First principles

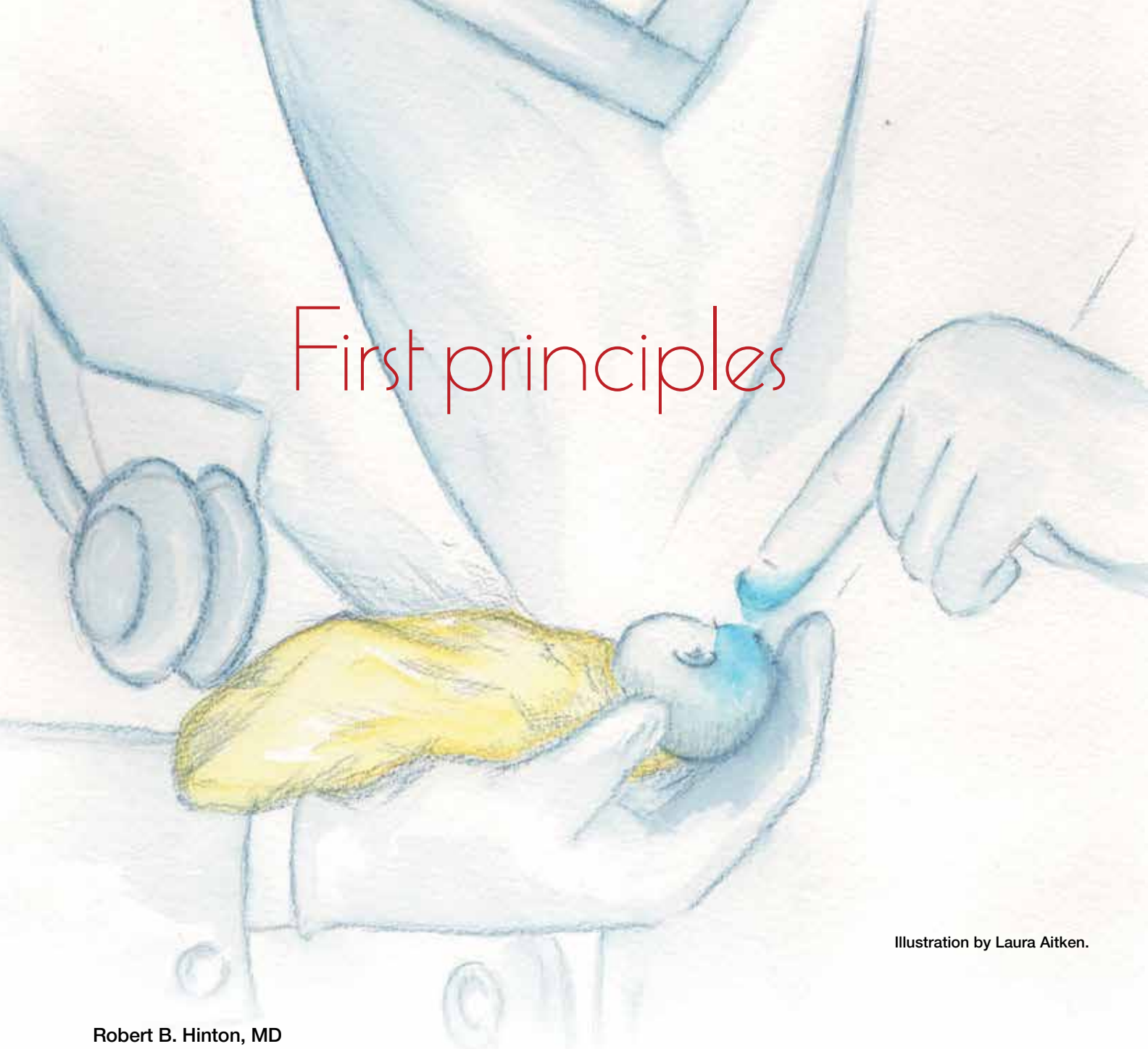

Illustration by Laura Aitken.

Robert B. Hinton, MD
The author (ΑΩΑ, Mercer University, 2002, Resident) is Associate Professor of Pediatrics in the Division of Cardiology at Cincinnati Children's Hospital Medical Center.

For my grandfather David R. Clare, 1925–2014.

He was stirred . . . by the ideal of a moral example.[1pp52–53]
—John Berger
A Fortunate Man: The Story of a Country Doctor

Because I had stopped wearing a watch as an intern, I had to steal a glance at the clock behind me. 16:46. I was rotating in cardiac catheterization, the third case had run late, and I was expected to round for call in the Pediatric Cardiac Intensive Care Unit (CICU) at 17:00. It was going to be close. As a new fellow in pediatric cardiology, I enjoyed the rhythm of training. After the exhilaration of real-time hemodynamics and helping to place a device, I was brought back to earth with the duty of holding pressure in the right groin after removing the catheters. As I recited the complications of inadequate hemostasis to myself, I trailed off into a counting game that quiets the mind. Starting with the thumb, I tapped my fingertips in sequence counting by threes (3, 6, 9, …), following my knuckles forward then backward across my hand, the end digits counting once per turn. To 48 then back to 3, the rhythm somehow comforting. Still bleeding at 16:58. I cursed the last heparin dose, a tradition among cardiology fellows, then asked for relief and hurried to the unit.

