

ONLINE FIRST | LESS IS MORE

At the End of Life, Sometimes Less Is More

A FEW WEEKS AGO, I HAD THE TYPE OF emergency department shift I dread. All the patients I saw were dying. But for 2 patients in particular, I was struck by the difference in care at the end of their lives.

In the first bay lay a woman with severe respiratory distress who appeared much older than her actual age of 62 years. She had the look I know too well of someone with multiple chronic medical conditions, so I asked the resident to review the medical chart. "Over 40 pack-year tobacco history, former IVDU on methadone, Hep C, asthma, poorly controlled diabetes, end stage renal disease on hemodialysis, multiple abdominal surgeries and ostomy due to a complicated cholecystectomy." Her breathing quickened and grew more labored as her oxygen saturation dropped. We barely spoke, but I told her what I planned, yelling above the noise so she could hear me. "We have to put in a breathing tube. Is that okay?" She gave a quick nod. Then I paralyzed and sedated her, performed direct laryngoscopy, and passed the tube between her pearly white cords. I put in a central line, ordered a stat portable chest radiograph, and called the intensive care unit team. I knew that any other emergency medicine attending physician would probably have performed the same procedures and called the same consults, but I wondered if I had done the best for the patient. I have seen this scenario play out too often. While she may survive this hospitalization, her quality of life will be poor and she will suffer. We were managing her from one crisis to the next, without real pause to discuss her wishes or her prognosis.

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In the next bay, an elderly man in his 80s came in by ambulance vomiting blood. He was visibly uncomfortable and starkly pale. His eyelids drooped downward leaving only 2 unfocused slits. His chin and undershirt were streaked with coffee ground emesis. As we transferred his frail body awkwardly from the stretcher to the bed he moaned in pain. I had to decide quickly how to treat him. Should I tube him to protect his airway? Does he have a health care proxy or advance directives? The nurses were drawing up the etomidate and succinylcholine. I was ready for intubation when the sliding doors opened and

a middle-aged man rushed into the resuscitation bay. "Dad!" he cried. He explained that his father had Alzheimer dementia and that he was the health care proxy. His father would not want a breathing tube. "Make him comfortable, please." I was relieved and knew this was the right thing to do for this patient. I would treat his nausea, ease his pain and discomfort, and transfuse him if necessary. We spoke about what was important to do next. Call his regular doctor. Tell the family to come, and come quickly.

As I looked to my left, I saw my first patient again. She was motionless on the stretcher, except for the ventilator that breathed for her 12 times a minute. Her boyfriend stood silently in the corner, expressionless. I saw her oxygen saturation, 88%, and went to turn it up only to realize it was already delivering 100%. Her blood pressure was 80 mm Hg systolic and her heart raced at 130 beats/min. The lactate level was 11 mg/dL. "She needs more fluid." Finally, the critical care fellow arrived and whisked her off to the intensive care unit.

After intravenous fluids, morphine, Zofran, and a unit of packed cells, my second patient's color returned. His daughter-in-law and 2 grandsons had arrived. I peeked behind the worn curtain and saw the youngest grandson with the cell phone on speaker. I heard my patient's granddaughter laugh all the way from Virginia as he looked at me smiling. I smiled back.

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