# Please Breath For Me
# by Dipesh Navsaria

> I would like my doctor to understand that beneath my surface cheerfulness, I feel what Ernest Becker called 'the panic inherent in creation' and 'the suction of infinity.'…My friends flatter me by calling my performance courageous or gallant, but my doctor should know better. He should be able to imagine the aloneness of the critically ill, a solitude as haunting as a Chirico painting. I want him to be my Virgil, leading me through my purgatory or inferno, pointing out the sights as we go.
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> My ideal doctor would resemble Oliver Sacks. I can imagine Dr Sacks *entering* my condition, looking around at it from the inside like a kind landlord, with a tenant, trying to see how he could make the premises more livable. He would look around, holding me by the hand, and he would figure out what it feels like to be me. Then he would try to find certain advantages in the situation. He can turn disadvantages into advantages. Dr Sacks would see the *genius* of my illness. He would mingle his dæmon with mine. We would wrestle with my fate together…
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> — Anatole Broyard, *Intoxicated By My Illness*

It was about three weeks into my time on the anesthesia service as a medical student. Most of my time was spent in the operating room, assisting with the induction of general anesthesia under the watchful eyes of both a nurse anesthetist and an anesthesiologist. After the first couple of days, the unfamiliar strangeness of gently lowering patients into unconsciousness and back out had become almost routine. While it's far from what I savor as a career, it was a welcome break to have my interaction with patients consist of the solely technical — assessing their airway status, monitoring their oxygenation, watching their cardiac activity. In some ways, it's entirely the opposite of what I love most about medicine. The opportunity to interact is transformed into something approaching a laboratory experiment — without the experimentation, of course.

One morning, I teamed up with a particular nurse anesthetist who was a good and encouraging teacher. I looked over the list of patients for that room and saw a name that looked familiar, but it was common enough that I brushed it off as a coincidence. We got ourselves started with the first case, and before long I was busy with the routine monitoring and paperwork necessary.

We got to our third case of the day, the gentleman with the familiar name. The staff rolled him into the room. He looked like he might be mildly familiar, but at the same time, I have a thoroughly lousy memory for faces; it takes a couple of encounters for me to remember someone, and if I see them out of context, it's even harder for me. (This is another reason I couldn't work in an operating room long-term. Everyone is dressed in scrubs that look almost the same, have their hair covered, and in the ORs themselves, have masks on. Couple that with the fact that many people don't wear their IDs in the OR or have their IDs covered by their surgical gowns, and it's all but useless for me to figure out who's who. But I digress.)

We got ourselves started with getting him set up, helping move him over to the operating table, hooking up monitor leads. He seemed fairly tense, and I can't say I blame him. The

surgery he was about to have was a fairly common procedure, but even the most routine operation is anything but routine for the patient themselves. I did the small kindnesses we try to do to mitigate the unpleasantness (warning about the cold EKG pads we're about to stick on, etc.), but I didn't feel like it was my place to do much more; as I said before, we don't really have much interactive contact with our patients on anesthesia, and we also had to get busy drawing up medications and getting ready to begin inducing. Yakking with patients was not particularly highly valued on the anesthesia service.

I placed the mask on his face with some oxygen flowing while the nurse anesthetist administered the induction agents. This meant that the patient was, within seconds, unconscious and paralyzed – this reversible paralysis meant he wouldn't unconsciously fight our attempts to intubate him or breath against the ventilator later. I tilted his head back to ensure his airway was open, made sure the face mask was squeezed tight to his face now that he was unconscious and began to "bag" him, providing breaths to his lungs via the rubber bellows on the ventilator. Some patients are difficult to bag – it can be for a variety of reasons, but sometimes it's just hard to get a good seal against their face. Luckily, for me, this one was pretty easy. I was watching his chest rise and fall with each breath, and the end-tidal carbon dioxide detector was verifying that the air coming out was from the lungs. Good.

