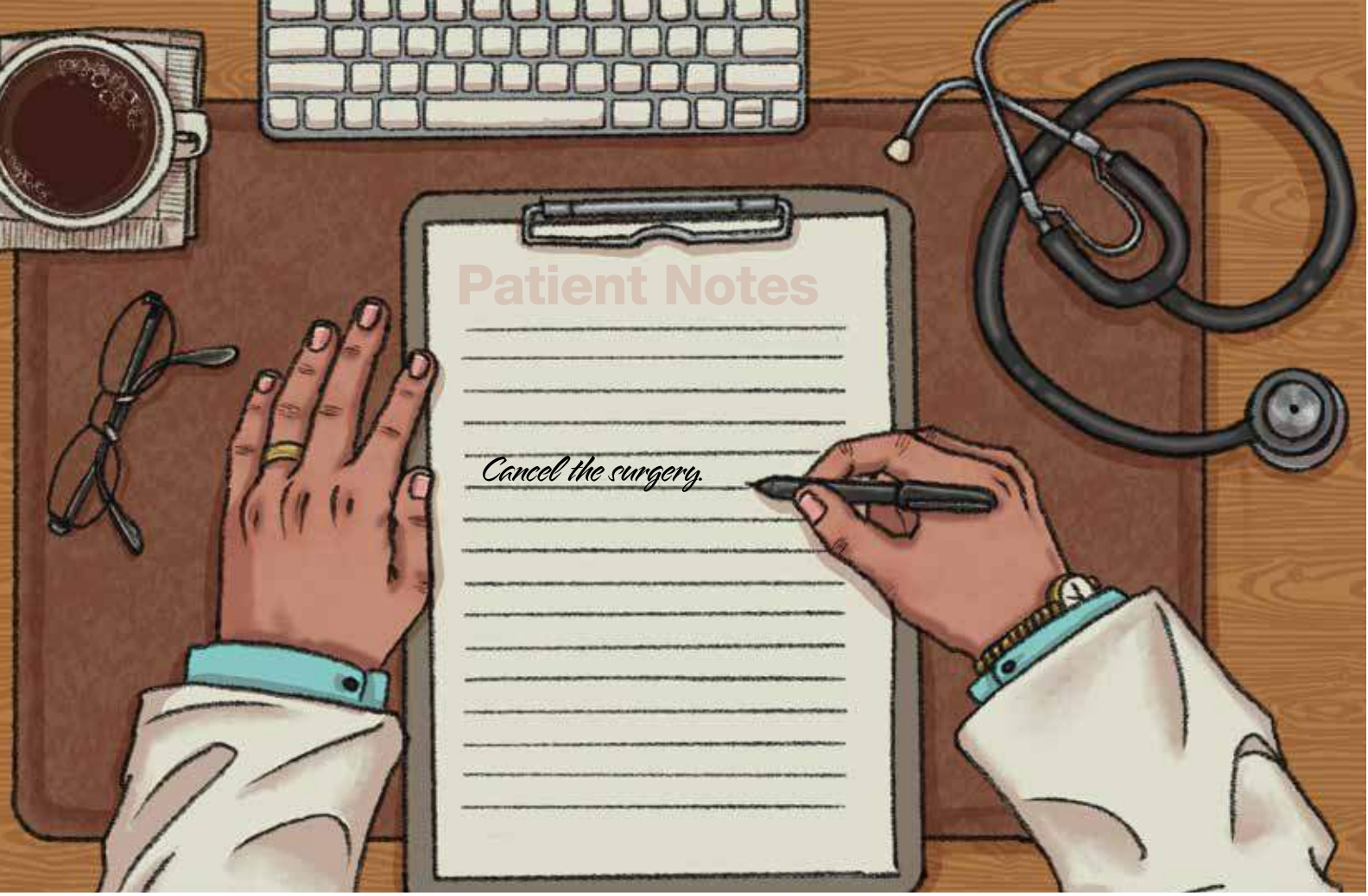

Illustration by Ezra Gilmore

On doing the right thing

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On a chilly fall afternoon in Nashville in 1985 my name was called. I walked to the front of the darkened room and carefully loaded a 35 mm film into the sprockets of the Vanguard projector that was aimed at the screen. Its whitewash painted a moonlit glow across the assembled white coats in the Vanderbilt Medical Center cardiac catheterization conference. As a first year fellow it was my responsibility to identify and present the important case of the week. With a snap, I turned the controls, and the familiar luminescent streams of contrast snaked their way across the coronary arteries that stretched over the blackness of a diseased heart.

