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ESSAYS/PERSONAL REFLECTIONS

The death that almost didn't make me cry

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On one of the first days of my clinical rotations during my third year of medical school, I watched an old man with a stroke struggle to lift his right arm. As his eyes welled up at his failure to command his own body, my tears poured, hot and loud, down my cheeks, down my white coat, right in the middle of the intensive care unit.

After a few months of strokes and heart failure and chemotherapy regimens, I almost always made it home without tears. Often, I would let the water run over me in the shower and cry for everything sad I'd seen that day—the warm drops running down my face and merging into the stream of shower water and papaya body wash. I stored up my grief for a time when I didn't have to be responsible or right or dry. It was maximally efficient. It was what we in the medical training community would call "high yield."

I never saw any of my residents or attendings cry, so I figured this was part of the process—the acquisition of knowledge or expertise or self-satisfaction or some combination thereof forming a convenient shield from the heartbreak of every hospital admission. *Oh, a left middle cerebral artery infarct. I know about that. Let's get a CT to rule out hemorrhagic origin. Check for timing of onset to see if the patient is a candidate for thrombolysis*. I can manage this. I don't have to feel this.

As I accrued more and more experiences in the hospital, my shower cries decreased in frequency. Then again, I had less time to shower. I couldn't tell if the etiology was emotional hardening or practical time management. I switched between self-loathing and pride, depending on what I diagnosed as the cause. My only external barometer was that I was getting honors on every rotation, meaning that clinically I was at the top of my class. My ability to assess, manage, and do, rather than feel, seemed linked to my success in the hospital.

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It was during this dry season that I experienced my first "code."

I'm unable to change the name of the person in this code to protect his identity. I don't know his name.

There is a specific, high-pitched pager beep that pierces the entire medicine team room when someone's heart stops beating. *Eep eeeep EEEEEEP* crescendos as every resident's pager goes off. It's not long before a loud speaker is announcing "Team 7000 to room X." Someone's heart has stopped, and it's up to us to beat/shock/trick it into starting up again. Team 7000 always sounds like some sort of 1980s superhero squad to me. Maybe that's why they chose the name.

My first Team 7000 code, I ran after my resident to a room on the ninth floor. Her white coat was stiff. Our triumphant sprint into the room shattered when we saw the patient. Old. Trached. No capacity. We quickly learned he had no DNR—the religious family wanted "everything done."

The man lying in bed must have been 90. He had a coarse gray beard and thick gray hair that was long and matted on his hospital bed pillow. In truth, the first thing I noticed about him was that he was trached. A hole had been cut in his trachea so that a tracheostomy tube could be connected to help him breathe. It told me that this man had been very sick. Any effort we would make to jumpstart his heart back into sinus rhythm would be buying time at best. We all knew that we—a group of strangers—would probably be filling this man's last moments with IV epinephrine and electric current.

By the time we got there, a few other residents had already begun chest compressions. The chief resident was running the code, an algorithm with ratios of chest compressions to checking for cardiac rhythms to pushes of IV meds. Despite how valiant the whole procedure seemed, we were really just following a detailed set of instructions. There are no superheroes in this algorithm, which is probably the sign of an effective algorithm.

My fellow medical student was doing a round of compressions. Every time he rammed his palms

against the old man's chest, a reflexive squeak came out of the tracheostomy tube. It sounded like a shrill hiccup, a reminder that the physics of airflow remained beyond the patient's ability to breathe on his own. The old man's mouth was gaping open. His eyes rolled back a little as his body was jammed down under the strong, locked elbows of my rock-climbing peer. A respiratory therapist began to suctioning blood from the tracheostomy tube. The old man did not flinch, his face completely relaxed, eyes still open. I didn't notice what color they were.

As is standard, the man's relatives had been asked to remain outside. No one should watch a loved one die this way, his head flopping as we thrust and thrust into his mediastinum. I wondered if this was to protect the psyche of the loved one or to protect the shroud of heroism around our code checklist.

As we ran down the to-do list of mandatory two-minute compression cycles, his pulse came back: 30 beats per minute, with a blood pressure of 50/30 on vasopressor drugs. I sensed the attitude of the room: Old. Trached. Ugh. It had already seeped into me. I looked over at a resident in the corner checking his email on his phone as the other doctors kept their fingers on the old man's thready, labile pulse. One doctor checked the pulse with one hand and checked her phone with the other. The whole room seemed to take a collective nihilistic sigh.

His pulse stopped again, and it was my turn for compressions. I interlaced my fingers, locked by elbows, and threw the entirety of my 110 pounds into the old man's chest, pumping 100 times per minute. His skin felt damp. I could tell that my predecessor had broken a few a ribs—a sign of great compressions. I kept going as the hole in his trachea hiccupped. I kept going, his thin body floppy and limp and damp, or maybe that was now the dampness of my palms.

My hands were the last to beat on his heart before he was pronounced dead at 4:02 p.m.

We left the room. I washed my hands. I checked my phone.

As I was walking home that day with my peer, the one with the great compressions, he mentioned, "Hey, did you know that guy was a Holocaust survivor?"

I barely had time to feel the hotness behind my eyes before the tears began to fall. My first instinct was to be embarrassed that I was crying in front of my rock-climbing, rib-cracking fellow student. It seemed weak in an environment that wanted me to fix things. But I couldn't delay my response this time. This man's sudden realness caught me off guard, his matted gray hair, his soft open mouth. His life instantly became sacred to me. I felt shame that it took knowing how much he must have suffered to break through the protective shell of my white coat. I felt my mundane, mechanical, no-prognosis nihilism thaw into sorrow.

A conditioned part of me wanted to escape, to take a shower. I found myself walking back to the man's hospital room. The room was empty, sterile. The bed had already been stripped of its sheets. My tears poured, and I liked how they felt on my cheeks right there in the doorway. I stood in the fluorescent light peering at the blue plastic mattress.