Eastern Association for the Surgery of Trauma
Advancing Science, Fostering Relationships, and Building Careers

2016 Oriens Fellow Winning Essay
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As trauma and acute care surgeons, we have the privilege of bearing witness to humanity at its most vulnerable. Every time I rush to the trauma bay or round in the intensive care unit or meet with a patient post- operatively, I am reminded of this.

"Am I going to die?" is the first question the brash young man with tattoos and bullet holes asks after I tell him that he will need surgery. Stripped naked, inspected from head to toe, poked and prodded, blood drawn, writhing on exam, things get very real very quickly. "Probably not." I don't like to sugar-coat things. "But we won't know how much damage there is until we get into the operating room." His aggression and bravado fades. "But, you're going to fix me, right?" Faced with mortality at a time in life when everyone forgets they are not invincible, even the most aggressive and strident young men seem fragile and intensely human. "I'll do my best." And that's the truth. When I check on him post-operatively in the early hours of the morning, his eyes closed and blanket tucked under his chin, his mother asleep in the bedside chair, he looks no different from the young man with appendicitis in the next room.

In the ICU, weeks stretch on for the forty-something woman who had gone to an urgent care center with what she thought was a muscle strain in her chest, but turned out to be an aggressive necrotizing infection that consumed most of the soft tissue of her left trunk. She arrived at our hospital severely septic, and despite aggressive surgical debridement and resuscitation, she had arrested twice the first night. Her husband spent every day at her bedside while their two children were in school. After extubation, day eleven, she was confused and hoarse and we weren't sure at first if her British accent was a sign of delirium. This made her husband laugh for the first time since she had arrived. He pulled me aside a few days later and asked if I thought seeing their mother like this would be too much to handle for middle-school aged children. As she cleared and progressed, her hand—which had infarcted the first night—progressively demarcated, necrosed, and required amputation. Weeks later, I saw her make her first lap around the unit grinning broadly and leaning on a walker fitted with special padding for her forearm. Her husband and children were one step behind with a chair in case she tired. I was at once elated for her and her victory and awed by their resilience, but also plagued with disappointment that we couldn't make her whole again.

In moments like these I find solace reflecting on those we were able to restore: the woman in her third trimester who was taken for emergent caesarean section after becoming hypotensive and unresponsive in OB triage. Responding to a STAT page for trauma surgery to the obstetrical OR, I encountered hemorrhage cascading over the sides of the table as I entered the room. As the anesthesiologists raced to replace her blood as quickly as it was pooling on the floor, I blindly passed my arm through her pfannenstiel incision and reached up to the hiatus for aortic control. I breathed an immense sigh of relief when reinforcements arrived. After fourteen units of blood products and a distal pancreatectomy and splenectomy to control her ruptured splenic artery aneurysm she was stable in the ICU and her child was safe in the NICU. When I came in to round on her the next day, after she had been extubated and seen by doctors from many different teams, she asked me what my role was. I told her and she cried, and I cried too, re-experiencing the realization of what she had been through, how close she had come to dying, and overcome with the jubilation and catharsis of celebrating life.

Trauma and emergency general surgery issues can affect anyone, young or old, vigorous or frail, privileged or disenfranchised. Patients come to us with unexpected afflictions and we are called upon to provide remedy. To prepare for this role, we undertake lifelong study and training. As a medical student first experiencing the thrill of the operating room—holding a beating heart, seeing limbs flayed open and bowel cut and sewn—I was dazzled by both the vivid intensity, but also the horror of it. To be effective, a trauma surgeon learns to be unaffected by those horrors. But practiced dissociation can tend toward dehumanization. And so I have chosen to embrace those occasions of clarified humanity: the cautious reassurance given in the face of trepidation; the modest and incremental steps toward a semblance of normalcy after a marathon slog through critical illness; the revelry of appreciating life in the wake of near death. I want to be a trauma and acute care surgeon because it affords me the opportunity to participate in people's lives in those moments. That opportunity is a responsibility and a privilege that I embrace and honor each day.