BROKEN BODIES, BROKEN SOULS

By Emily R. Transue, M.D.

A DMS alumna rues the limits of medicine, writing revealingly about the angst that can beset doctors as they face the vagaries and ultimatums of the health-care system. But at the same time, she celebrates the moments of humanity that can occur despite the system's limits.

ALL: WHITNEY SHERMAN

Halfway through a 12-hour emergency room shift, a week into the month-long ER rotation that's part of my residency in internal medicine, a code is called in Trauma Room 2. That means a patient has either suddenly gone into—or arrived in—cardiopulmonary arrest, without a heartbeat, not breathing. There's a protocol for restoring those functions that all doctors learn by rote. Someone "calls a code" to initiate the process, and the people assigned to manage it come running. They quickly check A-for-airway, B-for-breathing, C-for-circulation, then begin a staged series of interventions: CPR; oxygen; an IV line in the arm; a breathing tube in the throat; a cardiac monitor to display the electrical rhythm of the heart. Next come electric shocks of escalating intensity, then a series of medications, then . . . and so on. In theory, it's a standardized, orderly process. But in reality, it's often confusing and unpredictable. A "code" can last anywhere from a few minutes to more than an hour.

By the time I arrive at this one, on the run, several surgeons are playing a losing game of tug-of-war with death on a blood-drenched field. The medics had been doing CPR when they brought the patient in, a nurse quickly tells me. He's clearly suffered some kind of massive trauma, though there's no time to get the story.

The surgeons have pulled me in to run the code, so I, technically, am presiding over this drama. But it's an odd position to be in. Usually surgeons manage codes in trauma cases, but they want me to handle this one from the medical perspective—to assess the effectiveness of our arsenal of drugs and shock and such—while they assess and try to control the traumatic damage.

But the medical and the surgical realms aren't totally independent—and the surgeons keep doing things I don't expect or sometimes don't even know about. By the time I'm on the scene, the patient's abdomen has been cut open. All I can see is a bloody mess—occasional recognizable bits of organ floating in a sea of blood. I'm not sure quite what the surgeons are doing, and there's no time to stop and find out in any detail.

"Continue CPR," I call out, after I've checked the patient's heart rhythm. I look up and suddenly notice that the surgeons are cutting his chest open with a saw.

"Okay, don't continue CPR, if you're going to do that," I murmur.

A moment later one of the surgeons has thrust a hand inside the chest incision and is doing cardiac massage—squeezing the heart itself to make it pump.

"Do we have a femoral pulse with that?" I ask. If a pulse is evident in his thigh, that would be a good sign.

A surgical resident looks up. "We cross-clamped the aorta." In other words, they'd stanched the flow of blood to the lower half of his body—probably to clear the abdominal field.

I glance down into the open chest cavity, where all I can see is a pool of blood, and I try to absorb this fact. *Cross-clamped the aorta.* I experience a moment of pure absurdity. What are we doing here? What am I doing, trying to run a code without even knowing which major vessels are pumping blood, without knowing that the blood supply to everything from his waist down has been cut off? What are they doing, opening up the chest of a man we all know is going to die anyway, thinking they can save someone who needs to have his aorta cross-clamped? I see myself for an instant as a sort of crusty maiden aunt, complaining about the excesses of today's young. *Is that a nice thing to do?* I want to ask. *Is it civilized behavior to go around cross-clamping people's aortas?*

Instead I say, "Okay, do we have a carotid pulse?"

During a brief pause in the action, I step over to the wall phone and page one of the ER staff physicians, Pete. Clearly some backup would be good here. Pete arrives quickly, but rather than taking over the code—which I half hoped he'd do—he decides that the heart needs to be warmed. He sends a couple of students running for heated bottles of saline solution. Then he pours them in a steady stream over the heart, mixing the freely flowing blood with the warm saline. The bloody water pools steadily in the sheets on the stretcher and then suddenly overflows, cascading in a broad, red river down Pete's leg—soaking his pants, his socks, his shoes.

"Shit," he mumbles and keeps pouring.

The code continues. "Monitor shows an organized wide-complex ventricular rhythm," I announce during a pause in the cardiac massage, partly for the code stenographer to record, partly because it's easier to think aloud. "Do we have a pulse now?"

"No," answers someone, after a moment.

"Okay," I say. "So we're in PEA." Pulseless electrical activity—that means a rhythm is showing on the cardiac monitor, but there's no detectable pulse. It's a state that used to be called EMD—electromechanical dissociation—meaning the pacer system of the heart is firing but the muscle isn't contracting.

"Not exactly," points out Pete. He gestures, and I look down into the open thorax at the patient's heart, which is still twitching in a regular if not entirely organized way. Theoretically, in PEA/EMD it would just be lying there stunned.

"I'm really not used to having that kind of data," I say. We internists rarely have a chance to look into an open chest cavity. I stare at the heart for a moment, waiting for a medication I've just ordered to be given.

"Well, continue cardiac massage . . ."