I was late, but relieved to discover that I was the first to arrive for rounds. There were more people in the unit than usual

and everyone was in motion, busy and unaware of the time. By necessity, ICUs have exquisite temporal resolution, which paradoxically obscures perspective: time is measured in minutes, not days; medications are titrated to effect through infusions, not doses; and vital signs are monitored continuously, not periodically. The charge nurse gave me her unadulterated assessment. There was much to do. The last room in the second pod was dark and the nurse's stand was clean, suggesting a vacant room. But after rounding on the second to the last bed, the team continued to the last room. The checkout was terse: "She was born earlier today, got here a couple hours ago, not a surgical candidate, the family is coming, care needs to be withdrawn." The surgeon nodded in agreement.

The room was uncluttered and the technology muted. Our CICU rooms have windows, but little sunlight was left. Aside from the monitor's lights, the room was dark, giving me the sense that I was standing in a shadow. The baby lay motionless, sedated and intubated, drips running. The electrocardiogram marched on steadily, elegantly poised despite the sinus tachycardia. Oxygen saturation blinked 64 percent. She was "dusky," an unsatisfying but familiar adjective. Her face was unnaturally drained, not pallid exactly, the color of her orbits and mouth an exaggerated almost regal purple, the hypoxemia akin to drowning. It wasn't long ago that blue babies were compassionately sent home to die. Considering the clinical context of a lethal cardiovascular malformation in an earlier era, I imagine the family's resignation and the clinician's frustration. How was I going to explain our inability to intervene?

Before attending to my first task, placing a chest tube to relieve pleural effusion, I considered the now unusual circumstance in our specialty of not being able to offer any intervention, any hope. I pondered what to say while stitching the chest tube in place.

The family arrived. Six or seven family members gathered at the foot of the bed, the mother alone at the head, hand on her daughter's cool arm. There is a strange perfection to the lower end of pediatric ICU beds: clean military folds and a neatly placed patchwork quilt. The quiet was conspicuous. I plainly described the anatomy and resulting physiology. I explained the lack of treatment options, the reasons surgery could not be done, and finally the natural history of the disease. What does "withdrawal of care" mean to a mother? We discussed (I recommended) removing the breathing tube and stopping the medications. She maintained eye contact, and her body language suggested she understood but desperately sought alternatives. When I asked her if she had any questions she looked away, away from me and away from her family, then tentatively down at her daughter. We stood in silence for ten minutes until my beeper went off, startling all but the patient. I excused myself, at which time the mother cleared her voice with difficulty, tears finally breaking down her face, and asked: "Can she be baptized?"

Baptism is generally considered entry into the church, and in Catholicism it is viewed also as a sacrament. I happen to be Catholic, and I believe in the sacraments. But when the chaplain on call told me that he was four hours away and that I should perform the baptism myself, I was alarmed. The suggestion was simple. But I was thinking about the post-op tetralogy of Fallot patient who was unstable, the hypoplastic left heart syndrome patient who needed a new central line, and the follow-up chest X-ray in the patient with a new chest tube, let alone the to-do list I had not yet started to do.

Straining to remember my catechism teaching, I paused uncomfortably, then said: "I'm not sure I can do this. I'm Catholic and I'm not a priest." A common misconception, I learned.

"What do you think they are asking you to do, exactly?" the chaplain asked patiently.

I remembered a preceptor from medical school telling me that pediatrics is one part medicine and one part advocacy (which is when I realized that those called to pediatrics are first and foremost advocates). I considered the active medical issues elsewhere in the unit, and tried to convince myself that performing a baptism might not be the best use of my time. Then I remembered something that instantly provided clarity. *Act, don't react*. My grandfather's advice and commitment to decision making for the long-term has long influenced my own thinking and judgment.

"Tell me how." The requirements for an official baptism are surprisingly straightforward: the word "baptize" must be spoken aloud and water must be applied to the initiate, preferably on the head. I wondered if the water had to be sterile, and imagined two priests arguing the merits of using either crystalloid or colloid. In the end, I found a small bottle of sterile saline, the size of my thumb, five milliliters maybe, with a stark white label. I carried it secretly in my pocket while attending to other patients, turning it over excitedly just as I had my bride's engagement ring. When the time came, I managed the full formal sentence: "I baptize you in the name of the Father, the Son, and the Holy Spirit." The mother's expression was one of profound relief. I marveled at her response and reconsidered the many meanings of healing.

