

Memorable Moments

By Laura Stephenson Carter

Emergency medicine calls for a cool head, but also a deft touch with people: With a dying child's parents. With a patient who thinks he's Jesus. With someone who's slit his own throat but is still alive. Here are some compelling stories from caregivers in perhaps the most harrowing specialty.



Fifty years ago, hospitals didn't have emergency departments. If they had emergency rooms, they were staffed by a resident or two, or a nurse-supervisor who'd call in a physician when necessary. And ambulance services were operated by funeral homes—with hearses often doing double duty as ambulances, and the drivers and attendants usually having basic first-aid training but little more.

As the field of emergency medicine began to evolve, some hospitals advertised "physician on duty 24 hours." But that didn't mean a physician was on the premises—only that a doctor could be summoned by phone if necessary. Many physicians didn't particularly welcome this on-call duty. And no one was specially trained or certified in emergency medicine.

"It was a very loosely organized endeavor," says Dr. Norman Yanofsky, medical director of DHMC's Emergency Department. "Then some farseeing people realized there ought to be a way to produce competent physicians" trained to practice in emergency situations.

In 1968, the American College of Emergency Physicians (ACEP) was founded by eight physicians from Michigan. The first residency program began at the University of Cincinnati in 1970 with one resident. By the time Yanofsky graduated from Tufts Medical School in 1977, there were 10 emergency medicine residency programs in the U.S.; he got his training at Northwestern. In 1979, emergency medicine was officially recognized as a specialty. In February 1980, more than 600 emergency physicians sat for the first certification exam. Yanofsky took the exam soon after that and, in 1982, became board certified in emergency medicine. Today, there are more than 32,000 emergency physicians in clinical practice and about 180 emergency medicine residency programs.

When Yanofsky was hired by Dartmouth-Hitchcock in 1982 as the head of its new emergency department—and the department's sole staff physician—he oversaw three residents and several nurses. Gradually, the fledgling department grew. It went from seeing some 13,000 patients a year—only about 9,000 of them sick enough to be seen in an emergency room by today's standards—to more than 30,000 a year today.

As emergency medicine has evolved, DHMC has kept pace. In 1994, the Medical Center established an air ambulance service known as DHART (pronounced "dart"), for Dartmouth-Hitchcock Air Response Team. In 1996, DHMC was designated a Level I Trauma Center. In 2000, DHART acquired

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a ground-based mobile ICU and changed the name behind the acronym to Dartmouth-Hitchcock Advanced Response Team. In 2006, a much bigger emergency department opened as part of DHMC's Project for Progress expansion. And the department is now developing its own residency program, which, if all goes well, may start up in 2009.

It takes a special kind of person to work within emergency medicine. "I think most of us like the variety, not knowing what's going to come through the door next," says Dr. H. Arnold Muller, a 1953 graduate of DMS. "For me," he adds, "part of the fun of it was the challenge of effecting rapport with somebody who didn't start the day off thinking they were going to be there and [who] doesn't know you from a hole in the ground."

DARTMOUTH MEDICINE asked Muller, Yanofsky, and several others with Dartmouth ties to share their most memorable moments in emergency medicine. The following stories are edited from either written or taped accounts.

H. Arnold Muller, M.D.

A 1953 graduate of DMS, Muller was the founding chief of emergency medicine at Penn State-Milton S. Hershey Medical Center in 1973. Later, as Pennsylvania secretary of health from 1979 to 1987, he lobbied for accreditation of trauma centers and for EMT training standards. From 1987 to 2003, he was chief of the emergency department at the Lebanon, Pa., VA Medical Center. He retired from practice in 2003 but continues to teach part-time at Penn State-Hershey. Here he describes an experience he had back in the 1970s.

My most vivid memory is not a gripping story per se, but one that illustrates how far the field has come. I clearly recall an ambulance pulling up at the ER door with the two attendants both in the front seat—and the patient all alone in the back. The driver and the other fellow both got out and brought in the patient, who was dead. Even so, one of them should have been in the back. I was startled, to say the least. It's not that they didn't care—it's just that they saw their job as simply being to drive the patient to the hospital.

