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The emotional impact of patient deaths on physicians

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Abstract
In recent years, more importance has begun to be attached to emotional life, especially in the case of doctors dealing with the death of patients. The care and death of seriously ill patients has a strong emotional impact on doctors. The grief caused by the death of patients affects not only the personal life of physicians but also their professional life and, if left unaddressed, can lead to burnout and impact both patient care and the doctor-patient relationship.
Aim: The aim of the study was to identify the emotional experiences of physicians coping with the death of patients and to understand how it affects them. The overall objective of the study was to reduce the emotional impact of patients' death on physicians by normalizing the loss and using coping methods.
Material and Methods: A retrospective study was conducted between March and June 2023, which consisted of a 21-question questionnaire distributed online and addressed to physicians who had experienced at least once in their lifetime the death of a patient. The research questions focused mainly on the impact of patient death on the personal and professional lives of doctors. A total of 124 physician respondents were included in the study.
Results: The frequency with which physicians experience patient death differs by specialty and professional experience. The medical specialties where physicians face the most patients who die are oncology, internal medicine, cardiology, anesthesiology and intensive care. The most common emotions that physicians encounter after the death of a patient are: acceptance, anxiety, depression, disappointment, exhaustion, frustration, anger, helplessness, stress, sadness, guilt.
Conclusions: The death of a patient can have a significant emotional impact on physicians and varies from physician to physician. The emotions generated by the death of a patient can influence physicians' personal and professional lives to varying degrees. In order to prevent burnout, doctors should be more aware of their own emotional experiences related to the death of a patient and seek help from colleagues or a psychologist to keep themselves in the best possible physical and emotional state.

Keywords: emotions, bereavement, burnout, coping

Rezumat
În ultimii ani a început să se acorde o mai mare importanță vieții emoționale și în special în cazul medicilor care se confruntă cu decesul pacienților. Îngrijirea pacienților gravi și decesul acestora au un impact emoțional puternic asupra medicilor. Durerea provocată de moartea pacienților afectează nu numai viața personală a medicilor, ci și viața lor profesională și, dacă nu este abordată, poate duce la epuizare și poate avea un impact atât asupra îngrijirii pacienților cât și asupra relației medic-pacient.
Obiectiv: Scopul studiului a fost de a identifica experiențele emoționale ale medicilor care se confruntă cu moartea pacienților și pentru a înțelege modul în care acestea îi afectează. Obiectivul general al studiului a fost de a reduce impactul emoțional produs de moartea pacienților asupra medicilor prin normalizarea pierderii și a folosirii metodelor de coping.
Material și metode: În perioada martie-iunie 2023 s-a realizat un studiu retrospectiv, ce a constat în aplicarea unui chestionar cu 21 de întrebări, distribuit on-line și a fost adresat medicilor care s-au confruntat cel puțin o dată în viață cu decesul unui pacient. Întrebările pentru cercetare s-au axat în principal pe impactul morții pacienților asupra vieții personale și profesionale a medicilor. Au fost incluși în studiu 124 de respondenți medici.
Rezultate: Frecvența cu care medicii se confruntă cu decesul pacienților diferă în funcție de specialitate și de experiența profesională. Specialitățile medicale unde medicii se confruntă cu cei mai mulți pacienți care decedează sunt oncologia, medicina internă, cardiologia, anestezia și terapia intensivă. Cele mai frecvente emoții cu care medicii se întâlnesc după decesul unui pacient sunt: acceptare, anxietate, deprimare, dezamăgire, epuizare, frustrare, furie, neputință, stres, tristețe, vinovăție.
Concluzii: Decesul unui pacient poate avea un impact emoțional semnificativ asupra medicilor și variază de la un medic la altul. Emoțiile generate de decesul unui pacient pot influența în diferite grade viața personală și profesională a medicilor. Pentru prevenirea sindromului de burnout, medicii ar trebui să fie mai conștienți de propriile trăiri emoționale legate de decesul unui pacient și să ceară ajutorul colegilor sau a unui psiholog pentru a avea mereu o stare fizică și emoțională cât mai bună.