Then, miraculously, the heart's pulsations get more organized. We stop compressions. "Carotid pulse?" I ask.

"Yes," says a nurse, feeling the patient's neck. "Thready, but yes."

"Blood pressure?"

"Seventy over forty," answers another nurse after a minute.

I look at the surgeons.

"We've got a rhythm," responds one. "We've more or less got a pulse. Let's go to the operating room. He's not going to get any better down here."

He's not going to get any better anywhere, I think.

"All right," I say.

I watch the procession until it disappears into the elevator. I shake my head and frown, trying to collect my thoughts. I have a flashing memory of my first code, also in an ER. It was a simpler code than this one—no blood and guts, no trauma, no staring at a throbbing, dying

Emily Transue, a general internist in private practice in Seattle, is a 1996 graduate of DMS. She started writing about her experiences with patients (changing identifying details) when she was a medical student. Her first story for Dartmouth Medicine, *based on an experience during her obstetrics clerkship, ran in our Winter 1995 issue. Many of her stories have appeared in our pages since then. St. Martin's Press has just released a collection of Transue's stories drawn from her experiences as a resident at the University of Washington in Seattle. This story is from that book,* On Call: A Doctor's Days and Nights in Residency; *it is now available in bookstores. This excerpt is copyright 2004 by the author and is reprinted here with the kind permission of St. Martin's Press, LLC.*

My first code shook my psyche, and this one strikes me mostly as just another messy piece of business. How can I be so unfazed by what I've just been a part of? Have I lost some essential part of my humanity, to not be moved by something like this?

heart. I also had no responsibility then; I did chest compressions but otherwise only watched. Yet that code shook my psyche, and I realize that this one strikes me mostly as just another messy piece of business. What's happened to me?

I ponder the fact that I was stressed but not scared when this patient came in, amazed but not thrilled when we got a pulse back. And I would be neither surprised nor especially upset to learn, half an hour later, that he'd died on the table in the OR. My heart rate never went up during the whole episode.

I'm disturbed, I realize, by my imperturbability. How can I be so unfazed by what I've just been a part of? Have I lost something, have I given up some essential part of my humanity, to not be moved by something like this? (In telling the story later to a friend, I would be further distressed to realize that I was completely unable to answer her basic questions. How old was the patient? I never even really looked at his face. Was it a car accident? I assumed so—trauma cases usually are—but I didn't know for sure. Was he drunk? Did he have family? I never thought to wonder.)

Back in the here and now, I don't have time to ponder these questions for long. Patients have been piling up while we were busy with the code. I grab the next chart: a young man complaining of shortness of breath and "pain all over," according to the nursing note. *Oh, joy,* I think. Indeterminate pain is one of the hardest complaints to diagnose. Well, maybe I'll be lucky and he'll have the flu or something.

I find the patient on a stretcher in the back hallway, a sign that the nurses didn't feel he was particularly sick. It takes my eyes a few seconds to adjust from the bright lights and stark contrasts of Trauma Room 2. Everything about this patient—his clothes, his hair, his skin—is a uniform dark gray, except for his bright blue irises and the whites of his eyes, which peer out startlingly from the dark mass of the rest of him. He is, quite possibly, the dirtiest human being I've ever seen. There are flakes of dirt and skin collecting in little piles on his sheet. I try not to breathe deeply but cough just from a whiff of the dust on him. He smells awful.

But there's something beyond the dirt and the odor, something in his eyes, in the way he sits, the way he speaks: the indefinable but unmistakable aura of the mentally ill. I understand now why, despite a potentially serious complaint like "shortness of breath," he's here in the back hall. We're probably not going to find anything—at least nothing we can treat in the ER—and the triage nurses knew it.

Talking with him gets me no further, either medically or psychiatrically. I find nothing that points to a medical problem that would account for his pain or his feeling of being unable to breathe. His thought and speech patterns are highly suggestive of schizophrenia, but he says he's not hearing or seeing things, he's not suicidal, and he's not thinking of killing anyone—in other words, there is nothing I could use to get him admitted immediately to the psychiatric unit.

I put on gloves before starting the physical exam. I don't usually wear gloves unless I'm doing something invasive or someone is bleeding. But he's just so filthy. "Do you hurt here?" I ask when I get to his belly. He's said that he hurts everywhere else I've probed so far.

"Yes."

Thoughtfully, I palpate more deeply, in case there's an area of localized tenderness.

"It hurts."

"I'm sorry."

I continue pressing, as gently as I can, trying to see if there's anything going on in his belly that we need to be worried about. Abruptly, roughly, he shoves my hand away.

"I told you it hurts when you push, and you keep doing it!"

I stare at him in surprise, then turn stern for a moment. "I can't evaluate you without doing a thorough exam. I'll try to make it hurt as little as possible. But I can't help if I can't figure out what's going on."

"I'm sorry," he says, suddenly meek.

"That's okay," I say. "I'm sorry that it hurt. But I'm just trying to help."

