

# Ready to Live, Be Prepared to Die

Quratul Ain Aziz, MD

*“It was a meditation on life, love, old age, death: ideas that had often fluttered around her head like nocturnal birds but dissolved into a trickle of feathers when she tried to catch hold of them.”*

—Gabriel García Márquez, *Love in the Time of Cholera*<sup>1</sup>

As a primary care physician for the last 10 years, I take pride in supporting my patients and their families. Every day I see patients and help them control pertinent risk factors that ideally will help them live long and healthy lives. However, with the emergence of the COVID-19 pandemic, I realized what I have lost sight of in the past 10 years is that the reality of life is death. While I build relationships with patients and promise to give them the best insight I have, I have failed to prepare them for end-of-the-life decisions.

During the first couple of weeks of the pandemic, as physicians, we did not really understand how this new disease affected people, and learning how best to treat it was challenging. With COVID-19 and its spectrum of symptoms in different patients, we did not know what the clinical course would look like, and it was difficult to predict a patient’s prognosis. These moments broke my heart—when I was uncer-

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tain about the patient’s prognosis, and they were looking to me for answers I did not have.

For patients, perhaps the hardest part of the pandemic was the isolation they experienced when they were sick enough to be admitted to the intensive care unit. They had to battle the disease alone, without the support of their loved ones. For those who weren’t getting better, this was undoubtedly even more difficult as those caring for them questioned their “code status”—something many may never have heard of or considered before.

For families forced to be apart from their loved ones, the stress was even greater if no one was sure of the patient’s wishes or even who they would want as their health care power of attorney. For these families, too often they had to leave their family member at the emergency department, and a few weeks later they received a call from the ICU that their loved one was dying. Under “normal” circumstances, a patient’s family members would see the day-to-day deterioration. Instead, because they could not be with them, there was a disconnect. They were forced to make difficult decisions, such as withdrawing life support, without having been present to witness the decline or even getting a chance to talk to their

loved one. In these instances, family members sometimes turned toward the patient’s primary care provider to seek answers—a situation I personally experienced a few times and that had a huge impact on me.

Today, I continue to build relationships with my patients as they pursue a healthy life. But I have changed my view to include the end of their lives. I have started taking my time in their preventive visits to go over medical terms like “full code,” “DNR,” “health care power of attorney,” “guardianship,” and “living will.” It is important that while our patients are physically and emotionally healthy, they consider what kind of care they want toward the end of their lives. These conversations will give them a chance to think about and share their end-of-life wishes, including who they want to make decisions for them if they cannot.

Fortunately, the pandemic has ended. And while it was a soul-crushing experience for so many patients and clinicians alike, we emerged having learned countless lessons that will hopefully leave us better prepared for the future. As Jay Asher writes in his book *Thirteen Reasons Why*,<sup>2</sup> “After all, how often do we get a second chance?”

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## REFERENCES

1. García Márquez G. *Love in the Time of Cholera*. Penguin Classics; 2007.
2. Asher J. *Thirteen Reasons Why*. Penguin Books; 2017.

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