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# THE TOUGHEST MAN IN THE HOSPITAL BECOMES THE MOST PITIABLE

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“Without hesitation Dove chose the nowhere road. For that was the only place, in his heart of hearts, that he really wanted to go.”

—NELSON ALGREN

**A**S FAR AS “handles” on the street went, the toughest characters were all invariably known by their full first names. In the world of the street gang, appellations evolved in the opposite direction from how they developed back in grade school: nicknames did not inspire fear, so Andy became Andrew and Rick went by Richard. In the ’hood, it was your full name that conferred gravitas and meant you were a serious dude on the street.

About 1982, one really serious guy happened to become my patient. He was logged into the hospital as Jeff, but his street name was, of course, Jeffrey. The first time he came to the hospital he was about twenty-three,

with a huge Afro, piercing blue eyes, and a fierce visage projecting an air of menace to all who came near him. *Don't make eye contact and don't come too close.* Think Samuel L. Jackson in *Pulp Fiction*, but meaner—much meaner.

To Jeffrey, the hospital was merely an extension of the street. No matter if you were a doctor, a nurse, or another patient, his scowl, if directed at you, left no doubt that to mess with him was to do so at your own peril. Unless one had medical business with him—to draw his blood, take his vitals, or see him on rounds—you were best off avoiding him.

Jeffrey was a street gang member and a heroin addict, and nakedly unapologetic on both counts. He was in the hospital for abscesses on his legs from needle use. His skin had sloughed from drug injections, and he required intravenous antibiotics and evaluation for skin grafting.

Occasionally, he would receive visitors in the hospital. They were also a menacing bunch, most likely his associates in the street gang. There was no question he was the alpha, and perhaps they came to deliver drugs to him (a frequent transaction in the hospital), or maybe they were just there to confer on business affairs sinister. While Jeffrey waited for his skin grafts, I would see him every day on rounds as his attending physician. Like everyone else, I adhered to the unstated protocol of the street: no eye contact. But part of my job as a physician was to understand the patient, and I was used to treating drug addicts. I gradually earned a modicum of Jeffrey's trust and he granted me the privilege of talking with him. Nevertheless, I still hesitated to make eye contact. The rules of the street could be enforced at any time.

In the hospital, no less than out of it, dealing with gang members and heroin addicts is invariably a precarious proposition. Physicians are authority figures, and gang members, by their very nature, distrust authority figures. It's not on the level of their interactions with the police, but it's a close second.

One of the best illustrations of this is the doctor's coat. A subtle difference between working at a county hospital and a university or suburban

hospital (I have done both) is the doctor's coat. It is a uniform of sorts, meant to inspire trust. At university and suburban hospitals it generally fulfills that function, at least among most patients and staff. Wearing the coat gives you respect; people who don't know you smile and say hello. But at the county hospital the physician's coat sometimes has the opposite effect, especially with patients like Jeffrey. Official uniforms of any type are regarded with suspicion. As a symbol of authority, the coat represents a barrier. For this reason, sometimes I would go without my coat on the wards. Not wearing a coat would be unthinkable in the university hospital.

The other part of that equation was a lesson I learned the hard way: that heroin addicts can rarely be trusted. They are clever and manipulative. Early in my career, in my naïveté, I would fall for some cockamamie sob story and loan some drug-addicted patient five dollars. He would invariably promise to pay me back. Of course, not a single one ever did, and this learning experience cost me about fifty dollars before I adopted a new personal policy: no more loaning money to drug addicts, no matter how dire their story. Most of my colleagues, who were less trusting to begin with, never fell victim to those scams. Live and learn.

Some of these addicts could take their ruses to incredible limits. I once saw a young man in the emergency room fake abdominal pain. Since his veins had been destroyed by the constant injection of drugs, the doctors had to insert an intravenous line in his jugular vein, a large vessel in his neck—a minor surgical procedure. However, once the open vein was established, the patient simply walked out of the hospital with the intravenous line still in his neck when no one was looking. The abdominal pain turned out to be nothing more than a ploy to have the doctors establish a useable vein into which he could inject street drugs.

In the same vein, excuse the pun, another addict once told me there was an enterprising and talented amateur in his neighborhood. This guy could use a syringe to find a vein in addicts when even the doctors failed. His basic charge was ten dollars per customer. Word was he did a thriving

local business in the niche industry of finding usable veins. I always wondered if perhaps he had become the beneficiary of some of my loan money.

