Physician Attitudes Towards Death and Pain and Their Effects on Care
Keith LeBlanc, Jr.

Palliative care is a medical specialty derived from the hospice movement which began in 1967, and was realized as a specialty within itself twenty years later. It is an inter-disciplinary approach dealing with the care and symptom management of patients who are (usually) no longer receiving curative treatment. There are exceptional circumstances in which patients, still in the process of receiving curative treatment (e.g., cancer patients still receiving radiation), are referred to and treated by palliative care for pain and symptom management purposes. The World Health Organization offers another description of palliative care: “the active, total care of a person whose condition may or may not respond to curative treatment. That care encompasses physical, psychological, social, and spiritual aspects of suffering, and aims at reducing and pain and enhancing the quality of life.”¹ I mentioned earlier that hospice and palliative care share similar origins, yet it is important to understand the differences between the two. Palliative care includes but is not limited to hospice care. Hospice is accessible only those with a terminal disease having less than six months life expectancy; the service is also restricted in that all curative treatment must be forgone in order for a patient to receive such care. In contrast, the patients who are candidates for palliative care encompass the spectrum of medical disciplines, any patients with a “chronic medical condition, which most likely cannot be cured.”² The patients seen by palliative care most commonly suffer from cancer, heart disease, Alzheimer’s disease, and lung and/or neurological diseases. The palliative care physician often assumes a consultant role and oversees all palliative treatments with a team including nurses, social workers, and chaplains. In regards to health insurance coverage, palliative care is covered not only by Medicaid and Medicare, but by private insurances as well, though historically reimbursement has not been as reliable for comfort services as it as been for curative treatments, and this may serve as a deterrent to palliative care referrals.

Throughout the course of my research, three main questions arose, and the purpose of my work is to discuss and possibly answer them: what are the common physician attitudes towards death and pain? Do these different attitudes lead to deficiencies in patient care? And what role, if any, can palliative care play in the alleviation of these deficiencies if they are found to exist?

When considering the questions of how these different attitudes towards death come about and how they affect patient care, we must first consider the more fundamental questions of just what death is and how medicine relates to death. Despite death’s universal qualities, there is a natural aversion within our society to thinking and talking about the subject of death. Because death is an obstacle that cannot, no matter how advanced our medical technology, be overcome; it is human nature for societies to strive to assign it a meaning. The problem with assigning such a meaning, and the reason for the aforementioned aversion to the discussion of death, is that “awareness of death confronts us with questions that go to the very nature of existence….Such questions define our place in the world and our relationship to others.”³ Concerning medicine’s
relationship to the concept of death, Byock\textsuperscript{3} summarizes well in saying: “The preciousness of life underlies all clinical disciplines and preservation of life is a paramount clinical goal. Understandably, for clinicians death is the enemy to be conquered, and when it occurs, it represents defeat and failure.”

Why does death, despite the fact that we know it to be inevitable, represent defeat and failure for the physician? I argue that, in addition to the reasons mentioned by Byock concerning death’s obscurity and the reasons underlying the existence of the clinical disciplines, this is in part the result of the major strides taken in the advancement of medical technology—particularly life-prolonging measures made available as a result of this technology since the middle of the 20\textsuperscript{th} century. While these opportunities for life-prolongation may at first seem beneficial, in many end-of-life cases they are actually disadvantageous to the patient. Its as if the increased availability of therapies perpetuates the physicians’ and the patients’ notion of death as an enemy and an obstacle to be overcome, as if the patient is “giving up” if they do not exhaust all possibilities before transitioning from curative therapy to comfort care. Unfortunately, these last efforts are oftentimes unsuccessful, and they serve instead as sources of distress and unnecessary suffering for both patients and their families.

Evidence clearly suggests that the “death is the enemy” attitude is quite common among physicians. A real-life case that I personally experienced was that of Ms. Doe, a patient who last fall underwent a coronary artery bypass graft (CABG) despite the fact that she was morbidly obese, had diabetes and kidney failure, and was host to myriad other medical complications. Unfortunately, the procedure was unsuccessful and Mrs. X suffered a great deal in her last 90 days of life post-surgery. What trends can be seen in this case? First of all, this case is illustrative of the fact that terminal cases are often extremely convoluted, as can be seen by the host of medical problems that Ms. Doe was dealing with. In addition, physicians cope with difficulty in prognosis for such complex cases. There is rarely a point in the patient’s dying process when a physician can objectively determine that a patient is indeed terminal and that all aggressive treatment should be terminated.\textsuperscript{4} This case also hints at the family’s crucial role in terminal patient care. Despite their initial doubts, the surgical team performed the CABG on Ms. Doe; the effects of the pleading patient and her family in the decision-making process to carry on with the procedure, irrespective of her other medical problems, are not to be discounted. Indeed, physicians are often faced with inappropriately high expectations from the patient and/or the family that aggressive treatment will save the patient or prolong his/her life.\textsuperscript{4}

What is the experience of death like for patients such as Ms. Doe and others like her who die in institutional settings (2/3 of all Americans\textsuperscript{5})? In a 1997 study polling over 4000 dying patients and/or their surrogates, quality of life was reported as poor in 2/3 of patients who could communicate, and the most common symptoms were fatigue (80%) and severe pain (almost 40% of conscious patients).\textsuperscript{6} Although most patients (59%) were reported to prefer a treatment plan centered on comfort, as opposed to curative, care, life-sustaining treatments were often used.
Clearly this is a state of affairs in need of some significant changes on behalf of the patients and their families.

