

Watchful waiting

REFLECTIONS

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His name on my patient census that morning was John Doe. The admitting note said he was found unresponsive in a bodega. The paramedics said they had been called by the bodega's manager. The manager found Mr. Doe alone and unresponsive on the floor by the milk. No one in the bodega knew how long he had been there or what had happened to him. The paramedics said his vitals were stable during the ride to the emergency department, but beyond that, they had nothing.

By the time he arrived in the emergency room (ER) he was alert, but no one in the ER could get him to say anything. The nurses tried questioning him in English and Spanish, but he wouldn't give them anything, not even a name. They searched for clues on his person, but he had nothing in his pockets, except for some completely ordinary keys.

He was a small man, wiry, and well-kept. He looked to be older, dad or grand-dad aged, but his age was hard to pinpoint. He was nondescript. He could have been anyone.

We went through his bag of personal effects to try to find some identification, though why we thought we'd be able to when neither the paramedics, police, nor ER staff had been able to, I don't know. His clothes were clean— a pair of well-worn jeans, an old leather belt, a faded button down shirt, and a pair of sturdy leather shoes. He seemed well taken care of and I felt sure that there must be people missing him.

Mr. Doe was a mystery. Not only did we have no idea who he was, we also had no idea what had happened to him.

By the time I saw him, the morning after his admission, no one had

been able to find anything medically wrong with him, except his continued inability or refusal to answer questions. His vital signs remained stable. He had no drugs in his system. His labs were perfect. The radiologist reported his brain scan showed a completely normal and perfectly healthy-looking brain.

When I asked Mr. Doe basic questions like “What’s your name?” “Do you know where you are?” “What happened?” he would answer me in nonsensical Spanish.

In order to do something, anything, we decided to search through his belongings again. Again, we only found keys.

Why would he go to the bodega without his wallet? Maybe, we thought, he was confused when he left home... Maybe he had some sort of underlying dementia? Maybe he had wandered off from where he belonged? Maybe someone was searching for him?

All we had were a bunch of maybes and some nonsensical mumblings. He kept mentioning “m’ija,” which means “my daughter” in Spanish. However, we couldn’t get him to tell us his daughter’s name- we couldn’t get him to tell us anything useful at all.

He looked so incredibly frustrated and scared and helpless. We were feeling all those things too. It’s not often in a hospital that the entire team- attending, residents*, medical students, everyone- feels quite as lost as we did that day.

As clinicians, we’ve spent years training, learning how to fix, to remedy, to prescribe, and to work through complex problems to find solutions. With Mr. Doe’s case I felt like my training hadn’t prepared me quite enough. We didn’t know what to do, so we did the only things we could: watch and wait.

The hospital neurologist happened by as we were discussing Mr. Doe’s case one more time. We briefed him on what was happening. He did his own thorough exam and attempted to speak with Mr. Doe. He stepped back and looked at us as though we had missed something obvious and said “He is aphasic. He’s had a stroke.” We quickly agreed in regards to the aphasia, but told him that the radiologist stated that the brain scan was normal. He replied “We must read it for ourselves.”

As we crowded around to look at the scan over the neurologist’s shoulder it became apparent he was correct. There was a subtle defect in the temporal region of Mr. Doe’s brain. Mr. Doe had a stroke, and a recent one at that.

The neurologist explained that the way Mr. Doe was speaking was a classic presentation of Wernicke’s Aphasia. For a moment, our entire team was elated. We had a diagnosis! Now there was something for us to do!

Except, there wasn’t anything for us to do. All we could do was continue to watch and wait. I was horrified. I couldn’t

wrap my head around the fact that we couldn’t help him. It was unacceptable to me that we couldn’t “fix” this situation. This poor man was basically locked in his own brain and we weren’t going to do anything. There was nothing for us to do. Time was his only hope.

Mr. Doe helped me realize that there are some mysteries in medicine that we’re not going to be able to solve. Even the best medicine can’t always provide us or our patients with the answers we so desperately want. There are going to be those patients we can’t fix. Sometimes the only thing we can do is *watch and wait*. Our impulse is to help, to heal, to do something- anything- all the time. But I think it’s important for us to be able to recognize and gracefully accept those situations where watchful waiting is the most appropriate plan. We can’t fix everything; sometimes the best course of action is no action at all.

It took days, but in Mr. Doe’s case, the watching and waiting paid off. We all got our answers. The local police discovered his identity; he wasn’t Mr. Doe anymore- he had a real name and a family. His “m’ija” had been looking for him and was relieved to know he was safe. Eventually, he was even able to answer questions and speak meaningfully.

He was a mystery that solved itself with a little time.

Ethical Statement

This work is a piece of creative writing inspired by several real patient encounters. No patient identifiable information is contained within this work, and the personal details given represent a fictional person.

**The use of the term "attending" here refers to the equivalent of a UK consultant, whilst "residents" refers to junior doctors.*



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