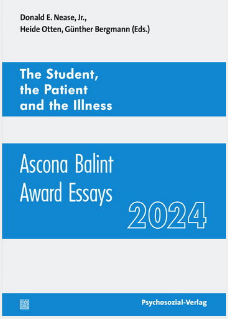
Vivian Lu

The Celestial Gaze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The Student,
the Patient
and the Illness

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The Celestial Gaze

Vivian Lu

I

"I want to meet the Grim Reaper," the patient said to me after I asked him his goals. He was 95 years old and a firecracker. I was 25 years old and an anxious MS2 on my internal medicine clerkship. He was here with pneumonia. We fell into a routine – I would bring him 2 cheese sticks and a coffee, black, when I came to pre-round and ask him the usual questions. I'd watch him drink the coffee through a straw, afraid he'd spill hot liquid on his thinning, almost translucent skin. Then I would order his breakfast from the cafeteria over the phone, since he had difficulty hearing. His daughter and son-in-law would visit from a few hours away, often in time for the team to round in his room. In the afternoons, I would check in on him, bring him another cheese stick. Before I left the hospital in the evenings, I would put his hearing aids on their charger.

He wanted to go home, where he had a large, marbled bathroom and a wooden chair his buddy had built by hand. His buddy had been dead for a while and his widow was happy that someone was enjoying his chair. He closed his eyes when he talked about that chair, how comfortable it was. I imagined him watching the news in that chair, surrounded by picture frames and knickknacks, snow falling thickly outside the mountain home where he lived with his daughter and son-in-law. His wife of decades was long gone and before she died, she had forgotten who he was.

He also wanted to go to his eternal home. But no, he wasn't suicidal. "I've lived a good life. A long life. I'm so tired now." He said that a few times. He had been an instructor in the military, saying, "I turned those boys into men, goddamn good men." He laughed when he recalled one of his trainees at the end of the course saying, “Sir, at times I wanted to shoot you. At times, I had a mind to do it. But thank you Sir, thank you.”

When his pneumonia became an empyema, I watched as he got a chest tube placed and he gave me two thumbs up. When it was time for him to be discharged, it was my day off but the senior resident contacted me, knowing we would want to say goodbye to each other. Not in his blue and green hospital gown anymore, he wore a flannel shirt and slacks. We said goodbye. And we talked and laughed so hard that the senior resident down the hall texted me, saying he thought I was going to give him a pneumothorax.

Later when checking his chart, I found he had called the hospital, requesting aid in dying. I left that rotation site soon after and no longer had access to the medical records. But I did leave with vague knowledge now of Medical Aid in Dying (MAID), legal in Colorado, and an indelible memory of a patient who wanted to die. It was comforting knowing he likely soon reached his goal of meeting the reaper, finding peace.

II

“Breathing may become more rapid or shallow or irregular; breathing may stop for short times, and then start again. Sometimes there is a moaning-like sound when the person breathes out. This does not mean distress, but is just the sound of air passing over relaxed vocal cords. Snoring noises may be heard as the throat muscles relax.”

In November, now an MS4, I began a palliative care and hospice elective. I had always wondered what happened in their meetings after sending a consult. The teams worked on the 10th floor and their room filled with light from the large windows. Thank you cards hung festively on a garland. I sat at a workstation near a table where people brought in goodies, like bread and chocolates. Social workers, chaplains, coordinators, and providers filled this space. In the mornings, they checked in on each other. If they said they were green, they were doing peachy. Orange meant they were not doing great, but powering through the day. Red meant not well – people talked of ill family members, of harrowing stories of patients they had cared for.

On my first day, I went with a team to meet Maria, a new consult, hospitalized after a prosthetic hip infection. We entered the gently lit room and a woman was crying over the patient in the bed. “Nobody told me. Nobody called me.” I looked to the physician to say something. Then the patient took a breath again.

"I thought she had died while I was away." The woman introduced herself as the patient's daughter. She said her brother was coming soon. We went to a conference room to have the family meeting, since their mother was unable to participate.

