Manhole Cover Project: A Gun Legacy 1996

Testimonial Sequence A: Doctors & Nurses

DR. ANTHONY MORGAN
In the last decade the shootists are much more accurate in determining what part of your body they are going to shoot — and they're quick; I mean many of these terminations are done shooting someone in the back of the head near the brainstem and so a brainstem shooting or a brainstem injury from a shooting is immediately lethal. If they want to maim you, an excellent way to do it is to aim for the back or aim for the spinal column, hoping then to injure the spinal column, which can permanently paralyze someone. These things are done with great intent and most recently from 1993 to the present a thing that really stands out is this Colombian style injury where someone actually runs up behind the back of a victim and chooses a very precise spot in the back of the ear, aiming to shoot across the back of the ear, hoping then to terminate them by injuring the brain stem.

JACQUELINE MCQUAY, RN
We never know who the person is that's been shot. To us they are a gunshot wound victim. We don't know if they are president of a bank, if they are president of a gang, who they are. All we know is we have someone who is coming who has been shot and we will do everything we can to save their lives. But we can't always do that.

DR. ANTHONY MORGAN
A 14 year old on Christmas day who is walking with a friend and gets his brainstem blown away — what could a 14 year old child who is not part of a gang, who doesn't use drugs; what was his crime, what was his sin that someone needed to end his life? You find, after the fact, that the reason why this 14 year old, whose life was sucked away, was only [killed] because he happened to be walking with a gang member, was not part of the gang, was not part of any drug usage. His only crime was that he was walking with this person. So by association the 14 year old doesn't see Christmas anymore, doesn't see his mom anymore, doesn't see his brothers or sisters anymore, doesn't see his father anymore, doesn't go to school anymore. Then you look at his face and you say, "My God, you know, my 16 year old son looks very similar to you."

JACQUELINE MCQUAY, RN
You don't see the look on the mother's face when you have to tell her that her 21 year old kid has been killed. You don't know what it does to someone, because on TV it's make believe. But we see this all the time, where someone's been shot, whether they survive their injuries or whether they are killed. When you have to call a family and ask them to come to the hospital I can tell who the person is the minute they come in the door because they all have that same look in their eye, of pure terror.

DR. ANTHONY MORGAN

No one is inherently evil or violent. There is no special gene, all right, that makes them violent. The environment for the most part, creates that. What breeds evil is not a gene; Hate, hate and what breeds someone who, at one point, is sane, but now resorts to violent, animalistic acts is. When that person begins to hate themselves, the evil grows even worse. I understand that. I don't like the fact that I understand it, but I understand it.

JACQUELINE MCQUAY, RN
The kind of gunshot injuries that are, for me, the most distressing particularly to see, is a gunshot wound to the head or the face because of the extent of damage that occurs. That's really important because even if someone is shot in the chest or shot in the abdomen, when you bring the family in to see them, if the head and the face is intact they can kiss that person's face, they can touch their hair. You know they could put their hands on the face and whatever, but when you have a devastating disfigurement to the face or to the head, it's just much more horrific for the family members because this will be the last memory they are going to have of their loved one.

DR. VERNON COWELL
Someone put a shotgun in their mouth and pulled the trigger. The moment you hear that, there is a certain sinking in your heart and you immediately start building brick walls because you know; number one, this is going to look bad. I mean, the visual impact of someone's face blown off; number two, that there is a family somewhere that is going to be just grieving uncontrollably; and number three, there is that fear that you are not going to be able to do anything for this person. I would say more times than not that your nightmare becomes the reality. There isn't anything you can do.

DR. ANTHONY MORGAN
Let me tell you something. You know, it is unusual for the trauma surgeon to remember his or her best cases through the years. It is much more common for the true trauma surgeon to remember the bad outcomes, the disasters. I can see the faces of the dead and mutilated much stronger than I can with the ones that I successfully were able to save from mutilation and death.

