Editorial

What we still don't know about surgeon response to patient death

Amanda B. Cooper^

Department of Surgery, Penn State Milton S. Hershey Medical Center, Hershey, PA, USA

Correspondence to: Amanda B. Cooper, MD. Division of Trauma, Acute Care, and Critical Care Surgery, Department of Surgery, Mail Code H075, 500 University Drive, PO Box 850, Hershey, PA 17033, USA. Email: acooper2@pennstatehealth.psu.edu.

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The article "S*urgeon Response to Patient Death*" by Drs. Wiemann *et al.* (1) not only adds to the small quantity of existing literature on the response of surgeons to patient deaths, but is also timely because it provides some information about how health care providers' responses to the deaths of their patients from COVID-19 early in the pandemic differed from their responses to deaths due to other causes. It is also significant because with the worsening of physician burnout due to the COVID pandemic (2), it is important to understand how other factors (such as patient deaths) contribute to burnout and what sort of interventions might be effective in mitigating symptoms of burnout. Understanding contributors to burnout and effective mitigation strategies is particularly critical for surgeons in general, and trauma/critical care surgeons, who often experience the deaths of their patients, in particular, both because of their already high rates of burnout and because of the already existing shortage of trauma surgeons in many states and rural areas (3), which is predicted to worsen in the coming years (4) and may have been further exacerbated by the COVID-19 pandemic.

Despite not being the main focus of this manuscript, the description by the authors of the patient memorial service in their department of surgery may represent one such intervention to help mitigate burnout. While the medical literature contains a few descriptions of patient memorial services involving physicians and other healthcare providers (5,6), theirs is the only description of such a service in a surgical department and serves as a blueprint for other surgical departments. Given the value of the memorial service to participants reported in each of these descriptions and the frequency of burnout (36% in this study) resulting from experiencing the death of a patient, it seems as though more surgical departments would benefit from initiating similar memorial services. Such memorial services have the potential to increase camaraderie among members of the department (and thus provide protection from burnout) and decrease the reliance on maladaptive coping strategies for dealing with patient deaths. Healthy coping strategies are especially needed for surgeons given the comparatively high rates of alcohol and drug abuse in surgeons (7) and the relatively high risk of suicide for general surgeons relative to other surgical specialties (8).

While the manuscript by Drs. Wiemann *et al.* adds to the scarce literature on how surgeons respond to the death of their patients, it brings up more questions than it answers (1). Given that 45% of their study participants were medical students, one should consider whether and how the results might differ if the study participants had been limited to resident and faculty surgeons. *Tab. 3* breaks down the responses to patient death for medical students, residents, and faculty, allowing a partial answer to this question; however, the authors do not report similarly stratified data on the symptoms experienced as a result of dealing with the loss of a patient. *Tab. 4*, which stratifies these symptoms by the age of the respondent suggests that there may be significant differences given that there were statistically significant differences in the rates of reported anxiety and

^ ORCID: 0000-0003-3975-3897.

burnout in the 18–34-year-old cohort; however, such a broad age range likely includes medical students, residents, and perhaps even some junior faculty members. Another question prompted by the 44% response rate for faculty and the roughly 64% response rate for residents is whether those surgeons who participated in the patient memorial service but opted not to respond to the survey might utilize more maladaptive responses in dealing with patient deaths or experience more symptoms associated with the deaths of their patients. Considering that the survey used to collect the data for this study did not allow respondents to provide free response answers to the question of how they respond to the death of a patient and the most maladaptive option provided by the survey for response to a patient's death was "tried not to think about it", this study also does not answer the question of whether surgeons frequently use maladaptive coping strategies such as alcohol or drug use in response to the death of a patient. The survey also did not include suicidal ideation in the potential symptoms that respondents might have experienced due to a patient death, so there is the definite possibility that the study underestimates the negative impact of patient deaths on the healthcare providers studied. Perhaps the biggest question this study brings up is how would these results look different for deaths that were either intra-operative deaths or deaths due to surgical complications as opposed to deaths due to disease progression. Previous qualitative work with Australian surgeons by Zambrano *et al.* (9), suggests that surgeons experience perioperative deaths differently than those due to disease progression; however, this study did not explore the ways in which the experience differs in depth. In my own personal experience, intra-operative deaths are the most challenging to cope with, followed by those due to perioperative complications, because of a heightened sense of personal responsibility compared to patient deaths due to disease progression.

I hope that this article will inspire other investigators to design studies that begin to tackle some of the above questions, so that general surgeons as a group can better understand our responses to patient deaths and how we can better support our colleagues and trainees as they navigate their own responses to patient deaths. I hope it will also bring to light the need for education at all levels (medical school, residency, and continuing medical education) on healthy ways to cope with patient deaths. Both of these changes would represent an important step in improving the mental health and well-being of surgeons at all levels of their careers.

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Footnote

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