Media Vita in Morte Sumus

("In the midst of life, we are in death..." – Latin antiphon)

Text by Dr Chan Yeow
Photos courtesy of the Koh family

I ATTENDED SG-ANZICS 2015, the third Singapore-Australia-New Zealand Intensive Care forum, held at Suntec City one weekend in April. The scientific programme was superb, the line-up of speakers impressive, and if not for the multitude of Asian faces and the delicious spread at each tea break, one could be forgiven for assuming it was a European or American intensive care unit (ICU) meeting.

However, I left the lecture series on medical ethics feeling depressed. The speakers were each experts in their own field, but the overwhelming message was that people are getting older and sicker, and even if they survive ICU, they may die in a few years. They will not be the same again, they are likely to need help with their daily activities, and they may suffer lingering symptom burdens. All these are not surprising, but the unspoken conclusion was disturbing. The question (or was it the implied conclusion?) was whether life after ICU was worth living.

Crux of the issue

The problem, I believe, lies in the way we are deployed at work. Acute care physicians (emergency physicians, intensivists, anaesthetists) work scheduled shifts, days or weeks in highly stressful environments, where patients are kept in suspended animation by sedative drugs and paralytics, their vital organ functions taken over by ventilators or renal replacement machines, and persons are reduced to statistics and numbers ("89 yr old; APACHE Score 25; EF 25%; Creatinine 300"). How many of us know that Mr XYZ is a loving grandfather who sent his grandson to school every day by bicycle, before that fateful day when he was knocked down by a bus? Does it really matter?

Yes, it matters! It matters because if one–quarter of the patients we look after die in ICU, without the opportunity to manifest their personalities, and the rest are discharged from ICU while still bedbound, completely dependent in all daily activities, and perhaps frail, breathless and delirious – we may indeed ponder if there is any point in what we do. I could not help but wonder if this was indeed what was happening, and why these renowned physicians from Canada and Australia seemed so lacking in optimism. I was fearful that this sense of futility would be communicated to the young doctors and nurses in the audience, and they would stop believing in what drew them to healthcare in the first place: the calling to cure sometimes and to comfort always.

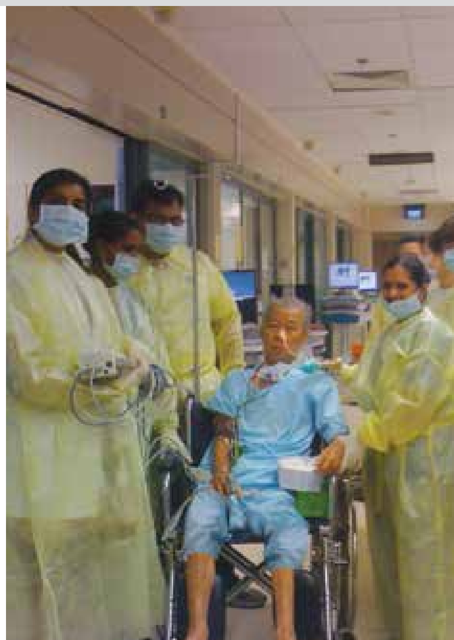
If we take a poll of young doctors or nurses and ask how many would want to live on if they become permanently in need of help with mobility and activities of daily living, or if they have some pain or breathlessness daily, many would say "no". They would feel that such "survival" is painful, not worth it or "less than human".

However, isn't such an attitude judgemental, and perhaps unfair, to the many individuals who are disadvantaged in mobility, unable to look after themselves, or perhaps suffering from inadequacies in their memory or cognition? Would we, doctors and nurses then, be betraying the trust of so many sick and disabled people?

Beyond numbers

Many ICU outcome studies use certain validated quality of life tools, which give a summated "score" to a patient, integrating their ability to work, participate in recreational activities, have sex, their mobility and ability to perform daily activities, and their subjective psychological experiences. If we look at only the final number of such scoring systems, ICU "survivors" would indeed seem to do badly.

However, we must not confuse a "quality of life" score with a "satisfaction with life" score. In my own dealings with patients with serious neuromuscular degenerative



From left
One of Mr Koh's first outings outside of the surgical ICU room
Mr Koh's regular exercise on Saturday mornings
Mr Koh on a Chinese New Year shopping tour with family

disease, I have observed that their goalposts in life change. For many, it no longer matters that one cannot attend late night parties or dine on haute cuisine at Michelin-starred restaurants. It is good enough to be near loved ones, to be able to sit near a window and hear birdsong or watch a sunset.

Having this "mindset change" in ourselves is so important because our job as doctors is also to teach (*doctor* – from Latin *docere*, "to teach"). We need to teach our patients to learn how to live well, to cope with life, to see the cup as half filled with life-giving water instead of half empty.

If someone receives a diagnosis of definite death in years, with interminable deterioration until death, they would initially be at a great loss. How do you grapple with such a sentence? Is there any more meaning in life? Yet, this is not a rare occurrence. In my home ventilation work, I deal with people diagnosed with amyotrophic lateral sclerosis. That might be the most extreme example. However, the ones diagnosed with advanced cancer, Parkinson's disease, interstitial lung disease, etc, also have to confront such a crushing realisation. How do you and I, healthy doctors, help them handle this? When they ask us for "a jab or a pill" that would kill them and solve all their problems, what do we have to offer other than the lame excuse that "physician-assisted suicide is not legal"?

Yet, "healthy people" like us, are we not living in a sad illusion of permanence? Did some wise observer not comment that life itself is a sexually transmitted terminal condition?

Memorable Mr Koh

In 2012, I was privileged to look after Mr Koh Chong Ming, then aged 75. He had survived surgery for colon cancer, but postoperatively suffered almost all the complications described in the textbooks. Like most of my colleagues, I despaired of his recovery and reiterated the "poor prognosis" to his family. But we were impressed by Mr Koh's unfazed spirit, and his chidren's devotion and optimism. He became the "champion patient" in our ICU's early mobilisation project and successfully went home.

Last year, I met his daughter at the Toast Box outlet in the hospital and started chatting with her. An elderly man greeted me in a loud and clear voice. It was none other than Mr Koh! We conversed a little about his experience during his illness. He is now very happy and grateful for the new lease of life he has received.

55% mortality = 45% chance of survival. One may not be able to walk again, but now we have wheelchairs. Furthermore, as doctors and nurses, are we doing our best not only to help our patients to survive, but also to think clearly, to communicate and to walk?

Yes, we need to be realistic. But we also need to have hope in moments of uncertainty and patience in moments of difficulty. Even when we are looking after imminently dying patients, rather then "helping them along" in our despondency, might our role not be to accompany them one more day and try to make the best of each day? Thank you, Mr Koh, for your lessons on life and medicine! ■

Dr Chan Yeow is an anaesthesiologist and an intensivist at Tan Tock Seng Hospital, and Director of the Home Ventilation and Respiratory Support Service. He gets a great kick when ventilated, tracheostomised patients can speak audibly, return home and do things they enjoy. His other interests are in philosophy, medieval history, Romance languages and calisthenics.