CLINICAL ETHICS

The absence of sadness: darker reflections on the doctor–patient relationship

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Recognising a diminution in his emotional response to patients' deaths, the author analyses in detail his internal reactions in an attempt to understand what he believes is a common phenomenon among doctors. He identifies factors that may erode the connection between patient and physician: an instinct to separate oneself from another's suffering, professional unease in the case of therapeutic failure, the atrophying effect of perceived hopelessness, insincerities in the establishment of the initial relationship, and an inability to imbue the sedated or unconscious patient with human qualities. He concludes that recognition of these negative influences, without necessarily changing behaviours that are natural, may be a first step towards protecting doctors against what might be an otherwise insidious process of dehumanisation.

When a patient under my care dies, I ponder the fact, reflecting on nature's caprice and the patterns of mortality, but the sadness I feel is usually fleeting. Where once an emotional reaction of some depth occurred, now there is only an abstract equivalent. Such frigidity worries me, because it has evolved over the 10 years since I qualified, and there are many years of medical practice to come.

Doctors do not enjoy revealing the workings of their own minds, and explanations as to how and why the normal human response to death appears to undergo such erosion are discussed rarely. Casting a harsh light into previously unexamined corners of the psyche, death (or its prospect) offers an unfortunate opportunity for analysis. Recognising this, I have tried to study my own thoughts at such times in an attempt to gain a better understanding.

A PARADOX

The initial connection between doctor and patient is often based on the accelerated exchange of information and confidences that is a medical clerking. Details about lifestyle, habits, relationships and vices will be coaxed from the anxious patient. The connection, if broken at this early stage, will of course be immature; the sadness, one would assume, correspondingly slight.

Having presented with chest pain, an elderly man opened a narrow window into his life by describing his family, and became expansive when relating how energetically he had played with his grandchildren earlier in the day. When shortness of breath and confusion, presaging cardiogenic shock, resulted in mechanical ventilation, it became clear that we would not speak again. He died the next day. I barely knew him… but the sadness I felt was intense, far greater than the sadness associated with the death of more long-standing patients on the ward. Why the paradox?

In this case, my sadness derived not from torn attachment, but from the juxtaposition of familial devotion with death. The brief sketch of his life, drawn during our first interaction in casualty, contained only positive images. My appreciation of him as a person was unchallenged, our relationship unsullied by the more complicated emotions that can accumulate on the ward. It is there, where illness and time combine to challenge both patient and doctor, that more discomforting insights take place.

SAFETY IN DISTANCE

A young woman developed liver failure. She had no close family and seemed isolated in her suffering. She made an effort to smile and be light-hearted, despite the horror she evidently felt when gazing into a hand-mirror. Her face was yellow and oedematous, her conjunctivas swollen and suffused. The team, myself included, developed a good relationship with her. It was based on honesty (the possibility of transplantation and death was explored), trust and a pleasing chemistry.

Then came the decline. Somnolence, intermittent confusion, periods of distress and panic ensued. Our visits grew increasingly business-like. As the registrar I focused on the signs, the drug chart and the blood tests, evading her deeper need, to be talked through this illness. I knew that her chance of survival was shrinking, and that knowledge made me wary. By the time she was transferred to the intensive care unit, the relationship between us had become formalised. By immersing ourselves in the necessary minutiae of her medical management, the team and I left her emotionally isolated. I protected myself from the impact of her anticipated death by allowing a space, namely medical efficiency, to form between us.

Although she did not die, the connection between us did.

VESTED INTERESTS

A patient's fear is hard enough to deal with—a doctor's is far more unsettling. Fear is the quintessential sensation that arises when I come to believe that I have a professional stake in a

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patient's ''outcome''. This occurs most acutely after a perceived mistake in diagnosis or management.

Having performed a therapeutic endoscopy on a lady with end-stage liver disease and varices, I was shocked to hear that she died overnight from massive blood loss. Death's merciless searchlight found me out. My thoughts ran thus: what did I miss? did I do any damage? will this death be attributed to poor technique? Only when a colleague described her difficult conversation with the patient's husband did I begin to reflect on her life. Not until the post-mortem report was released (identifying a quite unrelated source of bleeding) did I begin to contemplate her death without a degree of personal unease.

On this occasion sadness was displaced by trepidation, revealing an important truth. Doctors, although driven by vocational altruism, are sensitive to criticism and protective of their reputations.

ATROPHY

A middle-aged lady with a pleural effusion sat by her bed. The reassurances of the inexperienced admitting house officer had proved baseless; the fluid was due not to infection, but cancer, creeping back to the pleura from the breast. She was waiting to be reviewed by an oncologist, but his ''day'' at this particular district general was the wrong side of the weekend.

There were no more investigations to perform, there was no news to give. She knew that ''inoperable'' was synonymous with ''terminal'', and expressed anger and frustration at the injustice. My attempts to counsel her met with polite nods, but I left the bedside sensing only a feeling of resentment. Concluding that further discussions about her illness would be counterproductive, I offered only generalities. In the end her monosyllabic replies defeated me; my registrar-led ward round stopped by her bed for shorter and shorter periods of time.

