Virtual Mentor
American Medical Association Journal of Ethics
June 2008, Volume 10, Number 6: 401-403.

MEDICINE AND SOCIETY
Physician Responsibility for Patients' Quality of Life
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One of the tasks of modern medicine is to endeavor to ensure that patients' quality of life is, at least, no worse when they leave our care than when they entered, and, at best, that it is better, according to recognized index quality indicators. To be sure, doctors who treat patients with life-threatening conditions focus quite rightly on instituting therapeutic measures to preserve life, and often they are not able to address the impact of medical care on quality of life (QOL) until after the life-saving intervention. Social factors (e.g., poverty, nutrition, housing, the support of others) significantly influence the way people live and how they derive pleasure and worth from their lives and, though they affect treatment, may ultimately be beyond the power of physicians to influence.

This observation should not imply that physicians have either an anodyne or a conscious disregard for the conditions of life that shape so much of a person's experience and the pleasure derived from living. A perceived inability to influence what may appear to be intractable social ills outside of the clinic and beyond the scope of medicine is not a justification for failing to try. Bearing all of this mind, we can then ask whether physicians who work with the elderly have a responsibility to commit to safeguarding their patients' quality of life, to the degree that doing so is physically or fiscally reasonable.

Extending Life
Medicine has been outstandingly successful in lengthening the lives of Americans; "from 1900 through 2004, life expectancy at birth increased from 46 to 75 years for men and from 48 to 80 years for women" [1]. As a consequence, the percentage of the U.S. population over the age of 65 in that same time period grew from 4.1 to 12.4 percent [2].

In this light we can pose some fundamental ethical questions. Should doctors be concerned only with curing disease (i.e., extending life), or do we also have a corollary social responsibility to attempt to ensure that the extra years that medicine has given our patients are of the best possible quality? This question has been answered in the affirmative by Michel and his colleagues, who believe that physicians now face the dual challenge of helping preserve an acceptable quality of life and managing chronic disease among the aging population in Western societies [3]. That leads us to the next question: if there is—or should be—such a responsibility, how can it be realized? If we claim to have scant influence on the social factors that contribute so heavily to QOL, especially for the very young and

the very old, then we must face a far more serious and challenging question: should we refrain from offering certain life-preserving (or life-saving) therapies when we know that, as a result, the patient's extended existence may not be a "life worth living"?

Of course doctors, consciously or unconsciously, take social factors and QOL into consideration all the time when making decisions about whether to institute or even continue therapies that may extend biological life, though not necessarily improve it. If one is caring for an elderly, partially demented man with recurrent urosepsis and a large Stage 3 or 4 decubitus ulcer, who lives in a nursing home with marginal resident conditions and care, how are we helping him or enhancing his QOL by curing his infection and healing his wound, only to send him back to the environment that promoted the problems in the first place? Naturally, we would do everything we could to see whether it was possible to place him in a more healthful setting, but the fact of the matter is that we would probably not succeed in finding him a home that was significantly better than the original, given the resources available for his care [4]. It goes without saying that the decision about a patient's quality of life—whether he would prefer being dead to living under the described conditions—belongs to the patient and his family. It is not up to the doctor to decide.

This is a common and dramatic example. We can also consider some equally important nonmedical contributors to quality of life, such as social connections, activities, and physical independence. The complex interactions between organic disease and personal well-being are extensively documented as, for instance, in data suggesting that married people live longer and remain more self-sufficient than their unmarried peers (both single and widowed) [5]. Can we make a meaningful distinction between our duty to ensure that patients have the wherewithal to obtain the drugs or other treatments we prescribe and our duty to look out for the social factors and milieu that contribute so heavily to the success that we hope to achieve by medical intervention?

Such a Herculean task may be beyond the scope or power of physicians in the absence of a commitment on society's part to provide adequate resources to care for an aging population. That should not stop us from attempting to change social policies that directly affect patients' quality of life; surely the poor state of institutionalized elder care is one outstanding example. But we may need to acknowledge that, while we have some power to influence immediate outcomes, our ability to affect pervasive social problems that impact individual patients may stop at the clinic door. This may be the reality for a medical practice in a society that does not regard health care as a guaranteed right and has yet to address seriously many of the social challenges that compound the anguish of illness. Under these circumstances, we may wish to ask the morally troubling question of whether it is better, even more compassionate, to offer not to treat even when we can, if treatment brings prolongation of suffering and a diminished quality of life. This callous-sounding question should ring out as a clarion call to physicians to become aware of

their role in framing and shaping the social policies that affect our patients and contribute to the success of our treatments outside of the clinic.

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