

Room 3206

JANE CHURCHON

Mr. K. was forty-two and almost dead, kept alive by machines, tubes, and liquids that would at best give him two or three days more. His wife had brought him to the emergency room, probably because he was confused or vomiting or had chest pain. It soon became clear that he had taken too much Vicodin or heroin or any one of a number of potentially lethal drugs, perhaps by accident, perhaps not. No one knew for sure; he'd fallen unconscious soon after his arrival at the ER. We had only his lab results and his family to fill in the blanks, and they told different stories.

He was from Bosnia, someplace I knew nothing about. Under the cold lights of the ICU, his smooth skin shone like light coffee. His wife was from the Philippines. He was Muslim; she, Catholic.

I'd been an ICU nurse once but had scaled — or, depending on one's viewpoint, descended — the ladder into an administrative nursing position. When I'd swum in the ICU ocean, I'd performed CPR on a regular basis, and I'd cared for many patients who were on life support. I used to tell people what I did for a living was “keep dead people alive.” Machines inflated their lungs and kept their hearts beating so we could officially count them among the living.

I pieced together Mr. K.'s story from conversations overheard in the hallways and comments made by the nurses. For some reason it made me long for the days when I could touch patients with my hands, when I would turn them every two hours or bathe them, imagining each one was my child, my partner, my mother. I still miss the physical intimacy of running my hands across their failing bodies, hoping that perhaps

this one will live to see his grandchildren, will walk out of the hospital with a healed body and an able mind.

As Mr. K. got on with the business of dying, his multicultural, multilingual family congregated outside my office, which is just around the corner from the ICU. I keep my office door open, and on the day Mr. K.'s relatives and in-laws arrived, all of them missed the sign for the ICU. I could hear them wandering the halls, murmuring in different languages until they stopped at my open door and waited for me to turn around at my desk. Each group of two or three asked me, in accented English, where Mr. K.'s room was. At first I was as courteous as a new nursing student, but by the tenth or eleventh group of people, I began to tire of my role as information booth. By the time the last batch straggled in, I'd stopped turning around in my office chair and simply interrupted them with a curt “Room 3206.”

There were twenty or thirty of Mr. K.'s relatives in the corridors, small children running up and down, their shoe rubber squeaking on the waxed linoleum. As I determined where to put patients in our overcrowded hospital, the sound of foreign conversations drifted into my office — so many that I closed my door to concentrate. The ICU waiting room, which shared a wall with my office, shook with the sound of cartoons and the shrieks of young boys and girls. In the afternoon I heard arguing and walked over to see a middle-aged man poking his finger into the chest of another middle-aged man while a woman cried in the corner. The first man said, “How do we know you care about us, when you ain't never visited our house?”

A woman cried, “She's my baby sister. I can't stand it.”

A man told her, “You got to. You don't have no choice. Your babies need you now.”

One woman stood outside my office speaking on her cell-

Some details in this essay have been changed to protect privacy.

— Ed.

GARY MATSON



phone: “They’re giving him until eight o’clock to die. His liver’s shot. There ain’t nothing there no more where it was. He ain’t got no brain waves neither.”

When death hangs over a patient, the stress for the family becomes almost unbearable. Arguments that have lain dormant for years arise like floating coffins after a flood. Mr. K.’s and Mrs. K.’s relatives, it seemed, had never gotten along. Mr. and Mrs. K. were married; their families were not.

The ICU staff chatted about Mr. K.’s liver failure and approaching death. As medical professionals, we could tell which type of drug had caused his liver to fail, but we could not say how Mr. K. had come to acquire and ingest that agent. According to his laboratory values, Mr. K.’s blood was weighted with foreign substances purchased and consumed in quantities that the manufacturer did not intend. The labs told us that Mr. K. had been medicating his pain, whether physical or emotional, by swallowing or sniffing or shooting drugs into his body, and in so doing had shortened his life.

