EDITORIAL

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Death of a Homeless Woman

Among patients returning to emergency departments repeatedly because of chronic recurrent illnesses, many are also homeless, including a large percentage who have psychiatric disorders and, sooner or later, alcohol and substance abuse problems as well. Eventually, the reason for their ED visit may be more serious and possibly fatal. But this editorial is not about a cause of death. Rather, it is about how one such death affected our ED staff, what they did about it, and some surprising things they learned from it.

"G.D." had been brought to our ED by ambulance hundreds of times during the past few years, usually because of a loss of consciousness. She was often discharged the next morning but occasionally, especially during cold winter months, required admission for decompensation of one or more chronic conditions, such as CHF. Over many ED visits and admissions, psychiatrists and social workers offered her a variety of possible placements and long-term treatment support, none of which proved to be as appealing to her as returning to the streets.

As difficult a patient as G.D. sometimes was upon arrival, when she recovered enough to be discharged, she was always grateful and appreciative for the care she had received, as well as for the food and a change of clothes. Whatever the staff thought of her when she began appearing regularly in our ED, after a while, G.D. just sort of blended into the background. That is, until one evening when she was brought in with resuscitation in progress and died without regaining consciousness, at the age of 63.

Initially the staff was shocked that a member of our "ED family" was gone, never to be seen again. Afterwards, shock turned to dismay when they learned that the Office of Chief Medical Examiner was about to release G.D.'s body for burial in New York City's potter's field. Responding to the staff's hope that something better could be done for G.D., we located and contacted a member of her family and, at her suggestion, arranged for cremation. Afterwards, we held a modest but dignified memorial service in the hospital chapel and arranged for return of her ashes to the family.

Some staff were surprised to learn that G.D. had a family. But the rest of her story was even more surprising to all of us who thought we knew everything necessary to treat G.D.'s acute medical problems, only to discover that we knew almost nothing about her as a person.

After graduation from college, G.D. embarked on a promising career in international banking and was engaged to be married when suddenly, everything changed. The family was told that she was schizophrenic, and what followed was alcohol abuse and a life on the streets for the next 4 decades. Even more startling and revealing was the photograph of G.D. that her sister provided for the memorial service. It showed a much younger, stunningly attractive woman about to graduate from college, whose eyes and smile showed all of the hope for a bright and wonderful future—a future G.D. would never experience.

In the several weeks that the picture remained in my office, none of the staff connected it to the patient they had themselves treated so many times in our ED. As emergency physicians we are usually very successful at fixing acute problems, but not necessarily as good with the underlying conditions—especially those intertwined with social problems our society has still been unable to solve. G.D. helped teach many medical students and residents—and more than a few attending physicians and nurses—how to care for patients in the fullest sense of the word care. For this, we are grateful to her and hope that she is now in a better place. **EM**