Canadian Journal of Bioethics
Revue canadienne de bioéthique

Reflecting and Regretting

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Volume 6, numéro 3-4, 2023

Numéro hors-thème & AMM
Open Issue & MAID

URI : https://id.erudit.org/iderudit/1108013ar
DOI : https://doi.org/10.7202/1108013ar

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Éditeur(s)

Programmes de bioéthique, École de santé publique de l'Université de Montréal

ISSN

2561-4665 (numérique)

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Citer ce document

Avny, O. (2023). Reflecting and Regretting. *Canadian Journal of Bioethics / Revue canadienne de bioéthique*, *6*(3-4), 142–145. https://doi.org/10.7202/1108013ar

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Canadian Journal of Bioethics
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O Avny. *Can J Bioeth / Rev Can Bioeth.* 2023;6(3-4):142-145

TÉMOIGNAGE / PERSPECTIVE

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Ohad Avny[a,b]

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C'est l'histoire d'une femme âgée qui souffre de démence et qui a enduré toute une vie de mauvais traitements de la part de son mari. Au fil du récit, nous découvrons l'histoire tragique de cette femme âgée et les tentatives faites par son médecin au fil des ans pour l'aider. Les questions éthiques auxquelles le médecin est confronté, ses émotions, ainsi que les dilemmes stratégiques auxquels il doit faire face alors qu'il planifie et gère le traitement et les soins du mari et de la femme, créent une toile de fond troublante pour une histoire de comportement du patient et du médecin. Les dilemmes éthiques, émotionnels et professionnels liés au traitement d'un mari violent et de sa femme sont examinés en détail.

Mots-clés
fin de vie, maltraitance, soins primaires, démence, relations médecin-patient, dilemmes professionnels

Abstract
This is the story of an elderly woman who suffers from dementia and has endured a lifetime of abuse from her husband. As the tale unfolds, we learn about this old woman's tragic history, and of the attempts her doctor has made over the years to help her. The ethical issues the doctor struggles with, his emotions, as well as the strategic dilemmas he is forced to confront as he plans and manages the treatment and care of the husband and the wife create an unsettling backdrop to a story of patient and doctor behaviour. Ethical emotional and professional dilemmas when treating an abusive husband and his wife are discussed in detail.

Keywords
end of life, abuse, primary care, dementia, physician-patient relations, professional dilemmas

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INTRODUCTION

I remember well the day Edward (names are fictional) arrived at my clinic and said to me, "Dr. Avny, I have decided to transfer from my current doctor to your care, and I would be delighted if you would accept my wife as well."

Edward was an elderly man of eighty-five, vigorous and with piercing eyes. He stepped into my office with a vital, determined step. Something about his body language and his tone of voice had generated in me a certain discomfort: Was it his certainty that I would be pleased to accept him, or his sense of entitlement? Or the question in my mind: why might he want to change doctors? I immediately attempted to direct our conversation to my own comfort zone as we briefly discussed his medical history. During the conversation, other thoughts came to my mind: *"Why had he decided to transfer to my care? And why was I feeling so uncomfortable with him?"*

After the interview with Edward, I asked if I could meet his wife for an introductory interview. Edward replied coldly (a reaction that surprised me) that his wife was unable to attend the clinic and that she had already agreed to be transferred to my care. I decided to call her while Edward was still in my clinic. I distinctly remember her reticence during our telephone conversation, how brief her replies were and how feeble her tone. I concluded the meeting with Edward with a nod. And all the while, inside, the un-named discomfort continued to grow.

As soon as Edward had left the room, I telephoned their previous attending physician who was a close colleague of mine and my mentor during my residency. It did not take long for me to understand the sort of 'trouble' I had gotten myself into by agreeing to take them on as patients. I was told by my colleague that Edward had been abusing Malka, his wife, for many years, despite many efforts by my colleague as her attending physician, and the interventions of a social worker and the welfare services, who had tried to assist Malka countless times. I was slowly comprehending the kind of reality I had stumbled upon, a reality of loneliness and anguish suffered by an aging woman who was also apparently slipping into dementia and who was starved of affection by her husband. No wonder Edward had said, "I decided to turn over a new leaf with a devoted and professional doctor like you. I have heard so much about you."

