

OPEN FORUM INITIATIVE



HUMANS of CARDIOLOGY



Pennsylvania
CHAPTER

The harsh realities of becoming a physician can creep up on you. Looking back on the trajectory of my journey through medical school, residency and currently fellowship, almost 15 years of practice, I have seen my development from being an excited student yearning to be a doctor and make a difference, to tasting the actual satisfaction of saving someone's life and basking in all its glory. But at some point, this glory slowly begins to fade, priorities change, and you begin to wonder how often we are inflicting harm. How do we decide as physicians when to draw the line once our treatment fails to bring about the subjective benefit perceived by each patient while remaining committed to the common underpinning of the Hippocratic Oath as *primum non nocere*: first, do no harm. How does this impact our own burnout?

Walk through your cardiac ICU now and see how many patients with no meaningful recovery are being kept alive with support devices, either because of our own innate drive to save them or because of the inability of a family member to let go. Is it just easier for us to continue treating the patient than to derail the train that's already in motion? Or do we not have the appropriate ability to confront family members, our colleagues or even ourselves?

In this era of door-to-device/support time (which is possibly a metric that we will be judged on in the future), when do we stop and say, "no more". When do we say that this is unnecessary suffering for a patient who we know will not have a good outcome? For these occasions, should we be focusing on the family? Helping them to fully understand the gravity of their loved one's condition and if this is indeed what the patient would want? Or should we just not offer any of the options available in our arsenal? Is it our responsibility to stop this spiral before it even begins? Do we understand that palliative care is always an option and is complementary care and should not be considered only as last line therapy?

Take for example, a hypothetical patient presenting after a prolonged cardiac arrest requiring revascularization and a support device. CT shows diffuse anoxic brain injury, but we tell the family to give us 72 hours. Then a twitch on the ventilator or some non-purposeful movement prolongs the duration for another 72 hours. This goes on until the patient develops some other life-threatening illness. Finally, the family decides to discontinue aggressive care. Remember that even though the family and the patient are going through this terrible time, we too as physicians must watch this patient suffer for that duration of time. Understand that the burden of care does not lie solely on the shoulders of the family members, but it also affects every single member of the medical team taking care of this patient.

In addition to this door-to-support time concept, shouldn't there be a door-to-stop time which we can click in our check box? Dealing with these patients and their families, watching them suffer and die in front of us, leads to physician burnout, as well as, other psychological distress amongst the staff.

My views have been greatly altered after doing 2 months of cardiac ICU in my second year of general fellowship. No amount of medical school training or residency prepares you for this perceived treatment in futility. As a society we need to do better. It's not only about saving lives and putting in devices. It is about better communication with families, to help them understand and build their prognostic awareness and manage the uncertainty of treatment outcomes to make the best decision for their loved ones. It is also about allowing a patient to die with dignity. The real question then becomes can you "save" someone by providing a good death when a good life isn't a realistic outcome?

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