

# Somebody Will Pay

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A baby who should have died did not die. Somebody was to blame. Clearly, somebody would have to take responsibility. Certain parties would pay and pay a lot to find out why the baby survived. They would figure out who was answerable. The culprit would roast.

This being America, somebody also wanted to prove that nobody was to blame. No, they would argue, this terrible tragedy was not a tragedy; this apparent negligence was nothing like negligence. Instead, they would try to convince a judge and jury that such suffering was allocated randomly and chaotically, perhaps even unfairly. Bad things happen to good people all the time for no reason at all, your honor. There isn't a damn thing we can do about it. These people had hired me to help them.

The deposition was to take place in the ornate offices of an obviously successful downtown law firm. I don't particularly like lawyers, but I love their offices. Their offices always have the feel of wealth. The upholstery is always lush, the numbered lithographs on the wall that the decorator picked out at ArtExpo are sort of modern and a cut above the framed prints that are usually on the walls of doctors' offices. The big law firms are always in tall buildings and on high floors, as if to suggest that elevation somehow correlates with moral stature or at least litigious zeal.

There seems to be a lot of money in guilt and blame and accountability and punishment. Somebody would pay.

The terrible, tragic case was every parent's nightmare. How should I describe the case? The first line of prose is important. In this case, it said, "Baby Boy Jones is the 680g product of a 25-week gestation to a G1, P1, 25-year-old married woman." Most of us, born in hospitals, were first described in some such way. Our first role in life was as patients, even if we were perfectly healthy.

It doesn't have to be that way. We don't need to be born in hospitals. We could be born at home in bed or underwater in a hot tub. We don't need to start life as a patient.

There could be other ways to start the story:

"A baby was born at one o'clock in the morning in a small, Catholic hospital in an economically depressed Midwestern city."

"In the still hours of the morning, a very tiny baby was born..."

"A baby came to us but had not come to stay..."

"A miscarriage occurred..."

"A tragedy happened..."

But why focus on the baby? Perhaps he should not be the central character of the story. What does the story look like if we focus on the doctor?

Dr. Miller, a middle-aged neonatologist, was on his last night on call for the month. It had been a difficult month. A number of extremely premature babies had died after prolonged courses in the hospital. He'd been in the neonatal intensive care unit (NICU) most nights that month, trying to rescue them. He hadn't been able to spend much time with his wife or teenage sons. Neither wife nor sons were happy. Dinner that night at the Miller house had been a sullen affair, the resentment palpable in the air. One son asked Dad why he seemed to care so much more about those damn preemies (his mother: "Watch your mouth!") than about his own family. When Miller hesitated before answering, the boy went on to conjecture that Dad was mindlessly driven by a

technological imperative, and when Dad still didn't answer, he announced with all the certainty of his 15 years that he would never, ever be a doctor when he grew up. Then sullenly, with a politeness that violated the very spirit of etiquette, asked to be excused. Miller wondered where the boy had learned the term "technological imperative."

Miller was brushing his teeth, exhausted, and getting ready to crawl into what would likely be a loveless bed, when he got a call summoning him back to the hospital to attend the birth of a high-risk neonate. No, not one of his patients. Nobody they knew. The woman had just arrived by helicopter, 25 weeks. A baby at the borderline of viability. An extremely premature baby...

**D**r. Miller rushed to the hospital where he was met by the entire healthcare team. The obstetricians were there, the nurses from the delivery room and from the neonatal intensive care unit, the anesthesiologist. The whole team was poised and ready, waiting for their cue. The baby was reported to be approximately 25 weeks gestational age.

The obstetrician handed the tiny pale blue baby to Miller who listened to the chest. There was a faintly heard heartbeat but no pulses. The baby's little heart seemed to be quivering, churning, like an engine on a cold morning that coughs and sputters and whines but won't quite turn over. The bluish-gray baby did not move his arms or legs. He did not grimace or cry. He did not gasp or breathe. He just lay there.

What should we do for him now? What would he want us to do for him now? Perhaps he would want us to dry him off and wrap him in a warm blanket, to sing him a lullaby, to say a heartfelt prayer. Perhaps he would want to be enveloped in his mother's arms, held against her swelling breasts. That is what has been done for such babies from the beginning of time. We could have done that. But that is not what we do now.

The neonatologist intubated the baby and gave a dose of epi. The heart rate remained slow, faint, distant. He squeezed the tiny chest 100 times per minute, just a half-inch deep with each squeeze. After 10 minutes, Miller paused. The baby still did not breathe spontaneously. The monitor showed a heartbeat but Miller couldn't feel any pulses in the neck, the arms, or the legs.

