



*This is a resident case log of a patient encounter in which  
an "Aware Medicine topic" was central.*

### The Best Laid Plans

An elderly female ("Mabel") was brought to the ER via ambulance after becoming non-responsive and apneic at home. She was intubated in the ER and had a cold, mottled leg. She had a history of a TIA, atrial fibrillation, and had recently been feeling "unwell" per her caretakers. She had no living family whatsoever but now lived with a caring family in her small hometown. "Mabel" had grown up in this small place and lived with her brother for her entire life. She never married and had no children. After he passed away in the 1980s, she lived on her own until suffering a TIA a few years ago. Following a rehab stay in a local nursing home, it was clear Mabel was not capable of living on her own again. A local family consisting of a respiratory therapist and her teenage children stepped in and agreed to assume care for Mabel in their home. By all accounts, this was a "win-win" situation. Mabel enjoyed the near-constant companionship of young people, card games, and makeovers from teenage girls. Mabel had a healthcare power-of-attorney--a former "neighbor-boy" of Mabel's who was now a local businessman in his 50s. The POA and her caregivers comprised Mabel's de facto family. The arrangement was perfect for this delightful lady, who was by all accounts as sharp as a tack.

Mabel's caregivers and healthcare POA were available within hours of Mabel's arrival to the MICU. We had a family meeting--myself, the "family", and the hospitalist were present. Based on all available information (scans, labs, etc), we believed that Mabel had likely suffered an embolic event (CVA) with intraabdominal consequences and also had bilateral pneumonia. Mabel had previously indicated to her POA that she desired a "DNR" or no code status. This was documented in several progress notes at her PCP's office. (Unfortunately, when called from the ED, the POA "gave in" and Mabel was intubated in the ER. This seemed sad to me.) In the beginning, it seemed like everyone was on the same page. Through a deliberate discussion of the facts and Mabel's wishes, the decision to withdraw care "in a while" was made. Everyone shared memories of Mabel and had a good cry. I remembered thinking, "Great! Finally, a situation where it seems everyone is in agreement." We told the family that based on her current status, we did not feel she would ever tolerate extubation and might die of overwhelming sepsis or ischemia. We discussed comfort cares, end-of-life issues, etc. The hospitalist and I believed that from an objective, medical standpoint we had presented the facts in an unbiased way. However, we didn't paint a very rosy picture for this patient's prognosis.

Hours and then days went by. Mabel had no clinical change. The family became increasingly optimistic, "She hasn't died yet--she's a fighter." Although the POA and most caregivers were initially content with our non-intervention plan, her primary caregiver (the respiratory therapist) began questioning our lack of medical intervention. She had a medical background and persuaded the POA to reconsider this as well. The nurses and physicians involved in Mabel's care were frustrated with the family's desire to do more despite having initially decided against this. Discussion of an Ethics Committee consult was entertained. We tried to always ask the question, "Is this what Mabel would want?". The family noted that she was "a fighter" and they wanted to give her every chance available. We tried to explain that even if she survived this catastrophe, her quality of life would be greatly diminished. There was more and more tension with each encounter. I remember experiencing relief when other residents began rounding on Mabel. I felt uncomfortable and wanted to distance myself. I felt that I had somehow failed both Mabel and her family.



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We acquiesced to the family's request and incrementally added antibiotics, anti-arrhythmics, and anti-thrombotic medications. Over the next 3-4 days, Mabel began squeezing the hands of nurses and her family. Her leg became warm again. On hospital day number 9, Mabel was successfully extubated. She was able to whisper a few simple words. It was decided that Mabel would go back home. Two days later, a nurse showed me the obituaries. I saw Mabel's name and felt relieved.

Looking back at this experience, I have mixed feelings about this patient's care. I wish that she hadn't been intubated initially--she didn't want that. We did not adhere to our initial treatment plan and the situation became increasingly uncomfortable for all involved. We did not advocate for a time-frame in which to withdraw care. To add to the uneasiness, multiple members of the healthcare team thought that the primary caregiver had ulterior (financial) motives for keeping this patient alive, which was a possibility I didn't even want to consider. However, in the end, the patient died at home surrounded by those she loved. I do not know if her death was more peaceful or fulfilling than if she would have passed in the ER. We cannot quantify how much she suffered and if her suffering was somehow worth her eventual ability to be at home for a few more days. As with so many other cases, this patient's end-of-life decision making process was frustrating, constantly in flux, and unsettling. Obviously, our initial prognosis for this patient was wrong. She tolerated extubation and did not die in the hospital. As I look back, I wonder if we should have been less dire in our predictions. All too often, I think patients and families seem to see medical providers as pessimists when it comes to end of life. We are always talking about code status, POAs, and hospice/palliative care. Perhaps we are so accustomed to seeing death in elderly patients we are overly bleak in our prognostication. We want to make patients and their families more comfortable with the concept of death, despite their unreadiness for this discussion in many cases. In retrospect, I do not remember strong personal feelings about prolonging life vs accepting death in this patient. I hope that I was objective in my care, but I am sure that some level of personal opinion or morality seeps into many decisions that providers make.

This experience taught me a few things: always keep lines of communication open, do not assume that you can always give a prognosis, and if conflicted, always advocate for the patient and his/her wishes.