

Freedom to Fly

Elizabeth Brigham, MD

Entering the pediatric intensive care unit for the first time as a second-year resident, I found the unit to be different from anywhere I had yet to encounter within medicine—a space filled with excitement, tragedy, hope, and a healthy dose of “don’t do anything without discussing it with me.” My week of night float in the unit had made a particularly strong impression. We had significant events in the unit every night that week. For me though, one patient had stood out: an adolescent with relapsed cancer. I had admitted him exactly one week prior during a night on call, and it had been gut-wrenching. In septic shock and respiratory failure, his mean arterial pressure couldn’t support the sedation needed to keep him comfortable. We apologized profusely with each pass of the suction catheter down his endotracheal tube as he shook his head from side to side in discomfort. Multiple times that first night his parents were told we might not be able to keep him alive until the morning, but somehow we did. A week later, his vital signs had stabilized, but progressively through the week he had declined, one organ after the next giving its final effort before collapsing in defeat. Our palliative care team had done their job. The family knew what was coming, but they hadn’t yet been able to say goodbye. With a milestone birthday fast approaching, they simply wanted more time. The patient’s prior pleas that he “didn’t want to die” left them questioning their ability to end the fight he had fought with such grit and grace for so long.

Around midnight, his nurse came over to the workstation to inform me that she had been going up on his pressor support for about an hour—nothing dramatic, just a slow and steady need to titrate up. She was curious about the plan for when he maxed out. Judging by the inquiring faces not so subtly listening in, so were many of the other nurses. This was a code that no one wanted to run. This patient was nearly as beloved in the hospital as he was at home. I cringed along with everyone else at the thought of his last moments being surrounded by nurses and doctors trying to pound

life out of his now jaundiced and edematous chest and body.

As per my now ingrained routine, I assessed the patient, talked with my attending, and updated the family. My attending was just meeting them, but this was the latest in a series of nights that I had spent at the patient’s bedside. An hour, and multiple discussions with my attending later, we were in the same place. Once again maxed out, the inevitable coming closer.

I gently woke his parents so that we could talk—this time about his code status. I knelt on the floor by the window seat where they were camped out for the night, a position that under any other circumstance would have made my ankles and knees scream. We talked about their wishes for his final moments, and I shared mine as well. I didn’t want his last moments or their last memories of him to be our team trying, with little hope of success, to restart his heart. His mother looked at me and conveyed simply, “I know what I should say.” The words “Do Not Resuscitate” were too painful for her to verbalize, but a mutual decision had been made.

Pediatricians by nature are protective, perhaps because we care for some of the very most delicate lives. Lives with years of potential ahead of them; bodies so far unblemished. It is tempting to be conservative with what we allow trainees to do on their own: with the procedures we allow them to attempt, with the conversations we allow them to work through. My attending could have taken over and simply told me to keep an eye on the rest of the unit while he spoke with the family, or shuttled me off to put in orders. Instead, he stayed behind the scenes, never more than a friendly telephone call and thoughtful answer away, emerging only when I specifically requested his help. Even then, after a brief bedside assessment to make sure that I hadn’t missed anything, he stepped outside to watch the patient’s monitor from a few rooms away, allowing me to remain at the patient’s bedside and build on the relationship that I had formed with his family over the past week. For my professional growth, the experience was invaluable. As a human, and as a caregiver for this patient from the moment he

DOI: <http://dx.doi.org/10.4300/JGME-D-18-00609.2>

entered our unit, it was a much needed opportunity for closure.

Our patient passed away peacefully several hours later, his parents and siblings at his side. It was a blissfully quiet night in the unit otherwise, allowing me to focus on his care largely uninterrupted. I left in the morning, drained of all I had, but filled with a purpose I had yet to experience as a resident. What a humbling experience to walk a family through the death of their child—one I never would

have had without an attending who was willing to let me fly.



Elizabeth Brigham, MD, is a Third-Year Pediatric Resident, Department of Pediatrics, Penn State Health Children's Hospital.

Corresponding author: Elizabeth Brigham, MD, Penn State Health Children's Hospital, Department of Pediatrics, H085, 600 University Drive, Hershey, PA 17033, 717.531.5685, ebrigham@pennstatehealth.psu.edu