Chapter 01: Cracking The Chest – A Trauma Room Reality

"ER, we are coming to you with a 32, three two-year-old male with a gunshot wound to the left chest. He has lost a significant amount of blood. CPR is in progress. He is not intubated; BVM support is adequate. IV attempts have been unsuccessful; still working to get IV access. ETA approximately six minutes out."

Ambulance notification calls always started a chain reaction that I knew by heart, and I never grew tired of. As soon as I heard that, I could sense the change throughout the entire department. Within seconds, the overhead announcement blared:

"TRAUMA TEAM TO TRAUMA ROOM, LEVEL 1. TRAUMA TEAM TO TRAUMA ROOM, LEVEL 1."

A "Level 1" trauma is the highest level of alert we get. It's like a mayday call in aviation, which instantly puts everyone on high alert.

Everything, including every bit of training, comes together to try to save a life.

The person who received the radio call quickly dispatched a runner to the blood bank. I had witnessed this many times: the runner sprinted down the hall to grab a cooler with four units of O-positive blood, then hurried back, shielding the cooler like a precious cargo. The rule was clear: the nurse at the rapid infuser must receive that cooler immediately. The runner returned, precious cargo in hand, stood still, awaiting the nurse to remove it from his hands. No detours. No distractions.

At the same time, security was called. They were just as good at their part. They started getting ready for lock down without making everybody panic. The ER would be secured and ready by the time the ambulance got there.

The choreography had already unfolded in the trauma room. Two nurses and two techs moved briskly, as they had many times before. I still picture them snapping on robes, face shields, and two pairs of gloves for their personal protection. Afterward, each person owned their tasks for preparation.

One nurse went to the rapid infuser to prepare blood products. The other nurse spiked IV fluid bags, prepped, pushed out air, filled the lines with saline, clamped them, and placed each into a pressure bag. Saline sloshed as one bag hung on each side of the gurney, ready for patient arrival.

The technicians moved simultaneously. One powered up the monitors and untangled wires, so nothing would stall us when connecting the patient to the life monitoring equipment. He also placed an extension to the suction tubing onto the suction catheter

and, while still partially in its clean packaging, stuck it under the mattress at the right head of the bed to keep it close by if needed. There were others who gripped trauma scissors, ready to clip away garments and reveal the true extent of injuries. Together, they gently moved the gurney a little more into the center of the room, clearing a seamless path for transfer from the EMS stretcher to the gurney.

We then stood in position, waiting. The techs were ready to unstrap the patient from the EMS litter as soon as it came through the door. They were ready to transfer the patient to the ER gurney in one swift motion. We would then cut away the clothes immediately to see what we were dealing with.

The respiratory therapist quietly entered the room and took the big plastic bag from the ventilator. If CPR was still being performed when they got there, the patient would be hooked up to the ventilator right away. I had seen it happen before: the transition from chest compressions and assisted breaths quickly shifted over to machines, as if the speed of that connection hinged on life itself.

The nurse checked the passage to the blanket warmer, the bear hugger had a pad on it, and ensured no clutter all around the rapid infuser to make sure nothing was in the way. No wires crossing or table legs hanging out into the walkways.

The IV/medication nurse, on the other hand, moved quickly to the crash cart after hanging the IV bags. I saw the plastic security seals being twisted, ripped off, the pharmaceutical drawer being unlocked, and the internal locks and plexiglass barrier being removed. The Zoll defibrillator began its familiar hum, and the wires for the leads, as well as the defibrillator pads, were connected and ready.

The scribe, another nurse, came in silently, without a gown or gloves. Their position in the room was at a mobile computer workstation, with an extended desktop where pre-printed trauma care forms, a clipboard with blank paper, pens, a highlighter, and nothing else. They were in front of a phone bank on the wall, if there were any immediate needs not in the trauma room. The scribes' task was clear: document everything, every order, every intervention, and every second that was important.

Next, the trauma team arrived, consisting of the ER doctor, trauma surgeon, trauma PA, and a trauma nurse. They checked their carts and ensured the trauma table had nothing on it. Their carts and the table were located just out of the zone where the trauma care was about to happen, but close enough to put them into action. With this team's arrival, I could feel the tension tightening in the air.

