lies beneath the skin. They'd need to take him to the operating room, check to make sure the bowel wasn't injured, and sew up the little gap.

"No big deal," John said.

If it were a bad injury, they'd need to crash into the operating room—stretcher flying, nurses racing to get the surgical equipment set up, the anesthesiologists skipping their detailed review of the medical records. But this was not a bad injury. They had time, they determined. The patient lay waiting on his stretcher in the stucco-walled trauma bay while the OR was readied.

Then a nurse noticed he'd stopped babbling. His heart rate had skyrocketed. His eyes were rolling back in his head. He didn't respond when she shook him. She called for help, and the members of the trauma team swarmed back into the room. His blood pressure was barely detectible. They stuck a tube down his airway and pushed air into his lungs, poured fluid and emergency-release blood into him. Still they couldn't get his pressure up.

So now they *were* crashing into the operating room—stretcher flying, nurses racing to get the surgical equipment set up, the anesthesiologists skipping their review of the records, a resident splashing a whole bottle of Betadine antiseptic onto his belly, John grabbing a fat No. 10 blade and slicing down through the skin of the man's abdomen in one clean, determined swipe from rib cage to pubis.

"Cautery."

He drew the electrified metal tip of the cautery pen along the fat underneath the skin, parting it in a line from top to bottom, then through the fibrous white sheath of fascia between the abdominal muscles. He pierced his way into the abdominal cavity itself, and suddenly an ocean of blood burst out of the patient.

"Crap."

The blood was everywhere. The assailant's knife had gone more than a foot through the man's skin, through the fat, through the muscle, past the intestine, along the left of his spinal column, and right into the aorta, the main artery from the heart.

"Which was crazy," John said. Another surgeon joined to help and got a fist down on the aorta, above the puncture point. That stopped the worst of the bleeding and they began to get control of the situation. John's colleague said he hadn't seen an injury like it since Vietnam.

The description was pretty close, it turned out. The other guy at the costume party, John later learned, was dressed as a soldier—with a bayonet.

The patient was touch and go for a couple days. But he pulled through. John still shakes his head ruefully when he talks about the case.

There are a thousand ways that things can go wrong when you've got a patient with a stab wound. But everyone involved got almost every step right—the head-to-toe examination, the careful tracking of the patient's blood pressure and pulse and rate of breathing, the monitoring of his consciousness, the fluids run in by IV, the call to the blood bank to have blood ready, the placement of a urinary catheter to make sure his urine was running clear, everything. Except no one remembered to ask the patient or the emergency medical technicians what the weapon was.

"Your mind doesn't think of a bayonet in San Francisco," John could only say.