THE BLOOD OF STRANGERS

Stories from Emergency Medicine

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"I DON'T THINK ANY OF US HERE seriously expect this man to survive," the attending said every morning when we reached room 6. We expected the remark. The intern would begin the presentation, and it was always the same.

"This is ICU day 28 for Mr. Johnson, a twenty-six-year-old cowboy with pneumonia, sepsis, respiratory failure, renal failure, and anemia . . ." A detailed analysis of each problem, in descending order of severity, then ensued. He was growing steadily worse. The ventilator had been at maximum settings for weeks, supplying the man's ruined lungs with just enough oxygen to ensure another identical presentation the next morning.

"This is ICU day 29 for Mr. Johnson . . ."

"I don't think any of us here seriously expect this man to survive," the attending would say, and
we would move on, halfway through rounds and already worn out.

Mr. Johnson was a bullrider, thrown at a local rodeo, who had broken several ribs. He’d gotten up, dusted himself off, gone home, and over a few days he had developed pneumonia in his injured lung. His family brought him in nearly unconscious, with both lungs full of pus, and over the ensuing weeks his other organs also failed: liver, kidneys, intestines. He lay drowning in his own fluid, the fever unrelenting, his family gathering and staring at him. Over the past few days they had stopped coming, consigning him, it seemed, to his fate alone.

One night, more than a month into his stay, I was on call when his blood pressure began dropping yet again. The intern and I stood looking at him, swollen like a toad on the ventilator. He always tormented us like this.

“Give him some more fluids,” I said. “And let’s go up on his dopamine.” The nurse sighed; she’d heard all this before.

Listening to the ragged sounds of his lungs, I thought something had changed. His left lung sounded a bit quieter than it had the night before, an ominous sign. “All right,” I said, resigned. “Let’s get a chest X ray.”
The chest X ray had not changed much. Looking hard, though, the radiology resident thought he saw a slight difference on the left. “Could be a pneumo,” he said, “though I’m not sure. Let’s get a CAT scan.”

He referred to the possibility that air was leaking out of a hole in the lung, collapsing it. The treatment for this is minor surgery, done at the bedside. You cut into the chest between two ribs, insert a finger into the chest cavity, and push the lung out of the way. Then you slide a long plastic tube between the lung and the chest wall. When suction is applied through the tube, air and blood rush out, allowing the lung to re-expand. Mr. Johnson had been the victim of this procedure so often that his chest was a mass of wounds that refused to heal and oozed blood-tinged fluid into the bedding.

The intern and I looked at each other, shaking our heads. This meant hours of work, wheeling him with his ventilator and multiple IV drips down to the CAT scanner, waiting for the scan to be read, then putting in the chest tube and getting X rays to make sure we’d done it right. Any chance of sleeping that night vanished. It was already early morning, and we were tired.
“Looks like a pneumo, all right,” the radiologist said, pointing to the dark mass of air visible on the CAT scan. “A pretty big one. I’m surprised we didn’t see it better on the X ray.”

Mr. Johnson’s lung, by the time I finally cut down to it through the deep, soggy tissues of his chest wall, felt exactly like a piece of cork. It was stiff, as if already embalmed. “You’ve got to check this out,” I said to the intern. “Put on some gloves and feel this thing.”

For a few moments he felt around with his finger, then withdrew it, covered with blood, and held it instinctively up in the air. “Feels like a piece of meat,” he said.

The next morning we were reprimanded. “I think we should seriously consider the ethics of performing such aggressive procedures in this man,” the attending began. “I should have been called. It’s high time, in fact, that we considered withdrawing support altogether.”

There was a long silence. “He’s a young guy,” I protested. “And we’ve done it before. And it helped.” This was only marginally true. His blood pressure had come up slightly, but it was hard to know why.

About this time another attending came on the service, and for the next few weeks he alternated
call nights with his colleague. He had different views. “This is a young man,” he would say, when we reached room 6. “This is exactly the kind of patient we should be most aggressive with.”

A bizarre dynamic developed. On even days we did almost nothing, checked no lab work, stopped antibiotics and tube feeds, and nodded solemnly as the attending shook his head and said things like “The most important thing we can do now is keep this man comfortable.”

On odd days it was the full-court press. We worked to undo the previous inactivity, checking arterial blood gases, blood cultures, and X rays, adding antibiotics and fluids, tinkering with the ventilator. We nodded solemnly as the attending said things like “This man deserves everything we can give him.”

This went on for over a week, until my tenure in the ICU came to an end and I rotated back to the emergency room, leaving my nightly struggles with Mr. Johnson behind. I was glad; he had unfailingly robbed me of sleep, and I had come to dread him. I knew him intimately, had examined him dozens of times, turned him over to look at his back, put my gloved finger in his mouth, in his rectum, into the interior of his chest cavity, and I had never once exchanged a single word
with him. He was gone from the waking world, as nearly dead as a human being can be, lying at the edge but never quite crossing over, his body, his animal self just strong, or not strong, enough. I had hoped many times that he would die.

About six months later I was walking down the long hall back to the ER from the cafeteria. It was mid-afternoon, a slow day. The door to the pulmonary clinic was open as I passed. A few patients sat in plastic chairs, waiting for their appointments. In one corner, leaning casually against the wall, a man stood reading a newspaper. The paper obscured his face, but as he turned the page I saw it, and I stopped immediately. I felt a strong and sudden force. It took me a few seconds; I knew the man, I knew his face was significant, but I didn’t know why. Then I realized, disbelieving.

“Mr. Johnson?” I asked tentatively, stepping in through the clinic door.

He looked up at me from his newspaper.

“Are you Mr. Johnson?” I asked, beginning to feel foolish.

“Yes,” he said, looking at me suspiciously. “Do I know you?”

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