# Emotional reactions of medical doctors and students following the loss of their patients at the Dr George Mukhari Hospital emergency unit, South Africa

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**Keywords:** death; emergency unit; patients; emotional reactions; medical doctors

## Abstract

SA Fam Pract 2010;52(4):356-363

**Background:** Studies on death and dying predominantly emphasise the needs of the dying patient and the process of bereavement. Few studies have focused on the reactions of medical doctors and students when the patients they have cared for die.

**Methods:** The aim of the study was to explore the thoughts and feelings of doctors and medical students who have lost patients while under their care at the Dr George Mukhari Hospital emergency unit in Ga-Rankuwa, South Africa. The participants included 10 medical doctors and final-year medical students. A qualitative study methodology using a phenomenological approach was used.

**Results:** Meanings were formulated from transcriptions and themes were identified. The following themes emerged: emotional reactions, which included anger, helplessness, guilt and pain; recurrent thoughts about the incident; blame; perceived incompetence; detachment from emotions; religion; death of a paediatric patient; medical training; psychological services; work environment; coping with the family of the deceased; and facing mortality.

**Conclusion:** From the study it was concluded that doctors needed enhanced training in communication skills and communicating death to the patients' families. Bereavement counselling and debriefing should be available to provide them with an opportunity to share emotional responses and reflect on patients' fatality.

Ⓟ **Peer reviewed. (Submitted: 2009-09-03, Accepted: 2010-02-07).** 

## Introduction

Caring for dying patients is part of every doctor's clinical experience both during training and in subsequent practice. Doctors working in emergency units are the ones most frequently exposed to dying, as trauma patients seek help in the unit as the first line of treatment. They constantly confront death and respond in a variety of ways to the many deaths that they witness and to their own sense of mortality. Doctors who grieve the deaths of their patients often also face a unique set of issues that challenge historical models of bereavement.[1] Multiple losses and the overwhelming task of living in a situation where continual loss has become commonplace have become very important issues that distinguish patients' losses from other types of grief.[2] It is the accumulation of multiple losses that presents the greatest concern for medical doctors. Dane suggests that when the loss of patients to death occurs consecutively, without the opportunity to process the multiple deaths, doctors are susceptible to bereavement overload and an emotional state of chronic mourning.[3]

## Aim of the study

The aim of the study was to explore the thoughts and feelings of doctors and medical students who have lost patients while under their care at the Dr George Mukhari Hospital emergency unit in Ga-Rankuwa, South Africa. This study sought to understand and answer the question of what specific and unique reactions medical doctors and students experience after the deaths of their patients. The study was undertaken to explore the links between the existing literature, which was deficient, and to add to empirical literature on patient-related bereavement studies.

## Methods

A qualitative research design following a phenomenological approach was used, as thoughts and feelings of people cannot be explored by quantitative methods. Purposeful sampling was used for the recruitment of participants. This sampling method entails selecting participants according to the needs of the study.[4] Ten participants (medical doctors and students) working at the emergency unit of

Dr George Mukhari Hospital in Ga-Rankuwa, South Africa, at the time of the study (between May and June 2006) were purposefully selected. Each had experienced the loss of a patient in the unit in the preceding 48 hours before the interview was conducted. Individual free attitude interviews were conducted. In this technique, the only question allowed to be asked is the 'exploratory' question.[5] The interviews were audio-taped and transcribed. The participants were assured of the maintenance of privacy at all times throughout the interviews and that all information would be treated with confidentiality. Collaizi's[6] method of descriptive analysis was used. This involves formulating meanings from transcriptions and organising them into clusters of themes. This led to an exhaustive description, which synthesised and captured the meaning of their thoughts and feelings into written form without distortion or loss of richness of data. The data were returned to the participants for validation and member checks.

