

# Physicians must address emotional toll of patient's death

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My first experience with a patient's death occurred during my internship. Although her death occurred 22 years ago, I still remember her with amazing clarity.

## Dealing with feelings

How to cope with emotions surrounding a patient's death is a topic rarely addressed in medical school.

Heather was a 3-year-old, full of curiosity, who was admitted to the oncology unit secondary to relapse of leukemia. One day during rounds, she coughed a single time. She didn't look sick, but the attending asked that I order a chest X-ray (CXR), which I did. However, I forgot to check the results. The next morning when I returned to the hospital, I saw Heather and suddenly remembered. I ran to radiology and to my sadness, Heather's CXR showed she had pneumonia. Although the attending and I immediately started antibiotics, Heather got progressively sicker from her pneumonia.

The next night I was on call, and Heather died in her mother's arms. I was devastated. I will never know if the 18-hour delay in initiating the antibiotics made a difference in her outcome, but I will always wonder. I felt so guilty that I was unable to talk with Heather's mother, unable to comfort her and offer her support. I remained awake that entire night on call, thinking about Heather and her mother.

The next morning on rounds, members of the team asked where Heather was and I informed them she had died. However, instead of a discussion about the chain of events and my involvement, we moved on to the next patient. Selfishly, I feared the chairman would call me into his office and fire me. I feared a lot of things. But to my amazement, no one said anything. Not only did no one review the whole course with me, but no one asked me how I was coping with Heather's death. It was as if it had never happened. Although I never talked about it to anyone, and I never cried, I thought about Heather often. I felt very badly about myself and questioned my decision to become a pediatrician. I suffered in silence and isolation.

Six months later, I was working in the pediatric intensive care unit. A 9-year-old girl was admitted with leukemia and was very ill with multiple system involvement. I was assigned as the intern covering her care. Since she was on a ventilator and sedated, I was never able to talk with her. Despite very aggressive treatment, she died two days later. Although I didn't know her at all, I ran from her bedside into the utility closet and began sobbing hysterically. Some of my colleagues saw my reaction and followed me into the closet. They were surprised by my response, since I had hardly known this young girl.

Their support comforted me. But suddenly it occurred to me that I was mourning Heather's death, six months later. It made me realize how unhealthy it was that I had never discussed Heather's death with anyone, had never had a forum to gain insight into my reactions, to understand my need to mourn and what the emotional toll might be on me as a health care provider. I needed an opportunity to review my decision-making, to face the reality that I wouldn't always cure patients that sometimes patients get worse and sometimes I would make mistakes. Yet, I still had an important role with the family to support them in their suffering.

These topics are rarely addressed in medical school and residency. I don't know which was the bigger failure to me: that I hadn't checked the CXR or I hadn't supported Heather's mother during this tragedy. I had failed to be a healer.

Addressing the emotional needs of both the bereaved family and the health care professional are equally important. Since the death of a child is the most tragic experience parents will encounter, it must be approached with compassion on the part of health care professionals. The manner in which information is shared with a family and the amount of support they experience can make a difference in their long-term coping. If approached in a sensitive manner, parents are more likely to be able to integrate the experience and channel the love of their child into something productive.

This support can be offered in a variety of ways: at the time of death in the disclosure of the news and willingness to spend time with the family, by arranging a follow-up visit to determine how the family is coping, by sending a sympathy card, by attending the memorial service or funeral, or by acknowledging the anniversary of the child's death with a note of remembrance. These forms of support also may help the health care provider better integrate the experience into his or her life. When a patient dies, discussing the experience with a close colleague can help you cope with your emotions.

For health care professionals to be able to provide this support, they must be nourished themselves. The Institute of Medicine report *When Children Die* ([www.nap.edu/books/0309084377/html](http://www.nap.edu/books/0309084377/html)) and the AAP policy statement on palliative care (*Pediatrics*.2000 ;106:351 -357 [Abstract/FREE Full Text](#)) both emphasize the importance of health care providers talking about deaths and addressing the emotional toll on themselves. When unexpected outcomes occur, health care professionals often question their judgment and decision-making, feel a sense of responsibility and experience emotions of sadness, anger, guilt and sometimes relief. All of these are normal reactions.

One way to nourish ourselves is to share our experiences with others. We need to have the advantage of others' perspectives, to have an external barometer to process our reactions, to get an external reality check in order to integrate these experiences into our lives. It is beneficial to talk about these experiences for many reasons: to acknowledge and bear witness to the life and death of a patient, a fellow human being, to acknowledge responsibility and review our decision-making if needed, and to gain emotional support from others to maintain our resilience. This support can help transform an incredibly stressful experience into one of the most rewarding of our careers, one in which we perceive it as a true privilege to have been involved.

There still is much to learn about the needs of health care professionals for emotional support and how to take better care for ourselves and our patients. With whom should we share our experiences? A peer, a supervisor or a member of our family? Should it be done one-on-one to facilitate openness and comfort, or include other members of the medical team and additional disciplines in order to hear and understand the emotions of others?

I suspect the answers vary according to the individuals and circumstances of the death. But we need research to determine the most effective strategies to ensure the best outcomes. We need to change the medical culture to make certain that health care professionals' needs are addressed, that residency training programs train residents in self care, and that institutions provide the time, space and personnel to allow the discussion of these experiences. This investment will result in better care of our patients, their families and ourselves.

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