Countdown

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"Blood pressure 120/87, heart rate 95, respiratory rate 22, O_2 sat 94%."

"Blood pressure 95/70, heart rate 68, respiratory rate 16, O_2 sat 81%."

These words filled the silence of the operating room (OR). They started the moment Ms. Thompson was taken off life support in her nearby room in the intensive care unit (ICU) and continued until she was brought into the OR. This was not at all what I expected of my first experience with patient death. I had envisioned an elderly patient on an inpatient ward, surrounded by family. I had imagined there would be ample time to comfort the family while they grieved after the patient had passed. This was nothing like that. This was unique, and had a distinctive sense of sadness, chaos and excitement all at once. This was an organ harvest.

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It had been a long few weeks for Ms. Thompson and her family, as they grappled with the difficult decision to withdraw life support. She fought for as long as she could, but her death would be one of great generosity: offering what she could to save a life as she lost her own. As a medical student, I knew what organ donation meant in a theoretical and distant sense: a patient dies and gives organs to others who need them. It seemed simple enough. But as those vital signs sounded in the OR, I quickly realized it was not simple at all. Unbeknownst to me, in order for a liver to be viable, there is a strict 30-minute window from the time the patient is taken off life support until the time it must be fully removed from the body. However, once life support is withdrawn, death is not immediate. From that moment forward, the countdown began.

"Blood pressure 30/10, heart rate 17, no respiratory rate, O_2 sat 22%."

It felt surreal. I was in the OR, with the whole team standing ready, while Ms. Thompson lay in the ICU next door, surrounded by her family. And as I waited, I listened. I listened as the ICU nurse read Ms. Thompson's vitals over the speakerphone every minute, each number marking her slow decline into death. I could not see her, yet I was present for her last moments of life. However, this wasn't a moment of sadness or grief as I had expected. Rather, I felt a paradoxical — and maybe inappropriate — sense of anxiousness for death to come. The numbers were slowly trickling down, as the elapsed time seemed to be speeding toward the 30-minute mark. My heart started to race as a thought crossed my mind: *This isn't happening fast enough. We aren't going to get the liver out in time*. Immediately, I felt a heavy curtain of shame overwhelm me. I realized that in that moment, I was really thinking, *she needs to die faster*. Those numbers weren't just numbers. I was listening to her death over the speakerphone.

"Blood pressure undetectable, heart rate undetectable, no respiratory rate, O_2 sat 4%."

By the time Ms. Thompson was brought into the OR, her liver was no longer viable. The urgency had passed, but it came with a sense of disappointment and loss, knowing there would be a patient waiting excitedly for a new liver — but none would come. Nevertheless, we worked through the night to procure as many of her other organs as we could. Whatever feelings accompanied witnessing Ms. Thompson's death would have to wait; the task at hand was far more important.

As I stood before the lifeless patient, I made a conscious effort not to look toward her face. Though I wanted to see and

acknowledge the woman giving pieces of herself away, it simply felt easier to dissociate if I could and focus on the surgery rather than the person in front of me.

The culture of medicine has created an unspoken expectation that there is no place for a physician's emotion. We are constantly reminded to validate our patients and empathize with their feelings; however, we are seldom taught to acknowledge our own, and we rarely see our senior staff — those we strive to emulate — acknowledge their feelings either. Within the medical community, we are able to objectify even the most intimate of circumstances.

Ms. Thompson's imminent death was, in those moments, represented only by a set of four numbers. Her life and donation were acknowledged by a mere 10 seconds of silence. It felt unfairly short, given the significance of the situation. Internally, I experienced a surge of emotions, but I put them aside. I maintained a rather indifferent, professional composure as I listened to the surgeons, ensuring I demonstrated adequate interest in their teachings. After all, they said this would be the best anatomy lesson I would ever receive. Yet, my innate emotions lurked as the night wore on. They were at odds with my conscious thoughts, as I told myself to set them aside to focus on learning. I looked around the room and saw faces of competent, focused surgeons, entirely detached from the patient in front of them. It almost felt insensitive — yet, at the same time, necessary.

In moments such as these, perhaps our role as physicians is not to become emotional or grieve with the family. Maybe our role is not to sympathize or become distressed when the organs we tried so hard to obtain can no longer be used. Maybe physicians have the most challenging role of all. Not only must we force ourselves to be distant, we must also know when this is the right course of action. We must choose to set aside the fact that this patient just breathed her last breath and the fact that her family is weeping in the next room. Because in that moment, we need to focus on doing all we can do honour her last wish.

As medical students, we often feel the need to tough it out, to meet expectations and appear resilient. We keep going as though we have no limitations — but we do. We perform an organ harvest, and receive the next consult inside of a minute. We pronounce a patient dead, then continue on to the patient in the next room. We carry on as detached as we can, but we do not go unaffected. For staff and students alike, a career in medicine carries weight; how we choose to handle that weight will affect how we practise. We cannot separate the patient from the medicine. There is no perfect recipe or equation telling us how to balance the algorithms and facts with the personal and social aspects of medicine. There is no rule telling us when to relegate our feelings to the sidelines, and when they are actually critical to patient care. The balance between objectivity and vulnerability is an art that is never taught and can be learned only by dedicating time to reflection and introspection.

As I continue my training, I don't know if it will get easier to manage the depth of sadness that comes with the pain I see every day. However, I have learned that whether physicians take a moment in the midst of a situation or spend a longer time reflecting after the fact, acknowledging our emotional response to what we do is part of what keeps us going, keeps us connected to our patients, and keeps us human.

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This article has been peer reviewed.

For the purpose of confidentiality, the patient's name was changed and details were kept to a minimum.