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ESSAYS/PERSONAL REFLECTIONS

A mother's love

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God could not be everywhere, and therefore he made mothers.

Jewish proverb

David was an active 25-year-old who lived on the edge: alcohol, drugs, and a youthful disdain for seat belts. But now his body, supported by the hum of a ventilator, rested silently in the surgical trauma intensive care unit, quieted 9 days ago after ejection from a truck traveling 70–100 miles per hour. And as was usual for David, he was not wearing a seat belt. Diffuse axonal injury was diagnosed, a common traumatic brain injury with a tendency for progression to a persistent vegetative state. His mother was terrified. But the neurosurgeons held out hope that with his young age and the absence of severe head trauma on a computerized scan of his head, David might recuperate, but to what level of functioning no one knew—perhaps normal, but most likely with some degree of physical and/or cognitive disability.

But after 9 days, David's mother sensed an urgency, an urgency that tugged at her heart. She had had numerous conversations with David about what he would want should he find himself in such a situation—after all, David lived a reckless life, daring death to try and capture his wild spirit. His answer was always to let him die and not condemn him to a life with a feeding tube, a tracheostomy, a wheelchair, or even worse, placement in a nursing home. But could a young, healthy, impulsive male really know what he would want in a life-threatening situation? Or was hormonal bravado the reason for his answer?

His mother, after discussion with David's wife, father, sister, and maternal and paternal grandmothers, requested withdrawal of the ventilator. They wanted to honor David's wishes, and allow him a dignified death. They were certain of the resolve of his oral advance directives, and were determined to withdraw the ventilator. And in addition, what would they do if David recovered enough to find himself incarcerated in a disabled and dysfunctional body contrary to his stated wishes? The emotional suffering would be unbearable, and his mother had no doubt that with his addictive behavior and independent character, David would not be able to cope with any disability and would, if he could, "get a gun and kill himself." Such a suicide would be unfair to David, and leave emotional scars for his caregivers and family, and most assuredly, a grief and bereavement wrought with guilt. His mother, a retired respiratory therapist, felt that her son could not survive off of the ventilator, and pleaded to withdraw without delay so he could go to his final rest.

The medical and nursing staff were ethically and morally divided on removal of the ventilator—in fact, the neurosurgeons documented their disagreement in the chart in no uncertain terms, but I have no doubt that this was their heartfelt belief, and that they were honest in their words and actions. They wanted to wait to see if David improved, but the fact remained that they could not guarantee that he would fully recover, and that element of uncertainty troubled his mother, engendering a sense of urgency in regard to withdrawal of the ventilator. I was asked to meet with David's mother to provide support and to further explore her request.

I met her at David's bedside, and heard the story of his fast and untamed life. There were multiple DUI's, cocaine charges, a period of experimentation with methamphetamine, and a freedom that although at times was irresponsible, touched a rebellious jealously from my own youth in the 1960s. But there was also a story of a maturing and growing self-awareness that was, regrettably, shadowed by drugs and alcohol. But after a prolonged visit with David's mother, I was certain of two things: she loved her son, and she undoubtedly knew what he wanted, and what he wanted was to die as he had lived:

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without regret, and without the tether of disability. This was clearly her own Gethsemane, but the show of love for her son was humbling. I agreed that the ventilator should be removed. As happens in such cases, the Ethics Committee was consulted, as was the medical center's lawyer. A family meeting was convened, and everyone attended: neurosurgeons, critical care physicians, nurses, ethicists, a lawyer, me, and David's mother and father. The meeting was long and emotional, with emotive dissension among some, but in the end, David's mother remained resolute in her decision. Her bravery and dedication to David were admirable and radiated from the heart of a mother who 25 years earlier brought forth this young and vulnerable child. Finally, after all sides were heard and the legal i's were dotted and the t's crossed, the ventilator was withdrawn, and David was transferred to an inpatient hospice center, where he died 5 hours later in the presence of his mother. It was a death that was peaceful, dignified, and in his mother's own words, "bearable and beautiful."

After he took his last breath, David's mother called me on my cell phone, and we talked for quite some time, reviewing his life and his death, but two sentences will remain with me for the rest of my life. She said: "You may think this sounds strange, but I am so blessed. I saw my son take his first breath in this world, and I saw him take his last breath; I feel so blessed." I knew she had done right, and that God had welcomed her son home.

What should we learn from this as physicians? The depth and commitment of a mother's love? Yes, of course. But we should also learn that in spite of evidence-based medicine, statistically derived prognoses, and well-intentioned clinical counsel, families know what is right, what should be done, and most importantly, what must be done. As physicians, we all bring our own beliefs, values, and life experiences to the clinical table, but irrespective of our paternalistic innuendos and prejudices, we must hear families' words, because in the end, when the last breath is taken and everlasting sleep descends, things will be as they should, and things will be as they must—and they will be all right.

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