

Humanity in the Bays

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As a medical student, one of my goals for every rotation is to seek out the toughest situations, the conversations that are the hardest to have, and lean into those situations. I am seeking to file away those intangibles that people either do well or poorly so that in my chosen field of emergency medicine, I will be developing my ability to support people even if only for a few minutes while our paths cross in the emergency room. Some days, I don't choose to lean in - I just find myself enveloped in difficult situations by chance.

During a recent day in the emergency room, an overhead announcement alerted us to a cardiac arrest that would be arriving shortly. I found the resident who would be running the code and asked if I could participate as the trauma service was currently quiet. The resident agreed. Meanwhile, the attending stepped out to get an update on the call-in and came back announcing, "they are about 30 seconds out", and then a pause... "and guys, we might know this one."

Amidst the familiar swishes of blue plastic gowns being pulled overhead and gloves tugged on with muscle memory, the bay was buzzing with worry and hoping that the attending was wrong. Thirty seconds later, EMS came striding through the entrance. A split second later, the stretcher turned into the bay, and we all could see was our patient's face. A face that was already deeply blue and cyanotic, lifeless, but one nearly everyone in the bay recognized. It was an employee of the emergency department, a young guy - too young to be coming into the bay on a stretcher with a "non-shockable rhythm" as the EMS provider quickly called out. At these words, one of the emergency techs immediately began sobbing behind her mask, but chest heaving, started her documentation nevertheless. The clock started. With no need for manual compressions thanks to the relentless drive of the Lucas, I stepped back and could see the jaws

around the room clenched. Lines were placed, medications were called for and delivered. Minutes stretched on. Twelve rounds of epi, narcan, bicarb, calcium - everything that was possible was given, but it was too late. Most of us knew it was too late before the code had officially started. Fifteen minutes in, the paramedic stepped in and asked if our patient's mother could come in. She was an ER nurse at another hospital he explained, "she won't be in the way." It goes without saying that she wanted to be with her son, perhaps to let the grieving process begin or maybe to offer hope in closer proximity. Those who had heard his request looked at the senior resident and attending, neither of whom had any color left in their faces as they were facing the monumental decision of whether to end the code while making a decision about having the mom at bedside. The attending nodded to the paramedic.

The code continued as she came in. She knelt on the littered trauma bay floor and grabbed her son's hand. The EMS paramedic pulled in a chair, and stayed there, leaning over her with his arm around her. It was an incredibly touching moment of humanity in the face of the relentless clinical activity of the code to see two people holding tight, one in grief and one in support. Fifteen long minutes later, there was still no shockable rhythm and no heart activity. Faces more drawn more than I've ever seen, the resident looked to his attending, and the attending looking to the patient's mom. He asked her if she wanted us to keep going. She had seen this before, had been in similar rooms, and knew we had reached the end of our options. She agreed for the code to end.

Time of death was called, and the attending's voice cracked as he said "I'm sorry" through the mom's renewed sobs. The trauma bay doors opened and his stretcher was pushed to a clean room where the photocopied and laminated picture of the lily was placed on the door, and thirty people stood in the hallway, contemplating the news that we were losing one of our own.

Half an hour later, drawn faces were jolted into action as the trauma pagers went off. “12-18mo, other” read the page. As the team hurried off to the pediatric bay, there was confusion about what ‘other’ meant. Passing our earlier patient’s mom in the hallway, all I could do was murmur a quick “I’m so sorry” and keep moving. I pulled on my gown and chatted nervously with one of the lifeflight nurses trying to put on a happy face when EMS showed up with our new patient. “Other” was not an accurate description; assault was what the toddler had faced. This toddler was covered in bruises and cigarette burns, and bore all the hallmark signs of non-accidental trauma. He cried throughout the exam, quieter than what would have been expected, and we soon found his frenulum had been torn, likely from having been slapped on the mouth from crying. Faces were drawn tightly again as we walked through the protocol, moving as quickly as we could to stop bothering this child who had already been through so much. One of the residents, in a flash of inspiration, grabbed his phone, and was able to quickly pull up the *Papa Troll* video his children had been watching earlier that morning. Our patient quit crying, and we finished the exam feeling terrible, holding this child down to take pictures documenting the extensive injuries. Eyes that had previously shown how awful it was to be witnessing this particular trauma softened as he snuggled his head into one of the nurse’s shoulders the moment we were finished and could let him up.

The day went on. More pages came in. Level 1, level 2, level 3. Patients continued to be seen and treated in the pods. Everything felt heavier that day, and I wondered if patients would notice the malaise just below the surface of the department. Leaning in that day felt like falling in. However, I will always remember teams of people doing their job no matter how much their own hearts were broken - a paramedic holding a mom tight, an attending asking a mom’s

blessing to end a code, and the sounds of *Papa Troll* comforting a quiet, bruised baby, as the best of humanity in the bays.