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## DISPATCHES FROM THE EMERGENCY ROOM

I SPENT MY EARLY childhood in a trailer park in Texas so, until I became an emergency physician in Oakland, I thought I knew something about barriers to healthcare access, and maybe even something about poverty. The Emergency Department at the Oakland county hospital has around 75,000 visits a year—say, 200 a day. It has 43 beds; because of overcrowding, there are ‘extra’ patient beds in the hallways, which have ended up being designated as official patient-care areas: first came Hallway 1, then, a year later, Hallway 2, and now Hallway 3 as well. The ED is usually covered by one supervising physician with a couple of housestaff—trainee doctors—a student or two, and around ten nurses; there is double supervising coverage from the late morning through to about 2 AM, the hours of heaviest traffic.

County hospitals are where those with no insurance go. The elderly and disabled who qualify for Federal Medicare and Medicaid insurance may also go there, but they often take the insurance elsewhere. Those who have no insurance, no money and nowhere else to go, come to the county hospital. Our speciality is the initial management of everything. There are patients who bless me for my time, after they have waited 18 hours to see me for a five-minute prescription refill, and another who regularly greets me with, ‘Yo bitch, get me a sandwich.’ I did have one patient, born at the county hospital, who lied about his private insurance in order to return to what he called ‘my hospital’, but many more who feel they have hit bottom when they cannot afford to get care elsewhere.

Around 47 per cent of the patients are African-American, and 32 per cent Hispanic. We call the Mongolian and Eritrean telephone translator-lines on a regular basis. We also see the patients who are not

entirely disenfranchised, but fall out of the system when they lose their jobs; most Americans have insurance linked to employment, either their own or a family member's. It is not infrequent to see the primary reason for a visit to the hospital listed as 'Lost Insurance', 'Lost Kaiser' (the main private health maintenance organization in California), 'Lost to Follow Up' and once, just 'Lost', but we all knew what it meant. We see patients every week with decompensated chronic disease who say, 'I was doing fine until I lost my job and couldn't get my meds.'

Some of the visits are for true emergencies—there are 2,500 major trauma cases a year. These are usually shootings, stabbings, falls, assaults and automobile accidents; many, if not most, involve alcohol and drugs. In 2008 there were 124 homicides in Oakland alone, most of them due to gun violence; many victims have been involved in violence before. The Emergency Department gets a stream of teenage gunshot victims, cursing and yelling as they come in, swinging at medics and police with arms scored with gang tattoos; by the next day we see them emerge as the children they are, cowed by the presence of their mothers beside the recovery beds. We also see the bystanders, the teenagers who get shot while walking home from school, the elderly Chinese man hit by a stray bullet as he stepped outside to get the newspaper, the mother shot stepping in front of her son—who claimed not to know the shooters when interviewed by the police, but was overheard by the nurse the next day rallying his 'boys' for a revenge run. This kind of trauma has a way of turning victims into perpetrators. The first 'death notification' I did as an intern was to the mother of three boys. The older two had spent three months on the East Coast with relatives to let a 'neighbourhood situation' cool off. Less than 24 hours after their return to Oakland, they were shot while walking down the street together. The two older boys died. The 18-year-old had a collapsed lung, but survived. At his last trauma clinic follow-up, he was referred to social work for 'clinical evidence of depression', though at the time there was no outpatient social-work clinic available.

Drugs and alcohol increase all kinds of risk, and traverse all social classes, but cocaine is its own special force in this community. Smoking crack cocaine is such a common trigger for asthma exacerbation that we have come to call it 'crasthma' at signout. At first, Emergency Department doctors were startled when small, wiry elderly women coming in for chest pain tested positive for cocaine on the urine screen. It turned out they were social opium smokers from the hills of Southeast

Asia, who turned to smoking crack cocaine when their immigrant families moved them to Oakland. It must have seemed somehow similar, though it turned out to be much worse for their hearts. I recently saw a 55-year-old woman who had been found on the floor by her family in the middle of the night. Her CT scan showed a large bleed in her brain. After years of planning she had managed to set things up to move her family back to Mississippi where she thought her teenage grandsons, who had begun flirting with gang activity, would be safer. She had been up all night cleaning the house and packing to leave the next day, and had used the cocaine that had likely caused the brain bleed to help her stay awake.

