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Collector's Envy

By Emily Milam

Ryan joked that he had blimp-like legs after failing to shimmy sneakers over his bilaterally swollen feet. He was the picture of heart failure. My finger pads sunk into his edematous shins. His lower lungs, treading water, emitted crackles between coughs. Like a dependably misfiring engine, his heart sputtered and rumbled with each beat. He uttered the necessary buzzwords and complaints— "gasping for air," "four pillows," "heavy legs." I could neatly and proudly box him into the diagnosis.

On teaching rounds, Ryan was heralded for his "classic" findings of severe aortic regurgitation. He had it all: the V/VI blowing diastolic murmur, the widened pulse pressure, the decrescendo finish. There was a crowd of eponyms: De Musset's systolic head bob and Corrigan's water-hammer pulse were in good company with Traube's pistol shot femorals. His numerous physical exam findings fit together in puzzle-like fashion, helping me appreciate the wisdom and staying power of the physical exam.

Given his textbook presentation, he became a local celebrity of sorts to medical students and residents from other teams. News of a severe aortic regurgitation patient spread fast. Everyone wanted a chance to press his stethoscope against Ryan's heaving chest and give that knowing nod, a sign that he too had identified the characteristic diastolic rumble. For medical students, ticking off a murmur from our "must-see-on-the-wards" list is like collecting baseball cards—everyone wants a complete set. Like many patients, Ryan was a prime learning opportunity, and also a checkbox.

But Ryan was far less amused. Belabored by visitors and repetitive questions, he gradually became less cooperative and testy. At times, he shooed away eager medical students, avoided eye contact with our attending, or bickered with his nurses. After witnessing him recite his history for the sixth time in a day, I could not blame him. Beyond the prodding and piercing from his daily blood studies and thrice-weekly dialysis, the never-ending influx of curious students asking him to hold his breath and clench his fists was laborious. His frustration was exacerbated upon learning that his faulty heart valve needed surgical repair. The onslaught of more medical tests and exposure to more medical teams proved irritating. Tied down by EKG wires and IV lines, there was little he could do to escape. "I just want to get out of here," he reiterated day after day.

As a third-year medical student rotating on the medicine clerkship, I dutifully visited Ryan throughout the day. He seemed to understand that I needed to regularly examine him as part of his routine care, not just to marvel at his murmur. Over time, we developed a

companionship. He always smiled when I entered the room and he never abstained from questions or my daily physical exams.

Perhaps he tolerated me because I always apologized for bothering him, always asked for permission to interrupt his day to lay my stethoscope down to revisit his stammering chambers. Perhaps it was my habit of lingering after the physical exam to ask about his non-medical existence: What was his favorite restaurant? How was his family? What did he dream of eating for lunch instead of the rolodex of green, white, and yellow purees? I lamented with him that it must be hard to be the subject of curiosity and away from his usual life, to which he would emphatically agree.

Perhaps it was the gatekeeper mentality I ultimately assumed. I found myself growing protective as the barrage of interested attendings and students arrived:

"Can we practice our cardiac exam on your patient?"
"You would be the fourth group today—I think he needs a break."

"Any good murmurs on your team?"
"Yes, but my patient's eating lunch with his family. Try stopping by another time."

Throughout his prolonged hospital admission, we shared many laughs and personal stories of life outside the wards. In hindsight, these conversations often seemed more therapeutic to him than his daily battery of tests and medications, and they also left a lasting impression on me.

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You hardly ever hear, "There's a pleasant guy with a witty sense of humor in Room 52" on the wards. Instead one is apt to hear about the impressive pericardial friction rub down the hall or the shocking disseminated zoster confined to isolation. Curious trainees flock to the unique exam findings out of sincere interest, but also collectors' envy. We want to see the "classic" or curious cases outside of the textbooks. Our first exposure to exam findings becomes a reference point that often persists throughout our medical career. I know that I will never forget my first dermatomyositis or my first cryptococcal meningitis patients. Patients teach us about medicine through their diagnoses, after all.

I won't forget Ryan. Ryan will always be my first patient with aortic regurgitation, and I will always remember his list of physical findings. But beyond educating me on the cardiac exam and heart failure algorithms, he also reminded me that patients are more than diagnoses at my educational disposal. This is especially pertinent in teaching hospitals, where patients are often subject to the medical gaze en masse, blurring the line between curious trainees and rubberneckers. Striking a balance between learning from patients and respecting their rights is a delicate but crucial feat. When we start to value patients only for their physical findings, we lose sight of the human who is bearing those symptoms.
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