Peabody's Corner

The Last Word

". . . for the secret of the care of the patient is in caring for the patient."
— FWP

Fady Joudah, MD

Some people are born with compassion. Alas, I had it beaten into me." I recently heard that from an older colleague. The context was the difficulty we shared in approaching end-of-life care for a patient—and his wife. My colleague, a cardiologist, had cared for this patient for more than 30 years, and now the patient, in his 9th decade of life, was dying of advanced heart failure. I was the hospitalist who admitted him and had never seen him or his wife. He had come to the emergency department after his defibrillator shocked him out of ventricular tachycardia.

Forty-eight hours later, I had an intense conversation with his wife. The patient lay in bed, exhausted and confused. She was distraught, adamant that his fatigue was the side effect of an antiarrhythmia medication started after admission. I told her that she might be right and that I had no objection to stopping the medication, but it would not change his prognosis. I wanted her to consider that this was likely her husband's last hospitalization. I did not express this without having consulted his cardiologist, who had confirmed my assessment. We had spoken on the phone because he was out of town during the patient's episode of possible drug-induced encephalopathy. Over the next day, after the suspected drug had been stopped, the patient became more alert, but his overall clinical decline persisted.

The next conversation I had with the patient's wife was strained. She would not relinquish her certainty that her husband's condition would improve. While acknowledging her belief, I asserted that all good possibilities had come to an end. She was frightened, and I was frustrated. The cardiologist returned a day later and transferred the patient to the cardiac care unit for palliative measures. By then, he was hypotensive, and the infusion of vasopressors would buy everyone the time necessary to come to terms with the prognosis.

When I visited the couple one last time, the patient was still alert, but his wife would not make eye contact with me. However, as I gently placed my hand on her shoulder, she spoke: "I hated you 2 days ago. I really did. But I'm okay now."

I took a deep breath, let a few moments of silence pass, then asked her to tell me how she and her husband met. She recounted their singular love story. Among other touching details that I leave out for privacy's sake, they had been high school sweethearts. I listened to all of it, asked questions. Then I had to leave the room. She and her husband needed the time left all to themselves. They were having their final conversations, and he was lucid. The patient died the next day.

It was then that I understood what my colleague meant about compassion. I don't know how much compassion I was born with, but what I lack of it still continues to hit me over the head, much like a hard lesson that needs to be learned and relearned.

Some may credit me for not avoiding the difficult conversation with the patient's wife. Had I opted for the perfunctory, diffusive detachment that many physicians associate with professional conduct in similar circumstances, the couple may not have had enough time to say goodbye to each other in such a peaceful, loving manner.

I had understood that the wife's screaming at me to stop the drug was her way of beginning to grieve. My painful insistence on breaking the news to her was compounded by her husband's watching and listening to us while cognitively unable to weigh in. I remember feeling anguish at his anguish, which I could detect on his face as he witnessed his beloved wife in distress. She was terrified to accept his death, the end of a lifelong companionship. And he had to deal not only with his own impending death, but also with his inability to comfort his wife.

Regardless of how I viewed the incident, I could not shake the thought that she used the word hate to describe her transitory feelings toward me. Unquestionably, I could have behaved better. For example, I could have sat next to her and held her hand,

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as I had with many other patients and their family members. But why had such kindness or mindfulness abandoned me?

Seven years earlier, I had cared for a patient with congestive heart failure. He was tall, had a full head of white hair, and always wore blue jean overalls and a mesh cap on his visits to my clinic. His wife was always by his side. He had been referred to me because of frequent admissions for heart failure exacerbation, which had disrupted his life and dampened his spirit. For 2 years, I saw him monthly. I educated him about his condition, and, like an A student, he followed my instructions for restricting fluids, measuring blood pressure, weighing himself daily, and reporting symptoms. I micromanaged his progressive cardiorenal syndrome, and the results were often good. Then came the last 3 months, when nothing he or I did relieved his shortness of breath or edema. Repeated hospitalization and invasive testing served only as cosmetic measures with Band-Aid effects. I grew concerned that this was the end of the line for him.

Instead of acknowledging my own fear as a physician who had been deeply engaged in and committed to my patient's welfare, I began to act as if I were losing a battle with the Grim Reaper. I intensified my clinical efforts. I turned into a football coach whose good intentions were to motivate his player. I drilled my patient again and again on monitoring himself, so that *we* could control the things we could and leave the rest to fate. Nothing worked.

One day the medical examiner's office called to let me know that the patient had died in his sleep the night before. I immediately called his wife. She was calm and resigned, as if she'd known what was coming for a couple of months, having seen the changes in her husband's condition and recognizing the shift in my behavior. "Doctor," she said, "you helped him to the best 2 years of his life. He was happy again, always in his toolshed." I silently accepted the praise. Then she continued, "But Doctor, you could have been kinder to him during the last few weeks."

I don't remember what we said to each other after that, but our sentiments were caring, cordial, and genuine. What my patient's wife told me has—and, apparently, has not—stayed with me. How many times in my life as a doctor have my last words, or my last interactions with patients or their family members, been less than kind, despite my good intentions? Why has it been so difficult for me to maintain a state of awareness in which I don't err on the side of tough love, which often stems from my own fear of witnessing yet another person's dying?

This woman's words of advice were extraordinary. "I know you work hard and mean well. Just remember to keep your last words kind, Doctor."

She did not say *polite*; she said *kind*, intimating the need for me to show higher, more difficult levels of compassion. Her message now strikes me as a physician's greatest aspiration—to speak to one's patients and their families as if it were the last time you are seeing them, or they, you; and to have one's last words reach beyond decorum, ego, and knowledge, into a kindness borne by the deepest empathy, ever mindful of the power one holds over others and when to surrender it.

Submissions for Peabody's Corner should 1) focus on the interpersonal aspects of a specific patient–doctor experience; 2) be written in storybook fashion; 3) contain no references; and 4) not exceed 5 double-spaced typescript pages.