ENDOSCOPE

Why doctors don't attend their patients' funerals

By Benjamin W. Corn — March 7, 2013

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Many doctors see a patient's death as a failure or acknowledge a need to desensitize themselves against burnout. *AP Photo/Kevin Wolf*

The cavernous hospital amphitheater in Tel Aviv, normally used to screen videos and new surgical procedures, was illuminated only by tea candles floating in decorative dishes of water on a recent Wednesday in January. Hundreds of doctors, nurses and other medical personnel filled the seats, as usual. But we had not come to learn the latest life-saving technique.

Dr. Ofira Ben-Tal, one of Israel's leading hematologists, had lost her battle with aggressive bladder cancer at the young age of 57. Few physicians were able to attend the funeral, ostensibly due to time constraints, so the hospital elected to accommodate us doctors who wanted to acknowledge the loss of a dear teammate. And the eulogies went beyond her rare braiding of meticulous professionalism with artsy elegance. Ofira was unique in her approach to her illness. Throughout the ending of her life, she sought opportunities to reflect on her disease, to clarify what she valued in life, and to encourage others not to fear what she referred to as "the journey" of dying. By contrast, most of her peers—doctors like me—tend to be reluctant to speak about death and, particularly, to ponder our own demise.

Almost four years ago, I reported in The Oncologist that my colleagues in Israel rarely participate in bereavement rituals when informed that a patient has died. Approximately two-thirds of the 126 doctors I surveyed said they simply do not have the time to attend funerals or visit mourners during the shivah (a seven-day Jewish ritual where condolences can be expressed). But half also reported that they construed a patient's death as a failure or acknowledged a need to desensitize themselves against the burnout.

"Palliative care" focuses on relieving patients of their suffering. Dr. Balfour Mount, a McGill University urologist credited with coining the term, has argued that healthcare providers are, themselves, so fearful of death that their trepidation compromises their ability to care for the terminally ill and even makes them uncomfortable at being around dying patients. If Mount is correct, then we have reached a dire state that screams for immediate repair.

Dr. Ofira Ben-Tal was a woman of many talents and decorated her lab with some of her paintings. This one is called "Medusae" (circa 2006). (Permission for reproduction provided by surviving family members.) *Miri Gattenyo*

The published evidence suggesting that physicians are *more afraid* of death than the general population is, at best, sketchy. But by the same token, there is no evidence to suggest that physician are *less fearful* of death than the general population, which in itself may be a problem since the general population is likely to cross paths with physicians when death is at hand. However, as better, statistically validated tools have emerged to measure our fears we are left with conflicting information regarding the physician's degree of death anxiety. We are not sure where we stand.