I sensed that I had fallen victim to the machinations of a patient who wished to find a family doctor who would remain uninvolved and not interfere with the suspected violence that Edward evidently inflicted on his wife. For the first time in my professional career, I began to ponder how I might possibly untangle the complexities involved in such a situation and assist a woman living with dementia to leave her home or take some other possible steps to disentangle her marital relationship. I had to try to figure out a way that I could rescue a person who had apparently succumbed to a kind of imprisonment in her home, a place normally expected to be a haven of safety and security. I decided to invest in my relationship with the patient, Edward, adopting a well-planned attitude aimed at gaining his confidence – despite a sense of apprehension and many reservations. My goal was to slowly convince Edward that I should be able to visit Malka to assess her condition, as a first step in understanding the dynamic

ISSN 2561-4665

of their relationship and whether there was a need to ‘rescue’ her. That sense of treating Edward with little or no compassion for him, and with an attitude aimed at assisting his wife, was difficult and unnatural for me. Empathy and acquiring rapport with our patients have always been the cornerstone of my work with my patients. But at the same time, Edward also needed medical attention as he was suffering from heart failure, ischemic heart disease and peripheral vascular disease. Thus, I felt that it was a case of “ethical tension” of a physician struggling between his professional duty to treat all patients and criticism of his patient’s moral behaviours.

I realized that considering the advanced ages of both Malka and Edward, it was likely that I would be treating and accompanying them through the final years of their lives. Only this time, the therapeutic experience would be completely different from those I had generally experienced with other patients who were nearing the end of their lives.

At that stage, I could consider whether it would be better if I could relieve myself of the duty of treating Edward and Malka using a variety of pretexts. But here, the question arose whether my commitment as a doctor was limited by my personal preferences. Was choosing who I wanted to treat an act of moral dereliction? I knew that most Western countries mandate physicians to act within a framework of ethical practice, and from that basis policies have been implemented that put the welfare of patients before that of the treating physician. That is why, for countless generations, physicians have treated patients afflicted with serious infectious diseases, for example, physicians in Africa who often put their lives at risk, despite using the best available protective measures, to care for Ebola afflicted persons.

The reasoning I normally use to convince myself of anything is that beneficence and justice, two of the founding principles of the so-called Georgetown Mantra (1), the most recent basis of medical ethics, should be respected. How can I convince myself, and, if necessary, the medical regulating body that I can discharge a patient from my care? How could I discharge a patient to whom I am not historically attached, and of whom I might even disapprove? I recognized that at this time of his life, perhaps Edward would be better off being treated by a different doctor, one who might be more empathetic and assist him in an unbiased way. Or was that just an excuse I had been telling myself?

During our second meeting, as I pondered the other very pressing ethical issue, I decided to probe a little more in an attempt to find an interest in Edward as a patient. I looked into his medical history – ischemic heart disease, anemia that had been put down to an undetermined cause, and an abdominal aneurysm that was being regularly monitored. I decided to try and create a work environment that would allow me to gain Edward’s trust and convince him, in an empathic manner, to allow me to examine Malka. Since Malka was “too weak” to come to my clinic, I asked Edward’s permission to pay her a house visit. I saw Edward pale at my request, but he consented.

I arrived at their house on a cold, inclement day. Malka was sitting in a chilly room wearing a sweater. I introduced myself and we started talking. She told me she has been suffering from diarrhea lately, as well as weight loss and abdominal discomfort (as she said in lay terms, “stomach-aches”). I offered to examine her and did so when she agreed. She was bent over and showing all the signs of aging. She was unbruised and the physical examination yielded no significant findings other than extreme emaciation. I asked her about possible reasons for her loss of weight, and Malka told me again about her diarrhea. The possibility that she was being deprived of adequate food seemed a more probable cause. At one point, her husband left the room, and I immediately used the opportunity to ask her, gently and with as much empathy as I could generate, if she felt safe in her home and if she had been suffering any form of violence. Her reply was simple. “My husband takes care of me, as he always has.”

Over the next few months, Edward visited my clinic at intervals to discuss his medical conditions. Whenever I asked after his wife’s wellbeing, his stock answer was that she was still eating very little and still suffering from diarrhea, but that her general state of health was unchanged. He did ask for periodic blood tests for himself and his wife since he was “concerned for her health.”

I felt the need to try to interfere again when one of my patients, a woman who lived not far from Edward and Malka, told me about the shouting she regularly heard coming from the couple’s apartment. The woman then asked if I was their attending physician. I was shocked. I bit my lip and said nothing. I realized I had to adopt an active attitude, and I knew that the key to my ability to help Malka involved conducting a cognitive evaluation test at her house in the hope of finding her to be demonstrate some degree of cognitive impairment. In that case, I felt I would be justified professionally and legally to call in a welfare officer and remove Malka from her house and the apparently non-caring and maybe even planned damaging attentions of her husband.

