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By Sunita Puri

It's been almost a decade since I finished my medical residency and became a "real doctor." After training ended, I faced one final hurdle: passing a grueling eight-hour-long internal medicine board exam. Back then, it seemed as though there was nothing more important than knowing the right answers. What I didn't know was that when practicing palliative care, it's really about asking the right questions.

As a resident, I would have never let myself consider only the most obvious diagnosis for a patient's illness. But when it came to my patients' personal lives, I too easily assumed the simplest narratives: Amid a health crisis, previously divided families would surely rally around their loved one. A person dying at the age of 90 must have lived a long and fulfilling life. Agreeing to hospice care meant that a patient had accepted that they were dying.

Back then, I didn't question what "accepting" death really meant, or whether it was something I could expect from my patients. I struggled to ask about their suffering unless they seemed ready to embrace their fate, fearful that I might inadvertently worsen it. But as I [write in my guest essay this week](#), I've learned that awaiting specific imaginings of acceptance only justified avoiding having necessary conversations with patients and loved ones about what they fear and need as death nears.

Several days ago, I sat in the corner of a hospital room with the daughter of a patient suffering from incurable cancer. She was a nurse, and told me that she was worried that her mother hadn't come to terms with the end of her life. I know the stages of grief, she said, and I think she is in denial, but maybe you could help her understand she needs to accept what is coming.

Ten years ago, I would have nodded, confident that I might help her mother, earnest in my naïveté. I still feel the initial rush of my inclination toward rescue. I knew the answer she wanted, but instead I asked a question. "I'm happy to speak with your mother and understand how she is making sense of what she is going through. But is this conversation also a way to help you to find peace?"

She considered my question. Then she met my gaze, her eyes brimming with emotion, whispering, only, "Yes."

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GUEST ESSAY

As a Doctor, I Know Being Ready to Die Is an Illusion

It is easier to search for readiness than to process what its absence means.



By Sunita Puri

Dr. Puri is the author of “That Good Night,” a memoir about her work as a palliative medicine physician.

Nine years ago, near the end of my residency training, I sat opposite a patient, wondering whether he’d accepted that he was dying. He was in his 60s, an artist with sinewy arms and serene eyes, someone I’d come to know well over the past three years. Cancer had broken into his liver and bone marrow, robbing him of hunger and energy.

Each time I saw him, the hollows of his cheeks deepened. I wanted to tell him that he was dying, that I wanted to understand how he envisioned spending his remaining life. But he mostly spoke about his plans: a camping vacation in six months, a friend’s wedding after that.

I awaited some sort of arbitrary signal that it was safe to talk about dying. Maybe he’d tell me that he didn’t want more chemotherapy or that his affairs were in order. Like many physicians, I feared that by talking about death before he appeared ready, I might take away his hope, make him give up or send him into an unstoppable tailspin of anxiety and depression.

Whether he hadn’t accepted his fate or simply wished to avoid the subject, he didn’t appear to be ready to talk about his death. How could I reconcile what appeared to be our radically different interpretations of his condition? By waiting for him to act in ways that I understood as acceptance, I thought that I was being compassionate and sensitive.

“I don’t think he understands how sick he is,” I told my supervisor. “He’s not there yet.”

In the years since, I have learned that trying to find immutable evidence of someone’s readiness to die is like trying to wrap your arms around a ghost.

Reconsidering what we think acceptance means — and whether it will come to pass — requires loosening our expectations of those who are dying. To become better at talking to one another honestly about death and to truly

prepare for it, we must first understand why we expect the dying to demonstrate readiness in the first place.

During residency, my compatriots and I relied on Elisabeth Kübler-Ross's stages of dying. We were quick to diagnose denial and wait for acceptance. We assumed certain decisions that we wanted people to make reflected readiness — a patient with heart failure who agreed to a do-not-resuscitate order, another with emphysema who enrolled in hospice.

