

The Physician's Attitude towards the End of the Existence

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ABSTRACT: The physician's attitude towards death, a phenomenon which he frequently encounters in his work practice, is most of the times ambiguous, uncertain, lacking a philosophical significance coherent enough. During the period corresponding to the transition from life to death, when the human being who is about to relinquish life for good lives, suffers, understands and needs assistance, most of the physicians adopt a particular detachment conduct. The physician's participation in assisting the patient, constant until then, natural, sharply decreases the moment the diagnosis has become, "there is nothing else to be done". This phrase "there is nothing else to be done" should be only the conclusion of one phase of the assistance given by a physician, the curative, healing assistance and the beginning of another one, the phase of "assisting the dying person", a phase that has to be an integral part of the physician's mission which represents a more difficult medicine, much more demanding for the physician. At this point, assistance, treatments depend on the ability of the person providing assistance to endure the fear of death in which he is included himself. The necessity of meeting the needs of the dying people has led to the drafting of "a charter of the rights of the dying". Such charter was drafted during the symposium, "Terminally ill patient and helping person" organized by Wayne State University, Detroit, USA. Taking into account the idea that the dying person "has the right to live until the end" within the best possible conditions the palliative care have been developed. According to the French Society of Palliative Care, 1996, the palliative care aim is to ensuring the patient's quality of life (and not extending it by any means) and that of his family. In these conditions the pain control, the psychological, social and spiritual development are essential.

KEYWORDS: *old person, palliative care*

Introduction

In most cases geriatrics does not address the problems of death, which is nothing else but the limit of old age, there is also a "physiological death", unknown as such, as a closing of the vital cycle. Death issues are generally left to other disciplines such as tanatology, tanatopsychiatry, pathological anatomy and forensic. If this is normal, the aforementioned disciplines with their role physicians' concerns and practice [8,9].

The purpose of our study is to pass in review the available data in order to determine the physician's attitude from the bioethics perspective in front of the end of the existence. We intended to approach within this study three aspects: the physician's attitude towards death, death within the medical practice and death assistance.

Physician's attitude towards death

The physician's attitude towards death, a phenomenon which he frequently encounters in his work practice, is most of the times ambiguous, uncertain, lacking a philosophical significance coherent enough. If he sometimes manifests some interest, scientific curiosity for

the cause of death, this happens regarding the corpse or specific organs viewed as anatomopathological pieces deprived of identity, inherently depersonalized. Death can eventually become a study object.

But the period that precedes it, which corresponds to the transition from life to death, period of time which includes preagony and agony, when the human being who is about to relinquish life for good suffers, understands, needs assistance, imposes to the doctor most of the time a sort of detachment, of distance [11,12].

When it seems that "there is nothing else to be done" for the purposes of effective treatments intended to prevent the end, there is still a lot to be in the study of death, it is not normal that the end of old age to be ignored and separate from old age itself, because it harms the very understanding of the ageing process as a whole stage of human existence.

It can be seen that the problem of assisting the dying person has rarely been until a few decades ago, and for many physicians, even nowadays, a topic of interest in the medical literature in the medical education in general

within the physicians' concerns and practice [8,9].

The purpose of our study is to pass in review the available data in order to determine the physician's attitude from the bioethics perspective in front of the end of the existence. We intended to approach within this study three aspects: the physician's attitude towards death, death within the medical practice and death assistance.

It is considered that the phrase "there is nothing else to be done", more sententious, is right in the case of the elderly person, because old age also associates reality to the natural closure of the vital cycle and it has to represent the phase completion of the assistance granted by the physician and the beginning of another one, the last one, because one can talk of assisting death, assisting the dying person, which represents a problem with real content, not to be neglected. As a matter of fact, the preexitus period is considered to be a distinct period where takes place the transition life-death, the sequences well defined from the bioethical, clinical, therapeutical point of view being as follows: sickness (interventions may be effective in the sense of recovering for health or survival), preterminal phase, (the interventions become palliative: pain relief, moral and spiritual preparation life ending) and terminal phase (the exitus) [2,5].

One can easily notice that the problem of assisting the dying person in general and the dying elderly person in particular is only rarely a topic of interest in the physicians' concerns. The content mostly psychological, sociological, moral pushes it to the side in the concerns of the physician beneficiary of a biological and medical training, who avoids to give too much importance to a situation which constitutes rather a failure of his work or of the medicine and this may happen as well out of a reflex of defense, according to psychologists (the death of another human being makes the physician think, more or less, of his own death). At this time assistance, healthcare depend on the ability of the person offering assistance-care to put up with the fear of death which influences him as well [12,18].