DR. VERNON COWELL
I would say the toughest part is talking to the family of any gunshot victim. Particularly of the self-inflicted wound that is a suicide attempt that is successful because sometimes they are looking to you for answers. I still haven't found a good way to approach a family, I found one that works for me.

DR. ANTHONY MORGAN
The stronger emotions come into play when you have lost that 5 year old child. When you have to explain to the family that their 18 year old son, in terms of his ability to remember or to think or to figure or to analyze, will never be the same, or that the young man who was shotgunned in the back, whose legs will never function again. That's when emotions are most strong.

DONNA FEINSTEIN, RN
Generally what people have to do in hospital or acute care settings is that you have to deal with the situation at hand. In emergency departments people have to react quickly. There is a stunting or blunting of emotional information. You do that so that you can perform at the highest level that you have to take care of that person. The emotion, the emotional piece you allow to catch up with you after the clinical piece is done.

DR. LENWORTH JACOBS
In the operating room it is really a technical challenge. Either you have the technical skills to stop the bleeding and repair the injury or you don't, and if you don't the patient dies. I don't ever think that this is a 12 year old, or a 14 year old or something like that. I think that this is a lacerated liver or spleen or artery, or something that I have to fix. What is very different is when you are finished with a procedure and have to talk to the family, because now it is not an artery, or a liver, or a spleen. This is a human being and the family of that human being cannot relate to the fact that their loved one is in a very precarious state.

JACQUELINE MCQUAY, RN
One of the things we really truly believe in here in the Emergency Department is that a family's place is with their loved one. We feel that the family should be there, you know, with the patient, especially if it's a child. Or if the patient is going to die and we will bring the families in the room, encourage them to say what they are gonna say, touch them, do whatever they have to do, because for the family member this may be the last opportunity they are going to have to be with their loved one before that person dies.

DR. VERNON COWELL
He had basically come in under traumatic arrest. They were doing CPR on him and we did an ER thoracotomy, which is where you make an incision in the left side of the chest, right in the Emergency Department to try to see if there was some type of tamponade or if there is a hole in the heart that we could fix right then and there, because obviously he was extinguishing. When we did that a ton of blood came out. His heart was completely empty, there really was no activity from the heart and he was subsequently pronounced [dead]. I had gone to write my note on the events that had taken place and he had been wheeled to another area in the Emergency Department and I noticed one of the nurses that I knew from the General Surgery ward had come down and was in the Emergency Department and she was heading toward that room, and I walked over to her, she was very upset. She told me that, that was her brother and that he had just not more than several hours ago dropped her off at work and that he taken the car. I hesitated, really nothing came out of my mouth. All of the sudden it became...it was no longer a profession, it was no longer something non-technical and I was totally taken aback by the fact that, that was this nurse's brother. The nurse and I were pretty good friends, we became better friends after that. I remember the emotions that welled up in me; I had to quell them.

JACQUELINE MCQUAY, RN

I recount one day we had a situation where we had two gunshot wounds to the chest come in and both of them were shot at point blank range and they came in with CPR in progress. We ended up having to open up the chests of both people in an attempt to perhaps locate a hole in the heart and when the trauma fellow opened the chest and went to go in to grab the person's heart all that was there was clumps of tissue because the bullet had literally shattered the heart. So, obviously the person died, and when we were finishing up and cleaning up, I noticed that there were pieces of this tissue on the stretcher and so I was saying to myself, "Well I'm sure the medical examiner will need this for his investigation", so I was putting it in the proper kind of a container and a police officer looked at me and said, "What are you doing?" and I said, "Well, I'm picking up, you know, what's left of this person's heart, and you know, getting it to put back in". He said to me, "Ah, this guy was selling drugs, he deserved this". I said, "You know what, this is somebody's kid, and this is the man's heart and if nothing else I can do for this man, at least I can give him his heart, because that's all there is left".