The infant died two hours later. After I pronounced the death, the mother said "thank you" distantly by rote, and the few of us in the room quickly and quietly departed, leaving her with time alone. She stayed thirty minutes and left without saying another word. When things slowed down, I went to rest, thoughts racing. I watched my fingers tapping, my mind circling the unit bed by bed with a mental check list (3, 6, 9), punctuated by images of the mother and child (12, 15, 18), some patients tilting in the wrong direction (21, 24, 27), St. Peter upside down at the end (30, 33, 36), likely scenarios and contingency plans (39, 42, 45), St. Peter now at the gate (48 and back again). Ultimately the rhythm prevailed and I slept.

At rounds the next morning, I announced the death and the baptism. Some were intrigued, others dismissive, most

were confused by the nonmedical interjection. Medical specialization and rapidly advancing technology have resulted in increasingly narrow realms of expertise and a convoluted parsing of responsibility. Sometimes achieving standards of care requires only technical expertise. Interestingly, realizing standards of care does not require professionalism. I thought back to the night before, and my grandfather: *Act, don't react*. Be the advocate.

ICUs demand timely decisions, and declining to engage this family might have been justifiable, possibly advisable—but it would not have been professional. The baptism did not adversely affect the care of other patients, and it did not change the patient's outcome—but it benefited the family. I needed to act for the patient and not react to the pressures of expedient decision making.

Professionalism in health care delivery is defined as actions that are respectful and collaborative, responsive, ethical, and fair.[2–4] Clinical judgment is an essential aspect of medical practice, affecting communication, diagnosis, and decision making. In addition to the central role of critical thinking in clinical judgment, self knowledge and reflective thinking are necessary components of effective problem solving and sound decision making, allowing the physician to maintain advocacy for the patient as the primary goal.[5,6] End-of-life situations contain many complicated issues related to professionalism such as respect for patient autonomy and dignity, as well as the sanctity of human life. Cultural and religious differences often present challenges to standards of care when a patient is dying; professionalism coupled with knowledge is required to navigate the complexities.[7,8] More broadly, changes to health care organization may conflict with the basic tenets of professionalism by decreasing access and delivery, as well as dramatically changing how medicine is practiced.

The importance of professionalism cannot be underestimated. In the context of health care reform and the increasing role of various third parties in health care delivery, it is paramount that physicians continue to view professionalism as a critical component of medical care. It is encouraging to know that professionalism is teachable and that national associations representing medical schools and training programs recognize its primacy in medicine. But it is discouraging to find that professionalism is not practically or rigorously taught, and—more importantly, perhaps—not something that we talk about openly. While it is critical that both those who lead and those who mentor emphasize the importance of professionalism, individual physicians setting an example is the surest way to show how crucial professionalism is to each of us.

I remember the baptism when difficult situations arise and I find myself considering first principles, conscious of the pros and cons that reflective thinking has on decision making in a complex medical situation. If thoughtful reflection is a part of all momentous personal decisions, considered judgment, the core of professionalism, should equally be applied to difficult professional decisions.

I can imagine Dr. John Sassal, the subject of John Berger's *A Fortunate Man*, taking a practical approach to religion. His identity was formed by both the need to be useful and for his life to have meaning—for his actions to transcend a job and become a calling, a profession. His moral example was simple and disciplined. He was pragmatic, *and* he attended the dying. He balanced delivering scientific medicine with helping patients and families navigate the experience of illness. The intimacy of the bond between patient and physician reveals the self through illness, as Susan Sontag illuminated in *Illness as Metaphor*.[9] Optimal medical care must be based on this universal faith in humanism.

References

1. Berger J. A Fortunate Man: The Story of a Country Doctor. New York: Vintage Books; 1967.

2. Accreditation Council for Graduate Medical Education. Celebrating Teamwork: 2007–2008 Annual Report. https://www.acgme.org/acgmeweb/Portals/0/PDFs/an_2007-08AnnRep.pdf.

3. Greiner AC, Knebel E, editors. Health Professions Education: A Bridge to Quality (2003). Washington (DC): National Academies Press; 2003. www.nap.edu/catalog/10681.

4. Fallat ME, Glover J, American Academy of Pediatrics Committee on Bioethics. Professionalism in pediatrics. Pediatrics 2007; 120 (4): e1123–1133.

5. Maudsley G, Strivens J. 'Science', 'critical thinking' and 'competence' for tomorrow's doctors. A review of terms and concepts. Med Educ 2000; 34 (1); 53–60.

6. Kienle GS, Kiene H. Clinical judgment and the medical profession. J Eval Clin Pract 2011; 17 (4): 621–27.

7. Samanta A, Samanta J. Advance directives, best interests and clinical judgment: shifting sands at the end of life. Clin Med 2006; 6 (3): 274–78.

8. Edwards SJ, Ashcroft R, Kirchin S. Research ethics committees: differences and moral judgement. Bioethics 2004; 18 (5): 408–27.

9. Sontag S. Illness as Metaphor and AIDS and Its Metaphors. New York: Anchor Books, Doubleday; 1988.

The author's address is:
240 Albert Sabin Way, ML 7020
Cincinnati, Ohio 45229
E-mail: robert.hinton@cchmc.org