Lessons in dying

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Edna died this morning. It was expected but I might have felt better if I had been there on the ward when she took her last breath. Her final days were lamentably someone else's responsibility; the residency juggernaut's pace is immutable, and I was finished internal medicine and already into my next rotation when I heard the sad news. I might also have felt better if I had not been so intimately involved in the last days of her life and her death.

Finding Edna

Edna was "one of mine" from the start. I admitted her from the emergency department late at night. She was one of the many so-called weak and dizzy who populate a large number of emergency beds—the sort you might stabilize then assign to a medical student to write the admission note, because extracting the usual history from them is often quite challenging.

Edna was a resolute 86-year-old lady with all her marbles. The emergency physician had done a wonderful job stabilizing her; she had earlier presented in florid congestive heart failure, short of breath and complaining of chest pain from an evolving non–ST-segment elevation myocardial infarction. Or, as she would correct me on many occasions over the following weeks, "It's *tightness,* Dr Stewart, not pain."

When I first met her she was lying on a gurney looking thin and drawn, puffing away on 6 L of oxygen. She smiled at me through her big brown-rimmed bifocals, and asked me if I was going to try to feel her radial pulse because, as she proudly put it, "nobody seems to be able to find it."

She calmly answered my questions, and a picture of what made her unique slowly emerged as I scratched out a lengthy admission note. She was alone in the world. She had no children. Her husband had died several years earlier, and her only friends were a tight circle at her retirement home. Until recently she'd been in moderately good health, as much as could be expected of a woman who'd gone through many coronary angiograms and 2 stents and was now "divorced," as she put it, from her cardiologist, limited to only medical management.

That meant that, among other medications, nitroglycerin patches and spray were her best friends. She'd been resorting to the spray more often lately and had been slowly declining over the past 6 months; she was increasingly "puffy," she said, with exercise.

After Edna was finally moved to our ward, my daily ritual while on rounds was to ask her about her morning chest "pain," have her correct me that it was "tightness," then enter into an educational session about the benefits of early rather than late use of her bedside nitro. Her heart was so dysfunctional that it was a struggle for me to keep her out of failure, even with all the advice of my senior resident and the attending physician.

Throughout her time on the ward she was always good-natured and sometimes apologetic about her condition. She endured and was very grateful for treatment, and we seemed to be gradually winning the battle to get her stable enough that she would be able to manage in an assisted care facility. But Edna was pragmatic. One day she summoned her lawyer to her bedside to discuss her situation and "put her affairs in order," as she explained to me later.

Seeing truth

When I arrived on a Sunday morning for my last shift of the internal medicine rotation, I decided to check in on Edna first. The nurse emerged from the room as I approached and turned to me, her face a mixture of concern for Edna and relief at seeing me. "Edna's feeling chest pain again, but the nitro isn't helping."

I quickly strode into Edna's room, trying to exude the calm manner that had been working so well to alleviate her anxiety during recent days. Sitting down on the edge of the bed, I asked her what was wrong. She explained to me that she was experiencing chest pain.

"You mean chest *tightness,* don't you, Edna?" I replied, thinking it was part of our normal repartee.

"No, *pain,* Dr Stewart," she told me with a grimace, putting her hand over her left breast, then tracing a line diagonally across her chest to her right shoulder. "And it's different than before. I can feel it all the way to my right shoulder blade."

Struggling to remain calm, I told her to wait there just a minute—as if I expected her to go anywhere—strode to the doorway, and started giving orders. "Hope for the best and plan for the worst," I thought, adding sinister items to her differential diagnosis. Meanwhile, I called my attending at home and asked for advice. With some fine-tuning, he assured me that I was doing the right things and that he was on his way. Before long, blood was drawn, the x-ray technician had come and gone, and I was alone with Edna.

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"Why are you doing all of this?" she asked me, concern in her eyes. "Why don't you just let an old girl die? I'm being such a bother."

I was stunned. We'd had several discussions over the weeks about how she would eventually go about managing her condition out of the hospital. Things had been looking up, I'd thought. She'd never talked about withdrawing care.

"We're trying to figure out what's going on," I said. "You've never had this sort of pain before and it troubles me."

"I've lived a good life," she replied. "Why don't you just stop. You're not going to make me any better. I'm not leaving this hospital, am I?"

Maybe she saw more of the truth than I did. Maybe I didn't want to let go; didn't want to fail; didn't want to see her die. I paused, and thought things through. Yes, she was cognitively intact; no, she wasn't delirious, although she had been from time to time during her stay.

"Are you saying that you don't want us to do anything?" I asked, hoping for some time and space to think.

"I really don't want you to stick anything more in me. I don't want any more trips for x-rays. I just want to die in peace, with no pain."

This made me more pensive. I'd been taught that when lucid patients give you their final wishes they must be respected, as long as they don't require you to take active measures to hasten their deaths. But this was the first time I had to face this reality as a physician, and it was a gut-wrenching moment. As we continued to talk, I realized that it didn't matter whether she was experiencing any of the sinister items on my differential; it was time to switch gears to palliative care. To be a good physician for her now, I had to treat a person not a medical condition.

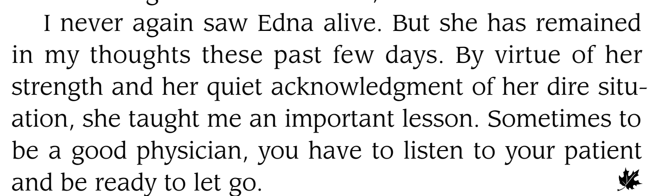
Letting go

The attending physician arrived and we discussed Edna's wishes. He agreed with me as I wrote orders to stop all oral medications, remove her IV, hold any further investigations, and give her more morphine to control her pain. I went back to Edna and discussed these changes with her and came away convinced that she was stronger than me; she had simply agreed with my plan, saying that she just wanted to have no pain.

Later that evening I came back to check on her. She was gasping for breath and snatched my arm in a surprisingly strong grip. "It's not supposed to be like this."

I put my hand over hers, and asked her what she meant. She described her pain—it was "horrific." I adjusted her medications and assured myself that she was comfortable before going back to my call room. Early the next morning I looked in on a sleeping Edna, and then, after turning over my weekend's patients to the incoming residents and staff, I went home.

I never again saw Edna alive. But she has remained in my thoughts these past few days. By virtue of her strength and her quiet acknowledgment of her dire situation, she taught me an important lesson. Sometimes to be a good physician, you have to listen to your patient and be ready to let go.



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Competing interests
None declared

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