By Mark Katz, MD

Earning A Second Doughnut

I'll never forget the moment I saved a doctor's life.

He was—and still is—a doctor of optometry, not a medical doctor, but a human on God's earth all the same. Sixty-four-year-old Ralph Peters entered the ER early one Tuesday morning with his wife at his side, his face ashen as he complained of severe chest pain. He didn't know it then, but he was about to develop the fatal rhythm disturbance known as ventricular fibrillation.

It was around 5:30 am, and it was my usual Monday overnight shift. I was especially rosy this morning—I had slept until 4:30 am in the call room as it had been quiet and the other two doctors on duty didn't need to call me until then. I had already downed a cup of coffee—a fresh brew that I had prepared myself. My teeth were freshly brushed and my mouth rinsed generously with cinnamon-flavored Viadent.

The major anxiety on my mind at the moment I saw Dr. Peters walk through the door with his fist over his chest—an interesting gesture which signifies surrender and/or angina pectoris—was that the department had become rather busy in the previous 15 to 30 minutes. The early morning hours of 4 to 8 am are known medically for a higher incidence of heart attacks, but, in addition, these hours often herald a parade of patients who need work excuses for the preceding day they have just missed—often feigned as "a cold which I just got over yesterday."

"Paul," I said to the other doctor in the department, "If you can see the rash in room 2, the UTI in 3, and start on the abdominal pain in 7, who looks stable, I'll get to this chest pain." Indeed, in ways more than metaphysical, in the lingua franca of emergency medicine, patients became and indeed were their diseases.

"My pleasure, Mark," he smiled, his kindness sincere! He was a cardiology fellow who was moonlighting with us, and it always felt reassuring to have a cardiologist on hand when the vapors smacked of something serious about to happen.

I erased the "TBS" ("to be seen") notation next to the name "Peters" which had been placed on the huge white traffic board and placed my "MK." I entered the room, noticing that my pens were lined up neatly in my pocket and that there were no stains on my new white coat. The patient was taking off his maroon LaCoste shirt and had sat down on the hospital cart.

"Hello, Mr. Peters, I'm Dr. Katz, the emergency physician on—"

"*Doctor* Peters," emphasized his wife, who was hastily dressed but with time nevertheless for lipstick. It seemed more important to her than to him, and he just smiled. Lynn, the nurse, placed oxygen prongs into her patient's nostrils as his wife spoke.

"Oh, excuse me, Doctor Peters," I politely corrected myself.

Now, at that moment, many of my fellow emergency physicians would have declared war, albeit a tacit war. The offense would be to use terms so technical and grandiose as to leave the enemy tethered and begging for mercy in the form of, "Could you please explain that to me? I don't understand."

But as for me, I was feeling centered as the caffeine coursed through my blood and thus inquired: "Oh, what kind of doctor are you? This helps me to know how technically to explain things."

"I'm an optometrist," he smiled again, as I noted the scratch on my eyeglasses and how spotless his were. He appeared to be in less pain since the oxygen had been started and he had been placed at rest.

I quickly set out to obtain a history while Lynn placed cardiac monitor leads on Dr. Peters' chest. His wife stood close by in this 8-by-10 foot treatment room; I was used to feeling claustrophobic, but I have always felt that a patient in an emergency department who so desires should be allowed at least one friend or family member present.

He told me as his wife stood by silently that he had developed the crushing chest pain 45 minutes earlier, during sexual intercourse (at which time I wondered if his wife's lipstick was applied before, during, or after; and I silently congratulated this couple on being sexually active at 4:30 am!), that he had never had chest pain before, and that he and his wife were both CPR instructors. Thus, they knew this could be a heart attack. The chest pain was now still present but was mild compared with the peak around 30 minutes earlier. I ordered a nitroglycerin tablet, and, as it dissolved under his tongue, I looked into his eyes and realized he was frightened.

I had already determined from his history that he would be "a keeper"—even if this were stomach gas or a pulled muscle, new chest pain in a man over age 50 gets the so-called "full court press."

"It's irregular," his wife nervously pointed out, and I observed, as I glanced at her now, much greater concern for her husband's heartbeat than even for his professional title. I looked up, my index finger on Ralph's radial pulse, and saw clear evidence of premature ventricular contractions.

We needed an IV line immediately in order to give a dose of lidocaine. I might have appeared calm to someone who didn't know me well, but I also knew my right leg was shaking uncontrollably under the white coat. Lynn was occupied with the EKG, which was also key at this moment to help diagnose a possible heart attack.

I walked out of the room, and another nurse, Steve, stood nearby drawing up an antibiotic I had ordered for a man in the next room who had been diagnosed with strep throat.

"Steve, I need you right now, please, to start an IV, stat, right here in 11. He's got multifocals with chest pain." I was simultaneously gentle and firm.

He clearly heard me and, competent nurse that he was, placed the line within a single minute. As the line was taped in place, I saw multiple PVCs again on the monitor, so frequent now that I assumed Dr. Peters would be dizzy or having some symptoms therefrom.

With my hand on his pulse, my eyes looking over at the computer-read EKG that Lynn was pulling out of the machine that read, "Acute myocardial infarction," I asked him, "Are you dizzy at all?"

