Emotional Boundaries: the Physician's Experience of Patient Death

by

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Dedication:

This thesis is dedicated to the physicians who kindly and openly gave me their time, and whose insights have allowed me to see myself and my chosen profession in a clearer light.

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How Physicians Grieve Patients' Deaths: a review of the literature

"human beings are creatures who seek love and meaning in the face of death, and the discomfort created for physicians by their proximity to death is rarely addressed because the discomfort lies within the physician’s personhood, the emotional bastard child of the good physician."

--Barnard (1988)

I. Introduction

As a second-year medical student, I see my own practice of medicine on the horizon. For the most part, I am excited and hopeful for the future. I have, however naturally, worries about that future as well. Alongside debates with myself around issues of ethical dilemmas, decisions about specialty choice, and worries of never knowing enough, I also harbor concern about how I will handle patients’ deaths. I will have to learn to care compassionately for dying patients, make difficult pronouncements, and comfort bereaved families—I will also have to learn to comfort myself. This latter concern led to a long reading list in the attempt to understand what impact grief has on physicians as professional caregivers and as individuals.

II. Is it Grief?

There is an entire body of literature illustrating that nurses, hospice workers, and social workers experience grief when patients die. The relationships between these health care professionals and their patients are not the typical attachment relationships that are referred to in the literature on bereavement and coping (Parkes, Bowlby, Weiss). Weiss details (2001) Bowlby and Parkes’ descriptions of the attachment bond, the bond that is capable of giving rise to a grief reaction when terminated. These authors state that
grief following the loss of such a bond involves protest and despair. Protest arises as “the threat of persisting inaccessibility of [the attachment] object triggers emergency reactions.” Despair comes from efforts to accept that the object of attachment is never going to return. Other important feelings that accompany loss of this attachment bond are feelings of insecurity and that the lost individual is irreplaceable.

This kind of attachment relationship that bereaved widows mourn (Parkes, 1970; Bonanno & Keltner, 1997) is qualitatively different in intensity, in closeness, and in most cases duration from the relationship between a nurse or doctor and her patient. In some cases, the doctor-patient or nurse-patient relationship may share some features of such a bond—such as if the deceased patient was in the physician’s practice for 20 years—but in most cases it does not. If the bond prior to death is qualitatively different, it seems logical to conclude that the process of recovering from the loss might also be different. How, then, do we go about examining grief in this context? Can we use the same models that have been developed for bereavement after the loss of attachment bonds as we do for the loss of less intense relationships or relationships that involve intimacy of a different form? Health care workers themselves would undoubtedly agree that were a family member of their own to die, they would experience grief differently than they do as professional caregivers. But many of the symptoms described below that are associated with grief are seen in these health care workers (Kalish 1985; Lev 1989). We do not know, given the current literature, how the grief of health care workers in response to patient loss differs from loss of an attachment bond. Moreover, we cannot say what parts of the existing models of coping with bereavement are applicable in this setting and which are not. Researchers who have concentrated on nurses’ grief have largely made
use of the existing models for coping, ignoring the fact that these models were not
developed with the nurse-patient relationship in mind.¹

Weiss does describe another type of bond, the affiliative bond. This bond is
typical among distant kin, work colleagues, friends. According to Weiss, unlike the
attachment bond, when the partner in an affiliative bond dies, the remaining person is
saddened and distressed, but not grieved. The loss is “less immediate, it is focused more
on loss of a social connection than of a particular figure, and it is more easily
interruptible by new… relationships” (p.55). Loss of this kind does not lead to protest or
despair, no “waves of pain…no pining for the lost figure…no vigilant alertness to the
figure’s possible return…no seemingly interminable stretches of despair such as follow
the loss of an attachment bond” (56). It would be simplest to assume, following this
differentiation, that the doctor-patient and nurse-patient relationships are ones of
affiliation, not attachment, and as such, that physicians may be distressed by patient loss,
but not grieved. How, then, do we account for the symptoms of grief in nurses? It is
uncertain to what degree the symptoms of distress due to loss of an affiliative relationship
overlap with those of grief over a lost attachment relationship. Furthermore, it may be
accurate to say that the doctor-patient relationship is not an attachment bond, but there is

¹ In making this statement I appear to be ignoring Harper’s 1977 publication, Death: the
coping mechanism of the health care professional. While she makes some good
observations about the caregivers she interviews (almost entirely social workers), she
goes on to develop a stage model of coping whereby health care professional attains deep
compassion with self-realization, self-awareness, and self-actualization all within 24
months. In the context of newer theories that consider and allow a variety of grief
responses and understand the complexity of delineating “successful coping,” Harper’s
theory is difficult to accept. Moreover, she claims that the experiences of social workers
can be transferred to other health care professionals, including physicians, but makes no
argument as to why that is the case. Notably, I have not located any studies that made
use of Harper’s stage model for health care professional.
no evidence that supports the notion that only attachment bonds can lead to grief responses. Certainly, as I have described, the grief response of a nurse for a lost patient differs than a nurse for his deceased wife, but these differences have yet to be clearly explained.

An intense search has revealed little formal research on the subject of physicians and grief, but there are a some notable studies. In addition, there is a rich body of editorial work on the subject in which the most intimate descriptions of how physicians grieve seems to be located. In the following sections, I will detail what the literature tells us about how physicians experience grief, and bring in discussion of bereavement and coping theories when applicable.

III. What is grief and what is coping?

Bereavement is the “objective situation of loss” while grief is an individual’s affective and cognitive response to that loss, their overall “reaction to loss of a loved one” (Stroebe et al. 2001). Grief is manifest psychologically, physically, and behaviorally. The original research in bereavement concentrated on describing grief in bereaved individuals (Bowlby 1980; Parkes, 1970). Based on longitudinal studies following the course of bereavement, those works detailed signs and symptoms that typically accompany grief. At different periods following the death of a loved one, all, any, or none of the following psychological symptoms may be present for bereaved people: positive and negative reflection on the deceased, denial of the death, feelings of guilt, shame, self-punishment, loneliness, despair, anxiety, anger, and/or isolation, a sense of meaninglessness, irritability, feeling the world is an insecure place, numbness, restless
business, dreams about the deceased, and depression. Likewise, the following physical and behavioral symptoms may be present: headaches, increased sleep or insomnia, crying, loss of appetite, somatic complaints, increased susceptibility to illness, increased alcohol or drug intake, loss of libido, immunosupression, and neuroendocrine dysregulation. These lists are not exhaustive, but give a general picture of bereavement.

Coping can be thought of as the operational part of grief, the aspect of grief with a purpose. Lazarus et al. (1986, p. 572) define coping as “the person’s cognitive and behavioral efforts to manage (reduce, minimize, or tolerate) the internal and external demands of the person-environment transaction that is appraised as taxing or exceeding the resources of the person.” Notably, this definition of coping is not specific to coping as it arises in response to bereavement.

In the complicated study of bereavement, discussion of effective coping strategies cannot realistically be extracted from theories of grief and bereavement. If bereavement is seen as an insult on a person—a stress, a misfortune—as soon as this insult occurs, the person is coping with its presence, with changes in her life, with the aftermath of the insult. In whatever way the person continues to be, she is coping in one form or another.

The challenge for theorists has been to formulate an overarching theory for understanding how individuals cope with bereavement and determine which coping strategies are adaptive in that context—that is, which strategies facilitate an individual’s arrival at a desirable end to the grieving process. Because people have various responses to loss, researchers have struggled to define “adaptive coping” and what constitutes the desirable end to grief. I will not make an attempt here. As W. Stroebe describes (2001), successful coping is difficult to evaluate because at any given instance, the most useful
coping strategy employed by an individual may differ from the moment before.

Moreover, like coping, grief is also individual and temporal. A person's response to loss
depends on the loss itself, the age of the bereaved, the presence or absence of a previous
loss in her life, and other variables. In other words, there is neither one healthy way to be
bereaved, nor one healthy way to cope with grief. Some authors' definitions of grief
might be discarded on this basis alone. For example, Weiss (2001) claims that true grief
involves a period of hopeless despair while Parkes (1970) states that a preoccupation with
thoughts of the deceased is "the central and pathognomonic feature of grief." But not all
individuals have these responses to even profound loss, and instead experience grief in
some other way.

To tie together these two important complications in theorizing about grief and
coping with bereavement, I provide the following example: If we claim that a widower
who never cries after his wife dies is having an unhealthy response to his wife's death,
we simultaneously define components of what we believe to be "normal grief" and
"adaptive coping." In doing so, we disallow his individual grief responses and perhaps
cease to consider ways he might be successfully coping with his loss that differ from our
expectation.

There is an understanding in the literature on bereavement that while the essential
symptoms of grief (sadness, social sharing, etc.) are similar cross-culturally, the norms
delineating appropriate behavior in bereavement differ across cultures. The complicated
nature of cultural variations on the expression and experience grief are too extensive to
explore here. However, the community of medical professionals could be considered a
subculture in which doctors and nurses follow a unique set of behavior norms. Some
aspects of the way doctors and nurses grieve may be “successful” in the context of that community if not elsewhere. For example, a physician’s insistence on professional distance in the attempt to maintain objective thought might be considered maladaptive or “avoidance behavior” by some theories of bereavement—Freud might contend that physicians who engage in such behavior will eventually suffer unwanted consequences.\(^2\) However, with constant demands for meticulous work, such a response to a patient’s death might allow a physician to guard against burnout and continue to perform his job (O’Hara et al. 1996, p.33). This type of behavior in physicians is described in more detail in the section on coping strategies.

\[A. \text{The physician’s personal experience of grief}\]

The most common feeling associated with caregiver grief in the medical literature is that of guilt. Both nurses and physicians feel a significant amount of guilt regarding the death of patients. In a study designed to explore how general practitioners experienced notification of a death or bereavement in their practice, Saunderson & Ridsdale (1999) completed 25 semi-structured interviews with physicians in London. Although the study focused more on how the physicians dealt with the grief of deceased patients’ families than their own grief, 22 of 25 physicians “described fears of making

\[\text{2 In his 1917 work “Mourning and Melancholia,” Freud described the process of grief as one that cannot be ignored. He used the phrase “work of mourning” to describe the process in which the bereaved person is able to “free herself” from or “sever ties” with the deceased. This “grief work,” as it has since been termed, required effort and change on the part of the bereaved in order to reformulate a life without the deceased. Freud warned that individuals ignore and avoid their grief work at their own peril.}\]

Freud’s ideas surface in multiple other theories on bereavement including Bowlby’s attachment bond theory. However, his theory has also been widely criticized for not being culturally sensitive, for disallowing individual variability in bereavement, and for ignoring the role of positive emotions in bereavement.
mistakes and feelings of guilt and self-blame when their expectations of the clinical course of illness differed from reality” (294). These feelings of guilt carried over into how the physicians handled contact with families in that they saw contact with the family as important for admission of guilt.

Guilt is a common component of bereavement in general (Parkes, 1970). In studies of bereavement not specific to health care professionals, guilty feelings were present, but not as prominent (Parkes, 1970, 456). Parkes describes widows who needed “reassurance that all was done that could have been done,” and had a “tendency to go over the events of the death” to that end (455). Rarely would a widow who is the primary caregiver of her dying husband be questioned on the specifics of her husband’s death in order to uncover her mistakes. By contrast, because physicians are trained professionals who make treatment decisions, they are responsible for the outcomes of those decisions. Thus, to a large degree, the guilt physicians feel as a part of the experience of bereavement is grounded in a real responsibility society has given them. In response to this societal endowment, physicians assume “unilateral responsibility for their patients” (Haan 1979). Regardless of the inherent uncertainty in medical practice, these physicians and nurses often subsequently blame themselves when patients die. An important point to make is that while these guilty feelings physicians and nurses endure are a natural accompaniment to their professions, the literature on coping with grief does not address the conflict that may arise between feelings of professional responsibility and personal loss. For a physician who has lost a patient of 20 years, for example, the concurrence of self-reproach and self-questioning with the pain of loss might throw a new twist on how that individual must cope with his bereavement. Indeed, Shanfield reports in a study on
mourning in health care professionals, "a sense of responsibility for the patient's illness" led to intensified grieving and "questions of what else could have been done" (1981). Moreover, Dickenson et al. (1994) also found that physicians often wondered if they had done all they could in their attempt to save the patient.

A preoccupation with the deceased is another symptom of grief noted frequently in the literature. This preoccupation is largely manifest as dreams about the deceased patient. In a poignant example, Dr. Remen (1996) describes a disturbing set of over twenty dreams in which she recalled intricate details about the cases and faces of children who had died under her care, children for whose deaths she had felt responsible. This example demonstrates a trauma theory that has been applied to bereavement, the Stress Response Syndromes of Horowitz (1986). In this theory, the impact of the loss a person endures can be measured based on the degree to which the individual experiences the intrusion of memories of the deceased or avoids confronting thoughts of the deceased. Dreams of the deceased are an example of intrusion. In Remen's case, she had gone many years in avoidance mode, but eventually the memories of her former patients and the grief associated with them demanded attention in the form of intrusive and disturbing dreams.

