Care of the Dying Doctor
On the Other End of the Stethoscope

Erik Fromme, MD
J. Andrew Billings, MD

THE PATIENT’S STORY
Twenty years ago, Dr B was a 50-year-old chair of the department of medicine at a major medical center when he first presented himself as a patient to Dr C, a junior cardiologist at the same center. Dr B had been on his daily jog up a steep hill when he developed severe fatigue and appeared at Dr C’s department office with the complaint, “I’m sick.” He was found to be in complete heart block and had a pacemaker implanted. Although Dr C advised cardiac catheterization at the time, Dr B elected not to have the procedure because his noninvasive evaluation did not suggest coronary artery disease. He was asymptomatic for the next 5 years until he developed exertional dyspnea from congestive heart failure. Although Dr C again recommended cardiac catheterization, Dr B declined because his noninvasive study results remained negative for coronary disease, and he thought his risk for ischemic disease was low.

Dr B retired from his position as chairman but continued to work at the hospital in an administrative role. He was treated successfully for heart failure with an angiotensin-converting enzyme inhibitor and diuretic until he had a 10- to 15-second episode of unresponsiveness that was witnessed by Dr B’s son, Dr B Jr, who was also a physician in the same hospital system. Although Dr B thought that he “just fell asleep” and that nothing serious was wrong, he agreed to undergo electrophysiologic evaluation at the behest of Drs C and B Jr. He was found to have inducible ventricular tachycardia, and reluctantly he underwent placement of a bulky implantable cardiac defibrillator about which he complained bitterly because it tugged on his abdomen. Several years later Dr B did have a potentially life-threatening arrhythmia that responded to overdrive pacing by his device.

Ten years ago, Dr B had developed polycythemia vera and referred himself to Dr H, a hematologist in the same department. Dr H treated Dr B conservatively with phlebotomy until Dr B became anemic and was diagnosed with myelofibrosis. The subsequent clinical course was characterized by transfusion-dependent anemia, thrombocytopenia that did not respond to splenectomy, and progressive decline with cachexia and impaired mobility. Dr H allowed Dr B to determine his own transfusion schedule, even though Dr H worried that Dr B was waiting too long before he came in to receive blood. As the patient became more debilitated, Dr B Jr played an increasingly important role in his father’s care, first accompanying his father to appointments, then advocating for his father’s appointments, then advocating for admission to the hospital in an administrative role. He was treated successfully for heart failure with an angiotensin-converting enzyme inhibitor and diuretic until he had a 10- to 15-second episode of unresponsiveness that was witnessed by Dr B’s son, Dr B Jr, who was also a physician in the same hospital system. Although Dr B thought that he “just fell asleep” and that nothing serious was wrong, he agreed to undergo electrophysiologic evaluation at the behest of Drs C and B Jr. He was found to have inducible ventricular tachycardia, and reluctantly he underwent placement of a bulky implantable cardiac defibrillator about which he complained bitterly because it tugged on his abdomen. Several years later Dr B did have a potentially life-threatening arrhythmia that responded to overdrive pacing by his device.

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dential consultations and evaluations, and eventually arranging for a splenectomy at an outside hospital. In the final months, Dr B began to experience peripheral edema and dyspnea on limited activity. Despite this, he continued to believe that his condition was going to improve, and he did not agree to establishing a do-not-resuscitate order or to turning off his implantable cardiac defibrillator. He did accept home hospice care and his son became primarily responsible for Dr B’s management there. The patient died 6 weeks later at the age of 70 years. Dr C and Dr H were interviewed by a Perspectives editor in October and November 2001, and Dr B Jr was interviewed in November 2000.

**Perspectives**

Dr C, the treating cardiologist: I was a relatively junior person when this all started. I enjoyed talking to [Dr B] because we had wide-ranging philosophical discussions about the status of academic medicine and all the things that he was expert in. In a funny sort of way, I enjoyed it because he was a bit of a mentor in that regard. I think that because I was junior, in the beginning, I probably did not approach him as much like a patient as I should have. . . . With the progression of his illness, he became more like other patients and less like the head of a hospital, a physician. I think he realized he was ill, but like most patients, every time he was ill, he always found a reason that was not an underlying severe illness. Again, this is not different from dealing with most patients but surprising that a physician could, in a sense, delude himself in the same way that other patients did. I think it shows a lot of humanity.

