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Doctors Find a Crowd Waiting In Peru

Medical mission changes, saves lives

By Joseph Shaw

Dr. Joseph DeBellis leaned against the wall in the hospital hallway, his blue scrubs damp and clinging, his hair touseled and tinged with sweat. The Peruvian humidity slipped in through the open windows and doors, and the combination of heat, exhaustion and emotional overload brought tears. Just for a rare moment, the veil of professional detachment dropped. "It's a real good indication that these people care—we all care," the plastic surgeon said of the emotional moment, which came near the end of a seven-day stretch in April that he and 15 other medical professionals had spent providing charity medical care to the people of Pucallpa, Peru. The mission was the 11th sponsored by International Surgical Mission Support, a Southamptonbased charitable organization. ISMS was founded by three of the medical professionals who made the trip to Peru: Dr. Medhat Allam, a general surgeon from Southampton Hospital; Bob Mineo, a nurse anesthetist at the hospital; and Dr. Ravi Kothuru, a general and thoracic surgeon at Brookdale Hospital in Brooklyn and a medical school friend of Dr. Allam. The group includes numerous professionals with Southampton connections, and friends from hospitals in other parts of New York. Since the organization's first trip in 1997, the annual effort has grown. On the seven-day visit to Pucallpa, the 16-member team did 121 surgeries, the most ever for a single trip. This year a second mission to Morocco was added in May, shortly after the group returned from Peru.

The medical missions are lifelines for the communities they visit—in Pucallpa, an impoverished city in the Amazonian heart of the country, not far from the border with Brazil, scores of people waited for days, some sleeping in the hospital's outdoor courtyard, hoping to have the visiting American doctors evaluate them. All had gone without surgery because they could not afford it, even in this country with socialized medicine. Most seemed to have more faith in the Western doctors than their Peruvian counterparts.

But the international trips are also rewarding for the doctors and nurses who volunteer their time. They are also trying times emotionally, in part because the generous nature of the relationship instills more emotion than American doctors and patients share in an age of managed care and malpractice lawsuits.

"It not just about people showing up, doing their thing and going home," Dr. DeBellis said, his eyes welling, having dropped his guard while discussing a particularly difficult case, and his palpable relief that his patient had a near miraculous turnaround.

"It's about an emotional and very personal journey," he said. "If it's not, then ultimately it's not going to do anyone any good, least of all yourself."

The ISMS mission to Peru began on Friday evening, April 11, when a Berkoski Ice truck, driven by Berkoski employee Matt Corbett, pulled into the driveway of Dr. Medhat Allam's Southampton home. The 14-foot truck, donated by Berkoski Ice, along with the driver, was packed nearly full of equipment and supplies for the trip to JFK—more than two dozen large duffel bags, cases and containers full of things the team would need on its visit, with plans to leave much of the remainder behind. On the last trip, to Zambia in 2007, ISMS left more than $100,000 worth of donated medical supplies and equipment.

The travel is often one of the most trying parts of the mission: many of the countries the ISMS teams visit have strict customs rules, and some tend to be suspicious and even harassing. "In Brazil, they confiscated everything," said Dr. Vito Alamia, an ob-gyn at Southampton Hospital who has been a part of several missions.

Officials in Lima, Peru, turned out to be difficult—there was a great deal of looking sternly at clipboards, shuffling papers, and furtive looks inside the cases of equipment—but hardly the worst the team has encountered. It took about 90 minutes of negotiation before the matter was resolved with the help of an older man with graying temples in a leather jacket. He turned out to be the medical director of the Regional Hospital of Pucallpa, where the team was headed.

A young patient in recovery.

Dr. Ravi Kothuru,one of the founders of ISMS,carries a young patient. DANA SHAW PHOTOS

At the Lima airport, the team also met a local Peruvian congressman who had helped set up the trip. He had also changed the team's hotel reservations, dismaying some team members—although it would turn out to be the lesser of his transgressions on this trip.

On Saturday morning, having traveled all night and lugged a caravan of supplies through a succession of airports, the team finally arrived at the hospital in Pucallpa.

A low-slung warren of concrete buildings surrounded by a concrete wall, the bunker-like facility had a closed gate in front, and an armed guard to limit access. Still, children played in the courtyard inside the fence.

