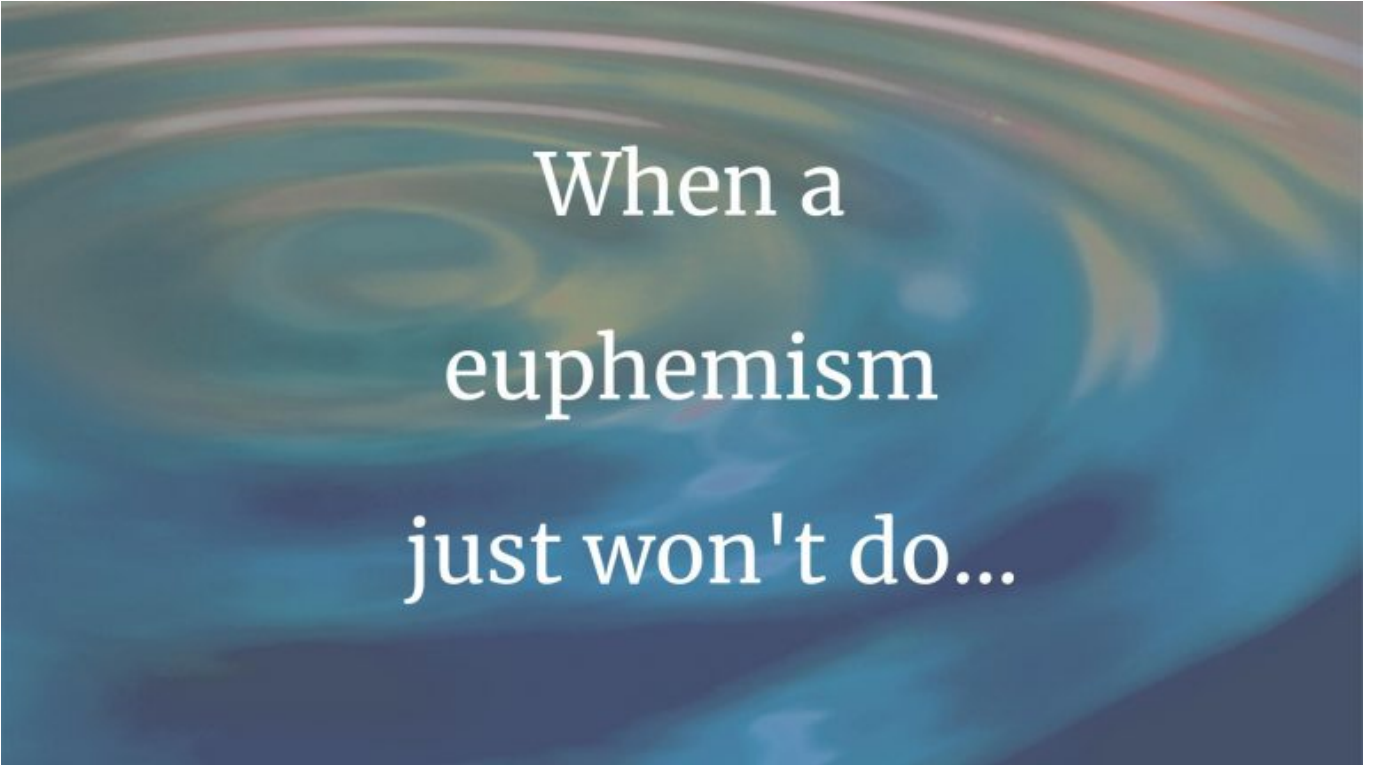


Saying the D-Word

Category: Stories

written by Charlotte Grinberg | June 12, 2020



When a
euphemism
just won't do...

It was late in the evening, and I was ready to start my night shift as an intern in the intensive-care unit. I sought out my fellow intern, who was finishing his shift, so that we could perform signout—the ritual of passing the patients’ information from one clinician to the next.

“Mrs. Klein in Bed 15 might go,” he whispered.

“Go? Go where?” I asked. “It’s 10 o’clock at night.”

“I mean she might go away.” He wasn’t making eye contact with me.

“Where?”

“Forever.”

My look of confusion remained. Also, why was he whispering?

“She’s comfort measures only.”

Only then did I understand: He was telling me that Mrs. Klein might die.

Before I could say or do anything to indicate that I understood, he moved onto the next patient. His voice resumed its normal volume as he talked about gastrointestinal bleeds and small-bowel obstructions.

As physicians, we discuss intimate topics with our patients. We talk with them about things that they discuss with no one else in their lives. We ask about sexual activity and drug use. We hear about affairs, and breaking the law. We talk about bowel movements and bladder control. We perform rectal exams and bowel disimpactions; we palpate scrotums and examine pelvises. I’ve seen my colleagues ask these questions and complete these physical exams with assurance and poise. And I’ve seen how their confidence puts patients at ease, creating an atmosphere of trust that allows for meaningful caregiving. Hours into my shift, one of the intensive-care nurses walked up to me. I was slumped over the computer, typing vigorously, as interns often are, and

eating a packet of graham crackers meant for patients, as interns often do. "Bed 15 expired," she murmured.

Expired? I thought. *What type of medical diagnosis causes that?* Then I remembered that this was the patient I'd been told was "comfort measures only." She had died—and, as the intern, it was my assumed responsibility to pronounce her dead.

This was the first time I'd pronounced a patient dead on my own. As I walked to Mrs. Klein's room, the word *expired* kept rolling around in my mind. I couldn't help thinking of food that's past its "use by" date—and then of my grandmother, and her approach to such food.

I've seen her do it all: scratch off expiration labels, transfer expired food to unlabeled containers, retrieve food that we'd dared to throw out, then return it to her fridge. I thought about all the bouts of food poisoning I've suffered after agreeing to stay for dinner. I thought about how she holds on to my grandfather's medications, even though he died years ago.

"What if I'm prescribed a similar medication?" she insists. "No point buying what you already have."

My stomach started to churn.

But then I saw Mrs. Klein, with her perfectly painted toenails, dented wedding band and well-earned wrinkles. She was not a number, a bed, a smelly refrigerator or a cluttered pill cabinet. Mrs. Klein was a spouse, a mother and a friend.

I called Mr. Klein.

"Your wife has died," I told him as gently as I could. "I believe she died comfortably."

On the other end of the line, I heard his tears. I asked him to share a memory of her that I could keep with me, instead of just remembering her as the patient who'd expired.

"We fell in love at the age of eighty, at a senior center," he told me. "She was a widow of fifty years. I had never married. She was an amazing wife." As clinicians, we frequently bear witness to death. I am the only one of my friends, and almost the only one in my family, to have seen a person die. Like many of my peers, I find it hard to experience this, and even harder to put the news into words for the loved ones left behind—especially if I've never met them.

But I know that, as a physician, it's my responsibility to help guide patients and their families through this inevitable part of the life cycle. As I grow more comfortable in that role and overcome my reluctance to explore end-of-life questions with patients and their families, I hope that I'll be able to remind myself and others that it is completely normal to discuss and think about death.

Physicians can make this process easier, I believe, by simply revising our vocabulary. Only a few months into my intern year, I'd already heard so many euphemisms: "He didn't make it," "He bit the dust," "He croaked," "He's going home in a box," "He kicked the bucket," "He's not with us anymore," "He passed."

Rarely do we say, "She will die," "She is dying" or "She has died."

I've started to make sure I say the words "dying" and "death" with confidence and compassion—just as I would any other medical diagnosis. That way, I like to think, my patients will see my honesty and lack of fear and hopefully find comfort there.