Phallucies of trauma care (or, Getting shafted on night shift)

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I was one of the first emergency medicine residents to fall into the clutches of our trauma service. At the time, the surgeons were intrigued and suspicious about this hokey new specialty of emergency medicine; therefore, they scrutinized my every move. Or so I thought. It was the glory days of trauma — the pre-Haldol, pre-sedation, big line, MAST pants era, when RSI meant Really Sweaty Intubation — the days when vocal cords were a moving target, and leather restraints and a security guard were essential intubation equipment. And the hospital had flare: there was a greasy spoon serving fries with gravy at midnight, and a burnt-out schiz living in a sleeping bag down near x-ray (you could call it that then). Rumour had it that his wife died during a routine operation and the hospital didn't have the heart to kick him out. Either that or he was the surgeon who botched the job.

I was fresh from medical school in New Zealand, armed with false bravado and an unusual vocabulary. I was two weeks into this "wonderful educational opportunity," but the 1 in 3 felt suspiciously like 24:7.

It was 11 pm Saturday night and I was feeling the heat. My problem was chest-tube envy. I'd done just about everything else with the 16-gauge needle and strong arm referred to in Shem's *House of God*. Even burr holes hadn't escaped me. But despite my eternal presence and steely nerve, a chest tube had not yet graced my latexed palm. And thanks to endless glib reminders from the senior surgical resident (SSR), this had become a standing joke with the attendings.

Then suddenly it happened. The ED doors burst open and in came 4 sweaty paramedics pushing two 19-year-old multi-traumas. After tuning out their ethanol-induced diatribes, I saw that their respiratory patterns suggested acute chest tube deficiency. I sprung into action. Moments later, after rapid primary surveys, I determined that they were indeed deficient, to the tune of one apiece.

"The chest tubes are mine!" I screamed, as the trauma team burst in. (The trauma team, circa 1986, consisted of a family medicine resident, two rotating interns, a friend of theirs and a dermatology resident from Poland who was enduring his purgatory in the burn unit.) Frantically, I gathered my equipment and looked over at the saviour of my professional credibility — the soon-to-be recipient of a virgin chest tube — who was now muttering rude remarks about my mother's wardrobe and cursing the 68-year-old security guard sitting on his chest. The patient struggled gamely but the guard prevailed, despite advanced COPD and exertional cyanosis. With a sustained stridorous crow and a triumphant expectoration, he announced, "All yours, . . . (wheeze, hack) Doc! (cough, gasp)."

Trembling but confident, I approached the bedside, armed with a number 15 scalpel and "the tube." Before taking the plunge, I glanced over my shoulder to see what blessed souls would witness my pleural baptism. There, to my dismay, stood the senior surgical resident and two attendings — haggard and blood-stained after a 6-hour battle with an aneurysm. My fine tremor became coarse, and my resolve disintegrated as fast as my first episiotomy sutures. Nevertheless, I forged ahead. Scalpel through to the rib, tunnel up a space, pop through with the Kelly, a quick finger sweep, then in with the tube. Almost!

My patient's blood alcohol level of 67 was enough to slow but not block intercostal nerve conduction. Just as I was poised to advance the tube, his addled brain received the delayed but intense pain messages from his chest. He arched and screamed! "YOU TRUCKER!" (or words to that effect). Then he grabbed the bedrails and squeezed as hard as his muscular forearms could squeeze.

Now it happened that I had lowered the rail and was hunched over the side of the bed, so that when he attempted to grab the bedrail, he in fact grabbed me. More precisely, he grabbed a tubular part of me that, at that instant, bore little resemblance to a bedrail. Then he squeezed. Hard.

They say participants experience catastrophic events in slow motion. I don't know about the future nuclear physicist lying on the bed, but for me, the moment was frozen right out of Shakespearean tragedy. It was a standoff — two gladiators locked in mortal

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combat. I had him, and he had me. My left index finger was deep in his chest, and his right fist clutched my ability to sire future generations. It was Capulet and Montague, St. George and the Dragon, Ralph Klein and the Canada Health Act. All this flashed by in the instant that it took my own pain impulses to traverse the pudendal nerves and reach my brain.

I screamed. "You trucker!" (or words to that effect). Then I rammed the tube toward his cerebellum, by way of the right pleural space. Fortunately (from a medicolegal standpoint), it stopped conveniently at the lung apex and did not doom him to the life of slurred speech and ataxia that I intended.

This stunning assault on his pleural space caused him to release my nightlife. I disengaged and sewed him up in a flash, all the while resisting the desperate urge to drop everything and rush to the loo to inspect the damage. When I finally slunk out, I bumped into the SSR (grinning like an idiot) and one of the attendings, who'd seen the whole thing — or thought he had.

"Well, Huber," he chuckled, "you finally did it. That was the fastest chest tube I've ever seen. You really had balls to ace it when he was yelling at you. Next time, go a little easier on the insertion though."

I grinned weakly, confidence in my "balls" somewhat shaken.

Later, back in the trauma room, one of the nurses approached, jabbed the trauma flow-sheet at me and said, "Dr. Huber, would you mind putting your John Henry on this?"

She probably never understood why I panicked and ran. You see, in New Zealand, "John Henry" refers not to a man's signature, but to his . . .

Since then, I've done many chest tubes, but none as slick as that first one.

Or as dangerous.

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I Am a Canadian Doctor

(A tribute to Canadian medicine inspired by the "I Am Canadian" commercials)

I'm not wealthy, or golfing on Wednesdays. I don't enjoy health politics,
and I don't know Dr. Doug Ross, Dr. John Carter or Dr. Kerry Weaver from ER,
but I'm sure they all make much more money than I do.

I enjoy helping the sick and I speak medical lingo sometimes without realizing it.
I enjoy medical trivia,
using Greek and Latin words when I could easily use layman's terms,
and rereading *The House of God*.
I believe in universal health care, but realize that it cannot continue in the current medical paradigm.

In medicine, the patient comes first.
I can speak authoritatively on countless medical conditions,
yet I can't recall the basic sciences. And maybe I can't read my own handwriting,
but at least I know
what I mean to have written.

Because Canadian medicine is still the best medical system in the world.

The home of Banting & Best, Norman Bethune, and William Osler.
The profession where despite frustrations in health politics and underfunding,
medicine is still practised at a world-class level.

My name is Doctor and I am Canadian. I toast to your health!

— Benjamin Barankin
3rd year medical student, University of Western Ontario,
London, Ont.

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