

Final Request

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HOW TO CITE: Haq C. Final Request. *Fam Med.* 2025;57(7):513–515.

doi: [10.22454/FamMed.2025.946029](https://doi.org/10.22454/FamMed.2025.946029)

PUBLISHED: 2 July 2025

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Santa Catalina Island seemed like a great place to work part-time after retirement. An hour-long ferry ride from my home in Southern California, the health center needed family physicians to care for their population of 4,000 year-round residents and more than 1 million visitors per year. People may live on only 12% the island. The remainder is protected for a dazzling array of endemic and endangered species of plants, animals, and marine life.

Catalina Island Health includes a rural hospital and clinic. The emergency department, open 24/7, coordinates helicopter transport for unstable patients. The clinic provides care for patients of all ages. Patients with potential infectious diseases are seen at a picnic table on the patio.

Mr T.,* age 90, Ms D., and I met on a bright sunny day on the patio. They had met as teachers, been married 57 years, and lived on Catalina for decades. Mr T. had recently developed profound fatigue with anorexia. They thought he might have COVID-19. Physical exam revealed an irregular heart rhythm, harsh murmur, coarse rales, and pitting edema. Labs revealed elevated creatinine, BUN, and BNP; COVID PCR was negative. Following our visit, I called him to discuss the results, adjust medications, and to submit electronic consultation requests with his nephrologist and cardiologist on the mainland.

Mr T. returned the following week. He was still fatigued. Labs revealed increased creatinine and BUN. I suggested he might benefit from treatment on the mainland. However, he declined further travel. He wanted to remain in the place he dearly loved. I adjusted his diuretics and ordered dietary supplements. Because he had not completed advance directives, we reviewed California's Physician Orders for Life-Sustaining Treatment.¹

The following week, Ms D. came alone for Mr T.'s appointment. He was too tired to get out of bed. She asked, "Will he get better?" I offered to make a house call and suggested hospice.

After clinic, I walked uphill to their home. Ms D. led me upstairs to the bedroom where Mr T. was resting. His window overlooked bluffs, fields, and the local school. His blood pressure was low, with pulmonary rales and 2+ edema. Mr T. asked to speak with me privately. Ms D. excused herself.

Mr T. began, "I have a request."

"Yes," I replied, "anything."

He went on, "This is the end. I'm ready. Can you help get this over as quickly as possible?"

I was taken aback, so confirmed, "Are you ready to die? Do you want me to help?"

"Yes," he replied.

The California End-of-Life Option Act (EOLA) clearly describes steps for medical aid-in-dying.² The request must be initiated by a competent patient with a life expectancy of less than 6 months; two discussions must be documented 2 days apart; another physician must confirm the appropriateness; an affidavit is signed and witnessed; competent caregivers stand by.

I had never received a direct request and explained this could take time. Did I have permission to discuss with Ms D.?

"Yes," he agreed.

In the meantime, would he accept hospice? He needed a hospital bed and more.

“No,” he declined.

I went downstairs to talk with Ms D.

“What?” she asked. “He wants to kill himself? Not on my watch.”

I explained that Mr T. accepted the end of life. Rather than prolonging suffering, he wished to expedite the inevitable. I could help but would need to determine the process on the island.

Back at the clinic, colleagues didn’t know about EOLA. I asked whether they might serve as consulting physicians. They were willing to learn. An academic health center provided forms³ and recommended a pharmacy to ship the drugs. While Medicare covers costs for hospice, it does not cover aid-in-dying. The medications would cost at least \$800 out of pocket.

As I gathered information, I wrestled with the ethics. Could I support this in good conscience? I took an oath to preserve life. However, physicians often artificially extend life beyond when death would naturally occur. Prolongation of suffering is another ethical dilemma. I have counseled many families about when it was time to stop life support. This was not assisting suicide but supporting a patient’s request for alleviation of suffering at the end of life.

When I followed up, Ms D. was adamant that she would not support medical aid-in-dying. I was relieved when they agreed to consult hospice. The following day, the hospice nurse and I returned to the patient’s home. The nurse listened carefully. If the patient wanted to complete steps for medical aid-in-dying, they would not help. However, they could look the other way.

My month on the island was coming to an end. Colleagues and hospice agreed to provide follow-up. During our final visit, I sat on Mr T.’s bedside and reminded him he was loved, respected, and appreciated. He would be sorely missed. He was in good hands. I wished him peace.

He asked, “Will I see you again?”

I replied, “Yes, but not in person.”

As I was leaving, Ms D. gave me a handmade ceramic angel kneeling in prayer.

I shed tears as my ferry departed, sad I was leaving and inspired by the people and beauty of Catalina. Mr T. and Ms D. had entrusted me with their fears and wishes. Although they did not agree on the EOLA, this was not a decision to rush. I looked forward to returning.

Family doctors value longitudinal relationships. I needed follow-up, so I called Ms D. a month later. Mr T. had rallied.

She said, “We’ll do whatever he wants. In the meantime, we are enjoying every day.”

Nine months later, Mr T. died peacefully at home with his wife, supported by hospice. His wife remained grateful.

This brief experience was a profound lesson in humility. Physicians cannot always determine the best steps or precise timeline for each person’s journey through the end of life. Nevertheless, I found it a privilege to provide options in the context of uncertainty.

AUTHOR NOTE

* Patient granted permission to share his story; names have been concealed for privacy.

ACKNOWLEDGMENTS

Thank you to Drs Ron Pust and Heather Haq for their feedback on the manuscript.

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