

The art of medicine

Losing a patient

He made his way into my exam room supported by two metal crutches that braced at the elbow, lurching his withered legs forward, step by excruciating step. His spine was twisted and scoliotic, causing him to list precariously to the left. He was a wisp of a man, barely clocking in at 100 lbs—wasted away, it looked like, from untreated polio and a lifetime of subsistence living.

Yet somehow here he was in bustling Manhattan, having made his way from East Africa a few months earlier. He was living in the nearby homeless shelter and had managed to navigate the New York City public hospital system and make an appointment in the medical clinic.

I assumed we'd have to use an interpreter, but Mr M spoke English quite nicely and his lively personality shone through. He explained to me that he didn't know what had caused the paralysis of his legs and the severe deformity of his spine. He'd been told that he'd fallen down when he was a young child and that everything was related to that injury.

I found that explanation medically wanting. I wondered if had been an infection, or a tumour, or a childhood illness. But he didn't know any details and in any case, there had been no medical care available in his village at the time, he told me, so whatever had befallen him went untreated. I wondered if he might have suffered a violent attack or abuse at that young age. But no one around him ever spoke of it, it seemed, and he himself had no way of knowing. He'd been told that he had fallen down as a toddler, and that was that. He simply had to make do over the ensuing decades.

There are always heartbreaking moments in the daily practice of medicine, but Mr M's case was the kind that feels particularly tragic because so much of his suffering was related to the unfairness of how the global dice are rolled. Lack of access to health care, a remote location, and a struggling country left a child with a spinal injury untreated. Had his accident—or whatever it was—occurred where there were adequate resources, it all could have been different.

The luck of the draw, however, had Mr M born into a village where there was no capacity for diagnosis, let alone treatment. A child with such a disability easily could have ended up living on the street. But in a testament to his family and to his community—and to his own remarkable talents—he was not ostracised. He attended the local school and thrived. He made it to a regional high school. He went on to college and graduate school. Along the way, he married.

It was his involvement in politics, though, not his medical condition, that was the biggest threat to his health. Agitating for government accountability and increased civil rights protections had led to threats. He'd seen colleagues harassed, beaten, and imprisoned. Worried for his safety

and that of his family, he scraped together what little money he had and set off to seek political asylum in the USA.

And now here he was in New York—hardly a dollar in his pocket, living in a bleak homeless shelter, trying to figure out a way forward. He didn't know anyone in the USA, and couldn't offer me single name to put down as an emergency-contact.

Contemplating the hurdles that he had overcome to make it from a paralysing injury in rural Africa to the chair across from me in my New York City clinic was, frankly, breathtaking. Just surviving his childhood injury without medical assistance seemed overwhelming to me. I tried to imagine how he navigated his village with only rudimentary crutches. Resources for people with disabilities were probably scant. Yet somehow, he managed. In medicine, we are given unwitting front row seats to the fortitude of humanity. It's inspiring but also unbearably saddening.

But the other things we are given in medicine are tools to fix things. I say that with a grain of salt, of course. And even more grains—pounds really—of bruising, humbling reality checks. Nevertheless, the opportunity to try is one of the true gifts of the profession.

I immediately got on the phone. Yes, our rehab clinic could set up physical therapy. Yes, they would be able to fit him with leg braces and better crutches. Yes, our spine surgeons could evaluate his scoliosis. Yes, our Program for Survivors of Torture could help him with the asylum process.

I was thrilled. I knew there were no instantaneous solutions, of course, just as I knew of the hubris trap of "western intervention". Nevertheless, I felt confident that there were at least some concrete steps available that could mitigate Mr M's situation. Even if he didn't ultimately succeed with political asylum, the leg braces could ease his full dependence on crutches. Even if there weren't options for surgical correction of his spine at this late date, there was still physical therapy to enhance his flexibility.

There's nothing we doctors love more than a plan. Yes, we end every clinical note, with the A&P—the Assessment and Plan—but we grow restless with the intellectual machinations of the assessment part; we just want The Plan. And now Mr M and I had a plan. We parted ways on an optimistic note that day, solid roadmap in hand.

