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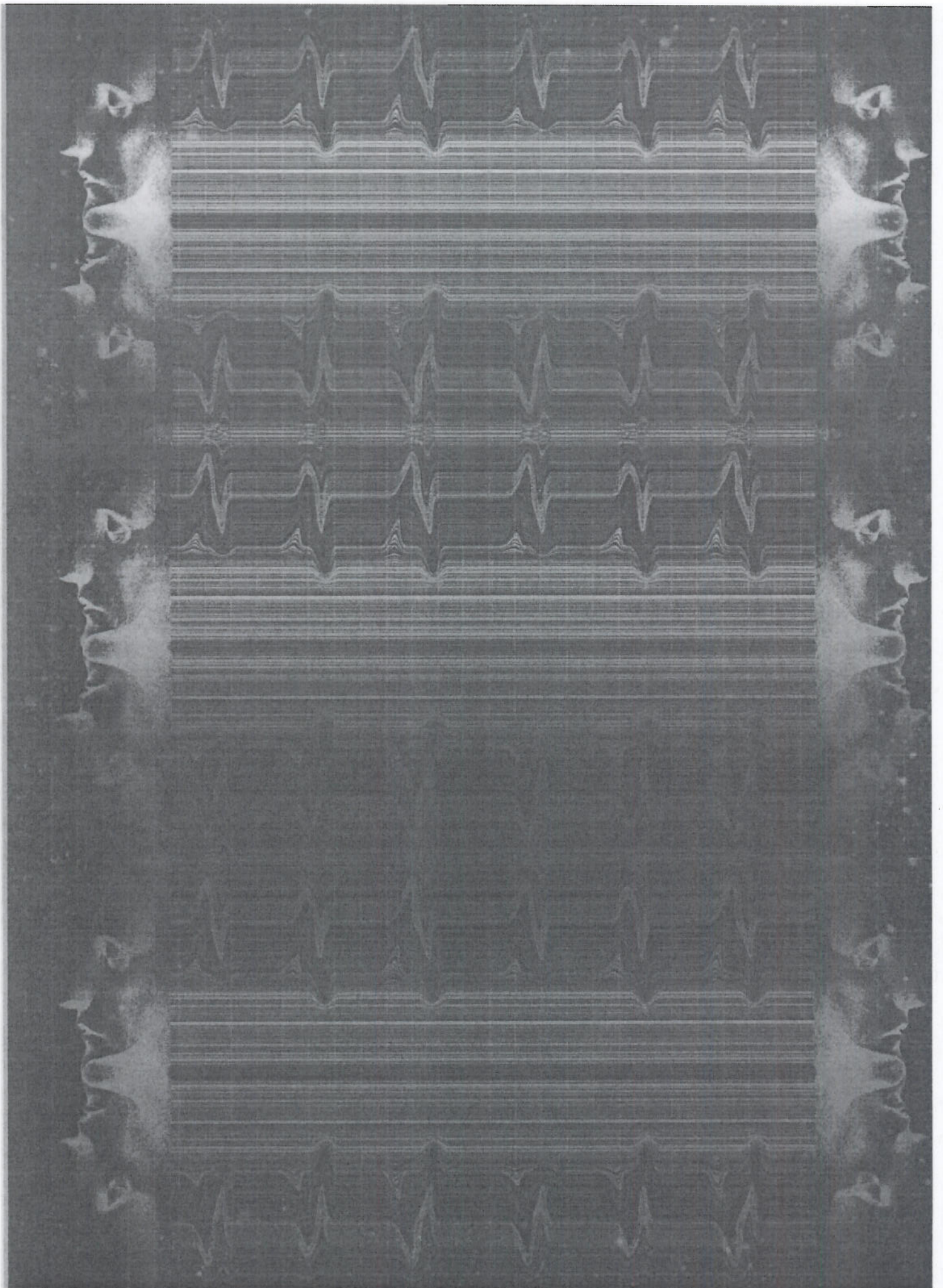
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THE PERFECT  
CODE

*Terrence Holt*

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A faint click opens the air. A disembodied voice calls out: 'Adult Code 100, Adult Code 100, 5 East. Adult Code 100, 5 East.' Or it might be 'Code Blue, Code Blue 3C, Code Blue 3C.' From place to place the wording varies, but the message is always the same: somewhere in the hospital, someone is dying.

