Caught in the Middle

Category: Stories
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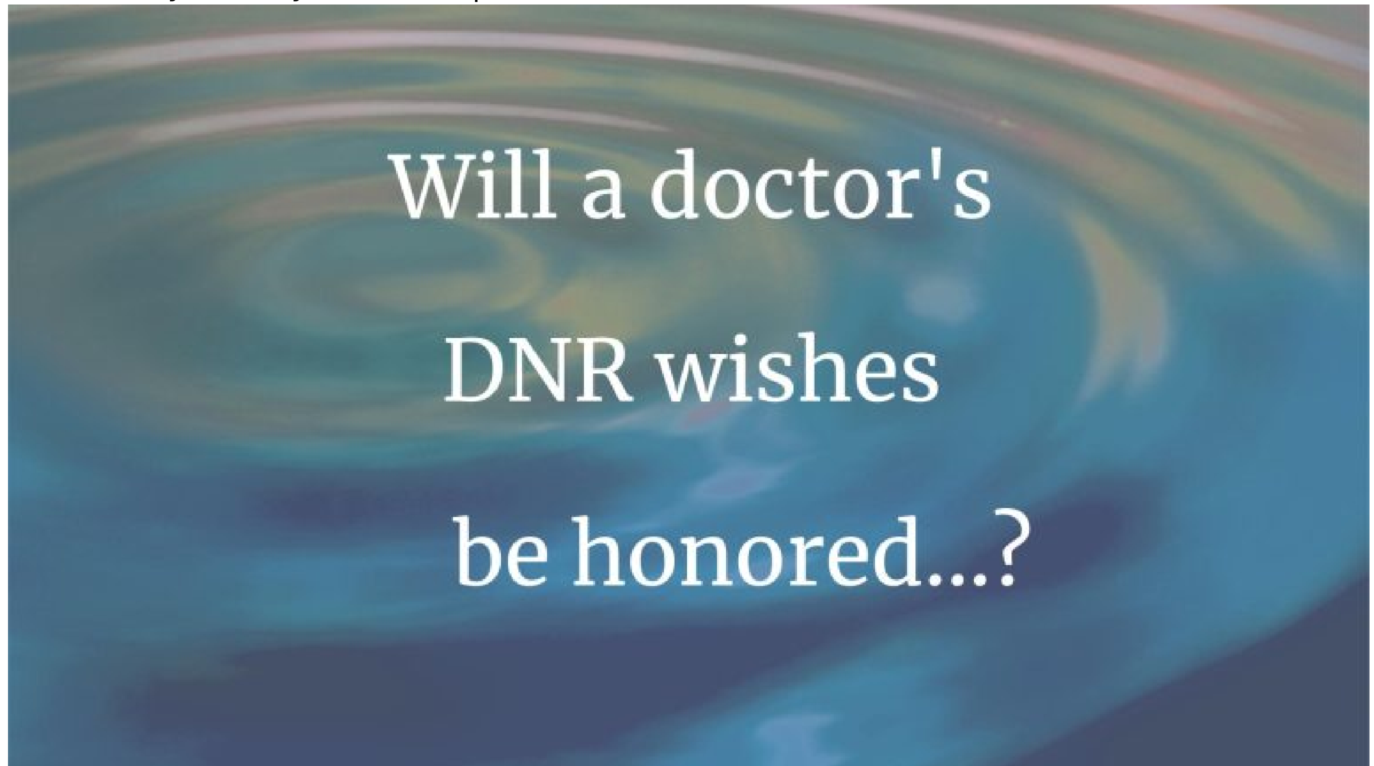

One day several decades ago, after morning rounds, Dr. Prescott slipped into the ER where I was the cardiac nurse. She did something a doctor would never do: She placed her leather medical bag on a stretcher instead of on the desk. Her eyes locked onto mine.

"I'm having a heart attack," she said calmly.

Oh my god, I thought. Having been on friendly terms with her for years, I knew how much she'd given of herself to her patients. *Now she needs to be a patient. Hurry.*

Although she looked healthy, I knew that an arterial blood clot might be starving her heart of oxygen. A series of drugs, from aspirin to tissue plasminogen activator (tPA), could dissolve the clot and restore blood flow to her heart. The sooner she received this therapy, the greater her chances of survival, and of escaping permanent heart damage.

As she removed her lab coat, linen suit and shoes, I yanked the curtain closed around the stretcher, shouting, "Need EKG in ER One!"

While the EKG was being done, I gave Dr. Prescott oxygen, attached her to the monitors and took her vital signs, keenly aware that the clock was ticking.

"Thanks, hon, I know you guys'll take good care of me. Sure hate to think about going to the other side," she said with a nervous laugh. "What'll happen to my family and patients?"

As I leaned over, listening to her heart sounds, she made a quick sign of the cross.

“Dear, this may strike you as strange, but I don’t want to be defibrillated at all,” she said. “Period. Amen.”