This incident may sound banal to someone not in emergency medicine, but anyone now in the field would surely be shocked by it, as I was then. We've come such a long way. Today, emergency medical technicians (EMTs) and paramedics evaluate patients at the scene—be it the highway or the home—and start treatment right away. And they're in contact with the emergency department, to let the staff know what's coming in and to ask advice. They can even send ahead EKGs and other test results. It's a much better, more mature field now.

Norman Yanofsky, M.D.

Yanofsky, the medical director of DHMC's Emergency Department (ED), was in training in the 1970s when emergency medicine was on its way to becoming a specialty. After doing his residency at Northwestern and working as an ED physician in Chicago, he came to DHMC in 1982 to head its new emergency department. Here he describes the inauguration of the Dartmouth-Hitchcock Air Response Team (DHART) on July 1, 1994.

I'll never forget the first day the helicopter was in service. We had no idea what would happen. I thought that it might be as much as two weeks before anybody called us. We went on line at 7:00 in the morning on July 1, and within 15 minutes we got called down to Springfield, Vt. It was a scene call—an unconscious person who had been in an automobile accident.

I think we got seven calls the first day DHART was in service, and we were able to respond to six of them. In fact, one of our crew members got so tired and dehydrated—because it was a very hot July day—that they had to give her IV fluids just to keep her going.

and shoulders—in order to breathe. That's a sure sign of trouble.

"There's no way I'm going to put that boy in the ground ambulance," I said to myself. I was afraid that he would go into cardiac arrest in short order. So I called Dr. Filiano, the chief of Dartmouth-Hitchcock's Pediatric Critical Care Section, and requested that the helicopter be sent to pick us up. I asked that a transport respiratory therapist be sent down, too.

I also recommended that the child be intubated at the sending hospital before we left. This was accomplished in an OR by an anesthesiologist on their staff.

On the flight back, the crew included the pilot, the respiratory therapist, the nurse, and myself. We made room for the boy's mother as well. I remember it was a challenge, and we had to rearrange the equipment to fit everyone in.

Sadly, the boy died 13 hours after he arrived at DHMC. It turned out that he had a massive tumor in his left chest that no one knew about until it was too late.

Recently, I was representing DHART at a New Hampshire Fisher

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John Hinds, B.S.

Hinds, a flight paramedic and the current operations manager for DHART, has worked in the emergency services field for 29 years—as a paramedic for 23 years and as a National Ski Patrolter in New England for 29 years. He is also a member of a federal Disaster Medical Assistance Team (DMAT) based in Massachusetts and was deployed with the team to Plattsburg, N.Y., after the 1998 ice storm; to Ground Zero after 9/11; and to Bam, Iran, after an earthquake there in 2003. He is also a paramedic for a joint FBI-Boston DMAT tactical medical support program.

About a year and a half ago, I was part of a DHART specialty ground transport team that had been sent to another New Hampshire hospital to pick up a nine-year-old boy from their pediatric ICU and transport him to DHMC. We had been told that he'd been sick for three days and was having difficulty breathing, and at Dartmouth, he would be able to get more intensive care.

Upon entering his room, I was immediately convinced that he needed to go by DHART air and not by ground. He was lying on his left side and was dusky in color and lethargic. His skin was pale and clammy, and he appeared tired and distant. He also had a croupy cough, and as he was gasping for air, I could see that he was using his accessory muscles—the muscles between his ribs and in his neck

Cats baseball game in Manchester. The boy's family happened to be there. His father came up to thank me for all that we had done for his son. He said that if I hadn't interceded that day, it would have taken longer to get his son to DHMC. He and his family were grateful for all that we had done, even though his son died.

Drew Remignanti, M.D., M.P.H.

Remignanti, a 1975 graduate of Dartmouth College (and a member of DARTMOUTH MEDICINE's Editorial Board), earned his M.D. at Rutgers and completed his emergency medicine residency in Jacksonville, Fla. He currently practices at North Shore Medical Center in Massachusetts.

Just as I headed into the ED on-call room, to get a little sleep, I heard the emergency services radio begin to squawk. I tried to convince myself that it was either random interference or a routine radio check from a neighboring town. But instead of getting comfortable in the on-call bed, I wandered back out to the ED to listen in.