Is this life?

Dr. Miller decided not. He stopped his resuscitative efforts. What did he feel at that moment? Regret? Sorrow? Perhaps he was relieved! Perhaps he'd been worried that the baby would survive and then he would need to be up all night in the NICU trying to save the baby when he really wanted to be home in bed. Perhaps, while he was brushing his teeth, he'd been anticipating getting into bed, thinking that perhaps tonight, for the first time in weeks, he would make love to his wife and that she would

welcome him, that it would be nice the way it used to be nice. Perhaps this fantasy was interrupted by the ringing of the phone, and perhaps he still clung to it, even though he knew that it wasn't likely before and was less likely now. Or perhaps it was nothing so spicy. Maybe he was just exhausted from recent political struggles in the hospital, battles over capitation payments for the NICU under the new managed care contract that the administration was proposing. Perhaps he was thinking that it was about time to retire, that medicine was no longer fun.

We don't really know what he was thinking. In his deposition, he stuck to the medical facts. The heart rate was 60, then 30. The Apgar scores were one at 1 minute, one at 5 minutes. The baby's head was quite bruised from the delivery.

Dr. Miller carried the baby to the parents. Later, much later, under oath, he said that he brought the baby to them because he thought they should be allowed to hold their son for a few moments before he died. He murmured something to them about "doing everything we could, too small to survive, I'm sorry." He paused for a few moments, watched them cry, and then, feeling awkward and excluded from the terrible privacy of their grief, he walked away. He went to the doctors' lounge, had a cup of decaf coffee, stared out the window at the dark night sky.

The father later testified that Dr. Miller just gave them the baby and left. The father didn't remember any conversation. He remembered being handed the baby, the tiny baby, the blue baby, as he sat sobbing by the head of his wife's bed in his gown and mask. Nobody else recalled the moment at all.

A few minutes later, the baby began to gasp. The parents anxiously called the nurse, who sympathetically assured them that these were only "agonal" respirations. She sat with them a few minutes and observed the baby, who gasped a few more times, and then she left. More minutes passed. The baby's gasps become more frequent. The baby let out a faint cry. The parents again summoned the nurse, who checked the baby's heart rate. It was 125 beats per minute. Shocked, she summoned the doctor who, also shocked, reintubated the baby and arranged for his admission to the NICU.

The baby's neonatal course was a nightmare. He had nearly every complication a premature baby could have. But each got better. Throughout the neonatal course, neither the doctors nor the parents ever discussed discontinuation of treatment. They didn't talk much about prognosis, either. Those moments after birth must have been much on everybody's mind, but they were never mentioned. Instead, memories of them would lurk in the background, hovering over each doctor and nurse as they drew blood, suctioned a tracheal tube, or inserted a chest tube, or hover over the parents as they taped their pictures to the inside of the isolette, as they placed tiny teddies in the corners, out of the way

of the cardiac monitor wires or the intravenous catheters. Perhaps fear of those memories was one of the forces that kept everyone away from discussions of prognosis or of the wisdom of continuing intensive care treatment. Start one of those discussions and somebody might wonder, “What if. . .”

Throughout the hospital stay and the months that followed, the baby’s parents were cooperative, friendly, even docile. They seemed to like the doctors, nurses, and therapists. The doctors and nurses and therapists liked them. Everybody was working together. The baby had many problems, but each problem seemed to be self-limited, and none of them seemed to be of sufficient severity to warrant a decision to allow the baby to die. They all took things a day at a time, a decision at a time.

Three years later, his parents sued the neonatologist and the hospital. They alleged that the decision to discontinue resuscitation after 10 minutes constituted malpractice, that the baby had been without oxygen during the time between when resuscitative efforts were inappropriately discontinued and the time when they were re-initiated, and that this period of anoxia caused his neurologic problems. They asked for 35 million dollars.

Somebody was to blame and we were sitting on soft leather chairs in a dark-wood paneled conference room on the 42<sup>nd</sup> floor, overlooking the city that Carl Sandburg had called the “hog-butcher of the world” to decide who that somebody was and how much they would have to pay.

We settled in. The court reporter set up her arcane and complex set of recording devices, and, after being sworn in (without a Bible) I stated my name and recounted my education. Undergraduate, medical school, internship, residency, a fellowship in medical ethics.

