"Paging Student Doctor Dye!"

...or How I Spent My Summer In A Las Vegas ER And Lived To Tell About It

By Brittany Lynn Dye

Introduction

"And this is where you will stand when they bring the traumas in. Any questions?"

We were in the emergency room of Sunrise Hospital and Dr Johnson (not his real name) barely glanced my way when he spoke. It was the end of my whirlwind orientation and Dr. Johnson was in a serious hurry. As the head doctor of the largest emergency room in the fastest growing city in the United States Dr. Johnson might have been—besides the average Caesar's Palace craps dealer—the busiest man in the city.

My senses swam laps around the fluorescent room, overwhelmed by various beeps, chirps and burps of monitors, the acrid bite of alcohol and the piercing lights. I was crazy-jittery with nerves. Still, I had a question.

"In an emergency room," I said, in a voice so tiny it surprised me, "Isn't everything a trauma?"

Dr. Johnson smiled, the same look I've seen from my father, mostly when I was younger, a smile—no, a smirk—that was at simultaneously reassuring and maddeningly patronizing.

"You'll see," he said. I made an instant mental note: *Student Doctor Dye: YOU WILL STAND IN THIS SPOT ALL THE TIME!*

To most of the culturally aware, Las Vegas is Sin City, but hey, to me—its home. Perhaps growing up in Las Vegas is a bit of a surreal experience. I suppose it probably is, except when you're in the process of it, like I am. Other than my first two years away at college (pre-med at Georgetown University) it's what I know, and love. See, I think it's perfectly normal to live in a place where 38 million strangers come every year for a party of their own devising. But despite all of the marketing, Las Vegas is a real city, trying to cope with the same issues and concerns as any other. Still…after my summer of 2007, it sure seemed like the local campaign's slogan should have gone something like "Whatever happens in Vegas…gets treated in the ER of Sunrise Hospital."

It was through an extraordinary confluence of circumstances, but I somehow managed to pass an interview with Dr. Johnson and receive a five-week internship in the ER of Sunrise Hospital. This wasn't my first experience in a hospital. In high school I'd been a "candy striper", a volunteer whose job consisted basically of pushing semi-coherent patients around in wheelchairs or on fancy stretchers—gurneys.

Now I was volunteering again. This time, however, it was a kind of pre-med school internship. I was home from school for the summer between my sophomore and junior year. Though I was just an undergraduate, with applications for medical school more than a year away, I thought I needed practical experience to go along with my vast (ha-ha) medical knowledge gleaned from episodes of "Grey's Anatomy."

I was finally going to be able to see what life was like from a doctor's perspective. To follow doctors around, witnessing countless medical procedures and having doctors teaching me in real time—this was an experience that most people wouldn't have until medical school. I didn't know how much I was expected to know, or need to know, or what exactly I was going to learn. I had no idea how an ER even operated. But I knew this job would be a tremendous opportunity for a quantum leap in knowledge.

More than anything, I needed to answer some pertinent questions about myself. My medical ambitions had been part of my psyche since grade school. Now that I was finally embarking on a career in the field of my dreams I had to know: Did I have the stomach for all that came with it, namely, the blood and guts, tubes, CT scans, drugs, pain, loss, body parts and death? I knew this internship would be life-altering experience; that it would make or break my decision to become a doctor. For five weeks I would watch, look and listen. Nothing more, nothing less. I wasn't qualified to do anything—not even clean the floor. For five weeks my job was to observe, absorb…and shut up.

I was on my way. Or so I hoped.

Chapter One: First Shift—9AM-6PM

For better or worse, I expected my first day in the ER to be an experience that would come back to me with great clarity for the rest of my life. I was *positive* the outfit would. Dressed, for the first time, in a costume of crisp scrubs and new walking

shoes, I felt professional. Whether I would fit in at the ER and be taken seriously was a question only time would answer. Luckily, Dr. Johnson, the head of the ER, was on duty my first day. At least his was a friendly face early in the morning.

"C'mon," he said with a wry smile. "There's somebody I want you to meet. Your first patient."