Inside, the doctors and nurses found a building that resembled an abandoned and neglected elementary school in America, with institutional green paint and high-traffic floor tiles everywhere, the paint flaked and stained, the tiles damaged and missing in places, the plaster cracking, mold visible. Although it was winter in Peru, the daily temperatures climbed into the 80s and beyond, and only a few rooms had air conditioning. Others had windows wide open, some without screens. Bugs were not uncommon.

The ISMS team arrived in the portion of the hospital where a clinic was to be held over two days, deciding which patients would get surgery and which would not. They rounded a corner, and there, a mob was waiting—some 200 to 300 people, many of whom had been waiting for days. When they saw the team, the crowd broke into spontaneous applause, sheer appreciation for their effort, and relief that they'd finally arrived. As the team members marched to the clinic rooms, arms reached from the crowd to pat their backs, shake their hands, and faces showed pure gratitude.

It was a moment that made an impression on the ISMS team—its members were so moved that they recalled the moment several times during the ensuing week.

"That alone made the trip," Dr. Kothuru would say later. "That alone."

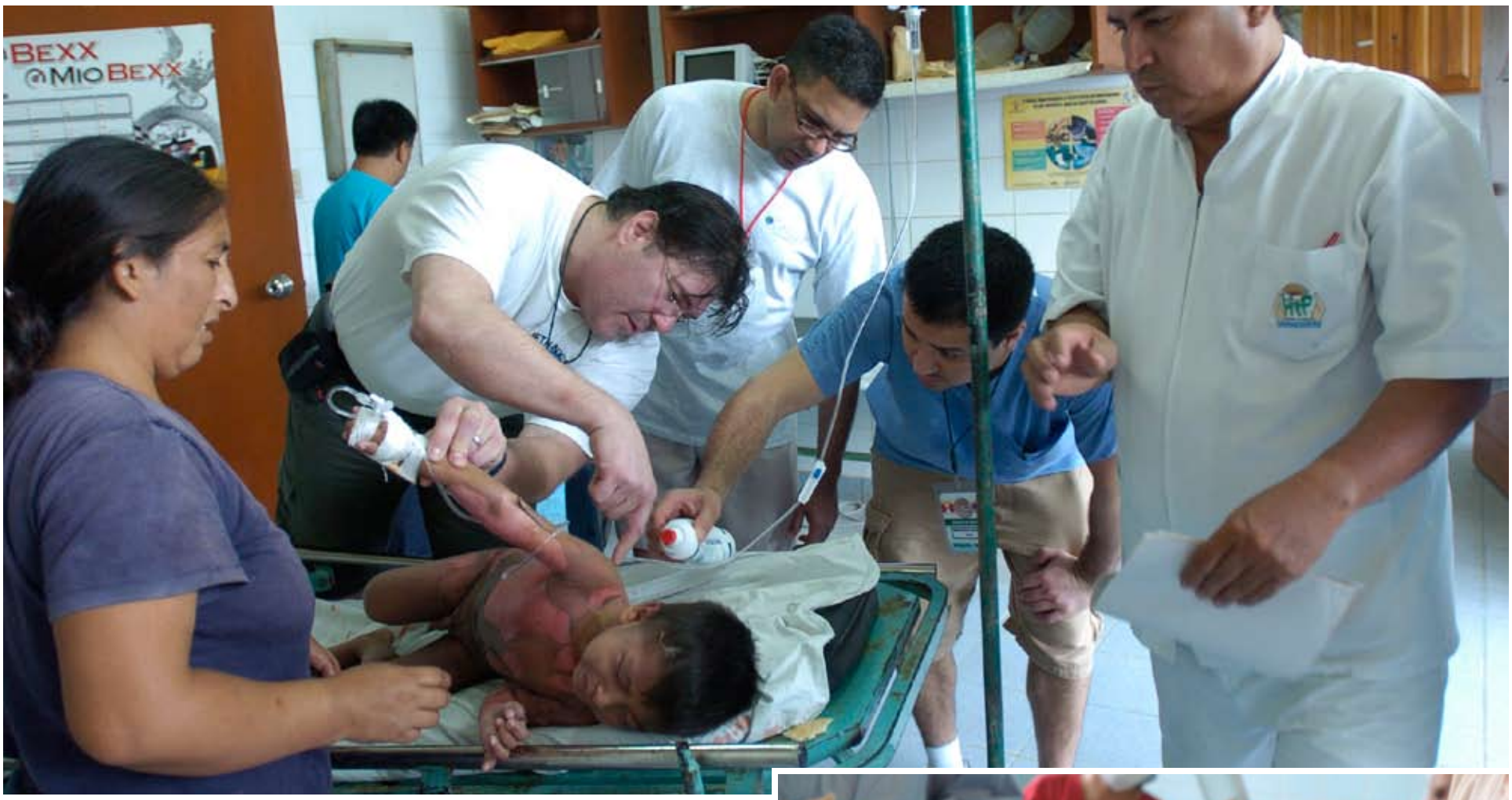
For the next two days, the hallways never cleared. Still, the crowd was calm, patient, polite and, when they finally saw a doctor, uniformly grateful.

