

Red Line Rising

By Michael Brown

If you could walk in my shoes and look through my eyes as I fight in the primary care trenches of America, you might see something like this:

It would begin with a fight between two homeless men, probably over some spare change or a scrap of food, under the I-565 overpass. One of them, a 61-year-old African American male, would get the worst end of the exchange—a fist fit neatly inside the bony orbit of his right eye, his assailant's bare knuckles impacting like a rock from a slingshot.

The concussive force of the blow would send a shock wave through the eye and its crystalline lens, which is about the size and shape of a plain M&M candy. Situated behind the colored tissue of the iris, it captures the light entering the pupil and focuses it onto the macula, the bull's-eye of the retina.

Microscopic cracks and fissures would form, allowing water in the vitreous humor to penetrate the protective lens capsule, flooding its inner core. The sudden intumescence, along with a chain of deleterious metabolic events, would cause the lens to enlarge and opacify, like a milky white water balloon.

The lens, waterlogged and heavy, would start to tear away from the zonules, the tiny fibrils that anchor it to the ciliary body at the base of the iris. It would begin to shift forward, blocking the pupil and impeding the flow of aqueous humor from the posterior segment of the eye to the anterior chamber, the space between the iris and the cornea, where, in its angular crevice, the fluid is drained away in the trabecular meshwork, the eye's "sink." The intraocular pressure, normally a delicate balance of tension ranging from 11 to 21 mmHg, would begin to spike.

This shift in stasis would cause the iris to bow forward toward the cornea, further crowding the space where the aqueous drains, causing the pressure to rise even more. The iris would shift forward so much, in fact, it would begin to touch the back surface of the cornea, the clear window of the eye, causing the endothelial "pump" responsible for maintaining the delicate balance of water required for corneal clarity to fail.

The cornea would start to swell, too. The rising pressure would force fluid past the normally watertight endothelium and into the laminated middle layers of the stroma, and finally into the outermost epithelium, where tiny blisters would begin to form and erupt.

The pressure would also push backward toward the optic nerve, causing its delicate structure to begin to cave. The retinal nerve fibers, converging to form the optic nerve like the wires in a fiber optic cable, would begin to fray and atrophy.

As the cataract became denser and the optic nerve more wasted, the homeless man's vision would begin to fade. As the cornea continued to swell and blister, his eye would begin to hurt like hell.

The homeless man would start to make his rounds from ER to ER, begging for pain medication. An ophthalmologist on call at one of them gives him two prescriptions for eye drops and tells him that he needs surgery. He does not give him samples, nor does he admit him.

He has no car, no money, no health insurance, and no way to get the needed medicine. He has even less hope that things are going to turn out even remotely close to well.

Because he is a military veteran, he is eligible for care in your clinic and eventually shows up on your doorstep near the end of the day as you're trying to finish your last two patients. How he got there, and how he found you, nobody knows.

When the primary care physician doing walk-in intake that day dumps him in your lap (you don't blame him), you sigh, plant your face in your palms, and pull down on your skin in an effort to relax your jaw and facial muscles.

You know you're being tested, and you don't want to fail.

You invite the man back to the exam room. You don't think about how he got to be homeless, you don't judge, and you don't ask yourself whether or not he "deserves" care.

He has a disease, he's in pain, you're a doctor, and he's standing there in front of you. Your duty is clear.

You speak very slowly and plainly, and you observe. You notice there is swelling in the lids and tissue around his right eye and he is holding it as if trying to keep it from popping straight out onto the floor.

But you know the real reason for this universal gesture of distress is he can't stand the glare of your office lights. You dim them as much as possible, and you seat him in your exam chair.

You test his vision in the damaged eye and discover he can barely see the motion of your hand in front of his face. You measure his intraocular pressure and it's 45 mmHg—lower than you thought it would be, but still dangerously high.

You see the milky balloon of a lens, the bulging iris nudging the back surface of the cornea, the painful blisters—hundreds of them.

You diagnose a traumatic cataract with pupillary block glaucoma, but you don't use big words with the patient. You simply tell him his eye pressure is dangerously high and he will likely never see well out of the eye again.

