Dinner Stories: The Emergency Room

by W. Scott Olsen

Prologue

Here is a truth that crosses every border. Dinner is a time for stories.

There is something magical about the meal. Or, to be more precise, there is something magical about the occasion. We don't often tell breakfast stories. We have to get going. The stories we tell over lunch are brief, summaries at best. But dinner stories can be long. They hold drama and nuance. They hold backstory and foreshadowing. They have an arc that reveals something deeper than just what happened.

Gather a group of friends at an evening table and we share stories that nourish the soul as well as the spleen.

The Chef

My friend Eric Watson is a chef. Talented, imaginative and creative, he owns a restaurant in Moorhead, Minnesota, called Rustica. What if, I asked Eric, we gathered just one person, someone with an interesting job, and asked them to tell stories? Could you come up with a menu to provoke those stories? Could you come up with a menu that was based on or inspired by the work they do?

Eric paused, but only for a moment. "Yes" he said. "I think I could."

The Guest

Warren Hintz. Emergency Room Physician. Sanford Hospital. Fargo, North Dakota

The Menu

Wood Roasted Manilla Clams
Preserved Meyer Lemon, Garlic, Basil, Caper, Olive & Sweet Tomato

Ginger Miso Glazed Cauliflower
Edamame, Tofu, Sweet Potato & Sticky Black Rice

Scallop Crudo with Toasted Coriander
Fresh Orange, Shaved Fennel & Asparagus

Flash Seared Beef Tenderloin Medallion
Cumin Scented Quinoa, Black Beans, & Carrot Tahini Puree

Caramelized Pear
Coconut Milk, Ginger & Almond

Eric and I sit at the bar at Rustica, going over the menu he wants to serve.
Is there a connection between food and profession?

“That’s what I’m shooting for,” Eric says. “We have an Emergency Room doctor. So I am trying to keep it healthy. A lot of the ingredients on here—I just feel like certain ingredients hit my stomach and make my stomach feel better. Healing food. So like miso, or things that are umami driven, really savory. When I eat salmon roe for example, it makes my body feel better. It’s personal to me. Everything on here seems, to me, fresh, vibrant, healing. Something that’s good for the body.

“I tried to create a menu based around things that are going to cook really quick,” he says. “When I think of the emergency room I think fast, speed, so I wanted things that were quick. Like the beef medallions, for example. We can flash sear them really quick and they’re done. The caramelized pear requires very little cooking time. Everything on here requires very little, if any cooking time.

“I start light and work toward things that are heavier. The clams are super light, super clean. Manilla clams are petite and tender. The cauliflower—I just wanted to keep it healthy, so anything kind of along the vegan lines, health conscious, plant-based. The pear? Just wanted to keep it as free of animal fats as I could.”

I smile, looking at the piece of paper that holds his notes, imagining the evening.

“Should we tell him?” I ask.

“This is the Emergency Room,” he says. “I think it’s kind of fun to let him be surprised.”

Dinner Stories

Dinner is at 5:00 p.m. on a warm clear April evening. Warren and I arrive at nearly the same time. Grey hair and a closely trimmed grey beard, the man radiates calm. He moves quietly. His voice is soft.

Eric has reserved the best seat in the house, a table in the front window overlooking the intersection of Main Avenue and 4th Street South. Cars and trucks, the occasional motorcycle, people out for a stroll go by. Walkers peer in the restaurant windows as they pass, all of them looking at the food on the tables more than the faces of the diners. A happy, curious young woman named Madi appears at our table and pours water, then takes our order for drinks. She knows this is an occasion. Be right back, she promises.

Warren and I smile, then start with beginnings.

“I was working for an engineering consulting company in Bismarck,” he says.

“Remember those aptitude tests we all used to take? They said I would be good at engineering, so that’s what I went into. With nothing else to do I thought ok, they’re smart, I’ll do that.

“Anyway, I was sitting in my office three years into it, after graduation, and I happened to look across the hallway to my bosses’ offices. They were both behind their desks. I realized at that moment, even though there was probably a little wanderlust happening before then, that these guys were forty-two years old and I was twenty-six. I was doing the exact same thing they were doing. And I said, do I really want to do this when I’m forty-two? Do I want to do this when I’m forty-five? The answer turned out to be no.