The portable X-ray machine rolled in, and I watched the trauma surgeon halt it. He held out his hand, then he knelt and peered under the bed. After looking, he put up his hands in a surrender motion; "Just making sure the plate is already there. Last time it wasn't, and we didn't get the images I needed right away." His voice stayed sharp but steady as X-ray moved their machine to a position just outside of the trauma circle on the floor. The trauma team was present; they already had all their equipment stationed just outside of the major care area, within easy reach if it came to that.

The ER doctor walked to the head of the bed, positioned his Glyde-scope intubation cart, the scopes and the machine were turned on, his suction tubing hung over the oxygen valve with his requested extension tubing, and tucked under the right head of the bed, right where he wanted it, and the suction cannister was tightly attached and already turned on. The tubing stretched from the wall to the right

corner of the bed. He touched it twice; it was attached to the suction catheter already, just as he preferred. He then raised both thumbs, looked around the room. "Everyone ready?" he said, his voice seeming like it was a mix of habit and urgency. His thumbs up, a passive message, 'I am ready, I am good to go, are you?' Everyone was looking at him now. Multiple staff were nodding their heads gently up and down.

He calmly called the report out loud again to remind everyone what we are dealing with:

"Thirty-two-year-old male with a gunshot wound to the chest. He needs blood. CPR is in progress, a bag-valve mask is in use, and there is no IV access."

He looked at the nurse by the rapid infuser. "You ready?"

She quickly looked over everything: the tubing was primed, the blood was spiked, there was no air in the lines, and the rapid infuser machine was powered on and warmed up. "Yes, I am!" she said firmly.

"Time?" someone yelled.

Without thinking, the trauma PA answered. "Our six minutes were up three minutes ago. Any moment now."

The registration technician stood just inside the ambulance doors, armed with her mobile laptop. I saw that the on-duty chaplain had also discreetly gone to the ambulance entranceway and was waiting for whatever news might come next. The job of registration was always twofold: to obtain the patient's information as quickly as possible and to gather any background information that would aid in care. They were also the ones who would give the chaplain phone numbers and help him make that initial, dreaded call to the family.

At this point, this patient didn't have a name. He was pre-registered as "Trauma 246," which was a registration encounter number we used to prepare orders and documentation before he arrived. When I heard it on the system, I thought, 'Why 246?' Why that number? It felt cold and almost like they didn't care, but that's how the system operated.

A few moments later, the shout came from down the hallway: "TRAUMA ARRIVING!" Next, security staff called out on their radios,

"SECURE THE ER! Secure the ER!" The first announcement was much louder than the second.

The words rang out through the department. The hospital had to be ready for everything because they didn't know what caused the gunshot wound to this patient. We went into lockdown right away. Security guards took their places at the main entrance, the ambulance doors, and the hallway that connected us to the bigger hospital. For the armed guards, they now had one hand on their holstered sidearm, their eyes looking at every person who approached the ER. Watching, observing, focused on preventing danger, stopping our mission to care.

The bay doors swung open for the two guards standing near the ambulance bay. At the same time, a second ambulance slowly backed up toward us, its brake lights flashing as it lined up with the entrance. Three EMS personnel leaped out of another arriving vehicle and ran to the back of the ambulance before it had come to a complete stop.

As soon as the brake lights went out, people reached up to open the back doors. "Prepare to roll back... backing out," said the

paramedic at the patient's head in a commanding voice, coordinating his crew.

With a click, the litter lock snapped open and slid toward us. Two staff members seized the side rails to steady their weight as it cleared the deck. The paramedic kept up the breathing pattern on the bag valve mask, one hand squeezing air into the patient's lungs, ventilating, the other pressing the bag valve mask into the patient's face. All the while, the Lucas CPR device continued to drive chest compressions. ‘Thud, thud, thud,’ the pounding of the device upon the patient’s chest.

When the litter was almost clear, the lock activated at the head of the bed. The EMS Team lead grabbed the patient’s identity information, while another released the legs of the litter. They fell and locked into place with a snap.

The paramedic called out, "Is the litter secure?"

The answer was, "Yes, legs are locked!"

He said, "We're moving!" in a calm but hasty voice.