One afternoon in the last days of Jeffrey's hospital stay, I came by and asked if we could talk. He eyed me up and down suspiciously but then nodded his assent and pointed to a nearby chair, signifying that I should pull it up next to his bed. He tended to communicate primarily with gestures. When he did speak it was usually in short, terse sentences.

"What'chu want, man?"

"Nothing, just want to find out how you are doing. If you need anything."

"I'm OK. I could use some more pain medicine."

Standard request from addicts. "Sure, I'll take care of it."

Whether he needed more pain medicine or not, it was worth the price of prescribing him more to gain his trust. In that case, the doctor/patient manipulation was mutual.

"Jeffrey, how much heroin do you use?"

I knew he might not answer that question, but if he did, his answer would be in a dollar amount. I wanted to get a rough idea of the extent of his habit. Of course, the correlation between what he said and what he used was probably imprecise. Almost all heroin users exaggerate the actual amount they use. To my mild surprise, he was not reluctant to answer; I considered this a display of trust.

"Bout \$100 a day."

Even if it was half as much, this was a significant habit in those days. This also told me that, although he may have been a fairly high-ranking and feared street gang member, his extensive drug use would eventually be an impediment to his rise in the organization. A top capo could not function with that kind of addiction.

"Where do you get that kind of money?" I was familiar with most of the answers to that question, but I was curious to see what he would say. Young male heroin users had a wide range of ways, violent and nonviolent, to support their habit. Older men who were not as physically agile were

more apt to commit some sort of fraud. Writing bad checks was especially common. Meanwhile all but the oldest female addicts gravitated toward shoplifting or prostitution.

Jeffrey was quite direct. "Different things: selling, boosting." He smiled and continued, "Sometimes I get it from guys like you."

I didn't know what he meant by that remark and I was slightly taken aback.

"Guys like me? What do you mean?"

"You know. You have to ride the 'L,' walk around at night."

He meant he would get money by robbing people like me. It was a subtle attempt to assert his dominance. But that was, as they say in poker, a "tell."

In the hospital, patients lose their freedom; they are no longer in control of their environment. As a response they will occasionally do things to reassert their independence. A subtle fact about hospitals is that to ensure smooth running, the hospital must infantilize patients in small ways—the hospital gown, tests scheduled at certain hours, strict mealtimes, and occasionally a patronizing remark by the staff.

A patient may rebel in his or her own way, by adopting an argumentative or demanding posture. Women may become flirtatious with the staff, men sexually suggestive. These are signs of weakness rather than strength, and at least to some degree, they are understandable. In fact, doctors and nurses who become patients are among the worst offenders in attempting to regain control. They are more aware than most of what is happening to them in the hospital.

Jeffrey's attempt to scare me told me that actually he was the one who was scared. Right then, I knew I could make eye contact with him, something very few people did outside the hospital. And looking into those eyes, I did not see a vicious street gangbanger, but a frightened twenty-three-year-old who knew he was quite sick. I did not linger on the subject of his drug use.

"Well, Jeffrey, you won't be on my ward much longer. You will be going to surgery pretty soon."

He trembled slightly. "You think it will be OK, Doc?" I knew when he asked that question he was indeed no different from any other scared young man in the hospital.

"Yeah, I do. But you have to shake that habit."

My reassurance allowed him to revert to type. He nodded and his scowl reappeared. The conversation was over.

The next morning something unexpected happened. In the cafeteria I was approached by one of the women from "environmental services" whose job it was to clean the ward. I knew her casually; she was a friendly but taciturn middle-aged woman who always greeted me with a smile. Every Christmas, she gave me a religious card.

"Dr. Franklin, do you think Jeffrey is going to be OK?" I knew that as a woman of faith working in the hospital, she was concerned with the welfare of every patient, but for her to approach me and ask about a particular patient by first name was unusual.

"I think he will, Mrs. Andrews." The fact they had the same last name didn't occur to me. Then, without prompting, she explained the cause of her concern. It was something of a shock.

"Jeffrey is my son."

A faint air of resignation was in her voice. It must have been difficult for this churchgoing woman to acknowledge what her son had become and see the state he was in. But the most powerful force in the world is maternal love. She was deeply worried and so I tried my best to console her.

"Mrs. Andrews, I'm sure he will be OK."

That afternoon, Jeffrey sat on the open ward when Mrs. Andrews walked right by him, no more than three feet away. From a distance, I watched as she passed him without saying a word, although she did acknowledge him by staring directly in his face. Men's lives had undoubtedly been threatened for lesser stares at Jeffrey. Yet he could not confront her gaze for more than an instant before bowing his head in shame. She shook her head ruefully and left the ward while he glanced around to see if anyone had noticed.

