



The Code

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“Code Call Baker 632,” announced an urgent voice over the hospital intercom. Simultaneously, the code beeper worn by our team’s resident went off. We sprinted to the 6th floor of the Baker

building. As we rounded the corner, we saw the crash cart in the hall, which directed us to the right room. Several residents were already there when we arrived. The chaos of the residents rapidly sorted itself out under the calm guidance of the senior resident, who directed the chest compressions and the Ambu bagging until the resident who would intubate the patient was ready. Someone else slipped a central line into place, and fluids were administered. The EKG leads were placed, and the senior resident quietly said, “V Fib — shock.” Zap went the defibrillator pads. The body reflexively jerked. “Still in VF, keep pumping. Give an amp of bicarb and start lidocaine.” Meanwhile, the endo-

tracheal tube had been inserted, and each side of the chest was auscultated to be sure the tube was in position. During the next 20 minutes, multiple vials of bicarb, epinephrine, procainamide, lidocaine, and finally bretylium were given, stat blood gases sent, and the results analyzed while we worked together to bring back a viable rhythm, pulse, and blood pressure.

As often happened, the code was unsuccessful. Deciding that we had tried everything, the senior resident said, “The code is called.” We all stopped what we were doing, and then, as though the whole episode had been some minor distraction in our otherwise packed day, we filed out of the

room. We were no longer involved. We left to others the jobs of cleaning up the mess we’d created and of notifying the patient’s doctor and family. We returned to our rounds, picking up as though nothing had happened.

As a newly minted intern, I was most aware of my own uncertainty about what to do, what drugs to give, how to tell what was happening. The senior resident seemed almost godlike — leading us through our tasks in his calm, methodical way until he was convinced we had done enough. I was sure I would never be able to do this. Codes were one more situation that made me wonder how I had come to be here, where I so often felt in over my head.

The learning curve is steep in those first months of internship, and as with so many other medical tasks, codes gradually became less chaotic and more comprehensible. I came to anticipate what the

senior resident would ask for. I found I could put in central lines, intubate a patient, and do chest compressions; I came to know the medicines being asked for and to grasp why they were needed. I began to think about matters other than my own inadequacies. But I found that when someone said “the code is called” and we all walked out of the room, returning to rounds or going off to lunch, perhaps laughing about some goof-up, some part of me was aware that I was forgetting something. Eventually I realized what it was: the patient. Someone had just died. But we all behaved as though that was not at all what had happened. What had happened was that the code was unsuccessful.

Where did we learn this detachment? For most of us, the first lessons came very early in medical school, when we were confronted with the dissection of a human body — conveniently called a cadaver, as though that made it something different from a person who had died. How rapidly we moved from our first tentative slices through the chest wall to look at the heart and lungs and then into the abdomen, finding ourselves lost in the fascination of how our bodies are arranged and overwhelmed by all we had to learn. Soon, we were casually slicing the head in half with a saw to see how it looked from the middle, having paused only briefly when we first unwrapped the hand, which struck us as uniquely and somehow poignantly human.

We learned to bury our fear of

death in an avalanche of knowledge. We learned the trick of silencing the parts of our brain that didn't really want to be this close to death. And for good reason. We could not do what we do — take responsibility for the lives of our patients — if we were aware, minute to minute, of the true significance of what we were actually do-



ing. We could not come into a code fully aware of the profound event taking place and still be able to do our job. So we learned to put those feelings away. The question, of course, is how to avoid losing them altogether, how to come back to them later, when we have time to think about them.

Sometime late in the fall of my internship year, I happened to be the last person to leave the room after a code. Once again, it had been unsuccessful. Once again, we had come from all over the hospital to try to save the life of a patient few of us knew. For whatever reason, perhaps because I was

alone, I was struck by the reality that a person had just died. I made myself turn around and look at the body of this stranger. He was lying on the stretcher, a pacer wire sticking out of his chest, the endotracheal tube now disconnected and hanging uselessly in the air, EKG leads still in place, and reams of readouts on the floor surrounding the now-silent EKG machine. I tried to imagine his family — who in minutes would be told that someone they loved had died and for whom this would be a devastating loss. And what of the person himself, who had died despite our attempts to pummel and pound him back to life?

Half-remembered words from the end of a requiem mass came into my head, and I said aloud, “May choirs of angels greet thee at thy coming” — less a statement of faith than a simple attempt to acknowledge the passing of a life. Since that day, I have never had a patient die and not said those words — my small attempt to remember what it is that we are ultimately doing: trying to protect our patients' lives.

In recent years, other physicians have told me about the rituals they perform when a patient dies — offering a prayer, a poem, a gesture — something that each has felt compelled to do to recognize the life lost and the fact that, in the final analysis, death will always win. What is striking is that most of us do this in private. We don't share these rituals. We don't talk easily about how hard it is to lose a patient, to confront death. In the anatomy laboratory, we learned to

focus on the path of the vagus nerve, not the human being to whom it belonged. Early in our training, bending over our cadavers, we learned to silence a part of ourselves. We learned the power of humor as a means of avoiding hard conversations about more complicated feelings. Often we kept those feelings to ourselves, rarely giving voice to them as we proceeded through far more challenging situations during our clerkships — a newly diagnosed lung cancer, a 2-year-old with an inoperable and therefore fatal brain tumor, a young man with quadriplegia from diving into shal-

low water. We discussed the medical management and the complications in detail and with intense care, but we could not give voice to the feelings these events evoked, often reducing them, in the formal case presentation, to the single word “unfortunate.”

And because we cannot comfortably express these feelings, sometimes we put them away forever or feel incompetent and overwhelmed when we do try to express them. Perhaps if we could discuss this part of our practice lives as easily as we discuss a diagnostic dilemma or the proper management of a complex case,

we might create a culture that supports and nourishes us as we try to come to terms with experiences that are part of our daily lives. Being able to communicate more honestly with each other might help us to do so with our patients as well. How different might those codes have felt if, at the end, having declared, “The code is called,” the resident then said, “Let’s have a moment of silence to honor this life.”

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Perspective
FORUM

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Cases in Vaccine Court — Legal Battles over Vaccines and Autism

Stephen D. Sugarman, J.D.

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Do childhood vaccines cause autism? This scientific question has now become a legal one — perhaps inevitable in our society. Some families with autistic children are pursuing legal channels in an effort to prove that vaccines are responsible for their children’s condition. Most of them allege that the cause is the mercury-containing preservative thimerosal, which was formerly used in many vaccines in the United States and elsewhere. Others ar-

gue that the culprit is the measles, mumps, and rubella (MMR) vaccine itself or perhaps the vaccine in combination with thimerosal.

Although most experts have concluded that there is no proof of a causal tie between autism and thimerosal or the MMR vaccine, some doctors and scientists, some groups representing families with autistic children, and many parents fervently believe there is a connection. Claimants not only want to prove that the

federal government, the Institute of Medicine, vaccine makers, and mainstream science are wrong; they also want money. A child with autism is likely to require extraordinarily expensive services — and to have very limited employment prospects in adulthood. Besides, many parents of autistic children may feel better psychologically if they can blame profit-seeking drug companies for their children’s problems.

More than 5000 such families