



IN REFLECTION

Carried Away

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“Te agradezco mucho, doctor.” / “Thank you so much, doctor.”

The relief, appreciation, and gratitude were so clear across his face.

“¡No hay de qué! / Don’t mention it!” I say as I walk out of the room. But as I close the curtain and walk out the door, I feel like a fraud — and know I do not deserve such appreciation and praise.

This young man had been suffering for years with recurrent kidney stones, hypertension, polyuria, and constipation. Many ED and clinic visits led to temporary relief, but never an explanation of why this kept happening or how more sustainable relief could be achieved. As I review his chart, I see the clues were already there. Even the answer was in his labs.

But why was nothing done? Was it ignored? Forgotten? Deferred implicitly? Fatigue from the inherent limitations of our health system? I try to rationalize why nothing happened and why not even a whisper of it is found in the documentation. I can’t. And before I spend even longer pondering, I remind myself, sadly, that I will never find the excuse I seek.

This time he arrives to the ED with shoulder pain after a car accident. His clavicle is broken. His prior symptoms are still there, pushed even further down

the problem list. The call for admission is for “medical optimization prior to surgery.”

But this time, the lab abnormality present for so long is so abnormal it cannot be ignored anymore. Alerts in the EMR. Calls from the lab that make it to me and the nurse.

“The calcium is 14. Ortho wants it fixed before surgery tomorrow,” the ED team shares.

His PTH returns profoundly elevated. He gets IV fluids, calcitonin, and pain control and feels much better. He gets his clavicle fixed. But every time we try to wean down the IV fluids, his calcium quickly rises again. Additional workup reveals a parathyroid adenoma.

“So when is he going home?” the case manager messages me.

I scream internally. She is just doing her job — I know this — but in the moment I lose myself and ignore that she is facing the pressures of increased ED boarding and the push for discharge from hospital leadership. But this case serves as just another reminder of how the healthcare system fails so many.

He is, like the majority of the patients I have the privilege to care for, uninsured, undocumented, and relied upon as the sole breadwinner for his family —

both domestic and abroad. I cannot fathom the pressures that come with this, growing up as privileged and fortunate as I have.

I try to explain to the case manager that discharging him without a definitive plan to treat the underlying cause of his hypercalcemia is not something I find acceptable or safe.

“But what about doing this outpatient?” she asks.

Again, I feel the frustration rise. But how can I blame her? She sees a number in the computer and a patient at the bedside who feels okay. I see years of suffering, significant hypercalcemia and its symptoms missed for over five years, and “outpatient follow-up” that has continuously failed.

Where I practice, we are fortunate that many of these vulnerable patients can receive health insurance through an indigent care program. But strict financial criteria are in place. He makes just a little too much. He tells me he has applied for years and has always been declined. So all those recommended ED follow-ups? He cannot go. He also cannot afford to pay out of pocket and miss more work. Bills are piling up. We try again to apply — no luck. He makes a little too much, though still nowhere near enough to support himself and his family comfortably. The explanation that he has not worked for two weeks and will not work for at least six more after surgery falls on deaf ears. He can reapply in thirty days with a new paystub showing less income, and they will reconsider.

It is only because things become so bad — and because he broke his clavicle and was admitted — that he finally gets the help he needs. The calcium skyrockets as soon as we stop the fluids. There is now no clear path to outpatient treatment. We consult surgery, and he receives the parathyroidectomy he has likely needed for years. After a couple days, he is feeling great, his calcium is stable in the normal range, and he feels as well as he has in a long while.

He goes home soon after, grateful for life and all the care he received. But I struggle to understand him and his grace. How could he not be frustrated? Angry? Upset? The health system we implicitly expect people to trust had failed him repeatedly. It was not me that

noticed something was wrong and fixed it. It had been there all along.

How could I explain to him that the more likely explanation was that although something could have been done sooner - and probably should have been - the health system doesn't live in the same reality, only taking on the extra load when things are so advanced or severe they can no longer be ignored?

In the end, I cannot work up the courage to tell him. Instead, I try to direct the conversation toward him, his family, and the others who helped him heal more than I ever have or will.

He is grateful for what he has; I resent what he doesn't.

But selfishly, his smile heals me a bit as I walk toward the next patient — and inevitably the next case where medicine, and the structure created to deliver it in the United States, helps and harms every day.

Maybe one day it will be different. For now, it is not. The whirlpool - the constant pull between what is best for the patient and what the system permits - continues. I depend on occasional moments like this, where the waves carry the rubble and debris free from the seemingly inescapable vortex beneath — a reprieve for my patients, for me, and for humanity.

CONFLICT OF INTEREST STATEMENT

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REFERENCES

None