intima
a journal of narrative medicine

NON-FICTION | FALL 2016

Two Minutes

By Tim Cunningham

Lunch was not rushed. I made sure of it. There was a falafel cart across the street and though the avenue sometimes takes three minutes to cross, there was plenty of time—57 minutes.

Four years before that lunch break, I sat in a lecture at nursing school:

"To prevent burnout, you need to take time for yourself, take breaks, make sure other nurses cover for you. If you are not healthy, how can your patients be? If you are not present, how can *you* heal?" I don't remember how the italics actually landed that day, I want them to have landed on *you*, but I think they landed on *heal*. That same night, I worked a 12-hour shift with a preceptor on a pediatric unit. There was no time for a lunch break that night. We were too busy *healing*.

40 minutes to go, falafel in hand.

It was no easy task to take 40 full minutes to eat. I had the option to taste my food, chew, swallow, repeat. My last bites were delicious, a last meal before stepping back into the unpredictability of a pediatric emergency department.

Edward was rushed. He was hungry. A trickle of sweat betrayed his attempts at a calm façade:

"I have three patients that need work-ups, we lost the line on room one, I got a 24 gauge in his hand, it was positional and when we were taping it, the kid moved…"

"It's OK, I'll take care of it. Other patients?"

"OK. Room one…"

"Age?"

"Three."

"Is he sick?"

"No. Room two, asthma."

"Sick?"

"I think she's fine. She won't stay in bed, she keeps trying to run out of the room and play."

"Not sick."

"Room three just got here, he tried to get seen at another hospital, got sent here. The kids in the hallway: Two have ear infections and one has a rash."

"Does three have a line?"

"No, but he has a port."

"He has cancer?"

"Yeah, came up from another state to visit some family, got sick."

"Go to lunch."

I walked down the hallway passing each of the patients now under my watch for the next hour: not sick, not sick, not sick, angry mother-but not sick, too playful to be sick, and then, Brian.

He watched "SpongeBob Squarepants" on the DVD still running after the last room's occupant left.

Brian was bloated. A lifetime of steroids shaped him more than any dietary choices could. A feeding tube flanked his right side and a colostomy on his left. Anteriorly, he had a nephrostomy for his remaining kidney. Brian had undergone more surgeries than years in his life.

"I'm Tim, I'll be your nurse for the next hour. How are you feeling?"

If Brian had told me then that in less than 20 minutes he would die, I would have changed my approach.

"My back hurts. Can I have some medicine?"

His mother belted, "Look at the nurse when he's talking to you! Tell Tim what you need."

Brian looked at me, "Just don't access my port. Can you do an IV?"

He was thirteen; his port had not been accessed for months after his oncologist back home decided there were no more treatment options. Brian was diagnosed with neuroblastoma when he was two years old. Neuroblastomas grow along neurons, tiny tumors that over time spread to nerve endings in digestive organs causing failure and pain. Pain is everywhere.

"I need something for pain."

"What?" his mother chimed.

"Please."

"I'll get it, but let's start that IV first."

"Hurry."

"Brian!" Brian's mother was tough love.

"Please."

He was septic. Inflammatory cells filled his bloodstream, electrolyte and lactic acid imbalances ensued, the leaking of fluids, decreased perfusion, and coagulation could be imminent. I returned to the room with the IV and fluids set up.

"Do you have my pain medicine?"

"We need to get these bloods first and the fluids going. Have you been sick like this before?"

Brian rolled his eyes and I was happy to see this first typical teenage response.

"What grade are you in?" I made small talk while finding his antecubital vein. We would soon have to access his port but I wanted to get pain medication onboard soon. His veins were clamped down, desperately trying to centralize his blood to his vital organs. It had been 10 minutes since I met Brian and I had just gotten the IV started--too slow.

11 minutes passed and fluids were running wide open.

"Now do I get pain medication?"

"Yes."

Brian had waited for 15 minutes before his first dose of pain medication. I pushed the morphine fast, knowing he could handle it and that the head rush he may feel might trigger a memory of pain relief that will help quell his suffering for a moment.

"Brian, what's your favorite part of New York?"

"Seeing my cousins," his cheeks were rutilant, but lips pale. "Oh wait, but they are in New Jersey. I don't know about New York."

"What do you want to do when you see them again?"

"I don't know, watch TV," his entire body contracted.

"The morphine's not working, huh?"

The blood pressure cuff alarmed--80/40.

Brian was volume depleted, a reversible symptom of sepsis if rapidly addressed. We needed to access his central line, but I did not have the Huber needle, the 0.75 inch 20-gauge needle bent at 90 degrees, with which I would puncture his chest. I did, however, have an extra IV catheter with me and a bag of fluids. The antibiotics had not arrived yet, but there was no reason to delay giving more fluids.

35 minutes into his stay and Brian's mother shrieked a guttural cry. It was a primal request; some torment had expunged itself from her body. With urgent desperation she called me back into Brian's room.

I found him, eyes rolled back and his lips mauve. The four liters of oxygen surging into his nose profited only an 85% oxygen saturation. I rubbed his sternum with my fist and he woke up, his lips regained color and his saturation returned to 95%.

