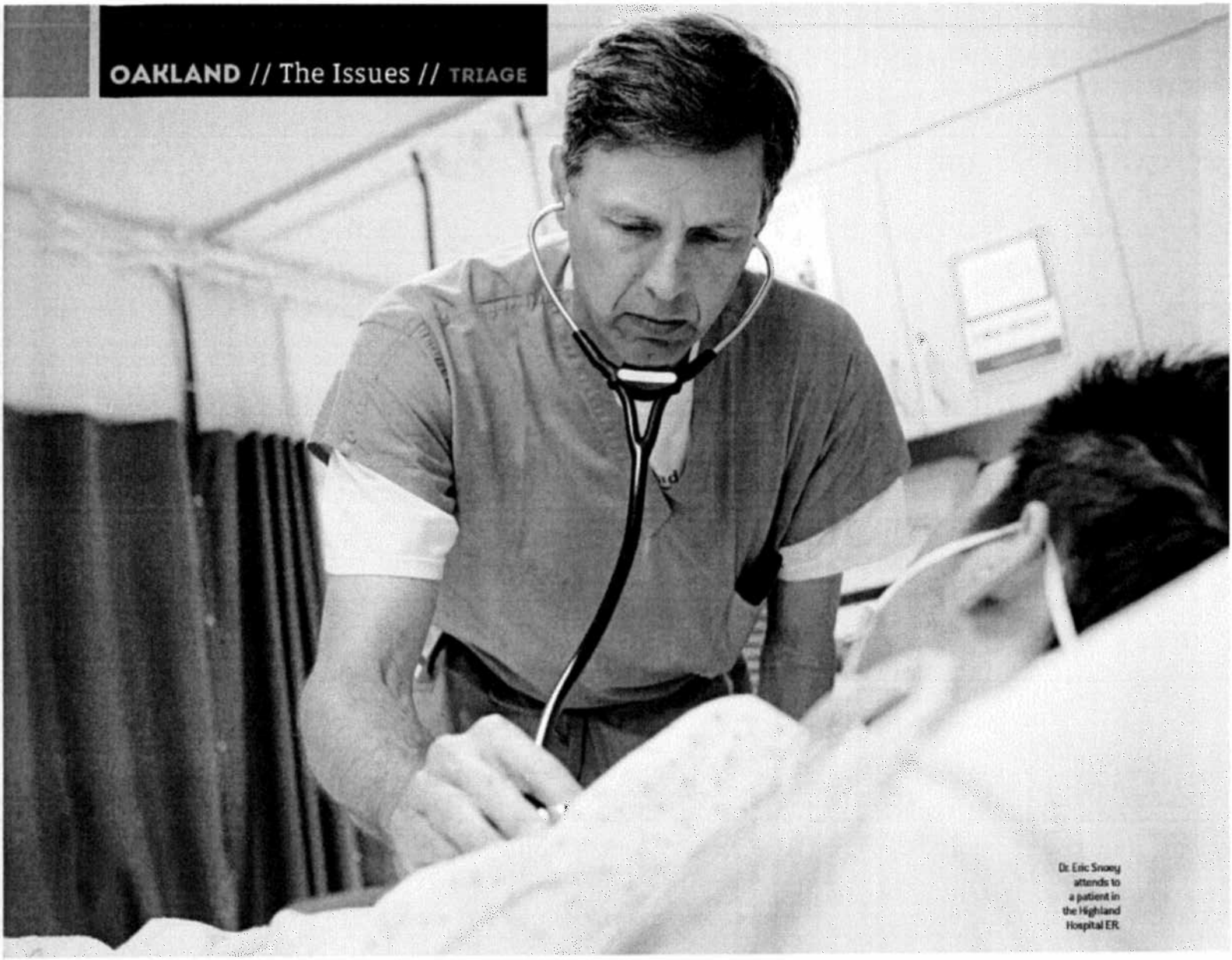

Dr. Eric Snoey attends to a patient in the Highland Hospital ER.

MY STATE OF EMERGENCY

REFLECTIONS ON LIFE, DEATH, AND OBAMACARE INSIDE OAKLAND'S MAIN TRAUMA WARD.

BY DR. ERIC SNOEY

PHOTOGRAPH BY PETER EARL McCOLLOUGH

WE SEE 270 PATIENTS PER DAY, 100,000 PER YEAR: THE HOSPITAL IS WOVEN INTO THE LIVES OF TENS OF THOUSANDS OF OAKLANDERS, AS INTEGRAL AND QUOTIDIAN AS A TRIP TO THE POST OFFICE.

"HEY, DOCTOR SNOWMOBILES!" C.J., the Highland Hospital emergency room's "greeter-in-chief," sashays over and offers up one of the hundred hugs that she'll dispense to patients and staff today. As I move through the triage area and cross the threshold into the ER, I hear another four or five variations of my name called out: Snowman, Snowballs, Snooty, even Snoop Dogg, a throwback to my Highland handle in the '90s. Those who stick with the more formal construct of Dr. Snoey are usually the newer staff—ex-military types or East Coasters for whom calling a colleague by a nickname runs too hard against the grain. The joke goes that the only person who calls me Dr. Snoey is my mother, and then only when I do something wrong.

