Oncology surgery, end of life, compassion and empathy: from legislation to practice, sharing of experience and empathetic approach.

FEAMC Symposium, Assisi, Italy, 27-29 May 2022

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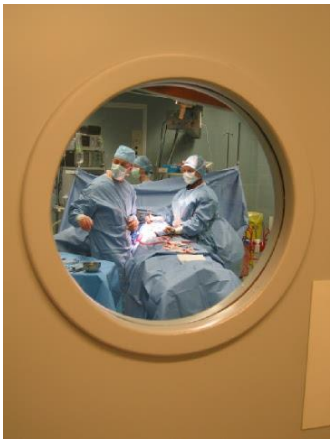

A. Introduction:

The medical art is a difficult art because of its important and inflationary scientific component which requires a lot of learning and investing, day and night with the one who suffers, with in surgery in addition a physical commitment to the heart of people which sometimes exhausts the operator. The application of validated scientific rules is a daily objective in the search for quality care. The rules of the art are thus defined by the learned societies of each organ specialty but they ultimately only address the care of the organ and not of the Human Being except in Psychiatry. Compassion or above all empathy must be taught in the same way as the art of surgery (indication, intervention, management of complications, etc.). The ultimate outcome of a care relationship is the high art of empathic sharing at the heart of a meeting of two consciences around a skill.
From the Hypocratic oath content of 400 BC to the legislative texts of the 20th century, what is the reality of this spirituality of care?

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B. A bit of history:

The Philosopher and doctor Hippocrates of Cos (-460/-360 BC), father of all medicine, established for the first time the idea of a medicine that places the patient at the heart of care with an ethical approach rich in observation clinical observation. He thus calls on his disciples to direct the diet of the sick to their advantage, according to their strength and their judgment, and to abstain from all evil and all injustice. He invites his disciples to inform patients of the decisions envisaged and their consequences. He imposes never to deceive them or to use medical power to force consciences. (1)

This philosophical approach still remains the basis of any medical approach.

It was reinforced by a paternalistic approach in the Middle Ages where the Lord had an obligation to protect his vassals.

Reality that will be swept away by the French Revolution in 1789 which will give men equal rights. (2)

Right that will then have to be built and defined by the drafting of the Napoleonic Civil Codes in 1804 and Penal Codes in 1910.(3-4)

The medical relationship tries to escape the law since the Academy of Medicine and the highest French Jurisdiction, the Court of Cassation consider that no one, apart from God and the doctors themselves, can judge a doctor. They consider in 1834 and 1835 that the sole responsibility of a Doctor lies in his examination of conscience. (5)

Throughout the world during the 19th century, national societies of Catholic doctors organized themselves around the collective and individual will to develop medicine in accordance with the values of the Gospel.

In France, a urologist Doctor Octave Pasteau, secretary general of the French association of urology, and President of the Saint Luc society organizes under the approval of the Pope Pius XI a central secretariat of national societies of Catholic doctors then the first Congress of the European Federation of Catholic Medical Associations (FEAMC) in 1934 in Paris. (6)

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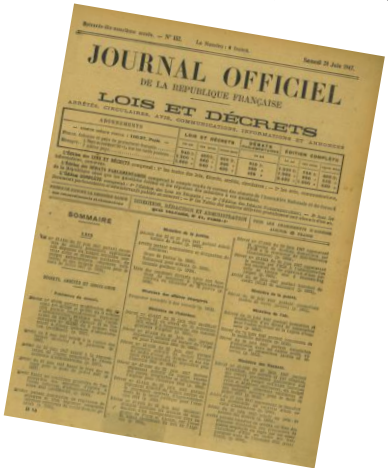
He will participate with other Catholic doctors in the drafting of the first Code of Medical Ethics, the decree of which will be published in the French Official Journal on June 27, 1947. (7)



This is an important step where for the first time in the world medical law appears in a modern legislative text. This code is a balance between the rules of the medical art and the humanist

approach, between the scientific and compassionate benevolence. This last notion does not appear as such but it gradually imposes itself by building article after article around the duty of information, protection, listening, respect, altruism, etc.