The anesthesiologist had come in at some point and was reviewing the chart with the nurse anesthetist. From behind me, I heard him say to the anesthesiologist:

"Oh, yeah, and this one is a doc here."

"Here?!"

"Yeah, he's in peds, real funny guy."

"He's a doc *here*?"

I looked back down at the patient and realized that I hadn't been wrong — this was exactly who I thought it was. He looked so different — the white coat gone, lying on a table clad in the standard-issue hospital gown. So vulnerable.

At this point, I fully expected the anesthesiologist would do the intubation himself — docs tend to be protective of "their own". To my surprise, he let out a sigh and said to me "Okay, go ahead." I gave him a few extra breaths to "pre-oxygenate" him, and then removed the mask. I grasped the laryngoscope in my left hand and slipped it into his mouth, pushing the tongue up and away. Unfortunately for me, I had a difficult time seeing the vocal cords, which is what we pass the tube right in between. I heard a quick "Well?" from over my left shoulder, and I awkwardly said I was having difficulty seeing the cords. The nurse anesthetist quickly tapped my shoulder and told me to pull out. I let out a quick sigh of relief and put the mask back on to breath for the patient again. It was only a few seconds, of course, but you want to make sure you minimize the time spent. While I was a bit annoyed with myself for not being able to see the cords, I was also being more gentle than I probably should have; the last thing I needed to do was to accidently break a doctor's teeth

with the laryngoscope. I'd probably end up doing a residency in northern Siberia if that happened.

The nurse anesthetist stepped in to intubate. To my surprise, he couldn't get it either. Finally, the anesthesiologist, who was not known for his patience, told us both to get out of the way, he'd do it himself. I was secretly pleased when he looked in there and gave a surprised little sound — he wasn't able to do it either. Something about this man's anatomy was just a bit off, making it difficult to do this. The anesthesiologist declared we'd have to do a fiber-optic intubation, which from a learning perspective was good for me, since I hadn't seen one yet. (From the surgical team's perspective, it was a necessary pain since they were all ready to go and just waiting around for us.)

At this point, I had the mask back on his face and was giving him breaths via the bag. The anesthesiologist went to get the fiber-optic unit, and the nurse anesthetist was busying himself with getting things prepared. He tapped me and said "It'll take a couple of minutes to get this set up. Remember, he's paralyzed, so you're breathing for him." Of course, he was quietly keeping an eye on absolutely everything I was doing, and I knew and appreciated that.

Usually, when doing all this, I have very little time to think much about anything else. As I said before, we don't really know these patients at all, so there's very little connection between us and them as individuals. On top of that, I'm very focused on performing the technical aspects of the procedure correctly. At this point, however, I was just standing there bagging him and occasionally glancing at the monitors. There was nothing else to watch since the surgical team was waiting for us.

I looked down at his face, unconscious, eyes closed.

*You're breathing for him.*

My left hand was grasping his jaw and the mask, pulling them tightly together to ensure a seal. My right hand squeezed the bellows, rhythmically pushing each oxygen-laden breath into his lungs. My eyes periodically flickered over the monitors, watching his body systems, making sure a reading didn't stray too far. His chest rose and fell in response to the motions of my hand on the bag.

*You're breathing for him.*

I looked down again at his face and remembered the last time I had seen it.

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It had been almost two years ago when we had been trying to adopt a child. My wife's recent bout with breast cancer had meant pregnancy was on hold for a few years at least, if ever. Through a friend, we had found a young woman locally who was pregnant but didn't think she would be able to parent this child. As you can imagine, there were the usual emotional ups and downs one would expect.

She had given birth on a Saturday morning, and we received a call from the hospital telling us that. We stopped by in the middle of the day to see her and hold the baby. This is a profoundly strange situation to be in; under state law, she can't sign a surrender until 72 hours after birth, so this little girl was both not mine and mine. And while we never had reason to believe that she was stringing us along, there's always a risk that she may change her mind — and we knew that. After a while, we went back home — she needed to recover and to deal with this complex emotional situation. We had planned to come in the next day.