Dr H, the treating hematologist: Did I talk to him about the exact details (of dying)? No. As I said, I didn’t really see any point in belaboring it. I really thought that he understood. After all, he’d been a physician. He’d obviously cared for patients who died. He was very realistic. I frankly thought, and this may be a rationalization, that I would just raise his level of anxiety. He didn’t have to know what the possibilities were, and of the increasing difficulty we were having maintaining his blood count. And he could see himself wasting away. All he had to do was look in the mirror.

Dr B Jr, Dr B’s physician-son: There was a presumption that because I was a physician, I could handle more in the care of my father. As he got more and more ill, instead of stepping in, the way physicians usually do, they assumed that I could take on more responsibility, that I could make judgments about “Did he need a change in medicine?” There are two reasons why that is important: One, because it simply shouldn’t happen, and I think physicians need to know that. But the other is, it got in the way of being the grieving family member because there simply weren’t enough hours in the day to do all the responsibilities that caregivers came to expect of me—and, frankly, that my family did—and at the same time to grieve.

Few experiences in medical practice affect the physician more deeply than caring for a dying patient. When that patient is also a physician, our experience is likely to be all the more powerful, touching us personally in a manner that, for better and worse, influences our familiar professional role. Physicians may feel honored to be entrusted with the care of a colleague and may place greater demands on themselves, becoming more aware of their uncertainties, helplessness, and failures in the face of death. We are likely to identify more closely with the physician and the family, readily imagining ourselves in their shoes and sensing their suffering more acutely. Attending to a patient who is a physician may erode our sense of authority, distance, and equanimity in the challenging work of caring for the dying, and we may have difficulty recognizing how this particular person is both so similar to other patients—appreciating what Dr C called the patient’s “humanity”—and yet also different. Attending to the dying physician-patient, then, can teach us about the chasm between the professional and personal experience of the medical system in end-of-life care, and how to skillfully navigate it.

The challenges of caring for a dying physician reflect both common issues in helping the terminally ill and special problems in working with physician-patients. Many of these same challenges exist when a physician or other healthcare professional is a member of the dying person’s family. We focus herein on the physician-patient although many parallel issues arise with Dr B’s physician-son.

**Understanding the Physician-Patient’s Perspective**

Physicians facing the end of their lives deal with a familiar environment and set of problems from a radically different perspective. Plunged into the realm of patients with life-limiting diseases, their eyes open to the gnawing anxiety, creeping gloom, and maddening arbitrariness of illness, as well as the frustrations, indignities, and frank dangers of the health care system. Writing as new arrivals in “the kingdom of the sick,” they remind us in countless books and articles about how the patient’s plight was never quite so apparent to them when they were well.

Medical knowledge can be a mixed blessing for physician-patients. Dying doctors may be intimately familiar with the illnesses that afflict them and with associated treatment modalities, allowing them to explore their options intelligently, make informed decisions, and muster desirable resources, such as the right specialist. Yet, a physician-patient’s awareness of the complications and adverse effects of medical procedures and of the limitations of clinical providers and the health system may produce a heightened state of anxiety, vigilance, or frank fear. Trust or acceptance of medical advice may be difficult; the opinions of other clinicians may be rejected too easily. Physicians have greater than average death anxiety, and although they may intellectually grasp the terrible significance of new facts much faster and more vividly than the average patient (eg, the prognosis of advanced heart failure), their rational understanding does not necessarily translate into emotional comprehension or adjustment to the facts. And they are burdened with the feeling of being at least partly responsible for the care of their own fragile lives in a setting in which
one can anticipate mostly "bad news" and then death. At the same time, physician-patients are expected to take a more passive stance in matters of their own lives and deaths—not "running the case," but relying on the wisdom of other clinicians.