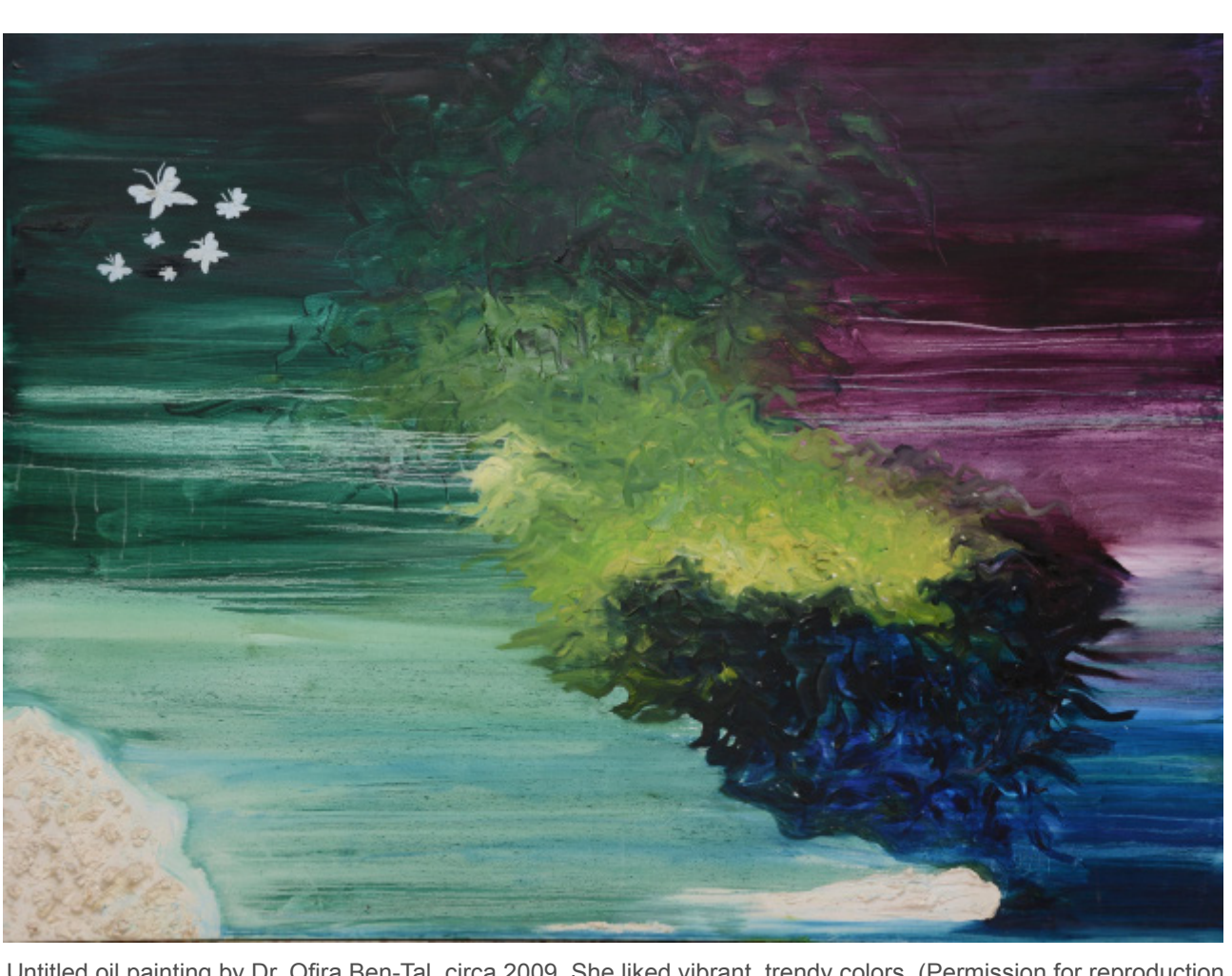
When patients come to me to discuss their cancer, the conversation invariably tilts to "what ifs" and worst-case scenarios of unsuccessful treatment. At those moments, most patients expect us experts to serve as anchor. When a team of Harvard researchers led by Dr. Jennifer Mack reported in last year's Annals of Internal Medicine that only 30% of oncologists conduct end-of-life conversations with their cancer patients—and even then, only during the final month of the patient's life—we have a glaring societal hazard.

In medical journals, discussion of the death of a physician generally takes two forms: tabulations of surveys of various groups of physicians and "confessional reporting" by physicians revealing their emotional responses to terminal diagnosis or even misdiagnosis. In 1986, investigators from the National University of Singapore developed a questionnaire to survey 102 general practitioners on their attitudes about their own death. More than 70% said they would prefer to die at home. One perhaps startling conclusion is that most physicians were disappointed with their peers' ways of practicing "end-of-life medicine." In particular, more than 85% expressed dissatisfaction with terminal-care pain control as well as emotional, spiritual, and other types of support. The authors do caution that strong Chinese cultural influence on participants may render their findings less applicable to Western physicians. And use of hospice services in the intervening 25 years has increased significantly, so the picture today could also differ.

