultures, bed sharing was probably more the norm than not.

Perhaps it was just my hope, but I thought I saw a subtle hint in their body language that Mandy and Joe were somewhat soothed by my words. Several minutes into my conversation with the parents, a nurse asked me to speak with her outside the room.

"There is a detective here from the City PD. Would you mind speaking with him?"

Off to the side, with all the stigmata of a plainclothes cop, was a

man who looked quite uncomfortable. It is routine procedure to summon the police when a child is brought to the emergency room dead, but the glamour of TV police shows notwithstanding, investigating such events must be truly dreadful. As was the case with the ER staff and baby's family, this detective was amazingly pleased to meet me. Mandy and her family were unknown to everyone in the ER. No one could vouch for this mother's character or circumstance. She was clearly in no condition to answer any interrogative questions from a law officer. With my reassurances about Mandy's competent parenting, sound mental health, and stable family, the detective departed, planning to resume his investigation at a later time.

There were several other chapters of this encounter that continued for a couple more hours that morning. At one point, Mandy and Joe, desperately wanting to make some small part of their awful situation better, asked me about organ donation. However, after reaching the state medical examiner, we were told this was not permitted since an autopsy was mandatory in such cases.

When I left the ER, it was almost noon. The sun was higher, the air warmer. As I climbed on my bike I wondered what had happened to the class of students I had stood up. It was humbling to reflect on how I had initially considered my responsibilities as a teacher more urgent than attending to the death of my patient. I felt ashamed when I remembered that I had thought because the baby was dead, there was nothing to do, no algorithm to follow, no intervention to aim toward an optimal target. Mandy's and Joe's loss left me deeply saddened and drained, yet in a strange way, a way that perhaps only other doctors would understand, the morning's events also rejuvenated me.

Upon learning of my patient's death, I had thought that my role as the PCP was irrelevant. Now, as I pedaled, I felt exalted as the family's doctor. My role in that emergency room was the essence of what I believed a physician should do, long ago when I first decided to become one. We so seldom have the opportunity to cure, yet almost always there is the chance to minister to the sick and bereaved. A couple of decades of evidence-based practice in an academic setting seemed to have clouded my early vision.

The next week, when I returned to the medical school to teach the clerkship students, I told them everything that had happened. As I look back now, I wonder if my recounting the events may have taught them about a dimension of doctoring perhaps more important than the formal curriculum they missed when I no-showed. It certainly taught me.

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