**Self-doctoring**

Physician-patients can readily access medical consultants and other health care services, and even order tests and prescribe medications for themselves. Self-doctoring is common, and volumes of published opinions against physician self-care (eg, Osler: "the physician who doctors himself has a fool for a patient") as well as indications that physician-patients prefer that their doctors take responsibility for major decisions, multiple studies show that physicians avoid using a primary physician or a regular source of care, continue working when ill, rely on their own clinical abilities for medical advice, and obtain curbside opinions from colleagues or friends. The physician-patient, like all patients, may have a perspective on the case that is distorted by personal fears, pride, and lack of appreciation for how his or her behavior is affecting family and healthcare professionals. Such distortions of judgment are most likely to occur in the setting of a fearful illness, and medical care may suffer.

**Professional Identity**

DR C: I should step back and say that the patient probably had as much difficulty being a patient, or probably more so, than I did being his physician in this context. He was a very smart man and knew cardiology very well; because he kept up to date on the problems that affected him... Taking care of the physician who is head of the hospital in which you work is difficult. Telling him what to do when there were things to be done was sometimes approached very gingerly.

The physician's professional identity is a prized possession and often pervades life outside of medicine. The loss of a job, professional status, and the familiar routines of work life—difficult for many patients—may be particularly devastating for a physician who has sacrificed and labored for years to become a doctor and perhaps engaged in few activities beyond the practice of medicine. Realistic opportunities to nurture a dying physician's professional identity should not be missed. Peter Morgan, MD, diagnosed at age 29 with metastatic synovial carcinoma, described his feelings after his physicians helped arrange work for him as a volunteer physician in a student health clinic:

Yesterday, I was a doctor again. Oh, what a feeling to be there for another human being. I had originally let go of practicing. To practice my art was a godsend from heaven—the greatest accomplishment of my life.

Although many patients may respond to a terminal illness with a renewal of investment in family and other relationships—"Nobody on his deathbed ever said, 'I wished I'd spent more time at the office'"—physician-patients may take refuge in the familiarity and esteem of their professional lives, rather than deal with the helplessness, vulnerability, and uncertainty that they may experience as ill persons. Unwillingness to step down from cherished medical roles, despite disability or absences, can be a disservice to patients and to colleagues.

**Perfectionism and Control**

DR C: I think that in the beginning we saw his personality come through in his illness. He had everything on his computer: every lab test, every medicine, so if our chart didn't arrive, I didn't need his chart ever.

A degree of compulsivity and perfectionism are well-known, normal, and typically desirable traits in physicians. The habits of scrupulous attention to the details of care and the sense of responsibility, formed during years of medical training and practice, do not simply disappear when one is ill. Dr B made sure that his complete record was always readily available and well organized. Physicians who find that aspects of care do not meet their high standards and who are unable to trust their professional caregivers or the health care system may feel they must take charge of their own care. Physician-patients may also respond to the threat of illness by attending obsessively to technical details, but, in the process, also avoid painful truths and the big picture.

Associated with perfectionism is often a high need for control. The story of Dr B illustrates how a physician-patient may not cede control of care to other physicians. Although Dr C suggested that he should have approached Dr B more like a regular patient, we conjecture that Dr B chose Dr C precisely because he did not want to be approached as a regular patient. Dr B might not have responded warmly to one of his junior faculty asserting authority over him.
Many physician-patients find great relief when they are able to turn over the responsibility for managing their care to a trusted treating physician.\textsuperscript{4,16} Others, having seen difficult patients and the hazards of self-doctoring, will strive to be a perfect patient and avoid being overly assertive or demanding.\textsuperscript{62}

Physicians who prefer to play an active role in their health care can become “activated consumers” who participate energetically in determining the course of their care, ideally sharing decision making with their physicians. They may also wrestle control from the health care system, coerce or manipulate physicians into following their own agenda, or even bypass their physicians. When physician-patients insist on being their own doctors, their lack of objectivity places themselves and their families at risk of poor care.\textsuperscript{63} They may alienate clinicians by such behavior, and suffer a loss of the expertise, perspective, and caring provided by the health care team.

