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# The lived experience of physicians dealing with patient death

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## ABSTRACT

**Background** A growing body of research indicates that physicians suffer high levels of stress, depression and burnout. Related literature has found that physician stress can negatively impact patient care. This study builds upon previous research that found some dying patients experienced ‘iatrogenic suffering’ caused by the way physicians communicated with them regarding terminal diagnoses and palliative treatment. The goal of this research was to explore physicians’ experiences of dealing with patient death in order to understand how such experiences affect them and their communication with patients.

**Methods** This study used qualitative methods to conduct and analyse 10 individual, semistructured interviews with senior physicians from several specialty areas at a large, tertiary care hospital. The resulting themes were validated using member checks and expert review.

**Results** This article presents five essential themes that provide a concise description of the lived experience of patient death for these physicians. Interpretation: These themes indicate that physicians can experience very strong and lasting emotional reactions to some patient deaths, and also that patient death can elicit intense experiences related to professional responsibility and competence. A key finding is the description of a complex process of managing the balance between personal and professional reactions in the face of patient death. The implication is that difficulties negotiating this balance may lead to unintended lapses in compassion and suboptimal outcomes in patient care.

## INTRODUCTION

A growing body of research indicates that physicians suffer high levels of stress, depression and burnout.<sup>1–3</sup> Related literature has found that physician stress can negatively impact patient care.<sup>4–7</sup> Patient death is a complex stressor in physicians’ work. Experts in physician wellness have

acknowledged ‘the death of patients is an experience that almost all physicians must confront’<sup>8</sup> and asserted ‘psychological distress (among physicians) derives largely from identification with suffering, the presence of death and the spectre of failure’.<sup>9</sup> Given the close relationships physicians develop with patients, it is reasonable to expect that patient deaths could affect physician stress and resilience. The current research grew out of earlier qualitative research conducted by David Kuhl, who supervised my research and acted as consultant to this article. In his research Kuhl explored the lived experience of patients with terminal illnesses<sup>10 11</sup> and found evidence of ‘iatrogenic suffering’: the suffering of patients caused by the way doctors speak to them. The purpose of the current research was to use qualitative methods to understand the ‘other side’ of iatrogenic suffering: the experience of physicians dealing with patient death, and how it contributes to iatrogenic suffering for patients.

## METHODS

This research used a phenomenological qualitative method.<sup>12</sup> The phenomenological approach attempts to capture the essence of a phenomenon through detailed analysis of a number of particular instances of the lived experience of that phenomenon. In this case, individual, in-depth interviews with 10 senior physicians explored (1) the daily experience of patient death, (2) particularly memorable patient deaths and (3) the impact of these experiences on their personal and professional lives. The interviews were transcribed and thematically analysed in order to identify the themes that described the essential structure of the lived experience of patient death for these physicians. Individual themes were identified for each participant and

validated through a detailed member-check in a second interview. Individual themes were then revised according to the comments and suggestions of the participants and a set of common themes was created. The final set of 10 common themes was then validated by a further member-check. An independent expert in the field was also asked to review the final 10 themes, once they had been agreed to by the participants. This expert was a family physician with many years of experience as a teacher and administrator who had a keen interest in the doctor-patient relationship, physician communication practices and physician resilience. The final 10 themes were separated into three categories: the impact of the context surrounding the experience of patient death; the immediate experience of dealing with patient death; and the impact of the experience on the physicians' personal and professional lives. Due to space constraints this article will focus on the five core themes that emerged as descriptions of the immediate experience of patient death for these physicians. The other themes will be presented in later articles.

### Participants

The five male and five female participants were all Caucasian. All were affiliated with a large, tertiary care hospital in Vancouver, Canada, had a minimum of 3 years work experience and self-identified as being exposed to multiple patient deaths. Three came from palliative care, two from emergency, two from hospital transplant teams, two from family practice and one from intensive care. The physicians ranged in age from 35 to 60 (average 48) and had from 6 years to over 20 years of experience (average 16.5). They represent a convenience sample identified through informal work contacts and then contacted with a formal letter of invitation. Interest in participating in this study was in part due to Kuhl's earlier research that identified 'iatrogenic suffering'. This previous research was known to most of the participants, and the letter of invitation identified that the current study was a follow-up to that research.

