Vita Brevis
Life is short

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Death happens daily in medical wards. Whether expected or not, we often see our patients "go to the unknown, a destiny without return and without address" (Levinas). Every moment of departure transforms itself in an opportunity to reflect on the many doubts around it and which are of various indoles: scientific, emotional, existential, relational, spiritual. My experience whilst a physician is still short, on time, proven by my condition of Internal Medicine resident which I have chosen by the holistic vision of the sick person. Even so, throughout these almost 5 years of specific training, rare were the moments where death was the subject of learning, making immense the wasted hypotheses of growing whilst a physician and whilst an individual.

I often wonder about the reason of being of such paradox. Assessing my own difficulties, I realized that many of them rely on the insufficient acquisition of skills to deal with this delicate and complex issue.

At present, I have no doubt that my own history made me sensitive to suffering, to death, to the dignity of the sick person and their respective families. The impetus of caring/treating associated with it, has motivated the choice of medicine as my way of being. But rapidly I was aware, while attending university, of the failure in the course attended. On one hand, demanding in its scientific component, giving future physicians solid and structured skills, enabling a sustained growth overtime; on the other hand of an extreme fragility regarding the humanistic training, neglecting such aspect that has always seemed crucial to me. To reduce Medicine to its scientific aspects, using the words of Lobo Antunes, to allow science to smothering the art, defined by Sir William Osler as an art based on science.[1]

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During my post graduation journey, there were two high moments, in distinctive training stages, where death as a learning starting point. And in both cases, curiously, it was presented to me as a fact and not as a process. In the first year, the arrival at the anatomy theatre was lived with enthusiasm and the lightness of those starting a wished journey, full of novelty and enchantment. The intellectual fascination unraveled slowly as it was dissecting the complex human machine lying on the table. Perhaps the youth, or the need to adapt to a reality without a major existential suffering, would keep away thoughts which would entail a deeper approach. To overcome the challenge of learning what weekly was proposed to us was an exercise of resistance and perseverance. But, truthfully, those bodies with an unaltered face were sending us to the life that once inhabited them, with a narrative sometimes one tried to guess. Without room for philosophical or existential discussions, whether we wanted or not, the first year would come to an end giving us the notion that the imperturbability – an expression Osler used to define one of the characteristic he found crucial to practice medicine[2] – had been an acquired skill.

After going through most of the journey of under graduation training, in the last year of the course, death was once again the subject to learn Forensic Medicine. There its brutal or unexpected character was revealed to us, giving us the troubling challenge of discovering its most obscure paths, revealed by a set of thanatology signs over which the learning is focused upon, explored in a kind of ritual. The imperturbability previously developed reached a maximum expression, keeping away once again the reflection on humanity or the lack of it.

All the time elapsing between these two moments that I mentioned, was time to learn about a triumphal medicine, as Lobo Antunes.[2] In medical school we are trained to be experts in the art of treating/cure, being the syllabus based on a success paradigm founded on the triad of etiologic investigation – diagnosis – cure,

[3] too centered on the disease and not enough on the patient. And if, as in Osler words "It is more important to know the patient that has the illness, then to know the illness the patient has", then with the learning model we have, we learn to be a physician with a reducing look on the patient which in extremis is often taken as if he/she was only a disease. Under such point of view of medical (de)formation, death works like a kind of obstacle to the very professional activity, because is often lived as a failure facing the curative objective which is taught to us. To make death secondary, withdraws the space it should have in order to happen with the dignity which is due.

Wear D, published in 2002, in the Academic Medicine journal, a study carried out based on the narratives of experience of undergraduates on the 4th year of Medical School in an American University when confronted with clinical situations involving terminal patients.[3] The vast majority of students had training in such area, while it was mainly based on acquiring knowledge and not developing skills and attitudes. Even so, all of them have reported endless difficulties. The failures they recognize in themselves are the same they point to senior doctors following them. They make evident the discomfort of communicating bad news, the difficulty on handling emotions (not only the patient's but also their own), the inability of discuss with the patient or the relatives, therapy options at the end of life, or when evaluating the suffering which is beyond the physical pain. They come to a conclusion that theoretical knowledge, which learning can be made in school and classroom, cannot replace the development of skills that only circumstantial living can provide. Therefore, students refer that would like to learn how to be with terminal patients observing physicians which would do that in a compassionate and competent manner. They highlight that to be able to make the debriefing of those more complicated experiences with a physician accompanying them would be an important part of their learning process.

A good training demands good role models – physicians with whom one can learn what is neither written in books, nor in the official syllabus, but who can help us to be more human and compassionate while performing our roles.

I do not believe that the Portuguese reality is very different from the American one. Here as there it is urgent a change in the syllabus. My personal experience is a paradigmatic example of this. I have finished graduation in medicine without one single class on death or how it is related with. Without knowing even how to certify a death. However it is a daily reality in Medical wards where I work and I am called to be an example for the younger in an exercise appealing to responsibility.

The inherent difficulties to managing situations in life cannot be centered only in the failures of under graduation training because in some way they perpetuate themselves in the training journey afterwards. And the journey does not have to be walked alone, necessarily. Sharing experiences is always a source of growing and learning, making easier the experience of living something that on its own it is not easy to face. We cannot forget that the physician dealing with such reality has an added difficulty: to be confronted with his/her own vulnerability, emotions and doubts lacking an appropriate processing in the name of emotional health and absence of contra-productive interferences in the relationship between a patient and his/her physician.

The importance of such issue does not end in the aspects that so far I have tried to approach. It goes well beyond it. The incapacity of thinking about it and approaching it with the many intervening in it — patient, family, working team — leads us often to prolong invasive and futile treatments, without any advantage for the patient.

Change is therefore unavoidable. In order to deliver the best care to patients that one day we chose to serve. Even when they are dying. Because "*Morir reclama humanidad*" as JC Bermejo says, "*y ensena a vivir humanamente*"*.

*To die claims for compassion… and teaches to live with compassion. ■

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