Meanwhile, a 1999 study based on the responses of more than 600 US-based physicians—both specialists and generalists from private practice and academic medical centers—appeared in the journal, Resuscitation. The overwhelming majority of those physicians did not want cardio-pulmonary resuscitation (CPR) performed in the context of incurable illness, including Alzheimer's disease, quadriplegia, metastasized cancers, and end-stage damage to the heart, lung, liver, or kidney. The doctors agreed that they wanted CPR only if they were otherwise in good health.

A larger survey of 818 physicians, last updated in 2008, queries doctors who graduated from the Johns Hopkins University Medical School between 1946 and 1964. The study benefits from long-term stability because its participants agreed to be questioned at regular, three-year intervals. Nearly 60% said they had executed a "living will" and/or established durable power of attorney for health care, a DPAHC. The doctors with a living will or DPAHC were more likely to refuse life-sustaining interventions, but also more likely to accept potent medications for alleviating pain. The Hopkins study may not apply to all physicians, but results do seem to say that, for themselves at least, physicians would use advanced directives as a means of *limiting* the provision of life-sustaining treatments rather than as a tool to enable life-sustaining treatments to be provided.

Less empirical but no less compelling are the narrative essays penned by doctors in the process of confronting their own death. Many physicians joke about a dying doctor's greatest fear: "How could *others* possibly recover from such a loss?" In truth, however, most of these physicians write about their own death with sensitivity and insight rather than narcissism or humor.



Untitled oil painting by Dr. Ofira Ben-Tal, circa 2009. She liked vibrant, trendy colors. (Permission for reproduction provided by surviving family members.) *Miri Gattenyo*

I am not the first to point out that physicians have distinctive ways of contending with mortality. In an article posted on the website Zocalo Public Square in 2011, Dr. Ken Murray—a California family physician—shared some observations and anecdotes about the modes of death chosen by medical doctors whom he knew. The article garnered a surprising amount of attention, evidenced by its citation in mainstream media outlets including the New York Times, the Wall Street Journal, and National Public Radio. It went viral on social media. Why all the commotion?

No doubt because Dr. Murray had the temerity to suggest that, rather than pursuing heroic measures for themselves, physicians who are dying consistently opt for *less* treatment. He writes, "…they know exactly what is going to happen, they know the choices, and they generally have access to any sort of medical care they would want, but they go gently."

In the Canadian Medical Association Journal, internist Dr. Mark Cheung recalls the debilitating pneumonia that he contracted at a time when he was caring for patients during Toronto's SARS epidemic. "I was forced to confront the possibility of SARS as a cause of my fever," he recounted. "I reflected on the disease itself, a novel virus whose treatment was based on opinion rather than evidence. I struggled with the thoughts of parting from my wife and not being able to watch our wonderful children grow." The infection in his lungs turned out to be treatable, and he was discharged after three weeks.

In a phone interview, Cheung told me that the prospect of fatal illness helped crystallize his personal values. He developed a heightened appreciation of family, greater sensitivity to his patients—especially those suffering from shortness of breath or diagnosed with a terminal condition. He made a commitment to healthy lifestyle changes—he now exercises five days a week in a gym—and even developed a willingness to be *less* frugal. "Near-death," he said, "is a game changer."

Doctors face death in different ways. Dr. William Shimp, a semi-retired oncologist, feared that he was dying of cancer until the "ratty-looking" lesion in his pancreas was unmasked as a benign cyst. He wrote about his experience in an article entitled, "Oncologist as Patient–Or Not." Shimp told me that he couldn't help but alter his life focus following his ordeal on the examining table. Shimp re-ordered priorities and contemplated his personal legacy while, on a professional level, he redoubled his devotion to his patients, resolving, for example, never to make them wait for test results and to interpret results for his patients rather than simply passing on laboratory values or x-ray reports.