“So then it was a matter of what are you going to do if you’re not going to do this? I toyed with going into law school for a little while but there was a movie that came out in the late 70s called *And Justice for All*. Al Pacino. It was a great movie. It was really a spectacular movie. But it was horrible in the message it was offering. The message, and one of the lines I remember, was Al Pacino saying ‘There is no truth. Truth in law is only what you can get people to believe.’ I realized I don’t believe that. I couldn’t do that. So I started processing other things.”

Warren takes a sip of his water and begins a smile.

“I had a recollection of a girl I was dating during college and she had mentioned I should go to medical school,” he says.

Then he waits.

“Because?” I ask.

“She thought I’d look good in white.”

We laugh.

“Why not interrupt my whole life and my career path and everything else in the world I had at that moment because I would look good in white?”

Madi shows up with red wine for me, a gin and tonic for Warren. Her timing, I think, is perfect. Warren and I take that first sip of our drinks and survey the room. Other people are arriving and the room is filling with laughter. One couple, at a table a bit distant from our own, is clearly on a date. Perhaps a first date. Obvious, awkward eagerness.

“To be serious,” Warren says, “it was during this same time that I would ride my bicycle all over North Dakota and I was out riding one evening after dark. I was right down by the Holiday Inn in Bismarck, just about to go underneath the Memorial Bridge, and I heard this horrible screeching and scratching and crash. A car crash. This was obviously before cell phones. I ran up to the middle of the bridge. There was this car with four young girls in it. High school age. And then the other car, the notorious drunk driver. And these young girls kept saying, ‘Help me. Help me. Help us. Help us.’ There wasn’t anything I could do. I didn’t know anything. There wasn’t a thing I could do other than just try and reassure them, encourage them to stay calm. At least I knew enough that they shouldn’t move around too much. Another person came up after that, backed up, went somewhere and made the phone call to 9-1-1. I was able to stay there with them. And it was that evening, night, next morning that I said I would never be in a position where I don’t know what to do. So within two weeks I signed up for an EMS course. Joined an ambulance squad. Went to medical school.

“I am firm believer that everyone has a calling at some time in their life, he says. And we always look at things we like to do and might want to do. That night I found mine.”

Starters

Madi shows up again. Right behind her, Eric appears, deep plates in each hand. He sets them in front of us.

“Oh, my heavens,” I say, then make introductions.

“We’re starting out with a wood-fired, roasted clam,” Eric says, “with a sweet tomato broth, olives, capers, basil, a little garlic, chicken stock, a touch of butter and olive oil.”

I understand plating as an art form, I think to myself, but I am always amazed by the beauty of well-presented food on a plate.

“This came to be,” Eric says, “with the idea of trying to pair it with an ER doctor, at least the best I can. Just fast. Things that are flash cooked. I was just thinking speed. I picture an ER doctor moving quick. Or at least thinking fast. Nutritious. Good for the soul. Not a lot of saturated fat. But a lot of color. A lot of vibrancy. That’s where I was starting and where I was heading.”

“This smells grand,” Warren says.

Warren smiles at me after he takes his first bite. Behind us, the sounds have changed to forks and spoons and knives put to work. A dozen variations on the way to say “hmm” that means “this is really good.”

“I will confess,” I say, “I am afraid every time I get a meal like this. Shells and such. Do I really know how to eat this? But I’m also old enough to know I really don’t care.”

“Indeed,” Warren says.

I take my own first bite. Oh lord, I think.

“You’ve seen a lot of water under the bridge,” I say. I already know he is the second most senior physician in the ER. More than thirty years waiting for disaster.

“It’s remarkably changed,” he says.

“The technology has changed,” I say. “Has practice changed?”

