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MONTHS TO LIVE
At the End, Offering Not a Cure but Comfort

By [ANEMONA HARTOCOLLIS](#)

Deborah Migliore was pushed into a small conference room in a wheelchair, looking kittenish in red and white pajamas and big gold hoop earrings. Her weight was down to about 90 pounds, from 116, her face gaunt, her sad eyes droopier than ever.

Dr. Sean O'Mahony had been called in to tell her the bad news: she was sicker than she realized, and the prognosis did not look good.

"What's the [cancer](#) I have?" Mrs. Migliore, a 51-year-old former cocktail waitress, asked jauntily. "I have no idea."

"Carcinoid," Dr. O'Mahony replied.

"I don't want to lose my hair," she said, laughing nervously.

"Currently, there are no established cures," the doctor said. "Think very carefully about what treatments you do and don't want to have as these issues arise."

It was what doctors in the end-of-life business call "firing a warning shot," but Mrs. Migliore did not seem to hear the bullet whizzing past.

"It's more or less, I want to be alive again," she interjected. "Going here, going there. My husband, I want to be able to do things for him."

Part psychoanalyst, part detective, Dr. O'Mahony had to listen to the cues and decide what to do next.

Most doctors do not excel at delivering bad news, decades of studies show, if only because it goes against their training to save lives, not end them. But Dr. O'Mahony, who works at [Montefiore Medical Center](#) in the Bronx, belongs to a class of doctors, known as palliative care specialists, who have made death their life's work. They study how to deliver bad news, and they do it again and again. They know secrets like who, as a rule, takes it better. They know who is more likely to suffer silently, and when is the best time to suggest a do-not-resuscitate order.

Palliative care has become a recognized subspecialty, with fellowships, hospital departments and medical school courses aimed at managing patients' last months. It has also become a focus of attacks on plans to overhaul the nation's medical system, with false but persistent rumors that the government will set up "death panels" to decide who deserves treatment. Many physicians dismiss these complaints as an absurd caricature of what palliative medicine is all about.

Still, as an aging population wrangles with how to gracefully face the certainty of death, the moral and economic questions presented by palliative care are unavoidable: How much do we want, and need, to know about the inevitable? Is the withholding of heroic treatment a blessing, a rationing of medical care or a step toward [euthanasia](#)?

A third of [Medicare](#) spending goes to patients with chronic illness in their last two years of life; the elderly, who receive much of this care, are a huge political constituency. Does calling on one more team of specialists at the end of a long and final hospital stay reduce this spending, or add another cost to already bloated medical bills?

Dr. O'Mahony and other palliative care specialists often talk about wanting to curb the excesses of the medical machine, about their disillusionment over seeing patients whose bodies and spirits had been broken by the treatment they had hoped would cure them. But their intention, in a year observing their intimate daily interactions with patients, was not to limit people's choices or speed them toward death.

Rather, Dr. O'Mahony and his colleagues were more subtle, cunning and caring than their own words sometimes suggested.

An Escort for the Dying

They are tour guides on the road to death, the equivalent of the ferryman in Greek myth who accompanied people across the river Styx to the underworld. They argue that a frank acknowledgment of the inevitability of death allows patients to concentrate on improving the quality of their lives, rather than lengthening them, to put their affairs in order and to say goodbye before it is too late.

Dr. O'Mahony, 41, went to medical school in his native Dublin, straight out of high school. He intended to go into oncology. But during training at a prominent cancer hospital in New York, he changed his mind as he saw patients return to the hospital to die miserable deaths, hooked to tubes, machines and [chemotherapy](#) bags until the end.

"In Ireland, and I think most other places, it would be very much frowned upon," he said.

Sandy-haired, a wiry marathon runner, Dr. O'Mahony is the sixth of eight children; his father is a university professor devoted to preserving Gaelic as a second language, and his mother a painter. When he was 3, his brother, who had [cerebral palsy](#), died at age 4. His awareness of his parents' helplessness, burnished through years of family conversations, helped steer him to palliative care, he said.

Dr. O'Mahony entered the field a decade ago, shaped by an almost messianic movement that began as a rebuke to traditional medicine but has become more and more integrated into routine hospital practice.

As medical director of Montefiore's palliative care service, he helps train fellows, supervises research projects and manages the pain, often with powerful drugs like fentanyl, methadone and morphine, of patients with a range of illnesses, like cancer and [AIDS](#).