Of the 20-or-so dying physicians whom he'd taken care of during his career, Shimp said some dying physicians had experienced shame or remorse. Could they, the "all-knowing," have been diagnosed with malignancy because they had not adhered to screening recommendations or practiced denial when early warning signs appeared? Others, also not represented in the published studies, had harbored a sense of entitlement and insisted that all heroic measures—even when apparently futile—be pursued. The latter group "had an ugliness about them," Shimp said, "which was often manifest as a seething anger." They could be argumentative at times, he reported, and were likely to be patients who wanted to die in the hospital environment, "fighting until the very end."

What can we do to improve our situation? We can do more to determine contemporary physician opinions on heroic measures, pain control, and euthanasia. And if 70% of physicians are still intent on dying at home, we can try to find out more accurately: Is it because doctors understandably prefer to be surrounded by family in comforting settings? Or is it because doctors know enough to want to distance themselves from colleagues who don't grasp how to care for dying patients? We could identify physicians who are imminently dying and create a database to document their outlook. That would be useful because conclusions would no longer be hypothetical. We must do more to learn about the respective overlaps and divergences in attitude between physicians and patients on the final, and most mysterious, phase of the human experience.

And we can go beyond statistics. Rather than confine ourselves to quantitative investigations, we can work with quality. What is the fabric of physician death anxiety? Shame? Remorse? Inbred fear? Something else?

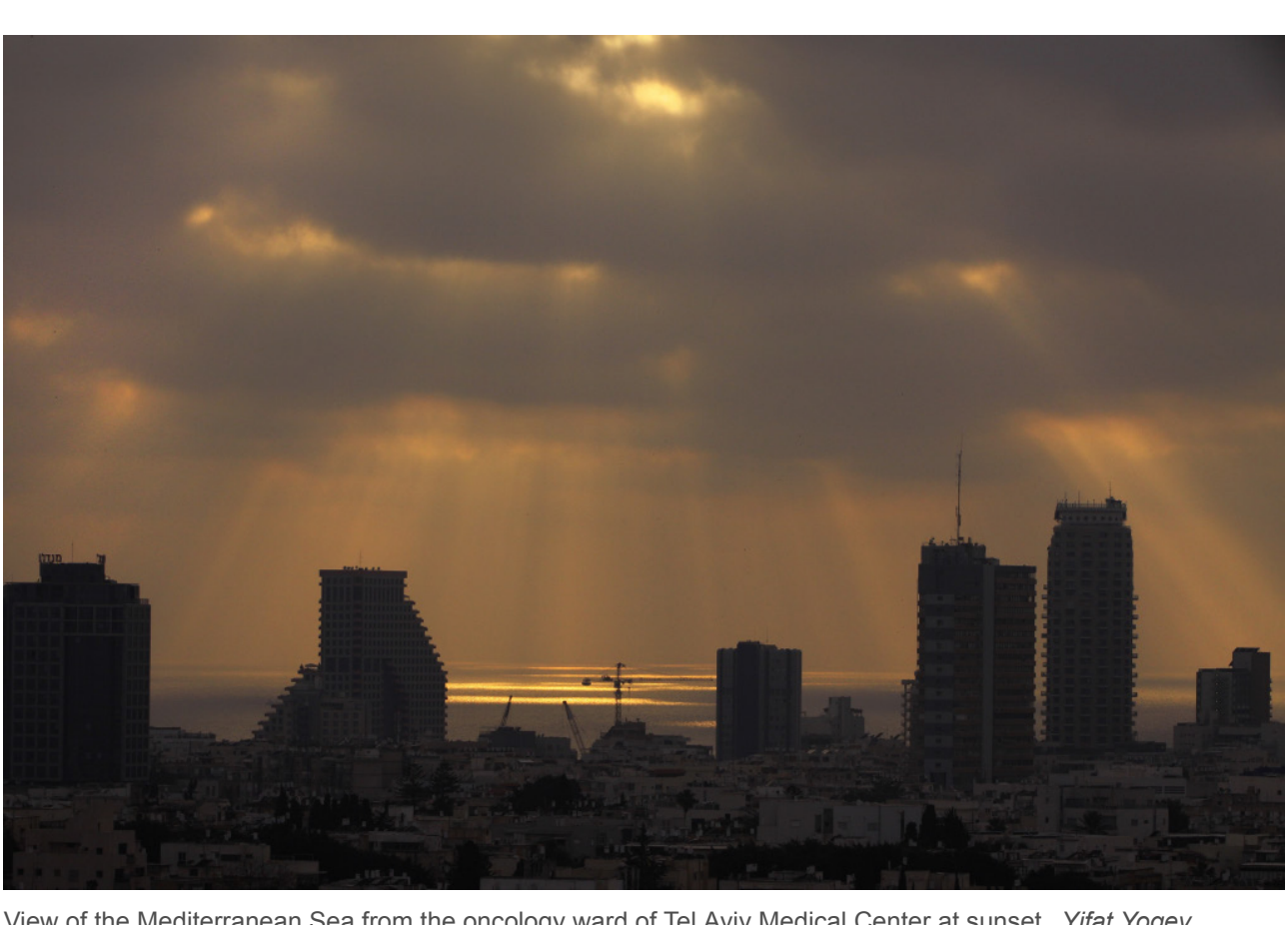
Dr. Irvin Yalom, professor emeritus of psychiatry at Stanford University, has been called the Father of Existential Therapy. He points out that, because lives perceived as unfulfilled tend to engender regret, to face our "death terror" requires us to work at understanding ourselves and the values that drive us.