## Results and discussion

Most participants were able to disclose vivid and detailed feelings evoked by their experiences of patients' deaths. The following themes emerged and are discussed immediately after each theme to provide context and meaning:

***Theme 1: Emotional reactions***

The experience of traumatic deaths of patients seemed to be hard for the doctors. This supports the contention by Tedeschi and Calhoun that traumatic deaths cause the most distressing psychic pain because of the difficulties in integrating the change to internal meaning structures, especially where the self-theory is insufficient to contain such change.[7] Saunders and Valente found that when doctors had not been able, for whatever reason, to assist a patient to die a good death, or if they were off duty when a patient died, they stated that their grief was more difficult, using terms such as "more complicated", "difficult", "painful" and "distressing" to describe the grief.[8] Participants in this study indicated that they were deeply moved by the losses of their patients. Underlying feelings of hurt, anger, frustration, remorse, sadness, guilt and unhappiness surfaced, as exemplified in the following quotes from the interviews:

*"After my experiences of losing those two patients, I realised that … err … It does not matter how old or young you are, death is death, and it is painful. You do not have to be a family member, a daughter or a friend to feel it."*

*"Losing patients makes me feel like crying. Experiences of losing patients make me feel unhappy, sad and angry."*

*"I lost two patients on the same day. Ten minutes apart to be exact. I felt traumatised. This feeling of being on the edge … makes me feel so bad."*

Ash identified anger as part of the progression of burnout in those individuals who are extremely focused on their careers and success.[9] According to Rando, there may be a great deal of guilt and anger in cases where the relationship between God and a human being is tentative.[10] At the time of the patient's death, the attending doctor may experience feelings of anger towards the self and God, as expressed by two participants in this study:

*"You get angry. After losing a patient … err … I could not believe it. I was angry with myself and at myself. I was angry because I could not save the patient."*

*"I felt so angry. I was angry at myself and at God at the same time. I was angry at myself because I could not save her … err … I was angry at God because God took this young person way too soon."*

Williams and Gamino comment on how negativity or anger towards a higher power may indicate the mourner's inability to derive a sense of meaning from the experience of the death.[11] Clearly, working with trauma patients engenders a myriad of psychological distresses. According to Farber, a sense of helplessness emerges from this work. He defined this as "an experience of powerlessness, impotence or defenseless generated by the perception that a particular aversive event cannot be controlled, altered or remedied".[12]

***Theme 2: Recurrent thoughts about the incident***

The reawakening of an old loss refers to a reluctance to grieve because the current loss reawakens a significant and painful loss (i.e. any prior death) that has not yet been resolved.[13] Participants in this study mentioned that they found it hard to come to terms with what had happened and to finally accept the losses of their patients. This became evident in the following statements:

*"Even now, I have difficulty suppressing the image of her while trying not to give up on fighting for her life. Seemingly, other events of patients' deaths will trigger it in my mind."*

*"The pain stays here for a long time because at times you remember."*

*"Every patient that dies on my hands … I find it very difficult to forget."*

Abnormal grief reactions stem from an individual's inability to tolerate emotional distress, exhibited by avoiding feelings and emotional distancing.[14] Not grieving an unresolved earlier loss, and perhaps adopting a coping strategy of avoiding all grief reactions, may be characteristic of doctors forced to endure the loss of patients on a daily basis.

***Theme 3: Blame***

One of the many unpleasant aspects of grief is the need to feel responsible or guilty.[14] Several doctors in this study blamed themselves for not succeeding in saving the lives

of their patients, whereas others found it easier to put the blame on the relatives of the deceased patient, as indicated in the following extracts:

*"I felt bad. Actually, the team that was helping me to resuscitate the patient … err … we all felt bad. We blamed ourselves."*

*"I blamed the relatives because … err … how could they have not known? And how could they stay with someone in the family and not know her medical condition?"*

Accidental deaths may increase feelings of helplessness, which expresses itself as anger and blame.[15] Blame is associated with marked psychic pain and unhappiness. The dysphoric mood associated with the experience of loss is always exacerbated if there is any sense of guilt or self-blame attached to the circumstances of the loss.