This was a family deeply connected with the spiritual world. They believed in signs from beyond. Once Maria had felt two droplets of dew appear on her hand in the kitchen and said a gift of two was coming. Maria's daughter learned she was pregnant with twins a week later. When Maria's other son had died, she thanked the nurses for spraying the room with rose fragrance. They hadn't. The chaplain mentioned in the workroom that this could be the sign of St. Padre Pio, with his spectral scent of roses. The family was Catholic after all.

The son and daughter smiled as they recalled how their mother had met their father. Maria had traveled to visit a sick uncle and the small town took note of her. Her future husband overheard his dad telling his brothers there was a beautiful woman at the hospital, perfect for marriage. He hopped in his car and beat them there, and as Maria's daughter said, it was truly love at first sight. This love lasted in an earthly space for 17 years until her husband died from liver failure. But in a way, he never left.

Maria saw visions of her husband. Other members of the extended family also saw her husband, and this would happen shortly before they died. "He was coming to take them home," Maria's daughter said. Before Maria's hospitalization, she had made up the couch with blankets and pillows, saying, "He told me he's coming home." Her daughter asked who, and Maria said, "Your father."

While I never spent more than ten minutes in person with Maria, I felt I knew a little part of her core from the cumulative reminisces of her son and daughter. When we visited her the next day, she was surrounded by multiple generations of family. Her eyes were closed, her brow unfurrowed. She did not rouse to voice. Her daughter smiled and said that her time was coming close. I told Maria as we left her room that she had left such a legacy.

She died two days later. The note from the chaplain prior to her death read, "Family is ready for Maria to make safe passage. They will sing her "happy birthday" as her heart stops, a family tradition." I liked the phrase "safe passage." It implied she was going somewhere worth traveling. That she would not be gone, merely elsewhere.

After Maria, there were more consults, more meetings. In one, I remember a mother who said to her son at the end of his life, "I fought for you to come into this world and I will fight for your death." In another, a woman barely older than me talked of wanting to go on a cruise and also to Vegas. Looking at her, you wouldn't know she had metastatic cervical cancer and this breathing, vibrant woman who talked about her career as a deputy would be ashes in maybe three months – she wished to be cremated. Later, her sister brought in a device that overlaid the tiled ceiling with ripples of ocean waves. “I can’t bring her to the ocean but I can bring the ocean to her.” At night in the hospital, she would lie looking up at the waves, pressing her PCA intermittently, until she fell asleep. I hoped at these times she was far from this hospital, somewhere she could smell salt air, feel fine sand under her feet, and hear waves cascading onto shore.

Not every patient was end of life, or near it. Some had chronic, barely manageable pain. Others were waiting for a liver. But I was drawn to those who qualified for hospice. Six months left, or less. I believe I was fascinated by this demographic because we had spent so much time in medical school on learning about pregnancy, birth, and the rest of life. But end of life and, finally, death had only been briefly mentioned. But I saw it now as meaningful as a birth, something that should discussed and processed. I believed now that one should plan as much for the casket as for the crib.

I noticed planning for death started late. Nobody likes to think of death after all, for oneself or loved ones. The palliative care team was there to help with the process. They were emotional surgeons, working with the viscera of guilt, regret, anger, relief, love. They talked deftly. They knew when to be blunt, when to guide gently. When they misstepped, they corrected course with ease. They untangled turmoil of patients and families as they faced end of life. They referred patients to hospice, clearing up misconceptions or reassuring families who had a previous unfortunate hospice experience. Most often, they talked about hopes and worries, two sides of a coin that every patient carried in their pocket.

For a team often working with patients who were dying, the palliative care notes were filled with life. They wrote of patients before they became patients. The notes were biographies of sorts. They spoke of fishing, baking, raising families. They mentioned beloved pets and favorite foods. These notes stood out in the electronic files of patients, a glimmer of meaning among the others that listed a host of medical issues, medications, plans of action, checklists, labs.

