Confidence, Consciousness, and Compressions: Navigating a Medical Student's First Resuscitation Attempt

Caroline Yi, BS[1]

[1]Department of Psychiatry, University of Maryland School of Medicine, Baltimore, USA

KEY WORDS: addiction; medical student; resuscitation

J Gen Intern Med
DOI: 10.1007/s11606-025-09722-0

Nobody told me that it's hard to start an IV on a dead person.

I'm a third year medical student in the ED on my second rotation. A 20-year-old patient, B, was brought in unresponsive, likely from an overdose. She was discharged yesterday after a week of treatment for suicidal ideation. Recently, her father overdosed and died.

Now in Room 22, I awkwardly stand by B, unsure of what's happening. I'm in the intern's way. She palpates B's thigh and advances a large needle into an anatomic structure that I should probably know, but don't. Feeling useless, I inch towards the door to watch from a distance, but now I'm blocking nurses wheeling in ultrasound machines. I shuffle into the hallway and flatten myself against the wall, trying to shrink into the smallest inconvenience possible.

Suddenly, my attending appears from the bowels of the ED. "Jump in," she chastises. "Be an active learner."

And that's how I find myself trying to start an IV on a dead woman.

I've started IVs on living patients before—six, to be exact. But now, B's arm feels like pizza dough. I look for a faint blue vein, but her entire body is a strange, purplish hue. I ask if I should try blindly, but a nurse advises against it, warning I might stick an artery. I'm not sure if a dead woman can bleed out, but I step aside to let her try.

The room is chaotic—beeps and buzzes, white fluorescent lights. People with established roles are doing important things. Suddenly, the senior resident announces the automatic compression device isn't working.

"We need people for compressions!" she calls.

Moments later, I'm standing on a stool, two feet above B. I lock my arms straight and press down as hard as I can. Over, and over, and over again. I'm sweating. Her entire body moves.

Looking down, I see her closed eyes and tattoos. She does not look like she is asleep; she looks unmistakably dead. This feels surreal. Unexpectedly, anger wells up in me. Anger against the social systems that failed her. Anger at the addiction that consumed her. Anger at whoever sold her the drugs that killed her. I wish I could go back in time and rip them from her hands.

I channel that anger into my compressions.

After six minutes, a nursing student takes over. We give the dead woman epinephrine. We shock the dead woman with electricity. We push air into the dead woman's lungs.

And then we repeat.

And repeat again.

Back on the stool, I push into her chest.

"It's been two minutes," the senior resident announces. "Do we feel a pulse?"

I rest my hand on B's chest. I don't feel anything. I glance at the nurse opposite me, who's also checking. She's undoubtedly better at this than I am.

"Do we have a pulse?" the senior resident asks, again.

I hesitate. I could be mistaken, but I feel a faint heartbeat. Nervously, I say, "I think we do?".

The senior resident snaps, "Do we or don't we?".

Looking up, I see a new electrical rhythm on the monitor. "We do," I say, with more confidence.

The monitor makes a different beeping sound—the sound of someone who is *not* dead. I look at the woman who is not dead. I look at the monitor. I am now a trained medical student who can, confidently, feel a pulse.

The senior resident doesn't skip a beat. "We need access!".

The intern is still trying to stick a large needle into B's thigh. There is a lot of blood. She is visibly frustrated. I later learn she is trying to start an arterial line.

Suddenly, she straightens and stares at her finger. "I've stuck myself," she says, quietly.

A pause hangs in the air.

The senior resident sighs. "I'll finish up," she says. "You can go." The intern scurries away, ripping off her gloves.

The patient is transferred to the ICU. She never regains consciousness. She's not dead, but she's not alive, either. The next day, she donates her heart, lungs, liver, and kidneys. B's chart is closed. She does not need a discharge plan. In the end, B completes a 48-h round trip from death to liminality and back.

Received March 3, 2025
Accepted July 1, 2025
Published online: 14 July 2025

Long after my clerkship ends, I wrestle with the dialectic of success and failure that defines clinical medicine. The psych team successfully stabilized B enough for discharge—yet she overdosed the next day. A senior resident confidently led a code—yet an intern failed to safely obtain an arterial line. The ED team obtained ROSC—yet B did not regain consciousness. B's organs saved lives—yet B is gone.

In B's absence, I stand a little taller. My first resuscitation effort taught me that confidence is not just knowing what to do but executing it under pressure. It is built one action at a time. Taking a pulse. Recognizing a rhythm. Making a decision that alters the next step.

That moment became more than a clinical milestone—it marked the beginning of a deeper lesson. Confidence is shaped not only by the triumphs of good outcomes, but also by the lessons learned in the face of impossibility. As medicine has yet to find the panacea for the many determinants of health, physicians are confronted daily with situations beyond their control. The trauma of our profession exerts a relentless undertow of depersonalization, threatening to pull us away from ourselves and our patients. Defining success not only by outcomes, but also by presence and growth, allows us to remain conscious and connected—for the patient in front of us.

B was one of those patients. In her illness and death, she gave the hope of life to five others. She also gifted something quieter, but no less enduring: a shift in perspective for a student at the beginning of her clinical journey.

Thank you, B.

With gratitude to Dr. Marissa Flaherty for her generous feedback of this piece.

Identifying information altered to protect privacy.

Corresponding Author: *Caroline Yi, BS; Department of Psychiatry, University of Maryland School of Medicine, Baltimore, USA (e-mail: cyi@som.umaryland.edu).*

Funding *The author received no financial support for the research, authorship, and/or publication of this article.*

Declarations

Conflict of Interest *The author declares that she does not have a conflict of interest.*