Commentary

The role of the physician in the preservation of life

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Introduction

In the modern hospital, and in the present climate of increasing concern over medical costs, it has become fashionable to question the traditional duty of the physician to preserve life. Anguished relatives wait in the wings, expecting and fearing that death will come, and sometimes disappointed that it does not. We are urged to consider the needs of society in determining the type and amount of care we deliver. Ethicists and churchmen indicate their up-to-date orientation by proposing an action of ‘allowing to die’. Grieving relatives, wracked by the strains of a terminal illness, write powerfully about the callousness of physicians who keep patients alive. Honestly distressed doctors sometimes talk of ‘the right to die’ with the fervour of a Rousseau declaring the rights of man, and increasingly take refuge in that Orwellian phrase, ‘Comfort measures only’.

It was easier 100 years ago in the era of therapeutic nihilism. Then, for many more patients than at present, the matter seemed to be out of our hands. There were fewer decisions to be made. A gentle manner and a firm, wise countenance did wonders for the physician and the family, if not for the patient. ‘Pneumonia,’ said William Osler, ‘is the friend of the aged.’ Antibiotics were not available; transfusions were given in homeopathic amounts; mechanical ventilation and dialysis machines were unheard of. It was easy to let an old, sick patient die, and even to believe that it was God’s will.

But it is harder for us. We have become, some feel, too successful in rescuing life. For some perversive reason, God has made dialysis machines, respirators, cardiac catheters, and antibiotics available, and we don’t know whether Osler would call them friends of the aged or not. And on this subject, (and in the absence of facts) everyone feels entitled to philosophize.

My point of view has been shaped by years of helping to care for desperately ill patients, and teaching about their diseases. I believe there are practical as well as legal and moral reasons to adhere to the ancient Hippocratic dictum: when efficacious treatment is possible, the physician’s duty is to the patient, and to no one else—not to the family, nor the community—to prevent suffering and preserve life for as long as you can.

Life after death

I will assume for the purpose of this discussion that after a person dies he or she ceases to exist. If some kind of life continued after death, it would be easier to think of death as a favour to the deceased. If death is really the end, then we must look very carefully at any argument that suggests death for the patient as a gift on his or her own behalf.

The patient’s suffering can be relieved

With proper care and modern techniques, physical pain can be relieved in almost every instance. If necessary, a patient can be put to sleep or made drowsy for most of the day. There is a clear distinction between putting a person to sleep and taking his or her life. Most terminal patients, contrary to lay belief, do not suffer from pain.
Excruciating pain is almost never present in dying patients, and when it is, it can be controlled.

Our obligation to ameliorate the patient’s pain is sometimes distorted into a primary obligation to prevent the suffering of relatives, friends and other onlookers. In fact, much of the so-called ‘suffering’ of patients from nasal oxygen tubes and intravenous drips is entirely imaginary, projected by shocked relatives who are sickened and frightened by unfamiliar procedures and apparatus. Such suffering by the spectator is often compounded by guilt. The loudest pleas to ‘end her suffering, doctor’ often come from the neglectful children of a comatose mother who is not suffering at all. In this situation, we must remember that we have only one client—the patient. The physician’s contractual and moral obligation is to the patient, not to the family, nor the welfare agency, nor the kindly clergyman, squeamish at the sight of ‘tubes.’ For most patients with end-stage renal disease, for example, haemodialysis is not a painful procedure that inflicts suffering, but rather a routine event, necessary for life, that incidentally provides a regular source of human contact.

Death with dignity

The term ‘death with dignity’ is sometimes used to justify withdrawal of medical treatment and consignment to ‘comfort measures only.’ ‘Death with dignity’ has become a cliché that requires definition of the vantage point. The dignity often exists only in the eye of the beholder. Several years ago, with Susanna Bedell and Tom Delbanco, we undertook a study of 294 patients with cardiopulmonary arrest, resuscitated at Beth Israel Hospital. Forty-one survived to leave the hospital; most lived for at least a year after discharge. When interviewed a year after their arrest, none remembered being resuscitated. Almost all were glad to have been given the chance to live a little longer. In their case, given a choice between foregoing the indignity of resuscitation and life, they preferred life. Not one of those who lived, lived as a vegetable. Not one was without human consciousness, not one was tied to a respirator or a machine. Tragedies like that of Terri Schiavo may preoccupy our time and attention, but they are vanishingly rare, and should not influence our decisions about therapy.

Euthanasia versus suicide

Whether a patient has a right to take his or her own life is a separate question that I will not discuss here. The issue as far as the medical profession is concerned is whether the physician should be the instrument of death. The physician’s connivance is not required for a patient in command of his or her faculties who genuinely wishes to commit suicide. A sick patient who wants to die and who thinks the physician is keeping him alive against his will can always discharge the physician. A patient on dialysis need not keep his or her appointment for a week or two if death is really desired. Most people will, in the course of a lifetime, say more than once that they wish they were dead. But actions speak louder than words. A good measure of the general will to live is that so few suicides are actually attempted. A firmly expressed and genuine wish to die is usually encountered as a thought disorder in depressed people with few physical problems, rather than in terminally ill patients.

