A good death

By Jennifer Brokaw, M.D.

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As I put the telephone receiver up to Mr. Ling's ear, I could hear the rapid cadence of Mandarin from 6,000 miles away.

During my 13 years as an emergency physician, I've seen many technology breakthroughs—from clot-busting drugs to sophisticated imaging capabilities—that save lives. But I've rarely thought of technology as a tool for improving the quality of someone's death. I now know it has that potential, too.

Contemplating how to help a patient die is not something that emergency physicians do with regularity. We often don't know patients' end-of-life preferences, so we tend to err on the side of caution. "Do everything" is the default setting in the emergency room. But experienced physicians perform painful procedures on terminal or very elderly patients with a heavy heart. Receiving CPR, having IV needles inserted, or being put on a ventilator are not actions any of us would want if we knew we were at the end of our lives, yet we inflict these processes on strangers on a regular basis.

Procedures: Part of the pressure to do something over nothing is the opportunity to teach medical students and residents life-saving procedures. Another part is everyone's discomfort with death. Someone once noted that Hindus place their dead on a burning funeral pyre and float the body down a river, while Americans often leave this world looking like an artificial life-form: full of tubes and electrodes. It's a ritual that we learned during our training and now pass on to the next generation of doctors.

That's why a recent experience I had was so memorable. It involved Mr. Ling, an 87-year-old widower with a loving family: a son, Tom, and daughter, Sylvia (I've changed their names and certain other details to protect their privacy). After being diagnosed with diabetes and then suffering a debilitating stroke, Mr. Ling had lost the ability to speak coherently, so his children spoke for him. Everyone agreed he would want to die with peace and dignity. Tom signed all of the necessary "do not resuscitate" and "do not intubate" forms to insure that his father's wishes would be honored. One day, Mr. Ling developed pneumonia, and Tom authorized his hospitalization so he could receive antibiotics, respiratory treatments, and IV fluids. He looked very fragile, and I was sure he wouldn't leave the hospital alive.

Gasping: In fact, he did go home. But just two weeks later, the medics ran in bearing a stretcher with an elderly man gasping for air. It was Mr. Ling, with his son close behind. He was *in extremis*—barely breathing and septic, his body riddled with infection.

If he had been younger and healthier, we would have placed a breathing tube immediately and started IVs and medications to maintain his blood pressure and keep the infection at bay. In this instance, I moved slowly. "Have your wishes changed?" I asked Tom. His look was desperate. "No," he said, "we don't want the breathing tube. But my sister is in China, and she wants to see my father before he dies."

"I don't know that we can keep him alive even if we do everything," I replied, glancing at the barely conscious Mr. Ling. If we placed a breathing tube down his throat, I explained, we'd have to sedate him, which would eliminate the opportunity to have any meaningful interaction.

Just then, Tom's cell phone rang. It was his sister calling from Shanghai. They spoke for a while in Mandarin. I waved off the residents and medical students who were hovering, ready to place a breathing tube and a central IV line in Mr. Ling. They looked at me as if I were a heretic. They had been taught that in the ER, doing nothing was not an option.

Suddenly I had an idea. I turned to Tom and asked, "Can your sister call the ER?" The senior resident looked at me over her glasses with an expression of skepticism. But in a 21st-century minute, the phone rang in our cubicle. It was a good connection to Shanghai. I explained the situation to Sylvia and asked if she wanted to speak to her father.

There was a moment of silence, then I heard "Yes, please."

I stretched the cord across the room and put the receiver up to Mr. Ling's ear. I could hear the rapid cadence of Mandarin, a daughter talking to her barely conscious father from 6,000 miles away.

Expression: Mr. Ling had been laboring to breathe with his eyes closed, but at the sound of Sylvia's voice his eyes flew open and his expression lightened. He began to emit a series of "Unhs," a sound I took to mean "Yes" or "Okay."

Sylvia talked without pause for a good three minutes. During a break in the conversation, I took the receiver back. "Did you say what you needed to say?" I asked. "Yes, Doctor. But I want to tell you: Please just make my father comfortable. Please don't let him suffer."

I turned to the huddle of residents. My voice failed me. "Did you hear that?" I choked out.

The senior resident nodded. "We will make him CMO," she said, referring to "comfort measures only." On her way out, she grabbed my arm. "Wow," she said. "I've never seen that before."

I was startled. "You mean making someone CMO?" I asked.

"No," she replied. "Using the phone that way."

Sometimes, I realized, the best medicine can be achieved simply by improving communication. Enabling the Ling family to say good-bye, even if it was via a satellite orbiting miles above the earth, was the very best use of technology imaginable in that situation. It allowed us to save someone from a painful and impersonal death, which, to my mind, is an essential part of doctoring.

I hope the medical students and residents realized that, too. ■

The Point of View essay provides personal insight or opinion on some issue in medicine or science. Brokaw is a 1993 graduate of DMS. She practices emergency medicine in San Francisco and is also the founder of Medical Consult and Advocacy Services, an organization that provides care coordination and support for patients in the Bay Area.