But if patients dying of cancer insisted on life support, we figured that they probably weren't there yet. When people sobbed or screamed during conversations about their illness worsening, we told ourselves they simply weren't ready. We didn't want to stumble through the thicket with them; we wanted to meet them at the clearing.

My patients' families often searched for similar clues, their pain amplified if their loved one didn't appear to have come to terms with death or wasn't ready to let go. Such searching, while well intentioned, betrays fears about suffering — the patients' and our own. If the dying reassure us that they are ready to die, perhaps we may live with a softer grief. If they show us that they are ready to go, we can be readier to let them go.

The stark separation between those who are dying and those who are not is complicated inside a hospital. Family members and medical teams experience and respond to dying people's suffering in distinct ways. Yet doctors and families alike can shackle those who are dying with gauzy expectations: Perhaps they have newfound wisdom to bestow. Maybe their regrets will remind us what really matters in life. Saccharine fantasies of deathbed reconciliations protect us from the full spectrum of our emotions and those of the people we will lose. But romanticizing the dying strips them of their complexity. They are still human, equally capable of picking fights or making amends.

Fantasy also obscures a scarier question: If a loved one or a patient isn't ready to die, how should we respond?

It is easier to search for readiness than to process what its absence means. Distilling human experience into supposedly self-explanatory concepts like accepting death becomes a bandage that we apply, hoping that the raw emotions about death won't bleed through. We want neatness and containment, not the spill of grief.

But death is never neat. A good death should be defined by how well and honestly we care for the dying, not by their performance on our behalf. Expecting them to make death a process full of insight and peace only limits our full emotional and spiritual participation in their death. By sacrificing neatness, we can have a conversation about what the dying truly need from us. Understanding their authentic experiences helps us not only to see them more fully but also to prepare, together, for losing them.

Nine years ago, I wasn't ready to confront my expectations of my patient; doing so would have required dismantling the myths I had about myself as a steward of hope. My expectations were a self-aggrandizing way of holding him at a distance. Fearing that he couldn't handle a conversation about death was infantilizing, a form of paternalism, however well intentioned. How was I any different from physicians in decades past who withheld patients' diagnoses to spare them suffering they supposedly couldn't handle?

To be the physician my patient needed, I had to accept that neither he nor I could be fully prepared for his death. I had to trust that a man three decades my senior was capable of handling life-altering information, that he had experienced tremendous loss before, that nothing and nobody could control how he would contend with this last leg of his life. But instead, I waited for him to initiate a conversation that was my responsibility to start.

Now, as an attending physician, I hear echoes of my younger self when I talk with residents. If they mention that a patient isn't ready to die, I ask what it looks like for someone to be ready to die. I remind them, gently, that awaiting specific imaginings of readiness may only justify excusing themselves from sharing hard truths with someone whose reactions they cannot anticipate. Abandoning this search may allow them to care for people in a way that might inspire their own versions of preparation.

Nine years ago, I think my patient sensed both my urge to tell him something and my hesitance. "Are you OK?" he asked me one day.

"I've been meaning to talk to you about something," I stammered, looking past him at the eye chart on the wall. "I'm worried about you, because every time I see you, you're losing weight and seem less like yourself."

"It's because I'm dying." He was matter-of-fact, as though he'd just said it was raining outside.

I was stunned, then relieved. Yet I still struggled to tell him what I wanted to say. “I am so sorry,” I whispered.

“It’s not your fault. My father died in my arms. So did my wife,” he said. “It’s just my turn now.”

“I feel bad that I didn’t talk to you about this sooner,” I said. “I thought I’d upset you or maybe you weren’t ready yet.”

He laughed. “Ready?” he said. “I’ve wrapped my head around being dead, certainly. Not sure if I’ll ever really be ready. It’s not like packing a bag and standing outside waiting for a taxi.”

He died in his sleep a month later, missing his vacation and his friend’s wedding. Even if he told me he was ready, nothing could have lessened the blunt force of losing him.

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