

A must read for heart patients. The lessons of this compelling and amazing story apply to every community in the United States. It offers a poignant, touching glimpse of the inner workings of a family impacted by cardiac arrest.

A Heart Too Good to Die

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A HEART TOO GOOD TO DIE

A shocking story of Sudden Cardiac Arrest

“The lessons of this compelling and amazing story apply to every community in the United States.”

Mickey S. Eisenberg, M.D., Ph. D, author of *Life in the Balance*

“A poignant, touching glimpse of the inner workings of a family impacted by cardiac arrest. This is a must read for heart patients and their loved ones.”

Wayne M. Sotile, Ph.D., author of *Thriving with Heart Disease*

“It makes you laugh, it makes you cry; it has everything. The descriptions are so interesting. It is fast paced, the action and details capture you.”

Mary Newman, President, Sudden Cardiac Arrest Foundation

A HEART TOO GOOD TO DIE

A shocking story of Sudden Cardiac Arrest

Jeremy Whitehead

Foreword by David A. Rubin M.D.

A HEART TOO GOOD TO DIE is a work of nonfiction.
It is based on the recollections of the author and witnesses.

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*For Carolyn, she missed so much
and yet she endured it all.*

Contents

Introduction	1
In Good Company	5
Welcome to Dallas	41
Intensive Care	55
Three Days to Life	69
Plumbing for Answers	105
The Electricians	117
A Shocking Device	137
Leaving Dallas	147
Miracles	155
Letting Go	161
Epilogue	173
What Can We Do to Stop Them Dying?	177
Public Access Defibrillation (PAD) Programs	187
Hearty Facts	193
Shocking Numbers	198
Chapter Notes	203
Glossary of Medical Terminology and Procedures	217
Acknowledgements	229
Associations	231
Bibliography & Attributions	233

FOREWORD

Carolyn Whitehead was one of the few—*is* one of the very few—lucky ones. She not only survived an out-of-hospital cardiac arrest, but regained full use of her faculties. Despite all the improvements in the detection and treatment of heart disease, over 300,000 people have died each year, and will die of sudden death in the next year. Before the advent of bystander CPR and paramedic teams equipped with automatic external defibrillators, the chance of survival was less than 5%. Carolyn had the good fortune to sustain her episode in the presence of two people trained in CPR, and a team equipped with a defibrillator quickly arrived. Even so, her chances of survival without significant brain damage were less than one in four. She had all the predictors of a poor outcome: arrest duration more than 15 minutes, hypotension, tracheal intubation, and coma. Her story is truly remarkable.

Her story is also unusual. Although sudden death is the initial presentation of heart disease in nearly half the patients, there is usually some identifiable underlying disease. In the United States, the most common cause, accounting for roughly 80% of cardiac arrests, is coronary artery disease—thus the initial thoughts of her treating physicians. The second leading cause is thickening of the heart muscle (left ventricular hypertrophy). In the United States, hypertension is the most common cause of left ventricular hypertrophy. There are also rare inheritable disorders of the heart muscle that can cause abnormal thickening of the heart muscle, termed hypertrophic cardiomyopathy. The third most common cause is cardiomyopathy, a weakening of the heart muscle that can affect either the squeezing out of the blood to the rest of the body (systolic dysfunction), or the relaxation of the

A HEART TOO GOOD TO DIE

heart muscle that allows the blood to enter the heart (diastolic dysfunction).

Lastly there are disorders of the ion currents that control the electrical activity of the heart. These disorders can lead to short circuits that cause rapid, ineffectual contractions of the heart muscle that result in collapse.

Carolyn had none of the above, as proved by the extensive but ultimately frustrating evaluation by her extremely competent team of physicians. Carolyn is an excellent and unfortunate example of what we do *not* know about disorders of the heart.

She is, however, the beneficiary of therapy that we do know prevents recurrence of cardiac arrest. Unlike lightning, cardiac arrest *will* hit the same place twice. Studies report a recurrence rate of 50-60% at two years. Drugs have been relatively ineffective in the prevention of recurrences. The introduction of implantable defibrillators has revolutionized the care of cardiac arrest survivors. These devices detect the cardiac arrest and automatically deliver a shock to terminate the arrhythmia. The devices are extremely effective, but they are not without their shortcomings. The recalls due to defects in battery and lead design are now, unfortunately, commonplace news headlines. There are risks attendant with the implantation, including collapsed lungs, heart perforations and infections. Fortunately, the recalls and complications are rare.

