Clear as Mud: A Third-Year Medical Student's Perspective in Emergency Medicine

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I had always looked up to emergency physicians for their ability to handle virtually any patient who comes through the door, regardless of the patient's condition. The "jack-of-all-trades" training and ability to devise a plan represented characteristics I admired, but I have only recently come to appreciate the ethical and moral dilemmas that may obscure each decision.

Emergency medicine was the final rotation of my third-year schedule. After months of family medicine, internal medicine, pediatrics, psychiatry, and surgery, I was finally facing what brought me to medical school in the first place: the challenge and excitement of caring for patients with emergent needs.

Before arriving at the Rocky Vista University College of Osteopathic Medicine in Parker, Colorado, I had worked as a technician at 2 large emergency departments in Nebraska. That experience, I figured, would help me feel comfortable in a fast-paced environment and make it a very fulfilling month.

Spring arrived, and as my first shift in the emergency department neared, I felt the anticipation building. Needless to say I was not disappointed.

Soon, I was treating patients with pemphigus vulgaris, osteogenesis imperfecta with blue sclera, and massive gastrointestinal bleeds. I sutured countless wounds. During my first 6 shifts, I was actively involved in multiple types of emergency situations. I quickly learned to tread water by being efficient with my time and having a plan once I left the room.

The constant flood of patients was tracked by means of 2 large flatscreen monitors. Once they went through triage, patients' relevant information appeared on the first monitor. By my seventh shift, I learned the purpose of the second monitor, which was to track the patients who were in a separate area: the psychiatric unit.

With its 5 beds and isolation from the flurry and noise of the main emergency ward, the psychiatric unit looked to my eyes like an enormous convenience. These rooms were usually reserved for patients in dire straits, meaning patients who were hallucinating, acutely homicidal, or acutely suicidal. Patients were placed on a 72-hour hold; as long as they were medically stable, they called this unit home until they were evaluated by the psychiatric service. This process buys additional time to get patients evaluated and to organize the means to turn things around. From there, they were typically transferred to a short-stay psychiatric facility or discharged to home.

But how does one determine whether to assign someone to a 72-hour psychiatric hold? One would imagine the answer would be as clear as mountain waters: if patients are acutely suicidal, then keep them in the unit so they do not harm themselves. Well, one night those waters turned muddy when the attending physician and I met Ann.

Ann was an elderly woman with progressive dementia and severe anxiety. She was sent to us from her psychiatrist's office to be evaluated for recent changes to her behavior—changes that her psychiatrist believed were acute. She was accompanied by her family. Her husband, son, and son-in-law did most of the talking, relaying an accurate picture of her difficulties.

Ann's son-in-law had been staying with her for the past month and was especially troubled by what he had seen. Ann had been avoiding the things she usually enjoyed, such as cooking, attending plays, and spending time outside. She was growing increasingly forgetful, often taking her morning medications and then asking minutes later if she had taken her medications yet. Her husband agreed that her anxiety had been out of control. Ann refused help and refused to acknowledge any problem. Her son emphasized that she had been increasingly agitated lately, as she was throughout our interaction in the emergency department.

After many visits to a local emergency department for somatic complaints that were possibly related to her anxiety, her family tried establishing home health care. This experience left the family a little disappointed—at-home care did little to allay Ann's anxiety—and Ann and her family remained in need of help. How they got her to the psychiatrist that day was a mystery to me, but they felt it was time for action. Like any caring family, they wanted what was best for her, and they wanted her remaining years to be as enjoyable as possible.

While talking to Ann, the attending physician and I got a glimpse into her troubled past. Ann had been an orphan since she was 2 years old and had endured a lifetime of hardship. Her first husband died years ago, and she had been battling the slow cognitive decline that is dementia. While interviewing the family privately, we found out she had mentioned suicide 3 separate times recently. When we later questioned the patient about these comments, she did not deny them but minimized their importance. Suddenly we seemed to be in clearer waters: Suicidal comments meant that she obviously needed a 72-hour hold, right? Not quite. We realized that Ann lacked several qualifications for being considered suicidal: a suicide plan, a suicide attempt, a history of suicidal ideation, a history of drug or alcohol abuse. The waters were still a bit murky.

The attending physician and I tried to break it all down. Should we keep Ann on hold—and thus temporarily take her rights away until psychiatric help arrived—or let her go home? The very mention of even an overnight admission got her blood boiling. "If I stay tonight, it will be more traumatizing than my childhood!" she said. Her family members wanted her to get help, but they did not want to be labeled the "bad guys" for the rest of her life. If Ann were admitted, her son-in-law said, she would never let them forget that they were responsible for that weekend she spent confined to a room against her will. However, if she were to be discharged and sent home, he said, then her denial of her condition would be validated. She would reject help for the rest of her life saying, "You made me go to the hospital, and they did nothing." It was going to be "I told you so" until her final days. Either way, it seemed to be a lose-lose situation. (And, unless I inadvertently skipped it, a lose-lose situation was never mentioned in any of my textbooks.)

The psychiatric evaluation team arrived and eventually determined that Ann did not meet the criteria for admission. That seemed to settle the question. But when the attending physician and I mentioned the psychiatric evaluation team's decision to Ann's family, they were disappointed. Her son said it would be a shame to take her home and risk her doing something drastic when "the writing was on the wall the whole time."

I was torn. We were stuck with a dirty decision to make. Each side of the argument was justifiable or at least convincing. We clearly wanted to do what was best for the patient, but we were responsible for her only for as long as she was in the emergency department. Her family, on the other hand, was going to be an integral part of her future care. We could have talked to them more and gone back and forth all night, but this complicated situation had slowed down the usually brisk flow of the department. It was time to do what physicians are trained to do: make a decision.

Ann was discharged home. We referred her to a geriatric psychiatric facility and encouraged her to follow up with a neuropsychiatrist. In the end, we decided not to admit her for a psychiatric hold because she was not a danger to herself or others and was not profoundly disabled by her current state. Furthermore, she never mentioned suicide while in the emergency department. Although she was agitated and anxious, the attending physician believed her care could be most effectively managed in the outpatient setting. In retrospect, it all seems so simple.

And yet we had to navigate a fairly muddy river to get there. I underestimated the importance of decision making during my early medical school career. I always thought if the patient has X, then you prescribe Y (or Z if they are allergic to Y). There is usually a "standard of care," an algorithm, or a study demonstrating the generally accepted, most effective approach for almost anything. Every emergency medicine textbook seemed to provide different criteria for decision making, such as when to order a radiographic image for an ankle or remove a c-collar. Ann's predicament became a lesson in how medicine involves much more than cut-and-dry science.

My medical knowledge repertoire has grown by leaps and bounds, but I took something else away from that particular experience. Medicine is an art as much as it is a science. Sometimes the most stressful situations don't necessarily involve an active bleed or a frightening electrocardiogram. Not every patient's situation fits neatly into an algorithm. There are many things to consider before uttering "Okay, here is what we are going to do." Its implications can be life-changing to the patient and to the patient's family. As I closely followed the attending physician, I took careful note of how he was able to think several steps ahead, handle an active code, or recognize when an acute gastrointestinal bleed required a call to the surgeon. But what I will remember most from that rotation was what enabled him to say, "She is going home."