***Theme 4: Perceived incompetence***

Doctors often experience a sense of powerlessness for not being able to affect or alter the final outcome for the patient, i.e. that of death. Medical doctors suffer from guilt, incompetence and feelings of failure[16] as well as feelings of helplessness[17] when a patient dies. These findings corroborate the results of this study in that many participants expressed feelings of failure or incompetence after the loss, as is evident in the following quotes from the transcripts:

*"But, at the moment that my patient died, I felt as if I had not done enough to save the life of my patient. When I lost my patient, I felt like a failure. I thought I could have done 1, 2, 3 or even more."*

*"I still wonder if a more experienced doctor would have saved the child."*

*"When you lose patients, you always feel incompetent, inadequate and ashamed."*

Some doctors attempt to overcome fear of failure, incompetence and insecurity by working harder and longer hours.[16] Almost all doctors who work harder and longer have in common an excessive need for approval and a compulsive approach to work as a defence against problems of aggression. Accordingly, at the moment that the patient dies, the attending doctor may also question his/her ability, as articulated by a participant in this study:

"*The first ideas I think that would come to my mind, is that whether I could have done something to have saved the life, whether there was any human insufficiency in my part, whether there was any understanding of processes."*

***Theme 5: Detachment from emotions***

In order to deal with patient's deaths efficiently, doctors may put a barricade between themselves and their patients to avoid any feelings that could result from the death. Many doctors in the denial stage of grieving attempt to avoid pain by choosing to reject the emotions and feelings that they are experiencing.[18] The problem with the avoidance strategy is that doctors cannot escape the pain associated with mourning. According to Bowlby,[19] "sooner or later, some of those who avoid all conscious grieving break down – usually with some form of depression. Tears can afford cleansing for wounds created by loss, and fully experiencing the pain ultimately provides wonderful relief to those who suffer while eliminating long-term chronic grief". Doctors may have a greater need than others to reject death.[20] Some doctors may compensate for their unconscious personal fear of illness and death by distancing themselves from dying patients. This was expressed by one of the participants in this study:

*"Because of our line of work and because we see [death] so often, so regularly, you end up putting a wall between you and your patients … err … I guess with the environment that we work in … where we have a lot of patients … where we see a lot of patients daily … it becomes a bit easier to just look at a patient as a patient and just treat them … do your part and not get attached."*

Participants from this study stated that they regularly encounter patients who are seriously ill, and these intense reactions generate a significant amount of personal emotional stress. They expressed the necessity to detach themselves emotionally in order to maintain a heightened sense of awareness as well as to avoid compromising medical judgement. As Knight phrases it, *"Medicine can sometimes be a dirty business".*[21] In fact, they have described a certain measure of insensibility required for the practice of medicine and used to counsel medical students to "acquire early the art of detachment".[21] This is not always easy. It is evident that death evokes discomfort in doctors. Some participants in this study emphasised this, as can be seen in the following extracts:

"*… because, if you become emotionally involved, you become destroyed."*

*"I always ignore my feelings. I cannot afford to feel anything. I have to see a lot of patients and if I dwell on one incident, I will lose focus. I do not worry about my feelings."*

In contrast, some doctors appeared to be desensitised by death due to the repeated exposure to death over a period of time, as stated by one participant:

*"I do not think about that person as a human person but I just think of him as an incident that has followed from a phenomenon of medical process and medical realities. The fact that I begin to take them for granted, it comes naturally to me as if it is a mechanic sort of machine that you can just switch it on and off."*

This apparent desensitisation may reflect depersonalisation on the part of the doctor. Depersonalisation refers to an

unfeeling and callous response towards people, often the recipients of one's service or care.[22] This negative attitude may get translated into rude, insensitive or even inappropriate behaviour towards patients as well as to withdrawal from them.[23] Reduced personal accomplishment refers to a decline in one's sense of competence and of successful achievement in one's work with people. This may develop into more extreme feelings of inadequacy and failure, loss of self-esteem and even depression.