The team released the mechanism keeping the head of the litter locked onto the ambulance, then lifted the litter out of the ambulance in one fluid motion, gently down onto the four wheels at the bottom of the legs. There were two people walking, one on either side, with the paramedic at the patient’s head and another at the foot of the bed. The team leader took their place in front of the litter by the patient's left leg and led the group as they rushed down the hallway toward the trauma doors.

The lead handed the paperwork from the ambulance to the registration clerk, who began entering the information immediately.

The lead then guides the group from the front of the litter and looks for any bumps or objects that could catch the wheels and cause the patient litter to halt or tip over. Their job is to ensure that the way is clear and that the transfer to the hospital proceeds smoothly and without any problems. The team moved quickly through the extra-large doors, down the hallway, and directly into the middle of trauma room 3.

The team guided the litter quickly through the extra-large trauma room doors and shifted it directly next to the trauma gurney. As they entered, the ER doctor called out, “Quiet!” marking the formal beginning of the coordinated trauma response handover. The room went silent. The EMS team positioned the litter beside the ER gurney. The respiratory therapist immediately took over the task of breathing for the patient from the paramedic, switching hands on the facemask and squeezing the bag to push air into the patient's lungs.

The ER doctor instructs the room, "Shout out!" Staff are waiting with scissors in hand, pausing quickly while everyone stands ready, but suddenly still, their role for the next 10 seconds is to focus, to clearly listen to the shout out. Everyone is prepared to release straps and clear the way, but remain quiet, ready to act.

This “Shout Out” instruction initiates a focused communication protocol in which the EMS paramedic must provide only the most vital patient information. The paramedic, standing next to the patient’s right chest, is now the only one speaking:

"32-year-old male, found alone inside his home. Single gunshot wound to the lower left chest; (paramedic points “HERE”) the pistol was still in his right hand. Single entrance wound with packing in place. On arrival, we noted a significant amount of blood on the floor and... on his paperwork. Missed 3 IVs at his apartment, en route, we

placed two IVs with 500 cc's of saline infused. No exit wound was observed through his clothing. Now, no spontaneous breathing, no pulse, no shockable rhythm anymore. Consistent CPR and respirations for approximately 18 minutes."

The ER doctor gave the paramedic a bewildered look from the head of the bed. "Paperwork?"

The paramedic was embarrassed. His facial expression clearly implied, he stated, “Yes, I said paperwork”, as he shrugged his shoulders and raised his blood-covered gloves, palms up. The paramedic steps back two to three steps away from the EMS Litter but remains close to the bedside.

The ER doctor then nodded at respiratory therapy. Their silent, returned nod confirmed that the bag-valve mask was in good shape and secure on the patient's face.

The ER physician then spread his hands left and right, palms down, and the staff instantly moved to release the straps holding the patient to the EMS litter. Once cleared, multiple hands positioned themselves to securely and safely move the patient. The doctor didn’t say anything; he only moved his hands, and the team shifted into action. Seven people are now on the sides of the patient, all the straps have been unclipped, released, and are positioned not to interrupt the move.

The ER physician said, "Let's move him."

This command was important for two reasons: it closed the communication loop that the paramedic's radio report started, and it indicated that the ER doctor had now fully assumed responsibility for the patient's care. “Let's lift, move.” With seven people, the patient is

gently lifted from the EMS litter and is now on the ER Gurney. This was not like television shows, where the patient is practically dropped onto the table. Instead, it was a quick and very gentle lift, moving the patient onto the hospital gurney and softly laying him down. EMS personnel quickly rolled the EMS litter out of the room, while three other trauma room staff took their places near the patient. The paramedic stepped toward the wall; he remained in the room and stayed close by for any additional information, but the handoff was complete. The paramedic removed his dirty gloves and threw them in the trash. The ER/trauma team was now responsible for the patient.

Looking over the patient for any immediate areas of attention, the ER doctor's next instruction is called out: "Expose!" The order came through clear, crisp, and definitive. Scissors flashed instantly. They cut open the pants, belt, and underwear, and sliced the shirt into pieces. As the compressions continued to pound, the blades darted around the Lucas device—down the sleeves, across the chest, and straight down the middle. His torso lay bare in seconds. The cutaway clothing, sodden and heavy with blood, was pulled off the top of the patient, lying by his sides.

