REFLECTION

I'm a Doctor. Can I Help?

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ABSTRACT

Medical school does not prepare trainees for the reality of the practice of medicine, where book knowledge takes second place to the more pragmatic skills of time management, conflict resolution, and damage control. Junior residents, overwhelmed by the demands of daily floor work, can easily lose sight of the reasons that they went into medicine to begin with. Taken out of the context of the hospital, though, the opportunity to care for a patient one-on-one can be a vital reminder of the gift that is to know how to heal the sick. Reflecting on the opportunity to care for an accident victim at the scene, rather than in the hospital, reinforces to one young physician the remarkable thing that it is to be a physician.

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My first year as a resident would probably be familiar to any medical trainee. It was a study in contradictions: boring, except that any given moment has the potential to become a life-or-death situation in a second. Satisfying, except that much of the time you're miserable; tragic, yet often very, very funny. You're tired to the bone, but unable to sleep. Trusted with the lives of your patients to a fault, but not with office supplies. Making just over minimum wage, but able to spend tens of thousands of dollars with the click of a mouse and never see the bill. It wasn't long before I felt that I might have made a terrible mistake in dedicating my life to medicine, deluded by the belief that I would be a healer when in fact I was a widget in a vast and flawed enterprise.

By the Spring, I had almost resolved to call it quits. With a week's break, I flew to San Francisco to visit an old friend and talk to him about the possibility of leaving medicine. We took a drive north, and it was on a California highway that I reclaimed purity of purpose in an hour of simple doctoring.

It was March 2006, on a road between 2 cliffs, winding down toward a pristine Pacific beach. We had followed the coast with no fixed destination in mind, making a series of changes to our itinerary as the day wore on, and toward sunset found ourselves at Point Reyes, a scenic bluff with steep switchbacks leading down to sandy beaches. We came to a fork, went left on a whim, and found a body lying in the road.

A young woman bicyclist had fallen on a steep grade, her un-helmeted head slamming into the curb. A large flap of her scalp had been avulsed, and the skull underneath was clearly fractured. Her mangled bicycle lay a few feet down the hill, in the path of a small river of blood that ran from her head onto the road. She screamed and fought with a man who had stopped ahead of us. He was trying to stop the bleeding with a pack of napkins.

I had read about the phenomenon in head trauma known as the lucid interval. In the immediate moments following a severe blow to the head, the patient loses consciousness from the initial impact. Then, before the swelling and bleeding into the fixed space of the skull compresses the brain, usually from the high pressure of a bleeding middle meningeal artery with associated epidural hemorrhage, patients often wake up, and can seem almost normal. As the pressure builds, though, they lose con-

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sciousness again. It's a sign of an acute increase in the pressure within the skull, impending herniation, and, untreated, death.

In the Emergency department, I'd heard reports from the paramedics as they brought in horribly injured patients to the ER that the patients had—amazingly—been awake at the scene. But by then, the patient had been packaged—IVs in both arms, a tube in the airway, clothes removed—their individual circumstance reduced to a set of physiologic criteria for us to objectively measure and modulate. Our patient that day was speaking, seemingly aware of the world around her, and yet it was clear that something was very wrong. Soon, the lucid interval passed, our patient lost consciousness, vomited, and obstructed her airway.

In this era of medical specialization, much is made of the importance of highly trained, siloed specialists in taking care of patients. But the team that happened to save our patient's life on that lonely beach road was a testament to generalists and spirited improvisation. In my car was an experimental physicist, who quickly fashioned a spine stabilizer from a hammock, and a Russian literature professor, who held our patient's hand and reminded us, quietly but firmly, of her humanity. We were joined, in time, by a ranger with a truck full of supplies and a radio, a passer-by to hold pressure on her gaping head wounds, and a motorist with a well-stocked first-aid kit who declared himself my "orderly and scrub tech" and slapped gloves into my hand with laudably surgical precision. There was a surfer who made it his sole mission to assess whether our patient was showing any movement, any movement whatsoever, in her toes.

For the first time in my experience as a physician, there was no intrusion of another ambulance full of injured, no pager ringing me to a hundred other obligations, no 30-hour workday. There were just 8 people under a clear blue sky, with the sound of waves and gulls in the silences we shared as we waited for the helicopter. We were 8 strangers bound by our common humanity to another stranger who needed help.

As a doctor, my obligation to our patient was no greater and no less than anyone else's on that highway. Still, for all the frustrations of my job, all the bureaucracies and the time pressures and the feelings of impotence and impossibility that obscure the true mission of medicine, for all the sad realizations that this is the only patient all year whose name I will be able to remember, I knew what to do that day. Start with the ABCs: Airway: get the oropharynx cleared with a finger sweep and open the airway with a jaw thrust. Breathing: she wasn't. Arriving medics had a bag valve mask and took over breathing after I assured that we had a good seal and bilateral chest rise and breath sounds. Circulation: with the medics handling the airway, I placed 2 large bore IVs. Disability: absolute attention to cervical spine precautions, and once we had the spine stabilized, getting her feet pointed downhill to minimize blood pooling in her head. Exposure: warm blankets from nearby cars, and then, thankfully, a warm ambulance called by the ranger. They said it would be a 45 minute drive to the hospital. I asked them to call a helicopter.

A 2006 study estimates that between 1981 and 2001, 10,552 people in the United States died because they didn't wear a bicycle helmet.[1] I'm thrilled beyond measure that my roadside patient is not among them. Discharged from the hospital after 3 weeks, having undergone a craniotomy and bone flap for epidural, subarachnoid, and sub-dural hemorrhages, she returned to college. Last week, I attended her wedding and joined a parade down the streets of Oakland led by a brass band and a woman you'd never guess had been sick a day in her life.

When I walk into the hospital in the pre-dawn darkness, when I start to feel like my job is to be a paper-pusher, or a page-answerer, or a functionary of an insurance industry with more responsibility to shareholders than patients, I think of my roadside patient. I think of her and remember that I have the fortune to make a living exercising my fundamental humanity by helping other people. The industry of medicine sometimes seems badly broken, but the act of healing, I'm glad to say, is not.

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