

PERSPECTIVE

LESS IS MORE

The Gift

Ramya Sampath, BA
University of Rochester
School of Medicine and
Dentistry, Rochester,
New York.

“As you know, your husband is very sick,” the intensivist said to my mother in a voice as gentle as the dim lighting in my father’s hospital room. “There are some decisions we need to make together about what our goals for him should be going forward.” My mother shuffled uncomfortably and stammered, “What kinds of decisions?”

I knew what kinds of decisions he meant, given my work as a researcher in advance care planning, wherein I studied families like ours at decision points like ours in chronic illnesses like my father’s. The intensivist responded calmly, “Well, when we realize that someone is in as bad a shape as he is, that changes how we look at things. At this point, his medical team feels that the goal for his care should be his comfort, and we want to know what you are thinking in terms of his goals of care.”

I knew where this was going. When I had looked at my father’s hospital admission paperwork, I found that his code status was Full Code. In the section below that asked for further comments, he had scribbled in cryptic handwriting, “*all decisions ask my wife.*”

A few days before, when my father was intubated, I tried to preempt this decision point with my family, suggesting that despite my previous attempts at advance care planning, we had reached a point where we were now just care planning. My father’s lungs were full of fluid, his ejection fraction had dropped to a mere 9%, and when his sedation waned, he writhed in discomfort. His blood pressure was only stable on high doses of pressors. I asked my mother what she knew about cardiopulmonary resuscitation (CPR), and she responded promptly, “It’s when they revive you.” *When.*

Most people in the US seem to think of CPR as a sure-fire procedure to restart the heart, imagining it as the heroic (and successful) lifesaving intervention performed in countless medical dramas.^{1,2} As physicians know, the reality is not always as alluring as this myth of easy reanimation—fewer than 20% of patients who receive CPR in a hospital survive to discharge, and many incur cerebral injuries.³

So when my mother said, “It’s *when* they revive you,” I knew it was going to be a long set of conversations. I told her what I knew about CPR from my research and training in medicine. She asked me what I thought we should do, and I offered my opinion that given everything my father had been through during numerous intensive care unit stays, I thought he should not have to undergo CPR if it came to that. I wanted us to prioritize his comfort. But this message did not seem to resonate with my mother, and I could hear the “what ifs” cascading in her mind. It was not a conversation about the facts of CPR but about our values—how could we make any choice but the one wherein he still had a possibility of living?

Responding to the intensivist’s measured inquiry outside my father’s hospital room, my mother said ten-

tatively, “We talked about CPR a little. I know that there are risks,” and looking at me, she continued, “I know we have different opinions in the family so far, but I still feel that if there’s a chance we can give him to come back, shouldn’t we give him that chance?” I did not envy this intensivist for having to answer that question while looking my mother in her eyes now brimming with tears.

He nodded slowly, and with a practiced calm, he shared his thoughts. “Normally, when there is a reasonable chance, we want to do whatever we can to bring the person back if that’s what the family and the patient would want, if we can know that. But in this case, his heart is so fragile and enlarged that the risk of injuring his heart during CPR is very high. On top of that, we hoped the pressors would give time for his heart to recover enough that it would be pumping on its own, but his heart is pumping too weakly. Even if we did CPR, there may not be enough heart function left for it to keep him alive in the way that you know him.”

My mother, beginning to grasp the meaning of his words, replied slowly, “So you’re saying you don’t recommend CPR because he’s in such bad shape it would not make a difference. He won’t be able to really *live.*”

The intensivist seemed more pained than relieved at the clarity of her understanding. “Yes, that’s exactly what I’m saying.”

With comprehension spreading across her face, my mother’s shoulders relaxed. She looked down at her feet and said, “I understand. Now that you’ve explained it, I get it.” Then looking up at the physician with her tears flowing freely, she continued, “I just didn’t want to take away any chance he had. But you’re telling me he doesn’t have a chance anymore. We must think now about what’s best for *him.* Thank you for explaining that.”

The best way I can describe what the intensivist gave us is as a gift—a true compliment for someone in the business of giving families bad news. He told us my father was dying, and my mother *thanked* him. He helped reveal that the weight of choice my mother felt may not have been the dilemma she imagined at all. Rather than conceiving of a do-not-resuscitate status as taking away his chance at life, this physician helped us reframe this decision as one where we could think about prioritizing my father’s comfort over prolonging his life at all costs. Although it was challenging to arrive at this shared decision, the intensivist’s skilled communication helped elucidate how my father’s limited scope for recovery ought to shape what we wanted for him at this precarious time.

After this pivotal discussion, we sought palliative care’s assistance to keep my father as comfortable as possible, even if this meant fewer opportunities for him to interact with us. A few days later, we decided to extubate my father and wean him off pressors. Within a few

Corresponding Author: Ramya Sampath, BA, University of Rochester School of Medicine and Dentistry, 601 Elmwood Ave, Rochester, NY 14620 (ramya_sampath@urmc.rochester.edu).

hours, he passed peacefully, with a hospital room pulsing with his favorite music and the voices of his dearest family and friends saying their goodbyes. Although we wished for so much more time with him, our hearts were filled with gratitude knowing that we ultimately made decisions that put his comfort above anything else.

Taking the time to clarify the clinical realities that surround a patient's prognosis and disease progression can help all members of the care encounter—clinicians, families, and patients—to reduce the

stress that can pervade end-of-life care.⁴ Nationally, physicians are encouraged to initiate these conversations early and often to make sure they understand what patients wish for at the end of life. These conversations are undoubtedly essential. But on a more fundamental level, ensuring that a family understands the specifics of a patient's clinical situation is key to helping clarify what possibilities are and are not on the horizon and how goals of care shape decision-making as a loved one approaches the final moments of their life.

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