III

I often didn’t know what to say when leaving the rooms of patients on palliative care. “Have a good day” seemed banal and wrong. I did hope their pain would get better, but “I hope your pain gets better,” didn’t seem to work well as a farewell. I settled on “I hope you have a peaceful day.” As always, with the word “hope,” there was the opposite side of the coin. “I hope *this*, but I worry *about this*.” That was the phrasing the care team members always used. While I hoped for peace for all the patients, I worried they would not have that.

The palliative care team members had no trouble with banter. They could go from discussing the existence of dragons to last night’s football game to talking to a patient about their PCA dosages. They built rapport fast. And when that rapport didn’t quite come as easily, they still managed. A chaplain told me that when there was a strong emotion in the room, to name it. Naming frustration, anger, and sadness helped. People want to be seen. They want acknowledgement of their emotions, bubbling over like champagne in the face of the inevitable.

While most specialties didn’t sit down since they would be out of the room quickly, palliative care had time. We rolled office chairs into rooms and sat with patients and families. We got on their level. Sometimes that was a vulnerable thing to do. I uncomfortably wore the luxury of youth and of health in front of patients in blue hospital gowns. Untethered by IVs, I could leave the hospital and return home to my soft, sweet cat and eat any foods I wanted. I could sleep in my own bed without pain awakening me. If you opened me up on the operating table, you would find a smooth liver, arteries only beginning to show signs of atherosclerosis, clear lungs with grape-like alveoli tempting to pluck, a pulsating heart ready to donate. Of course, this wasn’t about me then. But I have the gift of being able to reflect on these moments.

IV

A while before my palliative care and hospice elective, I was taking care of a patient with liver failure of unknown etiology, along with a host of other issues. She had been transferred to us from the ICU but I felt she was inappropriate for the care on this floor. AOx0. AOx1 occasionally. Every specialty I consulted, from liver to infectious disease, asked if I had considered consulting palliative care. I asked the senior resident if we should consult palliative care in light of the patient’s condition and the other specialties recommending it. And she answered, no, since the husband who sat by the bedside day after day had not requested it. I also asked if we could use an interpreter, as English was not the patient’s nor husband’s primary language, but I was also told no, since the husband had not requested it.

The husband was hopeful. Sometimes the patient moved with meaning. She was able to say her name at times. But she was clearly not on the road to any meaningful recovery, at least how I defined it. She would not be the way she was before she entered the emergency department, or close to it. And it became clear she was at the end of her short forty-something years of life.

After days of futile consults and efforts, I made a stronger stand that she should be transferred back to the ICU and the attending agreed this time. A resident from the ICU disagreed, but ultimately the ICU attending overruled her. The patient was intubated within 2 hours of arrival in the unit. Her chart continued to bloat with notes. Each one showed a deteriorating woman from a different perspective – nursing, nephrology, neurology, liver, infectious disease, wound care. "Husband at bedside" was a common phrase in these notes. Her edema went from 1+ to 2+ to 3+ to unclassifiable. She required dialysis.

Palliative care was finally consulted. They came to a decision with the husband to use an interpreter. Her two children were brought to see their mother at the hospital – they had been kept away previously by her husband. Other family members, I saw from the notes, were "shocked" at the condition this woman was in. "She walked into this hospital, how is she like this now?" they asked. And I could see how it seemed as if this place had killed her. Her "discharge deceased" note was brief, devoid of any sense of who she was as a person. She died with family at the bedside, and that is all I know.

I regret everything I did not do. I have told this story again and again in residency interviews when they ask about something I have failed at. While at the time I had a sense that consulting palliative care early on could have helped, after taking the elective, I am certain this patient and her family were failed by us not consulting them. Now I know they could have facilitated conversation. They might have been able to discuss matters with her husband in a way that led to the most peace for our patient instead of prolonging life to every extent possible. This is perhaps something she would have wanted had she been able to speak. Or perhaps, what happened is exactly what she would have wished for. I understand it is not my place to impose what my own preferences would be, but it will be my duty as a physician to offer options, to start a dialogue.

