But even this solution is not sufficient. As a liberal society, we take pride in protecting the rights of minorities against the tyranny of the majority. Of all the unpopular values and preferences that we might respect, should not we favor those that have life-or-death consequences for the persons involved? Families live with the memories of the death of a loved one for years; certainly their religious, cultural, and personal preferences during that process should be honored, or at least tolerated, whenever possible.

The principal advantage of the Texas Advance Directives Act is that it provides a path for resolving intractable dilemmas in situations in which clinicians may feel compelled to do whatever patients and families demand. The law may therefore serve a useful purpose when patients are subjected to unwarranted pain and suffering or when clinicians have defensible claims that these demands compromise their moral integrity.

On the other hand, the Texas law's effectiveness as a mechanism for reaching closure in difficult cases is also what makes it most problematic. It relies on a due-process approach that is more illusory than real and that risks becoming a rubber-stamp mechanism for systematically overriding families' requests that seem unreasonable to the clinicians involved. During a 2-year period at Baylor Health Care System, for example, the ethics committee agreed with the clinical team's futility assessment in 43 of 47 cases.[1] Although there may be cases in which the law should be used to trump the demands of patients and families, it is doubtful that the Gonzales case was one of them. Rather than jeopardize the respect we hold for diversity and minority viewpoints, I believe that in cases like that of Emilio Gonzales, we should seek to enhance our capacity to tolerate the choices of others, even when we believe they are wrong.

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The Art of Letting Go

Ranjana Srivastava, F.R.A.C.P.

"Is there any money we need to pay? Is that why you won't treat him?"

Her face wears a hunted expression; her slender frame is weighed down by fatigue and untold distress. In her native country, people died for lack of sufficient funds for treatment.

"No, no," I hurry to reassure her. "This has nothing to do with money. Health care is free here. It is just that he is not well enough to have treatment."

"Anything, doctor — we will do anything to make him better. We have three young children."

"I know."

She walks down the corridor, whispering a prayer. I feel sick with the unfairness of life.

Her husband felt well 2 months ago. Last month, he developed an irritating cough that would not resolve with multiple courses of antibiotics. A CT scan of his chest revealed some suspicious opacities. When he rapidly became anemic, he was immediately admitted to the hospital for further tests. A gastroscopy uncovered a sinister gastric carcinoma, and further staging demonstrated the involvement of multiple lymph nodes. Simultaneously, his liver function started to deteriorate. The medical unit requested an oncology consultation. The entire sequence of events took place within a matter of days.

I met the patient and his wife on the medical unit. He walked in slowly, holding onto an IV pole with a saline bag on it. His skin was jaundiced, his face filled with telltale signs of sleepless nights. Small pieces of cotton-wool marked failed attempts at venipuncture. "He has lost a lot of weight, and his back hurts," his wife offered. "I am tired and sweating a lot," he added. I was not surprised at the revelation. The cancer was highly catabolic. His hematologic reserve was dissipating every day; he had already required transfusion support. The skyrocketing liver-function readings beggared belief. The diagnosis of metastatic gastric carcinoma had been clearly established but for an unexpected occurrence — repeated imaging failed to

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demonstrate any distinct liver abnormality, even as the liver continued to fail. This enigma led to a debate over the origin of the liver disease: Was it related to cancer or to the prolonged use of multiple antibiotics preceding the diagnosis? With the numbers worsening faster than one could perform blood tests, the question was more a matter of intellectual interest than clinical relevance. The patient was dying.

I informed the couple about the incurable nature of the man's cancer and the serious obstacle to systemic chemotherapy presented by his poor hepatic and hematologic reserves. They absorbed some of this information, but their chief concern was that he be transferred to the oncology unit, where treatment could begin straightaway. I did not think he would recover enough to receive chemotherapy but hoped that an oncology unit would be better equipped to deal with the many ramifications of the hopeless situation unfolding before us.

"So is there nothing you can do to cure this?" his wife pleaded. I strove to curb the impulsive stream of false reassurances about to spring from my lips and instead corrected her gently.

"There may not be any chemotherapy we can give," I said, "but there are other things we can do to make him more comfortable."

The weary patient looked longingly toward the exit, but his wife was unconvinced.

"Maybe when he gets to oncology, they will think of something else," she murmured to no one in particular.

He has been on the oncology ward for 3 days now. It has rapidly become clear that his health is beyond salvage, his days numbered. Daily blood tests demarcate a dismal trail, his hemoglobin and bilirubin edging dangerously toward the wrong end of the spectrum. Not involved in his day-to-day care after his transfer, I drop by to see him.

"They are waiting to see what the liver does," his wife relays. "He could still have some treatment. . . ."

Out of the corner of my eye, I see that he is looking less hopeful than his wife and ask him, "Have you thought of getting home for a while? Maybe a few hours outside will feel good."

He breaks into a smile. With childlike eagerness, he says, "I have a strong faith. It would be great to get to church on Sunday."

His wife speaks slowly. "But they still have to do tests. He can have chemo if the liver gets better."

I try to reassure him about going out for just a few hours, but his interest soon fades. He is hostage to a futile hope of therapy, fueled by his wife's desperation. He mentions the uncertainty surrounding medical conversations and expresses a desire to "know for sure." Other things he and his wife say indicate that they have sized up the ominous nature of his illness quite accurately. He knows he is dying. We know he is dying. But we are reluctant to acknowledge it, instead finding distractions that will carry us into another day.

