Do No Harm

On the General Medicine Ward

When I started my rotations, I assumed that I would lead a code blue while covering both the cardiology and ICU services. As an intern a year earlier, I only assisted in codes. The "privilege" of leading a code was given to the second- and third-year residents. Several times throughout the month, I nervously reviewed the American Heart Association guidelines on leading a code. I kept a "cheat sheet" in the pocket of my white coat just in case.

It was 11:55 PM on my last call night. I sat at the nurses' station writing a note while waiting for the ICU night resident to arrive. As I turned to ask a question, I heard over the public announcement system, "Code blue, Shepardson 4, Code blue, Shepardson 4." At first, I thought I was imagining it, but when the code pager went off as well, I knew it wasn't a dream.

I arrived at the scene and, as usual, the room was crowded with medical personnel, an ECG machine, and the code cart. A surgical resident had already started the code. I pushed my way through the crowd, thinking that I could let her continue running the code, but I realized this was as good a time as any to grab the reins and forge ahead.

The patient's heart had pulseless electrical activity. I thought, "drug-drug – epinephrine and atropine, send labs to help determine the cause, periodically stop chest compressions to see if the patient regains a pulse." This process went on for 10 to 15 minutes, but there was no pulse. After 5 more minutes elapsed, I thought, "I should stop the code." Then it happened.

I said, "Stop chest compressions. Does the patient have a pulse?"

"Yes, there's a pulse," someone replied.

I replied in utter disbelief, "There's a pulse?"

We transferred the patient to the ICU. Her family arrived and found her on a ventilator, unresponsive and with a central line in her groin. We learned that she never wanted to be intubated; she had been physically deteriorating over the past year because of myotonic dystrophy, diabetes, and emphysema. The patient information indicated that the patient was "full code." Obviously, this information was not consistent with what the family told us. Did anyone actually discuss code status with the patient?

Instead of code protocol swirling through my head, I heard the words, "Do no harm." Whom had I helped? Certainly not the patient or her family. I thought about the time likely spent obtaining the patient's up-to-date medication list. I thought about how we persevere until we have the correct dosages, often taking time to call the patient's pharmacy. I thought about how frequently discussion of code status is postponed until the next morning… when the patient is more alert…when the family is present… when the family insists on bringing in the patient's living will... when the attending physician is present.

The first code that I led was over, and the patient "lived," but it was not a time of celebration or relief. I overcame my trepidation, but the patient's family was left with the painful decision to withdraw care. I stood at the patient's bedside with my "cheat sheets" in my pocket and thought about the fear I had leading up to this code blue. At that moment, it became clear. The true fear should lie in, "Is this really what the patient wants? Am I doing harm?"

—Teresa Fama, MD, MS
Charlotte, VT

Copyright 2005 by Turner White Communications Inc., Wayne, PA. All rights reserved.