## RESULTS

### Theme (1) memories beneath the surface

Most participants responded to the question concerning daily experience of patient death by saying it was a 'normal part of the job': 'I think because I'm around it all the time, it's just kind of normal' (Dr B). 'It's become part of what I expect when I go to work' (Dr H). However, the question of particularly memorable patient deaths brought up strong memories. Before our interview Dr G anticipated this question:

I first thought...I can't remember any—and then *boom* ... this unbelievable image of a 21-year-old guy who'd been in a car accident... This was 20 years ago, and it's still one of the most vivid experiences that stays with me.

The physicians' recollections seemed to spring suddenly into consciousness. Their descriptions were accompanied by intense emotional reactions and vividly recalled details. Dr J described a memory from many years ago, which affected her deeply: 'It triggered me ... I felt this incredible flood of sadness,... emotion, ... grief,... fear'. Most memorable patient deaths occurred early in the physicians' careers and the consequences were often substantial regarding changes in career or personal choices. While daily experiences of patient death may have become 'normal', these memories carried a clarity and intensity reminiscent of traumatic memories, vividly powerful, just below the surface.

### Theme (2) expectation and responsibility

The experience of patient death was consistently associated with intense feelings of responsibility and an awareness of expectations from patients, families, the medical system and society. The physicians described how responsibility over life and death was attached to their role early on. Expectations of the 'heroic ideal' of the physician were ingrained by their families first, and then encountered in medical school and residency. Several physicians described the expectations and responsibilities as 'brutal' and 'inhuman' (Dr C) or 'impossible to fulfil' (Dr H). One physician summarised these expectations: 'We're supposed to know everything, and have the answer for everything, and somehow be larger than life' (Dr B). Many described how the sense of intense personal responsibility over the life or death of a patient was something they were forced to come to terms with during their careers. One physician described it as 'getting away from the expert culture of medicine' (Dr I). Another, who described being seen as a 'miracle worker' by many patients and families, said he had to limit this kind of adulation: 'The miracle wasn't me...that obviously feels good, but ... *nobody* lives up to that' (Dr C). These dynamics suggest that throughout a physician's career it can be difficult to balance the expectations of 'medical responsibility'<sup>13</sup> with the uncertain and unpredictable nature of patient care.

### Theme (3) the question of competence

Many memorable patient deaths caused the physicians to question whether they had done everything they could have, or should have, for the patient. In some cases they questioned whether certain decisions or actions may have caused harm, or even led to the patient's death. Mortality and morbidity rounds are intended to review difficult patient outcomes, learn from mistakes and avoid personal blame; however, they often magnify the question of competence:

You're exposed, and... people are able to see you're not perfect, and you have flaws... You always want that ability to say you are competent—and that detracts from your professional identity (Dr H).

Several physicians commented that in order to feel they had acted competently, they needed to feel 'clean' (Dr J) about the patient's death—that is, for the physician to be able to say, 'I know that I've done everything that could conceivably have been done' (Dr G). However, many situations include an inherent ambiguity that makes this difficult to achieve. Dr H pointed out that professional competence for physicians is not easily measured. What can be reasonably expected from a physician depends upon the situation, including what information and resources were available and what particular skills the physician had. A sense of competence depends in part upon how one compares among peers. 'I think we all compare ourselves to other people. ... That's something that probably everybody struggles with' (Dr H). Dr J described an obstetrical emergency that created 'terror' regarding her competence:

The *terror* of... how deeply responsible I felt to be competent in that moment, and how the chance of not being able to do something, or not doing it right, is so overwhelming. ... I might never know whether it's that I didn't do the algorithm right, or I didn't do it quickly enough, or... whether it was just this moment of fate and there was nothing that I could have done about it. You'll never get a clear answer.

#### Theme (4) breakthrough experiences

Descriptions of particularly memorable patient deaths often included unexpected details that jarred the physicians out of their normal awareness and connected them to the meaning or emotion of the event. These 'breakthrough experiences' would 'hit home' (Dr H) in a deeply personal way. One physician described a mother's comment upon seeing her 16-year-old boy dead after a car accident:

'He just got his hair cut today.'—She'd seen him earlier that day and everything was normal, and then the next thing you know... [it] makes you sit up and think about your own life (Dr H).

These breakthrough experiences often involved a sense of identification or relationship with patients that resulted in a personal awareness of mortality or other unresolved emotional experience for the physician. 'The ones I have trouble with are patients reminding me of my parents... that's too close to home' (Dr D). Dr H described a patient who was close to his own age, also married with children, and previously perfectly healthy, yet he died within 24 h of entering the hospital: 'It made me feel so vulnerable for my own mortality... Life can be ripped out of your hands so quickly' (Dr H). The quality of these 'breakthrough experiences' indicated how deeply these physicians were touched by 'the human part of the tragedy' (Dr J).

