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Chapter 30

The Physician and the Dying Patient

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EDITORS' INTRODUCTION

What is it like to be dying and to have a detached individual as one's physician—how would this differ from dying when one has an empathic physician? How much does it help if the physician has come to grips with his or her mortality, and can deal with death rather than avoid thinking about it? Does it always help to be told all the truth? How important is it to be able to rely on the presence and support of one's physician? These issues are important for many dying patients. In this chapter, an internist and teacher who confronts this challenge takes the reader with him as he ministers to a dying patient.

Most physicians have three types of experiences with death and dying. The first is the direct involvement with dying patients. The second is the physician's involvement with the loss of parents, family members, and friends. This more personal and disruptive experience is only rarely without pain. The ability of the physician to be more simply human than professional in response to personal loss encourages the work of mourning to reach a successful conclusion. Often, however, the physician struggles to maintain a more detached and "objective" position and, in so doing, not only postpones or circumvents personal mourning, but makes it most difficult for other survivors either to be "with" the physician in his or her pain or to

mourn appropriately themselves. The physician's unmourned losses may lead to such excessive distancing from death as to make the physician unavailable for the kind of sensitive involvement with dying patients outlined in this chapter.

A third type of experience with death is at a different level, and involves the expectations, fears, and fantasies of the physician's own death. Such concerns are often submerged, but ubiquitous. Awareness of one's finitude, coupled with the thoughtful individual's concern about the meaning of one's life, can lead to concern, anxiety, or despair. When this pain is avoided totally by the denial of personal death, the physician is more apt to respond to dying patients with detachment and distancing.

The challenge to the physician presented by this chapter is one of both maturity and wisdom. Perhaps some readers will react, as we did in reading it, with the hope that, as that final life chapter is experienced personally, there will be available to them the kind of physician-guide presented in the following pages.

INTRODUCTION

I am going to illustrate the care of the dying by following one patient from my first visit with her until her death. The details are drawn from her hospital chart and from my office records, and most of the dialogue comes verbatim from tape recordings of our visits. Try to imagine that we are seeing and discussing this woman together, through the course of her illness.

Sally Gordon is a sprightly, pleasant-appearing woman with light brown hair and a sparkle on her face that goes with her wry humor. Smooth skin and the suggestion of a double chin (she is somewhat plump—especially for her short stature) make you think she is younger than her 62 years. Her daughter or one of her sisters is almost always with her, and the bedside table has pictures of her grandchildren and other family objects.

The surgeon asked me to see Sally Gordon the second time she came to our hospital, in April 1975. She was admitted because of persistent back pain that had raised the possibility of metastatic cancer. In August 1974, when she had been 61, she had had vaginal bleeding, and after 10 days she had visited her gynecologist. He had found a pelvic mass that had not been felt by him 6 months earlier, and advised hospitalization. Mrs. Gordon said he told her, "I feel something there and I don't know just where it is, and you're in trouble." She had asked him whether it meant a hysterectomy, and she remembers him saying, "It's a lot more than that."

Originally from Boston, she was living in Alabama, where her husband, a highly specialized electronics engineer, was working. She preferred to come to a hospital in New York, where most of her family lived.

Examination under anesthesia confirmed the pelvic mass. Preoperative studies revealed no evidence of metastatic disease, although the barium enema showed a constricting lesion at the junction of the sigmoid and descending colon. At operation in September 1974, she was found to have adenocarcinoma of the

colon extending into the serosal fat and metastatic to several mesenteric lymph nodes and the right ovary. A segmental sigmoid resection and bilateral salpingo-oophorectomy were done. The left ovary was not involved.

Postoperatively, she developed a right serosanguinous pleural effusion, at first thought to be from pulmonary infarction, but later believed to be a malignant infusion because a preoperative chest x-ray revealed a small effusion and ascites showed in the preoperative sonogram.

Before operation, the surgeon explained to her that she might require a temporary colostomy, which she dreaded. It was her understanding that "the tumor ate a hole in part of the colon and was working itself away from the colon." After surgery, she said she was relieved because, although "of course, it was malignant, they got everything, and all the radiologists and everybody said there was no concern for treatment and everything was fine. So that was that."

The surgeon was explicit to the family about her extremely poor prognosis.

She went home in 10 days, feeling fine and optimistic about her future. She was pleased about her weight loss (keeping her weight down had always been a problem), and pleased that her bowels were moving. She said later that she had "almost a phobia about bowel movements, something I never even thought about before. I interpreted somewhere that the movements were very important—after all, it was colon surgery." Her preoccupation with her bowels continued until her death in June 1977.

She came back to New York in April 1975 for a 6-month follow-up. There had been a 5-pound weight gain, which worried her because "Why should I gain weight when I'm eating so little, although I'm delighted to have so little appetite." The surgeon showed no concern, and told her how well she looked.

While she was in New York she decided to see an orthopedist about her back pain, which had been present for many years. The many other physicians who had seen her about her back always told her it was "nothing" or "a little arthritis," but it was a nagging concern to her. The orthopedist she consulted in New York found ascites during his examination and suggested a bone scan, thus raising for her the specter of recurrent cancer, and she was readmitted to the hospital.

The surgeon asked me to see her, rather than an oncologist, because I had cared for many patients who were dying of malignancy, and had become interested in the problem of the dying patient. In the surgeon's mind, in mine (and probably, in yours), she was already in the category "dying patient."

DEFINITION OF A DYING PATIENT

Why? She was not literally about to die. She did not think she was dying, nor did her husband. Indeed, she felt fine (except for her back). On the other hand, as every physician knows, she was going to die of her cancer no matter what was done. The dictionary definition "at the point of death" is certainly not how doctors use the word *dying*. A resident once said that a dying patient is someone for whom medical science has no more to offer. And a surgeon told me that "a dying patient is a patient whom I can't help." Those definitions are important to us