I asked Edward for permission to visit Malka again. I was more confident this time, feeling I had been able to “gain the trust of the husband”, who I knew now felt safe with me. During my meeting with Malka, I asked her several questions using a brief a Mini-Cog cognitive screening test. And, indeed, the test results indicated a high probability of cognitive impairment, although at what level was not clear, but at least bordering on dementia. We called in a welfare officer and, eventually, a judge visited the patient’s home. Once the judge had formed his impression of Malka, she was removed from her home, against her will, and a place was found for her in a nursing home.

I subsequently received several welfare officer reports that Malka’s general condition had improved in her new place of residence. She gained weight and her mood improved. Unfortunately, her dementia worsened, but the quality of her life did

generally improve and, eventually, she died peacefully in the nursing home where she lived. Over the course of the following year, Edward, her husband, continued to frequent my clinic. At his advanced age of eighty-six, it was clear to me that he was subject to making what to some, including myself, were futile medical inquiries. I refrained from taking the lead of his medical care which necessitated trying to convince him to avoid these unnecessary medical tests to which he was referred by various subspecialists. I must admit that to a certain extent, I was inwardly not terribly disturbed to see the man spending his final years in endless inquiries, running from one doctor to the next, all to no avail.

"*He deserves it*," I said to myself, even though I knew deep down that was an unprofessional view and one that would be frowned upon by leaders in medical and Jewish-based ethics. I distinctly remember the day he came to see me with symptoms of worsening new congestive heart failure. It was obvious that he was approaching the end of his life and required close medical supervision and intensive care. It was then that I chose to tell him how I had long felt about him.

"Edward," I said bluntly, "I feel I can no longer treat you. I know how you abused Malka for years, and I am asking you now to transfer to the care of another doctor. I feel that because of the great anger I feel for you, I will be unable to provide you with the best care."

I remember how he had paled. He stood slowly, gave me a chilling glare, and walked out of my office, slamming the door behind him. The whole clinic heard his angry shouting as he left. Ultimately, he agreed to be transferred to the care of another doctor. Two weeks later, his neighbor who was also my patient, came to see me and asked if Edward had been to the clinic lately. I told her he hadn't. I then called the social worker who tried to contact him. She was unsuccessful. Later, she called me to say that Edward had been found dead after the authorities had been forced to break into his house.

I was shocked. The following thoughts were overwhelming:

- **Guilt of his death:** Had I been the trigger for his suicide, if he had indeed taken his own life? Was I responsible for a deterioration in his state of health that had caused his death? Had I intentionally intended to hurt him?

- **Empathic failure:** How could I manage a lack of empathy and feeling of alienation toward a patient? Maybe I missed something about Edward that would have led to a different interpretation of his actions: What if it were ignorance, fear, frustration and his own personality failures that led him to act this way rather than true malice?

- **Professional failure:** I knew that the regulatory body has very strict protocols about ending the doctor-patient relationship. And I knew that in no way had I followed that regulatory body's dictums (1). The English dictum obligates preplanning separation (2). The patient may feel he was abandoned by the only person who cared for him. Words and phrases said in these situations might have a critical effect on our patient's life. Emphasized is the importance of communication with the patient even if the patient was violent or abusive. A patient's reaction depends on how the physician discusses separation with them. None of these were present in my case.

And then there were further ethical questions that I was forced to ponder: Could I, as a physician, dismiss my patient? Was I obliged to care for an abusive patient? Could I treat a patient when despising him? As an experienced primary care physician, I doubted my professionalism. Somehow, I was not practicing reflective strategies while dealing with this difficult medical situation. Why didn't I share with my colleagues my agonizing ruminations, why didn't I discuss it with my Balint group (a small group of physicians that discuss and share challenges in medical practice)? (3).

