

*This is a resident case log of a patient encounter in which an “Aware Medicine topic” was central.*

### Becoming Comfortable with Death and Dying

During my second rotation through the MICU, there were a number of patients who were at end-stages of chronic illnesses. End-stage CHF was the most common diagnosis that month. The medical care of these patients was quite challenging, as many of them were medically optimized and still failing treatment. However, what I found even more challenging was the emotional aspect of care. One family in particular challenged me significantly in that they were not able to accept the fact that the patient (their husband, father, brother, grandfather) was dying. I think what was most frustrating to me was that we did not do a very good job of helping the family to accept and understand this.

The patient was an older gentleman who had had worsening CHF over the past few months. He was seen by cardiology who gave him a very poor prognosis given that he was on all the “right” medications, had a bi-ventricular pacer, and was not a candidate for a heart replacement as he had multi-system organ failure as a result of his CHF. He was admitted for worsening shortness of breath with bilateral pleural effusions. The patient seemed to understand that his prognosis was extremely poor and was essentially requesting to be comfortable. We helped him to be comfortable by putting him on Bi-pap, diuresing him as much as possible, and doing a therapeutic thoracentesis. His family however did not understand his prognosis and was pushing for higher doses of Levophed and insisting that there must be other treatments that could make him “better.”

Personally, I thought that we should be working with the family to accept the prognosis of the patient. Ideally, I felt that we should be encouraging them to think about end-of-life care such as comfort care and hospice. However, as a team we spent a number of days just continuing to increase the patient’s Levophed and avoiding the discussion of the extremely poor prognosis.

I brought up my personal beliefs and discomfort with this situation to our attending which resulted in a very interesting conversation. He was a pulmonologist by training and explained to me that in his experience hospice doesn’t work well for patients with chronic lung disease because they oftentimes are able to recover from significant exacerbations (such as those resulting in intubation). He went on to say that he although realized that this situation was different he personally had a very difficult time discussing end of life care with patients.

In the end, through a number of long family meetings where we brought up the concept of hospice and comfort care, the family did come to a point where they were able to accept the patient’s prognosis and allowed him to die in peace. What I learned from this experience was that it is not always easy to discuss end of life care, even for the most experienced physicians. Despite this, I also learned that I am extremely uncomfortable when it is not discussed, and that it I feel that discussion is one of the most important ones you can have. I believe that as a physician it is not only our job to help patients medically to keep them as healthy as possible for as long as possible, but also to help them and their families through the process of dying. I think patients and families can come to terms with death and by doing so are able to appreciate what is left of their time together more effectively and grieve appropriately.