The plaintiff’s attorney was leafing through my resume.

“You were a resident back in the early 1980s?”

“Yes, 1981-84.”

“How many premature babies did you care for?”

“Oh, we used to cover a 40-bed neonatal intensive care unit. I would be responsible for 10 or 12 babies on my own, and would cross-cover the others at night. We did that for 6 months during the 3 years of residency. So, over the years, I cared for at least a couple hundred babies. Not by myself, of course. There was always an attending physician supervising me.”

“And during that time, did you ever have occasion to witness the deaths of any babies?”

“Many times.” Almost every month at least a few of the babies would die. Some died blessedly quickly, others only after weeks or months of lingering in the strange twilight zone between premature birth and premature death.

“Were decisions ever made to withhold or to withdraw life-sustaining treatment?”

“Certainly.”

“Did you participate in those decisions?”

“Well, sort of. But they were mostly made by the attending physicians.”

“But, as a resident, were you taught the proper way to go about making those decisions?”

“Proper?” Well now; I could see where he was going. He was laying the groundwork to build up a completely idealized view of medical education; he would move on to a completely idealized view of what the decision making process for decisions about life-sustaining treatment should look like. Then he’d try to show that Dr. Miller’s behavior in the real world didn’t match the fictional ideal, and bingo!—millions of dollars.

“Well, it wasn’t quite like that. Some of the things that we learned as residents were things that we were taught. Others were things that we observed. In still other cases, we had to figure things out for ourselves.” That statement, I thought, pretty much summed up the entire, surprisingly haphazard process of medical education.

“What do you mean, exactly, when you say that you had to figure things out for yourself?”

Now there was a good question. I learned many lessons about both life and death during internship, and I learned a lot about myself as I faced life and death. It was while I was working in the NICU that I first achieved that dream of doctors everywhere, to actually save a patient’s life. This happens a lot on TV but not so often in real life. Most of medicine is much more mundane – colds, rashes, vague aches and pains that can’t be diagnosed, can’t be cured, and don’t go away. But every once in a while, it’s not like that. For me, the first time, the patient was a 600-gram preemie and I was on call as a second year resident.

The obstetricians called the NICU to warn us that a woman was in labor at 25 weeks. I called the neonatology fellow, assuming that he would be there to take over. Alas, he was at home, 45 minutes away. Don’t worry, he said, he’d get in as soon as he could. In the meantime, do my best.

Forty-five minutes? Do my best? Was he kidding? I was just a resident. I was just covering at night. I wasn’t ready to solo. I panicked. I was angry. I felt abandoned. I froze. I didn’t want to do this, didn’t want to be there. I was in the middle of a 36-hour work shift, tired and alone, holding the bag for the neonatal fellow who was holding the bag for the neonatal attending physician. I wondered whose bag she was holding.

As residents, we spent a lot of time in the NICU. Interestingly, this was not because anybody thought it was

essential for our education as pediatricians to learn so much about neonatal intensive care. By this time, in the early 1980s, there was already a subspecialty board in neonatology. Any doctor who wanted to work in a NICU would have to do a 3-year postresidency fellowship in neonatology in order to become subboard certified. Thus, most pediatric residents would never again work in a NICU, would never again take care of 600-gram preemies, and would probably never need the skills that we were so painstakingly learning and endlessly perfecting. But the NICU was the most labor-intensive unit in the hospital. Every tiny baby needed three or four professionals hovering over the bassinets. As a result of these personnel demands, such units claimed a disproportionate amount of the residents' time. The NICU needed us and the hospitals needed the NICU, so there we were, night after night, month after month.

My anxiety and fear were gradually replaced by a seeping sense of vindictive euphoria. F@#% 'em all, I thought, I can do this, or at least I'll try, and, in the end, nobody will really know or care how well I do because the task itself is so meaningless. In a moment, they will hand me a baby who by all rights should just die and I will run through the paces of a resuscitative routine that I've rehearsed and rehearsed and rehearsed until I could do it in my sleep. You could learn this stuff by watching TV. The ABCs: Airway, Breathing, Circulation. Suction the trachea, intubate, check a pulse, start an umbilical intravenous line, give some fluid. If the heart rate is low, give some adrenaline. This wasn't magic. It wasn't rocket science either. I made sure my hair was combed, put on a clean scrub suit, and strolled over to the delivery room to see how Mom was doing.

