Code Blue in The NICU

Joseph B. Philips, III, MD

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The moonlighter had just returned with our dinners when the code alarm sounded. Almost simultaneously, our pagers went off "Code infant 3312." We all knew who it was. The 23-week gestation, two-day-old baby had coded earlier in the afternoon and had been doing poorly since. Oxygen saturations were in the low 80s despite maximal support, and blood pressures were marginal on dopamine, dobutamine, and epinephrine drips. Upon entering the room, we found the infant with saturations in the 40s and a heart rate in the 50s. We quickly assumed our positions around the warmer. The resident began chest compressions, the respiratory therapist handbagged, the fellow at the head of the bed assessed the airway and ordered fluid pushes and medications, the bedside nurse administered the medications, and I, the attending physician, oversaw it all. The nursing staff also rapidly began their roles, one opening the crash cart and drawing up drugs, another charting, and multiple others observing and ready to assist if needed.

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We quickly fell into our all-too-familiar routine, counting "one, two, three" for chest compressions, followed by "breath." Over and over again. "Ten mils normal saline," said the fellow, followed by "epi, point 0 five" every five minutes. The intern took over the chest compressions after about 10 minutes, but the cadence remained the same. Blood was bubbling up the endotracheal tube, indicating the presence of a pulmonary hemorrhage. A nurse was dispatched to retrieve emergency-release blood from the blood bank. The saturation and heart rate were steadily falling.

The mother was literally rolling on the floor, wailing, "Save my baby! Save my baby!" over and over again.

Despite several rounds of fluids and epinephrine plus a push of the blood, the baby continued to deteriorate. I knelt beside the mother, put my hand on her shoulder, and asked her to listen. She immediately stopped her wailing and looked me in the eye. I told her that her baby was dying, that we were going to stop CPR as it was not working, and that her baby's brain had been irreversibly damaged. She nodded in agreement.

"Stop," I said. The scene instantly shifted from the hustle and bustle of a code to a stony silence pierced only by the sobs of the mother whom the nurses had assisted into a recliner chair. The monitor was turned off, the ventilator and lines were disconnected, syringes and other debris were removed from the bed, and the baby was wrapped in a blanket and placed in mom's arms. The nurses began their familiar postmortem care routine. The fellow auscultated the baby's chest and confirmed the death.

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We returned to the workroom and ate Chinese takeout. I had cashew shrimp. I conducted a debrief during our meal, asking everyone how they felt. The intern was visibly shaken, with a tear trickling down her cheek. It was July, and this was the first death of a patient in her charge since she had become a real doctor. "His life slipped through my hands when you told me to stop," she said. One of the upper-level female residents hugged her as she sobbed for a while before regaining her composure and resumed picking at her food.

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Few outside our world would understand a situation like this. We were eating while a baby had just died and a mother was grieving. For her, life had just changed forever. For us, we had to nourish ourselves to have the strength to continue caring for the living. Nothing taught in medical school can prepare one for these moments. They must be experienced first-hand, processed, and reflected upon. Doing so is what gives us the strength to move forward.

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