Cuvinte cheie: emoții, deces, burnout, coping

Introduction

Physicians working with critically ill patients are among those most frequently exposed to death and respond in various ways to the numerous deaths they witness and their own sense of mortality. When patient deaths occur consecutively, without the opportunity to process multiple deaths, physicians are

prone to a state of chronic mourning [1]. Physicians who treat critically ill patients and confront end-of-life issues must establish certain emotional boundaries or limits to avoid being overwhelmed by grief when losing a patient. A balance must be found, as unprocessed grief related to patients' death negatively impacts physicians' personal and professional lives. [2]

Over time, the topic of death has garnered interest, with psychologist Herman Feifel being a pioneer in research on the perspective of death, death anxiety, and coping with life-threatening illnesses. Through over 1000 published studies, the American psychologist Herman Feifel demonstrated the multidimensional and heterogeneous nature of attitudes toward death. When people face moments where their lives are at risk, the fear of death can manifest differently at both conscious and unconscious levels, leading to various coping strategies. [3] Herman Feifel's research laid the foundation for the development of psycho-emotional and psycho-social perspectives on death and dying. Elisabeth Kübler-Ross is recognized for popularizing the emotional stages of dying and integrating them into the field of thanatology. [4]

Fear of patients' death is common among healthcare workers and is associated with a negative attitude toward caring for a dying patient. [5] During their professional development, physicians first encounter the theoretical concept of patient death in the first two years of study, during anatomy dissection courses. Later, in subsequent years, they face patient death directly through various hospital internships and volunteer work.

Most clinicals eventually encounter patient death in their current practice. Although these events are not rare, especially for physicians caring for critically ill and terminal patients, the analysis of the emotional aspects generated by death among physicians is quite limited. The grief experienced by physicians after patient deaths is significant as it is a source of stress that can subsequently lead to professional burnout in approximately 50% of specialists treating terminally ill patients. [6]

Physicians instinctively develop emotions related to their patients, which are an integral part of the doctor-patient relationship. The challenge for physicians is to find an inner balance so as not to be emotionally overwhelmed and to avoid affecting their compassion for future patients. [7] The grief caused by loss is a normal response after the death of a patient and involves a range of emotions and reactions that can complicate the process, sometimes leading to a need for psychiatric intervention. Several predictive factors for the onset of depression in physicians include difficult relationships with superiors, colleagues, and patients, lack of sleep, errors in medical practice, loneliness, witnessing dying patients, and self-criticism. [8]

Over time, studies have been conducted on physicians' feelings regarding patient deaths, particularly among oncologists and emergency medicine physicians.

A study conducted between 2010 and 2011 with 20 oncologists from three hospitals in Canada highlighted that these physicians attempted to manage their feelings caused by patient deaths and to remain detached in order to treat their patients as well as possible. More than half of the respondents felt failure, sadness, doubt, helplessness, and one-third experienced guilt, sleep problems, and crying. One of the study's conclusions showed that physicians never discussed their feelings and kept them hidden, as pain in a medical context is considered shameful and unprofessional. Additionally, the grief associated with patient deaths negatively impacts the relationship and communication between the physician, the patient, and the patient's family. Most physicians distance themselves from the patient and the family as death approaches. The study also noted an impact on the personal lives of physicians and emphasized that oncologists are not prepared to handle their own grief and should be trained and supported in this regard. [9]

Between March 2013 and June 2014, 22 interviews were conducted with oncologists treating adult cancer patients in three centers in Israel. The results showed that emotions related to patient loss can arise from the moment of communicating an unfavorable prognosis, at the time of death, or a few days after death. In response to these events, oncologists experienced behavioral changes (crying, sleep problems), feelings of guilt, lack of confidence, physical symptoms (palpitations, fatigue, chest pain), and emotional reactions (anger, sadness, anxiety, irritability). [10]

Regarding emergency department physicians, a study was conducted in two hospitals in the United States, which included 188 physicians. Most physicians reported a moderate emotional impact caused by patient deaths. Those who had cared for patients for a longer period before patients' death, as well as female doctors, reported a stronger emotional impact. The level of physicians' training did not correlate with the degree of emotional distress.[11]

Physicians who develop a longer-term relationship with a patient until the time of death become more vulnerable and are more affected by the emotions related to loss. One effective way to cope with these experiences has been found to be sharing emotions with other colleagues and reflecting on the case of the deceased patient. [11]

The doctor-patient relationship remains one of the most satisfying aspects of practicing medicine; however, it can also be one of the greatest sources of stress. Boerner et al. report that emotions associated with patient death play a major role in professional burnout among long-term care workers. This issue may be even more evident for oncologists who frequently deal with patient deaths in their practice. Therefore, they are at the highest risk of burnout. [12]

The PubMed database search has generated publications regarding emotional reactions to the deaths of oncology patients among physicians in Canada, the United States, and Israel. This underscores the need for new studies involving physicians from other parts of the world, particularly from the European continent. Results may vary and be influenced by geographical area, moral, cultural, social, personal, or religious values of the studied population.

