Student Name

English 1010

Date

Purpose-Driven Work

The tile floor is cold as you step into the Emergency Department at Methodist Hospital. A constant smell of harsh cleaning products lingers in the air. The glass doors to each of the patient rooms are covered with a slight foggy haze from the same harsh cleaners. Everything in the department has a feel of sterility that is only dampened by the knowledge of the substances that are constantly being coughed, vomited, spurted, or dropped on in the everyday occurrences of emergency medicine. The harsh chemicals used to fight this constant barrage of fluids and substances are made to kill anything and everything. These chemicals are necessary to the work done here. The purpose of the Emergency Department is to do the most good for the patients that walk through the doors.

The entrance to the Emergency Department at Methodist Hospital has two sets of double sliding glass doors about fifteen yards apart. Once you pass through this set of doors you turn a sharp left and are greeted by the admissions secretaries sitting behind glass windows. You are questioned as to your need and sent through a secured entry door to your right. As the door swings open and you pass through, you are brought into a small room on your left labeled in large letters "TRIAGE." From this point you are either brought into a patient room or placed in the waiting room to wait your turn based on your determined urgency.

The main section of the Emergency Department is a large rectangular room. A large desk area sits in the middle for the staff to do their reports. Twelve patient rooms along the perimeter of the room are labeled 1 to 12. Room 1 sits in the northeast corner and is used for trauma patients and patients brought in with CPR in progress. This is called a "code 99." Rooms 10, 11, and 12 are used as accelerated care rooms, when possible. There are also twelve emergency overflow rooms across from the waiting room that could be used if needed. In a department this size we will typically run seventy-five to one hundred patients through on a daily basis, all with various complaints and problems.

Normally the Emergency Department is bustling with activity. Today is slightly slower than normal which is not very comforting. When it is slow, a looming sense of danger constantly clouds over any enjoyable period of rest. Any time of rest in emergency medicine usually means something bad is just around the corner waiting to catch you off guard. Today is one of those days. We have a total of three patients. One is a 22 year old nausea and vomiting patient who had too much to drink last night. The second patient is a 92 year old female who has fallen in the shower for the eighth time this month and the nursing home she lives at still leaves her unattended while doing such activities. From looking at the x-ray it seems she has once again shattered her hip. The other patient is a 38 year old chronic back pain patient who was seen here two days ago for the same thing and has been seen at multiple emergency departments across the city for the same thing. Each one has given him a few days' worth of narcotic prescription pain medication. Today will be a different story as the emergency physician is refusing to give him anything other than regular Tylenol. He wants a second opinion so he will have to wait until eleven o'clock when the mid shift physician gets in.

The radio goes off at the desk, "Medic 52 to Methodist, Medic 52 calling Methodist." The voice on the radio is a deep, male voice that sounds very out of breath. The charge nurse Lee gets on the radio ever so calmly, "Methodist, go ahead Medic 52." The response is instantaneous, "Methodist, we are coming in code 99 with an approximate 50 year old male found down and unconscious." He pauses slightly and takes a big deep breathe. "Family is unaware how long he's been down. CPR in progress upon arrival. Asystole on initial rhythm check, CPR continued and Atropine given to no avail. Epinephrine given and round two of Atropine given en route. Rhythm flipped to V-Tach, shocked at 250 Joules. ETA two minutes."

With that short twenty second report, our restless daze flips into a scurry of motion. I grab the phlebotomy tray and hurriedly walk to the northeast corner of the department into room 1. I set the tray down on the back counter and start prepping as much of the equipment as I can. The code cart is unlocked and ready for access. The Zoll cardiac monitor and defibrillator is opened and the pads are pulled out ready for use. Lee puts the page out to the house supervisor, pastoral care, and respiratory, as is protocol. Another nurse, Julie grabs a clipboard and prepares to document the chaos that is about to ensue.

To anyone that has never been in a code 99 situation, everything happens all at once. In the emergency department a code tends to run very smoothly. There are many jobs to be done and everyone picks a job to do. The team works in sync with each other, attempting to not get in each other's way. We run on protocols and we focus on doing those protocols as best we can, leaving the human factor out. We refuse to think of the patient as a person until all of our jobs are completed. As ridiculous as it may sound, it is the only way we can do what we do. The medications and interventions we use generally have the same ability to kill as they do to save. In the situations we use them in, it is our first line in our last ditch efforts to save someone's life.

The ambulance bay doors swing open and the bright yellow squad stretcher pushes into the hallway. A medic stands on the bars of the stretcher base leaning with his hands over the patient's chest. With all the strength of his shoulders he rapidly pushes down and releases. His compressions are rhythmic and systematic. Another medic follows behind restating his previous report. His lips are moving and indistinct words float through the air. I am not paying attention, however, because my focus is on moving the patient over to our cart. I switch places with the medic doing compressions. I continue the rhythmic down and up, down and up of chest compressions. My fingers begin to tingle and my knuckles turn white. The patient's face is right in front of me pale, white and empty. An ashen haze in the patient's eyes does not leave me much hope. As I continue my compressions I can feel the crinkly feeling, like Rice Krispies under his skin. I know that feeling to be his broken ribs that are now shattered from the continued abuse of compressions. My mind goes blank as the adrenaline pumps through my veins.