***Theme 6: Religion***

After losing a patient, the attending doctor may rely on religion for strength. Religious beliefs can provide higher-order cognitive schemas of universal truths and values that provide shelter from chaos and the need to make sense of an essentially senseless event.[7] This is especially helpful where God is seen as benign, as it can be used to minimise the crushing aspects of an event by incorporating them into something larger. In the excerpts that follow, the participants appear to derive comfort from the belief that although what has happened is unbearable, this mortal life is only accessible through faith and that within that larger existence, what has occurred can make sense:

*"I am a God-fearing person and I have got my own religious values. My religion helps me make more sense of life as a doctor and as a person."*

*"For my religion, this is just a transit and we are going to enter the real world after death."*

*"Whatever different religious backgrounds we come from, we have to learn to accept that there is only so much you can do and so much that you can go. And beyond that, there is a superior being that we can all belong to, who will take us back because he or she is our creator."*

This would appear to corroborate findings of Davis and Nolen-Hoeksema, indicating how religious or spiritual beliefs facilitate the process of meaning making even though this does not put an end to the process of searching or sorrow.[24] Spirituality or religion may assist the bereaved person in living with the loss and does not reduce the experience of the grief. In this study, some doctors started questioning their religion after losing patients, as expressed in the following quote:

*"When you lose a patient, you start questioning your purpose as a doctor, and you start questioning religion as well. It makes you wonder about religion … actually, it reminds you about … you know … your faith, whatever it is that you believe in."*

***Theme 7: Death of a paediatric patient***

When an infant dies, grief may overwhelm not only the parents but the doctor who cared for the child as well.[25] Participants reported that they found it difficult to deal with the losses of paediatric patients since a child's death is more tragic and unnatural than any other death. Many doctors in this study pointed out that they deal with this situation with limited support. Doctors often receive no formal training in coping with paediatric deaths likely to be encountered in practice. Unpreparedness for these intense experiences may negatively affect the attending doctor and the quality of care provided to survivors. This was evident when some of the participants revealed their lived experiences regarding paediatric deaths:

*"It is better to lose an elderly person than a child. A child should not die before its parents. It is not right. It really gets to you. It hits you right there in your heart. The pain is so unbearable. The pain stays there for a long time because at times you remember."*

*"You become more sad and incompetent if you lost a child. You have this guilty conscience and blame others."*

The nature of the emergency department is such that the doctor on duty often does not have an ongoing professional relationship with the patient's family. The doctor only performs emergency procedures and does not have the opportunity to become well acquainted with his/her patients. A paediatric death frequently results in the attending doctor and the patient's family meeting each other for the very first time. This can be a difficult and an emotional situation for both the attending doctor and the family. Doctors with children of their own may be especially vulnerable to an emotional response to a child's death, as they may identify with the loss. This became clear when some of the participants shared the following:

*"It was very traumatic. Maybe I was affected by this because I also have a son of that age."*

*"It is even worse if it is a child whom I lost. Losing a patient who was a child affects me as a doctor. I feel like I did not do enough to save the child. I feel like it is my own child that I lost and I failed to save him."*

In view of the fact that a child's death may be perceived as catastrophic, an emergency unit doctor may have strong feelings of nonspecific sadness and loss. In the aftermath of a paediatric death, a doctor may have extreme emotions that make it difficult to maintain composure. Natural psychological defences are unconsciously summoned to assist the doctor in maintaining composure. A problem may develop if the doctor's own defences produce reactions that may be upsetting to family members of the deceased child.[2]

***Theme 8: Medical training***

The dying patient is a deviant in the medical subculture because death poses a threat to the image of the "doctor as healer."[18] It has been revealed in the present study that doctors do not receive the training necessary for

competence in end-of-life care with regard to the loss of patients and coping with the families of the patients. Many studies have confirmed the inadequacy of training in this area.[27] Most participants in this study stated that when they lose their patients, they feel incompetent and often question the purpose of being a doctor. They highlighted the following:

*"We are trained to save lives. As a doctor, I should save lives. I was trained to do that but, facing deaths of patients, it is challenging, disappointing and unpleasant."*

*"You may be naïve as a medical student when you begin your training, but you still have this sense that you are going to be able to save lives. Clearly, we cannot always do that, but it can be an emotional, brutal realisation. Medical school does not prepare us for such things [deaths of patients]."*

*"Because medical school does not prepare us for such things [patients' deaths], when you lose patients, you always feel incompetent, inadequate and ashamed."*

The Discovery Foundation trustees commissioned an independent research aimed at identifying the skills needed to give disadvantaged communities in South Africa access to better health care as well as the steps that would nurture and retain those skills.[28] The study revealed that South Africa does not have enough skilled medical personnel in many areas of health care to meet its people's needs; it is not training enough people to address the gaps; there are not enough educators to teach medical skills; medical skills are concentrated in urban areas, and specialists are leaving the rural areas where they are most needed; and there are several environmental issues, such as working and living conditions of medical doctors, that contribute to the problem.