B. Grief as a stressor

The cognitive stress theory (Folkman & Lazarus 1984) provides another way to conceptualize grief. Grief is seen as a source of stress in that it puts demands on an individual. The consequences of those demands, the disruption of the person's usual homeostasis of emotion and cognition, are seen outwardly and inwardly as grief. If we
apply cognitive stress theory to this aspect of how physicians grieve, the differentiation between emotion-focused coping and problem-focused coping can be brought out. According to the theory, problem-focused coping is an attempt to make changes to the external environment such that stress is reduced while emotion-focused coping is an attempt to make changes to one’s emotional response to the environment so as to reduce stress. Since medical education and the medical community socializes physicians to be problem-solvers (Novack 1999), physicians are taught de facto to submerge emotions that come up during work. Thus, when a patient’s death arises, we see an individual who is faced with an unsolvable problem, death, and who is unable to tap into the other side of this coping dyad—who is less able to cope through emotion letting, but instead stifles those feelings and focuses on fixable problems.

As an extension of the theory, an imbalance between stressors and resources to mediate them is what, in turn, leads to professional burnout (Edelwich 1980). Thus, if grief is a stressor, unmitigated grief could lead to burnout in a health professional. In considering how a person responds to grief, it might also be useful to determine how that same person responds to other stressors. Otherwise, it becomes difficult to know what is a grief response versus what is a general stress response. This reality is evident in Vachon’s (1987) extensive exploration of occupational stress in health care professionals who work with the dying and bereaved. Her report gives a long list of physical, behavioral, and psychological stress manifestations seen in this population, but we can never quite extract occupational stress due to grief from occupational stressors of other forms.
Further complicating this question, Jaffe (1986) provides three characteristics of health care professionals that contribute to burnout. Each of these characteristics, I argue, can not only contribute to burnout, but can make acknowledgement and coping with personal grief more difficult for health care professionals: 1) the belief that they should always be immediately available to patients, 2) the belief that they should have no personal needs or feelings, and 3) the belief that they should be able to make the patient healthy or at least make a significant difference for the patient. The combination of grief, stress, and these underlying beliefs might seem then impossible to overcome. Research has shown that physicians have higher psychosocial demands compared with almost all other occupational groups (Caplan et al 1975), and suffer from high rates of stress-related illnesses (Johnson et al. 1995, Moaz et al. 1992), and higher suicide rates (Rose 1973; Richings 1986). It is unknown how much of their stress is due to grief, resolved or otherwise. Vachon makes an important attempt to untangle the two in her study on occupational stress. She found that the most stressful aspect of working with the dying and bereaved is not the presence of death itself, but the institutional and systemic factors of the work environment (Vachon 1987). Unlike other health care professionals, in Vachon’s study (1987), physicians defined their number one stressor as “difficulty communicating with others in the organization, usually other physicians, but sometimes other departments.” This research suggests that aspects of practicing medicine other than grief are what lead physicians to burnout, that grief is not the most significant stressor for physicians. The next section reveals that stressful features of medicine are not easily separated from one another. It may be that grief becomes a more significant stressor in the setting of the medical community where grieving physicians are not supported.
C. Social support

The most dominant theme in this body of literature is that for their own good, physicians need to support one another emotionally, to increase their support-seeking during times of grief, and to share their experiences with colleagues. Merlino (1997), in a report on support groups for staff caring for AIDS patients, notes that “caregivers, especially professional caregivers, are not typically good at receiving care or asking for help and assistance,” that they tend to go it alone and resist taking time to talk about themselves. In another study on staff caring for AIDS patients, Frost et al. (1991) note that work can often be isolating for caregivers because “they seldom are able to share their personal experiences with each other.”

These authors do not suggest why physicians do not share with each other, but part of the answer may lie in the literature on medical education. In a large survey study (n = 258), Wagner et al. (1997) found that of nurses, physicians, and medical students, the students cried the least in the hospital, and were “most afraid of negative consequences of crying.” Novack et al. (1999) stress significant short-comings in the socialization of medical students around the issue of sharing grief experiences. They charge that attendings rarely “share with students how they have coped with feelings of anger, anguish, or shame in caring for certain patients.” Assertions such as these are frequent in the literature, and when juxtaposed with research that suggests patient death presents significant difficulty for medical students (Shanfield 1981; Weisskopf & Binder 1976; Morrison & Firth 1986), lend credence to the finding of Saunderson & Ridsdale (1999) that family practitioners’ strategies to deal with bereavement are derived “from
personal experience, not education." As in editorials by physicians, numerous editorials and studies from the nursing literature pleads with senior nurses to provide support and guidance to young nurses as they begin to grapple with their own grief after patients have died (Saunders & Valente 1994; Spencer 1994; Lewis 1999; Lynn 1992; Lev 1989; Gardner 2000).

Fitting with this discussion are the concepts of disenfranchised grief and professional socialization. Doka defined disenfranchised grief as "grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported." Within this definition is an understanding that "appropriate grief" is in most respects a socially defined process. Doka claims that "disenfranchised circumstances can intensify feelings of anger, guilt, or powerlessness," and that when grief is not socially recognized, "many of the factors that facilitate mourning are not present"—funeral rituals, time off work, verbalization of the loss, expressions of sympathy for the loss. Nurses, and to perhaps a greater extent, physicians, in the United States are largely not believed to suffer grief in response to patient loss. Mentioned twice above is a piece of this puzzle that contributes an important aspect of this disenfranchisement: medical professionals make up a subculture with strict norms about the appropriateness of displaying grief. In other words, not only does the lay community not anticipate grief in a physician, but through professional socialization, physicians as a group disenfranchise their own colleagues by not creating an environment in which grief is acceptable. A poignant example of this phenomenon is offered by Dr. Remen's description of two surgeons who were partners in practice, both suffering "loneliness, depression, and burnout. Neither was aware that the other was also...seeking
help...," and it never occurred to them to confide in one another—each was sure the other would never understand (Waring, 2000; Remen, 1996).

Saunders & Valente (1994) reviewed articles that addressed what factors influence nurses’ bereavement. After doing so, the authors put forth guidelines for how nurses might best manage their own grief. Though Saunders & Valente have altered the components of the original task model (Worden 1982/1991), the basic idea is maintained—that certain tasks should be performed during the course of bereavement to facilitate an individual’s recovery from loss. For our discussion, the relevance is that in the context of individuals who are socialized to be problem-solvers, the appeal of a task model may be that it offers concrete steps aimed at solving the “problem” of grief. For those who are not “permitted” to engage in a messier emotional form of grieving, these tasks offer a sterilized though still complex set of steps for the disenfranchised caregiver to follow.

Lev writes specifically on the disenfranchised grief of nurses, and suggests that “it may be that when grief appears in the caregiver, it is identified as such only when it is expressed in a way perceived to be pathological, or when it appears to interfere with a person’s usual functions” (Lev 1989). Meanwhile, several authors suggest that caregivers might be highly susceptible to grief due to the nature of their motivation to be caregivers: unresolved past loss, own feelings of guilt, wanting to prove one is a caring person (Lev 1989; Raphael 1977). Thus, while grief can be a real and may even be an enhanced experience for the caregiver, that grief goes largely unrecognized both by caregivers themselves and the larger society.
As detailed, both the problem-focused response to patient death and the disenfranchisement of that grief by other caregivers have been described as negative aspects of the culture of medicine because they are seen as consisting of and contributing to maladaptive coping in physicians and nurses. This determination is consistent with popular culture (and in agreement with the psychological theory on the necessity of grief work; see footnote 1), wherein we believe that expressing emotions is good for us (Zech 2000). However, in some instances, control of one’s emotions may be highly adaptive and limit stress for self and others. For example, if a physician can limit his display of emotion in front of a bereaved family, perhaps he will engender in them a sense of his competence and control, thereby assuring them that all was done medically for the deceased patient that was possible. Moreover, if he is certain the family is confident in the care he provided, perhaps he will feel better about that care himself. Importantly, we are thus brought back to the assertion that “successful coping” cannot easily be defined, and that the most adaptive form of coping at any one moment and in any particular situation may differ from the one before (Stroebe et al 2001). This is not to disagree with Doka and say that denying someone else the opportunity to grieve (disenfranchising them) is a good thing, but instead that the act itself of not grieving openly is not necessarily negative. The idea is that simultaneously, professional socialization and disenfranchisement of grief may give the physician strength and hinder his ability to cope with his own grief.

A recent addition to major theories on bereavement and coping has been the reanalysis of positive affect during bereavement, and this theory relevant to our consideration of how physicians control their emotions. The term “positive affect”
refers to an individual’s upbeat and optimistic disposition and attitude. While earlier
theories focused heavily on the function of negative thoughts, sadness, and depression in
the bereaved individual, Folkman (1997) insists we also pay attention to the import of
positive affect in a bereaved individual. In her work with informal caregivers of AIDS
patients, Folkman discovered that maintaining a positive affect at various points through
the bereavement process allows an individual the fortitude to continue adaptively coping
in other ways, that a positive affect gives a bereaved individual strength. As was
described above, we often assume in Western culture that if a person is not outwardly
displaying despair, they are not coping with their loss. If we apply Folkman’s new data,
however, we might consider that those who are not displaying negative emotion may
actually be promoting their own process of coping. Bonanno & Keltner (1999) also
noted that positive emotions may allow individuals a reprieve from tiring grief. If one is
always encouraged to talk about painful experiences, one might dwell more on negative
aspects of that experience than on positive thoughts of the deceased (Bonanno & Keltner,
1999; de Ridder, 1997). Moreover, several authors contend that “the capacity to
minimize negative emotions during bereavement should make it easier for a grieving
person to continue to function in areas of personal importance, such as performing in the
workplace or caring for others” (Shuchter & Zisook, 1993; Stroebe & Stroebe, 1987), and
may free up “greater resources for problem-focused coping.”

D. Variables of the death

Many variables have been shown to have an effect on how physicians and nurses
experience grief following patients’ deaths. Folkman (2001) concurs when she states that
“coping may have a relatively small influence on adjustment and recovery compared to factors such as the timing and nature of death, history, and personality.” As would be expected, the longer the relationship between physician and patient, the more painful the loss experience (Shanfield, 1981). As Egger states in an article on support systems for physicians, “They have a patient for 30 years and when that patient dies, it’s like part of their family. Why shouldn’t they grieve?”

Other patient variables that effect the intensity of the bereavement experience for caregivers include the age of the patient (eg. same age as physician or “too young”), the nature of the illness (eg. painful or disfiguring), the trajectory of the illness (eg. faster than expected, lingering, or unknown), the circumstance of the deceased’s family (eg. the deceased leaves behind young children), and the degree to which the caregiver is reminded of herself or her loved ones by the patient (Vachon, 1987; Herrle & Robinson, 1987).

E. Physician gender and grief

There is an abundance of research revealing differences between male and female physicians that might be relevant to their grief experiences. Perhaps the most important fact is that the patient populations of male and female physicians tend to differ in that female physicians see more female patients, more patients with complex psychosocial problems, and more patients described as difficult (Johnson et al. 1995). Women physicians are more likely to be satisfied with their relationships with their patients, have 60% greater odds of burning out, and report less control over their work environments than do male physicians, a finding that is consistent with lower levels of job
dissatisfaction and more psychiatric distress (Johnson et al. 1995). Finally, some stressors are still largely restricted to female physicians (such as the tug of family needs versus work)(McMurray, 2000). All factors that influence the relationships physicians have with their patients might affect their grief responses when patients die. Johnson et al. (1995) note that “work involving helping patients, solving problems, and developing relationships with patients and families may be experienced both as a positive aspect of the job, and, at other times, as one of its most stressful elements.” If female physicians are more stressed overall, yet have less control over their work environments, it seems quite likely that female physicians might have less opportunity to address their own grief responses.

In Western culture, women are given leave to be more openly emotional than are men, and at least one study has shown that in their responses to grief, women (not necessarily physicians) tend to be more focused on their loss versus their recovery than are men (Dijkstra et al. 1999). The culture of medicine may prove to equalize male and female physicians in this respect. In order to feel a part of the professional fraternity, perhaps women physicians have adopted the stoicism of their male peers. However, Wagner et al. (1997) did find that women professionals cried more often in hospitals than did men. A recent study survey study by Richardson & Burke (2000; N = 2584 with 10% women) showed that female physicians ranked dealing with "life and death situations" higher on their list of stressors than did male physicians. In contrast, in a study on how nurses deal with their own grief, Spencer (1994) found that there was no difference between men and women in feelings experienced when a patient died. Just as it is not
clear how grief operates for physicians in general, it is not clear how grief operates for female physicians.

F. The proximity of death

Dickenson et al. (1994) conducted a longitudinal study of “physicians’ attitudes towards death and terminally ill patients,” and report that “death creates problems, not the least of which are the emotional reactions to death and difficulties in acknowledging its inevitability for all.” Key findings in this study include the observation that ten years into practice, physicians were less comfortable with dying patients than other patients, and thought about death more often. Multiple editorials on physician grief argue that patient deaths force physicians to confront existential questions they might not otherwise consider. This contention is frequently discussed in reference to the initial experiences of patient deaths for medical students (Morrison et al. 1986). Weisskopf & Binder (1976) declare that “dying patients may violate the students’ sense of omnipotence” and belief in a benevolent world, and Morrison & Firth (1986) label “confronting death” as a major stressor for medical students. The findings of Dickenson et al. might reveal that such questions only become more prominent as physicians’ careers approach ten years in length. These studies support the notion that physicians must develop ways of understanding “their own existence…life and death, as well as intermediary life processes” (Harper 1977). According to Saunders (1994), “death ushers in an awareness of personal mortality and an anxiety about one’s own death, which shakes one’s illusions of security,” and allows the bereaved an opportunity to examine the meaning of life and death, to question his priorities, and to do a general reevaluation.
It should be emphasized that it is the “unnatural” proximity to death that makes the occupations of nurses, doctors, and other health care workers unique. The typical exposure of individuals to loss in Western culture was eloquently described by Raphael (1983):

Man sets the thought of his own death aside in the years of his young adult life. He makes his family and embarks upon his achievements. Yet death will not be denied: in his middle years he glimpses it again, reminding him that his time is not infinite. In the latter half of his life, its reminders become more constant, more persistent. And, at last he meets it, fearfully or as a friend, his own, his personal death.

