Editorial

Care of the dying can increase your job satisfaction

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The care of the dying is one of the most challenging and potentially satisfying areas of medicine, but we are often poorly prepared for this task in our undergraduate training and in hospital experience.

Medical students will talk about health promotion, disease detection and saving lives, but rarely reflect on death as anything other than the ultimate treatment failure. As junior doctors we have a great deal of experience of death, but little constructive exposure to the process of dying. In hospital settings most deaths occur as the result of an acute or acute on chronic disease process or accident. Unless trainees work on oncology wards or in long-stay geriatrics, they are unlikely to gain much experience in terminal care. The severity of the presenting illness usually precludes the close relationship with the dying which occurs far more in a primary care setting.

Even in the community, changes in therapeutics and technical advances in secondary care have changed the relationship between the GP and the dying patient. For one thing, death from slow non-cancer causes has substantially declined in western society. Earlier this century, GPs spent a considerable portion of their time administering palliative rather than curative treatment to patients with TB, chronic sepsis, uncontrolled diabetes and congestive cardiac failure. Offering relief to the dying was a significant part of their workload.

There was also more acceptance of the limitations of medicine both by the public and by the profession. Since the sixties and seventies, the popular belief that science is all-powerful has created a perception of death as a failure of care rather than as a natural outcome of serious disease processes. The myth that medicine can solve all problems creates a tension that makes terminal care a particular challenge. Any doctor is somehow an arm of a system that has failed the dying and he/she may feel they have to compensate the patient for this perceived dereliction of duty.

It is easy to fall into a detached fix it/problem-solving approach to terminal care to avoid this tension or to avoid our own fear of death. To engage fully with the dying in their last journey is very demanding, but very rewarding. As a GP, I regard my involvement in the process of death as a privilege on a par with attending a birth. Death and birth are such intimate and profoundly confronting events.

The challenge of fully engaging with the patient and their carers while maintaining self care and professionally objective judgement is particularly difficult in terminal care. Our own beliefs and fears around death and dying inevitably come to the surface. At present both the patients in my practice requiring terminal care are women who are within a year of my own age (38). Their dying reminds me inescapably that people (and their doctors) are mortal and that it is our mortality that binds us together as human beings and which, ultimately, separates us.

Working with the dying is a sad but particularly satisfying aspect of family medicine, an area where, ironically, we can be most effective in improving quality of life. As GPs we are uniquely placed and skilled to deal with the wide variety of challenges presented by the dying and their carers. It is an area of medicine which is most demanding of time, effort, clinical skills and compassion and least rewarding financially for GPs, but is one of the most worthwhile in terms of job satisfaction, in spite of the fact that death is an inevitable outcome of the process. In this issue we offer some thoughts and clinical information to support those who take up the challenge.

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