Walking the tightrope: Compassion, detachment, and the cost of healing

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A college-aged premedical student eyed the clock, only 20 minutes separating him from a hot shower at the end of his Emergency Medical Technician (EMT) shift. But when the radio crackled to life with an address and an alert ("male, unresponsive"), it became clear the night had other plans.

Arriving on scene, he and his fellow EMT saw a small white house with flashing red and blue lights out front and a street lined with police cars and a fire engine. He opened the ambulance door, slung his bags over his shoulder, and walked into the open garage. There the patient was, lying on the cold concrete jammed between the car and the wall, a noose tight around his neck. The young EMT felt for a pulse. Before that night, he had found a pulse every time, sometimes only barely, sometimes at a rate much too fast or slow, but it had always been there. Now, he felt nothing. His mind went blank.

Luckily, the paramedics were only a few steps behind. With the paramedics there to lead the code, everyone sprang into action quickly, the practiced motions coming back to the EMT as well. Oxygen on, trauma shears out, clothes off, monitor attached. He told himself this procedure would unfold just like it had with the mannequins that he had practiced on, but as he pushed down on the patient's chest again and again, he felt ribs cracking under his hands. The door from the house to the garage opened. He heard a flurry of footsteps as one of the police officers rushed to intercept the patient's fiancé, but the officer was too late. The young EMT would remember the fiancé's scream for a long time, long after the patient was transported to the hospital. Eventually, the patient was declared dead in the Emergency

Department (ED). As the EMT was cleaning the backboard off in the ambulance bay, one of the paramedics walked by and put a hand on his shoulder. "You did good. You'll get used to it."

By this point, the EMT had responded to hundreds of emergencies, but nothing had prepared him for this—the stillness that came after the sirens were gone, when everything was "normal" again. He was unsure how he felt or how he should feel. He would enter medical school two years later, but for every death afterwards, that question would remain in the back of his mind: how should physicians process death?

The weight of witnessing

Death is not only inevitable in medicine, but an intrinsic element of the profession. It is an event physicians repeatedly encounter throughout their careers. However, the frequent exposure to death does not make it easier to process. In fact, this exposure creates unique challenges for physicians that force them to navigate an incredibly complex emotional landscape.

For many physicians, the experience of death is formative, but also relentless. Approximately 700,000 to 800,000 deaths occur around a wide range of healthcare professionals in United States hospitals annually.[1] Exposure to patient death varies by specialty. Critical-care specialists and emergency-medicine physicians regularly encounter death due to the nature of their fields: up to 1.5 percent of visits to the ED may result in death.[2] Fields like trauma and neurosurgery also frequently involve high-risk cases; physicians in these fields frequently treat critically ill patients and encounter patient mortality. Even prior to COVID-19, almost half of attending physicians, and more than half of medical students and residents, in the U.S. reported significant emotional distress and compassion fatigue.[3] These rates have only risen since.[4] Despite the heavy emotional toll on those who witness death, formal training on how to process it is often lacking.[5]

An impossible tightrope

Physicians are expected to balance two seemingly opposing roles: to be compassionate healers deeply invested in their patients, but also to be competent professionals with the emotional detachment necessary to perform highly clinical and technical procedures in a stressful, high-stakes environment, day in and day out. The sociologist Renée C. Fox famously described this paradoxical stance as "detached concern"—a combination of empathic sensitivity and emotional distance.[6] Fox emphasized that detached concern, far from indifference, is a learned posture cultivated in medical training as a protective mechanism against the overwhelming emotional intensity of suffering, death, and dying. Maintaining this posture, particularly when confronting patient death, is one of the defining challenges of the physician's profession.

On one end of the spectrum is excessive emotional involvement, which is unsustainable for physicians, especially if they frequently work with the critically ill and dying. Growing deeply attached to every patient, only to have so many of the illnesses of those patients worsen or end in death, can take a devastating emotional toll. At a certain point, physicians must start setting boundaries around their compassion. Otherwise, they may become overwhelmed with emotional exhaustion, no longer able to perform their job suitably.[7] This emotional distress also has the potential to spill into physicians' personal lives and relationships.[8]

On the other end of the spectrum is emotional withdrawal from patients' suffering and death, which poses significant risks as well. Such withdrawal may lead health care workers to treat patients like objects instead of people. Consider a scenario where an elderly gentleman has collapsed on the carpeted floor of his living room during a family get-together. While the EMTs and paramedics perform CPR on him next to his couch and daughter, his grandchildren and other family members sit on the front doorsteps, audibly crying outside. What if in the middle of the code, the senior paramedic glances down at her watch, casually expressing a wish to "just get a TOR" (termination of resuscitation) so that she can go to lunch?

