Journal of Palliative Care & Medicine
ISSN: 2165-7386

Barbato, J Palliat Care Med 2014, 4:2
DOI: 10.4172/2165-7386.1000173

Short Communication Open Access

On Being a Doctor

Barbato M*

Palliative Care Unit Port, Kembla Hospital, Cowper Street Warrawong NSW, Australia

***Corresponding author:** Barbato M, Honorary Research Fellow, Palliative Care Unit Port Kembla Hospital, Cowper Street Warrawong NSW, Australia, 2505, Tel: 61 2 4233 2643; E-mail: Michael.barbato6@gmail.com

Received Date: March 12, 2014, **Accepted Date:** March 28, 2014, **Published Date:** April 07, 2014

Short Communication

This short reflection wishes to highlight an underutilized gift that all of us possess, namely the ability to be fully present to another person's suffering. For doctors this often involves sitting with a distressed patient, free of the medical imperative to do something. Such perceived inactivity is almost foreign within the biomedical paradigm, but taking time to listen to another's pain is one of the most valuable things we can do for patients. To sit silently while another person pours out his/her distress is hard work. Incorporating this skill into our day-to-day practice, however, elevates the doctor-patient relationship to a higher level and helps doctors successfully navigate emotionally confronting situations.

The biomedical model prepares us for most clinical situations, but is found wanting when a patient's suffering is existential rather than physical. The therapeutic model with its focus on doing stalls when there is no answer to the challenge that confronts us. Paradoxically, the way forward here is to do less rather than more. A compassionate presence will benefit these people beyond anything we may do, say or prescribe. It allows patients, often for the first time, to enter into the darkness of their despair; a necessary step in the process of healing.

To feel vulnerable and inadequate in the face of an emotionally charged situation is normal. Our instinct and training often compels us to do something or, worse still, to avert our attention away from the person's suffering. This response is poignantly captured in the words of one physician who says, "In order to deal with these aspects of my work I have developed something like a Ned Kelly suit of armor – an outer shell that protects me from the anguish and stress of people dying; a mask that prevents too much eye contact…while at the same time preventing the emotion within me from escaping [1]." The vulnerability described here is normal, but to hide from it is ultimately damaging, both personally and professionally. Patients do not always look for answers. What they want is someone to hear their plight and to manifest ultimate commitment [2].

Given that most deaths, in post-industrialized countries, now occur in institutional settings, a considerable amount of a newly- graduated doctor's time is spent caring for those who are dying. Ironically, it is the most junior and least experienced member of the medical team who finds him/herself in the front line of caring for these patients. They are often the ones designated to break bad news, speak to grieving relatives, certify a patient's death and comfort distressed families. This is challenging, and is all the more difficult when it involves patients and families previously unknown to them. There is, however, no escaping this responsibility for, "The quid pro quo in becoming a doctor", says one medical student, "is to be comfortable that death is as much a companion along the journey [3]."

Caring for someone who is dying is a privilege and will, with reflection, teach us about ourselves. For this reason it is prudent for interns (or any doctor for that matter) to debrief with a trusted mentor or pastoral care worker following any emotionally unsettling, or traumatic experience. There is also evidence to suggest that hospital orientation programs that include sessions on the how to sensitively pronounce death and effectively communicate with grieving families, prepares young doctors for these and other challenging situations [4]. The ability to communicate effectively not only has a beneficial and long-lasting effect on those we speak with but also transforms patient and family interactions into rich and maturing experiences.

The practice of medicine involves as much being as it does doing. Despite its obvious benefits, the biomedical model can blind us to the most valuable resource we have to offer–our very presence. If we cultivate and integrate the art of being present [5] into our privileged work of caring for others, our patients and their family will benefit, but so too will we and the medical profession generally.

References

1. Edwards KD (2003) Death in the emergency department: a not so absolutely ordinary rainbow. Med J Aust 179: 647-648.
2. Byock IR (1994) When Suffering Persists. J Palliat Care 10: 8-13.
3. Mohd Slim MA (2013) The Superhero Mythos: a Medical Student's Experience of Death. J Palliat Med 16: 803-805.
4. Marchand L, Kushner K (2004) Death Pronouncements: using the teachable moment in end-of-life care in residency training. J Palliative Med 7: 80-84.
5. Miller JE (2001) The Art of Being a Healing Presence: A Guide for Those in Caring Relationships. Willowgreen Publishing, Fort Wayne Indiana.