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My First Patient - Before I was a Doctor

Lea Alfi

When I first saw Paul in the hospital, COPD was making its first overtly symptomatic debut. I had no inkling of how easily or quickly it could release the floodgates to an ocean of other pathology, or how grossly misunderstood such a common diagnosis could pass at a time when all of the baby boomer Marlboro Men are coming of age, and when the dangers of nosocomial infections are so widely known.

In his first hospital visit, Paul was wearing a blue pinstriped Ralph Lauren dress shirt over pajama pants in a sea of hospital gowns, watching "Pretty Woman" for the second time, while fielding an unending stream of calls from well-wishers. His family physician had simply suggested he "be observed" for shortness of breath, as he observed his first work-free Sabbath.

The next weekend, I saw Paul at his home. At 58 years old, he still embodied the Madison Avenue chic he created for his salon patrons. He stood in sharp contrast to my own 58 year-old father, who preferred the safety of matching monochrome shirts and slacks to the world of patterned sartorial adventure. I was sitting on the deck, his wife was out buying a new flat-screen television for their bedroom, and he nonchalantly asked me what COPD was. I looked up, wondering at which of the four letters to start. Did he really want to know that chronic meant forever? Should I explain chronic bronchitis and emphysema separately? Would the analogy of a stretched out rubber band suggest futility?

I explained to him that lungs were like an upside down tree, and his difficulty breathing could be because of inflammation (a bark buildup) or more mucous (sap) in the branches of the tree, or alternatively because of weakening (wilting) of the leaf buds. Logically, he asked what would cure COPD.

I said some physicians gave bronchodilators, or inhaled steroids; and he nodded that he already had those. When I said most physicians recommend not smoking, he beamed that he had ended his 40 pack-year smoking history one year ago using Chantix. I suggested exercise for the man who considered the basement too far for the television, and he jokingly replied that his doctor had told him about deep breathing exercises. He would be getting his flu shot and pneumonia vaccine the following day.

As soon as his wife appeared in the front door, he proudly announced that he was my first patient, and that I had just given him my first diagnosis, no matter that I had felt my way through an explanation of the already-diagnosed COPD, and did not explain that COPD is the fourth leading cause of death in the US, and the second leading cause of disability.¹

That night, Paul woke up in a breathless panic. He was admitted to the hospital for the second time, intubated as his two front teeth were knocked out, and remained in the hospital with the same uncertainty that his wife did while waiting for the cable company. Though this time he too was in the hospital gown, his family was pointedly not worried. They knew he had had bronchitis a few weeks prior, and thought this would pass. He had been fine during his last hospital visit. He was only 58. On the other hand, I thought of nosocomial infections. I wondered if

his sudden interest in COPD was really a window into how horrible he was feeling that day, and if asking was akin to his way of sharing symptoms.

The doctors could not determine what was causing his disproportionate difficulty breathing. He was put in isolation for a few days, as physicians considered TB. The physicians very quickly sedated him to prevent the extreme anxiety he would periodically wake up with. Over the course of one week, the physicians realized he had been suffering from pneumonia. This delayed diagnosis seemed so intuitive; had therapy time been wasted contemplating the much less likely TB? It was unclear what the doctors knew, and how much the family understood and shared, as I was only an observer. I later learned that he had not even told his wife about his COPD diagnosis.

It was inconsequential, as his original pneumonia was suddenly compounded by a Staph infection, or as Paul's daughter put it, "double pneumonia." My mind wandered to the unforgiving statistics: patients with community-acquired pneumonia had a mortality rate of 6.7%; the mortality rate for hospital-acquired pneumonia nearly tripled that, to 18.4%.² With each organ failure, he slipped further away into percentages.

At his funeral, his female clients mused that he was a master at manipulating unwieldy Jewish hair, his friends recounted how his desire to take care of everyone meant 10 people on his family phone plan, and even more in the "good hands" of Allstate insurance. Away from the podium and the immediate family, there were whispers of the pneumonias others had seen, and the disbelief that an active, overwhelmingly healthy man's death had not been prevented. Paul's mother, at 94, had in four months lost her two sons to pneumonia. Pneumonia had not discriminated between the two brothers, who had wildly differed in their underlying health. Paul's daughter, 8 months pregnant, tried to solace others, quietly replying that her father's pneumonia is not uncommon. It kills over 60,000 Americans each year.³ She said they knew it was bad when he got the Staph infection, but added that the doctors said this was common.

"This delayed diagnosis seemed so intuitive; had therapy time been wasted contemplating the much less likely TB?"

To my ears, this was most tragic of all. While common, it is by no means acceptable. According to the CDC, healthcare-associated infections account for 1.7 million infections and nearly 100,000 deaths each year in the US alone. Furthermore, of these infections, 15% are pneumonia.⁴ While my first "patient" was taken by pneumonia, medicine sadly cannot guarantee that Paul will be the last. The prevalence of COPD continues to increase in our aging and smoking population; by 2020, it is projected to be the third leading cause of death in the United States,¹ and unquestionably one of our most commonly encountered clinical diagnoses. In turn, we should be prepared to recognize its signs, even when disguised by a smile. And more importantly, for patients across diagnoses, we must "do no harm" by compounding original illness with nosocomial complications.

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