The gauze was still soaked with blood from the small entrance wound; some still seeped out, gently dripping over the side of his body. While the machine hammered compressions into his chest, the trauma surgeon pushed his fingertips against the left femoral artery to see how much life was left. The CPR pulsed, *Whoosh! Whoosh! Whoosh!* He looked more serious. The pulse was not as strong as expected, and its sensation was also different. He looked up and nodded quickly to the ER doctor, as if to say, "Is there an exit wound?"

The ER doctor stated, "Ready to roll."

Hands moved into position. On the left side, the staff tightly curled the linens that were soaked in blood against the patient's body. Others on the right prepared themselves to pull and carefully catch his weight while rolling the patient towards them, maintaining the patient in a log roll maneuver. The ER doctor secured the head and neck to protect the cervical spine at the head of the bed to keep the spine in line.

The ER physician nodded his head at the two people for the Lucas Device, one on each side of the bed. He said, “Ready,” and the Lucas device was turned off, the sides were unlocked, and the hard plastic brace was pulled off the chest.

The ER physician then looked at the respiratory therapist, again, no words, the eye contact delivered the message. As respiratory therapy withdrew the BVM, the ER Physician verbalized, "Three, two, one—roll." The patient was rolled easily onto his right side. Staff pushed and rolled the cut clothing and the EMS litter sheets under the patient from the patient's left to his right side. The trauma surgeon aggressively leaned in between two of the staff and felt the back, shoulders, chest, and pelvis, looking for something: a hole, blood, torn flesh. He said, "No exit wound." Then, in a flat voice, he said, "But he soiled himself." The possibility of a spinal injury was immediately felt; however, less common for bowel incontinence is the level of consciousness.

The trauma surgeon looked up at the paramedic. "Did you know that?"

The paramedic didn't move. He said plainly, without any defensiveness: “The scene was a bloody mess. I wasn’t worried about piss or crap—I was trying to get a pulse.” (A patient who has suffered with spinal trauma can have loose bowel and loss of bladder control,

which increases the concern for severe anoxic brain injury and demonstrates less chance of recovery and survival. Bowel incontinence is not normally observed in anoxic brain injuries, and unfortunately, this immediately indicates a very poor neurological prognosis.)

Someone came forward with towels and swiftly cleaned the patient up. To prevent contamination, the soiled linens were placed in a plastic bag, sealed, and moved away. That staff worker removed one pair of gloves, ensured her PPE gown was clean before returning to her position at the side of the bed.

The ER physician said, "Ready to roll back."

"Three, two, one—roll" was the count again.

The patient was lying on his back. The others on the right side lifted him slightly enough to get the soiled, bundled-up sheets out. When he settled down again, it was onto clean sheets that didn't have any blood, urine, or poop on them.

Respiratory therapy rapidly restarted bag-valve-mask ventilations. I could hear the ER doctor's voice over the noise, saying, "Continue compressions." An EMS worker swooped in, standing on a step stool on the patient's right side and leaning forward to give manual compressions.

I saw the compressor's arms straighten out, lock up, and with each repetitive thrust downward, his shoulders got heavier. The rhythm was clear; his pattern was matched to the song "Staying Alive," a melody that seemed to echo faintly in our minds. Though no sound was audible, the familiar tune resonated in the back of our heads like a ghostly whisper, replanted in our minds biannually with renewing our CPR certifications. Every time the thrust went down, the heart was

pushed into the chest wall, sending blood into circulation. Every release recoiled the chest, filling the chambers again. That recoil was vital; without it, there would be no way to keep the flow of oxygen-rich blood to the brain and other vital organs. The room seemed to move in sync with the compressor's rhythm, and we all adjusted our pace with those relentless, merciless beats.

Again, the trauma surgeon gently leaned down and put one gloved left finger over the left femoral artery, while with his right finger, he placed it into the gunshot wound. He did this to assess the amount of blood present. The feeling in the room, possibly stopping the trauma call response at this time; however, by placing his finger into the wound, he had observed something I had almost missed: it was a twitch, a shake, a movement from the patient's left arm. Small, fragile, yet undeniable. This was a sign of life. It was only for a short moment, but it meant an opportunity; we had to keep the airway open. The patient's left fingers tightened slightly and remained tight. They did not form a complete fist, but it was movement. Without that independent movement, this rescue could have been called off now. I heard him say with some urgency, "Let's paralyze and intubate."