“Skills,” he says. “Skills relative to procedures that you do to either save lives or make things more comfortable for people. Whether it’s lines, IV lines, or intubating, or something else, the skills have certainly followed the technology. Better equipment. Better techniques. Procedures have changed. Patient population has changed too, to some degree. Initially the patient population was truly emergency medicine people. Then it started falling into urgent care, walk-in clinic types of things. Now it’s all of that, plus. The only thing we don’t do is preventative care. And only because the setting isn’t right for preventative care. But whether it’s psychiatry, whether it’s chronic medical care, whether it’s urgent care, whether it’s emergent care, it’s kind of the full gamut of everything.”

“I had not thought of emergency psychiatry coming to your room,” I say. “Other places, yes. But not the ER.”

“Most of that, unfortunately,” he says, then pauses, “is despair. It’s an incredible social, cultural type of issue. Despair issues run the gamut of suicidal, whether it’s just thinking about it or actual attempts, to alcohol and drug related issues, overdose issues, intentional or otherwise. And just some health issues. Certainly we know that physiologically and medically people get sick from their stress. They get sick when they are in despair. Even if they are not using things. Even if they are not suicidal. Just physiologically they would get sick.”

Warren and I sit quietly for a moment, take bites of our meal. I'm coming to understand his pauses are a consideration of options. His life is based on getting it right.

"It's curious," he says, "that you ask what would bring people to the emergency department for even routine things, like a cold, or a child who has a fever, when there are walk-in clinics available. I used to ask myself that a lot. But then I learned.

"I think it's been—I'm just going to guess on the timing of this—ten years ago? It was in the middle of the night. About 2:30 in the morning. Even ten years ago we weren't overly busy overnight. Ten people, maybe twelve. Maybe even five? From 10:00 p.m. until about 6:00 a.m. it was not a grand crowd. This one particular morning, I was in our sleeping room, study room, whatever, and I got a call there was a patient to see me. I came out to see him and here's this eighty-seven-year old little guy, nicely dressed, looking healthy, and his primary complaint was fatigue. At 2:30 in the morning. And I wondered, I wondered what he was thinking.

"So, fatigue. I went through the whole gamut of what could cause a little old man to have fatigue. He hadn't fallen or been dizzy or anything. As I was interviewing him, and then examining him, I was asking him—what do you mean by fatigue? Tell me what you're experiencing. What has changed recently?

"He had more energy than I did! He was telling me that twice a week he would go down to the Eagles club and dance until they closed at midnight. He was telling me stories about little old ladies. 'They just won't let me alone,' he says. 'There're more old women than there are old men there, so I don't have to worry about not being able to dance,' he said. 'In fact, sometimes I just wish I could just sit and chat for a little while.'

"And I thought, so you dance all night, once or twice a week, and he says yes, I do. And then he said he hikes miles a day! So I ask—has anything changed? He said, not really. So I'm still processing, how does a little eighty-seven year old man, nicely dressed, 2:30 in the morning, come into my department saying he's fatigued? I did some diabetes

checks, some anemia checks, whatever else I could come up with for fatigue. And I came back half an hour later and I said you know, everything looks good. I don't have an explanation for what you're experiencing. He said, it's okay. I'm not necessarily fatigued. I'm just sad.

"And I said, what are you sad about? He said, 'Well, in the middle of the dance night tonight, I got a phone call that my last best friend died. And I just wanted somebody to talk to.'

"Since then, I realized that everybody comes to see me, comes to see us, for a reason. And whether that reason is something I understand, whether that reason is something I agree with, whether it's a reasonable reason or they just needed somebody to talk to, at 2:30 in the morning, I'm there. I'm serving a function. And so I kind of vowed that I will never ask again, in my mind let alone out loud, if they should be there. Sometimes I do ask *What are you here for?* because I just don't understand their whole process, and that does clarify a lot of things. Sometimes it still just doesn't make sense, but at least most of the time it clears things up. But at least I vowed I would never be angry or frustrated with somebody who's there that I don't think needs to be there."

"Have you been able to keep that vow," I ask?

"I think for the most part yeah," he says. "I have. I was so impressed with that little old man."

Second Course

Madi arrives, smiling. "Can I take this first course out of the way?"

"It was wonderful," I say.

"I think I devastated it," Warren says. "Thank you."

Eric arrives right behind her.

