Reflections

Two Beds in the Emergency Room

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The emergency room teaches medicine, but it also teaches anthropology. On some nights, the monitors hum loudly enough to drown out thought; on others, silence presses harder than noise. Years ago, it was during one such emergency night in my residency years that two patients arrived with the same condition, altered level of consciousness and revealed to me how differently human lives can be held.

The first was an elderly man with Parkinsonism and long-standing hypertension. He was dehydrated and unresponsive to verbal commands, yet everything about him spoke of care. His clothes were clean and carefully chosen his skin well moisturized and his nails neatly trimmed. Even in unconsciousness, dignity remained intact. His family hovered attentively, not anxiously but deliberately, carrying his medical history with precision. They knew his allergies, especially his reaction to sulfonamides, and questioned each medication I prescribed. When I recommended furosemide, their concern sharpened immediately. They asked about its sulfur component, its risks, its necessity.

At first, I felt the familiar tension doctors experience when decisions are scrutinized. I explained the pharmacology, the minimal cross-reactivity, the balance between benefit and risk. They listened carefully, weighing trust against fear. It took time, patience, and repeated reassurance. But beneath their vigilance was something unmistakable: devotion. This man's illness had not reduced his worth. It had activated a circle of protection around him. As I stepped away from his bedside, I felt unexpectedly light. Amidst the chaos of the emergency room, it was a privilege to witness such love.

A few hours later, another elderly patient was wheeled in. She, too, had an altered level of consciousness, but her body told a different story. Her hygiene was poor. Her breathing was labored. Her left leg was swollen, inflamed, and neglected; an untreated injury that had been silently worsening. The brother who accompanied her could offer little information. He did not know when the swelling began or how severe it had been. He only remembered that she had fallen "some days back." She was unmarried and lived with him, though he himself was mentally compromised and struggled to care for her.

As her oxygen levels dropped and her condition deteriorated, the need for ventilatory support became clear. I felt a familiar tightening in my chest, not from the

medical decision, but from the conversation that would follow. I rehearsed how I would explain her critical state, how I would soften the words, how I would prepare them for uncertainty.

But I never had the chance.

Her sister and brother approached me first. Without visible distress, without hesitation, they asked what they should tell the rest of the family when she died. They asked if the hospital could arrange the funeral. There was no denial. No grief. No plea for hope. They had already accepted her death.

In that moment, the emergency room felt unbearably still. This woman was alive, breathing, though with difficulty, but socially, she had already been mourned. Or perhaps, never fully claimed at all. Her body bore signs of neglect, but what struck me deeper was the absence of emotional urgency. She was not being fought for. She was being released.

As physicians, we often measure outcomes in survival rates and lab values. But standing between those two beds, I realized how profoundly care extends beyond physiology. One patient lay unconscious yet deeply held by his family's vigilance. The other lay equally unconscious, already untethered from expectation or grief.

Medicine can sustain life. It can delay death. But it cannot manufacture attachment.

That night, I treated two patients with the same condition and left with two different lessons. One about how love complicates care and makes it meaningful. The other about how its absence can make death arrive long before the body is ready.

These are the stories that stay with us. Not because we failed or succeeded medically, but because they reveal what illness exposes, how unevenly dignity, attention, and belonging are distributed, even at the very end.

And long after the shift ends, those differences continue to echo.