Brother, 69: Pancreatitis, Sepsis, ARDS, Organ Failure

Families' FAQ: “What are his ICU treatment options?” | Quick tip for families in intensive care

A sister's 69-year-old brother is critically ill with severe pancreatitis, sepsis, acute coronary syndrome, kidney failure, ARDS and multi-organ failure. He has been unconscious for over a week, and his son, the healthcare proxy, is holding on for hope while the family is heartbroken and confused. Here is what families in this situation need to know.

Q. What is actually happening in his body?

Severe pancreatitis with sepsis: the pancreas is destroying itself and releasing toxins into the blood, and the immune response is attacking the body's own organs. Mortality is very high when it causes multi-organ failure. **Acute coronary syndrome:** blood supply to the heart muscle is critically compromised on top of sepsis. **Kidney failure:** likely on continuous renal replacement therapy (slow dialysis, 24 hours a day), a major prognostic indicator. **ARDS:** the lungs are severely damaged, which is why he is on a ventilator; it can take weeks or months to recover from. **Multi-organ failure:** three to four organ systems failing at once; the more that fail, the lower the survival rate.

Q. Why hasn't he woken up after more than a week?

He has been taken off medically induced sedation but is now on ketamine, Dilaudid (hydromorphone) and methadone, powerful drugs, and has not regained consciousness. This is a **red flag that must be formally investigated** with a neurological assessment, if it hasn't been done already. Write down every condition above and discuss each one specifically with the ICU team.

Q. Who makes decisions when he can't?

If he lacks decision-making capacity, and over a week of unconsciousness clearly meets that threshold, the **healthcare proxy is the primary decision-maker**. If the directive is ambiguous or applied inconsistently, escalate: ask for a formal family meeting with the ICU consultant, social worker and palliative care team; ask for the proxy directive to be reviewed, clarified and documented in the records; and ask for a hospital **ethics committee** consultation if the document's meaning is genuinely unclear. The author advises checking that its members are independent and not hospital employees.

Q. What are the treatment options?

1. Full active treatment: continue the ventilator, medications, dialysis and cardiac support. Ask whether the team believes it is likely to lead to a meaningful recovery and what that recovery looks like. **2. Goals of care, transition to comfort:** if there is little to no realistic chance of meaningful recovery, focus shifts to comfort, palliative care and dignity. This is a values-based decision, not giving up. **3. Time-limited trial:** continue for 48 to 72 hours, then reassess, giving a hopeful family a defined time frame. **4. Limitation of treatment:** continue current care but agree not to attempt CPR (DNR/NFR).

Q. Should we agree to a DNR as a “middle ground”?

Many families choose it, but the author advocates against it, because in his 25 years of experience a DNR or NFR order often leads the hospital to wind down treatment. It needs **further consultation** so that you understand exactly what it will mean in practice. Whichever option you choose, make it with full information, and remember that what counts as a meaningful recovery for you may differ from what the ICU team considers meaningful.

Q. Why should we read the full medical records?

You have the legal right to the **full** records, not just the bedside summary: nursing notes, lab results, imaging reports, ventilator parameters, medication records and every documented conversation between the ICU team and the proxy. Request them in writing if needed. The records show the trajectory (improving or deteriorating) and whether the proxy's directive is being followed.

Q. Could he survive but stay ventilator-dependent?

Yes, especially with ARDS and sepsis. He might need invasive ventilation through a tracheostomy, non-invasive ventilation (BiPAP/CPAP), or a tracheostomy without ventilation, and **does not have to stay in ICU or go to a nursing home**. **Intensive Care at Home** (operating since 2012) provides third-party-accredited 24-hour intensive care nursing at home across all Australian states and territories, and also for those choosing **palliative care at home**. Families in the US, Canada, UK and India can reach out too.

Q. What can independent advocacy do for us?

Intensive Care Hotline reviews medical records, speaks with you and the ICU team, joins family meetings, asks the questions families don't know to ask, and gives a second opinion in real time. The biggest challenge for families is that they **don't know what they don't know**: what to look for, which questions to ask and what their rights are.

Need independent expert advocacy? Intensive Care Hotline can help.
Patrik Hutzel brings 25 years of critical care nursing experience. We review your records, join your family meeting, ask the questions you don't know how to ask and advocate for your loved one's rights and dignity. Book a **free 15-minute consulting call**.
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General information for families, not a substitute for advice from your loved one's treating medical team.