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Everything

By Simone Blaser

Tears well and I breathe quickly into my N95 mask. Shouts echo down the hallway. Mr. G has coded during morning rounds.

It is the first week of April 2020. Thousands of patients in intensive care units across different hospitals in different cities and different countries have a single diagnosis. With this single diagnosis, a tsunami of patients, hospitals underprepared, staff overworked. With it, a tsunami of death, and desperate families who beg us to do everything to save their loved ones. *Everything*—that's the word they always use.

I have been working in the intensive care unit, and many times this past week I have returned to the literature I studied before becoming a physician. There's the line from Thomas Mann's novella *Death in Venice*, when, at the onset of a cholera epidemic, the main character has "a feeling ...that the world was undergoing a dreamlike alienation, becoming increasingly deranged and bizarre." Only the unreality of fiction can describe the reality of this week, and the line has been in and out of my head like a refrain.

Our own world has undergone a dreamlike alienation, increasingly bizarre and deranged. In medical school we study the role of touch in establishing diagnosis, in building physician-patient trust and mother-child bond—but this highly infectious virus precludes all human contact. Only one physician performs a physical examination each day. We group medicine administrations with blood draws to decrease nursing exposure. The patients are tucked away out of reach, isolated from the hospital ward and the world beyond.

The families beg us to do everything, but our ignorance vastly outweighs our knowledge. There haven't been sufficient randomized controlled trials, the gold standard for medical decision-making. The disease is too new. We are bushwhacking, basing treatment decisions on hearsay or on anecdotal reports or on theories of how the body breaks down in response to disease. Low-dose intravenous blood thinners, steroids, hydroxychloroquine–so much the focus of the press—none of it seems to help, but still we administer it. We, too, are desperate. We turn patients facedown to let gravity pull open diseased lung tissue, so clogged with dead cells and fluid that no space remains for oxygen to enter and carbon dioxide to exit. This maneuver seems to help, except when it doesn't. Some patients indeed need less supplemental oxygen while they lie prone. But other patients, with bodies so ravaged by disease, deteriorate further with the flip on their bellies. Sometimes they die.

We practice medicine with humility, urgency and fear.

Rounds in the ICU now feel as if they've been crafted by Samuel Beckett. The patients are all middle-aged men who presented to the hospital with respiratory symptoms, developed respiratory failure and now lie in the ICU paralyzed and sedated to tolerate the machines that breathe for them. Eventually their kidneys will fail, and they will require medication to maintain their blood pressure. Every morning we walk up and down the narrow hallway of the ICU, weaving our rolling computers in and around the ventilators and IV poles, stepping over wires and stopping outside each patient's room. Just outside the door, we discuss the patient tucked away within. His story, his recent blood work, his imaging and medications. We make a plan. The plan is the same for all the patients, every day, and essentially what it all amounts to is: watch and wait. On occasion, beeps and alarms and shouts emerge over the basal mechanical hum of the ICU, the only punctuation to the macabre sameness. This new cacophony signals a patient's rapid deterioration. Three patients have died in the last four days.

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Asystole, asystole! The familiar shouts interrupt us as we conduct rounds this morning. Mr. G's heart has stopped and my own heart races as we scramble to his room to evaluate him. His family, like all of the families, has asked for everything.

Before April, when we knew the diseases, our conversations about code status centered on patients' values given our understanding of their prognoses. What makes a patient's life meaningful? How does she imagine her death? Are his values compatible with chest compressions or with a breathing tube? Are his values compatible with lifelong dialysis should his kidneys fail? If her body needs longer than two weeks to heal from the ravages of her disease, are her values compatible with a throat incision through which we would insert a breathing tube?

But now our poor understanding of who survives this new disease hinders our ability to guide these decisions. On most days, I wonder if less is more. Few interventions seem to work by the time patients land in the ICU, and each intervention feels an added torment for our comatose patients with no way to accept or decline invasive measures. "*Nothing happens, nobody comes, nobody goes, it's awful!"* Estragon says to Pozzo in "Waiting for Godot." *Nothing to be done.* Perhaps the disease has already passed the point of no return. I haven't seen a single patient survive, though I've heard elsewhere they do.

Now we conduct these crucial care conversations by telephone with family members who are not permitted to sit vigil at bedside and witness the deterioration of their loved ones but only to receive news of it. They do not see their loved ones swollen with fluid from kidneys that no longer urinate; they do not see blue hands or facial bruises from spending 16 hours a day prone.

We reach Mr. G's room and stop outside. The monitor has a flat line. Overnight his blood pressure had plummeted. Four different blood pressure medications snake into the room from the hallway beyond. The medication pumps newly sit in the hallway, to allow the nurses to adjust the drip rates without an additional exposure.

When families ask for everything, I think about religion, how belief in miracles is central to the faith of many. I wonder if asking for less than everything—asking for anything less than full code—is an acknowledgement no miracle will occur. Is that ask tantamount to loss of faith? When the families ask for everything, I understand this choice and I respect it. But sometimes I wonder if those wishes might change were they permitted to visit the hospital, to witness the surreal comatose body, now bloated and bruised, perhaps only tenuously linked to the vibrant loved one they picture. Would they beg us to stop, to let their loved ones die in peace? Would they pray harder?

He's gone, my attending says. I peer through the glass doors to his swollen body and sallow skin. He looks no different than he did when I visited him yesterday: a swollen sallow body alone with his buzzing and beeping machines. I stare at my feet. *There's nothing more we can do. He's maxed on pressors. His kidneys have failed. Chest compressions won't bring him back. He's gone.* We nod. The mask pinches my cheeks. He's gone. I'm breathing fast and my chest heaves. Someone told me once that trying to understand death was like looking directly at the sun–indeed it is blinding. Time of death: 9:34 AM.

We observe a moment of silence. I slip to the bathroom to cry. I anticipate the relief when, just after I wash my hands, I will remove the mask. I soap up and start to count to twenty. I lose count, and start again from one. I wonder if my runny nose will mar the mask's integrity, and the tears flow faster. I restart twice more before I reach twenty. Finally, the mask comes off, and I weep freely and breathe deeply. I glance at myself in the mirror: my red, puffy eyes; my face indented from 12 hours a day in this mask. My raw skin. I splash water on my face. Then I wipe my eyes, return my mask to my face and rejoin my colleagues. We continue making our rounds. We wait.

—New York City, April 2020

References

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