

Chapter 1

When Meaningful Life Has Ceased

Out of the chaos of the bustling Emergency Department they emerge: one male, one female, walking briskly down the corridor.

They are clad in scrubs and running shoes, with ID lanyards draped around their necks: the unofficial uniform of Brigham and Women's Hospital Emergency Department.

They briskly rub Purell® sanitizer into their hands as they walk, from one of the countless squeeze bottles positioned on every wall and flat surface. The commercial product has even become a verb at the hospital. "Purell in, Purell out" is the standard protocol before entering a patient's room.

The two deftly sidestep a large, shirtless man who is shouting incoherently as security guards restrain him. They pass a room where an elderly woman lies suffering quietly and an adjoining room where a middle-aged man with severe abdominal pain is being comforted by his wife. In the next bed, a teenager lies sprawled, nauseous and miserable, but still managing to tap out texts on her cell phone.

They walk briskly and purposefully through the mix of nurses and EMTs, crash carts and gurneys, because nothing is ever done at a slow pace in the ED.

At the door to a conference room, off the main corridor, they stop.

"Ready?" says the tall female.

With her athletic physique, blue eyes and brown hair, she looks like a neighborhood soccer mom. She is, in fact, a mom, a soccer player, and a distance runner. She is also a physician and one of the doctors in charge of the Emergency Department on this cold January night.

Her companion nods affirmatively. He looks young enough to be mistaken for a premed student from one of the many local colleges here in Boston, but is actually a third-year resident in the elite Harvard program.

They open the door and enter the room.

At the table, a petite, middle-aged blond woman sits, flanked by a friend on one side and Elaine Devine, the Emergency Department's social worker, on the other. Her lip trembles, but when she sees the two doctors enter the room she takes a deep breath and manages a smile.

"You look young!" she says to the male physician.

He smiles. "I am Young," he replies. "Dr. Young."

David Young, MD, extends his hand in greeting. She smiles, blushes slightly.

"And I'm Dr. O'Laughlin," says his companion, offering her hand.

Everyone sits.

The woman's father had been brought unconscious to the Brigham Emergency Department earlier in the day. The man was in his early seventies, a Vietnam veteran with a long history of heart trouble. An hour or so earlier, his struggle had finally come to an end.

The man had apparently collapsed in his home. EMTs raced to the scene after his daughter discovered her father lying on the floor. They administered CPR, and gave him a dose of epinephrine, but it was too late. There had been a period of about 5–10 minutes when his heart

had stopped, cutting off the blood supply to the brain. So while his heart had been re-started, and would continue pumping at least for a while, the man was dead for all practical purposes. An EEG might ultimately be needed to confirm absence of brain activity, but the physicians already know that he will not regain consciousness.

Dr. Young explains this, clearly and in layman's language. Unlike some physicians, who talk in jargon that leaves patients befuddled, he uses direct, plain English, a must in emergency medicine, especially in this kind of situation.

"...and so," concludes Dr. Young, "I'm sorry to tell you that your father is most likely brain dead at this point."

The woman, who has listened attentively to this point, suddenly goes pale.

"You mean... there's nothing you can do?"

Dr. Young sighs. "I'm afraid not. We don't think he will ever regain consciousness."

The recommendation is clear: Meaningful life has ceased for this man. Further treatment would be futile.

The daughter's eyes water.

"I had a feeling this time, it wasn't good," she says, bravely trying to summon the words. The look of weary resignation hints at many previous trips to hospitals. And then she weeps, as her boyfriend wraps his arm around her. "I'm so sorry," he says softly.

The woman looks up at the doctors, eyes pleading. "You mean there's really nothing..." her voice trails off, and quickly she composes herself. "I know you've done everything that's possible. And I want to thank you."

"No," says the social worker, as both doctors nod in agreement. "We wish we could have done more."

The gracious response of this woman to her father's death is not always the norm. In similar situations, some patients become combative and argumentative; others hysterical; some can even get violent. There are no classes in medical school that teach doctors how to perform this delicately human art of communicating bad news. "Everyone knows coming into this job that you're going to have to deliver terrible news if you work in the ER," Young says later. "We learn how to do it by watching others, and by reading people. Some want more information, others just want to grieve. Others get angry."

Dr. Kelli O'Laughlin, the senior physician, had no doubts that Dr. Young would handle it correctly. "We get to know the residents well," says O'Laughlin, who has been at the Brigham since 2008. "David has an amazing bedside manner. For some others, I would have stopped and said, 'Have you done this before?'"

If not, she would have reminded them that they should never have any blood on their coats when they meet with family members. She would have reminded them to introduce themselves and to find out exactly what the family members know at that point. And she would have reminded them that the best way to share the news is in the clearest, most direct way possible. If a person has died—or in this case, death appears imminent—say so. Don't say, "They're not going to make it," or "they've passed."

"We try to be appropriate but explicit," says O'Laughlin. "Which David was."

The poised and measured reaction of the daughter to her father's situation made it a little easier. "It's always hard," Young says. "But it's different if you're talking about an older individual. If it's a 20-year-old kid, you may cry yourself."

There is a brief, respectful moment, when the doctors, the daughter, the social worker, and the boyfriend sit in silence, reflecting on a life that is about to end. Then the two doctors rise, express their sympathies, and leave the room. There is no further discussion or commentary.

There is no time.