**Selflessness, Stoicism, and Dependency**

Dr B Jr: \textit{I knew that he was going to die within a matter of a week or so, and I started seeing that there was less and less that I could do. The weight of emotional grieving became much more, and I would see my father and just feel completely sad, and at a loss as to how I could help him. And he, actually, would even notice this and he would say to me: “You look very troubled. You’re upset about this.”}

Even though he is dying, Dr B, in a touching show of selflessness, seeks to take care of his grieving son. Physicians are taught that they should put their patients’ needs ahead of their own. Even before medical school, some physicians’ personalities predispose them to avoid dependency and deny their own needs, which they meet vicariously by taking care of others.\textsuperscript{73} The culture of medicine discourages physicians from complaining about or even discussing their personal problems.\textsuperscript{3} Furthermore, physicians tend to prefer patients who do not complain, and may “hate” so-called dependent clingers,\textsuperscript{64} thus adopting stringent standards for themselves about when to ask for help.

Selflessness on the part of a physician-patient may translate into altruism but also into stoicism or minimization of one’s own desires. It can lead to difficulty acknowledging one’s neediness or that of one’s family and to discounting or concealing symptoms and suffering. Selflessness may be associated with an unrealistic sense of self-sufficiency in the face of increasing dependence and with problems adjusting to the role of a care-receiver. Unfortunately, Dr B’s stoicism isolated him from his son who sought to grieve more openly. We suspect that Dr B might have felt more comfortable in his cardiology visits because he could return the favor at each appointment by contributing his expertise in academic medicine to mentor Dr C. Physician-patients may try to schedule their illness to minimize the amount of work they miss or the inconvenience they cause for patients and colleagues.\textsuperscript{65} They may avoid medical care, delaying appropriate treatment.\textsuperscript{66} Admitting to pain, doubt, or, especially, emotional or spiritual distress may be perceived as weakness or personal failure rather than the common experience of dealing with a terminal illness. Struggles with dependency, therefore, are a frequent feature of care of the dying doctor.

**Equanimity: A Challenge for the Treating Physician**

Dr H: \textit{One of Dr B’s very human complaints was that when his blood count got too low he couldn’t play with his grandson as much as he wanted to, which was painful to hear, but very telling.}

Our emotional reactions to our patients—both positive and negative, sometimes called \textit{countertransference}—complicate as well as enrich our relationships.\textsuperscript{67,68} Physician-patients are likely to share much in common with the physicians who treat them, not just their medical background, but their ambitions, cultural interests, and lifestyles. These similarities may lead treating physicians to bond more closely with physician-patients than with others and to provide more personal attention—perhaps in the form of special office hours, shortcuts to obtaining procedures, prompt telephone calls about laboratory test results, or home visits. The treating doctor risks suffering more intensely as the patient and family endure the multiple losses that characterize death from cancer, congestive heart failure, or other chronic, progressive illnesses.\textsuperscript{25} Just as family members react when feeling personally threatened, an overly involved treating physician may respond with anger, anxiety, depression, or withdrawal. Moreover, since physician-patients are acutely aware of all the uncertainties, delays, mishaps, and errors that can occur in medical settings, they may make their professional caregivers feel particularly vulnerable to criticism and unusually defensive about medical decisions.