Dr. George Dreszer, chief resident at St. Luke's Hospital in Roosevelt, New York, set up a general surgery clinic. Dr. DeBellis organized the plastic surgery clinic, and Dr. Kothuru and Dr. Rajesh Patel of Quogue, a pulmonary physician at Peconic Bay Medical Center in Riverhead, helped to screen patients. Dr. Alamia and Dr. Geri Schmitt, also an obgyn at Southampton Hospital, screened women for gynecological surgeries.

Meanwhile, the unpacking began. Grace McCarthy, RN, of the Ambulatory Surgery Center in Queens, was the OR manager, and so she went about setting up the OR supply room with the help of the other RNs who made the trip: Stephanie Porey and Kathy Berger, both OR nurses at Southampton Hospital; Erin O'Driscoll, a Speonk resident who is an OR nurse at Southside Hospital in Bay Shore; and Ellen Herfield, an OR nurse at Catskill Regional Medical Center in upstate Sullivan County. "Sutures, over there," Ms. McCarthy directed. "Laparoscopic stuff, over there on the shelves. We'll take it from there."

In another part of the hospital, Maryellen Spandonis, RN, a Rocky Point resident who works at Eastern Suffolk Cardiology in Southampton, worked with the local nursing staff to set up the recovery room. Bob Mineo and two other nurse anesthetists, Chris Torres of Hahnemann Hospital in Philadelphia, and Michael Sherwood of Catskill Regional Medical Center, set up a separate supply room for their own purposes.

The entrance to the Hospital Regional de Pucallpa sits behind a chain-link fence and an armed guard.



Two-year-old burn victim Jose Luis is brought into the ER on the second day in Pucallpa,Peru,and examined by Dr. Joseph DeBellis,Dr. Ravi Kothuru and Dr. George Dreszer. DANA SHAW PHOTOS

Doctors work to scrub the burned skin of tiny Jose Luis.

The team was diverse in every way beyond medical discipline: they were Christian, Jew, Moslem and Hindu, with a variety of ethnic backgrounds. Dr. Allam, who is Egyptian, said ISMS is avowedly non-political and secular in nature: its goal, solely and expressly, is saving lives.

Dr. Dreszer, who was born in Colombia and is bilingual, was able to interact with the Spanish-speaking patients himself. The others relied on volunteer translators, most provided by United Servants Abroad, a missionary group. Its primary representative, Tom Hough, arrived on the scene; he was to become the invaluable all-purpose "fixer" for the group throughout the mission, providing background information, translations, transportation, and mundane tasks like changing money.

When medical specificity was not an issue, others got by without translators, using a combination of English, mangled Spanish and hand gestures that would become familiar over the coming week.

Maryellen Spandonis, for example, needed sonargram gel for an examination, and the language barrier made it difficult to pass her request along to a staff nurse. After a few seconds of uncomprehension, an exasperated Ms. Spandonis bridged the gap with pantomime: She held an imaginary bottle of gel, raised it up high, brought it down sharply and imitated the splat sound perfectly: "Pfffffffffffft!"

"Ah, vasolina! Si," the nurse replied.

Others had learned a few Spanish words—"caliente" was one of the first. At one point, tellingly, nurse Ellen Herfield, who was helping process patients, asked Mr. Hough, "How do I say 'patience'?"