It was a quiet scene. Doctors and nurses talking in whispers. I should go to the woman on the table, who was the quietest of all, should introduce myself, should try to give the pre-delivery schpiel. "Very high-risk, may not be viable, we won't know for sure until the baby is born, we'll do what we can, I'll let you know as soon as we know." This conversation seems to offer important information, but really offers almost none. It really only offers a chance to check each other out.

Her eyes searched mine quickly then turned away. What is she hoping for? That I will save her baby, perhaps? Or that I will wisely allow her baby to die, saving for her a life unburdened by a NICU cripple? Or are her hopes even more vague, a primitive fear and a longing for comfort and caring? Perhaps they are more modest, the chance for some simple recognition as someone who is suffering?

What sort of heroism is called for here?

What sort of doctoring?

Based on this conversation, I might soon have to make some profound decisions about the baby about to be born. Should I

have gone into more detail about the risks and benefits, the chances of intracranial bleeds or chronic lung disease or cerebral palsy, about the options for treatment or nontreatment? That sort of talk didn't seem appropriate to the powerful emotional tenor of the moment.

The nurses, as always, were solicitous of a rookie. They helped me set out my equipment. A DeLee suction trap. A tiny laryngoscope to open the baby's airway and visualize the vocal cords. Endotracheal tubes in the smallest sizes made. An umbilical catheter. Syringe with some saline flush. We turned on the heat on the warming table, got the leads for the temperature monitor and the transcutaneous oxygen monitor ready. We were robed, gloved, and masked. The tension was like the tension before a ball game or the tension before a showdown. I kept thinking that the neonatology fellow would arrive any minute to rescue me, that I was really a bit player, a stuntman, maybe even a stagehand, certainly not the star. We watched the great big clock on the delivery room wall. It was a little after 2 am.

Here it comes! The obstetricians were doing their final schtick, "One little push, that a girl, here we go. OK, relax now. Ohhh. It's a girl! A pretty girl. Looking good. Just relax, now. Now we'll give her to the pediatricians. Lie back. There you go."

There you go! Check pulse — weak and thready, about 70. Respirations — an occasional gasp. Color— pale, blue. Give oxygen. Suction. Intubate. I got the laryngoscope, give me the 2.5 ET tube. There, I think that's in. Check breath sounds. With the puffs of the ambubag, her chest rose and fell. I'm amazed at my competence. Good. Heart rate? 100. Can we get a BP? It's not reading. Pulse is still a little thready. Want to start a line, doctor? (This is the nurse's gentle way of telling me what to do, handing me the umbilical catheter.) I chose the larger umbilical vein, rather than struggling with the tiny arteries. No time for subtlety here. It went in easily, good blood return. Give a bolus, 10cc/kg would be what, 6 ccs? A teaspoon of saline. BP 40/20. OK, let's get her back to the NICU.

As we rolled into the NICU, the neonatology fellow strolled through the door, calmly shed his street coat and slipped into the sterile yellow gown. He took over, effortlessly. The nurse read out the numbers to him, he listened, briefly, to heart rate and breath sounds, shook his head slowly, patted me on the back. "Nice job. The kid probably won't make it, but you did a nice job."

He was right. The baby died 2 days later, in spite of receiving all that neonatal intensive care could offer. There was no further discussion with the parents about whether or not to continue treatment. At the end, there was a short, symbolic attempt at cardiopulmonary resuscitation. And the fellow was right. I did a nice job. I got all the tubes in place, the lines started, the right



doses of the right drugs calculated, calibrated, and delivered. I felt good about all that, but deeply bad about something that I couldn't quite name, about the things that hadn't happened but perhaps should have, or the things that had but didn't help. We never talked about the case again.

**H**ow to explain this to the lawyer? "Well," I said, "Much of what we were learning was not really what we were being taught. It was almost in spite of what we were being taught."

"Didn't you learn that preserving life is the central goal of the medical profession?"

"Sometimes, well, yes, sort of. But not always." What could I say? That you just had to be there?

There was something both terrible and arbitrary about the NICU. It was hard to tell which babies would live and which would die. Sometimes, babies we were sure would die would get better. They would begin to breathe, and to pee, and to eat, and to move. The light would come back into their eyes. They would go home, swaddled in a blanket, and come back to clinic, looking for all the world like normal happy babies in normal happy families.

Other times, the endings would not be so happy. The babies would remain on oxygen, ventilators, multiple medications. But we couldn't tell, early on, which babies would be which, and by the time we could tell, it wasn't clear whether it was morally right or legally permissible or emotionally tolerable to stop treatment and let them die.