Carolyn's story also illustrates the non-medical complications of cardiac arrest and its therapy—the social and psychological problems. Cardiac arrest is a life changing experience for both the patient and her family. Mr. Whitehead delineates these problems in a passionate, yet lucid and empathetic manner.

Thus, Carolyn's story, as told by her husband, has a lesson for many people. It is instructive to patients who have survived cardiac arrest and have not come to grips with the emotional trauma. It is instructive to family members and friends who have to deal with a loved one who has survived cardiac arrest. And, yes, her story has something for those

Foreword

of us who deal with sudden death victims. I gained insight into the struggles of families dealing with such a catastrophic event, and how we as physicians appear to families. I have cared for Carolyn for the past few years. Yet, it is only now, through this book, that I believe that I truly know Carolyn and her husband.

Lastly, this story is a lesson in love—the love of a husband for his wife, the love of a brother for his sister, and the love of friends and colleagues for a remarkable person. This is a lesson of value to us all.

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Columbia University College of Physicians and Surgeons
November 2007

INTRODUCTION

When sudden cardiac death strikes, there is nothing you can do. Nothing the spouse can do, nothing the family can do, and nothing best friends or colleagues at work can do. It just takes them away, around nine out of ten victims, and it takes them in minutes. They do not come back. They are gone. But it doesn't have to be that way. They can survive, and become "hearts too good to die".

Most die before reaching the hospital, and it happens to outwardly healthy people with no known heart problems such as high school kids, college sports stars and professional athletes, as well as thousands of children.

Sometimes there is a warning sign, but often there is not. You would be surprised if your favorite nightly news station reported the cases—over ten times more deaths than car fatalities—nearly one thousand per day in the United States alone. When this "serial killer" strikes, it is usually not gruesome, and yet it is sudden and shocking, so why don't we hear about these tragedies?

Even if we did hear about them more, what could you do? How do you deal with a sudden cardiac arrest? Cardiopulmonary resuscitation will not bring them back, although it may keep them going long enough for the one thing that will save them.

They need a defibrillator.

To shock them back to life.

Dick Cheney has one; his cardiologist thinks he is in danger without one. Reggie Lewis and Hank Gathers didn't know they needed one. An external one could have saved Sergei Grinkov on the ice rink.

Those that survive are changed forever. Most likely an expensive device, similar to a pacemaker, will be implanted in their chest. The

A HEART TOO GOOD TO DIE

spouses, family and friends will all be impacted. Who helps them? Where do they get the information and support to deal with the changes? The facts are easy to come by, often too plentiful, and yet so uninformative. There are few books that tell the story, or offer to educate and explain without a clinical approach.

We want to understand what is happening, what will happen next, and how to prepare for the future.



For the survivors and family, emotions run high. Grief is not far away and yet we need to be prepared for the implant procedure to be performed “in a few days time”, and the subsequent invasive tests. Too often, the advice is preoccupied with prevention, rather than the rehabilitation and recuperation we all need—for the mind as much as the body. Even though the emotions are often buried, they resurface and the questions start all over again. Why did this happen? What does it mean? Will they recover? How do we deal with it?

I had very little information, with even less experience, and even today, it still feels unreal.

Carolyn had arrhythmias for over twenty years; mild and annoying irregularities in her heartbeat, sometimes as a result of strenuous exercise or periods of high emotion. The technical term is Premature Ventricular Contractions (but always called PVCs) and to her it felt like “a pause, then thump” at the wrong time. No big deal, sometimes she put up with hundreds of them in a day, and never did they interfere with her quality of life.

That was not the case in October 2002. With odds of ten million to one, a PVC landing at just the wrong time would do it. *It* happened while she was sitting down, having just introduced herself to a large group of co-workers at a management seminar. She fainted and fell out of her chair—a big surprise to those around her.

She had suffered a sudden cardiac arrest. Her heart was not pumping blood, she was not breathing, and her brain was not getting any oxygen. She was clinically dead.