The present research aims to explore the emotional experiences of Romanian physicians who encounter patient deaths to understand how these experiences affect them and their communication with patients.

The specific objectives for the study were:

1. To identify the emotions of physicians facing patient deaths
2. To assess the emotional impact of patient deaths on physicians
3. To identify the main coping methods and strategies

Inclusion criteria for the study:

- Physicians who have faced patient deaths at least once
- Participants who answer all questions on the questionnaire completely
- Participants who sign the informed consent form for the study

Exclusion criteria from the study:
- Medical students, nurses, psychologists, and other healthcare staff
- Participants who do not complete the questionnaire

This cross-sectional study was a sociological survey based on a questionnaire. Respondents who participated in the research were included randomly, based on the study's inclusion criteria. Before data collection, we obtained informed consent from all participants. Data were collected through physicians completing a questionnaire consisting of 21 questions, from March to June 2023. Some questions had predefined or open-ended response options, while others gathered general and socio-demographic information about the physicians (age, gender, county of practice, professional experience, medical specialty, certification in palliative care).

The questionnaire was administered online. Participants were not exposed to any risk by participating in this study. There were no direct benefits resulting from the physicians' participation, but the research results could be useful for the emotional support of physicians dealing with patient deaths.

The results obtained from the completed questionnaires were compiled and processed using Google Forms and Microsoft Office Excel 2016. Graphical representation was carried out using bar charts, column charts, and radial structure diagrams, employing Google Forms and Microsoft Office Excel 2016.

Results and Discussion

The study included 124 physician respondents who completed the online questionnaire and answered the 21 questions. Of the 124 study participants, 98 were women and 25 were men, resulting in a female-to-male ratio of 3.92. The ages of the physicians included in the study ranged from 20 to 80 years, with the majority being between 31 to 40 years old.

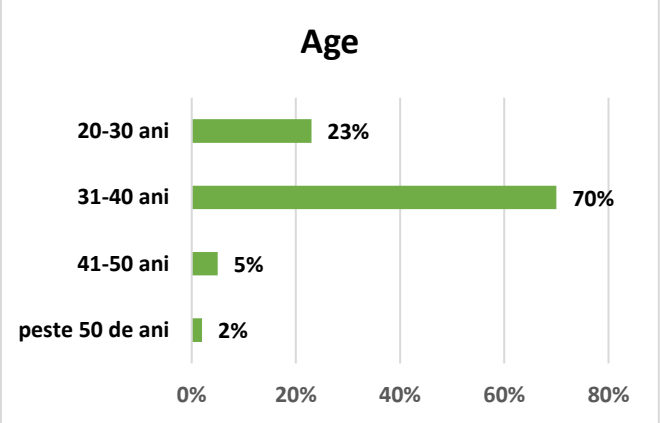

Figure 1 - Respondents age % distribution

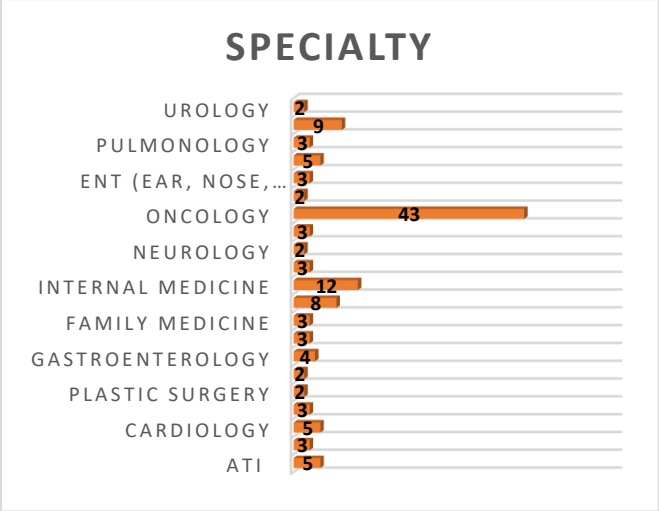

Figure 2 - Respondents age % distribution

Most of the doctors included in the study have a medical specialty in oncology (43), followed by internal medicine (12) and radiotherapy (9), with emergency medicine (8) indicating that these specialties most frequently deal with critically ill patients. (Fig 2)