***Theme 9: Psychological service***

One of the most emphasised aspects that emerged from this study was that doctors needed someone with expertise (particularly a psychology counsellor) to talk about patients' deaths and feelings of self-doubt, inadequacy and guilt. Persaud stresses the importance of "ventilation and validation".[29] Support from work-related sources is more beneficial than outside sources.[30] Participants in the current study pointed out that they needed counselling to assist them in finding a balance between caring for the dying patient, handling the patient's family and performing their academic or professional work. This became clear in various statements by the participants, such as the following:

*"Sometimes when things like these [losing patients] happen, we realise that we need the help from psychologists … you know, people with expertise. People who will help us make a balance between caring for the dying patient and our academic and professional work."*

*"It is quite important that psychologists have to come into play with regard to the emotional stress that the doctor is undergoing for treating patients."*

*"The challenge rests on the management of the Emergency Unit to provide accessible, acceptable and constructive support for staff during those stressful times by employing a psychology counsellor."*

It was evident from the results obtained in this study that no doctor had an experience of talking to a psychotherapist for support. The staff members in this emergency unit need support and encouragement, possibly from members of the interdisciplinary team, to continue providing high-quality care or else their resources to deal with patients' deaths may be depleted. Psychological support can act as a protective measure against the negative effects of stress that doctors working with trauma patients experience.

***Theme 10: Work environment***

The hospital where this study took place is an academic teaching hospital. Though doctors are qualified to perform the procedures that are demanded of them, they are continuously learning through the ongoing supervision by others more senior. This can be stressful and may also cause difficulties related to being evaluated by others as well as evaluating others. Role stress is theoretically composed of role ambiguity, role conflict and role overload.[31] Role overload is one of the most common complaints among doctors. Senior doctors and consultants may experience added stress by being in positions of authority and having to make and enforce decisions, while trying to cultivate a teamwork approach and allowing the younger doctors the opportunity to learn. Role strain may possibly lead to burnout in medical doctors when there are gaps between expectations and performances, between promise and delivery, and between values and norms.

Doctors in this study indicated that there are some factors in the emergency unit that placed them under extreme pressure and that these added to their stressors. They reported excessive work overload as the single most stressful aspect of their work, as was clear in the following quotes:

*"Sometimes due to the pressure of treating many patients, we tend to forget some procedures."*

*"There are also patients from students and nurses. We need to show them how to do activities that could help save the patients. Sometimes when I have to think about that, it is a lot of stress because, I suddenly have to change my attitude from doing something on the patient to showing the students and the nurses how to do the job properly."*

The World Health Organization estimated in 2008, that the global shortage of doctors and other health care workers

at 4.3 million.[28] For Africa and sub-Saharan Africa, the figures are even more alarming. To meet the United Nation's Millennium Development Goals by 2015, Africa would need a million more health care professionals to service its population. It was pointed out by *Discovery Magazine* that sub-Saharan Africa with 11% of the world's population and 24% of global disease has only 3% of the world's health care professionals. Participants from the current study mentioned lack of manpower as one of their stressors in the following extracts:

*"Another reason that we lose patients unnecessarily is that there are not enough doctors working in the unit."*

*"When there is no manpower … when we are short-staffed, it is so stressing because then I'd be working alone and I won't be able to concentrate on one patient as I have to attend to other patients as well. I have to run around trying to help everybody at the same time. Without manpower, a person can make mistakes. Mistakes occur when you try to help everybody at the same time and then you lose focus. When mistakes do happen, it is easy to blame yourself and without manpower, a patient can die. We should not be short-staffed in the emergency unit."*

The administrative demands of running an emergency unit require that each doctor document every procedure that he/she performs every investigation and its result, as well as a comprehensive case history of each patient. This aspect of his/her work can be time consuming and contributes to higher stress levels. Doctors at Dr George Mukhari Hospital work as a team; if one doctor is unable to attend to a patient, another doctor takes up all the responsibilities and this places additional stress on the other doctor. Scheduling who works which shifts can create a number of problems and difficulties that may lead to feelings of "unfairness, arbitraries of decisions, suspecting favoritism, and unjustness"[31]

