

# Popping the Question

Category: Stories

written by Mitch Kaminski | January 16, 2015

Mr. Dwyer isn't my patient, but today I'm covering for my partner in our family-practice office, so he's been slipped into my schedule.

Reading his chart, I have an ominous feeling that this visit won't be simple.

A tall, lanky man with an air of quiet dignity, Mr. Dwyer is eighty-eight. His legs are swollen, and merely talking makes him short of breath.

He suffers from both congestive heart failure and renal failure. It's a medical catch-22: when one condition is treated and gets better, the other condition gets worse. His past year has been an endless cycle of medication adjustments carried out by dueling specialists and punctuated by emergency-room visits and hospitalizations.

Hemodialysis would break the medical stalemate, but Mr. Dwyer flatly refuses it. Given his frail health, and the discomfort and inconvenience involved, I can't blame him.

Now his cardiologist has referred him back to us, his primary-care providers. *Why send him here and not to the ER?* I wonder fleetingly.

With us is Mr. Dwyer's daughter, Karen, who has driven from Philadelphia, an hour away. She seems dutiful but wary, awaiting the clinical wisdom of yet another doctor.

After thirty years of practice, I know that I can't possibly solve Mr. Dwyer's medical conundrum.

*A cardiologist and a nephrologist haven't been able to help him, I reflect, so how can I? I'm a family doctor, not a magician. I can send him back to the ER, and they'll admit him to the hospital. But that will just continue the cycle...*

Still, my first instinct is to do something to improve the functioning of his heart and kidneys. I start mulling over the possibilities, knowing all the while that it's useless to try.

Then I remember a visiting palliative-care physician's words about caring for the fragile elderly: "We forget to ask patients what they want from their care. What are *their* goals?"

I pause, then look this frail, dignified man in the eye.

"Mr. Dwyer, what are your goals for your care?" I ask. "How can I help you?"

My intuition tells me that Mr. Dwyer, like many patients in their eighties,

harbors a fund of hard-won wisdom.

*He won't ask me to fix his kidneys or his heart, I think. He'll say something noble and poignant: "I'd like to see my great-granddaughter get married next spring," or "Help me to live long enough so that my wife and I can celebrate our sixtieth wedding anniversary."*

Karen, looking tense, also faces her father and waits.

"I would like to be able to walk without falling," Mr. Dwyer says. "Falling is horrible."

This catches me off-guard.

*That's all?*

But it makes perfect sense. With Mr. Dwyer's challenging medical conditions commanding his caregivers' attention, something as simple as walking is easily overlooked.

A wonderful geriatric nurse practitioner's words come to mind: "Our goal for younger people is to help them live long and healthy lives; our goal for older patients should be to maximize their function."

Suddenly I feel that I may be able to help, after all.

"We can order physical therapy—and there's no need to admit you to the hospital for that," I suggest, unsure of how this will go over.

Mr. Dwyer smiles. And Karen sighs with relief.

"He really wants to stay at home," she says matter-of-factly.

As new as our doctor-patient relationship is, I feel emboldened to tackle the big, unspoken question looming over us.

"Mr. Dwyer, I know that you've decided against dialysis, and I can understand your decision," I say. "And with your heart failure getting worse, your health is unlikely to improve."

He nods.

"We have services designed to help keep you comfortable for whatever time you have left," I venture. "And you could stay at home."

Again, Karen looks relieved. And Mr. Dwyer seems...well...surprisingly *fine* with the plan.

I call our hospice service, arranging for a nurse to visit him later today to set up physical therapy and to begin plans to help him to stay comfortable—at home.

Although I never see Mr. Dwyer again, over the next few months I sign the order forms faxed by his hospice nurses. I speak once with his granddaughter.

It's somewhat hard on Mr. Dwyer's wife to have him die at home, she says, but he's adamant that he wants to stay there.

A faxed request for sublingual morphine (used in the terminal stages of dying) prompts me to call to check up on Mr. Dwyer.

The nurse confirms that he is near death.

I feel a twinge of misgiving: *Is his family happy with the process that I set in place? Does our one brief encounter qualify me to be his primary-care provider? Should I visit them all at home?*

Two days later, and two months after we first met, I fill out Mr. Dwyer's death certificate.

Looking back, I reflect, *He didn't go back to the hospital, he had no more falls, and he died at home, which is what he wanted. But I wonder if his wife felt the same...*

Several months later, a new name appears on my patient schedule: Ellen Dwyer.

"My family all thought I should see you," she explains.

She too is in her late eighties and frail, but independent and mentally sharp. Yes, she is grieving the loss of her husband, and she's lost some weight. No, she isn't depressed. Her husband died peacefully at home, and it felt like the right thing for everyone.

"John liked you," she says.

She's suffering from fatigue and anemia. About a year ago, a hematologist diagnosed her with myelodysplasia (a bone-marrow failure, often terminal). But six months back, she stopped going for medical care.

I ask why.

"They were just doing more and more tests," she says. "And I wasn't getting any better."

Now I know what to do. I look her in the eye and ask:

"Mrs. Dwyer, what are your goals for your care, and how can I help you?"

#### **About the author:**

Mitch Kaminski is a family physician who has practiced, taught and led in primary care for thirty years. He is the medical director for AtlanticCare Physician Group in southern New Jersey. "Our technologically advanced medical system, which is oriented towards treatment and cure, often forgets to address the patient's goals of care. As a provider, there is no easy time to acknowledge the end of life with a patient. I have come to realize that, especially with an elderly patient, any discomfort about the talk comes more from me than from the patient or the patient's family."

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