With CPR ongoing, the crew prepared to give drugs for rapid sequence induction. An RN connected a saline syringe to the IV port in the patient's right arm. She gave a small amount of the saline to clear the line, then drew back to see if blood was coming into the tubing. Nothing. My gut felt like we had lost the line. She tried to flush it by pushing more saline in, but a bubble formed immediately above the insertion site, under the skin. Her verbalization, “Right Arm IV is infiltrated.” It’s not useful anymore.

Another nurse promptly started to set up a new IV line in the right arm. This same nurse then shifted sides, and the IV in the left arm was

checked. This time, the syringe pulled back a dark red fluid. Blood flow was good, and the saline fluid pushed through the IV extension tubing went in without any resistance. The RN said out loud, "Left arm IV is patent." She then connected the catheter hub to the IV tubing and pressurized the IV bag, but she left the clamp closed; the line wasn't open yet to ensure we didn't lose it.

The vial of Etomidate had been drawn into a syringe and labeled with a sticker: Etomidate. I knew it well: a dissociative anesthetic drug that we use for rapid sequence induction (RSI). In just a few seconds, it would calm the central nervous system, inducing sleep, putting memories on hold, and preparing the body for paralysis. (The patient would have no memories for a temporary time after this medication).

"Etomidate ready. Getting Succs ready."

The words rang out crisp and deliberate. I knew the weight behind those two medications when used in sync. Succinylcholine, also known simply as "Succs." I had seen it a million times before, but it always carried the same gravity. Twenty seconds, maybe twenty-five, and the body would produce minuscule muscle twitching. The body's last involuntary muscle fasciculations before paralysis. The diaphragm would also stop functioning.

"Succs ready!" was the answer.

The ER physician calmly checked his intubation equipment setup at the head of the bed. He felt the tubing for the stethoscope still around his neck and then asked, "Where is my suction?" An ER tech quickly ensured it was turned on at the wall unit. The tech also released additional extension tubing hanging over the wall unit. The Yankauer suction catheter, which was already tucked under the right head of the mattress, was pointed out to the doctor.

The doctor nodded, then instructed, "Is everyone ready?" People nodded their heads, stopped what they were doing, and everyone was focused on this task now.

The ER doctor said, “ok, we are about to intubate.” A member of the crew leaned in, their fingers deep into the patient's right femoral artery. "I still have a CPR pulse." The pulse was only there because of the compressions, but it was still there.

The nurse who checked the IV lines now remained at the bedside. She was positioned on the patient's left side. She looked over the IV tubing in the left arm one last time. She was sure of the line; the IV tubing connections were tight. Then she gently unclamped the tubing, reaching up, and flicked her finger on the chamber at the bottom of the fluid bag, keeping an eye on the drip chamber for movement. "Fluid is running," she said. "I've got a good flow!"

The Glide-scope, a camera-equipped laryngoscope, was ready to show a clear view of the vocal cords. The ER doctor, now holding it with his left hand, the respiratory therapist is positioned on the right side of the ER physician, still using the bag-valve mask to deliver breaths in rhythm. The respiratory therapist had a CO_2 detector (a carbon dioxide monitor), a tube securement kit, and a suction catheter in hands reach, to clear the way to secure the tubing from the intubation attempt.

The physician said, "Okay, let's push Etomidate 20 milligrams."

The nurse answered just as quickly. "Giving 20 mg of Etomidate now." The IV port was linked to the syringe, and the medicine was given in one smooth, yet steady push. In a matter of seconds, the words came out: "20 mg Etomidate is in, flushing." She watched the IV fluids

flow in from the pressure bag. She then looked at the arm, proximal to the IV site, to ensure it was patent.

I watched the patient and counted the compressions and breaths in my head. Fifteen seconds. Twenty. I sensed the body relaxed, and the patient's mind, if he is still there, faded away.

Then, the doctor's next order captivated the room's rhythm: "Push 100 mg of Succs now."