Under the severe stresses of wracking illness, even mentally competent persons, gripped by hopelessness, may initially opt for suicide but later change their minds. Instead of promptly cooperating with an expressed wish to die, it is always wise to allow time for reconsideration.

A 45-year old woman physician with juvenile-onset diabetes mellitus had required haemodialysis for 3 years because of dwindling renal function. After being suddenly blinded by vitreous haemorrhages, she requested that dialysis be discontinued. She attempted unsuccessfully to bite through her arteriovenous fistula. A psychiatric consultant pronounced her of sound mind, and the hospital chaplain agreed that it was most merciful to allow her to die. Nevertheless, her physician insisted on continuing dialysis treatments for at least a month and convinced the patient to agree. At the end of that time she had begun to learn Braille and thanked her doctor for keeping her alive. Six months later, the haemorrhages had resolved and sight was restored. She lived for another five years, working part time, until she died from a myocardial infarction.

The incompetent patient

For most physicians, the most difficult issue centres on the mentally incompetent, withdrawn, or unresponsive patient. Indeed, the largest category of patients ‘allowed to die’ in dialysis centres where this is a common practice, are said to be demented. If the patient is demented, unconscious, or otherwise incompetent, it seems self-evident that any decision to reverse the physician’s usual role by ending rather than conserving life should be in the hands, not of the physician, but of a legal surrogate for the patient. Quite properly, most
jurisdictions require elaborate legal procedures for such legal surrogates to be appointed, not only in order to protect vulnerable patients, but to safeguard society itself.

Dementia may be reversible

At this point, it must be stressed that dementia has many causes, some of them self-limited or amenable to treatment. A common cause for dementia in elderly persons is depression, often treatable with mood-altering antipsychotic drugs. Inadequate cerebral oxygenation contributes to dementia in some patients, because of misguided attempts by physicians to control the blood pressure to so-called ‘normal’ levels or because of inadequately treated anaemia. Infections, often not attended by fever in the elderly, frequently cause profound deterioration of cognitive functions that resolves when the infection is overcome. Vitamin deficiencies and drug reactions are other causes of reversible dementia. Additional reversible causes include subdural haematoma and normal-pressure hydrocephalus. If the physician’s orientation is toward solving dementia by doing away with the patient, there will be little incentive to seek out reversible reasons for the decline in mental function.

The usual bedside tests for dementia emphasize short-term memory and cognitive functions like simple arithmetic and knowledge of the correct date. Patients may not know the name of the President or of their physician and yet appreciate the simple pleasures of warm sun, food, and a comfortable bed. I have often been surprised by a so-called demented patient who expressed a clear preference about whether or not to have a surgical procedure—and who was quite certain about not wanting to die.

Cost of terminal care

Even if we doctors know, at least in theory, that our primary allegiance is to our patient, we are often appalled at the astounding cost of the services we order, and we are consumed by a sense of guilt at the cost we impose on society. This is most keenly felt by physicians who work in hospitals and hospital intensive care units and therefore care for the sickest patients, many of whom will die, despite the most expensive help, in the course of their final illness. There is the sense that a lot of money could be saved by not treating those who will die anyway. This is a situation that cries out for facts, rather than philosophy. Such facts are available in an analysis of Medicare expenditures. It turns out that spending for medical care in the last 2 months of life accounts for only 15% of the entire Medicare budget. That is because, although such patients take up all of our time in hospitals like this, they are a small minority of the Medicare population. The bulk of expenditures in medical care goes to routine medicines and procedures that are prescribed for everybody all the time. Even if we had perfect clairvoyance, and were able to predict outcomes with 100% accuracy; even if we denied all treatment to patients whom we know would die within 2 months despite our best efforts and our ICUs were reserved only for those we were certain would recover, 85% of health expenditures would remain.

Physicians are interested parties

An elementary principle of justice is that interested parties should be excluded from impartial decisions affecting the rights of others. It is not widely enough appreciated that the psychological pressures on the physician conspire against his or her impartiality. The doctor suffers when the patient doesn’t improve. Only the practicing physician can appreciate how difficult it is to visit a dying patient day after day, with support, condolence, and hope, how frustrating it is to contemplate months of decline, of weary, anxious relatives, of vague complaints poorly understood. Only the doctor knows the overwhelming sense of relief experienced when, on hurrying to the patient’s bed in the morning, nerving oneself to face the ordeal of a patient who is not getting better, we learn that death arrived, unexpectedly, an hour earlier. The sense of relief can be so intense that it is hard to remember that the patient cannot share it!
trust the only life you will ever have to such odds? I think not!

A 38-year-old housewife had had carcinoma of the cervix treated by hysterectomy and irradiation 2 years previously. She entered the hospital uraemic and anuric. Her physician, an experienced and eminent gynaecologist, made the obvious diagnosis: carcinomatous invasion of the ureters with obstruction. A long-standing friend of the patient decided that she had suffered enough, and that further investigation was unwarranted. She died quietly while under heavy sedation with morphine. At autopsy there was no trace of cancer; the ureters were occluded by post-radiation fibrosis, causing obstruction that could easily have been relieved.

