The Opportunity in Death

Emilie Y. Prot, DO

It was my first week on the intensive care rotation, and I stepped into the intensive care unit (ICU) with a sense of fear. The constant beeping of patient monitors kept me on my toes. I knew, deep down, that the patients I was going to care for were very sick. Their status could change at any time.

I was responsible for the care of 6 patients. One of them, Benson, needed an emergency blood transfusion. He gazed up at me, and reached out for my hand. I held his hand while he was poked multiple times. His veins had been chronically fibrosed by all of the central lines he had to endure. Another patient, Rose, who needed open heart surgery, told me, "I want a hot young cardiothoracic surgeon to operate on me!" Moments later, an older, not-so-good-looking surgeon stepped into the room. We both laughed.

The next day Rose went into the operating room. I was sitting in a conference, like any other day, when I heard my pager buzzing. I dialed the number as I had a thousand other times, expecting a simple question from the nurse and a quick answer from me.

The voice on the phone said, "Rose has passed away on the operating table; she did not make it." Suddenly the air felt thin and I couldn't catch my breath. I felt a sense of emptiness set in and the world stopped moving. How could this have happened? I was just laughing with her an hour ago; I could still see her smiling face. The tears started streaking down my face, which, like everything else, I could not control.

Benson's body gave up the night before after 1 hour of cardiopulmonary resuscitation. Just like that, 2 of my patients, within a few hours of each other, were gone. I realized how much they had touched me in just the few moments we had shared.

As upset as I was, I did find comfort from my colleagues and the staff. Within a few minutes, I received pats on my back, hugs, and comforting text messages. Our program is like a high school in that news travels fast. Many residents told me emotional stories about losing their first patients. I felt thankful for everyone's kind words, but a part of me kept asking: Just how do you learn to cope?

For many, discussing death is taboo. With medical advances, patients live longer and death is equated with failure by many physicians. Patients expect physicians to "save them," and often want everything (eg, intubation, chest compressions) to be done in case of a cardiac or pulmonary arrest. When I stood among my class at medical school graduation, and we pledged to *first do no harm,* this seemed straightforward. Now I see the potential contradiction when it comes to changing a code status. When addressing terminal diseases and end-of-life care, there are no algorithms to follow.

My medical school offered a simulated patient laboratory to teach us how to announce bad news. For my role play, the short scenario had read, "You are here to discuss the CT [computed tomography] findings with your patient: a large 8-centimeter lung mass was found suggestive of cancer." I stepped into the simulation room then with the same feeling of apprehension as when I entered the ICU as a resident. I knew that once I announced the imaging results to my patient, I might elicit a reaction that I could not control.

What you cannot control scares you.

One of my pulmonary critical care attending physicians told me how he coped: "Ethics . . . if I can go to sleep at the end of the day, I know I have done the right thing." In the ICU, I quickly discovered that these discussions and decisions are far more complex than one's personal ethics. Every situation, every individual, is different.

Later in my ICU rotation I cared for Sandy. Sandy was a woman in her seventies, recently diagnosed with metastatic breast cancer. She was receptor positive, with a good prognosis, and undergoing chemotherapy treatment. Then, a dose of chemotherapy resulted in Sandy ending up in the ICU with multiorgan failure. Suddenly her prognosis was poor. I stood by my attending physician and listened as he discussed code status and prognosis with Sandy. She kept saying, "I don't want any more chemotherapy, but I want to live."

A couple of days later, Sandy developed a gastrointestinal bleed. We had 2 choices: to intubate her or to give her morphine and change her code

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status. Sandy said she did not want a tube down her throat, nor did she want to be on a ventilator. With Sandy, her family, my senior resident, attending physicians, and her nurse, the discussion about resuscitation went on and on.

In the end, Sandy passed away surrounded by her family.

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I will not forget Benson's hand holding mine, Rose's laughter, Sandy's courage, or the blunt reality of death. Tears are shed, and some become numb, while others develop coping methods. I was enlightened by the opportunity in death: the opportunity to learn as a physician, grow as a person, and value respect, communication, and truthfulness. Death is the natural succession to life. The medical point of view is just a piece of the puzzle of death. Rose is still on my mind. I know that by now she has met that hot surgeon.

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