Awareness of well-being and doing well is at the heart of the text as a common thread that gradually establishes compassion as a strong and immutable legal obligation. Nevertheless, by imposing it as a forensic reality, the legislator takes the risk of making it cold and indifferent, emotionally drainedt.

C . Compassion and the Code of Medical Ethics: (Article 4.4127 of the Public Health Code)(8)

1. Respect for the human person:

Article 2 (article R.4127-2 of the public health code CSP) specifies that the doctor is at the service of the individual and of public health, he exercises his mission with respect for human life, person and his dignity. The respect due to the person does not cease to impose itself after death.

2. Morality, probity and devotion:

Article 3 (Article R.4127-3 of the CSP) recalls that: The doctor must, in all circumstances, respect the principles of morality, probity and dedication essential to the practice of medicine.

3. Medical secrecy covers everything before and after death:

Article 4 (Article R.4127-4 of the CSP): Professional secrecy, instituted in the interest of patients, is binding on all doctors under the conditions established by law. Secrecy covers everything that has come to the doctor's knowledge in the exercise of his profession, that is to say not only what has been entrusted to him, but also what he has seen, heard or understood.

In a decision of the Council of State seized in cassation, on September 21, 2020 (Request 427435) the magistrates of the high court recall that article 2 applies and that medical secrecy does not cease to be imposed after death. of the patient. (9)

4 . Universal access to care, with awareness and kindness:

Article 7 (article R.4127-7 of the CSP) requires doctors to listen to, examine, advise or treat with the same awareness all people regardless of their origin, morals and family situation. , their membership or non-membership of a specific ethnic group, nation or religion, their disability or state of health, their reputation or the feelings they may have towards them.
He must support them in all circumstances.
He must never deviate from a correct and attentive attitude towards the person being examined.

5. Assistance to person in danger:

Article 9 (article R.4127-9 of the CSP) imposes on any doctor who finds himself in the presence of a patient or injured person in danger or, informed that a patient or injured person is in danger, to to provide assistance or to ensure that he receives the necessary care.

6 Honesty, loyalty, and prudence in the service of others

Articles 13-19 (article R.4127-13 of the Public Health Code) recall that ..when the doctor participates….he shows caution and is concerned about the repercussions of his remarks on the public. …..Medicine should not be practiced as a business.
The communication of a doctor is loyal and honest, …. It does not undermine the dignity of the profession or mislead the public.

7. Conscientious and united in the search for the best care:

Articles 33 and 34 specify the level of quality of care:
The doctor must always draw up his diagnosis with the greatest care, devoting the necessary time to it, using as far as possible the best suited scientific methods and, if necessary, appropriate assistance.
The doctor must formulate his prescriptions with all the necessary clarity, ensure that they are understood by the patient and his entourage and strive to obtain their proper execution.

8 . Fair, appropriate and respectful information:

The doctor owes the person whom he examines, treats or advises fair, clear and appropriate information on his condition, the investigations and the treatment he offers. Throughout the illness, he takes the patient's personality into account in his explanations and ensures that they are understood.
However, when a person asks to be kept in the dark about a diagnosis or prognosis, their wishes must be respected, unless third parties are exposed to a risk of contamination.
A fatal prognosis should only be disclosed with circumspection, but relatives should be notified, except in exceptional cases or if the patient has previously prohibited this disclosure or designated the third parties to whom it should be made.

9 . Relieve the physical and mental state, without relentlessness:

Article 37: this article requires physicians to relieve suffering, assist, and respect the patient in all situations: In all circumstances, the physician must endeavor to relieve the suffering of the patient by means appropriate to his condition and assist him morally. He must refrain from any unreasonable obstinacy and may renounce undertaking or continuing treatments which appear useless, disproportionate or which have no other effect than the sole artificial maintenance of life.