“So what do we have?” he says. “This is a pan seared cauliflower medallion with a ginger miso glaze. We got a little tofu, a marinated tofu with a little splash of tamari. Same thing with the edamame —it’s got a little splash of tamari as well. And a sweet potato puree and a black sticky Tai rice.”

“Oh my, Eric,” I say. “Where did this idea come from?”

“You give me too much credit for ideas,” he says, laughing. “No, it’s just I like the color scheme, I like the textures and flavors together, so yeah, that’s really where it’s born from. Just kind of going all vegetarian, vegan on this dish actually, so again just trying to keep it clean, healthy, small portions.”

We invite him to linger but Eric says he cannot. Other customers. Other patients.

Warren starts to talk about diagnostics and protocols. He tells me about ABC—airways, breathing, circulation. But then he takes a bite, stops and points at his plate, at the presentation of the food. All he says is “mmmm.”

“I wish I had Eric’s imagination,” I say.

“That sweet potato puree is just absolutely breathtaking,” Warren says.

We are suddenly in that comfortable silence of good food. A shared, atmospheric joy. Something shared even before language. Something ancient.

“I marvel at creative people,” Warren says.

“Don’t let anyone know,” I say, “but I actually like the tofu.”

“I’m there with you, too,” Warren laughs.

“I’m always amazed when people can bring out a flavor in cauliflower,” he says. “Something that is so”—he pauses, then just smiles.

We pay attention to the food, sip our drinks.

“Tell me about diagnostics,” I say. “It seems to me, from the outsider’s perspective, that you, your department, has to have the fastest diagnostic skills in the world. The range of things you could be presented with is everything.”

“I think that’s accurate,” he says. “You have to have at least a pretty clear picture of what the possibilities are. We use the term differential diagnosis relative to whatever complaint they have. So you came in with belly pain—what are the possibilities? You came in with chest pain—what are the possibilities? You came in unresponsive—what are the possibilities?”

“What information do you have before you see a patient?” I ask.

“It certainly varies,” he says. “A critical patient is really the only type of patient I hear about before I generally go in to see them. For the most part, all of the patients we see have a chief complaint or a primary complaint. And maybe a little bit of details from the nursing staff.”

“So usually you’re just looking at the chart hanging on the door as you go in?”

“Right. Whereas critical patients, the staff are exceptional in letting us know there’s somebody critical coming in in ten minutes, fifteen minutes, and this is what we know. Sometimes it’s we know they’re not breathing well, some of it is blood pressure is low, some of it’s that they’re unresponsive. And some of it they’re not doing well. I hesitate to

use the term routine patients, but their vital signs may not be there when I walk into the room. But anyone that has something that's pretty dramatic, we'll know."

"So you're already thinking as you walk down the hall," I say.

"Correct. And probably the first thing I think about is 'is this person sick or is this person ok?'"

"How do you…" I ask, then retreat. "Wait. Is a broken arm sick? Is that what you mean?" I ask.

"No. Sick meaning are they, unless I do something quick, going to deteriorate? Or are they already deteriorating? And that's a relatively quick assessment. You get just this general gestalt of what you're seeing. Pale. Sweaty. Heartrate of 230. Minimally responsive. Those things you can just boom. You can have a big picture. Or at least a focused picture. And that's where the ABC comes in.

"And when I say okay," he continues, "when they look okay, or they look ill but their vital signs are okay, and everything else is working okay, at least I have a little bit of time to process. I don't have to do anything immediately to manage something that's life threatening."

"How essential is the interview?" I ask. "You have the machines to tell you what the body's doing. How essential is the talk to you?"

"It's vital. Mostly because it gives you a clearer picture of what direction to go. By the time you're done with the interview and an examination, things should be narrowed down pretty close to two or three potential items. And then it's just a matter of the process of doing the investigation work that helps support those two or three items you're thinking about.

