Humor in Medicine

The Grandson of the Heimlich Maneuver

Matthew Michael Eschelbach, DO, MS
Sunriver, Oregon

There are very few lessons we learn that remain important throughout our lives. "Primum non nocere," or "First, do no harm" is one such lesson. I recall it was inscribed on the bronze plaque on the way into the medical school lecture hall. It is part of the Hippocratic oath and probably the only Latin a doctor needs to know today. Our great physician-mentor Hippocrates made this declaration so that we might think first and treat later. Sound advice in ancient Greece; sound advice today.

"Laughter is the best medicine" is another modicum of guidance worth remembering. When I first read the *Reader's Digest* section bearing this title, I was 10 years old, but the wisdom it embodies is just as contemporary today as then. If you can laugh, even when sick, you've won half the battle.

These two pieces of sage advice are both important, but I have always considered them mutually exclusive. They didn't seem to lend themselves readily to combination, at least until recently, when they helped me save a patient's life.

On one cold winter morning recently, I was summoned to the emergency department at Mountain View Hospital, where I am an emergency physician. I was catching up on some long overdue medical journal reading when the PA system bellowed, "Dr Eschelbach to ER, STAT! Dr Eschelbach to ER, STAT!" I tossed my copy of *The New England Journal of Medicine* on the floor and ran to the ER. As I entered, I saw one of the nurses, MaryKay, helping a patient. MaryKay is a registered nurse with a natural sense of what is right or wrong with a patient. Today, she was quite right in her assessment that something was terribly wrong.

She greeted me with, "This man is having a very difficult time breathing, Doctor."

I glanced at the patient and could tell immediately the man before me was scared and struggling. He was breathing, but his coloring suggested cyanosis. Somewhere along the way, this man's life-flow of oxygen was getting cut off. Leaning forward seemed to help in his search for air. Out of pure intuition, MaryKay placed a nasal cannula and O_2 beneath the man's nose; within seconds, his color improved to a more vital pink. His breathing slowed, as he felt somewhat safer now that both a nurse and a doctor were with him. He continued to lean forward, however, taking deep, labored breaths and looking as frightened as the moment I first saw him. Oxygen alone was not the answer for this man.

"Can you tell me what has happened to you, sir?" I asked. "Are you having any chest pain?" I wanted to know if he could talk; if so, at least some air was traveling in and out of his trachea. If he had aspirated something into his lungs or trachea, they might close again at any instant.

He began to speak slowly and quietly. "I was eating lunch." He drew another deep and noisy breath. "My wife made me some stew today," he gasped. "It tasted fine—but all of a sudden"—he paused after every four or five words, gasping for air—"I felt as if I had swallowed broken glass—lots of it—a mouthful of broken glass. It's stuck—right here—" he pointed, "tearing at my throat." His dyspnea seemed to be worsening.

I considered all the options and possible outcomes in a moment's time. Maybe he had aspirated bone fragments that were now perched dangerously above his trachea or bronchus, threatening to fall and choke off his breath. Perhaps he had formed a fistulous tract that was widening or occluding both his esophagus and trachea as we spoke. If he collapsed, intubation would be necessary to ventilate him. If there was a major obstruction, such as a large piece of meat or bone, I would have to do an emergency tracheotomy. I thought for a moment and scanned the room to locate the closest available scalpel and trach tray, just in case.

It is taken for granted that in medicine, we train our brains to operate as computers, scanning all the available information, sending it down a diagnostic pathway or two, then recommending a treatment plan. If that treatment plan is rejected for any reason, the loop begins again, the entire process taking seconds or less.

In this case, the procedures I considered were invasive or required some sort of bodily intrusion. Since scal-

From Mountain View Hospital District, Madras, Oregon. Address correspondence to Matthew M. Eschelbach, DO, MS, 18160 Cottonwood Road, #105, Sunriver, OR 97707.

ISSN 0094-3509

pels, tubes, and medicines all carry inherent risks, simple is better, as long as it works. "First, do no harm," I thought. Maybe a simple Heimlich maneuver would help. If there was something lodged there, this time-tested maneuver would work quickly and efficiently. The Heimlich maneuver would be it, I concluded.

The computer in my mind surged again. The word *Heimlich* popped in and, in a stream of consciousness, I thought of my grandmother, Anna Heimlich, and her beloved stack of copies of the *Reader's Digest*. "Laughter is the best medicine," I remembered. Then it clicked and I began to grin.

"You say you were eating stew when this occurred?" I queried.

"Yes, Doctor, and I felt like I swallowed glass. It's still there, tearing my throat," he said again, drawing a tight breath.

My decision was made and my treatment plan selected: I would tell a joke.

"Sir, you feel like you swallowed glass, and your wife made the stew. Did your wife recently increase your life insurance, too?" I asked, unable to stop the grin from turning into a smile.

All at once, he laughed and choked. As he did, he spit and propelled across the room the largest single bay leaf I have ever seen. As the leaf landed at my feet, I looked upon it in awe. The man's color soon returned, his breathing became more comfortable, and he was still snickering to himself about the life insurance. The leaf had been acting as a flap above the trachea. It had embedded itself sideways in the soft tissue of the throat, thus the feeling of ground glass. Each time the gentleman tried to breathe, the flap partially cut off his airflow. My joke had acted as a self-administered Heimlich maneuver: a medical emergency ended by a guffaw.

A laugh, which is certainly less invasive than a bronchoscope or an 8.5-mm French endotracheal tube, is not a bad therapeutic choice. During the inhalation phase of laughter, the diaphragm descends as the lungs expand. In the exhalation phase, air is forcibly expelled as the diaphragm rises. Essentially, a good laugh is worth at least two Heimlich maneuvers, or perhaps 5 to 10 cm of PEEP!

"I think you'd better get your wife's hearing checked, sir. I told her to put a little spice into your life, not use a little spice to take your life," I retorted like some bad improv comedian. He smiled and laughed. Even MaryKay had to stop and chuckle. I picked up the bay leaf and tossed it into the trash.

The great insurance god in the sky smiled broadly at that time: no expensive procedures and no need for preapproval from the patient's insurance carrier. "How should I charge this man?" asked MaryKay. "How do I document in my notes what just happened? I can't say, 'The doctor entered the ER, assessed the patient, told a joke, and then left!'"

Famous innovations get their own moniker, like the "Pasteur pipette," the "Kelly clamp," or the "Heimlich maneuver," but I knew the "Eschelbach trick" or the "joke maneuver" would never fly. "Just call it the 'Grandson of the Heimlich Maneuver,'" I quipped, as I returned to my journals.

Do no harm, but first laugh. I wonder how you say that in Latin.