Sure enough, it was a real trauma case. Generally EMTs are pretty solid and reliable, but this one sounded a little rattled. She reported that she was at the scene of a single-car motor vehicle accident (MVA) with a young male who had a neck laceration from ear to ear that—get this—was “possibly self-inflicted.” This made no sense. First,

how could you draw a knife across the entire width of your own neck? Second, why at an MVA and why just “possibly”? Why not ask the guy how it happened? Anyway, the EMT described the patient as stable but breathing through his neck and reported that their ETA was eight minutes.

The nurses and I moved into the resuscitation room to prepare for whatever. I was sorting various-sized tracheostomy tubes with my back to the door when I heard them coming in. I turned and saw this guy on his back on a gurney with his head thrown back. His neck lay open like the Grand Canyon. It was truly sliced from ear to ear. His lower neck had sagged down toward his chest so the wound was open in all directions. The EMTs were holding a non-rebreather oxygen mask loosely over the opening as the patient breathed on his own.

I had never seen anything like it before. Every-

was about to insert it into the patient’s mouth. But his eyes bore through me as he gritted his teeth tightly. He was beyond reasoning with, and in fact he tried to get off the table. It was frightening to see a man in his condition needing to be restrained by four people, each holding a limb.

“Valium, five milligrams, IV,” I ordered. After a repeat dose, he was much calmer. I then opted for a nasal approach. Under ideal circumstances an endotracheal tube passed through the nose will follow the natural curve of the throat and, with a minimal amount of head positioning, will find its way smoothly past the epiglottis and into the trachea where it belongs. In this case, however, the tube began by following its expected course but then rose like a cobra through the patient’s neck. I grabbed the tube with forceps and redirected it past the epiglottis into its proper position. Once the integri-

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one turned to me for professional words of guidance. “Holy s—!” was all I could manage. Then I said it again for good measure.

The tracheostomy tubes were obviously useless, so I tossed them aside and grabbed a laryngoscope and an endotracheal (ET) tube. The worst thing was that this guy was fully alert; his eyes were bugged out and darting rapidly around the room. The neck wound had obviously bled extensively, but by then had all but completely clotted up, thank God. As I examined the wound to determine the status of his airway, the guy was swallowing reflexively. With each swallow, his lower neck took on a life of its own—heaving chinward in a vain effort to meet its mate. The epiglottis, the guardian of the entry to the trachea, was visible as his neck muscles relaxed and the gap again fell open.

I considered passing the ET tube through the wound into his airway but discarded this idea when I realized the tube would get in the way of repairing the wound. Intubation via the usual oral route seemed preferable, so I selected a laryngoscope and

ty of the patient’s airway was ensured, I could finally take a few deep breaths of my own.

In the meantime, the nurses had been following standard procedures without direction from me. In fact, the only thing I had managed to say until ordering the Valium was “Call in the general surgeon and the ENT surgeon.” By then the patient had two IVs in place, was on oxygen and a cardiac monitor, and was having his vital signs monitored. I noticed that he was both hypotensive, the blood pressure gauge showing an abnormally low reading of less than 90, and hypothermic, with a body temperature of only 86 degrees. We were resuscitating him with warmed intravenous saline solution and heated oxygen mist via the ET tube. His heart was racing, not surprisingly. But as we warmed him up, all the severed blood vessels that had been clotted off began to bleed again.

For the first time, I looked closely at the wound. I could see that he had positioned the blade so it was too far up on his neck to sever his carotid arteries. In fact, the blade had passed so high that part

of his mandible, or jawbone, had been shaved off on the right. Most of the bleeding was coming from the right submandibular salivary gland. I had to use more than a dozen small vascular clamps on the little vessels before the flow of blood was reasonably stanchied.

On the left side of his neck, there was less bleeding. As I was using a gauze pad to soak up the pooled blood, I came across the entirely exposed carotid artery. It had been bluntly dissected from the surrounding tissue and was standing free like a large pipe. Reflexively, I yanked my hand away from it, not wishing to disturb any clots. Had the blade reached this vessel, the patient would have achieved his goal. As I was completing the task of clamping off the final bleeders, I noticed the general surgeon standing over my right shoulder. After a long silence he said, “This guy has to go to the OR.” It wasn’t a hugely helpful observation, but it was a whole sight better than “Holy s—.” Soon we were done packaging the patient for transport, and he was on his way to the OR.

I could finally relax, although my adrenaline was still pumping. I joined the EMTs and the police, who gave me a more complete story.

out a plan, and I wasn’t sure I wanted him knowing who I was in case he decided he was dissatisfied with his care.

