Part I: The primary source

This is the tale as it was told—in the words of its protagonist—in the 1982 Mary Hitchcock Memorial Hospital Annual Review. The setting of the story is the southern New Hampshire town of Spofford, on the Fourth of July in 1981. Its dramatic personas are:

Adam Dubriske: the two-year-old who is at the heart of the tale
Paul and Gail Dubriske: Adam’s parents
Dr. Bill Toms: a family physician in Keene, N.H.
Dr. David Glass: the director of Critical Care Medicine at DHMC
Dr. Susan Edwards: a pediatrician at DHMC
Dr. Harvey Bograd: a resident in pediatrics at DHMC
Melissa Trimble: a staff nurse in the DHMC intensive care unit
Ann Rubright: a physical therapist at DHMC
Carol Levin: a physical therapist with the Cheshire, N.H., Home Health Agency

Paul Dubriske: “Adam left my father-in-law and me in the garden across the dirt road and headed for the house, where Gail, his mother, had gone. A few minutes later I saw the screen around the pool in the backyard move, and I thought Gail was taking a swim. Shortly, I went to the house; we couldn’t find Adam. I went to look in the woods nearby, thinking he had gone for a walk. Gail headed for the pool. I was near the woods when I heard her scream.

“When I got to the pool, Gail had jumped in and pulled Adam up off the bottom and handed him to me; then she headed for the house to call the ambulance. I saw that he was blue and purple and wasn’t breathing at all.

“As a diving instructor in the ’70s, I was certified in CPR, lifesaving, and first aid; I also taught CPR to others. Now here I was putting this training to work for the first time—on my son.

“After a minute of CPR, I still couldn’t detect a pulse or heartbeat, so I thumped him in the chest and resumed the ‘heart massage’ and mouth-to-mouth resuscitation. Adam responded almost immediately. I got a strong heartbeat and a good pulse, and his color improved a lot.

“When the ambulance got here, the Emergency Medical Technicians, all of whom I’d certified, worked with me another 10 minutes to prepare him for the run to Cheshire Hospital in Keene.”

Dr. Bill Toms: “When Adam arrived [at the Cheshire Hospital Emergency Room], resuscitation was being maintained. It was unclear as to how long he had been in the water. We treated him as if he were in full respiratory arrest, which included the placement of an airway tube, starting him on 100% oxygen, and starting IV lines with medications.

“The results of initial blood tests indicated that minutes later I saw the screen around the pool in the backyard move, and I thought Gail was taking a swim. Shortly, I went to the house; we couldn’t find Adam. I went to look in the woods nearby, thinking he had gone for a walk. Gail headed for the pool. I was near the woods when I heard her scream.

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Paul Dubriske: “When they told me Adam had to go to Hanover right away, I felt, for the first time, that he was in real trouble. I went outside with my father and cried a little bit. I felt better after that.”

Bill Tom: “Paul Dubriske’s presence of mind and his control had been remarkable. Now, with Adam in the care of others, he could let down; he could be a father again.”

The trip by ambulance was uneventful. Adam was still unresponsive. He required assisted ventilation, for he could only manage an occasional spontaneous breath. We were in radio contact with Mary Hitchcock’s Emergency Department, so that they were ready when we arrived.

Dr. Susan Edwards: “When Adam arrived in the emergency department, our main concern was his respiratory status and resulting pneumonia. I met with [MHHN anesthesiologist] Dr. [David] Glass the night of Adam’s admission and agreed on a plan. Over the next few hours we knew he was going to get worse, and we tried to prepare his parents.”

Dr. David Glass: “When Adam was brought to the Intensive Care Unit, it was obvious he was in severe respiratory distress and had minimal brain function. Our first order of business was to get as much oxygen into Adam as possible and make every effort to deliver as much of that oxygen to his brain as we could. At first, Adam’s treatment consisted of mechanical breathing support, and the establishment of monitors to measure pressures in his heart and to measure the amount of blood the heart was pumping, in an effort to minimize any further brain damage.”

Susan Edwards: “As a pediatrician, I was Adam’s primary physician, and coordinated his care. The excellent cooperation that exists between the pediatric service and the intensive care specialists is necessary, for we were especially dependent on them for advice and help in managing his severe pneumonia.”