From the corner of the ward I witnessed the entire mini-drama, although he did not realize it.

The next day he was transferred to surgery. I didn't see him again during that hospitalization. I was told he had his skin grafts and went home without complications.

About a year later, I saw Jeffrey briefly. I was doing a consult in the trauma unit and he walked through with some of his fellow gang members to visit a friend who had been involved in a gang firefight, with several nonlethal bullet wounds to show for it. He and his friends were outfitted in what appeared to be gang colors (a type of uniform that does draw respect) and he walked through the ward with a swagger and a sneer. He made no effort to conceal his contempt for the doctors and nurses taking care of his friend.

His eyes met mine for a second; I could tell he recognized me, but he made no effort to acknowledge me. I earned the same withering glare as everyone else, and I averted my gaze quickly. The brief reunion was over. I thought that would be the last time I would ever see Jeffrey.

I was wrong.

All of this transpired in the early 1980s, when it was common knowledge in the medical community that drug use involving dirty needles could cause skin abscesses, blood infections, and hepatitis. But the AIDS virus, HIV, had just been isolated, and while the association between drug use and AIDS was suspected, dirty needle use was still not recognized as a major risk factor. That would become known just a few short years later. As we later learned, the drug users of the late 1970s and early '80s like Jeffrey were at an incredibly high risk of contracting AIDS from their needle use.

Flash forward twenty years to the early 2000s. One day on my way to the ICU, I walked through the dialysis ward of the hospital and saw a chart with the name Jeff Andrews. The names of certain patients stay with you, sometimes for decades. That one had stayed with me. My first thought was that it couldn't possibly be the same Jeff Andrews, but I had to know. I checked the date of birth on the chart. The patient was in his early forties,

the same age Jeffrey would have been. I went to the room number on the chart. (These were the days before confidentiality laws made finding a patient's room much harder.)

In that room, an old man was in bed, sleeping lightly. He was certainly much older than Jeffrey would have been. He was bald, and even though he was sleeping his hands and face trembled involuntarily. The sign above his bed said he was blind. Next to his bed was a wheelchair, but there was no sign of the type of walking cane blind patients use. It appeared he was unable to walk by himself.

My first thought was that I had misread the room number. I was about to go back to the chart to find out where Jeff Andrews was when I stopped and looked at the old man's legs. There were skin grafts, in the exact places where Jeffrey had his skin infections twenty years ago. I looked closely at the face on the old man. There was a facial tic and spittle running off his lower lip—certainly no fierce visage. But his face told the story: there was no question the old man was Jeffrey. How could that be? This man looked to be eighty years old. And it was clear to me he was close to death.

I found the resident responsible for the cases on the ward and asked about Jeffrey. I didn't mention my connection; when I first met Jeffrey this resident would have been in grade school. He wouldn't understand.

The resident told me Jeffrey did indeed have end-stage AIDS, contracted from needle use. Infections from HIV had blinded him and he was on the dialysis ward because his kidneys were destroyed. He was demented, unable to feed himself or use the bathroom, and wheelchair-bound. In the twenty years since I had last seen Jeffrey, he had aged more than a lifetime. The resident told me that Jeffrey had three months to live, six at most. Having cared for hundreds of AIDS patients, I knew the resident's prognosis was overly optimistic.

I went back to see Jeffrey, who was now awake. The nurses had him sitting in a chair and were spoon-feeding him. The feared gangbanger who once terrorized the West Side of Chicago had grits dribbling down his chin into his lap. I did not say anything to him and he probably couldn't hear



me or understand anyway. Ironically, there was no point in making eye contact, that same eye contact that once made people shiver. For the first time, I noticed his facial resemblance to his mother.

The next day I went to environmental services and looked up a woman whom I had known for many years, since the days she was a young trainee. Now she was a supervisor of environmental services.

“Ms. Logan, does Henrietta Andrews still work here?”

She gave me a surprised look.

“Mrs. Andrews? Dr. Franklin, she hasn’t been here for ten years. She retired when she got cancer of the womb. She died about four years ago. I remember her homegoing.” Her funeral. “It was beautiful.”

“Thanks, Ms. Logan.”

It was sad to hear that Mrs. Andrews was gone. But in a way I was thankful. She would never have wanted to see her son the way he was now.

And it turned out I was right about how long Jeffrey had to live. Ten days later, he was dead.