The sketch created at our first meeting (when, in ignorance, she appeared vivacious and outgoing) had by now been tainted by developments. The relationship between us had atrophied into an exchange of symptoms and prescriptions, anxious glances and shallow platitudes. On this occasion, due to what I hope was a rare alignment between some deficiency in my empathetic skill set and a patient's emotional response to the worst imaginable news, we failed to develop a therapeutic bond.

She left the ward for a hospice, death within weeks the only possible outcome. I felt regret, having failed both her and myself as a doctor, but recognised that the connection between us was by now too slender to bear genuine sadness.

FOUNDATIONS

I was awaiting the arrival of a patient for assessment of a large, indolent tumour. With a colleague, standing before the *x*-ray box, I discussed aspects of the case. As she walked away, I asked, raising my voice, what evidence there was concerning survival with this condition. She turned, shook her head, and said, her voice carrying, ''It's all palliative, nobody survives over five years.''

I walked up the ward, and a man in a gown holding a drip stand by his side intercepted me. ''Was that conversation anything to do with me?'' he said, ''because if it was I'm not very happy about it.''

I could not lie. I took the battery out of my pager and devoted 40 uninterrupted minutes to him—sitting down by his bed, recapitulating his history and telling him precisely what I knew about his condition. He knew well that the proposed procedure was intended to extend his life rather than save it. Nevertheless, he needed that discussion, and in a state of deep uncertainty responded with trust in me.

An excellent relationship developed because I made a mistake and tried to atone for it. That such a connection can evolve from what was, initially, a piece of acting to salvage an unforgivable indiscretion on my part challenges the sincerity of the foundations on which our relationships with patients are built.

THE ORGANISM

The ultimate challenge to my sense of humanity arises when all vestiges of personality appear to have left the patient. Typically this happens in the intensive care unit, where over days and weeks a person can become unrecognisably altered. Their organs fail and supportive machinery accrues around them, oedema alters their entire shape, and sedating infusions ensure that the essence of the person, their expressions, their voice, their thoughts, remain under the surface, invisible to their loved ones—and to their doctors.

I can recall many such cases. Typically, a family photograph tacked to the wall or standing on the ventilator provides proof of a full, emotional life, but glancing past it one may appreciate only a collection of dependent systems, caught in a fragile balance that could still veer the wrong way. The daily assessments, unfelt hands on inert flesh, the mathematics of fluid balances, the small adjustments and the sudden interventions, concentrate the mind on pathophysiology. But should the body give signs of succumbing despite these efforts, does my sense of the biological, of the ailing organism, wane before the realisation that this is a dying personality?

The answer, quite frequently, is ''no''. I might manipulate and experiment to the very end, trying to achieve stability, but when he or she dies, and I step back from the busy bed space, I will perceive a body that could not be coaxed through an illness despite all the technologies to hand.

It takes a glimpse at the photograph to remind me that my appreciation of him or her was wholly incomplete. My knowledge of the mechanics of his or her vital organs may have been deep, but I have next to no conception of who it is beneath the sheet. At this level of engagement sadness appears to have no place.

JUSTIFICATION AND RESOLUTION

The tensions created by sudden, severe or incurable illness settle on the most vulnerable aspect of our experience with patients; not our medical proficiency, not our energy, not our commitment to advocacy—but our sense of attachment. The perfect doctor would have no need to characterise those tensions; he or she would manoeuvre around them and maintain the strength of the connection with unthinking ease. However, the responses described above are natural reactions and cannot be denied. If a lack of sadness permeates my responses to colleagues, to friends, or to my patients' relatives, then I will appear uncaring. This is not the case. How then should I deal with it?

Analysis by itself does not necessarily lead to modification in behaviour. The process of recognition, although requiring a painful degree of honesty, may be the first step. Awareness of potential challenges to the relationship may allow their development to be anticipated and counteracted. This rather objective approach may denaturalise our exchanges, but as I have shown here, there is little that is ''natural'' in the intensity of the atmosphere in which those exchanges take place.

Should this approach make no difference, I may lean on an alternative view: a justification. Perhaps it does not really matter if sadness remains elusive. As long as I can assure myself that the absence of sadness in death does not equate to a deficiency of caring in life, there should be no reason to dwell artificially over the lost lives that a career in medicine will

inevitably bring me to witness. Such an assurance requires achieving a reconciliation between disconnection and genuine caring—without acting, without pretending. It is at this level that the professional carer faces his or her most difficult challenge.

HONESTY

My assertion that other doctors experience a similar change in their response to death cannot be substantiated. I have seen colleagues respond to the news of a patient's death with silence, a shrug, a sigh of relief, a joke, or angry accusations of medical incompetence in others, but I cannot presume to know how deep or long-lasting their sense of sadness was. If the results of this self-analysis do not represent the thoughts and feelings of others at some level, their value will be limited. They are products of a particular individual in a specific environment, but may not strike a chord unless medical personnel across the spectrum of character react in the same way. However, just as identifying the (occasionally unattractive) factors described above required honesty, reading them and reflecting on whether they apply may demand a similarly uncomfortable process of introspection.

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