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Love and Boundaries in Medicine

By Ira Byock

It's a little-known and rarely discussed fact of medical practice that doctors value the ability to love our patients. If the thought of doctors loving patients makes you queasy, be reassured. I'm not talking about romantic love but the visceral sense of goodwill and impulse to service that draws young people to the profession and allows them to endure the years of arduous training required to become a physician.

To know a patient as a person is to recognize their unique history, as well as their sensitivities, interests and idiosyncrasies. This depth of doctoring honors a tender therapeutic covenant within which patients can feel safe in sharing a full range of personal information – including things they may never tell another soul – and confident in being heard and understood.

Relation-based practice of this nature offers a chance to thrive professionally at a time when more than half of all doctors are experiencing burnout. It's what entices some physicians to become concierge doctors. It drew me and others in the specialty to palliative care.

As a teacher, I encourage medical students to bring their whole selves to their practice – to learn about, kibitz with, and enjoy their patients. But I emphasize that while the genuine affinity between a doctor and patient is wholesome, in order to protect patients' vulnerability and preserve the special trust of this relationship, there are some things that doctors must not do. The big three are: No sex, No personal gain, and No killing.

No sex is obvious. Doctors possess unique authority to observe, touch and probe people in intensely intimate ways. The prohibition against sex allows patients to be vulnerable, protected from even subtle manipulation. *No personal gain* means that the generous compensation physicians receive for their services is enough; they must refrain from accepting personal gifts or requesting donations for their clinical center or research project. (Fund development professionals can engage grateful patients without compromising the sanctity of a doctor-patient relationship.) *No killing* means just that. While alleviating suffering and, when death is near, allowing someone to gently die are our duties; even in jurisdictions where physician-assisted suicide is legal, it is beyond the scope of medical practice.

Last fall the American College of Physicians (ACP) affirmed this principle stating that, "Physician-assisted suicide is neither a therapy nor a solution to difficult questions raised at the end of life." In May, after two years of study, the American Medical Association's Council on Ethical and Judicial Affairs similarly recommended that the organization remain opposed to physician-hastened death. Just a few weeks later, however, the AMA's House of Delegates voted against that recommendation, sending the issue back to the Council for still more study.

Especially in light of the continued sorry state of end-of-life care in America, I hope the AMA eventually does more than merely affirm the principle of No killing or opt for a stance of neutrality that some state medical associations have chosen. This is a moment when American physicians can demonstrate what we are *for*.

The recent statements from the house of medicine suggest a framework for constructive action. The American College of Physicians' position avowed, "ACP remains committed to improving care for patients throughout and at the end of life." And the AMA's Council declared, "The profession also has a responsibility to advocate for adequate resources for end-of-life care…" I applaud the altruism, but as the saying goes, talk is cheap.

America's doctors must get our own house in order. I'd start by fixing long-standing deficiencies in practice and clinical training related to care for seriously ill people. We must teach subjects of communication and symptom management with the same rigor we apply to anatomy and physiology. A model program at Oregon Health Sciences Center now tests medical students on skills of sensitively giving bad news and discussing people's feelings. Requiring training and testing of this sort can help ensure that, before graduating, young doctors have the attitudes and basic proficiencies needed to take good care of people who will be literally trusting them with their lives.

How people die lies squarely within the medical profession's purview. The debate over hastening death must not distract us from taking boldly positive actions. Physician organizations like the American Medical Association and American College of Physicians could assert proper social leadership by championing affirmative public policies to measurably improve care for dying Americans. They could, for instance, draft legislation and regulations to:

- Require Medicare and insurance companies to allow patients to receive hospice care while they are being treated for late-stage cancer or organ failure.
- Make data on quality of end-of-life care publicly available for people to use in choosing hospitals, nursing homes, and hospice programs.
- Rescind the licenses of long term care facilities that repeatedly fail to meet their residents' basic needs. We've all heard patients say that they'd rather die than be sent to a nursing home.
- Require hospitals to fully staff palliative care teams and make palliative care available 24/7, including weekends and holidays. Suffering never takes a vacation.

If this sounds overly ambitious to the elected members of the boards of medical associations, I'd ask them to think again. For the love of our patients and our profession, it's the least the nation's doctors can do.

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