WHERE NIGHT IS DAY

A volume in the series

The Culture and Politics of Health Care Work

Edited by Suzanne Gordon and Sioban Nelson

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Where Night Is Day

The World of the ICU

James Kelly

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For Loren, my true companion

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INTRODUCTION

You may never get to Big Sur or drive the Going-to-the-Sun Road in Glacier National Park or see where Hemingway lived in Key West, but the odds are that, one day, you will lie in a bed in an ICU.

I've been an ICU nurse for twelve years. I came to nursing late in life, after getting a BA in English just as the ten-year time limit was running out at UMass, having a little arts-and-crafts business, helping with the U-Pick at Hicks Orchard in Granville, New York, getting married, honeymooning at Sugarloaf campground in the White Mountains, studying theology at a Benedictine college, being a waiter in Vermont at the Wilburton Inn and then at the Dorset Field Club. I graduated from Castleton State College in Vermont in 1998 with an associate's degree in nursing two years after my wife graduated, passed my Boards in June, and we packed everything we owned on the tops of a red '94 Jetta and a yellow '84 Saab and drove across the country on I-80, then down to Albuquerque and our first jobs at what was then St. Joseph's Hospital.

On my very first day I walked into the ICU on the eighth floor of St. Joe's and saw a row of patients in small windowless rooms, flat on beds; some unconscious, some with their arms flailing, some with their hands tied down; some half naked; surrounded by machines and tubing; the smell of urine, sweat, feces, fear. Almost my very first thought was: What had these people done in life that they should be made to suffer this way?

The ICU seemed a world apart.

Walter Benjamin wrote that "philosophy is a struggle for the representation of a limited number of words which always remain the same." *Illness* is one of those words. Disease is the known world, mapped on the organs, rendered visible by autopsy, conquered by medicine. Illness is the new frontier.

Illness is said to have changed, to be postmodern, biocultural, a spiritual journey of self-discovery. In *Close to the Bone*, Jean Bolen writes that

illness is a soul experience that brings us close to the essence of who we are: "Illness is a source of personal meaning and wisdom that can transform life and heal us."

Both nursing and medicine talk about the world of illness and the experience of people who are ill. Nursing less so. Medicine is more like a chorus, a symphony of voices; nursing, occasional solos. Nevertheless, they both talk about their role in understanding the world of illness, ameliorating suffering, healing, the very nature of their practice.

Medicine is what Jean Lyotard calls a "grand narrative." Medicine dominates the subject of illness like a colossus. Illness is the lost birthright that medicine says it has rediscovered. The history of medicine was not only a rise but also a growing away from the world of illness. Arthur Kleinman writes, "One unintended outcome of the modern transformation of the medical care system was that it drove the practitioner's attention away from the experience of illness." Physicians themselves write of how the world of doctor and patient grew distant, silent; how, with the turn to science, medicine forfeited the spiritual, humanistic qualities it possessed earlier and focused only on disease—a biological entity. Books like *The Wounded Storyteller*, *The Illness Narratives*, and *Narrative Medicine: Honoring the Stories of Illness* declare that the biomedical model has changed, that it is now the task of medicine to give voice to the silent world of suffering, to uncover the meaning of illness, to heal as well as cure.

Caring is considered by many to be the essence of nursing. Jean Watson, the architect of the philosophy of caring, writes that not only does caring distinguish nursing from medicine but the future of both medicine and nursing belongs to caring more than curing. Caring is moral and spiritual, in contrast to the technical skills and functional tasks of nursing. Caring is said to create a shared world for the nurse and the patient.

Medicine's theory of illness reflects its own social history: its elimination of competition, the embrace of disease theory, its accumulation of power, the increasing distance from the patient. Medicine sees illness the same way it sees disease: as something to be diagnosed, interpreted, as requiring medical intervention.

Nursing still lives in the shadow of medicine. Nursing theory is often distorted in the attempt to emerge from that shadow. Nursing, though, does have something that medicine does not, the thing medicine believes it lost and maybe covets: closeness to illness. A privileged proximity to the world of illness.

This book examines the concepts on which these perspectives are based—empathic knowledge, transpersonal caring, the meaning of illness, the silence of suffering. The world of illness may be different from that seen by either nursing or medicine. It may not be visible, but it is not hidden; it may not be articulated, but it is not unknown to the ill. It's not a mystery; it doesn't require interpretation. But it does not readily offer itself to our understanding. I use the works of James Agee and Michel de Certeau as metaphor and example.