V

"Has anyone ever talked to you about talking about code status?" A palliative care physician asked me this in the morning one day. I told her yes, someone had taught me about DNR/DNI, but I knew there was more to learn. "How do you ask someone about code status?" she asked. And I repeated what I had heard a resident say once to a new admit, “If your heart were to stop beating and you were to stop breathing, would you want us to do everything?” The physician smiled and told me that was often what was said, but it was an incorrect approach.

She explained. Of course everyone would say yes to “doing everything.” And treating code status like a buffet was not ideal – after all, in a code, the patient would most likely be intubated, so being full code but no intubation made little sense. She pulled out a PowerPoint. Oh no. But it was blunt and short, showing the statistics of surviving with CPR after coding in the hospital and the rate of disability and levels of function status if one survived. They were shockingly low, even though I knew they would be low. I asked if she ever showed patients the numbers and she said no. “Everyone always thinks they will be the 1%.”

She said she does guide patients on deciding code status based on their medical context and their goals. For example, survival and morbidity rates with CPR in patients who have metastatic cancer are dismal. She would say to such a patient, “It would not make sense for you to be full code, for us to perform heroic measures if you died, as it would not cure the underlying disease that caused you to die.”

As a result of TV shows and movies, combined with optimism, many people who are not in the medical field don’t comprehend the violence that CPR is. It is squeezing the body hard enough to physically make the heart pump blood to the body. Ribs will crack. The body jerks from the force. CPR rarely “works” if the goal is to bring the person back to the way they were before their heart stopped, before they died. Before I knew all of this, I had taught CPR to elementary schoolers when I was in college. “This might help save a life one day!” I had said.

I respect patients’ autonomy to make decisions on their code status, whether they want full code or DNR/DNI. I also believe they have the right to know the facts about the likelihood of survival after resuscitation, and what that survival could potentially look like. I’ve heard patients say, “No I don’t want to be hooked up to machines and be a vegetable” and others say, “Do everything possible.” Ultimately, I will uphold what they choose.

VI

My dad was in a bad car crash when I was little. When my mom told me, I asked if my car seat was okay. This was not a marker of psychopathy, just a sign I was too young to understand death. A while after the accident, I asked if we could buy a new dad at the store and my mom said no, we could not. I was disturbed by this. If he had died in the accident, it meant it would have been permanent and it also meant he was irreplaceable.

In college, a friend showed me pieces by artist Adrian Piper, which involved the phrase *"Everything will be taken away"*. There were blackboards with the phrase written over and over in cursive chalk, like a student's punishment. Then there was the follow-up project with the phrase tattooed in henna on volunteers' foreheads, and they walked through the streets provoking all kinds of responses. Finally, a series of photographs with the phrase imposed over altered, blurred figures.

The idea that everything will be taken away was ominous. I oscillated between believing in its totality and trying to think of what could not be taken away. I decided I wanted to build a life for myself in which there would be immense meaning and enjoyment, even if everything was to be taken away anyways at the end. In a way, the idea that everything will be taken away is reassuring. It means go ahead, make mistakes. Say the truth. Shoot your shot. Live your life the way you want. It is all ephemeral.

During end of life, there is much that is taken away. Memories, energy, bodily functions, privacy. The desire to eat or drink. The body is shutting down. The kidneys are ceasing to produce urine, the lungs are working erratically. The heart is slowing, sometimes irregular. Blood is shunting away from the extremities to more vital organs and the fingers, toes, and knees turn a mottled blue-purple color. Oxygen levels are decreasing. The brain may be hallucinating, or suddenly become clear-headed. The person is "transitioning," the note always say. Changing. Not being taken away, not being obliterated, just becoming a different form.

For all that is taken away, there are remnants when one dies. The corporeal shell on the bed. The photographs, clothes, and knickknacks in their home that someone will throw away, donate, keep, pass down to next generations. The memories will linger, until the last person that remembers them dies. One's legacy will not be gone as soon as one's physical self gives out. But eventually, everything will be taken away.

VII

"The person will enter a coma-like state before death. There may be moments when they are more alert; those moments will decrease as death nears. Assume they can still hear you and feel your touch."

