Crusin' for a Diagnosis

One Physician's Memorable Admission From the Heart

By Faith Fitzgerald, MD
ftfitzgerald@ucdavis.edu

Many years ago, the City of San Francisco had a program where ambulances (then unkindly called the "boozer cruisers") would set out at night to pick up people on the street, mostly alcoholics, found collapsed on the sidewalk, huddled in doorways, staggering into traffic, or otherwise clearly unable to care for themselves. They would then bring them to the emergency room (Mission Emergency) at San Francisco General Hospital. There they were triaged by the ER medical resident, deloused if necessary (dipped into the Cuprex bathtub) and given cots in the men's area.

Each was hooked up to a "yellow bottle" to supply vitamins B and C intravenously. By tradition, the yellow bottle (so colored by the vitamin B) once yearly turned into a "green bottle" when a house staff wit added drops of methylene blue to the yellow IV fluid on St. Patrick's Day.

Those men found in life-threatening withdrawal (delirium tremens), injury or other illnesses were admitted to the wards.

Those judged to be safely manageable in the ER, and fit enough for probable discharge the next morning, were held in the ER's overnight ward. Their clothes were taken away to be laundered. They slept on clean, white sheets, and in the morning delivered to them were several large trays of hot buttered toast, oranges and coffee. Those well enough to return to the streets were dressed in their now clean clothes and discharged, but not until they ate the toast and oranges, drank the coffee, and in most cases, had their hair combed by the nurses and ancillary staff.

Before any discharges, however, the chief of internal medicine and the chief residents (of whom I was one) would make early morning rounds with the ER house staff on all the patients under their care. Most of the patients were ready to go, and many thanked us for the cot, the caring, and the food. They were given Alcoholics Anonymous contact information, and, almost to a man, praised future abstinence from alcohol, as they had promised many times before.

Some presaged this with a a wave and a smile at us, saying:

"See ya later."

One old man, however, was still on his cot when we rounded. He was very, very thin, ribs protruding, scaphoid abdomen, wasted arms and legs, and breathing shallowly with his eyes closed. He was, however, easily arousable.

When the division chief asked him how he as doing, the old man said repeatedly, and in a whisper, little other than:

"I am so tired."

He had been found down in a gutter by the Boozer Cruiser team, reeking of alcohol and vomitus. His physical exam, other than cachexia and mild hypothermia was, the ER resident had declared, unremarkable. His CBC and chemistries were within normal limits. My division chief listened to his heart and lungs, palpated his abdomen, and checked his reflexes. All were normal.

The division chief then nodded, turned to the ER resident and said, "Admit him."

The ER resident was both surprised and very, very unhappy. It was, during that era in medicine, that the ER physician was proud to be a "rock," admitting as few patients to the medical wards as possible, either by discharge or cunning triage to another specialty. His umbrage, as they say, was quite palpable.

The resident began to argue with the chief, who repeated, with set jaw and steel in his voice, "Admit him. Now!"

The ER resident challenged the chief again.

"With what diagnosis? What do I tell the ward resident is the reason for admission?"

The chief looked straight at the resident as he gave him his answer.

"Compassion."