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Code Status

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Early in my time as a medical student, the days fell into a routine. I'd check test results, make rounds, wrestle with the Electronic Medical Record, do workups, write more notes, and read about my patients' medical problems, as much as I could. Everything was orderly and predictable, until one day I heard the hospital PA system announce, "Code Blue room 148. Code Blue room 148."

The senior resident jumped out of his seat. "That's us!" he exclaimed. "Come on, there's a code down the hall."

As I ran after him, a nurse came from the opposite direction pushing a bright red crash cart full of supplies and medications. Other nurses, residents, and medical students converged on room 148 in a swarm. My instinct was to hold back and observe, but my resident pushed me ahead of him.

"What's the story here?" he asked in a commanding voice as he helped pull the crash cart into the room.

"85 years old, metastatic breast cancer, full code," responded a nurse who was stripping the hospital gown from the patient's body.

My resident pointed at me. "You! Chest compressions."

"Um, OK."

"Climb on the bed if you have to."

The bed had been raised to make the work easier for the staff. It was awkwardly high for me, so I climbed up, aligned my knees next to the woman's naked torso, placed the palm of my left hand over the back of my right, lacing my fingers, and planted my right palm firmly on the woman's sternum. Her body was thin and frail; her sparse white hair haloed around her head. She was dead.

"Okay, start the compressions," said the resident.

I pressed. The idea of chest compressions is to push down hard enough to squash the heart so blood pumps out, but this woman's rib cage curved high above her sunken abdomen, the sternum not even close to touching her heart muscle. Her ribs barely flexed as I compressed. I was afraid I would break her.

"One and two and three …" I said, counting with each compression.

A nurse placed a ventilation mask over the patient's mouth; another nurse felt for the patient's pulse in her groin.

"… and four and five," I said. I paused; the nurse squeezed the bag.

"One and two and three …"

"No pulses transmitted," said the nurse, confirming my fears that the compressions weren't effective.

I pressed harder, leaning my weight onto the woman's chest. "and four and five." The rib cage remained stiff and unpliable. I noticed nodules along the ribs and wondered if they represented metastatic cancer that had spread to her bones. The nurse pressed the oxygen bag. I raised up on

my knees so more of my body weight would be over the patient's chest.

"One and …" I felt a crack under my hands. "Two and three and …" Sickeningly, the ribs gave way under my hands. "Four and five…" The nurse squeezed the bag again. I could feel the gritty edges of cracked bones scraping against each other.

"One and two and …" More ribs cracked. "Three and four and …" The final rib gave way, the sternum collapsing into the woman's thorax. "Five …" The nurse squeezed the bag. I backed my weight off the old woman's chest.

"One and two and three …" I compressed, my hands sinking with little resistance. As one nurse ventilated, another told me my compressions were producing blood flow in the groin. Around us, my resident barked orders as an EKG machine spit out a rhythm strip.

"One amp epinephrine!"

"Four and five …" I said, loud enough for the nurse doing the ventilations to hear me.

"One amp epi!" repeated a nurse as she grabbed a vial and snapped the narrow glass neck with one hand while grabbing a syringe with the other. In one smooth motion, she gripped the plastic needle cover between her teeth, pulled it off, drew up the liquid from the vial into the syringe, and handed the filled syringe to the nurse standing at the patient's left arm. "One amp epi!" she repeated.

"One and two and …" I continued compressing.

The other nurse bent over the patient's arm, located the port in the IV, and injected the medication, running the fluids wide open. "One amp of epi!" she shouted.

"Three and four and ..."

"Time!" yelled the resident.

An intern checked the clock. "Four minutes!"

The shouting continued with each drug that the resident ordered. A nurse anesthetist pushed her way to the head of the bed, plopping her equipment next to the patient's head. She checked the light on her laryngoscope, a curved metal instrument used both to push the patient's tongue aside as well as to visualize the trachea and vocal cords. She eyed the patient's head and neck and selected a long, white breathing tube (ET tube), which she would thread down the patient's throat into her lungs, so that ventilations would be easier. The nurse with the oxygen bag stepped aside, gesturing to me to pause my compressions. Tilting the patient's head back, the nurse anesthetist inserted the laryngoscope, peered intently into the patient's mouth, and without taking her eyes off her object, she grabbed the ET tube and threaded it down the patient's throat. As she removed the laryngoscope, the first nurse attached the oxygen bag to the (ET) tube. The nurse anesthetist listened to the patient's chest with her stethoscope, first one side then the other, as the other nurse squeezed the oxygen bag. It had taken maybe ten seconds to get the patient intubated.