The syringe was ready with the dose, 100 milligrams for an adult. We all knew what was going to happen next.

The voice of the medication nurse sliced through the team, "Giving 100 milligrams of Succs now."

I saw her attach the syringe, push the medication, and then flush the line with saline. Five seconds later, she confirmed, "100 milligrams of Succs is in, flushing is done." There was no going back. Succinylcholine has no antidote or reversal agent, and it works quickly.

The room grew mysteriously quiet. Succinylcholine didn't just paralyze the patient; it paralyzed all of us, too. It was as if we all froze, even if it was just for a few seconds. As the tiny ripples of fasciculations, fine muscle twitching, danced subtly across the patient's body, A wave of realization coursed through me—this was the calm before we took absolute control over his physiology. Compression heartbeats were steady; it was again as if I felt mine sync with the compressor. The unnerving twitch of muscle under a trained eye's watch, the respiratory therapist paying close attention to the amount of pressure he was squeezing the bag with. Then, gently, without struggle, his left hand loosened, and the arm became limp.

For respiratory therapy, breathing became easier after paralysis set in. The bag-valve mask was squeezed by the respiratory therapy, and it became much easier. The chest rose with less resistance. Respiratory therapy nodded to the ER physician. The ER physician accepted the subtle message from respiratory. The patient was ready for intubation. The ER physician gently adjusted the patient's head, putting it into a position that would support intubation. He then called for "Stop respirations," and bagging stopped. Respiratory therapy removed the bag valve mask from the patient's face. The ER doctor then opened the patient's mouth, used his suction catheter to vacuum secretions from the back of the mouth, and then inserted the Glide-scope camera device into the patient's mouth.

The anatomy on the small video screen became quite clear as it was inserted; teeth, tongue, back of the throat, the esophagus, and the vocal cords, which were slender and oval, were framed in light. "Suction," the physician requested, without taking his eyes from the small glydeoscope TV Screen. The Yankauer suction catheter was placed into his right hand, guided into the oral cavity, and after suctioning, having a clear view, he asked, "Tube." The suction catheter was removed from his hand, and the ET tube was placed into his right hand. He then guided its movement, along the glydeoscope, into the back of the throat, then inserted it into the voice box, the space between the vocal cords.

He carefully inserted the 7.5 French endotracheal tube between the vocal cords, placing the balloon just adjacent to the cords, identifying that it was advanced to the 22-centimeter mark at the lips. He removed his glydeoscope, "Pull the stylet," he ordered. While he held the tube firmly in place, steady, an aide pulled out the stiffening wire. The cuff balloon was held in place in the trachea by ten cc's of air pushed through a syringe, and that syringe was quickly removed to

prevent air loss. In a matter of seconds, the respiratory therapist had connected the carbon dioxide detector and the bag-valve device, reestablishing breaths through the ET tube. The color of the detector went from purple to yellow with each breath, indicating a transfer of carbon dioxide from the patient.

The physician put the stethoscope in his ears, placed the head of the stethoscope on the patient's right chest. A breath was delivered, and in a normal volume, he called out, "Normal on the right," a second breath, decreased on the left." Another two breaths, "normal upper left, decreased lower left." That made me pause in my thoughts. There was nothing wrong with the placement of the breathing tube; the intubation was perfect. There was something else wrong, lower left chest.

The trauma surgeon sensed it too; you could see the puzzled look on his forehead, above his mask. He requested the Doppler right away. The probe was placed onto the patient's left femoral artery, and the room, which had been quietly buzzing, became much quieter, as the Doppler sound filled the air.

What was that sound? It was not the powerful pulse that made a crisp, reassuring thud-thud-thud sound associated with CPR. It was more like a gentle, eerie "whoosh, whoosh, whoosh." Silent tension, you could feel.

After a five to ten-second pause, the trauma surgeon's voice broke the tension.

He said, "How is that pulse? What do you feel?" while looking at the staff member holding their fingers at the right femoral artery to monitor the CPR compressions.

The answer came right away, but it was bad news.

She stated, “It’s a pulse... but weaker than it should be. It just doesn’t feel right.”

