

The Dying of the Light

By Craig Bowron

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It's January, and with the holidays behind us, here in Minnesota the deep psychosis of winter settles in. The cold has a sharper edge; the darkness of night seems more penetrating and brittle. We'll take the ornaments off the tree but leave the lights on and keep watering it until it gives up its photosynthetic ghost. The green must be cherished until life returns in earnest in the spring.

I'm a physician in a large hospital in Minneapolis, where I help care for patients struggling through the winter of their lives. We've got a lively spring unit, an obstetrical ward where fresh-faced tulips are popping up at all hours, but that's not my specialty. As a hospitalist, I see adult patients of all ages and complexities, most of whom make good recoveries and return to life as they knew it. But taking care of the threadworn elderly, those facing an eternal winter with no green in sight, is definitely the most difficult thing I do.

That's because never before in history has it been so hard to fulfill our final earthly task: dying. It used to be that people were "visited" by death. With nothing to fight it, we simply accepted it and grieved. Today, thanks to myriad medications and interventions that have been created to improve our health and prolong our lives, dying has become a difficult and often excruciatingly slow process.

Take one of my patients. She started dialysis six months ago at the tender age of 85, and the diabetic vascular problems that put her kidneys in the tank persist. One leg has been amputated above the knee, and several toes on her remaining foot have succumbed to

gangrene. Robbed of blood, they appear dry, black and tenuously connected, like an ash dangling off a cigarette.

This patient was brought in for a decreased level of consciousness and low blood pressure, but she has been having periods of nausea, and her appetite seems to have died with her kidneys. The initial workup revealed little, perhaps a low-grade bladder infection, but treating it and her low blood pressure doesn't seem to make much of a difference. She is withdrawn; food goes into her mouth, but she won't chew and swallow unless her children instruct her to. She intermittently refuses pills. There's a language barrier, but her children are there to interpret for her. Translation: She feels exhausted and weak, and she feels that way most of the time.

This woman is suffering from what we call "the dwindles," characterized by advancing age and illness. Although dialysis is a miraculous technology -- she'd be dead without it -- it exacts a heavy toll from someone her age or with her medical problems. Three days a week are spent in dialysis, and the other four are spent recovering. It is extending her life, but she's miserable.

Her family has designated her "full code," meaning that if her heart stopped or she were to cease breathing, we would do CPR to revive her, even though there would be a very slim chance of success -- and even though it would be God's or the universe's way of giving her an easy way out.

Another patient is in even worse shape. He's 91 and still a very big man. When I enter his room to examine him, he seems like a giant oak felled into a hospital bed, stiff and rigid, with swollen arthritic joints. A stroke four months earlier paralyzed his right side and left him bed-bound and nearly helpless, with pressure sores on his heels. He is mildly demented, and the pain pills aren't helping. He was

brought to the ER because he was thought to be having another stroke, though these new symptoms quickly resolved.

Talking with this patient, I recognize his face and the Cajun accent; I'm certain that I took care of him sometime in the past, but he is not the man he was then. Staring at his 230 pounds stretching the length of the bed, I wonder how difficult it must be to care for him. To transfer him to a toilet or a chair requires the use of a Hoyer lift, a gigantic sling that's wrapped around the patient and attached to a mobile mini-crane. Fully suspended, he looks like a massive baby being delivered by a giant stork. The contortions and gymnastics of getting him slung up and moved must drive him wild with arthritic pain.

Though I reviewed the patient's chart before going into his room, I can't recall seeing what nursing facility he had come from. So I ask the nurse. She tells me, unbelievably, that he has come from his home, where his son cares for him. Later in the day I place a call to this Clark Kent, this Superman in disguise.

The son answers with soft echoes of his father's Louisiana brogue, and I ask him how in the world he manages to take care of his dad. He replies that for one, it's all he does, a full-time job, and moreover, his experiences in Vietnam numbed him to some of the intimacies of caring for another human being. "Once you've shoved some guy's guts back into his stomach, you know, you can get used to the rest of it," he says.

He tells me that his father is wearing out and that it's hard to watch. The arthritis has become quite painful, and sometimes his dad just weeps. Some nights he needs a couple of Vicodin to be able to sleep through the pain. The old man is also spending a lot more time

thinking about his wife, who passed away before him. His son thinks he may be ready to die.

Nothing in my medical training qualifies me to judge what kind of life is satisfying or worth living. Many would say that if we were to become paralyzed in an accident, just let us die. But many quadriplegics, once they've gone through an initial period of adjustment, find their lives very satisfying. Patients can and do make enormous efforts and fight precipitous odds to get back to life as they knew it, or even just to go on living. But the difference for many elderly is that what's waiting for them at the end of this illness is just another illness, and another struggle.