I anticipated the hospice part of my rotation to be bleak. Instead, I found a one-story building, surrounded by trees and flowers, and filled with cozy hotel-like rooms in contrast to the sterile hospital rooms I was expecting. There was a TV, comfy armchairs, no beeping machines. Light entered strongly through windows that looked out to shrubbery or small gardens.

I went rounding with Dr. T. A kneejerk response crossed my mind – I wondered the purpose of a physical exam on patients who were dying. He showed me how their limbs become so cold that I could feel my own warmth seeping into their skin, how their breathing becomes irregular and accompanied by the gasping, gurgling sound I was well familiar with.

When I was younger, I associated death with dirt, worms, cracked stones in cemeteries, and (the myth) of fingernails continuing to grow inside the casket. Death was the worst thing that could happen, unimaginable. But here, it was expected, sometimes welcomed with relief from both patients and their loved ones. A sign with a blue-winged butterfly hanging on the door meant to check with the nurses before entering a room, because someone had departed. A metamorphosis. At the university hospital, they used a hummingbird. Death is associated with flight, the iridescent wings of a delicate creature, a lifted spirit.

VIII

The hospice facility followed Catholic ideologies and their physicians and nurses signed a contract that prohibited them from providing medical aid in dying (MAID) information to patients. Fortunately, they did allow a physician to come in for a MAID visit with Laura, a patient who had initiated the process before arriving in room 211. She had already had her first MAID visit and was awaiting the second required visit, from a different physician.

Under Colorado law, a person qualifies for MAID if they are a resident of this state, if they have capacity to make that decision, if they are at least 18 years old, if they have an illness with a prognosis of six months or less to live, and if they have not been “coerced or duly influenced” by others. They must have a visit with a physician willing to prescribe the medications and must make an oral request for medical aid-in-dying medication. Then, they must have a second visit, fourteen days later, with a second consulting physician to ensure they still meet these criteria, with a second oral request. A form must be signed with a written request. Then the aid-in-dying medications are prescribed, picked up from a pharmacy, and taken by the patient at a time of their choosing. Or not. Some patients like having the security, to have that choice in their back pocket, even if they never use them. It represents the ultimate autonomy.

On a Tuesday, Laura was in incredible pain. Her son waited restlessly in her room. Dr. T had been withholding morphine per her and her son's wishes since last night, so she would be lucid for this meeting. I took up my stakeout outside the room, since I wanted badly to sit in on the MAID meeting. The consulting physician arrived at 1:30 p.m., dressed as if she were going on a hike, with sturdy boots and a backpack. She agreed to me joining her and we walked into Laura's room. She pulled up a chair beside the bed, her back to the window. She spoke frankly about the process. The conversation was raw. I have memorized the essence but remember only a few exact snippets and phrases.

Laura was certain she wanted MAID. Her voice was low and she was weak. "This, this is not living. I am already dead."

The physician asked a few more questions before discussing the medications, which she described as lethal. No euphemisms here. They came in a liquid formulary. "I recommend a sorbet with the meds. The taste is, what is the word I am looking for? It is bitter."

The alternating sips of bitterness and of sweetness would be the taste of death. She advised that the transition would occur about an hour after drinking the meds. Sometimes, longer. She said it would be possible to linger as long as overnight.

Laura understood and consented. She seemed relieved. The physician wished her well on her journey.

There was still another hurdle to surmount – Laura would not be able to complete the process at this facility. She would need to be transferred to either a facility that supported MAID or her home. Fortunately, her son was prepared to move heaven and earth for her to die the way she wished, and arrangements were made to move her home tomorrow. Almost as soon as the meeting was over, her morphine was readministered. She had been so brave. After half an hour, she was still in pain, her anxiety exacerbating pain and then pain exacerbating anxiety. A positive feedback loop.