The reasons of physicians' reserves towards the issue of death, apart from the anatomopathologic interest mentioned before, are varied. To those deriving from his training as a physician, are added those specific to man as a mortal human being [12]. A general reflex of self-protection that tries to chase away the

serious or sad things makes him limit his attachment, the deepening of this domain [16] In addition the nowadays society interested in putting forward the health, vigor and youth rejects, by contrast, old age, decrepitude, death [24]. Furthermore, the society invests physicians with the duty to heal, and education generally trains the physician according to a pharmacotherapist status able to heal everything"[11,12]. As a result, physicians are themselves invested only with the power to heal.

Death in medical practice

Death is a biological phenomenon, implacable, compulsory, of an inexorable fatality, but the attitudes towards death represent a cultural manifestation. The physician gets his action force from his professional culture, and equally from the culture thesaurus. The attitude towards death has to represent the fusion of the concepts offered by biology, medicine, psychology, philosophy, culture, religion.

The life research polarizes a greater interest than death research, although it could serve a better understanding, in general, of the ageing process, knowing that death is obligatorily associated with ageing that it puts an end to [24,25].

The principles of palliative care are the same as medicine principles in general. Physicians hold the double responsibility: preserve life and reduce the suffering. The benefit principle (charity, the care to do well) and non-injury (the care not to do any harm) applies both in the case of palliative care and medicine.

In the light of these two basic principles of medical ethics, the physician's responsibility is not to tolerate isolation. Only death in a climate of collective participation, medical care, human permanence gives the person in question the feeling of accomplishment, of human detachment from the life and the world [14,18]. Death, and especially the preceding period, cannot be excluded from health care and, therefore, the physician may not avoid obligations (especially moral ones) that devolved on him. Yet, unfortunately, sometimes things are totally different. The dying person, maybe often consciously, spends his last moments in a dramatic isolation. Most of the times the dying elderly person spends his last sufferings in hospital, where he feels the isolation in a more painful way. He has the feeling that he is removed from life earlier, all the more so as he sometimes still hopes that death will go away [11,12,14].

Whether he is in hospital or close to his family, the physician will always be that person who has to provide him assistance until the end. Even if he is at home, although there is no hope, the family provides the physician's presence as a psychological support to solace the sufferings, to calm his pain. This demonstrates that the assistance of death represents a reality that must be included in the training of the medical practitioner who is going to embrace in the assembly of his knowledge and attitudes the elements necessary to ensure this assistance to deal with the attitude in the face of death [21,22].

Taking into account that any elderly patient will reach at a certain point the end of life, the attending physician may question himself about the following three attitudes: to keep a tight hold on the fight against the disease using all therapeutic means, to hasten the inevitable end in order to put an end to sufferings, we are not talking here about an active acceleration but rather about a passivity attitude or to accompany the patient staying close to him without abandoning him, giving him care in order to relieve his sufferings [8,10]. It is obvious that the most natural behaviour is the last one. Giving effective and qualitative palliative care represents the moral answer to the immortality of euthanasia [1].

There are authors who do not approve to the practice of therapeutic methods and laborious investigations in the case of agonizing patients, as other authors claim that the treatment of the dying person will not be suspended until the last moment [25]. If this issue can be further discussed being different from one case to another, what there cannot be discussed is the moral therapy that has to be always applied by the physician, well trained for this purpose, convinced of its necessity when all the other means become ineffective [3,4]. The elements of such therapies are represented by ensuring the human presence, communication, then patience, understanding, moderate optimism, warmth, kindness. The doctor has the responsibility to also prepare the environment around the dying person, care staff, relatives, and caregivers.

In order to comply with this duty, the physician has the advantage of experiences he lived. Ever since the beginnings of his activity each practitioner find himself near death [10,11]. It depends on each person to draw from these great intensity moments the lesson of life and understand that the presence alongside the dying person is an integral part of the medical

profession, a profession which never ceases to exist alongside with the sentence "there is nothing to be done", or when the subject comes of a certain age. This is an attitude in accordance with the principle of respect for life, which animates our profession, life coming to an end only with the last breath and the last heart beating [10,11].

Death in medical assistance

The physician patient relationships evolved from the paternalistic aspect, where the physician is the one who makes the choice for the "well-being" of the patient, to a negotiation between two partners. Finally, the informed patient autonomously decides his autonomy, the therapeutic conduct. The problem of palliative and terminal care highlights the need for information and effective communication of prognosis and therapy goals.

The Convention on Human Rights and Biomedicine (Convention from Oviedo), besides the provisions with general character, it refers to the situation of patients in terminal phase that do not have the legal capacity to decide on the medical action, showing that: „the wishes regarding a medical intervention, that was previously expressed by a patient who, at the moment of the intervention is no longer capable to express his wishes, should be taken into consideration” [18,25].

The medical assistance of the dying person has a well determined content. It has to meet his fundamental needs (of comfort, hygiene, feeding, breathing, rest), his specific needs: (to eliminate or calm the pain), his personal needs (human presence, communication, ensuring his respect as a person, self-esteem).

