



## BECS: BEST EFFORT COULD NOT SAVE

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**ABSTRACT** Physicians dedicate themselves to saving lives, often succeeding in cases of non-terminal illness. However, there are circumstances where, despite optimal management and diligent care, a patient with a potentially treatable condition cannot be saved. We propose the term "Best Effort Could Not Save" (BECS) to describe such instances. BECS refers to situations where untimely complications or unforeseen disease progression lead to death despite appropriate and timely interventions. We illustrate this concept with the case of a 50-year-old woman with a liver abscess and chronic obstructive pulmonary disease (COPD) who received standard treatment, including drainage, antibiotics, ventilatory support, and management of complications. Despite comprehensive multidisciplinary efforts including tracheostomy, repeated bronchoscopic clearance of secretions, and infection-directed therapy the patient developed ventilator-associated pneumonia, acute respiratory distress syndrome, and septic shock, culminating in death. This case emphasizes that BECS is distinct from terminal or palliative scenarios. It highlights the unpredictability of clinical practice, reminding us of both the limitations of medicine and the humility required in patient care. Recognizing BECS may help frame such outcomes not as medical failure but as an acknowledgment of the complex interplay between disease, complications, and fate.

**KEYWORDS** : BECS, ARDS, COPD, LIVER ABSCESS**CASE REPORT**

As part of their duty, every doctor strives to do everything within their power to save a patient. In non-terminal illnesses physicians often succeed in saving the patients. In terminal illnesses, doctor's best efforts are often destined to fail. There are certain circumstances however where the patients have non-severe illness and still physician's best efforts are unable to save the patients. We have coined a terminology "Best Effort Could Not Save" (BECS) for such non-severe illness. It can be defined as the course of the disease and deterioration of condition or untimely complication is such that despite the doctor's best possible efforts, the patient ultimately succumbs. Such instances are most commonly observed in ICU settings, though they may also occur in general wards.

During the COVID-19 pandemic, many healthy young and old patients presented to the ICU with respiratory failure. Among them, a few died, and others survived, even with the same measure of treatment and diligence of care. Many young treatable succumbed but some very severe ones did survive. To explain the term BECS in non-covid patients we have described a case with a liver abscess. A 50-year-old woman, with obesity and chronic obstructive pulmonary disease with good compliance to medications, presented to the surgical emergency room with fever and abdominal pain. On abdominal examination, tenderness was noted in the right hypochondrium. Ultrasound of the abdomen revealed a liver abscess.

The patient was hospitalized, given intravenous antibiotics, and treated with pigtail drainage of the liver abscess. During her hospital stay, she developed an acute exacerbation of COPD, resulting in type 2 respiratory failure and prompting a transfer to the intensive care unit. Non-invasive ventilation was attempted(1) but was unsuccessful, leading to endotracheal intubation. She remained on the mechanical ventilator for 10 days. Her respiratory status improved, and weaning was initiated. However, despite multiple attempts at weaning, the patient experienced failure and subsequently underwent tracheostomy. During the weaning trials, the patient also developed atrial fibrillation due to stress, which was managed conservatively with intravenous amiodarone. Meanwhile, the pigtail catheter was removed as the liver abscess was fully drained.

Despite receiving all necessary care to prevent ventilator-associated pneumonia and hospital-acquired infections, she contracted ventilator-associated pneumonia(2), which further complicated her weaning process. The antibiotics were adjusted according to the results of the culture and sensitivity report. The patient also experienced left lung collapse due to pooled secretions, despite routine chest

physiotherapy and regular suctioning. This required repeated bronchoscopy and lavage to clear the secretions. The patient eventually developed acute respiratory distress syndrome (ARDS) with septic shock, leading to the initiation of inotropes. Unfortunately, the patient ultimately succumbed to her illness despite all the best possible efforts by the doctor.

In conclusion, the term BECS can be applied to situations where doctors have exerted their best efforts to save a non-terminally ill patient, but despite their dedication and skill, they are unable to preserve a life proving 'fate is immutable'.

**REFERENCES**

1. Shah NM, D'Cruz RF, Murphy PB. Update: non-invasive ventilation in chronic obstructive pulmonary disease. *J Thorac Dis.* 2018 Jan;10(Suppl 1):S71-9.
2. American Thoracic Society; Infectious Diseases Society of America. Guidelines for the management of adults with hospital-acquired, ventilator-associated, and healthcare-associated pneumonia. *Am J Respir Crit Care Med.* 2005 Feb 15;171(4):388-416.