Hearts stop. Vital signs droop. Whatever the nature of the emergency, the response is the same: from all over the hospital the code team comes running, and the attempt at resuscitation begins.

I'm not sure, still, just what I learned running to so many codes, but the experience haunts me, long after the fact. As if somewhere in the tangle of tubes and wires, knotted sheets, Betadyne and blood, I lost track of something important. Listen.

In the hospital where I work, codes go something like this. A nurse finds a patient slumped over in bed. The nurse calls her name. No answer. The nurse shakes the inert body. No answer. Harder. Still no answer. The nurse steps to the door and calls, in tones that rise at each syllable, 'I need some help here.' The rest of the available nurses on the floor converge. Within a minute, every bystander within hearing is gathered at the door.

In the basement of the hospital, an operator listens intently to her headset. She flips a switch, and a faint click opens the hospital to the microphone on her console. 'Adult Code 100, 6 South. Adult Code 100, 6 South.' The message goes out on the hospital PA system, her disembodied voice filling the hallways. It also goes out to a system of antique voice pagers, from which the operator's measured words emerge as inarticulate squealing. The pagers are largely backup, in

case some member of the team is, say, in the bathroom, or otherwise out of reach of the PA system.

The team consists of eight or nine people: respiratory techs, anaesthesiologists, pharmacists, and the residents on call for the Cardiac ICU. On hearing the summons, the residents drop whatever they are doing and sprint. In their voluminous white coats, from whose pockets fall stethoscopes, penlights, reflex hammers, EKG calipers, tuning forks, ballpoint pens (these clatter across the floors to be scooped up by the medical students who follow behind), the medical team's passing is a curious combination of high drama and burlesque.

The team arrives on a scene of Bedlam. The room is so crowded with nurses, CNAs, janitors and miscellaneous onlookers that it can be physically impossible to enter. Shouldering your way through the mob at the door, you are stopped by a crowd around the bed; the crash cart, a rolling red metal Sears Roebuck tool chest, is also in the way, its open drawers a menace to knees and elbows. There are wires draped from the crash cart and tubing everywhere.

At the centre of all this lies the patient, the only one in the room who isn't shouting. The patient doesn't move at all. This time it is an elderly woman, frail to the point of wasting; her ribs arch above her hollow belly. Her eyes are half open, her jaw is slack, pink tongue protruding slightly. Her gown and the bedding are tangled in a mass at the foot of the bed; at a glance you take in the old mastectomy scar, the scaphoid abdomen, the grey tuft between her legs. At the head of the bed, a nurse is pressing a mask over the patient's face, squeezing oxygen through a large bag; the woman's cheeks puff out with each squeeze, which isn't right. Another nurse is compressing the chest, not hard enough. You shoulder her aside and press two fingers under the angle of the jaw. Nothing. A quick listen at her chest: only the hubbub in the room, dulled by silent flesh. Pile the heels of both hands over her breastbone and start to push: the bed rolls away. Falling half onto the patient, you holler above the commotion, 'Somebody please lock the bed.' Alternate this with 'Does anyone have the chart?'

A nurse near the door hoists a thick brown binder, passing it over the heads jamming the room. 'Code status,' you bawl out. 'Full code,' the nurse bawls back. You reposition your hands and push down on her breastbone. 'Why's she here?' There is a palpable crunch as her ribs separate from her sternum. 'Metastatic breast cancer,' the nurse calls, flipping pages in the chart. 'Admitted for pain control.' You lighten up the pressure and continue to push, rhythmically, fast. You look around, trying to pick out from the mass of excited bystanders the people who belong. The noise is immense. On the opposite side of the bed you see one of the respiratory techs has arrived. 'Airway,' you shout, and the tech nods: she has already seen the puffing cheeks. She takes the mask and bag from the nurse and adjusts the patient's neck. The patient's chest starts to rise and fall beneath your hands.

'What's she getting for pain?'

'Morphine PCA.'