The trauma surgeon's face got tense. “We have decreased breath sounds on the left side and a weaker pulse than I’d hoped for. We can assume blood loss and vascular injury,” He didn't wait to argue; his instincts were already moving faster than words. He turned his attention to the nurse beside the rapid infuser, who was already getting ready for what was about to happen. "Second IV in place?"

"Yes, it is!"

"Push two units of blood, now."

With those words, I could feel that same tension spread further through the room. The rapid infuser machine was moved to the patient’s right side, the tubing for the new IV was connected to the rapid infuser, and the nurse began to give life-sustaining blood. In less than five minutes, two units of warmed O-type positive blood would be pushed into the patient's IV line.

The surgeon's eyes, now fixed on the ER physician, "You secure up there?"

"Yes, airway is intact, now secure in place," was the firm answer.

There were no other words, just a long, heavy breath and an up and down nod that spoke it all. A brief silence took over, charged with an overpowering sense of urgency. The surgeon turned, stepped towards the trauma PA and his Trauma Nurse, and stated,

"Let's crack the chest."

I watched him leave the bedside and head to the surgical cabinets that loomed over us. The surgeon, PA, and trauma nurse moved a mobile cabinet into an open position. The plastic lock snapped, the seal broke, and the drawer opened. A sealed aluminum box slid out. It remained attached at one end to the cabinet. On it, a simple label, “Chest.”

The stainless-steel table was rolled in next to them. The surgeon snapped the ties of the box, removed the lid, and handed it to the nurse. Attached under the lid, she swiftly removed the sterile drape and spread it across the table. I watched it fall into place, sharp-cornered, as if practiced a thousand times. She then grabbed the sterile gloves package next to the box.

I could feel my own breath hitch; the adrenaline was fully present now. The trauma nurse held open a package; from it, the surgeon pulled his sterile gloves. Perfection in practice, as the surgeon put on his sterile gloves. His actions were so quick and confident that they almost seemed to blur in my vision. He reached into the box, pulled out the insert, and with one sweeping motion, rolled the tools onto the table.

The tools stretched out perfectly across the drape—a choreography of hours of practice. Accuracy that makes you gasp. It seems every piece of the chest kit for this procedure rolled into exactly the place it was supposed to be in. Knowing what it means: the chest would soon be opened.

"Lights," the surgeon called out.

"Got your lights," came the answer. Within seconds, three surgical spotlights flashed on, filling the room with flickering dazzling

brightness, then a solid blinding light. The buzz of anticipation seemed to be vibrating in my chest.

The surgeon quickly walked to the patient's left side and pulled the instrument table closer with his foot. The personnel quickly made a circle around him. The choreography was perfect. In less than a minute, the whole area felt as if it had turned into an operating room.

The trauma RN moved one of the lights so that it shone directly on the patient's left chest. The surgeon moved the table closer again, and the PA now moved right next to it.

The PA opened a bottle of Betadine and poured it on the patient's chest. The fragrance was strong (even through my mask). Once you smell iodine, you remember it. The liquid poured in streaks, leaving stains on the body, running to the linens and the floor, but most of it coated the skin where it mattered. A single, large wipe with a sterile, clean towel left a glistening field of antiseptic amber.

"Stop CPR!" the trauma surgeon said.

The compressor repeated, "Stop CPR!" The frantic beating on the chest stopped. The hands lifted away, the compressor stepped off the stool, back from the table, careful not to bump into the rapid infuser, and away from the gurney. It was nearly too much to take how deep the stillness was that followed.

The surgeon pressed his left hand on the chest and counted ribs precisely. "Fourth rib, fifth rib," he quietly murmured, completely focused.

"Scalpel," he said firmly.

I watched as the trauma PA gave him the handle with the blade pointing away from him, just like the protocols dictated. The surgeon held it tightly and sliced a one-inch incision along the left border of the sternum without thinking twice. As the scalpel moved over the gap between the fourth and fifth ribs, it felt like my heart stopped. The surgeon cut from the sternum of the left chest, all the way to the mid axillary line, on the patient's lateral left chest just below his armpit. This is called a "clamshell" incision.

The PA handed him the next tool, "Mayo scissors." After four forceful snips/cuts, the pleura and chest muscles gave way. Then came the rib spreader, an OR tool, which I will always remember as 'Finochietto.' The PA and the surgeon worked together to attach, then held it in place and crank open it. The sound was piercing, like metal grinding, a tearing, a cracking, and it stuck with me.

