

Fighting On

Jeffrey M. Drazen, M.D., Nihar R. Desai, M.D., and Philip Green, M.D.

Related article, p. 527

She had been living with multiple myeloma for more than 7 years before she showed up in our intensive care unit (ICU). It had not been easy, but she had beaten the median survival time by a factor of two or more. Now, late in the game, the myeloma was winning, and the options for this 83-year-old woman were dwindling. Seven months earlier, she had undergone cervical spinal fusion and the placement of rods for instability. Things had not gone well postoperatively, and she had developed renal failure, most likely from the triple hit of her myeloma, wound sepsis, and intercurrent gastrointestinal bleeding from ischemic colitis. She still had a surgical wound draining pus and had spent much of the time since surgery in one sort of health care facility or another; now, back in our ICU, she was the patient in bed eight.

Her admission diagnosis of sepsis seemed correct. She was febrile, delirious, and hypotensive; pus was still draining from her wound. Although there was anasarca from her renal failure, we could find no other source of infection. We cultured her wound, rounded up the other usual suspects for fever, started her on broad-spectrum antibiotics, and supported her blood pressure with the use of vasopressors. Within 48 hours, she was mentally clear and no longer febrile or hypotensive. Although out of crisis, she was comfortable only when placed in a specific position in which her upper back and neck were sup-

ported. She tried to eat but had no appetite. We had managed her care without dialysis, but it was clear from the clinical course that she would require it soon.

On her third day in the ICU, we were at her bedside for early-morning rounds. She was one of two patients in our 10-bed unit with whom we could converse, so we lingered. We talked about the local news with an emphasis on the weather; she was concerned that her grandchildren might not be able to do what they had planned because of the threat of thunderstorms. We steered the conversation to what had just happened to her and how the next chapters in her battle with myeloma might play out. Then, without warning, she turned to us and said with great clarity, "This is it. I do not want any more treatment."

We had been through such cases many times before, so we adhered to standard guidelines and made arrangements to have a family meeting at her bedside later that day. All her care providers had met and agreed that although there were treatments yet to be tried, even under the best of circumstances, her chances of living more than a year were slim. Even if she were lucky and could survive another year, she would probably spend most of that time dependent on dialysis in hospitals and nursing homes. Her daughter, who was her designated health care proxy, already knew and understood these facts, but she was intent on maintaining family harmony.

The patient's husband, son, and daughter were at the meeting, along with many members of her care team. We ran the meeting by the books and started with the usual discussion. The patient's oncologist had told her that there were treatments for her myeloma that had not yet been tried, but though it was possible her cancer would respond to one of them, it wasn't likely. Since her kidneys were failing, she would probably require dialysis; even then, the chemotherapy would not be easy. In the meeting, the patient stated that she had reached her limit.

After we had answered the family's questions and tried our best to ensure that they understood she was unlikely to get better, they asked for some private time together. We left the room; 45 minutes later, her son emerged to tell us that we should do "everything possible to save his mother." He did not want to discuss the matter further.

When we visited our patient the next morning, she said little, but we later learned that she had acquiesced to additional treatment in order to please her son. She left our unit later that day for the oncology floors, where she faced more chemotherapy and implantation of a dialysis catheter. The system had failed our patient: there was no family physician whom the family knew and trusted to intercede on her behalf.

The daughter told us that despite her pleas that her brother and father heed her mother's wishes, they had urged the patient to

“fight on,” and she had reluctantly agreed to do so. In our ICU alone, variations of this basic scenario were played out three times that week. We wondered how often the same thing happens in the thousands of ICUs around the world — a family facing a crisis but desperate not to lose a loved one makes a decision that is in the family’s interest and not necessarily the patient’s. Try as we might to keep the family focused on the patient, we often fail. If enough families decide to extend medical care in such circumstances, we fill our hospitals

with patients who are reluctantly accepting treatment they really do not want.

We have to admit that our team was happy to see the woman leave our ICU. It was not that she no longer required ICU care; we simply could not face her in the morning with the optimism needed to convey to her that we were helping her achieve her goals. We worried that we were torturing her for little gain. Since her departure, we have not stopped questioning whether we, as her physicians, did right by this woman. Conflicting wishes and demands re-

garding end-of-life care are a common problem, but one with no clear solution (for another type of example, see *Clinical Decisions*, pages 527–531). Those of us on the front lines can’t but wonder: for whom do we “fight on,” and why do we do it?

Editor’s note: The patient died within 3 months of leaving the ICU; she never returned home.

Dr. Drazen is the editor-in-chief of the *Journal*. Drs. Desai and Green are residents at Brigham and Women’s Hospital, Boston.

Copyright © 2009 Massachusetts Medical Society.