Over the years, I have successfully erected a self-preserving wall between my patients and me. My emotions and I are on one side, and patients and their problems stay on the other side. But the night before, this guy had come barreling through the wall, and before I knew it he was right there next to me.

I found him in the ICU with his neck wound nicely sewn together. He was medically stable and sleeping, thank goodness. I learned that the ICU staff had nicknamed him Mr. Pezhead. Although outrageously insensitive, such black humor is another defense mechanism—like my wall—that medical personnel use to cope with the sometimes grim nature of our work.

When I got back to the ED, the security guard asked me, “Were Ward and Wally there visiting?” The comment clearly sailed over my head, so he explained: “You know, the Cleaver family.” I have to admit that I laughed. Maybe it wasn’t the right thing to do, but it’s what helps us get ready to face the next patient who rolls through the doors.

..... We found the six-month-old girl lying on a stretcher; her eyes were open but she was barely responsive



A cop had been making routine rounds in a remote parking lot when he came across a car that had crashed headfirst into a tree. Its windows were frosted over. As he approached the vehicle, he noticed several large areas of deeply blood-stained snow. He opened the driver’s door and found this guy sitting there, covered with blood. “Are you okay?” the cop asked. The guy turned silently and looked right through him. Later the cop told his partner, “I’m sure that if he had come toward me, I would have shot him.”

Further investigation revealed the following items on the floor of the car: a piece of two-by-four; the blade from a large butcher’s cleaver; a ruler; and several C-clamps. After a disagreement with his girlfriend, the guy had clamped the blade to the two-by-four, which he placed across the steering wheel. Then he accelerated into the tree, apparently in an effort to cut off his head. He nearly succeeded. I shudder to imagine his shock when he found himself still alive. The blood in the snow and the backseat of the car made it clear he’d moved around quite a bit, no doubt trying to find a comfortable way to breathe while awaiting death. But the cold weather, which slowed his bleeding, and his unacknowledged will to live conspired against him.

The next day I went to the ICU to look in on the guy. I felt more than a little trepidation about seeing him again because, frankly, he scared me. He was obviously a person who was capable of carrying

Timothy Bray, B.S.N.

At age 17, Bray was one of the first hospital-based EMTs in Massachusetts—in the ED of Framingham Union Hospital. That was 1972. He earned a bachelor’s degree in nursing in 1985, then worked in emergency departments and intensive care units in Boston and in New London, N.H. He has also served on many volunteer rescue squads. In 2000, he joined DHART’s then-new Mobile Intensive Care Unit, and in 2006, he became the service’s first chief flight nurse. There have been many memorable moments during his career, but one transport stands out in his mind.

At 2:30 a.m., my paramedic partner, Tony, and I received a page to respond to a small community hospital for a child with sepsis—a massive infection—who needed helicopter transport to the pediatric ICU at the Children’s Hospital at Dartmouth. The pilot characterized the weather as marginal, but within the acceptable minimums. During the flight to the community hospital, the pilot said we would need to be as quick as possible in the emergency department as the weather was expected to worsen.

Upon our arrival in the ED, we found a six-month-old girl lying on a stretcher; her eyes were open but she was barely responsive. She was clearly in septic shock. The diffuse rash on her trunk and the history of her illness suggested meningitis. Her mother and four-year-old

brother were standing at her bedside. The ED physician looked quite concerned and said he hadn't been able to get any IV access to give the patient fluids or antibiotics.

After a brief assessment of the child, it was clear to Tony and me that she was so ill she needed to be intubated immediately, before we transported her. But first we needed to get IV access so we could deliver sedation and paralyzing drugs to aid in the breathing tube placement. I was able to place an IV catheter in a scalp vein, while Tony got one into the bone marrow of her right leg. With the baby now paralyzed and sedated, we were able to place the breathing tube.

