professionalism of medicine that it reflects, are scalded frequently by the absurdities of managed care. Mrs. Thomas’ well-being and care is challenged by shifts in business contracts; the sacred relationship she has with her personal physician is disrupted. In attempts at cost containment, the logical preservation of a healing relationship is not prioritized—patients are now "owned lives" and physicians demoted to "providers." The once-honored relationship is viewed more in terms of replaceable commodities by the economic decision-makers. How in the face of the economic denominators can we hold true to our professionalism? How can we continue to practice whole-person care in a “drive-by” culture? How do we remain true to the vow to care?

Dr. Fins is fortunate to find a way. He maintains his “alliance in caring” for ten years and is with Mrs. Thomas in the final days as she dies at home. He confronts the frustrations of pain and symptom management in a culture focused on “drug management” and not pain management. Sadly, he does this without the involvement of community-based hospice, which, if present, may have smoothed some of the difficulties of accessing support. He facilitates closure for the family and for himself by attending the funeral, by reflecting on the life of Mrs. Thomas, by writing this article. He provides complete care for a patient and her family.

The goal of completeness in care requires completeness as a physician. Striving beyond the technology to the practice of whole person care, to embrace the tenets of our professionalism. Physicians can find the needed peer support for these practice goals within the field of palliative medicine, with its emphasis on physical, psychological, spiritual and social wellness. Death in this domain is seen as a natural phenomenon, not a treatment failure. The expertise in symptom management and supportive care is accessible through this specialty field. Here, physicians find information and skills to facilitate comfort for patients throughout their lives, sometimes called the “science of comfort”. And here as well, physicians find instruction and affirmation in the art of caring. The field of palliative medicine supports the professionalism of the physician, and the vow to care.

Commentary

Palliative Care and Primary Care

Neil MacDonald, MD

Dr. Fins’ case vignette describes the compassionate application of palliative care principles throughout a ten-year association with Mrs. Thomas. Over that span, problems, both social and medical, were prevented, ‘in time’ decisions on DNR’s and advance wills were made, and sources of suffering were avoided.

One could readily visualize another scenario that may have confronted Mrs. Thomas. Her care could have been fragmented and offered by a series of physicians, each rising to the episodic occasion, but none of whom really would come to know Mrs. Thomas and her family. Disasters, as they occurred, would be competently addressed, but, as no one was ‘in charge,’ and as no one viewed Mrs. Thomas’ illness in the context of her family and society, simple measures that could prevent the sequence of disasters would not be employed. Indeed, at one point fearing the consequences of impersonal care, Jennifer, Mrs. Thomas’ daughter, rescinded a DNR order when her mother was admitted to an unfamiliar hospital.

A few years back, Portenoy and colleagues pointed out that cancer patients under consideration for chemotherapy already have multiple symptoms. Those with a poor performance status had a mean of 14.8 but even the patients with a good performance status had, already, multiple symptom problems (mean – 9.2). While the patients Portenoy describes had cancer, the SUPPORT studies demonstrate that patients with other advanced chronic illnesses also have a wide range of symptom problems. Would both the quality and quantity of patient life be enhanced if symptoms were clearly identified at onset and impeccably managed throughout the course of an illness? We recognize that a number of symptom complexes are not simply markers of progressive illness but, in their own right, may adversely affect the course of illness. “Pain can kill,” so may depression and the cachexia-anorexia syndrome.
so common in a range of chronic illnesses. We also know that symptoms are not static hallmarks of disease. Heraclitus states “everything flows and nothing abides; everything gives way and nothing stays fixed.”6 Perhaps this sixth century philosopher was reflecting on chronic pain or cachexia where lack of control equates with increasing pathophysiologic aberrations and consequent poor response to therapy. Mrs. Thomas’ physician was on top of each situation as it arose. As a result, no doubt she and her family were saved from additional hours of suffering.

Dr. Fins is to be congratulated for his forebearance in dealing with administrative snafus as they occurred. As I read his account, I visualize a man, head in hand, explaining to yet another administrator that regulations may help the bottom line and maintain orderly process, but severely harm the individual patient. The practice of medicine is inherently messy. Diseases don’t give a damn for regulatory strictures.

The experience of the Thomas family and Dr. Fins illustrates a paradox—medical schools now preach the importance of developing communication skills and of community care. On both sides of the forty-ninth parallel, the systems within which we practice clearly do not value these attitudes. Dr. Fins’ managed care company colleagues seem to have respected the rigid strictures of organizational policy over ethical practice, while in Canada the government-engineered shortage of health professionals has led to a situation where we may value patient and family communication but must learn to apply its principles in Olympic sprints time. The care that Mrs. Thomas received requires health professional time with the patient, time in organizing care, and time for reflection. The health economists of today fail to appreciate that within medical systems of increasing complexity, the duties involved in shepherding patients through the medical maze coupled with proliferating demands from apparatchiks with their inspiring forms requires an awesome amount of professional time. A good part of this time is well spent as we play our role in inter-professional teams: periods spent in working out organizational complexities which otherwise impair patient well-being are, however, a dismaying feature of modern medicine. As Dr. Fins alludes, The Trial and perhaps Catch-22 should be required reading for new professionals; Yossarian’s insights hold relevance for today’s practice.

I was deeply moved by the account of Mrs. Thomas’ funeral. Recently a number of articles and physician commentaries have pointed out the benefits of physician participation in funerals and during the period of family bereavement.7–9 While we may worry that our presence may be evocative to family members of a time of distress, this is apparently not so. Rather, physicians are commonly gratified by the warm reception we receive in response to a letter, or to our presence at a Shiva or at a family mass and reception. The presence of the doctor gives further emphasis to the life recently lost.

Few honors can exceed the privilege of actually delivering the eulogy upon the death of a beloved patient. As Dr. Fins spoke, those present would sense both the enormous family respect he had earned, and the privilege he received through joining the Thomases as a close and trusted family friend. Dr. Fins will remember that day.

At times when we are lost in the derivative tangle created by medicine as business, reflecting on Dr. Fins’ experience can add perspective to our practice. We should remain “awe-struck by the solemnity of doctoring.”

References