"One and two and three and …" I resumed the chest compressions.

The nurse administered a couple of breaths, and I pumped the chest. The broken ends of the ribs gnawed at my wrists as I reached between them; her breastbone moved easily, unmoored, against the heart underneath.

When the action paused for electric shocks to be administered, I got off the bed so another medical student could take my place. I threaded through the mob of people, staying long enough to see the patient's body jerk and flop in response to the electric shocks. I shook my arms to try to remove the sensation of the bones crunching under them. It didn't work. All these years later, I can still feel the ribs crumbling under my weight, the sensation living in the bones of my arms.

I hovered in the hallway for a while, watching the action, wondering what it was all for. I wondered if the patient had agreed to have this done to her. I wondered if the family had. I wondered why the patient's doctor hadn't insisted on a peaceful death for this elderly woman with metastatic cancer.

This patient did not make it. The code was terminated, the people left the room. A couple of nurses stayed to clean up the body. I made a silent vow that when I became an attending physician, I would fully inform my patients about their prognosis and do my best to protect them from having to withstand a futile code.

Many years later, when I worked as an attending physician in a university medical school, I found myself taking care of a 56-year-old man in the ICU. He had metastatic lung cancer, and his prognosis was grim. Still, he was alert with a lively mind and sense of humor and was still adjusting to his recent diagnosis. Medically, he was having sudden problems with his breathing, presumably caused by a plug of mucous blocking off a major airway. The pulmonary specialist wanted to

perform a bronchoscopy, threading a long tube into the patient's lungs so he could remove the mucous plug. While ordinarily, the procedure was fairly routine, for this patient, it was fraught with unlikely, but possible, disaster, as hitting the wrong part of the lung—a swollen blood vessel or vascular tumor—could start a cascade of bleeding that couldn't be stopped. The patient knew the risks and benefits of the procedure and wanted to proceed. The pulmonologist wanted to have a code status established before he started. Since the patient's prognosis was so bad to start with, he didn't want to have to run a futile code on an already terminal patient if the procedure went awry. We had to have the patient's consent.

The pulmonologist, the senior resident working with him, and I, as the attending physician, circled the patient's bed while the residents and medical students on my team watched in the background. The patient was sitting up, an oxygen mask over his nose and mouth, looking at us with curiosity. "I'm all ready for the bronchoscopy, Doc," he said to the pulmonologist.

"Yes, that's good," he said. "But I have to ask you something before we start."

"Sure, no problem," said the patient.

"I just need to know what you would like us to do if we run into complications. Do you want us to do everything in case you stop breathing?"

"Sure, Doc, I want you to do everything."

The pulmonologist's shoulders slumped. This was not the answer he wanted.

Next, the senior resident tried. "When we say 'do everything' we mean push on your chest and

break your ribs and give you medicines and run a code. Is that what you want us to do?"

"Sure, Doc, I want you to do everything."

Next it was my turn. "You know, you are in the ICU. We are already doing everything. You're getting oxygen, you're being monitored, you're getting all kinds of medications. What we're really asking is, if you die, do you want us to try to bring you back?"

The patient's eyebrows shot up. "No way! That would be stupid!"

I could feel a collective sigh of relief in the room, and, I have to admit, a feeling of accomplishment for myself. Not that I wished for this man to die—later that day he had the bronchoscopy with no complications—but that I had finally helped him understand what we were asking. Very few people survive a code in the hospital to walk out and live normal lives. Most die anyway or are left with brain damage from lack of oxygen. The concept of doing everything is very different, I suspect, for patients than for doctors.

This patient responded enough to chemotherapy and lived long enough to leave the hospital. He was still expected to die soon, but at least he could spend his last days with family in his own home. He would not have the threat of a code hanging over him, as he would in the hospital.

I hope I taught the medical students and residents who were with me something important that day. Maybe we don't need to be so anxious about discussing death with our patients. Maybe we don't need to sugarcoat our words. While we can feel like failures if we acknowledge that our

patient is going to die, that we can't help them anymore, avoiding the issue places the suffering onto our patients, who are already thinking about their own deaths, but are too nervous to bring up the topic with us. It seems kinder to spend our energy on attending to those patients we can help and offering comfort and care to those we cannot.

About the Author

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