You tell him he might be able to save his eye, and what little vision he has left, if he has surgery. This will require a trip to Birmingham and hospitalization. “But first things first,” you say, “let's lower the pressure.”

You give him two drops chosen from a small stash of ocular pharmaceuticals you keep in a locked drawer for such occasions. One is to lower the pressure, and the other one is to quell the inflammation inside his eye that is raging like a California wildfire.

You would like to give him some pressure-lowering pills, too, but it's after hours, the in-house pharmacy is closed, and nearly everyone else has gone home.

You ask where he's staying, and he gives you the name of a local homeless shelter. You tell him a social worker will come find him tomorrow and help him return to the clinic to get the pills.

He heads out the door and back to the streets. You wonder if you'll ever see him again.

You think about little else that night. You're very quiet over dinner because your brain, including the parts where words and screams are formed, is fried. You sleep fretfully.

The next day, the homeless man is the first thought on your mind. You go to work and find the social worker and ask her to find the man. She locates him and makes arrangements to bring him in.

When he arrives, he says his eye feels a little better with the drops. But when you measure his vision, he says he can no longer see your hand, only light. You examine him with your slit lamp, and if anything, the cataract is even bigger and the bulging iris displaced even further forward. His intraocular pressure has risen to 52 mmHg.

You prescribe the pressure-lowering pills and make him take one before he hits the streets again. You've already called and made arrangements for him to be admitted to the ophthalmology department at your main facility for surgery. You try to explain to him how important it is that he keeps this appointment, how his eye will become even more blind and painful if he waits.

You tell him he needs to arrive early at your clinic the next morning to catch the shuttle to Birmingham and remind him that he'll probably be hospitalized for several days. He doesn't like this one bit—he's not the type of guy who likes to be pinned down and held captive to a regimented routine. You persist, though, gently at first, then more firmly.

He voices his understanding of all this and promises he will be there on time, but you know the odds are he's simply telling you what he thinks you want to hear so he can get out of there and move on. The social worker gives him city bus passes to make it easier for him. He walks out the door and back onto the streets. You wonder, once more, if you'll ever see him again.

You do all this while trying to provide quality care to the other 15 or so regularly scheduled patients already on your plate that day.

The next morning, he doesn't show for his scheduled shuttle.

A few days later during your lunch break, you read in the online edition of your local paper about a man who was hit by a car and killed while crossing a major thoroughfare. The story names the victim, and you recognize him as your patient. The car had hit him from the right, his blindside.

On the drive home, you think about your country's healthcare system and your role in it. You know it's not really a "system," because that word implies a well-coordinated arrangement of smoothly moving parts.

You picture it as more of a million-piece jigsaw puzzle that has spilled onto the floor. You spend your days, some days more than others, scrambling like mad, picking up the jagged pieces and trying to assemble them into some kind of coherent, meaningful picture.

You think about the people who speak glibly of healthcare, who speak ill of "government doctors" like you, who dismiss the need for healthcare reform with the wave of a hand and opine that catch-as-catch-can ER care is "good enough" for patients like yours.

You find yourself muttering things under your breath about such people, words and phrases you thought you'd never say, ones that would disappoint and anger your mother and cause her to smack you across the mouth.

You stop yourself because you want to be a better person than that, and you try to cut them some slack.

When you arrive home, you consider the cardinal signs of professional burnout—exhaustion, cynicism, and second-guessing both your abilities and your odds of making a significant difference—and you realize you're so dangerously close to self-immolation your face is flushed and you're starting to smolder.

You reach for a \$10 bottle of halfway decent Cabernet to help douse the fire. You pour yourself a glass, the red line rising full to the brim. You turn toward your keyboard, and you pour out your soul.

Michael Brown is an optometrist who has practiced with the U.S. Department of Veterans Affairs for over 25 years and served as an adjunct clinical professor at the University of Alabama at Birmingham School of Optometry. He contributes a regular column to *Optometry Times* and serves on its Editorial Advisory Board. His creative nonfiction work has also appeared in *The Huntsville Times* and *Arkansas Times*. For him, writing is a two-way lifeline that enables him to extend better care to his patients and to receive encouragement and hope from their stories. He lives in Huntsville, Alabama.