Blue gown, white coat

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I came in through the staff entrance for my 10–6 shift recently at one of the hospitals where I work. My ED colleague greeted me with the usual, "How are you doing?" I paused briefly: "Andrew, I think I should see you. My pulse is a little fast, a little irregular this morning." Instead of the ritual handshake to signal the beginning of our work together, he took my right wrist in his hand. "130, 140, you're right, kind of irregular. Why don't we put you on the monitor? It's not very busy in here right now."

This was only the second time in my career that I appeared in the emergency with the dual identity of doctor and patient. Years ago, I went over the handlebars while cycling in a little too enthusiastically for a shift. I carefully extracted myself from a large wild rose bush, pedalled on to the hospital, and had my abrasions cleaned by a solicitous ED nurse, prior to seeing my first patient. I can't remember if I sustained a mild head injury.

Today I exchanged my white coat for a blue gown, climbed on to an empty stretcher and waited for one of the nurses to hook me up. The rhythm strip wasn't difficult to interpret: atrial fibrillation with a few short runs of flutter, 2:1, 3:1 block. My palpitations had started 2 hours before — shortly after I began a few minutes of exercise on a Stairmaster®. I carried on to my 15-minute swim, thinking, hoping that plunging into the cool water might help to slow me down.

Andrew came by to check the monitor, ask a few more questions and run his stethoscope over my chest. He recorded in the abbreviated script of ED charting the history that I supplied: "onset palpitations while exercising / now 2 ½ hr, feels unusual / no Ch pain or SOB / by hx 3 previous episodes palp 20–30 min/PHx R.F.—mit. St—valvotomy." I'd had an open mitral commissurotomy during my final year of medical school 20 years ago. Apart from some mild re-stenosis, the valve has performed well, opening and closing some six or seven hundred million times over the past two decades. I'm aware, however, that atrial fibrillation is an almost inevitable consequence of rheumatic heart disease. I just wasn't expecting it to catch up with me on this particular Sunday.

On my way to diagnostic imaging for a CXR, I made a brief pit stop at admitting and triage. Complete vital signs were duly recorded and a paper bracelet attached to my wrist. I began to feel like a legitimate patient, rather than someone who knows the secret handshake and can jump the queue for quicker service. Neither role suited me. Other than a little tired, I was feeling "fine." The fast-track area was starting to fill up, so Andrew and I decided that I may as well see a few patients. Stripping off my blue gown, I was soon back into the more comfortable white coat. The change was good for my morale, and maybe

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good for my heart. I saw a few kids with sore ears, an asthmatic, and someone with back pain; I could feel my pulse slow and become more regular.

Once the fast track was clear I walked back into the acute care area. I was becoming something of a quick change artist. Back on the stretcher, I was disappointed to see my slower rate on the monitor was actually flutter with 4:1 block. Just about that time Andrew reappeared at my bedside. Abruptly, I converted to sinus. Some doctors have a healing presence. It was now noon. Time to shed the blue gown and get to work.

Not so fast. The post-conversion 12-lead showed some mild ST changes inferiorly. Ischemia or early repolarization? Despite my desire to resume my ID as an EM physi-

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cian, Andrew wisely suggested we track down a previous ECG, do a troponin, and chat with the cardiologist on call. Before climbing back on the increasingly uncomfortable stretcher, I looked around for some fresh reading material. I'd already sifted through *Maclean's* and a back issue of *Parkhurst Exchange*. The rest of the shift was now officially a lost cause, as Andrew said he'd find someone to come in to cover for me. It was time to unsettle once more into that blue gown.

Is the care I received different from the care I usually provide?

"My" cardiologist arrived before I had time to finish reading an article on Syndrome X. We reviewed familiar terrain for each of us. He couldn't resist an exclamation of professional admiration for my pathological heart sounds. He called for a bed-side echo. We didn't wait very long. Doctor, patient and tech all listened attentively to my "boom-shush, boom-shush" soundtrack. We chatted animatedly about mitral valve opening area, calcification, left atrial size, aortic regurge. All mine. The troponin was negative. The CXR was kind of irrelevant. We discussed the conclusions of the recent AFFIRM trial and the uncertainties of predicting individual stroke risk.

To thin or not to thin the blood: that is the question. He assured me I could probably manage my own INRs. For the rest of my life. We also discussed the screening colonoscopy that I was booked for in a few days time (a 50th birthday present from my FD). Best to start the anticoagulants after the procedure. Then he smiled, shook my hand, I thanked him, and he was gone to do his next consultation.

Shortly afterward I disposed of blue gown and white coat. Clothed in anonymity, I crossed the doctors' parking lot and headed for the café. Sipping "a tall 2% decaf cappuccino to stay," I quietly reflected on one of my more memorable shifts. One question and a few observations remain. Is the care I received different from the care I usually provide? Emergency stretchers are uncomfortable. Always take something to read. If the blue gown fits, wear it. And don't forget, it opens in the back.

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