Introduction

This book can help those of you who have faced the trauma of sudden cardiac arrest in your circle. I sought just such a book when confronting my wife's medical emergency, but could find few similar stories, and they did not address the topic of sudden cardiac arrest directly.

Candidates for an Implantable Cardioverter Defibrillator, and their families, have many unanswered questions. I still face despair and confusion over what happened to my wife that October morning. Maybe it will never go away. Knowing more helps, but sharing the feelings and experience has certainly aided the healing.

This is a story of a medical emergency, seen from the eyes of a spouse. Close friends and colleagues should find familiarity and comfort in these words too. The practitioners do not always handle us very well, even when our services are required. I do not lay any blame; they too are not necessarily well informed. Their job is to diagnose and remedy the physical damage presented—the pathology. Medicine is a science, and has rules to operate by. Our job is to support and nurture our loved ones' will to survive; without it, they don't stand a chance. You and your survivor will find much joy and fulfillment in your "new" relationship, with extraordinarily tender moments and intense closeness, purely because they are still here, against the odds.

Chapter 1

IN GOOD COMPANY

Great crises produce great men, and great deeds of courage.

—John F. Kennedy

It was the most frightening time of my life. Nothing had prepared me for the responsibility or the dread. That precious heart had to be stilled. An electric shock would do the job. Only a small shock, but delivered at just the right time and in exactly the right place. She would be dead; there would be no pulse, and thus no life giving oxygen for her brain and organs. Her blood pressure and heart rhythm had to be monitored to ensure the precise conditions were achieved. But first she must be sedated so she would not feel any pain, or suffer in any way.

Naturally, I was apprehensive and worried. Their reasoning was unequivocal. It was vitally important—her life depended on it!

How could this be possible? What justification could there be for terminating my beautiful wife's heartbeat? She was young, fit and healthy—normal in every respect. Why should she succumb to this hideous proposition? And how could a spouse be asked to sanction such a grave act?

To find out we should start at the beginning; to the first time she dies.

Carolyn and I were newly married and had left Australia to begin a wonderful new life together in America. We had grand plans, and I felt lucky to be accepted into this land of opportunity. Our home was now Boston, Massachusetts, and I was still adjusting to my new surroundings when Carolyn had to leave for Texas. She had no indication that

A HEART TOO GOOD TO DIE

this routine business trip would have such a dire outcome. Neither did I, so the phone call from Dallas was both alarming and confusing—it left me terrified.

I had expected our wedding day to be the highlight of my New England experience. Thursday, October 10th, 2002 has now been permanently imprinted in my mind. It was mid morning when the call came on the home phone—the one the telemarketers had already found. It wouldn't have been Carolyn, as she preferred to ring my cell phone, which had all those free minutes we paid for every month! The caller was no stranger, although we had never spoken before. Unquestionably, he had shocking news.

“Is that Jeremy Whitehead?”

“Yes, speaking.” A chill passed down my spine. Nobody ever starts a telephone call that way unless...

“This is Jim Hardee, Carolyn's boss. Your wife's had a bit of a turn, and we've taken her to the hospital. I think you should get down here.”

“Get down where?” I wondered, although I should have known. Carolyn had left the previous day for the conference in Dallas and we had spoken just a few hours earlier to say good morning; a small ritual of love we used to help bridge the physical distance.

Jim had been Carolyn's boss just a few months. He had taken a bold step in hiring her as a Business Unit Executive, just before the summer. We were both in the IT industry, successfully climbing the corporate ladder in Australia. I was in sales and marketing, and she was a regional manager. But Carolyn had found an opportunity to advance to “the next level”, leading a sales team with revenue targets in the hundreds of millions of dollars. She matched the job requirements perfectly, although there had been an underlying sentiment of, “how could someone all the way from Australia be successful in this role?” Unperturbed, Carolyn had proven herself within a few short weeks to be an inspirational leader, motivating her team to overachieve, as well as boosting morale to an all time high. But now, Jim was calling to say there was some problem with her health, and he seemed worried.

In Good Company

Maybe Carolyn had overreacted to a minor ailment like an upset stomach, cramp or a bad headache. I was always teasing her about her low tolerance to physical pain, so I was embarrassed to hear Jim say they had sent her to the hospital. He and I had not met, but Carolyn had talked about him enough for me to feel that I knew him. Alas, he did not feel the same way.