So he remains an inpatient, undergoing an astounding array of tests, fielding barrages of questions, expecting a turnaround any day now, even as he presides over the decline of his body. First the walls confine him, then the limitations of his physicians. We sidestep the conversation about prognosis, so much more at ease discussing the various reasons his liver could be failing or ordering new tests whose only value lies in permitting us to avoid a meaningful discussion about palliation. Each time he edges toward closure, our conversations introduce new and confusing avenues of hope, hope that may be sustained at least until the next ward round. We may not do this intentionally, but it is easier than facing what stares us in the eye: his death. I curse the modern medicine that permits us such an excuse.

His failing liver has stained his skin a deep, striking yellow, against which the gleaming white of his teeth looks macabre. His dim, hollow eyes, bloated abdomen, and lax skinfolds add to the haunting image. The oncology fellow takes me completely by surprise when he reveals that a liver biopsy is being contemplated to ascertain the reason for the patient's liver failure. The fellow explains that the patient may get "a bit of chemo" afterward, adding, "He is desperate; he will take anything for his children."

"Even an early, toxicity-driven death?" I ask, dismayed at our inability to recognize our own limitations.

"But he is so young," the fellow protests. "It's hard to let go." I realize he has hit the nail on the head. It is hard to let go. There is no room in our psyche for accepting the wrath of nature or the vagaries of the human constitution. It is hard to let go, and no one really teaches us how.

I find the patient lying in bed, his wife pacing the corridor.

"I can't believe this," she says, her face streaked with tears.

I ask him how he feels. Not so good, he reports.

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"They are having a hard time getting blood from me," he says. I note the gentle reprimand in his voice.

"I will see that we cut back," I promise.

"I am praying. That's the only thing that can help now." Overcome by a rising tide of sadness, all I can muster is, "Prayer can be very helpful in such times." I think cynically that prayer has a greater chance of benefiting him than chemotherapy. Many patients have said that prayer infuses some spirituality and meaning into such wretched situations. If we cannot ease him into the process of dying, we ought to be grateful for his trying.

He is saved from a liver biopsy by the radiologist's refusal to perform it. As if to underscore that he has had enough, the patient dies the next morning. The room is filled with a stunned silence, punctuated by despairing words of incredulity that this could have happened to a family man, a man who had done no wrong. There are no words of consolation powerful enough to cut through the grief. Among the staff, his death elicits familiar expressions of sympathy. We are all dumbstruck, in awe of a disease that could strike so swiftly. This death makes us pause for thought.

As I drive home, the fellow's words echo in my ears: "It's hard to let go." I recall an exchange I had one Friday night during my fellowship, when I was hurrying to an urgent consult. As I jabbed anxiously at the elevator button, my attending remarked, "The most difficult lesson you will learn is when to stand back and do nothing."

The two statements represent two sides of the same coin, encapsulating a dilemma of modern medicine that is bound to grow. Throughout medical training, residency, and beyond, we learn how to combat disease, equating our duty of healing with the mission of curing, leaving little room for uncertainty, let alone death. As we celebrate ever more spectacular advances in medicine, we almost will ourselves to forget the plethora of diseases that are fated to be chronic, incurable, and, on occasion, terminal. In fact, it is the very achievements of medicine that have underscored the importance of effective palliation, since not all patients will be suited to or will benefit from the wide array of tests, drugs, and interventions. We need to feel comfortable caring for our patients even when we run out of new ideas. It behooves the medical fraternity to strongly encourage and invest in sound training in palliative care, ethics, and communication, areas that are often perceived as optional extras in the making of a physician.

These are exciting times in medicine. But let us not forget that no therapeutic discovery will ever eliminate the need for good judgment, sensitive communication, and the art of letting go.

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The Age of Teleradiology

Robert Steinbrook, M.D.

Teleradiology has become an essential part of the practice of radiology, with broad implications for care delivery and the organization of work. The same technology that can transmit a radiograph or a computed tomographic (CT) scan obtained at night at an emergency department in Philadelphia to Bangalore, India, for reading during the day can move any digital radiograph anywhere at any time.[1] Within minutes, images can appear on the desktop of a radiologist at home, in an office several floors away from a central reading room, or at another hospital. Studies can be transmitted to the referring physician, a workstation in the operating room, a specialty radiologist for a second opinion, or a "nighthawk" company for after-hours coverage.

The continuing transformation of radiology is made possible by advances in computing and networking and by the conversion of more departments to entirely digital operations. At the same time, the volume of imaging services is growing dramatically, creating business opportunities. For example, between 1999 and 2004, imaging services grew more rapidly than any other type of physician service paid for by Medicare (see Figure 1). Nonetheless, a shortage of diagnostic radiologists has eased, apparently because radiologists have increased their productivity.[2]

A recent study found that 67% of all radiology practices in the United States (which included 78% of all radiologists) reported using teleradiology in 2003 (see Figure 2A); the most common users were private practices and medium-sized practices (consisting of 5 to 14 radiologists).[3] The most common purpose was to transmit images to radiologists at home; about a quar-

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