"Watch out for the bump, ma’am. ... We wouldn’t want you to get hurt when I go around a tight corner." — Fuat Sarieminli

“Fuat! We’ve run out of stretchers!”

In the E.R., Mr. Sarieminli, a divorced father of a preschooler and the son of Turkish immigrants (the hospital has turned to him as an impromptu Turkish interpreter), stands with the other wisecracking, nerve-snapping, giddily intense staff warriors: he is a member of a hospital team, a battalion, a family.

It’s mid-afternoon, and the emergency room at Long Island College Hospital in Brooklyn is at double capacity. With the bays filled, patients on hospital transport stretchers are now lining corridors and being parked under the counters of the nurses’ station.

A prisoner in a fluorescent orange jumpsuit, wrists and ankles shackled to stretcher bars, moans and waits alongside the other patients, as two armed guards search in vain for a corner to isolate him. The din builds, the stench ripens, and the backup
balloons for X-rays, CT scans and hospital beds. But the patients keep trooping in by foot and by ambulance.

And now there are no stretchers for those new patients. The emergency department is careering toward diversion — that clumsily named, must-avoid status where incoming ambulances will be told to divert to other hospitals. For patients, diversion can be dangerous, even deadly. Plus, it is bad for business.

But rounding the corner to start his 3:15 to 11:15 p.m. shift comes Fuat Sarieminli, 41, smartly turned out in a fresh haircut, button-down shirt, tie, lab coat and thick-soled walking shoes. Patient transporter. Gridlock buster.

He whips down remote hallways, alights on some empty stretchers huddled together and systematically races them back. With heavy steel bars, sturdy wheels and thick padding, each weighs several hundred pounds (and that is before piling on the patient and monitoring equipment).

“Fuat! Fuat!” hollers the X-ray technician, as Mr. Sarieminli speed-walks by. “Bring on those patients, baby, bring ’em on!”

“Fuat! Fuat!” hails a nurse. “Get this patient to CT scan!”

“Fuat! Fuat! This patient needs a hummer!” a nursing assistant calls out, using the hospital nickname for the sturdy new wide-body wheelchairs for larger patients.

Over the next 15 minutes, Mr. Sarieminli, rescuing stretchers and moving eight patients to the emergency room’s X-ray and CT scan departments, imperceptibly begins to break apart the logjam. Diversion averted.

Even so, it will be two and a half hours before beds upstairs become available so that Mr. Sarieminli can actually transport patients cleared for admission to their hospital rooms.

“I’ve seen patients in the E.R. all day on my shift,” he says, “and I’ll go home, sleep, come back and guess what? They’re still here!”

In modern health care, delay is a leading complaint of dissatisfied customers, a threat to the critically ill and a vicious headache for hospital administrators and
efficiency experts, who measure it assiduously. Many emergency rooms track “door to floor time”— how long it takes a patient who arrives in the E.R. to be wheeled to a bed on a hospital floor.

Of all the cogs in that process (reports! scans! diagnoses! lab results! consults! chains of command! available beds!), one of the most essential and least respected is the patient transporter, whose qualifications typically include a high school diploma, a pleasant disposition and a clean record. “My job is to move the patient from Point A to Point B,” says Mr. Sarieminli, who has worked in this position for seven years.

Few people realize that “patient transporter” is a distinct job category. “I blame those TV medical shows,” says Mr. Sarieminli, taking umbrage. “Who wheels the patients around on them? Doctors!” As if.

At Long Island College Hospital, some 35 patient transporters work under the command of the logistics department. From a central dispatch system, similar to that of a taxi company, transporters are sent to move patients to diagnostic appointments and operations. The dispatcher watches the progress of each job on a computer monitor: blips of red, yellow, green and purple signify “nursing delay,” “patient in bathroom” or that the transporter is taking too long.

As administrators in major hospitals around the country know well, a dawdling patient transporter can set off a chain reaction of delays throughout the institution.

Mr. Sarieminli, however, is not tracked by the computer. The emergency department is so busy and his job is so demanding — on a typical shift he will make about 50 trips from Point A to Point B — that the computer cannot keep up with him.

In fact, most transporters do not like working the emergency room. The work is not only faster-paced than elsewhere in the hospital, but “transporters feel disrespected here,” says Mr. Sarieminli, assaulted by the cacophony of so many on-the-spot bosses, commanding him to move someone right now.

He loves it.
He has wheeled a woman in labor, crowning in the elevator, and hurtled a stab victim through the corridors to the operating room. “That’s me, I’m in the driver’s seat,” he says.

He even has a designated sliver on a hospital pie chart that tracks “door to balloon time” — how long it takes to get a heart attack patient to the cardiac catheterization lab for an angioplasty. Administrators realized that having a patient transporter standing by with a stretcher outfitted with lifesaving equipment, rather than having to order one from the dispatcher, could mean a gain of critical moments.

“Without Fuat, we can’t get the job done,” says Dr. Tucker Woods, vice chairman of the emergency department.

As Mr. Sarieminli moves through the E.R., he does his bit to preserve dignity in a place notably lacking in privacy. He taps a woozy, swaying patient whose open gown is flapping. “Sir!” Mr. Sarieminli says. “Let’s cover you up. You’re exposing yourself.”

Outside the CT scan department, he whispers to a patient in a wheelchair: “I know you’ve waited a long time, but it’s very busy tonight, ma’am. We haven’t forgotten about you. You’re next.”

For if a transporter is, fundamentally, something of a parking attendant, he can also resemble a bellhop, a frontline meeter-and-greeter who settles the weary, the frightened, the frustrated in their room after a grueling journey.

“I remember you!” Mr. Sarieminli says brightly to a patient with diabetes, as he starts wheeling her to her room after long hours of waiting. She returns the smile, nodding, her angry edginess noticeably fading.

“Watch out for the bump, ma’am,” Mr. Sarieminli says. “Please keep your elbows and feet inside the bars. We wouldn’t want you to get hurt when I go around a tight corner.”

It turns out that the paths connecting Point A to Point B are many and varied. Does the transporter choose the scenic route, with languid pauses for chats with co-workers? The steeplechase course, accounting for every thud and poorly executed
corner? Or the circuitous route, involving misread hospital ID bracelets, wrong room numbers and long, chilly waits in the wrong corridors?

Mr. Sarieminli has his own code of professionalism. Always stand behind patients’ heads, not at their feet, so their view is not blocked and they can feel more at ease. Avoid chitchat with co-workers, especially in a foreign language, when in the presence of the patient. “That’s unprofessional,” he says. “So I’ll point to the patient and say, ‘We can discuss the Jets game later.’” He is not permitted to give water or food to patients, but he can escort them to the bathroom.

“I’ve had telephone numbers given to me by patients for their granddaughters,” he says, and adds, a touch wistfully: “But I never pursue them. I just say, ‘I’m at work and I’m a professional,’ and I leave it at that.”

“Ahh, here’s your room!” he says to the diabetes patient, as he lowers the rails of her hospital bed and carefully slides her onto it. “I love this room! What a great view! If you watch carefully sometimes, you can see that cruise ship go by, the Queen Mary, a ship like you wouldn’t believe ... take your time ... hey, you’re doing good!”