

Letters to the Editor

To the Editor:

Dr Hake raises a valid and interesting point regarding the functional outcome of “Closed Digital Artery Injuries” (*The Ochsner Journal*, Volume 11, Number 2). Documented cases to date have focused on confirming that surgical intervention is necessary for digital survival and unfortunately provide minimal outcome data.

A complex comminuted fracture pattern was present in 6 of the 9 surgically repaired cases, which does appear to correlate with the number of cases labeled as just survival rather than good functional outcome. However, follow-up information is insufficient, and no quantifiably comparable functional data are available. Although it is likely that a more severe fracture pattern is associated with a worse functional outcome, it is difficult to draw any statistically significant conclusions.

Bernard Luczak, MBBS
Royal Perth Hospital, Perth, Western Australia
bpluczak@gmail.com

To the Editor:

The 2011 winter issue of *The Ochsner Journal* (Volume 11, Number 4) devoted to end-of-life issues is of intense interest to this 86-year-old Ochsner pediatrician. I have had personal experience with superb care at the end of life (dad and wife) delivered at Ochsner and know of horrible experiences of patients treated at “St. Elsewhere.”

Throughout the issue, in every superb discussion for which you must be proud, your staff of today demonstrates recognition that your technical advances have brought you closer and closer to being able to control the time of death than ever before. And at the same time, increasing publicity and legal opinions about your actions—and interference with same—have made life so much more difficult for you. I’m sure there are others, such as “young” Frank Riddick and George Porter, who sympathize with you all as do I.

I’m proud to point out that nowhere in this issue does anyone make a statement with which the founders and older staff would disagree. I heard the phrase stated by Dr Brooks—“Cure Seldom, Relieve Sometimes, Comfort Always”—a number of times when I was a student at Tulane. Every piece of good advice and intention stated in this issue is similar to what I heard from the Clinic founders, all of whom were my teachers.

Clearly today you have the same concerns that we did and try to involve the family in each and every case to the maximum extent possible. We had a luxury denied you of having much more time to spend with patients. Bill Arrowsmith, Bill Davis, Tom Weiss, John Archinard, and of course Harrison Snyder, Millie Pouncey, myself, and Andy Thalheim had plenty of time to spend with the families of dying patients. Rarely did we have problems with communication and divergent family desires as discussed in several examples in the winter issue of *The Ochsner Journal*.

Only once in my 40 years of experience in our Ochsner institutions can I recall that we did not follow the wishes of a family. Until reading the most recent issue of *The Ochsner Journal*, I was unaware that there might be a difference of opinion as to what is considered to be in the best interests of an infant patient. In 1954, the diagnosis of trisomy 21 depended entirely upon clinical examination of the patient. Then Dr Harold Cummins and Dr Ralph Platou of Tulane described a particular pattern of a central palmar triradius detectable by doing a palm print to confirm the diagnosis. (Chromosomal studies came later.) Of course, as an extension of the Tulane Department of Pediatrics, we at Ochsner had many such patients referred to us. Invariably we discussed all options with the family, and then the management of each case was determined by what they thought was in the best interests of the infant—and of the family.

We older staff are mighty proud of how your generation is performing. You might ask John [Ochsner], Frank [Riddick], and George [Porter], but it seems to me that Dr Townsend’s article in this issue could well have been written by The Chief—Alton, Sr. I enjoyed the issue and look forward to continued discussion of this important topic.

Jim Fruthaler, MD
New Orleans, LA
jfruthal@att.net

To the Editor:

I enjoyed the article by Rome et al (“The Role of Palliative Care at the End of Life,” *The Ochsner Journal*, Volume 11, Number 4) regarding the role of palliative care in a cure-oriented medical model.

We are taught starting in medical school to cure the patient. When this fails, there are often silence and frustration on the part of the physician. A patient dying is often looked at as a “failure.” In the neonatal intensive care unit (NICU), we have a unique situation

because the baby's life has just begun. Our patients can't express their end-of-life "wishes." Hence, we must form a trusting relationship with parents and carefully tease out their wishes and desires for the last hours, days, or weeks of their child's life. Simply finding out what is important to the family can be difficult but attainable. This is made more difficult if the timing of the discussion is at the end of the baby's life and can lead to feelings of being rushed.

At Ochsner, I have found a group of dedicated medical caretakers in the NICU who want to passionately embrace end-of-life care issues. This core group is now starting to formalize standing orders for comfort care and to offer palliative care consults for our babies with life-limiting illness. There are no specific flow diagrams from the American Academy of Pediatrics (AAP) or other committees for newborns. These AAP guidelines essentially state that parents must become active participants in the decision-making process after open discussions that are guided by the child's best interest.¹ This requires an open and trusting relationship between medical caregivers and parents. So I completely agree with the concept that palliative care is not to be turned to when all else fails, but rather to be included in the complete care of a complex patient at all stages.

Palliative care teams are often the link between families and the medical team. We must try to filter and present options to the family that keep the child's best interest in mind. We can form bonds that no other medical professionals in the hospital are able to do. In

our unit, we have primary nurses and neonatologists assigned to each baby who help facilitate these relationships. Our tiny patients with complex problems and their parents deserve a physician/nurse advocate who can synthesize all these data into salient, easy-to-understand language so they can attempt to do what is best for their dying or critically ill child. We must provide passionate care that is focused on the entire family because they deserve to be treated with human dignity.

In closing, we must always remember that the art of medicine includes realizing that we as physicians are given a gift to relieve suffering. We must not be afraid to discuss end-of-life issues with the families of dying babies. As stated by Dr Brian Carter in a recent article about the need for frank and open discussions to find out what matters most to families when their child is not expected to live: "We must remember that the goal is not to be perfect during such exchanges, but be **present**."²

Matthew Cortez, MD
Ochsner Neonatology, NICU Palliative Care Team
Member
macortez@ochsner.org

REFERENCES

1. American Academy of Pediatrics Committee on Fetus and Newborn, Bell EF. Noninitiation or withdrawal of intensive care for high-risk newborns. *Pediatrics*. 2007 Feb;119(2):401-403.
2. Carter BS, Brown JB, Brown S, Meyer EC. Four wishes for Aubrey. *J Perinatol*. 2012 Jan;32(1):10-14. Epub 2011 Nov 17.