He consults on questions with ethical, moral and sometimes religious overtones, like whether to remove life support. He acts as a troubleshooter with recalcitrant patients, like an elderly man who was sneaking [cigarettes](#) (they negotiated a schedule of when he could get out of bed to smoke), and advises the terminally ill and their families.

Dr. O'Mahony favors crisp button-down shirts, but no white coat. His bedside manner ranges from gentle amusement to studied neutrality; he eerily resembles the unemotive Steve McQueen of "Bullit."

His coolness is his armor. "I do not feel obligated to be sort of eternally involved with the experience of death," Dr. O'Mahony said. "It's not healthy to be there all the time."

But the danger is that "death gets to be banal," he said.

"Do you know that poem by Dylan Thomas?" Dr. O'Mahony asked with a faint smile. "After the first death, there is no other."

But How to Tell Her

He had seen many deaths before he met Debbie Migliore. She left her home in the Bronx at 19 to pursue the one talent she knew she had, looking good in a bikini.

Old photographs show her flaunting a saucy smile and a mane of black hair. "I used to be a topless dancer, excuse the expression," she said. She worked at clubs in Manhattan and upstate, and was married twice before meeting Joe.

It was a marriage of opposites. Joe had always been socially awkward and studious, a nerd, he said with a touch of defiance. He went to [New York University](#) part time, got a culinary degree and worked as a chef in a casino. Finally, he got a job with the New York City parks department as a horticulturist. Working with plants suited him, because he worked more or less alone.

He had embraced his solitude so completely that when he met Debbie he had been thinking of becoming a priest.

They met 12 years ago through a personal ad she had put in The New York Post, and married almost instantly. Joe's mother had spotted the ad, which said, roughly, "Likes to dance."

Debbie's big regret was never having children, after a [hysterectomy](#) in her 30s; Joe would have liked a large family but accepted that it was too late.

Her health started to fail soon after they married. Over the last decade, she suffered two strokes and developed an autoimmune disorder. Three or four years ago, doctors found a [tumor](#) in her lung, which was attributed to a neuroendocrine cancer known as a carcinoid tumor. She was treated through surgery and radiation. Apart from a dry [cough](#), her husband said, "she was wonderful."

In March, she broke her arm while turning a mattress. While repairing the arm, doctors found more cancer, and Dr. O'Mahony was called in to talk about her uncertain future.

They met at Morningside House, the Bronx nursing home where she was recovering from surgery, joined by Mr. Migliore, social workers, nurses and a physical therapist. For about an hour, Dr. O'Mahony asked open-ended questions, looking for clues as to how much she knew and how much she wanted to know.

"What are your biggest concerns?" was his opening move.

"First of all, the food is terrible," Mrs. Migliore said. She was trying to fatten up with spaghetti — the thought of other food disgusted her, which is often a sign of deteriorating health. But the pasta was cold, she said.

One leg would not support her weight. Her back hurt; she would like a massage. "I get annoyed when things are not my way," she said. "And I cry too much."

"Well, it's hard for most of us not to have control over things," Dr. O'Mahony said.

"Aside from the food," he pressed, "what are the things that concern you?"

"I want to get better," Mrs. Migliore said.

"What's your understanding of the status of the tumor?" Dr. O'Mahony asked.

"The doctor that took it out, he was just amazed," she said. "He says, 'Oh, Debbie, I did a good job.' I said, 'Yes, you did.'"

Dr. O'Mahony tried to remind her that she still had cancer. "One of the frustrating things about this illness is the way it can pop up in different parts of the body," he said.

Mr. Migliore joined in, asking whether there was a way to slow the growth of the cancer.

“The treatments that are available for it can provide some local control, and they can slow the progression of the illness,” Dr. O’Mahony replied.

“But there is no way of knowing it, right?” Mrs. Migliore asked, astutely, apparently registering the equivocation in the doctor’s tone.

Then Dr. O’Mahony fired his warning shot: “There are no established cures.” And Mrs. Migliore fired back with her wish to be “alive again.”

Picking up on her cue, Dr. O’Mahony asked, “What gives you strength?” She liked to shop, she said. Perking up, she chided her husband for forgetting to bring the Victoria’s Secret catalog.

“You sit home and watch ‘I Love Lucy,’ ” Mr. Migliore said. “Do you think ‘I Love Lucy’ cares if you wear a \$400 outfit or a \$22.95?”