DONNA FEINSTEIN, RN
These are highly trained individuals that immediately go to the bedside of a victim and perform the appropriate management for that particular patient. The complex piece comes in with the provider's emotional feelings about this incident. We do get both perpetrators of the crime simultaneously as victims of a crime. That's very intense emotionally, it's a roller coaster ride for the provider. Usually the perpetrator may or may not know the victim is here and vice versa. Both people get the same level of care by a provider, but the provider's feeling on this are rather intense. You get angry.

DR. LENWORTH JACOBS
But what gets you is especially a young person who is shot for no apparent cause, who is either severely injured, which affects his life dramatically, or dies. You think where did that come from, the one that comes to mind recently is a 14 year old shot by another 16 year old using an AK-47 which is a Russian assault rifle. You wonder, "How come we are in the middle of a US city where a 16 year old is shooting a 14 year old with an assault rifle." We're not even at war?

DONNA FEINSTEIN, RN
Instead of lashing out with a fist they lash out by killing someone or shooting them and that is now what seems to be an acceptable form of behavior by people that don't know how to manage their anger. I have seen anger be the threshold for an act of violence, and when people get angry they use that anger in a different way, and they use the gun as their vehicle for demonstrating how angry they really are.

DR. LENWORTH JACOBS
I would say in the last 10-15 years what has changed is: a) much more gun violence, because there is much more availability of guns, and 2) the type of gun has changed. So we went from a Saturday night special which would be a .22 or a .32 relatively small caliber, not much in the way of gunpowder, very slow — the bullet is going relatively slowly — and it doesn't cause a huge amount of damage, unless it is in the right place. But relatively easy to fix. Now what we

see is magnums, .45's, .38's and then assault weapons which have a small bullet but a huge amount of gunpowder so the bullet is traveling extraordinarily fast. That's a military weapon. And also if it's automatic, it is many bullets coming in a short period of time. And to put it in context, a military person usually is well schooled in the weapon so they only fire the weapon when there is a reason to fire it. If they are shooting at somebody they usually shoot at that person not somebody else. And only a very small number of rounds are fired. A non-military person in the civilian sector is using a gun which is difficult to hold. When you pull the trigger it is firing 10-15 bullets out the end and there is a very low likelihood that he is going to hit what he's shooting at, which means there is a high likelihood that other people, since we are in an urban environment, will be the recipient of these bullets. And if you are in a house the bullet will go straight through the wall and hit somebody else. It's just an absurd situation. And if the person can shoot straight, you are putting 3, 4, and 5 bullets into the same person, so in terms of repairing this, it is a major challenge. You have many bullets with many wounds to fix simultaneously and frequently you can just plain run out of time.

DR. VERNON COWELL
Sometimes outward appearance seems like there is just something minor, a little pin hole, maybe but you know good and well that the bullet can travel and that it can do a lot of damage.

DR. LENWORTH JACOBS
The particular bullet here is manufactured to really hurt people, because the casing of the bullet has sharp edges to it, not only is it designed to do maximal damage to the person it hits, it is also designed to do damage to the person that takes care of him. You then have to ask what would be in the mind of a person who manufactures a bullet like this. When it hits something, the sides of the bullet get peeled back and they have very sharp pieces on it so that number one, the bullet is now twice the size, and number two the edges of the bullet are very, very sharp and they make a huge hole in the patient and since this bullet is turning when it goes in it is cutting and lacerating a huge hole in the patient. So this is really designed to just do maximal amount of damage to both the patient and the person who operates upon the patient. And we are in a civilian theater here. We are in a city and it just doesn't make any sense.