"Do you have more pain medicine?" he asked.

"What just happened?" His mother seconded.

I stepped backwards towards the curtains to take in Brian and the monitor showing his decompensation.

"Don't leave, Tim!"

"I won't. I am not sure what happened, but we will watch closely."

His mother mumbled, "I should not have traveled with him, we shouldn't have flown, we should have stayed at home. I did this to him."

"Mom!"

"Ma'am--"

“Mom! Can you move my pillow? I don’t want to be admitted,” Brian hazily interjected, “I know what it is. I know why I am sick.”

I explained to his mother, he just zoned out for a minute. It looks like he is better now. We could watch his monitor from the desk. “Just say my name and I will come back in.”

45 minutes, just five minutes more than it took to find my lunch, 10 more minutes and I will have sat to eat it. In 15 more minutes Brian’s primary nurse would be back from his break and able to help out.

Fewer than ten minutes before Edward was supposed to return from his break, Brian died for the first time.

“Tim! Tim! Brian!” His mother begged for help.

In the room I found Brian, lips blue and still. I called out his name and his eyes opened.

“What’s happening?” asked Brian, sounding as if he had awoken from drunken stupor.

“This is not right,” his mother said.

I grabbed another bag of fluids and cycled Brian’s blood pressure: 78/50, O2 saturations: 88%, heart rate: 125.

And then Brian died a second time. He was unresponsive for no more than 20 seconds.

Awake again, now of his own volition, he calmly looked around the room, strangely new to him.

“I just want to know if I am still here.”

“Yes, Brian, you’re here in the hospital.”

“OK, then can mom be in bed next to me. I just want her here.”

Brian never asked for pain medication again.

"That's all I want, just my mom here."

The room increased from the three of us to eight. His mother had the countenance of a statue, a roman goddess, calm but ferocious. She held his arm and he fogged up the non-rebreather oxygen mask on his face.

"We need antibiotics."

"Renal dosing!"

"Page pharmacy!"

"Page oncology, get the dose."

"Page the PICU."

"Call the manager."

"Do we need respiratory?"

"Page respiratory!"

In fewer than two minutes we had to paged all teams and moved Brian into our resuscitation bay. In a period of time when so much rapidly occurs, it feels as if useless, precious minutes pass.   After we rolled the stretcher into the larger room, Brian shot up in bed, his skin translucent, and asked again, "What is happening?"

58 minutes since arrival.

I asked a security guard to close the door to the room, in which was sealed a primordial wail from Brian's mother as he again went unconscious.   We brought a wheelchair for her to sit at the foot of the bed.

Another fleeting moment of coherence and Brian sat up one last time; he asked for his mother.

"I'm here Bri!"

"I can't breathe. What is going on? "

"I'm here, baby. "

His eyes closed gently; he stopped breathing.

"Oh my God, oh my God, my God!!" Brian's mother spit as she grabbed a resident, "He's not breathing!"

His face was blue, but he had a pulse. I began to attempt to oxygenate Brian with a bag valve mask. I squeezed the bag looking for pink in his skin.

One hour and 10 minutes since arrival.

"We need anesthesia."

"Do you have chest rise?"

"Heat rate? Pulses?

Brian's mother interjected, "Don't leave him!!!!"

"We need social work."

"Where's pharmacy?"

"What is our access?"

Brian's mother leaned over him up as if to lift him off the stretcher to take him to another hospital, "Oh my God! Do SOMETHING! Help him!"

"We need to intubate."

"Where is anesthesia?"

"Get RSI meds!"

"We don't need meds!"

"Heart rate?"

Brian turned purple.

“We need to intubate now.”

“Where is anesthesia?”

“We’re here.”

Four more people entered the room, a white whoosh of long coats. One anesthesiologist took the bag from my hand and placed his hand over my own.

“We’ve got this. You can let go now.”

In this moment, I cannot let go. I think of the gentleness with which we aspire to treat our patients, while anticipating the violent pounding upon which we are about to embark.

Brian becomes *the patient*, he loses his name. With new providers in the room, fewer people know him. He will soon become *the code*. I reassess what my next role will be and Brian’s mother yells, “Tim, don’t leave him!”

Edward flanks the door to the resuscitation room, he is five minutes late coming back from his break. He is horrified that the patient he left under my care is dying.

One hour and 15 minutes.

I ask the anesthesiologists as they depart, “What sedation did you use for the intubation?”

A gloomy response, “None.”

Brian’s pulse rate went from 130 down to 70 in mere seconds; and then the rate was 30 and the pulse became impalpable.

“Start compressions.”

One thing worse than the sound of chest compressions being done is the sensation of starting them. The first person to initiate compressions, needing to violently sink the sternum

low enough to squeeze the heart at a rate of about 100 compressions per minute, feels the texture of cracking ribs, separating tissue from bone. It feels sickening. It feels inhumane.

His mother groans, a miserable soundscape for the now otherwise silent room. Chasing her groan is a fleshy *thud* of the compressions.

Thud, thud, thud, thud thud.

Two minutes pass. Pulse check. Nothing; change providers, administer epinephrine and continue and repeat.