The meeting ended on a lighthearted note, and Dr. O’Mahony never returned to the prognosis that the nursing home staff thought Mrs. Migliore would want to know.

Beyond Mrs. Migliore’s hearing, he said: “People giving very concrete estimates of survival can in essence cause as much harm as good. I think she was signaling to us quite a lot that it was important to her to be able to go home, to walk, to be able to promote her self-image, to shop for clothes.”

He predicted that her disease would progress, perhaps rapidly, through a series of crippling events.

But he said he had learned from mistakes early in his career that it was not always helpful to presume to have answers, to mark a spot on the calendar. He said he would rather focus on things he really could help with, like making sure Mrs. Migliore was getting enough pain medication.

But before leaving, he made sure that she had a health care proxy — her husband — who would make decisions for her if she became incapacitated. He knew it would be harder to get one later.

Palliative care doctors are taught to lead by example. Dr. O’Mahony’s proxy is his companion, an oncologist himself.

But Dr. O’Mahony does not press hard for a written advance directive, sometimes called a [living will](#), in which patients can specify treatments — like [cardiopulmonary resuscitation](#), breathing machines, [dialysis](#), transplantation, blood transfusion, [antibiotics](#), and food and water delivered through a tube — that they would or would not want if they were unable to speak for themselves. “The mere fact of putting words on paper may be very distressing,” he said.

Perfecting the Technique

Delivering a grim prognosis used to be something that doctors figured out how to do on their own, or did not do at all.

Now “Breaking Bad News” is a standard part of the curriculum at many [medical schools](#), including the [Albert Einstein College of Medicine](#), the school affiliated with Montefiore.

In an experimental role-playing exercise, fourth-year medical students were given 10 minutes to tell an actress, Susan Telcher, that her [mammogram](#) indicated a high likelihood of [breast cancer](#). During one session, led by Dr. Charles Schwartz, a wisecracking internist and psychiatrist armed with a stopwatch and a Coke, not every student proved to be a natural.

The students, most in their late 20s, often had a hard time getting beyond medical jargon. One of them, who planned to become a pediatrician, failed to read the handout on the patient, with disastrous results. She spent most of her 10 minutes sneaking peeks at the clinical notes, trying to divine the problem, while the actress blithely chattered on about how well she had been feeling.

A student named Paul (most asked to have their last names withheld for fear of harming their careers) told Ms. Telcher that her mammogram had revealed a “finding.”

“You’ve got to get that cancer word out there early and often,” Dr. Schwartz admonished.

Students often excuse a poor performance by saying they would have behaved differently in real life. But “the data is, they do what they do,” said Dr. Schwartz, who conducts the training with Dr. Sharon Parish, an associate professor of clinical medicine at Einstein.

In his experience, physicians who themselves have signed advance directives are more comfortable talking to their patients about dying.

But Dr. Nicholas Christakis, an internist and social scientist at Harvard who has studied end-of-life care, has found that doctors are generally bad at making prognoses. The better they know a patient, the worse they are at prognosticating, possibly, Dr. Christakis has theorized, because they view death as a personal failure. Most predictions are overly optimistic, he has found, and the sicker the patient, the more likely the doctor is to overestimate the length of survival.

In one study by Dr. Christakis, doctors who privately believed that patients had 75 days to live told them they had 90; the actual median survival period was 26 days.

“Go to the bathroom mirror, look yourself in the mirror and say, ‘You’re dying,’ ” Dr. Christakis said. “It’s not easy.”

Lessons Learned

Along the way, Dr. O'Mahony has picked up the wisdom of the trade. He has learned that older people tend to take bad news better than younger people.

That patients with advanced cancer generally go into a sharp decline three months before death, but those with [dementia](#), heart disease or [diabetes](#) may have a bad month and then get better, making their prognosis trickier.

That people who do not have family or friends, or are alienated from them, are more likely to want to hasten death than those with more social support.

That patients who are agreeable by nature may not admit that they are in pain.

That people who blame their self-destructive behavior for their illness are less likely to ask for help, and that hard-charging professionals sometimes would rather not manage their own illness.

That people can know in their darker moments that the prognosis is grim, yet at other moments imagine they will go back to being their old selves.

And Dr. O'Mahony knows that the family is sometimes best at delivering bad news, as in the case of Eddie Ascanio.

Mr. Ascanio, a 52-year-old limousine garage attendant, arrived in Montefiore's emergency room last spring, in the last stages of [head and neck cancer](#).