'What rate?'

The question sets off a flurry of activity among some nurses, one of whom stoops to examine the IV pump at the patient's bedside. 'Two per hour, one q fifteen on the lockout.'

'Narcan,' you order.

By this time, the pharmacist has arrived, which is fortunate because you can't remember the dose of opiate blocker. You doubt this is overdose here, but it's the first thing to try. Out of the corner of your eye you see the pharmacist load a clear ampoule into a syringe and pass it to a nurse.

Meanwhile on your left, the other resident and the intern are plunging large needles into both groins, probing for the femoral vein. The intern strikes blood first, removes the syringe, throws it onto the sheets. 'Send that off for labs,' you shout. Blood dribbles from the needle's hub as the intern threads a long, coiled wire through it into the vein. The other resident stops jabbing and watches the intern's progress. With a free hand she feels for the femoral pulse, but the bed is bouncing. You stop compressing. The resident focuses, shakes her head. Start compressing again.

A nurse reaches around you on the right, trying to fit a pair of metallic adhesive pads onto the patient's chest. You shake your head. 'Paddles,' you shout. 'Get me the paddles.' Then, into the general roar, 'Somebody take that syringe and send it off for labs.' A hand grabs the syringe and whisks it off. 'You!' you shout at the med student, who is hanging by the resident's elbow. 'Get a gas!' The resident throws a package from the crash cart, then steps back to give the student access to the patient's groin. The student fits the needle to the blood-gas syringe, feels for the pulse your compressions are making in the groin and stabs it home: blood, dark purple, fills the barrel. The student looks worried; he may have missed the artery.

The nurse at your elbow is still there, holding the defibrillator paddles. She stands as though she has been holding these out to you for some time. Clap the paddles on the patient's chest. Over your shoulder on the tiny screen of the defibrillator a wavy line of green light scrawls horizontally onward. You look back at the other resident. 'Anything?' You both say at once, and both of you shake heads. The intern has finished with the femoral catheter. He holds up one of the access ports. 'Amp of epi,' you say, but there's no response. Louder: 'I need an amp of epi.' Finally someone shoves a big blunt-nosed syringe into your hand. Without stopping to verify that it's what you asked for, you lean over and fit it to the port and push the plunger. Another look at the screen. Still nothing. 'Atropine,' you call out, and this time a nurse has it ready. 'Push it,' you say, and she does. Stop compressions, check the screen.

Suddenly the wavery tracing leaps into life, a jagged irregular line, teeth of a painful saw. 'V fib,' the other resident calls out, annoying you for a moment. You clamp the paddles down on the patient's ribs. 'Everyone clear?' Everyone has moved back two feet from the bed. You check your own legs, arch your back. 'Clear?' You push the button. The patient spasms, then lies limp again. The pattern on the screen is unchanged. The other resident shakes her head. You call over your shoulder, 'Three hundred,' and shock again. The body twitches again. An unpleasant smell rises from the bed.

The pattern on the screen subsides, back to the long lazy wave. Still no pulse. You start compressing again. 'Epi,' you call out. 'Atropine.' There is another flutter of activity on the screen, but before you can shock, it goes flat again, almost flat, perhaps there is a suggestion of a ragged rhythm there, fine sawteeth. 'Clear,' you call again, and everybody draws back. 'Three sixty,' you remember to say over your shoulder, and when the answering call comes back you shock again, knowing this is futile. But the patient is dead and there is no harm in trying. As the body slumps again, there is a palpable slackening of the noise level in the room, and even though you go on another ten minutes, pushing on the chest until your shoulders are burning and your breath is short, and a total of ten milligrams of epinephrine has gone in, there is nothing on the monitor that looks remotely shockable.

Finally, you straighten up and find the clock on the wall. 'I'm calling it,' you say. Against the wall, a nurse with a clipboard makes a note. 'Time?' she says. You tell her.

There is more. Picking up, writing notes, a phone call or two. There is a family member in the hallway, sitting stricken on a bench beside a nurse or volunteer holding a hand. You need to speak to her, but before you do you have to find out the patient's name. And then you go back to whatever you were doing before the code went out over the PA.