For health care workers, death comes far more frequently. The ever-presence of death insists that the individual give it thought or expend effort to avoid thinking about it. Barnard (1988) contends that physicians struggle with existential questions because they are encouraged to pursue an unattainable and unrealistic division within themselves, a division between themselves as professionals and as people. In his estimation, “human beings are creatures who seek love and meaning in the face of death, and the discomfort created for physicians by their proximity to death is rarely addressed because the discomfort lies within the physician’s personhood, the emotional bastard child of the good physician.” Indeed, the nursing literature repeatedly refers to existential questions arising for the practicing nurse, and of the perceived pressure to stifle tears and be “professional.” They report that dying patients are “a reminder that control over one’s fate may be an illusion,” and that “being engaged with patients who are dying provide[s] an opportunity for nurses to deal with their own mortality and to develop a certain comfort with death” (Lev, 1989; Rittman et al. 1997).
Janoff-Bulman (1992), Parkes (1972/1996), and Rosenblatt (1993) take this issue further in several discrete but overlapping theories proposing that traumatic events force a person to examine their beliefs and assumptions about the world. Furthermore, they suggest that recovery from trauma requires the individual to examine her assumptions about the world, and make changes therein to accommodate the traumatic experience and allow her to move past it. In addition to the existential questions described above, for physicians, a host of assumptions may be called into question by the death of a patient: the belief that health outcomes are controllable with enough knowledge, dedication, perseverance, and/or technology, the belief that the physician will be able to do some good for all patients at all times, the belief that the purpose of medicine is to prevent death, the belief that what happens to those around us always makes sense, and the belief that one is a good and capable physician.

Schaefer & Moos (2001) insist that we must consider a person’s pre-bereavement state\(^3\) in thinking about how that person has responded to a crisis, and the probability that the person will be better for having come through the crisis. This piece of the picture is important when we note that several authors insist physicians enter medicine because they believe they can care for others better than they themselves or their relatives were cared for, because they have unresolved guilt for not having cared well enough for a loved one in the past, or because they lost someone they loved and want to prevent others from experiencing similar losses (Lev 1989; Kalish 1985). In addition, Raphael (1983) cites a number of studies that suggest that “those in the caring professions...may have higher than average levels of perceived deprivation in their childhoods.” If a physician

\(^{3}\) Schaefer & Moos actually refer to a “pre-event state”, but for this paper, we are assuming the event is the loss of a loved one.
has had a troubled childhood, and has built up expectations of himself that are unrealistic, he will likely handle patient deaths differently than will a physician who understands his role and purpose in another way. The former physician is likely to endure a great deal more self-doubt and engage in far more reorganization of his assumptions about the world in order to come to grips with the reality of his experiences.

G. Coping Strategies

There are not a great deal of coping strategies detailed in the literature in reference to physicians. One in particular, however, is mentioned often. Weisskopf & Binder (1976) state that students may respond to their own grief by engaging in “compensatory behavior” that will limit their grief in the future. In the nursing literature and bereavement literature, this is described as “avoidance coping” or “anticipatory grief” wherein the individual anticipates future losses and makes behavioral changes such that when new loses occur, they are not as painful. Weisskopf & Binder propose that such avoidance coping serves to “lead to a future breakdown or difficulty connecting with dying patients and their families” (also in Raphael 1983). Shanfied (1981) confirms the development of anticipatory grief in medical students and claims that it “can be a good thing because it can blunt the student when loss is experienced, but can also decrease the intensity of relationships with patients in order to avoid the pain of loss.” Multiple other studies have shown that if death is anticipated, the grieved person will have less emotional pain associated with the death (Borne & Raphael 1994; O’Bryant 1991; Parkes & Weiss 1983). Furthermore, as stated previously, Vachon’s occupational stress study (1987) confirms that when an illness leads to death much quicker than was expected,
health care workers have less time to prepare themselves for the loss, and experience more stress/grief in relationship to that patient's death. The rationale for this is not only compensatory behavior, but probably also a return to the issue of physician responsibility because an unexpected loss undoubtedly brings up questions of clinical competence for the physician.

A component of the cognitive stress theory not yet mentioned is relevant here. The second dyad of coping identified by cognitive stress theorists is confrontation versus avoidance coping (Folkman & Lazarus 1984; Billings & Moos 1981). In this dyad, in order to reduce stress, the bereaved individual will confront or avoid various aspects of the bereavement experience. A physician who endures the painful death of a patient will naturally make adjustments so as to minimize the stress of that experience—both immediately and long term. Like the researchers mentioned above, Feldstein (1995) and Carmack (1992) have both shown that through repeated exposure to loss, people tend to anticipate grief and to develop "avoidance behavior" in order to protect themselves from the pain of loss. The same physician, however, may simultaneously endure a personal review of the case at hand and her contribution to the deceased patient's care in an attempt both to learn from mistakes and assure herself she performed adequately. This examination is a form of confrontational behavior because as she reviews the case, she risks making discoveries about her performance that make her uncomfortable. As the cognitive stress theory suggests, this physician would be simultaneously avoiding and confronting different aspects of her grief.

The incremental grief model (Cook & Oltjenbrun, 1998) of coping with bereavement also suggests that one loss within the context of multiple other losses, as
often happens with health care professionals, can lead to “incremental loss,” an “additive factor of grief due to multiple related losses.” This theory also relies on the idea of “avoidance coping” in that the multiple losses make it more difficult to adaptively cope with each loss individually. The only difference to the “anticipated grief” described earlier is that in this theory, cumulative grief is believed to differ in intensity and quality from singular grief. Not all studies agree that this phenomenon occurs, however, and have instead found that other variables such as social support and control over work environment have a greater effect than the overall number or temporal relationship of patients’ deaths (O’Hara et al. 1996; Feldstein et al. 1995).

In an interesting twist on this topic, Steinhauser et al. (2000) found that compared with other health care professionals, physicians differed greatly in their reflections of what comprises a “good death.” The physicians concentrated heavily on the biomedical aspects of death such as adequate pain management, and gave little attention in their responses to aspects such as life review, resolving conflicts, saying goodbye to loved ones, and receiving affirmation as having made an important contribution to the world. The authors, in their surprise at the physicians’ focus, comment that “for most persons involved with care at the end of life, death is infused with broader meaning and is considered a natural part of life, not a failure of technology.” I would venture to say that this biomedical focus is another example of avoidance coping on the part of physicians, and also another example both of how the sense of full responsibility physicians have for their patients’ outcomes tends to dominate their thoughts and of how physicians are trained to concentrate on problem-focused and not emotion-focused aspects of work.
In accordance with the discussion on social sharing and support, it should be mentioned that talking with colleagues, families, and other supportive people is a coping strategy employed by both physicians and nurses. In ethnographic interviews and use of a visual analog rating scale, Steinmetz et al. (1993) found that “sharing their own feelings with patients and families can be the most powerful tool that family physicians have to understand, feel, and care for their dying patients.” Steinmetz et al. also found that physicians who had personal support systems outside the workplace “believed they were better prepared to manage their own feelings.” There are numerous articles wherein the need for further support systems for health care professionals was mentioned (Merlino 1997; Frost et al. 1991; Sheard 1984; Johnson et al. 1995; Macks 1992; Lewis 1999; Lynn 1992; Lev 1989; Barnard 1988; Colon 1996; Kelly 1996; Novack 1999; Egger 2000; Gardner 1999).

The import of social support and sharing in the processing of grief may seem contradictory to the points made by Folkman (1997), Bonanno & Keltner (1999), and de Ridder (1997) regarding the importance of positive affect in recovery from bereavement. However, as Pennebaker, Zech, & Rimé (2001) point out, there is a difference between working through aspects of grief through communication and simple disclosure of painful memories or events. In other words, emotional sharing is a complicated variable for which there are useful forms of sharing, and there is painful, pointless focus on negative aspects of one’s grief. Sharing has the potential to contribute to “the processing of the emotional information and to the completion of the cognitive needs that were elicited by the emotional event.” Moreover, sharing can “decrease the physical distance between two persons.” Schaefer & Moos (2001) corroborate that several studies have shown
social support following the death of a loved one can contribute to "mitigation of the negative aspects of bereavement." The difficulty for physicians and nurses may be, again, the issue of the subculture of the medical professionals. Talking to others about important events can help a person as just described, but such benefits depend on an environment in which the person sharing his feelings does not have a fear of negative consequences professionally.

Other coping strategies reported in the nursing literature and more briefly in the physician literature included crying, carrying on with work, thinking and talking about the patient, dealing with their own mortality and developing comfort with death (the specifics of which were not described), accepting that there are limits to the medical aid they provide, engaging in activities outside work, getting routine exercise, attempting to balance their future level of engagement and detachment with those around them, and trying to accept that you did as much as possible for the patient prior to death (Spencer 1994; Saunders et al, 1994; Lewis, 1999; Ehrenfeld et al., 1995; Rittman 1997; Fields et al., 1995; Larea 1982; Carmack 1992; Gerber 1990). Herrle & Robinson (1987) stressed that caregivers must explore their own feelings concerning past losses in their personal and professional lives, recognize their personal limitations, and practice a positive attitude.

**H. The 2-track model and physicians' grief**

In 1981, Rubin proposed a significant new addition to existing models of bereavement, the two-track model. Rubin's model combines important pieces of bereavement that had been addressed individually in theories up to that point. Rubin's
two tracks to the process of bereavement are 1) grief as it is associated with the loss of a particular attachment bond, and 2) the changes forced upon the individual aside from the loss of the particular bond. The reason this model is presented near the conclusion of this literature review is that the two-track model might offer some clarification of conundrums detailed earlier.

When we agree with the notion that the loss of a patient for a physician cannot possibly be the same grief experience as the loss of an attachment bond, we agree that the severity of a physician’s distress does not frequently reach the level of protest and true despair. By extension, the physician does not greatly engage the first track of the process of bereavement, grief due to the loss of a particular attachment bond. On the other hand, the presence of death in the physicians’ lives leads to the emergence of existential questions for them and changes in the assumptions they make about their world—clear examples of their engagement in the second track of the model. In this way, physicians are experiencing a great deal of what it means to grieve because they have the potential to undergo personal change. This would account for the self-reproach and self-examination that follows death of patients and other symptoms of grief that nurses have been shown to endure. Furthermore, in cases where a physician had a twenty-year relationship with a patient, his journey down the first track will be more prominent, and he will focus more heavily on the loss of a particular individual than he does when he loses patients to whom he is less attached. Individuals thus go down track one and track two to the extent that doing so fits the context of the loss, their preparation for it, and their personality.
IV. Conclusions

This review of the literature reveals that while much is understood about grief following the loss of attachment bonds, little is known about grief following the loss of less intense relationships. Particularly, little is known about how or if physicians grieve when their patients die. A glance at the editorials physicians have written on the subject suggests grief in physicians is a critical issue. At the same time, some research has shown that it is not a pivotal issue, that systemic features of the environments in which physicians work have a greater impact on physician well-being than does grief. Clearly, grief, in some as-of-yet ill-defined way, affects physicians.

Future research in this field should assess the impact of grief on physicians’ personal and professional lives, their ability to work, and their tendency to burn-out. Likewise, a study in contrast—how most physicians resist burn out—is also likely to be revealing. In addition, since the existing literature on this topic is centered on physicians who see death relatively frequently, it is unclear how grief influences the more typical doctor, the family physician or internist. How medical students experience death may influence the specialty they subsequently choose.

Physicians-in-training would undoubtedly find useful a glimpse of how seasoned physicians think about their patients' deaths, how they process those deaths in their minds and in their continuing work, and how they assuage their own grief. The literature suggests that the way physicians handle their grief changes as they age, but we really have very little understanding of these changes, of how they come about, and of what factors influence them.
For every editorial written lamenting the trials of physicians’ grief, there may be a hundred silent sufferers. Conversely, those who write such editorials might represent the rare physicians for whom grief is an ongoing problem. In an attempt to answer and/or further elucidate these questions, a qualitative interview study was undertaken. Through the study, I hope to glimpse the variability in how physicians experience grief, to get a better idea of gender differences in that experience, and gain some understanding as to where physicians come to fix grief in the context of their careers.
V. References


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Emotional Boundaries: the Physician's Experience of Patient Death

"We would actually be better doctors for our patients if we had a better understanding of ourselves."

--Study Participant

I. Introduction

Physicians have a unique proximity and relationship to death through their careers. Few other professions involve exposure to death with such a high frequency, and no profession combines that exposure with the same form of responsibility. Certainly, nurses, emergency medical technicians, hospice workers, and other health care professionals are sometimes present at patient deaths as often as physicians, and each have responsibilities in patient care. But because physicians occupy the peak of the health care pyramid, the onus of medical decision-making typically falls on their shoulders.