They call it a *resuscitative thoracotomy*, but no one in the room uses those words. We just say, "crack the chest." This is the last card we have to play. It's a procedure that can only be done when death is seconds away and there isn't enough time to wheel the patient to the OR. You cut directly into the chest wall, peel aside the ribs like prying open a rusted gate and expose the heart and lungs. If you're lucky, it buys you a few minutes to see if there's anything remaining to salvage. Sometimes, we clamp the descending aorta in order to keep the remaining blood flowing up to the brain, and to the heart and lungs. Apart from that, they can quickly repair any open wounds, resulting in a significant blood loss. However, the procedure often reveals wounds that are too severe to correct, that will not heal, laying bare the grim reality within.

I remember seeing the surgeon put his left hand inside the cavity, and some bloody fluid pouring out. He moved the lung tissue out of

the way while his right hand went for the heart. He lifted it and held it with a kind of reverence. It was still. No vibration, no twitching, no spark, no pulse of life.

He gripped it carefully, firmly, assessing for any sign of a spontaneous contraction. His eyes focused on the muscle, but his voice told him what his hands were saying.

"Entrance wound, right anterior ventricle."

A pause, then a gloomy continuation.

“Exit wound... posterior left ventricle, near the left atrium.”

Then came the moment of conclusion. Above his mask, his eyebrows went up like Mr. Spock from Star Trek! His breath caught up, and the words that came next were heavier than the air itself:

“Oh. There’s a tear.”

He shook his head slowly, calmly. He looked to the ER physician. We all knew what that shake meant, even though no one said anything.

One hole in the heart, sometimes there's a chance. You can plug it with a finger and squeeze, compress it by hand for a time. Two holes, unlikely, but still a possible attempt. But this was different; the bullet went from one side to the other, tearing its way out. Blood flowed from the right ventricle into the pericardium and the chest cavity. The left ventricle, near the atrium, was torn. Adequate pressure was gone; blood flow was diminished. CPR made only a faint pulse; the blood flow was not strong enough to feed the brain or keep the person alive.

The surgeon's voice was quiet and final. His glance at the ER physician said only one word:

"No."

He let go of the heart, and his hands slowly fell away. He closed his eyes for a second, then sighed and dropped his head. The room was suddenly weighed down. The surgeon then stepped back, turned, and walked away from the bed. The silence that comes after hope runs out was all that was left.

The room was so quiet that it was hard to bear. A pin drop would have sounded like an explosion. The ER doctor finally broke the silence by asking, "Is there a family member present?"

The chaplain shook his head slowly. "There is no family in the local area."

The doctor nodded once and then looked around the room. "Does anyone have any ideas? Any thoughts?" There was a hint of desperation in his voice, with the confidence of knowing, but no one said anything. We were all out of choices.

I looked at the Zoll screen. No waveforms—just post-compression artifact on a flat line. No shockable rhythm. The pulse ox tracing was as flat and quiet as morning is on a lake. The blood pressure cuff wouldn't register pressures without an independent beat of the heart. Now, without the CPR in progress, there wouldn't be any blood flow either. The pulse ox numeric reading was 64%. That number hit hard. Below 90% is concerning, but 64%—with a weak flat trace—proved what I knew: not enough blood flow, not enough oxygen, not enough life.

Sometimes, faulty equipment gives us false optimism, but not this time. The monitoring devices weren't failing; the patient was.

I looked at the time. We had only been in the trauma room for about 14 minutes. Fourteen minutes that seemed like an eternity. Fourteen minutes of almost-perfected teamwork. Fourteen minutes with over ten people directly focused upon saving one person's life, and another 15 to 20 supporting that rescue. Yet it still ended in the same dreaded silence I felt so many times in Baghdad.

The ER physician, his vision focused down at the patient, his face unreadable, looking for any sign of life, and then he delivered the words that stopped everything:

"Time of Death."

There was no sound in the room. No more orders, no more moving, and no more urgency. Just silence. We all froze in place. The scribe, who was partially sitting on a stool by her computer, looked up from her notes, looked at the clock, and said again, almost in a whisper.

"Time of Death".