There is a great deal of mess in hospital medicine, literal and figurative, and the code bunches it all into a dense mass that on some days seems to represent everything wrong with the world. The haste, the turmoil, the anonymity, the smell, the futility: all of it brought to bear on a single body, as if to point to a moral that I would understand better if only I had time to stop and contemplate it. Which I don't. Not today. We're admitting and there are three patients, two on the floor and one down in the ER, waiting to be seen. There is no time to read the fine print on anything, least of all the mortal contract just executed on the anonymous woman lying back in the room.



I can barely make out the large block letters at the top: our patients die. And very often they do so in the middle of a scene with all the dignity of a cafeteria food fight. We can't cure everybody, but I think most of us treasure as a small consolation that at least we can afford people some kind of dignity at the end, something quiet and solemn in which whatever meaning resides in all of this may be – if we watch and listen carefully – perceptible.

Which may be why one particular code persists in my memory, long after the event.

John Mongay was the name I got from the medicine admitting officer. I wasn't sure what to make of the MAO's story, but I knew I didn't like it.

The story was a 72-year-old guy with a broken neck. He had apparently fallen in his driveway while picking up his newspaper that morning, cracking his first and second vertebrae. I had a vague memory from medical school that this wasn't a good thing – the expression 'hangman's fracture' kept bobbing up from the well of facts I do not use – but I had a much more distinct impression that this was not a case for cardiology.

'And ortho isn't taking him because?' I said wearily.

'Because he's got internal organs, dude.'

I sighed. 'So why me?'

'Because they got an EKG.'

The MAO was clearly enjoying himself. I remembered he had recently been accepted to a cardiology fellowship. I braced myself for the punchline.

'And?'

'And there's ectopy on it. *Ectopy*.' He then made a noise intended to suggest a ghost haunting something.

Ectopy, meaning literally 'out of place', refers to a heartbeat generated anywhere in the heart but the little knob in the upper right-hand corner where heartbeats are supposed to start. Such beats appear with an unusual shape and timing on the EKG. They can be

caused by any number of things, from too much caffeine to fatigue to an impending heart attack, but in the absence of other warning signs, ectopy is not something we generally get excited about. And it sounded to me as though a man with a broken neck had enough reasons for ectopy without sending him to the Cardiology service.

‘So?’ I said.

‘So he’s also got a history. Angioplasty about ten years ago, no definite history of MI. You can’t really read his EKG because he’s got a left bundle, no old strips so I don’t know if it’s new.’

We were down to business.

‘So I rule him out.’

‘You rule him out. Ortho says they’ll follow with you.’

‘Lovely. And once I rule him out?’

‘Ortho says they’ll follow with you.’

I said something unpleasant. The MAO understood. ‘Sucks, I know, but there you are.’

And there I was, down in the ER on a Sunday afternoon, turning over the stack of papers that John Mongay had generated over his six hours in the ED. There was a sheaf of EKGs covered with bizarre ectopic beats, through which occasionally emerged a stretch of normal sinus rhythm, enough to see that there was, indeed, a left bundle branch block, and not much else. The heart has several bundles, cables in its internal wiring. When some disease process disrupts a bundle, the result is an EKG too distorted to answer the question we usually ask it: Is this patient having a heart attack? Of course, the bundle itself is not a reassuring sign and, if new, it merits an investigation, but plenty of people in their seventies have them and it’s pretty much a so what. But the ectopy on today’s strips was impressive – if you didn’t know what you were looking at you might think he was suffering some catastrophic event. I read between the lines of the consult note the orthopaedic surgeons had left, and it was clear they regarded John Mongay as a time bomb and didn’t want him on their service.