In 1938, James Agee was commissioned by *Fortune* magazine to go to Alabama to write about the people who were the poorest of the poor in America: the southern sharecropper. Agee struggled to write the book. He found the world of the sharecroppers more complex than he had anticipated, more dignified. He felt that words would obscure what was already difficult enough to give appropriate clarity and intensity to and said that, if he could have, he would have shown the world of the sharecroppers by doing no writing at all, but just through photographs, fragments of cloth, bits of cotton, lumps of earth. The book's title, from Ecclesiastes, is *Let Us Now Praise Famous Men*.

Writing about everyday life, the French philosopher Michel de Certeau described ordinary people as "unrecognized producers, poets of their own affairs, trailblazers in the jungles of functionalist rationality."

Nursing has a unique relationship to medicine: intimate yet subordinate, aligned yet dependent. In the ICU, they come as close as possible without touching. The teaching hospital makes doctors. They go from medical students to interns to residents to attendings. They begin as acolytes and leave as priests of health. This is described as an epic journey. Nurses witness it every day. How doctors are shepherded, nurtured. How they learn skills: "See one, do one, teach one." Becoming a nurse isn't like that. It isn't a journey. This book examines the relationship between doctors and nurses: how doctors sees nurses, how nurses sees doctors, how they are alike, how they are different.

A theory is often less the truth of an object than the reflection of a self-image, how a profession wishes to be seen. I look at the history of medicine, of medical education, and the growth of nursing to see that image. I try to see it through the words of medical historians like Paul Starr and Charles Rosenberg, doctor-writers like Ellen Rothman and Bernard Lown, nursing scholars like Jean Watson. And through my own experience.

This book is grounded in the day-by-day, hour-by-hour rhythm of the world of an ICU in a teaching hospital in the heart of New Mexico. It

takes place over a thirteen-week period, the time of the average rotation of residents through the ICU. It begins in September and ends at Christmas. The patients are mostly poor. Hispanic, Native American, Anglo. The days are twelve-hours long. Unless the patient is so sick that one-to-one care is needed, an ICU nurse has two patients. The rooms have their own valence. They draw you to them, back and forth, all the day long. They call to you like the Sirens called to Ulysses.

At work I carry a clipboard. I write down the patient's past history, why he or she came in, the diagnosis, what happened during the course of the stay. I use it to keep track of what we did, what needs to be done. I organize it by systems, one page for each patient. As I was writing the book, during the day I wrote down conversations, events. The next day, or my first day off, I would rewrite the notes. And I would try to remember other things that happened that I couldn't write down. Some things—a death, unimaginable grief—write themselves in your soul and are always there. I've changed everyone's name, most of their ages, left out some things, so that they would be unrecognizable to themselves and to others.

WHERE NIGHT IS DAY

1

THE VOYAGE INTO THE SEA OF CRITICAL ILLNESS

There is no night in the ICU. There is day, lesser day, then day again. There are rhythms. Every twelve hours: shift change. Report: first all together in the big room, then at the bedside, nurse to nurse. Morning rounds. A group of doctors moves slowly through the unit like a harrow through a field. At each room, like a game, a different one rotates into the center. They leave behind a trail of new orders. Wean, extubate, titrate, start this, stop that, scan, film, scope. The steep hill the patient is asked to climb. Can you breathe on your own? Can you wake up? Can you live?

Day is procedures: bronchoscopies, lines, taps, chest tubes. Day is traveling: MRI, CT, to dye the blood, radiate the organs, look inside the body. Then the plateau of the afternoon. Post-ops. A heart comes out. In the evening, the families. Then night to knit the raveled sleeve of care. Nights are quieter. But there are admissions, codes. The lights are always on. In the day you make progress; at night you keep them alive. Until day.

