Intensive Care Med (2019) 45:707–708
https://doi.org/10.1007/s00134-019-05581-6

FROM THE INSIDE

A thirty second pause

Alberto García-Salido[1*], Daniel Clemente-Garulo[2], Silvia Escalada-Pellitero[1,2] and Ana Serrano-González[1]

It was a normal evening in the pediatric critical care unit (PICU). I was doing a PICU round with Silvia, the clinical fellow on-call. We were discussing antibiotics, resistance, respiratory parameters, and respiratory distress. It was a normal day, no different from any other.

But the phone rang.

On the screen I saw the name of one of my best friends, Daniel. He is a pediatric rheumatologist. When he said hello, I realized that something was wrong just by his voice. He started to talk about one of his patients. A girl with juvenile idiopathic arthritis that had been previously admitted to our unit because of macrophage activation syndrome. He explained to me that she was very ill in the emergency department of a non-pediatric hospital. She needed to be transferred to our PICU. He knew this because the girl's father had phoned him. Daniel was there from the very beginning of her disease. After talking with my friend, we waited for a new phone call from the hospital.

They explained to us that the child was in shock, with lactic acidosis. The pediatrician at the emergency department explained to me that initiation of mechanical ventilation, fluids, inotropic agents, and broad-spectrum antibiotics was necessary. They had also initiated corticoids in high doses because of the previous macrophage activation syndrome.

While we were preparing the PICU bed, we were told that the child had suffered cardiac arrest at intubation. After 20 min, they were able to resuscitate and stabilize her blood pressure and respiratory status. They started to prepare the transfer to our hospital.

Two hours later, during the night, we received the child. At first sight, we realized that she was ill, very ill with low blood pressure, high heart rate, very altered perfusion, and non-detectable oxygen saturation as determined by a finger pulse oximeter. We quickly moved her to the PICU. The first arterial blood gas analysis indicated a very low pH. At that moment I rose my head and saw him; Daniel was there with his chief. We looked at each other and no words were needed to understand. We started the stabilization as fast as we could.

The parents arrived at the PICU 20 min later. We explained the situation. They sat next to Daniel while I broke the bad news to them.

A few minutes later, their daughter suffered another cardiac arrest that was resolved after 20 min of cardiopulmonary resuscitation. After this, she showed no response to inotropic treatment or fluids. It was clear that if faced with a new cardiac arrest it would be difficult to treat.

We again sat with her parents. After explaining the possibilities, we offered them the possibility of staying in the room with her in case of a new cardiac arrest.

They decided to stay.

And it happened again.

We started the cardiopulmonary resuscitation procedures. I explained to them what we were doing. Daniel was a few meters from us; in silence, but beside his patient, close to the parents.

After 40 min, I again spoke with the parents. I explained to them that because of the absence of response we should stop the resuscitation and allow the natural death of their daughter. Of course, it was not easy; it never is. After 5 min we stopped. I turned off the ventilator and removed the endotracheal tube.

Then "the pause" occurred naturally.

*Correspondence: citopensis@yahoo.es
[1] Pediatric Intensive Care Unit, Hospital Infantil Universitario Niño Jesús, Avenida Menéndez Pelayo 65, Madrid, Spain
Full author information is available at the end of the article

Springer

All of us stayed in the room in silence. I looked at her with respect. The nurses and Silvia did not move. No one spoke. Daniel was also there. We stayed there to show respect. To recognize the girl who was there. To remember her life and laughs. Through silence, we tried to emphasize the brevity and importance of that moment. Because she deserved it as a human being. With those seconds, we were able to recognize and honor her. Some of us cried and these tears were our words without words.

The pause can be initiated by anyone in the room. In addition, a phrase can be said to introduce it or explain what is going on (e.g., "let us pause to honor the passing of…"). In a situation where resuscitation was attempted, it is preferable to perform it immediately after death. This allows all involved to be present and share in the practice before leaving the room. It is recommendable to invite the family to participate in the practice. This increases the shared experience and is a way to acknowledge their loss [1, 2].

After nearly 30 s, we left the parents alone in the room.

Daniel left the PICU around midnight. We talked to the parents a couple of times before he left. They asked about an autopsy in order to know what happened.

Days later we knew that their daughter had developed an interstitial lung disease as a fatal complication of the juvenile idiopathic arthritis. The psychologist from our unit interviewed the parents to follow their grief. In addition, we sent them a condolence letter signed by Daniel and the entire PICU team.

We received a medical response concerning what had happened that evening, but it was not the only lesson. Those 30 s were much more than time. Thanks to the pause we will never forget her and how we must fight and honor life even after death.

Author details
[1] Pediatric Intensive Care Unit, Hospital Infantil Universitario Niño Jesús, Avenida Menéndez Pelayo 65, Madrid, Spain. [2] Pediatric Rheumatology Unit, Hospital Infantil Universitario Niño Jesús, Madrid, Spain.

Compliance with ethical standards

Conflicts of interest
The authors have no conflicts of interest to disclose.

Ethical approval
An approval by an ethics committee was not applicable.

Publisher's Note

Received: 8 January 2019 Accepted: 22 February 2019
Published online: 6 March 2019

References

1. Bartels JB (2014) The pause. Crit Care Nurse 34(1):74–75
2. Ducar DM, Cunningham T (2018) Honoring life after death: mapping the spread of the pause. Am J Hosp Palliat Care 27:1049909118813553. https://doi.org/10.1177/1049909118813553