Dr. Harvey Bgapal: “I was part of the team that had formed to help Adam. My role as a member of the pediatric housestaff was, in part, to help assess the multiple medical complications Adam encountered, and to help implement the treatment necessary to solve those problems. Communicating with the family, I endeavored to explain clearly the medical problems, to answer all of their questions as fully as possible, and to provide emotional support to the family during this crisis.”

David Glass: “Our major concern came on the second day, when his lung damage led to leak air into the closed chest cavity. The resulting pressure collapsed the lung and severely interfered with his heart function as well.”

“At that point, Dr. [Stephen] Plume, a cardiac surgeon, drained air from around the heart, which helped the heart function, but we were not able to get the necessary amounts of air into Adam to adequately oxygenate his blood without putting more air outside the lung. We discussed with the Dubriske the use of a new type of respirator. Although we were not certain of its success, we had enough experience with it to give us some optimism that it might be successful.”

Paul Dubriske: “When the doctors talked to us about the new respirator, I was apprehensive, but I could understand that because of Adam’s condition, it was the best thing to try.”

David Glass: “This respirator utilized very, very high rates of ventilation and small volumes of air, much like a painting dog, rather than the larger volumes and higher pressures generated by traditional respirators. We hoped to minimize the amount of air leaking from the lung by producing a lower pressure, and in doing so be able to get more oxygen into Adam’s blood.”

“Almost miraculously, Adam’s oxygenation improved and over the next three days, he had less and less air leaking from the lung because the respirator was successful in doing its job.”

Harvey Bgapal: “Throughout their ordeal, Adam’s family demonstrated strength and the utmost concern for Adam. His parents worried about their son’s survival, and they were keenly aware of his discomfort. It was important to keep them well-informed in an effort to ease their natural fears of the unknown.”

Melissa Trimble: “Near-drowning victims are one of the most critically ill patients we treat in the ICU, and Adam being a two-and-a-half-year-old child made the situation even more of a nursing challenge.”

“Initially, his respiratory status was the most unstable factor. We had to keep the tube that was placed down his throat to his lungs clear of secretions, take frequent blood samples for oxygen levels and monitor his brain sounds. We watched his cardiac monitor to detect any irregularities in his heart rate and rhythm, and monitored his neurological condition by checking his pupils, his response to stimulation, and asking him to follow voice commands. By now, Adam was awake. He was also extremely restless and needed to be sedated.”

“When he was placed on the high-frequency ventilator, we continuously checked to see that the ventilator tube was correctly placed for optimum ventilation. Adam had become highly agitated and really fought the ventilator, and additional sedation was needed to keep him from trying to remove the various tubes that were connected to his body.”

Gail Dubriske: “I was very concerned about Adam—he was medicated so much to keep him from pulling out all the tubes and IV lines. It was a hard thing to see, but the doctors and especially the ICU nursing staff were wonderful. They really helped us deal with the situation.”

Melissa Trimble: “All the technology employed in modern nursing did not obscure one of the most important ingredients in patient care. Stated simply, it is emotional support for the child and family. Gail and Paul Dubriske made the ICU their ‘home’ for 12 days. Seeing Adam in a busy, three-bed ICU room, with tubes and IV lines, surround- ed by machines that beeped and sighed, made it dif- ficult for them to believe that the child in that bed was their son. We encouraged them to bring fa- vorite family photos, a favorite toy, and to talk to Adam as they would at home.”

“After Adam was off the respirator and no longer receiving narcotics and barbiturates, he be- gan experiencing withdrawal symptoms. This was another difficult time for his parents. We encour- aged them to visit him as much as possible and talk to Adam calmly. Within two days Adam had improved enough to be transferred to the Pediatric Unit.”

Paul Dubriske: “When Adam went to the Pediatric Unit, we felt a little relieved. At this point, even though Adam was groggy from the medications, un- able to walk, or even talk because his throat was sore from the ventilator tubes, Gail and I felt strongly that he was going to be all right.”

David Glass: “Many near-drowning victims ultimate- ly die because of the lung insult. We now have enough expertise to usually correct this, so that our discussion with the parents during that time of de- cision becomes the amount of brain damage that has occurred. Because of the excellent and prompt treatment Adam received from his father at the time of the drowning, there was adequate blood flow preserved to Adam’s brain. It would have done very little good for us to have successful- ly treated his lung if the brain was damaged beyond repair at the time of his drowning. Conversely, a brain that was salvaged would have been of little help if we were unable to ventilate and correct his...
Part II: The saga revisited

By Dr. Bill Toms

Bill Toms was one of the first doctors to treat Adam Dubriske upon Adam’s arrival at Cheshire Hospital in 1981. And when Adam was transferred to DHMC, Toms traveled with him in the ambulance. In 2005, Toms again crossed paths with the Dubriske family in the Cheshire ER. He wrote here about the two encounters—and rectifies an omission in the 1982 MHMH Annual Review story about Adam’s near-drowning.