In terms of professional experience, 57 of the respondents are specialist doctors, 47 are resident doctors, and 20 are consultants. Among the doctors included in the study, 73 practice in Bucharest, 11 in Cluj County, 8 in Ialomița County, 7 in Timiș, 5 in Prahova, and one or two doctors from each of the other 11 counties.

Regarding acquired competencies, 95.2% of the respondents (118 doctors) do not have a certification in palliative care. This is not surprising given that in Romania, in 2021, there were only 106 doctors employed in palliative care services. The education of palliative care professionals amounts to 722 doctors who obtained the complementary studies certificate in palliative care. Among these, only 106 (14.68%) are employed (full-time or part-time) in the palliative care services reported in 2021. However, there are significant differences between counties, with Bucharest (105 doctors) leading, Iași County (70 doctors), and Brașov County (65 doctors), while Gorj, Tulcea, and Vâlcea counties each have only one doctor with a palliative care certificate. Acquiring the certificate is mandatory for the authorization of specialized services. [13]

Communicating with patients about death can be extremely challenging for doctors, as it is a sensitive topic. Firstly, discussing a patient's death has a strong emotional impact and is often a challenge for doctors. [14], [15] The first question of the questionnaire reveals that most doctors find it difficult and very difficult to discuss death with patients.

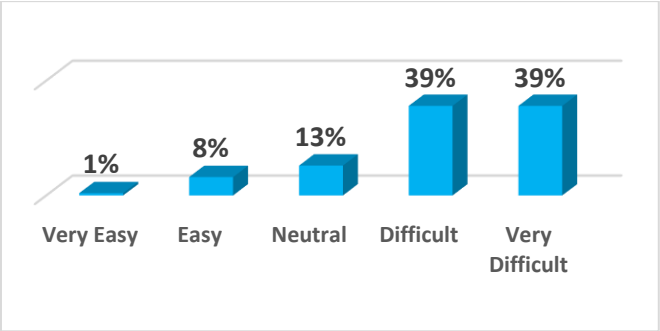

Figure 3 - How difficult is it to discuss death with patients?

Discussing death with a patient's family is a significant moment and creates discomfort for doctors. They need to recognize their own emotions and communicate using clear and empathetic language. The news of death can evoke a range of intense emotions in the family, which may vary from sadness and shock to anger and denial. They must be prepared for these emotional reactions and offer support and empathy. Additionally, doctors should use appropriate, clear, and accessible language, avoiding complex medical terms that may create further confusion. [16]

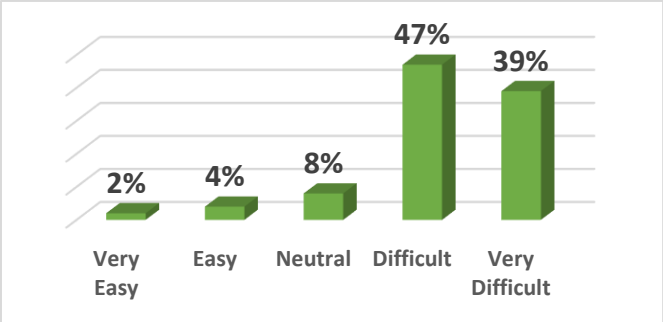

Figure 4 - How difficult is it for you to discuss death with a patient's family?

In the study conducted, 47% of doctors stated that it is difficult for them to approach this topic with a patient's family, while 39% found it very difficult.

Throughout their training and professional development, doctors may encounter various difficult situations, including a patient's death. The frequency of deaths that doctors may face varies depending on their specialty as well as their professional experience. Specialties that most frequently deal with patient deaths include oncology, internal medicine, intensive care, and geriatrics. Most doctors included in the study have faced more than 10 deaths (67%), 22% have encountered 1-4 deaths, and 8% have faced 5-10 deaths.

