

D/C IV, D/C Home in AM

An Inpatient Ward

One of the most exhilarating and exhausting events during medical school is a code blue. As a student, I always tried to squeeze into the room to be part of the action. I found myself knowing neither the patient nor the team performing the code, but I just watched the code blue and learned. I was so comfortable with the fundamentals of a code blue that I knew I would be ready when my turn came to run a code. Little did I know that my turn would arrive soon enough.

Less than one year later, as an intern on evening rounds, my team and I stopped to examine one of the chairman's patients. The patient was an elderly woman who was complaining that she had an uncomfortable intravenous (IV) access and wanted it removed. The plan was to discharge her in the morning, so the chief resident ordered me to "D/C IV and D/C home in AM." As the intern, I questioned the order with utmost respect, but the chief was firm on his decision to discontinue her IV catheter. Obviously, the patient was doing well—she was off all IV fluids, tolerating oral medications, and had no need of IV antibiotics. Why retain IV access for another 12 hours?

The next morning I came in to the hospital at 5 AM to pre-round my patients. I noticed an inordinate amount of commotion in the hallway, and then I heard those dreaded words, "CALL A CODE BLUE!" Immediately, I asked the nurse which patient was coding. She responded, "Your patient, Doc!" After I felt my gut drop to the floor, I rushed to my patient's room. She was lying flat in bed and was a color so intensely blue I will never forget it.

I checked for a pulse that was already thready, but the patient remained unresponsive. Then I started cardiopulmonary resuscitation and instructed the nurse to push IV medications.

"I can't find an IV!" the nurse responded.

"Start one!" I told her. She ran out of the room to look for an IV.

I continued cardiopulmonary resuscitation while the nurse struggled to find a vein. Then, my senior resident came into the room.

"What drugs have been administered?" he asked.

"Nothing yet, we have no IV access," we responded. The senior resident yelled a string of expletives and then ordered a central venous catheter, which seemed to take forever to arrive and be inserted.

After approximately 30 heart-pounding minutes (for both the patient and me), the code was called. We were never able to start an IV for the patient.

Needless to say, "No IV access" is a horrible cause of death to write on the death certificate! An action as simple as keeping an IV in the patient can make all the difference in the world. I felt terrible that I did not stop the chief resident from discontinuing her IV access.

On autopsy, the pathologist found a massive pulmonary embolism that led to her death. He claimed that the embolism was so large that the patient would not have survived. Nevertheless, I lost a patient, and the fact that no IV catheter could be placed has affected the way I practice medicine today. Chief residents and attending staff physicians still instruct me to discontinue IV catheters while the patient is still an inpatient. I strongly volunteer my resistance to the order. Unfortunately, they do not listen. They have never been in the situation *D/C IV, D/C home in AM*.

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