Bread and Butter

Category: Stories
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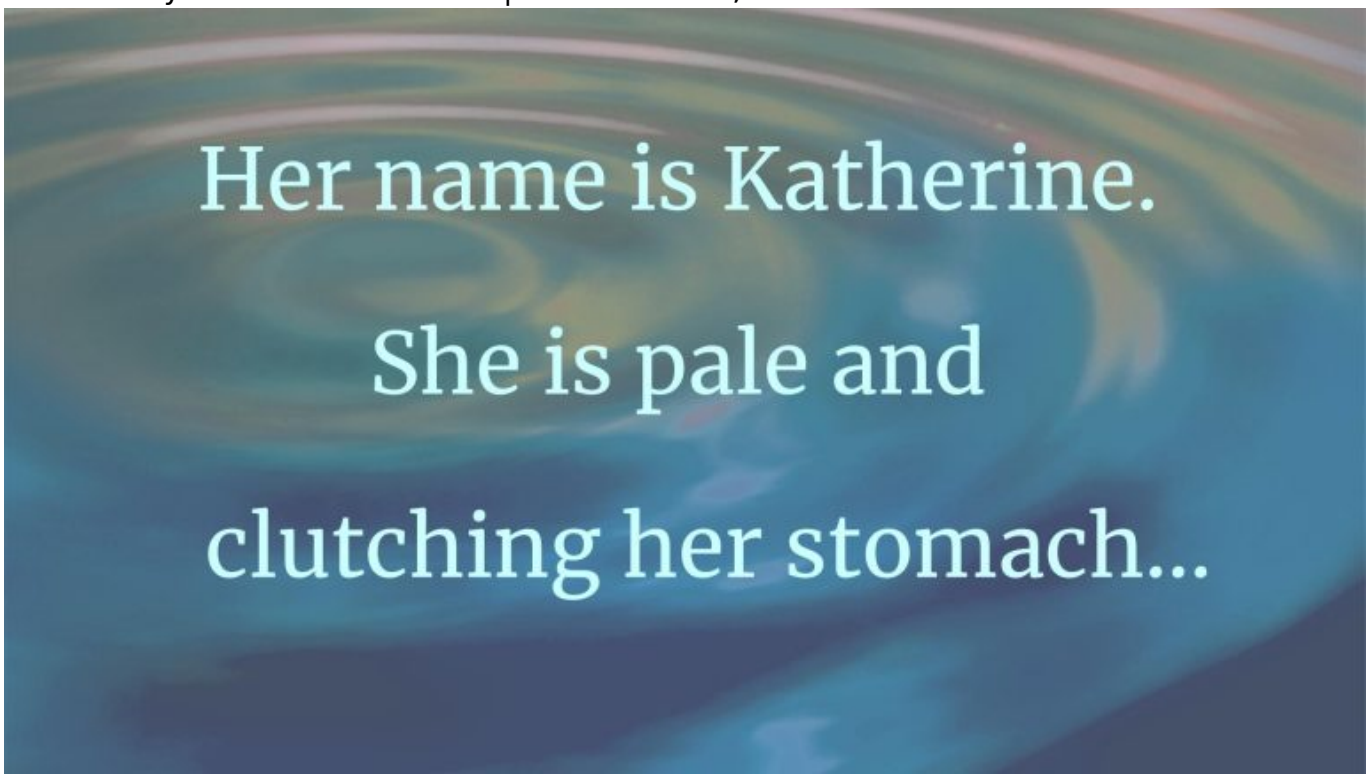

Shattering the relative peace of an early Sunday morning, a chorus of assorted ringtones echoes through the emergency department where I work as an attending physician. The noise is a heads-up from an incoming ambulance, directed to the ED staff members' portable phones.

I sigh and set down the cup of cafeteria coffee I'd been enjoying: The pace of the day is about to pick up. I unclip my phone from the waistband of my scrub pants. Sitting next to me, Ben, the senior resident, grabs his phone from the pocket of his fleece vest.

We read our respective screens: "ETA 5. 22 yo F, AP and syncope. BP 80/palp."

The incoming patient is a young woman who had abdominal pain and passed out; her blood pressure is dangerously low. She's arriving in five minutes.