Two nurses, the physician, and I are inside running the code. Outside of our room is one nurse, Ann, and the secretary, Katie, who continue patient care on the three other patients in the department. Ann pops in and out of the rooms checking on their statuses. The drunk 22 year old continues to vomit but complains that his IV is irritating and cannot understand why no one is helping him. He just received Phenergan, a drug that will relieve his nausea, but it will take up to thirty minutes to take effect and that is obviously not quick enough for him. Surgery staff arrives for our 92 year old female. She will be taken for immediate surgical hip repair. Luckily, she will not return to us post-surgery; she will be admitted to a floor.

As Ann gives report to the surgical nurse the back pain patient stomps out of his room yelling at the top of his lungs how this hospital is "full of crooks and kooks." Katie attempts to get him back into his room but he refuses yelling, "I will not go back to my room until someone helps me!" Ann leaves her report halfway to talk with the belligerent patient when a very disheveled middle-aged woman comes running into the Emergency Department.

"Where's my husband?" She yells. "Oh, where's my husband?" Tears are streaming down her face as Katie grabs her by the hand and takes her past the code room and into the family quiet room. The pastoral care minister is waiting for her in there. He will provide comfort and care for her while her husband is being worked on. The door closes behind Katie as the page of "triage red" bellows overhead. This is the signal that an individual with chest pain has come in. She sprints over and grabs the EKG machine, the machine that shows the electrical output of the heart, and pulls it into triage. The mid-shift physician just came on and is there to read the EKG. The back pain will have to wait because this "triage red" is positive for myocardial infarction, or a heart attack. The cardiologist is paged and as quick as this person came in, they are rushed off to be prepped for surgery.

My arms begin to go numb as I continue compressions. Dr. Ahlers is about to call the code when he sees something on the monitor and tells me to stop compressions for a moment. I stop for a moment and stare at the monitor as the squiggly line on the screen goes flat. I count in my head, "one, two, three, four, five, six, seven, eight, nine, ten." Dr. Ahlers takes off his gloves and throws them into the trash bin. Defeated he mutters, "Time of death, 11:08am. I'm gonna go talk to his family." He walks out of the room and turns to the left heading towards the family room.

Looking around the room, medication boxes lie all over the back counter. Bloody syringes and laboratory tubes lay piled in the corner. The clipboard with Julie's chicken scratch notes lay on the stainless steel tray next to me. Looking over the patient in front of me I start thinking, for the first time, about who this patient is. I can't help but start to think about what type of life this patient has had. My heart sinks when I think about the pain his family is about to go through. I bite my lip and fight back a tear as I force myself to get busy helping clean up this gentleman.

Blood and mucous begin seeping out of the breathing tube that is in the patient's mouth. The respiratory therapist begins aggressive suctioning to remove all the contents. I begin cleaning the floors and countertops. The masses of supplies and packaging that get thrown around during a code never fails to amaze me. Once the trash can is filled and counters cleared, Julie and I begin cleaning up the patient. Any remaining clothes are removed and placed in a belonging bag. A fresh gown is placed over the patient. We place a warmed blanket over the patient. Even though the patient is deceased, it is still comforting for us to think that if he were alive at least he is comfortable. It is unnerving for someone to have such icy skin.

With the room ready for family, Julie brings in the patient's wife. Her legs tremor slightly as she makes her first steps into the room. A hand clutches her mouth as she takes in the sight of her deceased husband lying before her. The first tear of many to come gets wiped away as she reaches towards her husband. She clutches his shoulders and gives him a hug. Her blonde hair lightly brushes across his face as she kisses him on the cheek and whispers a final "I love you" into his ear. The tears stream down her face like parallel creeks running down her cheeks. Her puffy eyes dart around the now clean room and she begins to wonder how this all happened. I cannot even begin to imagine what thoughts she has flying through her mind, if she is even able to think about anything other than the cold, pale body that lies on the cart in front of her.

I slide out of the room and back onto the department floor. The smell of cleaning products hits me again and wakes me up to the work that's before me. Another "triage red" is announced overhead. As I grab the EKG machine to hook up and print off the EKG I can't shake off the look in that woman's eyes. That emotion is the reason we do what we do. Preserving life, to prevent more families and loved ones from experiencing this same emotion is our purpose in emergency medicine. Through the toughest of our jobs we fight through in attempt to do the most good possible for the greatest amount of people. That is the goal of the Emergency Department.