The palliative care staff immediately called a meeting of Mr. Ascanio's family members to determine whether they realized he was near death.

Mr. Ascanio was too angry about being in the hospital to attend the meeting. His sister, Helen Wilson, who had taken on the role of family anchor while her husband, a plumber, served time for bank robbery, told the doctors she had brought her brother to Montefiore because she was unhappy with his treatment at another hospital.

"Listen, I need to know what's going on with my brother; he's losing massive weight, not eating," she said she had begged the previous doctor. "Something is not right."

Two doctors on Dr. O'Mahony's team listened quietly, and she seemed relieved just to be able to talk things through. When one of the doctors asked if she wanted to take her brother home to die, she said, "That probably will make him very happy. We'll set him up in my daughter's bedroom."

Her nephew, Tony, balked. "Is that to say there isn't even a 1 percent chance of recovery?" he said.

Mrs. Wilson answered before the doctors could. “The cancer’s spread too far, Tony,” she said. Mr. Ascanio died four days later, in his niece’s bedroom, surrounded by stuffed animals and his family.

Lagging on Hospice Care

While palliative care is available to give patients a chance to die without being tormented by excessive medical care, statistics suggest that in New York, the world center of academic medicine, aggressive treatment is still the rule.

At Montefiore, only 12 percent of dying patients from 2001 to 2005 entered [hospice care](#), for an average of 4.9 days, during their last six months of life, according to the latest data from the Dartmouth Atlas of Health Care.

At Mount Sinai, it was 14 percent of patients for 4.6 days; at NewYork-Presbyterian, 15 percent for 5.2 days; and at [New York University Medical Center](#), 20 percent for 6.7 days, according to the Dartmouth data.

Nationally, nearly 32 percent of dying patients had hospice care during the same period, for an average of 11.6 days.

In New York, hospice is “brink-of-death care,” said Dr. Ira Byock, the director of palliative medicine at Dartmouth-Hitchcock Medical Center in Lebanon, N.H., and the author of “Dying Well.”

While treatments that try to extend lives produce more fees for doctors and [hospitals](#), they may be given for reasons besides money. “Many clinicians don’t want to send the message that they’re giving up on their patients,” said Dr. David Goodman, a co-author of the Dartmouth Atlas. “They see palliative care as diminishing hope.”

Dr. O’Mahony suggested that family finances also played a part in decisions on hospice care, because Medicare typically covers only a few hours a day of such care at home.

The health care bill being discussed in the House would ensure Medicare reimbursement for consultations about end-of-life treatment between patients and their doctors, [nurse practitioners](#) or physician assistants every five years, or more often in the case of a life-threatening change.

The bill would help validate the work of palliative care doctors, who often work on salary and whose services are often subsidized by the rest of the hospital because they do not generate much revenue.

But the provision has fueled criticism. Former Gov. [Sarah Palin](#) of Alaska has raised the specter of “death panels” that would rule on whether to treat defenseless patients like her son Trig, who has [Down syndrome](#). While there is nothing in the House bill to suggest that such panels would exist, the end-of-life language became so radioactive that several members of the Senate Finance Committee said they would not include it in their version of the bill.

The [Congressional Budget Office](#) estimated that the proposal would cost \$2.7 billion over 10 years.

There was no estimate of savings at the other end, from patients forgoing expensive tests and treatment. A few studies have found that hospital care for patients who get palliative care consultations costs thousands of dollars less than care for those who do not. But some of these studies have been conducted by advocates, and they have looked at hospital costs after the fact, rather than using randomized controlled trials, the gold standard in medical research.

The author of one study, Dr. Edmond Bendaly, an oncologist in Marion, Ind., said cost studies had been hampered by the ethical and practical difficulties of signing up dying patients for trials that might provide disparate care. But he said the research so far showed a “strong signal” of savings from palliative care.

Dr. O’Mahony and his colleagues are well aware of the ethical debates over the boundaries between proper conduct and euthanasia. “We’re not vested in having patients refuse treatment,” Dr. O’Mahony said. “We are there to support patients and their families.”

Families sometimes worry that by refusing treatment for a patient — especially food and water, which are so closely associated with comfort and love — they are approaching euthanasia.