James E. Groves argued that patients who fill clinicians with dread can be assigned to categories that include "clingers," "entitled demanders," "help-rejecters," and "self-destructive deniers," and that these same categories can provide guidance to clinicians interested in managing their care (4,5). Yet Edward did not fall into one of these categories since the shadow of his abusive behaviour toward his wife was always present in my mind when I met him. Perhaps diving into his deep psychological complexity could have helped me override his apparent sociopathic behavioural traits. Knowing his world, personal narrative, and complexities could have allowed me to overcome my own fears and anger and feel more comfortable and capable as his physician. I could put aside my anger and frustration and have more interest in Edward as a patient. Counter transference (bringing my own anger and frustration) could have been minimized and I could have humbly treated Edward as a patient suffering from CHF pending his death. I had some comfort when reading the paper published by Winnicot "Hate in the counter transference" where he acknowledged outright hatred for some patients in certain circumstances as perhaps I had felt. Winnicot, in his writing acknowledges counter transference of hate as "objective counter transference" where patients evoke such feelings regardless of the therapist's personality and difficulties when treating their patients. He describes physician-hatred as being normal reaction to the patients' personality and behaviour. Yet, even if that is the case, I should have chosen a different strategy in ending our relationship (6).

As a private person, and as a professional, I consider myself tolerant and permissive. I find myself filled with anger when dealing with malice, abuse, and social injustice. It is at these times that I act impulsively. As a primary care physician in a well-off neighborhood, I am less experienced in dealing with criminal patients. It is clear to me that this point of conflict arouses in me a sense of loss of control and victimization of myself as if I was also threatened by the violent patient. At these times, perhaps I retreat to the more basic "flight or fight" mode and so cannot sublimate my anger and divert it to a professional action when treating violent patients. I would think that bridging the gap between abusive behaviour, and acting as a caring objective

physician, demands introspection, clear thinking, as well as cognitive and conduct strategies. Each physician has their own narrative and psychological difficulties, and in extreme situations we confront our personal vulnerability, at times losing clear strategic thinking and engaging in counter-transference (of fear, as was the case with Edward) that overrides our clinical judgement – impulsive behaviour "pops out". I presume that disavowal of the hateful feelings toward Edward required less effort than bearing them, and which allowed me to dismiss him in such a way. As from a psychoanalytic perspective being aggressive and with no empathy toward Edward is understandable, these emotions should nonetheless be reshaped according to a higher purpose.

I sometimes tell the story of Edward and Malka in an ethics workshop that I teach for medical students. Interestingly, almost all students sympathize with me and acknowledge my impulsive behaviour as being understandable, even trying to comfort me. It is at these moments that they also acknowledge, subconsciously, our fragility as physicians trying to balance our medical mission with our own personality and sensitivities. At these moments in our discussions, I thank them for their empathy and the opportunity to openly discuss with them my mistake in the hope that they will remember our session when they experience similar situations as physicians, in the future.

I discuss with them these three dimensions of our relationship with patients: *emotional*, *ethical*, *professional*. Although at first one could justify my decisions and behaviour, further reflection of this story would reveal dilemmas and mistakes when treating and ending the care of Edward and his wife, Malka. Emotionally, I regret not reflecting and processing my alienation to Edward, I regret my impulsive behaviour. Ethically, I regret my decision to dismiss Edward and my manipulative strategy when treating him. Professionally, I regret not discussing this case with my colleagues, both in staff meetings and Balint groups. I failed in appropriately handling the complexity of being the apparent abuser's physician. I am reminded of this very moment when feelings of anger override coherence when treating "difficult" patients, that I should cultivate empathy, morality, and professionalism to the best care of my patient.

To this very day I still feel a "pinch in my heart" whenever I recall the tragic story of Malka and Edward.

As the renowned Maimonides (who was a Sephardic Jewish philosopher, physician and became Torah scholar of the Middle Ages) wrote: "Allow me to look upon every sufferer, who comes to ask my advice, as a human being, without the difference between rich and poor, friend and hater, good and bad man". And as Maria Tereza said, one should strive to glimpse the dignity in every patient (4).

Reçu/Received: 21/09/2023

Publié/Published: 04/12/2023

Remerciements
Je tiens à remercier le professeur Michael Gordon, professeur émérite de médecine et membre du Joint Centre for Bioethics, Université de Toronto, et le professeur Mayer Brezis, professeur de médecine émérite, Université hébraïque, Jérusalem, Israël, et poète et auteur, Ronit Yochel Hittin.

Acknowledgements
I would like to thank Prof. Michael Gordon, Emeritus professor of medicine and member of Joint Centre for Bioethics, University of Toronto, Prof. Mayer Brezis, Emeritus Professor of Medicine, Hebrew University, Jerusalem, Israel, and poet and author, Ronit Yochel Hittin.

Conflits d'intérêts
Aucun à déclarer

Conflicts of Interest
None to declare

Édition/Editors: Jessika Roy-Desruisseaux, Jacques Quintin & Hazar Haidar

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