Breathing Grace

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CHAPTER ONE

Gospel Debt

Few events sear themselves on the memory of a surgeon with more heat than a patient without an airway.

Seconds tick away, each a hammer blow against survival. A cascade of negative metabolic consequences rockets forward with the imminent precipice of death in sharp focus.

Without a workable immediate plan, the patient will free-fall into eternity.

I'll never forget Ray Stafford. I was chief resident on the trauma service the night Ray died on my watch.

My trauma-alert pager sounded the five-minute warning to assemble the team. The Sikorsky medical transport helicopter raced toward the

university hospital rooftop carrying a critical patient. I stopped in the small cubicle that housed the flight dispatch in the center of the emergency room. "Hi, Joe, what's coming?"

He leaned back in his chair and gave me a bullet presentation. "Twenty-seven-year-old male, victim of a close-range GSW to the face." GSW is traumaese for gunshot wound.

I smiled in spite of my fatigue. A penetrating trauma like this one meant surgery, a welcome contrast to the majority of blunt-trauma victims whom general surgeons baby-sit for the orthopedic service. "Sweet," I said. It's a response I doubt non-surgeons will understand. I wasn't glad the patient was injured, but if it was going to happen, I wanted it to happen when I could gain experience through the case. That's the twisted sort of attitude that makes a competent surgeon.

A few minutes later I met Ray as the team transferred him off the transport stretcher onto one of ours in a trauma bay.

I observed the rise of his chest and placed my stethoscope against his thorax. *Airway. Breathing. Circulation.* "What happened to you?"

His face contorted with pain. "Some dude shot me," he grunted.

I'd heard a similar story dozens of times. It was always "some dude." Later I learned that a vengeful father shot Ray because of Ray's intimate relationship with the angry man's daughter. The interesting stories always came out later, but in the midst of the initial workup the histories all sounded the same and were surgically succinct: "young white male involved in a social altercation sustaining a GSW to the . . ."

Ray had a small entrance wound on his left cheek. His right upper neck was swollen, and an exit wound was visible on the right lateral, posterior neck near the hairline.

The team swarmed. Vital signs were assessed. Blood pressure was 140 systolic. A nurse secured a second intravenous line. *Follow the ABC's.* A chest X-ray was taken. A urinary catheter was inserted. After a phone consultation with my surgical attending, Ray was taken to

the angio suite for an arteriogram, a specialized X-ray that visualizes the blood vessels and provides a road map to locate possible arterial injury.

I threw the X-rays up on the view-box as they came out of the processor. I examined the films, still warm from the developing process. An arterial blush clouded the area lateral to the internal carotid artery, an indication of bleeding, a serious injury that was partially contained, a situation that needed stat attention before the artery free-ruptured, ensuring exsanguination and death. Although stable for the moment, the patient needed emergency surgery and was soon whisked across the hall to the operating suite while I called in my attending surgeon.

Blood made the neck bulge, tenting up the skin near the exit wound. How long would it be before the bleeding could not be contained or the airway was compressed by the expanding collection of blood?

Nurses positioned Ray on the operating table as his eyes widened in fear. The anesthesiologist prepared to put the patient to sleep and slid a breathing tube into Ray's trachea. The vascular surgeons scrubbed their hands.

But the patient's restlessness escalated, his knuckles whitening as he gripped the sides of the operating table. And then without warning he wretched, vomiting what appeared to be undiluted blood. *A lot of blood.*

Ray sat bolt upright, fighting for air. Then he fell back, thudding against the operating table. Pulseless. Without respiratory effort. *Time for the ABC's.*

The anesthesiologist slid a laryngoscope into Ray's mouth. "I can't see anything," he yelled. "There's too much blood."

With the airway obstructed, without oxygen, Ray was dying in front of me. On my watch.

Oxygen debt: When our bodies are screaming for payment and the currency is oxygen.

At that moment my patient was in shock, a clinical diagnosis defined as inadequate flow to the end organs, kidneys, heart, and brain. The vital organs are starving for oxygen, and what defines the crisis is a lack of the same.

At a cellular level, all the metabolic activity is screaming for payment, and the currency is oxygen. Without an adequate supply, a situation occurs that we know as *oxygen debt*.