To its core, the Highland ER is an informal place. Its staff feels more like family than like coworkers. We can be more ourselves here than anywhere else, in large part because those of us who have dedicated our careers to Highland have become defined by this place. After 25 years of working in its ER, I feel as if Highland is *my* hospital, but it is also a public hospital, an indigent care hospital, a safety net hospital. The qualifiers are both meaningful and prejudicial, reinforcing perceptions built upon decades of misunderstanding and distrust.

Highland and its patrons live on the other side of the tracks. It is the hospital of last recourse for those who have options and the one of first resort for those who have never known anything else. We see 270 patients per day, 100,000 per year: The institution is woven into the lives of tens of thousands of Oaklanders, as integral and quotidian as a trip to the post office or the grocery store. "I need to see the doctor" is never ambiguous in our community. It invariably means a visit to Highland.

When I tell people where I work, they usually respond with something like "It must be crazy there." They envision a chaotic trauma ward teeming with drunks and addicts and gunshot victims. Although this perception is inaccurate, I understand it. If you are shot or stabbed in or around Oakland, you are likely to be sent here. Oakland has the highest violent crime rate in the nation, so I have indeed seen my fair share of victims over my long career here. When Oscar Grant was shot at Fruitvale Station, he ended up in our ER. The same goes for Chauncey Bailey and Judi Bari, as well as countless others who have merited little more than a sentence or two in the next day's *Chronicle*.

And yet, despite our knife-and-gun-club bravado, patching people's bullet and stab wounds and dealing with drug-crazed patients is a tiny fraction of what I do. Patients everywhere suffer from pretty much the same ailments, and the differences between Highland and the tonier ERs at Sutter and Kaiser across town are more about style than substance. The poor get just as many heart attacks and broken arms as the wealthy do. The difference is that at Highland, we may be the only doctors our patients ever see.

THIS, OF COURSE, IS NOT A perfect system. As in many inner-city emergency rooms, wait times, though much improved, can be frustratingly long. During peak times, over 30 patients may arrive each hour, quickly overwhelming staff and space. But when people are seen, they are taken care of in ways that other hospitals' patients would envy. Highland is a teaching hospital, one of the top facilities for emergency medicine in the country, so we draw some of the best medical students in the world as our interns and residents. And because we are a county hospital, we provide an army of social workers, financial counselors, and translators, who, together with clinical staff, address far more than a patient's chief complaint. Limp in with a broken toe, skip out with temporary Medi-Cal, social worker support, a follow-up appointment with a primary care physician, and, hopefully, a renewed sense of possibility regarding your health.

The other day, a friend and colleague reminded me of why this is so hard to ➤CONTINUED ON PAGE 114

CONTINUED FROM PAGE 107

pull off. During one shift, in the span of an hour, he saw four patients who each spoke a different language: The first spoke only Yemeni, the second Tigrinya, the third Spanish, and the fourth Lao. Many of the people we see are nearing retirement age and have never—not once in their life—been to a doctor. Filling this void means compensating for decades of delayed maintenance.

Because of the Affordable Care Act, many—perhaps all—of these patients will for the first time be able to make an appointment to visit a primary care doctor in an office, rather than spending hours waiting to see me. A side effect of this is that Highland now has an entire team that does nothing but think about how we will deliver healthcare in the Obamacare age, when patients actually have a choice about where they go. The hospital is undergoing a major makeover to rival its new "competitors" across town. State-of-the-art new clinic spaces are being built, along with central gardens and an acute care tower that'll open within 18 months. An initiative on this June's ballot, Measure AA, will ask Alameda County voters to reauthorize an existing ½-cent sales tax in order to fund many of these efforts. I hope they do.

But this new state of affairs also brings concerns, both for me and for my patients. Chief among them: I don't think that the medical profession—or, for that matter, society—understands what it really takes to care for the poor. Plop the Mayo Clinic down in the middle of Oakland, offering free care to everyone, and many of the same obstacles to health would remain. Liquor stores would still outnumber grocery stores 32 to 1 in part of East Oakland. Unemployment rates in West Oakland would still far surpass the state average. Poverty and its attendant symptoms force patients to run a veritable gauntlet of competing choices. I often hear stories about people cutting medication doses in half in order to stretch the time between costly refills. There are missed primary care appointments because the third bus in a series of transfers didn't arrive. People fall off the wagon, lose their insurance coverage, move in with abusive relatives, or become homeless.

