

The Dilemma of Death's Call

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He sat in my office smiling. His haircut smart, hair white, shirt bright; he appeared pleasantly content. However, in stark contrast to this serene scene, he stated plainly, "I've overstayed my welcome."

Just two days prior, he'd completed a pre-visit questionnaire through his online patient portal. It was delivered unceremoniously to my electronic in-basket. I typically delete these, preferring in-person interviews. A halting alert popped up because I hit the trash button: "C-SSRS Warning – Confirm Delete." The Columbia-Suicide Severity Rating Scale? ([Supplemental Appendix 1](#)). I opened the questionnaire.

I knew this patient well and had seen him recently. Previously employed in a stressful analytical job, he'd expressed readiness for retirement in his "golden years." He'd also been recently widowed. His decades-long sweetheart had battled valiantly. She'd ultimately met her end peacefully through hospice care. "It's how we should all hope to go," he'd declared then. So, when that C-SSRS flagged "High Risk" I blinked twice, forehead knotted.

I called him immediately.

"Hello doctor!" he answered recognizing my number. "I knew I'd hear from you," he chuckled. "Apologies for answering so frankly. I was trying to be honest with you and myself."

"Please don't apologize. I *want* you to be honest. How can I help?"

His reply was candidly clear. He denied suicidal thoughts or specific plans/action(s) for self-harm. However, he reported feeling very "blue." It was Friday afternoon, our next appointment that upcoming Monday. I was emphatic on what to do if he found himself in crisis before our visit. He carefully repeated the steps back to ensure I had communicated clearly. I provided the National Suicide Hotline number, which he wrote down stating ruefully, "You know I won't need this, doc, but thanks."

The weekend felt endless as I worried about him. He was, thankfully, one of my first appointments that Monday. Walking in, I steeled myself for an emotionally charged exam room. The opposite was true. His warm smile the same as I'd remembered, maybe even more so.

We jumped right in.

He recounted that throughout the course of his wife's illness, he'd been her primary caregiver. He perhaps retired for this; he reflected uncertainly. He'd witnessed her not quite succumb, but instead find peace with her terminal diagnosis. He'd supported her as she died gracefully, easily, on her terms. I asked about grief—was that part of what he was feeling now?

He thought about my question. A long but not uncomfortable silence ensued. "I don't think so. I'm at a point in life where I've done everything I wanted. I've just overstayed my welcome." He told me his adult children led busy lives. He kept up with them and his grandchildren intermittently. He was limited, however, by chronic pain. It was strenuous to leave the house. He didn't want to be a burden. I asked about current hobbies, interests, passions. He smiled, "Doc, a man can only watch so many Westerns." More seriously he said, "I just think when you reach a certain age, for us older folks, we should be able to choose when and how to go. I'm not scared to die."

His feelings seemed more complex than a lack of interest in his usual pleasures. He'd accomplished his desired goals and seen the world. His halcyon days were now past, but he found comfort in this, not loss. It was a kind of ennui; a listless

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purposelessness. He expressed uncertainty of what else to live for—akin to undertaking a journey happily at first, but now anxious about exactly when he'd reach his destination. To me, his loneliness was palpable.

We discussed medications for depression, but it felt like polite banter. I didn't get a sense of buy-in. When I suggested joining a senior center, he reminded me of his chronic pain. "What about the YMCA?" I said, "They have a heated pool. You can get physical therapy with water aerobics and meet people." He nodded, seeming to consider this suggestion.

Neither of us said "euthanasia,"—maybe too taboo—but our conversation felt laced with it. We talked about the blessing of dying in our sleep and the unbelievable mercy of hospice. He softly bemoaned the complicated social stigma and spiritual implications of wanting to choose how/when to die. I nodded, feeling helpless. We spoke openly of modern medicine and the consequences of living longer. We spoke of isolation and facing our own mortalities with dignity and autonomy, long after loved ones are gone. As we ended, I felt heartbroken and frustrated by the lack of resolution. We compromised that he would start therapy and I vowed to call him in 2 weeks to check in.

After he left, a heavy space remained. My throat felt lumpy, eyes prickly. As a doctor and human, it was the hardest of conversations. Much of that visit had been open-ended sentences, many trailing off without end. It was a little room full of silences and unanswerable questions.

Caring for an aging population requires niche knowledge that needs to be sought out. Often, things that are not part of normal aging get incorrectly chalked up to "old age" and dismissed. Cognitive and functional declines, ageism, and social isolation do not have easy algorithmic treatments. Even widely used clinical tools can be inadequate for older adults. The Patient Health Questionnaire (PHQ) for example, is commonly used to screen for, diagnose, and monitor depression ([Supplemental Appendix 2](#)). Our office's electronic medical record uses it. The PHQ, however, is inferior to the

Geriatric Depression Screen (GDS) for older adults, in my view. The latter was designed specifically for this population ([Supplemental Appendix 3](#)). Unsurprisingly, geriatric depression is often underrecognized and undertreated.^{1,2}

My patient's depression could have easily been missed. Outwardly, he seemed happy, his PHQ score "mild." His GDS, however, was off-the-charts positive for depression.

Patients often look to physicians for solutions. Sometimes it's harder to lend support and simply listen when no easy solutions exist. This can be especially true in geriatric care: it's hard to talk about dying. My patient's points and questions stayed with me. Like so many unanswered questions discussed that day, I'm unsure how his story ends. But maybe that's the point when caring properly for older patients. There is no ready-made template, no one-size-fits-all. The work should be tailored, delicate, and doesn't always end in quick referrals or the prescription pad. It requires subtlety, patience, and compassion. It demands partnership and relinquishing our physician desires to fix problems swiftly. It's care that needs to exist in gray zones, because unlike a movie ending, life doesn't end with a convenient fade to black.



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[Supplemental materials](#)

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