Wherein Lies the Balance Between Caring and Detachment?

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The first patient death I witnessed as a physician was 3 weeks into internship. I had made it through a night of being on call, and had completed the next day’s progress notes. My goals at the time were by no means lofty—surviving the week held a high premium, and the rest was gravy.

Then I received the message: “Code Blue, Tower Code team activated.”

I ran up the stairs to the oncology floor and made my way to the room number that flashed on my pager. It was already bustling with activity. As the official designee for chest compressions, I identified myself, forced my way to the patient, and began to push on his chest.

Chest compressions allow an intimate view of the patient. He was young—probably in his mid-20s—and his eyes stared back at me, unblinking. I continued my rhythmic compressions as various people inserted needles and tubes into his flaccid body. The monitor showed pulseless electrical activity. There was no electrical activity in his heart despite 30 min of vigorous cardiopulmonary resuscitation. Every resuscitation method was attempted. By this time, his mother was in the room, her cries piercing the background buzzing of various hospital monitors. The code leader called time of death. And then it was all over; the code team and onlookers disbanded. All of a sudden, I was alone.

I walked to the parking garage, drove home, ate a sandwich, and fell asleep.

The next morning, I went to work. I thought about that young man during the day, but it seemed like the hospital had moved on and expected me to do the same.

Fast forward almost 8 years, and I am now an advanced heart failure fellow. Heart failure is sometimes called the “oncology of cardiology,” because many of our patients have worse prognoses than many cancer patients. I have seen a lot of death this year, and each one brings with it a unique type of agony. I was in the operating room when a surgeon removed the heart of an 8-month-old baby for organ donation soon after the nurse had read a letter to the baby from his mom. I watched, from the bedside, as a 40-year-old man’s organs slowly shut down and he turned the color of the sun from liver failure while his necrotic limbs disintegrated. I have witnessed a wedding in the critical care unit where the patient went into terminal ventricular fibrillation 30 min after the vows. I have watched an 80-year-old patient who experienced a stroke after a left ventricular assist device die on a morphine drip, as she was surrounded by her family who celebrated her life. Unfortunately, the complete list is quite long.

Each death is difficult, and requires a period of mourning. In our field of advanced heart failure, the sting of loss can be particularly painful, as caregivers have generally developed long-term relationships with their patients. However, I have noticed that it is almost always a private mourning; as a profession, we tend to maintain and encourage a stiff upper lip about patient death. In team settings, when the subject of a patient’s recent demise comes up, there is a moment of silence when everyone stares at the floor; perhaps a few people will sigh, or someone might say a few words about the departed. Then, we move on, because there are always more patients to see and more care to be delivered. As I noted during my intern year, we are isolated in our mourning and are expected to rebound quickly.

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When I raised this issue with some of my more experienced mentors, their answer was that dwelling on the death of our patients could hamper our ability to take care of patients who are still alive. Such advice is aligned with the virtues that Dr. William Osler felt to be crucial for the effective practice of medicine—imperturbability in the face of the slings and arrows of patient care, such that the physician maintains a degree of detachment from their patients, and aequanimitas, or keeping emotions from clouding judgment.

But wherein lies the balance between caring and detachment? At what point does engagement in the life of our patients begin to interfere with our ability to make appropriate medical decisions? Can we practice true empathy and withdraw our emotions at will? In advanced heart failure, patients are at a high likelihood for complications and death. Oftentimes, I develop very close relationships with them and their families. Where should I draw the line between my role as a human being entrusted with the care of another person in need, and a physician who needs to maintain a degree of dispassion?

Perhaps, and this might be a somewhat controversial contention, the new age of medicine demands that we not view surrendering an emotional barrier between ourselves and patients as a failure—it may not make us as ineffectual as we fear. A somewhat extreme account from the life of Dr. Harvey Cushing might help illustrate my point. Dr. Cushing was an attending surgeon at the Peter Bent Brigham Hospital in Boston, when he was notified that his son, a junior at Yale University, had died in a car accident. Dr. Cushing carried out his scheduled operations for the day, informed the patients’ families about the outcomes, and then drove to New Haven, Connecticut, at night to claim his son’s body. Although his actions may rank highly in the scorebook of imperturbability, I would suggest that submitting himself to normal human emotions would not have made him a less successful physician, and conceivably, may have improved his reportedly dismal treatment of his staff and family (1).