#### Theme (5) action versus presence

Many non-palliative physicians reported that at critical moments surrounding a patient's death they entered a 'mode' or state of mind in which their awareness was intensely focused on the actions they needed to perform. Palliative physicians, on the other hand, reported a very different sense: being *present with* the patient in a way that provided calm reassurance and support. Careful review of the interview protocols revealed that at patients' deaths many physicians experienced both of these 'modes' as well as a tension between them.

##### Action mode

When physicians described having to deal with a patient in crisis, many reported similar experiences of entering into 'protocol mode' (Dr G), 'automatic mode' (Dr F), 'mechanical mode' (Dr I) or 'action mode' (Dr J). The shift into this action-oriented state of mind helped the physicians focus and set aside any emotional reactions. 'At that moment, you don't think. You just go into that automatic mode... It's almost like you turn off part of your brain' (Dr F). Dr G described how he managed his personal reactions:

[I feel] an intensified feeling in my stomach, racing thoughts, and... I have to force myself down. I slow down and go into protocol mode. I have to go back and say the 'A, B, C's.

##### Presence mode

In contrast, the palliative care physicians described 'simply being present' with dying patients once they no longer needed to *do* something for them. Addressing the patient's medical needs was important; however, after all appropriate medical interventions, the need for 'presence' was still important for patients, families and the physicians themselves.

There are certain things that it's good to try and fix, ... but ... [when] it can't be fixed you have to be okay... Okay in the presence of death, knowing that some suffering you can't change, and that you'll be there with them *in it* (Dr B).

All three palliative physicians appreciated the quality of relationship they had with dying patients. 'It's a very close sort of relationship because people when they're dying are often very honest and open, and they need us to be honest and open as well' (Dr E).

The tension between these two 'modes' arises because physicians must either exclude or include an awareness of personal experience for themselves and their patients. Action mode requires physicians to shut down awareness of personal experience: 'You have to go into that checklist place, which becomes quite impersonal... You absolutely have to do that' (Dr J). Dr H described it as a 'functional disconnect': 'There is a separation between your professional and your private life that has to be there ... a disconnect ... that

has to be there for you to function'. These physicians' descriptions of action mode indicated that it disconnected them from their own emotional reactions and from the patient *as a person*: 'You've been so trained, you know—this is what has to be done at this time—that you just stop thinking of the patient as a person—as an individual' (Dr F). The personal awareness of presence mode is the antithesis of this functional disconnect. Dr I described a poignant example of the tension between action and presence. He was called to an emergency in which the patient was someone he knew personally:

I came in thinking in the mechanical mode – Then – 'I know him, he's younger than me, and he's dying!'... and then, between 'you do this, you get that, you do the other thing', I would flip into 'Oh my god, oh my god, oh my god,' and have tears in my eyes – back and forth and back and forth.

## DISCUSSION

The findings of this study expand our understanding of 'the other side of iatrogenic suffering.' They confirm other recent research indicating that while physicians do not have strong emotional reactions to every patient death, many report that some patient deaths have a strong emotional impact on them.<sup>14 15</sup> One qualitative study reported 'anti-emotion expectations'<sup>16</sup> in physician training and culture, yet identified that some patient deaths result in intense emotional reactions which can remain buried for decades and still erupt suddenly in vivid memories. In recent years there has been increased awareness of the need to support physicians in training to help them manage the emotional impact of difficult work-related experiences.<sup>10 17 18</sup> Changes have been made in some medical programmes to address this, and there has been some evidence of success.<sup>19</sup> However, many recent studies indicate that there is still little support for medical students and residents who experience emotional reactions to patient suffering and death.<sup>14 20–22</sup> Several authors suggest there is a 'hidden curriculum'<sup>21</sup> or 'conspiracy of silence'<sup>14 23</sup> in physician training that encourages a repression of emotional reactions. The current study indicates that physicians' experiences of patient death are complex and at times dominated by an awareness of professional responsibilities. Emotional processing can be set aside in order to 'functionally disconnect' from personal emotional reactions and remain focused on the technical aspects of the physician's role. This provides a new perspective on 'anti-emotion expectations' in medical culture. It seems that as long as physicians deal with patient death, they will at times need to go into action mode and functionally disconnect in order to sustain their professional role. The balancing process of reconnection needs to become as integral a part of physician training and role expectation as the

functional disconnect. In this way the emotional processing that is part of self-regulation and effective communication with patients will also be supported within medical training and culture.