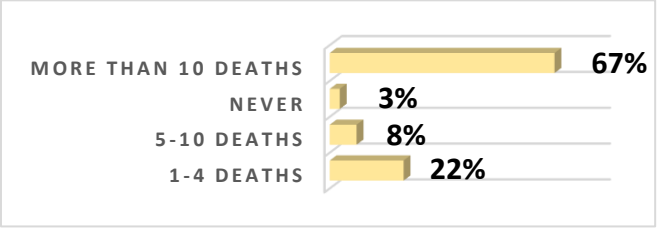

Figure 5 - Number of deaths

The death of a person is a natural part of life. Those who face the loss of a loved one may experience the pain of the process through denial, anger, depression, and acceptance. This event can be a traumatic experience and may impact both personal and professional life. [17]

In the study conducted, 39% of doctors reported that patient deaths impact their personal life most of the time (39% sometimes and 33% frequently). Regarding the professional impact of patient deaths, 36% of doctors said this happens sometimes, 30% rarely, and 18% never.

Debriefing sessions after a patient's death represent a very useful way for doctors to reflect on the experience in a safe and confidential environment. Considering the impact of a patient's death, participating in these sessions allows doctors to express their emotions, receive or offer support, and prevent professional burnout. The most important benefits of participating in debriefing sessions are: recognizing and expressing emotions, improving medical practice, professional development, strengthening working relationships with other team members, managing stress, and developing emotional regulation mechanisms. [18]

Regarding the results of the study, 70% of respondents stated that a debriefing session after a patient's death would help them to a great extent (30%) and to a very great extent (40%).

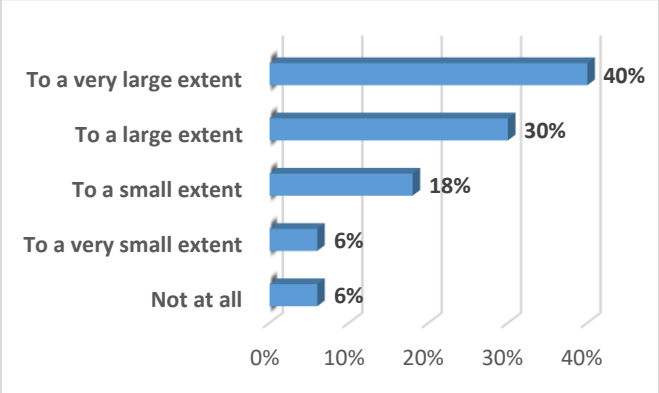

Figure 6 - To what extent can a debriefing session after a patient's death be useful?

Sleep problems or loss of interest in certain activities can be normal after the death of a patient. Intense thoughts and emotions related to the event can affect the quality and duration of sleep. [19] In the study conducted, 35% of respondents have never encountered sleep problems, 30% rarely, and 22% sometimes.

Regarding the loss of interest in certain activities after a patient's death, 35% said it happens sometimes, 23% rarely, and 20% never. Emotions related to a patient's death can be significant and vary from one doctor to another. Throughout treatment, doctors tend to develop a connection with their patients and sometimes become emotionally attached. A doctor might feel that they have failed in their primary goal - that of saving lives. Regardless of the efforts made, a death can produce a strong sense of personal failure. It is important for doctors to recognize the emotional impact and take time for their own emotional regulation and healing. [20]

Respondents in this study reported that 67% frequently manage their emotions well, while 22% do so sometimes, indicating an effective capacity for managing emotional reactions. These responses are correlated with a rejection of

emotional support, with most doctors believing they do not need emotional support, predominantly selecting responses of sometimes (32%), rarely (32%), and never (21%).
To cope with a patient's death, doctors may resort to various methods or strategies for more effective management of these moments. In the study conducted, 38% of respondents accept the difficult moment they are going through, 22% turn to faith, 15% seek specialized help (psychological support), 18% use other coping methods (smoking, alcohol, compulsive eating), and 7% take leave.