The ICU could be said to have begun in 1854 on the Fields of Scutari during the Crimean War. Of the 1,650,000 soldiers who fought, 900,000 died. Most died not from wounds but from cholera, typhus, dysentery. Florence Nightingale traveled with thirty-eight nurses from England, separated out the critically ill patients into a Monitoring Unit, and reduced the deaths of hospitalized patients from 40 percent to 2 percent. It may have begun in 1928 at Johns Hopkins Hospital, where Walter Dandy created two two-bed rooms for craniotomies and critically ill patients for the first twenty-four hours after surgery. Or in 1952, when Peter Safar, who invented mouth-to-mouth breathing, CPR, and the mannequin Resusci Anne, opened a six-bed Urgency & Emergency room at Baltimore City Hospital.

The ICU is pure medicine. The patient is a network of systems. Nine: neurologic, cardiovascular, pulmonary, gastrointestinal, genitourinary, integumentary, renal, hematologic, endocrine. Systems are the language, the code of the ICU. The progress notes in the chart are organized by systems. When they round, the residents present by systems. Nurses give

report to each other by systems. For a patient to be in the ICU, a system has to fail. The principle of the ICU is actually simple: single-organ-directed interventions to support failing organ systems. A ventilator for the lungs, dialysis for the kidneys, a balloon pump for the heart. Death is indexed to organ failure. For every organ that fails, your chance of dying increases 20 percent. If more than two fail, you have MODS, multiple organ distress syndrome. MODS is unique to the ICU, like saguaros to the Sonoran Desert. MODS was discovered in 1973 and is sometimes called the disease of medical progress.

The ICU is pure medicine but like the hospital in general, it is a nursing world. The intensive care is intensive nursing care. Florence Nightingale's Monitoring Unit meant moving the most severely injured soldiers to beds nearest the nurses' station. Walter Dandy's neurosurgical unit had a trained nurse in constant attendance. Medicine comes and goes. Doctors come, write orders, leave. You find an order in the chart: Avelox 400 mg q day. In the afternoon, they are gone from the unit and, like a tide that goes out and leaves behind exposed coral reefs, what is left behind is the eternal terrain of the ICU: nurses with patients.

It is seven o'clock. The room where we get report is long and narrow, the size of a small trailer home. The two kitty-corner doors at each end are closed. The blinds are drawn. Outside, the western wall of the Sandia Mountains is in shadow. The streets of the city, with their Spanish names—Candelaria, Osuna, Lomas—are filling with cars. The room quiets when the night charge comes. It feels as if beyond the drawn blinds, the closed doors, is a storm and this room is a refuge.

"Bed One," Kate begins, "Bed One is . . .

. . . Cory Granger. Fifty-one-year-old patient of Critical Care and Neuro. Chest pain while up in the mountains, hiked out. One hundred percent occlusion of the right coronary artery. Stented in cath lab. Was on a heparin drip after and had an intracerebral bleed. He's got a left hemiparesis. He's been hot: 39.7 temp. He's gone from 40 percent to 90 percent oxygen on a nonrebreather mask. He's going for a CT this morning. He'll get sick before he gets better.

Bed Two. Dakota Yazzie. She's Hopi. Forty-two. New admit. Occipital bleed. Probably nonoperative. She's awake, alert. Moves everything. Left visual deficit. Room air. She had her CT this morning. Neurosurg hasn't come by yet. She might go out.

Bed Three is Valentín Sanchez. Sixty. He's from Guadalajara. Came up to visit his family. Presented in the ER with weakness, weight loss. Was on Med-Surg. Went into respiratory distress. Came to the ICU. Emergently intubated. They're ruling out TB. He's on propofol for sedation. Big family. They want a conference today.

Bed Four. Leroy Guzmán. Fifty-two. Found down, unconscious. Hit his head. Status post craniotomy for a subdural hematoma. No deficits. He's a drinker. Extubated yesterday. Nasal cannula. He's still withdrawing but not getting much Ativan. Restrained. His wife calls in the afternoon, totally drunk.

Bed Five is Nancy Vigil. Forty-nine. She came from Española for a higher level of care. Sepsis, renal failure, afib. Heart rate was in the two hundreds. They put her on a Cardizem drip. She converted to sinus rhythm at twelve thirty. She spiked a temp last night, 39.2. Pancultured: blood, sputum, urine. She's vented. Propofol's at thirty. Stage-two decub on her coccyx. Chest X-ray shows a pneumonia behind the cardiac silhouette. She's sick.

Bed Six is open.