Surely every doctor remembers his or her first patient, and though I was no doctor, there was no reason to think I would be an exception to the rule. I was as nervous as I'd ever been. I had no idea what, or who, to expect. My father had warned me that I would be seeing "tons of blood and guts" so I was relieved when we walked into a trauma bay and saw my first patient sitting up in a chair with a big smile on her face. Danielle was a sweet, nine-year-old Latina girl who said simply, "Something metal fell on my head."

Dr. Johnson held Danielle's head and gently pushed her hair aside, revealing a bloody laceration. Suddenly I felt like any random person on the street thrown into an emergency room. New words were suddenly being thrown around the room, words I had to process and translate, like "sutures" and "laceration." I knew my words would no longer do: "stitches" and "an owwee."

"I'll need lidocaine," Dr. Johnson said to the nurse. This would be the first of a hundred times I would hear that phrase. A common anesthetic used in minor surgery, lidocaine is injected, via a needle, into and around a wound. Because it's the first jab into the skin, it's usually more painful than the stitching. Danielle howled and bit her lip, tears forming. I watched intently as Dr. Johnson expertly sewed up the laceration, his doctor hands moving with a practiced, swift technique honed by thirty years in an ER.

All thing considered, my first patient was a cakewalk. I was relieved to discover, in those first few moments, that I really *could* take it. I felt completely engaged in everything I was experiencing. I didn't flinch. Instead I found it strangely intoxicating. I was ready for anything.

Or was I?

"Student Doctor Dye." Dr. Johnson was looking in my direction. "Can you tell me what an EKG is?"

Huh? A test?! So soon?! I thought I was just an observer! My palms moistened, and I wiped them on my scrubs. I thought fast.

"Uh…" *Good, Brittney, way to think on your feet!* And then I remembered. "I think it's measure of something, uh, of the heart?"

"Right." Dr. Johnson chuckled. "Just checking. You know, to see where you're at."

A few minutes later we were in another examining room and Dr. Johnson was asking a completely different set of questions. An older female was having trouble breathing so the doctor ordered a "chest x-ray STAT." "Stat" I got; it means *right now*, *faster than immediately*. (Assist to "Grey's Anatomy" for that one.) Within seconds a radiology technician was wheeling a huge, portable x-ray machine into the room. Chest x- rays are the most commonly ordered x-ray within the adult emergency department because they can tell you so many things about the patient. Before I could even barely begin to comprehend how the x-ray machine works, the woman's lungs popped up on the computer screen. I had never seen a chest x-ray before much less had any idea how to read one. Dr. Johnson got excited to point out a rare feature on this x-ray.

"Right there. See? A spontaneous tension pneumothorax."

I wrote it down, certainly misspelling "pneumothorax." "And that would be—?"

"Well, basically, one of this lady's lungs has completely and spontaneously collapsed. It's pretty rare."

I watched in awe as a tube was inserted in the woman's chest. In a matter of seconds it had suctioned out the escaped air around her lung. It reminded me of the childhood saying: *Out goes the bad air, in comes the good.* Immediately, her lung re-filled and re-expanded.

Dr. Johnson was pleased. "She's going to be fine," he said.

I was in awe. A woman's life had been saved. And I'd only been in the ER for twenty minutes.

Admission charts began to pile up on the desk in front.

"Only fourteen in the waiting room," the charge nurse said. I thought to myself, "Only fourteen? Isn't that a lot?" But, no. Evidently not. (Which scared me for a second—how many *was* a lot?) Dr. Johnson was nonplussed, and explained A Rule Of The ER: Worry about what's in front of you and not about what's to come.

What was in front of us was the next patient in line, an older gentleman who had somehow managed to slice his leg open. Since it was another "lac"—short for laceration—Dr. Johnson figured I was an expert now and grilled me.

"Whattya think? Does he need to be closed up?"

I inspected the man's leg, and could see pretty deep into the cut, nearly to the bone. I felt pretty good about my answer.

"Yes."

