On Being a Doctor

Preventing Trauma Surgeons From Becoming Family Doctors

The beeper reads: “Multi Gun Shot Wound, 20s Male, ETA 2 Mins.” In 6 years as a trauma surgeon in Baltimore, I have seen this page hundreds of times. Sprinting through the basement hallways, I arrive as the paramedics burst through the doors of the trauma bay with a young man, calling out, “PEA arrest!”

The patient is strapped to a backboard, unconscious and bloodied by three bullet holes. Our chief resident, a poised young woman in her early 30s, stares intently at our monitors and confirms the rhythm. I look at the paramedics and ask how long the patient has been “down”—about 8 minutes. “Go for it,” I nod to the chief, and she makes the cut, beginning yet another emergency department thoracotomy, the surgical equivalent of a Hail Mary pass in football.

Several minutes later, at 11:51 p.m., I call out the time of death and explain to the two medical students present that the bullet had hit the patient’s aorta and heart and was simply “unfixable.” With blood on our shoes, the chief resident and I discuss exactly how to break the news to the soon-to-be-grieving relatives and friends gathered in the waiting room. We take along the students to watch us deliver the same news given to families in America more than 30 000 times each year: their loved one has died of a gunshot wound.

The chief resident leads the emergency department attending, the two medical students, and me into the room. Everyone looks up. Before the chief can deliver our grim message, the elderly matriarch of the family rises and says, “Oh, thank God, it’s you again—but he’s dead.” In the brief pause that follows, all hell breaks loose. Everyone is crying and screaming. I vaguely recognize the elderly lady, who sits down, quiet and defeated in the midst of the madness. I do the only thing that I can now and sit with her.

“I know you must have tried your best. I was wondering if it was going to be you,” she says. I offered my condolences, and as I try to recognize her she tells me that she’s Patient K.’s grandmother. “Do you remember Mr. K.?” I do. Of course, he was a patient of mine from last year. “I remember after he was shot, you walked out with a big chest, head held high, and you said that he had a big hole in his liver, but you fixed it. That he was going to live. And do you remember Mr. P.? He’s another grandchild of mine.” I did. Gunshot wound to the head, 2 months ago. “When you walked out that time, you were staring at the floor, shoulders down, and I knew he was dead before you even said it. That’s how you looked this time.”

When I decided to become a trauma surgeon, I never knew that I would be anyone’s family doctor. I didn’t expect to be recognized by grandmothers so familiar with the local trauma surgeons that they could call a death from across the room. When I am your family doctor, we have a crisis on our hands. My story isn’t unusual among trauma surgeons and emergency physicians at urban hospitals, but it doesn’t have to be.

There is no reason to believe that injuries from violence can’t be prevented. Fatalities from injuries arising from other kinds of social and behavioral ills, such as alcohol-impaired driving, have already been dramatically reduced in response to smart, targeted interventions (1). In 2006, the American College of Surgeons mandated that all level one trauma centers implement interventions to assist patients screening positive for alcohol abuse (2). A key motivation behind the mandate was the unique ability to intervene during the “teachable moment”—when the patient and his or her family realize that they’ve nearly lost everything, and they’re open to listening.

Similar hospital-based interventions are not mandated for violence prevention because there is no scientific evidence proving their efficacy. Nevertheless, I try to leverage this “teachable moment.” I tell patients that although I don’t know why or how they got shot, I do know that the next time it happens they’ll probably die. For each subsequent gunshot wound, the patient is more than twice as likely to die. Unfortunately, these second and third acts of violence are common and quick (3).

Sometimes, the only practical, immediate solution is to get the patient out of his or her current environment. One father asked me whether he should send his son to live with family in North Carolina. I told him, “If it’s good enough for the Fresh Prince of Bel-Air, it’s probably good enough for your son, too.” The son went to North Carolina, and since then I’ve been receiving Christmas cards from his aunt informing me that my former patient is in school and doing well.

This pattern of violence, the “vicious cycle,” emerges in a social and economic environment that remains unchanged when the patient heals and returns home. Once a patient has been violently injured, retribution and reinjury are of course more likely. When people go home to a place without opportunity, without education or decent-paying jobs, even without health insurance, the cycle of violence and hopelessness emerges. I see this in the families that I talk to in the waiting room, often the ones on the edges, in the poor neighborhoods of Baltimore, too often dismissed by society.

When I was a surgical resident, an attending once brashly told me, “I have never treated someone who was shot who didn’t deserve it.” But is there anyone who deserves to be shot in the head? As doctors, have we dismissed and blamed our own patients for their injuries? Shouldn’t we be less concerned with what the patient did to “deserve” his or her injury and care more about the environment that leads to more than 51 000 violent deaths across America, costing approximately $46 billion every year? (4)
Many of my injured patients live in an environment that perpetuates violence, rooted in poverty and inequality. It is up to us to protect them. To stop only sewing up the wounds and to start looking at the social ills that led to them. The first thing that we have to do is to recognize that there’s an epidemic of violence in the United States and look beyond its concentration among minority populations to the real cause, poverty and lack of opportunity. As doctors, we have a role to play in calling for and creating interventions for violence prevention and we know that there are models that work.

In Chicago, the CeaseFire campaign has demonstrated statistically significant reductions in gun violence by intervening in crises, mediating disputes, and changing social behaviors and norms (5). At our own hospital, Marla Johnston, a nurse and injury prevention champion, has interviewed dozens of young men to understand what they need to break out of this cycle of violence—most often, a job. In response, she is implementing a novel 12-step program to help patients develop life skills and identify resources to give them the means and motivation to break the cycle of violence.

We are still in the early days of violence prevention interventions, but more must and can be done. We are facing an epidemic of violence in the United States, and by ignoring it, we are losing tens of thousands of lives, many of them linked by neighborhood and family. I don’t accept that—I didn’t become a trauma surgeon to become anyone’s family doctor.

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References