So much of my medical practice is devoted to chronic, unyielding diseases—diabetes, obesity, emphysema, atherosclerosis—diseases that rarely cede more than incremental progress. Mr M was that rarer type of patient, one with conditions that if not outright fixable then at least with the possibility of tangible improvement. The kind of patient whose plan involves definitive and actionable items,

not vague paeans to lifestyle changes that mask the grim, nihilistic immutability of chronic disease.

When Mr M's name appeared on my clinic schedule for a follow-up appointment some months later, I was bristled with anticipation. How far along the plan had we progressed? Would he be walking more easily now that he had the braces? Would the physical therapy have begun to increase his flexibility? Would he have initiated the asylum process?

But the buoyant blush of expectation faded as the afternoon wore on and Mr M's chart never made it to my box. I ploughed through my day adjusting medications, ordering mammograms, listening to lungs, urging exercise, encouraging patients to eat broccoli, but Mr M didn't show.

I saw in the medical record that he'd gone to the rehab clinic and been measured for leg braces. The physical therapist had done an initial evaluation and set up a programme. But that was it. Mr M never returned to pick up the braces. He never saw the spine surgeons. He never began the physical therapy programme. He never got to the programme to support survivors of torture.

I called his cell phone number but it was no longer in service. And, of course, there was no emergency contact—he didn't know a soul in the USA.

I was gripped with panic. Had he been injured? Admitted to hospital? Had he had an accident or died? Had he been preyed upon by a street gang? Had he been deported?

I called the homeless shelter, sifting through layers of recalcitrant bureaucracy. When I finally reached a human being, she informed me that he had been transferred to a "medical shelter", the place for frailer residents who might not be able to survive in the regular shelter system.

As it is, medical care in the USA is an uneven affair. The global dice are rolled just as indifferently at home as abroad. Those without the luck of a job that comes with robust health insurance are left to fend for themselves. Medicaid helps those at the lowest income levels, but substantial numbers of Americans fall through the gaps. Medical care is even more challenging when circumstances hamper stability—unemployment, mental illness, homelessness, criminal history, poverty, substance use, and undocumented immigration. Thus far, the USA has resisted that notion that health care is a right for everyone. American "exceptionalism" continues to make exceptions for far too many of its people.

I called the medical shelter to track down Mr M and fought through three levels of administrators who rebuffed me, citing infuriating bureaucratic rules. Finally, a kindly manager was willing to investigate. She uncovered documentation of an initial intake several months ago, but nothing after that. "He probably just walked out", she told me.

What would that walking out be like, I wondered. I imagined him making his way out of the shelter's doors,



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hobbling with his old metal crutches, swinging his legs along in his laborious, punctuated gait. All 100 pounds of him setting out into the roar and tumult of the city.

I hunted on the internet and Facebook, but quickly learned that his first and last names were the local equivalents of John Smith. I even considered calling his country's embassy, but immediately reconsidered. Even if they did have the ability to track down an undocumented national roaming a city of 8 million, sporting the most prosaic name possible, this was the government he was seeking asylum from.

All I could do was sit with my sadness.

"Losing a patient" is an odd phrase that has stuck in the otherwise jargon-laden language of medicine. It's what we say when a patient dies. But what about when you actually lose a patient? When your patient disappears without a trace? When there's no phone number, no address, no next-of-kin, no legal documentation, no online footprint?

A fragile hope flickered in me that his absence might indicate a turn of good fortune. But why wouldn't he have at least picked up the new leg braces before sallying forth to whatever better station awaited him? No, I was convinced it was tragedy. Even with the famous anonymity offered by New York City, a man with his disabilities would stand out—vulnerability there for the trammelling. How easy it could be for cruelty to flare.

I write this article now with the faint hope that Mr M might somehow stumble across it and get back in touch. But it's hard to stay optimistic. I'd lost a patient. The grief is no less intense than if I'd lost a patient in the traditional sense. Loss is loss.

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