Death is Something to be Avoided

The psychodynamics of end-of-life planning for the general practitioner.

A thesis submitted as a requirement for the degree of
Doctor of Philosophy

by
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January 2008

Trust me,

this will take time

but there is order here,

very faint, very human.[1]

[1] Ondaatje M. **In the Skin of a Lion**. New York: Knopf, 1987.

P. PREFACE

P.1 ABSTRACT

The seeds for this research were planted in the emergency rooms of a tertiary Metropolitan Hospital Emergency Department where I practise as an Emergency Physician. My aim in the research is to develop an understanding of the psychodynamic processes that limit general practitioners from involvement in the groundwork of end-of-life planning with their patients who suffer from chronic and terminal illnesses and the dependent elderly patient. The focus in this thesis is to communicate an understanding of the general practitioners' perception of the community and their role within it to end-of-life plan. At the commencement of the writing I acknowledge my limitations in the academic spheres of sociology, philosophy, anthropology and social history but these aspects of the thesis are developed to contextualize the research within the community of work of the general practitioners.

Over a period of days, a number of frail elderly patients were transferred from their Nursing Home by a mobile intensive care ambulance to the Emergency Department to be resuscitated. My feelings of concern for these individuals generated questions. Who decides? Who has the right to make life and death decisions for others. Where is choice? Are the patient's wishes known at this time? Do the patients have any rights when they are incapable of making their own choices known? Does anyone know what their choices would be? Or, is 'death something to be avoided', no matter what the circumstances?

So this research springs from a passionate concern for the rights of the other, with the desire for others to appreciate their personal autonomy and their capacity for choice, in dying and death, as in life. As Yalom puts it:

> If he doesn't *know* he is about to die how can your patient make a decision about *how* to die? Yes, he must decide *how* to face death.[1]

The research commences with a quantitative study using data derived from a survey of adult patients attending the Emergency Department in May 2002, to quantify if end-of-life planning is occurring in the community. It then moves to the process of purposefully selecting a group of general practitioners, as a series of case studies, with whom to explore and understand the concept and process of end-of-life planning within the community. Using an interpretive paradigm with a clinical method of in-depth interviewing, data are collected from these general practitioners. System psychoanalytic and psychodynamic theories and practice are applied for the analysis of the data.

The dissertation reveals the factors that limit general practitioners in end-of-life planning. These factors include; emotional collusion with members of the community, the lack of clarity in the primary task, the inability to recognize and manage the emotional experience associated with the role and limited education in communicating issues of significance. Theory is generated depicting the context of the work, and recommendations are made for future participation in end-of-life planning by the general practitioner and members of society.

[1] Yalom I. When Nietzsche Wept, USA: Basic Books, 1992: p. 69.

P.2 STATEMENT of ORIGINAL CONTRIBUTION

I state that the dissertation is to the best of my knowledge my original work, although it is extensively referenced by the writings of others. These excerpts are acknowledged and referenced within the text as well as in the bibliography.

Any errors in the writing of the dissertation belong with the researcher.

I state that the thesis and the material contained herein have not been submitted for the award of any diploma or degree in any other tertiary Institution or University.

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P.3 ACKNOWLEDGEMENTS

I sincerely acknowledge the general practitioners who participated in the research process. I acknowledge your honesty and commitment to the exploration of end-of-life planning with me. The collected data are profound. What sits with me is an immense sense of responsibility to work with this data respecting your diversity. Each person involved has granted me a unique insight into their own praxis.

Dr Jenny Ouliaris enlisted the support of the staff of the Regional Division of General Practice by arranging meetings with the Chief Executive Officer.

Mr Ken Mansbridge, the Chief Executive Officer of the Division, in recognizing the importance of this research facilitated the participation of the general practitioners within the Division of General Practice and enabled the research to occur.

Professor Susan Long, my supervisor supported and sustained me from the beginning of the research to its completion. Her scrutiny, generosity in time and teaching are recognized.

Associate Professor John Newton has been available and always helpful.

Eve Steel, as supervisor, has encouraged my commitment and exploration; challenging me and aiding my synthesis and analysis of the research data.

Mrs Joanne Lee-Dow has assisted me to improve my writing style.

Alastair Bain and my training peers of the 2002 Fellowship group, of the Australian Institute of Socio-Analysis stimulated my interest, exploration and learnings.

My friend Beverley has encouraged my writing.