Bed Seven. Lena Begay. She's from the Jicarilla Apache Reservation. Twenty-eight-year-old patient of Internal Medicine. Idiopathic pulmonary hypertension. End-stage. Awake, alert. Flolan drip at four. She made herself a DNR/DNI. She's very sweet. She's a mom. Two kids. Her family's all here.

Bed Eight is James Cushman. Fifty-six. Came in with upper-GI bleed. Scoped and banded. Went septic. Unresponsive. Hypoxic. ARDS. Lots of comorbidities. No family. He needs to die.

Bed Nine is Ricky Lucero. Ricky Boy. Twenty-one-year-old patient of Neurosurgery. Fell, was hit, or was thrown from a vehicle—take your pick—big, deep laceration on the back of his head. Restless, agitated. Extubated himself in CT to everybody's horror. He follows a couple of commands. He's on mannitol q six hours. Nasal cannula two liters. He took off his cervical collar. His C-spine's not cleared yet. If he doesn't paralyze himself, he can go out. He's a little *lloron*. His mother never leaves the room.

Bed Ten is Carolyn Britt. Meningitis. She was exposed to it in her dormitory. Was started on Cipro but stopped taking it. Go figure. She came in with a classic presentation: confused, fever, stiff neck. Trached two days ago. CPAP since four o'clock this morning. Doing okay. They're going to try her on a collar today. Awake. Alert. They had to take off both legs below the knee. It was going after her kidneys. She's seventeen.

Bed Eleven. Code name Tucson. Found down in the desert. Dehydrated. Acute renal failure. Rhabdo. CKs coming down. He's still intubated. He's on Levophed to keep his systolic pressure above ninety. They've got it down to two micrograms a minute. Normal saline's at two hundred to get his kidneys going. He gets fentanyl and Versed as needed for sedation. He's a little guy but he's wild when he wakes up.

Bed Twelve. David García. Alcohol, IV-drug history. Status post hiatal hernia repair. His stomach was in his chest. They nicked his esophagus. Got repaired. But he had a GE junction tear, so his esophagus is not connected to his stomach. I'm not making this stuff up. He's got three chest tubes, a jejeunostomy tube, a Jackson-Pratt drain, and a nasogastric tube to drain that we are not to touch. They're going to connect everything later. He's on a vent. Fentanyl drip.

Bed Thirteen. Maria Leyba. Sixty-four. GI bleed. Cryptogenic cirrhosis. Came in through the ER. Third of four units of blood going in now. She's a frequent flyer. She'll be scoped today.

Bed Fourteen. Peter Richardson. Sixty-eight. Motor vehicle accident. Fender bender. Came in with right hemiparesis, facial droop, drift. CT showed a large basal ganglia tumor. He's going for a biopsy today. He's still a full code. There's an abdomen in the OR. Four may be able to go. The ER is empty."

When she leaves, Kate leaves the door open.

Sue is the day charge. "How many nurses do we have?" She bobs her head as she counts around the table. "Eight nurses, thirteen patients. I'll be free. Who's back?"

Assignments go quickly, as though at an auction. A hand lifted off the table, a nod. Lori pushes her chair back. "I had Seven and Eight."

It's between Kay and me. She looks at me. "I don't care."

"You decide," I tell her. She takes Five and the admit. I get Two and Three.

Lacy is the night nurse. She has Sanchez. "This guy came to the ICU on the fourth. Yesterday. He was admitted on the second for shortness of breath. Went to the floor. Crumped. Sorry. Let me start over." She looks at handwritten notes on a yellow piece of paper folded in half. "He was admitted to the floor, went bad, came to us, and got intubated. I've got him on propofol and fentanyl. He doesn't do anything. We need one more sputum to rule out TB. I don't know what they plan on doing. He

desatted last night so we bumped his oxygen to seventy from fifty. He's not making much urine. His creatinine's climbing. He might need to be dialyzed. He's got a femoral line. He's got a big family and they're all here in the waiting room. I think there's a thousand of them. Good luck with that. Questions? I'm back."

Nights are long. Some of the nurses sleep, in turns, on the one couch in the lounge, so in the morning the room has a trapped, tangy human scent, or they rest their heads on the white patient blankets on the roller tables where we chart outside the rooms. You can see a trace of their profile like a petroglyph. It must be a jolt at seven o'clock, the day shift coming at you like a car with its high beams on.