Which I couldn’t help noting was exactly how I felt about having a patient with a broken neck on my service. But I didn’t get to make

decisions like that. Instead I wadded the stack of papers back into their cubby and took a brief glance through the curtains of Bay 12. From my somewhat distorted perspective, most of what I saw of the patient was his feet, which were large, bare and protruding from the lower end of his ER blankets in a way that suggested he would be tall if I could stand him up. At his side sat a small, iron-haired woman who at that moment was speaking to him, leaning in close. She wore a faint, affectionate smile on a face that looked otherwise tired. I watched her for a moment, her profile held precisely perpendicular to my line of sight as though posed. For a moment her face took on an almost luminous clarity, a study in patience, in care – and then it wavered, receding into a small, tired woman with grey hair beside a gurney in Bay 12. The patient's face was obscured by the pink plastic horse collar that immobilized his neck. I watched the woman for a minute. Her expression, the calm progress of their conversation, suggested that nothing too drastic was going on. I took a walk to the radiology reading room to get a look at the neck films.

There were many of these, too. They showed the vulture neck silhouette all C-spine films share. There were several unusual views, including one that I decided must have been shot straight down the patient's open mouth: it showed, framed by teeth palisaded with spiky metal, the pale ring of the first vertebra, the massive bone called the atlas, and clear (even to me) on both sides of it were two jagged dark lines angling in on the empty centre where the spinal cord had failed to register on film. The break in the second vertebra was harder to make out, but I took the surgeons at their word: *C1/2 fx: cont immob pending halo. Will follow.*

I was not in the best of moods as I made my way back to the ER, I grabbed a clipboard and parted the curtains to Bay 12. Still, I managed an adequate smile as I introduced myself. 'John Mongay?' I said tentatively.

The woman at his shoulder blinked up at me, wearing that same weary smile, brushing a lock of hair from her face.

'It's "Mon-zhay",' she said, with an odd combination of self-deprecation and something else – perhaps it was warmth? – that made me like her. 'It's French,' she explained. She welcomed me into Bay 12, which I had been inside more times than I cared to count, with a curious air of apology, as if concerned about the quality of her housekeeping. I was charmed. This was still relatively early in the day and I was capable of being charmed. I shook myself a little, and straightened my back (her posture was perfect).

Her husband made a less distinct impression. The cervical stabilization collar has a dampening effect on most people, as would the eight milligrams of morphine he'd absorbed over the past six hours, so it was a bleary and not very articulate history I got from him. His wife filled in the relevant bits. No prior MI. Occasional chest pain, hard to pin down. Otherwise a generally healthy, alert and active man. On the one really critical point – what had caused the fall – Mr Mongay insisted on giving account. He had *not* fainted. He had not been dizzy or breathless or experienced palpitations or anything of that sort. He had tripped. He had caught his toes on the uneven edge left by the damned contractor who'd resurfaced the driveway two years previously, and gone down like a stupid ox. As he said the last he shook his head vehemently within the confines of his collar, and I caught my breath: you're not supposed to do that with a broken neck.

Even so I was partially reassured. The history didn't suggest a cardiac cause to his fall, and he denied any of the other symptoms that go along with impending doom. The physical exam was similarly reassuring, although hampered by the cervical collar and my dread of doing anything that might disturb his neck. He was a tall, bony man, with a nasty-looking cut across the scalp above his right eye and dried blood crusted in his bushy eyebrows. The cut had been sutured already, and the blood made it look much worse than it was. Aside from the cut and a large bruise on his right ribs (none broken), he seemed fine. Except for the neck, of course. I stayed another few minutes, making idle chat with the wife, who promised me that her

son and one of her three daughters would be coming back soon, and then excused myself to write my orders.

**H**e ruled out with the 4 a.m. blood draw the next morning, which I announced on rounds a few hours later with less pleasure than I would have ordinarily. I knew what was coming.

'So now what?' the attending asked.

'I guess I call ortho.'

Everybody – from attending to fellow to the other resident on the team and the intern, even the two medical students – started to smile.

'Well, I can call them, can't I?'

'Go ahead,' the attending said.

I made the call, and after three or four hours the ortho resident returned the page. I knew by that time that I was already defeated, but I went ahead and asked the obligatory question, and received the inevitable answer (the ortho resident having anticipated as well) that the ortho attending did not feel comfortable taking the case, '... and besides, it's not that bad a break. We'll follow.'

'How long?' I asked.

'What do you mean?'

'How long does he need to be in the hospital?'

Puzzled. 'When will you be done with him?'

'We've been done since eight this morning.'

'You mean you'd send him home?'