Despite the unique relationship physicians have with patient death, few studies have examined how physicians respond to and cope with patients' deaths on a personal level. While the nursing literature demonstrates that nurses sometimes display features of grief when patients die, the same exploration of physician grief is rarely pursued (Kalish 1985; Lev 1989). The nursing literature frequently refers to coping and grief theory, but it is not clear that such literature should be applied to physicians when they experience a patient's death. The literature describes relationships of attachment with focus on the grief of family members for deceased loved ones (Parkes 1970; Bowlby 1980; Bonanno & Kelter 1997; Weiss 2001), but the bond between a doctor and patient is clearly not the same as that between husband and wife or parent and child. Thus, the application of theories derived from this research to the experiences of physicians or nurses may not be
sound. Moreover, because it is not specific to health care workers, the literature on coping with grief does not address the interaction between professional responsibility and personal loss. It is even unclear whether grief is a component of how physicians experience patient death. Are physicians attached enough to their patients to experience the trappings of grief such as despair, anxiety, anger, meaninglessness, depression, or guilt (Parkes 1970)?

The paucity of research in this area leaves room for exploration of how physicians experience death’s disruption of the unique doctor-patient bond. Nineteen physicians were interviewed about how they emotionally and intellectually responded to patient deaths. A specific focus for this study was to understand how physicians’ responses to patient deaths change over the course of their careers.

II. Research Design

The study used semi-structured interviewing to gather physicians' experiences of patient deaths. At the start of each interview, physicians were reminded that the goal of the interview was to understand “the impact on you as a physician and an individual, how you cope and how you feel.” The interview guide was constructed to direct the interview chronologically and topically, but as participants introduced relevant topics out of order, I pursued them. In addition, if some component of the physician’s response needed further explanation, I added clarifying questions as the interview progressed. Each interview lasted a maximum of one hour.

The interview guide constructed for this study was based on the literature review and on evaluation of how physicians’ experiences of patients' deaths compare with
existing theories. General research on coping and grief was used in this study to guide development of the interview questions even though such research does not address the peculiar situation of the doctor-patient relationship. The nursing literature on nurses’ grief and editorials by physicians were also examined; and provided additional interview questions. The amalgamation of these sources produced the interview guide (Appendix A).

The format was open-ended so that unpredicted issues might emerge. In order to see what features of their experience were the most immediate for participants, I wanted to avoid suggesting what affected them the most. For example, I voided specific questions about guilt, and instead asked: What features of patients’ deaths make your response more intense and/or your coping period more difficult? In this manner, the physicians were free to bring up feelings of guilt only if such feelings were an issue for them. When they introduced their feelings of guilt independently, I attributed more significance to it as a factor in their grief experiences.

Other interview questions were directed at addressing particular variables of physicians’ responses to patient deaths, such as whether or not the participants ever cry about patients who have died. Follow-up questions in such cases were attempts to elucidate the factors behind the reality such as: does the physician not cry because he/she thinks it is inappropriate for him/her to do so? does the physician not cry because he/she is not generally a crier? does the physician not cry because he/she feels no need to? under what circumstances might the physician cry or not cry? In this manner, each interview question represented a starting point to best understand the participant's response.
Prior to recruiting physicians for the study, three pilot interviews were conducted to test the interview guide. These three interviews were used to refine the interview guide but were not included in the analysis or results of the study.

III. Methods

A. Recruitment and Participants

"Snowball sampling" was employed to recruit physicians for the study. The original names of potential participants were of family practitioners and internists and were supplied to me by doctors I knew. These individuals were contacted via phone and then sent a follow-up fax (Appendix B) that explained the study and asked for their participation. Routinely, a second phone call was required in which I either scheduled an interview or learned the physician would not participate. Most physicians gave no reason for non-participation; a few cited a lack of time. At the end of each interview, I asked the participants to suggest other doctors they knew who might be willing to participate in the study. These physicians were subsequently contacted in the same manner. In one case, I randomly called a physician whose name appeared in the ACCMA Physician Directory, happened to get through to him in his office, and was able to schedule an appointment with him. Approximately fifty physicians were solicited for participation. The resulting sample size was nineteen.

Originally, the only requirements for participation in the study were 1) that the physician was unknown to me; 2) that the physician was willing to participate; and 3) that the physician was either a family practitioner or internist. I knew none of the physicians prior to my interviews with them. I felt if I had no prior relationship with any of the
physicians, I would avoid adding the variable of familiarity to the interview process. As a medical student, I had met two of the interviewees prior to my interviews with them but had no ongoing contact or working relationship with them and knew nothing of their personal lives.

During the second interview with a family practitioner, I discovered the interviewee had been trained as a family practitioner but also functioned as an oncologist. I could not judge if her more frequent exposure to dying patients had an effect on her responses to the interview questions. In a rudimentary way, I attempted to gauge the influence of an increased frequency of exposure to patient deaths on an interviewee by interviewing an additional three physicians who might have higher exposure to death than might a typical family practitioner or internist—one oncologist, one hematologist, and one HIV specialist. With only four interviews to compare with fifteen others, the analysis of this component was highly abbreviated and the significance difficult to assess. However, these interviews allowed a preliminary assessment of the difference high death frequency has on a physician’s approach to his own grief. Interestingly, the number of patient deaths experienced by the family practitioners and internists varied dramatically, depending on how many geriatric and nursing home patients were in the practice, and some of them experienced patient deaths as frequently as the hematologist. Because the four outlying interviews (with the oncologists/hematologist/HIV specialist) were not uniformly and starkly different in patient death frequency from the other fifteen interviews, all nineteen interviews were included in the final analysis of physicians’ personal and emotional responses to patient deaths.
The study sample contains ten men and nine women. Fifteen participants were family practitioners or internists while one man was an oncologist, one man was a hematologist, one woman was an HIV specialist, and one woman was a family practitioner practicing oncology. Aside from these four physicians who were not family practitioners or internists, five men were family practitioners, three men were internists, four women were family practitioners, and three women were internists. In addition, three of the physicians had been in practice less than ten years: two men had been in practice only six to seven years, and one woman had been in practice only six years. As a result, the length of time the participants had been practicing medicine ranged from six years up to forty-two years. The average length of time the participants have been practicing medicine is approximately nineteen years. Eliminating the two longest and two shortest careers, the average career length was eighteen years.

Additional demographic information included in what type of practice the physician participates. Only three participants were in solo practice, each of them for over twenty years. Two participants were part of an in-hospital team of physicians. One physician was currently in an administrative position, had a history of group practice, and still worked with patients and did shift work occasionally. The remainder were in group practices of some sort, be they at county clinic facilities, groups affiliated with health maintenance organizations, or private group practices.

Three of the participants were currently unmarried—one divorced, one widowed, and one never married. The remaining sixteen were all married or partnered. Three of the participants did not have children while the remaining sixteen had an average of two children each.
The physicians in the study were trained all over the country in both medical school and residency—everywhere from Harvard, Albert Einstein, Iowa, and Tufts, to Stanford, the University of California at San Diego, and the University of California at San Francisco—just to name a few. A conceivably important demographic that was not adequately obtained in the interviews was religious affiliation. Many of the interviewees volunteered this information when asked if there was a spiritual or religious aspect to their coping processes, but not all participants provided the information (Table 1).

**B. Data Analysis**

Completed interviews were transcribed into the format specified for the use of The Ethnograph™ version 5.0. Transcribed interviews were then read through with special attention to recurring or unique themes. With a list of potential themes in hand, I used The Ethnograph™ to begin coding each one individually. As I proceeded, the code book grew considerably; coding families and sub-themes were identified and grouped. Finally, the coded interviews were reviewed a third time, and coded sections were grouped according to the interview questions they addressed. By the end of this process, an overarching set of themes and an understanding of how the participants understood their own responses to patient deaths began to emerge. This paper details and discusses only a small but significant piece of the data obtained from the interviews.

**IV. Design and Method Limitations**

The most glaring limitations to the current study are the small sample size and the neglect of cultural, religious, and social variables in the interview construction. The
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<td>NYC, Roosevelt Hospital</td>
<td>Internal medicine</td>
<td>none</td>
<td>25</td>
<td>group</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>50</td>
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<td>0</td>
<td>U of Tennessee</td>
<td>Alameda Co. Hospital</td>
<td>Internal Medicine</td>
<td>HIV****</td>
<td>10</td>
<td>group</td>
<td>5 years</td>
<td>5</td>
</tr>
<tr>
<td>51</td>
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<td>0</td>
<td>UM, Albuquerque</td>
<td>Jewish Hospital, St. Louis, Missouri</td>
<td>Internal Medicine</td>
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<td>16.5</td>
<td>group</td>
<td>months to 16.5 years</td>
<td>6</td>
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<tr>
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<td>University of Rochester</td>
<td>Internal Medicine</td>
<td>Hematology</td>
<td>19</td>
<td>group</td>
<td>1-2 years</td>
<td>15-20</td>
</tr>
</tbody>
</table>

* Those participants who are permanently partnered but not married are listed as married.

**Yrs** = the number of years the physician has been practicing since the end of residency.

*** Length = the average length of time the physician knows a patient before that patient’s death.

**** Though this physician has no additional residency training in HIV-patient care, her practice is entirely devoted the care of HIV-infected patients, and she is thus an expert in the field of HIV-care.
small sample size is a result of time constraints and a low response rate from solicited physicians. For the most part, questions aimed at cultural, religious, and social variables were omitted from the interview guide for practical reasons. The norms for appropriate bereavement behavior differ across cultures, and cultural and religious variables are wide-ranging and complicated, so cultural and religious variation on the expression and experience of grief was beyond the scope of the current investigation. The small sample size further diminishes any potential to discuss the many permutations of culture and religion in a meaningful way. Based even on the few interviewees who discussed the influence of their religious upbringing on their current view of death and the process of becoming comfortable with patient death, the importance of cultural and religious variables must be recognized but cannot otherwise be discussed.

The study design allowed for poor control of several variables. Key variables that were not controlled include: the frequency with which physician participants experience patient deaths; the length of time the participants have been practicing medicine since completing medical school; the level of educational exposure to issues of death and dying in medical school. It is reasonable to consider that each of these variables might have an effect on how a physician experiences his patients' deaths, and while each was explored with individual participants, a comparison across the participants was not possible.

Lastly, the "snowball" sampling method employed for locating and recruiting possible participants contains inherent bias. Interviewed physicians often recommended I contact physicians they felt were likely to want to participate and who were likely to have unusual perspectives on how patient deaths affect them personally. Furthermore, it is possible that physicians who were willing to be interviewed are not a representative

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group in that they might have greater comfort discussing their emotions. Even so, there was a wide range of attitudes, experiences, and interview depth associated with each individual participant, and there is no way of estimating how much broader are the experiences of physicians in general.

V. Thesis

A. Introduction

The purpose of this study was to detail the variability in and nature of how patient deaths personally affect physicians. Through the interviews, I came to discover that before asking questions that define physicians' feelings as "grief," or their relationships with patients as "attachment bonds" or "affiliative bonds," it is necessary to understand the factors that determine how physicians approach those relationships long before patients die. To my surprise, the interviews with physicians led me to conceptualize their responses to patient deaths and the doctor-patient relationship in a way that I had not previously considered. It became clear that while each physician interviewed thinks about patient death uniquely, there is an overarching theme I, a non-physician, had not anticipated, a theme centered on what it means to be a physician.

The main finding of the study is that physicians' delineation and prioritization of their professional duties has a considerable impact on the course their feelings take when patients die. In addition to the specific features of their relationships with patients and the circumstances of individual patients' deaths, physicians' prioritization of their responsibilities, the boundaries of what they perceive to be their duties, the tasks they choose to take on in the care of each patient, and most significantly, their assessment of
how completely they have fulfilled those responsibilities, duties, and tasks will determine how they experience patients' deaths (Figure 1).

![Diagram of Professional Responsibility]

Figure 1: Consequences of Professional Responsibility

The study participants detailed some of what they perceived to be their responsibilities in the care of dying patients. Given the original goal of the interview—to elicit a discussion of how patients' deaths affected them emotionally—the participants only described those responsibilities that were relevant in this context. Through an examination of how they
interpreted those responsibilities in the context of patient care, it was possible to understand how their prioritization of responsibilities influences their response to the death of patients. The responsibilities the participants outlined included: make no mistakes—do no harm; give the patient the best care possible; shoulder the grief of others: the patient, the family, the medical team; make patients and families feel they are well cared-for; make the death peaceful, pleasant, and as painless as possible; attend to your own emotional state and allow yourself to be emotional. In the end, how physicians feel about the death of patients is determined by how they judge their own performance in the face of their perceived duties. Not all physicians identified all five of these responsibilities, and there were as many permutations in the ordering of these responsibilities as there were participants. But on an individual basis, whether or not a physician feels at peace about a patient’s death was determined by an assessment of his or her own performance.

In addition, the fifth responsibility listed—attention to one's own emotional state—reveals that for some participants, an analysis of one’s emotions has an important influence on the ultimate outcome of those feelings. For almost all the physicians interviewed time was allotted for attention to one's own emotional state and grieving only after all other responsibilities were complete. Moreover, if physicians were not pleased with their own performances, their attention was immediately pulled back toward other responsibilities—what they did wrong, how they might avoid making the same mistakes next time, how they should have behaved. For most participants, the personal side of the patient's death was secondary to all other concerns, and grieving was possible only in the context of having fulfilled professional responsibilities (Figure 1).
Finally, physicians' prioritization of their responsibilities is not static. Many factors influence physicians' ability to fulfill their duties. For most, this shaping of professional responsibilities occurred most significantly early in their careers. In contrast, for a few, little reprioritization has seemed necessary, and they felt their response to patient deaths was the same as it was twenty years ago. Still for others, there persists an ongoing pursuit of a more functional organization of these duties (Figure 2).