Unfortunately, compassion fatigue, a condition that affects up to 60 percent of Emergency Medical Services (EMS) clinicians,[9] can lead to this kind of detachment. The condition is not unique to EMS, afflicting nurses and physicians throughout the health care community as well. All these medical professionals must constantly walk a tightrope, seeking a balance between empathy and detachment. Nonetheless, cultivating a healthy relationship with patient death is essential, not only for them to preserve their own well-being, but also for them to provide the high-quality, empathetic care that their patients and their patients' families deserve.[10]

Burnout

What happens when this balancing act fails? The short answer is burnout: a syndrome involving emotional exhaustion, depersonalization, and a sense of reduced personal accomplishment.[6] Burnout results from long-term stress and emotional exhaustion leading to cynicism, detachment, lower job satisfaction, and reduced professionalism.[11] Physician burnout in particular has been found to increase the rate of patient-safety incidents, sometimes doubling it.[11,12,13] Reasons for these incidents are manifold: physicians suffering from burnout can be less sympathetic when faced with patients' needs, less capable of effective teamwork, and less able to detect and correct medical errors.[12] Physicians experiencing chronic stress from patient suffering and death may also try to avoid the treatment of patients facing similar conditions in the future, which has the potential to compromise patient care and the physician-patient relationship.[13,14]

The physical dangers of burnout are not limited to patients. The rate of physician suicide has been steadily increasing for the last several decades: in what some refer to as a "silent epidemic," physicians have an estimated suicide rate two to three times greater than that of the general population.[13] It is estimated that 300–400 physicians die by suicide every year in the U.S.,[15] the equivalent of roughly two cohorts of medical students. One 2016 study reported an alarming 11.1 percent prevalence of suicidal ideation among medical students, with 7.4 percent of those students reporting suicidal ideation within the past two weeks and 24.2 percent in the past year.[16] It is no exaggeration to say that burnout, given its association with depression, anxiety, and suicidality, is a tremendous danger for physicians and their patients alike.

Consider the experience of one second-year medical-school student during an afternoon rotation, sent with a team for a rapid response in the Intensive Care Unit (ICU). The patient had suffered a cardiac arrest; his bed was a whirlwind of activity, and the LUCAS CPR device worked away rhythmically at his chest. In the corner stood the medical student, her eyes wide as the frenzy of interventions eventually slowed, the device was taken off, and the patient declared dead. This death was the first that the medical student had witnessed. When a team member walking back to the resident workroom with her asked her how she felt, she paused for a moment, responding only that she felt "weird." An uneasy expression settled on her face and she grew quiet, saying nothing further.

Every year, 20,000 new students matriculate into medical school, where most, like this student, will witness their first death.[12] Experiencing patient deaths during medical school significantly influences the development of occupational burnout in physicians and other health care personnel.[17] Witnessing suffering, trauma, or death repeatedly over time in the health-care environment can have profound long-term cognitive and emotional effects.[13] However, the frequency or gravity of such experiences has less impact on the burnout and functioning of medical professionals than does the way in which they frame and deal with what they have witnessed.[17] Thus, simply experiencing patient deaths is not the issue for medical students, residents, and physicians so much as how appropriately they process those deaths, walking that tightrope between empathy and detachment.

How to cope

Research points to several evidence-based strategies for coping with patient deaths. Some strategies such as Schwartz Rounds can occur at the organizational level. Schwartz Rounds are interdisciplinary forums, similar in style to grand rounds, but with a focus on the emotional impact of patient care.[18] A panel of providers shares experiences on a theme or case of significant emotional impact, then open the floor to a facilitated discussion among all participants. Schwartz Rounds and similar strategies allow physicians and other health-care personnel to exchange their different perspectives on and interpretations of emotional events, allowing them to frame patient deaths meaningfully and thereby promote their emotional welfare and connection.[18]

Debriefing at the team level can also be effective, particularly for small teams, fostering a closer sense of community and designating a shared space to acknowledge the weight of patient death. Consider a case where a patient has died unexpectedly overnight and the day team arrives in the morning, surprised by the news. The attending physician, rather than brushing off the news or sifting through the ever-growing, already overwhelming pile of impending work, pulls a chair into the middle of the workroom and takes a seat. "One of our patients died last night," he starts. "The day you stop feeling sad about this sort of thing, you need to leave medicine. So, let's all stop what we're doing for a moment and talk about

how we feel." By openly acknowledging the impact of the patient's death and creating a safe environment for conversation about it, the attending physician has gone a long way in promoting a healthy team culture, reducing the risk of cynicism and burnout.

