The Darkening Veil of “Do Everything”

THE HOUR IS LATE AND THE SITUATION DIRE. Huddled by the patient’s bedside, a nurse and respiratory therapist stand just behind the physician who speaks to the family members. Sometimes the patient is a child—perhaps an infant, just born, with severe congenital anomalies, or maybe a toddler who fell into a pool and nearly drowned. Other times, the patient is far older, and may have had a sudden massive heart attack or may have been living with progressive cancer for months or years. The family members could be young parents or a spouse married half a century. The conversation focuses on the patient’s history and diagnosis, the gravity of the predicament, and the possible treatment options, outlining the possible benefits and harms.

Then someone says, “do everything.” The physician may offer this up as a pledge: “We are going to do everything.” Or asks the question: “Do you want us to do everything?” Alternatively, a family member may utter the phrase as a request or demand: “We want you to do everything.” Heads nod in silent agreement. We will do everything.

Problem is, no one can really be clear about what has been said. What do the words “do everything” mean? The phrase is vague at best and vacuous at worst, permitting anything every possible medica tion.2 One must try to defibrillate the patient’s heart. One cannot simultaneously cradle a grievously ill infant in one’s arms and at the same time insert vascular cannulas for extracorporeal membrane oxygenation; nor can one hold a loved one’s hand while they are dying at the same moment that the code team yells “clear” and attempts to defibrillate the patient’s heart. One must choose. Whether acknowledged or not, choices are woven throughout the fabric of medical care. The phrase “do everything” though, seems to say otherwise: let’s avoid any choice for now and do this and do that. Behind the veil of “do everything,” the choices we inevitably are making—and the responsibility for those choices—are obfuscated.

Equally muddled is the mirror image phrase that “there is nothing more we can do”—full stop. Just as we cannot do everything, we can always do something. Intensive care is composed of both invasive care and intensive caring, and even if the former is failing, the latter can continue unabated. Our commitment to do the-best-something-that-we-can-do may make a world of difference. When operating within the confines of the increasingly tight constraints that progressive disease can cause, clinicians need to be more precise, complete, and empathetic.3

I wish there was more that we could do that would halt the progress of this disease, but none of the treatments we have are able to do this. We are still devoted to taking care of your child and will do everything in our power to keep pain and discomfort away.

Second, the veil of “do everything” leaves a disturbing amount of room for misunderstanding what will actually be done. Families and physicians approach the patient’s illness crisis from different frames of reference and thus infuse the “do everything” phrase with different meanings. Rather than assuming (often mistakenly) that the family understands the vast array of possible interventions and the detailed physical implications of what “doing everything” might mean, clinicians can respond to “do everything” statements by responding that “yes, we will do everything that we can do that can possibly help your loved one.”

Third, when confronting the ominous circumstances that envelop the patient, the dark veil of “do everything” prevents families and clinicians from making genuine connections. The etiology of this vague and unattainable verbal imperative originates, in many instances, in an anguished outcry against how the critical illness threatens the patient in the bed and an urgent need to establish and affirm a basis of trust. For the family, “do everything” can be a way of asking that the clinicians stay committed and engaged with their loved one: “Don’t give up.” “Don’t abandon us.” In this sense, “everything” is not an object; rather, “everything” is an adverb, describing a “doing” that is vigorous and trustworthy.

Fourth, the “do everything” stance may stifle discussion by fostering an adversarial air in conversations. If a patient or family has framed the choices (or had them framed by others) as “do everything” vs not doing so, they may be more likely to fear that care is being rationed for some reason other than the patient’s best interests. They may then become unwilling to consider alternatives to what they see as the one path that proves their loved one is not being shortchanged. Once a family mentions the phrase “do everything,” clinicians may use it as an excuse to escape from or shorten a difficult conversation, thinking, “well, we know what they want.” But to shy away from engaging in this discussion does not build a collaborative partnership between family and clinicians, nor does it serve the patient well.4
Ours is not an argument for confronting daunting choices bluntly—or, worse, brusquely—relying chiefly on medical facts and clinical logic to grapple with frightfully difficult situations. Rather, we argue for taking the time in these conversations to explore the choices that could be made. When confronted with requests or demands to “do everything,” we view this as a starting point for a discussion, not an ending point. The discussion should not so much debate the pros and cons of particular interventions but rather focus on and elaborate specific commitments. Our response might be:

I respect how deeply committed you are, and we are also absolutely committed to figuring out what the best thing to do is. Let’s talk for a few minutes about what the different options might look like.

In the crisis that families confront when a loved one is critically ill, increased clarity of speech is not a cure-all. Still, being clear and forthright helps. When a family member talks about “doing everything,” clinicians might pause to insert a reflective comment:

We always ask ourselves what we can do to help the patient. To answer this question, we have to be clear about what we are hoping for—recovery, comfort, dignity—and do all that we can that has a reasonable chance of getting us there.

Finally, with each passing year, this veil of “do every-thing” grows darker. A mere 60 years ago, “do everything” would have at most meant lying in a hospital bed on a regular ward, receiving oxygen by mask and antibiotic injections, and perhaps undergoing surgery. There were no intensive care units, no telemetry monitors, no mechanical ventilators, no dialysis, no transplantation, no extracorporeal membrane oxygenation, and no left ventricular assist devices. Over time, the medical and surgical interventions that we can do are increasingly invasive and effective, all of which is nothing short of marvelous; yet, these miraculous technologies are also effective at merely forestalling death even in those cases where recovery never happens, and most likely never could have, while nonetheless creating in their wake the pain and suffering associated with invasive care, bereft of any benefits.

The bottom line is simple: saying that we are going to “do everything” is dangerous nonsense. If we really don’t mean it, then we really must not say it. A moratorium is warranted, halting all medical personnel from further casual utterances of “do everything.”

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REFERENCES