MISTER JONES!

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Inevitably, every physician will be called upon to declare a patient dead. For me, the moment arrived late one July evening in 1981 during my first night on call as an intern at the Montreal General. Even though our early medical education at McGill had involved cadavers rather than the living, we were never taught that essential privilege of physicians — how to declare someone's life officially over. By the time the cadavers were ready for us to learn the essentials of human anatomy, the issue of defining the end of life had been clearly addressed and resolved by others.

Assigned to an internal medicine clinical teaching unit, I found myself carrying out a routine admission off-service on another floor when my pager beckoned. The night nurse on my home ward was calling to advise that Mr. Jones (not even close to his real name) had died. Mr. Jones, who had a terminal illness at an advanced age, was expected to die. There was to be "no code" as far as resuscitation went, and his death would not surprise the staff or his family. I thanked the nurse for letting me know and as I prepared to hang up the phone and return to my living patient, she chided me: "I need you to declare him dead."

I hesitated momentarily and then assumed the mantle of my new profession and confidently answered into the receiver, "I declare him dead." A small yet interminable silence followed. Then, in a more stentorian tone, the nurse advised me that I actually needed to come to the ward to declare the patient dead. I acknowledged this with a cavalier laugh, letting her know we shared collegially my ruse of ignorance as an antidote to an otherwise sombre event.

Hanging up the phone, I immediately reached for the *Washington Manual of Medical Therapeutics*, whose coil binding stretched the seam of my lab-coat pocket. I thumbed through the index to no avail; there was nothing about death, declaration, or declaration of death. There were still

8 hours left in my on-call shift and I sensed that my final visit to Mr. Jones should precede the onset of *rigor mortis*. Ignoring the small rivulets of sweat at my temples, I proceeded to my ward. In the dimly lit nursing station, the now suspicious nurse greeted me perfunctorily and handed me a basket of medical examining equipment. "He's in Room 12," she announced as I strode confidently down the darkened hall, lugging the equivalent of a medical supply house shopping spree.

I pushed open the door of the single room. Mr. Jones was sitting bolt upright in a raised bed, eyes staring forward glassily. Cautiously, I proceeded toward the bedside, carefully noting the absence of chest-wall excursions and breath sounds that would otherwise undermine my task. Arriving at the rails of his bed, I clutched them firmly. My gaze met his. I paused for a moment, studied his face and yelled: "MISTER JONES !"

No response. I continued to stare at him, wondering what more subtle test of lingering life I could devise, when I heard barely suppressed giggling near the door. The nurse, unbeknown to me, had followed me into the room.

I blithely reassured her with a "just kidding" and indicated I would get on with my real job from here on in her absence. She left, although her footsteps stopped sounding the moment the door closed. To this day I suspect she lingered to collect more acoustic evidence of my innovative approach.

By this point, my confidence that this patient had died was growing. There were no findings on chest auscultation except for my own shallow tachypnea. The patient lacked a pulse. There was no rebound tenderness on abdominal exam and really no guarding. None of the eponymous signs I could remember from DeGowin and DeGowin's *Bedside Diagnostic Examination* — Homans', Murphy's, Romberg's and others — was present. My newfound mastery of ophthalmoscopic examination was no doubt aided by the extreme dilation of his pupils. There were, however, no detectable venous pulsations. In short, I may have given Mr. Jones a more thorough physical examination than he ever underwent in life. I wasn't going to screw this up.

Later that evening I concluded my evaluation and shared my findings with the completely perplexed nurse and the utterly relieved family. "I'm afraid he's dead," I told them all. My lingering fear, of course, was that he was not.

Most Canadian medical schools have moved beyond the Flexner report and have incorporated the best of the innovations of the McMaster model of education. Today our students are taught much more about the importance of communication between doctors, patients and their friends and families, especially when it comes to difficult issues like death and dying.

I hope someone is teaching them that important technical skill of declaring someone dead. Police on TV can do it in a second by brushing a hand against a bad guy's neck, and families have known how to do it for centuries.

The power to make this declaration, and its very intimacy, are important components of our privileges as physicians.

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