EDITORIAL

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Dealing with Death/dying in Medicine

Isaac KS Ng[1] and Joanne Lee[2]*

[1]Department of Medicine, National University Hospital, Singapore

[2]Department of Hematology-Oncology, National University Cancer Institute of Singapore, National University Health System, Singapore

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The medical field has consistently made remarkable progress in developing treatments for previously incurable illnesses, improving clinical outcomes, and alleviating pain and suffering. Yet, the time-honored problem of human death remains an inevitability of life that modern medicine can never defeat. Indeed, Dr. Benjamin Franklin famously quipped in the 18th century that "in this world nothing can be said to be certain, except death and taxes". Ironically, as medical physicians who are thoroughly trained to diagnose and treat a wide spectrum of illnesses, we often find ourselves wholly unprepared and uncomfortable to come face to face with death and dying in clinical settings – because it serves as an unwelcome reminder of the limitations of modern medicine and the inevitability of our mortality, conjuring up unconscious feelings of fear and anxiety.[1–3] However, unrecognized and unresolved negative emotions and attitudes of physicians toward death/dying can have serious implications for both patient care and their personal well-being. For instance, physician discomfort and fear towards death/dying may manifest as maladaptive clinical behaviors such as avoidance,[4,5] over-attachment,[4] condescending/dismissive behaviours,[4] or becoming robotic and emotionless in interactions with dying patients and their families.[6] Moreover, there may also be suboptimal clinical care delivered, such as an unwillingness to break bad news to patients in a timely manner,[7] or developing incoherent treatment strategies and care goals.[4] Finally, physicians who labor under heavy emotional burden in providing care for dying patients eventually suffer from burnout and lose their sense of work fulfillment and purpose.[4,8]

In this article, we suggest multi-pronged, practical strategies to help physicians cope with the psychoemotional aspects of caring for dying patients in a healthy and meaningful manner. This includes normalizing conversations about death in the medical field, cultivating physician insight and emotional self-regulation towards death/dying, and developing a robust psychological support system for physicians providing care to terminally ill patients.

Normalizing conversations about death in the medical field

In many societies, especially in traditional Asian or Chinese cultures, death remains a highly taboo topic.[9] However, over the past few decades, there has been an increasing recognition of the importance of advance care planning and goals of care discussion, leading to increasing conversations surrounding death/dying at the societal level. Nonetheless, it is particularly important that discussions on perceptions of death, experiences with dying patients and personal emotions/fears about death should be normalized in the medical field as physicians commonly share the unique experience of caring for patients in their most vulnerable moments pre-death.[10] As Sutherland writes: "these conversations shouldn't be viewed as awkward..., should happen over time whenever possible, not just once, and not just in the moments preceding eminent death."[10] Practical ways to normalize conversations about death within the medical field may include medical education-related projects and campaigns that promote dialogue about death/dying, palliative care, and personal legacies.[11]

Cultivating physician insight and emotional self-regulation towards death/dying

For physicians managing dying patients, they must be attuned to their own perception of death and emotions toward the present clinical situation, to provide quality, objective care, and support to

*Corresponding author: ✉joanne_lee@nuhs.edu.sg

these patients. To this end, death education training workshops that educate learners on salient aspects of death (definition, common meanings and interpretations, process and awareness of death, coping with grief, and sociocultural/religious aspects of death/dying) would help mitigate death anxiety and fears among healthcare professionals who work with terminally ill patients.[12] Through such programs, healthcare professionals will have the opportunity to reflect on their perception of death (which may be guided by personal convictions, family/cultural traditions, or religious beliefs) and explore their emotions and attitudes towards death/dying in a safe environment.

In particular, fear of death is a universal phenomenon,[5] which Hoelter classifies into eight categories: 1) fear of the dying process, 2) fear of the dead, 3) fear of being destroyed, 4) fear of the death of significant others, 5) fear of the unknown, 6) fear of conscious death, 7) fear for the body after death, and 8) fear of premature death.[13] Florian and Mikulincer conceptualized death in three dimensions, at the intrapersonal, interpersonal, and parapersonal levels.[14] As such, death denial commonly becomes a natural human adaptive/defense mechanism against negative emotions and fear that are typically associated with death.[12] In the 1988 *NEJM* article: The Dying Patient, the Physician, and the Fear of Death, Seravalli stated that the fear of death in physicians is different from that in the dying – where for those who are dying, they worry about what death signifies (the idea of personal extinction) and how the process will be like, while for the physicians, they may not only identify with the universal anxiety associated with death but also see death as a form of defeat from a professional standpoint.[5] Hence, it is important that physicians receive professional, psychological-guided training to cultivate self-awareness of perceptions of death, identify personal emotions and attitudes that may lead to maladaptive behaviors when caring for dying patients, and develop the clinical maturity to self-regulate and utilize cognitive restructuring approaches to replace negative thought patterns with more constructive ones.[15] In addition, experiential learning[16] or simulation activities[17] may be helpful to aid physicians/medical trainees to empathize with how different individuals across sociocultural and religious contexts interpret and face death/dying experiences.

Developing a robust psychological support system for physicians caring for dying patients

In recent years, there has been increasing recognition of the need to provide adequate mental health support systems for physicians who are increasingly suffering from work-related burnout. Given that caring for terminally ill patients can come with significant emotional burdens, psychological interventions and support systems should be made available for physicians to maintain their mental well-being and sustain their efforts in continuing to provide optimal clinical care. For example, Schwartz rounds and Balint groups are evidence-based psychological support systems that can be helpful for physicians taking care of terminally ill patients.[1819] Other potentially useful psychological techniques to support physicians managing end-of-life patients include mindfulness-based interventions,[20] communication training, and peer coaching.[8]

In summary, physicians share the common privilege of journeying with patients in their most vulnerable periods, especially in the terminal moments of their illness. However, coping with the emotional burden of caring for dying patients is not an easy task, and unresolved emotions, feelings, and fears towards death/dying can manifest as unprofessional or maladaptive clinical behaviors with serious repercussions in patient care and physician well-being. Therefore, there is a need for multi-pronged strategies and interventions to help physicians cope with the psychological and emotional challenges of managing terminally ill patients in their clinical practice, which can include normalizing general conversations and attitudes about death, promoting physician insight and self-regulatory behaviors, and ensuring the presence of a robust psychological support system. In the book *Tuesdays with Morrie*, when Mitch Albom asked Professor Morrie about how one could prepare for death, he quipped that "the truth is... once you learn how to die, (then) you learn how to live".[21] Perhaps, as medical trainees and practitioners spend time to reflect on their mortality, they may also develop a newfound appreciation for the impactful work that they get to do in medicine and be recharged in their pursuit of the ideals of medicine – that is, to "cure sometimes, to relieve often, and to comfort always".

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