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BOOK REVIEW: FINAL EXAM: A SURGEON'S REFLECTIONS ON MORTALITY BY PAULINE CHEN

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Our local medical school has a mini-medical school for the public.[1] Various specialists come and lecture. One evening we were shown something which, at a distance, looked like a small loaf of French bread. "This is the liver of a fifteen year old boy. It is several times the usual size. We all loved him; we all tried so hard."

The disease and the treatment went something like this: "We treated it aggressively, doing X. X worked well but lead to Y, which we then treated aggressively. Again, good success with Y, but that led to Z. We treated Z aggressively. Finally we lost."

"Questions?" Having heard "aggressive treatment" as "intense suffering," I raised my hand, "Thinking back, would you do anything differently?"

I was expecting an insightful discussion by folks who have struggled, not hypothetically, with the agonizing decision to go ahead with painful, problematic treatments, or step back and let nature take its course. Instead, I got a deposition transcript on why no one committed malpractice.

Most likely doing nothing was not *considered.* The old adage, *first, do no harm,* has been, thanks to the advances in medicine, amended; *First, do no harm, but at least do something.*

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1. The University of Arizona College of Medicine, http://www.opa.medicine.arizona.edu//minimed/ (last visited April 9, 2007).

Dr. Chen writes:

> Even medicine's essential framework for approaching clinical problems – the treatment algorithm[2] – presumes physical action. Frequently diagramed in textbooks and medical journals, these algorithms outline step-by-step therapeutic plans for different diseases. For every point along the algorithms there are several possible outcomes that in turn may have several of their own therapeutic options. On no branch of the decision tree, however, is there a box reserved for *Do nothing* or *Hold tight* or *Sit on your hands*. . . . Moreover, once treatments have started, there is an obligation to the interventions themselves. Having done so much already, doctors – and many patients and families – find it nearly impossible to let all their efforts simply drop.[3]

The mindset that, "We can defeat disease," has, at one time or another, saved us all. However, it does not bode well for our final illness.

Despite all of the literature praising Hospice, the ballyhoo surrounding living wills (where most check "no heroic measures"), and the common knowledge that the American way of death is frequently a long, painful, and expensive stay in ICU, the American way of death persists.[4]

Why? Dr. Chen offers many partial explanations. First, patient denial. Second, family confusion linking continued treatment with love. Third, too many doctors – as there are often many different specialists involved in end-of-life treatment, no one is really in charge of making tough decisions

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2. *See, e.g.*, American Society of Health-Systems Pharmacists, Algorithm for Treatment of Hypertension (2003), http://www.ashp.org/ahfs/print/Ess-gjnc_algorithm.pdf (last visited Mar. 7, 2007.)

3. PAULINE CHEN, FINAL EXAM: A SURGEON'S REFLECTIONS ON MORTALITY 147-48 (2007).

4. *See id.* at 70-73. In The mid-1990's there was a large study of hospital care given to dying patients. The findings were dismal. There were many calls for reform and many new corrective programs. But after two years, researchers found no notable improvement. "Terminal patients in the last six months of their lives still received aggressive treatment, and many of them were in the intensive care unit. A high percentage . . . continued to complain of moderate to severe pain . . . and a large number of physicians still had no idea of their patient's final wishes regarding cardiopulmonary resuscitation and artificial life support." *Id.* at 70.

or triggering tough discussions. Finally, physician "self-interest" – fees generated by continued treatment and the fear of malpractice claims if they stop treatment too early.

Nothing new here. What you do not know, and what you will learn at a deep level, is how powerful and deeply ingrained is the instinct to take action, to keep on fighting. Dr. Chen describes the revolution in medicine – doctors no longer were simply bedside, they could actually cure disease:

> Their ability to treat diseases empowered physicians, and that empowerment soon translated into the urge to treat not selectively but almost indiscriminately. The implicit meaning of the converse – doing nothing at all – came to represent a willful refusal of power and strength over disease.[5]

Even more basic than their training, Dr. Chen argues, is physicians' fear of death. She quotes some writers to the effect that those with a heightened fear of death are drawn to the medical profession.[6] Whether correct or not, the fear of death prevents those dealing with terminal disease from even discussing death. (During her hospital training, that topic was always left to the next intern.)

While the major topic of *Final Exam* is how medical education and physicians' attitudes influence end-of-life care, Dr. Chen's book is a much richer read. One lives her life as a medical student, from the first and much-dreaded autopsy (with the deceased facing down, face covered) to the first time she took a hard, sharp steel knife and cut open another living human (being gentle doesn't cut it). Dr. Chen writes so well, you meet many of her patients, many of her colleagues, many of her instructors, many of her triumphs and dreams, and many of her failures and fears. Knowing what they went through, I know doctors better.

