to die, while J.D. had taken a sudden, unexpected turn for the worse. A planned, compassionate withdrawal of support is a very different ending from a code situation, with its feelings of failure and defeat. And, of course, the personalities of the people involved change and mesh in different ways. Or maybe there was some difference in me over those two years, some evolution. I don't know for sure.

Not for a second do I believe that these losses are truly mine; the tragedies belong to the grieving families, but there is undoubtedly a connection left asunder between provider and patient. The cold, objective perspective we learn in medical school doesn't always hold true — we contain human feelings: ego, love, compassion, and grief. In the act of bearing witness to others' loss, I can salute and honor that which once was and that which now is.

I do know, however, that after every death I hear about, I go out of my way to find my fellow residents and interns (as well as medical students), make sure they're okay, and let them know that if they need to talk, I'm here.

The Care of Strangers

Rachel H. Kowalsky, MD

A BROTHER AND SISTER have run away from home — or at least, they wandered away from their grandmother in the Bronx and took the subway 17 stops, exiting at South Street Seaport. They were found climbing over a railing to get a better look at the boats. The brother, Rafael, hands thrust deep into his pockets, is seven. His sister, Laura, is four. She wears a raggedy sundress and pink sequined shoes. Oblivious to the quorum of cops and case workers their presence has summoned, they were ogling the fish in the seaport's fish tank.

Their grandmother arrives in the emergency department. She is thin, anxious. She wears thick glasses and thick heels. I break the news to her — we've had to call ACS, the

Administration for Children's Services, to investigate the family. Even if the children didn't run away — even if they only wandered off — they were improperly supervised.

The woman is indignant, frowning at me over her glasses. "We are *buena gente* — good people. You don't know anything about us!"

She's right; I don't know them. In my job as a pediatric emergency physician, I care for thousands of children and families in a year, entering their lives at critical moments and exiting just as quickly. While many patients develop a relationship with their doctor over months and years, a typical ER shift is between 8 and 12 hours — about as long as it takes to fly cross-country, charge a battery, or marinate a chicken. It takes longer for paint to dry on the hospital walls.

The grandmother is interviewed by the ACS social worker. The office door is closed, but I can still hear the escalating emotion from down the hall. Through the shouting and crying, I catch that phrase again: *buena gente*. When she emerges, the grandmother is crying. Laura, the four-year-old, pulls herself away from the fish tank, rushes over, drapes her arms around the old woman's neck, and then starts to cry herself. The woman and child add their tears to the general din of the ER. The medical student I am working with looks at me, distraught. "Maybe we shouldn't have called ACS."

I have a set of rules for taking care of strangers, and I lecture the student about Rule Number One: *Treat every family the same*. In this frenetic setting, I will never learn

whether a family is *buena gente* or not, so I have to do the same thing for every little wanderer: call ACS. If the children had strayed from a picnic on the well-heeled Upper East Side, I'd have to do the same (and I have).

Then, because I have a few moments (and the medical student is a captive audience), I share Rule Number Two: *Learn one thing from each patient*. Rafael, the seven-year-old, has a benign heart murmur. I tell her to go and listen to it. That way, when she hears an abnormal murmur, she will know the difference. "See?" I expound. "You'll never see Rafael again, but he will influence your practice for years to come."

Rules one and two are basic. Anyone who went to medical school in the last century has been lectured on both of these topics. The more difficult task, when caring for strangers, is to inject humanity into these brief encounters — to pop in and out of people's lives with grace. Thirty minutes later, when my shift ends, I make an attempt. The children and their grandmother are sitting miserably in an alcove, situated directly between me and the door. "Good-bye," I say, standing uncertainly before them. Nobody looks up. I kneel down to Laura's eye level and offer her a sticker. She scowls at me. I accept my defeat.

The other rule of caring for strangers is one I learned as a resident in pediatrics. It was routine to cross-cover patients, or to care for a patient briefly, usually overnight or on a weekend. On weekdays, each patient had a primary resident, a resident who knew the patient well and was

responsible for his or her care. But, despite being called "resident," no doctor truly lives in the hospital—and when the primary doctor went home, somebody had to assume care of those patients. This is true in essentially every hospital in the country, and it's why the cross-cover role exists. Cross-cover doctors, like ER doctors, must take care of children they do not know.

When I was a resident, we had systems in place to make cross-coverage as seamless as possible. For example, each patient had a weekly log with a column for each day of the week. Each day we recorded the vital signs and lab results, the child's medications and diet specifications, and any important events that had occurred. When we "signed out" a patient to the cross-cover, we handed that doctor the log. It became all-important—the patient's whole illness distilled into a few lines of text.

Despite all the organization, cross-coverage was always a delicate situation. Entering a child's hospital course *in medias res* felt like opening a novel to a random page or entering a movie theater halfway through the film. I learned to ask a lot of questions at sign-out so that I would never walk into a patient's room unprepared. And I became used to hearing "You don't know my son," or "You don't know what works for my daughter." Experienced parents would even say, as I came by to introduce myself, "I know—you're just cross-covering."

And then, a resident's nightmare: I was cross-covering Amanda Lopez the night she died. Amanda (not her real name) had a rare and virulent form of childhood leukemia. She was DNR (Do Not Resuscitate) and ALOC (Altered Level of Care). The latter meant that we were not to do anything invasive or painful, such as draw blood or put in IVs. She was to receive comfort measures only.

