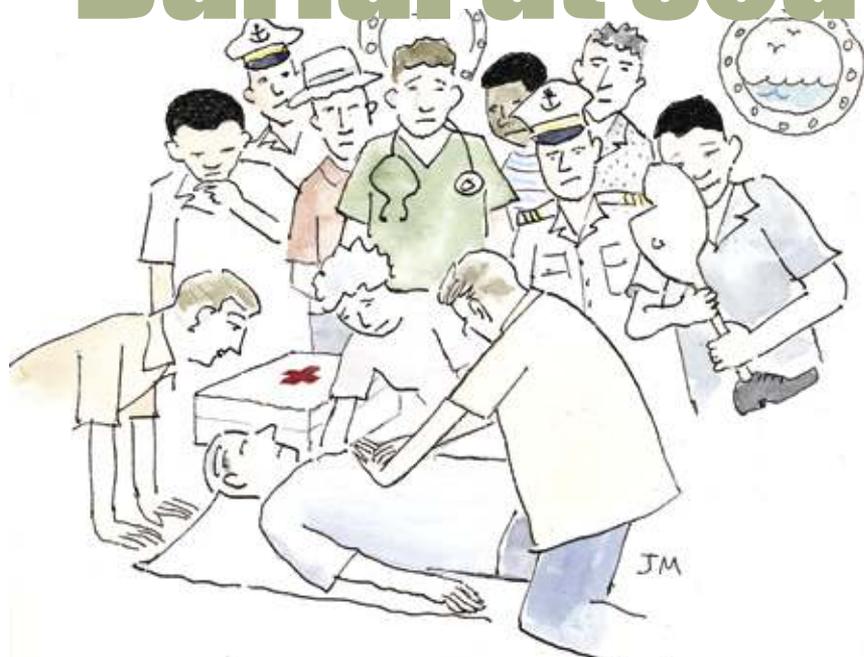


Burial at sea



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Our cruise ship was ten minutes out of port, and my daughter, my niece, and I were in the lounge playing bingo. My sister-in-law, a nurse, approached suddenly. She appeared tense. “Karen needs you right away. The man in the cabin next to yours is having a heart attack and he looks really bad.”

My thoughts raced as I hustled up the decks and forward, wondering what medical equipment or personnel would be available for an emergency. I entered my neighbor’s cabin and saw that there was no shortage of people or equipment and that attempts at CPR were in progress. Unfortunately, the scene was a case of “how many things are wrong with this picture?” A woman was performing what could best be described as mattress compressions. The patient lay in his soft bed, without a backboard. Each downward thrust of CPR was pushing his chest into the

mattress, but I didn’t see the sternum descending into his thorax. Our steward, in white uniform, was at the head of the bed using a bag and mask device, but he had failed to establish a seal. He was fanning the victim’s face and oxygenating the room, but not supplying much air to the man’s lungs. A defibrillator and a medicine cart stood in the corner. Several other people were watching silently.

I introduced myself as a doctor and started giving instructions. We immediately put the man on the floor, and I reminded the steward to hold the mask tightly over the nose and mouth while squeezing the bag. As I opened the man’s shirt, I asked for the EKG paddles. Sure enough, he was in ventricular fibrillation. A second woman said she was the ship’s nurse, charged the defibrillator, and applied gel to the paddles. With the second discharge the victim converted to sinus rhythm but remained pulseless. We resumed CPR. I commented that the pulse was strong with each compression and the woman working on the chest appeared relieved and proud. My wife Karen, a pediatrician, entered and told us she had spoken with the patient’s wife. The report: a diabetic, high blood pressure,

prior mild stroke, intermittent heart failure, peripheral vascular disease. He had been shaving before dinner when he clutched his chest and slumped to the ground.

I asked a staff member to call the captain to tell him to head back to port. We needed to get the patient to the hospital urgently.

No veins were evident. As a nephrologist I have inserted many femoral dialysis catheters, and it was now gratifying to place a line quickly in the right groin. Epinephrine was given. We administered saline as fast as we could, in the hope of overcoming the patient’s electromechanical dissociation. The staffer told me that we couldn’t go back to port because no tugs were available for an unscheduled arrival. I asked that efforts be made to mobilize a helicopter.

