The toothless smile

Runner up of the Penelope Gray-Allan Memorial CJEM *Writing Award*

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Medieval medicine was simple, wasn't it? The task was to find the balance in the four humours. A purging, a few bloodletting procedures, and, if you were lucky, a trephination, and you could call it a day. No evidence-based practice, no complicated decision-making rules.

Despite an "evolution" in the paradigm of practice in medicine, the body still does its job at expelling "evil humours." The scent of some of these humours has the ability to stop you dead in your tracks as you are hustling through a busy emergency department. You would think you would get used to the repugnant smell of a fecal disaster in a nearby room, but, indeed, the taunt of "evil humours" lingers.

In the fish bowl we call the emergency department, we sometimes treat patients in an attempt to practice the "art" of medicine while applying evidence-based decisions. I am almost there, a real emergency doctor, in my final year of training ready to take on the world. While working on increasing my flow and meeting the needs of the department, I try to temper my "type A" personality, which wants to rule out every possible diagnosis and perfectly package the patient for the consulting service. I am equipped with an exhaustive list of differential diagnoses and an armamentarium of diagnostic strategies and algorithms. I can have a list of 10 to 15 patients on the go; I can make the spot diagnosis and work up, diagnose, and treat even the most complicated of patients. This is what my residency has trained me to do.

With a bounce in my step, I glance quickly at the triage note for the next patient I am seeing. A CTAS score of 4 and a story of increased confusion with a history of dementia. I think to myself that this should be quick—then on to beds C14 and C12 and then to reassess F3, discharge E2, and call Cardiology when the troponin is back for B12. Thinking ahead, charting as I am going, I'm on a roll. I am PGY-5. Medieval medicine has nothing on me.

As I walk into the room of the 87-year-old patient with the triage note complaint of confusion, I am greeted by a frail, pleasant lady who gives me a toothless grin that stops me in my tracks. At her bedside is her daughter, who holds her hand while gently stroking it and repeatedly asking her mother if she is okay. The daughter appears disheveled, distraught, and exhausted from having cared for her mother for so long. Although there was no chart with her name on it, I realized that she needed as much, if not more, care than her mother who lay in the stretcher beside her.

This time, I don't dart out of the room as quick. Rather, I sit, hearing the story and the details. As I leave the room, my pace is slowed with lingering thoughts of the toothless smile and the totally worn-out daughter. How can I help? As the results of her investigations trickle in, I hope for the abnormal test, a

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validation of clinical acumen and reason. As suspected, a simple urinary tract infection—the imbalance of the "evil humour" rears its head once again. I had solved the mystery. I had the answer and was going to administer the cure to find balance in the four humours once again. Or not?

I brought the daughter a coffee and asked the patient once again how she was doing while instinctively stroking the top of her head, much like I do to my newborn son, and thinking how life really does come full circle. She sat in her diaper, incoherently uttering several words to me, once again like my newborn son. She then turned directly to me and gave me a huge smile while she reached for and gripped my hand tightly. Without words she thanked me, and with that smile, she changed me. I realized that despite her aged, confused, and debilitated state, I had at that moment made a difference in her life. Her daughter had tears in her eyes, having made the same realization. This moment lasted only seconds but had the power to make even the chaos of the emergency department stand still.

There I was, a PGY-5, almost a real emergency doctor, determined to clear up the waiting room and manage the department, but I was simply sitting at the bedside of this elderly lady with her daughter.

Despite our intricate rules and evidence-based strategies, I couldn't find one tool that helped me dose empathy. The literature is scant when looking at the adverse outcomes versus potential benefits of hand-holding. Despite teeth getting whiter, I couldn't find any evidence on the dose of applying more smiles per minute of patient care versus patient satisfaction. The randomized controlled trial on listening to the caregiver to treat the patient versus simply finding the diagnosis has still to be completed, although I hear that the double-blinded controlled trial was attempted but failed as a lack of eye contact was a strong confounder.

Maybe medieval medicine has something to teach us, founded on the balance of "humours." Perhaps the power of a smile, a holding hand, or genuine empathy can restore a little more of the balance that is skewed with many of the patients we encounter.

I left that day feeling more satisfied than when I had "cracked a chest" and "saved a life." Although I didn't save anyone's life that day, I think I played a small part in making at least one, if not two, a little better. I went home and stroked the top of my son's head while he was tucked in his crib. He gave me a smile that made me melt for the second time that day, and I thought to myself that I hope when I come into the emergency department in my elder years, likely demented (hopefully not belligerent, but very likely), someone will find the time to hold my hand and care.

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