We call the bedside report a handoff. It can be good or bad. Things get left out, forgotten. It's like you're standing on one side of a crevasse and you have sand cupped in the palm of your hand and you're going to pass that sand to a person on the other side. Every twelve hours this is done and what happens is that the sand slips through your fingers and there is less and less each time, like when they came in, how many days on the vent, you need to check all stools for blood.

I find the history and physical in the chart. It's typed on blue paper. The progress notes are yellow. Everything else is white. *Past medical history: diabetes, hypertension. Was vomiting blood—coffee-ground hematemesis—for two weeks, abdominal pain, 40 pound weight loss, positive cough and fever. Admitted to the floor with a differential diagnosis of aspiration vs mass vs community-acquired pneumonia vs TB.*

And then the trapdoor in the floor of the hospital opened—respiratory distress, unresponsive, transferred to the ICU, gets intubated, they do a pulmonary angiogram to look at his lungs and the dye wrecks his kidneys.

He's like a pebble crack in your windshield that spreads and spiders until the whole glass is shattered but still there and all you have to do is touch it and it will crumble into pieces. Because we're ruling out TB, I have to put on a special face mask—it looks like a duckbill—before I go in. He looks much older than sixty. His flesh is loose on his body and thin like the skin of rotten grapes. Like it would rip if you touched it. The bones of his face are sharp under his skin and his cheeks are sunken. There is a creamy haze over his pupils. Cataracts. His pupils are pinpoint

from the sedation. He doesn't do anything when I pinch his trapezius or press my pen into the nail bed of his finger. He's riding the vent. He's on sixty-five of propofol. Propofol's a sedative-hypnotic. We use it in the ICU because it has a rapid onset and a short half-life; you stop it and ten minutes later they're awake. It's white. It comes in a glass bottle. Some nurses call it the milk of amnesia. He's completely snowed. I cut the drips in half.

Mateo, the respiratory therapist, is at the door. He makes a face at having to mask up. Mateo's heavy, with bad knees that make him wobble when he walks. He lives out by Airport Road in a big double-wide. He's divorced but still lives with his ex-wife. They live at opposite ends of the house. They say he was wild, a gangbanger, when he was young. We need a sputum, I tell him. Mateo puts a bullet of saline into the tube before he slides the suction tube down Sanchez's throat. It makes the guy cough violently but Mateo gets thick tan stuff in the trap. He lifts it into the air and looks at it like a wine taster examining a cork. "That'll work."

Dakota Yazzie in Two had come in yesterday evening. The post-call resident is with the day resident looking at her chart. The post-call's name is Lucas. He's a big guy, maybe twenty-eight. Beefy. He looks like a high school football player. The day resident is a woman. She's flipping through the chart.

"Why is she on bicarb? You usually don't need to treat low bicarb in DKA." He says they checked it twice, with an arterial blood gas and then a venous.

"It doesn't matter. It corrects with rehydration." She asks him if he ordered an EKG and a chest X-ray. "I'll write for them," he says.

After they leave, I look in the chart. There's no history and physical yet, just the first day's progress notes: *Had presented at the Indian Hospital in Crown Point with nausea/vomiting for two days, right upper-palate pain that progressed to a right retro-orbital headache; was hyperglycemic in the 500s with probable diabetic ketoacidosis so was transferred to Gallup; CT there showed right occipital intracranial hemorrhage, 28 x 34 centimeters with no midline shift.*

Then she came to us. If you're sick, they move you along to a higher level of care. We're the highest level of care. We're the ICU for the state of New Mexico.

She's alone in the room, awake. When I introduce myself, she looks past me as if at someone standing behind me. She doesn't say anything. She has a wide face, high cheekbones. She doesn't have a headache. She can hold her arms out straight without drifting. I ask her to smile and then stick out her tongue and she does and then smiles after that as well. She looks like Annette Funicello. I ask her if she knows who she is. She laughs. "I know my Mouseketeers." She says she can't see the diamonds on her wedding ring. It looks like it melted. Her pupils are equal, dark like all her features, dark like starless nights, but tracking to the left she can't see. Her voice is calm, though, when with my finger off to the side she says, "I don't see it." I know it starts with an *h*, but I can't remember what it is.

Two residents are outside the room hunched over the chart.

"Who are you guys?"

"Neurology," one says.

"What's the word for a deficit in half the visual field of both eyes?"