Figure 2: Formation of Professional Responsibility

The following uses findings from the study to support the model just proposed. It is an exposition of some influences on physicians' perception of their professional
responsibilities as they are related to emotional boundaries and patient deaths. An attempt was made throughout to place the findings of this study in the context of the literature on grief, bereavement, and the emotions of doctors. With the intent to explain how a young physician comes to understand her professional responsibilities, I will begin with an exploration of the personal evolution that comprises the process of medical training and early medical practice, with a specific focus on the adjustments participants made early in their careers in order to cope with patients' deaths. Thereafter, I will discuss the influence of physicians' personality and past experiences on their prioritization of responsibilities. Furthermore, I will explore the conflicts that arise as a physician's professional responsibilities are confronted with an unfortunate but persistent lack of time. Importantly, it is less the concern of this paper how physicians' particular responses to patient death manifest themselves than it is how physicians arrive at those responses through their particular conception of their professional responsibilities.

In an attempt to understand the comments of physician participants within the context of the above thesis, it may offer clarity if the participants' general responses to patient deaths are first described. Those responses can be divided into three groups based on the level of personal emotionality they associated with the death of patients. At one end of the spectrum were physicians who consistently described themselves as being greatly affected by their patients' deaths, people who actively sought deep connections with their patients while knowing that doing so might make them more susceptible to intense grief. Four of the nineteen participants fit firmly into this category. Of these, three believed they were essentially unchanged in this dimension since entering practice, while one described a transformation she made after enduring a life-threatening illness.
At the opposite end of the spectrum were physicians who described themselves as having always been relatively unaffected by the deaths of their patients. Seven of the participants could be placed in this category. The final group of nine participants fit somewhere in between. All but one of them described themselves as having been far more susceptible to emotionality and grief at the beginning of their careers. The one exception was clearly unique in that he was actively working to move himself into the first group, to a place where he could allow himself to be greatly affected by his patients' deaths. Notably, there were physicians at all locations on the spectrum who described themselves as being "good at" dealing with death.

B. Development of Boundaries and the Conceptualization of Professional Responsibility

The study participants felt that since their careers began, they had become more adept at handling patients' deaths both personally and professionally. This finding is consistent with the findings of Dickensen et al. (1994) who conducted a longitudinal survey study of "physicians' attitudes towards death and terminally ill patients," and who reported that ten years into practice, physicians were "less likely to refer dying patients to other physicians and found it less difficult to deal with the family of the dying patient" than they did at the beginning of their practice (emphasis mine). One of the most significant factors that appears to contribute to the interviewees' growing comfort with caring for dying patients revolves around the development of emotional boundaries. The majority of the participants in the current study identified ways they had adjusted their boundaries since they started practicing medicine. Though often not made consciously, these adjustments were, at the core, attempts to find a balance between emotional
involvement with and distance from patients so as to maximize one's ability to fulfill professional responsibilities. These adjustments included drawing boundaries around one's availability to patients emotionally, physically, and mentally; recognizing the importance of caring for self; accepting the limitations of doctoring; and redefining expectations of self to fit within those limitations and, by extension, learning to conceive of death as an acceptable outcome.

1. Developing Boundaries: the Need for Emotional Distance

The most common adjustment the participants made as maturing doctors was to develop or maintain what they saw to be a necessary amount of emotional distance from patients. There were two main justifications they made for developing distance, and both stem from a desire to provide quality medical care to patients through fulfillment of their professional duties. The first reason was a perceived incompatibility between emotionality and objectivity. The second reason for emotional distance was to lessen the tide of continuous emotions in order to make the job sustainable.

The belief that emotionality and objectivity are not compatible is an old one in the medical profession and society at large. In medicine, this point of view stems largely from the emergence of the biomedical model over the past 150 years, which arose in the wake of new technologies and increasing reliance on objective, evidence-based data obtained through the seemingly impartial scientific method (Foss & Rothernberg 1988). A physician's emotions were, in the biomedical model, just as cumbersome as a patient's emotions, and as such, could contribute nothing more than an additional obstacle in curing the patient. Over the past fifty years, with new exploration of psychosomatic
illness and the biopsychosocial model, the patient's emotions have been understood to affect his or her health and so have become a necessary line of inquiry for physicians (Alexander 1950; Lipowski 1976; Foss & Rothenberg 1988). Moreover, in the seventies and eighties, the physician's emotions began to be addressed in the literature, recognized as having been ignored to the detriment of patient satisfaction by means of countertransference (Zinn 1988; Girard 1988; Gorlin & Zaker 1983; Lewis 1979; Maltberger & Burk 1974) (and less frequently recognized, to the detriment of the physician herself).

The physician's emotions are largely still considered to be entirely outside-the-box, relevant only in negative terms if the physician allows his emotions to have an impact on the patient-physician relationship. Furthermore, it is generally believed (if unspoken) that the better a physician is, the less he will allow his emotions to have such an impact. Most of the participants in the current study were in medical school in the '70s and '80s, when both the curriculum and the educators largely ignored the emotional states of medical students. Only seven of the study participants recalled having had a class in medical school that addressed issues of death and dying, and of these, only three recalled any mention of how physicians emotionally respond to death and dying. In fact, in many instances, professionalism was "understood" to include stoicism, to be infused with impassivity and repression of emotion (Webster 1989):

Medicine does that. There are certain things that are not appropriate in the moment.

I remember medical school friends of mine who would cry. And it was like they knew they weren't allowed to do that, and they'd run off somewhere and kind of tuck into a room. And people would kind of talk about it, and it was never discussed as a good thing that she's crying...
just thought, 'Well, I better not do that'...it just validated that that was not allowed.

Notably, the latter quote came from a physician who was educated in the 1990s. There are numerous editorials in the literature from physicians lamenting the fact that they have cried alone, out of the sight of other doctors and health care professionals, in hallways, in pillows—so many, that it is fair to say there remains a considerable stigma for a physician who cries openly (Schultz 1994; Clark 1993, Hilfiker 1985).

While most of the participants in the current study still considered emotionality a threat to objectivity, unlike the traditional view, they did not as a whole believe that stoicism is a requirement in order to consider someone a respectable physician. Instead, they tended to personalize this need, not wanting to generalize to all physicians. Most spoke only for themselves when they said:

If I get too close, I don’t think I can function as a physician.

As much as I like the people I take care of, I feel that if I was too friendly with them, or cared for them too much, I would lose my objectivity.

Without the separation, I can’t be objective. The emotion begins to drown you.

I tend not to be friends with my patients. I mean I tend to probably keep a little bit of distance there. It makes it easier for me to be the doctor when I don’t also feel involved with that patient. It makes it harder for me to feel like I’m being objective and doing what I really need to do if I feel like I’m also too close to the patient.

We had a talk and I just told him about this and I couldn't get it out, I just bawled. I just cried my head off, the first time that has happened openly...so that was maybe a lesson in avoiding situations that would have impaired my ability to be a doctor.

To place this creation of emotional distance for the sake of objectivity in the context of professional responsibilities, the participants who stressed objectivity ultimately felt that
if they were unable to create such distance, the quality of their work would suffer—and by extension, their patients. Thus, although the idea of emotional closeness with patients was not necessarily an undesirable one, these physicians felt it critical to subvert closeness in order to assure they could give the best care possible. In addition, they tended to look for closeness in ways that were less threatening to their emotional stability. As one participant said, she "learned that technique of holding patients over here, and being sad if they died, but not overly."

Multiple participants stated that there was a growing frequency with which they saw other physicians exploring their emotions, but those colleagues were almost inevitably women. Indeed, all study participants who were exceptionally comfortable with their emotions were women. On the other hand, five of the nine women in the study were not openly emotional. One male participant commented that he admired the ability of a female colleague because she "just sits down and cries, and she's able to express her vulnerability." Another physician commented that, "women here kind of give men permission to say it's okay to be a person, too." The sample size in this study is not large enough to draw any conclusions in this context, but these findings are consistent with literature suggesting that female physicians are more emotionally accessible to their patients (Johnson et al 1995; Wagner et al. 1997), that female physicians "tend to better relate to dying patients and their families" (Dickenson et al. 1979), and that "women are more likely to be satisfied with their relationships with patients" (McMurray et al. 2000).

The second and more extensive reason physicians gave for erecting emotional boundaries between themselves and patients is that they believed, as often as people died, they could not physically withstand the emotional trauma every time. Such high-energy
emotion would cause them to burn out, and they would be unable to perform their jobs due to sheer fatigue. The participants voiced a need to protect themselves from the heartbreak of loss when patients die and through common sense and experience discovered that the more distance you have from patients, the less painful it is when they die. This desire for distance was clear to many participants when they were young doctors who found themselves easily overwhelmed by emotions. One physician described being "wiped out," while another said,

It wasn't at all uncommon for me to have one of my patients die or to sit down and tell them that they were about to die, and then to have to leave the hospital. I knew all the quick ways out. You'd leave the hospital for half an hour and just kind of take a walk, cry by myself.

In this context, it is not hard to imagine that these new physicians found themselves guarding against feeling too much emotion.

This discussion of pursuing emotional distance for the sake of longevity in medicine would not be complete without addressing the possibility of denial on the part of physicians. It would be naïve to suggest that following each hour interview of this study, I could proclaim an interviewee to be in denial about why she/he deems emotional boundaries to be necessary. Yet, it is unlikely a person in denial would themselves mention it. There was only one instance in the interviews when a participant suggested that he might conceivably have pent up grief in the recesses of his psyche because he was not an outwardly emotional person. Otherwise, the interviewees tended to believe that the responses they had to patients' deaths were full and complete, that the maintenance of objectivity and prevention of burnout were the reasons for emotional distance, and that they were
in denial about nothing. Yet, it is important to ask what the risks are of being too close. The participants felt that the risks included losing objectivity and career longevity. What they implied is that closeness with patients makes one more vulnerable to painful emotion (Moaz et al. 1992). Emotional vulnerability is the result of intimacy. Thus, when the participants spoke of "avoiding burnout," they were essentially saying they need to avoid vulnerability. Avoiding burnout is avoiding the vulnerability of emotionality—the two are inextricable. As Sheard (1984) states in her essay on nurses' grief, nurses choose "to protect [their] emotional health rather than to risk another grief." Closeness is an issue of personal risk, intimacy, and vulnerability.

Finally, closeness is also an issue of responsibility. In addition to all the responsibilities physicians have to a patient's physical health, the more closeness they have with a patient, the more demands are placed on their time and their emotional lives, and the less they can prevent themselves from being emotionally overwhelmed when patients die. There exists a complex interaction between physicians' perceptions of appropriate emotionality, their perceptions of their professional responsibilities, their need to avoid emotional vulnerability, and their need to maintain career longevity. Thus, when physicians choose to limit their emotional availability to patients, they are making a decision that reflects their priorities of professional responsibility by placing an emotional connection with
the patient and attention to their own emotional state below other concerns.\(^4\)

2. Developing Boundaries: the Adaptations of Emotional Distance

The ways these physicians went about creating emotional distance from their patients differed dramatically among them. Some required only a periodic vacation while for others, a higher level of continuous distance was maintained. Notably, even the physician who seemed most connected to her patients, most affected by their deaths, and most comfortable with her own emotions had periods of time in which she had to step back and regain her emotional strength:

There'll be a period of time when I don't allow myself to get really too close to anybody because I just can't do that anymore. And so I'll go through a period...when I can tell that there's a part of me that's kind of staying reserved.

\(^4\) The cognitive stress theory on coping (Folkman & Lazarus 1984) might offer some insight into why and how physicians come to guard themselves against emotion. According to cognitive stress theory, if physicians see emotionality as a source of stress in their lives, they will be inclined to find a balance between emotionality and stoicism that minimizes that stress. By extension, if unmitigated emotionality is a source of stress, it could lead to burnout in a physician. Thus, the motivation for reducing emotionality is essentially to reduce stress.

Physicians may guard themselves by engaging in what cognitive stress theorists call emotion-focused and problem-focused coping. Problem-focused coping is defined as an attempt to make changes to the external environment in order to reduce stress while emotion-focused coping is defined as one's attempt to reduce stress by making changes to one's emotional response to the environment. Because it is ultimately impossible for physicians to eliminate death in their practices, problem-focused coping in this context is limited to their attempts to provide the best care possible while knowing that patients will still die. This being the case, emotion-focused coping is where they find the opportunity to mitigate the stresses of patient deaths. If physicians cannot alter the inevitability of death, they can still alter their emotional responses to the event of death. Through the interviews, it appears that the consequence of these alterations is the development of emotional boundaries.
Most study participants maintained an emotional separation from patients by strictly limiting their availability to patients and by making a sharp distinction between the significance of patients' deaths versus the importance of a death in the family.

The physicians in the study limited their availability to patients by setting firm "boundaries around my involvement" in very practical ways—by returning phone calls only at the end of every day (unless the issue was urgent) instead of just after receiving a message that the patient called, by going on vacations during which they could not be reached by patients and during which they "recharge" by not "think[ing] about patients."

The development of boundaries to availability was a dramatic change for one physician:

I started out being very much completely available to patients, totally devoted and theirs. No boundaries at all...and over the years, I have to say I have slowly changed, and I got to realize...it was killing me physically.

Another way physicians limited their emotionality in the face of patients' deaths was to draw strict lines around their participation in funerals and memorials. The majority of the physicians interviewed did not attend the funerals of their patients, though interestingly, most had been to at least a few, and they reported that doing so was very valuable because "It was a sense of closure" when they "had been with [a patient]...for years." But overall, the physicians felt that "it kinda feels like too much, or if I go to one, I should go to them all."

