2:00 am

Category: Stories
written by Katie Lin | February 5, 2016

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It’s 2:00 am, and the fluorescent bulbs flicker gently overhead along the quiet hallways of the intensive-care unit.

Tonight I’m the ICU resident on call, and the weight of that title sits heavily on my shoulders. My team is in charge of keeping our critically ill patients safe from harm overnight. Although the supervising physician is only a phone call away, I’m the acting team lead for any codes called during the night on patients elsewhere in the hospital who may need our life-support services. Code Blue: cardiac arrest. Code 66: anything else requiring assistance.

The metronomic beeping of the life-support machines keeps time as I blink the weariness from my eyes and share a few muted smiles with the nurses who work tirelessly alongside me while the rest of the world sleeps.

Then the call comes over the intercom: Code 66, unit 74, Highwood Building.

We fly into action—a rush of wrinkled scrub tops, stethoscopes and coffee breath. The elevator ride up to the seventh floor is interminably slow; it’s rendered all the more surreal by the number of people crammed clown-car style alongside the crash cart, and by our jesting banter, born of shared exhaustion. But when the doors open onto our destination, we’re all business.

We can tell from the moment we walk in that this is a tragedy unfolding.

Mr. Smith is a seventy-nine-year-old man admitted for shortness of breath, otherwise healthy. Expected length of hospital stay: two to three days.

That’s when the story goes downhill.

He fell a few hours ago and bumped his head on a ledge, report the nurses, but he seemed to be doing okay. Sure, he was a bit confused, but he shook it off and went back to sleep. Now, as the nurses try to rouse him for his routine vital-signs check, he won’t wake up.

In fact, as I quickly evaluate him, I realize that he’s very nearly brain-dead. His pupils no longer react to light. He has lost most of his reflexes. He doesn’t respond to any form of stimulation.

Every step we take is calm, cold and clinical. He requires intubation for airway support: He’s intubated. He requires a CT scan of his head: He’s rushed to the scanner. His family must be notified: They’re on their way.

By phone, we inform the neurosurgeons and our supervising physician of the

situation and transfer Mr. Smith to the ICU for further management.

The only surprise in his CT scan is how extensive the damage is. The bleeding has unceremoniously displaced the rest of his brain in a process that will slowly take his life throughout the predawn hours.

The neurosurgeons tell us there's been too much damage for any meaningful intervention to take place. My supervising physician tells me that she will see us in the morning. She instructs me to keep him alive as long as I can—hopefully until his family has had a chance to say their goodbyes.

Then the phone goes silent, and I walk down the hall to tell a roomful of hopeful strangers that there's nothing more we can do to save their loved one.

In medical school, they teach us how to break bad news. There are rules and etiquette that help to ease the process for families. But we're never taught how to keep our own raging, desperate helplessness in check at moments when we realize that modern medicine cannot stop a life from slipping away.

Experience has taught me that the stages of grief are messier and more heart-wrenching than any textbook could possibly convey.

First, there's denial.

"I don't understand. We were told just yesterday that he would be coming home soon."

"If we could fly him to the Mayo Clinic, do you think they'd be willing to operate on him?"

"Are you sure you're old enough to be a doctor?"

Denial, I've learned, is best countered with patience, Kleenex and truth.

Next comes anger. This is what happens when overwhelming sadness descends for the first time, but doesn't yet have anywhere to land.

"How can you just let him go like this?"

"We don't have time for this right now! You need to do something!"

"Don't you realize that his children and grandchildren need him? *I* need him…."

More patience. More Kleenex. And more truth.

Then comes bargaining.

Bargaining is hard, because saying no to a desperate loved one feels unbelievably cruel.

"Why can't we just do the surgery and see what happens after?"

“Are you sure there are no neurosurgeons in the city who would try?”

“I’m sorry, but…” is how most of my responses begin. The bargaining stage usually ends when families are brought to the bedside to see what life support really looks like.

Sadness comes next. Surprisingly, this is actually one of the easier stages to manage, because it is the one that most accurately reflects how we, as physicians, feel when we are helpless in the face of a patient’s death. I offer a few hugs before making my exit—an exit intended to give myself a moment alone to breathe and reflect as much as it is to give the family some privacy.

Finally, there’s acceptance.

For me, this is by far the hardest. I can take rage or criticism in stride, because I know they’re not really meant for me.

It’s the kindness that I find so incredibly hard to accept when I feel I’ve so utterly failed.

Several hours have passed since I first walked into the room with Mr. Smith’s family. The talking is winding down; I manage to slow the bleeding with specialized blood products and clotting medications in order to protect what precious little is left of his brain until they’ve said their goodbyes. The morning crew begins to trickle in.

And then Mr. Smith’s wife and son turn to me.

“Thank you,” they say. “We’re glad that he had someone with him for his last hours. We know it’s been such a hard night for you.”

They don’t get to see it, but it’s this kindness that makes me curl into a ball when I finally arrive back home at the end of my shift. As I lie drifting to sleep in the dark safety of my room, that moment replays again and again in my mind. It nearly breaks me.

And then 6:00 am comes again. I put on a fresh pair of scrubs, sling my stethoscope around my neck and embrace the inevitable coffee lineup. My tears have been traded in for a fresh, albeit unsteady, smile.

Sometimes, it takes a lot of effort to remember that this job is worth it.

As I walk past Mr. Smith’s room—his bed now occupied by another critically ill soul—the thank-yous still echo in my mind, but they begin to feel less hollow. They represent a moment shared, a life remembered and the human connection that runs deeply throughout these otherwise sterile corridors.

Sometimes, it just is. Worth it, that is.

About the author:

Katie Lin is a second-year resident in emergency medicine at the University

of Calgary. This is the first time she has ever written a personal piece about her medical experiences. Mr. Smith’s story was written the morning after his death. Despite her initial hesitance, Katie was encouraged to publish this piece by colleagues who have had similar experiences. “The culture of medicine continues to shift away from the unyielding stoicism of tradition and towards a more accepting, patient-centered form of care. I hope that by sharing this story I can help to chip away at the hard-held attitudes that have forced so many physicians to keep their emotional burnout hidden away. We all have vulnerable moments, and there is no shame in our shared humanity.”

Story editor:

Diane Guernsey