One of them pulls a piece of paper from the chest pocket of his white coat. "Homonymous hemianopsia. I'm just doing a rotation. I'm in general surgery." There are other groups of doctors in the unit. They hover outside the rooms looking at charts the way hummingbirds feed in mid-air, always in flight. "We'll be by to see her later," the other one says.

Rounds is starting. The Medical team is outside One. In the middle, older by far than any of the residents, is Fowler. Fowler and Morgan are the two attendings. Murphy is the chief resident. The Good, the Bad, and the Goofy, Michelle calls them, although Murphy isn't really goofy; it's just that he wears nursing scrubs with funny designs because his mother is a nurse and he wants to show that he's on our side. I have about ten minutes before they reach my patient.

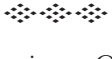
"Can you check blood with me?" Dana has Bed Ten, the meningitis girl. She looks small, smaller where the blankets below her knees drop off and lie flat against the bed. At first you see she has a cute round face with her hair in pigtails with paintbrush tips below elastic bands like Pippi Longstocking and buck teeth with a space between. But that's where the look-alike ends. Her skin is moist and colorless and sprinkled with acne from the steroids. Her central line is an internal jugular and juts from her neck as if someone is tugging at it, raising the skin into a little tent. So she won't pull things her hands are wrapped in gauze and look like boxing

gloves. The drain sponge under her trach collar is mangled and wet with thick yellow mucus like Jell-O.

"We're just going to give you some blood, sweetie," Dana says to her. The girl raises her eyebrows and her eyes widen. "It's all right." She can read her face. Dana takes her a lot. Some nurses do that, take the same patient again and again. We check the numbers quickly. The medical record number, blood type, expiration—wristband to paper, paper to bag. "Your mother called. She said she loves you," Dana tells her. The girl makes a guttural sound that makes the mucus on the sponge shiver.

A man and a woman are in Dakota Yazzie's room. They didn't call to come in but people slip in all the time. The man is standing under the TV, which is on struts high on the wall, and stops punching the station buttons to shake my hand and introduce himself, in a soft voice, as Terrell. He is wearing a gray T-shirt with lettering about a basketball tournament. His hair is combed straight back in a rakish way. The woman is seated. She's wearing a maroon sweatshirt with a dream catcher logo over a flouncy skirt that goes all the way to a pair of black single-strap ballet shoes. She is obese. Everything about her is huge except her hair, which is thin and permed into tight ringlets. Resting on her chest on separate chains of different lengths are two silver crosses. She looks up at the door suddenly. The team is here.

Fowler leans toward a western style even though he's from Chicago and went to medical school at Northwestern. He wears a thick leather belt with Texas Gold Star conchos, bolo ties, and sometimes real cowboy boots. He's patient with the residents and generous. The residents are different from Fowler and not just because they're younger. It's like those waterfalls you can buy where the water flows down into a container and that container fills up and the water flows down into the next container. Somehow the water in Fowler doesn't seem to be flowing down. There are seven residents. They all wear white coats. They stand in a tight circle.



The hospital is like a two-way mirror. On one side you see yourself reflected and you think it's all for you. What you don't see but what sees you is the world on the other side. The world on the other side is teaching. The teaching hospital is a kind of workshop that makes doctors,

where they are put together, assembled, polished, made sure they are in working order, put through tests to make sure they're up to it. They're their own solar system, orbiting each other, balanced by their own gravity, whirling through the hospital.

Medicine is collegial in a way that nursing is not. Doctors call themselves a "team:" the ICU team, the Medical team. They never criticize each other in rounds. The progress notes say things like "Appreciate Dr. So and So's comments"; "Thank you, Dr. So and So, for the consult." They rotate through the hospital—ER, ICU, Med-Surg—climbing the ladder rung by rung. Nurses are alone most of the time—in a room spiking a bag, titrating a drip, charting at the desk. Alone like a person ice fishing on a frozen lake. You almost never see a doctor alone.

Lucas has already begun: "Denies weakness, no sensory deficits, no family history, no meds, never seen a doctor." He's reading from notes on loose four-by-six-inch pieces of paper that are also stuffed into both pockets of his white coat and is standing not in the middle but maybe a foot into the center. "Has a three over six systolic murmur, one son, married, one weekday drinks heavily and takes several days to recover." They all laugh at this with smirks and titters. They look alike, the residents, like a cluster of ripe cherries, plump, full, smooth skin glistening with dew. Even Fowler says, "Why am I not surprised?" I look into the room; the curtain is half drawn but the door is open. "That sounds familiar," he says. "Any visual changes? HH?"