Well…bingo. I was correct. Good thing, too, because I'm pretty sure a wrong answer might have horrified the patient. I imagined him wondering *hey, who's the dumbo intern who doesn't even know when to stitch up an owwee?*

Dr. Johnson examined the wound further and pushed deep on a bulge that had formed within the cut—a hematoma. I

scribbled down "hematoma." I was pretty sure it was a blood clot. Bingo again; I was right. Platelets in the blood cause a clot to form in order to prevent too much bleeding. However, I didn't know the answer to Dr. Johnson's next question.

"So why do I need to push the hematoma out of the cut?"

I didn't have a clue and admitted it. Dr. Johnson doctor carefully but firmly squeezed the laceration and *blurp!*—a bloody mass the size of a golf ball shot out of the wound, right into the nurses' hands. *Nice catch*, I thought.

"Because hematomas are excellent places for bacteria to grow." Dr. Johnson showed the same patience with me that he did with the patients. "If we left it in there, the risk of infection increases." Made sense. "Hand me that staple gun, please."

A nurse handed me a staple gun, and I passed it to the doctor. Yep, a staple gun. Sometimes real metal staples were used instead of sutures. But again, it was the shot of lidocaine into the wound that got the old guy's attention. When the wound was closed, no more red was visible and, as weird as it sounds, I thought it looked beautiful.

From there, the day was blur. The action was practically nonstop, although it was not as frantic as I expected and—surprise!—nothing like I'd seen on television. It was controlled and organized. Doctors, nurses and technicians worked together like a pit crew at a NASCAR race; wheeling patients in and out of pit row. I got totally lost in the day—the hours and minutes that passed meant nothing.

I was standing at the doctor's desk, taking notes when suddenly the doors flew open and paramedics rushed in. Finally, I thought, a classic TV moment, complete with an unconscious man on a stretcher. Semi-frantically the paramedics shouted out vital signs to the nurses and looked for a doctor to whom they could recite their story. As nurses hooked the man up in one of the trauma bays, I went to watch. Mistaking me for a medical student, a paramedic began to brief me on what happened.

"Somebody found the guy found face down in a parking lot. On the pavement. Out there his temp was 106."

"Not any more," a nurse said. "Try 108."

Immediately people were yelling for cold blankets and ice packs to cool him down. The man's clothes were cut off; monitors were hooked to his chest. I could see burns all up and down his arms and legs. A parking lot was no place for an unconscious human being. In summertime the Vegas pavement easily gets griddle-hot enough to cook bacon and eggs with a side of hash browns. Being outdoors in the middle of the day for any length of time was a dangerous proposition without jumping into a swimming pool at regular intervals.

Just then the other doctor on the shift came in, Dr. Watson. When the paramedics repeated their story Dr. Watson turned to me and said it was the second highest fever he had seen. His record: 112 degrees.

As the doctors and nurses and technicians continued to work on him I tried to write everything I heard into my notebook. They might as well have been speaking Martian. The medical profession comes with its own language that, to the untrained ear (mine) can only be inputted into the grey matter over time and with lots of practice.

I found the language kind of quirky and funny. For instance, take the aforementioned EKG, which monitors the heart. Formerly known as ECG, short for electrocardiogram, it was later changed to EKG for the sole reason that it sounded too much like EEG, which measures brain activity. Got it?

As an unwritten rule, EKGs are ordered for every male patient over 50 years old who come in with chest pain. Dr. Johnson and I once examined a 70-year old male patient, who came in complaining of shortness of breath. A chest x-ray and EKG were automatically ordered to determine the cause of this man's symptoms. Could there be fluid in his lungs? Is he under stress? A reaction between two of his medications? We saw five more patients before the results came back for our 70-year old. The diagnosis: bilateral infiltration. Into my notebook it went as I watched as the doctors reviewed dozens of x-rays and CT scans.

A chest x-ray came up onto the screen. Dr. Johnson pointed out everything out on the x-ray and described what it was. The clavicle, the scapula, the AC joint, the diaphragm…I wrote it all down.

Then the doctor pointed to something in the middle of the x-ray, between the ribs in the air cavity of the lungs. It was white, small, and seemed to be hanging out all by itself. The doctor turned to me.