Another patient of mine has 86 years behind her and was brought to our hospital from a nursing home in the wee hours of the morning. Her diabetes has become very brittle and difficult to control; the day before, paramedics were called because her blood sugar had dipped so low that she was becoming unresponsive. She also has dementia, and a couple of months ago, she fell and broke a hip. Although it was repaired and she completed rehabilitation, she has wound up essentially bedridden. Strictly speaking, losing your mind won't kill you: It's the falling, the choking, the weakness, the bed sores.

This patient was brought in because the nursing home staff thought that she might have aspirated some food or secretions and developed pneumonia. She thinks it's 1982 and is, as we say, "pleasantly confused." She denies any and all symptoms, and her breathing looks comfortable. A review of her chart shows no fever and a normal white blood cell count. Her chest X-ray shows perhaps a subtle pneumonia but also a compression fracture of one of her vertebrae, which has gone from being 50 percent to 90 percent collapsed. Her dementia has mercifully spared her a lot of pain from

the fracture, but it also keeps her from recognizing members of her extended family. Sometimes she doesn't recognize her own son, who drove to the hospital to be with her at this early hour.

He and I discuss what brought her in, and then we talk about her code status, which he confirms is Do Not Resuscitate. "She wasn't supposed to be brought to the hospital in the first place," the son tells me, and puzzled, I ask him to say that again. She was never supposed to be hospitalized: Whatever troubles arrived, the plan was to deal with them in the nursing home. His mother had made that decision herself, several years prior to this hospitalization, before the dementia really set in.

Later that day, I meet with the son and a few other close family members. They want to continue the medications that would bring their mother comfort and discontinue all the rest. They aren't looking to end her life, but they aren't looking to prolong it, either. They can see that she is moving away from them in both body and mind, and they are ready to let her go.

To be clear: Everyone dies. There are no life-saving medications, only life-prolonging ones. To say that anyone chooses to die is, in most situations, a misstatement of the facts. But medical advances have created at least the facade of choice. It appears as if death has made a counter-offer and that the responsibility is now ours.

In today's world, an elderly person or their family must "choose," for example, between dialysis and death, or a feeding tube and death. Those can be very simple choices when you're 40 and critically ill; they can be agonizing when you're 80 and the bad days outnumber the good days two to one.

It's not hard to identify one of these difficult cases in the hospital. Among the patient-care team -- nurses, physicians, nursing assistants, physical and occupational therapists, etc. -- there is often a palpable sense of "What in the world are we doing to this patient?" That's "to" and not "for." We all stagger under the weight of feeling complicit in a patient's torture, but often it's the nurses who bear most of that burden, physically and emotionally. As a nurse on a dialysis floor told me, "They'll tell us things that they won't tell the family or their physician. They'll say, 'I don't want to have any more dialysis. I'm tired of it,' but they won't admit that to anyone else."

This sense of complicity is what makes taking care of these kinds of patients the toughest thing I do. A fellow physician told me, "I feel like I am participating in something immoral." Another asked, "Whatever happened to that 'do no harm' business?"

If we can be honest and admit that we have no choice about dying, then the only thing we do have a say in are the circumstances. Like many nursing home patients, Dorothy was on the cholesterol-lowering medication Lipitor. Why? So that she wouldn't die of a heart attack or a stroke. But don't we all die of something?

Everyone wants to grow old and die in his or her sleep, but the truth is that most of us will die in pieces. Most will be nibbled to death by piranhas, and the piranhas of senescence are wearing some very dull dentures. It can be a torturously slow process, with an undeniable end, and our instinct shouldn't be to prolong it. If you were to walk by a Tilt-A-Whirl loaded with elderly riders and notice that all of them were dizzy to the point of vomiting, wouldn't your instinct be to turn the ride off? Or at the very least slow it down? Mercy calls for it.

This isn't about euthanasia. It's not about spiraling health care costs. It's about the gift of life -- and death. It is about living life and death with dignity, and letting go.

In the past, the facade of immortality was claimed by Egyptian kings, egomaniacal monarchs and run-of-the mill psychopaths. But democracy and modern medical advances have made the illusion accessible to everyone. We have to rid ourselves of this distinctly Western notion before our nation's obesity epidemic and the surge of aging baby boomers combine to form a tsunami of infirmity that may well topple our hospital system and wash it out to sea.

At some point in life, the only thing worse than dying is being kept alive.

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