The results of this study confirm that physicians' process of grieving patient death is somewhat different from that described in traditional bereavement models. Papadatou identified that while healthcare providers (HCPs) may experience grief related to the loss of the individual patient, which could be consistent with bereavement models for the general population, there are other dimensions of loss, which can be substantially different for HCPs given the nature of their work context. The most important of these is the possible loss of confidence or recognition in the self-identity and self-efficacy expectations attached to the professional role.<sup>24</sup> Papadatou put forward a professional grieving model for HCPs that describes a fluctuation between experiencing and repressing grief reactions. She points out that there is a similarity with the 'dual process model'<sup>25</sup> of bereavement in that both describe an oscillation between orienting either towards the loss experience or away from the loss towards continued engagement with life. This oscillation is similar to the dynamics between action and presence as well; however, for Papadatou and for the action/presence dynamics, emotional experience is often avoided by HCPs in order to preserve the professional role and 'get the job done'. A point of difference from Papadatou's model is that action mode and presence mode describe two states of mind that occur in relation to patient death, but they do not yet constitute a grieving 'process'. Physicians and other HCPs are confronted with many patient deaths over time, resulting in the possibility of repeating cycles of loss and adjustment. Further research is necessary to understand how the dynamics between action and presence influence the grieving process and psychological adjustment over time.

In recent literature on physician wellbeing there is evidence of a growing tension as physicians struggle to keep up with technical and bureaucratic demands while also being asked to improve on their ability to communicate and respond empathically to their patients.<sup>26</sup> Understanding the balance between action and presence may help physicians negotiate these different aspects of their role. While current demands may work to emphasise action and efficiency, the consequences of a one-sided emphasis on action mode may affect physicians' ability to respond with empathy and compassion towards patients. 'Iatrogenic suffering'<sup>8</sup> may occur when physicians maintain the 'disconnect' of action mode at times when their patients require the openness and connection of presence.

## Limitations

This study generated descriptions of the common essential qualities of the experience of patient death

for 10 physicians from widely different practice areas. The breadth of professional expertise was a strength as well as a limitation. The range of specialties helped to deepen the resulting description of the physicians' experience of patient death, and yet it also resulted in a less detailed understanding of the experience of physicians in any one specialty.

The study was also limited by the small number of physician participants, who represent a convenience sample, self-selected after hearing of the current study through word of mouth or an introductory letter. Participants consistently expressed an interest in participating in order to better understand physicians' work-related stress or to improve doctor-patient communication, which does suggest a certain bias among this sample.

#### Future directions

Research into nurses' experiences with patient death has identified a number of themes similar to those found by this study.<sup>27</sup> Future research could explore whether the particular finding of action versus presence is also applicable to nurses, allied health professionals and others dealing with patient death. When considering interprofessional healthcare teams, it would be interesting for future research to investigate whether the action versus presence dynamics have an impact on emotional processing and communication among team members, particularly when dealing with end-of-life care and patient death.

The findings of this study also have many implications for doctor-patient communication and the quality of patient care, as well as for the professional resilience of physicians. The training of the physicians who participated in this study occurred some time ago, and many training programmes have changed. Future research needs to identify and compare recent efforts to provide training and support for emotional awareness, communication and self care in medical schools and residency programmes. Future research could also determine whether specific training and emotional support using the concepts of action and presence can help young physicians understand and value the process of reconnection, and whether this aids them in learning to manage the emotional stress inherent in their work. Recent literature on physician wellness has suggested that professional resilience is enhanced when physicians engage in open communication with their dying patients, the patients' families and the other colleagues involved in the patients' care.<sup>28–30</sup> This research suggests that the open communication and compassion of presence could help create 'healing connections'<sup>29</sup> which would allow physicians to gain strength and resilience through their interactions with dying patients. Greater understanding of the action versus presence dynamics will help physicians learn to use the functional disconnect of action mode when needed *and* maintain the

healing connection of presence with their patients and themselves.