Deep sedation, to the point of [unconsciousness](#), may also be used to relieve intractable suffering, and it “has caused almost as much distress and debate in the palliative care-hospice world as euthanasia has,” said Dr. David Casarett, a palliative care doctor at the [University of Pennsylvania](#), who is leading a national evaluation of end-of-life care at Veterans Affairs hospitals.

“Is it used to end a life, or up until the end of life?” Dr. Casarett said, summarizing the debate. Among those who use it, he said, the consensus is that “we would never sedate with the goal of hastening death.”

Palliative care doctors talk about the difference between prolonging life and prolonging death.

“So it’s not euthanasia,” said Dr. Desiree Pardi, who went into palliative care after learning that she had breast cancer, and is now the director of the service at the Weill Cornell Medical College of NewYork-Presbyterian Hospital. “It’s just sort of letting them die completely naturally. It’s hard to explain to a lay person, because we know we need food and liquid to live. But we don’t need them to die. We’re just feeding whatever is killing them.”

In the political wars over end-of-life care, advocacy groups for the disabled are often as adamant as religious groups in challenging measures that could be seen as hastening death. “Health care providers encounter people at a time of crisis; they see the worst happening,” said Diane Coleman, the founder of an advocacy group for the disabled, Not Dead Yet. “They don’t see them get through it and say, ‘Even with my functional losses, I’m still having a good time.’ ”

A Resistance Among Doctors

Palliative care still goes against the core beliefs of many doctors.

In a teaching session one day last winter, Dr. Lauren Shaiova criticized a group of idealistic young residents for sending a 42-year-old patient with end-stage [liver disease](#) and a lifetime of drinking to a nearby hospital for a [liver transplant](#).

Dr. Shaiova is a friend of Dr. O'Mahony's — he marched in her wedding procession — and is chief of palliative care at Metropolitan Hospital, a city-run hospital serving the poor and working class of East Harlem.

She is also Dr. O'Mahony's counterpoint, demonstrative and impulsive where he is cautious and unemotional. Married to a hospice doctor, with three young children adopted from Russia, Dr. Shaiova, 50, would be a rebel and something of a nonconformist in most settings. She plays a harmonium for chemotherapy patients and chants a Buddhist prayer before staff meetings. She says that her husband once confided to her, as they were lying in bed one night, that he was not afraid to die. Her Russian grandmother in Brighton Beach has made a do-not-resuscitate order, and so has she.

Dr. Shaiova's older brother, Michael, a car mechanic, was shot in the head on a street in Chicago, their hometown. She heard the news from emergency room doctors who called to ask about "harvesting" his organs.

"Harvest?" Dr. Shaiova recalled thinking. "I'm growing beans? Nobody was willing to say he was brain-dead."

Now, facing the abashed residents in their white coats, she reviewed the history of the patient, who was living in a single-room-occupancy hotel: He was agitated and confused, and had alcoholic brain damage. He could no longer walk. To qualify for a transplant, he had to be alcohol-free for six months.

"We had done a day's work on him — got the D.N.R., treated his pain, arranged for hospice," she said. The receiving hospital, she believed, was part of the conspiracy of denial, only too happy to get the payment for accepting the patient, who ended up dying before he could be evaluated.

But, several residents objected, the man kept asking for a liver transplant. It seemed unprofessional, even inhumane, to refuse.

"They say when a person is drunk or out of it, he tells the truth," one resident said. "His options should not stop."

"Was it really a viable option for him?" Dr. Shaiova demanded.

"Maybe we should take it as a last wish," the senior resident said, from the back of the room.

Dr. Shaiova said they should have realized the patient would never survive. “Doctors are the worst predictors,” she said after the session.

Asked how she deals with the death of her patients, Dr. Shaiova said, “I play the harmonium.”

Her Final Days

In early June, Dr. O’Mahony went to Ireland on vacation. He was looking forward to seeing his mother, Kathrina, 74. She had received a diagnosis of breast cancer in 1995. The cancer returned in 2006, and she was told it was not possible to remove all of the tumor.

She had recently painted over the image of her body on a PET-[CT scan](#), used to confirm the presence of a local recurrence of cancer. “I got her the scan,” Dr. O’Mahony said gleefully.

While Dr. O’Mahony was away, Mrs. Migliore received radiation to try to shrink a tumor that the doctors said could wrap around her spine and paralyze her. She would return from the treatments — administered every day for 29 days, her husband said — in a stupor. “Most of these doctors are convinced they’re doing the right thing,” he said. “It’s just that I don’t want to have a walking wife who’s in zombieland, you know?”