"What does that look like to you?"

Sheesh. I half-smiled. "I really don't know."

"Good!"

Oh, great! Now he's teasing me!

But Dr. Johnson explained himself. "It's always better to say that you don't know then to guess wrong. Because I don't know what that is, either."

An x-ray of a wrist came up and I studied it. Again, Dr. Johnson turned to me.

"There are eight bones in the wrist. Do you know their names?"

Oh, man. "Uh. No."

"Well, you *will* tomorrow, won't you?"

Yes, doctor sir, I certainly <u>will</u>, doctor sir, you can count on me, doctor sir…

It had been a nerve-busting, exhilarating, exhausting, first day. On top of trying to make a good impression and being

completely overwhelmed by all the information thrown at me, I was exhausted.

Wouldn't you know? Now I have homework!

Chapter Two: Night Shift—6PM-3AM

Among other things, night shift meant that I would be on my feet for nine hours, so a stop at Starbucks on the way to the hospital was definitely more psychological than anything else. But, I figured, it couldn't hurt either. I was curious to find out if there would be a medical correlation between the city and its famously after-hours personality. If most of the action in Las Vegas happened at night, then won't most of the action happen in the hospital?

I was fortunate to be shadowing Dr. Cheng, one of the two doctors on the shift. Dr. Cheng was a warm man with a nice, friendly smile. The two doctors on duty occupied two designated swivel chairs in the center of the emergency room. Since my position was at the hospital was literally created for me, I decided to create my own place—right in front of the hospital computer…between the two doctor's chairs. Hey, why not?

So I had just assumed my position and was sipping on my Starbucks when the doors flew open and a stretcher rolled in. A female. Car accident. *Oh, my. This'll be something,* I thought. Since Dr. Cheng had come in a little early, and hadn't begun his shift yet, he sat with me and as we watched the trauma drama unfold together, he explained what happened when a situation like this one occurred.

"Trauma nurses are the best nurses in the hospital," he said. "They have to be on top of their game at all times, ready to look for every little thing."

I had to admit, the burst of activity was impressive. What looked, on the surface, like unadulterated chaos was in fact a team of highly-skilled people performing their jobs very rapidly. In a matter of seconds the woman was wheeled into the trauma area, hooked up to the necessary machines and then rushed out for emergency surgery, since the sonogram revealed internal bleeding. Meanwhile, her case went from the ER doctor to the trauma surgeon who took her away to an OR.

What a way to start my day, uh, night. Dr. Cheng grabbed a few charts and nodded toward me to follow him down the hall toward our first patient. The charts were labeled with identifying room numbers. That should have helped steer me toward the right door, but it didn't—not yet. At this point in my brief ER career I didn't have a clue where anything was.

Our first patient was a 62-year-old male who got to the point. "I'm sick," he said.

"Okay." Dr. Cheng took a deep breath. "What's wrong with you?"

After a little polite-but-firm interrogation the man finally admitted that he hadn't taken his medication in two weeks. He seemed to be in some kind of pain. But he also didn't appear to understand exactly what was happening to him.

"Do me a favor," Dr. Cheng asked. "I want you to remember three things for me. Okay? A pen, an orange, and a rainbow."

I knew that this was a common, very quick neurological assessment. (Thank you Intro To Psych.) Sure enough, after a few more general questions Dr. Cheng asked the man about the three things again. He could only remember a pen, and that was all Dr. Cheng needed to order a few tests to get to the bottom of the man's medical problem.

Our next patient was a 71-year-old male with an incredibly swollen foot. It almost didn't look human. The man wasn't in a lot of pain, but felt a shortness of breath when he walked. Which might have a blessing, because from the looks of his foot, he couldn't have gone far. The doctor cradled the man's foot in his hands.

"Watch," he said, and pushed down on the swollen area. "Normally, the skin would've popped back up, this time the skin stayed down. That's excess fluid, outside the cells and tissues. In itself, not dangerous. But I think we ought to look for a DVT, or a blood clot in the veins of the leg. The lack of blood circulation can cause swelling. Might need some blood thinners."

