StarTribune Editorial

Our perspective

Never say die

The wisdom in talking about death

A fly on a hospital-room wall passes many dull hours. Even when a doctor pops in on a patient, there's not much to listen to. Doctors and patients don't seem to know how to talk to each other — especially when it comes to that dark subject called death. Afraid to consider the possibility that things won't turn out well, they put off discussions about what to do if things don't. They're reluctant to acknowledge death's inevitability or to plan for its coming. Most people reach their last days without ever having contemplated how they'd like to die.

This isn't surprising, given society's conviction that death is an elective rather than a required course. Americans would rather do anything than talk about death, and many doctors are more than happy to help them out.

But such stalling serves neither doctor nor patient well: It can turn every dying moment into a harrowing emergency — spurring decisions driven by reflex, rather than reason, depriving all players of the chance to find meaning in life's last act. How much better it would be to nod now at the certainty of death, to decide now how to greet it.

The opportunity exists. Federal law guarantees citizens the right to spell out their wishes for medical care in the event of serious illness. Patients are free to tell their doctors what they hope for, and doctors are free to inquire.

Few patients tell, however, and few doctors ask. The proportion of Americans who actually have written living wills remains remarkably small — about one in five, by most counts. Most who do complete an advance directive express wishes so vague that they're virtually useless when a medical crisis descends.

Doctors and patients dwell together in this procrastination society. Both seem to regard planning for life's end much as they do straightening the linen closet: They agree it ought to be done — once life settles down. (Never mind that life settles down only when it's over, and that most people die with their linen closets in disarray.)

It ought to be up to doctors to break through this denial, but doctors won't talk unless they have something to say. Most are speechless for a reason: Medical students and residents are never taught how to care for or talk to the dying. And they know just as little about how to explore the subject of death with the healthy.

Even if doctors do muster the courage to talk about end-of-life care, they tend to do it late and badly. The 1995 SUPPORT study of thousands of dying people found that most do-not-resuscitate orders were written only when patients were close to death. This suggests that many doctors are ushering patients in and out of their clinic offices — even installing them in hospital beds — without ever addressing a critical question.

Learning to die

Rethinking one's care at life's end

When physicians manage to raise the subject, they may not be comprehensive: A 1996 study published in the Archives of Internal Medicine showed that doctors who talk to hospitalized patients about cardiopulmonary resuscitation usually leave out the basics — neglecting to speak clearly about risks, benefits, possible outcomes and the likelihood of survival.

This avoidance is unhealthy. It deprives sick patients of knowledge they need and, as the SUPPORT study showed, sometimes condemns them to more intensive treatment than they want. It can lead to unwanted use of intensive-care beds, ventilators and resuscitation — and thus to more physical pain, more psychic suffering and higher hospitalization costs.

But the price of silence about end-of-life care is paid not only by the dying. It is charged to those by the bedside left mystified about a patient's wishes. Indeed, hesitancy to talk about death imposes a cost on everyone. It reinforces fear and pain — two of death's most frequent and least welcome attendants.

Breaking the silence will take more than resolve. It will require a revolution in the relationship between doctors and patients. Doctors — and other medical caregivers — must be taught from their first day of training to talk early and often about end-of-life care. Hospitals and health plans should emphasize that such discussion is part of what good medicine is all about; they should require doctors to initiate it. Patients should be urged, and should feel obliged, to be explicit about their preferences.

Encouraging talk about death may not save a lot of money. Indeed, the effects of more talk may not be easy to measure at all. The purpose of starting a conversation about death may actually be more moral than practical: By facing death before it comes, we may make it less strange. By anticipating death, we may be able to have some small influence over it.

Doctors could start the process by asking a question many go out of their way to avoid. Dr. Lachlan Forrow, a teacher at Beth Israel Hospital in Boston, frames the question very simply:

"As you look ahead, have you thought about what you would like the last part of your life to be like?"

It's a question every person should take the time to answer.