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CRITICAL CARE:

Critical care at Shockarama

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This is a story, loosely based on fact, about starting a critical care fellowship. There are many reasons for wanting such a fellowship; I hope the following shows you some of mine and maybe helps you realize if critical care is right for you, too. On that note, here's my two cents. And it really is two cents, because that's what fellowship pays. But, it's worth every cent. Really, both pennies!!!

Mirror, mirror on the wall, who's the cutest fellow of them all? ME!

I am in my critical care fellowship at Shock Trauma, also known as "Shockarama" or, simply, "Shock." It's a surgical hospital separate from, yet connected to, the University of Maryland. We have our own "ED" called the trauma resuscitation unit, or TRU. We have our own ORs, PACU, ICUs, intermediate units, and floor beds. We do some rotations at the University of Maryland, or "the dark side," as we call it, but most of our time is at Shock. We rotate only through the TRU and ICUs.

My first block was in the multi-trauma ICU. I volunteered to take the first call - Saturday, July 1, a date that strikes fear in the hearts of interns and residents everywhere. Too foolish to be scared, I was exhilarated. I can hear all of you across the miles, "What a schmuck!" Or am I?

That night I placed an a-line, a subclavian triple lumen, changed another subclavian triple lumen to a Cordis, and then floated a Swan through that Cordis. That was my first Swan ever. Woo-hoo! I did 2 floor consults, admitting one to the ICU. The other one? Well, she may have been hypotensive, but she was mentating just fine; well enough, in fact, to tell me to go away. In medical school they always told us to listen to our patients, so I did as she said, and I went away.

> "Where else can you work 36 hours, go home exhausted, and think 'what an awesome night?', and you can't wait to get back?"

Since then, I have done a bunch of bronchs, a crop of chest tubes, a series of central lines, a lot of a-lines, started an FFP drip (I had never even heard of an FFP drip!), vented with nitric oxide, excellently extubated, and run a cadre of codes. We run our own continuous renal replacement therapy (CRRT) without any nephrology involvement, so I write all kinds of crazy orders: substitution fluids, ultrafiltrate, trisodium citrate, and more.

My first "code" wasn't really - it was a patient who went into a-fib. Transferred to us from the SICU on the dark side, cardiology was already following him for a-fib w/ RVR. They had considered shocking him, but didn't. Of course, he waited until I was alone at 3 am to go into a-fib with a ventricular response of more than 150. The nurse gave him metoprolol before I could get there. That did nothing. I gave diltiazem. That didn't do anything except drop his pressure. So I ordered dig, which also did nothing except bring his pressure back up. I ordered amio. The amio laughed at me as it had no effect. I shocked him at 100, 200, 300, and 360. I'm sure it hurt, but it didn't touch his a-fib. I gave another 150 of amio. Now both doses of amio were laughing at me. I felt like I was in Shel Silverstein's "When the Sidewalk Ends." What do you do when you get to the end of the algorithm?

I've learned that "24-hour call" is like the Hanukah Armadillo, both are good stories, but eventually you learn they are figments of your imagination. Call lasting 30-36 hours is more like it, and it's awesome! Where else can you work 36 hours, go home exhausted, think "what an awesome night," and you can't wait to get back? I've learned to take power naps and

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EMRA welcomes 4 new members to the Board of Directors!

Learn more about them on pages 20-21.

ACEP REP REPORT:

Reflection: wisdom from a senior physician

BY DEREK J. ROBINSON, MD, *UNIVERSITY OF CHICAGO HOSPITAL, CHICAGO, IL*

ACEP REPRESENTATIVE

As young emergency physicians, we have the unique privilege of serving patients from all walks of life, most of whom we have never met before. There is an awesome amount of trust that we are afforded by our patients as we provide them with medical care. At the end of a shift, we have made several hundred decisions, leaving far behind the energy level that we brought to the ED. Often lacking is an opportunity to reflect upon the decisions of the day. In my final article as the ACEP Representative, this is also a time of reflection for me.

After a recent shift, I thought of one of my attendings from medical school, Dr. LaSalle Leffall. For many years, Dr. Leffall has been an icon at Howard University College of Medicine and widely respected in the specialty of surgical oncology. Moreover, Dr. Leffall was known amongst the medical students for his famous sayings and high expectations. As I walked to my car, I could hear his voice saying, "At the end of the day I ask myself, what did I do that I should not have done and what did I not do that I should have done?" Our many decisions each shift span from patient care to staff management to risk management and beyond. Incorporating such reflection into each shift can serve to improve each of us as clinicians and leaders in our EDs.

It's hard for me to mention Dr. Leffall without elaborating on the indelible impression he made upon my class each time we met. Always respectful, confident, and meticulous, he did not have to ask for our admiration. He was the physician that every medical student strived to be. When presenting a patient's case before the esteemed Leffall, most students were prepared to elaborate on any aspect of the pathophysiology and appropriate treatment plan. What scared each of was whether he would call one of us to spell "guaiac" or recount some other seemingly less important detail in medicine. I think most of us took those surprises in stride as they only served to improve us all.

> "In short, he emphasized that 'equanimity under duress' was an important obligation."

On the drive home, I recalled more. Another engrained memory from my observation of Dr. Leffall was his sense of urgency with everything. From answering questions during a presentation to providing care for patients, his voice refrained, "Quickly! Quickly!" We learned that the purpose of his request was not to be disruptive or to encourage loss of control; his desire was to teach each of us to be efficient, excellent, and in command of ourselves despite the circumstances. In short, he emphasized that "equanimity under duress" was an important obligation.

A final reflection of Dr. Leffall reminded me of how his brisk pace and good looks masked his age, which was only revealed by the caliber of his wisdom. Growing up in the 1930s, he was educated in the era of Jim Crow and "separate but equal." When I think of the important personal choices that I have made in my life, I frequently attribute my better decisions to the wisdom and guidance provided by those around me. He often quoted one of his mentors, Dr. Charles R. Drew, by reminding us that, "Excellence in performance will transcend artificial barriers created by man." Leffall was the first African American president of the American College of Surgeons and the American Cancer Society.

Regardless of your social or cultural background, this reminder can serve as an important motivator for you when facing an uphill battle. To learn more about Dr. LaSalle Leffall, you can read his recently published autobiography *No Boundaries* (ISBN 0-88258-251-8). ■

Critical Care

CONTINUED FROM FRONT COVER

discovered the rejuvenation power of a clean pair of socks.

I've learned when you get a floor consult, you go ASAP, because it means there's a nervous resident who knows only that something bad is happening. I've intubated on the floor. I've run a code for a patient in acute pulmonary edema after a hyperbaric oxygen treatment (our chamber is the largest on the east coast). Lacking things like a nitro drip at the chamber, we ran the code while running back to the ICU, bagging the patient in a sitting up position flying through the hospital. Like a scene out of "ER."

Finally, I took care of an organ donor, an experience both tough (dealing with the family) and humbling. Her family had the worst July 4th ever, but four other people had the best July 4th ever. Saving four people at once! Humbling.

I've become comfortable returning pages with "Critical care fellow, I was paged," and gotten used to having acronyms like APRV (look it up, or lookup "Bi-Vent") and BiVAD bounce around in my noggin while trying to remember the difference between SLED, CVVH, and CVVHD. I go to sleep wondering what crazy thing will happen tomorrow.

On the lighter side, Baltimore is great. I live a block from Camden Yards and two blocks from the Inner Harbor. The area is wonderful, and I'm happy I'm here. I can't wait for my first attending job, but if I could make the money as a fellow, I'd sign up forever and never look back. ■