

It wasn't until just before graduation that **we they** talked about what to do when a patient is dying. A single three-hour seminar with a group of specialists from the palliative care service; at least it was mandatory.

The presenters were young physicians, and they seemed kind and thoughtful. But **I John** wondered why anyone would devote their medical career to end-of-life care. **My his** classmates and **I he** had spent years of medical school sharpening **our their** history-taking skills, learning to recognize heart murmurs, memorizing the drugs used to treat high blood pressure, diabetes, even cancer. In the final months of school, **I John** had worked in the ICU, taking care of critically ill patients who required breathing tubes and life-sustaining machines. **I he** had learned how to perform intubations and place central lines. **I he** marveled at how much **I he** was able to do to help sick people. Nearly all of **us them** became doctors to keep patients alive, to treat them.

**I he** thought: The ultimate treatment failure is death. **I John** graduated medical school and moved on.

Except for a cadaver in **my his** first-year anatomy lab, **I John** did not see a dead body until the second month of **my his** medical internship. When **I he** finally did, it was **my his** first overnight shift; **I he** was the sole intern charged with cross-covering all of the medical patients. The pager never stopped beeping. **I he** handled issues as they arose. **I he** solved problems. But at some point in the night, a nurse called and said **I he** needed to "come pronounce room 556." **My his** heart sank.

**I John** was not precisely sure what pronouncing a patient dead entailed. When **I he** reached room 556, **I he** entered to find a frail woman lying still on the bed. **Mrs. Lee. She** was surrounded by **family members** young and old, and, to **my his** amazement, **they** were smiling, chatting, even laughing with one another. **I he** mumbled a greeting, then crossed to the bed, where **I he** proceeded shakily through the pronouncement checklist in **my his** intern handbook.

One of **Mrs. Lee's** daughters touched **my his** hand. "This is my mother; she was a wonderful woman but had a long battle with Alzheimer's, and it was time for her to go," **she** said. "She just wanted to be comfortable in the end."

The other family members nodded in agreement and went on talking about how much **they** had loved **Grandma Lee's** custard buns and who would be getting **her** recipes. **Mrs. Lee's** family and friends, who had gathered around **her** to say goodbye, moved **me John**. **Mrs. Lee** had had the forethought to tell **them** how **she** wanted to pass, and **they** were by **her** side until the end. **I he** had never before pondered the idea of a "good death," but that night **I he** walked out of room 556 with a smile on **my his** face, because, somehow, **I he** had just witnessed one.

When I **he** was a newly minted doctor, I **he** found **myself himself** back in the ICU, no longer a lowly medical student but with real responsibilities.

The patients in an intensive care unit are very sick; they require the highest level of monitoring and intervention that a hospital can provide. This particular unit was lined with patient care bays featuring sliding glass doors, glaring white walls, blinking monitors, and little natural light. Alarm bells dinged constantly, and the smell of bleach disinfectant made **my his** eyes water. I **John** began **my his** rounds each morning at 5, checking in on **my his** patients and learning about those who had been admitted overnight.

One morning, I **he** came in to a commotion. There were several nurses scurrying around **a new patient's** bed, and the night residents were huddled in a corner, concerned looks on their faces. Before I **he** had a chance to ask what was going on, a loud code blue alarm went off overhead, and the team of doctors descended upon **the patient**. I **he** peered into the room, and underneath the breathing tube and profusion of lines, I **he** saw an elderly man.

**The senior resident** called out orders. The intern hopped up on a stool next to the bed and began performing rhythmic chest compressions that cracked **the man's** ribs. The nurses pushed various medications into **his** IV and watched the heart monitor intently. I **John** stared at the spectacle in front of **me him**. This was **my his** first time seeing a code situation. For 30 minutes I **he** watched strangers in masks and gloves race around **an unconscious old man**, trying everything they could to keep **him** alive. But after the heart rhythm monitor fell into a flat line, the team pronounced **him** dead, removed their protective garb, and walked out of the room.

I **John** later learned that an ambulance had brought in **the old man** for decompensated heart failure. **His** heart could no longer effectively pump blood to **his** organs, and **he** had been drowning in fluid that backed up into **his** lungs. On arrival, **he** was immediately intubated and rushed to the ICU. **His** family members were out of town, and **he** had not come with advance directive paperwork, a document stating **his** wishes.

This was not **his** first trip to the hospital. **He** had been admitted five times in the previous six months. During **his** first hospitalization, **his** records showed that **he** was a "full code" and that **family** had wanted "everything done" to keep **him** alive. Despite multiple readmissions, the question was never revisited. I **John** wondered whether **they** knew what "everything" meant.

I **he** learned that **the old man** was named Mr. Azarov. **He** was 88 years old, a widower, originally from Russia, where **he** had worked as a tailor and musician before coming to the United States. In San Francisco, **he**'d opened a bakery and had led a simple life. Over the months of **his** hospitalizations, **Mr. Azarov** had slowly deteriorated, and each time **he** became weaker. **He** battled kidney failure, a stroke, and worsening dementia. Well before **he** came to **us them** for

the last time, **he** had lost the ability to stand up on **his** own. **His** adult children were no longer able to care for **him**, and several months before **he** died **they**'d moved **him** into a nursing home.

**I John** never knew **Mr. Azarov**, but **I he** realized then that **this man** had been dying for a long time. **He** had a brutal, impersonal end, one **he** received by default. Who would die that way if they had a choice? Expiring in a hospital room, doctors screaming and scurrying and cracking your ribs, away from your friends and family — **I John** wondered how many opportunities there had been to explain **his** end-of-life options to **him** or **his** family. Did they understand **his** prognosis? **I he** will never know. But as **he the man** lay there alone in the hospital bed, curtains drawn, still attached to machines, **I John** felt as if **we they** had failed **him**.

