

GUEST ESSAY

Who Are We Caring for in the I.C.U.?

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By Daniela J. Lamas

Dr. Lamas, a contributing Opinion writer, is a pulmonary and critical-care physician at Brigham and Women's Hospital in Boston.

We gathered as a medical team in front of my patient's room early one Saturday. She was one of the sickest patients in the intensive care unit. Her lungs were destroyed by cancer and a rare reaction to her chemotherapy, and her condition worsened each day, despite aggressive interventions. It was clear that there was nothing more that we could do. Except to keep her alive until Monday.

Struggling to come to terms with this reality, her family had begged us to continue our interventions through the weekend. So we would keep her intubated, deeply sedated and, we hoped, pain-free, performing the rituals of intensive care until the family was ready to say goodbye.

There is a largely unacknowledged moment in critical care when doctors and nurses shift from caring for the patients in front of us to caring for their loved ones. Often these two aims are not inconsistent: Even when family members like these are not ready to stop life-prolonging interventions or ask for a treatment that is unlikely to work, they are speaking on behalf of the patient. But increasingly I wonder if it is possible to go too far to accommodate family. When a patient is at the end of life, what is our responsibility to those who will be left behind?

On another recent shift, I received a call from a colleague at a different hospital. He was caring for a patient in his 60s with severe respiratory failure after a coronavirus infection. The patient's family was desperate for him to be transferred to our hospital, a larger institution with greater resources. But intensive care unit beds were a scarce resource, and there was no clear medical reason for the transfer. His team had already done everything that we would do, and the simple act of transferring someone so sick could be catastrophic. I was the critical care doctor on call, charged with accepting transfer requests, and it would have been easy to say no. But then there was the matter of his family.

The patient arrived overnight, just as sick as we expected. His oxygen levels had dipped in the move and never recovered. Standing outside his room the next morning, his wife asked me if I thought the transfer had been a mistake.

Maybe it was. Not because his numbers were worse; that was inevitable, regardless of the transfer. But because I had made the choice to bring someone to our hospital in large part so that his family members would believe they had done absolutely everything. Of course, family request alone is not a sufficient reason for a hospital transfer. And though I suspected that we would have nothing more to offer in terms of medical interventions, that was not possible to know with absolute certainty when the other hospital called. But perhaps even more important, I did not want his family to wonder what might have been.

And so the transfer was an act of caring for him, too, to leave his family without regret. I do not believe that we went against his wishes, sacrificed his dignity or caused him pain. When he died a few days later, it was peaceful, with his family at the bedside.

But that's not always the case. Not infrequently a family will demand that doctors perform chest compressions and shocks if someone's heart stops, even though we are nearly certain it won't help. I used to find myself infuriated by these conversations. On occasion I have used hospital policy to take the decision away from the family altogether. But maybe that is not the only response.

Some years ago, Dr. Robert Truog, a critical care doctor and ethicist at Harvard, published a provocative essay arguing that there may be a role for cardiopulmonary resuscitation if it is necessary for the family, even if it will not directly benefit the patient. He told the story of a chronically ill child with a dismal prognosis whose parents were unwilling to stop aggressive measures. During one hospital admission, the child's heart stopped, and at the parents' behest, the team moved forward with attempts at cardiopulmonary resuscitation. When the efforts ended and the child had died, the parents entered the room, surveyed the detritus of the cardiac arrest, the lines and the tubes, and surprised the medical team members by thanking them for doing everything. Dr. Truog wrote that even if it was futile from a medical perspective, what he had come to realize was that the procedure let the family members know that the doctors had tried. That was the way to give them a narrative they could live with.

I am still not sure what to make of this argument. We would not resuscitate patients against their stated wishes, regardless of what their loved ones want. But in these moments, we are so often making decisions for both the patients in front of us and the people who will carry

their story forward. And so maybe resuscitation attempts can be for a family just as much as or even more than they are for a patient. Maybe in some cases, that is justification enough.

But at the same time, I worry that even if my patients are beyond pain, there is also a cost to those who are forced to perform emergency efforts that are just that: a performance. I wonder, too, whether this very scenario means that doctors have failed. Perhaps if we were clearer communicators, no family members would choose for their loved ones to undergo intensive treatments that only postpone the inevitable.

That Saturday in the I.C.U. passed quietly for my cancer patient. But when I returned on Sunday, I learned that her blood pressure and oxygen levels had started to teeter when the nurses turned her, as they did every few hours to prevent bedsores. The daily activities of critical care were beginning to cause harm. We had planned to wait until Monday to readdress goals with the family, but was that the right choice? I hoped my patient was pain-free but could not guarantee it. And perhaps it was unkind to allow her family to spend another day hoping she might improve when we knew that to be impossible.

We called in her adult children and told them that their mother was dying. They cried and questioned, and I asked myself whether I should have waited, but they ultimately understood. If there was no way that doctors and nurses could make their mother better, then they would focus on her comfort. They gathered by the bedside. We waited for a chaplain. And late that night, in the last of our many rituals, a nurse disconnected my patient from the ventilator, ensuring she had enough medications so that she would not struggle. It was a final act of compassion, at once for the patient, her family and for us, too.

Daniela J. Lamas (@danielalamasmd), a contributing Opinion writer, is a pulmonary and critical-care physician at Brigham and Women's Hospital in Boston.

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