I was too shocked to respond.

A heart attack isn’t necessarily fatal, my mind protested. *Why are you saying this?*

During my assessment, it emerged that she didn’t have a living will—which would have compelled her caregivers to follow her wishes and shielded them from liability for doing so.

As an RN, I had no authority to write her wishes into her medical orders; I was expected to convey her request to her attending physician. And we didn’t have the luxury of a long discussion. Time was of the essence.

The techs started IVs as I continued the assessment, stopping only to run the EKG printout to Dr. Mueller, the ER’s very capable medical director.

He read the EKG, hastened to Dr Prescott’s bedside, confirmed her self-diagnosis and ordered clot-buster therapy. I admired his coolness, faced with treating a revered colleague who might crash before his eyes.

When he turned to leave, I pulled him aside.

“Dr. Prescott doesn’t want to be defibbed if she arrests,” I murmured, fully expecting to see him nod understandingly, then turn back to discuss it with her. Most patients who made this request were uninformed, and easily persuaded to accept resuscitation if need be. But this was a fellow physician making a fully informed choice.

Dr. Mueller thought for a second, looked at the floor, then said softly, “I didn’t hear that.”

Suddenly, the walls seemed to close in on me. I felt trapped between two powerful forces: the patient, a seasoned senior physician who most likely feared a traumatic outcome and the indignity of being splayed out naked while nurses or interns shocked her repeatedly; and her doctor, a highly competent young medical director who shouldered the responsibility for every medical decision in the ER.

My attempt at patient advocacy had backfired. The usual directives—”Go up the nursing and medical chains” or “Report the situation to the doctor in charge”—were futile: The doctor in charge was the source of my dilemma. Few medical professionals would have dared to challenge his authority. I could ask for an ethics consult, but that could take days. At best, we had minutes.

Meanwhile, the ER secretary was hastily ordering Dr. Prescott’s tPA from the upstairs pharmacy.

“This is Mary from the ER. Need a stat tPA for Dr. Prescott.”

“Why is Dr. Prescott ordering tPA?” the pharmacist asked. “Isn’t she an internist?”

“No, she’s the patient.”

“Oh, Christ!”

I started her tPA infusion in record time: nineteen minutes. But she wasn’t out of danger. Any second, her heart could stop—and if that happened, it was my job to initiate emergency resuscitation. My nurse manager was tending to another crisis, and though my fellow nurses would readily help with patient care, no one would step into a conflict between two highly regarded physicians. This was my problem alone.

If nurses are “angels,” I thought desperately, *I hope a savvy guardian angel is looking out for me.*

Never before had I been afraid to do the right thing. Now I anguished over my possible actions.

Scenario one: Follow routine protocols. If Dr. Prescott develops V-fib, defibrillate her as many times as indicated.

But what if the code fails, and she has a bad outcome, like brain damage? Despite our previously cordial relationship, she might sue me for assault, and I’ll lose my RN license.

Scenario two: Respect my patient’s wishes. Don’t defibrillate her. Stand by as she dies; get charged with negligence.

Her family might sue me for wrongful death, and I’d risk losing my license. Personally, I’d rather expire myself than be labeled a “Mercy-Killing Nurse” in the news headlines.

Scenario three: If the need arises, pretend that I’m preparing to shock her, but “trip” and sprain my ankle.

I won’t be charged with a crime—but I’ll probably never sleep through the night again.

In the hour that followed, I stayed vigilant, praying that Dr. Prescott wouldn’t need resuscitation and that I’d keep my license, my job and my sense of self-worth. Holding the crash cart at the bedside, just in case, I watched her heart rhythm and rate like a hawk.

Fortunately, the ER team was able to catch and treat any subtle arrhythmias before they turned lethal. Although her lab tests revealed extensive heart damage, her chest X-ray showed no heart failure, which bought us some time.

Her best chance of having her wishes honored, I decided, would come in her next destination: the ICU. I called the ICU manager, my trusted nurse friend

Scott.

To my eternal gratitude, Scott immediately grasped both Dr. Prescott's request and the dilemma I was facing. He promised to relay the situation to whichever cardiologist was assigned to her care.

My guardian angel came through: Dr. Prescott's status stabilized, and we transferred her to the ICU. There her cardiologist sat with her to discuss her code options at length. Although I never learned the final decision, I felt relieved that they'd made it together.

Looking back, I wonder what was going through Dr. Mueller's mind when he brushed me off. Perhaps something like: *This patient came to me for emergency treatment. I took the Hippocratic Oath to "first do no harm." Maybe she's not thinking straight because of her heart attack—plus she has no living will. If she has a cardiac arrest, a prudent ER doctor would fully resuscitate her.*

About fifteen years later, I saw Dr. Prescott's obituary in the newspaper. She'd died in hospice care, under comfort measures. Although I felt sad that she had passed away, I also felt satisfied. She'd died on her terms, without defibrillators—and with her dignity intact.