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Finding Your Voice to Champion Hope in the Intensive Care Unit

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As an early trainee, I equated emotional distance with strength and wisdom. The first cardiac arrest I witnessed hit me hard; afterward, I promised myself I would walk away from the next code unscathed. I strived to be like the fellow who heard about a critically ill patient, coolly predicted their imminent demise, and moved on. With the ongoing uncertainty and stress caused by the coronavirus disease (COVID-19) pandemic, this separation between patient and physician could seem more important than ever. But as residency winds down, I've realized that holding hope for my patients allows me to maintain my passion for medicine in a way emotional distance never could.

One of my first patients as a senior resident in the medical intensive care unit (ICU) highlighted the importance of holding hope. This was a young woman with COVID-19 acute respiratory distress syndrome (ARDS) who was rapidly declining, transferred to our center for extracorporeal membrane oxygenation (ECMO) consideration. After hearing the story from the other hospital, she seemed unlikely to survive even with our best efforts.

On arrival, her oxygen saturations dropped to the 60s. As a new senior resident, I felt anxious stepping into a leadership role for such an ill patient. But with the help of seasoned nurses and respiratory therapists, we were able to place an esophageal balloon and titrate positive end-expiratory pressure (PEEP), and by post-call rounds the next morning our once hopeless case seemed to be heading in the right direction. Days later she was extubated, and not long after that she was back at home with her spouse and children.

With hindsight, it became clear that with intubation her high body mass index led to dramatic alveolar derecruitment and resultant hypoxemia (1). Her hypoxemia

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was resistant to prone positioning, neuromuscular blockade, and inhaled vasodilators because what she really needed was more PEEP (1). Up until this point, I considered this case a win. But I was surprised that as I turned to my teammates to celebrate, they had already moved on to the next patient. Their lack of enthusiasm confused me; within one day we went from discussing ECMO cannulation to extubation and acute care transfer.

I presume that my colleagues likely guarded themselves upon our patient's arrival in response to her initial grim prognosis. With the volume of death and other tragedy healthcare providers witness on a regular basis, allowing ourselves to deeply invest in each case leaves us open to suffer defeat after defeat. Creating distance between ourselves and patients can be a protective mechanism (2). By declaring that a patient was always doomed to a poor outcome, we may save ourselves from future grief (3, 4). If we believe empathy and compassion are fixed quantities, we reserve some for the next patient we think may have a chance.

This approach ignores what we lose when we defer hope with the goal of protecting ourselves. Our patient came amid the third wave of COVID-19 cases in 8 months, with no end in sight, at a time when I needed hope and inspiration to keep coming back to work. I'm grateful that more than a year later, ARDS, ECMO, or not, I can reframe this case as a win. I regret not using my newfound leadership role at the time to encourage hope in my team.

Allowing the anticipated clinical course to impact our sense of hope becomes even more fraught when considering that our ability to independently predict patient outcomes is limited. Physician prediction has failed to reliably predict extubation readiness (5, 6), ICU readmission (7), and long-term functional outcomes in critically ill patients (8, 9). When predicting in-hospital mortality, experienced physicians do better than random chance but still get it wrong much of the time (9).

Of course, not every patient survives. I recently found myself caring for a young man with COVID-19 who had been cannulated for venovenous ECMO a few days prior. Over the next month, we spent countless hours fighting for his life. On the last day of my rotation, we all felt a glimmer of hope as he was on minimal ECMO settings and preparing for decannulation the next day.

That night, he suffered a series of setbacks, and he died soon after. His death was an incredible loss to me and to the hundreds of ICU staff who spent the previous month caring for him. This time, though, I had no misgivings about the relationship I built with him and his family. I'm proud that I kept holding hope throughout his prolonged admission and that I was able to encourage my colleagues to do the same. My sense of empathy and compassion were strengthened by witnessing and sharing in his family's grief.

I used to compare these two cases, trying to decide which of these outcomes was worse: losing a patient after spending days hoping for a good outcome or missing out on celebrating a success to avoid making an emotional investment. I'm still not sure, but I do know despair is often much easier to find in the ICU than hope. Cultivating hope in the ICU is an active process: taking time to celebrate a successful extubation, starting rounds by reflecting on the privilege of caring for a patient who recently died, or sending the team a follow-up e-mail describing a

patient's continued recovery after their ICU discharge. I'm grateful for the times when a team member deliberately highlighted hope in our patients.

These moments of shared hopefulness have far-reaching effects. Families of patients in the ICU value shared hope and appreciate when providers take time to explicitly discuss hopefulness (10). A brief daily ritual of reflecting on positive events of the day may improve feelings of burnout among ICU nurses (11). The ICU is an emotionally challenging environment (12–14) for both trainees and seasoned professionals. Although not a panacea, I've witnessed hope unify teams, forge new relationships, and remind providers of their motivation for pursuing careers in medicine. As senior members of the team, fellows and attendings set the tone and norms of their teams (15). With this influence comes a responsibility to encourage hope among their teams.

For my own career, I now appreciate that I won't survive without finding ways to hold hope. I'll never be that steely fellow who seems unmoved by the death around him. Instead, coming into my own as a team leader has meant seeking and celebrating hope and embracing the vulnerability hope brings. There will still always be a role for creating distance between me and my patient. But I reject the idea that a deep divide between patient and provider saves something for the next patient. I carry the hope of the patients I've saved, and those I've lost, into each new patient's room, reenergized to face the challenges ahead.

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