The doctor ordered a sonogram and when we left the room I had a question.

"Doctor, what causes something like that?"

"Could be lots of things," he said as we walked. "Being immobile, dehydration, even cancer and birth control pills. I'm guessing it was birth control pills."

I caught a smile. Dr. Cheng had a nice dry sense of humor. Which I would discover comes in pretty handy in an ER.

Shock time. Here's what I wrote in my notes regarding our next patient: *Middle-aged female experiencing chest pains. A smoker, the woman weighed 320 pounds.*

And then Dr. Cheng showed me her real age: 25. *Whaa—?*

But she was nothing compared to Patient #4 of the shift: a 28-year-old female who also complained of chest pains. Tests showed CHF, or congestive heart failure. The young woman had the heart of a 70 year old!

What the—? How could—?

I had a million questions but couldn't ask them…yet Dr. Cheng could tell I was puzzled. Silently he pointed to her chart.

Two words popped off the page: *drug abuse*.

Just as I was wondering how in the world someone could do that to themselves I saw the flip side of the equation. Our next patient was a 100-year-old female. She had a fever and, after giving a quick listen to the lungs, Dr. Cheng heard fluid in one of them. (Dr. Cheng let me listen—you can really hear the difference.) The woman had a touch of pneumonia, but it was nothing that antibiotics couldn't cure. And then she'd be as good as new. At 100 years old.

But would I? Someone had just staggered into the ER and barfed on the floor.

Allow me to introduce a patient I'll call Clem. Clem was my first smelly, drunk, homeless guy. And when I say smelly, I'm talking, wow.

But Clem certainly wasn't everyone else's first smelly, drunk, homeless guy. In fact, everybody knew Clem. Clem was a "regular." Still, Dr. Cheng was required to do a physical exam and the usual battery of normal tests to ensure that Clem's only problem was alcohol-based. Which meant that Clem would have to sober up at least to the point where he could pass a "road test"—walking a few steps without falling or tripping. Which meant that Clem would be occupying a room for an extended period of time. Which was not a good thing on a typically busy Friday night.

I could tell that dealing with Clem took a little out of Dr. Cheng when he made a funny comment.

"Sometimes," Dr. Cheng said with a medium-sized sigh, "ER doctors are nothing more than glorified waiters. Traveling from patient to patient, asking what they need, taking care of requests, and then turning the table over to get the next patient in."

But I barely had time to digest this when paramedics rushed in with a female in full-tilt crazy mode. The woman looked awful and smelled worse. Her eyes were classic pinpointed pupils, and she was alternately unresponsive and in the throes of a seizure. Oh, and vomiting, too. *Yikes.* This was by far the scariest situation I'd encountered. I watched as nurses attempted to hold this poor mess of a woman down.

"Obviously, she's od'ed." Dr. Cheng yelled. "But the question is: On what?"

So the big challenge was to try and figure out which drug—or drugs—was doing the damage. And once again, there was the age thing. The woman was 37 although she looked 65. Sallow, deeply lined skin and no teeth, only dentures.

After a brain CT and urine drug test were ordered, a psychiatrist arrived to examine the woman. When drug overdoses come in, there is an automatic consult with psychiatry in order to eliminate the possibility of a suicide attempt, which sets into motion a whole bunch of other issues and treatment plans. After that, there isn't much to do for these patients but monitor them.

Three similar cases in a row was a pattern, a theme. I started to wonder about the doctors. *How do these doctors keep helping people who keep harming themselves? Don't they ever stop feeling sorry for them? Don't they lose the will to want to help them?*

Eventually, I would come to the conclusion that one must hope and hope and hope that something, somewhere deep inside will click for these sad people before it's too late. Something will give the person the strength to recognize the errors of their ways, and finally do something about it. As we were leaving the hospital when the grueling shift was over, Dr. Cheng said as much.

"As a doctor you just hope," he said, thoughtful as always, "that at the end of the day you've performed some little bit of good in the world, as cold and uncaring as it may be at times."

And he wasn't smiling.