'Except for the neck thing, yeah.'

'Oh.' This he hadn't anticipated.

'So what does he need from you?'

'He needs a halo.'

A halo is one of those excruciating-looking devices you may have seen somebody wearing: a ring of shiny metal that encircles the head (hence the name), supported by a cage that rests on a harness braced on the shoulders. Four large bolts run through the halo and into the patient's skull, gripping the head rigidly in place like a Christmas tree in its stand. A little crust of blood where the bolts penetrate the skin

completes the picture. They look terrible, but patients tell me that after the first day or so they don't really hurt. Getting one put on, however: that hurts.

'So when does he get it?' I asked. Again, I knew the answer. It was already past noon. I was pretty sure it was Monday.

'Well,' the ortho resident replied, 'it's already past noon.'

'And you're in surgery.'

'Yeah.'

'And tomorrow?'

'Clinic. All day clinic.'

I didn't say anything. I waited a long time, biting my tongue.

'I guess we could do it tonight,' he said.

'That'd be nice.'

'Unless there's an emergency, of course.'

'Of course.'

And of course there was. And clinic ran overtime the next day, or so I was told. Their notes on the chart (they came by each morning at 5.45) ran to five scribbled lines, ending each time with 'Plan halo. Will follow,' and a signature and pager number I couldn't quite decipher. This left me holding the bag. Not only had I one more patient crowding my census, one more patient to see in the morning, round on and write notes about (this during the month our team set the record for admissions to cardiology), but I also had the unpleasant responsibility of walking into Mr Mongay's room on Tuesday and Wednesday morning to find him unhaloed, and making apologies for it.

It would have been unpleasant, at least, but for Mrs Mongay and her children. There were four in all. The son, John Jr, was a very pleasant fellow in his late thirties, intelligent, well educated, unusually sophisticated about medical matters. The three daughters were hard to tell apart – I never did learn their names – but they accepted my apologies with a sympathetic understanding. Like their mother, with their quiet grace and gentle good humour they put me in mind of faces I'd seen in old oil paintings, glowing against a warm chiaroscuro. All of which only made the situation even more intolerable, driving

me to want to *do* something for them – and the only thing I had to offer lay in the gift of the inaccessible ortho resident.

Wednesday I was on call again and had pledged myself, in the brief moments between admissions, to track down the ortho team and make them come up and put that halo on. Unfortunately, this was the day we admitted fifteen patients, as the failure clinic opened its floodgates and the Cath Lab pumped out case after case. The sheer volume of histories to take, physicals to perform, notes and orders to compose was overwhelming. The phone call – with its necessary sequel of waiting for the paged resident to call back – never happened.

Sometime in the late afternoon, however, I looked up from the counter where I had been leaning, trying to absorb the salient features of yet another failure patient's complex history, and saw through the open door of Mr Mongay's room a strange tableau: two tall men in green scrubs wielding socket wrenches around the patient's head, a tangle of chrome, and the patient's hands quivering in the air, fingers spread as if calling on the seas to part. Sometime later I looked up again and the green scrubs were gone. Mr Mongay lay propped up in his bed, his head in a halo. From the side, his nose was a hawk's beak, the rest of his face sunk in drugged sleep, but his mouth still snarled as if it remembered recent pain. He looked like a strange, sad bird in a very small cage.

Still later – time on that service being marked by missed meals and sleep, I can say only that I was hungry, but not yet punchy – a nurse stopped me.

'Fourteen,' she said.

She meant Mr Mongay. 'How's he doing?' I was harbouring some vague hope that he was awake and asking to go home.

'He's complaining of chest pain. Ten out of ten.'

'Crap,' I said. The nurse looked at me. 'Get an EKG.'

My vague hope vanished entirely ten minutes later as I watched the red graph paper emerge from the side of the box. The squiggle on it looked better than the initial set from the ER, but that was only

because the ectopy was gone. What was there instead – Mr Mongay’s souvenir of the activities of the afternoon – were T-wave inversions marching across his precordium. This was not good. T-wave inversions generally signify heart muscle that isn’t getting oxygen. What I was seeing here suggested that his LAD – a major artery supplying blood to the heart’s strongest muscle – was about to choke off. I looked up at the nurse. She had been reading the strip as well, upside down, as cardiology nurses can.