While the phrase “24/7” has become common in today’s society, it has real meaning here. The Brigham’s Emergency Department is always open for business. Twenty-four hours a day; three hundred and sixty five days a year. Sixty thousand Boston area residents and others rely on it annually for everything from toothaches to heart attacks. According to the Centers for Disease Control and Prevention, emergency rooms like this one treat 136 million Americans a year. Additionally, the next generation of Emergency Room physicians train here and at its residency partner facility, Massachusetts General Hospital.

The physicians and nurses in these emergency departments are typically referred to as being “on the front lines” of the healthcare system. They’re also in a relatively new branch of medicine.

“In the old days any doc trying to make a few extra dollars would work the ER,” says Dr. Gregg Greenough, one of the Brigham ER’s supervising physicians.

The specialty only began to emerge in the 1960s, prompted in part by a blistering critique by prominent trauma surgeon Robert Kennedy that labeled emergency room care “the weakest link in the chain of hospital care in most hospitals in this country.” Indeed, the ER of that era was a terrifying place. Most were poorly organized and had long wait times and crowded conditions. This created an environment that was inefficient, inconsistent, and, in many circumstances, dangerous.

Pioneering heart surgeon Michael DeBakey helped provide the funding that built the modern emergency medical system, when a commission he led advocated an overhaul in healthcare infrastructure that would include improved “immediate and emergency care for patients with acute cardiovascular emergencies.” DeBakey’s report led to the Heart Disease, Cancer, and Stroke Amendments of 1965, which poured hundreds of millions of dollars into the creation of our modern medical system, including emergency services.

Meanwhile a few visionary physicians who saw the dire need for improved emergency services, forged the new specialty that would help ensure that the new system of hospital ER’s would be staffed not by moonlighting docs looking to make a few extra dollars, but by professionals dedicated to a new form of medicine: emergency medicine. In 1973, a new professional association representing this new medical specialty, the American College of Emergency Physicians, was formed.

Of course, neither a national organization nor even a world-famous heart surgeon can compete with Hollywood for attention, and many people believe that it was a TV show that gave the emerging discipline of Emergency Medicine a needed boost of glamour and excitement.

Greenough was a young emergency room physician at UCLA medical center when the TV drama *ER* debuted on NBC in 1994. “I think the show really helped drive the profession,” he said. “Suddenly we felt like it was a sexy thing we were doing. And it gave the public an appreciation of the specialty.”

As with any profession, the reality of both the training and the job is a little different from the television portrayal. Suffice it to say, George Clooney, who played Dr. Doug Ross on *ER*, is not on the staff at Brigham and Women’s. As for the torrid love affairs, the melodramas, and the political intrigue that dominated the plot lines of the show that ran for 15 years—well, none are quite as torrid or as intriguing.

Even the name is inaccurate. The emergency area of the hospital in the 1960s was called an ER, because that's basically what it was. A room. Today, it's called an Emergency Department, to better reflect the size and complexity.

"We cringe at the thought that it's only one room," says O'Laughlin, chuckling.

Whatever you call it, the ED is not a place for the faint of heart; or those who prefer a calm, structured work environment. Intense pressures are placed upon those who work there and with good reason. The stakes are simply higher. That reassuring bromide used in other professions to allay fears over the ramifications of a decision—"hey, it's not life or death"—does not apply here. Many of the decisions being made in the ED *are* a matter of life or death.

The purpose of this book is to show you what life is really like in a big, urban Emergency Department, and what it takes to become one of those who work there; one who has to make the split-second judgments that will determine whether a patient survives or not—and deal with the consequences, either way.

We'll explore what it takes to be an emergency physician through the insights of Dr. Michael VanRooyen, Vice Chairman of Emergency Medicine at the Brigham, and the observations of co-author John Hanc—a veteran health writer and narrative journalist, who was given unprecedented access to the ED.

In his position as vice chair, Dr. VanRooyen oversees a staff of 56 physicians certified in emergency medicine, including Young and O'Laughlin. But among his colleagues, he is best known for his work in humanitarian medicine. He has worked as an emergency physician with relief organizations in over 30 countries affected by war and disaster, including Somalia, Bosnia, Rwanda, Iraq, North Korea, Darfur-Sudan, Chad, and the Democratic Republic of Congo.

His work in the midst of conflicts in Africa and the Middle East would help him in surprising ways back at home. On April 15, 2013, the Brigham would find itself in the unusual position of being a trauma center for bombing victims. In the wake of the Boston Marathon terrorist bombings, VanRooyen, as well as David Young and Kelli O'Laughlin, Gregg Greenough, and most of their colleagues, would find their metropolitan ER transformed into something out of Baghdad circa 2006.

But on this night—the night Young had to tell a daughter that her father was brain dead—the Boston Marathon was still three months in the future.

Waiting for them when they emerged from the conference room on this night was a long list of typical ER patients: a heroin addict who had overdosed; another flu case; a woman who had slipped on the ice while skating with her child and gashed her face; a man with abdominal pain.

Within minutes, Young was in a patient room examining an elderly woman who had fallen and bruised her hip. O'Laughlin was being told that another heart attack victim was being transported by Medivac from a small hospital near Cape Cod. He would require cardiac surgery.

As she picked up the phone to contact the cardiac surgeon on call, she noticed a patient lying in one of the trauma bays. It was the father of the woman they had just met with, the now brain-dead Vietnam veteran.

She called one of the nurses. "Have him brought up to ICU," she said.

Had there been hope of his regaining consciousness, this is where he would have gone. But this was not Dr. O'Laughlin's motive in this instance. In less than an hour, he would expire. "He deserves to die somewhere quiet," she said, gesturing at the clamor around her. "Not here." She pauses. "Besides, we need that space. We have more acute patients coming in."