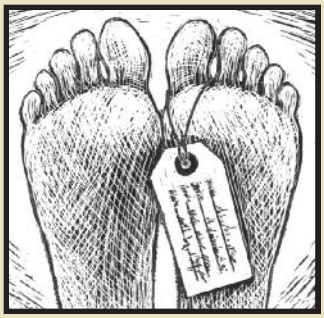
Code team

By Michael S. Smith, M.D.



SUZANNE DEJOHN

The last thing I wanted to do that Friday evening was perform a spinal tap in the MICU, the medical intensive care unit. I'd had a long, difficult day in the office and was tired from having been on call the previous night. I also knew the patient who needed the spinal tap and knew that, regardless of the results of the test, her outcome was unlikely to be good. So I wasn't the least bit eager to do the procedure—it's delicate to perform and can be painful for the patient. But my rule was to proceed if I ever argued with myself about a procedure's necessity.

This evening, I was to learn a new skill that had nothing to do with either performing a spinal tap or discussing death.

Walking from my office to the hospital, I looked at the long shadows in the canyons of the Santa Catalina Mountains, at the waxing gibbous moon in the southeast sky. It would be a nice night—for somebody, but not for either me or the patient I was about to see.

Work: I thought of the MICU as a place with "so much work and so little hope." In most of the intensive care units, the nurses mirrored their jobs. In the SICU, with its surgical patients, many of the nurses were men and all of them had an aggressive, "let's do it" attitude, reflecting that of the surgeons. The nurses who cared for the cardiac patients in the CICU were mostly women and superb at understanding electrocardiograms, cardiac physiology, and pharmacology.

The nurses in the MICU were different; a tight-knit group, they quietly melded competence, toughness, compassion, and support. There was little hope of a cure for most of their patients, who were often end-stage transfers from the other two units. I had learned a lot from the MICU staff. They'd refined and honed my skills at dealing with catastrophic nervous system failure. They'd taught me how to handle complicated patients and their families. Together, too often, we helped patients transition out of life when it was their time.

But this evening, I was to learn a new skill that had nothing to do with either performing a spinal tap or discussing death.

Hand: Pat, one of the unit's nurses, was waiting for me as I walked into the patient's room with the spinal tap tray. I was immediately assailed by the all-too-familiar smell of incontinent stool. Pat smiled and motioned me to come closer, saying, "Give me a hand."

What the hell, I thought, *this day can't get any worse*.

I liked all the MICU staff, but Pat and I had a special bond; we both opened our homes to a remarkable number of stray animals—dogs for her, cats for me. Pat was smart, had a dry sense of humor, and was well respected. Now, she asked me to pull the heavyset, 70-year-old woman toward me. I did so, holding my breath as the source of the stench was uncovered. "Phew," I said, nearly gagging. "How do you do this?"

"It's part of the job," Pat replied, gently cleaning the patient's perineal and perianal areas. I noticed how kind Pat was with the patient. There were no jokes, and Pat constantly spoke to the woman, even though she was unconscious. I realized that I often conversed about and dealt with patients in the third person, whereas Pat used the second person.

As Pat continued cleaning, she rolled the soiled sheet under the patient, folded a new sheet and bedpad together, then asked me to roll the patient back toward her onto the clean sheet. I realized that I was supposed to pull the soiled sheets toward me, which I did.

"Good job, Mike," Pat said. "Now put those sheets in the soiled-linen holder behind you." I complied, as she finished cleaning the other side of the bed.

"You want me to tuck this in?" I asked, pulling the new sheet toward me. Pat muttered something that sounded like "Didn't your mother teach you how to make a bed?" I took that to mean "Yes."

With the patient clean and properly positioned, the spinal tap went smoothly, and the fluid I withdrew appeared normal. While Pat watched, I cleaned up the procedure tray, using a method where I put the tray, minus all the "sharps," or needles, back into the box—an efficient, quick way to finish up. As I left, Pat said, "Good job. Let's do it again sometime." I laughed.

Words: I don't remember what happened to that patient, but I did remember Pat's words. Thereafter, if I was in the room when a patient was incontinent, I often helped. Sometimes, I even did it myself. I wasn't as skilled as the nurses, but I never heard any complaints about my work, either. I would make my notations in the patient's chart, then quietly leave the room.

After one cleaning-up, as I walked away down the hall, a nurse passed me, mentioning that she was going to change the patient I had just been working on. I stopped and turned around to see what would happen. A minute later, the nurse left the room with a puzzled, "what in the world . . ." look. It was priceless.

I often felt that I spent much of each day doing little for my patients. Far too often, I encountered conditions, common and uncommon, for which a treatment was nonexistent or poor. But if my hospitalized patient was incontinent—ah, now that was something I could fix, if I had time. I found it relaxing to do what Pat had taught me. I was less hurried, gentler. I started talking to patients who didn't know what I was saying. More than once, I was the first person to spot a bedsore. I saw scores of patients whose congestive heart failure was evident only from the pitting edema on their backs.

Years later, on the eve of an extended leave of absence, the MICU staff presented me with a brown T-shirt. On the front, in white lettering, were the words "Official Code Brown Team." On the back, it said "MICU." It's one of the best presents I've ever received. ■

The Point of View essay provides personal insight or opinion on some issue in medicine or science. Smith, a Dartmouth College '70 and a retired neurologist, lives in Tucson.