Hope, Truth, and Expectations

by Richard Van Zyl-Smit

This past week in ICU has probably been the most brutal week I have ever experienced in the past 22 years of working in an ICU. Our team looks after 2 units (of 6) with 12 ventilated COVID ICU patients. This week we lost: Jasrin (60), Anita (24), Thania (33), Niel (44), Maria (35), Shiela (44), Frank (64), Ed (48), Chipo (64), Mary (52), Precious (54), Martha (62), un-named (28 weeks).

13 deaths in one week; we are broken.

In the middle of the week whilst doing our best to keep one of our patients alive, the comment was made between us that 'we had given up hope that this particular patient would survive'. Our expectation was that they would die. The reality was however, that the truth (live or die) was not dependent on our hope nor expectation.

In our resource-limited healthcare system, we never admit a patient to the ICU who does not have a hope of survival. Our expectation must be that the patient will survive – how great the expectation is dependent on the disease, age of the patient, requirement for organ support, etc. We accept the patient for admission, based on the referring doctor's information and our judgement call on the expected outcome, and our ability to support the patient whilst the disease/trauma resolves. When the patient arrives in the ICU, the truth is revealed, and we adjust our hope. Whether the patient survives or dies has nothing to do with our hope nor expectation, it depends on the fact that we provide the best care we can and ultimately whether the patient's own body can recover with the support we provide.

Hope is irrelevant.

In this COVID pandemic, we have had to accept that when the disease gets bad – it is really bad. We thus have a particular revulsion at the media celebrated "recovery rate." We are on the other end, and our reality is not that 98-point-something percent recover. Our reality is that in the hospital we only look after the 5-point-something percent that get really sick, and in the ICU the 1-point-something percent that are really really sick (and we have hope that they will survive. If there is no hope for your survival, you won't be admitted to the ICU).

So, we get up each morning and go to work. We tabulate who has died and who the new patients are, and we start our ward rounds. We look at every aspect we can to support each organ system of each patient. They are introduced by name and then we suspend the name, family, and personal context of the patient. We focus on doing the best for each patient be they 24, 44, or 64. Each patient must get our very best, irrespective of our hope and expectation. If we adjust our quality of care based on hope, then we do our patient a disservice. We focus as much as we can on the truth of the medical condition and our ability to support the patient and reverse the problem. Once we have attended to the practical, we un-suspend the patient name and engage with the reality, the hopes, the expectations and the family of each and every patient. Twelve times this week we have sat down, in person (or telephonically), with the family members and dashed all hope that they might have had. We have failed their expectations, and we do our best to convey the truth that we did everything we could. Often our best is not sufficient, no more can be done.

We have had more tears this week than I can ever remember; we have consoled families, colleagues, staff, undertakers, and ourselves. We have worked ourselves to a standstill and done our best for each and every patient. We have laughed and cried, we have fought and sweated, we have drunk far too much coffee, and had far too little sleep. We are broken.

So, this morning I have got up and put on my scrubs and will start a ward round with hope – that the best I have to offer will be enough to keep my patients alive. My expectation is that that will not be true for all.

But without Hope, it is pointless.

This message was adapted from Dr. Van Zyl-Smit's article in MedPage Today*, January 31, 2021*

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