THE WRONG SIDE OF MIDNIGHT

a short story

by James V. Pagano

There was blood on the floor, mostly dried but still tacky enough in spots to stick to the bottom of a shoe. The worn linoleum bore evidence to this fact, decorated as it now was in swirled, geometric, and cobbled patterns, representing the shoe preferences of the various individuals who had walked through the area since the mess was made.

There was blood on the stool, on the gurney, and on the privacy curtain separating treatment bay number one from treatment bay number two. Most annoyingly, there was blood on the white lab coat and blue scrubs of Dr. G. B. 'Fish' Hooks, M.D., FACEP, ER doctor.

"Fucking mess," he mumbled to himself. Then, out loud, "Has housekeeping been called?"

The question was directed toward anyone in the department close enough to hear, but Fish realized it was rhetorical. It was 0640 on a Saturday morning. The night shift was over in 20 minutes. The blood would have to wait a little longer.

Gilbert Bass Hooks had been born in Alabama nearly thirty-six years earlier. His was an old Southern family with deep roots. But then the war happened. By the time Gilbert senior returned from his tour of duty, lucky to have survived and thrilled to meet his by then five-month-old son, his vision of the future had changed. As soon as his honorable discharge was processed he said goodbye to the family, and the family textile business, packed up the wife and son, and drove off to California.

It was not a popular choice among his relations. California in the late '60's was, after all, *the* hotbed of radicalism and antiestablishment insanity. Gilbert replied that while fighting he'd become accustomed to insanity and that an environment supportive of it might be just the thing.

He was cajoled, wheedled, sweet-talked, and finally threatened, but to no avail.

"You'll be disinherited."

"You'll never see your grandkids."

And that was that. The family settled in Lakewood, where young Gilbert and his siblings, two more boys, and, finally, a girl, enjoyed a Beach Boys, Ozzie and Harriett type of childhood. Most free time was spent outdoors, riding bicycles, scooters, and surfboards.

Gilbert senior found lucrative work at McDonnell-Douglas, allowing his wife, Marlene, the dubious luxury of being a stay-at-home mother to the growing family.

By the time Gilbert entered high school, though, things had begun to change. The airline industry was crashing, and Lakewood, the postcard-perfect LA suburb of his childhood, was showing signs of wear. Any thoughts the young man had of building planes for a living or, better still, becoming a professional surfer, required serious reconsideration.

He was a good student, 'college material', according to his guidance counselor. A career in one of the professions was not, in his opinion, beyond Gilbert's grasp. There had never been a 'professional' in the Hooks' family and the idea of being the first was intriguing. The first 'what', though?

Lawyer? Nah. Nobody likes lawyers. Dentist? Maybe. Respectable, good hours, only three years of school after college, decent money. But drilling teeth all day would probably drive him to madness well before he could afford to retire. Doctor? Sure. Why not? They seemed to do O.K.

Despite his lack of passion for the job he managed to do well enough as an undergraduate at UCLA to get accepted to the medical school at UC Davis. Two years and seventy-five thousand borrowed dollars into the curriculum he began to have an inkling what life as a physician could be like if one made the wrong choice of specialty. The idea of being on-call every night and weekend until he was too old to care had about as much appeal as drilling teeth.

Internal medicine? No way. All the call and none of the fun. Surgery? All the fun, but also all the call and about a million years of residency after medical school. Plastic surgery? All the money but way too much bullshit. Radiology? Is that even being a doctor? Dermatology? Please.

Eventually Gilbert decided on Emergency Medicine, the newest of the medical specialties. It was some of the fun, some of the money, none of the call, and flexible hours. That there was a big difference between 'flexible hours' and 'regular hours' was something he didn't appreciate until years later.

So, he applied to, was accepted, and completed the four-year residency in Emergency Medicine at USC. Now, some eight years later, he was exhausted, spattered with blood, and drinking something the nurse insisted was coffee but had the viscosity of crankcase oil while trying to finish his charting before the day shift arrived. He'd just completed a twelve-hour Friday night shift. He'd had enough of the flexible hours for one week. He wanted to go home, take a nap, and hit the beach for the late afternoon surf.

Saints' Hospital sat in the middle of the San Gabriel Valley, once a seemingly endless stretch of orange groves, now a series of small cities and towns skewered on the 10 and 60

freeways running east-west through the northern and southern ends. The ER was an eight-bed unit. One doctor and four nurses during the day, three nurses at night, but only two the previous night because one had called in sick and no one from the registry was available on short notice.

Aside from the nursing shortage the shift had begun routinely. The ER was jammed when he started at seven. It almost always was at that time of the evening. But by midnight the rush was over. The waiting room was empty and of the four patients remaining in the ER only one, the drunk, schizophrenic, homeless man dropped off by the paramedics a few hours earlier, posed a potential problem.

The others were easy. The two-year-old with fever would get a Tylenol suppository and a prescription for antibiotics. Whether or not he actually needed them was unclear. His left eardrum was a little red, whatever that meant, but it gave Dr. Hooks the excuse he needed to write the prescription the child's mother expected.

