AMWA Linda Brodsky Memorial Journal

Sharing our Zebras

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Bzzzz… the patient's phone vibrates. My preceptor is searching for the new labs in the chart. The patient takes this as an opportunity to peer down.

"Two new Eastern Equine Encephalitis cases," the patient states, looking up at me. My stomach drops. "The first one died a week ago. News said he was from right here in Warwick, too."

I nod and say, "They sprayed the area this weekend. Hopefully no one else will be affected."

Two weeks earlier. It is early September and I am driving home to Boston for my first free weekend. My phone buzzes - My cousin is calling. I answer, excited to catch up with her and let her know how my third year of medical school is going.

"I have something I need to tell you," she begins. "You know that triple E story all over the news ..."

I pull over to the side of the road.

The next patient comes into clinic for a routine follow-up, but she's preoccupied with Eastern Equine Encephalitis, which she and many news outlets refers to as "triple E." She asks me to examine all bumps and bruises, review symptoms, and if I know anything about the Warwick case.

EEE was all over the news this summer and fall, as mosquitoes, and then humans, across the Northeast tested positive for the rare yet deadly disease. Typically, patients initially present with flu-like symptoms - headache and high fever. The infection then rapidly progresses as the brain swells. Within a couple of days patients begin to exhibit more severe neurological symptoms including seizure, hallucinations, and coma. About a third of those affected with EEE die; survivors often suffer brain damage and paralysis.

As summer gave way to fall, frightened parents kept kids inside. Night football games were rescheduled and canceled. Towns announced aerial spraying to kill the infected mosquitoes. By November, when the first frost hit, the CDC had received reports of 36 confirmed cases for 2019, including 14 deaths. Three cases were in Rhode Island. The first case was my cousin.

My cousin was the man who was there to build up my self-esteem after my father left. He was the person who made me smile when it was hard to, and who was always unapologetically himself.

He lived in Warwick. He was a dad, a brother, an uncle, a coach, a fighter, a friend…

He was only 58.

He was much more than ***the*** EEE case.

I say nothing about the case to the patient. Instead, I calmly reassure her that the bumps she is concerned about are blisters from her new shoes and that it is unlikely she will get EEE. We move on to discuss the reason for her follow-up today.

I escape after clinic to Neurology Happy Hour, eager to chat more about the field. As a medical student, and thus assumed to be well versed in social media, the doctors ask me about what I'd want to see posted on their residency program's Instagram account.

"I like learning about medical cases on the accounts I follow," I reply without much thought.

"We could post about our triple E case," one of the doctors eagerly chimes in.

Wednesday didactics happened to coincide with flu clinic, so classmates I haven't seen in a while are at the Medical School. I approach a circle of friends standing in line to get flu shots. We trade rotation tips and talk about exciting cases we have gotten to see so far while we wait.

"I saw the guy with EEE!" one friend shares.

Another friend tells me about how she heard about the case from the doctors on the ID consult service – "they said he was so already so gone by the time they rounded."

I excuse myself, blaming didactics for my abrupt exit.

It's another day at the clinic. I knock on the door and proceed to enter. A man, middle aged, presents with general fatigue and a headache that he reports as 8 out of 10 on the pain scale. He says he works outside in the early mornings and evenings. My heart races. *Could this be EEE?* I don't want to exclude it from the differential, but if I include it will the residents think I am being extreme? I think of the medical proverb, "When you hear hoofbeats, look for horses, not zebras."

I decide to include it.

"It is unlikely, but if it was EEE, not much we would be able to do," the resident replies.

I agree.

Throughout our medical training, it can feel like we carry around a trainee passport. We eagerly fill each page with stamps of new exciting cases, cherishing the "zebras" we manage to collect along the way. Often in our practice of recording and sharing these experiences, however, we lose sight of the personal.

Throughout my family medicine clerkship, I was unable to escape the personal impact of the EEE case, with daily reminders of my loss from patients, peers, residents, attendings, and the local news. Each time EEE was mentioned, it stung. I did my best to remain professional; I did not flinch when patients innocently asked questions and I made every attempt to exit conversations when they were explicitly about my cousin. The medical professionals I interacted with did not know my personal connection to the case, but in a small state where n=1 it is not unlikely that somebody in our medical community knew my cousin personally. The attendings, residents, and students were eager to share ***their*** zebra EEE stamp with others, excited to tell others they were able to see a case that seemingly only existed in textbooks. In doing so, however, they lost site of the personal impact that that stamp had left behind for not only me, but everyone who knew my cousin personally.

This experience made me reflect on my own practice of sharing cases I have seen and the expectations I have for the medical community at large. I thought about ways we can be more sensitive, not only to our peers in medicine, but also to our patients, honoring our vow to protect their privacy. Sharing our experiences can be powerful, serving not only to help us cope with difficult decisions and cases we have seen, but also as a tool to enhance our learning and ultimately become better doctors. I think we need to be more sensitive however and reflect on why it is that we are deciding to share. *Will it add to other's learning? Am I seeking advice on how I could've better managed a case? Can I share*

without compromising a patient's confidentiality? If the answer is no to any of those questions – then perhaps we should limit the practice of sharing to our teams and those who also worked directly on the case.

While my EEE stamp is far more personal than medical, in an attempt to find my silver lining, I've decided to be grateful for the opportunity so early on in my career reflect more deeply on my own practice. I feel more confident that I will be more thoughtful in the future when sharing cases I have seen with peers and mentors. I have also been made more aware of how the personal is truly intertwined with our practice of medicine; even though we may be practicing and future clinicians, we too are patients and loved ones.

And to those who may have contributed to my experience, I only ask that you also take time to reflect on the lessons my cousin taught you. I hope you too record a piece of his persona, and not just his diagnosis, in your own medical trainee passport.