He was taking things a day at a time, and taking [sedatives](#). “I’m on 350 milligrams of [Zoloft](#) every day, so I feel pretty good,” he said.

When Dr. O’Mahony returned, he learned that Mrs. Migliore had been admitted to Montefiore a few days earlier, as cancer infiltrated her bone marrow and she became dehydrated. He scheduled a bedside conference his first day back.

Mrs. Migliore could no longer walk, or even sit up on her own. She was checked in to Room 954A North. Her window had a panoramic view of the Bronx, with Calvary Hospital, which cares for terminal cancer patients, in the foreground, its red-brick bulk marked by three crosses.

Dr. O’Mahony and Mr. Migliore stood side by side at the foot of the bed. Mrs. Migliore looked incorporeal, so slight she melted into the bedsheets.

“So we’re just here to see how you’re doing today,” Dr. O’Mahony began.

“Well, I want to go home; that’s all I want to do,” Mrs. Migliore said. “I do not want to stay here.”

“O.K.,” her husband answered, sniffing.

“So when are you taking me home?” Mrs. Migliore said.

“Well, we just need to get you a little bit stronger, O.K.?” Mr. Migliore said. “That’s what we’re here to discuss. We’re here to tell you what’s going on.”

“How are you doing?” Mrs. Migliore asked her husband, her voice softening.

“I’m doing O.K.,” he said.

Growing agitated, Mrs. Migliore said that a woman at the nursing home had tried to marry her. She said that she objected that she was already married, and that she was locked into a room in what seemed to be a funeral home. She said she had thrown china plates out the window in a vain bid to be rescued. It sounded like an elaborate parable about the bride of death, and her husband could not convince her that it was all in her head.

Turning to a visitor, she kept asking, “Are you pregnant?” as if she wished she herself could be.

Dr. O’Mahony adjourned the conversation to a conference room, leaving Mrs. Migliore alone.

Mr. Migliore immediately asked how much time his wife had left.

“I can’t give a definite response in terms of the number of days or weeks,” Dr. O’Mahony said.

Mr. Migliore said another doctor at the hospital had estimated four to six months.

Dr. O’Mahony gave his standard warning: It is hard to go from prognostic estimates based on large populations to individual cases. Nonetheless, he conceded that she was getting much worse.

Mr. Migliore said he did not think he could take care of her at home and proposed she go to Calvary. “How do we convince her this is the right decision?” he asked.

“During these times when her thinking is impaired, you are her voice,” Dr. O’Mahony replied.

Two days later, Mrs. Migliore was across the street at Calvary. Her husband tacked photos of their wedding to the bulletin board. Within a few days, her speech had deteriorated to “baby talk,” as her husband put it, and she was eating little more than Italian ices.

She turned 52 on June 30, and her husband managed to feed her a spoonful of birthday cake. He was thrilled when she said it tasted like excrement. For that moment, she sounded like herself.

Much of the time, she was heavily sedated to stop her from screaming. She was given morphine for pain and haloperidol, an antipsychotic, for [delirium](#), which can be a side effect of advanced cancer and opiate drugs. "She seems terrified," Mr. Migliore said.

He said the staff had asked if they should disconnect the tube feeding her sugar and water. "Then what, she starves to death?" Mr. Migliore said. "I can't. I can't, even though I'm the proxy." A fatal injection, if that were possible, seemed more merciful to him. "The way things are going now at this point," he said, "I'm hoping God takes her tonight. Living like this is barbaric."

He got his wish three days later. "She never asked me, 'Am I going to die?'" he said, so he never had to do what he feared most: give her an answer.

Mrs. Migliore died on July 3, after eight days at Calvary, less than four months after Dr. O'Mahony fired his warning shot. He had several conversations with her before she died, a luxury that other types of doctors might not have. But he never told her directly that she was going to die.

Asked why, Dr. O'Mahony said that Mrs. Migliore had appointed her husband as her surrogate, and that she had responded to open-ended questions with a focus on the details of her everyday life, rather than a desire to foresee the future. He saw that as a road map for his approach to her prognosis.

"Patients sometimes will be very explicit about wanting that information very, very clearly delivered," he said. "Whereas other people don't."

Dr. O'Mahony has not spoken to Mr. Migliore since his wife died, and he does not expect to. Once the ferryman has delivered his patients across the river, he rarely looks back.