He'd learned than most parents who take their children to the hospital in the middle of the night are unlikely to be satisfied with an 'it's only a virus, give him lots of fluids and Tylenol and he'll be O.K.' No. They expected more, and if Dr. Hooks was unwilling to provide it someone else would. Meeting peoples' expectations was as important, if not more so, as curing their disease. Now, all he needed to do was brush off his high school Spanish so he could explain the dosing regimen.

The old woman from the nursing home who 'didn't look right' according to her attendant almost certainly had some sort of infection. Patients like her usually did. He'd ordered the usual work-up, including blood tests, cultures, urinalysis, and chest x-ray. Something would turn up and the patient would get admitted to the hospital. Easy.

The last patient was a man in his forties who'd been awakened from sleep by a vague burning sensation in his chest. Blood tests, EKG, chest x-ray, oxygen saturation, all ordered and results pending. Even if everything returned perfectly normal this patient would not be going home, unless he chose to do so against medical advice. Chest pain meant possible coronary artery disease. A normal evaluation in the emergency room did not rule the possibility out.

Of course, when repeat tests the next day were also normal the cardiologist would have some fun at the ER doctor's expense, chiding him for not knowing the difference between heartburn and a heart attack. Still, with 'failure to diagnose heart attack' being the most significant malpractice risk facing the ER in terms of total dollars awarded to plaintiffs Fish had learned it was better to be derided than sued.

So only the homeless guy was left. He'd been found sleeping on a bus bench by a concerned citizen, concerned, Fish thought to himself, about what his presence would do to property values in the neighborhood if he was allowed to stay there until morning. IV fluids fortified with vitamins, a couple of warm blankets, an alcohol level, tox screen, blood count, and serum electrolyte panel. Probably overkill, Fish realized. His main hope was

that the guy would stay asleep until the morning, at which time he would be fed and evaluated by social services. Then he gets placed in a shelter, or more likely, exercises his right to return madly to the streets until the next time.

Fish checked the clock above the nurses' station. One thirty-five A.M. He felt almost smug. If things stayed this way he might even be able to catch a little sleep before the shift was over.

"HEY! STOP IT!" But it was too late. By the time Kathy was able to get to his bedside the homeless guy had managed to wriggle out of his soft restraints, pull out his IV, climb halfway off the gurney, and urinate on the floor.

"DOCTOR HOOKS!"

Fish heard the familiar screech and slowly made his way to the scene of the disaster. The patient was dangling half on half off the bed, blood dripping down his arm from the former IV site. The sheets and blankets were soaked and yellow, possibly due to the IV fluid alone, which takes on a deep yellow color when the vitamin solution is added, but possibly not, and Fish wasn't about to get close enough to make a positive I.D.

"Well, Mr. Doe," Fish began calmly, "it would seem you're feeling better."

"I need to go to the bathroom," the patient replied with an intoxicated slur.

"I think he's ready for discharge," Kathy opined.

Fish smiled. The man's blood alcohol level was three-sixty at the time of his admission to the ER, which meant that now, four or so hours later, it was no better than two-sixty. Plus, his urine was positive for amphetamines and benzodiazepines, a class of drugs of which Valium is the most famous. There was no way this guy was competent to sign a discharge against medical advice form, at least not yet.

"Gee, I don't know," Fish replied, getting a scowl from Kathy in return.

Kathy was a night-shift lifer. Mid-fifties, bad blonde dye job, fat, and mean. Most of the staff were afraid of her and some flatly refused to work with her, a fact Dr. Hooks considered when he heard he'd be shorthanded. But she knew the job. She had the technical and cognitive skills of an experienced ER nurse, and she was willing to work weekends, nights, holidays, whatever. Her ability and availability, combined with a nationwide nursing shortage, gave her the sort of job security most Federal employees could only dream of.

Dr. Hooks was one of the few who could actually get along with her. He understood the rules. You did things, most things, Kathy's way. If you followed that simple rule your

shift would be bearable, maybe even pleasant. Sending this guy out onto the streets at this hour and in this condition, though, wasn't going to happen.

"Mr. Doe," Fish continued.

"Tha's not my name," the man replied as Kathy, with Micky's help, tried to get him reorganized on the gurney.

"Sorry. What *is* your name?"

"It's John!" the man declared proudly.

"John. Perfect! Well, John, we need a little help from you, O.K.? We need you to stay on this bed for a while, maybe go back to sleep, and in the morning you can go back home."

The patient considered the offer for a moment. "I'm hungry."

"We'll get you some food, but you have to behave. Deal?"

"Okay."

This wasn't the first time around for any of the principals involved, except possibly Micky. The patient would behave for a while and get his meal. Then he'd act up in some intolerable way and Kathy would throw his ass out of the department. Fish knew he was merely buying time pending the inevitable.

"Get him cleaned up and find him something to eat. I've got some charting to finish."

