

Well, death's been here for a long time

—“Live,” Anne Sexton, February the last 1966

Seeing in the *New York Times*, or any other newspaper, a photograph of a doctor breaking into tears as he announces that his patient has died, is unusual. Well, there it was . . . Dr. Dean Richardson crying as he spoke at a news conference in a poignant moment after that noble horse, Barbaro, was euthanized. “It is what it is,” said Richardson. “It’s not the first horse I’ve cried over.” Somehow I don’t think that it will be his last. This veterinarian, may well have had multiple reasons for his demonstrative sadness: the loss of a friend, frustration about not being able to save the horse, relief that his suffering was over, and others that we cannot know. My point is that this is compassion, an emotion that should be expressed more freely by all of us who deliver care. Assuming that Dr. Richardson has students, it is likely that he has shown them that a good doctor can be world class, technically competent, and man enough to be moved to tears over a patient’s situation.

Compassion appears in interesting places. For example, in the ACGME list of six competencies that are now required for all residents in all specialties, compassion is set forth as a trait, a quality that can indeed be learned. The six are:

1. Patient Care
2. Medical Knowledge
3. Practice-Based Learning and Improvement
4. Interpersonal and Communication Skills
5. Professionalism
6. Systems-Based Practice.

The leading sentence under the competency of Patient Care is: “Residents must be able to provide patient care that is *compassionate*, appropriate, and effective for the treatment of health problems and the promotion of health.” Similarly, under Professionalism is the dictum, “Residents are expected to . . . demonstrate respect, *compassion*, and integrity.” And under Interpersonal and Communication Skills is the admonition that “Residents are expected to: create and sustain a therapeutic and ethically sound relationship with patients.”

I have observed that there are many who would say that compassion should not be considered as one of the ACGME competencies because it cannot be taught, but rather is an “innate” quality that, similar to a dominant gene, one is either born with or not. “You either are innately compassionate with an emotive spirit . . . or you are not,” some say. Others, and I hear this from trainees and students, feel that expression of compassion by resident physicians must be tightly controlled if it is to escape from repression. The reasons for this include a couple of possible realities: expressing compassion won’t be helpful in getting a fellowship; if you give compassion excessively, it will tear you apart emotionally in residency; and hypothetical objections: being compassionate carries the risk of becoming emotionally involved with your patients. Another reason for restraint is that there remain remnants in many training programs of a “macho” culture that encourages one to brag about “the great case that came in last night with [fill in the blank]” without focusing on the fact that the great case

now has a widow and two children who will be fatherless.

Let me push the argument that expression of compassion can be learned, belongs in the competencies of the ACGME, and that it is okay to be emotionally involved with your patients, as was Dr. Richardson. In addition, being compassionate can be a joyous reward for those who can give of themselves in this way. What, then, are the pathways for developing it in those of us in whom it is not innate?

One pathway is to have experienced a great personal tragedy or loss, something, as one dear friend has said, that is “profoundly destabilizing to the point where one is forced to reevaluate one’s place in the world.” I would not wish such loss on anyone, but these events happen and help make permeable the usually dense walls within the mind, enabling the internal sorrow for oneself to flow out to others as support, empathy, encouragement, or tears.

Fortunately, most residents and students do not have to suffer personally to be compassionate. The dense walls within the mind can be made permeable by gentler means. The prescription, in contrast to Sir William Osler who was a great one for compartmentalizing emotions, should be, “Let your mind run free within your brain.” Lewis Thomas had the right ideas: “Perhaps only one or two thoughts should be repressed each day, at the outset. . . . regain the kind of spontaneity and zest for ideas, things popping into the mind, uncontrollable and ungovernable thoughts. . . . There is no delusion more damaging than to get the idea in your head that you understand the functioning of your own brain. . . . If we should give away the capacity for embarrassment, the touch of fingertips might be the next to go, and then the suddenness of laughter, the unaccountable sure sense of something gone wrong.”¹

I suggest that allowing sadness and melancholy to pervade our senses when sad things happen, such as a patient’s death, is healthy. Melancholy, that gray veil that takes color out of life, can, at the same time, add to the brilliance and value of life, if we feel what it is asking of us. Melancholy and sadness, similar to love, can make those compartment walls in our minds permeable, enabling us to express empathy that is truly felt within. At the least, it will stimulate our awareness of others’ pain or suffering and loss, as well as allowing our true compassion, with or without tears, to be expressed. At the most, providing a mixture of empathy, compassion, and hope to others will enrich our own lives and enable those compartments of our mind to open more easily the next time.

Reference

1. Thomas L. *Late Night Thoughts on Listening to Mahler’s Ninth Symphony*. New York: Viking Press, 1983.

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