For most of the attending physicians, the death of a baby was a personal defeat. Only one, Dr. Fletcher, seemed to have gotten beyond this narrow view. She was willing to talk to parents of babies in the NICU about stopping treatment and allowing their babies to die. Some parents seemed receptive to such talk, and together, the doctor and the parents would make a decision that it was time to discontinue life support. The baby would be moved to a quiet back corner of the NICU, the families would gather around the bassinet, the nurses would remove the endotracheal tube, turn off the monitors, and sit with the family. Usually, death came quickly. It was usually peaceful and almost anticlimactic after the drama of intensive care.

As interns, we had mixed feelings about Dr. Fletcher. She was the only attending physician who seemed to have any sense of the perverse reality of what we were sometimes being called upon to do in the NICU and the only one who seemed to be willing to do something about it. Her willingness to acknowledge the limitations seemed so right in some ways. But there was also something a little frightening about it. What if she was wrong? What if some of the babies for whom she stopped life support would have survived? Was she just "into death" in some weird

way? We made jokes about her and kept our distance. She had a different sort of power and mystique than the other doctors. It didn't seem to be something that she could teach or that we could learn, even if we did aspire to it. Her special power was something that she had earned herself, in ways that we could only imagine. She seemed to carry within her some secret, incommunicable grief that allowed her to talk to parents in a special way and to gain their trust. Mostly, we were happy to be in the NICU during the months when she was the attending physician, though it was sometimes a little hard to tell whether that was because she was taking good care of the babies, or taking good care of us. And we needed care badly.

By February of internship year, the schedule was taking its toll on those of us in the trenches. The hospital was full to the brim, mostly with children who suffered from some chronic disease or other and who'd gotten diarrhea or the flu and who, in their already debilitated condition, couldn't handle one more virus. Every night would bring six, eight, or ten new admissions, and as many discharges. We were both treating and triaging, trying to allocate the scarce resource of a bed in the children's hospital, and to figure out who really needed one and who could get along without one. Our care was all crisis intervention. We were not sensitive or holistic, we were technical, pragmatic, and ruthlessly competent. The emergency room was full and chaotic. The busier it got the more tired we got. We were starting to catch all the viruses we were treating. We were beginning to wonder if we were going to make it. We insisted on a staff meeting with our chief residents.

It started as a basic gripe session. Too much work, too little sleep, complaints about medical records. But then Ellie began to talk. Ellie had the toughest schedule of any intern. By the luck of the draw, she had gotten her vacation months early in the year, and then had 8 straight months on the wards. February was her sixth month in a row on call. She had gone from the NICU to the cancer ward to adolescent medicine and back to the NICU. At the beginning of the year, Ellie had never been without a smile. Now, her face was tense, her eyes hollow, and in her voice there was both a strange resignation and an unsoothable ache.

When she began to speak at this meeting, she didn't complain about all the things that everybody else was complaining about, the inadequate food when we were on call, the medical records that didn't show up when we needed them, the lack of sleep, the unfair call schedule. She seemed almost beyond those petty concerns. Instead, she started to talk about death, the topic that hovered all around us all that year like a faithful ghost that we were all afraid to acknowledge.

Ellie described how, the previous night, one of her teenage patients had died. It was someone whom Ellie had met during her month on oncology and to whom she had gotten quite close. The girl had bone cancer. Her leg had been amputated but, in spite of that, the cancer had returned and metastasized and there was nothing more that we could offer. Her death was anticipated, inevitable. There was no home hospice at that time that would accept a teenager and so she had been in and out of the hospital, receiving palliative care for the incurable and painful metastases to her liver and brain. On some admissions, she would perk up a bit and even tell funny stories. She liked to titrate her narcotics so that she would still be able to read, to watch movies, to enjoy the little bit of life she had left. Her story was moving and tragic. We'd all gotten to know this patient over the course of the year but Ellie had cared for her the most and gotten the closest. Her parents and younger sister were loving and devoted, and also dejected and angry. They sometimes fought with each other or with us. Like all good advocates, they were not always easy to get along with.

When the end came, it was peaceful, but was also very sad. No matter how much a death is anticipated, it is always, for loved ones, shockingly painful. Ellie cried. The family cried. The nurses cried. The hospital room became transformed momentarily into something different, a surprisingly spiritual place. As deaths go, this was a good one. The grief that came with the inevitable end was not entirely unwelcome. It was a healing sort of pain.

