

Caring for the dying: the doctor as healer

Michael Barbato

The care of a dying person requires qualities of a medical practitioner that do not sit neatly within the prevailing medical paradigm. (MJA 2003; 178: 508-509)

“DON’T JUST DO SOMETHING, SIT THERE!” This twist on a well known adage was coined by the American social psychologist Richard Kalish,¹ and at the time was directed to those whose task it was to care for the sick and dying. It is a novel, but pointed, statement that stresses the importance of being really present for people who are suffering, and truly hearing their pain.

The statement may not have been made with the medical profession specifically in mind, but it is nonetheless as pertinent to doctors as it is to anyone involved in caring for the sick. For doctors, the challenge implicit in the statement is that patients, particularly those with a life-threatening illness, may not be well

served by a model of care that concentrates on diagnostic and therapeutic interventions.² Indeed, the threat of death creates needs that can never be met by attending to the physical domain alone. Pain relief and meticulous attention to troublesome symptoms certainly go a long way towards restoring comfort and dignity, but emotional and existential issues need to be approached in a more holistic way — one in which honesty, empathy, authenticity and the ability to communicate feature high on the list of qualities required of the doctor.

The emphasis in medicine over the past 50 years or more has been on cure, or at least on what can be done technically and pharmacologically. With the increasing number of tests and treatments now available, the tendency to intervene has reached a point where it is hard to imagine how we, as practitioners, could function in anything other than this model — a model described by Moskowitz as a “medical juggernaut driven by a logic of its own, one less focused on human suffering and dignity than on the struggle to maintain vital functions”.³

As a young physician in the early 1970s, I vividly remember an elderly general practitioner reflecting on his 60 years in practice. It was both fascinating and enlightening to hear someone talk about the care of patients at a time when there were no antibiotics or specific treatment for chronic illnesses such as asthma, diabetes mellitus and hypertension. It was a time when morphine, mercurial diuretics, digitalis leaf, tourniquets and venesection were the only interventions available for heart failure, and treatment for most conditions

was guided by clinical judgement rather than “numbers” and x-rays.

By present-day standards, this doctor had little in the way of a medical armamentarium. But, although he may have been helpless to influence the course of many illnesses, he did not consider himself to be helpless. He comforted the sick, sat with them and their families during difficult times, and was a trusted and reassuring presence in the face of death. He may have had little to offer medically, but what struck me was that I, with my newly acquired specialist ticket and accompanying bag of tricks, felt more uncomfortable and helpless than he when faced with a dying patient.

Times have changed, and many of the illnesses that claimed lives in the early part of the 20th century are now preventable, curable or more easily palliated. For many patients we have succeeded in postponing death and have hopefully improved the quality of their life. But have we improved the care of those who cannot be cured? Are we as skilled as my GP colleague in comforting and communicating with the sick and dying, or are we distracted by unnecessary tests and futile treatments that threaten to engage us in a form of subterfuge that serves only to conceal a sense of helplessness, while adding considerably to a patient’s distress?

In a retrospective study of 100 deaths at an Australian hospital, Middlewood et al⁴ noted that 74 of the patients were considered by the attending medical team to be dying, and “do not resuscitate” (DNR) orders were completed for 88 patients. Despite this, 78 were subjected to one or more tests after the DNR order, 67 received antibiotics, and 88 were given intravenous fluids. At the time of death, 27 of the patients were still receiving antibiotics and 49 had a drip *in situ*. Although most of the patients were thought to be dying, the approach to care did not appear to reflect this, or if so, only very late in the course of the illness. Similar outcomes were found in a study of 200 deaths within a large medical centre in the United States.⁵ In this study, comfort-care (palliative-care) plans were completed in just 46% of the patients and, once again, this occurred late in the admission, even though most patients had been identified as dying and DNR orders were completed well beforehand.

In a report entitled *Pursuing a peaceful death*, Callahan⁶ intimated that the medicalisation of death has made the prospects of “dying well” more of a hope than an expectation. “Death”, he says, “is now harder to predict, more difficult to manage, the source of more and more moral dilemmas and nasty choices, and spiritually more productive

*“The physician is only the servant of nature,
not her master”
Paracelsus (1493–1541)*

Palliative Care Unit, Braeside Hospital, Prairiewood, NSW.

Michael Barbato, MB BS, FRACP, Palliative Care Physician.