"Nope," he smiled, "and I feel real confident in you. What's up?"

"Well, it appears you're in the earliest stages of a heart attack,"

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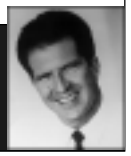

and I returned the compliment by smiling and speaking calmly. "And you're certainly in the right place, because we can take care of anything which happens from this moment on." (Not entirely true, but there are moments where reassuring the patient becomes tantamount to the realities which may supervene.)

"Lynn, give Dr. Peters an aspirin to chew, stat, and draw up 100 of lidocaine. Also start a drip at 2 per minute, and I'd like a half-bolus—"

I cut my own words off as I saw the monitor above my head, but behind his, change its wave form to the entirely irregular saw-tooth form which could only mean one thing.

"Call a Code!" I shouted out to Michelle, seated ten yards away at the clerk's desk. I quickly and methodically rattled off orders as if delivering my lines in a play I had acted in every night for several years: Lie him flat! Oxygenate him with the Ambu bag! Get the crash cart over here! Start CPR! Get ready to defibrillate super-stat!

I recited my part, but I felt my mouth become sticky as cotton as his eyes rolled back and his face became plethoric. He began to froth at the mouth as his limbs contorted into spasms followed by seizure-like waves.

"Where's that defibrillator?" I snapped to Steve, who appeared with the huge red, oversized tool-box-like contraption within another ten seconds.

I turned around to see that Mrs. Peters was gone and in her place stood two nurses and a respiratory therapist who had come to assist with the resuscitation. I began performing CPR on the chest of this CPR instructor who was probably in the bliss of orgasm an hour ago and was now in the process of actively dying.

"Bag him, please, Gina," I ordered the respiratory therapist until he could be properly intubated by the anesthesiologist.

The moments of waiting for the defibrillator seemed like hours, and I imagined Mrs. Peters calling her lawyer and reporting, "He came in walking and talking. They didn't start the IV soon enough. I even saw the PVCs. They've killed him!"

As I compressed Ralph Peters' sternum the requisite 1.5 to 2 inches mandated by the American Heart Association, I looked at his lifeless face, and I felt some of the life drain from mine.

Within the next minute, the paddles were placed on his chest by the charge nurse, Liz. "Shock him at 200," I proclaimed, and I heard the combination zip-hum of the machine as it warmed up, and with a touch of the red button, its accumulated wattage surged through Dr. Peters' chest.

Within three seconds, the monitor showed evidence of restoring a normal heart rhythm.

I breathed more easily as he began to breathe on his own—still with the assistance of oxygen, but his diaphragm was now spontaneously contracting as it had done approximately 10 million times a year since his birth.

Mrs. Peters now appeared in the doorway and, with a lump in her throat, asked, "Is he back?"

I looked down at her husband, whose eyes were now opening as he put his hands almost reflexively to his chest, to the site where the current had entered.

"You're okay now, Dr. Peters. Your heart went into a faulty rhythm, but we've corrected it and have the situation well in hand."

"He's doing okay now," I said to Mrs. Peters. "Would you like to come in?" I offered. I realized as she stepped into the room that for the more than 500 patients I had taken care of in cardiac arrest over my 19 years as an emergency physician, all but a few were in arrest at the time I first came upon them. It was easy to objectify and depersonify someone with whom you never have had a conversation. But to see someone to whom you have been speaking suddenly "go out"—this causes the heart of the nonfibrillating onlooker to palpitate furiously!

As if to rescue me from my probably visible anxiety, Ralph began to speak, his words directed at me. "It was a dream. I saw you and everyone else in black and white, moving without words and in slow motion, almost like the blacklights we used to have. Then you all suddenly came to in color again and I heard voices—'he's back,' or something like that."

His wife took his hand, and, as she squeezed it, she said in such rapid succession, "I love you" to him, and "Thank you" to me, that the combination caused my eyes to engorge with tears. "You saved his life, Dr. Katz," she acknowledged.

"We actually had the entire staff here to act swiftly," I said. "It's our job, and we're glad you came in when you did."

I accompanied Ralph and his wife in the elevator to the intensive care unit, feeling as if I was bouncing on the same high-pressure oxygen that we had given him a few minutes earlier. I said "Good morning" to people I would have usually merely nodded to.

As my shift ended, I performed my usual Tuesday morning ritual of driving away from the Kaiser Permanente campus and stopping at Yum Yum on the next block for a chocolate-covered, old-fashioned doughnut.

As a counterboy in my Dad's luncheonette 35 years earlier, I used to wonder how people could eat the same thing every morning, but now, on the other side of the counter, I found a sense of security in the consistency of my request! I often thought about the calories, empty ones at that, contained in these beautifully shiny glazed confections which nevertheless afforded me some sense of tranquillity which I desired, if not deserved, after my overnight shifts.

I also appreciated now that both countergirls knew my order as soon as they saw me enter. I gave Rosa a dollar tip this particular morning, then smiled and exchanged greetings as she all but bowed to me. After leaving the shop, I quickly finished the doughnut before even my first sip of coffee.

I stopped walking toward the car and felt a pang of desire—for another 450 calories—but today it didn't bother me. I turned around and retraced my steps into the shop and told a smiling Rosa, "I'll have another one, please!" ❖