Throughout the week, there are as many patients and prospective patients in the hallways, it seems, as in the rooms. Some are barefoot; clumps of dirt in the hallway reveal the rural nature of the community. Some walk by with family members carrying IV bags for them.

Some clinic rooms are packed, with people spilling into the hallway and beyond. But there are few patients seeing Dr. DeBellis for plastic surgery consults—surprising, since cleft palates and other deformities are common, and typically untreated, in countries like Peru. Soon, there is an answer: Tom Hough explains that the same politician who changed the hotel reservations also announced that the doctors would be arriving one week earlier. Nearly as many patients, including many seeking plastic surgery, showed up that weekend and waited in vain, then left disappointed. When another announcement was made, Mr. Hough says, some were too disillusioned to believe it.

He notes that some of the patients had paddled up the Ucayali River for five days to reach the hospital while the team is in residency.

The team would take what came, but would focus on a series of maladies that are common in rural Peru, and which can be fatal if left untreated, as they often are here: fibrous ovarian and uterine tumors, gall bladders in need of repair, reconstructive surgery, and many, many hernias. Almost all are simple surgeries in America, and many would be considered elective, although "elective" means nothing in a country where virtually no one has the money to pay for surgery. As a result, people walk around with gall bladders that are inflamed to the point of near rupture, and women with uterine tumors as large as gestating fetuses, which cause them to bleed nearly to death every time they menstruate.

There are also cultural issues. Mr. Hough—though he looks and talks like a Midwesterner, he is a 52-year-old native of Pucallpa, the son of missionaries—says that a typical Peruvian family will choose one child to nurture, providing medicine, education, everything he needs. The other children go without. The plan is that the favored child might one day prosper: "He will take care of the family. If he makes it."

Pucallpa is a city of well over a quarter of a million residents, with block after block of ramshackle buildings, mostly one story, that serve as storefronts. But at a glance it is difficult to tell the abandoned buildings from the active ones, and the storefronts have little behind them. The streets look more like sidewalks. The prevalent form of transportation is a "motorcar," a three-wheeled motorcycle fitted with bench seats in the back, that serve as taxis. They outnumber the beat-up cars and trucks by 20 or 30 to 1.

Ominously, the blocks near the hospital's emergency entrance are lined with funeral homes, which are simply storefronts with caskets stacked inside.

Dr. DeBellis says his most memorable ISMS case was in Nicaragua: a man walked four days to be seen, only to be the last person to be turned away. Instead, Dr. DeBellis operated on him while the team, packed and ready to leave, waited in the idling truck.

It happens every trip, he says—there is always one more patient, always one more to see.

Wrapping up the first day of clinic on Saturday, there is a glimpse of that fact: a woman sobs in the hallway outside. Dr. Kothuru investigates and learns she has been waiting since 3 a.m. and was told to come back on Sunday. Without a word, he leads her into the examination room.

The reality of life in Peru is driven home by a conversation between Dr. DeBellis and one of the Peruvian doctors, regarding a diabetic patient. As is routine, Dr. DeBellis asks if the woman is insulin-dependent; the local doctor looks puzzled. She is not, but it doesn't matter, he says—they can't get insulin in that part of Peru.

Dr. DeBellis is confused. "The diabetic patients, what do they do?"

The doctor answers simply, "They die."

Dr. DeBellis has found his "heartbreak case"—every trip has one, he says. This time, it is Gladys, an adorable 11-yearold brought in by her grandmother. She has a scar on her knee to be treated by the plastic surgeon.

It seems like a simple case—until the doctor notices that she also has a broken tooth, and an older wound on the back of her head. Only then does he get the tiny girl's complete history: her unstable mother regularly abuses her physically. The leg wound is a stab wound, made by a knife wielded by her mother. The wound on the back of her head is the result of a blow from a two-by-four more than a year earlier.

The hospital has an MRI unit operated independently on the premises, but the procedure on Gladys's skull will cost $68. Dr. DeBellis waves a hand: "I think we can spring for it."

On Sunday, the team wakes early and starts the day with strong coffee served in plastic pitchers, eggs, baked goods, fresh papaya and fresh-squeezed orange juice. Mr. Hough makes sure the team is fed well all week, with the help of a team of women affiliated with his group.

Tom packs team members into his pickup truck for the short trip to the hospital on Sunday morning. Along the way, he talks a bit about Pucallpa and Peru in general.