10 . Respect the last wishes of the patient:

Article 37 requires that when the patient is unable to express his wishes, the doctor in charge of the patient is required to respect the wishes expressed by the latter in advance directives, except in the cases provided for in II and III of this article.

11 . Accompany death, assist, comfort

Articles 38-39-43: recall that the doctor must accompany the dying until his last moments, ensure by appropriate care and measures the quality of a life that is coming to an end, safeguard the dignity of the patient and comfort those around him.
He has no right to deliberately cause death.
The doctor must be the defender of the child when he considers that the interests of his health are misunderstood or poorly protected by those around him.

Conclusion: Thus the code of medical ethics integrated into the public health code structures and organizes a benevolent relationship between the doctor and the patient: a legal and compulsory state of compassion, which seems sufficient for a quality care relationship.

Yet a large number of patients complain of abuse and a large number of caregivers fail to find serenity in a fulfilling care relationship.

D . From ego-centeredness to allocenteredness: the path to the heart of empathy

Thus compassion is imposed by ethics and the law, but for many caregivers this dimension must evolve for more feeling and sharing.

This legal compassionate relationship is reaching its limits, and as Mathieu Ricard points out: “If compassion without action is hypocritical, compassion without wisdom is blind.”

According to other authors (10), everything rests on the capacity to change the center of interest: to pass from an ego-centeredness to an allocenteredness where the individual detaches himself from his own interest to feel only the feelings of the other. Move from a system of thought turned towards the ego to a system of thought and care fully turned towards the other. It is the culmination and the fruit of a sensitive perception that comes from the unconscious and the will to act and feel. So for Michel Chiambretto (10) you have to open your mind to the good of compassion, empathy. There is at the bottom of being a Truth of Good. And benevolent, empathetic beings need to act in this direction. The love of others cannot exist without the awareness of the indivisible Unity.

For Bishop Jacques Suaudeau (11): "The duty of charity, which must be expressed vis-à-vis the sick and the dying through accompaniment, is accomplished in solidarity, the moral and human support of the person".

From sympathy to empathy, 2400 years of evolution of a word and a concept, for Hippocrates sympathy "sun pathein" which literally means "to suffer with" is the basis of the care relationship. Over the centuries, the notion loses substance to become more superficial, just friendly. It is the notion of this simpler feeling that then pushes psychoanalysts to define a stronger word for what Freud calls “affective fusion”: empathy (12). Created in Germany in 1873 by an art historian under the name of "Einfühlung", it was translated into English by an English-born psychologist Edward Titchener in 1909: empathy.

E. Our experience in surgery-oncology: a daily experience that enlightens and engages, by building a caring, compassionate but beyond empathetic relationship with a shared and felt suffering…

We must prepare and think about the future, to accompany Life until death.

From the first surgery-oncology consultation we explain the therapeutic choices, the benefits and the risks, we feel the concerns, the questions, the anxieties...

We listen, we reassure and we accompany the patient and his entourage. The subject is accepted but unfolded gradually, the meeting and the emotional sharing evolve at the desired pace, imposed by the patient. It is the patient's emotion that defines the level and depth of empathy. The caregiver immerses himself in the other to the point of forgetting himself emotionally but he must always keep the therapeutic course.
We evoke from the start, the possibility of a "path of end" by making the commitment to be there to allow a departure in serenity, gently and in love.
Even if this possible end is not always developed, it is evoked and it then makes it possible to build a medical truth assumed and shared during all the therapeutic care. This empathetic management of medical truth makes it possible to build a path, a more serene truth.

Our patients have our mobile numbers and throughout the course of treatment they can reach us 24 hours a day. This possibility is like a guardian, it makes it possible to lift the anxiety of the complication without solution, this loneliness in despair which is imagined or experienced as a moment which can announce a violent end. The invisible link and the caring presence allows management of the anxiety or even the terror of leaving.

