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FAST FACTS AND CONCEPTS #31

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Most of us fear our own death; it is part of the human experience. Various authors suggest that the desire to deny mortality is part of every physician's decision to enter the field of Medicine. When learning about taking care of the dying, we are often told to "confront our own mortality". However, asking people to suddenly confront their own mortality is a bit naïve. Young physicians may have no real context for this (unless they have had a near death experience). Confronting one's mortality typically means different things to different people and different things to the same person at various stages of life. Rather than making blanket statements about confronting mortality, it may be helpful to break it down into individual episodes, times when we feel particularly vulnerable, as windows to self-exploration.

I recently told the following story at the end of a Grand Rounds presentation. A 49 year old patient of mine with severe emphysema was in the hospital for the third time in a year for pneumonia. Each admission was worse than the last. One afternoon as I came to see him, I paused at his door. Through the window I saw a cachectic man with pursed lip breathing hunched over a tray table. He was breathless and suffering. At that moment I could not get myself to open the door; it was too difficult for me. I walked around the hospital doing other things for an hour before I finally made it into his room. He said he felt terrible. I said I was sorry, and that I was giving him all the medicine I could think of. The conversation was brief and difficult—it was the same conversation we had the last time he was sick and it went no further than symptoms or treatments. Neither he nor I felt better after talking. Four months later I received an early morning call from the emergency department. My patient had presented in respiratory failure, was intubated, had three chest tubes placed for ruptured bullae, and died. In the words of the ER physician, 'it was ugly.'

Other than the housestaff asking if he wanted 'everything done' (he said yes), I had no discussion about end-of-life care/hopes/wishes with my patient. Two aspects of personal vulnerability hindered me. First, I have asthma, and my identification with this patients' dyspnea was painful for me. Second, every time I met with this patient I felt bad about the encounter, as though I had nothing to offer as his physician. I felt as if I had failed him because I had no cure. To avoid the feeling of failure, I avoided discussing issues surrounding his imminent death, and thus, failed him in another way. Had I been more self-aware of my own issues, I would have been able to identify the reasons I couldn't enter the room.

Since then, I have learned to listen to my feelings – when I am avoiding something unpleasant, it usually means I am feeling vulnerable. My guess is that adding up these individual episodes when we feel vulnerable, becoming increasingly aware of self, is what is meant by the term confronting your own mortality. At the end of the Grand Rounds where I presented my story, I asked everyone to turn to the person next to him or her and tell their own story, the one that came to their mind as I was telling mine. The room boiled over with conversation.

Reference

Buckman R. Communication in palliative care: a practical guide. In: Doyle D, Hanke G, and MacDonald N, eds. Oxford Textbook of Palliative Medicine. 2nd Edition. New York, NY: Oxford University Press; 1998: pp141-156.

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