But doctors aren't robots. They are human, and occasionally, their humanness comes through loud and clear. In my first two days I was already picking up on a fact: Hospitals are just like any other place of work (or school) where a bunch of strangers are forced together and have to learn to interact. Sure enough, there was a whole secret world of drama away from the patients. Each of the doctors had a different opinion about every doctor and of course, there was always talk about the nurses between doctors. It was a strange, shifting dynamic. Not only was I observing the practice of medicine, but… everything that came along with it.

It isn't just patients with whom a doctor has to interact. There's the charge nurse, the other nurses, the other doctors, the administration (the "suits") and, in the case of Sunrise, the little intern in the corner. As nice and honest and open as Dr. Cheng was, I could tell he felt differently about various doctors and nurses. How could he not?

So after working with many doctors and nurses, and over hearing many conversations between them, I started to notice there was considerable pointed conversation about a certain doctor. I'll call him Dr. Fine. I had yet to work with Dr. Fine but from what I heard, when I did, I would be in for a most interesting day. But, ooh, I had no idea.

Dr. Fine was a real handful.

Right off the bat Dr. Fine started bragging to everyone how he has never, ever been sued. Never! And everybody heard it: doctors, nurses, EMT guys, me—even the patients. Everybody got the same blowhard story.

And then Dr. Cheng gave me the inside scoop that any day now a big lawsuit was coming down the pike, and it had Dr. Fine's name on it.

According to pretty much everyone, when it came to even basic doctoring, Dr. Fine wasn't so fine. Everyone complained

about him. The other doctors hated how he dumped his "unfinished" patients on the doctor coming in on the next shift. But it was the nurses who really despised Dr. Fine. They hated how he treated them—Dr. Fine was bossy and a big yeller if they did something wrong. Which went against everything Dr. Cheng told me about dealing with nurses—you *never* want to dis the nurses. It's the worst move you can make. Nurses have the power to make your job easier…or your life miserable. Nurses work so hard in the ER, and for so very little credit, that if you don't treat 'em right, watch out.

So now it was time for my three shifts with the infamous Dr. Fine. I was nervous, but really tried hard not to let any of my preconceptions of him get in the way of my learning.

It started off well, fine. Dr. Fine introduced himself and we got started. At first, Dr. Fine was actually nice and fairly helpful in understanding the major medical concepts surrounding the patients. But four patients into the day I noticed a shift in Dr. Fine's patience. Sentences got clipped. Sometimes he feigned not to hear me. By the time we left the sixth examination Dr. Fine was bitching loudly that the patient had no right to be in "his ER."

I didn't know what to say, except *funny, I don't remember seeing his name on the hospital sign out front,* which I didn't say, of course, but from that moment on I was extremely uncomfortable in Dr. Fine's presence. So I went about asking my normal questions about patients and procedures and jotted a note to myself in my little notebook to change Dr. Fine's fictitious name to a more appropriate moniker, Dr. A-Hole.

Chapter Three: Graveyard Shift—11PM-9AM

Every night on my way to the hospital I drive across the nuttiest, craziest, most insane street in the world: Las Vegas Boulevard, *aka* The Strip. I don't know if it's the traffic, the humanity, the heat, the energy, the alcohol or some unholy combination of it all, but it's a mad, mad place where the madness never stops. And at 11 PM the madness tends to spread to a new mad place—the hospital ER.

Now, I always thought a "Graveyard shift" was called thus because more people died during that time than in the other shifts. But I was wrong. Turns out "graveyard" refers to how "lively" the hospital is during these hours.

Get it? It's sarcasm. Like a joke.

Yeah, me neither. I think my definition is better.

Evidently the shift is called a "graveyard" because all the patients (hopefully) are sleeping—unless a nurse or doctor wakes them up for something.

I was surprised to learn how much I enjoyed working graveyard. Because of the quietness I found I could think and work faster. And since there is only one doctor on call, I could sit in the other doctor's chair instead of having to stand.

There was also time for Talks With Doctors. Get doctors started on their favorite subject—themselves—and sit back and listen to 'em go. They *love* nothing more than to pass on their words of wisdom, and oh, do they have wisdom! They've seen it all, you know, oh, yeah, and do they ever love to share it!