His family refused to hear this information, insisting that the tests were wrong, that Mr. K. was all that he’d appeared to be: a loving husband and father, a good son. We of the American medical profession knew better. But Mr. K.’s family members were not originally from the U.S. and were suspicious of our pink do-gooder faces. We were liars, telling them that Mr. K. did drugs. We were liars, telling them that he was going to die, when just yesterday he’d been sitting with his three young children, his head thrown back in laughter, his teeth white against his beautiful brown skin. We were wrong. We must do everything we could to save Mr. K.

On Mr. K.’s second day in the hospital, his nurse told me about some changes in his lab values: his blood-clotting factors had been affected by his liver’s degeneration. The fragile mechanism by which bleeding is stemmed has a romantic-sounding medical name: the “coagulation cascade.” A series of blood factors must be present to cause a scab to develop. Too much coagulation causes blood clots in the veins; too little causes us to bleed to death from small cuts. Hemophiliacs are most often lacking factor 8. If any one of the factors is missing, the ones that follow — 9, 10, 11 — will not be able to form. The cascade will become a rushing river, impossible to dam. When the nurses drew Mr. K.’s blood for labs, his bleeding times were quite prolonged. He was running the risk of hemorrhaging.

At his family’s insistence, Mr. K. was what we call a “full code.” This meant that if his heart rate began to falter, rather than allow him to die peacefully — as we did with a “no code” patient — his nurses would perform CPR on him and shock his heart back to life. Because Mr. K.’s blood showed an inability to clot properly, CPR presented a problem. As his nurse put it, “When he codes, he’s just going to start squirting.” Pressing hard on his chest would cause any blood leaking from his organs to shoot up through his esophagus and out his mouth and nose and ears. “It will be a blood bath in there,” she said. “But the wife won’t let him be a no code. When I went home last night, all I could see were his kids’ eyes. He’s got the Catholics

praying for him; he’s got the Muslims praying for him. I’m just praying those kids aren’t in the room when he goes.”

I remember the ambivalence an ICU nurse sometimes feels about saving lives. We run and sweat our way through sixteen-hour shifts, doing everything possible to save patients. Yet we know the horror of maintaining life near the end. We are aware of the needless suffering that our patients often endure for the sake of a few extra days or weeks of life, time they will spend as victims of our needles and tubes. Our tasks seem simple enough. For instance, we turn patients from one side to the other every two hours. But this does not tell of the pain we inflict while we lift the sheet beneath frail bones and raw skin. After a few months of hurting people on their road to death, we become cynical. We begin to feel more like torturers than caregivers. We dread those moments when we will be called upon to perform extraordinary measures — CPR, defibrillation — to keep death at bay for a few more hours or minutes. Most often it is against our better judgment that we keep the machines running and the medications flowing, forestalling the death of a body whose soul seems already to have fled the scene. We wish that we, too, could flee.

Mrs. K. had spent the night at her husband’s bedside. On the afternoon of the second day, I saw her drag herself to the bathroom across from my office. She was so tired she tripped on the tile threshold. Mr. K.’s bored children prowled the halls with eyes staring straight ahead, not smiling, not sad. Like the rest of their family, they didn’t understand that their father was dying in Room 3206. The waiting room was littered with potato chips, crackers, juice boxes, Oreo cookies, even cans of Cheez Whiz. I’d expected some lumpia or sticky baklava, but it was all American junk food in that room. There were sheets and pillows on the floor, and in every chair an adult was sleeping.

By the third day, Mr. K.’s family began to accuse us of not giving him the care he needed. They phoned other facilities, seeking a liver transplant. Specialist after specialist explained that Mr. K. was not a candidate for a transplant: he would not survive the trip to the other hospital, let alone the surgery. The family didn’t seem to understand this. There were conferences in which doctors gave him no chance, and the family screwed up their faces and asked again about the odds of survival. The doctors ordered a CAT scan of his head, hoping it would show a brain hemorrhage: perhaps seeing bleeding inside his skull would help the family accept that Mr. K. was dying.

Before the scan, Mr. K.’s mother, his wife, and his sister waited in an empty room next to Room 3206. Passing by, I overheard his mother say, “They don’t understand. Everybody loves him. Everybody.” They wanted us to see how special Mr. K. was. We wanted them to see that, no matter how special he was, he was going to die.

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