As he walked back to the nurses' station he could feel Kathy's glare boring into the back of his head. Too bad. If she hadn't been out on the patio smoking she would have seen what the patient was up to before it became a problem. She knew better.

As he did his paper work he wondered how someone becomes a 'Kathy'. At some point she must have been like everyone else in her nursing school class; young, idealistic, with dreams of helping people, then marrying a rich doctor, having kids, and settling into a comfortable suburban life. Is it the job, he wondered?

He thought about Micky. She was new, out of school maybe a year. Fresh, up-beat, pretty, eager. Hmm, very pretty, he thought, glancing toward her, bent over the gurney trying to start a new IV. She was working nights until she gained some seniority and seemed to love her job. How long would that last?

Fish had heard the rumor she was dating one of the staff surgeons, a married guy with, like, three kids. There was no solid proof, just gossip. Hospitals were the worst when it came to rumor and innuendo. Sure, there was a certain amount of hanky-panky among staff members, but if *all* the rumors were true there would be no one to take care of the

patients because they'd be too busy screwing. He took another glance in Micky's direction and hoped the rumors about her weren't true.

He finished his last chart and checked the clock. 2:30. Might be a good time to lie down for a while, he told himself. He stood, but before he could announce his intentions to the nurses he heard the familiar ring of the paramedic phone.

"Fuck," he muttered. He looked again at the clock. "Nothing good happens after midnight."

Handling paramedic traffic was Kathy's domain and the ringing phone was her chance to get away from the homeless guy.

"Saints' ER, this is Kathy." "Uh huh." "How bad?" "Sounds like he meets trauma criteria." "Uh huh." "We're kinda busy tonight. Suburban is only two minutes farther out." "How long?" "Great."

She gave it a shot. She always did, and it practically never worked. There are legitimate reasons for an ER to be 'on diversion', closed to paramedic runs. If all your beds were full and you couldn't handle another patient, or if the patient en route was suspected of having a neurosurgical problem and your hospital didn't have a neurosurgeon on staff, or more likely, didn't have one on staff willing to provide back-up for the ER. Of if the patient was under the age of fourteen and your ER didn't have 'EDAP' status—an emergency department approved for pediatrics. Or maybe you had an internal disaster, a flood or power outage. Or maybe the patient had sustained major trauma and needed to be sent to a specialized trauma center where surgeons and anesthesiologists were standing by 24/7. There are a number of ways to avoid having a patient dropped into your lap at 2:30 in the morning and Kathy knew them all.

In the past she had resorted to lying. She would post on the County-wide ReddiNet system that Saints' ER was jammed and therefore closed due to 'saturation'. The paramedics were obligated to bypass Saints' and take their patients to the next closest facility. It was an effective strategy. Long, but peaceful nights, smoking and drinking coffee, Micky taking care of the walk-ins, while ambulances went screaming by to Suburban or wherever.

Eventually Dr. Riegel, the ER medical director, got suspicious. Associations were made between the working hours of a certain night nurse and the closure hours of the ER. Diverting patients from the ER was bad for community relations. Worse, as far as Dr. Riegel was concerned, it was bad for business. Kathy was informed that skills and availability notwithstanding she would be looking for another job if she ever pulled that stunt again.

Of course, finding another job wouldn't be a problem. But the director knew Kathy had things at Saints' running pretty much the way she wanted them. He was certain she had no interest in starting from scratch somewhere else.

"What are we getting?" Dr. Hooks asked after the call ended.

"TA. Eight minutes."

An ambulance will be here in eight minutes with the victim of a traffic accident.

"Details?"

"Not much. Multiple patients. Three going to Memorial, we're getting the minor. He's coming BLS."

Meaning three patients were going to the level one trauma center and one was coming to Saints', the one with minor injuries. The paramedics responding to the emergency call had made the determination that this particular patient was sufficiently stable to be released to a Basic Life Support Unit, manned by emergency medical techs, not paramedics. Once that decision was made the EMT's were free to take the patient to the nearest receiving facility regardless of its diversion status. The call to the ER was merely a courtesy. There was no room for negotiation. Not even for someone as adept as Kathy.

Dr. Hooks' good mood was fading fast. He knew that if the accident was bad enough to send three patients to Memorial it was unlikely the fourth was much better off.

"Trauma criteria?"

"Don't know. When I asked they just said our guy was all right. Probably bull. They said Memorial could only take the three bad ones."

The idea behind the trauma system is a noble one; saving the lives of severely injured patients. To do this requires a network of trauma centers across the County, each with specialized staffing and capabilities. A sufficient number of such facilities would guarantee that no patient anywhere in the County would be more than twenty minutes away from definitive care. In 1985 there were twenty-two trauma centers in Los Angeles County and the system worked. Now only thirteen remained. The trauma system itself was on the verge of death.

The reason is simple. Trauma care is expensive. In-house trauma surgeons, anesthesiologists, and operating room staff, on-call neurosurgeons and orthopedists, ICU care, and extended hospital stays, it adds up. Unfortunately, many, if not most, who require this sort of care have no means to pay for it. Street gangs are generally not in the habit of providing group health benefits to their members. Crip-Care. Blood-Cross. Don't leave the 'hood without it. But they do.