Boyd, my coresident, signed her out to me. Amanda's primary, Sam, was postcall—he had worked overnight the night before, going home at 11:00. So Boyd had covered Amanda. And now she was mine: double cross-coverage. She had been febrile all day, lapsing in and out of consciousness, her blood pressure falling. Boyd told me she was going to die. In fact, he had actually started the necessary paperwork for me: the death certificate, the organ donation papers, and the event note on the computer—the "event" being death. This is how it read: "Amanda is a 6-year-old female with leukemia. Status: post multiple rounds of chemotherapy, now with end-stage disease and presumed sepsis, on ALOC." I could write the rest later.

Amanda liked to wear ponchos. Her favorite was a nubby cream-colored poncho with navy stripes; it was way too big for her tiny body. I knew her but not well, the way I knew the kids in my apartment building. She had been in the hospital a long time. Her log had weeks and weeks worth of papers stapled together, but since she'd become ALOC, not much was written there. She had hollow cheeks, large, lovely eyes, and a wise, pointed chin. She was very close with her oncologist and with Sam, her primary—but neither of them was there. I was there.

I introduced myself to Amanda's parents. I said I was their doctor for the night. I asked whether Amanda was

comfortable and if they needed anything. Amanda's mom asked whether Sam, her primary resident, was around. I said no. He was actually at a wedding, but I couldn't bring myself to say this. She nodded. I suppose on the scale of disappointments, this final one was small. She asked me for a glass of water for Amanda. *Ice?* I asked. *No thanks.* I stood around for a bit, watching her offer the water to Amanda. I remember that the girl's lips were dry, that she didn't drink anything, and that her mom carefully applied some lip balm. Amanda lay on her side, propped up on pillows, a nasal cannula delivering oxygen with a soft whir. Her parents lay in bed too — one on either side of her. Nobody spoke to me or looked at me, so I left the room.

If Amanda's life was a novel, I was a minor character — a character without lines. I sat at the nurse's station, wondering what I could do for her. My pager went off all night, calling me to other rooms and other patients, but I kept returning to the desk outside Amanda's room. "Do you think they need me?"

Amanda's nurse shook her head. "Best to leave them alone."

It was torture not to go in the room. Shouldn't I know the patient whose final event note I was to write? Shouldn't there be a moment of connection? Well, I had brought her a cup of water. Somehow that made me feel better.

I checked on Amanda twice more. The first time, she was cuddling with her mother. The second time, she appeared to be asleep. An hour or two later, her nurse

called me. "I think she passed," she said. She was crying. Another nurse hugged her. I stood awkwardly, my hands in the pockets of my white coat. "Go on in," she said. "You have to pronounce her."

So that was my job — to listen to Amanda's quiet chest and confirm that she was gone. I put my stethoscope over her heart and listened for a long time. When I looked up, both parents were watching me. It was a strange moment, the three of us in the room with Amanda. I opened my mouth to speak, but they cut me off. They reached for each other. And that was the end of the story.

From Amanda, I learned Rule Number Three: *Family first.* I don't think her parents remember me. They probably remember Sam and their favorite nurse. I was just the one with the stethoscope, at the end — an extra in Amanda's story and the story of her family.

But in my own story, Amanda is a prominent figure. Because of her, I learned Rule Number Four: *12 hours is just the beginning.* Because I still think about Amanda Lopez, and it's five years later.

DON'T GIVE UP. The last rule, Rule Number Five. It's weeks later, and I am back in the ER with another medical student, telling him what I like about my job. The level of acuity, the interesting cases, the varied age groups. The many dramas, big and small, that come through my door each day. The medical student plans to go into general pediatrics because, he says, he likes the continuity of care. He wants to get to know his patients.

I defend my specialty. Children with respiratory illness often come back for a "resp check" — a second visit — and babies with fevers commonly are brought back to the ER for a follow-up visit as well. If we put in stitches, we usually take them out. I enjoy these reunions, the familiar faces, the "How are you doing?"

And even though there are many patients we never see again, I tell the student, *don't give up*. After all, a lot can he accomplished in just a few hours. Parties start and end. Entire weather systems change. Shakespeare's plays are just hours long, and think of all that happens there — people fall in love, wage war, return from exile. Kingdoms fall.

And, can you believe it? That same day, I bump into the grandmother at the end of my shift. We are both in the lobby, trying to exit the hospital through the revolving door. There are several people ahead of us, and we wait awkwardly together.

Finally, she nods at me.

"The kids?" I ask, looking around. She tells me she is here alone, visiting a sick relative.

"How are they?"

"*Malcriados*." Poorly behaved.

"I'm sorry…" I begin.

She enters the revolving door, waving away my apology. "The woman came from ACS, she checked the house, she talked to us — and she left. She saw we were good people."

"I try to treat every family the same," I say, defending myself as I stumble through the door behind her.

She stands and faces me in the bright sunlight. Then, she surprises me. "You did the right thing," she says. "If somebody had done that for my brother and me when we were young, it might have saved his life." And just like that, she strides off in her thick heels. The whole conversation is two minutes from start to finish — about as long as it takes to adjust to the winter light, shake my head, and watch her disappear down the broad avenue.