Back to Basics

On the General Medical Ward

It was the second month of my internship. I was carrying 12 patients on the general medical floor at a large community hospital and was on call. While writing progress notes on my patients, I heard a code blue announced over the public system. It was a patient in the ICU, and I breathed a sigh of relief. Almost 10 minutes later another code blue was announced, this time in the emergency department. I was not a member of the code team or rapid response team, so I continued writing my notes, thinking this was a bad day to have 2 codes. Not even 5 minutes had passed when a floor nurse came to me and said, "Doc, your patient in room 511 is unresponsive." I was not ready for this news, as an hour ago the patient was doing fine. I rushed to her room and found her unresponsive; her breathing was shallow and I could not detect a pulse. I asked the nurse to begin ECG monitoring and to announce another code blue.

Every one was looking at me, as no senior resident had arrived yet, and I was looking at the patient. Suddenly, I decided to do everything to save this patient. The monitor initially showed bradycardia and then pulseless electrical activity (PEA). I tried to remember what I had learned from my ACLS course and recalled to give epinephrine and atropine repeatedly. The patient had no IV access, so I asked the nurse to give me a central line catheter and I placed a femoral line successfully in only 3 minutes. I considered myself a great doctor, and even better than my senior resident, that I was able to run the code in my second month of internship. I recalled ruling out reversible causes. I thought of all causes starting with "h" such as hypokalemia, hypoxia, and hypovolemia. The patient was already intubated and had received 3 doses of epinephrine and atropine. I decided to give 1 ampule of bicarbonate as well. The patient did not respond, still showing PEA. Almost 5 minutes had passed. Sweating profusely, I tried to think what else could be done. At that point, my resident arrived and asked me what the blood glucose level was.

"I don't know." I replied.

He asked the nurse to immediately do a Chemstrip test and meanwhile asked me to push 1 ampule of D50W. The patient's blood glucose was 13 mg/dL. He asked me to give 1 more ampule of D50W and then told me "You should have given her dextrose; who knows how long she has been hypoglycemic."

My dream of being better than my resident had come to a quick end, replaced now by concern that my actions may have harmed the patient. I prayed that the patient would be fine; otherwise I could not forgive myself. Three days after the code, I was very happy to know that my patient was being transferred back to the medical floor from the ICU. She was doing well, and the plan was to discharge her home in a couple of days. I still think about this code blue sometimes. This experience reminds me not to be overly confident and not to miss very basic things. Fortunately, the patient did not have any complications.

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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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