

## A Second to Get Over It



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“You might want to get ready for this one,” my attending says, heading for our resuscitation bay.

I had taken the radio call. *12-year-old male, unhelmeted bicycle rider struck by a motor vehicle, no obvious injuries, depressed mental status initially, lost vitals at the scene, ROSC following chest compressions, blood running through an IO.*

“You’d have to pry this one out of my cold, dead hands,” I quip, readying my airway equipment. I mechanically click my trauma shears into and out of the halter on my scrubs. “I live for these resuscitations.”

The bay buzzes softly with anticipation, the sound of plastic being ripped open, Broselow tapes being laid out, equipment clicked on and off in testing. It is a strange sight, but a familiar one, the juxtaposition of stuffed animals and cartoon characters along the walls with the military and metallic austerity of a trauma preparation.

EMS is doing chest compressions as they barrel through the bay doors. “We lost vitals again.” The bay falls silent for report. “Uh...young kid, unhelmeted bicycle rider struck by truck at high speed. We found him 20 feet from his bicycle, GCS 3. Lost vitals at the scene once, ROSC after one round of CPR. No serious injuries that we can see outright, but he’s got scrapes all over the place. Unit of blood is in; that’s the second one hanging.... He was... He was just going to school.”

I catch my first glimpse of the patient as EMS pulls the stretcher beside me. His tiny, naked body looks out of place in the giant metallic stretcher, a poorly fitted C-collar obscuring his face. He isn’t 12. He’s 7...8 at most. I begin exchanging my blades, styling smaller tubes. I change the mask on my Ambu bag.

*He was just going to school.*

With near-robotic precision, 2 chest tubes pierce his skin as soon as he is transferred into the bed. Central access. Blood is hanging. Chest compressions continue. Nothing.

His face is small and serene. I scissor his mouth open to rows and rows of small gleaming primary teeth. One adult tooth sits proudly and awkwardly in his left upper jaw. It probably gave him a silly grin. My stomach twists in knots and I feel nauseated.

I slide a tube barely bigger than a straw through the soft, pink opening of the vocal cords.

“I need the left lung down,” the fellow says. “Mainstem it.” I flick my wrist to the right and nearly hub the tube in the process.

I see the silver flash of a scalpel unsheathed and then skin gives way quietly to muscle, his flesh whispering its soft protest in small spurts of blood. The rib spreaders are out now, the pearlescent glow of the pericardium then, and with another glint of silver I can see the rise and fall of his heart, fighting. It is pristine. There is nothing to repair. One pair of hands, then another, and then another take turns compressing his heart, *atria, ventricles, atria, ventricles, live, live, live. He was just going to school.*

Around me somewhere I can hear the obligatory call for *any other ideas*. It doesn’t register. The silence is hot and heavy.

This isn’t a survivable brain injury. I know that. We all do. Still, our hands trade out compressing his heart, each carrying the burden of that inevitable truth for a minute or two.

My hand is in his chest still, the fibrillating muscle fibers sending waves of nausea through me. *Take your hand out*, my mind screams but its message is lost along the electrical pathways to my hand, buried in the whirring, screaming stillness of this resuscitation. *This is done now*. I am in a fog, there and not there. *He was just going to school. He is gone.*

At the foot of the bed, a strong sure voice cuts through the stifling silence. “Time of death,” she announces. A moment of heavy quiet, and then with resignation, “I’m going to talk to the family.”

*He was just going to school.*

I pull my hand from his chest as though struck by electricity. The walls of his heart are still twitching with chaotic rhythm, protesting the indignity of his death. I look at this child, the shards of his broken future strewn and mixed with blood and plastic on the floor. I try to feel something, anything, but I can’t. A dull, shapeless gratitude fills me that I would not be the one to deliver the news, that I would be spared the sound of his mother’s screams, the agony in his father’s eyes. It feels like cowardice, but I don’t know how to

live with those things. The surgeons begin dutifully repairing his chest, thick black suture bringing the muscle layers together, reassembling his humanity, so his family can see him one last time. Skin and fascia zip closed over his still-fibrillating heart. I need to not be in here anymore.

I pull my resuscitation gown off and add it to the growing mountain of blood-stained equipment building in the biohazard bin. My shoes are trailing blood. I sit for a minute to clean them, the acrid smell of the bleach wipes cutting through the jumble in my mind. The air outside the bay feels cold and cruel; my scrubs are soaked through with sweat. Overhead calls buzz dully in the background. *New patient, P43, EMS arriving P25, nurse or ANA to G16 for bathroom assistance.* The world continued turning as this child took his last breath, oblivious. I feel numb.

*He was just going to school.*

One of my colleagues sits down beside me, cleaning dried blood off his trauma shears.

“You okay?”

*I don't know.* “Yup.”

He sighs. “That one's gonna take a second to get over, huh?”

I don't know the answer to that. A glance of understanding passes between us, a silent acknowledgement of the small piece of ourselves we left behind in that bay. I mechanically click my trauma shears into and out of the halter on my scrubs. *How do I live with these resuscitations?*

We let the silence linger. Then, having wiped the remnants of the resuscitation off our equipment, we stand up and go into the next patient rooms. And I wonder when I will find that second.

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## IMAGES IN EMERGENCY MEDICINE

*(continued from p. 542)*

### DIAGNOSIS:

*Bilateral tongue-type calcaneal fracture.* The patient received splints and was referred to the orthopedic service. Within 3 hours of arrival (Figure 2), he underwent open reduction and internal fixation, and he was discharged uneventfully the next day.

Although most calcaneal fractures are managed conservatively or with delayed repair, it is critical that emergency physicians recognize this uncommon fracture pattern. Splinting in plantarflexion and urgent surgical repair is mandatory because the avulsed tuberosity fragment places significant pressure on the skin and soft tissue of the heel; this can rapidly lead to tissue necrosis, with complications including amputation.<sup>1,2</sup>

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