Reprints will not be available from the author. Correspondence: Dr Michael Barbato, Palliative Care Unit, Braeside Hospital, 340 Prairievale Road, Prairiewood, NSW 2176. barbato@austarmetro.com.au

of anguish, ambivalence and uncertainty". Callahan is not making excuses for clinicians, nor is he suggesting a return to the days when death was more predictable simply because there was little that could be done to prevent it. Rather, he implores that we, individually and collectively, look at the way we care for the dying and reflect on whether our actions contribute to patients not dying well. He urges us to see death not as a failure of medical treatment but as one of the most important times in a person's life — a time that calls for respect rather than interference. It is a time when attention to suffering is more important than the maintenance of physiological function.

We physicians can help patients die with comfort and dignity by withholding or withdrawing treatment that is clearly futile. Such a decision is never easy, and circumstances pertinent to each patient can make this more difficult. Our honesty, authenticity, and the way we impart information can effectively bridge such difficulties and allow the patient, his or her family, and the attending team to refocus on the broader issues. To inform a patient that he or she is dying is painful and traumatic, but it is not made any easier by deferring or avoiding the subject altogether. Our honesty only confirms what most dying people already suspect. If we ignore the truth, we deceive ourselves as well as our patients and deprive them and their families of the opportunity to say goodbye and prepare for death.⁷

Grahame Jones, writing about an illness that ultimately claimed his life, said, "let the healthy talk of illness; let the sick talk of more important things".⁸ Care modelled around tests and futile attempts at cure only succeeds in maintaining a focus on illness. This may be comforting to the clinician, but it effectively robs the dying patient of the opportunity to talk about the "more important things".

In the many public talks that she has given in the past, Elisabeth Kubler-Ross, author of *On death and dying*,⁹ often spoke about a member of the hospital staff whom dying

patients would invariably seek out when they needed comfort or someone to talk to. This person was not a doctor, nurse, social worker or counsellor. She was the cleaner, and, when asked by Kubler-Ross why she was so sought after, her reply was simple but direct. "Death", she said, "is an old friend". This woman had seen a lot of death, not just in the hospital but also within her own family, and, like the elderly GP who had so impressed me, was not afraid to journey with people as they were dying. Neither she nor the GP relished the task, but neither sought to abandon their responsibility during the difficult and sometimes frightening time leading up to death. Both are excellent role models and demonstrate the important role we can play in helping patients prepare for death. If we are able to do this, we not only play an important part in their healing but also heal a part of us that may be uncomfortable with death.

Competing interests

None identified.

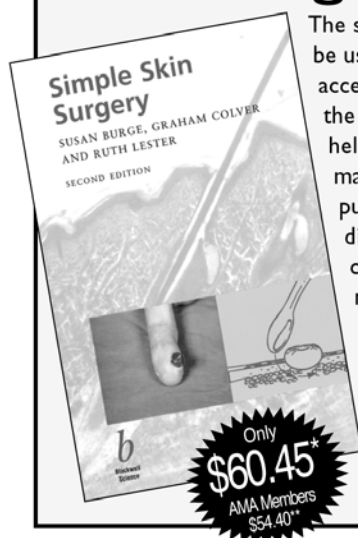
References

1. Kalish RA. Death, grief and caring relationships. Belmont, California: Brooks/Cole, 1985.
2. Chibnall JT, Videen SD, Duckro PN, Miller DK. Psycho-spiritual correlates of death distress in patients with life-threatening medical conditions. *Palliat Med* 2002; 16: 331-338.
3. Moskowitz EH, Nelson JL. The best laid plans. *Hastings Cent Rep* 1995 Nov-Dec; 25(6): S3-S5.
4. Middlewood S, Gardner G, Gardner A. Dying in hospital: medical failure or natural outcome. *J Pain Symptom Manage* 2001; 22: 1035-1041.
5. Fins JJ, Miller FG, Acres CA, et al. End-of-life decision-making in the hospital: current practice and future prospects. *J Pain Symptom Manage* 1999; 17: 6-15.
6. Callahan D. Pursuing a peaceful death. *Hastings Cent Rep* 1993; 23(4): 33-38.
7. Fallowfield LJ, Jenkins VA, Beveridge HA. Truth may hurt but deceit hurts more: communication in palliative care. *Palliat Med* 2002; 16: 297-303.
8. Jones GC. Magnanimous despair. Mount Nebo, Qld: Boombana, 1998.
9. Kubler-Ross E. On death and dying. London: Tavistock Publications, 1970.

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