We've all experienced this at some time or other, perhaps at the end of a footrace across the school playground. Our heart races, and our respirations increase, all in an attempt to supply oxygen to starving muscles. We collapse with our hands on our knees. All other activity ceases as we gasp to overcome the debt of oxygen.

So what does all this have to do with the gospel?

Gospel debt: When our souls are demanding payment and the currency is grace.

Sometimes subtle and insidious, but no less critical, is the current epidemic found within the church and within all of us: gospel debt.

Just as every cell (one hundred trillion in one human body!) requires a constant supply of oxygen, so every spiritual, emotional, and social aspect of our lives need a constant saturation with the gospel of grace.

Surgeons are trained to think on their feet, to make life-and-death decisions in spite of their own fatigue. Dozens of other details clamor for the surgeon's attention, distracting from the priorities at hand. Fortunately, there are simple guidelines, a mnemonic to focus the priorities. *Airway. Breathing. Circulation.* Simple enough to be remembered by everyone. Succinct. To the point. The surgeon targets the critical first need, the life-or-death problem that will determine the patient's ultimate end.

Without oxygen a death spiral begins. The metabolic machinery within every cell unravels into inefficiency. Unless reversed, irreversible consequences loom as the brain cells starve and die.

Without the true gospel, we quickly turn to other methods to fill the void—false gospels of self-sufficiency, blaming circumstances or others—all futile attempts to make up for a *gospel debt*. Without the gospel, we begin a death spiral of sorts, a slide into a life empty of peace. Joyless. Mechanical. We follow the rules. Outwardly holy, inwardly starving.

But just as the trauma surgeon turns to the ABC's, we can turn to the ABC's of spiritual resuscitation. Guidelines simple enough to be remembered by us all, even in the clamor of life's everyday disasters. So that's where we will start. The beginning, the elementary school chalkboard of our Christian lives. We're going back to the ABC's . . .

But what about Ray? We left our story as he fell lifeless onto the operating table. At that point a branch of his carotid artery had ruptured into the back of his throat. Ray was in full circulatory collapse, his airway obscured by blood and the swelling from the bullet's path.

So I followed the ABC's.

I made an incision through the skin, palpating for landmarks, opened the cricothyroid membrane, and inserted a breathing tube directly into the trachea, actions taken to secure an ***A****irway*. We began to ventilate through the tube, forcing oxygen into his lungs. That took care of ***B****reathing*. CPR was initiated, externally pumping on Ray's chest as additional blood and fluids were pushed into his empty veins, actions taken to support ***C****irculation* until a pulse was detected again.

The ABC's guided our steps. And Ray was brought back to life.

Of course, that didn't solve all of Ray's other problems. An angry father still preferred to see Ray pulseless and cold rather than carousing with the madman's daughter. So we admitted our patient under an assumed name to protect him from the father who wanted him dead. And in a few days we let Ray go again, with a scar on his neck as a permanent reminder of his brush with the Grim Reaper. So we cared

for his physical life, following established guidelines. What he needed next was someone to guide him through a spiritual resuscitation to reorder his dysfunctional life.

But we're all like Ray. We may not have the same set of problems, but we're all dysfunctional in our own ways. One moment we're saturated with the gospel, content in the sufficiency of the cross. The next, we're in gospel debt, showing all the symptoms. Some are subtle, visible only after dissection below the surface of false gospels. Some are pulse-pounding terrifying and require urgent intervention. That's when we need a solution, the ABC's.

It takes a scalpel to dissect below the skin.

It takes a spiritual scalpel of sorts to dissect beneath the scab of self-reliance. But I'm rushing ahead. Before we can offer a solution, we need to make a proper diagnosis.

For Further Reflection

1. What is gospel debt? How do you see this in your own life?
2. How does gospel debt relate to divine grace?
3. Do you really need grace as constantly as you need oxygen? Why?
4. Do you agree that "Without the true gospel, we quickly turn to other methods to fill the void—false gospels of self-sufficiency"? How does this reveal itself in your life? When you see this, what should you do?
5. "Without the gospel, we . . . follow the rules [but are] outwardly holy, inwardly starving." How can you be starving if you're following God's rules, if you're "outwardly holy"?