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#### REFERENCES

- 1 Sullivan P, Buske L. Results from CMA's huge 1998 physician survey point to a dispirited profession. *CMAJ* 1998;159:52–8.
- 2 Shanafelt TD, Sloan JA, Habermann TM. The well-being of physicians. *Am J Med* 2003;114:513–19.
- 3 Shanafelt TD, Bechamps G, Russel T, *et al.* Burnout and career satisfaction among American surgeons. *Ann Surg* 2009;250:463–71.
- 4 Meier DE, Back AL, Morrison RS. The inner life of physicians and care of the seriously ill. *JAMA* 2001;286:3007–14.
- 5 Shanafelt TD, Bradley KA, Wipf JE, *et al.* Burnout and self reported patient care in an internal medicine residency program. *Ann Intern Med* 2002;136:358–67.
- 6 West CP, Huschka MM, Novotny PJ, *et al.* Association of perceived medical errors with resident distress and empathy: a prospective longitudinal study. *JAMA* 2006;296:1071–8.
- 7 Shanafelt TD, Balch CM, Bechamps G, *et al.* Burnout and medical errors among American surgeons. *Ann Surg* 2010;251:995–1000.
- 8 Kvale J, Berg L, Groff JY, *et al.* Factors associated with residents' attitudes toward dying patients. *Fam Med* 1999;31:691–6.
- 9 Baider L, Wein S. Reality and fugues in physicians facing death: confrontation, coping, and adaptation at the bedside. *Crit Rev Oncol/Hematol* 2001;40:97–103.
- 10 Kuhl D. *What dying people want: practical wisdom for the end of life*. Toronto: Doubleday Canada, 2002.
- 11 Kuhl D. Exploring the lived experience of having a terminal illness. *J Palliat Care* 2011;27:43–52.
- 12 Van Manen M. *Researching lived experience: human science for an action sensitive pedagogy*. Albany, NY: State University of New York Press, 1990.
- 13 Becker HS, Geer B, Hughes EC, *et al.* *Boys in white: student culture in medical school*. Chicago, IL: University of Chicago Press, 1961.
- 14 Redinbaugh EM, Sullivan AM, Block SD, *et al.* Doctors' emotional reactions to recent death of a patient: cross sectional study of hospital doctors. *BMJ* 2003;327:185.

- 15 Moores TS, Castle KL, Shaw KL, *et al.* 'Memorable patient deaths': reactions of hospital doctors and their need for support. *Med Educ* 2007;41:942–6.
- 16 Kasket E. Death and the doctor II: a phenomenological investigation. *Existential Anal* 2006;17.2:385–96.
- 17 Dyrbye LN, Power DV, Massie FS, *et al.* Factors associated with resilience to and recovery from burnout: a prospective, multi-institutional study of US medical students. *Med Educ* 2010;44:1016–26.
- 18 Williams CM, Wilson CC, Olsen CH. Dying, death, and medical education: student voices. *J Palliat Med* 2005;8:372–81.
- 19 Ratanawongsa N, Teherani A, Hauer KE. Third-year medical students' experiences with dying patients during the internal medicine clerkship: a qualitative study of the informal curriculum. *Acad Med* 2005;80:641–7.
- 20 Jackson VA, Sullivan AM, Gadmer NM, *et al.* "It was haunting ...": physicians' descriptions of emotionally powerful patient deaths. *Acad Med* 2005;80:648–56.
- 21 Rhodes-Kropf J, Carmody SS, Seltzer D, *et al.* "This is just too awful; I just can't believe I experienced that ...": medical students' reactions to their "most memorable" patient death. *Acad Med* 2005;80:634–40.
- 22 Angoff NR. Crying in the curriculum. *JAMA* 2001;286:1017–18.
- 23 Sonneck G, Wagner R. Suicide and burnout of physicians. *Omega* 1996;33:255–63.
- 24 Papadatou D. A proposed model of health professionals' grieving process. *Omega* 2000;41:59–77.
- 25 Stroebe M, Schut H. The dual process model of coping with bereavement: rationale and description. *Death Studies* 1999;23:197–224.
- 26 Watt I, Nettleton S, Burrows R. The views of doctors on their working lives: a qualitative study. *J R Soc Med* 2008;101:592–7.
- 27 Wilson J, Kirshbaum M. Effects of patient death on nursing staff: a literature review. *Br J Nurs* 2011;20:559–63.
- 28 Kearney MK, Weininger RB, Vachon MLS, *et al.* Self-care of physicians caring for patients at the end of life: "being connected ... a key to my survival". *JAMA* 2009;301:1155–64.
- 29 Mount BM, Boston PH, Cohen SR. Healing connections: on moving from suffering to a sense of well-being. *J Pain Symptom Manage* 2007;33:372–88.
- 30 Jackson VA, Mack J, Matsuyama R, *et al.* A qualitative study of oncologists' approaches to end-of-life care. *J Palliat Med* 2008;11:893–906.