The patient’s rhythm reverted to ventricular fibrillation and failed to respond to defibrillation. I said that I would intubate, and a thin, bearded man in blue scrub attire who had been watching the action now stepped forward and said he was the ship’s doctor—a moonlighting ER physician. He smoothly placed the endotracheal tube and I heard good breath sounds bilaterally.

Nephrologists have to assess patient weights (and fluid status) regularly, and we like to think that we’re as good as carnival barkers at this task. I pegged the patient at 85 kg and we administered lidocaine and bretyllium* at the appropriate doses between shocks. I had the nurse raise the patient’s IV-free left leg in an attempt to attain a partial Trendelenberg position and then realized that I had overestimated his weight, because his leg fell off. Prosthesis.

The ship’s captain made a brief appearance. He said it would take time and great expense to get a helicopter to the boat and asked if the patient would survive. He quietly stated that he would

* At the time of this event, bretyllium was still part of the ACLS routine for treating ventricular fibrillation.

start making some calls and left.

We continued to work. It was humid and everyone was sweating. We used the various drugs and maneuvers in the ACLS algorithms, but ultimately the rhythm was asystole, we had no pacing equipment, and the effort had gone on for forty minutes. We agreed to give up. The ship's doctor slipped away without talking to the patient's wife.

Karen and I finally plodded down to the dining room. She was more drained than I was, since pediatric patients rarely suffer such cardiac catastrophes.

No one from the ship had thanked us for our efforts and now the waiters chided us for being late and upsetting the seating schedule. I recalled the prophetic words of a medical school professor, who had advised the students that if it was gratitude we desired, we should buy puppies rather than go into medicine.

The next morning our cabin steward told us it was common for elderly passengers to die in transit and he had never seen such a concerted rescue effort. They routinely stored the corpse

in the freezer until reaching the next port. Karen and I became aware of what should have been obvious earlier. Neither the ship's doctor, nor the captain, nor the cruise line want heroic interventions. It is more cost-effective to let people die. We had witnessed a perversely extreme managed care philosophy. Burial at sea, indeed.

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A fragile web of understanding

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Our ultimate salvation lies in that fragile web of understanding that one human being has of the sufferings of another.

—attributed to John Dos Passos

We've got a consult at the VA." The endocrine fellow paged me at the end of a long afternoon in clinic.

"Type 2 diabetes. Five days post-op after a triple-vessel CABG. His name's Theodore Peters."

I sighed with fatigue and met the fellow in the surgical ICU thirty minutes later. When I arrived, the fellow was waiting for me at the door of the unit.

"Everyone says that he's really difficult," she said.

"What do you mean?"

"They say he's pretty hostile and refuses to take his insulin."

"Well, is he?"

"I don't know. He seemed okay to me. At any rate, his pre-op A1c was 6.5%."

I was relieved that the patient's pre-operative glycemic control was so tight and hoped that we'd be able to keep it that way during his recovery. I was hoping the visit wouldn't take long.

As we entered the room, I saw an African American man in his early sixties lying in bed. His hair was close-cropped and gray, and he had that drawn and haggard appearance that goes with being in the ICU. With the sheet pulled up to his

chin, he eyed us warily. Suspicion and hostility radiated from him, filling the room.

I introduced myself.

"What do you want?" he asked. "Like I told them, I don't want to be told what to do."

"Actually," I said, "I'm not here to tell you what to do. I was hoping you could tell me what works for you and your diabetes."

Distrust still hung in the air like a fog.

Feeling awkward and wanting to establish a connection—any connection—to break through the tension, I asked him, "So what branch in the service did you serve in?"

"The army," he answered.

From his age, I took a guess: "Did you serve in Vietnam?"

"Yeah, I was there . . . for a year . . . a very long year."

I continued to fumble: "If it's worth anything, I respect your sacrifice."

"Yeah, well," he answered, "it wasn't voluntary. It was over a pork chop."

A pork chop?

"What do you mean?"

"I was drafted over a pork chop," he answered, matter-of-factly.

"I grew up in a little town in Missouri back in the fifties and early sixties. One night, my momma asked me to go down to the corner to buy pork chops for dinner. Well, in the butcher shop they had these thick, juicy, pink pork chops. A whole stack of 'em. And right next to them, there was a stack of grey, spoiled meat. Since the price was the same, I asked for the thick, pink, juicy pork chops.

"Well, the lady behind the counter—a big ol' white woman