Through the generosity of Charles R. Millikan, D. Min., vice president for spiritual care and values integration, an annual award competition was established at The Methodist Hospital among the resident staff. For the second competition, residents submitted a poem or essay of 1,000 words or less for the topic, "On Being a Doctor." A committee of 5 was selected from The Methodist Hospital Education Institute to judge the entries. Criteria for judging were established by this committee. The 2nd place winning essay is herein published. The author is a minimally invasive surgery resident. The 3rd place winning entry will be published in the next issue of this journal.

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BUT IT WAS TOO LATE

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Everywhere you turn today, health care is all about outcomes. Insurance companies use them to rank physicians. Hospitals use them to see where they stand among competitors. Even patients use them to determine which doctor they will visit. However, outcomes are not always what we want them to be. Sometimes things go wrong. Sometimes people die. And sometimes there is nothing we can do about it.

I have worked with many different staff physicians throughout my training. Each has taught me valuable lessons. But the biggest lesson I learned was when I was not looking to learn anything; rather, I was simply trying to maintain some inkling of professionalism and fighting the urge to run far away from the beeping machines and sick patients of the ICU.

It was a Friday night at the VA, and my staff had left. Ghost town doesn't start to describe it. I had just wheeled our fresh postop into the SICU, hadn't even tucked him in, when one of the ICU nurses came and tapped me on the shoulder to tell me another one of our patients was having respiratory distress. I asked for an updraft, but when I turned my head to glance in his room, I saw the dreaded swarm of nurses around his bed — the sign that my patient was about to code. I quickly realized that an updraft wasn't going to cut it. I hurried over.

"What happened?" I asked, watching his oxygen saturation hang in the high 80s. He had been fine when I had seen him just a few hours earlier. His nurse said she thought he aspirated. She had been suctioning tube feeds from his mouth for the past hour. I started positioning him for immediate intubation when I realized the fluorescent light above his bed was out. One of the nurses had a flashlight. I looked in his mouth with a Miller blade. All I could see was a rush of tube feeds.

Suction. Look again. More tube feeds. Cricoid pressure. Suction. More tube feeds. Couldn't even catch a glimpse of the cords. Called for help, CODE team, anybody. I really needed two sets of hands: one to suction, one to intubate. No other physicians were nearby. I tried to employ the respiratory therapist, but she was paralyzed watching the monitor as the oxygen saturation continued to drop. I blindly threw the ET tube down. It landed in the esophagus. Oxygen saturation had dropped to the 60's. I had to try something else.

Asked for a ten blade scalpel and a small ET tube. Palpated for the cricothyroid membrane, which was difficult in a patient curled up in an air mattress. Bit the bullet and made an incision, dissected down only to find I was above the thyroid cartilage … too high. Made a lower incision, found the membrane, incised it, threw the tube in, and kicked myself for making the wrong incision the first time. Vitals stabilized, oxygen returned to 100%, but the patient made no further purposeful movement. I feared he had gone too long without oxygen.

I called my staff to let him know. He came back to the hospital only to find me, in bloody scrubs, hunched at a computer outside the room, defeated. I thought he was going to yell, to ask me why I hadn't called him earlier. (It had all happened so fast!) Instead, he gave me a hug and said he was proud of me for trying.

"But it was too late," I moaned.

"Sometimes it is," he responded, "but you did everything you could. I've seen three staff surgeons standing around a patient stalling on doing a cricothyrotomy up until it was too late. You went for it. You did everything." I nodded in comprehension but still felt numb.

It was time to call the family. In the calmest voice I could manage, I explained to the patient's daughter what had happened. She came to the ICU in the middle of the night. She hugged me when she saw me at the bedside. All I could think was, "I was too late."

The patient was made comfort care after imaging confirmed my fear: anoxic brain injury. He passed in the following days. To this day, I still think "What if? What if I could have just intubated him? What if I had been accurate with my first cut? Would he still be here?" These questions will never be answered. But every time I rehash this in my head, I think of my staff and his reassuring comment, "You did everything."

The outcome may not always be what we want it to be, and sometimes, in reality, we have to accept that we did all we can do. Emerson said, "Finish each day and be done with it." Roosevelt said, "We have nothing to fear but fear itself." I think they are both right. If we hold on to all of the patients we have lost, we will become paralyzed — and we will not be able to help those who are still here and in need of a healing hand.