None of the major professional organizations—the American College of Physicians or the American Medical Association, for example—are well equipped to assist doctors to, as Yalom puts it, "to do the work." This is particularly surprising in an era where "guidelines" and "checklists" are available to provide direction on most professional matters. If we aspire to become effective escorts to the patients whom we are privileged to shepherd in our medical ministries, then we might consider revising Luke's well-known proverb to read: "Physician, *emotionally* heal thyself."

My dissonance sent me questing for authentic role models who engage in the kind of soul-searching to which Yalom alludes. And of course, Ofira Ben-Tal returned to mind.

Exactly one week before she died, I took the elevator to the oncology ward and entered Ofira's room. She had just vomited and wore a morphine haze on her face. Both of us knew the reason for my visit and recognized that this was not the moment to say goodbye. With obvious effort, she raised her right index finger and looped it around the air in small, clockwise circles, signaling that it would be best for me to return at another time.

The following day, late in the afternoon when my rounds were complete, I stopped by again. Her skin had shed its cold, damp appearance. She was able to quip, "I wasn't sure a technocratic radiation oncologist like you would have enough emotional intelligence to read my body language yesterday. How reassuring!" After allowing ample time for her sarcasm to seep in, she beckoned me to the bay window that faced west toward the Mediterranean Sea.



View of the Mediterranean Sea from the oncology ward of Tel Aviv Medical Center at sunset. *Yifat Yogev*

She appeared overwhelmed with appreciation for our final moments together and seemed to have some message to share. "Do you have an awareness of the setting sun, Ben? Do you appreciate the variety of tones and hues that mesh together *in perfection* at these moments?" Speechless, I nodded, trying to convey my intent to dedicate this time of each day to the lesson that she was trying to give to me as a parting gift. It was delightful to listen to Ofira. She was vibrant. No regret. She still had more to contribute. She chose to arrange our encounter to put me at ease and to bequeath a simple, spiritual keepsake for me to cherish.

Professor Yalom's book about overcoming the dread of death is called *Staring at the Sun*. He chose its title, he explains, based on a quote from Francois de La Rochefoucauld, who stated, "You cannot stare directly at the sun, or death." In the book, as throughout his writing, Yalom defiantly advocates that we stand and face our mortality.

In Ofira's hospital room, the two of us were staring at not merely the sun; we were staring at the setting sun. The metaphor could not be more apt.

This is the beginning of a series titled "Endoscope: An insider's look at medicine," where Dr. Corn will reflect and critique overlooked, controversial aspects of the medical system. We welcome your comments at ideas@qz.com.