Corruption, he says, is rampant and accepted. In elections, he says, "Whoever can buy the most votes wins." There are many tribes of indigenous people, and most are not well represented in government; some live in parts of the Amazon rain forest so remote that they're still being discovered, having never seen any-

A women waits to be seen in the emergency room.

one from outside the tribe.

Dr. Patel asks Mr. Hough what drives the economy. He smiles wryly and answers, "Cocaine."

It turns out that the coca plant, which grows at higher altitudes in the mountainous regions of Peru, is processed in the valley towns of Pucallpa and its neighbors. According to Mr. Hough, some 70 percent of the world's cocaine passes through the valleys of this part of Peru, where it is processed into paste and sent to Colombia for conversion into powdered cocaine.

The country is a relatively stable democracy, but it has had a troubled past. Terrorists from the Shining Path, a guerrilla-style Communist Party movement, caused unrest throughout the 1980s, until its leader was captured and the movement was all but disbanded in 1992.

Mr. Hough says the Shining Path would kill indiscriminately to terrorize the people of the community, and people rarely left their homes after 6 p.m. He remembers his daughter arriving in Pucallpa, and as he took her to her first day of school, they drove past bodies in the street, some dismembered, some with signs nailed to their chests. "I can't believe the things she saw," he says.

Another missionary, who works with an organization that translates the Bible into indigenous languages, is part of the translation team. She is concerned about a baby born two weeks prematurely, only a little more than 4 pounds, with a malformed leg and foot. The initial diagnosis by local doctors was brittle bone disease, but the new diagnosis, by Dr. DeBellis of the ISMS team, is that it's an isolated malformation that can be treated with a cast. She worked to get the baby into the hospital for treatment.

It is testimony to the nature of life in Peru that while she's a veteran missionary, and her story will appear only in a local newspaper on Long Island, she will not give her name, worried that there might be political repercussions for her organization.

Fans circulate air in the clinic as Dr. Patel sits down with the day's first patient. He hums to himself—he is nearly always singing, whistling or humming—but his sunny disposition hides a wry streak. Frustrated by the bureaucracy that occasionally hampers the mission, he declares one day: "Politicians are just a bunch of bananas. They're yellow. You only find them in bunches. And not one of them is straight."

Helping Dr. Patel is Miguel Trujillo, a young man in his early 20s who is attending university with Mr. Hough's support, learning English and business. Known as "Mike" to the team, he will prove invaluable, and he will volunteer nearly as much time as the doctors and nurses, spending hours in operating rooms and translating for doctors.

The patients file in for a few minutes of consultation with Dr. Patel. The first is a 38-year-old woman who has never had surgery. The doctor whistles merrily as he flips through her tiny file: gallstones. He spends less than two minutes with her, passing her over to Dr. Kothuru for a brief exam, then schedules her surgery for Friday—a good sign, since the simplest cases will be scheduled later in the week, when they can be trusted to recover with local staff overseeing.

Next is a 41-year-old man, then a 58-year-old woman. A thin 63-yearold corn and rice farmer, wearing an immaculate striped linen shirt, has a hernia on his right side, but he also complains of chest pain. Dr. Patel unrolls an EKG study, then asks a series of questions with Mr. Trujillo's help: Is he tired? Short of breath? Pain in his shoulders or neck? The man, helpfully, nods to each. "Tell him not to just say yes to everything," Dr. Patel says to Mr. Trujillo: the man might not realize it, but every nod makes his surgery less likely.

The doctor takes a full five minutes with the farmer, which seems like a lifetime in this setting. He is definitely a high-risk patient, with an irregular EKG and, most likely, an enlarged heart.

Dr. Patel notes that in a place like Peru, people like the farmer who cannot afford hernia surgery will live with the problem until the pain keeps them from working. That means the ISMS team's intervention, with such a surgery, has economic impacts as well as medical. Ultimately, with a sigh, Dr. Patel allows that the farmer most likely will get the surgery anyway—even though he'll be lucky to survive it, and it won't address the more serious health problem, the one that probably will kill him one day soon.

Mr. Hough seeks help from the team with a case that its members won't soon forget.

