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Please Don't Do Anything Else

By Teva Brender

At first glance there was nothing particularly noteworthy about our new patient Mr. Jones, an older man with heart failure and end-stage renal disease who had come to the Emergency Department (ED) for shortness of breath. In fact, just the week before he had come to the hospital for the exact same symptom, though he had chosen to discharge early "against medical advice" (AMA). Reaching the end of a long, stressful day I breathed a sigh of relief – this was going to be a very easy admission. We would get him scheduled for urgent dialysis, removing the fluid from his water-soaked lungs, quickly alleviating his respiratory distress. We would pick up right where the last team had left off.

Except one line in the ED doctor's note caught my eye: "The patient was brought in by his primary care doctor (PCP), Dr. Williams, after conducting a home visit earlier today. See personal cell phone number in the chart." A PCP who still does home visits – the last of a dying breed – and on the Wednesday before Thanksgiving, no less!

My interest piqued, I called Dr. Williams, who thanked me and my colleagues for taking care of Mr. Jones. But he ended our conversation with an unusual request. "Mr. Jones has cataracts," he said. "He's nearly blind and has been completely traumatized by the healthcare system. I've been his PCP for over 20 years. He just needs dialysis, please don't do anything else."

Don't do anything else? This was anathema to some of my most fundamental instincts as a resident physician training in the era of evidence-based medicine. For instance, we know that starting a cocktail of four drugs, so called "guideline-directed medical therapy," can cut heart failure mortality in half, and he was on none of these medications! Even considering Mr. Jones' case from a less clinical, more holistic perspective, he clearly was struggling to make it to his clinic appointments. While much of the testing typically recommended for patients with heart failure is done in the out-patient setting, given the inevitable scheduling delays caused by the upcoming holiday season, we could advance his care and do an expedited work-up while he was in the hospital.

But then I met Mr. Jones. With the ED stretched well beyond capacity, he had been assigned to a gurney in the hallway, where he stood out amidst the maelstrom, lying on his side, blanket pulled up over his head, hands covering his ears in a desperate attempt to block out the incessant cacophony of alarms. I made my way over to him and rested my hand on the edge of his bed, as nurses, ED techs and paramedics whizzed about. When I said his name, he pulled the blanket off his face – and with his milky blue eyes blinking under the harsh fluorescent lights, frantically trying to locate my voice in the din, he gave the unmistakable impression of a caged animal.

Mr. Jones got dialysis that night, and by the time I returned at dawn his gurney lay empty, sheets neatly tucked, the ED now almost tranquil in the early morning hours. He was gone. I quickly wrote a discharge summary and then moved on to other tasks. Just another busy day at San Francisco General Hospital (SFGH).

Mr. Jones' story is a fairly common one at SFGH. Like other public safety net hospitals, it serves the city's most marginalized communities – immigrants, refugees, the indigent and the marginally housed. Many patients stay to complete their treatments or until the medical team determines that it is safe for them to be discharged. But a not insignificant proportion choose to leave prematurely. Each patient has their own reasons for doing so. Sometimes it's because they don't have someone to look after a child or a beloved dog. Other times it's to go drink alcohol, smoke a cigarette or use drugs. Most frequently their reasons are more inscrutable, perhaps some combination of bad hospital food, lack of sleep, daily 4 am blood draws, loss of personal space and privacy, old traumas.

Sometimes, when someone is very sick, we try hard to convince them to stay; getting a patient some ice cream from the pantry is a time-honored technique. Other times – when they lack decision-making capacity and we determine they are a threat to themselves, others, or are gravely disabled – patients are placed on a hold. With this legal designation, if absolutely necessary, the sheriffs will physically prevent them from leaving the hospital. But most often, after an honest effort, we let them go. And if they will wait long enough, we get them wound supplies, antibiotics, Narcan or whatever else they might need to be safe.

On a bad day the work can feel futile. Sisyphean. We admit a patient, give them fluids, perform a procedure, stabilize them. And even if they don't 'self-direct their discharge' (the more patient-centered, less stigmatizing term that is now favored over AMA), often it feels as if fundamentally nothing has changed. Our patients go back to living on the streets, or to a single room occupancy hotel without electricity and potable water. Or to a life of such stress and poverty that their health – taking medications, checking their blood sugar, going to appointments – is one of their last priorities. On these days the work is heartbreaking, soul-crushing.

Hospitals and the broader healthcare system have at times inflicted great harm, especially upon society's most powerless. We, the medical establishment, have perpetuated racism, sexism, ableism, shamed the mentally ill, the homeless and people who use drugs. On that night in the ED, I saw the long shadow of that sordid history in Mr. Jones' cloudy eyes.

But on a good day, I remember that we treated an infection, ameliorated someone's pain, removed the water from someone's lungs so they were no longer gasping for breath. On a good day, I remember that the culture of medicine is changing, that hospitals are striving to be spaces of healing. I remember that, at places like SFGH, hopefully more often for better than for worse, for those who may have nowhere else to go, we will always be there. Sometimes, we will use all of the incredible tools in modern medicine's armamentarium. Other times, after listening to a patient, their loved ones, or a trusted PCP like Dr. Williams, the best prescription won't be to do more, but to do less. And on a good day, I like to think about Mr. Jones

celebrating Thanksgiving at home, surrounded by his family. I hope whoever made the mashed potatoes went easy on the salt.

Teva Brender is a second-year internal medicine resident at the University of California, San Francisco. He graduated from Oregon Health & Science University School of Medicine in 2022. His clinical interests are in hospital, pulmonology and critical care medicine. His other interests include physician advocacy, moral distress and narrative medicine. His writing has appeared in *The Oregonian, Academic Medicine, The Journal of General Internal Medicine* and *JAMA Internal Medicine*. Outside of the hospital, he enjoys cooking, rock climbing and spending time with his wife and their miniature dachshund Winston.