“Oh I don’t think that will be necessary,” I blurted out, while trying to work out where on earth Dallas was. I knew it was in Texas, but how far is that from Boston? Do I drive? Maybe a plane is better. Oh, how will I get a ticket? Who do I call? I was very used to sudden travel demands back home. The Qantas Club membership had made those types of dramas so easy to handle. Alone, in our rental apartment in Boston, I had my morning planned out and was busy getting my tasks done. Until that moment.

“Maybe you should talk to the doctor,” Jim replied.

I felt a bag of icy water land in the pit of my stomach. Doctor? What doctor?

“This is Dr. Diamond from Baylor Grapevine emergency ward, your wife has been admitted to intensive care in critical condition.” He paused, letting those words sink in before continuing, “We are not sure what happened to her, but she has had a cardiac arrest, maybe due to an aneurism. She is stable right now, and we should know more in twelve hours or so.”

My legs were suddenly weak; they buckled. The bag of icy water had broken and, now sitting on the floor, I wondered what could have happened to my bride.

Did he really say those terrifying words “critical condition”?

I wanted to be sick, I wasn’t breathing, and my stomach somehow knew what my brain was attempting to deny.



Carolyn and the three managers who reported to her, Pam Battistone, Bruce Senecal and Karen Davey, were part of a group of over two hundred attending a high performance management conference, as part of

A HEART TOO GOOD TO DIE

their IBM leadership development program. Carolyn had little chance to notice how well the Hilton Dallas Fort Worth Lakes Executive Conference Center specialized in such conferences. That morning they had numerous rooms allocated to handle the large influx of IBMers. The rooms were configured to accommodate groups of thirty people, each with four tables set for the morning's activity. A table captain had been assigned in advance; a little surprise for four of the best. This was going to be their office for the next two days.

Karen did not think there was anything amiss with Carolyn that Thursday morning. The four of them had met in the lobby to go down for breakfast together. "When we travel, we travel in packs" was her maxim. Carolyn seemed quiet, but they hadn't spent much time that early in the morning before, and Karen was still getting to know her new leader, so she accepted that Carolyn was not her usual self.

They found their way down to the auditorium; the basement level of the hotel was like a maze but the corridors were full of people headed for the same location. Karen had learned that her boss liked to sit up front and on the aisle, so they filed into one of the front rows. After hearing about the day's agenda, they were organized into groups and dispersed to the conference rooms. Another flight of stairs and winding passages brought them into a room with round tables; eight places each set with nametags, pitchers of water and bowls of candy.

Karen noticed that Carolyn had been pre-selected as table captain, and that Bruce was assigned the seat next to her. Karen was bound for a different table, however, and was thus among strangers. Everything went according to plan, until they were in the middle of the normal "show and tell" get-to-know-you session. Karen's table had been first to do the introductions, and she was watching Bruce as he stood up to begin his story.

Bruce felt well rested, as they had had an early evening the night before. The previous day had been long, the flight in from Boston providing an extra hour with the change in time zone, but having dinner with the three girls was fun; they had had a few drinks, and lots of

In Good Company

laughs. He liked this opportunity to be with them outside the office. But he was surprised to see Carolyn so quiet at breakfast. Nevertheless, they stuck together through the opening session, “as the team we are” he thought to himself. Then the huge group was split into teams for the real business to begin.

It was Tom O’Brien’s first time as co-facilitator and, wanting to make a stimulating and fresh start, he decided to add a twist to the standard course opening. Hoping to make the introductions interesting, he asked each person to describe something no one else would know about them.

Tom was pleased with the early results, as the attendees were a little challenged by the request and thus paying attention. It was going to be a memorable session.

As a Certified Professional Coach and Sales Transformation Manager, and based in Fort Worth, Texas, Sara Smith was technically in charge of the training session. She enjoyed having the chance to watch the group from the back of the room; normally she was out front doing the talking, but this time she could listen and observe. She felt comfortable with Tom leading, although neither of them realized how they would be tested by the forthcoming events.

Bruce was not especially thrilled to have to stand up and reveal something about himself to these “strangers”. And having to wait for his turn was an unbearable torture. With eight per table there was plenty of time for the stress to build up, and he couldn’t stop the mantra in his head, “What is it that I’m going to say?”

