From the Corner of the Room: A First Code

In a University Hospital

When I was a third-year medical student, I started my clinical rotations on the wards of a university hospital in Washington, DC. My most memorable code blue occurred during the first month, when each experience was new and exciting. One night on call, I helped my senior resident, Jack, admit a young woman with a deep vein thrombosis. Jack chose her from the team's admissions as an ideal student case—an otherwise healthy patient with one remediable problem.

The patient smoked and took birth control pills. She had a Homans' sign and a palpable cord. It took me hours to complete her history and physical examination. I asked her about recent airplane trips, family history of malignancy, toxin exposure, and whether she had smoke detectors in her apartment. I asked her about her future plans, how she was going to quit smoking, and whether I was doing a good job.

I spent most of that evening reading about anticoagulation and hypercoagulable states, prepared my presentation for the next day's rounds, and awoke 2 hours early so I would have plenty of time for pre-rounds.

As I walked to the patient's room early that morning, I saw residents and nurses rushing in and out. Some were standing along the hallway in silence, and others were talking about their own tragic cases, attending physicians they liked or disliked, the weather, and the role of thrombolysis in pulmonary embolism. Although I knew what was happening, this was the first time I had actually seen it. Until that day, my knowledge of codes was fashioned from the movies and television—where good outcomes were a *sine qua non* and the heroic physicians always knew what to do and never broke a sweat.

Jack called out orders to nurses while other residents performed chest compressions, bagged the patient, and placed a femoral line. I was frightened. I backed into the corner of the room, the farthest one from the action, and watched the maelstrom—medications, defibrillations, wide-open fluids, pressors, sterile fields, quick looks, central lines, intubation, and chest compressions.

I remember someone saying, "Let's call it," and then the sound of the group sigh that followed. I stood there thinking that none of my patients were ever going to survive. Most of all, I remember how much more senior and experienced those residents seemed. Several residents offered words of consolation to Jack and then returned to their morning rounds. I longed to be "used to it" like them. I remember the patient's mother coming to her bedside and crying, the attending physician kneeling by her side in silence, and the feelings of loss, failure, and fear. It seemed that the world would stop so we could take a breath, but it didn't. We still had to go to conferences, check laboratory values, and take care of the other patients.

Nearly five years have passed since this code. I recently completed my rotation as a senior resident and code leader in the intensive care unit at a large New York City hospital. I will probably never be better at running a code blue than I am right now. What was chaos to the uninitiated eyes of a student now seems orderly and rhythmic. The three minutes between doses of epinephrine are enough for contemplation and discussion. And every once in a while, my attention veers to the farthest corner of the room, where I see the eyes of a medical student and I realize how far I have come. I wonder if those students ever think that I am "used to it." I want to tell them that I am *not* used to it. But I also want to tell them that codes are easier for me now than they once were, that some patients will survive and do well, and that one day as residents they will be sharing this wisdom with a medical student in the corner of the room.

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