There are the everyday medical emergencies: septic shock, heart attacks, strokes, deadly lung and skin infections, respiratory and cardiac arrests. These, along with the major traumatic injuries, are the cases the ED was designed for. But most of our patients do not have emergent conditions; they are just ill, and have nowhere else to go. The county system has a wide complement of outpatient clinics, staffed by some of the best doctors I know. But the last time I checked, their next available primary-care appointment was six months away. Sometimes there are no appointments at all, just a clipboard where we scribble a name and medical record number, to put a patient in line for the six-month wait.

Then there are the patients who did have an outpatient clinic appointment, but no telephone, and so were not informed when their clinic visit was rescheduled. There are those who have to take three buses to get to the clinic and miss the last one; those who would like to see their doctors, but forget to come in when they drink too much; and others, especially the elderly, who won't come to late afternoon appointments because they are afraid to travel home after dark. Some patients just need prescriptions—those whose medications are stolen, those who finish a prescription before a refill is available because they feel bad and double their own dose, or those who just want the cough syrup with codeine that has become a popular drug of abuse. There are those who have lives so complicated—by three jobs, or six children—that a 3 AM emergency visit is all they can manage. They come to the county ED because we are always open, and refuse care to no one.

Coming onto a shift, we hit the ground running. There is signout, a 20- or 30-minute verbal handover of all the patients in the Department, with

an update on their status and discussion of what still needs to be done. Most of the shift is spent running around seeing patients and discussing their management plans. But we also negotiate with consultants and admitting doctors, intervene to control ambulance traffic, and troubleshoot staffing issues. There is no official break—we grab food when we can. I carry a portable phone that rings off the hook with referrals and questions. Emergency physicians are interrupted—by nurses, students, technicians, pharmacists and other physicians—every 3–4 minutes on average (this has actually been studied). There are shifts when I cannot find time to make it to the bathroom.

Nurses—they range from fresh-faced graduates in tight pink scrubs to ex-military medics covered with tattoos—are the front line of care at the county hospital. They see patients first and are responsible for screening the dozens that present to triage at any one time, and deciding which ones need to be seen immediately and which can wait. They bear the brunt of patients' frustration; they are the ones who undress them and find hidden wounds and weapons, medications and money, needles and crack pipes. There is a maximum nurse to patient ratio of 1:4 in the ED, mandated by California law and rigorously protected by the union. While the limits are designed to protect patients, there is an inevitable tension between the need to see patients quickly and the need to see them safely. With a fixed ratio and a national nursing shortage, nurse staffing can become the rate-limiting step in the process. Because physicians' orders—on medications, for example—cannot be executed without a nurse, patients can wait for hours to be roomed or get pain relief.

A few doctors rail at the patients who come to the Emergency Department for routine care, but most who have chosen to work in the county system pride themselves on being jacks-of-all-trades, holding steady in the middle of the maelstrom, being a part of the safety net. So when patients cannot get primary care, we tell them to follow up in the ED on our next scheduled shift. I have started patients on medication for newly diagnosed diabetes and transitioned them to insulin before they could manage to see a primary-care doctor. I have prescribed first, second and third-line medications for blood pressure. I have seen three generations of women, plus an uncle, in one family. There are a cadre of regulars we know by name; we discuss their recent visits and send around emails when they die. So we do deliver primary care; some of us

enjoy it, and the patients certainly need it. But in the end, we are simply not very good at it. The ED is a lousy place to manage chronic disease.

