

# Heroic Measures

Category: Stories

written by Gil Beall | December 30, 2011

## **Gil Beall**

“Doctor! Doctor! He’s stopped breathing!” the stout woman shouted, clutching at my white coat.

It was 1953, and I was a first-year resident responsible that night for the patients on the medical ward—including those in the four-bed room the woman pushed me into.

There I saw a melee taking place around a seventy-year-old man with chronic lung disease.

The man had been examined and admitted that evening by my colleague, who’d given me what little information he had before leaving for the night.

The man had been too absorbed in his breathing to talk much. We’d hooked him up to an oxygen tank and started an intravenous infusion of the bronchodilator aminophylline, which brought about modest improvement. We couldn’t think of anything else to do and agreed that his prognosis was poor.

Now I found him unresponsive and surrounded by frantic family members. Someone had knocked a vase off the nightstand, and the floor was littered with broken glass and roses.

Listening with my stethoscope, I thought I could hear heart sounds, but his chest wasn’t moving. And my informant was correct: He wasn’t breathing.

*But, I thought, he is not dead.* I had to try to revive him.

Nowadays, a man as ill as this would be admitted to an intensive care unit, a tube would be placed in his windpipe, and he would be ventilated with a respirator. Such machines were not in use in 1953.

Attempts to restore respiratory or circulatory function have a long history in medicine, and the method of choice has evolved over time. When this incident took place, mouth-to-mouth breathing and chest compressions were a brand-new development, and the standard form of emergency artificial ventilation was prone pressure—rhythmic bimanual pressure applied to the lower rib cage as the subject lay face down. Physiological studies have since documented this method’s inefficiency, but it was the method then taught in first-aid and life-saving classes, and it was what I was prepared to use with this patient.

I rolled him over, began to apply pressure to his back and called for assistance, but the only other person on the ward was a student nurse who had little knowledge of how to get help. (At that time, the patients’ nighttime

care was customarily handled by only a house officer and a student nurse.)

While refraining from the hackneyed request to “give him room to breathe,” I did suggest that people step back and give *me* room.

Looking back, I’m aware that what I really needed was an anesthesiologist to insert an endotracheal tube, which could be connected to a bag that, when compressed, would force air into the lungs.

At the time, of course, we didn’t have that equipment. The positive-pressure breathing machines common in ICUs today had only recently been popularized in Copenhagen, during a 1951 polio epidemic. (These machines were developed to replace the previous technology—a medical student who sat at the bedside, inflating the patient’s lungs by pumping on a bag.)

Back in those days, when polio patients needed artificial respiration, we’d use cumbersome Drinker respirator tanks. The Drinker respirator—commonly called an “iron lung”—was a large tank on wheels. The patient lay with body inside the tank and head outside, sealed at the neck. A bellows mechanism sucked air from the tank and inflated the patient’s lungs.

In fact, the Drinker respirator was difficult to use with any patient, and almost impossible with small children. (For that reason, when a child’s chest muscles became paralyzed by polio we resorted to using electrical stimulation of the phrenic nerve in the base of the neck. Stimulating the nerve caused the diaphragm to contract, thus inflating one lung. I once sat several hours by a two-year-old girl, my finger guiding an electrode to the spot on her neck that caused her abdomen to rise and oxygen to enter her lung. Ultimately, the nerve’s waning sensitivity and the intern’s fatigue forced us to try a tank respirator—an attempt that was, unfortunately, unsuccessful.)

In any case, the Drinker’s size and complexity made it inappropriate for emergencies like this one.

The anesthesiologist could not be found. I had no equipment and no assistance. The scene was chaotic. Family members and other patients were milling about, crying and making useless suggestions. One person slipped and fell in the water from the spilled flowers. The scent of roses added to the surreal quality of the atmosphere.

I knelt on the bed, straddling the patient and pressing on his back. I knew that what I was doing was useless, but I felt I couldn’t stop while all of the family was crowded about. The scene could have been a part of some black farce.

After fifteen or twenty minutes that seemed like an hour, I realized the ridiculous, futile nature of the situation and stopped to assess the patient.

He was pulseless. Perhaps he’d always been; I had never felt very confident that I’d heard heart sounds.

I pronounced the patient dead.

There was no wailing or dissent from the assembled family. I think they shared my embarrassment.

At the time, I regretted my contribution to the undignified nature of the man's death. Compared with our current medical expertise, we knew, and could do, so little.

Still, I suspect that if my patient were alive now and had the benefit of all of our modern-day medical bells and whistles, his exit from life would be even less dignified than the death he suffered a half-century ago.

**About the author:**

Gil Beall is a UCLA professor of medicine, emeritus. His subspecialty of allergy and immunology was the foundation for shifting his clinical interests to HIV/AIDS in 1980. "Since retirement I have volunteered in Africa and Asia with Medecins Sans Frontieres (Doctors Without Borders), the Global Medical Forum and Health Volunteers Overseas, and have maintained my connection with the immunology clinic at Harbor-UCLA Medical Center. My lifelong interest in writing is founded on early exposure to my family's weekly newspaper."

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