Other doctors—in this case, including Dr B’s son—are likely to be at least peripherally involved. In some cases, they may provide a variety of well-meaning, but perhaps also ill-informed, divisive, or inappropriate suggestions that complicate management.\textsuperscript{16}

In end-of-life care, even with the finest palliative care services, clinicians occasionally watch profound suffering in someone about whom they care deeply.\textsuperscript{69,70} At such times, we may be able to offer nothing more than our presence.\textsuperscript{71} Physicians typically protect themselves from the frightening and painful aspects of patient care through some degree of professional detachment or objectivity,\textsuperscript{72} a focus on problem solving, and by maintaining boundaries or setting limits.\textsuperscript{73} These defenses, while essential to good medical practice, tend to suppress or circumvent disturbing emotional experiences and have the potential of impeding the clinician’s empathic perception of patients’ suffering.\textsuperscript{26} When we focus only on the illness and its management without attending to the personal experience of the patient and family, we may be protecting ourselves from being touched by their suffering.\textsuperscript{74-76} At worst, we become so cold or distant that we effectively abandon the patient and family.\textsuperscript{77} Feel-
ing deserted by a respected colleague causes a particularly poignant loss for the physician-patient.21

At another extreme, professional caregivers are subject to the risks of overinvolvement, overidentification, or enmeshment. They can simply become incapacitated by sadness,78 More commonly, out of kindness, hoping to spare our patient from physical or emotional discomfort and spare ourselves from inflicting suffering, we may avoid important but disagreeable tasks, and thus provide substandard care.79 Examples of such behaviors might be skipping the rectal examination when it is indicated, sugar-coating bad news, failing to inquire about such personal issues as substance abuse or family violence, and generally avoiding exploration of psychosocial issues.

The treating physician, then, must guard against both overinvolvement and underinvolvement, and strive to be a guide to the patient and family through unfamiliar territory, a companion who is not afraid to listen to and explore the most upsetting matters, a person who can speak frankly when everyone else is ignoring “the horse on the dining room table.”80 Such a role was difficult with Dr B because discussions had to occur in the context of his unvarying belief that he was going to get better. Steering between overinvolvement and underinvolvement can be aided by self-reflection and informal review or formal consultation with trusted colleagues. A treating doctor who feels intimidated, overwhelmed, too personally involved, or similarly distressed in caring for the physician-patient should seek supervision and consider delegating responsibility for aspects of care or even withdrawing from the case.

STRATEGIES FOR TREATING THE PHYSICIAN-PATIENT

Negotiating the Relationship

Dr H: I realize that this can get complicated. I had the advantage of being a doctor’s son, who had observed his father in action, and I therefore knew that I had to be the doctor and he had to be the patient, which of course is easy to say and sometimes a little hard to achieve. But I tried to make it clear to him at the outset that we would have to have a doctor-patient relationship. It was particularly important in this case because Dr B had a very strong personality and was used to dominating his environment.

Contrast Dr C’s approach with that of Dr H. Dr H encountered Dr B at a later stage in both of their lives. Dr B had retired from his administrative role, and Dr H was a seasoned faculty member. Dr H also had the advantage of working with a clear diagnosis and an uncontroversial treatment plan that required less physician judgment or patient involvement in making decisions. Under these circumstances, Dr H was able to take the important step of directing attention to the physician-patient relationship. He also tried to lay down some ground rules. Although Dr B readily agreed to this arrangement, in practice he still ended up dictating his care to a high degree. Both treating physicians gave Dr B considerable autonomy in directing his own care, and ultimately they supported his decisions even when they would have done things differently.

The treating physician can set the stage for ongoing negotiation of roles by demonstrating from the earliest visit a sensitivity and awareness of the potentially problematic role of the physician-patient, as illustrated in the Table.

**The Physician-Patient is Like All Patients**

Many of the challenges faced by the professional caregiver in caring for a dying physician are no different than those faced in the caring for other dying patients. We first need to be reminded not to omit familiar tasks: meticulous attention to alleviating pain and controlling symptoms; shared decision making (which includes attention to preferences about how information is presented, education about diagnostic and treatment options, and elicitation of personal values and goals); psychosocial and spiritual support for the patient and family; and coordination of care across sites.81