But they were good at their jobs, too. I was real impressed at how they could almost diagnose a patient after just ten minutes of talking to them and they knew when a patient was faking, seeking meds, or just overreacting.

Right at 10:58 PM I enter the secret five-digit code in the lock and the doors to the ER open. All the nurses (who have been here since 7PM) are so excited to see me. Either "Your First Graveyard Shift!" is a celebration on the level of first prom or they were pleased to see I'd brought Starbucks coffee. For some people during graveyard apparently it's difficult staying awake when there are only a few patients. But not me. Are you kidding? I'm a college student! Come on! We can stay up all night every night!

Uh, no. I'm sorry. I lied. I'm pre-med. Every night around midnight (I'm guessing here) I fall asleep while studying, because I usually wake up with a book on my face around 5:30AM for more studying before classes and labs all day. Such a life, eh?

Tonight the hospital chatter was all about a New Policy that required nurses to address the doctors as "Dr. Such-and-Such", instead of calling them by their *(horrors!)* first names. (Heaven forbid the doctors should be placed on any level below their own, which is knocking on God status, at least in their minds.)

But then at 11:10 the madness of the city hit. Literally, for if the buildings in this city (the hotels) have a Theme (Paris, Rome, Venice, etc.) then tonight's ER theme is Madness, because the first of a series of nut cases had just fluttered through the doors.

On every patient's chart is a brief description of why the person is in the ER. This patient, a forty-seven-year-old man I'll call Jerry, was "having hallucinations, hearing voices and very suicidal."

Okay, pretty scary territory here. My extent of knowledge on crazy people is minimal. The only person I know that's nuts is my father.

(Just joking, Dad.)

"Uh, Dr. Cheng," I said. "Just so you know, Jerry's gonna be my first, uh, my first, uh…" *Damn…What do I call him again…crazy? Nutball?*

"Psych patient?"

Psych! That's the word, uh, abbreviated word!

"Yeah."

"Yeah, if they're not faking it, they can be kinda scary."

Oh, That makes me feel better.

"Just remember that when you walk into the psych ward, keep your eyes open and look around," he said. "You never know when someone might attack."

The psych ward of the hospital was closer to a prison cell, complete with armed guard. There was one nurse sitting at a desk watching over six patients sleeping in beds lined along the wall. There was no privacy, because the patients are considered to be a potential threat to themselves and possibly others.

Dr. Cheng woke Jerry up and began his interrogation.

"I'm hearing voices, man," Jerry said quietly, sitting up, eyes darting from side to side.

"What do the voices say?"

"Oh, I can't tell you. They swore me to secrecy, man. Secrecy!"

"Okay," Dr. Cheng said. I was enthralled. This was *exactly* like TV.

"Look, Jerry, I swear I won't tell a soul."

Jerry didn't open up much, but he opened a little. "There are male and female voices telling me to go places," he said, with urgency. "They can see through me. I also see things, like trees."

I kept eye contact with Jerry the entire time. Jerry didn't blink once.

"Do you want to kill yourself, Jerry?" Dr. Cheng's question took me by surprise *and* scared me.

"Yes."

"So, why haven't you?" asked the doctor.

"The voices! They tell me things!" Jerry started to get anxious and definitely louder.

"Calm down, Jerry."

The policeman turned toward us. "Everything okay?"

Dr. Cheng put up his hand to the policeman as to say, "It's okay…for now…but…" Jerry started moving his head around violently, back and forth, back and forth. That's when I took a few steps back.

"Jerry, you're going to have to calm down or I'm not going to be able to help you."

The nurse stood up. The other patients stirred. I took a couple more steps backwards.

"Secrecy, man! SECRECY!!" Jerry was really agitated now, and Dr. Cheng did the most amazing thing: he walked out—with me *real* close behind—motioning to the cop *he's all yours now, buddy* and the cop did indeed take over, convincing Jerry in his own way it would be in his best interests to lay back down and be quiet.

Well, wasn't *that* fun! And instructive! See, I learned two things: One, that Dr. Cheng could be one tough cookie and Two, one of the most important things to know in the ER is when a patient is Helpable and when they are Not Helpable.