‘You gonna move him?’ she asked.

‘Yeah.’

‘Write me some orders.’

‘I’ll write you orders. Just get him to the Unit. Quickly,’ I added, with a backward glance through the door of 14.

I didn’t give Mongay much thought the rest of the evening, beyond getting him scheduled as an add-on for the Cath Lab the next day. Around two in the morning the three of us – my partner Sasha, the intern Jeff and I – were gathered at one end of the long counter, pushing stacks of paper around and trying to count up the score. We were on admission twelve for the day, we decided, but couldn’t remember who was up next. I was digging in my pockets for a coin to flip when my pager went off. I swore as I tugged it from my belt, expecting to find yet again the number for the ER. I found instead the number for the CCU, followed by ‘911’. At that moment the overhead paging system called a code in the CCU. The three of us ran.

It was perhaps thirty yards to the CCU, but by the time we got there three of the six nurses on shift were in Mongay’s room, one at the head squeezing oxygen through a bag-valve mask, another compressing his chest, a third readying the crash cart. I had a moment’s awareness that something was unusual – the whole thing looked too emptily staged, some kind of diorama in the Museum of Human Misery, but the scene only appeared that way for an instant and then we were in it and perspective fell apart in a surge of activity.



Sasha and I had never made any formal arrangement about who did what in a code. I was the first one on the far side of the bed and started feeling the groin for a pulse. It was faint, driven solely by the nurse's compressions, but clear enough. I grabbed a finder syringe from the tray a nurse held out to me and plunged it in. Nothing. Pull back, change angle, feel for the pulse again and drive. The needle ground against bone. On this pass I saw the flash in the syringe, pulled back to confirm, then flung the syringe aside and put a thumb over the hub of the needle while reaching for the wire. The nurse had it out already, handle turned toward me. It threaded the vein without resistance.

I had the catheter in place a minute or two later, met at each step in the process by the right item held out at the right time. No one spoke a word.

On the other side of the bed, Sasha stood with her arms folded across her chest, nodding at two nurses in turn as they pushed meds, placed pads on the chest and warmed up the defibrillator. Her eyes were on the monitor overhead, where green light drew lazy lines across the screen. At some point in the proceedings anaesthesia had shown up and put an endotracheal tube down Mongay's throat; respiratory therapy was wheeling a ventilator to the head of the bed, looping tubing through the bars of the halo and cursing at it.

'Hold compressions,' Sasha said. The nurse stopped pushing on the chest. I saw for the first time that the halo was supported by a broad sheet of plastic backed with sheepskin that covered the upper half of the chest: the nurse had to get her hands underneath it to press; with each compression Mongay's head bobbed up and down, up and down. He was out, his eyes blank at the ceiling. The nurse at my elbow was hooking up the ports of my catheter, pushing one of the blunt syringes of epinephrine. We were all staring at the monitor above the bed, the long horizontal drift of asystole. As the second amp of atropine ran in, the lines all leapt to life, frantic peaks filling the screen.

'V-fib,' a nurse said quietly.

'Paddles,' Sasha replied in the same voice, taking the offered

handgrips of the defibrillator from the nurse as she spoke. 'Clear,' she said quietly, and thumbed the button.

John Mongay's body rose from the mattress, hung for a moment, collapsed. On the screen we saw scrambled green light settle for a moment, a rhythm emerge. Then the peaked lines consolidated into a high picket fence.

'V-tach,' said the nurse, and turned up the power on the defibrillator.

'Clear,' said Sasha. The body arched and fell again.

It went on for twelve more minutes, Mongay's heart flying through one arrhythmia after another. Each time we responded it would settle briefly into sinus rhythm before flinging out again into some lethal variation, until finally, after two grams of magnesium sulphate and another round of shocks, it found a rhythm and held it through another flurry of activity when his systolics dropped to the sixties, then rallied on a minimal infusion of dopamine. And through all of this, as the atmosphere in the room maintained its eerie calm, the nurses kept up their surreal economy of gesture, and Sasha intoned the ritual of the ACLS algorithm, I felt my own adrenalin surging through the night's fatigue in an approach to exultation. It was almost beautiful.