"I didn't notice," Lucas says. He looks down at his notes.

"She has visual changes," I say.

"What about drugs?" Fowler asks.

"Cocaine."

"Keep going."

"She denied problems, no history of falls, she was in minor DKA. Her glucose was three ninety." He stops. Fowler is bent over the computer bringing up the labs.

"I gave her bicarb," Lucas says.

"Her gap was closed," Fowler says. "You wouldn't give her bicarb. Her sugar's not that high. What's her A1C?"

"It's not back yet."

"There's no urgency," says Fowler. "Okay," he says, getting them back on track. "What do we need to do from a medical point of view?"

"I gave her hydralazine for hypertension."

"Wrong. Neuro likes to use beta blockers. Hydralazine can vasodilate, increase intracranial pressure. Neurosurgs like a short-acting drug. Something you can take away. Did you put her on half normal or start NPH?"

"No."

A female resident has the CT up on the computer and has turned the screen to show the other residents. Her hair is cut boyishly with one side jagged like a serrated knife. It makes her look like that kid doctor, Doogie Howser. She's small; she's sitting on my chair that's like a swivel bar stool with one leg tucked under her the way small people can do. The lettering on her jacket is a blue cursive that says "Internal Medicine."

"This location is not consistent with a hypertensive bleed," she says. On the scan, which looks like an old black-and-white movie and is a view from top down, even though they lie flat in the scanner, in the lower left corner, what should be gray is a white spot as big and soft around the edges as the butter pat you get in a restaurant.

In the room, Fowler asks her if her head hurts.

"Some."

"How long?"

She shrugs her shoulders.

Terrell is standing by her next to the bed. Maybe because she's so quiet he starts to talk as if to be helpful and says how she had tried to unlock the back not the front door of the car and then had been driving and turned left way too soon. They're all standing behind Fowler, who has gone only as far as the foot of the bed.

"Do you have any medical problems?"

"No."

"You've never seen a doctor?"

"Never."

It's like she is from another planet, a planet of the poor, the outcast, the invisible. Come here, live in a catacomb of your own language, your own way of life, until illness drills a hole into it and the light of the world is on you.

"I do have a murmur. My grandmother wouldn't let me run around."

"Let's get an echo," Fowler tells Lucas. He looks at Dakota Yazzie. "We're going to do what's called an MRI. It will give us a better picture of your brain. How's your vision?"

"I can't see to the outside."

Fowler leaves the room first and the residents follow. They move down the hall together, as if they were all in a revolving door, toward Sanchez's room.

Two surgical nurses walk by, slowly, looking in each room, strolling, as if they were shopping in a mall. "Where's our patient going?" one of them asks. They're wearing thin blue surgical gowns, open in the front, and soft blue surgical caps like spun candy.

"Six," Sue says. She helps them pull the bed out of the room. "What are we getting?"

"From the Indian Hospital. Open abdomen."

"How long?"

"Twenty minutes. Thirty. They're still closing."

It's clear Fowler doesn't know Sanchez because he winces when he hears the renal failure was from the contrast for the angiogram. A thin olive-skinned guy is presenting. He's sharper, more confident than Lucas. Wherever he is from, he's not from the United States, and most of the residents are not. The quickness has passed to the world, to Asia, India.

"So, one," Fowler says, "we have respiratory failure. Two, we have acute renal failure. Is ID involved? Let's get them involved." One of the residents picks up the wall phone right away. "What did Renal say?" he asks.

"That he's improving," a resident says.

"Let's get a cortisol level." He pokes a finger in the direction of olive-skin guy. "See if Pulmonary wants to bronch him. This guy's sick. This is what you want. This is good pathology."

The unit is quiet. Rounds over. Now they go look at X-rays, CAT scans, have a teaching session somewhere. In the hospital you're not just in your bed, in one room; your body is in your bed, your blood in the lab, your lungs in X-ray, your brain in CT, your history in Medical Records. They'll come if we call, if we need them. They'll round again in the evening. For us, day begins again.