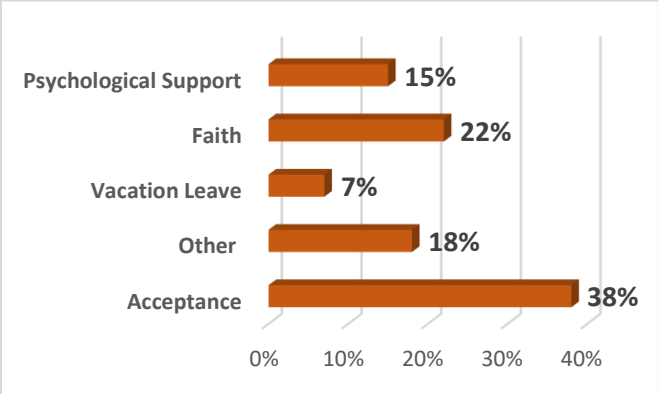

Figure 7 - What coping strategies do you use after a patient's death?

Among the respondent doctors, most (32%) would not consult a clinical psychologist or psychotherapist at all, and 38% would consult them to a small or very small extent. Additionally, only 10.5% of respondents sought the help of a psychologist after a patient's death. This indicates a reluctance among doctors to express their emotions to a specialist and to seek help when facing a difficult situation.
After a patient's death, doctors may take a range of measures and actions depending on specific circumstances and their personal needs. In addition to completing administrative tasks such as filling out the death certificate and other necessary documents, doctors may also be involved in communicating with the patient's family, providing them with information about the cause and circumstances of the death and offering emotional support.
The study's questionnaire also included an open-ended question where doctors could express their views on their personal attitudes after a patient's death. The responses were grouped into five categories, with the majority (34%) stating that they had considered changing their specialty or even leaving medicine. 22% of respondents thought about appreciating life and people more, 21% reflected on the case, 14% considered taking a leave of absence, and 9% thought about discussing the situation with a psychologist. Participants in the study were asked if they receive support from colleagues when dealing with critically ill or deceased patients. 65.3% of respondents are helped by colleagues, 32.3% responded negatively, and 2.4% could not assess.
Communication between doctors and patients is very important and plays a crucial role in the care process. Patients feel more heard and involved in their own care when communication is effective, which increases their trust in the doctor and the medical act. Often, doctors do not have the time or are not prepared to communicate effectively with patients. During their professional training, doctors are not provided with courses on patient communication, which affects the quality of medical care, treatment adherence, and patient satisfaction. [21], [22], [23]
Regarding their training in communicating bad news, 31.5% of respondents answered affirmatively, 66.9% negatively, and 1% could not assess. In the research conducted, doctors were asked if their employer had provided training courses for communication with patients. Results showed that in 87.1% of cases, doctors had not been offered communication courses. Doctors were also asked if they found participation in patient communication courses useful. Among them, 94% supported the necessity of such courses, while the remaining 6% felt they would not be useful.

Limitations of the study

There are few standardized measures that specifically assess doctors' emotions. It is possible that the quantitative measures used lacked the sensitivity to capture subtle and highly individual reactions to death, which might be better elucidated through qualitative methods.

Conclusions

The death of a patient can have a significant emotional impact on doctors and varies from one doctor to another. The frequency with which doctors encounter patient deaths differs based on specialty and professional experience. The medical specialties where doctors face the most patient deaths are oncology, internal medicine, cardiology, anesthesia, and intensive care. Emotions generated by a patient's death can affect, to varying degrees, doctors' personal and professional lives. The most common coping methods for doctors after a patient's death are acceptance, faith, specialized psychological support, or addictions (smoking, alcohol, eating). Debriefing sessions can be very useful for the entire medical team involved in a patient's death by allowing emotional expression, mutual support, prevention of professional burnout, and ongoing professional development. Most doctors have not participated in palliative care or bad news communication courses and desire such training. This study opens new research opportunities in this area for normalizing the painful experiences doctors face as an integral part of life and proposing new methods to improve the quality of doctors' lives as well as the doctor-patient-family relationship.

References

1. Masia R, Basson WJ, Ogunbanjo GA. Emotional reactions of medical doctors and students following the loss of their patients at the Dr George Mukhari Hospital emergency unit, South Africa. S Afr Fam Pract; 2010;52(4):356–63. Available at: 10.1080/20786204.2010.10874006
2. Ionescu F. The pain and anguish of doctors after losing a patient. Medical Life. 2020 7 February.
3. Feifel H. The meaning of death. New York: McGraw-Hill Companies; 1965.
4. Pallis, Christopher A. Death. Encyclopedia Britannica. Available at: https://www.britannica.com/science/death.
5. Nia HS, Lehto RH, Ebadi A, Peyrovi H. Death anxiety among nurses and health care professionals: A Review Article. Int J Community Based Nurs Midwifery. 2016 Jan;4(1):2-10. PMID: 26793726; PMCID: PMC4709813. Available at: https://pubmed.ncbi.nlm.nih.gov/26793726/.
6. Sansone RA, Sansone LA. Physician grief with patient death. Innov Clin Neurosci. 2012 Apr;9(4):22-6. PMID: 22666638; PMCID: PMC3366454. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3366454/.

