Clin Orthop Relat Res (2017) 475:592–594 / DOI 10.1007/s11999-017-5240-x

Clinical Orthopaedics and Related Research®
A Publication of The Association of Bone and Joint Surgeons®

Published online: 18 January 2017

Your Best Life

Your Best Life: Dealing with Loss

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Orthopaedic surgery focuses chiefly on restoration of function for the patient and improving their quality of life. Our interventions seldom are lifesaving. In fact, we know many surgeons who decide to pursue a career in orthopaedic surgery just to avoid dealing with death and dying. But let us be clear: We cannot completely avoid death.

What do surgeons experience when a patient dies under our care? Specifically, what does the orthopaedic surgeon endure when a patient dies during surgery?

Although the unexpected death of a patient is something one can never prepare for, surgeons receive woefully inadequate training on how to cope with death and loss [2]. When these events happen, it is heartbreaking, and the focus immediately turns to informing and comforting the patient's loved ones. As physicians, the responsibility obviously falls on us to deliver the devastating news. We have no choice but to sit down and talk to the families. Often stoic and straight-faced, we deliver the news that no one ever wants to hear. We try to explain. We empathize. We offer our condolences. We may suggest calling in Pastoral Care, and then we walk away.

Where do we go? We move on to the next patient because there is no time to process what just happened. Because someone else needs our help.

Unfortunately, our medical school curriculum does not apportion adequate time to teach us how to handle these emotions [1, 4]. Indeed, several hours of basic science jettisoned in favor of counseling on death and dying would serve medical education well. And once we graduate medical school, there is little opportunity offered or encouraged to discuss dealing with death. Though the Morbidity and Mortality conference may be an avenue for discussion, these conferences tend to be more scientific in their approach—problem solving and quality improvement—rather than providing a forum or conversation on our emotional responses to death.

Most of us are hesitant to broach this topic with mentors and colleagues. Discussing raw emotions is not the norm in our specialty. The culture in orthopaedics, though unspoken, creates a sense that it is weak or wrong to discuss these feelings. This prevailing attitude takes away an important

A note from the Editor-in-Chief:
I am pleased to present the next installment of "Your Best Life," *a quarterly column written by John D. Kelly, IV MD. Dr. Kelly is Professor of Clinical Orthopaedic Surgery at the University of Pennsylvania. His column explores the many ways that busy professionals—surgeons and scientists—might find peace, happiness, and balance both at work and in their personal lives.*

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opportunity to identify approaches for coping with such experiences. Granted, in our field, these are rare events, but an unwillingness to talk about it can only lead us down the road of developing unhealthy or detrimental coping skills. It prevents us from identifying appropriate outlets and resources to discuss our emotions. It leads us to believe that it is not okay to feel these things and that we need to be strong.

Although there can be an arcane "machismo" attitude among many orthopaedic surgeons, one can only assume that most of our peers have experienced similar tragedies and likely carry those scars for the rest of their careers. In those rare instances when we do discuss the death of a patient, it is often chalked up to an aberrant event and we tell each other there is "nothing you could have done." We are more comfortable discussing the "how" and "why" of the death and barely acknowledge our human reaction to it. While this seems to be the acceptable practice within our field, the weight of someone's death that we carry forward is heavy and intense. It is a constant struggle to reconcile whatever role we may or may not have played.

Recently, I (DD) had a 27-year-old man with a hip infection die on the table under my care. I met him for the first time in the holding area with his mother. We discussed the surgery and potential risks, including death, but this was briefly mentioned as, in my mind, this possibility was quite remote. The procedure began uneventfully. But near its end, the anesthesiologist informed me that the patient was becoming tachycardic and hypotensive, and that he was desaturating. I aborted the procedure, quickly closed, and repositioned him supine to resuscitate him. He developed a pulseless electrical activity arrest, and after 45 minutes of resuscitative efforts that were ultimately futile, he died.

I was distraught, but I executed my doctor duty. I changed my scrubs to ensure I did not demonstrate any bloody vestiges of the surgery. I donned my white coat and found the family in the waiting room. We found a private room in which to talk. The 50-yard walk from the operating room to the family area felt like 50 miles. In a vocation that is filled with highs and lows, that moment, that walk, was among the loneliest I have ever experienced. Praying and doing the best I could to maintain composure, I walked the family through the events, and told them that their son was dead. I asked if they wanted to speak to a chaplain; they declined. All they wanted to do was to see their son.

As I walked away, an overwhelming feeling of grief descended upon me. My eyes welled up and I felt a deep sense of loss. I had only known the patient and his family for a brief time, but it felt as if I had lost my own child. I felt responsible for their pain. The first time I met his mother, we discussed the procedure and the longer-term plan to reconstruct his hip. The second time I met his mother, I was telling her that her son was dead. I went home that night and, predictably, could not sleep.

The next day, I maintained my full office schedule, followed by a complex surgical case at the end of the day. I went through the motions, mechanically, and got through it. That following day, while rounding on the floor, our social worker (BP) approached me to check in. I was honestly taken by surprise that someone actually thought to ask how I, the doctor, was doing. With her question, I began to process the event. As I talked, it became clear that I could not brush it under the rug and walk away. This was an event that brought up a lot of complicated feelings, and needed to be dealt with in order for me to continue to do my job. That is when I realized I had no idea how to do so.

Through this experience, I have discovered that it is imperative to my mental health and longevity in this career to process my emotions and allow myself to evolve from them. Indeed, each individual will cope with tragic events differently. Personally, it

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was best for me during this process to find trusted individuals at work who were familiar with the case, and simply talk to them about what I was feeling, which eventually facilitated my ability to discuss these events with my loved ones. Additionally, taking the time to discuss the events with all the team members involved was extremely helpful. Realizing the power of saying my feelings out loud and owning them was therapeutic. This cathartic event allowed me to write it down on paper for others to read. It gave me permission to make this tragic event worth something, and potentially, serve as a benefit to others.

As the English poet, John Donne brilliantly stated: "No man is an island" [3]. We all need the support of one another. The time is now to institute more formal training in residency to deal with death and loss and to avail ourselves of the numerous counseling services available. Everyone needs a trusted confidante—whether close friend or spouse/partner. Unexpressed feelings ultimately surface, and the sooner disturbing feelings are discussed, the sooner healing will ensue.

Tomorrow, Try This

(1) Develop a strategy to process the death or terminal condition of a patient.
(2) Enlist the help of a reputable therapist. Getting help is a sign of strength, not weakness.
(3) Regularly consult with a trusted confidante—a close friend, colleague, or spouse/partner.
(4) Discuss your concerns with your family, recognizing that whatever you endure at work does affect them as well.
(5) Be a positive agent for change and advocate for more training in processing grief in both undergraduate and graduate medical education.

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