I arrived on the scene to find a big burly nurse, sweat on his brow, performing CPR on my patient—a petite elderly Asian woman. Rhythmic thumps from his compressions filled an otherwise chaotic room.

When CPR stopped and time of death was called, the weight of a thousand rocks caught me unprepared. She was 89; frail, yes, but previously healthy and spry. Just days before her hospitalization for influenza pneumonia, she had been cooking, climbing step ladders to reach spices just out of her grasp. I attempted to make sense of my tears, which were as unexpected as her death. I was riddled by sadness and self-doubt, anxiety and anger. What did I do wrong? Did I miss something on morning rounds? How could I not see this coming? Am I qualified to bear the title ‘physician’?

In the thralls of an uncomfortable confrontation with death, I was singularly obsessed with my failure to save her life. Months of reflection exposed the one-dimensional resolve of my questions as well as the limited philosophy of my training. In a profession that has married itself to finding the elixir of life, proclaiming that preventing death is our only responsibility as doctors, we are uncomforable and unprepared to help them.

Surveys show that nearly half of physicians, including resident physicians, are uncomfortable talking about death with their patients. This comes as no surprise since academic medical centers are devoid of such training. The result? We avoid the topic altogether. In contrast, we spend orders of magnitude more time being trained in resuscitation than on the family meetings I have led. For physicians who are used to having and providing definitive answers, uncertainty around death and prognosis engenders a system in which we tip-toe around the subject with our patients.

But the tide is turning. There is a growing body of literature that is bucking this trend. Atul Gawande, in *Being Mortal*, explores the aging and dying process, advocating for a way that humanizes it, as opposed to our current practice of over-medicalizing it. In his memoir, *In Breath Becomes Air*, Paul Kalanithi, a resident neurosurgeon-turned-patient, struggles with his own mortality after being diagnosed with stage IV lung cancer at the age of just thirty-six. Both books are best sellers, underscoring the burgeoning importance of confronting how we care for those at their final days or weeks of life.

Our role as end-of-life counselors has also crept into our medical journals. One survey of doctors revealed that we physicians, uniquely witness to the harmful effects of invasive measures, would choose do-not-resuscitate for ourselves. We owe it to our patients to bridge the gap in this information asymmetry. After all, we strongly influence how our patients spend the final days of their life. Patients who have end-of-life discussions with their physicians earlier rather than later are less likely to pursue aggressive care in their final days.

While we should continue to increase the accessibility and availability of palliative care, it is too easy to delegate these responsibilities to geriatricians and palliative care specialists. We do our patients a grave disservice by doing so. This is a skill that every physician—surgeons, specialists, intensivists, hospitalists, and primary care physicians—ought to develop, beginning in medical school and residency and then honed throughout our careers. In fact, recognizing its importance, the Hartford Foundation and the Institute of Medicine have commissioned groups to examine the dying process; Medicare has begun reimbursing physicians for having these

*Embracing Our Role at the End-Of-Life*  
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discussions with their patients; and more states are recognizing and implementing programs around Physician Orders for Life-Sustaining Treatment (POLST).

We cause unbearable amounts of suffering by inserting tubes and lines into every body orifice, surrendering only when the rib-crushing blow of compressions forces us to yield. Surely, we need to recalibrate. End-of-life care should be just as ingrained in our ethos as CPR. My competence as a physician is measured not only by how well I ward off death in some but also how well I ease difficult transitions for others, whether it is a patient who decides to focus on comfort or a family who loses their loved one. With an aging population, we must learn to nimbly navigate this rocky terrain between controlling destiny and accepting destiny so we can better embrace the discomfort at the end-of-life with our patients and for our patients.