Keeping in mind Dr B Jr’s poignant struggle to manage his father’s care while grieving the anticipated death, treating physicians should not presume that the physician-patient neither needs nor desires professional expertise and guidance in safe passage to death. The physician-patient’s familiarity with the world of medicine may lead clinicians to treat him or her as an unbiased clinical collaborator rather than as a sick person with intense and complex feelings, emotional turmoil, uncertainties, and ambivalence. Physician-patients and their families are no less likely than others to experience difficulties or have dysfunctional coping strategies and are no less likely than others to benefit from the expertise, guidance, detachment, and equanimity of a team of professional caregivers.3,82 Importantly, physician-patients deserve as much frankness as they desire and can bear, and the treating physician should not collude to avoid truthfulness, especially when the obvious is being ignored or minimized or when important decisions need to be made in the face of terminal illness. A few interviewing strategies follow:

**Attending to Bad Outcomes:** “I see that you are hoping for a great outcome here, almost a miracle, and I am strenuously hoping along with you. At the same time, I wonder if part of you also is thinking about what might happen if this option does not work out in your favor?”

**Hope for the Best, Plan for the Worst:** “One important point I have learned in dealing with life-threatening illnesses is to live well in the moment, to hope for the best, but also plan for the worst. For instance, if you knew you only had 24 hours to live—of course, this is not the case now—would important things be left undone? What would you want to do?”

**The Physician-Patient Is Different**

Physician-patients also tend to be different in some ways from most patients. Their familiarity with medical care enables them to be highly informed and active consumers. They
Informal consultation

“I know you may be tempted to grab me or your colleagues in the hall for questions and consults. That’s

Information sharing style with family

“How would you like me to involve your family? I need your guidance about when you want them present in

Information handling

“I am going to make a special effort to explain what I am doing and not to assume that you understand

Confidentiality

“I want to make clear that I will be treating you with absolute confidentiality, not gossiping about your care with

Information sharing style with family

“How would you like me to involve your family? I need your guidance about when you want them present in information sharing and decision making.”

“How would you like the staff to address you?”

Informal consultation

“I know you may be tempted to grab me or your colleagues in the hall for questions and consults. That’s understandable, but I don’t think it can substitute for a formal patient-physician relationship. I prefer that we set aside some time on a regular basis to review your concerns when I can give you my full attention and so we can figure out which consultants we want to involve in your care.”

Supervised self-doctoring

“Lots of physicians, when they become patients, end up taking a very active role in their medical care and making a lot of decisions and plans for themselves. Others look for more guidance from their doctor and expect a lot of guidance and assistance. How do you see this? Can we talk about it again, if we need to?”

“If you are thinking of making decisions or plans on your own, my request is that you keep me in the loop, so I continue to have a clear view of what is going on in your care and can offer my expertise.”

“I know, for instance, that you are quite capable of arranging tests, getting appointments with specialists, and so on, and you might prefer to do this, but I don’t want to dump responsibilities on you, just because you are a physician. We should at least discuss or negotiate situations when you are assuming responsibilities that might normally be mine.”

Providing comprehensive care

“I see being your physician as taking an interest not only in the details of your medical care, but also in how you and your family are coping with this illness. These are important aspects of good care. I want to make sure we talk about these sorts of things, and I am going to make an effort to ask you the same questions as I would with any patient.”

Monitoring the relationship

“Because of the challenges that sometimes arise when one doctor is caring for another, I will try to step back for a few moments every few months and reflect with you on how this relationship is going. I welcome your input anytime.”

can obtain informal consultation from several sources, and they enjoy greater access to professional literature, medical records, specialists, diagnostic procedures, and medications. They may also be less likely to accept received dogma or bland counsel. Indeed, a treating physician’s offer of advice may be seen as demeaning or undermining of one’s professional capability. Small, unintended slights, such as delay in notification of test results, may be perceived as disrespect.

Although some physician-patients “never give up” and eagerly embrace any strategy that offers a glimmer of hope, others seem overly cautious and hypervigilant about the dangers of medical care, having seen many bad outcomes firsthand.

Privacy can be an important issue. Physician-patients must often choose whether to seek care within or outside of the hospital or health care system in which they have worked. In general, physician-patients will have more authority, connections, and privileges (for example access to their own computerized records) at their own institution, but they will have more anonymity, privacy, and confidentiality elsewhere.

