One Good Night

In the ED

Downtime in the ED is unusual, but on this good night, there were few patients. There was time to eat takeout, swap stories about fascinomas, and wonder about patients not seen in a while. A *good night* is just as ominous as a full moon night when patients are drawn into the waiting room for nothing more than mysterious lunar reasons.

On this particular night, the paramedics called to notify us of a cardiac arrest in progress. The 53-year-old man was unresponsive, not breathing, pulseless, and in ventricular tachycardia. I ordered the paramedics to defibrillate the patient and administer epinephrine and lidocaine followed by accelerating jolts of defibrillation. There was no response from the patient. "Transport to the nearest emergency room," I told them.

"Ok, Doc. ETA is 8 minutes; we are going to you," said the paramedic.

I thought to myself, "Of course you are. Where else would you go on a *good night*?"

We designated a cubicle for the patient, opened the crash cart, and donned masks and gloves. We paced in silence. The atmosphere was somber. The paramedics called again, "Doc, we have a 51-year-old man who is unresponsive, pulseless, and not breathing. We're seeing ventricular tachycardia on the monitor."

"Is this the same patient?" I asked.

"Doc," the paramedic answered, "I know this is a coincidence. I heard the previous transmission, but this is a different patient." Again, I gave an order to defibrillate and give epinephrine and lidocaine followed by more defibrillation. The patient did not respond. I told them to transport to the nearest emergency room. "OK, Doc. ETA is 7 minutes. I know you have your hands full but we have to go to you. You're the closest," said the paramedic.

"Of course we are," I thought to myself again.

I paced in silence. What are the chances of 2 patients around the same age presenting with the same catastrophic problem at the same hospital on the same *good night*? I shrugged off the eerie similarities. Within minutes, 2 fragile patients dangling between life and death would arrive in the ED.

The patients were wheeled into the ED in tandem as their families struggled to keep up behind each gurney. The paramedics were compressing their chests and giving bagged breaths. "No change Doc," each team stoically reported as they rolled past me. In a singular swift move, the patients were placed on neighboring stretchers. I darted from patient to patient ordering monotonic medications, but the twin rhythms continued. There was still no response from either patient.

After 15 minutes, 22 orders, and 7 medications, I quietly planned my exit strategy. I thought, "Which patient do I give up on first? Can I pronounce them dead simultaneously? Which family do I speak to first?" Neither of the families looked prepared for what I would tell them. Not ready to give up, I gave more orders.

After 24 minutes, the patients' statuses changed. One came back and was transferred to the ICU, but the other was pronounced dead. One sobbing family heard promising news, while the other received devastating news. These patients were medically identical in unbelievable ways, except in the most imperative way. I spent the rest of my shift pacing in silence.

Before that night, I had often heard people say, "It just wasn't their time," or "When it's your time to go, you can't do anything about it." But that night, I learned that a patient may not survive despite my best efforts, and when a patient lives, it does not mean they would not have survived regardless. I realized that something anonymous and unyielding to doctors plays some nebulous yet masterful role in living and dying. Under the right circumstances, I am a humble conduit more than a doctor. No longer superstitious, I look forward to good nights and full moons with much anticipation.

—Jo-Ann Reteguiz, MD
Newark, NJ