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The last 48 hours

By Dr ALBERT LIM KOK HOOI.

Saying the final farewell to loved ones.

HE has battled for two long years. Unfortunately the patient's lung cancer progressed despite three lines of chemotherapy.

He drifts in and out of consciousness. Intravenous morphine takes the edge off his pain and suffering. Death is imminent. It will come in 24 to 72 hours.

Cancer testing and cancer treatment – stop. Care continues. Clinical findings – rather than repeated blood tests and x-rays – determine symptomatic and supportive treatment. The relatives and friends understand.

There is a hush in the room. The wife silently hugs her three children. Two siblings and three close friends are in quiet meditation. She recalls their times together and knows that most everything will be changed soon. The others are there for her.

Bach's *Air on the G string* (his favourite baroque piece) is being played. They all reflect on their own lives and how the patient has enriched theirs. It is a time of contemplation and soul searching about the meaning of life and death.

He breathes his last. Whatever ambivalent feelings course through the minds of those present, they keep their peace. The dying experience can be beautiful and enriching to the bereaved.

It is sadly not so tranquil most times. I should know. I have been with patients and their loved ones during those final hours on many, many occasions.

Anguish turns to aggression. "Why can't you do something to cure him?"

Reason takes a beating. "Do you want to make him a morphine addict?" "Don't you know that morphine will stop his breathing!"

Sometimes the rhetoric borders on the accusatory. "You doctors and modern science are useless."

When we can no longer cure cancer (life is a matter of weeks or months), relief of symptoms and quality of life are paramount. We tell the patient and his relatives such. We tell them to grieve (anticipatory grieving) as this will lessen the blow when death finally ensues.

Despite this, acceptance is difficult. One soon-to-be-bereaved even shouted, "Death is not an option. I want you to send him to the Intensive Care Unit (ICU)!"

It is not difficult to understand why relatives and friends are so distraught and often so unthinking at

such a time. Death is the ultimate existential issue. Whenever someone close to us dies, it reminds us of our own mortality. This is another of those “inconvenient truths”.

We feel guilty. Have we done enough? Did we love him enough? Ambivalence sweeps over us. We feel alternately sad, happy, guilty and relieved.

We project our fears, anger and uncertainties onto the doctors, nurses and other medical personnel. The whole scenario turns ugly. Soon, raised voices and unreasonable demands are heard. Those last 48 hours become a hellish battleground of wills and personalities.

But it need not be so.

Oncologists, palliative care specialists and oncology nurses have drawn up guidelines on how to manage the last 48 hours. The guiding principle is that patients should be comfortable, clean, pain-free and dignified.

No unrealistic measure should be undertaken. The doctors and nurses should clearly communicate these guidelines to the patient’s loved ones and carers and I am sure most of them do. I shall touch on a few salient points.

Morphine, oxygen and steroids (sometimes) play a very important role in providing comfort to the patient. An indwelling bladder catheter ensures that the bladder is empty as a full bladder can cause the patient to be restless.

Nasogastric feeding (a tube that goes through the nasal passage to the stomach) is sometimes used if the patient can no longer swallow.

Exquisite control of hypertension, diabetes and a high cholesterol level is no longer appropriate. In fact, we withdraw most of the drugs used for these chronic metabolic disorders.

Transfer to the ICU is neither warranted nor wise. This last point seems obvious but requests for such transfers are still being made. If bleeding cannot be staunched, it would help to place lots of green surgical drapes around the site of haemorrhage. White cloth would make red blood seem gory and should be avoided.

Many patients in Malaysia and Asia wish to die at home for religio-cultural reasons. By all means. Palliative care workers can instruct the patient’s carers on pain control and other symptom control.

Oxygen therapy can easily be made available anywhere. Subcutaneous hydration (giving fluids to a patient through the skin when oral intake is not possible) can be readily handled by carers at home. At least one litre of normal saline can keep the patient hydrated when swallowing is no longer possible.

Let him go gently into that good night with comfort and dignity. It is time to let go. He is at peace.

Soon, he will breathe his last. We will move on.

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