Vital Signs

College • Collège

A family doctor in emergency

Cal Gutkin MD CCFP(EM) FCFP, EXECUTIVE DIRECTOR AND CHIEF EXECUTIVE OFFICER

Family physicians always have patients they never forget, and some of my most vivid recollections come from times spent in the emergency department.

Early in my career in rural Ontario, a 17-year-old American primipara, 26 weeks pregnant, happened to be in our area while traveling with her boyfriend on their summer vacation. She arrived in our emergency department in established labour and within several minutes delivered a tiny cyanotic baby boy with a faint and very rapid cardiac impulse.

While carrying out resuscitation of this premature newborn now in an incubator, I was alerted by the nurse that a foot had just emerged from the mother's uterus. I discovered a footling breech presentation which, within a few minutes, proved to belong to an almost lifeless twin sister. The babies, together weighing less than 2600 g, soon shared an incubator where I performed CPR on both of them at once.

Amazingly, over the next few hours, both established relatively stable vital functions, compatible with life. All would have been great if not for the retained placenta, which I had to manually extract with the mom under a general anesthetic. Talk about a series of firsts in practice! With the telephone advice and support of the pediatric intensivist in Winnipeg—both during the resuscitations and afterward—I managed the 2 babies over the next 24 hours. When they were more stable, we transferred them to Winnipeg. Mom remained in hospital for about 5 days under my care. Fortunately mom and babies (and I) all survived.

Once a 72-year-old man arrived via his boat by the hospital dock. He was diaphoretic and complained of chest and abdominal pain. We started some oxygen and intravenous fluids and got him quickly to the emergency department, where we found him to be markedly hypotensive. At my request, the only consulting specialist in town took a look and recommended I admit and treat him locally for an acute myocardial infarction (MI). But was his progressing shock cardiogenic or hypovolemic? Or both? Why did his enzymes and his electrocardiogram not reflect acute MI? Why did he respond positively to a fluid challenge? The emergency nurse and I were not convinced that his clinical, laboratory, and electrocardiographic findings were diagnostic of MI, and we felt we had to rule out a leaking abdominal aortic aneurysm. We arranged for a surgeon to accept him in Winnipeg, stabilized him, and transferred him by ambulance to the city with IVs running liberally during the transport. The surgeons there took him straight to surgery where, as his abdomen was opened, he ruptured the suspected aneurysm. Fortunately, because he was where he was, they saved him.

In our Toronto teaching hospital emergency, a 29-year-old man presented to us. Two days before he had graduated in law and 3 days hence was to be married. He had been driving his open-roofed sports car up a ramp onto an expressway when a truck carrying hot tar overturned above him. He arrived in the emergency with all but his face and a bit of his neck entombed in a hot tar cast. He was conscious, joking with me about what had happened, and asking for his fiancée.

But his status was changing rapidly and his links to life were disappearing with each minute. Should we leave the tar in place to protect his vital structures or should we remove it to try to gain the IV access essential to countering his massive fluid and electrolyte losses? Almost 90% of his body suffered full-depth burns and we knew he would almost certainly not make it. With his family and broken-hearted fiancée at his side, he succumbed within a few hours. For a young physician like me, not far from graduation from medical school, recently married, it was hard not to internalize what I had just seen.

In a suburban Mississauga hospital, I met a beautiful 11-year-old girl rushed in just past midnight in status asthmaticus: cyanotic, severely hypoxemic, moribund. It was a difficult intubation, but we got the tube in and she needed every medication we had ever learned about in medical school or in continuing medical education through the years that followed—but she made it. I then managed her as an inpatient for about 10 days and, because she did not have a family doctor in our community, gladly agreed to provide her ongoing care. She remained in my practice for years during which time she was a total delight to get to know and care for, even though she needed many more admissions for acute bouts of asthma triggered by a never-ending array of food and environmental allergies. But as she matured, she outgrew much of her respiratory problem, completed her schooling, and today is a nurse in our health care system with a family of her own.

The continuity that defines family practice, that creates and cements the bond that defines the patient-doctor relationship, is strengthened when family doctors are there with their patients in the emergency rooms, in the hospitals, and in their office practices.

Of course, in the long run, the memories alone make it all worthwhile.