We came back in on Sunday, and went to her room. She was sitting there with some of her family members, and the first words out of her mouth were:

"There's something wrong with the baby. They've taken her to…I don't know what they called it."

My heart leapt into my throat. "The NICU?"

"Yeah, that was it."

If my heart hadn't already been there, it would've leaped again into my throat. "Did they say what was wrong?"

"I don't know…something about being dehydrated…the doctor didn't…I don't know!"

It was obvious from her face that she was scared and frightened. Having a child sent to the neonatal intensive care unit is not good for anyone. But for those of us in health care, in some ways it's worse: all of our paranoid thoughts are rooted somewhere in reality. I asked a few more questions, but it was fairly obvious that they had no idea what was going on. I was just as scared and frightened, but I didn't want to show that to anyone else in the room.

I felt trapped now. As a pediatric physician assistant, my first instinct was to go look at the chart. However, that wasn't an option here; I had never worked at this hospital, and I'm not in the role of a health care provider anyway, I'm…I'm…I don't know what I am. I'm a parent. But I'm not. I'm caught, somewhere between the moments.

I did go and ask at the nurses' station, but was told simply "The doctor will come down and speak with you in a moment." So all we could all do is sit and nervously wait. I tried to ignore the grim procession of specters marching through my head, those neonatal anomalies which don't declare themselves until a day after birth.

Finally, he showed up. Tall, distinguished-looking, the prerequisite white coat draped on his frame. He appeared in the doorway, and we all looked at him, hungry for information. Perhaps now I'd find out what I needed to know.

Unfortunately, it wasn't much. To this day, I can't remember exactly what he said, but he delivered it in several short sentences without even coming into the room. All he told us was that there was some vomiting and dehydration and the NICU staff would let us know when we could go see her. He turned, but I pressed him gently, asking what he thought was wrong, but he repeated his previous statement and then left abruptly.

I still remember him right then just before he turned to leave, that image seared in my mind. Standing in the doorway, an almost annoyed look on his face. Was he having a bad day? Maybe. But I was having a worse one. I felt thrice-rejected: rejected as someone who cared for this child, rejected as a parent (because I was-wasn't one), and rejected as a health care provider. I could've caught up to him and told him I was a PA as well as a first-year medical student. But, you know, it shouldn't have made a difference. You don't treat people that way.

Maybe he genuinely didn't know much more, but it wouldn't have hurt to discuss the possibilities, instead of leaving us there, floating in a sea of worry, anxiety…and now pain. It wouldn't have hurt to come into the room and sat down for even half a minute with us. Or even to say you'd come back after attending to something else pressing.

Just give us a brief moment in which we know we're the most important ones for you to be with, that this is the only place you should be, and helping us is the only thing you could imagine doing. Kindness and care are to the human psyche laid vulnerable what oxygen is to stressed cells crying out for relief. Please breath for me, doctor. Breath for me, if only for a moment.

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Before long, we were able to go back into the NICU and get some answers. And, to make a long story short, she ended up doing fine in the end, but the adoption fell through at the last possible moment, leaving us more hurt than we had ever been in our lives. Things did work out in the end — but that's another story, for another time.

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I kept on breathing for him; this was my specific job to do, and as my patient he was the most important one for me to focus on. Soon the fiber-optic equipment arrived, and he was smoothly intubated and the surgical team could start their job. Everything went smoothly from there on, and he had an uneventful surgery. I saw him in the hospital making rounds a couple of months later, so presumably he had recovered well.

Life is strange sometimes. Just remember to breath for others, because someday, they may be breathing for you.

> "I cannot create life, but I can breath on the remaining embers. It may not work."
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> "But I can hope."
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> "Hope is all we have."
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> — from *Whatever Happened to Mr Garibaldi?*, Babylon 5, by J. Michael Straczynski

This story is based on true events; certain details have been changed to protect privacy and assist with narrative flow. DN

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