REFLECTION

What Would I Want if This Were My Father?

We learn in medical school to avoid questions from patients and families requiring that we hypothesize what we would do in their situation, if our own health or that of a family member hung in the balance. It seems natural to avoid such speculation. There is something undeniably unsettling about inserting oneself as the proxy decision maker.

A little more than a year ago, during the final year of my residency, I completed a 2-week assignment as the night-float senior resident at the Veterans' Hospital affiliated with our university. Such night-float shifts were developed to comply with 80-hour work-week restrictions. While not the busiest of our educational rotations, it was perhaps the one in which we shouldered the greatest clinical responsibility. As the senior Internist overnight supervising 2 interns, I was on my own, without the reassuring proximity of fellows and coresidents at the university hospital.

During my last night of the 2-week assignment, several patients became acutely ill simultaneously. I was on call with 2 very conscientious interns, who were still only 1 month removed from medical school. Every question they posed to me that night had to do with a seriously ill patient whom I felt uncomfortable not assessing myself.

One of these was a 38-year-old patient, J.L., who was 150 days removed from a bone marrow transplant for relapsed acute leukemia. He was admitted the previous night for disseminated skin lesions, felt to be secondary to an as yet undiagnosed infection. He was being treated empirically with broad-spectrum antibiotics and had undergone multiple skin biopsies to clarify his diagnosis. When I arrived for my shift, the on-call senior resident I was replacing told me that J.L.'s systolic blood pressures were in the 70s, and that the intern was attending to this. Soon after, I was called away to a hypoxic patient requiring intubation, but then was called again by the intern, who reported that J.L.'s blood pressure had not improved. I went to see him. He was alert and oriented, but I felt that he belonged in the ICU. However, because no ICU beds were available, we moved him to a telemetry bed for closer monitoring. We planned to aggressively replete his intravascular volume, and re-evaluate.

I was then called away to other calamities and heard nothing more, which I took to mean our plan was successful. When I finally had a chance to see J.L. again early in the morning, his blood pressure had not improved. I told him that we needed to transfer him to the ICU. He declined. He was sitting up, speaking coherently, and answering questions appropriately. I updated the intern and attending from the primary service. The attending had a long relationship with J.L. dating to before his transplant, and knew he and his wife had always wanted everything possible to be done for him. He regarded J.L.'s refusal of transfer to the ICU as evidence he was confused. Indeed, despite his seeming lucidity, J.L. did not recognize him. We arranged his transfer in short order. Many days later, he died in our ICU.

Despite the intervening year and a half, I continue to have second thoughts about J.L. and the adequacy of the care I provided for him that night. What seemed to be individually reasonable decisions amounted to the wrong decision in sum. It is hard to not feel guilty when a patient remains hypotensive all night on one's watch.

Residents often treat shift work differently than their responsibilities as the primary team. It is easy to be lulled into a "keep them alive until morning" mindset, and hard to summon the discipline to question decisions made by others during the day. J.L. was seen by 2 senior residents before my arrival, making it easy for me to feel that his hypotension had been "dealt with," although clearly it had not. I wish we had transferred J.L. to the ICU when he first became hypotensive, even if it meant transfer to the university hospital. I wish I had communicated more clearly to the intern caring for him to notify me when his blood pressure did not improve. I wish I had been quicker to recognize his confusion when faced with his seemingly lucid refusal of transfer to the ICU.

In retrospect, it seems clear that I would have made different decisions had I considered what I would want for my family or myself under similar circumstances. Such introspection may be our only defense against the insidious allure of “groupthink” when there is ever increasing handover of patient care, a process that encourages passive receipt of clinical information rather than primary acquisition and synthesis.

J.L. taught me that accepting the assessments of other physicians at face value, a practice encouraged by the 80-hour work week, is not in the service of our patients. Now, as an attending, I find myself turning with greater frequency to the crutch of imaginative insertion to overcome the dangers posed by clinical inertia. “What would I want if this were my father?” has become a moral compass framed in a question, which I ask myself more and more, not for the sake of my patients but for my own. The primacy of that deliberative act forces me to regard patients with new, responsibility-laden eyes, unbiased by the attitudes and opinions of others. It allows me to serve them to the best of my abilities, which is after all what they and I deserve.

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