The shortage as well as improper maintenance of equipment in the unit added to the environmental stress that participants of this study experienced. They revealed that these factors hindered them in sustaining the heavy workload, as mentioned in the following excerpt:

*"There is also a shortage of equipment in the unit. Equipment that are in the unit ... sometimes stop working. You find that we have to use other measures to try and save the lives of these patients but, without enough and proper equipment, there is not much that we can do."*

***Theme 11: Coping with the family of the deceased***

There are some paradoxes in the practice of medicine that create role strain for the doctor. Participants reported stress resulting from attempts to meet the emotional demands of patients and families, and exposure to death and dying. They reported that they found it difficult to communicate bad news to the family of the deceased, as shared in the following extracts from the transcripts of the interviews:

*"Facing the family is very traumatic. It is bad enough losing a patient, but then when the family comes in and you have to break the bad news, it is very difficult."*

*"The mother was there. One could see and feel the pain she was enduring. The hardest thing I have ever had to do was breaking the bad news to her. I had no idea what I was going to say to her."*

"*I was holding my feelings inside and also I was putting on a strong face for what I thought was the best way to break the news."*

*"The family was there … crying. I did not know what else to do. I could feel their pain. I cried with the family … err … I cried as well. The whole experience was painful for everybody."*

Wolfram[26] states that unless the emergency department conditions are extraordinary, the doctor in charge of the patient should personally notify survivors of the patient's death given that for 14 many family members this might be their first encounter with death. Wolfram pointed out that, whether it is proper for the health care professional to display emotions, particularly tears, is a subject of ongoing controversy. If the emotion displayed by the doctor is genuine, a wide range of doctor behaviour probably is acceptable up to the point of role reversal. Families should not be placed in the position of consoling the health care professional. Participants from the current study emphasised that as doctors they are required to be sensitive, sympathetic, understanding and compassionate to the family of the deceased; while dealing with some tough personal issues after the losses of patients and attempting to maintain their performance unaffected by suffering and tragedy, as expressed in the following statement:

*"It is not easy losing patients because, after that, you have to talk to the relatives to break the news. You also have to counsel them. The most difficult thing is that you have to appear brave even though you are also breaking inside."*

Although this aspect of the participants' work may be difficult, they seemed to be aware that what the families of the deceased patients were going through could also happen to them. They described how hard it was to make the families aware that even if their loved ones have departed from this world, life must go on. One of the participants asserted the following:

*"It is difficult to make the family face the fact that life is still there for them as the remaining people that are left behind by the deceased and that they must be strong because this is not the end of the world. It takes a person a lot of bravery to finally come to terms with the loss. Life does not end at*

*the time of the loss of the loved one. They still have to live their own lives despite the difficulties that they encountered and ... the journey they will be travelling without that person will not be easy, but acceptance is the first step to moving on with their lives."*

***Theme 12: Facing mortality***

Medical doctors are continually challenged to defend against death anxiety. Death anxiety is defined as man's fundamental fear of death, of non-being and of no longer existing.32 The inevitable deaths of patients confronted doctors with their own mortality and provided the prime source of death anxiety.[33] One of the challenges encountered working with trauma patients is the onset of feelings of helplessness associated with underlying death anxiety. Farber[12] states as follows: "Such a response is likely to be elicited not only by the fact that these patients are dying, but also by the limits on the ability to provide significant relief from the overwhelming emotional distress that many patients experience. In this regard, as doctors witness the suffering of their patients, they are confronted with awareness of their own limits and finiteness."

