

## Help Ever, Hurt Never

### An Inpatient Ward

A few years ago when I was a resident in internal medicine, I started a new inpatient ward service with two relatively green interns. One of our patients was an elderly, severely cachectic woman with end-stage restrictive lung disease and altered mental status. While I was reviewing the vital signs noted on her chart outside her room, I heard one of my interns repeatedly asking, "Ma'am, are you okay?" When I entered the room, I found that the patient had no pulse and was unresponsive.

The chart for this patient carried the designation "full code;" thus, a code blue was called and cardiopulmonary resuscitation and the algorithm for pulseless electrical activity were initiated. The patient was cyanotic and cool, and she appeared to have been down for as long as 30 minutes. Because of her seemingly hopeless state, all medical staff involved in the code agreed that a "slow code" was appropriate. We all went through the motions, although we realized that the patient was all but dead. After pharmacologic agents were unsuccessful at helping the patient regain a pulse, the medical staff agreed that further action was inappropriate. The patient was pronounced dead.

Five minutes later, I was on the phone trying to call the patient's family with the news. The phone rang several times but no one answered the call. Just then a nursing student, who had been preparing the corpse for viewing by the family, came running out of the room shrieking, "Doctor, you better get in here!"

I hung up the phone and ran into the room.

Shockingly, the patient had regained a pulse! And a blood pressure! Her tracheostomy was quickly attached to a ventilator, and she was transferred to the intensive care unit.

When the family arrived at the hospital, I sat down with them and described the events of the morning. Much to my surprise, the patient's husband (and healthcare proxy) responded by saying calmly, "Doc, all we wanted was for her to go peacefully in her sleep." After a lengthy discussion with the family, the medical team in the intensive care unit disconnected the ventilator and the patient died within 24 hours.

To this day, the recollection of the experience disgusts me. All that was required to appropriately care for this patient was simple communication between the patient's family and the physicians who were caring for her, and this ugly sequence of events could have been averted. I am currently a gastroenterology fellow, and I sometimes feel that the housestaff does not appreciate me pestering them over the code status of their patients, especially when they ask me to see a patient with multiple organ dysfunction syndrome or widely metastatic cancer to evaluate for guaiac positive stool. I suppose that experience is the best teacher. My experience has taught me that by simply communicating with patients and their families, we might actually be able to occasionally help patients and avoid causing harm, as we vowed when we took the Hippocratic oath.

—Anonymous

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