Hospital administrators had to decide between relinquishing their trauma designation and going bankrupt. As more hospitals made the obvious choice the number of

available trauma beds dropped and transport times from the scene of an injury to the nearest available bed increased. On a busy Friday night the system could be overwhelmed.

Fish glanced again at the clock. 2:32. Somewhere in the distance he could hear the whine of an ambulance siren coming steadily closer. Three minutes later the back door of the ER slid open and two EMT'S walked through pushing a gurney on which was strapped a young man who appeared to be intent upon finding a way to climb off of it. Kathy, followed closely by Micky and, at a more discrete distance, Fish, moved to meet them.

"Bed Two," Kathy directed.

As the patient was being transferred to the ER gurney the junior medic gave his report.

"O.K. We've got a victim of a T.C., male, looks like mid-twenties. We think he was in the back seat. Single vehicle roll over. Big, maybe ten-centimeter, scalp laceration and some abrasions but that's it according to the paramedics. Apparently no KO. Vital signs stable. Open beer bottles in the car and by the way he's acting we're pretty sure he's had a few."

Fish wore a dubious expression. The patient was squirming on the backboard to which he was tied, and mumbling incoherently. There was a large, bloody gauze bandage wrapped around his head. There was no IV line in place. There's no way, he thought, this patient should have been dumped off on the EMT's and brought here. But there was nothing he could do about it now, and giving the medics a hard time wasn't going to solve any problems.

"What do you mean you think he was in the back seat?"

"Well, Doc, when we got there the vehicle was on its side and the guy was stuck between the two front seats, head first. One of the other guys was ejected. We think he was in the front passenger seat. The driver was still behind the wheel, and a fourth guy was crumpled up behind the front passenger seat."

Dr. Hooks listened as he began his primary survey, the ABC's of trauma care. Airway, Breathing, Circulation. The patient was yelling, so his airway and breathing were probably O.K. Bruise on the chest, but no instability, expanding symmetrically. Lung sounds hard to appreciate with all the noise but seem to be equal on both sides. Belly soft, pelvis stable, good pulses everywhere, and systolic blood pressure 135, so circulation intact.

"Get x-ray in here and page the CT tech so we can do his head."

The orders were directed at no one in particular, but Kathy quickly moved to the phone, leaving Micky to do the actual nursing. Kathy wasn't particularly fond of trauma patients, or at least seemed to dislike them more than she did the others. She'd done her

time at Memorial years ago and had felt the rush you get from blood, broken bones and unstable patients, working with the trauma team, win some, lose some, but always intense.

After a while, though, you start to burn out. You go through the motions, do your job, win some, lose some, don't let the intensity get to you and move on. And it's messy. Trauma patients are bleeding, vomiting, shitting, flailing. It gets on you despite the universal precautions of gown, gloves, mask.

In the old days, before AIDS, it wasn't such a big deal. You worried about hepatitis B, but they had a vaccine for that. It's different now. Now they have an alphabet soup of hepatitis viruses with no vaccines. You could get sick, your liver could fail, you could get cancer, maybe even die. And there's AIDS. Although it's true that only a few health care workers have contracted HIV from a patient, the possibility of its happening is very real. Trauma patients as a group are more likely than others to carry the HIV virus. So you begin to burn out. At some point you say, "Enough. I'm not going to risk my life for some fucking gangbanger." Kathy had reached that point.

Micky started an IV line and drew blood for the lab while Dr. Hooks cut off what was left of the patient's clothes and did a more deliberate exam.

"Send a trauma panel and put a Foley in him. Send the urine for a U/A and tox screen."

Starting IV's and inserting urinary catheters were nursing procedures, and Micky was still new enough to enjoy doing them.

Fish determined that except for the scalp laceration this guy had gotten lucky. There was the matter of his altered mental status, but like the medic said, he was probably drunk. How's that saying go, he asked himself? 'God takes care of idiots and drunks'. He looked again at the clock. 2:50. Only four more hours until the day shift arrives.

The x-ray tech came into the department driving the portable x-ray machine ahead of him.

"C-spine and chest," Fish said as the tech moved the machine into place.

With some tape and the assistance of a lead-aproned Micky holding the patient still, the tech was able to shoot the films. A few minutes later he returned to the department and slapped the images into the view box.

"Not bad, considering," Fish commented. Despite the patient's lack of cooperation the x-rays of the cervical spine and chest were passable.

"Nothing here. Let's get him out of that collar and off the board, see if he'll calm down a little."

The radiologist would review the x-rays in the morning. Any discrepancies would be called the ER for follow up, which was great, unless the discrepancy was a subtle neck fracture and by morning the patient was a quadriplegic. A CAT scan of the neck could be transmitted digitally to the radiologist's home computer and read that night, but Saints' didn't have an in-house CAT scan tech after hours, and with this patient unwilling to hold still, Dr. Hooks needed something more immediate.