It is of course tragic to see life support withdrawn when treatment is not indeed hopeless. Equally tragic is the assumption that an incurable but indolent illness is causing new symptoms when in fact a coincidental curable disease is at fault. The best way to ensure that a cure is not overlooked is to make it very hard for the physician to give up.

The median isn’t the message

It is my impression that the naı¨ve and uncritical interpretation of large-scale clinical outcome studies, termed (by some) ‘evidence-based medicine,’ have contributed to a false sense of omniscience by physicians. The results of such studies are usually expressed in terms of the mean, or the median. That is what sticks in the reader’s mind, and the variance is ignored. But we are responsible for individuals, not the mean or median of a group, and a patient who has a 10% chance to live, and lives, lives 100%. Stephen J. Gould, the Harvard evolutionary biologist, lived 25 years after treatment for a usually fatal malignant mesothelioma of the peritoneum. He wrote about the fallacy of naı¨ve statistics in a wonderful essay, ‘The Median Isn’t the Message’.

Quality of life

It is sometimes suggested that the quality of life should be entered into an equation in which length of the life multiplied by ‘quality’ would be a number that would grade the patient’s outcome and guide our therapy. But the patient, not the physician, is the only proper judge of the quality of life. If the alternative is death, it would be arrogant indeed for the doctor, employed by the patient to fight for his or her life, to judge its quality so poor as not to merit the effort. If we say that, for the physician-as-judge, life itself is less important than its quality, that the patient must be able to appreciate a poem, read a newspaper, love her husband or recognize him, or perceive the difference between light and dark or heat and cold, then we put ourselves in the position of saying that there is a human life that is not worth living. That is not the physician’s prerogative.

Useless treatment

If we are indeed obligated to do everything we can to preserve our patient’s lives, then we have a special and balancing obligation to evaluate our expensive methods of treatment in impartial, prospective studies, so that resources will not be unnecessarily squandered. It should be clear that when life is indeed irretrievable, useless treatments should not be employed. But discussions about the ‘quality of life’ should be discouraged as a factor in such decisions.

‘Comfort care only’

Too often, in our hospital routine, the prescription of ‘Comfort Care Only’ means that we don’t bother seeing the patient on rounds. After all, there are no lab results to discuss. But it is precisely these patients who need human touch the most. Nurses know that—doctors rarely do. Touching is important, especially for those to whom we can offer little else. Dickinson Richards, the great New York chest physician, who headed the Columbia service at Bellevue Hospital, said that the great virtue of the stethoscope was that it brought the doctor very close to the patient. Even in their final hours, semi-conscious, patients know when they are being abandoned or attended by a humane and unhurried doctor.

The attitude of the physician

Well-meaning physicians and ethicists often seriously underestimate the debilitating effect on
The professional attitude of the insidious notion that certain lives should not or need not be saved. In the best hospitals, the principle that human life itself has dignity and worth should affect all of the actions in every department. To maintain that attitude is the unique responsibility of the medical profession. The real danger of a policy of euthanasia is that the physician’s attitude will be corrupted. The danger is to the medical profession itself and to our other patients. Once physicians decide that they need not exert themselves on behalf of one patient, it is easy to find excuses for not doing so on behalf of the next, because most physicians (like most other people) have trouble in switching easily from one mode of thought and action to another.

The significance of the physician’s special responsibility is underlined by the history of the ‘Doctors of Infamy’ of World War II, studied by the Allied War Crimes Commission and summarized by Dr Leo Alexander in his classic article, ‘Medical Science under Dictatorship’.5

‘Whatever proportion these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude that there is such a thing as a life not worthy to be lived. This attitude is its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere encompassed the socially unproductive, the ideologically unwanted, the racially unwanted, and finally, all non-Germans. But it is important to realize that the infinitely small wedged-in lever from which this entire trend received its stimulus was the attitude toward the non-rehabilitatable sick.’

We physicians belong to an ancient profession, standing apart from all others in its primary concern and respect for human life and its enmity to death. And in the long run, that attitude of the profession may be as important to society as any miracle that modern technical medicine can perform.

The fact is that for all our talk and our science, we do only a little. Life cannot be prolonged indefinitely, and death comes at last. But the little we can do has an importance that transcends the patient, for it carries a message to all our patients and to the world: Human beings are important.

In the year 1897, the French poet and playwright Edmond Rostand attended the opening in Paris of his play ‘Cyrano de Bergerac,’ which later became world famous. He was 28 years old. Toward the end of the play, Cyrano, the gallant old warrior, the incurable romantic born two centuries too late, is dying. He has a hallucination. He sees Death standing at the foot of his bed, all in black with a black hood, and the face of a skull. And Cyrano sits bolt upright and shakes his fist at Death.

‘Je sais bien, qu’à la fin, vous me mettriez a bas. N’importe, je me bats, je me bats, je me bats, je me bats.’ (‘I know well that at the end, you’ll drag me down! I don’t care! I’ll fight, and fight, and fight and I’ll fight!’)

Well, that’s what you and I signed up for. That’s the doctor’s job.

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References