The failure of preventive, primary care creates emergencies that should never have happened. The county hospital is where diseases become the worst version of themselves: what should have been a case of simple diabetes, requiring oral medication and diet change, presents as diabetic ketoacidosis, a life-threatening condition of acid in the blood. We see severe infection that can only be treated with amputation, but was once simple cellulitis requiring antibiotics; numerous strokes, which could have been prevented through blood-pressure control. While the Emergency Department tries to give patients what they need, it cannot offer them a phone number they can call for refills, a clinic to return to or the chance to see the same doctor year after year.

Frequently, the ED fails to take the whole patient into account. Given the volume and acuity of the patients we see, some stable patients just have too many problems to address in the course of a visit. We talk about the ‘chief complaint’ in medicine—the main reason for the visit. It might be abdominal pain, a sprained ankle, lost insurance or chest pain. When patients start on a list of several complaints, we sometimes ask them to identify the main thing that brought them in that day. A colleague recently signed out a patient to me as ‘a 65-year-old man with vision loss in one eye for two weeks, seen here four days ago for indigestion, now waiting for a CT scan to rule out stroke’. I asked why we had not evaluated his vision loss when we had seen him four days ago, and was told that the patient had not mentioned it then. When we asked him why, the patient said he had been told he could only have one problem. He chose the indigestion because it hurt, while the vision loss was painless.

All Emergency Departments are legally required to examine patients and provide initial treatment, regardless of insurance status; but the definition of ‘initial treatment’ is broad. Frequently, we see patients with acute fractures diagnosed at a private hospital. They arrive with temporary splints in place and x-rays in hand, saying, ‘I didn’t have insurance, so they told me to follow-up here.’ When we want to transfer patients to a nearby hospital for cardiac catheterization to treat a severe heart attack, we are asked to fax over the ‘face sheet’, a summary printout of the patient’s basic demographic information: name, date of birth, address, phone number and insurance status. While it is technically

illegal for hospitals who have room to refuse to accept a patient who needs a 'higher level of care', such as the cardiac catheterization that our hospital does not offer, we are frequently told there are no available beds. We are told this much more often for our uninsured patients than for those with Medicare, or those who have secured disability payments from the government.

Care delivery in America lags far behind our pharmaceutical and diagnostic science. Most applications for new drug approvals are in categories where good drugs are already available; more than new medicine for diabetes, we need good research on how to get the medicines we have to diabetic people. Our health system has generated an enormous cohort of patients who are diagnosed but untreated, or under-treated. These are not medical mysteries, but social ones. The barriers to appropriate healthcare are myriad, and not all are a function of the system. I have seen a homeless woman, probably schizophrenic, seeking her first care for a breast mass that must have been there for years before it took over half her chest. And a man brought in by the ambulance he had finally called when his legs became too swollen from heart failure and blood clots to get through his bathroom door. He hadn't been outside in a decade. Or the young man who had been diagnosed with mild renal failure two years earlier and re-presented with a complication so severe that the kidney specialist I called told me he had only seen it once before, thirty years ago in rural India. The young man seemed reasonable—he was responsible enough to hold two jobs and support one family in the US and two in Mexico. He spoke no English and had not really understood that he was supposed to come back. Until he had become too weak to work, he had just carried on. These are patients disenfranchised by much more than the healthcare system in our country—by a collision of poverty, poor social services and lousy public transportation, substance abuse, language barriers and more.

## II

I have recently shifted my practice to the ED of the University of California, San Francisco Medical Center, 12 miles away, for a one-year speciality fellowship. This is a tertiary referral hospital, famous for treating patients with obscure diagnoses, syndromes that only affect five patients in the world; some are named for scientists who work upstairs in the

same medical centre. The Hospital is a transplant centre and many of the patients are on drugs that suppress their immune systems; the very medications that keep them from rejecting their transplanted organs leave them vulnerable to severe, rapidly progressing infections. Many of the patients have heart or lung abnormalities. I recently saw a child with so little circulating oxygen that his lips were blue-black. Before I could put a breathing tube down his throat, his father told me that he always looks like that due to his unrepaired heart defect. They had come for his abdominal pain. While we sometimes complained about the simple cases in Oakland, here we complain that there are no simple patients. Chief complaints such as 'finger laceration' are inevitably followed by 'heart transplant 2 days ago', 'rash' by 'history of Gorlin's Syndrome', 'cough' by 'awaiting lung transplant next week'.