Learning about medical education helps one assess legal education; nothing helps sight as much as contrasts. A few

5. *Id.* at 147.
6. *Id.* at 60-61.

things jumped out. Medical education is quite hierarchical and involves many more layers of instruction than does legal (interns instruct medical students, residents instruct interns, physicians instruct residents).

The practice of medicine, *House*[7] to the contrary, is quite structured and routine. Treatment algorithms are recipes – follow them and you won't make a mistake. The medical school adage, *See one, do one, teach one,* does not leave much room for *ponder one, reject one, tinker one.* Doctors who come to law school are blown away by our "bloomin' confusion." "What do you mean no right answers? Are you guys still in the 19th century?"

Does the nature of our callings dictate the different teaching and learning styles or is it a matter of historical accident or recent fad? One might venture that, when formalists walked the earth, law schools were much like today's medical schools, awash with right answers. Perhaps the two schools somehow passed in the night. But I digress.

One also gets a sense why doctors don't like lawyers very much, even doctors who haven't been sued. Scenes persist. The hurried 15-minute hospital breakfasts, gobbling down egg sandwiches with other interns, about to depart to walk the chaotic floors, to draw blood and do scut work, to have residents, in front of everyone, grill you, embarrass you, as to the proper algorithm. All of this, of course, with the fear that is always background. As an instructor assured Dr. Chen, "Somewhere along the line you are going to kill one of your patients."[8] Today?

Law students complain as to the intensity of legal education. Fiddlesticks. No wonder doctors feel an iron bond with all who have gobbled down egg sandwiches in the wee morning hours, how understandable the feeling that an attack on one is an attack on all.

Nursing schools have a fabulous saying: *We are not treating*

7. *See* Fox Broadcasting Company, http://www.fox.com/house (*last visited* Mar. 7, 2007.)

8. Chen, *supra* note 3, at 105.

diseases. But many doctors seem to. Chen quotes from an article by cardiologist Hacib Aoun:

> It hit me violently that I had lost sight of my patients as human beings and had begun to see them as a different species: the patient species. . . . The process of becoming a doctor is so protracted and arduous that it is easy to forget along the way the initial reasons and ideals for wanting to become a doctor, especially because the current curriculum is disease-oriented, not patient-oriented.[9]

Once you see your patients (or clients) as "representative cases," you will tend to overlook subtleties and treatments suffer. Indeed, the patient and the doctor may have different ideas about the disease and what it means to be cured. For a marvelous book on this problem see *The Spirit Catches You and You Fall Down* describing the failure of communication between western doctors and recent immigrants.[10] Treating diseases, and not people, may lead to similar breakdowns.[11]

Legal education has similarly been accused of robbing students of their idealism and giving them a distorted view of their future clients – from the case method they learn that defendants only want to escape liability and that plaintiffs only want more money - no one ever wants to make amends. Not only will this view lead to "representing causes of action" rather than people, but to the degree clients conform to their lawyer's expectation, they may be forced into positions they would not have otherwise taken.

There is another parallel between medical and legal education: students think interviewing classes are a waste. Why

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9. *Id.* at 133.

10. ANNE FADIMAN, THE SPIRIT CATCHES YOU AND YOU FALL DOWN (1998).

11. Arthur Klienman, a psychiatrist and medical anthropologist at the Harvard Medical School, developed questions for doctors designed to overcome communication gaps: How do you *view* your disease? What *caused* the disease? How should we *treat* it? What does it mean to be *cured*? Lawyers can plagiarize: What is your problem? What caused it? What would be a good outcome? How can we solve the problem? In medicine, no one considers the germs' point of view; in law, we must: What will the other side say? KENNEY F. HEGLAND, TRIAL AND CLINICAL SKILLS IN A NUTSHELL 277-78 (2005).

is this? I think the answer lies in a metaphor, that of *care/cure.*

Interviewing skills, understanding one's feelings, facing one's mortality, may be all well and good, but they don't *cure* anyone. Before antibiotics and surgery, doctors couldn't really cure much of anything either; the patient got better or died. But they were bedside, helping their patients through terrifying times. Once doctors were able to actually cure disease, care became the ten-minute consult and bedside became the ICU.

But eventually cure runs its course. Fifteen-year-old boys die of liver disease. We lawyers, for all of our statutes, cases, and policy arguments, and even if we never ask "why?" on cross, can cure only so many of our clients' problems. Many are left to live through terrifying times. *Final Exam* reminds us of bedside.