He is quiet through the rest of the exam.

"I—I'm sorry I pushed your hand away," he says as I pull my gloves off.

"It's okay," I say. "I'm sorry that I hurt you."

But for all my probing, I've found nothing. The only thing evident from the exam is that he complains of hurting everywhere I touch, but I can't find any of the qualities or patterns that would suggest a medical cause. And he says he can't breathe, his eyes tearing up with fear as he tells me this, but not only do his lungs sound fine, he's breathing quite comfortably—not hyperventilating, not gasping, not using any accessory muscles.

"How long has it been like this?" I ask.

"A long time."

"Days, weeks, months?"

"A long time."

"Months, do you think?"

"Doc," he says, with sudden urgency, his eyes boring through me, "you've got to help me . . ."

I check his oxygen levels, order a few basic lab tests, request a chest x-ray. I also ask for an alcohol

level and a drug screen, partly just to buy a little time. It'll take an hour or so for all the tests to be run, and in the meantime maybe I can think of something to do, or at least something to say to him. The tests, of course, all come back normal.

Armed with the normal results, I call the psychiatric social worker. I've done a medical workup and it's negative, so now the ball is in their court, right?

"I've got this guy here, came in with a complaint of pain all over and trouble breathing, but medically he's fine. I don't think he's a danger to himself or anyone else, but he's obviously got psych issues, and I was just wondering how that gets handled, whether there's a possibility you guys could see him right away."

"Is he suicidal? Is he homicidal?"

"No," I repeat patiently.

"Is he overtly psychotic? Is he grossly unable to care for himself?"

"I guess I'm not sure what that means," I say. "Do I think he's going to die tonight? No. But obviously he's not able to care for himself very well . . ."

"Just being homeless is not a reason for a psych eval," she snaps.

"I realize that," I say. "I'm quite sure that he's schizophrenic . . ."

"Is he hearing voices? Is he delusional?"

"He's not hearing voices. As for being delusional—well, he's got a delusion that he's suffocating when he's breathing fine, he's got a delusion of excruciating pain that I can't find a source for."

"Just being schizophrenic is not a reason for an emergent psych eval," she snaps again.

Excuse me, I want to say, *what have I done to you? We're all overwhelmed, sure. But I'm just asking a simple question in an attempt to take care of my patient, and you're getting hostile.*

I'm just a little too tired to be confident I could manage whatever confrontation might follow, however. So I let it go.

"He doesn't sound like someone we would see emergently," she says. "Make him an appointment and tell him to follow up."

"Thank you," I say stiffly.

I pour out my frustrations to my attending. "It sucks," she agrees. "But you've got to send him out."

I go back and stand beside his stretcher, at a loss for words.

"I know you hurt," I say, as gently as I can. "I know you feel like you're suffocating. But I'm afraid there isn't anything that we can do for you tonight."

He looks up at me with eyes that burn with agony.

"There are some doctors I think can help you, and I'm going to give you an appointment. But it will take a couple of weeks."

He closes his eyes.

"I—I'm sorry," I say.

"Hold my hand," he says suddenly. He stretches out a brown, crusted paw. I stare at it for a second. Then I reach down, and he takes my hand and clings to it as if for dear life.

After a minute I try to pull away.

"Don't let go." He looks as if he's about to cry.

"Okay."

We stay like that for a long time, my hand clutched in both of his, his eyes tightly closed. Finally he releases my hand. "I'll have the nurses get your things," I say quietly.

"Where are you going?" he asks as I turn away.

"There are other people I need to take care of."

"Oh."

I stare at him helplessly. What am I supposed to do . . .

"Can I have some 7-Up?" he asks timidly.

I am so amazed at being presented with a need that I can actually fulfill that I'm almost confused for a moment. "Of course," I respond, although I've told half a dozen other people tonight that I can't give them anything to eat or drink, that we have a policy of not doing that—or, at the very least, that they'll have to ask their nurse. "We're an ER, not a cafeteria," I recite a dozen times a night. But now I go into the back room where we stash some 7-Up for patients who are hypoglycemic, fill a cup with ice, pour in the bubbly liquid, and find a straw.

His hands are shaking as he sits up on the stretcher and reaches for the cup. He drinks half of its contents, then looks at me in dismay. "I want to finish drinking it," he says, "but there's nowhere I can set it down." I feel a spasm of irritation—I didn't go to medical school for this! But I set an emesis basin on the blanket next to him, and it's stable enough to hold the cup.

"Thank you," he murmurs seriously.

I send a social worker to find him a bed in a homeless shelter for the night, knowing how woefully inadequate the offering is. "I got him a place," she returns to announce, "but I doubt he'll stay." Similarly, I press a slip for a psychiatric consult into his hand but have little faith that he'll actually keep the appointment.

I have to go tend to another patient and don't watch him as he leaves. But, continuing on through the busy night, I can't shake his image from my mind. His startling, bright eyes, shot through with inexplicable, unanswerable terror. The pressure of

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