What, then, are the common physician attitudes towards pain, and why is pain relevant in the palliative care context? Pain management is particularly important in the context of palliative care because it is the most common cited reason for palliative care referrals and is often a reported symptom in dying patients. Ruddick suggests that physicians, through their training, develop a clinical concept of pain different from that of a layman. In addition, he suggests that a psychological “forgetting” of pain is also involved. This psychological “forgetting” is best described as a defense mechanism by which the clinician distances himself from the pain that he seemingly causes, albeit in a curative effort. Both of these physician characteristics lead to an undertreatment of pain among patients. Ironically, it is in part the constant reminders of patients’ pain (e.g., moans, screams, and winces) that the physician experiences which Ruddick perceives as responsible for such “forgetting.” Other factors that may lead to the undertreatment of pain are obvious, though unlikely—physicians with insufficient knowledge of pain assessment and management, and patients’ non-compliance with physician-suggested therapy.

Cases of pain undertreatment are unfortunately widespread. In the fall I conducted an interview with Mr. Smith, a man who is the survivor of two kidney transplants, and who received pain and symptom management from both post-op teams and palliative care specialists after his most recent transplant. After having received pain management from both fields and being questioned by myself in regards to his satisfaction on a 1-10 scale, Mr. Smith says that the level of management on behalf of the post-op surgery team was equivalent to about a 2-3, in comparison with the 10 offered by the palliative care team—“all the post-op team knows to do is to pump narcotics.” Again, this is clearly a situation in need of a remedy on behalf of the patients.

I propose, based on the research that I have done concerning physicians’ attitudes towards death and pain, that the integration of palliative care into therapy would most certainly lead to better treatment and pain management, and would also increase the number of referrals to comfort care among the dying. When examining the success of terminal care, the first question that we need to ask ourselves is: what are the elements of a “good death”? First and foremost, we must realize that a “good death” is a fundamentally individualistic concept—what may be a “good death” to one person may be completely opposite to a “good death” for someone else. Despite this individualistic aspect, some elements of a “good death” are desired by many; they include: high quality medical care, ethical decision making, pain management and symptom control, emotional and spiritual support for both patients and their families, continuity of care, involvement of family and caregivers, and adherence to patient and family preferences concerning care. Palliative care addresses all of these needs; indeed, such needs are almost identical to the “basic end-of-life care competencies” used by The Working Group on the Preclinical Years of the National Consensus Conference on Medical Education for Care Near the End of Life to assess the teaching of terminal care in American schools.
fundamental to the existence of palliative care, in which patient-physician communication is paramount, and the experience and specialization in pain and symptom management of palliative care clinicians are especially important here.

If palliative care can aid in the elimination of these patient deficiencies, what can be done to increase palliative care referrals? My first suggestion for increasing referrals would involve a change in American medical education reflecting the growing importance of end-of-life care. While the focus on such care has recently had an increased presence within undergraduate medical education, there is nevertheless room for improvement. There is evidence that the current level of training is insufficient, especially in the clinical years—“curricular offerings are not well integrated; the major teaching format is the lecture; formal teaching is predominantly preclinical; clinical experiences are mostly elective …role models are few; and students are not encouraged to examine their personal reactions to these clinical experiences.” In addition, palliative care education is received favorably by medical students. Additional suggestions include an increased public awareness of palliative care and an adjustment in reimbursement policies to eliminate legal, organizational, and financial barriers to better palliative care for patients.

In closing, I would like to point out that this proposed increase in palliative care referrals is an incorporation, as opposed to a substitution. In most cases, the focus should not be either active care or palliative (comfort) care, but rather an integration between the two. I would also like to underscore the importance of the topics discussed in this paper. First and foremost, death’s universality should make a comfortable, dignified death an important subject for us all. Furthermore, palliative care will assume an increasing level of importance within the medical community in the next decade as a result of the children of the baby boom filling the ranks of the elderly. This insurgence will create unprecedented demands upon the world of medicine, and as the majority of palliative care recipients are elderly patients, the sheer volume of referrals and recipients cannot help but to increase. Hopefully, this increase in palliative care use will lead to a subsequent increase in palliative care awareness and thereby solve some of the deficiencies in patient care discussed earlier.

References:

2. Palliative Care Pamphlet, distributed by University of Virginia Health System, nd.