DR. VERNON COWELL
A bullet can go anywhere and one of the reasons being is that you have organs inside of you of different textures and viscosity and solidness, plus bone. If you have a bullet at close range that is high powered it is usually gonna go right through you and get whatever organ is in the way of it. If you get shot in the chest, it could go right through, hit the lung, hit a blood vessel and then come right out. Or it could hit a bone and it's trajectory is changed. For example if it was coming from the front, it's trajectory could be changed and it could end up coming back out the front or the side or we have had cases where, for example, someone will get shot in the upper chest and the bullet will end up in a vessel in the leg. It's completely unpredictable. They will go through the stomach, they will go through the colon, in which case all the stool that's sitting there ends up all over the abdomen, it could go through the small bowel, the contents of the small bowel will end up outside. It could get major blood vessels and cause exsanguination and

that's when we see someone come in who has had a gunshot wound whose got a blood pressure of 80/60, there's usually a blood vessel that's been hit somewhere and so that raises the urgency. In other words, to get in there and find out what it is because it can get the aorta, it could get the portal vein, it could get the vena cava, it could go into the heart, it could go into the major vasculature of the lung and if you don't do anything that person dies; it's a given. If that person didn't come to the hospital, stayed on the street, they'd be dead, and it is not a matter of minutes at that point without urgent care, without emergency care, with EMT's, trauma centers, that person dies.

DR. ANTHONY MORGAN
From the uneducated eye it looks like chaos, but if you watch an orchestra from a distance without hearing, it doesn't seem to have a lot of organization to it.
Forget about the conductor; say you're watching the orchestra, you know, they're playing violins and drums and you know and there is a piano going off and there's horns and to the non-musician there may be, you don't hear, there may be chaos. In trauma, in that acute situation it looks rather chaotic, but to the trained eye it is an absolutely controlled chaotic event. Each of the members have their task and it is done in unison like a well-designed orchestra. Things are done in unison. So it's going to sound very cold but when that person comes in who has been shot or stabbed, it becomes very business like. You don't have time for emotion, if you expect to save the patient. So those first few seconds to 15 to 20 minutes the objective is to address those injuries that are most immediately lethal or potentially lethal to the patient.

DR. LENWORTH JACOBS
Well there is just a huge team involved in any incident like this and that team starts from the pre-hospital people, the emergency medical technicians, paramedics, police, etc., who respond. Actually, it starts even before that. Somebody has to identify the incident, call a public access number like 911. Those people have to know who to call, who to send, what the severity is. A response team gets here; they then radio into us here so we know that, that is; a beeper goes off with the team and there are six people on the team who respond to that room. They are there to start the resuscitation; they then communicate with the operating the start line and do what they have to do and get to the set position. Then you go to the operating room and there are nurses, technicians, anesthesia, the blood bank technicians to run the different pieces of equipment. There are probably 60 people which are intimately involved with this one person. The majority of those people are invisible to the patient, but that's what you need, and you need it right now. You don't need them in six hours, you need all of those people right now and that's what makes the difference between surviving a very severe injury where you are bleeding to death and dying. It is really that team of people and skill and expertise and equipment and so on being in place, now, that makes a difference to the patient.

JACQUELINE MCQUAY, RN
We had a little bit of a reprieve from the gunshot wounds over the last couple of months, but it starting to pick up again and it was kind of nice to have break because sometimes we go in, you

know — the gunshot wound comes in and it becomes a very, I would never say routine, but it becomes a very well orchestrated process.

DR. LENWORTH JACOBS
You have to pay attention to basic things. Is a patient breathing? Does he have an open airway? Is air going in and out of his lungs O.K. and does he have a good circulating blood volume? Is his heart beating and is it pumping blood in the right direction? The second thing you have to worry about is there is a hole and what is in the way of that bullet? Is it a blood vessel which is going to bleed? Is it something of substance, like the liver or the spleen or the heart or the bowels, because each one of those requires a different plan to fix it. So you are trying to discern what organ has been injured and then what you are going to do about that and then ultimately how long you have. If the patient is bleeding to death right now you don't have very long at all. If the patient has a normal blood pressure you have a number of minutes to get going. But you are really trying to figure out what was injured, what are you going to do about it, how much time do you have to get your plan and your action in place before the patient dies.