My eyes meet Ben's.

"Ruptured ectopic?" he asks.

"Until proven otherwise," I answer, using one of emergency medicine's most frequently invoked catchphrases. Like our other favorite, "Think worst first," it reflects the mindset that everyone is dying (or about to die) of something catastrophic until you can prove that they're not.

"Let's go get ready in critical care," he says, and we push up out of our chairs and head to the resuscitation bay.

A few minutes later the patient arrives. Her name is Katherine. She is pale and clutching her stomach. Her heart rate is fast, and her blood pressure is still low. She felt fine until about thirty minutes ago, when she suddenly had really bad stomach pain and passed out. No medical history. No trauma. Last menstrual period? Not sure; she's always pretty irregular.

Everyone in the room falls into their given role in the complex choreography that surrounds the bed of a critically ill patient. A tech applies a monitor, and two nurses get to work on IV access, one at each of Katherine's arms. Another nurse telephones the blood bank, and minutes later a tech who'd been sent as a "runner" through the green-grey corridors of the hospital basement returns with two units of uncrossmatched blood.

An intern rolls in an ultrasound machine and looks into Katherine's abdomen: It's full of blood.

Ben alternates between calmly giving orders to the staff in the room—lab work, pregnancy test, pain medication, intravenous fluids, blood transfusion—and kneeling next to Katherine to speak gently to her, telling her what's happening and what we're worried about.

"I'm glad you're here," I hear him say. "We're going to keep you safe and take great care of you."

My own heart rate is rapid with concern for this critically ill patient, but I feel confident that all the right wheels are in motion. I busy myself making phone calls while keeping one eye on the monitor's squiggling lines and flashing numbers.

I start with the ultrasound tech: "We need you to come STAT. It's a suspected ruptured ectopic; she's too unstable to go over to the radiology department."

Then I contact the gynecology resident. "Here's the clinical scenario: I don't have any test results yet, but this patient is sick, and we need you at the bedside."

Both of them appear within minutes.

Labs are cooking, blood is infusing, Katherine looks a little less pale and the monitor's flashing numbers have improved a bit. The pregnancy test comes back positive, and the ultrasound tech points to the screen of her machine: It's an ectopic pregnancy, implanted outside the uterus on the fallopian tube—as we'd suspected.

The gynecologist is calling the operating room to get a room ready. The nurses are hanging a second unit of blood. Ben crouches at the head of the stretcher, talking to Katherine, his tone comforting and confident.

A few minutes later Katherine is wheeled off to the OR, and I move on to the waiting patients who have stacked up while we took care of her. An hour later Katherine is recovering in a hospital bed, and I'm interpreting an EKG while simultaneously talking on the phone with an inbound EMS crew whose patient has atrial fibrillation.

The next day Katherine goes home to continue her recovery, and I'm back for my next shift.

So much about Katherine's emergency was "easy." She lived in a location with a functioning EMS system and within a short drive of a hospital that, in an era when many hospitals are closing their obstetrics departments, could get the right specialist to her bedside within minutes. Her presentation was "textbook," so reaching the correct diagnosis was straightforward. The necessary resources were available, and the OR had a room available. There was no difficulty with intravenous access or a blood shortage or a language barrier. It was the kind of case that a medical student rotating through the ED might be asked about on the end-of-rotation written exam, or that a newly graduated emergency-medicine doctor might encounter during the oral board exam. Everything about this case was "bread-and-butter" emergency medicine.

And yet…

Ruptured ectopic pregnancy is a top killer of pregnant women in their first trimester. The care that saved Katherine's life was remarkable.

Caring for critically ill patients like Katherine is all in a days' work for the ED staff, and it's tempting to minimize the experience as "just part of the job."

As Katherine was wheeled out of the critical-care bay that day, and I saw the team begin to turn their attention to the next task, I realized that I didn't want to let them scatter without acknowledging that their work, which felt routine, was in fact exceptional.

So I spoke up:

"Hey, everybody, before you all rush off, I'd just like you to take a moment to feel proud of the work we just did. Thank you all so much."

Bread and butter or not, a life had been saved—a job well done, no matter how you look at it.