Each time someone got up and told their story he changed his mind, and had to search for something new. Karen had surprised everyone with her story about being expert at throwing the javelin. How could he beat that? There was one thing he could reveal, but that would probably be too revealing. He was sitting next to Carolyn, and realized that he had better decide quickly. Once she was finished with her introduction it would be his turn.

Jim knew them all, and being a Vice President he had been able to

A HEART TOO GOOD TO DIE

arrange for his entire management team to be in the one room. Introductions were a normal part of these types of business meetings; he was listening, but not really paying attention. He had other things on his mind, thinking about how this course would help his team to uncover and resolve problems on the front lines.

Mark Johnson was sitting in the back of the room observing the introductions. It was rare to have all of the team in one place and he saw this as an opportunity to build rapport with them. He saw Carolyn stand up to speak and was enthralled in her unique story. As the Human Resources manager for Jim's team, Mark had been involved in Carolyn's recruitment. She was no stranger, but not yet well known to him. That was about to change forever.

Randy Fitch was sitting seven or eight feet away from Carolyn; her table was in front of his and over to one side. As each group introduced themselves, Randy moved his chair to face their table. He was particularly interested to learn that Carolyn was able to communicate via sign language, and yet she was not deaf and neither were any of her family. She stood up straight and moved her hands and fingers as she spoke, demonstrating her skill. It was a surprising trait and certainly memorable. The girls seemed to have the edge with the revelations, first a javelin thrower and then a hearing person that signs. As Jim's executive assistant, Randy had both an envious and challenging role. He's a cool-customer, very direct and forthright; not so much a hard taskmaster, but determined and disciplined—a man of actions rather than words.

Watching Carolyn as she sat down, Randy was glad his table already had their turn. Surprisingly, he was feeling a little clammy. "Probably just nerves. There is an element of risk here. This is an embarrassing thing to do," he told himself, and then sought to rationalize it: "Having to stand up and speak to a large group of people and reveal something new about yourself can be stressful." He could not have predicted just how stressful that morning was going to be.

Bruce had just stood up and opened his mouth to speak, when Carolyn collapsed at his feet. She just slid off her chair and fell to the

In Good Company

floor like a bag of potatoes, not quite graceful, almost gentle; a crumpling as opposed to a thud.

Randy sensed it happening in slow motion and thought, “I should be trying to catch her.” He knew she was going down—somehow before she fell—possibly from instinct. Time had slowed down, but his mind was running at a million miles per hour. He was not quick enough, however, and she was already on the floor before he was even out of his chair.

Standing at the front of the room, Tom could easily see everyone and was surprised when Carolyn slid off her chair. “She couldn’t have fallen asleep,” he thought, “maybe she slipped.”

Jim was shocked to see her fall, and thought, “Oh, I hope she’s just fainted.” Not sure what was going on, he wanted to know if it was serious or not. “I can’t believe it is anything more than that, I have to go to her.”

But it was much more than that.

Although Sara was at the back of the room, she had a clear view of Carolyn. She saw the energy drain out of Carolyn’s body, leaving a face devoid of expression—just blank. All of Carolyn’s muscles suddenly went slack, like cutting the strings to a puppet, and she dropped to the floor.

Randy’s first thought was that Carolyn had fainted, maybe due to a chemical imbalance in her blood; being hypoglycemic, Randy knew the feeling. Once before, he had been in a meeting where someone had fainted, but this time he was uncertain, for there had been no warning, no gasps or moans, just silence until the thump.

Sitting at the adjacent table, Karen also guessed that Carolyn had fainted and feared that she may have hurt herself in the fall, as she herself had experienced a few years back. Even though Carolyn had been sitting down, she could have hit her head or banged her nose. Knowing that she was not going to be of any use medically, Karen rushed outside to alert someone. Looking back into the room she saw several people were already attending to Carolyn on the floor. She decided to

A HEART TOO GOOD TO DIE

approach everyone she met on her way to find the conference command center, and ask whether they had any medical training.

When Carolyn hit the floor, Mark stood up. He could see Tom and Randy rush over to her. All the panicked faces at the front of the room told him something serious had occurred, and his first instinct was to get help. He raced over to the back door of the room, and out into the corridor.