DR. ANTHONY MORGAN
You worry about the airway, you worry about them breathing appropriately, and you worry about circulation. So you make sure that they are able to exchange air. You make sure that the lungs are OK and that you are able to exchange Co2 and oxygen. You make sure that the heart is beating normally or beating the way it should be beating, or beating period. You assess them for any sort of neurological damage that needs to be addressed on an urgent basis. So within the first few seconds you address those ABC's of trauma management.

DR. VERNON COWELL
Four days ago we had someone come in who had a gunshot wound to the abdomen and the path of the bullet was such that it went through a particular area which is called the portal triad. There are three very important structures there. One is the portal vein which drains the venous blood from the bowel with nutrients; there is the common duct, which is the means by which bile gets into the bowel, and then there's the hepatic artery that sits there, which is the blood supply to their liver. The path of the bullet was such that it went through each of those structures and in fact completely transacted the common duct. It also hit the inferior vena cava which is a very large vein within the abdomen. Also there was a hole in the stomach. Each one of those things had to be repaired and it wasn't put back together the way it was originally made which means that there is some compromise, but we have to take it upon ourselves to recreate the master plan in order to save someone, so this person has their common duct stuck in a different portion of their bowel. They have repairs to each one of those holes and you run the risk of complications because of the extensiveness of the injuries.

DR. ANTHONY MORGAN
Well it's 1996 and they still show on T.V., and they still show in the movies: people having bullets removed. That's bunk, that's myth, that's childishness. I mean the majority of the time trauma surgeons do not spend trying to remove bullets out of one's body. We spend much more

time trying to identify injured body parts and repair them. Like an injury to the heart, you know, you try to repair or patch the whole in the heart. An injury to the intestine, you try to, you know, repair the intestine or resect or take away the injured intestine and put it back together again.

DR. LENWORTH JACOBS
It is a really major, major problem, the essence of which the 6'clock news does not capture. They capture the fact that somebody was shot. What they don't capture is the lifelong effect to the person who was shot in the family. In fact, that is not the movies. You don't wake up at the end of two hours or, you know, at the end of the scene, wake up and go home. This is a permanent affair. I think the other thing the news doesn't capture is the grief and anguish to the family members when they realize that their loved one is shot and/or dying.

JACQUELINE MCQUAY, RN
I really think that violence has become a very accepted part of our society: video games, movies, what's on TV. All people see is the action. They don't see the faces of the family members after we've had to tell them that their's been a very very severe injury or perhaps a gun related death. You never see that on TV.

DONNA FEINSTEIN, RN
When you see a life lost needlessly because a gun was an easy channel for this person to demonstrate their anger, it makes me angry that we still sit in a society with the highest level of technical advantages, with the knowledge that this is a serious situation, with the ability to change public health views on the usage of guns, yet we have an increasing problem with the volume and amount of gun violence that is happening nationwide.

DR. ANTHONY MORGAN
We got cars that can go 0-60 in 3 seconds. We got the technology that can destroy a whole country with one bomb. We can fly to the moon and back. We're going to drop highly technical equipment on Mars by 1997. Somewhere along the line, man or humans stopped evolving, or if they are, it is less than a snail's pace, and that is what I'm most, I won't say angry, but most upset about. That we're going through industrial revolutions, we have gone through political revolutions, we have yet to go through a positive social evolution of the way we think.

DR. VERNON COWELL
You have a kid who has been shot and there is immediately this thought of retaliation and it kind of goes through his group or his crew or his gang, therefore perpetuating the violence. That is, that gang is going to get somebody, maybe not even the guy who shot the first kid, but just somebody, then that kid's crew is going to come back and get whoever shot him and it could be the wrong person. In some case, it's an innocent bystander who happened to be standing in the wrong place at the wrong time. One of my goals is to try to wedge into the cycle and that when you have a kid who is, I think, after getting shot, you're just about at your lowest, and try to sway them away or at least let them kind of think about what they are getting ready to do. Say,

"You're going to go have your buddies go out and put somebody else through what you've been through, is that right?"

