

# When Death Arrives

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**W**hen death arrives, it can be hard to accept. I am 16 hours into a 28-hour Christmas Eve shift on the oncology service when I receive a page from Mr. G's nurse saying that his breathing is becoming more labored. Mr. G is a 62-year-old man with metastatic pancreatic adenocarcinoma. He is awaiting hospice placement, which has taken longer than it should in the midst of the holidays and the ongoing COVID-19 pandemic. I walk into his room to find his nurse sitting at the bedside, holding his hand. His eyes are closed, his face is pale, and his breathing is heavy—a distinct change from when our team rounded on him 12 hours earlier.

"I think we should call his wife," the nurse says. "I don't think he's going to make it through the night."

"Oh... okay. Okay," I stammer as I run this statement through my tired brain, trying to process. I can feel my face growing hot and my mouth going dry. "I... I know his hemoglobin was around 7 when we last checked it a few days ago. Maybe we should get repeat labs or just... transfuse a unit of blood."

The nurse is a tall woman in her mid-50s who has been working on this unit since before I was born. She looks at me, her eyes gentle, and says, "I think we're past that point."

"Right," I say. "Of course. I'll call his wife."

My medical education thus far has been largely focused on how to fight off death. I have carefully studied the fatal diagnoses that should never be missed. I have diligently practiced chest compressions and bag-valve-mask ventilation in simulation centers. I have learned how to diagnose, how to treat, and how to cure.

I know that when fighting off death, I will not always win. But I have not been taught when or how to acknowledge defeat. While death and dying were not ignored, they were not emphasized in my medical education. When I participated in code simulations, the lifelike mannequin always regained a pulse by the end of the session. I was never asked to practice the moment when, after 30 minutes of chest compressions, still without a pulse, it is time to stop. In the exam questions about the best next step in a patient's management, the correct answer was always a lab

test, an imaging study, or a medication. I have never been asked to recognize when it is best to do nothing at all.

In many ways, it is easiest for me to accept death when it arrives in the ICU—in the room of the patient who remains hypotensive despite maximum doses of 3 pressors, or at the bedside of the patient who is still hypoxic despite maximum ventilatory support. In those moments, I find comfort and clarity in the fact that I am doing everything I can, valiantly fighting off death until the very last moment.

I struggle more with patients like Mr. G. A few days before that Christmas Eve shift, our team held a family meeting with him and his wife. Mr. G told us that he was tired. He did not want further treatments or invasive procedures, knowing this meant he would die within days to weeks. We decided to transition to a comfort-focused approach. After the meeting, I sat down at my computer and opened Mr. G's chart, discontinuing the orders for frequent lab draws and changing his code status from *Full Code* to *DNR/DNI*. As I did so, I felt a vague sense of discomfort. I wondered if there was more that we could have done. After all, he still looked pretty good; he was not yet on pressors or a ventilator. Had we accepted death too soon?

In the room across from Mr. G was Mr. M. He was a 73-year-old man with acute myeloid leukemia. After 2 cycles of chemotherapy, he had relapsed and was now too frail for further treatment. He had presented with pneumonia and was found to have a very weak swallow. His pneumonia had likely been the result of an aspiration event, and in order to prevent further such events, our speech language pathologists recommended that he not take anything by mouth for the foreseeable future. They would work with him on exercises to strengthen his swallow, but it was unclear when, or if, this would improve.

When our team first told Mr. M and his son about the results of the swallow evaluation, they opted to pursue placement of a gastrostomy tube. They hoped that, with the nutritional support of the tube feeds, he might get strong enough to tolerate further chemotherapy. It was Saturday afternoon; we decided that we would consult our gastroenterologists about placement of the tube first thing Monday morning.

However, Sunday morning on rounds, Mr. M told us that he desperately missed having his usual tuna

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sandwich for dinner the night before, and that he was already longing for scrambled eggs. He understood that he was at risk of aspirating, and that another pneumonia could be life-threatening. But what he wanted most, he said, was to be able to eat.

Sitting down across from Mr. M and his son, our attending explained that the road toward more treatment would be difficult. Even if Mr. M did eventually regain enough strength to tolerate chemotherapy, he would face considerable side effects, and the likelihood of achieving a remission was low. Transitioning to a comfort-focused approach, he told them, would be reasonable; after further discussion, this was what they chose to do.

Later that night, I ran into Mr. M's son in the hallway. Standing outside his dad's room, he told me how worried he was that we were making the wrong decision.

"I just wonder. . . if we're giving up too quickly," he said.

I patted him on the shoulder, telling him I recognized how difficult this all was. I didn't tell him that I was struggling with the same thing.

I know how to fight off death, but I don't know how to embrace it. Like most things in medicine, I imagine this will get easier with experience. But I also wonder—is it something that comes with experience alone, or something that could be emphasized earlier in medical education? When we teach trainees about all of the interventions designed to keep patients alive, could we simultaneously teach them how to accept—and even celebrate—a peaceful death?

Mr. G and Mr. M both died peacefully. Their ribs were unbroken by chest compressions. There were no breathing tubes or continuous infusions. Mr. G died holding his wife's hand; Mr. M died a few hours after eating one of his favorite meals.

In these moments I am learning, slowly, how to exhale and accept death when it arrives.



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