Senior physicians play an essential role in setting an example for trainees. The activity surrounding a patient's arrival, especially in cases involving brutal or gruesome deaths in the ED, is devoted to immediate interventions. The room becomes full of intense focus and adrenaline. However, after a patient dies, the sudden stillness that occurs can be difficult to navigate, especially once the finality of the outcome sinks in. In such a moment, a senior physician can make all the difference. Suppose, for example, that the patient is a young man who had been in a catastrophic motorcycle crash which left his body broken and bleeding, and that in the shocked silence following the declaration of this patient's death, a senior physician steps forward to say, "We don't know this young man or his name. But we do know that there were people who loved him deeply, and now he is gone. So please, let's all take a moment of silence together in honor of his life." Everyone in the crowded trauma slot could then stand together in an absolute yet shared silence to acknowledge the horror of what had happened and to express respect for the patient. A silent moment like this can leave a profound impression, instilling a sense of meaning after a potentially traumatizing experience.

Efforts at the organizational and the team level are each important in processing patient deaths; however, the reality is that such measures are not by themselves sufficient. Though processing patient deaths soon after they occur is important, it does not prevent repeated exposure to patient suffering and death from having long-term consequences.[14] In many instances, a single death that does not initially provoke a strong reaction may increasingly cause distress weeks or even months later, especially if similarly stressful events accumulate. Studies have shown that difficulty sleeping, intrusive thoughts, and emotional distancing are common adverse long-term reactions,[14] and that these reactions are most pronounced when consistently normalized by trainees and physicians.[14]

For this reason, building robust long-term support systems, both inside and outside of the work environment, are crucial. Seeking and reciprocating the support of peers or mentors can help to offset the normalization of post-traumatic stress reactions.[14] Maintaining self-care is also critical for building resilience: ensuring adequate sleep, nutrition, and exercise; participating in enjoyable activities or hobbies; and sustaining supportive interpersonal relationships outside of medicine.[19] Actively maintaining physical and emotional well-being is a prerequisite for high performance at work. In contrast, leaving unexamined and unaddressed intense emotions associated with patient suffering and death is a recipe for poor-quality health care as well as failure to connect with patients and their families in the future.[20]

What death's all about

Death is not a monolithic entity for a physician—it can occur in a wide range of patients, from elderly patients on hospice care to children with incurable brain tumors. The spectrum of emotions that each patient death inspires in a physician is no less varied and complex, as is the evolution in the way that a physician will encounter and interact with it over the course of a career. Ultimately, functioning, if not thriving, in medicine is a matter not of avoiding negative emotion—avoidance would be a disservice to the patients and families whom the physician serves—but rather of learning to meet negative emotion and embracing that emotion openly, experiencing the reality of death and then gently letting it go. This journey in emotional awareness and discipline is perhaps the greatest challenge in a physician's profession.

Many conceptualize the role of a doctor as that of a healer, a role that is crucial. Yet doctors have another function: to offer companionship. Their highest goal should not be to avoid a patient's death, but to help the patient live life. And there comes a time when the life that some patients want to live will soon end. At this point, the most important duty of a physician is to fulfill the need of those patients to meet death with meaning, to stand by their side as a companion. Frequent encounters with death uniquely position a physician to provide guidance to patients during this moment, to model how to meet death with compassionate acceptance rather than with fear or denial. "This job is not just hard, it's impossible," as one medical trainee is fond of saying. Indeed, for any physician to accept mortality fully—to achieve the perfect balance between empathy and professional detachment at a dying patient's bedside—may well be an impossible task. But striving asymptotically toward such balance is the highest calling that any physician can answer.

Medicine is profoundly humbling work, and caring for patients at the end of their lives is immensely challenging. However, experiencing the death of a patient reminds doctors of the death inevitably in store for everyone. As is often said, "Just because a good book ends doesn't mean it wasn't worth reading." Death, as the last page of a patient's long and colorful story, is well worth celebrating despite the distress involved in witnessing it. Caring for and learning from a patient at this time is a privilege. Each encounter with death teaches doctors one last lesson of life's fragility, charging them to live every day as fully as they can.

The profession demands that physicians learn to navigate the space where life and death intertwine. It is simply not enough for physicians to enter that space with their knowledge and skills alone; they must have compassion, humility, and humanity as well. Although physicians cannot, and should not, avoid death or the emotional toll that it takes, they can come to understand how to shape its impact, letting the experience of it guide how they live, care, and connect with others. Embracing this experience is a way for physicians to honor not just the lives, but the deaths, of their patients: treating each death less as an ending than as the beginning of a journey to live and heal with greater purpose.

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