

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

### End of Life Care with a Lovely Patient Named LB

End of life care is one of the most challenging situations for patients, families, and physicians. One of my most emotionally involving, and personally challenging, was that of an elderly nursing home patient that I cared for on the Family Medicine Service. Ms. LB was a delightful elderly woman – she had a special shine to her that made the nursing and physician staff brighten when they were in the room. Reviewing her records indicated she had grown up in the Deep South, and had moved to Wisconsin relatively recently (approximately 30 years ago). She had had a large family, with more than 6 living children, some of which lived nearby; now, in her 80s, LB lived in a nearby nursing home with multiple medical problems, including diabetes with end-organ involvement, heart failure, and COPD; she had been hospitalized multiple times, and in fact, had had an unexpected recovery from an illness that required intubation. She was, and had been a full code. Eldercare was involved, and one of her out of state daughters was her health care power of attorney. I first took care of LB during my time on the Family Medicine Service; she was recovering from a gastrointestinal bleed, and ready to be discharged back to her nursing facility.

I was on call the night of her afternoon discharge – my pager went off, summoning me to the ED, where LB was present, after having been at home for less than 4 hours. She had had an acute bout of respiratory compromise – her pulse ox fell into the 70s without a clear explanation. By the time that I saw her, she was comfortable on Nasal Cannula, but things deteriorated to the point where she needed a non-rebreather face mask. With a swirl of medical work up occurring – labs and imaging, examination and history - we were all still perplexed about the cause of LB’s rapid deterioration. I called her daughter, the unactivated POA, and she was admitted to the floor. Later that night, her blood pressure fell sharply, and responded poorly to fluid boluses. We transferred LB to the MICU. LB stayed there for several days, on the cusp of requiring intubation, and without a firm diagnosis – treating for a potential PE lead to resumption of her GI bleed, her kidney function worsened, her CHF was worsening, her blood pressure required pressor support. Conversations with her daughter were increasingly distressing, as she was angry that we were unable to “fix” her mother. Other family members visited the MICU, and despite excellent updates by nursing, physician, and residents, continued to report that her breathing was “better”. We kept sharing our concerns that LB was failing, and in fact, likely to die from this illness. Anger met these responses – that we weren’t caring for their mother well, that we were just waiting for her to die... as days passed, LB let it be known that she did not want to be intubated; however, her family objected to this, that they were not ready to let their mother die, and that we should do everything.

Additionally, LB, a deeply religious person, did not wish to do anything to hasten her death; she was comfortable declining intubation, but was conflicted about receiving morphine, which might hinder her respiratory drive, and regarding whether she should remove the Bipap mask, which she found constricting and confining.

It was difficult to know how best to deal with these multitude of circumstances. This was a patient that I loved and respected – and one who was in conflict with her own family about her care. We did all that we could think of as appropriate. Family updates daily. Family meeting, with the teleconference access. Involving Eldercare. Involving social work. We had psychiatry see LB to determine competency. I called the church she said she had been a member of (which, it turned out, was a branch of the same name in the south), and had both them and pastoral care come and visit with my

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

patient. I reminded myself that every time I talked to her angry daughter, that it was her fear of her mother’s death talking. I held LBs hand when I gave her the daily updates as to her condition, and visited her at night when she was alone in a strange hospital bed.

My personal beliefs did influence my actions in this case – I felt I, and the other medical staff, were working to give LB the autonomy to make her own decisions at the end of her life. I like to think I helped give the patient comfort before she died; certainly, I worked to facilitate her passing in the ways that she would wish, including finding her and participating in her spiritual comfort. Additionally, I think the intensive communication between the family who was in denial about the upcoming death of their mother was important – not only for LB, who did have her daughter come to her bedside before she died, but for the comfort of the family, who it turned out, had a long history of distrust of doctors. Everyone worked hard to co-ordinate this patient’s end of life care – I felt very supported by the staff and by the senior faculty and residents as we all worked on this issue.