F. Make his death a way of Love:

All existence has meaning only in the vision of love. So it is with Death. It only makes sense if it becomes the end and the start of a less carnal, more spiritual transformation of the Love relationship.
Allowing love and tenderness to the end allows everyone in community to find a path of sharing that supports those who leave to find Peace and brings to those who remain to find the strength of a serene fulfillment.

The starting point is the meeting of the one who knows and feels the end of the path. He expresses his wish for a departure without suffering and if possible assumed. He is reassured by the presentation of palliative science but above all by the emotion of sincerity he feels in the look and touch. The strength of the therapeutic reality to be relieved must be affirmed with sincerity and perseverance because it is essential to soothe the anxiety, due to the conditions of departure.
The healthcare team will take care of the body envelope and its needs. Loved ones support and accompany the affective essence of the being.
Everyone has their own task, everyone has their place, everyone has their own role: for caregivers, the management of the body, for the family, the management of the soul.

Once the path and the place of each one have been defined, a family council allows the meeting of knowledgeable and loving people. All questions and concerns must be answered. The Claeys-Leonetti law (13) gave new rights to end-of-life patients and made listening to the patient and the collegial procedure mandatory before decision-making.

The Law structures rights and duties at the end of life but the ultimate outcome of this reality is not legislative because the objective is a departure without pain, without fear, in serenity and gently. All these feelings are affective realities that need to be felt, shared and lived. This is the key to the success of the path that gradually moves from legislative compassion to emotional empathy.

The patient remains at the heart of life, at the heart of the team and at the heart of the family until the end. At the last breath, love invades all the space, it leaves the envelope to enter each one like a thought of ultimate love which allows you to internalize the other indefinitely and even perceive your own end with serenity.

It is necessary to propose in this path of Love, a time for everyone to share in intimacy with the patient. It is necessary to propose that each member of the family, of the affectionate circle of the patient can come, talk to him, touch him... explaining that this time of sharing is important for the one who leaves and for the one who stays.

It is explained that feeling for the body does not consume energy, the sensitivity of touch, of feeling does not require any effort from the patient, but that reacting is more complex. Not reacting does not mean not feeling.

Finally, it is necessary to propose a task to each in this time which can be long to be useful to the other: shopping, tidying up the house, coordinating the care team, reading the newspaper, managing the television...

It is necessary to pay attention in the family to children and to the most fragile because all the attention is paid to the patient and we forget the others in particular the children. We must continue to maintain them in life: hobbies, school homework, carefree moments of sharing... Otherwise they could lose themselves between love, jealousy, guilt, pain, remorse...

The care team must be honored, it will define its price: social security rate or rate of friendship and compassion: a cup of coffee, a glass of water ... to allow the patient and relatives to express thanks for this care relationship that sometimes we cannot charge.

G. **Avoiding “double jeopardy**”:

There are two useless and very limiting feelings which inflict pain and grief on the parting party which engenders anguish and fear. The first “double penalty” is the isolation of the one who leaves. Emotional and intellectual isolation. The patient is ignored and isolated to "leave" him alone considering that dying is an important stain, we avoid telling him the things of life because they are too futile in relation to the things of death... In doing so, he is condemned to a double penalty: to be dead before their time and to die finally… We must therefore not hesitate to let life continue to circulate in this space of care that has become the place of family life. The sounds, the smells, the beings must continue to circulate, to speak so as not to

isolate and condemn to “death” silence the one who is about to leave. The second “double jeopardy” is related to behavior after departure. Leaving, dying is not easy, but knowing that loved ones will be destroyed after he is gone is unfair. It is a double penalty that we must avoid inflicting on ourselves because it reduces Love to a feeling without a future. Having been a good parent and dying leaving your child devastated is an unnecessary painful loop. To have loved, and to accept the departure of the other while rejoicing in knowing that he has left in peace and to carry it deep within oneself, in the intimacy of a happy existence, makes love stronger, more universal, more eternal.