My father and my mother have fostered within me a need to explore and with the exploration to gain understanding, and so to continue to learn.

My partner Brian demonstrating his love, patience and endurance has accepted my need to close myself away in my world to explore.

My canine writing companions are always at my feet, their loyalty is ever-present.

P.4 STYLE & STRUCTURE of this DISSERTATION

P.4.1 The Style

Each chapter of the dissertation commences with an overview of the specific topic to be explored. Following, is an academic framework of the theories and concepts used in the development of the topic: these are defined and discussed. The theory used is then contextualized into the current doctoral research and the data relating to the topic is analysed and working hypotheses generated. Theory is used extensively as it aids in illuminating and analysing the data and the generated themes pertinent to the task of end-of-life planning. Each chapter culminates with a summary of the exploration and further questions derived from the exploration.

Because system psychodynamics and system psychoanalysis is central to the methodology, the analysis of the system, group and dyad are fundamental to the research, the individual is rarely emphasized. Quotations are given and used as derived from the membership of the group.

Citations from the general practitioner interviews are introduced, indented, and annotated as [Interview: 1 to 13] at the end of each excerpt, for example, [I:3]. For other references including books and journal extracts, the Vancouver System for bibliography is used. Referencing, as an endnote, occurs at the conclusion of each chapter.

The research component of the thesis is written in the present tense.

The researcher is referred to in the first person.

The general practitioner is referred to as s/he, the balance of males:females involved in the process is 7:6. The style acknowledges this balance of genders and supports confidentiality in the writing.

The patient is also stated in the male:female gender; except for excerpts relating to specific patients in case histories, where the gender is factual.

P.4.2 The Structure of This Thesis

This dissertation has three distinct sections each of which focuses on a particular component of the research.

Part 1: Context and Methods

The section on Context and Methods places myself as the researcher within the research environment for end-of-life planning and then discusses the methods which are the essence of praxis in this clinical, interpretive research paradigm.
As researcher, I consider it important to contextualize this research formally before commencing the chapters that deal with the analysis of the data collected and theories generated.

In Chapter 1, I describe the background and the origins of this research. One question is: 'do general practitioners take up end-of-life planning as a component of their primary task?' The chapter commences with an internationally publicized debate about end-of-life planning decisions and their complexity. It then moves to survey, through a questionnaire, end-of-life planning for the adult patients attending the Emergency Department in which the researcher practices as an Emergency Physician. The next phase of the chapter discusses the difficulties in developing a researcher-researched relationship and the attendant anxieties in performing this research. The second chapter reviews the ontological and epistemological theories used to fulfil the purpose of this doctoral research. Chapter 3 relates to the methods employed. This includes not only the aptitude and skills required of the researcher, using the qualitative platform, but also the processes involved in data collection, analysis and the generation of theory. These initial chapters form the context and the paradigm for this research thesis.

Part 2: The Research Issues: the Theories and Research Findings.

This section details the topics germane to end-of-life planning in the environment of community General Practice. Chapter 4 begins by grounding the reader, in the community of the general practitioners, communicating their perception of the attitude of the community to dying, death and end-of-life-planning. Chapter 5 communicates the general practitioners' opinions of the primary task of General Practice as it relates to end-of-life planning. Chapter 6 gives an account of the general practitioner's interface with the systems within his/her sphere of work. A psychodynamic perspective is used to discuss the interplay between the internal and external the psychic aspects of the individual -the doctor, the dyad - the doctor-patient relationship, the group - the family with the doctor, and the organizations - the Primary and Acute heath Sectors, for each relates to the practice of the general practitioner in the community. Next, chapter 7, the role of the general practitioner is discussed using psychodynamic frameworks of role. Finally, chapter 8 reflects upon the general practitioners' assessment of conventional educational methods and their estimate of its adequacy in addressing critical issues and performing the task of end-of-life planning.

Part 3: Themes in the Thesis.

This segment of the dissertation reflects the outcomes of the research: on the data analysed. The themes generated which are pertinent to the task of end-of-life planning. The penultimate Chapter 9 advances the paradigms of practice in medicine; Cost-containment, Cure or Care, and their associated defensive techniques to defend against anxiety of the emotional context of the work. The final chapter of the dissertation, chapter 10, Can Death be Acknowledged, reflects upon the findings of the research using the working hypotheses of each chapter as a basis to discuss implications for future change. The relevance of the working hypothesis for Society, the Primary Task, Role and Education contribute to the development of recommendations for future action.

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