The last way that the participants limited their availability to patients and developed boundaries to their involvement in their patients' lives was to accept the natural tendency to become closer to some patients than to others:

If I really loved and cared for all of my patients the way I do for some of them...it'd be hard. Because your patients are like your friends...there are
some people you just like better than others. I had somebody that I
discharged today who I adore...you know, she's very much like me. We
share a lot of interests, we're the same age...if I felt that way about
everyone I saw, it would be exhausting.

You personally like some people better than others. I remember there was
one man who died who I'd never liked who died suddenly. He had a
sudden heart attack, and I have to admit I wasn't very unhappy at all.

Allowing themselves to be human in this way—to have natural affinities for some people
and less for others—allows the participants to make themselves vulnerable to only a few
patients at a time.

Participants also maintained an emotional separation by making a stark distinction
in their minds between the deaths of patients and the deaths of family members.
Physicians, like other people, usually have more opportunity for closeness with family
than with outsiders, so it is likely that this distinction arose quite naturally. However, this
separation is also the result of a self-protective choice on the part of physicians to not
become too close to patients:

I make a huge division. And I started making that division early on, so
immediately it felt very different...One of the reasons to be objective
about patients, and to stay separated from them, is to be able to be
sympathetic and empathetic in the moment, but you don't necessarily stay
awake thinking about it.

There's the doctor-patient relationship, and there is the husband-wife
relationship and the father-child relationship—totally different
experiences. And again, I will just literally bleed for the family and I
won't for the practice. I'll feel bad, but you have to be able to survive this
profession.

Study participants made this distinction even in the face of having known their patients
for years and having been with them at pivotal points in their lives—at the births of their
children, when their illnesses waxed and waned, even as one participant said, they have
became "a fixture in my life. I saw him much more often than I saw my kids and my wife, really...and he was suddenly out of my life and there's that sense of loss, and there's a sadness." When patients such as these die, the ability to separate in one's mind the significance of patient death from family death could become a very useful defense against emotions because it allows one to call up that sense of separation even in the face of grief. Notably, the only contradictory statement on this topic was made by a physician who tended to have fewer emotional boundaries between herself and her patients, who was very affected by her patients' deaths in general, and who saw patient deaths as a "kind of chronic, underlying stress...just like it would of the death of a close family member."

Each of the adaptations to emotional boundaries just described can impact how physicians understand their professional responsibilities. The boundaries on physicians' emotional availability to patients reflects the low priority of their emotional connections with patients and the low priority of understanding their own emotions.

Another adjustment the study participants made to their emotional boundaries was the need for self-care. The two justifications for emotional distance mentioned above—the need to maintain objectivity and the need to limit one's emotional strife—came from a growing understanding of the study participants' own needs for self-care, the self-care that is necessary to maintain one's job satisfaction and job performance. In this context, a large part of self-care for physicians involved accepting the limitations of doctoring and subsequently redefining their expectations of themselves. The main adjustments in this realm included an understanding that death, hardship, and pain cannot always be prevented, and that every physician makes mistakes.
The study participants who underwent the most dramatic adjustments to their conceptualization of doctoring said that they originally went into medicine because they wanted to be involved in helping people and in saving lives:

I wanted to do this—to prevent death. To be a guardian angel to stop people from ever dying when they shouldn't have. And, of course, once you get to medical school, you know that that isn't what you're learning to do. You can't do that. So that's disappointing, and at that point I wanted to leave. So...but until then, I was comforted by the fact that I would just learn all that, and then these things couldn't happen.

So many of the students had been motivated by these issues. They think, "I'm going to medical school to keep people alive forever." For these physicians, death is indeed a "cruel reminder of the limits of our power" (Peretz 1970). The shock for these physicians in finding that many things are beyond their control was difficult for them to confront, and patient death was perhaps the most difficult to confront. Study participants who entered medical practice believing they would prevent death were forced by the trauma of seeing patients die to examine their beliefs and assumptions about the role and power of physicians. These physicians were essentially pressed by the reality of medical practice to adjust their expectations of themselves. If they had not made such adjustments, it is likely they would have come to resent the profession or quit.

While at least half the study participants came into medicine believing that death was a natural part of life, applying this belief to medical practice involved the difficult task of accepting that sometimes there is nothing a physician could have or should have

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5 This reality supports the theories of Jannoff-Bulman (1992), Parkes (1972/1996), and Rosenblatt (1993) who theorized that traumatic events force a person to examine their beliefs and assumptions about the world, and that trauma requires the individual to examine her assumptions about the world and to make changes to accommodate that traumatic experience.
done to prevent a patient's death. It is logical to assume that if you believe death to be
the natural progression of things, you might be less mortified when it occurs because
prevention of death will not fit into your conception of your professional responsibility.
By contrast, if you believe it is the role of the physician to prevent death, you are more
likely to experience guilt and feel you have not fulfilled your professional duties when
patients die. The contrasting views of the physician's responsibility among participants
clearly coincided with the difficulty they had when patients died. A study participant
who had a great deal of unrest about her patients' deaths said, "They're all going to
die...my ultimate weapon against death, is to prolong and improve the quality of life." In
contrast, two study participants who tended to be accepting of their patients' deaths and
who experienced less emotional upheaval when patients die commented,

I eventually came to see that I think the goal of a physician is not to make
people dependent on you. The goal is to empower people. And not that
you can't be there for people because we all fall apart...there's a need for
guidance, there's a need for someone to be supportive and inspiring.

I really don't think I save anybody's life. I never have thought that. I do
not save lives. I do not think it is my responsibility to delay death. I do
not think I have any control over death at all. So I don't make myself
accept responsibility—for the most part, I don't think it's my fault that they
die. I think it's more my fault if I don't ease the transition to death. I
believe in—my responsibility is just as sort of an instructor on the path of
life, and it's to make suggestions, and people can either take them or leave
them, and if they're going down the death path, then it's my job to just
bring comfort...so I just accept the things that I cannot change.

These two study participants understood their role and responsibility to patients in very
different ways than did the first, and perhaps by extension, they were more comfortable
when patients died. The first participant reported that she never felt peaceful about a
patient's death while the other two often felt at ease.
Being forced to attempt futile patient resuscitations during medical school and residency was another influential factor in how some of the study participants came to view death. Currently, in the United States, the medical establishment accepts "Do Not Resuscitate" (DNR) orders, legal documents through which patients can, prior to their death, document their refusal of invasive life-sustaining procedures. For all but a few physicians interviewed, DNR status was not fully accepted when they were in medical school and residency (Rubenfeld 1995). At that time, all patients were "coded," regardless of whether or not there was any chance they would survive to live a fulfilling life thereafter. The process of "coding" a patient involves any or all of the following: cardiopulmonary resuscitation (CPR), putting a tube into the trachea in order to externally breathe for the patient (intubation), administering drugs to induce a new heartbeat, and applying electric shock to the heart in the hopes of inducing a new heartbeat (cardiac electroconversion). Thus, patients with advanced cancer and other fatal diseases were either kept alive despite unpleasant circumstances, or when cardiac arrest occurred, CPR was instituted, they were intubated, and cardioversion was often attempted. The performance of "codes" under such circumstances contributed, for many of the interviewees, to the impression that the institution of medicine believed death was

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6 According to Rubenfeld's review of the literature on DNR orders, before 1976, there was little open discussion or acceptance of DNR orders in hospitals because there was no legal support for physicians who curtailed a patient's care at the end of life (1995). "Codes" were initiated on all patients who died in the hospital. In 1976, new guidelines were published in the New England Journal of Medicine that "acknowledged the rights of a competent patient to refuse any medical care." Furthermore, after this dialogue on DNR orders had begun, critical research on the outcomes of in-hospital "codes" was undertaken. The majority of participants in the current study were in medical school or residency at or around the time these changes were beginning to take place.
never an acceptable outcome and that therefore, physicians should always strive to prevent death:

Medical school does teach you, and many of your mentors believe...something bad has happened when a person dies. And whether either caused by something bad or we could have prevented it or should have prevented it, I don't think people really just acknowledged that people die. And some of it was when I was in school. I mean we coded everybody.

Another physician similarly said, "At that time, letting a person die was considered still to be a little bit wacko. You know?...that really everybody really wanted to have themselves coded." Of those study participants who mentioned "codes," all felt very strongly that being forced to conduct futile "codes" when they were young physicians was difficult and damaging to them. Not only were the "codes" unbearable, but there was no outlet to have an emotional response to them:

Some of these cases were just horrible. Just horrible. And I would do everything I needed to do, and then when the code was over and this and that, I literally remember walking to the bathroom and throwing up. Crying. Taking about 20 minutes. And then going on, because you needed to go on.

Similarly, another doctor said she came "away feeling a little disgusted and sad." The lack of mentors in this context was isolating for many of the participants because, as one participant said:

There was nobody you could go to and say, 'You know, I think this person is irretrievably ill and we should cut off life support.' You just kept on until something went wrong. And it was all...so profoundly alienating...that I was so depressed I didn't even know I was depressed.

In the same way that being forced to "code" everyone conveyed the sense that death was an unacceptable outcome, the acceptance of DNR orders as a reasonable alternative to the
"code" has conveyed to many of the interviewees that medicine now views death as an acceptable inevitability in many cases.

3. Emotional Boundaries: the Impact of Mistakes

The central hypothesis is that physicians' sense of professional responsibility is pivotal in their emotional responses to patient deaths, and this hypothesis is supported strongly by the impact of perceived mistakes on a physician's subsequent experiences. Furthermore, how physicians frame what counts as a mistake is a direct reflection of the limitations they place on their professional responsibilities. It is significant that one of the two most powerful sources of stress identified by the study participants was the fear of making mistakes. The participants revealed, and the details of their examples profoundly suggest, that there are few events in a physician's life that have a larger impact than does a mistake:

The greatest stress is making clinical errors that result in some catastrophe or potential death. I mean, that's always the biggest worry and concern...and that's anxiety provoking.

If you make a mistake and someone dies, you're responsible. You're a physician to help people and to make them well not to hurt them or harm them in any way. So it goes against the whole reason why you decided to become a doctor.

I mean it's bad enough that you're sad that you miss them, but if you have to have an added burden of feeling guilty that they're gone, that's just more than a person should have to bear.

You're always thinking, could I have changed that? I'm always thinking that. Or is there something I could have done? And I need to know because I need to take responsibility or rationalize or whatever, to try to understand why people die too soon.
In this way, the participants in the current study resemble those of Saunderson & Ridsdale (1999) who found physicians frequently felt guilty about issues relating to the deaths of patients and for not meeting their own expectations for perfectionism. In addition, like the physicians interviewed in Christensen’s study on the “impact of perceived mistakes on physicians” (1992), many of the study participants had tragic experiences early in their careers that they still remember today, up to forty years later:

And really, every time I hang something on one of those hangers, I think about Mrs. Fisher and how I wish I had told her that she had leukemia, and I had told her that she was dying. I mean, it’s amazing, but after 25 years I still carry that regret.

I wasn’t sure what the problem was. I at least was sure...I don’t like to average it out, but I was sleepy, it was 2:30 in the morning. I said, “What am I going to do with her?” She’s not that bad and she’s not this and she’s not that, and she wasn’t running much of a temperature, and it had only started, like and hour or so before. And I thought, she doesn’t have appendicitis, she doesn’t have an ectopic, she never had relations, and she never...I just knew it wasn’t any of those, so I thought, well, she’s got some kind of bellyache. So I gave her some pain medicine, “Call me when you know...” see her in the morning, we’ll see how we’re doing. So they call me about six hours later and said, “We can’t get her out of bed and she’s bent over with horrible pain.” Wonderful. “So we’re going to the hospital right now.” We went right to the hospital, started taking x-rays, doing everything we could think of. X-ray couldn’t even read what was wrong with her belly, they didn’t know what it was...except we knew it was something horrible, and so we decided we’re going to operate immediately...she had a total volvulus of her bowel...everything had turned. So almost all of her bowel was gangrenous.

As this last example depicts, even in ambiguous cases, physicians have a tendency to berate themselves for not having known the answer. One study participant could not confirm that he had made a mistake, but he felt the impact of that uncertainty touched him irreversibly. He commented that he "had gone from being this topnotch medical student, topnotch resident, I’d maintained that perspective outwardly. But inwardly, my
view of myself pretty much collapsed at that point." Learning to forgive themselves for mistakes, or better yet, learning to accept that mistakes will happen and adjusting their expectations of themselves in that context is therefore a pivotal piece of maturing as a physician: "Physicians sometimes have to realize that they're not perfect." Furthermore, because physicians are imperfect, how they accept or do not accept their humanity has a profound influence on their conceptualization of their professional responsibilities. If you believe you are infallible, you are likely not only to struggle greatly with evidence that you are not, but also to overwork yourself in the pursuit of that unattainable perfection.7

Physicians deal with matters of life and death, and mistakes they make can therefore have deadly consequences. This being the case, there is good reason for perfectionism in medicine. At the same time physicians must seek untiringly for the source of an infection or keep themselves piqued to the possibility of an occult cancer, they must also recognize the limits of their knowledge and the limits to their ability to catch every diagnosis:

Part of what it did is burst my bubble. I mean I think a lot of physicians—there's some belief that they can practice perfectly with perfect judgment all the time, and I think I really did believe I was one of those.