“Things are not so much different here than they are anywhere else in the country,” he says, “in Boston, in inner-city New York. The quantity of trauma, quantity of violent trauma, is certainly different. But the general flow, the general what you do, the patient population, all of those things are pretty uniform all across the country. Right, wrong or otherwise, medicine has evolved into a clinic practice that is maintenance of things which have already been identified as problems. Walk-in clinics, urgent care clinics, and emergency departments are *I have something new*. Or, something old is now broken. My blood pressure is now, suddenly, too high. It’s difficult the way medicine is setup now. You can’t call up your doctor and say your blood pressure is now 210, you have a little bit of a headache, you’re having some problems with vision, and expect that he will drop two other patients in the next half hour to see you and try to manage that. So we see you. We have all the tools to manage that. And especially if it ends up getting worse.”

“Tell me about a particularly difficult diagnosis,” I say. “Is there a patient or whatever that particularly confounded you? Or one that you just nailed?”

Third Course

We are interrupted when Eric arrives again.

“Eric,” I say, “these are all beautiful dishes. Oh, that smells so good.”

“Probably one of my favorite ones,” he says. “We have a little scallop crudo, just keeping it raw and fresh. Quickly marinated and served immediately. That way the citrus doesn’t start to cook it. In this case, a nice, fresh, sea scallop. Came in fresh. We drizzled a mixture of orange juice and fresh lemon juice over the top. We got toasted ground coriander seed sprinkled over there, we got fennel, shaved fennel, red onion on the bottom with some shaved asparagus. That’s it. And fresh orange on top.”

We all look at each other, and I suddenly wonder if chefs and physicians don't often get the same looks. Gratitude for the ineffable. We stop talking. Eating is its own pleasure.

"I think the most memorable patients," Warren begins, finally, then pauses again. "It's interesting because when you think of the world memorable you think of something that touched your heart, that maybe has a bright spot in the back or in the forefront of your mind. These are memorable in the opposite direction. They certainly have impacted my heart. They certainly have impacted my perception of life. But I'm not fond of remembering them. Those are abused children."
We pause.

"It always amazes me," he says, then pauses again.

"As an aside," he says, "this is exceptional. Holy Moly! I just had my first bite and I go Oh Man… This has touched me. This is exceptional. Man, I like fennel, but I am not sure I've ever had fennel that's this good."

We pause again. Talking about pain in the midst of joy. The restaurant crowd. Laughter and love at the other tables. The happy noises. Somehow good food gives permission.

"The thing about child abuse," he says. "I'm always amazed. I can certainly come up with sad. Anger. But every time I would see a child that's been abused, either physically or sexually, and thank goodness it's not often, I'm always amazed anybody could do that to a child.

"The other thing I'm always amazed at is the demeanor of the assailant."

"Do you see them?" I ask, amazed. "Is it the parents who bring them in?"

“Sometimes the parents,” he says. “Sometimes the boyfriend of the mom. Sometimes a relative. Most of the time it’s somebody they know. And all the time I’ve experienced it, it is somebody they know.”

“And that somebody is standing in the room with you as you’re…,” I say.

“Yeah,” he says.

“Have you punched anybody?” I ask.

“No,” he says.
“You can almost always tell who the perpetrator is,” he says. “Because they’re removed. They seem concerned…”

“Concerned about evidence of their own guilt?” I interrupt. “Or concerned about the child?”

“Concerned about the child, he says. At least you get that impression. But there’s almost a sense of *laisse faire* intermixed among some of the other things. This is serious, and initially you think they don’t understand the seriousness, the seriousness of the injury, the seriousness of whatever is going on. And even if they’re engaged enough, that disconnect always comes through someplace.”

“How often does the child point a finger at someone and say that’s where my injury came from?” I ask. “Ever?”

Warren looks at his plate for what seems like a very long time.

“I’ve had very few abused children who are in a position to point the finger. The ones I see are toddlers, at best.”

“What about trauma,” I ask. “Not just car wreck trauma. But knives, bullets, beat-ups? Do you see a fair amount of that? I saw something today about an increase in the homicide rate.”

“I think there was a three percent increase in the homicide rate,” he says. “No, he says, it was a thirty percent increase. Which means we’ve had six.”

“So we’re not a violent town, in terms of your office,” I ask.

