System Failure

Upon arrival to the hospital one morning during my internship, I found out that E.G. had died. E.G., a middle-aged Nigerian man, was in the United States visiting his brother. Shortly after he arrived, he began to experience profound nausea and increasing abdominal pain. He had a long history of distended belly, but recently it had worsened, and one night he began vomiting bright red blood. In the hospital, a series of laboratory tests revealed severe, chronic liver damage and a past history of hepatitis B virus infection. A CT scan showed extensive masses throughout his liver with local invasion into his lymph and vascular systems. His alpha-fetoprotein level was greater than 35,000 ng/mL. Two things were clear: E.G. had end-stage liver cancer, and he wanted to return to Nigeria.

Nevertheless, the oncologists wanted a pathologic diagnosis to complete the case. It was extremely unlikely that the result would change E.G.'s prognosis or treatment, but still they requested a liver biopsy. As the intern caring for E.G., I was caught in the middle. I knew he would listen to my recommendation, but I was unsure of what to do. Would the biopsy be helpful in terms of treatment options, future hospitalizations, or hospice placement? Was the risk of internal bleeding too great? After discussing the risks and benefits with several doctors over 2 days, E.G. consented to the liver biopsy with my reluctant recommendation surely weighing heavily on his mind.

On the morning of the biopsy, E.G. remained ambivalent about the procedure. He was concerned about the risk of bleeding but was holding onto the small possibility that the results would be useful. Later that night after the biopsy, E.G. began complaining of worsening abdominal pain, and his hematocrit began to drop. His belly had become bigger, and he felt weaker. I was at his side, looking him in the eye with my hand, not on his abdomen, but on his shoulder, explaining that it appeared as though his worst fear had come true: he was bleeding from the biopsy site. The surgery resident I had called to evaluate him concurred, but E.G.'s bleeding would likely stop with fresh frozen plasma, provided that he wanted to listen to another discussion of risks and benefits, sign yet another set of consent forms, and invariably endure another day of needle sticks.

When I returned to talk with him, it was clear he did not want the fresh frozen plasma transfusion, the IV line, or more blood draws. This time, my recommendations clearly lacked their prior influence. Feeling resigned to his fate, E.G. refused all further interventions and died the following day—not from his terminal cancer, but as a result of a liver biopsy the health care system needed but he did not.

—Robert Roose, MD, MPH
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WHAT WAS YOUR MOST MEMORABLE CODE BLUE?

Real-life stories are sometimes more bizarre than fiction, yet they leave us with a profound lesson about the unique and fragile balance between life and death and the role of medicine within this context.

In a few paragraphs (less than 700 words), send us your most unusual, difficult, or humorous story of a code blue (resuscitative effort) in which you were involved. Include any long-term reflections that you may have about the case, or share with us the humor of the moment. You may discuss an event that took place in your first days of residency or one that occurred just yesterday. The story may have taken place on a back road or in a hospital cafeteria. Whatever or wherever it was, we want to know.

Please send us your most interesting personal stories. Submissions should include the author's name, address, phone and fax numbers, and e-mail address if available. We'll maintain your anonymity if you wish. The best stories will be selected for publication.

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