H. The way to the end of life is a way of the cross.

Would Christians exist without the Stations of the Cross? Doesn't this final stage of the Life of Christ take on its full value of Love because it allows those who remain at the foot of the Cross to wish for the last breath to extinguish forever the suffering and the violence of these last hours. Isn't this gift to the other the proof of an immense love for those who remain? If Christ had died violently assassinated or accidentally, how to conceive then that his love for men was immense. He suffered to bear the pain of the loss and separation of these apostles and Mary. In doing so, he helped them to accept the unacceptable: his departure!

It is so for each of us. The more violent, sudden and immediate the death, the more the separation is painful, long and devastating for those who remain, even though the departure was gentle for the loved one.

If the disease allows a way of the cross, of asthenia, of pain, of suffering then the final departure is tolerated, accepted or even hoped for by the relatives.

Death is a balance in pain, absent or total depending on the speed of departure it is inversely proportional between the patient and his entourage.

Pain and disease torture the bodily envelope and enslave the mind. The end is a relief for all but it necessarily includes a Stations of the Cross to allow everyone to understand, hear and feel the pain of the other.

In this difficult and painful path, the caregivers bring relief to the body which gradually reduces to the essentials...the functions are reduced...the senses fade...the loved ones maintain the affects and gradually understand that the other is going on…they carry out a daily work of mourning which allows “in fine” the acceptance of the unacceptable: the loss of the loved one.

I. Time of departure, final freedom:

The question is always there: when will it happen ? Will it last long?

Experience shows that no one can predict the time of departure. But it is very common that the time of departure seems to be chosen by the person leaving. There is a certain mystery here, as if the conscious or unconscious starter chooses the one who attends at the last moment... In this game of "chair without music", the final choice is mystical but it exists, whether it is 'a collective and unconscious mechanism of the relatives or subjective and personal of the dying person...

J And then…

We must explain, reassure, and continue to empathize with loved ones. The living is gone but the inert and warm envelope is still there. We must watch over her one last time, one last night. This path of accompaniment cannot lead to excluding the body too quickly. It's a departure, not an evacuation. It is also necessary to tame the idea that he will never be there again physically.

It is necessary to entrust missions to each one and to help them to find the serenity of having loved until the end and to explain that Love only has meaning if it continues to radiate in thoughts with the one who is left. Love is what remains when there is nothing left. This Love must carry and hold. This Love must dwell in everyone with serenity. Love cannot stop there otherwise Love has no meaning.

Conclusion :

The “regulatory” compassion transcribed in the code of medical ethics and the public health code is already sufficient to support life with dignity and respect, but this regulatory dimension is often unsatisfactory.
This path of accompaniment is the culmination of a medical path which then draws on spirituality to help, relieve and accompany the patient and his family.
The teaching of institutional compassion is essential to structure quality care, but it can also and above all allow sentient beings to move from egocentring to allocentring through empathy.
Some will thus be able to feel the grace of being able to carry and love in a simple and pure way in the gift of self.

The empathy of the feeling, of the emotional fusion allows to go further in the sharing and the accompaniment. The work on oneself, the surpassing of oneself, the abandonment of an egocenteredness for an allocenteredness allows a strong spiritual support for the patient but also for his family. Some will almost unconsciously have this fusion with the other while others will have to learn it as a search for spirituality or a quest. Not everyone will succeed because empathy requires strong willpower, self-surrender and sensitivity.
Empathy gives a particular meaning and emotion to the care relationship. It also brings serenity and exhaustion. The empathic caregiver will have to be careful not to develop a post-traumatic syndrome by saturation. Each empathic relationship can empty the recipient of their own emotion, it is the very essence of empathy but you have to be able to recharge, recharge your batteries or be able to feel the other as a resource and not as an emotional escape. .

This empathic care relationship, further than compassionate, is a gift, a sharing that nourishes sentient beings by giving meaning and emotion at a time when the medical approach accepts the transition from body care to mind care. and where the outcome of the treatment allows the acceptance of biological death.

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