When physician-patients choose to receive care in a familiar and trusted institution where they have practiced, their right to privacy poses particular problems. Not only are parts of the medical record likely to be available and a source of interest to various hospital personnel, but colleagues and friends may eagerly seek out information from each other. The patient may be reluctant to reveal personal matters with clinicians, fearing that information will be shared with others and widely communicated.

Supervised Self-doctoring

Entreaties against self-doctoring are well known in the medical profession, and all physicians should be clearly advised against such practice. On the other hand, as cited above, self-doctoring is common and appears to be nearly universal when a physician is ill. The usual pleas against such practices have not been effective. We propose a useful clinical strategy of addressing and negotiating the issue regularly rather than
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expecting that one can eradicate it. Especially when terminally ill physicians seek a high degree of control over their management or when their behavior reveals considerable engagement in managing care, we suggest striving for supervised self-doctoring, a negotiated relationship that acknowledges the specialness of the physician-patient but allows for ongoing stewardship by the treating physician. This patient-physician relationship requires that the treating physician be neither intimidated and conflict-avoidant nor insistent on maintaining total control of the care. In gentle and sometimes even humorous ways, the treating physician can seek to share power with the patient and maintain respect for the patient’s specialness, but try to be clear, without dismissing the patient when his or her actions or decisions seem wrong or inappropriate:

- Don’t you want to leave that to me?
- Help me understand your decision.
- I realize you are a fine physician, and I have heard that they can sometimes be difficult patients, but . . .
- Can I give you some feedback about what I am seeing as a consequence of your acting as your own doctor?

CONCLUSION

Caring for dying doctors can teach us a great deal about all patients and about ourselves. If we are open to appreciating the physician-patient’s experience of being ill and of receiving care, we can become more aware of the struggles faced by dying persons and the barriers to good care posed by our health care system. In particular, we may better understand death and dying and be sensitized to the gaps in personal and professional perceptions of the experience of being ill while developing greater empathy for the patient’s and family’s plight. If we become neither overinvolved and overwhelmed nor underinvolved and distant, we may appreciate more clearly how we want ourselves and our families to be treated in the crisis of terminal illness—in effect, practicing for our own dying—and can become better clinicians and stronger advocates for improved end-of-life care.

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WEB SITES FOR END-OF-LIFE SUPPORT

Advancing End-of-Life Nursing Care (ELNEC) Consortium Project
http://www.aacn.nche.edu/elnec
Sponsored by the American Association of Colleges of Nursing-End-of-Life Nursing Education, this Web site serves as a resource for nursing education, including a variety of courses for practitioners and educators and curricular materials.

Center to Advance Palliative Care (CAPC)
http://www.capcsmssm.org
Mt Sinai Hospital, New York, NY
This is the premier site for technical assistance on developing palliative care programs, especially hospital-based programs. Courses are given regularly, and helpful materials are available online.

Center for Ethics in Health Care
http://www.ohsu.edu/ethics
Oregon Health & Science University, Portland, Oregon Health Sciences University
This site serves as a resource for ethical issues, especially the popular form, Physician Orders for Life Sustaining Treatment.

StopPain.org
http://www.stoppain.org/caregivers/index.html
Department of Pain Medicine and Palliative Care, Beth Israel Hospital, New York, NY.
Among other issues, this site includes resources on assessing and managing pain.

The EPEC Project
http://www.epcnet.org
Education for Physicians on End-of-Life Care
This is a national educational program to train physicians about end-of-life care. It offers courses and curricular material.

End-of-Life Physician Education Resource Center
http://www.eperc.mcw.edu
This site houses a large repository of peer-reviewed educational materials on end-of-life care. A weekly e-mail provides notification about new materials.

Harvard Medical School Center for Palliative Care
http://www.hms.harvard.edu/cdi/pallcare
Advanced training, especially for physician- and nurse-educators, about palliative care education and program development is available from this site. Other courses are also offered on care near the end of life.

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