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A piece of my soul

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Like most critical care physicians, I have fought ethical battles in my career. We all know the cases—the patients in utterly hopeless situations that we continue to aggressively treat in the intensive care unit (ICU), which over time cause everyone involved—from interns to nurses—to feel uncomfortable about inflicting harm in situations that are so clearly futile.

In an academic setting, the simplest solution is to just do your rotation and pass the ethical dilemma onto the next attending. Unfortunately, my sense of responsibility and moral conscience occasionally lead me to call Ethics and fight the battle myself.

The most recent case was truly a battle in every sense of the word. It took weeks of meetings with a family that simply could not understand and multiple meetings with Ethics. I left feeling that the family had slandered my otherwise good name to multiple parties—patient relations, my division chief, my colleagues, and the members of the Ethics Committee. There was even a threat to contact the press. The family openly criticized every aspect of me that I value as a physician—my bedside

manner, my intentions as a physician and human being, my moral compass. Even though we were ultimately able to make a unilateral decision to not escalate care, the experience left me incredibly disheartened.

Weeks later, a colleague commented about this patient and began joking when he witnessed me physically reeling from the mere mention of the case. I snapped back at him: “Listen man, that case literally took away a piece of my soul that I am NEVER EVER going to get back!”

I spend most of my time working not in the medical ICU (MICU) where this case occurred, but in a surgical liver transplant ICU (LICU), comprised of patients awaiting and post-liver transplant (LT). There, we take aggressive care to another level, continuing seemingly futile treatments in the remote hope that patients will recover and later undergo LTs. When patients are ultimately denied for LTs, I help the surgical team conduct family meetings to transition patients toward comfort care. I work longer hours in that unit, a unit notorious for the high acuity and intensity of the patient population. Yet the LICU doesn’t seem to touch my soul. I sleep well without letting any end-of-life or ethical issues affect me. I encourage Ethics consults there and have no problem participating in Ethics meetings.

I recently saw our hospital’s ethicist and commented that I was never calling Ethics again in the MICU—that I couldn’t afford to lose another piece of my soul battling a family in front of the committee. I mentioned that the LICU didn’t affect me in the same way and he encouraged me to write about it. He emphasized that these are the exact feelings that drive physicians to practice medicine a certain way and make important decisions about communicating with families, especially with regards to end-of-life care. These cases chip away at the courage that it takes to stand up for what we as physicians should and should not do. After all, no job is worth losing your soul, right?

So I asked myself why the LICU didn’t bother me. Was it because I wasn’t primary team but rather co-managing,

making me feel less responsible? Was it because we were continuing aggressive care for the slightest chance that patients would have their lives saved? Was it because some patients had recently been transplanted so we had to try until the very end? Or was it because we occasionally transfer the futile cases to the MICU so my colleagues are the ones dealing with the difficult end-of-life issues?

It is likely a combination of all these factors. Our hospital recently examined intensivists' perceptions of the frequency of medical futility in our ICUs. The LICU was the only unit that opted not to participate. Though I was not part of that decision, I believe it reflects the tendency of that unit to avoid the topic of futility when possible. Turns out that when you work in an ICU like that, your soul can remain unscathed for a longer period of time.

At a recent pulmonary conference, my colleague insisted on attending a talk entitled "End of Life Care—How to Deal with the Family that Wants Everything." I refused to go, cynical at the idea that a didactic session would help us with these issues. My friend, who maintained a glimmer of hope that it would help, returned dejected with comments of "people that have clearly never dealt with these situations in real life and have no

idea how unsupported we feel during the process." Sadly, I feel back to square one: "stuck" when encountering these cases and still reeling from the last battle that I attempted to fight.

Ultimately, the ethicist is right—my concern for my own soul is affecting how I practice medicine. I am less likely to fight these battles from now on. The bottom line is that we need to feel supported in these cases—by the law, society, our colleagues, and our Ethics Committees. Otherwise, as ICU physicians, our sense of responsibility to do the right thing will likely wane with time as a result of the unrepaired wounds we sustained in our younger days. Whether we have the insight to realize it, the brief satisfaction of preventing futile care and the associated optimization of ICU resources may simply not be worth the turmoil to our souls. Perhaps I am one of the lucky ones—I still have the LICU, where I work long hours but am comforted by the fact that my soul will remain intact, at least for now.

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