Death was perceived by participants in this study as something inevitable. They expressed that when patients die, they are challenged with facing their own mortality and that of their loved ones. In the excerpts that follow, the participants shared their lived experiences with intense emotion:

*"These experiences make me think about how I would react when I'd die or when my parents die."*

*"This can happen to me. I can die anytime."*

*"Life is not fair and it can be short. Deaths of patients can change you as a doctor. You tend to look at life differently. You review your life. You wonder about your own death."*

*"Somehow after losing patients, you realise … err … these experiences make you realise that you just … err … as a person, you can just go anytime. A person can die anytime. Maybe it is because I am a doctor. So, I know that life is fragile. That is why I worry more than other people."*

This may result in doctors being overly concerned about the safety of their loved ones, as articulated in the following excerpts:

*"Because I get to see a lot of young people die, I always tell my children not to go out at night and that they should be careful and that they must take good care of themselves."*

*"You tend to become more cautious than other people. You tend to worry a lot. Even my children say that I worry a lot."*

Despite the negative impact of the deaths of patients, some doctors may perceive experiences of patients' deaths as liberating. The loss of a patient may provide some doctors with a sense of freedom from death anxiety. A more positive and philosophical outlook was also conveyed by some participants, as evident in the following excerpts:

"*Death is an unavoidable change which occurs in everybody's life. It is feared by many, welcomed by others and possibly one of man's greatest and most exciting experiences."*

*"Nevertheless, the death of this patient empowered me with a sense that it freed me from my fears of death, myself. It freed me from … err … the fears of another person dying in my hands … err … and it put perspective in terms of how I saw life and the continuum of life and death. Very, very liberating!"*

*"I do not fear death as a person and as a doctor. We are all going to die someday. Experiencing other people's deaths fascinates me. That's why I don't fear death. Experiences of patients' deaths help me to deal with my own death anxieties."*

Medical doctors working with trauma patients are forced to examine and confront issues of finitude and death. Perhaps the most salient issue that doctors working with trauma patients must confront is their own mortality.[33] Most individuals do not face the inevitability of their own death, but live their lives using a system of denial and vulnerability.

## Conclusions

This study, although descriptive, contextual and exploratory in nature, brings new information to the literature on patient-bereavement among medical doctors. The analysis of data revealed that working in an emergency unit and dealing with trauma patients are features that may make a doctor susceptible to a traumatic-grief syndrome.

It appeared that a number of doctors reacted to the deaths of patients with symptoms of trauma, grief and general psychological distress. Many of the stories narrated by the participants reflected sadness, helplessness, guilt, anger, blameworthiness, recurrent thoughts about the incident, perceived incompetence, the difficulty of facing mortality and death of a paediatric patient as well as stressors in their work environment.

The number of patients' deaths and the recency of the death were found to be associated with bereavement or psychological distress. Some doctors may be at risk for personal and interpersonal difficulties brought on by delayed or unresolved grief. The experiencing of many patients' deaths was related to an avoidant response. Avoidance is posed by the researcher of this study to represent denial, detachment, desensitisation or minimisation to the many deaths that doctors experience. Several doctors relied on their religious beliefs for strength, support and acceptance of the loss.

Furthermore, participants asserted that they found it difficult to cope with the families of their patients. Most doctors did not really know what the needs of the grieving families were or what these families expected from them in this time of crisis and perceive it as stressful, yet it is of paramount importance in emergency medicine. From the study, it was concluded that doctors need enhanced training in communication skills and communicating death to the patients' families. Bereavement counselling and debriefing ought to be available to provide them with an opportunity to share emotional responses and reflect on the patient's fatality.

## Recommendations

Based on this study, the following recommendations are made:

- A "death and dying" course should be offered to medical students and doctors. The objectives will be to identify and articulate feelings about death and to assist them in identifying and talking about their feelings in relation to death and dying.
- Access to a psychologist in the accident and emergency unit is critical. There should be debriefing sessions with the psychologist after occurrence of patient demise. Attending debriefing sessions should be as standard as filling out a death certificate. Debriefing can also provide an opportunity for the doctors to talk about work and personal issues, to resolve worries, discuss insecurities, offload experience, share emotions and get reassurance that everything was done.
- The management of the emergency unit should consider the possibility of having more staff members and proper equipment to manage the workload.
- Self-care strategies, including getting enough sleep, meditation, proper nutrition, exercise and maintenance of social support, will assist in dealing with compassion fatigue.

## Study limitations

The findings of this study cannot be generalised due to the small sample size, but the information generated by the nature of the study design provides rich and relevant information on the phenomenon studied.

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