Then, Ellie said, her beeper went off. It was the Emergency Room. She had two asthmatics to admit. Her beeper went off again. It was one of nurses on the toddler unit. A patient's IV line had fallen out and could she come and restart it. Her beeper went off again. As she sat by the deathbed, she felt a deep moral obligation to stay connected. And she felt her own emotional need to grieve a little. At the same time, all the routine stuff of a pediatric intern's night on call was piling up. The two sets of demands seemed incommensurable, absurd, ultimately enraging.

As she told this story to the hushed group of interns and chief residents, she began to cry but she kept talking, tears rolling down her cheeks, her voice getting huskier with her determination to say what she had to say, to demand what she knew was her right to say and be heard. One by one, we all began to cry with her. Even the guys. How could we be expected to carry on like this? How could we be human when our education consisted of such institutionalized inhumanity? She was not asking for much, Ellie said. She could do 8 months in a row of caring for sick and dying children. She could do it without sleeping every third night. She could cover the cancer patients and the preemies and the motor vehicle accidents and the child abuse cases. She was pretty tough, she thought. But she also thought that, when one of her

patients died, she should be allowed a little time, just an hour or two, without getting paged, to sit with the family and grieve and to let herself feel something. Couldn't the educational system allow a little time, she asked, allow a little time for doctors to feel something now and again?

Our chief residents said they would see what could be done. But not much could be done. Doing anything would require some explicit acknowledgment that death happens and some explicit planning for it. Such an acknowledgment was not part of the administrative mindset, the educational mindset, or the institutional culture. We were learning a lot about death and dying and about how doctors were supposed to respond to it.

In *The House of God*, Samuel Shem describes how, during his internship year, one of the interns committed suicide. The suicide came as a shock to the other interns because they all wondered whether they should have seen it coming, whether they could have done anything about it, whether it could happen to them. They were sad and angry. They needed time to process the loss, time to try to understand it, time to grieve for their lost friend and colleague. Shem writes, "The [Chief] seemed upset, puzzled that one of his boys had killed himself. He talked about 'the pressures of the internship year' and about 'the waste of a great talent.' He reassured us that he wanted to give us some time off to mourn. However, he could not do this. In fact, we'd have to all work a little harder, to fill in" (1).

The psychological result of this sociologic approach to death should come as no surprise. The lost emotions of grief became terrifying talismans of pain. Any situation that even begins to remind doctors of death becomes a situation to be avoided. The cycle is self-reinforcing. The longer it goes on, the harder it is to break. There was no attempt in *The House of God*, and no attempt in our residency program to begin to acknowledge the sadness, the pain, and the grief that comes when a patient dies. There was no inkling that these feelings were not something to be avoided but something to be honored. We hurt because we care. If we could not allow ourselves to really feel the pain, even for an hour or two, then we would certainly not allow ourselves to continue to really care very much either. And any conversation that came close to those places would become a dangerous conversation to be avoided. Discussions about death and dying would become discussions about ACLS, about pressors, about ventilator settings or, for the more touchy-feely, about new modalities of palliative care, or morphine drips, or living wills.

So, three stories of children and choices, three stories about death and dying. A tiny preemie is left to die, only to survive. Another is "saved" only to die later. A resident is not allowed time to grieve with a family when her patient dies. What do they have in common? Anxiety, moral uncertainty, anger, choice, tears.

Let me suggest that moral reflection begins with a particular type of personal suffering, an existential anxiety about whether we are living life as we should and doing the things we ought to be doing. Writing about these questions is an abstract exercise, but it is not at all abstract when we care for patients and make choices, when we are not philosophers or scientists but doctors.

In those moments, there is fear, power, and pain, a tremendous sense of responsibility but also an equally pervasive sense of helplessness. We can make choices but it often seems as if there are no choices to be made. There is something falsely reassuring in this passive stance.

We don't always recognize these moments right away. We can't always make sense of them as they happen. Often, it's easier to try to forget them, to run away from them. When we can't, they haunt us, we worry over them, and sometimes, someday, an understanding later coalesces. Such moments invite us to try to understand what happened, why we felt what we felt, thought what we thought, did what we did. And, ultimately, why we are who we are, and how we will become who we want to be. Social, cultural, economic, moral, religious, legal, and scientific forces all press against us, squeezing us, shaping us. But we can press back. Between the pain of being squeezed and the fatigue of pressing back lie the moments of moral choice, the moments when we have a chance to learn the most important lessons.

## Reference

Shem S. *The House of God*. New York: Dell, 1981.