After we administered initial IV fluids and antibiotics, the pilot said we really need to go. We gave a brief description of the treatment plan to the patient's mother and then we were on our way. The

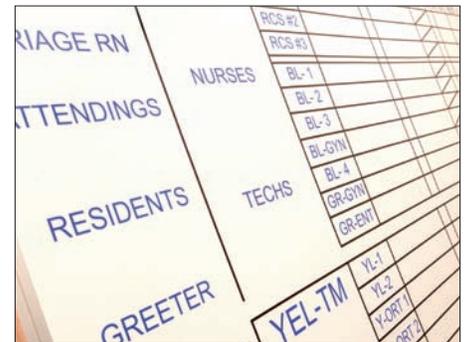
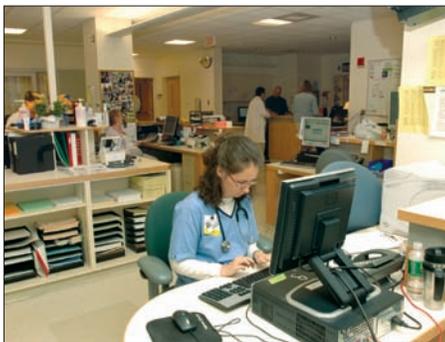
The child was successfully treated for septic shock due to meningitis and was discharged about two weeks later. I have used this true-life scenario in training exercises to teach critical-thinking and crew resource-management skills.

Katherine Little, M.D.

Little earned her M.D. at the University of Vermont in 1988 and did her residency in emergency medicine at the University of Louisville. She joined the staff at DHMC in 1991. She is also a member of DARTMOUTH MEDICINE's Editorial Board. Here she shares several vignettes from the front lines of emergency medicine.

Years ago, before I went to medical school, I worked as an EMT. I once helped deliver a baby in the back of an ambulance in the middle of the night. We were just minutes from the ED, and

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tiny tube providing an airway got kinked easily, so Tony and I had to keep the patient's head placed just so in order to maintain her breathing. During the flight, we also had to raise the patient's blood pressure by administering a vasopressor drug intravenously.

While we were trying to focus on the patient, the pilot notified us of some icing and freezing rain ahead. We would need to fly lower than usual, meaning it would be a bumpy flight the rest of the way. We were by then 10 minutes out, and the pilot said we might even have to set down short of DHMC, at an alternative landing zone. The baby was very ill, and we were quite concerned.

But after 10 more minutes of flying at low altitude, with quite a bit of turbulence, we arrived at the DHMC heliport. We rushed the child into the pediatric ICU and transferred her care to the waiting team of doctors, nurses, and respiratory therapists. As we returned to the hangar, the weather continued to worsen. Tony, the pilot, and I looked at each other with feelings of satisfaction and relief.

the baby's breathing sounded like gurgling because she had a lot of mucus in her airway. I was doing everything I could think of to try to suction out her mouth and clear her airway, but the baby's body was slippery and floppy even after I wrapped her up. The ambulance driver had called the ER on the radio to say we were having problems, so the moment we pulled into the bay, five people opened the ambulance doors and jumped in the back and started working on the baby. I sat there holding her steady for them while trying to stay out of everyone's way. They used a catheter to suction her out, and instantaneously her airway was cleared and her breathing got better. Then she started wailing, which is what you want to hear from the start.

One Sunday afternoon, a young man in his twenties got off a Vermont Transit bus in White River Junction, Vt. He was brought to the ED by ambulance because he had been acting funny—he was apparently talking as if to a companion, but no one was there. Then, after he got to the ED, he let his pet boa constrictor out of his backpack. "Baby"

hung draped from the IV pole in his room. He asked us for a banana for Baby, and we scrambled around trying to figure out where to find a banana for his snake and what to do.

Late one Saturday night, a man in his thirties came to the ED after being beaten up outside a bar. Around his eyes were a lot of small cuts that looked dirty even after the lacerations had been washed out and irrigated. As I was trying to untangle the mangled skin tags and flaps and put everything back into position, he told me he had had teardrops tattooed on his skin where the cuts now were, so could I please try to make it look like it did before he got in the fight?

I also recall several memorable patients with hand injuries. Much of what physicians do involves our hands, so hand injuries are particularly worrisome if your ED patient is a physician—just as they are if your patient is a musician. I have treated fellow physicians for a variety of hand injuries, ranging from a deep cut exposing a tendon, to a splinter under a fingernail, to a sudden swelling of the ring finger. Such cases are never routine because in the back of your mind is the thought “I’d better do this right, or I could wreck a colleague’s livelihood.”

Lucinda Rossoll, M.S.

