One of the most revered obligations of a physician is to alleviate human suffering, particularly when death is imminent and the indignities of illness consume every waking minute.¹ Lamentably, physicians all too often fail to address the terminal nature of patients’ diseases and instead offer therapies that in all likelihood will not prolong life and, in many instances, may generate additional suffering.² Such therapeutic strategies are often misdirected efforts to provide hope to patients and assuage physicians’ impotency over a disease process. In so doing, however, patients are deprived of opportunities to reconcile relationships, grant and receive forgiveness, and prepare for impending death. This is not to condemn aggressive interventions, but their use in the latter stages of a terminal illness may be symbolic and reduce any remaining quality of life.

So why do physicians have such a difficult time addressing death and the dying process? Four fundamental assumptions can be considered: the physician’s inference of failure, the physician’s self-confrontation of mortality, time constraints and economic disincentives, and the paucity of education and role models in end-of-life care.

The first assumption suggests that physicians have failed when confronted with a terminal illness and that disease has persevered and subjugated the clinician’s curative abilities.³ In such circumstances, it becomes easier and, seemingly, more beneficent to continue aggressive treatments such as chemotherapy and radiotherapy than to confront the inadequacy of restorative and curative therapies. In the end, however, such strategies instill false hope and weaken the venerable physician-patient relationship. Contrary to many physicians’ belief, discussing death and the futility of aggressive therapies in a candid and straightforward manner does not abolish hope but merely modifies its interpretation. Hope expectantly transforms into the control of physical symptoms, the promise of non-abandonment, and the discussion and potential resolution of spiritual, emotional, and psychosocial concerns.

The second assumption implies that self-confrontation of mortality may affect the ability of physicians to care for dying patients. Because death is often subconsciously obscured and removed from daily life, most physicians do not contemplate their own mortality and corporeal existence. A dying patient may move a physician’s awareness of mortality from the subliminal recesses of the mind into the glaring reality of one’s own measurable existence. The limits and finiteness of life are affirmed. Such confrontation of personal mortality may then be transferred to the treatment of the patient, provoking continued aggressive therapies despite an incurable and inevitably fatal illness or, even more lamentably, result in unintentional physician abandonment.

The third assumption suggests that time constraints and economic disincentives encourage poor palliative care, a premise espoused by many physicians and patients, even though their concerns originate from different perspectives. Such constraints may foster a professional deterrent to addressing the dying process by proscribed and time-limited office visitations, high patient volume, and eventual physician (and patient) dissatisfaction, particularly in capitated health care organizations. Such frustrations with the health care system may also generate additional liability issues and concerns, further eroding quality end-of-life care.
The fourth assumption implies that a paucity of palliative care education and role models for physicians promotes less than adequate end-of-life care. Without appropriate education and role models, it is unrealistic to expect physicians to manage dying effectively, particularly when life-sustaining and curative therapies are so dominant and revenue generating. Lacking applicable education and skills, physicians may reflexively distance themselves from patients, augmenting the fear, trepidation, and uncertainty surrounding the dying process.

Physicians must remember that it is an honor and privilege to care for dying patients. We enter the lives of patients and family members at a time that is distinct from any other: when life is departing, and loved ones are grieving from the impending loss and absence of someone they care for and very much love. At such a time, the presence of the physician escalates in importance for both the patient and family; consequently, we must make every effort to facilitate a peaceful and comfortable death and allow a satisfactory bereavement for surviving family members. We must address and resolve the aforementioned prohibitive assumptions through definitive health care system changes that preclude unnecessary suffering and bring about the ever-desirable “good” death. And we must also not forget that it is only a matter of time until we are all patients with the vulnerability and isolation that accompanies such a consternating status. What kind of care will we want?

References

Patients’ deaths mirror our fears of mortality