The necessary adjustment seems to be to shift from feeling they can and should be perfect, to knowing that perfection is unachievable, but striving for it nonetheless. Newman's interview study of twenty-three physicians on the emotional impact of

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7 The findings of an in-depth interview study with eleven physicians by Christensen et al. (1992) confirm both that "the perception of having made a mistake creates significant emotional distress for practicing physicians," and that "the severity of [that] distress...may be influenced by perfectionism."
mistakes similarly found that "family physicians may benefit from diminishing perfectionism and recognizing mistakes as a natural part of practicing medicine" (1996). But the dilemma then surfaces: how can physicians strive for perfection and have limits to their responsibilities? As one participant said, "I really thought this would be a useful profession in which I could be of service, and you kind of just totally lose track of that. And instead, you become buried under the guilt of 'it's never enough.'" Thus, just as many physicians are conflicted about demarcating emotional boundaries for the sake of self-preservation, conflict may also arise as they construct boundaries around self-imposed perfectionism. A physician's job is really never done until she decides it is done. There is always more she can research, more she can educate herself about, someone she can call, a patient she can check on—the limits of these demands are ultimately set only by the physician herself.

In addition, reference must be made here to the earlier discussion of a physician's view of death. If a physician views death as an unacceptable outcome, the limits of her quest for perfectionism will be all the less developed, and her requirements of herself more outlandish, unreasonable, and unattainable. Physicians' concomitant acceptance of their own fallibility is intertwined with their acceptance of death as a reasonable outcome. The sum of these factors influences how physicians conceive of their professional responsibilities to themselves and to their patients.

4. Developing Boundaries: the Role of Mentors

The study participants made all of the above adjustments in the pursuit of becoming more comfortable with patient deaths. Each of the adjustments had the
potential to be mitigated by the influence of mentor physicians and nurses. The status of being a medical student and new doctor is, for most, a very vulnerable position—one in which the individual is vulnerable to feelings of guilt and responsibility, having yet to decide where the boundaries of responsibility fall. The majority of study participants said that it is not possible to teach medical students how to cope with patients' deaths because no matter what is taught, students really only learn how to cope through experience. Even so, the study participants said that mentors can play an essential role in how students come to process patient deaths and which coping mechanisms they come to use. Senior physician mentors and seasoned nurses were thought to be of value when they spoke openly of their emotional responses to patient deaths. Several study participants had experiences of "some physician who will care about you enough to take you around, teach you what they know, sit down and talk about life, and give you insights into yourself and into medicine." Such mentors pass on advice about the practice of medicine and insight into how to handle the emotions that come with doctoring. In addition, mentors were especially valuable when they allowed their underlings to see them as comfortable with their own emotions. In this context, the study participants appreciated mentors who were "role modeling" skills "like kindness and supportiveness."

Sometimes, the model provided was unappealing to them, and they would be motivated to groom themselves into a different kind of physician by telling themselves, "I'm never going to be like that." One study participant told a poignant story illustrating how his opposition to a senior physician was an important avenue toward personal growth:
He was wrapped up in whether or not his medicine worked and whether they thought he was a hero...there's this mythology that a lot of doctors catch on to, which is that if they can just be a hero, that's a role that they're comfortable with. So there's this heroic thing where I come in and save you...but as soon as you really started dying, he would leave. And in a way, that worked well because it helped me realize I had a role in there, even though I didn't really care to become an erudite expert in the chemical interventions we were doing, I was fascinated with working with people who were dying. And there was a nurse there who was really pretty good at helping people process. So I kind of took on that role in the clinic, and I felt valuable for that...that was a big step for me.

On the other hand, a glimpse of an attending physician's emotional world allowed one participant to see her superior as experiencing much the same emotions she was feeling, giving her "a window into just how lost people felt." Several mentors required the participants to spend extensive periods of time with dying patients so they might become more comfortable with the process of dying and the fact of death in medicine. These sentiments expand the findings of Lewis in her exploration of a staff bereavement program in oncologic nursing. She found that staff "benefited from hearing colleagues had similar troubles and experiences regarding their work," and the comments of participants in the current study suggest that such a benefit is possible not only in oncology (1999). In addition, these sentiments support Zeidenstein's notion that when there are undesirable outcomes in the field of midwifery "collegial offerings of empathetic kindness are vital to facilitate the midwife's healing process" (1995).

Lastly, a couple of participants said they grew most through being a positive mentor: "I think that was where I grew...not so much as the student." In this way, though no specific strategies for coping with the death of patients were taught, an awareness of
the emotional side of one's profession was encouraged, and the participants often came to emulate the emotional boundaries they observed in their mentors.  

Furthermore, mentors have the power to impress upon new physicians the values of the profession because they are representatives of the culture of medicine. Mentors who do not accept emotionality as an acceptable response to a patient's death may fortify the belief in new physicians that emotionality is not acceptable in a physician in general. Doka's (1989) concept of "disenfranchised grief" unveils the seriousness of this predicament. As he describes, disenfranchised grief is "grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported." Moreover, "disenfranchised circumstances can intensify feelings of anger, guilt, or powerlessness." In this way, when mentors communicate to students that physicians cannot have an emotional component to their professional lives, they are truly doing a disservice to new doctors.

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8 The influence of medical education on the development of emotional boundaries can be further understood with the help of cognitive stress theory (Folkman & Lazarus 1984). As described previously (footnote 4), the coping dyad of emotion- and problem-focused coping are both employed because each has the potential to alleviate stress. In the context of medical education wherein new physicians are socialized to be problem-solvers, medical education is heavily focused on the development of problem-focused coping skills and leaves emotion-focused coping largely to the individual student to sort out. Thus, when a patient dies, we see an individual who is faced with an unsolvable problem, death, and who is not trained to functionally tap into the emotion-focused side of this coping dyad. In such a situation, the presence of a mentor who addresses the potential benefits of allowing oneself an emotional outlet, or even displays emotionality himself, pushes on the student an awareness of emotionality as a potentially positive coping mechanism. It is of great significance that a mentor who chooses to ignore her own emotionality is also sending a message to students about the coping dyad—denying oneself an emotional response to an event in order to reduce stress is a powerful example of emotion-focused coping. The nature of a mentor's emotion-focused coping in either direction influences how a student comes to cope herself.
In a previous section, having to perform futile "codes" was shown to suggest to study participants that death was not an acceptable outcome in medicine, and mistakes were shown have a powerful impact on their self-image. Mentors have a substantial role in the perpetuation of such policies and the ability to mitigate students' responses to such traumatic experiences (Singer 2001). One participant described the powerful influence of mentors when he commented on "attending mentors who were really willing to discuss the ambivalence they felt." Mentors who were "stretching themselves into an acceptance" of death" as an acceptable outcome provided an opportunity for some of the study participants to begin "to say to myself that death is not my enemy anymore...and so I was able to move away from seeing it as a personal liability."

In conclusion, maturing physicians' emotional boundaries, views of death, past mistakes, self-image, and mentors all influence how they come to understand their professional responsibilities (Figure 2). The comments of study participants suggest that it is through this understanding of their professional responsibilities that physicians experience patients' deaths. When patients die, the opportunity for physicians to freely experience emotions is dependent on their perceived fulfillment of professional responsibilities (Figure 1). In cases where they cannot assure themselves of this fact, their feelings about patients' deaths remain largely unexpressed and unexplored.

5. Developing Boundaries: the Role of Personality, Past Experience, and Other Variables

It would be naïve to suggest that the ways physicians cope with patient deaths and their development of emotional boundaries is entirely dependent on the mentoring they receive, on the mistakes they have made, and on their experiences in medical school.
Physicians' underlying personalities have a powerful influence on where they will choose to draw their boundaries. Likewise, physicians do not enter medicine with the same upbringing or the same experience and view of death, nor do they have the same experiences while in medical school. All of these variables influence where physicians draw their emotional boundaries. The role of past experiences has been somewhat explored in the above discussion of mistakes and mentors, but the role of personality has yet to be examined.  

Many of the study participants made comments reflecting the belief that how they felt when patients died was "natural" to them, that their responses are a reflection of "just the way you are, that you can't really change...[that] you only have so much latitude in changing who you are and how you deal with those kinds of things." One physician said, "It's just who I am as a person, and whether I was a doctor or not, I would be that way." As a result of such individual experiences and personalities, the "way" physicians approach patient death differs from doctor to doctor. The most poignant description of this reality came from a study participant who was highly affected by her patients' deaths. She spoke of not having yet found a coping mechanism that made her feel less sorrowful after her patients' deaths, and when asked if she had spoken to other physicians about her predicament, she replied, "People who appear to be less affected were, from the beginning, just less touched by it. So it's not that they're using a coping strategy that they could share with me—they don't seem to understand why I'm so upset to begin with." In a similar way, an oncologist believed that when it comes to coping with patient deaths,

9 Ethnic, cultural, political, and religious variables clearly influence physicians' understanding of their professional responsibilities, but were not addressed in this study and will not be discussed.
"you're either a natural, and all your previous suffering and your personality and the
genes you were born with make it right for you, or you shouldn't do it...because you can't
learn that skill."

What might be lost if too much weight is given to the influence of personality is
the reality that there are many ways to cope successfully with patient deaths—and
specifically, that one physician's successful coping might be undesirable emotional
lability to another. However, for a physician who has developed (or who always
possessed) stoicism in the face of patient deaths, the belief that one's response to patient
deaths is entirely inborn is a convenient one. Such a belief does not require personal
growth through examination or even acknowledgement of emotions. Thus, while a
prominent role for personality is clearly present in the development of emotional
boundaries, giving too much emphasis to its contribution might represent a form of denial
on the part of physicians.

Further arguing against personality as the most significant source of coping
mechanisms for physicians is the clear reality that once a physician's emotional
boundaries are erected, they are not immovable. The majority of the physicians
interviewed reported multiple adjustments they have made to their emotional boundaries
as they matured in their professions. Those adjustments were described thoroughly in a
previous section but are mentioned again here to illustrate that if a physician's emotional
boundaries were fully the result of personality, they would not require or even be
susceptible to such adjustments. The plasticity of emotional boundaries was exemplified
by a participant who was the survivor of a life-threatening illness. Before her illness and
by the end of her residency, this physician's emotional boundaries were relatively

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impenetrable—she allowed herself little emotion. "I think I just stuffed them...I removed myself emotionally. I think I really went very far away...you totally forget why you went into medicine." In stark contrast, through and after her experience with her own illness, she began to revise her emotional boundaries:

That was a really big turning point in my life. And when you have cancer, you tend to meet and hang out with other cancer patients. And so I started meeting other people who were dying, and we all talked about it a lot...to learn from the inside what a relief it is to talk about dying, when you think you are...you know, fear is an emotion like any other. And it's easier if you can talk about it. Then, also, the experience of growing close to people who then die, and kind of learning you can survive that.

Similarly, another physician, through no personal tragedy, came to believe that although his experience in medical school and residency had taught him that emotions other than anger were unacceptable in physicians, he expressed the desire to experience a full range of emotions in the context of his professional career. Learning to explore those emotions continues to be an arduous process for him, but he noted:

I strive for that because I think that's healthy...I remember coming to a conclusion of how healthy it was just a few years ago.... I teach now. And residents—it's been pretty much just women who have cried—and they're very embarrassed about it at first. And I basically try to encourage them and tell them that I wish I could do that, and that I think they are processing their grief in real time and that the rest of us have all this delayed process. And that that's a much healthier way...I feel like I've got a few hundred people back there that I've experienced...that are kind of tumbling in the back of my mind, and as I get stronger, I try to welcome those memories.

In contrast to the majority of the participants interviewed who grew progressively guarded emotionally, these two physicians reveal that it is also possible to experience a progressively wider and deeper emotional life within the context of one's professional life. Thus, it is clear that personality has an impact on the emotionality of individual
physicians, but personality is not the only factor, nor is the always most powerful. Just as they have made adjustments that erected emotional boundaries, physicians may also make adjustments that tear them down.

C. Fulfilling Professional Responsibilities: the Complication of Time

Numerous distractions make fulfilling professional responsibilities difficult for physicians. Recall that the study participants outlined their professional responsibilities as follows: make no mistakes; give the best care possible; shoulder the grief of others; make the death peaceful and pleasant and painless; attend to your own emotional state. Fulfillment of these responsibilities depends not only on the effort of physicians, but on a host of other circumstantial factors. For example, giving the best care possible may be difficult in the context of a personality conflict with a patient or the treatment constraints of managed care. Sometimes despite physicians’ best efforts, dying patients still experience pain and suffering. The most significant factor that complicates physicians’ ability to fulfill their perceived responsibilities is their persistent lack of time. Study participants mentioned time constraints as being the primary cause of stress in their careers—even more stressful for many, than the fear or experience of making mistakes:

By far the most stress I have is the stress that comes from time pressure...I mean, for every five minutes I spend taking care of a patient, I spent ten or more—fifteen doing paperwork and dealing with bureaucratic issues.

The most stress is just the hecticness of the day. It begins and it just goes non-stop until it’s over. And that causes chronic underlying stress, that I think I’m less aware of from minute to minute. I mean it takes its toll. And I’m aware of it now. I’m tired. I’m just physically tired.
Similar to one physician’s editorial statements, “You don’t sit around licking your wounds. I suppose it would be great to sit at a table with the other doctors and sympathize, but there just isn’t time,” study participants agreed that time constraints have the ability to interfere with every aspect of physicians’ careers, including their opportunity to pay attention to their own emotions:

As physicians, we never take time for ourselves. And we overwork ourselves and we never deal with our emotions and our feelings about issues.

You don’t have a minute to process it. So it’s just going past you and going through you, and you’re in the middle of it constantly.

You find out someone’s died and you don’t really have time to deal with it then and do your work...I don’t have time to sit and wallow in it...I don’t have enough time to talk with everybody who I would want to, to be there the way I would want to when I can’t do that for my own children.