Later Dr. Cheng, chuckled about the incident.

"You know, you might make a great doctor someday. But you're gonna have to stop being so nice."

I laughed too. "Now how in the world am I going to be able do that?"

"Easy. A couple more like Jerry, you'll be there."

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As the days in the ER passed, I found myself in a pretty strict routine: work a 10 hour shift, sleep, work a 10 hour shift, sleep and work a 10 hour shift, followed by more sleep. But the sleep I got never seemed to be enough and exhaustion started accumulating. It didn't take long for the people around me—my parents, brothers and boyfriend— to begin seeing changes in my personality. Normally, I'm a pretty easy-going, happy-go-lucky person. But I guess I was smiling less or something. I don't know. Had I changed? According to them I was more serious. I didn't feel it, but then again, why wouldn't I be? After all, I was spending every waking hour in one of the most serious places in town.

Despite the cumulative exhaustion and/or Change or Non-Change I loved going into work. Every day brought something different and something exciting. It was unbelievable. I was absorbing so much. And the best part was I was learning was I Can Handle Everything. Sure, stuff freaked me out occasionally, but I got through everything that was tossed at me (and quite few lunches were) with flying colors.

Believe me, if I can handle Mrs. Baker's family, I Can Handle Everything.

Here's what happened.

One evening Dr. Cheng and I were called up to the ICU to attend to a critical patient who was undergoing a Code 99, or cardiac arrest.

The patient was a cute little old lady who I will call Mrs. Baker. Mrs. Baker had driven into Vegas with her best friend the day before to do a little gambling, but had suffered a heart attack instead. We had examined Mrs. Baker yesterday. Dr. Cheng, unsure of her condition, decided to keep her overnight.

Twice she had to be revived.

Now we were about to meet her family.

A small group of unbearably sad people came into the room and I was struck with their sadness. But Dr. Cheng was unbelievably calm as he explained the situation: Mrs. Baker was a very sick woman who would be in a coma the rest of her life.

The other choice was to take her off life support.

The family was in agony over the decision. Who wouldn't be? I couldn't imagine having to make that decision. The family's sadness was coming in waves now and I tried to tell myself, *c'mon Dye, get hold of yourself, don't get too sensitive*. But I couldn't help it, I'm a feeler, a sensitive person, and, well… *thank goodness* Dr. Cheng right then decided we'd go back to the ER while the family grappled with their decision. Suddenly the ER felt like the safest in the world to me.

I managed to put Mrs. Baker aside for a few moments while we attended to the other patients but then word came that the family had made up their minds so Dr. Cheng and I went back up to the ICU. The family said, *it was time*, they said, *we don't want her to suffer anymore*. It was heartbreaking. I tried to focus hard on Dr. Cheng; how would he react to this situation? How would he deal with this heartbreak? Dr. Cheng was professional and sincere at the same time…but as for me…I, yi, yi…for the next several minutes I stood at the head of the patient's bed while each member of the family came in and said a very tearful goodbye. First came her children, grown adults, three of them, I think, and then came several grandchildren, one at a time, how many, I couldn't tell you because…well…

Inside I was *gone*.

But outside I couldn't show it. They cried and cried and cried and I couldn't. I had to at least *act* like a professional. I <u>had</u> to.

And that's when last but not least, Mr. Baker came in, the husband of over 50 years. bent down to kiss her forehead for the last time.

Oh, my…

The scene was excruciating. But I was <u>not</u> going to cry.

And you know what?

I didn't.

"You alright?" Dr. Cheng and I were walking downstairs, back to the ER, the safe haven, the refuge.

"Yeah. I'm okay." And I was, but…*wow*. I was a shell. Spent.

"That's the hardest part of the job," he said quietly. "Blood, guts, crazies, opening people up and sewing 'em closed…that shit's *cake* compared to *that*." Dr. Cheng tossed a thumb backwards.

"You were very professional up there. Nice job."

"Thanks," I said, feeling, yeah, okay, a little more serious after all.

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