

The Six-Code Day

A Community Hospital

During the second year of my surgery residency, I rotated to a small community hospital to gain some experience in “bread-and-butter” community surgery. The surgical service at this hospital consisted of a fourth-year postgraduate who served as chief resident and three junior residents—one second-year postgraduate and two interns. We juniors were on call alone every third night. We covered the emergency department, the floors, and the surgical intensive care unit (SICU). I had already served a 1 month rotation in our SICU and could help the interns during the day. Recently one of the thoracic surgeons had performed major lung resections on two patients with severe chronic obstructive pulmonary disease, and both patients were in the SICU for the night. Thankfully, I was off this night—or so I thought.

At about 3:30 AM my phone rang—it was the chief resident. She told me that the two unit patients were not doing well and were too sick for the intern to manage. As chief resident, she had been at their bedside for the past 8 hours. Now she was exhausted and needed me there as soon as possible. I immediately drove to the hospital and went straight to the SICU.

The chief resident was ecstatic to see me, and then she left rather suddenly. I introduced myself to the two lung surgery patients: Mr. A and Mrs. B, who were both in their late seventies. The good news was that both patients were intubated with Swan-Ganz catheters, arterial lines, Foley catheters, chest tubes, and all the “bells and whistles.” The bad news was that both patients were hypoxic and hypotensive. I started fine-tuning the ventilators, administering fluid, and adding vasoactive medications, all to no avail. Both patients continued to spiral downward. After about 6 hours, the impending crises came to a head.

Mr. A was the first to fulfill the requirements for advanced cardiac life support protocol. The nurses called the operator to announce a code, and I adminis-

tered shocks and started chest compressions. After we administered superhuman doses of epinephrine, an obtainable blood pressure returned. Then Mrs. B’s nurse called a code. I ran across the unit and started the same routine: shock, drug, shock, drug. Just as we brought Mrs. B back, another nurse shouted, “BP 30, Doctor!” Mr. A had started coding again, so I ran back across the room to the third code of the day. We brought him back but, clearly, the code was going to happen again. As I told the nurse to prepare Mr. A’s family for the inevitable, Mrs. B began coding again.

After bringing Mrs. B back, I had a few minutes to meet Mr. A’s family and explain that Mr. A didn’t have much more time. After a heartfelt discussion and many tears, they agreed to allow Mr. A to enter the next world without any further trauma. Our talk was cut short by Mrs. B’s third code of the day. We brought her back this time, but the fourth code was unsuccessful. Her family was on their way to the hospital and hadn’t arrived yet.

We ran six codes that day between our two patients. I spoke with both families and did my best to try to ease their pain of losing a cherished family member. The attending surgeon never came in to speak to the families personally. This experience taught me my most important lesson of the day: conveying the news of the death of a loved one is the most difficult task a physician encounters, and this communication should be handled with tenderness and compassion. Giving the news of a patient’s death should also be handled personally by the physician in whom the patient and family have placed their trust. Although the experience of simultaneously running code blues for two patients and ultimately losing both was difficult, I was lucky to be there. I will never forget the lesson I learned from the six-code day.

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