

Compromise

by Guang-Shing Cheng

The cases you never forget are the young ones, because they are the hardest to let go.

Karyn Woods was thirty-one years old and dying. Three different medications raised her blood pressure to a barely safe range; the ventilator delivered higher and higher levels of oxygen to her lungs. High doses of diuretics failed to make her urinate. Her right heart was failing, a result of longstanding, untreated pulmonary hypertension. Karyn was on no sedative medications, yet she did not wake up when I yelled into her ear. She had made no progress since she was admitted three nights ago for severe shortness of breath.

As the critical care fellow in the medical intensive care unit, I sat in front of her bed with James, a physician assistant. The most recent set of labs confirmed our fears. Karyn's lactic acid level—a measure of tissue damage—had risen to three times the normal value. We had been unable to correct the acidemia with the ventilator. Earlier that day, we had looked into starting her on dialysis to get rid of the excess acid and fluid that were contributing to her demise. Not surprisingly, the renal consult service declined, stating that dialysis was a futile measure. What she needed—and what we couldn't provide—was a new heart and a new set of lungs. What hope we had of saving her was rapidly slipping away.

At this point, James turned to me and asked what we would do if she coded—that is, if her heart went into a dangerous rhythm or stopped altogether.

We both knew that this would likely happen to Karyn in the near future. I could envision the event, which I had witnessed many times in the hospital: a mad rush of white coats and nurses, a young intern pumping the patient's chest, residents yelling for intravenous kits and epinephrine. I could see the patient's limbs jerk like a puppet's after the defibrillation paddles were deployed. For a moment everyone would be silent, fixated on the monitor, watching the rapid rhythm fade into nothingness, the hiccup of the blood pressure. And then the chest compressions would begin again. Twenty, thirty minutes of going through the algorithm of drugs, shock, drugs, shock, to end without an intact human life.

Full code—this is the default pathway for every patient who comes to an American hospital. For better or for worse, the medical team performs the drill unless the patient has a legal document saying “do not resuscitate.” Most of the time—particularly for young patients such as Karyn—any change to the code status is not addressed until death is imminent.

On television shows, the patient always seems to wake up from a code. In reality, cardiopulmonary resuscitation succeeds in less than 15 percent of hospitalized patients; of these patients who survive the code, an even smaller percentage leave the hospital alive. For a person like Karyn with severe underlying cardiopulmonary disease and profound acidemia, the likelihood of surviving the code is almost zero.

Knowing this, why should a physician perform a maneuver when there is no possibility of benefit? In the same vein, a surgeon wouldn't offer major bypass surgery for someone whose cardiac function was so poor that he wouldn't survive the operating table. And yet our current practice dictates that the default pathway of CPR must be actively discontinued. Although physicians can legally justify changing a patient's code status on the basis of medical futility without patient or family input, in practice this is rarely done.

Short of CPR, Karyn was already on maximal life support. CPR would make her death a violent, chaotic one. It was time to have that end of life talk with the grandmother who kept vigil at her bedside. She was next of kin, the one who'd raised Karyn and now had to speak for her. The attending physician, Dr. Taylor, knew, like James and I, that the likelihood of Karyn surviving the next few days was slim. He planned to meet with her grandmother later that evening to advise her that Karyn's code status should be changed to DNR—do not resuscitate.

Dr. Taylor told us the next morning during rounds that Karyn's grandmother still wanted everything done, including CPR and electrical defibrillation. “She wouldn't hear it. Trust me, given the family dynamics, we can't make her DNR,” he said, “so if she codes, do a slow code. Keep it short.”

Slow code. Everyone on our team knew what he meant without him having to explain. Any physician who has spent time in the intensive care unit has seen or participated in a code in which the team is halfheartedly going through the motions, fully expecting the patient to die.

On the face of it, a slow code sounded like a reasonable compromise between doing what Karyn's grandmother wanted (everything possible), while at the same time reducing our obligation to perform futile measures in order to protect Karyn.

And yet, the mandate to *keep it short*, knowing that Karyn was going to die in spite of it, seemed patronizing, dishonest, and born of expediency. If her

grandmother refused to accept that Karyn was dying, surely she could not divine our intention to perform a code for the sake of appearances, without hope of saving Karyn's life. If we were certain that the result of CPR and defibrillation was death, why did we offer it in the first place? If there had been any glimmer of hope that Karyn would survive, or even wake up long enough to see her family one last time, that would have justified proceeding with a code in earnest; but this was not the case. Was a slow code the only way to satisfy everyone involved at the moment, or was the decision made to avoid further conflict with the family? I didn't witness the dynamics of the family meeting, so in deference to Dr. Taylor, I said nothing.

Karyn's condition continued to deteriorate. She began to bleed from her endotracheal tube; worsening liver failure had caused her blood to become pathologically thin. Dr. Taylor, who was off the unit, called me that afternoon, exasperated with the nurse taking care of her. "She's calling me nonstop about Karyn's blood pressure, the bleeding . . . we're not going to escalate care on her. Which means no changes in the pressors, no blood products, no bicarbonate drips. Just make that clear to her."

I attempted to translate Dr. Taylor's wishes into some sort of guideline for the nurse. She looked at me with skepticism. "You're not going to give her

blood products, but you're going to code her?"

I realized she was right—it made no sense to deny Karyn other modes of supportive care while she was dying and then go through the motions of reviving her at the moment of death. Our medical team could continue to operate under these ambiguous directives, or we could clarify the goals of care—either press ahead earnestly or change her code status. If increasing our already high level of supportive care wasn't medically appropriate, then we had to make her DNR. For this I needed to speak with her grandmother.

"They told me before that she's going to die, but I don't believe it," Cecile, her grandmother, said when we first sat down. I braced myself. If I met the same resistance that Dr. Taylor did, we would remain in this dilemma. I explained how Karyn's body was failing in spite of life support: she was not going to get better, leave the hospital, and be able to go home as Cecile hoped. I described CPR and what it would mean physically for Karyn to experience it as she died. And then I said that if her heart were to stop, we should not subject her to CPR, because it was not going to help her. "If Karyn was able to make her own decisions right now, would she want to undergo this procedure and prolong her death?" It was almost a rhetorical question.

Cecile shook her head and gave a long sigh. Several minutes passed before she spoke. "It's a very hard thing to hear that your child is going to die," she finally said. "But I don't want her to go through that."

I was relieved, and I sensed that Cecile was as well. Perhaps she had needed time to accept that she was going to lose her grandchild. Or maybe she had to hear it in a different way, from more than one person.

In the end, there was really no other tenable choice—no compromise that could have satisfied anyone. I was relieved that Cecile understood what I told her, and that there was no conflict. And yet I could see how wrenching it was for her to accept that nothing more could be done for Karyn, a young woman with a life beyond the hospital that we knew nothing about. It is difficult for physicians to make unilateral decisions about the end of life, even when the outcome is clear. The patient is always someone's mother, father, sibling, granddaughter, child.

Karyn died the following day when the drips were turned off, one by one. No doctors pounded on her chest, no nurses stuck her with IVs. Her grandmother and her aunts sat at her bedside, held her hand, and smoothed her hair. At that moment, they were the only people who mattered.