“No, we are,” he says. “There’s no question. But we’re still the knife club. Not the knife and gun club. Lots of stabbings. Lots of knife violence.”

Madi shows up again, to check on our drinks. I can tell she wants to know what’s going on.

“How does this look from your perspective?” I ask her. “Is any of this on the menu?”

“No,” she says. “I don’t even know what any of it is. I don’t even know what Chef is bringing out because he’s been preparing it all. I haven’t got a clue. But I heard that you guys are writing a book?”

“Yes,” I say.

“And the courses are meant to go along with the story?”

“He’s an Emergency room doctor,” I say, pointing at Warren. “Eric has to come up with a menu to match his profession.”

“Oh boy, that’s a tough one,” Madi says, then continues. “I’m going to be studying nursing.”

“That’s good for you,” Warren says, genuinely.

“I’m excited to get into it,” she says. “I’m going to start this fall.”

“Is medicine still attractive to eighteen-year olds?” I ask when she walks away.

“It seems like it,” he says.

I look around the restaurant. Every seat is filled. Food arrives and conversation stops to allow eyes and noses their own vocabulary. The first date couple is gone, their seats replaced by two middle aged couples. I silently wish them all well.

We go back to knife and gun club talk.

“We do have firearm injuries,” he says. “But the majority of those are self-inflicted.”

“What about somebody just beating up somebody else?” I ask.

“We see a lot of that. It’s been that way for a while. Ten, fifteen years.”

“Stupid bar fights?” I ask.

“Stupid bar fights. Domestics. For the last ten years, twelve years, I work strictly days. I gave up shift work.”

“The benefits of age,” I say.

“Or the agonies of age,” he says. “I couldn’t do shift work anymore. So I don’t see as much of the violence as people who work the evenings and especially the overnights. Nothing good happens after midnight.”

“What’s the most common complaint during the day shift,” I ask.

“Chest pain,” he says.

“How many of them are ER necessary?” I ask.

He pauses, takes a bite and says “I go back, he says, to everybody who comes to see me believes it’s necessary in some way or another.”

The evening light outside our window has shifted into the golden hour. There is saxophone jazz in the background. Crowd noise.

“I have a strong—that’s a reasonable adjective—concept of the value of life,” he says. “The last twenty, twenty-five years, I’ve gotten even more understanding of the value of anybody and everybody, whether they’re a chronic drunk or whether they’re a psychotic on stimulants, whether they’re somebody who comes to see us too often. Whether it’s somebody who has chest pain that is obviously not life threatening. I think the simple answer is that I truly just appreciate the value of every living being.”

“Did that come from you’re your time in ER” I ask. “Before medicine? From family? I ask. Religion?”

“Certainly it is family,” he says. “My mom and dad had a strong influence on me. They had an intense sense of the worth of people. They came from little or nothing, but gave to people who needed it. I’m also the product of a world war two veteran and they have a tendency of touching people’s hearts. My dad was in the infantry in the South Pacific. I don’t have stories that he would share—about anything. Except being sick with malaria and yellow fever. His platoon was devastated, twice, and he survived. A man I admired all my life. He certainly had his struggles with depression, though fortunately not substance abuse. He was in a psychiatric ward a couple times in his life. And it certainly gave me an incredible understanding of those people who are struggling. And most

people are. Whether they're coming in for a heart attack, belly pain, or a bad headache. At that moment they're struggling with life."

Fourth Course

Eric presents the next dish.

That last one, we say, has to go on the menu.

"It might go on a special," he says, smiling.

We stopped the conversation for that one, we say. It was terrific.

"So here we go," he says. "Fourth course, I believe. Flash seared beef tenderloin medallion on top of a carrot tahini puree. Some brown rice quinoa with black beans. A little dust of toasted ground cumin seed. And then just the natural pan sauce drizzled over that.

"I started with the carrot and tahini," he says. "I've liked that flavor for a while. Then things fall into line with that. The black beans. The quinoa and then the cumin. Beef tenderloin. Small cut. Low fat."

Here, I think, is the center of the meal. At least for me. It looks so pretty on the plate, we hesitate to cut. But then we do.