This, I thought as we left the room (the lines on the monitor dancing their steady dance, the ventilator measuring breath and time to its own slower rhythm), this is what a code should be. A clean thing. A beautiful thing. The patient hadn't died.

The rest of the night was anticlimactic. There was a note to write (there is always a note to write), for which we had to puzzle some time over the strips churned out by the telemetry system, the notes scribbled on a paper towel recording what drugs had been given when, the values called over the phone from Core Lab and written in black marker on the leg of a nurse's scrubs. There was the call to the family: I had to temper my enthusiasm as I searched for words to use when calling from the CCU at 2.35 in the morning. It

was the son who answered. He took the news well enough, asked if I thought they needed to come now. I assured him his father was stable. I assured him everything was under control; I had anticipated the code, I realized, when I moved him to the CCU. He was in the safest possible place. 'In the morning then,' the son said quietly.

'In the morning,' I agreed, and turned to the call room at last, where I spent perhaps forty-five minutes on my back, replaying the code against the springs of the empty bunk above me, until my pager went off again and this time it was the ER. And then around five, another code on 4 West, where we found a man bleeding from a ruptured arterial graft and I had to put yet another catheter in yet another groin, and this time there were fourteen nurses in the room, all shouting at once, so that I had to bellow over them to be heard as I requested, repeatedly, the proper catheter kit, something big enough to pour in fluid as fast as he was losing it. The patient was alive when I saw him last, a scared and tousled surgery intern kneeling right on top of him to hold pressure as the entire ungainly assemblage – patient, intern, and tree of IV bags – wheeled out the door to the OR. Back to normal life, I said to Sasha as we trudged back to the cardiology ward. Whether she knew what I was talking about I couldn't say, and didn't really care. I was still warmed by a vague sense of something right having happened. Mr Mongay had coded, coded beautifully, and he had survived. We had done everything right.

The next morning on rounds, we were congratulated for our management of Mr Mongay's arrest, although there was an ominous pH value from a blood gas obtained early on in the event that occasioned some shaking of heads. He had not responded since the code, being content to lie there unconscious in his halo, his chest rising and falling in response to the ventilator's efforts. But his vital signs were stable, his labs from the 4 a.m. draw were looking good, and I had my hopes. No longer for an early discharge, but I was hopeful, all the same.

I shared these hopes with Mrs Mongay and the family when they arrived at seven. She stood at the bedside looking down, and her eyes

were wet, her mouth unstably mobile. She reached out almost to touch the bars supporting the halo, down one of the threaded rods that pierced her husband's skin above the temple, almost touched there, then withdrew her hand. 'Is this the . . . thing? What do they call it?'

I was silent a moment.

'A halo,' I said finally. 'They call it a halo.'

'Ah,' she said.

John Mongay died five days later, having never regained consciousness. As each day passed and he gave no sign of mental activity, eventually it became clear that not all of him had survived the code. The family decided, once pneumonia set in, to withdraw support. Even though I had anticipated the pneumonia, and was pretty sure I could get him through it, I had to agree it was for the best.

He had become something unreal to me – something beautiful, like a work of art, but unreal. Amid all the mess and squalor of the hospital, with its blind random unravelling of lives, in their patient dignity and kindness he and his family stood apart. In his case, for a little while at least, everything had gone exactly as it should have. The perfect code. And it hadn't made any difference. After a bedside service, I pulled his tube early in the afternoon, and took my place at the wall while the usual drama worked to its conclusion.

They sent me a card that Christmas, Mrs Mongay and her daughters. I kept it for a while, until it vanished in the clutter on my desk. She had written a text inside, something from the New Testament I had admired at the bedside service, but soon forgot. I do remember vividly the picture on the card. It was like the Mongay women: sober, attractive. It showed a medieval nativity scene, all saints and angels with their burnished golden ovals overhead. Their faces were sorrowful in profile, as if anticipating what will crown that rosy newborn, perfection laid in straw, with pain in time to come. ■

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