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Editorial

Patients' death: "Everybody hurts… sometimes"*

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Patients die. This is a reality physicians will face all along their career. What happens when a surgeon takes his sterile gloves off after a patient's death and goes back home? What are his feelings? How does he cope?

Brianne Wiemann, Erika Ketteler and Bridget Fahy from New Mexico tried to find answers to these questions in their article published this month (1). Surgeons and medical students surveyed by our colleagues reported emotional distress manifested as anxiety and burnout. One out of 4 younger respondents tried not to think about the patient's death. The most common coping strategies were seeking comfort from loved ones and extracurricular activities. Emotional burden was heightened for COVID-19 related deaths since support from colleagues was limited and concerns for one's own and loved ones' safety were present. Moreover, almost half of the respondents indicated they had not received any training on how to deal with a patient's death.

The COVID-19 pandemic drew attention to the impact patient death can have on physicians' mental health. Physicians have a higher rate of burnout, depression, and suicide than the general population (2), but some physician groups may be at higher risk than others. Surgeons are described as having their own "moral economy". Not offering surgery is experienced as giving up on a patient, and this view is strengthened by the expectations from patients, families, and society (3). Surgeon professional identity includes an acute sense of being responsible for patient outcomes (4), while a focused-on-surgery attitude leads to mainly consider "on the table death" and to operate when the benefits or the postoperative quality of life are uncertain (5). Such attitudes ill prepare surgeons to face patient death, all the more so that it is a comparatively rare event (6,7). Surgeons' typical traits are described as main reasons to choose this specialty, but also as important stress factors: commitment to patients, long hours work, high volume and performance level, decisions about life and death. Since surgical education traditionally focus on the care by a surgical procedure, death is perceived as a surgical failure (8). Surgeons could experience some difficulties discussing with patients with incurable diseases to avoid culpability feelings (9). They negotiate with patients a package of post-operative care prior to undertaking high-risk surgical procedures to shift responsibility of poor outcomes on patient's decision for treatment limitation (10) as a defence from a strong sense of responsibility for surgical outcomes. Pressure to succeed has already been described in sociological studies that focused on the image of a surgeon who feels himself as the only responsible of the patient's life.

Physicians regularly exposed to patient death come to integrate it within the scope of their clinical activity and seem to better come to terms with it (11).

When medical students are exposed to patients' death, senior personnel's empathy make the process easier. It seems important to not forget empathy with experience: looking for support and sharing experiences with colleagues still remains an important coping mechanism. Residents and fellows from the Mayo International Health Program were

* Everybody Hurts, R.E.M. 1992.

interviewed about their participation to International Health Electives in low or lower-middle-income countries (12). They reported a lack of preparation for exposure to death and a lack of closure. Even though this study explored an atypical experience, institutions should pay attention to these two aspects in undergraduate, postgraduate and continuing medical education (12).

Medical students and junior physicians represent a vulnerable group as far as mental health is concerned. Experiencing the death of a patient provokes various emotions in medical students, who report feeling upset, sad, and helpless (2,13). Although they are capable of positively transforming the experience into a professional and a life lesson, they express the need for support from senior physicians. The first clinical years are marked by an increased risk of developing depression. Prevalence rates among residents range between 20.9% and 43.2% (14). Most importantly, working conditions have been identified as a risk factor. Long working hours and imbalance between professional and family life compounded by study and examinations requirements are associated with mental health disorders (15).

Institutions should pay attention to the impact of patient death on physicians at every stage of their career. Organizational and physician-directed interventions showed effectiveness in protecting the mental health of medical staff. Strategies to help physicians and medical students better cope with a patient's death and improve their skills in caring for a dying patient could include better integration of palliative and end of life care in the undergraduate and postgraduate curriculum, systematic debriefings of the healthcare team after exposure to emotionally traumatic events, setting up of rituals intended to create time and space for pausing and reflecting, and easy access to a mental health provider. Interpersonal support is a valued and common coping strategy, and senior physicians should be educated in being effective mentors, capable of responding to medical students' and junior physicians' emotional and professional needs.

A paradigm shift also seems essential. Physicians are less likely to seek for mental health care than non-physicians. Barriers include fears concerning confidentiality and negative consequences for their career. Away from the image of the hero physician or the long-suffering physician, the medical profession and society should allow more space for the physicians' emotions, not as a sign of weakness, but as an essential component of a life in tune with its deeper parts. It is not just a matter of supporting individuals since burnout physicians are more likely to report medical errors and an intent to leave their job (16,17). Paying attention to the well-being of physicians is a responsibility of the medical community towards patients and society at large.

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