



Eastern Association for the Surgery of Trauma

Advancing Science, Fostering Relationships, and Building Careers

2021 Oriens Honorable Mention Essay

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In my two short years of general surgery training, I've pronounced several John Does. A few in the trauma bay, many more in the ICU. Not unusual when you train at an inner-city US trauma center. In many cases, we never learn the names or exact ages of these patients. Nobody comes to claim the body; no one steps forward as family or friend; no reporter comes to cover the story. They disappear to the morgue as if the shooting that brought them in never happened. Just half an hour later – after the floors have been mopped and countertops wiped down – a new patient and anxious family occupy the room. They are totally unaware that just minutes ago the ground beneath them was littered with syringes, the air around them filled with shouts for epinephrine and bicarb. So quickly John Doe is forgotten.

Early in intern year I began to keep a journal of these young nameless patients who died so unceremoniously. I felt compelled to document their existence. To validate that they once lived and died. I quickly realized I would never be able to keep up with writing the story of each one of them – they arrived by EMS in such numbers every week. Admittedly, my mind began to blend their stories together too: the same tragedy of the twenty-something-year-old gun violence victim unfolded over and over. Over my first two years of residency I grew a commitment to caring for these most vulnerable of patients who cannot identify, speak, or advocate for themselves.

The events of this year have only strengthened my resolve to care for nameless victims of trauma. When the COVID pandemic hit my city, I was reassigned to one of the hospital's many COVID-only ICUs. As I rounded with the trauma attendings who were reassigned to my same unit, I was in awe of the unique versatility their training had given them: they effortlessly translated their trauma/critical care training to help fight a nonsurgical disease. But more importantly, I noticed the grim fascination that physicians from other specialties developed for the disease: they were finally getting a glimpse of what it was like to treat patients who had been ripped of their identity. Almost all the COVID patients I cared for in the ICU were unrecognizable: face-down, deeply sedated, and paralyzed for days, with no family in the room to support them – not unlike my John Does. In many ways, the COVID ICU bore a strong resemblance to a normal Trauma ICU. Others' recognition of the inhumanity of COVID strengthened my resolve to treat an equally inhumane disease.

The recent escalation of racial tensions in the US helped me realize the inhumanity that trauma imposes even on its survivors. It disproportionately impacts people of color and people in poverty, stripping away their identity even after recovery. Those who survive their injury often face a lifetime of destitution (only worsened by their new medical bills) or physical limitations. Many end up forgotten by society, unable to preserve their job, house, or family. As recovering John Does silently make their way from ICU to floor to discharge, I admire the trauma surgeons who have cared for them all along, long before this problem came into the national spotlight.

For the typical patient, the role of the trauma surgeon is many fold: to oversee the trauma bay resuscitation, operate, offer comfort to families, and more. But even when those things aren't possible, in the most hopeless of situations, their singular remaining role is still indispensable: to be present for those who would otherwise suffer forgotten. To express silent outrage on behalf of the victims of horrific everyday crimes that otherwise go unremembered. Because when nothing more can be done, when tragedy becomes the routine, my job remains the same. I bear witness.