Kathy was manning the phones, looking busy. She'd gone through the patient's clothes and found his wallet and driver's license.

"Patient's name is Eric Peterman. He's twenty-three." She called out from behind the desk.

"Insurance?"

"No card."

"Perfect. Shit. O.K., Micky, let's look at this scalp laceration."

She lifted the patient's head to remove the bloody gauze dressing. Longish black hair was plastered to his head, held there by a large dark clot. Blood was oozing from the edges.

"Get a suture set, some 3-0 nylon on a big needle, and a bunch of lidocaine with epi."

It took only a minute for her to assemble what was needed. She held the lidocaine bottle as Fish drew up the anesthetic into a twenty-cc syringe. He injected the wound, which he estimated at twelve centimeters. Then, using a forceps, he began to tease away the clot. Mr. Peterman was more interested in getting off the gurney, and Dr. Hooks was becoming frustrated trying to work on a moving target.

"Kathy!" he shouted, "get over here and give us a hand."

Holding the patient still was more than Micky could bring herself to do. She was afraid of using too much force. Kathy had no such reservations. She slowly, deliberately, donned a pair of gloves, stepped to the side of the gurney opposite Dr. Hooks, placed a hand on the patient's forehead, and slammed it back down. Eric responded by flailing his legs. Before being asked, Micky threw herself across them.

With the motion problem solved the clot was scooped out and placed on the drape overlying the patient's upper chest. The source of the bleeding then became obvious as a small, severed artery began squirting blood onto Kathy's uniform.

"Oh, shit!" she said, turning the patient's head and redirecting the blood onto Dr. Hooks.

"Thanks a lot. Now get me some more gauze and some absorbable suture so I can tie this fucking thing off." He tried not to sound angry but it came out more like a shout than a request. Kathy released her grip and Eric lurched into a semi-sitting position. The clot was launched into the air where it did a neat 360 before landing on the floor with a disgusting thwop where it lay like a chunk of raw liver. Blood from the artery sprayed across the treatment area, and by the time Kathy returned with the gauze and suture the area was a complete mess.

Micky, splattered but enjoying the action, kept her hold on the patient's legs while Dr. Hooks closed the wound. She wanted a better look but didn't dare move. How, she wondered, could anyone be a floor nurse, passing out meds and emptying bedpans all day? Even the operating room wasn't this much fun, and the surgeons were a bunch of arrogant dicks.

Dr. Hooks heard the phone ring and Kathy answer.

"What's up?" he asked.

"That was the CT tech. He's on his way. He'll be here in forty-five minutes."

"O.K., that should do it," Dr. Hooks said as he tied the final knot on the final suture bringing together the edges of Mr. Peterman's scalp wound. "Clean him up, put a dressing on his head, and make sure he stays on the gurney. Tie him down if you have to."

Stapling wounds was a lot faster than using sutures, and, when used appropriately, gave about as good a cosmetic result. Scalp lacerations, especially those surrounded by a full head of hair, were perfect for staples. But the steel they were made of could cause interference with the x-ray beam of the CT scanner creating artifact, obscuring subtle abnormalities. Fish had decided to do things the old fashioned way.

While Micky tended to Mr. Peterman Dr. Hooks checked on the chest pain guy and the woman from the nursing home. Most of the labs were back. The old woman had a urinary tract infection. No surprise there. He wrote an order for antibiotics and handed the chart to Kathy.

"Give her five hundred of Levaquin and call her doctor for admission orders."

Kathy grunted a response as she took the chart from his hand. The smoke break would have to wait.

Fish then turned his attention to the man with chest pain, now sleeping soundly and in no apparent distress. His labs, as predicted, were normal. No matter. The disposition had been made the minute he walked into the ER. He was staying for observation. His regular doctor was someone unfamiliar and not on staff at Saints' so Fish asked Kathy to call the panel internist, a young and hungry doctor who'd appreciate an easy admission with good insurance.

Only homeless John remained. He'd had his meal and his trip to the restroom where, Fish was certain, he'd probably gotten half of what he voided into the toilet and the rest, hopefully, on the floor nearby, and was now enjoying a postprandial nap. Fish understood that sleeping dogs and homeless, drunk schizophrenics were best left that way. He turned out the light above his gurney and tiptoed back to the nurses' station.

It was 3:45 and the familiar 'midnight nausea' was gnawing at his gut. Fatigue, stress, and too much bad coffee were the usual causes and a brief nap would help but he knew there was little chance of that. Instead he kicked his feet up onto the desk, an indulgence he could not have allowed himself during the day, and closed his eyes.

"Hey, Dr. Hooks."

He was startled by the voice and the tapping on his shoulder and nearly fell out of his chair. He brought his eyes into focus and noticed the clock, which now read 3:52. He'd managed to fall into a near coma in seven minutes. To the left of the clock was the face of the CT tech. Fish assumed correctly that he had been the source of the voice and the poking.