I began to tell the story—a 50-something man who had come to our hospital clutching his chest, sweating profusely, with an electrocardiogram whose tombstones had given me palpitations. I drew the attention of the room to the blockage. It was not hard to see—the dye was, and then was not. It was all alone, a single blemish on an otherwise pristine map of coronary flow, somewhat off the main path, in a diagonal branch of the left anterior descending coronary artery. It was a coronary thrombosis.

At the time, the world had found new hope in streptokinase, a thrombolytic clot buster that could be dispatched to break the logjam of coronary thrombosis.

After initial trials had proved the effectiveness of direct administration of streptokinase through a coronary catheter, subsequent studies had shown an impressive mortality benefit from intravenous administration.[1,2] Snaking a balloon into the clot and expanding it—a direct frontal assault on the clot—was just beginning to be used in patients who had already received thrombolytics to attempt opening a blocked vessel.[3]

The patient was rushed to the catheterization laboratory, and intracoronary streptokinase was attempted, but the blockage had stubbornly persisted. A balloon was readied and, without the flight plan of a clinical trial, it was navigated through the clot to a spectacularly successful result. The blockage was, and then it was not. I played the frames back and forth. Was, was not. It was cinematic jubilation. I was the envy of the cardiology fellows sprinkled among the faculty.

After several technical queries from the crowd, the Chief stood up, one hand in his white coat pocket, holding his stethoscope. "All well and good. An impressive angiogram." Then, a long pause. The Chief was the master of the pause—not for drama, and probably not for effect, but because he was always thinking three questions ahead. There were points to be made. "Now, tell us, how have you changed this man's prognosis?"

The point was that I did not know and could not know. And no one at that time knew or could know. We had applied a novel approach that had not yet been rigorously studied. The angiographic outcome for this patient was stunningly successful. But had we really done the right thing? Ends do not justify means, and that day I learned that it is as important to think as to do. Doing can be right, but it is important to think about the rightness of doing. And if you do not know, then you should ask, and you should think about how to take your question to a scientific inquiry and answer it.

Two years later, I was rounding with the Chief as the senior fellow in charge of the clinical consultation service. We were at the end of a long day. The last patient was there for a routine preoperative cardiac risk assessment. The patient was a woman with a massive ovarian carcinoma, widely metastatic, with peritoneal implants and malignant ascites. She had hypertension, but no other risk factors, and no cardiac history. She was to get a debulking procedure in the morning. Low risk.

The Chief and I stood at her bedside. It was late enough that the medical students were gone. He began to talk with her about her family, about her church, and about her pain. He asked whether she was comfortable. "We'll be back," he told her. We walked outside. The Chief took his trademark fountain pen and began to write in the chart. In the quiet of the late hour, the rhythmic scratch of his pen tip was hypnotic. "Cancel the surgery. She is dying, and we need to make her comfortable." He picked up the phone and called the surgeon. We then spent a very long while with the patient. The Chief talked to her in the subdued tones of a minister, charting a course to comfort, and to her painless last hour.

We stood outside her closed door. I was dumbfounded. The Chief then, in characteristic form, as fresh as if he had just finished his morning coffee, talked about her prognosis. With her disease, the surgery would have had no impact.[4] That night I learned that when you do know, then truly the means do not justify the ends. Just because you can do something does not mean that you should do something. Doing can be wrong, and it is important to think about the wrongness of doing. Sometimes not doing is the right thing.

Dr. Gottlieb C. Friesinger, II (ΑΩΑ, The Johns Hopkins University School of Medicine, 1955), known far and wide as "Bud," died several years ago.[5] At his memorial service, I wore the Vanderbilt tie he had given me 24 years earlier, at our first farewell. Every day since that farewell, I relentlessly think about doing, about not doing, and about the right thing. And that, I think, would have given the Chief a pause of profound satisfaction.

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