Being like Mike — Fear, Trust, and the Tragic Death of Michael Davidson

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Around 11:00 a.m. on January 20, 2015, Stephen Pasceri arrived at the cardiovascular center at Boston's Brigham and Women's Hospital, where he had an appointment to speak to Michael Davidson, a 44-year-old surgeon who had performed valve surgery on Pasceri's mother a few months earlier. Davidson entered an exam room and greeted Pasceri, who fired two shots at the surgeon at close range before killing himself. A team of Brigham surgeons spent 9 hours in the OR in a futile attempt to save Davidson's life.

It was speculated that Pasceri "had some issue" with his mother's medical treatment. Though she had survived the surgery, she had soon developed complications, perhaps in part related to her underlying lung disease. She'd been admitted to a different hospital, where she'd had a pulmonary hemorrhage after being extubated. Apparently, she'd been on a medication whose side-effect profile included pulmonary bleeding. These facts might have led Pasceri to blame Davidson, according to Pasceri's brother: "He was the surgeon," the brother told the *Boston Globe*. "I don't know if he prescribed it, but he must have OKed it."[1]

Nearly a thousand people attended Davidson's funeral. Standing at the back of the synagogue, I met an anesthesiology resident who, like Davidson, had three children — a similarity that gripped him. He'd been assigned to the OR the day that Davidson's colleagues tried to save him, and he marveled at the way people from all walks of hospital life had engaged in that shared effort. Neither of us had brought tissues to the funeral, and when the tears began flowing, the anesthesiologist said, "It's OK — just let them fall."

Davidson's widow, Terri, described her husband as "Mr. Fix-It." The previous week, their refrigerator had broken; the repairman declared it unfixable and left. So Mike took the whole thing apart, she said, and reassembled it, rendering it as good as new. That refusal to accept that some things cannot be fixed characterized Davidson professionally as well: he pioneered techniques of cardiac surgery and interventional cardiology for patients with complex cardiovascular disease who were too frail to withstand more invasive surgical approaches — aiming to help people who might otherwise be told, "There's nothing more we can do for you."

In the days after Davidson's death, fear pervaded the medical community. Countless people told me about threatening patients, about people who had to be restrained or who were angry about an unreturned phone call, a cancer discovered too late, a side effect of a medication. One physician friend told me that her ongoing concern about her husband's vulnerability at his small clinic had now been generalized to all physicians: "We are all so vulnerable. There is nothing to protect us."

At the funeral, Davidson's best friend, a Chicago neurosurgeon, said that the day after Mike's death, the fiancée of a deceased patient whom he'd cared for showed up at his clinic wanting to speak with him. Alarmed, he went out, unsure what to expect, given his friend's experience the day before. The woman was waiting for him with flowers and hugs, there to thank him for his care.

I'd like to think this anecdote is much more representative than the murder, which will linger far longer in our minds. After all, violence against physicians, though common in countries such as China, is relatively rare in the United States. One study, for instance, found that between 2000 and 2011, about 154 "hospital-related" shootings occurred[2]; physicians were victims 3% of the time, and nurses 5%. The violence that does occur is most common in emergency departments; in one survey of emergency physicians, 28% reported having been physically assaulted in the previous year.[3] But though most physicians can name colleagues who've been targeted, data from the Bureau of Labor Statistics suggest that the incidence of homicides at general medical and surgical hospitals is similar to that in lawyers' offices and lower than the rates in hotels, real estate offices, and government work-

places. If we overstate the problem of violence against physicians, we risk grasping for solutions that may cause more harm than good: Metal detectors? Armed physicians?

The need to seek meaning in tragedy is fundamentally human, and yet the impulse to find reasons where there are none is as dangerous as it is therapeutic. Isn't that, in a sense, the root of our problem? That when something bad happens, we assume there's a cause that can be remedied, that someone is accountable? We are trained to ask ourselves, Where did I err? How could I do better? We are told that some 98,000 patients die in the United States each year because of medical errors.[4] But in focusing on ridding hospitals of error, are we denying the public a critical distinction? A mistake is not the same as a bad outcome. Sometimes there is no reason but life itself, which one day must end.

Chesley "Sully" Sullenberger, the pilot who landed his failing plane safely on the Hudson River in 2009, has become a patient-safety advocate, seeking to apply principles of aviation safety to our health care system. Asked to comment on a child's death from sepsis in a New York hospital, Sullenberger said, "Some in the medical field look upon these deaths as an unavoidable consequence of giving care. But they're inexcusable and unthinkable."[5]

Yet the analogy between airplanes and hospitals is seriously flawed: people don't get on airplanes because they would otherwise die. Of course we should strive as hard to keep our hospitals safe as we do to keep air travel safe. But the comparison creates an impossible expectation: that no one should die.

At Davidson's funeral, his friend and colleague Andy Eisenhauer, riffing on an old ad for Air Jordan shoes, explained how we should "be like Mike." In our era of publicly reported outcomes, Davidson took on the highest-risk patients. In a clinical environment intent on increasing efficiency, he willingly gave patients his time. In an academic setting where careers are made by publishing in one's field, he set up shop with the interventional cardiologists, aiming to advance clinical care. Working with Eisenhauer, Davidson sought a cultural shift: surgeons and cardiologists collaborating to extend lives in cases that others deemed hopeless.

There has long been an implicit understanding between the profession and the public. We have agreed to do all we can, while also recognizing when no more can be done. We will always strive to do better, but sometimes we will fail. Somehow, though, the public's trust in our best intentions seems to have slipped away. How can we convince patients that we are all on the same side? The stories that suggest otherwise cannot be untold. But when opportunities arise, we can at least tell those that might restore that trust.

One such story is that of a 5-year-old who declares he wants to be a cardiac surgeon and never looks back. Years later, at 2:30 in the morning, he sits for an hour with a patient's son and says, "Tell me about your mother." After a friend of his ruptures a patient's aortic annulus during a procedure, he operates to try to save him. When the patient dies, he tells the family that the death is his responsibility.

Tragedy can have meaning without having reason, and that's as true for us as it is for our patients. To seek reasons for the tragic loss of Michael Davidson is to become afraid. To seek meaning is, in a sense, to do the opposite. To be like Mike is to fear not threats to one's own safety, but the possibility of hurting others and of failing to sustain life when there is still life to be sustained. And it is to help our patients make meaning of their losses. Insofar as these have always been physicians' goals and values, finding meaning in this tragedy will mean not changing at all.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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