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Scrap of a Story

By Collin Mulcahy

Is there anything that makes you feel invincible? For me, the closest thing is doing 60 mph in open water on a jet ski off the coast of a Caribbean island. When I'm there I feel like nothing can touch me. It's almost as if I'm gliding over the water, looking down only momentarily to catch glimpses of brown blurs buzzing by. Coral reefs look a lot different from the surface, especially if they're being viewed from the seat of a Kawasaki wave runner.

When I was 16 my family took a trip to the Caribbean and I, with my best buddy sitting behind me, hit a 5-foot swell going sideways doing 40 mph+, only to come down hard. My mandible broke my fall by way of the handlebars. It didn't knock me out, but it came close. And it didn't break my jaw, fortunately. But it did give me pause. I never quite looked at a jet ski the same way again. I was smacked in the face with my own fragility.

As a young physician, I tend not to think about the fragility of life. At least not *my* life. The majority of patients I help treat are people with cancer, chronic infections; terminal patients, bariatric patients. These experiences certainly bring up thoughts of the brittleness of life, but they rarely push me to reflect on my own mortality. Most of these patients are "old" -- they have diabetes, high blood pressure, chronic kidney disease, lupus, chronic heart failure... and have been plagued by medical problems for decades.

Trauma patients, however, are different entirely. During my intern year as an otolaryngology (head & neck surgery) resident, I take call with the general surgeons. That is, each month I take general surgery *and* trauma call. My job consists not only of covering all of the surgical patients on the floor, but, more excitingly -- or perhaps more audaciously -- responding to trauma activations at our Level I trauma center. We are a small hospital serving the Washington D.C. metropolitan area. Far and away the vast majorities of the trauma activations that come in are minor traumas. Mr. F got drunk again and fell and split his scalp open. Or Ms. R slipped in the bathroom and bumped her head, and she takes blood-thinners.

No matter the situation, I try to get to know my patients as well as I can. On the floor, it's not difficult. When I have the time, I like to ask them how they are, where they're from, how they ended up in the hospital. They are typically polite, responsive, and eager to speak to someone. I find that most of the time, my patients don't have much to say, but they need someone to listen. By attempting to listen to and engage with their stories, caregivers can serve patients from a position of what Dr. Sayantani DasGupta refers to as "narrative humility."

This is often a difficult task in the trauma bay. Drunken patients in C-spine collars, people writhing in pain, and terribly confused patients are not the most forthcoming conversationalists. Sometimes, they can't speak at all. In the early morning hours of a summer

day, an overhead bell called a "trauma yellow" to the Emergency Room. I followed suit and headed down to the trauma bay alongside my three bosses for the night: a mid-level resident, a chief resident, and our trauma attending, Dr. J. In the trauma bay, the intern's job is to "run the trauma," meaning run the primary and secondary surveys on every patient that comes in. This consists of examining the patient to ensure an airway is established, that they have equal breathing sounds on both sides of the chest, and that they have pulses in all four extremities. We also assess their neurological status, and then perform an overall inspection for traumatic injuries.

"What's the story?" asked Dr. J.

"Thirty-ish year old guy, ped-struck, GCS 3 in the field." Everyone standing in the room knew what that meant. It was 3AM and a car, probably a drunk driver, had hit someone and it was bad. As in not opening eyes, talking, or moving bad. He came in on a stretcher and was immediately thrust onto the trauma bay in a swift, if somewhat uncoordinated motion by EMS, myself and the rest of the trauma team. He clearly wasn't breathing, or really doing anything that resembled living.

"Airway is not intact," I said.

"We need to intubate," was the anesthesia resident's response.

We never got around to intubating. "Can we get some monitors on this man please?" our attending barked. "What does the FAST show? Go to the pericardial window. I don't care about the belly right now."

"It's asystole, sir."

"Asystole? What about the monitor? Everyone hold on, stop what you are doing. Let's look at the monitor before we go any further."

The flurry of activity paused for a moment. It got quiet. Quietness is the enemy of life in the trauma bay. "He's asystole. There's no rhythm. Does everyone agree? I don't think we go any further," said Dr. J. matter-of-factly. The room gave a collectively dull "agree."

"OK. Time of death, 3:23 AM. Can you guys finish the physical exam and get him cleaned up?"

That was the first time I really looked at the patient. The time preceding it had been consumed by looking at his mouth to see if he was breathing, or his chest to see if it was rising, or the ultrasound machine to see if he was bleeding, or the monitors to see if his heart was beating. But now I actually saw him. He was a big guy. Probably 6' 4" 200 lbs. He looked young. He looked healthy. He looked alive.

I've come to find that there are two distinct groups of people that have just died. There are people that look like they've been dead for years when you examine them (mainly patients

who have had a long battle with a chronic illness), and then there are people that look like they could pop up off the bed at any moment, complaining of a headache, or blood in their eyes, or how cold the room is. But they don't. They just lie there. This man fell in the latter group. He was broad-shouldered, physically fit, and an overall good-looking person. I continued my physical exam. I lifted his eyelids to expose his pupils. They were dark, round, big, and nonreactive, almost completely obscuring his deep green eyes. Then, I noticed his ear. There was a stream of bright red blood that ran like a river from his left ear, then onto the bed, starkly contrasting with the crisp white sheet he lay on. Behind his ear was a big knot on the back of his head, suggesting he had sustained a blunt head injury, and a very serious one. Up until this point, I had maintained a sense of distance from my patient. He was not the first person I had seen die, or at least seen pronounced dead. He came in in such terrible shape that although we did the best we could to save him, it was just too late. We had nothing to offer this man except routine post-mortem physical exam and a table to lie on instead of the asphalt. Sure, I felt sad, I felt a little angry at the driver (who never stopped we were later told), but I wasn't connected. I was simply there, doing my job, checking the boxes, lackadaisically lamenting another lost soul.

But that all changed. The charting nurse had pulled his wallet from his trauma-sheared pants in order to try and identify him. He had recently turned 30. He worked as a bartender at a local restaurant not far from the hospital and had probably just finished closing up the place. He was an organ donor. He lived nearby. In his other pocket, the tech found his cell phone. She too was trying to glean more information about him, presumably to find someone to contact. She repeatedly tried to use his thumbprint to open up his iPhone, but it wasn't working. There was too much dried blood on his hands. Then, she and I both took a closer look at the screen. On it was an unopened text message from a friend that was sent not 15 minutes before. It read "Okay great, I will see you soon!"

The next morning, after I finished my 30-hour shift on-call, I walked by the scene of the accident. It was at a very busy intersection, one that I walk through every day on my way to and from work. As I stood on the corner, I looked around for evidence of the tragedy that happened just hours earlier. I walked from corner to corner trying to find anything that would indicate that a man had lost his life there.

The city had not seemed to notice. Everyone was going on with his or her business like nothing unusual had happened; like nothing at all had happened. There were people jogging across the intersection, cars cruising past, friends laughing, checking their phones. Then, I looked down and saw a scrap of yellow caution tape. It seemed to be the only evidence that something had gone horribly, horribly wrong earlier that morning. It was almost as if it was the only part of him left. His story, in the form of a little scrap of caution tape, "makes what's audible and visible that which otherwise would pass without notice."

References:
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