

By Dr Tan Yew Seng

"You are missing something, as well as the patient is missing something unless you come not merely in a professional role but in the role of one human being meeting another."



Commentary on the Wake

Many doctors are uncomfortable in dealing with dying, death and bereavement. Some of the complex feelings that are generated within doctors and people who are caring for terminally ill patients and their families are alluded to in this remarkable piece of reflection by A/Prof Cheong.¹ Generally speaking, dealing with death, dying and bereavement may generate inner conflicts, discordance and disequilibria in three ways.

Firstly, it is about facing the patient's and the relatives' expectations. Doctors are often perceived as people who can "fix the broken part" and return patients to health. This is in contrast to healers and shamans, who may talk of acceptance of destiny, fate or just sheer bad luck. Too often, the media contains news of the latest curative therapies, procedures and medical technologies. It should therefore not surprise anyone when we hear "Our hospitals have state-of-the-art technology. Look at these impressive machines beeping away to stave off death".¹ And if we were to conclude that "lay people do have unbridled confidence in modern medicine, sometimes misplaced", then it is perhaps that they have been misinformed by the glamorous news about the sensational marvels of medical technology that we reveal to the lay public, often without qualifying with the necessary perspectives.

The truth is, for all the new found gadgets and medical technology that we have devised

to cure specific diseases (preventive measures aside), the impact generally affects only a select patient group. And even when they can transiently "stave off death", what kind of life do they promise? And what impact do they have on death and dying, which affects *all* people? Then again, should death and dying, which is an inevitable part of life be "medicalised", that is, viewed as a disease that we must desperately seek a cure for? Have we inadvertently undermined our capacity to relate to the dying and bereaved in order to promote ourselves as "fix-it" men and women?

Moreover, even when we attempt to engage the patient and their relatives, which part of our training to become doctors specifically prepared us for this task? While there has been more emphasis in such communications modules in family medicine and palliative medicine programmes recently, it is important to realise that patients, young and old, die in the hospital wards across the disciplines.

Secondly, it is about facing our own sense of identity and purpose. To many, being a doctor is more than a vocation. Together with our values, beliefs and life experiences, it defines who we are; it is an identity of the self. Therefore, if we were to validate ourselves and our self-worth based on our abilities to treat and cure diseases, we can then understand the professional and personal disenchantment when it comes to managing conditions for which there is no cure; where



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uncurable conditions become our “failures”, a source of professional and personal shame and embarrassment. In practice, this may manifest as an unbridled passion “to treat to the end” even in the face of medical futility. “I want to give them every chance” might be a guiding principle.

I recall a dying patient with advanced cancer whom I saw at her own home. Even when she was bed-bound and drowsy, she was still on a new \$2,000-a-week chemotherapy. The family, HDB heartlanders, had been told that there was a 5% to 10% chance of response. She died a week later. The more affluent have even set up a “mini-ICU” in their homes, along with monitors, oxygen, drips, tubes, IVs, TPNs and other medical paraphernalia. Are we not merely treating ourselves if our patients become the antidote of our sense of inadequacies?

Finally, it is about facing our own mortality. Many are still shocked to hear of doctors dying unexpectedly, as if doctors are above disease and death. Many doctors seem to think so too, standing tall and aloft in the midst of disease and dying in the hospitals and clinics, helping patients cheat death over and over again. Far

from advocating that we should not be fearful of death and dying, perhaps it is best to recognise and accept the fact that we are human after all, and are therefore not exempted from the inevitability of mortality, and the fears and anxiety that come with it. It is in facing ourselves as a person, not as a doctor, that we will be able to address our own issues with death, and in turn, be able to understand and help people who are dying or are bereaved. For if we are fearful, defensive and evasive about death and dying, how can we expect our patients and their relatives, who often look up to us as the expert, to think, feel and do otherwise? To quote Dame Cicely Saunders: “You are missing something, as well as the patient is missing something unless you come not merely in a professional role but in the role of one human being meeting another.”² ■

References

1. **Cheong PY.** *The Wake. SMA News October issue, page 13.*
2. **Egnew TR.** *The meaning of healing: Transcending suffering. Ann Fam Med 2005; 3:255-262.*