"Sorry, Doc, but I had to bring your guy back to the ER. He's moving too much for me to do the scan."

"Did you try restraints? Tape?"

"Yeah, but it's not working."

Kathy, sitting by the phone impatiently waiting for return calls, smiled. "We have some of his labs back. Alcohol level is only 122, tox is negative except for marijuana."

Fish knew what she was implying. The patient was legally drunk, but not enough to account for his behavior. Something else was going on.

"Would you like me to set you up for an intubation, doctor?" she asked sweetly.

Fish ground his teeth for a moment. He needed a good quality scan and there was no way he was going to get one without paralyzing the patient. Once paralyzed the patient wouldn't be able to move but he also wouldn't be able to breathe, so he would need to be intubated. Fish would have to place a tube into his trachea so air could be blown into his lungs until the paralytic medication wore off. This was not something he wanted to be doing at this hour on this patient but he had no choice. Kathy realized all this and thought it just retribution for his having deprived her of her smoke break.

"Fuck. Call respiratory. Get me 100 milligrams of lidocaine and a hundred of sux." Succinylcholine is a short acting paralytic. Fish figured he could put the guy down, stick in the ET tube, get the scan, and have him back in the ER within twenty minutes, by which

time the medication would be wearing off and he could think about removing the tube. Piece of cake.

Thirty seconds after the drugs were on board the patient quivered and went limp. Ten seconds later, just as Dr. Hooks was inserting the laryngoscope to visualize the airway, Mr. Peterman vomited.

"Shit! Gimme suction! Get this guy onto his left side!"

It was impossible to see the vocal cords through a mouth full of vomit and thereby nearly impossible to get the breathing tube into the proper orifice. Fish tried to clear the way with the suction catheter while the nurses and techs tried to move the patient onto his left side, the one that would minimize the chances of any further regurgitation. They'd forgotten about the restraints.

"Cut the fucking restraints!" The vague nausea he'd felt earlier was back and sweat was beginning to run down his forehead. Fish needed a clear airway, and soon, or the patient stood an excellent chance of suffocation and death. Mr. Peterman was repositioned onto his side and Fish did the best he could clearing what appeared to be pizza from the young man's mouth.

"What's the O2 sat?"

"85," Kathy replied. Oxygen saturation could be measured by a probe attached to a patient's finger. Normally it should be 95% or higher.

"O.K. Put him on his back." Dr. Hooks took the respiratory therapist's hand and placed it down on the patient's larynx. This had the effect of moving the vocal cords into a more favorable position and also served to compress the esophagus directly behind it, blocking any more pizza en route to the mouth. He inserted the laryngoscope and pulled up hard to get the tongue out of the way. All he could see was pizza.

"Suction!" he yelled, removing the scope. Another attempt was made to clear the airway and the respiratory tech then placed a mask attached to an air bag over the patient's mouth and nose. He squeezed the bag sending some oxygen, and probably even more pizza, into Mr. Peterman's lungs.

"Sat down to 75," Kathy announced calmly. She knew, as did Dr. Hooks, that if it dropped any lower the patient was in serious jeopardy.

"Fuck it," he said, taking a new tube from the tech and reinserting the scope. He tried to visualize the vocal cords, the landmarks that would guide the tube into the larynx, but all he saw was debris. "Goddamn it," he whispered, and pushed the tube down Mr. Peterman's throat. It hit an obstruction and had to be withdrawn. There was no time for readjustments. The oxygen level was dangerously low, the vomit made bag ventilation impossible. He pushed the tube back down. This time it went past whatever the

obstruction had been. The question was whether or not it had gone into the trachea or into the esophagus, in which case Mr. Peterman was pretty-well fucked.

A capnometer was placed on the end of the tube protruding from the patient's mouth and the air bag was attached to it. If the tube was in the right place, the capnometer would change colors as air moved in and out of the lungs. The tech squeezed the bag while Fish stared at the gauge and held his breath. One squeeze, nothing. Second squeeze, maybe. On the third squeeze Fish clearly saw the gauge change from pink to yellow. The tube was in the right place.

"Sat up to 88," Kathy said.

"Way to go, Dr Hooks!" the respiratory tech added.

Micky remained silent. It had been a close call. The patient was her age.

Fish shuffled back to the staff lounge where he found Kathy about to light up and Micky making a fresh pot of coffee. Mr. Peterman had been left in the capable hands of the respiratory therapist and CT tech who wheeled him back to the scanner. Two sheriff's deputies had come in some time during the intubation to take an accident report. Kathy informed them they wouldn't be getting any information from the patient but they were hanging out anyway, flirting with Micky and waiting for the coffee. Fish fell into the last available chair.

"Tough night, Doc?" asked one of the cops, giving Fish a once-over.

Fish looked down at his blood-spattered clothes and smiled. "Just the usual." He considered the irony of that comment as the adrenaline wore off and a wave of fatigue washed over him. High intensity situations like the one tonight were what attracted him to the specialty in the first place, and some day they would drive him out of it.