Rossoll is a unit leader and charge nurse in Dartmouth-Hitchcock’s Emergency Department, where she has worked for more than 13 years. She has worked previously in surgical, ICU, and post-anesthesia nursing and has also been a volunteer EMT with ambulance services in Durham, N.H., and Wakefield, R.I.

A few years ago, a two-year-old boy came into the Emergency Department after having been hit in the eye with a stick. I initially saw him in the waiting room and immediately brought him back to an exam room and assumed responsibility for his nursing care. It looked like he was going to lose the injured eye. I applied medication to the eye to help with the pain. Then I started an IV and gave him medication to calm him down. While we were waiting for the ophthalmologist on call to come in and evaluate the injury, I asked the hospital priest to come to the ED and pray with the family. When the ophthalmologist arrived, it was determined that the young boy would not lose his eye after all and would be able to leave the ED that day.

..... I held the man’s hand while he went from begging us to save him, to saying we needed to let him “go.”



It was music that was at stake when a man brought in his son one afternoon in the late spring. The boy had a simple hand laceration, maybe a quarter-inch deep and a half-inch long and not involving tendon, bone, muscle, nerve, or blood vessel. This was before we had skin glue, and the father wanted the wound stitched up, so I sutured it. Then the father asked the dreaded question: “Will my son be able to play the violin once this heals?” I hate this question because I am usually so focused on suturing efficiently that I tend to automatically answer “Of course!” But often it turns out the parent is making a joke and responds, “Well, that’s good, because he could never play the violin before!” In this case I remembered to ask, “Well, can your son play the violin now?” It turned out the child was indeed a violin prodigy and had just been accepted into a special summer program for young musicians at Tanglewood.

Then there was the Christmas morning when three boys—unrelated but right in a row—came in with their fathers. The chief complaint was a cut on the hand. And the patient histories were identical: Each dad had bought his son a first jackknife as a stocking present. Each boy had been elated and had started whittling. All too soon, the knife slipped and gashed the non-dominant hand. After the third such patient, I decided that a local store must have had a sale on jackknives that Christmas! But it’s the only Christmas that ever happened.

About a month later, a package addressed to me came to the ED. It contained a picture of the child, with a note on the back saying the picture had been taken so I could “see his beautiful blue eyes,” plus a letter telling me that I would always be his guardian angel. I had done no more, or less, for this family than I would have for anyone else. But knowing that I was able to assist this young family (and hopefully many others throughout the years) during a stressful period in their lives is just one of the many reasons why I work in the ED.

Carol A. Goodman, R.N.

Goodman, a nurse in Dartmouth’s Section of Occupational and Environmental Medicine, worked in the DHMC Emergency Room from 1972 to 1998. She has also been a volunteer EMT in Canaan, N.H., since 1976 and is the service’s current president. “The ED was such a wonderful place to continuously learn new things,” she says. “Physicians and nurses were always willing to share knowledge and expertise with each other.”

I recall a tearful mother who came into the ED with her lifeless child in her arms. The child was not breathing. Luckily, respiratory resuscitation did the trick. But soon we realized she had a skull fracture from abuse. There was a happy ending—the child recovered without incident, and her mother (with assistance from our social services and

psychiatric departments) was able to provide a safe and loving environment for this adorable little girl to grow up in.

And then there was the 40-year-old construction worker with severe chest pain who was brought in by ambulance. The damage to his heart was massive. We were able only to make him comfortable. I stayed at his bedside and held his hand while he went from begging us to take away the pain and begging us to save him, to looking very peaceful and telling us that he was okay and that we just needed to let him “go.” I can still remember looking into his blue eyes and seeing them go from anxious to peaceful.

On a more humorous note, there was one memorable patient who thought he was Jesus incarnate. He insisted on stripping naked, standing on a chair in a cubicle next to another patient who was being

“juvenile onset diabetic”—meaning her disease was difficult to control and she often had to be hospitalized to bring her glucose level under control. Despite repeated admonitions from her endocrinologist, she frequently violated her diet and drug regimen. It wasn’t that she was rebellious. She just wanted to live like a normal person and was having too much fun to pay attention to the directives. But the severity of her disease was going to ruin her eyes, kidneys, and heart before she reached middle age.