One day, late in **my his** intern year, while working the emergency room, **I John** met a patient named Mr. Jones. **He** was a botany professor who lived in an affluent suburb outside San Francisco. **He** was married, with three grown children, and had the amazing fortune of good health over the whole of a long life. But now **he** was 72, and **he** was dying of small cell lung cancer.

**Mr. Jones** was receiving chemotherapy under the care of **a reputable oncologist**. **He**'d come into the ER that night because of severe, worsening shortness of breath that made **him** unable to walk across the room without collapsing. **He** told **me John his** family was scared and so was **he**.

Before coming into the room, **I John** had reviewed **his** labs and chest X-ray and found that **he** had significant bilateral pleural effusions secondary to **his** lung cancer. This was a bad sign. When **I John** came in, **I he** saw that **Mr. Jones** had once been fit and brawny, although now **he** was worn and thin. **We they** talked for a while. **I John** asked the customary questions about **his** symptoms, and got the sense that **he Mr. Jones** was a kind man. **I John** explained to **him** that fluid had built up in **his** lungs due to **his** cancer, and that while **we they** could admit **him** and remove the fluid with a needle, it would only make **him** feel better temporarily. **I he** told **him** **I he** believed **his** cancer had progressed.

**I he** felt unusually at ease talking to **Mr. Jones**. After delivering the news, **I he** decided to venture into unusual territory: **I he** asked **him Mr. Jones** what **he** understood about **his** diagnosis and **his** future. **He Mr. Jones** explained that **he** had read online how **he** likely had only months to live, but that **his** oncologist wanted **him** to continue chemotherapy for now. Then **I John** asked **him** what **he** wanted. To **my John's** surprise, **he** paused. After a moment, **he** looked up, tears welling in **his** eyes.

"I have had a wonderful life," **he** said. "I have an amazing family who loves me, and I want to be at home with them, not here in the hospital." **He** started crying. **He** grabbed **my John's** hand. "No one has asked me what I want. Can I please go home? All I want is to be home."

I **John** was shocked. *How could this be?* I **he** thought. How had **we they** all failed to take a step back from the diagnoses and treatment options and the lab and imaging results to ask the most important question of all? **Mr. Jones** did not want to be admitted to the ICU. **He** didn't want to be intubated and adorned with the lines **we they** use to sustain the dying. **He** knew there was no cure for **his** cancer, and **he** wanted what all of us hope for in the end: to die comfortably. With the help of the case manager and the social worker, I **John** was able to send **Mr. Jones** home with hospice care early the next morning. I **he** found out that **he** died in peace, two days later, surrounded by **his** beloved family.

I **he** took time to talk to **this man**, to learn about **his** life and wishes. Together, **we they** decided on a plan that fit **his** goals for **his** remaining days. The news of **his** passing gave **me him** a sense of fulfillment. I **John** felt relief that I **he** had kept **him** from suffering. I **he** thought back to the medical school seminar, and for the first time I **he** understood why those doctors chose palliative care.

As doctors, **we they** dedicate most of **our their** time in medical school to learning about the physical body, how things can go wrong and how modern medicine can fix them.

During residency, **we they** acquire methods for analyzing large amounts of data so that **we they** can accurately assess, down to the minute, what is happening with **our their** patients.

But **we they** spend almost no time at all learning about illness in the context of **our their** patients' lives, or how to heal people when modern medicine provides no cure. **We they** are rarely schooled in how to break bad news compassionately, or how to sit in silence with a grieving family member, or even how to make recommendations for appropriate end-of-life care.

I **John** have **has** become disheartened by the number of patients who received invasive treatment in the final days and hours of life. So many spend their final moments hooked up to tubes and lines in the ICU, alarms beeping in the background, hidden away from the people who care about them. Modern medicine is always poised to offer another procedure or therapy for prolonging life, but it often does so without considering the quality of that life. How much suffering is five more weeks worth? Or five days, or five hours?

Today's physicians are spread thin. **We they** have more responsibility than ever and are often tethered to a computer screen instead of at **our their** patients' bedsides. Maybe it's easier to just give someone more treatment instead of stopping and telling her that she's dying. These conversations are never easy, no matter how many times you've had them. They can be enormously difficult even under the best circumstances, and often the circumstances are more like a patient (or, more often, his family) arguing, denying what's going on and demanding to see another doctor. Maybe **we they** just don't want to go through it. Or maybe **we they** hide behind

more tests and procedures to make **ourselves themselves** feel better — like **we they**'re still fighting. Like **we they** haven't failed yet.

**I John do does** not see it that way. **I he believe believes we they** owe it to **our their** patients to have open, honest conversations about what the future holds. Patients and families need to be informed in order to make decisions that are in line with their values.

**My his** patients have all taught **me him** valuable lessons about what a "good death" might look like. Each one has reminded **me him** that there is more to medicine than placing a line to monitor the heart, or performing an intubation. Just because more tests and procedures exist does not mean that **we they** should perform them all each time. Sometimes the most powerful healing of all comes through the simple act of sitting and listening to **our their** patients with compassion.

**We they** know that 75 percent of Americans would prefer to die at home. Only 20 percent actually do. **We they** also know that 80 to 90 percent of physicians would not want CPR or mechanical ventilation at the end of life. Doctors actively choose to forgo the suffering that takes place in **our their** ICUs, because **we they**'ve seen it and **we they** know better. **My his** goal is to close this gap, to educate **my his** patients about their options based on open, honest communication. **I John** no longer **see sees** death as a failure but as a place **we they** are all headed at some point — and if **I he** can help someone live the fullest to the very end, **I John have has** practiced the best medicine.