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FROM THE INSIDE

Sometimes, less is just less…

B. Jason Brotherton[1,2*]

July 1, 2020—The first day of my critical care fellowship in the eye of a pandemic and my first day back in American healthcare after practicing for five years in resource-limited hospitals in Kenya. Comparatively speaking, I felt like I was returning to the land of limitless options. Sure, it was a little overwhelming at first, but having more time before saying, "That is all we can do," was incredibly encouraging.

One morning while making endless laps in the unit, a resident on the team and I made the decision to transfuse one of our patients. They were positive for coronavirus disease 2019 (COVID-19) and also positive for all of the critical care accoutrements: mechanically ventilated, proned, vasopressors, and a few nephrons shy of renal replacement therapy. Their hemoglobin had drifted down to 7.2 g/dL and seeing their pressor requirement continue to climb, I gave the go ahead for transfusion. Later during rounds, the resident came to the hematology section of their presentation and proudly announced that we had decided to transfuse. Much to our dismay, our attending was not impressed. Instead, they reminded us of laboratory margin of error, the Villanueva [1] and TRISS trials [2], and how that unit of blood could have gone to someone else before sticking the landing with "less is more."

This had not been the first time I had heard those words. I have undoubtedly said them myself, but it was the first time that they made me cringe like nails on a chalkboard. If I am being honest, those words actually made me angry because I felt they suggested that our decision was flippant and without consideration. Rewind five years and you will see why. My family and I left the United States and moved to Kenya where I lived, worked, and taught in two rural, resource constrained hospitals until boarding the plane to begin fellowship.

During those years, I learned way more than I could have ever taught. I learned that for nearly all hospitals outside of the capital, the closest thing to a blood bank was the antecubital fossa of relatives and individuals like myself willing to donate blood in real time for a loved one or patient. If a patient needed two or three units of blood, then we needed two or three family members to lend their arms (barring they are a match of course).

I have also learned the hard way what resource allocation really looks like. Our hospital has five of the country's 256 mechanical ventilators for a population of nearly 54 million [3]. This is a boastful surplus compared to many other countries on the continent. And pandemic or not, there is always an ongoing struggle to use these precious resources well. I, as well as others, have lost countless nights of sleep, wondering if we made the right decision in who should get them.

Further, being the attending on service when the average age and average oxygen saturation are both hovering in the upper 70s is not the ideal time for the charge nurse to come to me and say, "daktari, there is no more oxygen in the hospital." This occurred several years before the pandemic. Deciding who will get our last vials of ceftriaxone before helping family members find a chemist (pharmacy) so they can go buy the remaining doses or choosing which combination or permutation of tests and investigations we can order based upon the amount of money the family has are the least "glamorous" aspects of being a cross-cultural global health worker. None of this was part of a global health curriculum that I was ever exposed to, but they were all lessons, nonetheless.

Over time, my decisions on who may benefit from our scarce resources have been as much shaped by the local culture and values as it has been by my clinical training. Many of you reading this may instantly say, this rationale is contributing to poor resource utilization, but I would counter with attempting to understand the culture is as

*Correspondence: brothertonbj@upmc.edu
[1] Department of Medicine, AIC Kijabe Hospital, PO Box 20, Kijabe 00220, Kenya
Full author information is available at the end of the article

much multidisciplinary care as ventilator-acquired pneumonia bundles and out of bed initiatives. In this context, it is also patient centered.

Circling back, we have seen many clinicians and caregivers early on during the pandemic, in what many would consider the darkest night of our careers, struggling in earnest to do all they can not to have to say, "that is all we can do." Although, "less is more" is likely applicable in these situations, those words would likely ring hollow, and possibly seem detached.

After completing my first year of fellowship, I find myself back in Kenya and striving to thoughtfully implement some of what I have learned over the past year. I often reflect on that morning and know deep down that our attending meant nothing more than the medically cliché platitude in the midst of a chaotic unit. Though their retort centered on the medical decision making, it was probably not the genesis of their disagreement.

If I am truly being honest and introspective, I can relate and likely recall a time, or possibly several, when being confronted with stressful circumstances I have resorted to feverish attempts to control what I think are under my control. I believe the learning objective for me moving forward has absolutely nothing to do with transfusion thresholds and everything to do with remembering that our medical community is a growing and beautifully diversifying community that invariably includes individuals who have trained, worked, and struggled to care for their patients in far greater ways than you or I may ever know. When you have more, less becomes a choice. So, if we find ourselves thinking that less is more, I would challenge us to remember that more is a luxury of excess. And when less fails, more still remains an option. In that moment, I beseech you and me to be grateful for the alternative of more before the words "less is more" lands in the middle of our unit or ward. Because for many of our colleagues across the globe, sometimes, less is just less.

Author details
[1] Department of Medicine, AIC Kijabe Hospital, PO Box 20, Kijabe 00220, Kenya. [2] Department of Critical Care Medicine, University of Pittsburgh Medical Center, Pittsburgh, PA, USA.

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References

1. Villanueva C, Colomo A, Bosch A et al (2013) Transfusion strategies for acute upper gastrointestinal bleeding. N Engl J Med 368(1):11–21. https://doi.org/10.1056/nejmoa1211801
2. Holst LB, Haase N, Wetterslev J et al (2014) Lower versus higher hemoglobin threshold for transfusion in septic shock. N Engl J Med 371(15):1381–1391. https://doi.org/10.1056/nejmoa1406617
3. Barasa EW, Ouma PO, Okiro EA (2020) Assessing the hospital surge capacity of the Kenyan health system in the face of the COVID-19 pandemic. PLoS ONE 15(7 July):1–13. https://doi.org/10.1371/journal.pone.0236308