He closed his eyes and thought about what he'd do in the morning. Normally after a hectic night he'd take a nap in the doctors' sleeping room down the hall from the ER. But tomorrow, today actually, was Saturday. There would be no commuter traffic and the drive to his house in Los Feliz wouldn't take more than twenty minutes or so. He'd go home, sleep in his own bed, then head to the beach for some late afternoon surfing.

Kathy brought him back to the present. "Patient's back from CT."

Fish stood slowly and walked back into the ER. The tech was pushing Mr. Peterman's gurney back to its original spot with respiratory therapist walking alongside, ventilating the patient.

"So?"

"I'm sending the images to the radiologist. I didn't pay much attention to them myself."

"It's 4:40," Fish said, looking at the clock. "That means I won't get the results until like what, five or so?"

"That sounds about right. I'll check to make sure the transmission is going O.K., then I'm outta here. Call me if you need anything else."

Fish grunted. Having an on-call tech was a financial choice make by hospital administration. It was cheaper than paying someone to be in-house. From the tech's point of view it only made sense if you got called in a few times. The on-call fee was meager, but each time you came in you got paid. So, it made sense to get in and get out as quickly as possible, before another patient arrived in need of your services. You got paid by the trip, not by the scan.

From Dr. Hooks' perspective it was something of a problem. The disappearing tech routine meant longer waiting times. He'd complained to Dr. Riegel about it, but so far his complaining hadn't led to any changes in policy.

He walked to the gurney and reevaluated his patient. He noticed Eric making some respiratory effort. Good. His pupils were equal in size and reacted normally when light was shined into them. Pinching a fingertip caused him to withdraw slightly. Same with the other hand and both feet. Great. The paralytic was wearing off and the patient had calmed down.

"Put him on the ventilator, assist mode," he told the therapist. "Let me know when he's breathing on his own and I'll pull the tube."

There was nothing to do but wait so he returned to the lounge. Nausea or not, coffee was the fuel that drove the ER, and his tank needed a refill. Micky had returned to the nurses' station when Mr. Peterman was brought back from CT. The sheriffs took that as their cue to get back to work. Kathy was in the lounge, sipping coffee and flipping through a magazine. Fish was about to comment on how peaceful it had become when the relative silence was shattered by shouts coming from the direction of homeless John.

"Hey!" "Hey!"

Kathy put down the magazine and gave Dr. Hooks a meaningful look.

"Fine. It's after five anyway. Let him go."

"Thank you."

Kathy walked back into the ER and within five minutes had John up and out the door. It was beginning to get light out and she watched as the man walked down the

driveway and on down the street. She wanted to make sure he put at least some distance between himself and the hospital before lying down and drawing the attention of another concerned citizen. She didn't' want him back. At least not until the day shift arrived.

Back at the nurses' station Micky heard the familiar hum of the fax machine starting up. It was the radiologist's report of the CAT scan. She glanced at it briefly and took it to the doctor.

"SHIT!" Fish yelled after reading it. He burst out of the lounge. "Kathy, call the County transfer people. Peterman's got an epidural bleed!"

He read the report again. It said there was a small, about a centimeter thick, convex collection of blood under Mr. Peterman's skull. It meant that an artery had been torn in the layer of tissue overlying the brain. Because it was an artery, the blood was under pressure. In time the clot would expand, putting pressure on the brain, shifting it away from the bleed and down towards the base of the skull. Eventually the brainstem would be compromised. Mr. Peterman would stop breathing permanently. Without the expertise of a neurosurgeon, Mr. Peterman was a dead man.

There was no neurosurgeon on staff at Saints'. Patients with potential neurosurgical problems were not supposed to be taken there. The paramedics knew this, and the base stations that directed paramedic traffic knew this, too. But the base station hadn't been contacted on this run and the patient had been brought in by EMT's. Now Dr. Hooks, Kathy, Micky, and especially Mr. Peterman, were fucked.

"We need a transfer," Dr. Hooks said, but Kathy was already on it. She knew that without proof of insurance a transfer to a private hospital would be nearly impossible but she would try anyway. The best option was to utilize the County system, and she was already dialing the number to the central operator in charge of County hospital transfers. He watched as she put that call on speaker and picked up another phone. "Memorial?" He smiled. It was worth a shot.

"Memorial can't take him," she announced a few minutes later. The other two are still in the OR. The third guy was DOA."

At 5:43 the County operator picked up. Kathy gave him the details, listened for a minute, and hung up.

"Well?"

"He said he'll do what he can. Big County can't take him. No beds."

"Fuck!" Fish exclaimed to no one in particular. Kathy continued making calls but Mr. Peterman was a hard sell. He had no insurance and a potentially lethal injury. Neurosurgeons pay enormous premiums for malpractice insurance, and the patients most likely to sue them come from the ER. It's rarely about substandard care. Instead it's about

outcomes. A guy like Mr. Peterman was likely to have long-term problems, if he survived at all. In the hands of a talented, if unscrupulous, trial attorney, he becomes the sympathetic victim of a tragic accident.