It is stories like these that really tug at my progressive middle-class sensibilities. As much of an affinity as I feel for many of my patients, the truth is that a huge disconnect exists between my comfortable home life in the Oakland foothills and my work life in the Highland ER. As I make this daily transition, driving the five miles back and forth, I struggle to reconcile myself to a system predicated on separate and unequal access to care. In this system, there is our healthcare and their healthcare, and the two worlds never seem to collide. As providers, we may choose to blame the system and its perverse designation of healthcare winners and losers. Others may blame the victims for poor choices and lack of resolve. In truth, the complexity of the problem is overwhelming. For many of us, the answer is to find refuge in the simple care of patients, in the most unapologetic way possible. And yet, even here we may fall victim to our assumptions.

AS AN EXAMPLE, LAST MONTH BROUGHT ME AN ELDERLY, DISHEVELED man who appeared homeless. It was cold and wet outside, and my instincts told me that he was just angling for shelter and something to eat. I introduced myself, shook his hand, and asked him how I could help. He silently produced a crumpled wad of paper: a prescription for blood pressure medication, softened beyond recognition by the rain. He had come in because he didn't want to miss a dose. Soaked to his socks, he could have had a thousand excuses not to come here, and yet, here he was, following through with what some physician had told him months or years earlier: "You have high blood pressure—be sure to take your meds."

Patients not taking their medications is a perennial problem in my world. Viewed narrowly, it would seem incomprehensible that a diabetic would stop taking her meds or a patient with a serious leg infection would never fill his antibiotics prescription. Seen through a broader lens, one acquired through years of encountering the pathology of poverty in Oakland, these occurrences aren't surprising at all.

Last month, a medical student came to me exasperated about a patient who had suffered a stroke and lost the use of the left side of her body. In the student's eyes, the tragedy had been entirely preventable. The woman had had high blood pressure for years and had been prescribed medication to control it, but for some reason she had stopped taking the pills. How could the woman have been so negligent? In many ways I understood this student's impulse. I grew up in a small Midwestern town, reared by immigrant parents who had imparted a strong bootstrapping ethos: We all must learn to take care of ourselves.

But to me, the woman's condition was no more preventable than a sunset. I didn't know anything about her life, but if she was like many of the patients I see, she was probably a poor, single mother, working two jobs to support her children. Without the money to own a car, she used the unreliable, underfunded AC Transit system to commute. She barely had time for a restroom break at work. How was she going to find the time to get to Walgreens or the money to cover her copayment? Affluent people think of their good health as something that just requires a little time and discipline to address: Eat less, exercise more, take your vitamins. But the truth is, most of us wouldn't last a week in that woman's shoes.

Working in the Highland ER means knowing the backstory of a part of Oakland that most of my friends and neighbors will never see. In my car, stopped at a red light, I find myself unconsciously filling in the bios and medical histories of passing pedestrians. A cane, a limp, a cough, a tremor: A city's problems, often anonymous and impossibly abstract, gain context in the faces and lives of my patients. Urban violence is personified by the 19-year-old boy, shot square in the chest during a drive-by, whom I pronounce dead in the trauma bay. Domestic violence takes the form of a woman coming in for the fourth time this year, now with a dislocated shoulder and a broken wrist. The sexually trafficked 15-year-old, the homeless alcoholic, the diabetic with schizophrenia—the list goes on, and the tapestry of societal malaise is woven tighter and tighter.

You might think that cynicism would be rampant among ER staff who confront these issues day in and day out, but you would be wrong. Optimism runs deep here, as does pride. There is an inexorable sense that what we do matters, that it changes people's lives, that we are doing the right thing. The counternarrative to Highland's rough-and-tumble reputation is that it is a place of extraordinary humanity, filled with talented people who have dedicated their careers to its mission—and the patients who rely on Highland know it.

IT IS MIDNIGHT, AND I AM SEEING THE LAST PATIENT OF MY NINE-hour shift, a 54-year-old man who looks tired and a bit short of breath as he sits on the side of the bed. In his flat-brimmed hat, he reminds me of the men I see exiting local churches wearing their Sunday best. His bow tie is perfect. His shirt and suit jacket are pressed. Below his waist, he is covered by a gown, but I see puddles of water collecting on the floor around his bare feet. His legs are swollen to three times their normal size and seem incongruous with the narrow lines of his face and chest. Next to my patient is his sister, a stern, anxious look on her face—illness has brought them together. I learn that he is a widower who lives alone and that he recently stopped working in construction because of shortness of breath and fatigue. He can't recall ever having seen a doctor.

I ask about bad habits: tobacco, alcohol, drugs, swearing, playing poker on Sundays. He laughs. We like each other, but I have to give him terrible news. His heart is failing, and his life will never again be the same. He takes it quietly, then tells me that he is profoundly thankful for our time and efforts. As they leave, he and his sister ask about the water on the floor. I explain that the high pressure inside his calves is causing a weeping of fluid through his skin and down his leg. "I told you your legs were crying, and you didn't believe me," the sister says to her brother. I hope that Obamacare makes it possible for him to get insurance. He is going to need it. I also hope that I will be lucky enough to see him again. ❐