It is said that assistance shall not be provided in order to prevent death, but in order to prevent the suffering [2,4].

Hereinafter we will present some simple objectives that can become the support and guide of an individualized human relationship with the elderly patient in imminent terminal phase, both at home as in hospital.

A first objective concerns the avoidance of a change in the physician's behaviour that might detach himself from the patient the moment the latter is dying [21]. This change of attitude consists most often either in abandoning the patient, shorter, more sporadic and more formal visits, or in discussions in his presence with the caregivers, with the staff, discussions having as subject the aforementioned sentence, even if these discussions are whispered or are made in a foreign language.

Another objective of the palliative and terminal medical care is to maintain the normal atmosphere around the elderly person and avoid his isolation, which is so easily practiced from psychological reasons. Being surrounded by an adequate environment allows him to keep hold of the space and faces that are familiar to him in his last moments. In this way he feels safe and does not feel the trauma represented by the change of physical and relational environment.

Another imperative of the terminal phases assistance is ensuring the human beings presence, of an accompanying person, important element which gives the dying person a feeling of security and peace [21,22]. On the one hand, the treatment and healthcare persons will continue to be close to the dying person even more than before, thus avoiding the short and rare visits, the short lasting and formal contact. It will also be ensured the permanent presence of relatives, of those persons close to the patient. Not only that the forbiddances are not justified, being opposed to the medicine humanism, but they appear as repressive measures that do not belong in the hospital environment. Creating the adequate conditions for the close contact with relatives shall be a rule not only in the assistance of the dying elderly person, but throughout the entire geriatrics assistance. We refer in this sense to the "therapy with the help of the relatives" [11,12] which is a reality. The good influence on the elderly person's psyche, the feeling that he is not abandoned and isolated from the loved ones has a genuine therapeutic effect often superior to tranquilizers.

If all the things mentioned before represent measures intended to ease the mental sufferings, another important measure, component of this assistance phase, is the stopping of physical suffering [11,20]. Within this framework, pain control is one of the major objectives of the assistance.

Another component in palliative and terminal medical care is the proper nutrition and hydration of the patient [18,20,22].

A particular imperative in the case of the elderly person's assistance is taking care of the oral cavity, organ that changes during this phase ("non-functional mouth"), and may be a mirror of the sufferings evolution (dehydration, azotemia, infections).

Starting with the basic needs, the habitual healthcare represents a very important component in terminal phases assistance. It is about ensuring the general comfort of the subject to which the entire entourage must

participate and which will start from the fact that the dying person often finds himself in a situation of external dependence in relation to his entourage.

One aspect depending mostly on moral assistance, which has a significant importance in, palliative and terminal medical care is represented by the concern we have to express towards the personal needs and desires of the dying person, which should not be understood as a concession, but as a moral duty of the first order [19,20,21]. It is about recognizing the unique identity of the personality of each dying elderly person. His (last) desires should be listened to, the subject should be encouraged to express them and his entourage must try to satisfy them.

Throughout the assistance period, maintaining the communication remains an essential objective [9,10,11]. At home, as well as at the hospital, efforts must be made to ensure a "permanent human presence", sympathetic, receptive, able to face up to the needs and wishes of the dying person until the last moment. The peace and relief felt by the dying person in the presence of the priest make his presence necessary [11,19]. The exception is represented by the situations when he does not want this presence or, when having the hope of healing, associates this presence to his end.

All the gestures and material concerns mentioned before represent the base of maintaining communication and in fact it means the support and guide of the individualized human relationship with the dying elderly person. Communication through words is not always possible. The elderly person utters few words. It is imperative to know to listen, to understand, to ask, to guess his questions and answers, by examining his look, his facial expression. This non-verbal communication becomes very important and has a benefic effect on him, of tranquility, of peace, of satisfaction. Simple gestures of touching the dying person, shaking his hand, touching his forehead becomes an essential way of communication, an effective moral therapy [18,23].

The dying person assistance can be a life lesson that has the power to make us better. It is an integral part of the medical profession and completes in a necessary way the technical assistance, which changes from one epoch to another, while moral therapy is only once acquired. Its continuity will serve ourselves in a similar moment [10,11,12].

Conclusions

Terminally ill patient is regarded as a living person, until the end, and death if viewed as a natural process within the human evolution. The physician beneficiary of medical training of healing avoids giving too much importance to the dying person, a situation which represents more of a failure of his work or of medicine, it can be from a defense reflex, because as psychologists say, the death of another always makes the physician reflects more or less on his own death.

The natural consequence of such beliefs induced and accepted by most physicians determines the disinterest towards the people in terminal phase illness, underestimates the palliative care it considers unnecessary, but so essential and vital for the patient), attaches most of the importance to the healing and neglects the quality of life. A physician trained in this spirit feels helpless, the lack of healing is perceived by him as a defeat, as a failure.

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