"Tell me a story," I ask Warren. "Walk me through a typical case?"

"This one wasn't a difficult diagnosis," he says. "It was a difficult situation. And I hesitate just a little bit because it's to some degree well-known.

“Emotionally it was difficult,” he says. “Mechanically it was difficult, too. I was the physician for a woman who was in an auto accident. And one of my partners was the physician for her child. Her child died. And so, mechanically the difficulty was how do I do what I needed to do, to make sure that this woman is okay? And how do I provide whatever she might need from a trauma standpoint, and still allow the time for her to hold and grieve for her child?”

He continues talking, but seems to wait between every phrase.

“And…so, from a process standpoint, I chose to…. She was doing okay, and I was watching certain parameters…so even though with trauma patients we like to have things in order, ready to go for whatever investigating things we need to have done, within the first ten or fifteen minutes of them arriving…it took me an hour to identify the things I definitely needed to do, and in order to get them done…I chose to take that time.”

I want to know more, I think. But I also do not want to open a wound.

“Do you ever learn to give bad news?” I ask.

“I think so,” he says. “Early in my career,” he says, “and I have no idea why I thought this, but I thought I had to give an explanation of the process. And then give the bad news. Fortunately, that didn’t last very long, a year or two, maybe three years. But I began to realize they really don’t care about the process. It’s nice for them to hear the process before you give them the bad news because then they know. Once you give them the bad news it doesn’t make any difference what the process was and what actually happened. Some people ask, but very rarely.”

“So any more,” he says. “Obviously I introduce myself, I find out who are family members and who are friends, and who is the person I direct my comments to. And I usually just say I’m sorry, there wasn’t anything we could do.”

“How many times a week do you do that?” I ask.

“Every other week, maybe,” he says.

I would have thought it would be more often. Aging population and then add motorcycles.

“The ninety-year old,” he says, “is more difficult. You have to know, in a relatively brief amount of time, their whole medical history. You need to know what they’ve dragged along with them on this particular day. So even if they are not on death’s door, but they have something that’s potentially life-threatening, the information if vital. Fifty-year olds, sixty-year olds, seventy-year olds, even maybe eighty-year olds, with a heart attack, there is no question about what you do. Call a cardiologist. They go to the cath lab. They get stents. Whatever else they do. But a ninety-five-year old with dementia, diabetes, kidneys that aren’t working perfectly well. They come in with a heart attack. Now what do you do? The angiogram even by itself can damage the kidneys even more. Would the person really understand what’s going on?”

Dessert

Madi clears our plates and sets new silverware for dessert.

“How many different sets of silverware did we go through,” I ask.

“You guys are getting special treatment,” she says.

“My wife really likes these,” Warren says, “so I’ve been storing them in my pocket.”

“Oh, I know,” she says. “We’ve been counting.”

When she walks away, Warren continues. “We see a fair amount of people who…There’s a husband/wife team in Princeton who coined this term Deaths of Despair. They’re looking at demographics. Profound increases in suicide. Certain groups in that category. Late teens to early twenties. And the other group that’s really increased in incidence is the middle-aged white male. So, suicide. Drug overdose. And indirect deaths due to substances. Alcohol or drugs or whatever the case may be.”

“Not Corvettes and motorcycles,” I say.

“Not Corvettes and motorcycles.”

“That was the category they looked at,” he continues. “And in my mind the term Deaths of Despair is an incredible term. And it speaks specifically to what we see day in and day out.”

Eric arrives. Caramelized pears, sliced standing upright on the plate. A balancing act to carry across the restaurant.

“So final course here,” he says. “Ohh!” A pear tips, but he recovers.

“Caramelized pear,” he says. “With a little sugar in the raw to help it caramelize. We got natural pan drippings around the outside and a sauce in the middle. We got coconut milk and almonds over the top.”

“Any reason why you chose this as the finish?” I ask.

“Because I love pears,” he laughs.

“Honestly,” he says, “I just love the presentation. I like the way they slice and present. It just seemed like a nice grand finale.”

He has a meeting at 7 p.m., he says. We all shake hands, say thank you, try to express admiration and astonishment, and then he dashes off.