Two more minutes, repeat.

Two minutes.

The room is packed with medical onlookers, well intentioned buzzards wanting to do something, wanting to be a part of this tragic experience.

2 minutes, and repeat.

A rhythm evolves. The crush of compressions is softer now as Brian's chest wall has been broken from the trauma of our efforts to keep his heart moving. There is an ominous spaciousness in the room.

2 minutes.

I step from his body to check in with the staff managing the rest of the ED, for just a moment, but before I can get far: "Tim! Don't leave him! Don't let him go! Don't!"

In that moment, I realized that mine was the only name Brian's mother knew. In the flurry of sickness names get dropped, providers hustle in and out rooms not introducing themselves to the parents left suffering in the corner. There was nothing I could do in that moment that would improve Brian's case any more than any other provider, but his mother knew my name.

"You can't let him go!"

She was a lioness. She roared, but then turned ghostly pale and slumped into the wheelchair.

"Get her an oxygen tank and nasal cannula."

One resident ordered, "Take her out of here, make sure she's OK."

The attending physician interrupted, "No, she needs to be here for this."

Brian's mother opened her eyes "Please, please, don't let him go." She pleaded with a voice not louder than a whisper.

Two minutes.

A phone rings. His mother shrieks with a second wind of sorrow. She is unable to tell Brian's father that his son is dying. Our child-life specialist asks if I could speak with him to explain what was going on. Having just completed another round of compressions, I welcome the chance to step away.

His father was calm, his voice flat, hundreds of miles away.

"How is he doing?"

"Brian's not breathing on his own right now. We are doing everything we can to keep his heart going. He is very sick…"

"Will he be OK?"

"We are doing CPR; his heart will not beat on its own."

I knew I needed to say that he would not be OK; that it is very likely Brian would die.

"Sir, even though Brian is very sick, he might still be able to hear what you say if you want to talk to him."

"What do you mean?"

"Brian is unconscious right now, he cannot talk, he's not moving. But he might be able to hear what you say if you would like to talk to him. I think that would help. I can put the phone next to Brian's ear and you can say whatever you like."

I wish I could have said, *you need to say goodbye to your son.*

I squeeze between the nurse performing compressions and the resident in line to go next, I squat by Brian's left ear and then into the phone tell his father he can start talking.

The only audible words I heard were, "Hey Brian, I'm here, buddy…"

After some time, immeasurable, time that was not charted, I brought the phone back to my ear and found silence.

"Sir?"

A sigh, "Yes."

"Do you need more time?"

Silence.

"No."

Brian's mother lays her head upon her hands, her face bright red: "He's dying…he's dying."

2 minutes.

2 minutes.

The nurse recording this event, marking each two-minute time period was weeping.

The attending took the penultimate step asking, "Is there anything else we can do?"

Silence.

Each team member made eye contact with the attending physician and other care providers in the room. The sound of compressions was now overshadowed by the squeak of the stretcher at 100 beats per minute. The attending spoke:

"Ma'am, do you want to come next to him and be closer?"

His mother was wheeled over to his right side.

"You can touch him or hold his hand if you want," The attending began, "We have tried everything we can. We are going to stop doing CPR now. Do you understand?"

Brian's mother leaned over him.

"My baby."

We stopped compressions and turned to the monitor, with a hope that Brian's heart would continue on its own. And it did, but his cardiac rhythm reflected a chemical response to the pressers we had injected into his body, not a life-sustaining pulsation. His heart trembled down to 25 beats per minute. I turned off the monitor to stop the alarms from sounding.

We turned off the respirator.

Kuh- kuuush.

Kuh-kuuuuuushhhhhhhh.

*   *   *

It is now around 5:00 pm and our emergency department is packed. I face 20 or more patients needing to be seen. There is a new patient in room three watching the "Sponge Bob Squarepants" DVD on repeat. Other than Edward and myself, no one else has taken a break today.

My charge nurse asks, “Are you OK?”

She is not.

I lie to her, “Yes.”

“OK, then I need you to go back in and chart the event. You need to finish that before 7:30.”

The rushed blur of the following two hours incapacitated my sense of time: administering medications, reassuring parents that their children would be fine, apologizing for delays in dispositions, absorbing complaints and consoling other team members with a quick hand on the back or half-hearted, “You doing OK?”

Amidst it all, we find time to place Brian’s body in a white plastic bag. And after that I was requested to sit with his mother who sat in a “quiet room.” We held hands; she was nearly catatonic.

“What just happened? Why? What did I do? Did I do this to him?”

We sat silently.

“You gave him what he asked for, you never left his side.”

Thirty more minutes in the shift, and then nighttime. Time to eat, sleep, return to the world of the living, concerned about manicures and what to wear. Tomorrow will come, time will pass, and then repeat.

Tim is a pediatric emergency nurse, Assistant Professor of Nursing at the University of Virginia and the Assistant Director of UVA's Compassionate Care Initiative. He holds a joint appointment at UVA's Department of Drama and sits on the board of directors of Clowns Without Borders-USA.

© 2016 *Intima: A Journal of Narrative Medicine*