The case comes in before 10 a.m. on Sunday, the second and final day that the ISMS team is scheduling surgeries. It is a tiny 2-year-old boy from a neighborhood in the outskirts of Pucallpa. His mother was, as is customary in many parts of the community, cooking breakfast over an open fire outside, boiling a large pot of water. The boy was curious; the mother shooed him away several times. But when she moved away for a moment, curiosity got the better of him, and the toddler pulled the pot over, dousing himself with boiling water. His mother came running back, hearing his cries of anguish.

Dr. Joseph DeBellis checks on the young burn victim. DANA SHAW PHOTOS

Dr. Kothuru, Dr. DeBellis and Dr. Dreszer rush to examine the baby. Dr. DeBellis estimates that the child has been burned over 75 to 80 percent of his body, with nearly a third of his body covered with severe third-degree burns, where the skin had been destroyed. Dr. Dreszer looks grim; he notes that even at a burn center in the United States, there is little that can be done for a young child with such extensive burns. In America, his chance of survival would be only about 30 percent, Dr. DeBellis notes; in Peru, his mortality rate is close to 100 percent.

The ponytailed mother, a 37-year-old woman named Juanita who looks much older, stays with the child as the doctors examine him, clutching the blanket she had wrapped the child in. The child's dark skin is peeling, revealing pink skin beneath. He is in excruciating pain and screams uncontrollably until he is finally sedated.

Arriving on the scene is the Tanzaniaborn head of the hospital's burn unit. Dr. Eberhard Lucas Mbuligwe is Western-trained, skilled and dedicated, all of which made him stand out nearly as much in the hospital setting as his dark skin, bright red scrubs and authoritative demeanor. Dr. Lucas, as he is known, provides the kind of skilled care that can make a difference in such cases.

This one, though, visibly troubles the doctors because of its severity, and the likelihood that it will not end well.

In the gynecological unit, a life is being saved—although that isn't immediately evident.

Dr. Vito Alamia and Dr. Geri Schmitt, both ob-gyns, are discussing a 20-yearold woman who is as slight as a teenager. She has brought her mother and aunt to the clinic to be seen; both are later diagnosed with cancer. In passing, the young woman mentions that she'd had an abortion in February, and since then she's had a tiny bit of pain.

Dr. Alamia is skeptical and nearly moves on to the next patient—this is, after all, a clinic designed to treat the most serious cases, like the woman's mother and aunt. But something makes him agree to quickly examine her, and to do an ultrasound.

Both doctors would agree later: The woman had a guardian angel.

Dr. Alamia notices that the ultrasound imaging shows signs of pregnancy, but no fetus. He moves up the fallopian tube—and discovers a heartbeat where there shouldn't be one. The woman has an ectopic pregnancy, a non-viable implantation of the fetus in the right fallopian tube. The fetus will not survive; worse, the tube does not stretch in the

same way as the uterus, so as the fetus grows, it eventually will cause the tube will rupture, causing internal bleeding, and, if untreated, the death of the mother.

Dr. Schmitt says a preliminary look suggests that the tube could have ruptured within days, if not hours. That is the leading cause of death among women in Peru. The woman likely would have bled to death before making it back to the regional hospital.

The two doctors agree that they should operate that day, even though the ORs are not going to be set up until the following day, Monday. The pair moves off to make the necessary arrangements.

The guardian angel was also looking out for the woman's 41-year-old aunt: She has a lesion from uterine cancer, but it is operable, and she is scheduled for Friday. But the diagnosis for her 45-year-old mother is grim: Her cervical cancer has spread to her uterus and bladder, and beyond, metastasizing in her pelvis. It is completely inoperable, in a way that such cancers rarely are in the United States.

"It's heartbreaking—absolutely heartbreaking," she says.

