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When in Doubt

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It is practically a truism of emergency medicine that, when in doubt, the physician should resuscitate first and ask questions later. There is frequently doubt. End-of-life decisions are particularly challenging for patients and their families in the emergency department (ED). Even when there is an advance directive, it is often outdated, improperly filled out, or, more likely, missing.

When uncertainty exists, at least the reasoning for our actions is clear: you can always withdraw support later, but you can't bring someone back to life once they're dead. Even though I have adhered to it faithfully, this approach is occasionally a challenge for me. Legal and professional standards may ease the decision to preserve life, but it is often surprisingly difficult to intervene when one knows there is a real chance of increasing the patient's suffering.

I was therefore particularly moved by a 98-year-old patient who was found by her daughters, barely breathing next to 3 empty bottles of vintage Nembutal and Seconal and her recently signed do-not-resuscitate order. The medics were called and, without hesitation, they performed the intubation, placed the lines, and raced off to the ED. Advance directives don't cover suicide.

The patient was a retired physician who would have known the implications of her actions. She had saved prescriptions of sleeping pills for more than 40 years. It seemed clear to me that she had made an unimpeachably lucid and reasonable choice about her life and the medical establishment had reflexively taken it away from her. *She was ninety-eight.*

On arrival, my patient was stable and her workup didn't show anything surprising. She had overdosed on sleeping pills from the '60s. Talking with her family, I discovered that she hadn't complained of anything recently, showed signs of depression, or given any hint that she was considering suicide.

There was nothing for me to do but admit her to the ICU.

But this elderly physician's story stuck with me. Here was a woman who had executed a death plan almost identical to the one I had conjured up for my own old age, specifically to avoid the unit where I sent my patient. And somehow the intimately violent tools of our profession—laryngoscope blades, needles, stylets—seemed particularly misused on a woman who was clearly looking for a peaceful and quiet way to die after almost a century of life.

If she couldn't escape our culture's insistence on the extension of life above all else, who could?

Which is why I was stunned when I called her 3 months later to apologize and she cut me off midsentence to thank me. "I'm embarrassed about what I did and don't want to talk about it," she said. "But I am truly grateful to all the people who kept me alive so I could spend more time with my children. I was so foolish to do what I did."

According to the ICU records, my patient had awakened angrily, complaining about what had been done to her, arguing that hers had been an "intellectual decision," and renewing a commitment that she did not want to live. A 10-day psychiatric admission followed, where it appeared that she finally agreed that her life was worth living. There was no follow-up with her primary care physician, and before I called, I had assumed she was fed up, rightfully, with the entire system.

My patient's expressions of gratitude on the phone may have just been a way to get me to leave her alone—and to protect herself from a trip back to the psychiatric ward—but it didn't sound like that. Her tone suggested she was genuinely appreciative of what had been done.

The phone call affected me as much as her initial arrival in the department had. My interpretation of the primary role of a physician is to reduce suffering more than to extend life. In the old days, when there weren't a lot of tools to accomplish the latter, a physician's job was often simply to hold the hand of a dying patient or comfort a family member. Now, with the ability to prolong life farther and farther, our job is, at best, working with families and patients to navigate the thin line between quantity and quality but more often simply involves ordering more tests and treatments in the name of longevity. I have long worried that emergency physicians and our tendency to heroically save whatever comes in might be failing a critical aspect of our job.

I still occasionally feel uncomfortable during a resuscitation when I may be doing more harm than good, but this patient has at least helped to remind me why we do what we do. In the ED, things are frequently not at all what they seem. The service we may be uniquely able to provide is to give everyone a little more time to find the best way to proceed.

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