Epilogue: It was a warm and pleasantly-August afternoon, and I was taking a brief walk in the garden when I experienced the sudden gut-chill that occurs whenever a siren on the highway screams “Hurry!” Then my beeper went off—a staccato “Hurry!” Such was the sequence of events back in 1981 when a speeding rescue squad brought an unresponsive two-year-old boy, who would be found at the bottom of a backyard pool, into the Cheshire Hospital.

What followed were like scenes from ER—but with tension that lasted much more than an hour and with much less star-power. The heroes were there, though, starting with immediate CPR adminis-
tered by Adam’s father and aggressive resuscitation by the Spofford, N.H., rescue squad; continuing with further care in the Cheshire ER and a fast, fearful trip up I-91 to DHMC; and culminating in the in-
novation and dedication of the staff in Hitchcock’s then-rudimen-
tary Pediatric ICU.

The 1982 MHMH Annual Review account above detailed the challenges and heroics involved in Adam’s care, as well as his complete recovery. The story might have ended there but for two events 24 years apart.

The first occurred in 1981, after Adam’s arrival in the Cheshire ER. His heart was in cardiac arrest, and the only choc-
ker he had was one of the anesthesiologists who cared for Adam in the ICU and had done much of the work to develop the high-frequency ventilator.

Paul Dubriske: “With some knowledge of the respiratory system from my diver’s training, I was able to understand much of what he told us about research in this field. That conversation, coupled with the fact that Adam completely recovered from his accident, led me to think that prompt rescue action might allow more drowning victims to benefit from the tech-
nologies that had saved his life.”

I knew of Hal Brown, a Keene police sergeant, who had been working on a rescue team concept for a couple of years. Unfortunately, his timing was a bit off the mark, as the advent of the alternating current came in.

The second event occurred 24 years later, when Adam’s grand-
mother was brought to the Cheshire ER, and I ran into Adam again. We had time to exchange only brief best wishes before I had to leave to attend to an emergency elsewhere in the hospital. I muddled over these two events so distant in time but adherent in meaning. A boy who had come close to dying was now a man. One of the men who saved his life, Charlie McMurphy, had died in 1995. But even Adam isn’t one who doesn’t care about those things.

He is old school.

Part III: The “story in verse”

By Dr. Bill Toms

In the poem below, Toms celebrates the serendipity of his two encounters with the Dubriske family. In the most recent one, Adam Dubriske’s grandmother was brought to the Cheshire ER with an abdominal aortic aneurysm (an AAA, also referred to as a “triple-A”), which is a bulge in the portion of the aorta that runs through the abdominal cavity. (See dartmed.dartmouth.edu/AAA for more of Toms’ “stories in verse.”)

Siren

Summer siren, Route 9, coming in fast, again, like that July afternoon when Adam was two, was found at the bottom of the family pool. His father offered his own breath, a plea to stay alive.

Doctors, nurses, trauma-tough, doddled by daily death, melt before a blue, little child.

Roles rehearsed, skills unleashed, you do what you must.

But we can’t get a line, peripheral or central.

Charlie does a cutdown, threads the catheter.

We start to balance electrolytes.

We push air down a tube to squeeze out breakdown and prolong the heart beat. We must keep it safe. We resuscitate, we stabilize, we monitor.

We transfer to the ICU.

The PICU pulls out more heroes, new ideas. Adam lives, his later years, everything’s okay.

They do story, interview, photograph the young doctor “who saved Adam.”

They don’t mention Dr. McMurphy, the old, gumpy, so-good pediatrician who got the chance to do what he doesn’t care about those things.

He is old school.

Saw Adam recently. He’s twenty-six, married, all grown up. We talked briefly about his near-drowning, then I went to attend to his grandmother, whose triple-A was incoerced in the ER.

Next time I see him, I’m going to remind him about Charlie.

This quiet and efficient lifesaving maneuver didn’t get mentioned in the Annual Review story. Until recently, even Adam’s family was unaware of Dr. McMurphy’s role in Adam’s recovery.