

**LETTER FROM DR. MARTIN S. VONAU, M.D.**  
**RE HEALTH CARE DIRECTIVES**  
03-21-2020

It is always a good idea to talk to your loved ones about your Advanced Directives in the event that you became too sick to express your wishes. Now is a perfect time to do so, not after you get sick. It's good to have a Living Will, but making sure your family and significant others know what you would want can be just as good. Unless you have designated a healthcare power of attorney, the decision will go to your legal next of kin. In order, these are spouse, adult children, parents, adult siblings. I would, however, caution you that in some cases leaving it all up to your spouse can place a lot of pressure on him/her. This person may not want to let you go and may sign you up for a lot of aggressive measures that you would not have ever wanted to go through. Have the conversation frankly and clearly while you still can. Say things like "I would NEVER want a tracheostomy, even if I would die without it." Sometimes a spouse will acknowledge to him/herself that you said you didn't want something but will rationalize that it's OK to do it if you would die without it. If you do not want to leave the decision to your next of kin, be clear in a Living Will and designate a Health Care Power of Attorney.

**ICU level interventions to consider.** This is meant as a general discussion and nobody should take it as medical advice. Please consult with your own health care provider.

1) Central lines and arterial lines. These are larger than normal IVs that are placed in the large veins in your neck, upper chest, or groin region. These are very, very common in ICU patients and are necessary for the delivery of certain medications and to ensure adequate access to give medications. Arterial lines are usually in the artery in your wrist (sometimes groin) to constantly measure blood pressure and allow close monitoring of respiratory oxygenation status. Both of these procedures are quite low risk and not overly traumatic. But if you are very old or have a terminal condition, you may not want these types of things. Let your people know that now.

2) Endotracheal tubes and ventilators. A plastic tube is placed through the mouth (sometimes nose), passes between your vocal cords and into your trachea (windpipe). This is called intubation. The end of the tube is then connected to tubing which is connected to a machine that breathes for you. There are several reasons why you might need this procedure. Needed when your lungs are so sick or your breathing is too weak to keep your body oxygenated (all your organs need oxygen to survive). You will not be able to talk with the tube in, and often have to be sedated or even paralyzed with medication while on the ventilator. It is often very difficult to predict how long someone will need to be on a ventilator. If you are very old or have a terminal medical condition, you may not want this procedure in the first place. You may just want to go peacefully if your lungs got too sick to survive with just supplemental oxygen or other less invasive measures. Talk to your people about this.

3) Tracheostomy: This is a procedure where a hole is created in your neck through your trachea (windpipe) and a plastic tube is placed through the hole directly into your windpipe. In the medical ICU, the most common indication for tracheostomy (aka, "trach") is prolonged (>10-14 days) ventilator requirements. If you have had an endotracheal tube (see above) for more than 2 weeks, this can lead to long term damage to the vocal cord and upper throat. If after 2 weeks your

lungs or brain have not healed enough to come off the ventilator you would need a tracheostomy if you want to keep going. Depending on the circumstances, the trach might be temporary (a few weeks to months) and you may not need a ventilator forever. For instance, you may need the ventilator for a month, then be able to come off when your lungs heal. Down the road, the trach tube can be removed and the skin will eventually heal. However, in other circumstances the chances of not needing the trach or ventilator long term may be very, very low. For example, if your body was initially very, very sick and the brain went a period of time with low oxygen or low blood pressure, you may have suffered permanent brain damage. Please talk to your people now about whether you would ever want a tracheostomy. If so, would you only want it if your brain was healthy and there was at least a chance that it wouldn't be long term or permanent?

4) Renal replacement therapy. This intervention is used when the kidneys are too sick to do their job. This includes dialysis, or a form of dialysis called continuous renal replacement therapy (CRRT) that is often done in the ICU. To get dialysis in the ICU, you will need an even larger central catheter than #1 above, usually in the large vein in your neck or groin. It is also very difficult to tell up front whether this will become a permanent thing or whether your kidneys will recover. So far this discussion pertains to emergency need for dialysis in an ICU. Long term dialysis would include different considerations. For example, the long term access for dialysis will be either a catheter tunneled underneath the skin in your upper chest or a graft or fistula in your arm (further elaboration on grafts and fistulas are beyond the scope of this letter, so please talk more with your nephrologist if you have chronic kidney disease). If you would end up needing long term dialysis, you would have to go to a dialysis center for around 3 hours a day for 3 days a week. So if you are older or have a terminal illness, this amount of commitment to endure might not be what you want. Discuss with your people whether you would ever want dialysis, even if possibly temporary.

5) CPR (cardiopulmonary resuscitation): This is when either your heart completely stops or is so weak and ineffective that it is not producing a pulse. When this happens, it is not like the movies. The chest compressions are very forceful and often break ribs. Additionally, the brain and other organs will likely go some period of time with inadequate oxygen so even if you survive there is a chance that your brain and other organs suffered damage. This damage might be severe and you may never recover. If you are very old, frail, or have a terminal disease it might be best to tell people if your heart stops (you have died) to let you go and you would not want to be brought back to life. This is called a DNR (do not resuscitate).

Lastly, if you have a terminal illness or are nearing the end of life, you might want to avoid all life-prolonging interventions. You might be tired of getting blood drawn, going to specialist visits, getting IVs, being admitted to the hospital, etc. Instead, you might decide to change your goals of care to what we call "comfort care." This is often done through hospice services. These specialists do an excellent job at focusing fully on your comfort. Depending on your circumstances, this can be done for you at home or in physical hospice facilities. When end of life is near, hospice and comfort care can help you spend less time suffering and more time being with your loved ones

There are so many more things, but this is a brief list of things to really consider NOW before you are too sick to communicate your wishes to your people. These interventions are not

benign things. They in and of themselves will cause pain and suffering. The last thing you should want is to go through more pain and suffering for things you wouldn't ever have wanted in the first place.

Please share especially with your older friends. It's important for people to think about these matters in advance. We erroneously assume lay people know the chain of events that can happen to you in the ICU. Unfortunately, the default is to "do everything" when often that may not be what you would want. Doctors struggle with letting people die, too. It is much easier when we can say for certain that a person said he or she wouldn't want to go through certain things. No one makes it out of this thing called life alive (*i.e.*, we all will die). There are good ways to die, and other very slow, very painful ways to die. I will continue to do everything I can to give people the best chance. It would be easier on me and your loved ones if we knew how much and for how long you would want us to push on. You can even give concrete deadlines to your loved ones: like "I would be ok on a ventilator for up to 2 weeks, but if I haven't recovered by then I would want to be allowed to die peacefully." Or, "I would be OK with emergency short term dialysis, but I would never want long term chronic dialysis."

This isn't meant to be "coronavirus is coming! We are all going to die!!" But....yes we are all going to die at some point. It's now more important than ever to think about this.

Here, I'll go: I'm relatively young and (I think) pretty healthy. If my heart were to stop, I would want CPR to try to bring me back. But if after 30-45 minutes (there's a good chance that I have suffered brain damage by then), please stop. If my lungs were to fail, I would want to be on a ventilator if need be. If my lungs got sick from a reversible process and I need a trach, I am ok with that. However, if my brain has suffered serious damage and I am unlikely to be the person I used to be, I would NOT want to be kept alive. I would be ok with central lines and dialysis. If you feel like it, post your wishes! Not legally binding (as is a Living Will), but at least people you care about will know where you stand.

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