Saving a Death When We Cannot Save a Life in the Intensive Care Unit

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A 64-year-old woman came to the intensive care unit (ICU) with severe abdominal pain, a blockage in her large intestine due to metastatic colon cancer, and sepsis. Six months prior, she had experienced a nearly identical episode that was treated with placement of a palliative stent to relieve the blockage in her intestine. She was not currently ready to die—but she asked us to do everything we could to give her any additional weeks or months of life. She thought this could be possible because her previous stent had given her 6 months of good-quality life at home. We decided to pursue a colonoscopy to see if there was anything we could do. We electively intubated her prior to colonoscopy in the setting of evolving shock, lactic acidosis, respiratory distress, and high risk for aspiration. Unfortunately, her colonoscopy revealed acute, diffuse, and severe ischemic colitis in addition to complete obstruction of the stent. Neither endoscopic intervention nor surgery would prevent death. She subsequently developed hypoxic respiratory failure—and we were left wondering whether we could possibly extubate her.

The on-call surgeon and I sat in a room with the patient’s daughter to tell her that we could not fix the dead colon or the cancer or the respiratory failure. Both the patient’s daughter and I knew that if her mother woke up now, she would be in extraordinary pain and respiratory distress. With no cure or even temporary fix to her mother’s medical problems, we agreed that pursuing comfort measures and withdrawal of life support would be the best pathway forward. While the daughter was bravely acting in her mother’s best interest, she was not prepared for the timing of her mother’s death. The patient’s daughter had hoped that the obstruction would have a temporary fix and that she would take her mother home after the colonoscopy. Unfortunately, this was not the case. Her daughter’s tears flowed freely—both at the thought of losing her mother as well as the thought of not being able to say a final goodbye to her mother while she was awake. Her mother died peacefully a few hours later. While death was not preventable, perhaps the lost opportunity to say goodbye was.

Shortly after this experience, I learned about the practice of having a “going off to war talk” before intubating patients in the ICU. When parents send their child off to war, they take a moment to say goodbye. The best-case scenario (and hopefully the most likely scenario) is that their soldier returns home alive. But the worst case is that their parting words will be their last. Similarly, when patients are intubated in the ICU, they are left without the ability to communicate, at least temporarily, and they may never recover. A “going off to war talk” would help patients and their family members hope for the best, but at the same time prepare for the worst. It’s a way to avoid stealing last words from a person.

I decided to try the approach. The very next patient I intubated was a 51-year-old woman with refractory myelodysplastic syndrome and who had been admitted to the ICU with respiratory failure owing to diffuse alveolar hemorrhage. She had been dependent on continuous noninvasive ventilation for several days—and one night her respiratory failure worsened. I called her husband to come to her room. A decision was made to proceed with intubation. I told her and her husband that while I expected and hoped she would improve, we should also prepare for the possibility that she would not recover. In the worst-case scenario, this would be the last time they talked with each other. We all thought she’d recover, but they took my message to heart. As I left them alone for a few brief moments, they embraced and whispered to each other—she wearing a bilevel positive airway pressure mask and he leaning his mouth close to her ear. We then intubated the patient. Unfortunately, despite our best efforts, over the next 24 hours her condition deteriorated. She developed progressive hypoxia and shock and subsequently died.

A month later, I spoke to her husband on the telephone. I asked him what he told his wife in those final moments before intubation. He said that he told her he loved her—and she told him that she loved him. Among all the pain of unanticipated death, it gave him daily peace knowing that their last words to each other were “I love you.”

We measure the complication rates of almost everything we do in the ICU. Preventing avoidable complications is a clear marker of success. Intubation bundles and checklists have been created to prevent complications. But our focus on clinical and quality improvement sometimes forces a blind eye to the deeply human dramas that take place under our watch. Despite the many advances of modern medicine, up to one-third of patients admitted to the ICU still die before they leave the hospital. Stealing the opportunity for meaningful last words is precisely the kind of avoidable complication that ought to be visible to us in the ICU. My intubation checklist now includes this step.

A meaningful conversation can often be facilitated, even in urgent situations. Even if everything goes well and the patient eventually awakes and is extubated, having an opportunity to express love, encouragement, or support before intubation seems to strengthen family bonds. When framed as hoping for the best while preparing for the worst, families have generally welcomed the idea. My second patient’s final words with her husband will linger in his mind—and my mind for years. While we could not save her life that day, I think that we helped, in some small way, to save her death. I wish we could have done the same for many patients before her.
Conflict of Interest Disclosures: None reported.

Additional Contributions: I would like to thank Samuel M. Brown, MD, for a thoughtful review of the manuscript, and I thank the patients’ families for granting permission to publish this information.