The art of medicine at the end of life: *A surgeon's point of view*

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***Editor's note**: This article is based on Dr. Copeland's presentation at the Art of Medicine at the End of Life symposium.*

The doctor-patient relationship is a time-honored tradition and a reward for the compassionate physician and appreciative patient. The first code of ethics between physician and patient appeared in 1750 BC, when Hammurabi was commissioned in Babylon to establish laws that governed the practice of medicine.[1] At that time, an internist recited incantations and surgeons opened abscesses with a bronze lancet. If a patient died or lost an eye, the physician's hands were cut off—not an especially rewarding experience from an appreciative patient.

Over the years, fortunately, the relationships and rewards have changed. The turn of the 19th century was the era of the "country doctor" in his horse and buggy tending to patients at home with little else to offer other than compassion. In today's world, with the many evolving tests both invasive and noninvasive, restrictive insurance programs, and the recent eagerness of young physicians to have a better lifestyle than the country doctor, the relationship between the physician and patient is in the process of change. In the 1970s, the terms "consumer" and "provider" crept into the lexicon of medical practice, stimulating me to address this issue before the Association of Academic Surgery in a presidential address in 1979. During that speech, I said the following:

> I have remained in academic medicine for one prevailing reason: to be exposed to bright young minds eager to learn the morals and ethics of medicine, and eager to be instilled by example with the powers and rewards of sound professional judgment. To serve as an example to the young physician, the teacher must first embody the principals and skills he wishes to impart and then have patients who relate to him as their private physician. Through this unique experience, the student learns the meaning of the patient-doctor relationship as opposed to the relationship between consumer and provider….
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> …If the people are never exposed to the warmth of a relationship between a concerned physician and his trusting patient, they will learn to wait in line for care, see a different physician on each visit, and pay out in higher taxes what they think they are receiving in free care at an assigned clinic. If this occurs, the reason many of us entered and remained in academic surgery will have died.[2]

These statements were written almost 30 years ago and, in my mind, are somewhat prophetic.

If the prophecy proves accurate as I described it, the patient at the end of life may suffer the most. The views of physicians regarding death of one of their patients have been studied. Death is often considered a professional failure;[3] physicians are uncomfortable dealing with end-of-life issues with both the patient and the family;[4] impending death of a patient may awaken unresolved or unexpected anxieties within the physician;[5] and one-third of family doctors have trouble coping with their own emotional responses aroused by the end of life and, interestingly, their negative responses increase with the length of practice.[6,7]

It, thus, becomes quite easy to understand why and how hospice care and palliative medicine as a specialty evolved. Both fill a void in the life of everyone. Having just buried my father-in-law and mother-in-law, both of whom were elderly but healthy, within two months of each other, I have a personal respect for hospice care. Nevertheless,

the event that was most comforting for my wife was the attention paid to her parents and to her by their family physician of long standing. To lose this kind of personal involvement would indeed be unfortunate.

Long-standing relationships between physician and patient are rapidly becoming the exception rather than the rule because of a mobile society and changes forced by insurance issues. The surgeon's role at the end of life is often to make the decision to do a palliative procedure in the face of impending death. An example would be to attempt to relieve a small bowel obstruction in a patient with carcinomatosis or do a total gastrectomy in a patient with linitus plastica with liver metastases. A simple rule to follow is that it is often harder to make the decision not to operate rather than to do an operation. Once the decision has been made to do a palliative procedure, it becomes the responsibility of the surgeon to ensure recovery so that the patient can enjoy the benefits of the procedure. The personal bond between the patient and the surgeon is often the strongest, especially at the end of life.

Having been a surgical oncologist for my entire career, any one of my patients has the potential to be a statistic, even though the chance may be small. Since I have worked in referral institutions my entire career, the majority of patients come to me with the malignant diagnosis having already been made and they think the diagnosis is a death sentence. So, the news I give them about survival is often good news. Nevertheless, in this setting I have several personal axioms: create a trusting relationship with the patient and family—which often requires listening rather than telling; detail the informed consent in a compassionate manner; the truth of the illness should be shared with the patient and the patient's designee before and after the operation face-to-face and be reinforced on subsequent visits; emphasize hope in the context of reality; and don't forget the power of the personal touch. The bottom line is that physicians should empower their patients to make personal decisions and should be aware of the psychological, social, and spiritual dimensions surrounding their illnesses.

Surgery must remain a profession, not a trade. Edmund Pellegrino, director emeritus of the Kennedy Institute of Ethics, defines professionalism best: "a declaration of a way of life in which expert knowledge is used not primarily for personal gain, but for the benefit of those who need that knowledge."[8] And in the words of Gerald Healy, MD, FACS, in his Presidential Address before the American College of Surgeons in 2007: "Your patients do not care how much you know until they know how much you care."[9] Ω

References

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