I have never been cursed at by a patient in the Emergency Department here, rarely asked for a sandwich, and only occasionally see a urine test that is positive for cocaine. Patients can almost always get their medicines, and frequently have follow-up appointments already scheduled. They can usually list their medications and often describe their entire medical history by memory. I have more than once been told that the chair of a subspecialty department would be coming down himself because the patient is a University Faculty member or some other VIP—on one surreal shift, two of my first three patients were doctors themselves. I almost never refill prescriptions for more than a two-day supply, because that is the purview of primary care. On an average shift I see at least three patients who are 90 or older, most of whom drive themselves to the hospital. Almost no one seems to live to 90 in the county system.

The healthcare proposals generated under the Obama administration take as given the profound inequalities in the distribution of medical care in the United States. Both House and Senate plans fall within a range of middle-ground options that legislate for even more money to be paid into the private system in return for only minimal concessions. They neither create the benefits of risk-sharing for the public system (which currently covers the oldest and sickest), nor make the insurance industry take on the total risk-pool of young and old, sick and well, which alone would make universal coverage feasible. With insurance mandatory and non-coverage penalized, millions more would be required to pay into the private system, while tens of millions out of the 46 million currently uninsured would remain without coverage in both the House and the

Senate plan. The Congressional debate has avoided medical and social realities to focus on rhetorical dilemmas. Reproductive medicine, which should be a matter of scientific standards of care, has been thrown into the package as a negotiating *quid pro quo*.

Healthcare in America is the civil-rights issue of our time. Extended insurance coverage will not tackle the huge social barriers that stand between patients and optimal medical treatment. Adequate primary care would mitigate the devastating effects of these social factors. In the current County system, a patient who misses a bus and therefore an appointment may wait months to get another, and may not even be able to reschedule by phone. In a functional primary-care system, patients who miss appointments—or a patient newly diagnosed with renal failure—would be called back, not lost to follow-up.

It is hard to talk about a middle ground for something that is a fundamental right. Some believe there is no harm in taking what we can get and going from there; but this is probably not true. The insurance industry makes great gains in the current plan that will be hard to reverse. More, the proposals validate much of the profoundly unjust current system, which has grown up ad hoc but which, up till now, has never been explicitly sanctioned as a workable plan by the Federal government. To tolerate a disastrous bricolage is one thing; to extol its virtues quite another.

I have been well aware of the fallout our imbalanced system has for county patients; but until recently I don't think I recognized the damage it was doing to the small minority it serves well. On one of my early shifts at the University of California hospital the triage nurse passed me a handwritten note from a patient in the waiting room. It read:

Please help me. My jaw has been broken and I am in a lot of pain. I've been here over an hour and am still bleeding. My hands and feet are numb and I'm starting to shake. I need some care. I have insurance.

The young electrical engineer who wrote the note was in his mid-thirties, used neither drugs nor alcohol, and had never been in a fight in his life. He had been prescribed cough medicine with codeine for a viral illness and had passed out in his bathroom, breaking his jaw and several teeth on the sink as he fell. His injuries were no more and no less devastating than those resulting from violence in Oakland. What was striking was that a highly educated young man could feel that his pain, bleeding and



shaking might not get him care in one of the best hospitals in the country, but that his insurance would; could assume that the brief delay before he was seen was due not to the acute stroke and heart-attack patients who had come in just before him, but to our suspicion that he did not have insurance. If even the privileged feel their access to care is so vulnerable, it becomes hard to argue that the system is working for anyone.