Point of view

"… and needs to be admitted to the ICU"

A referral to an intensive care unit (ICU) means a referral to an intensivist. To be called by a junior doctor in a busy public hospital with a statement "Mrs. Jones is a day three post-op intestinal bypass patient who's had an excellent surgical result, but is now hypoxic and hypotensive and needs to be admitted to the ICU", is not a criterion for admission to the ICU – it is a request for an opinion. Intensive care units by themselves do not cure patients.

I trudged up the stairs to a surgical floor late one Friday evening after one such telephone request, where a patient who had been hypotensive and oligo-anuric for the previous 18 hours, had developed progressive hypoxia. She had been heparinised for a suspected pulmonary embolism (although the spiral CT early that day revealed only bilateral basal consolidation and effusions), given intravenous meropenem 500 mg 8-hourly for a suspected pneumonia and was currently being infused with the 8th litre of 0.9% saline.

She was a type II diabetic with a past history of ischaemic heart disease. The operation three days ago was a small bowel bypass for intestinal obstruction caused by peritoneal dissemination of an ovarian carcinoma. Her liver function tests showed moderate elevation of the ALT, AST and ALP and her plasma creatinine was 0.28 mmol/L. The arterial blood gases revealed a PO_2 of 55 mmHg, PCO_2 42 mmHg and pH 7.18 with an arterial lactate of 6.6 mmol/L. The chest X-rays confirmed the bilateral basal consolidation and effusions, and now revealed generalised pulmonary interstitial and alveolar infiltrates.

All of this I gleaned from the case notes, the attending nurse and the treatment sheet. The junior medical officer, with whom I had a cursory conversation some 10 minutes ago, had signed off on the week's work and was nowhere to be found.

The patient was in a side room surrounded by a bevy of concerned relatives. An oxygen mask sat awkwardly over her mouth and appeared to hinder rather than help her breathing. Her cheeks were sunken and her eyes were closed. All who surrounded her turned to me when I entered the room.

"G'day" I said, trying to sound 'homely' as I scanned the room. "I'm Doctor Worthley, an intensive care specialist. I've been asked to see Mrs. Jones."

I focused on the man who was at her side and said "You must be her ….?" waiting for him to fill in the gap, as I have been caught before by saying "husband" when it was the son, friend, brother or, these days, 'significant other'.

"Husband" he said firmly.

"I wonder if you would excuse me then, while I look at your good wife." I said gesturing to the door. "I will see you in about 15 minutes or so in the relatives' room, which is at the end of the corridor".

One by one the family gradually left the room. I closed the door behind them so I could be left in peace with the patient. Mrs. Jones opened her eyes slowly at the commotion.

"You've probably had better days" I said trying to put her at ease. She gave a smile and shrugged. With each breath her nostrils flared and a deep expiratory rattle could be heard. Her pupils were pinpoint. The morphine was having an effect.

"Have you any pain at the moment" I said, beginning my formal assessment.

I continued with many other questions that required largely 'yes' or 'no' answers, as I knew she was finding it difficult to concentrate. I finished by saying that I would return after I had talked to her husband.

I wandered down the corridor knowing that her respiratory failure was caused by bilateral pulmonary consolidation, pleural effusions and pulmonary oedema, much of which had been caused by sputum retention, sepsis and excess 0.9% saline. Her hypotension was also due to sepsis, which was probably caused by an acute abdominal disorder (e.g. leaking anastomosis, ischaemic or infarcted bowel) as she had diffuse abdominal tenderness. However, from the initial description by the referring doctor of a patient who had 'an excellent surgical result', I felt sure that the surgical team would not re-operate on my clinical interpretation.

"Ah, Mr. Jones" I said "I wonder if I could have a brief word with you" and ushered him away from the rest of his family to a small room close by.

"I have looked at your wife and reviewed her notes. Unfortunately, both her heart and lungs are failing following her operation, and I have been asked to review her concerning the possibility of managing her in intensive care on 'life support'"

"You know she's got cancer, Doc" was his curt reply.

"Yes…." I said, measuring my response, as I wished him to continue.

"Before the operation she said that she was probably going to die. Now after the operation she is in continual pain." he said, burying his head in his hands. He then looked up and with a degree of frustration and anger said "She just wants to be left alone with her family, Doc".

I paused just long enough before I responded, to ensure he knew that what I said would not be just a cliché.

"I can understand that." I smiled and paused again. "In intensive care, we *do* have equipment that can keep patients alive while treatment such as surgery may be given time to be effective, yet we are not in the business of prolonging death if there is no hope". I waited for a response. He gazed at the wall and remained silent.

"Has she said what she would want to happen if she required 'life support' therapy?" I said, attempting to open up the question of palliation.

"Oh, she has made it quite clear, Doc, she doesn't want to be kept alive if there's no hope. She only agreed to this operation when the doctors said that once they bypassed her cancer she could expect to live for up to a year or more in good health."

I thought that the surgical team would probably say an optimistic 'three to six months' to the question of: 'How long do you think the patient would live if the surgery is successful?', I didn't think that they would suggest 'a year or more'. In my estimate she would be lucky to survive more than a few weeks - less, if the diagnosis of an acute abdomen was right.

"A year or more" I repeated, trying to hide my disbelief, "Well, at the moment if nothing is done she will not survive the next 24 hours. Even if we admit her to intensive care and put her on 'life support', we may only just prolong her death".

Mr. Jones did not flinch. He had been direct with me, so I was direct with him.

"Doc, you have a talk to her. She does not want any useless meddling" he said, and stood as if to mark the end of our conversation.

I returned to Mrs. Jones and realised that after a few simple questions, intensive care and its technology was not what she wanted. She knew that she was dying, there was no bitterness towards the medical profession, she just wanted to be left in comfort, if not at home then at hospital, with her family, until she died.

I managed to contact the consultant who performed the intestinal bypass, and informed him that Mrs. Jones 'declined' the help of intensive care and wished only to be kept comfortable. I had the impression that he was grateful that I had discussed the issues of dying with his patient, but probably would have preferred me to have admitted her to intensive care to manage her palliation.

As I returned to my office I wondered about the future for intensivists. Will we become responsible for all end-of-life decisions and management of patients who have not responded to medical or surgical treatment and who require palliative care?

I suddenly began thinking about my retirement.

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