The pears are very good.

“If I get annoyed at anything,” Warren says, after a moment, “it’s chaos.”

“How so?” I ask.

“Chaos is out of control,” he says.

“But when the ambulance pulls up and the door goes up, that’s what you’ve got,” I say. “That’s who you are. You’re the emergency room.”

“But it doesn’t need to be,” he says, “if everybody who’s there does what they’re supposed to do. That’s where training comes in. That’s where protocols come in. Even in the most dramatic cases, it doesn’t need to be chaos.”

I ask about mass casualty drills. Airplane crashes. Train derailments. Chemical explosions in town. Suddenly hundreds of people heading for the emergency room. The hospital does participate with the police and fire department in regular training. But in-hospital care, he says, is much different than pre-hospital care. “The EMTs,” he says, “they have a whole specific role they need to do and they’re very good at it.”

“Is there a most chaos-filled, most dramatic story?”

He pauses for a long time.

“This particular instance was a young lady, early thirties probably, and she came in without the ability to breathe. Because of something that was going on in her throat.

“Fortunately, this doesn’t happen very often,” he says. “Most of the time airway management is reasonably routine. You might have a hiccup or two, but even with the hiccup you’re usually successful.”

“There was already a tube in?” I ask.

“No,” he says.

“Ok,” I say. “She brought herself in?”

“She came by ambulance,” he says. “But as she was doing somewhat okay, the paramedics are usually pretty judicial. I mean if they need to, they do. But if they don’t need to within the next ten minutes, they wait for us. It’s just that much easier. Because you’re in, to some degree, a controlled environment. You have everything you need and all the people around you. The respiratory therapists, everybody else that’s there. For the paramedics, you’re in somebody’s home. The light’s not good. Or they’re in the ambulance, bouncing down the road. So if they can wait for a better, more controlled environment, they usually do. And she was holding her own for a while. But it was obvious that wasn’t going to last for very long.

“And this was one of those airway managements that was more than a hiccup. Multiple tries by myself, even with anesthesia, even by our ear/nose/throat doctors, were unsuccessful. We were able to ventilate her a little bit, without the airway, but obviously that wasn’t going to last for very long. So we wound up doing a surgical airway in the operating room. And even that was more difficult than usual. It turned out that she had the airway about the size of a child. Maybe a ten-year old’s. Maybe eight.”

“Just a condition?” I ask.

“Exactly.”

“And it was not only the size,” he says, “but it was floppy. So instead of this hose that stays open, when she was not breathing it would collapse. Multiple tries but we finally got enough of a temporary air way she could be moved to the operating room for a definitive airway.”

“And nothing in her history,” I say.

“No.”

“You could have done some real damage if you continued to try to stuff an adult sized tube down her throat,” I say.

“Some of it was, you couldn’t even see,” he says. “Just the anatomy she had in her hypopharynx you couldn’t see enough even to attempt. Multiple attempts by multiple people. You just couldn’t see. Even fiber optic scopes were unsuccessful.”

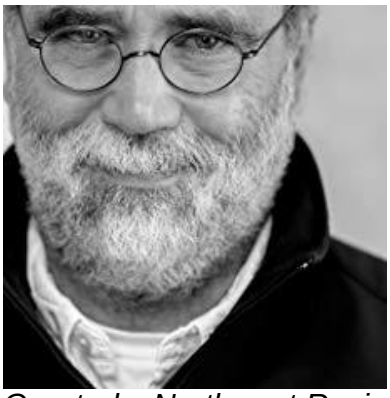
Warren takes a bite of his dessert. “That was probably the most harrowing and chaotic thing I ever did.”

Madi clears the plates. So much more to ask and say.

Behind us, the restaurant has grown quieter. Many people have left, heading out to other rooms, other places, for deeper comfort or rest. Some people linger over their knives and glasses, this place what they need.

But the evening is not late. Madi and the other servers ready the tables for new customers. Eric is gone, but another chef readies the kitchen for whatever orders may come.

Warren surveys the room. “Remarkable,” he says, quietly.



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