DEPARTMENT OF
FAMILY MEDICINE
University of Wisconsin
School of Medicine and Public Health

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

It's OK to change the plan!

An elderly patient had been on the floor for many days, after having been admitted from a nursing home. He had been a generally strong and healthy gentleman throughout his life. He had been alert and speaking to friends and family in the days prior to his admission, but had rapidly declined. With a new diagnosis of pneumonia compounding multiple medical problems, he soon required intubation and was placed on a ventilator. Over the ensuing days and weeks, his condition continued to decline despite our best efforts, including antibiotics and multiple pressors. When it became clear that his condition was likely irreversible, his family began to assemble from all over the country, and family meetings were conducted. The patient, along with his wife and children began the difficult stepwise progression toward consideration of the withdrawal of his care.

None of this was unusual in the ICU. What was different in this case was that the patient had rarely been ill, and the collected family was unwilling/unable to (quickly) discontinue many interventions simultaneously. Agreement had been reached to stop increasing his pressors, but he remained intubated, ventilated, and yet was responsive with minimal sedation.

As the days progressed, and his chances for recovery declined, I came to think that it was sad to keep him intubated in hope of extending his life, rather than extubating him and allowing him to speak with his assembled relatives for a potentially shorter period. I dislike seeing alert patients pass away while ventilated, as it seems to me that an opportunity for communication and human emotion has been lost, even as I recognize that determining the "right time" to extubate is nearly impossible. While intubation might visibly signal to family that we have done "everything," which indeed we had, I personally feel that once the medical team and family agree that death is inevitable, the patient should be enabled to "live" as fully as possible, through fuller interactions with loved ones, even at the expense of time.

One night I received a curious signout: I learned that the family's plans for withdrawal of care had evolved into a policy of weaning the pressors which were clearly keeping him alive, with orders not to increase. Extubation was not considered, because at that time the family was unwilling to tolerate the risk of observing or subjecting him to air hunger while awake. This seemed to be a reasonable and emotionally acceptable means of reducing interventions, and was being performed periodically by the nursing staff. If the patient did not expire after the complete withdrawal of pressors, the next step was anticipated to extubate with additional sedation at that time for comfort. No significant changes had been noted in the patient's status or vital signs until near midnight, when a significant drop in blood pressure and level of alertness was noted, and I was called by one of the daughters.

"Can't we wait?" was the core of the question. While the family was accepting of the inevitable progression, death in the very early morning when many of the assembled family were absent, tired and/or exhausted suddenly appeared unfortunate. We discussed the many issues, including the possibility that withdrawal of pressors alone might not lead to rapid death, and that additional difficult decisions might need to be made. At the same time, the family strongly desired assembling at bedside for the event. We discussed what would be best for both the family and the patient, and despite the previous orders, we agreed to maintain or increase the pressors as necessary (I called the attending) to keep the patient alive (if possible) so that the family could obtain rest and all collect in the morning, when pressors would be again reduced back to the current level, and the taper continued.

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

This pleased me, and I watched the patient carefully overnight. The plan worked. In the end, I believe that I helped to facilitate a better death, as seeing the effect of withdrawing pressors seemed to help the family accept the inevitable. When reassembled in the morning, the family changed the plan: instead of weaning pressors to the point of unconsciousness, the decision was made instead to extubate, so the gentleman could speak with his family and loved ones before passing. I learned later that he had conversed at length before losing consciousness. Only then were the pressors withdrawn and sedation readministered for comfort.

I would like to think that such an ending could have been planned in advance, but as I review the progression, it is clear that this could not have been planned: each decision point had to be arrived at and accepted by the family in its own timeframe. It's impossible to imagine that anyone who was at all hesitant about the medical situation would choose to withdraw the tangible immediacy and certainty of mechanical oxygenation and ventilation from a loved one before the intangible, slow, and uncertain effect of IV pressors. In the end, however, this was the outcome, and I am convinced it was better for all concerned. I am glad I helped the family gain a few more hours, and I was very happy to help change the plan.