A PIECE OF MY MIND

The Things We Have Lost

Jennifer A. Best, MD
Office of Graduate Medical Education, University of Washington School of Medicine, Seattle.

Before you know kindness as the deepest thing inside, you must know sorrow as the other deepest thing.
Naomi Shihab Nye

When most people consider the grief endured by physicians in training, they look first to the devastating narratives of patient care—sudden illness, agonizing decline, putrid decay, untimely death, haunting errors, and crushing uncertainty. Even more than a decade from residency, I am pierced by these tragic moments and faces—each still heart-shatteringly vivid. Recognizing the direct emotional toll of patient care, medical educators in some training programs have earmarked time for death rounds,[1] Schwartz rounds,[2] or narrative medicine[3] sessions. Many of these interventions are deployed in high-intensity settings within the clinical learning environment where residents wrestle daily with ethical dilemmas or end-of-life dynamics.

Where physician well-being is concerned, I offer that these curricular endeavors are a natural starting point, but may not represent a complete solution. With distance from my own training and countless meetings with residents as mentor and advisor, I am less sure that these charged patient encounters underpin the burnout and depression epidemic in the graduate medical education community. Rather, my residents' personal stories suggest that initiatives to improve physician wellness must address other forms of grief and loss that are no less inevitable, but less overt. We enter the field of medicine steeled to the fact that some of our patients will die. However, many of us may be less prepared for the reality that parts of ourselves will also die in the process. Although we may not recognize these sacrificial "deaths" as such in the moment, these losses are deeply visceral and their effects additive:

- Forming close-knit clinical teams each month that disband without a proper acknowledgment or good-bye.
- Being asked by family to provide medical advice for an ill relative and finding no space in that role for personal sadness or the intense anxiety of "impostor syndrome."
- A romantic relationship whose future success lies with the computerized Match algorithm.
- Hoping to become pregnant with a "ticking clock" but ovulating while assigned to a week on a night rotation. Again.
- Absence from "unique and unrepeatable" events—holidays, birthdays, weddings, and funerals.
- Vigorous and repeated bedside challenges to one's core ethical, moral, and spiritual framework.
- Strain in longtime friendships related to years of sustained unavailability, compounded by geographic distance.
- The sad recognition that months have passed since you've played your cello.
- Lamenting deterioration in one's physical body that has accumulated in the wake of sleep disturbance, quick meals, little exercise, and delayed health maintenance.

Each anecdote is an intimate door to the heart—closed quietly, dutifully, and without fanfare. Each reflects a loss that transcends clinical rotation, duty hours, or patient population. In moments when I am allowed to truly see, I see longing in their eyes.

Yet in light of life and death, hardly worth mentioning, right? *Wrong.*

In a session on physician well-being at this year's Accreditation Council for Graduate Medical Education conference, 50% of polled attendees had experienced at least one institutional suicide. One of the resident panelists shared the story of his medical school roommate who unexpectedly ended his life: "He believed he had been blessed," he said, and as the story unfolded, I came to believe he had been. He had boasted a supportive family, innate talent, a close-knit social community, and the opportunity to train at an elite institution. Although some may say blessed, others *fortunate*, I believe that most of our trainees would say the same of themselves to varying degrees. Most are humbly aware that along the road of medical training, they have benefited from family support, financial assistance, mentorship of leaders within the medical community, and perhaps a measure of luck. In the face of escalating personal distress, they tell themselves, not inappropriately, that they are the privileged few.

First-world problems, they say. *Who am I to complain?*

They carry that sentiment from the preclinical years to the bedside, where they sit eye-to-eye with patients. With trembling hands and voices, they learn to break bad news and do so regularly, seemingly always to the nicest of people. They learn to hold space for families in despair and deal haltingly in uncertainty. They discharge chronically ill or addicted patients without homes to the street. Day after day, residents experience firsthand the arbitrary nature of life and death and exist within the thinness of the line between. They, as I once did, stand before the ravages of disease and think:

It could be so much worse.

And they are right—it could always be worse. Nowhere is this more palpably observed than in the practice of medicine. I read an ancient proverb that says, "I was unhappy about having no shoes until I met the man who had no feet." But because of these stark and constant comparisons, heartbroken residents remain silent about their personal pain. And when on occasion one chooses death as the better way, the community is horribly saddened, vowing to do better: "How could we have known?" we say. "We didn't know."

Corresponding Author: Jennifer A. Best, MD (jabest@uw.edu).

Section Editor: Roxanne K. Young, Associate Senior Editor.

But as physicians, we should know this: if we compare our grief and loss to patients', theirs will win every time. As physicians, we are taught—we *promise*—to put them first. But grief and loss—theirs, yours, and mine—cannot be quantified, nor should they be compared. They are either present or absent. Many of us who are older have come to count the cost of many not-so-small good-byes demanded along our own paths. Sometimes, we step into this awareness after a more acute loss—as I did in the wake of my father's unexpected death. It is a daunting task, then, to reopen these doors of our hearts—to become reacquainted with need and, less comfortably, with desire—that for which we hope. *We cannot hope with our patients if we have forgotten how to hope for ourselves.*

The process of stepping into a new identity, physicianship included, always necessitates a farewell of sorts to the self that preceded it. Every beginning requires an end—a loss by definition. It has been said that "ending well" requires not only celebrating elements of transition that bring joy and opportunity, but also acknowledging aspects that have brought pain. Please do not misunderstand; there are few beginnings brighter than medical training, and I do not believe there is a nobler calling. Even knowing firsthand the ways in which the system fails patients and health professionals, I would choose medicine again. There is stunning beauty that accompanies the care of the sick; it is immensely satisfying and impactful work. But it comes at a price.

Let's name what is true. Let's name those places where our oath to come alongside patients on journeys of illness and health has brought heartache or regret. Let's give voice to our grief, mark it with tears, and, most importantly, own it as absolutely unique and worthy of time and honor. Should learners reflect on patient-related trauma? Yes. As a community, should we think carefully about how to cultivate resilience? Absolutely. But let's not apply the term in a manner that implicitly asks trainees to pull themselves up by the bootstraps or minimizes the impact of deep identity losses occurring parallel to patient care. Protecting space and time for our junior colleagues to mourn personal losses alongside our own is worthwhile work. As caregivers, minimizing our private grief and vulnerability deprives us of an opportunity to forge deep experiential bonds with the patients we serve. As educators, doing the same risks sending a perilous message to a talented generation of young physicians whose eyes are collectively trained on our every move.

Conflict of Interest Disclosures: The author has completed and submitted the ICMJE Form for the Disclosure of Potential Conflicts of Interest and none were reported.

1. Smith L, Hough CL. Using death rounds to improve end-of-life education for internal medicine residents. *J Palliat Med*. 2011;14(1):55-58. doi:10.1089/jpm.2010.0190

2. Lown BA, Manning CF. The Schwartz Center Rounds: evaluation of an interdisciplinary approach to enhancing patient-centered communication, teamwork, and provider support. *Acad Med*. 2010; 85(6):1073-1081. doi:10.1097/ACM.0b013e3181dbf741

3. Campo R. A piece of my mind. "The medical humanities," for lack of a better term. *JAMA*. 2005; 294(9):1009-1011.