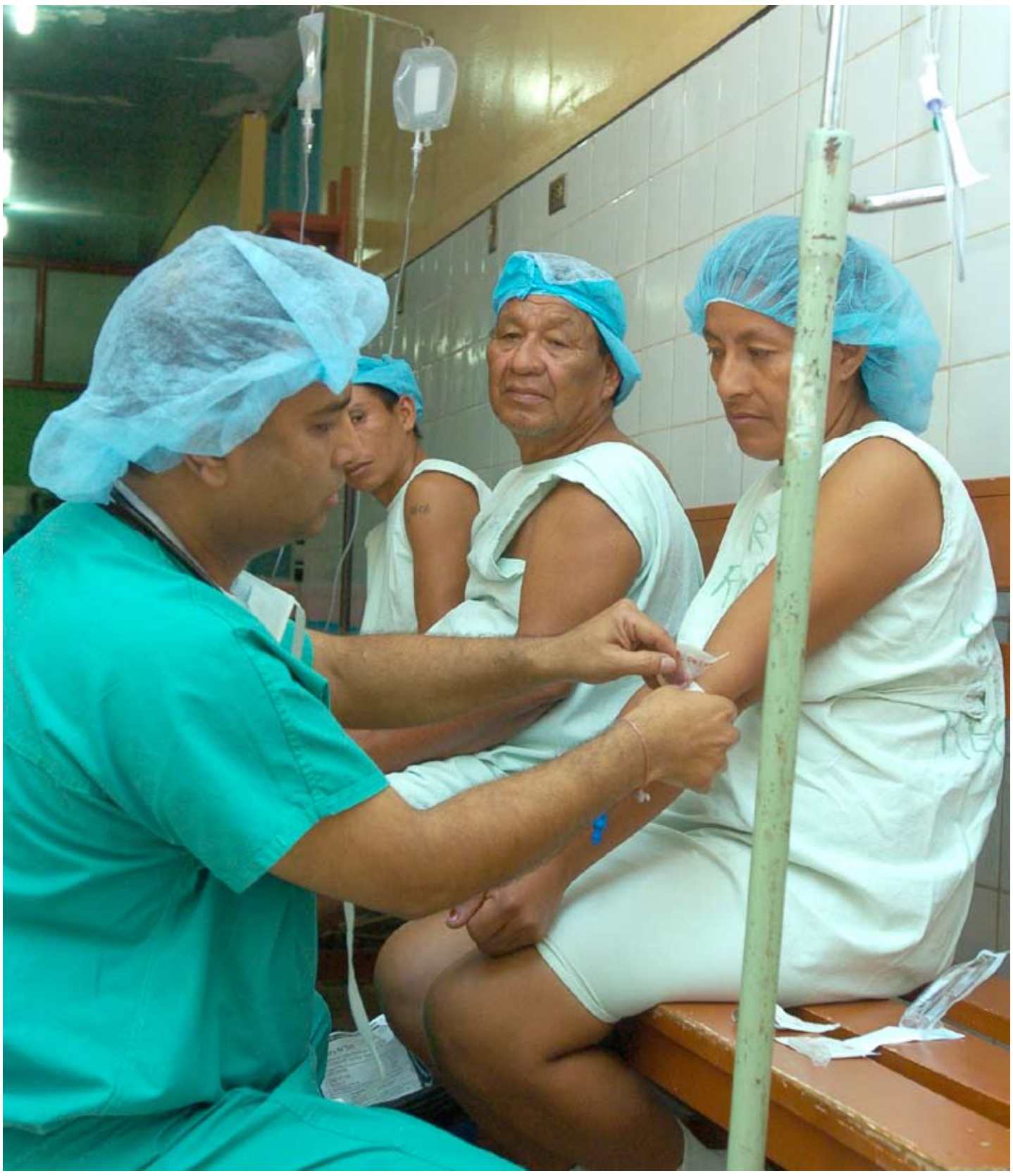
The first reports of the little 2-yearold boy who was burned begin to circulate among the rest of the team, and the consensus is that his outlook is bleak. "It's bad," says nurse anesthetist Chris Torres, "especially when it's a child ... It sucks. I mean, who deserves that?"

In his bed in the burn unit, tubes run from the child's face, his eyes taped shut, tears glistening beside the tape. The dark, dead skin is peeling back from his neck to his knees, and only small patches remain. He whimpers, sedated, but not completely unconscious.

A careful examination confirms that the child is burned over 75 percent of his body, and 30 percent of the burns are third degree, which means the skin has turned white and waxy, a sign that it will not regenerate and will require grafts. The boiling water had washed down his chest and back at the same time, leaving burns on all sides of his torso—even more troubling, because it raises the possibility that the healing wounds will harden into, essentially, one large scab, which can tighten and restrict his breathing, smothering him.