DR. LENWORTH JACOBS

Relative to drive-by shooting, the majority of drive-by shooting is not random. Usually, somebody knows the person who is doing the shooting. It might not be very approximate, in other words, something might have happened yesterday and they are driving by today, but it is unusual to be just sitting, for instance, here in this office, and have a bullet come crashing through the windows and hit you. That is an extraordinarily rare event. Again if you think of people in a tough environment, the overwhelming majority of people who live in a poor neighborhood are totally honest, reasonable people trying to get along. However, they are in a bad environment so they have a higher likelihood of bullets going close to them in that environment - and clearly the thrust is to get that environment cleared up for all the good people in that neighborhood. You really have to do that by getting the police to identify the drug-dealing people or gang members or whatever and really deal with that problem, because the overwhelming majority of people, 99% of the people in that environment are good solid citizens who really want to get on with their lives.

DR. ANTHONY MORGAN

I think that a good trauma surgeon is not only a specialist in treating injuries and doing trauma or critical care research, but he or she is also equally good at trying to develop prevention strategies.

DR. LENWORTH JACOBS

Could you have done it any better? Is there anything you could have done that would have had a better outcome, and in the early years those are mostly technical. Could you learn the anatomy any better? Could you have sutured this a little better? Could you have got a little better, faster control of a bleeding vessel? But with experience, you solve those issues. So then you become much more involved, "Can we decrease the incidence of this?" So you get much more into prevention and then from that, that leads you into public policy, so you start saying, "Well, how can we prevent this?" Well, you can't go and personally council every single shooter out there; plus, they might not particularly want to listen to you. So you get involved with the legislature, with public policy, with trying to make laws that will influence this kind of thing.

DONNA FEINSTEIN, RN

I think what the legacy of gun violence should be is learning from those who have died from this act. All of this is tragic. Someone loses. The force of the gun wins. It is a tragedy and a tragedy that continues to unfold day after day and city after city that we really don't have a handle on and it can happen more commonly than we even believe.

DR. ANTHONY MORGAN

I mean, in my mind there is nothing greater in terms of a rush than to take back from death - to bring them back. I have had several patients who were actually lifeless, and I and others were able to bring them back. To me, that is the greatest rush. To me, that's the greatest. I mean there is only one thing greater than that and that's where you actually give up your life for

someone else. I mean those are two great things - giving up your life for another, or saving a life.

We are always looking; we always go into it assuming we are going to win, that we are going to be able to save this human being no matter what the extent [of damage]. As long as there is life, there is a chance. We are not used to not finding a way. We come from the philosophy that if we cannot find a way, you make a way. This is how we are trained, because most of what we deal with is spontaneous and so our response to that spontaneity is to be equally spontaneous and so it becomes very frustrating when in a given situation not only can you not find a way, you can't even make a way. It becomes unacceptable to us. That is why we remember our worst cases easier than remembering our best cases. I thought I could fix the problem at each turn in the 7-year-old's situation; I couldn't. So I can't even forget his name. You know, you think that your inner self would find ways to make you forget this name, but you can't; you can't forget his name, the color of his hair, his eyes...

DR. VERNON COWELL
It's multi-factorial, the reasons we are seeing so much violence turning into the use of guns. Number 1, I think probably for the person who is pulling the trigger, there is a sense, a finality that for whatever reason, for whatever gripe, for whatever fear they have or anger that there is a feeling of release at the point they pull the trigger. I would say most of the shootings that I've seen have involved Hispanic kids. The exact ratio I'm not sure, but I believe that it's mainly African American males for the whole state. How does that impact on me? One of the reasons that I got into this field is I felt I could somehow make a difference and influence that kid who went through this trauma because they are at their lowest point, and I think human beings have a tendency to, when they get to their lowest point, to either completely crash and try to get out of this world, or to try and turn things around.