Lawyers know this, and use the fact to exploit kindly jurors who want to help in any way they can. A judgment for the plaintiff, Mr. Peterman in this case, could run into the millions, regardless that no malpractice was ever committed. Insurers and defense attorneys know this, too, and often encourage their innocent clients to settle out of court, thereby taking the case out of the hands of a jury that would likely have no understanding of the issues involved, such as neurosurgery and the pathophysiology of brain injury. The end result is fewer neurosurgeons taking call for emergency rooms and patients like Mr. Peterman lying near death waiting for the County to pick up the slack.

6:15. The patient wasn't waking up. His breathing had slowed and become somewhat irregular. He was more dependent on the ventilator. How, Fish wondered, had the system gotten this fucked up? He knew how.

"Give him 25 grams of mannitol". The sugar, given intravenously, would act as a diuretic, drawing water out of the brain and reducing the pressure within. It was only a temporary fix, though, since the reduced pressure would allow the bleeding artery to bleed more freely. Eventually the situation would be as bad, if not worse, than it was before the mannitol. He reviewed his options. Short of taking a drill and poking holes in the patient's skull to relieve the pressure, there was nothing else he could do.

First, the mannitol, he thought, then, if it looks like he's going to die and no help is on the way, I'll think about drilling the holes. It was a procedure he'd learned about during his training but had never actually performed, or seen done, for that matter. But, if the patient was going to die anyway, what was there to lose?

Finally the phone rang. Bay View Hospital, about thirty miles away, was willing to take him. Fish allowed himself to feel the relief for a moment before turning to Kathy. She was already on the phone arranging for an ambulance.

6:35. The ambulance, staffed by paramedics, pulled up to the ER doors. Seven minutes later Mr. Peterman was on his way to Bay View, sirens wailing and lights flashing.

"Is he going to be O.K.?" Micky asked as they walked back to the lounge.

The waiting room, which had been empty when Mr. Peterman was brought in, was now half full with patients waiting to be seen. Fish just shook his head. They would be a problem for the day guy, he thought.

"Maybe. I don't know. I hope so. If not I'm sure we'll hear about it."

He sat on the old sofa, leaning back into the worn cushions, and let out a sigh. Micky sat on the opposite end.

"Dr. Hooks? Can I ask you something?"

He looked up. She was an attractive girl. He imagined what she looked like naked, what she felt like, how she liked to fuck. Working in an intense environment created a type of intimacy among co-workers, and the end of a stressful shift had a feeling similar to sexual tension and release. He considered asking her out, but vetoed the notion almost immediately. It would eventually cause problems at work, and work was enough of a problem all by itself.

"Sure."

"O.K. Why do they call you 'Fish'?"

He paused for a moment, staring at her. Of all the questions she could have asked at that time, in that place, this was the one he would have least expected. He smiled, then began to laugh.

"It's kind of a long story, but O.K. My parents named me Gilbert Bass Hooks. Gilbert for my dad, Bass was my mother's maiden name, and, well, Hooks is, you know, Hooks, my last name. Gilbert pretty much sucked, so I tried Gil. Gil Hooks. Not good. My parents called me GB for a while, which worked in Alabama, where I was born, but didn't sound right in Lakewood. G. Bass Hooks, or plain Bass Hooks were just as bad. By the time I was in the third grade the wise guys had started calling me Fish Hooks. Fighting words for a while. But I kinda liked it, and in high school I let my friends call me Fish. Not Fish Hooks, though, just Fish. There was a T.V. character on some show called Fish, so it wasn't without precedent."

"Wow, thanks."

"You're welcome, and when we're not working you can call me Fish, too."

It was 6:55 and the day shift was coming in. Dr. Graber, his relief, looked at the full board of waiting patients, saw the fatigue on Dr. Hooks' face, the blood on his clothes, and knew it must have been a bad one.

"Hey, Fish, the place is jammed. What the hell have you been doing all night?"

Fish knew it was a joke and shook his head.

"Sorry about the mess, Bob. I was a little preoccupied until a few minutes ago. I haven't seen any of these new people so I've got nothing to sign out. But you should thank Kathy for dispo-ing the homeless, drunk, crazy guy. I was trying to hold onto him until social services got here."

"I *love* Kathy," he said with a grin, grabbing the chart at the top of the rack.

Fish stood and stretched, yawning audibly as he did so, then walked slowly out to his car. The morning air was cool and invigorating. He started the SUV, belted himself in, and pulled out onto the street toward the freeway. It was going to be a great day, he thought. Catch some sleep, then catch some waves, and no work until Tuesday. Five minutes later he merged onto the 10 freeway, heading towards home. Traffic was light and he pushed the accelerator a little harder. Eight minutes later he was fast asleep. He didn't feel the car hit the divider and go airborne. He was dreaming about surfing. All he felt and heard was the momentary weightlessness of dropping in on a big double overhead, the explosion of the breaking wave, and, somewhere in the distance, the wailing of an ambulance siren coming steadily closer.