Published studies in oncology show us that not only do doctors experience grief, but the professional taboo on the emotion can have negative consequences for the doctors themselves, as well as for the quality of care they provide. A study of 20 oncologists reported in JAMA Internal Medicine showed that they struggled to manage their feelings of grief with the detachment they felt was necessary to do their job (2). The majority of physicians reported feelings of failure, self-doubt, sadness, and powerlessness as part of their grief experience, and one-third spoke about feelings of guilt, loss of sleep, and crying (3). As a result of the shame about revealing their emotions to others and suppressing their natural responses to death, these physicians became more inattentive, impatient, and irritable, and were, therefore, more likely to experience burnout. Although these types of studies of the physicians who take care of heart failure patients are needed, our challenges are quite similar to our oncology colleagues: increased discussions are needed on how to destigmatize coping with death to improve our sense of well-being and make us better physicians.

In conclusion, I pose this question to more senior heart failure specialists: should this generation’s heart failure clinicians move closer to or further from the concepts of aequanimitas? Wherein lies the new balance? It is said that even Dr. Osler, at the age of 55 years, experienced burnout, causing him to leave Johns Hopkins Hospital for a slower pace of life at Oxford (4). Death is a natural part of life, and so is grieving—embracing this fact might make us better heart failure physicians.

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It is easy to understand why fellows-in-training are attracted to the discipline of advanced heart failure. The number of pharmacologic agents and device-based therapies that can prolong life and improve its quality has grown dramatically (1). Further, rapid improvements in left ventricular assist device technology and the promise of stem cell therapy offer hope to patients with advanced disease. Virtually no medical treatment is more dramatic or gratifying than a successful heart transplant. Nevertheless, heart failure is a progressive disease, and high mortality and progressive morbidity are expected outcomes.

Dr. Ahmad has raised several important questions regarding a career in advanced heart failure. He correctly points out that “each death is difficult and requires a period of mourning.” He cites the virtue of *aequanimitas* as extolled by Dr. Osler in effectively preventing emotions from clouding judgment. However, I would argue that *aequanimitas* and compassion are not mutually exclusive. Osler states that “imperturbability means coolness and presence of mind under all circumstances, calmness amid storm, clearness of judgment in moments of grave peril…” (2). I believe that Osler was correct in urging clinicians to maintain a degree of emotional detachment during true crises when life hangs in the balance. This does not preclude emotional involvement in the long-term management of our patients. A former mentor wrote that “the physician’s basic responsibility is to support life whenever possible and to relieve suffering, both mental and physical, at all times” (3). Although our goal should always be to improve quality of life and prolong survival when possible, preparing patients for death and helping them to move toward acceptance is also an essential part of our responsibility. Longitudinal care of patients over months or years provides the opportunity to get to know them and their families in profound ways. Rather than maintaining detachment during this time, personal interest and commitment to the patient are paramount and make for an effective therapeutic relationship.

Dr. Ahmad makes another important point. “If we become emotionally involved in the lives of our patients, how do we deal with the grief associated with their death?” Death, whether it is sudden or expected, is part of our profession. Grief should not be viewed as a sign of weakness or failure, but rather as an affirmation of our humanity.

Several possible solutions may help clinicians deal with their personal sense of loss. Early involvement in a palliative care team may be highly effective in helping patients, families, and physicians grapple with the dying process. Similarly, involvement of other health care providers via multidisciplinary heart failure teams allows for the possibility of shared reflection. To gain a sense of closure, it has long been my practice to call the family of each patient following a death. I typically follow-up with a personal letter highlighting varied reflections on my fondest interactions with the deceased. Finally, I have found it particularly cathartic to attend the wake of patients who I have known for many years.

Scientific knowledge, compassion, and personal investment in the care of our heart failure patients are essential qualities of an effective and humane clinician. Finding the correct balance requires years of experience and a personal commitment to do so. It is not possible for all physicians or equally applicable to all patients. Nonetheless, it remains an admirable aspirational goal for our profession.

**REFERENCES**