The danger, he says, is that the tiny boy's burned body is leaching fluid from the entire area of the burn. It is, he says, like bleeding to death while losing virtually no blood. The lines pump fluid back into his body—some 10 to 12 times his body's blood content in the next 24 hours.

If the child were in a U.S. hospital, Dr. DeBellis notes, the doctors would be more aggressive with treatment, particularly with blood transfusions. But in Peru, blood is hard to come by, and impossible for a family like this child's, with no money to pay for it.



Dr. Joseph DeBellis checks on the young burn victim.

People line the hallways,some for days,to be seen at the clinic at the hospital in Pucallpa.

Even for a seriously injured child, the system of medical care in Peru is shockingly ruthless. When a patient is brought to the hospital, he or she is examined, and then a family member is handed a list of supplies—bandages, medicines, everything that will be needed to treat the patient, none of it provided by the hospital. The family member must track down each item at a local pharmacy, or elsewhere, and bring it back to the hospital. If they can't, or if they can't afford the supplies, the patient is simply turned away. There is some government funding for care, but it is notoriously unreliable.

That is even true for a tiny baby burned by boiling water—although it helps when a team of American doctors takes an interest, and when a hospital has a burn unit run by a physician like Dr. Lucas.

The team of ISMS doctors and Dr. Lucas are joined by nurse anesthetists Bob Mineo and Michael Sherwood, as well as several local nurses, and the team works to strip the sedated child of dead skin by scrubbing with special soap and water. When they finish, the boy looks something close to healthy to the untrained eye—so much of his body looks pink and ready to heal, and other patches look white and hardly inflamed at all. In fact, the pink areas are second-degree burns, extremely painful and difficult to heal. The white patches are third-degree burns—the nerves, sweat glands and skin are all dead beyond saving.

Dr. Alamia and Dr. Schmitt scrub in for surgery on the 20-year-old woman with the ectopic pregnancy—her name is Lastenia—with Chris Torres as nurse anesthetist, and RNs Stephanie Porey, Ellen Herfeld and Kathy Berger all helping in the OR. As the patient is prepared, Dr. Alamia sings along to Counting Crows and "Mr. Jones," which plays on the OR speakers.

The slightly-built woman is nervous; a local nurse calms her by patting her cheeks. Ms. Herfeld helps, reading a few translated words in Spanish from a double-folded piece of paper she carries.

The two doctors opt to do laparoscopic surgery: small slits are made, her belly is inflated, and, using a camera and a monitor, they operate with tools inserted through the slits.

The bubble on the fallopian tube is less than a half inch long—but the heartbeat is clearly visible in the tube, just outside the ovary. The doctors decide the fetus is seven weeks old. Even in the United States, a fetus cannot be saved in such a situation.

Moments after the camera goes in, the bulging, purple tube is clearly visible on the monitor, dangerously close to rupturing and ending the woman's life at age 20. In 20 minutes, the procedure is over, and Dr. Alamia is shaking his head. "I almost blew her off, almost turned her away," he says.

Later, he visits her in recovery, and she is beaming, only in a little pain. He pinches her cheek. She is going home.

Bob Mineo exits the hospital's burn unit, having visited with the burned child, and his face is grim like everyone else's. "I hope this isn't going to be every day," he says of the case, which has clearly touched everyone, especially coming so early in the week.

Mr. Mineo sighs. "It's all right—if he can hang in there, we'll do some things to improve his chances."

Dr. DeBellis reports that the baby is on a ventilator. Dr. Lucas had impressed the American doctors, and he will direct the child's care, with the American doctors' input. The baby will stay on the ventilator, wrapped head to toe in gauze, covered with antibacterial cream, and kept separate from other patients. Infection, ultimately, is the greatest threat to the child. If he lives for two weeks, his chances of surviving will slip past 50-50.

Dr. DeBellis details the plan for treatment out loud, evaluates it, considers possible pitfalls along the way and what the response might be, trying to stay one step ahead. The tiny patient—his name, it turns out, is Jose Luis—has been the focus of the team's attention, and Dr. DeBellis's, for most of the day. Finished reviewing the case, he turns to leave the burn unit.

He stops, then turns back. He is worried that, to a layman, the detailed analysis might be mistaken for something like hope.

"He's going to die. You know that, right?"

Nextweek:PartII