7. Gilewski T. Encountering grief in patient care. *Am Soc Clin Oncol Educ Book* **32**, e81-e84(2012). DOI:10.14694/EdBook_AM.2012.32.302
8. Robert P, Bright LK. Depression and suicide among physicians. Current Psychiatry. 2011;10(4):16–30. Available at: https://www.mdedge.com/psychiatry/article/64274/depression/depression-and-suicide-among-physicians.
9. Granek L. When Doctors Grieve. The New York Times. 2012; Available at: https://www.researchgate.net/publication/284593084_When_doctors_grieve.
10. Granek L, Ben-David M, Shapira S, Bar-Sela G, Ariad S. Grief symptoms and difficult patient loss for oncologists in response to patient death. Psychooncology. 2017 Jul;26(7):960-966. doi: 10.1002/pon.4118. Epub 2016 Mar 14. PMID: 26988940. Available at: https://pubmed.ncbi.nlm.nih.gov/26988940/.
11. Redinbaugh EM. Doctors' emotional reactions to recent death of a patient: cross sectional study of hospital doctors. BMJ 2003;327(7408):185–180, doi: 10.1136/bmj.327.7408.185.
12. Boerner K, Gleason H, Jopp DS. Burnout after patient death: Challenges for direct care workers. J Pain Symptom Manage. 2017;54(3):317–25 [online], Available at: http://dx.doi.org/10.1016/j.jpainsymman.2017.06.006.
13. https://www.paliatia.eu/new/ro/2023/01/ingrijirea-paliativa-in-romania-in-2022-dezvoltare-organizationala-educatie-si-cercetar/. Accessed at 1 march 2023
14. Brown S. Why many doctors still find it difficult to talk about dying with patients. CMAJ .2019;191(1): E22–3. Available at: https://doi.org/10.1503/cmaj.109-5691.
15. https://ehospice.com/uk_posts/new-report-reveals-why-doctors-struggle-to-talk-to-patients-about-dying/ Accesed at 1 march 2023.
16. Okamoto S, Uneno Y, Mori M, Yamaguchi T, Nakajima N. Communication with families in the last days of a patient's life and optimal delivery of a death pronouncement. In: Palliative Care. IntechOpen; 2019; DOI: 10.5772/intechopen.84730.
17. BetterHelp Editorial Team. How to cope with a death in the family. BetterHelp. 2024; Available at: https://www.betterhelp.com/advice/family/how-to-deal-with-a-death-in-the-family/.
18. Schaap M, Hanskamp-Sebregts M, Merkx T, Heideveld-Chevalking, Meijerink J. Long-term effects of perioperative briefing and debriefing on team climate: A mixed-method evaluation study. Int J Clin Pract. 2021;75(3), https://doi.org/10.1111/ijcp.13689.
19. Monk TH, Germain A, Reynolds CF. Sleep disturbance in bereavement. Psychiatr Ann. 2008;38(10), https://doi.org/10.3928/00485713-20081001-06.
20. Yagil D, Shnapper-Cohen M. When authenticity matters most: Physicians' regulation of emotional display and patient satisfaction. Patient Educ Couns. 2016;99(10):1694–8. Available at: http://dx.doi.org/10.1016/j.pec.2016.04.003
21. Ha JF, Longnecker N. Doctor-patient communication: a review. Ochsner J. 2010 Spring;10(1):38–43. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3096184/.
22. Street RL Jr, Haidet P. How well do doctors know their patients? Factors affecting physician understanding of patients' health beliefs. J Gen Intern Med. 2011;26(1):21–7; Available at: http://dx.doi.org/10.1007/s11606-010-1453-3.
23. https://www.medichub.ro/stiri/studentii-la-medicina-vor-face-in-premiera-cursuri-de-comunicare-medic-pacient-id-8275-cmsid-2. Accessed at 19 July 2023