The study participants created emotional distance between themselves and patients in the ways previously described, but the lack of time also forces emotional distance between physicians and patients. Without enough time, there is a logistic inability to get to know patients. Furthermore, when physicians know their time to grieve deceased patients will be limited, they are doubtless more inclined to protect themselves from emotional vulnerability.

I often get the message [that a patient has died] during the day when I’m at work—I get really bad news, and I have to turn around and see another patient. And I walk in, and they have a muscle ache or sore throat or something that seems so irrelevant to what just happened. And I have to move, put it aside. It would be nice to be able to cry, but I don’t.

I had the death of the most wonderful person, and I get the call from the coroner and it’s the middle of the day, and she has been found with her inhaler in her hand on the floor and she...would never take care of herself...I couldn’t see why she had to die. And that was hard. And then
you have to turn around, and there’s a patient sitting there waiting to hear what you have to say about the pain in their wrist. So, I don’t have time to process it at all.

The practice and life is so busy that you just kind of, unfortunately, just go through the routine of—you know, you get a phone call, fill out the form for the death certificate, you talk with the family. And then it’s right back to seeing all the patients in a day, and then you’ve got to deal with all the stuff at home, and there’s really no time to even think about it.

It’s hard to make hospital rounds and go from the dying patient’s hysterical family to see the other three people you have to see, and just leave it behind.

With practical limitations such as these, it is understandable both that physicians do not always have the opportunity to pursue deep emotional connections with patients and that they might be inclined to avoid such connections. Most of the study participants place other career responsibilities ahead of emotional connections with patients and with themselves. As a result, even when they consider themselves to have successfully fulfilled their professional responsibilities, the range of emotional responses they might have to a patient’s death is limited by the nature of their relationship with that patient.

VI. Conclusion

In order to see physicians as the committed care-givers they are, we must remember that most build emotional boundaries because they believe doing so is required to fulfill their professional responsibilities to patients. Through a perceived need for objectivity and a desire for longevity in medicine, the physicians interviewed have come to understand where their emotional boundaries must lie, and those boundaries are clearly not the same for every physician:
Over the years, after getting shocked by death, I've sort of learned to be caring, but at the same time to hold back, to not be involved emotionally in other ways... I don't pull away, I don't not go in the door... on the other hand, I just don't want to have to deal with that type of emotion, so I don't. And I feel I've sort of made a compromise in how to be with people and how to be with death, how to be there for people, but not to be a family member or be sort of overwhelmed.

What I learned in my internship was to have tremendous distance, and to just never allow myself to get attached to them in any way, especially if I knew a patient was going to die when they came in.

I've had a lot of patients die. And I'm not inured to it, but I'm separated from it. There's a difference, I think. I'm still interested in how the patient feels and how the family feels, and still try to make sure that everything goes well, but I'm not—death is part of life.

I don't feel any need to be professional, and I don't think families want me to be professional. I think... whatever reaction I'm having is appropriate for how they know me... I'm pretty upfront, and I like to hug them, and I like to hold their hands, and I like to cry with them.

The need for emotional boundaries stems from the need to have some filter through which to be emotional about patients. For those who began with few boundaries, that initial lack often resulted in an overwhelming barrage of emotion. The differences between these mature physicians and their younger selves is a result of how they dealt with the need to mitigate this emotional onslaught because, as one study participant said, "you just can't feel everything as it's going by. You just can't do it." Some established walls through which little emotion could penetrate. Others became very selective about the feelings they would or would not allow to penetrate. A few participants have relearned to extend themselves emotionally to their patients, but for others, the original armor remains fortified and feels justified. Some recognized that there are things you give up in choosing not to be too emotionally involved with your patients, but most seemed to be comfortable with seeing emotional distance as an unalterable necessity.
Given a main finding of this study, that physicians are capable of developing and adjusting their emotional boundaries throughout their careers, it is worthwhile to consider some of the consequences of those boundaries. It is clear that emotional boundaries serve a vital purpose in the lives of physicians, making a career in medicine sustainable. However, as innumerable physicians have declared through editorial writing, there is a point at which the boundaries may be so impermeable that they prevent physicians from experiencing some potential joys of their profession. Novack et al. (1999) said it most eloquently in their article on fostering personal growth in medical students:

Students are stressed by the demands to acquire an overwhelming amount of knowledge and the impossibility of learning everything, the cross-examinations and occasional real abuse on clinical rotations, and experiences with patients' suffering and death. Like soldiers on a battlefield, students must often deal with their emotions alone, or in chance discussions with colleagues and friends. Many learn to protect themselves and survive, but at the cost of distancing themselves emotionally from patients and peers, and consequently from the greatest satisfactions of clinical care.

Some of the physicians interviewed in the current study maintained the same opinion:

I think it is an element of patient care that a lot of people withdraw from. But if you can engage yourself in it, you realize the important role you have, it can be actually quite rewarding.

I understand that the richest context of my career is in that clinic.

Every night I run through the day's events in my mind as I'm going to sleep so that I don't forget that I'm lucky to be alive and I am lucky to have all these contacts. Because, see, even talking to people about death—it's a privilege.

Each of these physicians would likely argue that an emotional investment on the part of the physician adds depth to one's medical career and that while emotional boundaries are necessary, it is worthwhile to erect them cautiously and to know what experiences you
are choosing to wall out. As one author wrote, self-aware physicians have the opportunity to "develop and mature to such a degree that they will be able to use more and more varied aspects of their own personalities in the physician-patient relationship, even those that may be recognized in the first instance as being meta-medical" (Moaz et al. 1992). Finding a balance between distance and closeness is a necessary part of being a physician. Unfortunately, most maturing physicians make these choices unconsciously and do not regularly reexamine them.

It is possible that physicians' integration of their emotions into their professional responsibilities would promote a healthier way for physicians to mediate guilt without subverting the role of perfectionism. If the "richest context" of one's medical career is also imbedded in the very situations that create this emotional anxiety, it might help to consider that an emotional challenge in one's career could be as rewarding as an intellectual one. We tend to believe that in our personal lives, challenges allow us to gain emotional maturity, but as one study participant reveals, most physicians want to clear their professional lives of that same challenge: "But again, it's my work, it's not my personal life."

Encouraging physicians to think about their responses to patient death in the context of how they delineate their professional responsibilities may allow them simultaneous examination of their emotional boundaries, core values, and their ability to fully experience their own feelings. The conclusion of this paper is that physicians' responses to patients' deaths occur largely after they personally assess their professional performances. For this reason, before physicians' responses to patient death can be understood, it is helpful to discover how they conceive of their responsibilities.
Thereafter, physicians might engage in an analysis of what assumptions, beliefs, and goals go into the formulation of those responsibilities. If students are encouraged early in their careers to think critically about what motivates their responsibilities, they are likely to make decisions about emotional boundaries in light of that knowledge, and the opportunity for simultaneous personal and professional change may be immediate.

VII. Future Directions

This understanding of the interaction between professional responsibility and the experience of patient death requires further clarification. Certainly a larger interview study should be pursued that better controls for influential variables such as cultural and religious affiliation, physician specialty, and frequency of patient death. Such a study could test the above findings and reveal finer subtleties. In addition, quantitative evaluation of the relationship between duty prioritization and how physicians feel when patients die, perhaps in the form of a survey study, could offer valuable insight. Lastly, it would be interesting to compare the findings herein to the literature on boundary development in other fields of study. For example, the field of adolescent psychology may house applicable theories on boundary development and social responsibility.

Many opportunities for the improvement of students' medical school and residency experiences are suggested by these ideas. No doubt, brainstorming with physicians could offer ways medical schools could better serve the emotional well-being of their students and residents. In addition, studies should examine what obstacles lay in the way of mentors' and medical educators' addressing the existence of physicians' emotions.
VIII. References


IX. Appendices

Appendix A: Interview Guide

Number:
Physician description:

First: Inform physician that I want to know the "impact on you as a physician and an individual. I want to hear about how you cope and feel."
Second: I may come to questions that you have already answered or which do not seem to pertain to you. To some degree, I will read the questions to you anyway for the sake of consistency, and so that you can add any comments you like.

General Information
- Age:
- Marital status/Divorce:
- Children:
- Medical School:
- In what and where did you do your residency?
- Specialty:
- Years practicing since end of residency:
- Nature of practice:
  - On average, how long do you know patients who die in your practice?
  - Number of patients who die in practice per year:

Past Experience of Grief
- How were you prepared, if at all, in medical school and in your residency(s) to deal with grief over the death of a patient?
- What past personal experiences have helped you formulate a strategy for dealing with the patients’ deaths?
  - Have you experienced any deaths in your personal life? Who? When?
  - How do you feel those experiences have an effect on how you experience death as a physician?
  - (Intellectual versus emotional understanding of death?)
- Tell me about the first patient who died under your care. What was that experience like for you? How did you feel when that patient died?
- Can you identify the strategies you used to cope with losing patients when you were a new doctor?
  - What specific actions did you take?
  - How did you approach your own grief? How did you alleviate it?
- When you first started practicing medicine, did you cry when you lost a patient? Did it help?
  - What feelings were you experiencing?
- At that time, with whom did you discuss your feelings?
• Was there a senior physician who ever spoke to you about your own experience of patients' deaths?
• Did you ever attend a support group to deal with the death of a patient?
• Did your feelings about patients' deaths have an impact on the specialty you chose to pursue?

**Current Experience of Grief**

• Tell me about the most recent patient in your practice who died. How did the loss of this patient make you feel?
• When does the grieving process begin for you? When the patient dies? When you make the transition from curative to palliative care? When you attend the funeral or send a card?
• Do you cry? Does it help? What purpose does crying serve for you?
• With whom, if anyone, do you discuss your feelings? Why that person/those people?
  o How often do you talk with this/these people about patients you have lost and your grief?
  o How has the landscape of your support system changed since you began practice?
  o Are your colleagues accessible in this regard?
• Does grief ever intrude on your work? How so?
• Do patients who have died ever appear in your dreams? If yes, what were those dreams about?
• What habits or rituals do you use to cope with the death of patients?
  o Is there a spiritual aspect or religious belief system that influences your grieving process? If yes, what role does your spirituality play? If not, what do you dialogue do you have with yourself about what has occurred? How do you think about death?
  o Do you review the medical histories and cases of patients who die? If so, why?
  o What else helps alleviate your grief? What other actions do you take?
• Do you go through the grieving process with every patient you lose? If not, what determines whether or not you need to grieve or you allow yourself to grieve? Do you ever feel relieved?
• Do you ever lose patients to specialists when they are dying? How does that alter your experience of that patient's death? How does that alter the way you cope and grieve?
• Are there any other factors you can identify that make for a more or less intense grieving process for you?
• Can you identify any features of your own response to patients' deaths that might make it more difficult for you to cope? For example, some say that physicians should always be immediately available to patients, that they should have no personal needs, and that they should always be able to make a significant difference in a patients' health? How do you respond to such statements? Is there a difference between disagreeing intellectually and emotionally?
- People have necessary defenses to help them cope with loss of this kind. How do you protect yourself? When in your practice did you begin to protect yourself? Do you plan to or think you will ever abandon these defenses?
- When a patient dies, do you ever feel conflicted between what you feel as a person and what your professional role requires of you at that time? If yes, of what does that conflict consist?
- Do you make contact with families after patients die? Why or why not? If the answer is “in some cases,” what determines whether or not you make contact?
  - What are your feelings about what is appropriate display of your own feelings around the families of patients who have died? Is it acceptable/ideal for you to show emotion?
- Many researchers would suggest that the presence of death in a person's life will force an increased awareness of personal mortality, anxiety about one's own death or the death of loved ones. Have you experienced this to be the case when patients in your practice die?
- What causes you the most stress in your career? When you think about what causes you stress, where does grief fit in, if at all?
- Do you keep track of patients who die in your practice? When did you begin doing so?
  - What purpose, if any, does it serve for you to keep record of those who have died?
  - Do you ever review those records? Why or why not?

**Future experience of Grief**
- How do you foresee your experience of grief and coping changing as you continue in your practice?
- Do you feel your personal concerns about the future and growing old will have an impact on how you grieve?
Appendix B: recruitment fax template

To: Dr. XX
Phone: XX
Fax: XX

From: Joyce Leary
Phone: XX
Fax: XX
Email: jleary2@socrates.berkeley.edu

Date: XX

Dr. XX,

My name is Joyce Leary, and I am a medical and graduate student in the Joint Medical Program of UCB/UCSF. Via a referral by Dr. XX, I recently called your office and left a message regarding your possible participation in my master’s thesis study, and this fax is intended to provide you with more information.

Very little formal research has been conducted on how physicians experience grief when patients die. Through conducting this study, I hope to allow physicians to benefit from the experience of their peers by allowing them to share coping strategies and support structures they use. Moreover, this research project has the potential to give insight to medical students and new physicians about what obstacles and experiences may lay ahead.

I am asking you to agree to a 1-hour tape-recorded interview. I will be conducting 40 such interviews, and intend to use the transcribed data to write and present my master’s thesis on this topic. All contents of the interviews are confidential, and pseudonyms will be used in the place of physicians’ names in all my written or verbal reports.

To this end, I am willing to meet you just about anywhere you choose for the interview. I realize physicians are busy people, and I want to minimize any inconvenience if possible.

Please call or email me if you are interested and willing to participate. In addition, if you know any other family practitioners or internists who might also participate, please feel free to either pass their names along to me, or pass this invitation along to them.

Thank you for your time,

Joyce Leary