Randy reached Carolyn first; she was curled up in a fetal position facing away from him. He put his hand on her shoulder, called out her name and then rolled her over. She looked asleep or heavily intoxicated, but there was something else, something not quite right. He could see she was “not there”—completely lifeless and not breathing.

“She’s having some kind of episode, and is not waking up,” he said to himself as much as to anyone else. Having spent a number of years as a policeman in a county North West of Atlanta, Randy had some experience with emergency situations. He remembered all those car accidents, heart attacks, and stabbings from long ago.

“Carolyn, wake up!” Randy bellowed. His training had kicked in instinctively, and he remembered that yelling into a victim’s face was the best way to clearly establish consciousness. As he shouted, he carefully watched her face, hoping to spot just a fluttering of her eyes, or a flinch. There was no response, no reaction. There was no life.

Tom had trained as a medic in the Army Reserves, and although he had not seen any action in Vietnam, he had felt prepared for it. He did not, however, feel prepared for this encounter. Tom saw Carolyn’s face turn blue, and realized this was an emergency. “She’s not getting any air,” he exclaimed.

Putting his ear to Carolyn’s chest, Randy could hear strange, unnatural sounds that were neither breaths, nor a proper heartbeat. But he could hear something, so he tried shaking her and calling her name again. It had no effect.

Less than a minute had passed by the time Jim reached her. He was alarmed by Carolyn’s unresponsiveness and the color of her skin. He

In Good Company

desperately wanted to see some sign of life. He looked towards Tom, hoping he knew what to do.

Whether it was the right thing or the wrong thing to do, Tom knew they had to do something. It would be better than doing nothing; she could die.

“I can hear something but it doesn’t sound right,” Randy cried out.

Carolyn then gasped a strangled breath and went limp.

Jim knelt down and held her head and, not knowing what else to do, he mimicked Randy’s approach, “Carolyn are you there. Wake up, Carolyn!” His shouts achieved nothing. “I must be able to do something more than this!” he thought. “Okay, I’m not a trained professional in medical matters, but what can I do?” The Boy Scout in him reacted; he put his hand under her neck and tilted her head back, recalling that this would prevent Carolyn from swallowing her tongue. Then the realization hit him, “That’s all I know to do.”

Randy and Tom couldn’t determine what was wrong with Carolyn, as there had been no warning, and nothing obviously untoward, apart from her sudden collapse. Had she had a seizure? Was she epileptic? None of them knew anything about her medical history; most had only just met her that day.

Jim could feel the panic taking over, and searched his mind for an antidote. “What should we do now? What does she need?” he asked himself.

Several people had gotten out of their chairs and moved towards the scene, drawn inexorably closer like iron filings to a magnet. Bruce was still standing at his chair, stunned at the suddenness of Carolyn’s fall, and startled by her convulsion at his feet. “Oh my God what is happening to her? What can we do to help?” He remembered seeing her take a candy from the bowl on the table, and called out, “I think she might be choking! I saw her take a candy!” He moved back to let the others get closer as he had never been in an emergency before. Bruce felt useless; a room full of high performance managers, and he had no clue what to do.

A HEART TOO GOOD TO DIE

Tom immediately checked Carolyn's mouth for obstructions, and found that it was clear, so he tilted her head back a little further, pinched her nose closed and put two big breaths into her mouth. There was a lot of resistance to his breath, "just like the first few puffs when blowing up a balloon," he thought. "Got to get the air in, and get the air out," he recalled from that training in the Army so long ago. He felt for Carolyn's sternum, and pushed down firmly on her ribs several times.

Once before, Tom had performed cardiopulmonary resuscitation in an emergency, (although he had learned to say CPR), and he was willing to do it again. It had been the mid 1980s, also at a training conference, when a colleague had collapsed on the volleyball court. All the IBM managers at that time undertook CPR training, so he was called to assist until the first responders could get there. Unfortunately, it had taken him several minutes to get courtside and his efforts were unsuccessful.

Unsure exactly how many times to pump and how many breaths to blow into her mouth, Tom was more worried about the likelihood that it was not going to do Carolyn any good. He thought his actions might make things worse than they already were; after all, that training so long ago had been perfunctory.