It struck me that a key aspect of MAID was Laura being capable of drinking the medications herself. She needed to physically hold the cup up to her lips and drink the bitter liquid. Her son could legally pick up the prescription for her, prepare the medications, yet it would be illegal for him to help her drink them. I thought about patients, for example some with amyotrophic lateral sclerosis, who could meet all the criteria of qualifying for MAID, yet be unable to drink without assistance. I don't fully understand the distinction between this step and all the other steps needed to reach the point – all are critical to achieving death, but people can assist with the other steps to varying degrees. Why is the final step in the chain of events, the lifting of a cup of medications to one's dry lips, illegal, and by that legal classification, deemed morally wrong? I don't know. Possibly because it is a momentous event. Someone is assisting another human in consuming a lethal mixture. Maybe the courtroom would call that euthanasia, something I do not believe in. But if one has capacity and wants MAID, I believe that reasonable accommodations should be allowed for those unable to physically complete the task.

As it turned out, Laura would never have a strawberry sorbet with the bitter medications. Her brow was furrowed the next morning in pain and she was not lucid, let alone capable of drinking the medications herself. She would not be able to go home and die the way she had hoped.

Colorado voters approved "Access to Medical Aid in Dying" in 2016. However, it is still difficult to find a physician to initiate the process, as MAID remains controversial and information on concrete options is elusive. With a Google search, I was unable to find any specific physicians to contact about initiating MAID. Only 316 patients in Colorado received aid-in-dying prescriptions in 2022 under the Colorado End-of-Life Options Act, though this is a 44% increase from 2021. Of these, 93% were classified as "White, non-Hispanic." The place of death for 81.5% was classified as "Residence."

There is reasonable concern that MAID could be utilized maliciously. This issue should be protected against and monitored, as people who qualify for aid in dying are often vulnerable in emotional and physical aspects. It is a class 2 felony for one to "coerce or exert undue influence" on a person to request aid-in-dying medication. There is also understandable worry about MAID as a weapon against marginalized populations. Yet interestingly, and not entirely surprisingly, studies so far show that this legal right is mainly utilized by educated non-minorities diagnosed with cancer. Overall, these individuals have the resources to search for a physician who would prescribe the medications, the money to pay out-of-pocket costs for these medications, and a support network to facilitate this process. Dying in peace is a luxury.

IX

Henry could not get comfortable. The problem was not with the hospice bed. The problem was with his spine – cancer had invaded his vertebrae. Possibly his liver too, as he complained of a pain on his right side, under the rib cage. He constantly shifted around and Grace, his nurse, kept attempting to ease his body into a tolerable position.

Henry asked about MAID later that day. Wasn't there some way that he could die sooner, so he didn't have to live in this pain?

The physician, bound by his contract, answered that this facility followed Catholic ideologies and that they did not support MAID. That was the end of the conversation. No referral to another physician, no information provided on the subject. Even though this physician believed in the right to MAID, I expected this reaction – he could lose his job, his ability to serve the patients at this place.

But I was not an employee and I had not signed any contract. And I believed in MAID. Even if I didn't, I like to think I would believe he had a right to know his options. Without any of the staff present in the room, as they could not be per their contracts, I offered Henry and his wife basic information on MAID and a website. I don't know if he ever initiated the process. I don't know if he was even able to find a physician that would perform the initial visit, as his primary care physician, when I called him, was unwilling to offer MAID. I don't know when Henry died. He could still be shifting around on his bed, searching for relief from his diseased vertebrae. But I do not regret anything I did, even if it amounted to a ripple in the pond.

X

During the height of the COVID-19 pandemic, I started medical school. For anatomy lab, a rite of passage, we did not dissect the cadavers, to minimize contact between each other. They were prosected professionally. I preferred it this way, even if I lost the experience of dissection. Muscles were displayed neatly, nerves remained intact under the skillful hands of the anatomy lab team. Everything was greyer than I had expected and the formaldehyde smell made us all strangely hungry. We craved burgers and tacos as we examined the brachial plexus.

I noticed our donor had scoliosis, like me. I held her uterus, amazed at its smallness. Her brain was submerged in liquid in a white bucket and we pulled it out to look at the gyri and sulci, feeling the intricate ridges and grooves that contained her experiences, knowledge, memories in neurons that no longer sparked connections. My classmates and I kept her draped and her body tissues moistened with a spray. There should always be dignity in death, whether one ends up six feet under, in an urn on the mantle, or on a stainless-steel table with medical students gently lifting intestines from the abdominal cavity.