Like many interns before me, I sought an explanation from her. “You know that you’re killing yourself. Why don’t you take your insulin like you’re supposed to? Why do you drink so much?”

“Because I’m a human being, or haven’t you noticed?” Wink, wink. She was attractive, but the disease was taking its toll. She had scars from poorly

..... It was the patient’s turn to educate me. “Oh, you doctors,” she grinned. “You don’t know so much.”



resuscitated, and preaching to the whole department. Our experienced registrar made several professional, but caring, attempts to get him to put his clothes back on and quiet down, to no avail. Finally, in a desperate attempt to gain control of the situation, she said, “Well, I’m God and I’m telling you to put your clothes back on and sit down in that chair and be quiet!” And he did.

Paul Auerbach, M.D.

Auerbach, who was a resident at DHMC in 1977-78, has spent 27 years in emergency medicine and practices now at Stanford Medical Center. He is the author of several books, including A Field Guide to Wilderness Medicine, Management Lessons from the E.R., and a medical thriller titled Bad Medicine. The following saga is excerpted from a forthcoming book.

A young woman came to the ER at Dartmouth suffering from astronomically high blood sugar and dehydration. Her breath had a strong fruity odor and she was hyperventilating. She was a “brit-

healing skin ulcers, and her complexion was sallow. “Besides,” she added, “I’m going to die, one way or another. I prefer to enjoy life.”

My inexperience with chronically ill patients made me stupid. “But you’re cutting years off your life,” I told her.

It was her turn to educate me. “Oh, you doctors,” she grinned. “You don’t know so much. If I listened to you, I wouldn’t eat anything I like, go outside, or have sex. What would be left? Work? This hospital?”

The more she spoke, the more I liked her. “You know, I’m going out with a doctor,” she said. “He’s really cute. He never tries to tell me what to do. I just want to feel good. Can’t you see that? It’s my life.” She wiped her eyes, then smiled and asked, “So, do I have to stay?”

“I’m afraid so. Your blood sugar is over 600 and you have ketones in your blood. You know what that means.”

“Sure do. Okay, get me out of here quick. But I’ll
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only stay if I get to eat cake," she asserted.

"What?"

As sick as she was, she was mischievous. "I know what you're gonna do. I don't want that ADA diet," she said, referring to the guidelines put out by the American Diabetes Association. "It's like eating cardboard. I want to eat cake."

"The food here stinks," I said. "You can have cake when you go home. I'm not allowed to give it to you."

"Then sign me outta here. No cake, no deal."

I thought about it for a moment. We were going to be replacing her body fluids and electrolytes with aggressive IV therapy and infusing her with repeated doses of insulin. We didn't have any chance to change her attitude, which was all that stood between her and despair.

"Cake it is."

"I don't really have a boyfriend," she said. "Are you interested?"

I walked from the room, laughing and shaking my head. I found out later that she wound up dating a medical student.

Hope isn't just about total success or failure, or about living or dying. It's about gradations of success, about things working out a little bit better than they might have. Hope is about a child suffering less pain or a wound healing with a smaller scar. It's about chest pain not being a heart attack or being a smaller one. At the very least, it's what I mean when I say, to every patient, "I hope you feel better."

There's always room for hope. Attitude counts for a lot in life, but never more than when it gives you strength during difficult times. In my opinion, being sick in the ER qualifies as hard times. In these moments of misery, you must strive to be strong.

As a patient, you should realize that it's much easier for a doctor to care for you when you are trying to get well, when you are making your best effort to understand your situation and to cooperate in the approach that your doctor has chosen to re-

turn you to good health. Everyone roots for a trooper. When you are either passive or negative, your doctor may misinterpret your mood as meaning that you don't care that much or even that you are angry.

In most of what any of us do, there is probably a desired outcome. When you walk on the beach, you hope for majestic waves, breaching whales, and magnificent sunsets. When you take a test, you hope for a good score. When you sleep, you hope for peaceful rest devoid of interruption. Think of any situation in which you are a participant, and you hope for something. Even when you have no expectation of achieving what you hope for, you are still hoping. That's a good thing, because it usually means that you care about what happens.

When you give up hope, it should be because you have come to peace, even if in surrender. If someone with you is giving up hope, then try to bring him or her to peace so that the ending is not a failure. And once you have accepted something as being in your past, then begin as quickly as possible to hope again. ■

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