

This essay was submitted by Nico Calderon-Hunt as part of the 2024 ANZSPM Aotearoa Palliative Medicine Essay Competition, winning the Māori Pacifica Category.

## **ONLY HUMAN: EXPLORING THE COMPLEXITY OF DEATH AND SUFFERING.**

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### **“Dying should be one of the great events of life.”**

– Alan Watts

Prior to our first cadaver dissection lab in the early years of medical school, we took part in a process of whakanoa, which aimed to remove the tapu associated with the practice. In doing so, we were all given a powerful opportunity to really appreciate the value and personhood of those who had generously donated their bodies for our learning; to recognise them not simply as cadavers or anatomical models – but as real people who had once lived real lives. This understanding persisted for me as I made my first incision and thought about the stories contained by their skin. As we assessed their anatomy for signs of pathology and previous medical intervention. As I held their heart in my hands and reflected on how many times it must have beaten, how their quiet lungs once filled with breath, and how the brain that now lay exposed before me was once active and alert with an abundance of memory, thought, and emotion – much like my own.

That experience would prove to be one of many throughout my time in medical school which shone a light on the nature of mortality, death, and dying. I can recall the first time a patient passed whilst under the care of our team – a malnourished male in his 50s who acquired an unexpected infection over a long weekend and was suddenly absent from our list upon my return. Behaviourally, he had been a rather difficult patient for staff to manage, but I remember being distinctly saddened by the idea that he would have likely died alone and fairly suddenly, which was quickly cut short by the need to move on to the next patient of the day. I noted how this experience compared to that of another patient a few weeks later – an older wahine Māori in her final stages of life, surrounded by whānau as my supervisor recited a karakia in what remains to be one of the more moving moments of my clinical experience thus far, and one which highlighted to me the value of culture in death and dying, particularly as someone of mixed Māori heritage.

More recently, I was once again confronted by the reality of life and limitations of what we are able to do, when one of the patients on our team was a young mother of three, diagnosed with terminal cancer. This was made all the more impactful by the fact that several members of my own family had lost their lives to cancer, and I had borne witness to the far-reaching impact that end-of-life illness can have on a person and their loved ones. This particular encounter reminded me of the value of palliative care, in ensuring that her symptoms were well-managed so that she could truly appreciate the time she had left with her family and friends.

And then in 2022, whilst working on an upcoming assignment, I received a call informing me that a close highschool friend of mine had unexpectedly passed from a quickly deteriorating respiratory condition. For the first time, death was acutely personal, and the weeks that followed carried an unfamiliar weight as I found myself stunned by the notion that the world simply continued, unaware of the loss. Reflecting on this experience deepened my understanding of what it means to grieve, and reaffirmed the importance of memory as the preservation of life. My interactions with patients who seemed to be approaching the end of their lives, or with friends and family confronted by their own experiences of death and dying, took on a new light, as did the nature of my work.

Certainly, medicine influences our perception of life and death in a uniquely impactful way. There is an implicit expectation to not become overly attached to patients, whilst still maintaining an awareness of their personhood, which can be challenged by an ever-changing list of names and new problems to solve each day. Moreover, difficult conversations and developing treatments in the field of end-of-life care are changing the way we think about death and dying, such as the respective use of euthanasia or psychedelic-assisted therapies – both of which cannot be discussed seriously without addressing the spiritual component of care, the nature of our role as healthcare providers, or the ethical implications of

patient autonomy and undue influence.

As I approach the end of my medical degree – the somewhat intimidating reality of becoming a bona fide doctor looming ever-nearer – I find myself reflecting on these ideas with greater frequency. On the wards, I observe as loved ones are forced to come to terms with the loss of someone dear to them, or as someone is forced to come to terms with their own mortality. I can accept that one day I will find myself in a similar situation, and I will allow the notion of such an inevitability to influence my approach to care with empathy and grace. I will attempt to remain open-minded when it comes to opposing beliefs around the sanctity of life, what it means to die, and what my role should entail, understanding that there may be times when there is no one right answer.

Much like death, medicine can be uncertain and, at times, frightening. But in the midst of such uncertainty, I find myself recalling a quote I read during my pre-clinical years:

**“We’ve been wrong about what our job is in medicine. We think our job is to ensure health and survival. But really it is larger than that. It is to enable well-being.”**

- Dr. Atul Gawande | *Being Mortal: Illness, Medicine and What Matters in the End*