After our anatomy course finished, we had a virtual ceremony to honor donors and their families. One donor's son-in-law talked about how he had spent ages picking out the perfect birthday card for her. He wrote in it with meaning, and on her birthday, his mother-in-law opened it, read it, said "That's nice," and threw the card away. But she meant no malice, he explained. That's just how she was. Practical. Of course she had donated her body. She had no use for it when she was gone, he said, repeating her words. Just like the birthday card after she had read the sentiment.

There were also letters for us to read. One donor's story written by her family started off talking about how they were surprised she had donated her body to science, but that they never understood why she did anything even while she was alive. She had been born on a dirt floor "with delusions of grandeur." I admired that. Even with their bodies in the anatomy lab, opened up, cut, and separated, everything had not been taken away.

XI

After my experiences, I strongly believe "Death and Dying" should be a more substantial part of the curriculum at medical schools across the US. With a growing aging population, medical professionals must be prepared for conversations around this weighty topic. Without seeking out the palliative care and hospice elective and winning the lottery pick to be enrolled in it, I would not have all the things I now hold in my heart and mind.

I would not have been exposed to the conversations that laid open the messiness of impending death or felt secondhand the visceral emotions rushing in to fill in the practiced silences of the team. The anger from daughters who did not realize the brain damage that had occurred during their mother's strokes. The relief of a family when the team explained the choice had already been made by their loved one's failing body – they would not have to decide. I would not have had the honor of being present during the ends of Maria's or Laura's lives and learning about who they were before they were in hospital beds.

I would not know a better way to discuss code status. Or understand much about MAID, except that it exists in Colorado and some other states. I never would have had the chance to provide Henry with information about a process that could allow him to die the way he wanted and was entitled to under the law. Everything would be different for me and the care I hope to provide.

XII

I wish for my family and friends to know that I do not fear death itself. I think it is not the end, but a new beginning for me.

Most patients I saw were religious or spiritual. They believed in a higher power, welcoming the chaplains, praying in bed, receiving the Anointing of the Sick. Me? I hope for myself a deep and dreamless sleep when I die, the same as when I have gone under anesthesia. One minute there was a surgical team around me, the next, nothing. And there would continue to be nothing if the anesthesia team was not so skilled. I don't want there to be *something* when I die. But I respect those who believe there is something more and find happiness when they find happiness in the comfort of a beyond. And most believed there was something more. They talked of reuniting with family and friends on the other side. Some could feel God calling them home.

Religious or not, spiritual or not, at the end, many of us want the same thing. To die with dignity. To be around loved ones. To be comfortable. During my elective, I filled out the "5 Wishes" booklet. Wish 1 designates someone to make my health care decisions in the event I cannot make them myself. Wish 2 delineates the kind of medical treatment I want or do not want. Wish 3 lets me decide how comfortable I want to be. Wish 4 describes how I want people to treat me. Wish 5 determines what I want my loved ones to know. Two witnesses signed it, a classmate and a palliative care provider.

I want to be prepared for anything, especially end of life. It is my wish that my future patients will also feel more prepared and that I can guide them to think about their end-of-life plans. I want them to have MDPOAs who will respect and advocate for their wishes even if they don't agree with them. I hope my patients will be able to die with clean sheets, loved ones speaking to them (as they say hearing is the last sense to leave), and the absence of pain. I hope for them a good death. Above all, I hope for them peace and I have less worry now about my ability to facilitate that.

"This is what we call the 'celestial gaze,'" Dr. T said to me during rounds once. The woman's eyes were fixed upwards, looking beyond the ceiling. "We see it a lot at the end."

Celestial. That implied the heavens. The pinprick stars, glowing orb of the bitten moon, or the orange sun sinking under still waters. Perhaps she could see her loved ones, alive or deceased. Perhaps she was in awe gazing at her idea of heaven. But after all, I think it is futile to wonder what she was seeing. This was hers, hers alone.

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