NARRATIVE
ESSAYS

Life, Liberty, and the Third of July

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My pager rang just after 3 am. Grab, flip, press twice. Motions I could—almost literally—do in my sleep.

July 3. Not my favorite time of year to be getting paged in the middle of the night. Later in the year, the medicine might not get any easier, but I would get to know the residents better, and they would be able to initiate more of their own learning. That made it easier to tease out the teaching points during an early morning case presentation. Of course, in July, the new residents were usually malleable and compliant. Once they told me why they were calling, whatever I told them to do, they did.

I wasn't even on call, so who was paging? Another press and the all-caps type—the same type that makes all the pages appear to be shouting—appeared:

SORRY TO DISTURB. PLEASE CALL CHARLE. And then his phone number.

Charle, a stellar rising third-year resident, must be on call tonight. I wandered to the hallway staircase as I dialed, hoping to avoid waking up my husband or children. He picked up on the first ring.

"This is Dr Player."

His voice was tense. Charle was a hardworking resident, but his default demeanor was relaxed and easygoing.

"Hi Charle, it's Kate."

"I'm sorry to bother you," he said. "I got this call. I don't know what to do. A patient—I think she's going to die tonight."

I sat down on the stairs.

"What's going on?"

"Her creatinine is 16, and her K is 6.7."

"Whoa!" He was right, she was ready for an arrhythmia.

"I attempted her contact number. I attempted each of her home, work, cell numbers, no response or no service." Now he was all business, with just a hint of panic. "I contacted her emergency numbers. I finally got through to an aunt, but she's in Wisconsin. She said there's nothing she can do."

"What's the patient's name?"

He told me.

"You've told me about her before," I said.

In her 30s, morbidly obese, living in far substandard living conditions with her two small children. She had poorly controlled medical conditions but nothing that had ever been this life-threatening. Charle struggled with her, with his desire to help her, with her inability to do more for herself than she was doing. I'd tried to help him see that every time she showed up in the office was a sign he was doing something right.

"You know her well," I said.

"She's my patient, Kate."

"Is she sick? What's it from?"

"I don't know. No history of any kidney disease. Maybe from the NSAIDs and ACE I put her on."

Guilt. "I called 911 when I couldn't reach her. I sent an ambulance out. No one answered at her house. I gave the go ahead to break down her door. She was there, but she wasn't opening the door. They said she looked okay, she was answering questions appropriately."

That was good. He was talking faster, rattling off information. I listened. "They tried to make her come in. Her K is 6.7, Kate. She didn't understand it, and she wouldn't go."

"So, what happened?"

"They just left! They said that she had a right to refuse treatment, but I don't think she understands exactly what this means." I could hear Charle pacing. He couldn't believe the paramedics would leave a woman this close to fatal hyperkalemia in her garden apartment without doing something.

"So I called them back. I told them to make her go. I talked to their supervisor, tried to explain the severity of her condition. He said there's nothing he can do."

We had gotten to the reason he was calling.

"What do I do?" he said.

From the Advocate Illinois Masonic Family Medicine Residency and Department of Family Medicine, University of Chicago.

I closed my eyes and could see the myocytes, pumping, pumping, pumping, then just not repolarizing, twitching, freezing.

"Well," I said, "I think the ambulance guys have done what they can. Is there any way you can talk to her, so she hears the real risk of staying at home from you?"

There was a pause.

"Yeah," he said. "I just don't know how to get her in. I don't know what to do."

"You don't know, but there's a limit to what you can do. At some point, you have to decide when you've done enough."

"When she's safe in the ER, then I've done enough!"

Now I paused. A teaching moment was presenting itself.

"If you don't think she knows what's going on, you can keep trying to get ahold of her. Maybe send the paramedics back, talk to her on their phone. But if she's heard it, and she understands it, then you have to back down. And it sounds maybe like she's heard it, and she doesn't want to go."

"Okay. Thanks, Kate." Charle wasn't done.

He left his own home that night, went to the patient's house, knocked on her door, and told her himself. He explained lab results, got her consent for a trip to the ER, and called her a cab. He gave her $40 for the fare. Doing what he could and sitting back was intolerable, so he did the only thing that seemed reasonable to him.

Charle showed up as a trusted family physician, and the patient willingly went to the hospital. The diagnosis was dehydration from a string of 103 degree days and, as Charle predicted, NSAIDs and an ACE inhibitor.

When I heard the follow-up the next day, I couldn't believe the risk he had taken, going alone into this possibly dangerous situation. Even the paramedics had told Charle that they would not go to this patient's neighborhood without police escort. So I was furious with him for taking the risk and proud of him for making the decision that my advice—which he called to ask for—wasn't good enough for his patient.

It was an astute diagnosis from an experienced resident, not a July-green one. He made me think hard about how to teach. When he called in the night and I gave him advice, he—ignored it.

This should be a story of failures: Charle called for my advice, ignored it, and only through extraordinary and dangerous measures managed to convince the patient to receive care. I see it as a success, though. As a teacher, as a coach, as a mentor, I want to grow residents who can ask for, hear, process, and absorb advice, triage it, and reject it when needed. As a teacher, I can be proud of someone who knows when he's getting advice that just doesn't set well. Or that just isn't good enough for his patient. Even though as a doctor, I know that I would not have done the same. After an hour of making those same phone calls, I would have hoped that those myocytes would keep going and tried again in the morning.

Each July, when we welcome a new class of residents, most of them are still in the passive stage of learning, and I kind of dread it. When I get a call in the night, it's easy, on one hand, to listen to the story, tell the resident what to do, and check in the morning that my teaching has been heard, and my directions have been followed. But I know that there's so much work to do to help them become successful doctors who can have failures like this one that Charle and I shared.

So when the pager rings at 3 am this July, I'll remember this call from Charle—who will be graduated by then and on his own—and consider what I need to say to get that resident to think like he was thinking in the middle of the night.

Charle made me proud. He made me marvel at his dedication. He made me think I'd make it through another July of new residents, even the ones who aren't listening yet.

But I also know that to nurture truly successful doctors, I must be able to create a space where my residents can actively hear and, on occasion, reject my advice when they do not think it is good enough for their patients. A "failure" like this one that Charle and I had can be a necessary prelude to even greater success, for both teacher and learner.

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