Bruce couldn't stand still any longer; he had do something more to help. "But what?" he wondered. He thought Carolyn may have been on some medication and seeing a purse on the floor he picked it up to check the contents. There were no pills or prescriptions that could give them a clue. He wasn't even sure it was her pocketbook! When he looked down at Carolyn again he couldn't stop the frightening thoughts, "Oh my god I'm witnessing her death! This just isn't fair. Someone like her, she was making such a difference."

Bruce couldn't have this happen right before his eyes, and believing that no one in the room had any medical background, he decided to go and get expert help. He, too, ran out into the hall, and rushed down the corridor. He frantically opened all the doors to the other rooms,

In Good Company

hoping to find someone who knew what to do.

“Oh my, her heart must’ve stopped,” Sara whispered to herself. She could hardly speak, having seen the pallor of Carolyn’s face and the way she had dropped like a rag doll. Sara had seen the events unfold in slow motion, and yet she was reassured by the speed of Randy’s response.

“He’s responding in ways that his hands know what he’s doing,” she muttered. Sara had also been trained in CPR, but seeing how quickly Randy and Tom were tending to Carolyn, she sensed she was not needed. Momentarily stunned by the sudden calamity, Sara was astonished to remember a workshop she and Randy had held in Atlanta, on September 11th, 2001. She realized that all eight participants from that day were together again at this conference!

Recognizing the seriousness of Carolyn’s collapse, Sara seized the conference room phone at the back of the room, and immediately called the coordination point for their conference.

“We have a medical emergency! It is a life or death situation, and we need someone who knows CPR now!”

She turned back to the room and saw that Tom and Randy were busy taking care of Carolyn, but everyone else had a “deer in the headlights” look about them. She stepped forward and suggested everyone help move the tables back. She knew they needed something to do; actions to break the mental paralysis, to help them move through the phases of shock.

Seeing Tom begin the CPR, Randy asked if he could help out. He was willing and able to assist, and he knew they had to get Carolyn breathing again.

Tom suggested that Randy do the chest compressions while he continued with the breaths. He presumed someone had called for help; feeling confident that, just as he was playing his part, others would be doing theirs.

Another minute had slipped by with no discernable effect. Jim was still holding Carolyn’s head and staring into her eyes, almost pleading

A HEART TOO GOOD TO DIE

for her to wake up. He saw that her eyes remained glassy and vacant. As Randy and Tom continued the compressions and rescue breathing, Jim noticed that Carolyn's chest only moved up and down when Tom breathed into her.

Jim's thoughts collided as he watched in horror, his world closed in and he couldn't hear the noises around him. He couldn't stop the feeling of helplessness. "This is really bad, she is not breathing by herself," Jim thought as he looked up at Tom, and then down into Carolyn's eyes again. "She's leaving us. This can't happen. This is really serious. She's dying."

Jim did not want to acknowledge these thoughts; they had no place in his experience. This youthful executive, with a vibrant personality that belies his many years in that Fortune 100 company, is smart and very deliberate in actions and words. He is a true southern gentleman, with clear blue eyes and a muscular physique that perfectly matches his zeal for sporting activities. Usually very capable and determined, Jim was not used to feeling powerless. But he just didn't know what else they could do.



All was calm outside the conference room, and only a few minutes had passed in what felt like an eternity, when Mark found some hotel office staff down one of the many corridors. He called out, "A person has collapsed in the conference room! We need help!"

Hotel security was alerted, and a middle aged, heavy-set guard came pounding down the corridor, with keys jangling, and walkie-talkie squawking. Mark led the way, and a moment later they were standing at the open door to the room. They saw Carolyn motionless on the floor, surrounded by a crowd of her colleagues watching with a hushed nervousness. A sense of helplessness filled the air.

Moving just a little inside the doorway, Mark could see that Jim was holding Carolyn's head, and that Randy was pushing on her chest, while Tom checked her pulse. One of them said, "She still isn't breathing." Mark tried to blink the image away, but it was so very real. On

A must read for heart patients. The lessons of this compelling and amazing story apply to every community in the United States. It offers a poignant, touching glimpse of the inner workings of a family impacted by cardiac arrest.

A Heart Too Good to Die

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