

Caring for dying patients can be a satisfying experience

Pam McGrath BSocWk PhD, John Kearsley MBBS PhD

See related research article by Sinclair, page 180

The *CMAJ* is to be applauded for featuring the research by Sinclair¹ examining the impact on physicians of dealing with death and dying. Although it has important implications for all in the medical profession, the publication of research on this topic is usually restricted to journals associated with hospice and palliative care.

The key message from Sinclair's research is that doctors can find caring for the dying meaningful and professionally satisfying when given support and opportunities to incorporate their experiences into their personal and professional lives. This message challenges widely held misconceptions about health professionals' experience of caring for the dying as inherently morbid and negative. Although the ideas presented by Sinclair are well documented in the writings of leaders in palliative and holistic care,^{2,3} they have received limited attention to date in publications that reach a wider medical audience. His findings have important implications for doctors, who are faced with death and dying in their daily work.^{4,5} Unfortunately, major barriers to such positive outcomes for clinicians still exist in medical culture.⁶

Limited research has been published on the experience of care of the dying from the doctor's perspective. A cross-sectional study by Redinbaugh and colleagues,⁷ using both qualitative and quantitative data, found that most of the 188 doctors interviewed at two academic teaching hospitals reported satisfying experiences in caring for a dying patient, with moderate levels of emotional impact. However, a survey by Moores and colleagues⁸ of 188 doctors at teaching and general hospitals reported reactions to a patient death of moderate to severe intensity by 5%–17.5% of doctors, regardless of sex, seniority or medical specialty.

The available research is testament to an underlying tension experienced by doctors associated with care of the dying: the potential for meaningful professional and personal satisfaction juxtaposed with the potential for emotional distress. In the palliative care system, doctors not only choose to work in terminal care but are also

trained and supported to deal positively and therapeutically with the emotional intensity of death. Yet research indicates that the culture of curative medicine,⁶ which is still the predominant setting for death and dying, is problematic from both the patient's and the doctor's perspective.⁹ The "hidden curriculum" of the highly competitive medical education system encourages depersonalization of patients, rewards emotional blunting and detachment in relation to patient care and provides scant opportunity for development of communication skills and education about death.⁴ This lack of preparation to deal with death is compounded for the medical graduate, who enters a time-driven, highly demanding system that rewards efficiency and affective neutrality, prioritizes technology and cure over empathy and caring, and provides doctors with limited support and few formal processes for debriefing.^{4,7,8}

There will never be easy solutions for the question of how best to prepare and support doctors to deal with the profound existential issues associated with death and dying, especially within the context of the highly complex and technologically driven system of Western biomedicine. At the core of any such effort is an imperative to maintain a professional dialogue on the issue. Sinclair's paper is an excellent stimulus for such a conversation, for it raises important questions for a diverse medical audience. At the heart of its offering is the question of whether the knowledge and practice referred to in the findings are transferable. It is easy to accept that those who are highly motivated to work with the dying (as are the selected group of experienced health professionals interviewed for the study) will

Competing interests: None declared.

This article was solicited and has not been peer reviewed.

Correspondence to: Dr. Pamela McGrath, pam_mcgrath@bigpond.com

CMAJ 2011, DOI:10.1503/cmaj.101627

KEY POINTS

- Although the impact on physicians of dealing with death and dying has important implications for all in the medical profession, the topic is usually restricted to journals of hospice and palliative care.
- With support and opportunities to incorporate their experiences into their personal and professional lives, doctors can find care of the dying meaningful and professionally satisfying.
- Major barriers still exist in medical culture that prevent such positive outcomes.

experience a real sense of worth, meaning and purpose in their chosen field of endeavour. The strong impression gained from the article is that this is the finding from a group of health professionals who have already embraced spirituality and sense of self in a way that allows them to come to terms with what occurs in their daily work lives. But what can nonpalliative care clinicians learn from Sinclair's paper?

Perhaps "Physician, know thyself!" is one important take-home message. Although traditional medical curricula emphasize the cerebral aspects of the clinician's role, perhaps what clinicians need is support and reflective space in which they can rediscover themselves, or, as Broyard¹⁰ puts it, be provided with the opportunity to "dissect the cadaver of (their) professional persona." For those who entered medical school with the desire to have a positive impact on the lives of their patients, maybe it is time to re-evaluate whether medical training has really enhanced — or has hindered — the desire to heal the sick and to cure disease. Expectations that clinicians should be detached, white-coated, aloof professionals can be life-sapping and isolating. Research on stress and coping among hospital doctors indicates that higher levels of distress are associated with coping strategies that involve emotional distancing.¹¹ To quote Broyard¹⁰ again, the doctor "has little to lose and everything to gain by letting the sick man into his heart." It is essential to give doctors permission to grieve for their patients and themselves, and to rediscover their wholeness by communing with patients.

Given that the practice of medicine has powerful dehumanizing characteristics, a number of strategies (e.g., promotion of empathy, inculcation of cultural competence, narrative medicine and mindfulness) have been attempted to rehumanize clinicians' work. In her review of mindful practice, Dobkin¹² refers to the need to create a cognitive and emotional space "in which expressions of doubt, dread and hope can be

heard." Health care facilities should put in place quarantined times when clinicians can come together to reconnect, share their struggles and celebrate their triumphs. Knowledge about and respect for effective coping strategies⁸ (e.g., debriefing, talking, spending time alone and exercising) need to be integrated within the professional life of the doctor. Clinicians need to be mindful and proactive about activities that sustain them and give their daily routines a sense of worth, meaning and purpose. Perhaps then the opportunity to integrate the end-of-life wisdom to be gained from working with the dying will be available to a broader range of doctors than those involved in palliative care.

References

1. Sinclair S. Impact of death and dying on the personal lives and practices of palliative and hospice care professionals. *CMAJ* 2011;183:180-7.
2. Saunders C. *Selected writings 1958-2004 Cicely Saunders*, Oxford (UK): Oxford University Press; 2006.
3. Cassell E. *The nature of suffering and the goals of medicine*. 2nd ed. New York (NY): Oxford University Press; 2004.
4. Kasket E. Death and the doctor. *Existen Anal* 2003;17:137-50.
5. McQuade J. Physicians and death. *Loss, Grief and Care* 1992;6:39-75.
6. Gillete G. Medical science, culture and truth. *Philos Ethics Humanit Med* 2006;1:13-24.
7. Redinbaugh EM, Sullivan AM, Block SD, et al. Doctors' emotional reactions to recent death of a patient: cross sectional study of hospital doctors. *BMJ* 2003;327:185-8.
8. Moores TS, Castle KL, Shaw KL, et al. 'Memorable patient deaths': reactions of hospital doctors and their need for support. *Med Educ* 2007;41:942-6.
9. Joske D, McGrath P. Palliative care in haematology [editorial]. *Intern Med J* 2007;37:589-90.
10. Broyard A. *Intoxicated by my illness and other writings on life and death*. New York (NY): Ballantine Books; 1992.
11. Tattersall AJ, Bennett P, Pugh S. Stress and coping in hospital doctors. *Stress Med* 1999;15:109-13.
12. Dobkin PL. Fostering healing through mindfulness in the context of medical practice. *Curr Oncol* 2009;16:4-6.

Affiliations: From the International Program of Psycho-Social Health Research (McGrath), Central Queensland University, Brisbane, Queensland, Australia; and Cancer Service (Kearsley), St. George Hospital, Sydney, New South Wales

Contributors: Both of the authors contributed substantially to the conception and interpretation of the content of the commentary and to the drafting and revision of the manuscript for important intellectual content. Both of the authors approved the final version submitted for publication.