Why Doctors Need to Mourn

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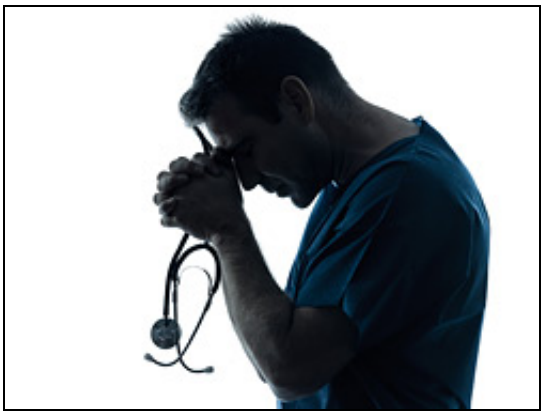
Whitney You, MD, stared at the baby girl lying on the warmer in the NICU.

"She wasn't alive anymore, and I just couldn't stop crying," she says. For the first and only time in her career, You, an assistant professor of obstetrics at Northwestern University's Feinberg School of Medicine, couldn't conduct her rounds.



Although she had lost babies before and the experience was invariably wrenching, this loss felt even more profound and personal. You had grown close to the family during the mother's high-risk pregnancy and had recently given birth herself. She understood the family's lost hopes and dreams and their tremendous pain. "A social worker came in and said, 'I think this is just too close to your heart right now,'" recalls You.

Society has words for people who lose their family members. They become widows and widowers and orphans. "But society doesn't talk about babies who die," You says. "There is no term for a parent who loses a child."

One might argue that there's a similar linguistic gap in describing the physician's experience of patient death.

As concerns about physician burnout mount, the experience of physician loss and grief is getting more attention. Experts say the research and resources are welcome and long overdue, but they're quick to point out: For physicians to heal, they have to take off their armor.

Detachment and Its Price

Most doctors say their medical training didn't prepare them to deal with patient loss.

"The mantra in medical school was, 'See one, do one, teach one.' That's how we were [taught to] approach procedures and dying as well," says Prateek Mendiratta, MD, an oncologist and assistant professor at Case Western Reserve University School of Medicine. "We watched attendings deal with dying and end-of-life discussions, and we had to learn to show up for work the next day."

Mendiratta's experience is far from unique. Doctors have long talked about the need for emotional boundaries in medicine. In a study of 20 Canadian oncologists conducted in 2010 and 2011, Leeat Granek, PhD, associate professor at York University's School of Health Policy and Management in Toronto, Canada, along with a team of researchers, found that physicians wrestled with feelings of grief but masked their emotions rather than appear weak or unprofessional.[1]

However, that stoicism affords doctors far less protection than they think: More than half the participants in the study reported feelings of failure, self-doubt, sadness, and powerlessness, and a third reported feeling guilty, losing sleep, and

crying.[1]

Stoicism can also negatively impact a doctor's ability to treat a patient and interact with the patient's family. Some of the oncologists in the study by Granek and colleagues[1] said their feelings distracted them or caused them to become more or less aggressive in treating other patients. Half said their feelings caused them to distance themselves from dying patients.

In a separate study of 535 Canadian medical oncologists, radiation oncologists, and palliative care physicians, published in the *Archives of Internal Medicine*, physicians who reported a feeling of failure after a patient death and those who preferred to not show emotions were less likely to attend a patient's funeral, write a note, or call the family after a death.[2]

The problem, says Evangeline Andarsio, MD, national director of The Healer's Art, a curriculum developed by Rachel Naomi Remen, MD, for first- and second-year medical students that explores the human dimension of medicine, is that too many doctors interpret "professionalism" and "compartmentalization" to mean putting their emotions in a little black box on a shelf.

We are human and we witness a lot of suffering and death in our profession, and there must be ways to process it at appropriate times.

"There's an attitude among doctors that you can handle anything. It almost makes you almost think John Wayne was the father of medicine," she says. "But the bottom line is that we are human and we witness a lot of suffering and death in our profession, and there must be ways to process it at appropriate times. Yes, there's a need for compartmentalization, but you have to acknowledge that the grief is there, and you have to work through it. You can put it in a box temporarily, but you have to take it out and work through it."

Physicians who tuck away unresolved grief are more likely to suffer burnout or turn to dysfunctional coping strategies, such as avoidance, denial, anger, drugs, or alcohol that, according to Andarsio, "may temporarily numb pain but won't heal loss."

Alan Wolfelt, PhD, founder and director of the Center for Loss & Life Transition and a faculty member of the University of Colorado Medical School's Department of Family Medicine, says grief is an internal, emotional response to loss, but unless physicians find a way to express those emotions, they risk becoming "physician functionaries," unable to fully engage with their patients and their families.

Walking the Razor's Edge

That's not to say that physicians need to wear their emotions on their sleeves. Wolfelt notes that some physicians may want to express their grief privately by observing a few moments of silence and reflection, journaling, or lighting a candle. According to Andarsio, others may need more psycho-social support, particularly when their grief is complicated by the fear of a lawsuit, hurt over a family's anger, or guilt that they might have failed in some way.

"Grief and loss aren't a one-size-fits-all experience," notes Granek. "Individuals are different in what they want and what types of interventions they think would be helpful. Some want more training to help them deal with their emotions, others want more vacations and sabbaticals to restore themselves, and many simply want validation that grief is inextricably embedded into their work," she says.

Physicians walk "the razor's edge between life and death," adds You, and the healthcare system is only beginning to explore ways to help them keep their balance.

For example, many medical schools have incorporated electives such as The Healer's Art into their curricula, and practicing physicians have access to bereavement training sessions such as those conducted by Wolfelt. Some professional associations, such the American Academy of Pediatrics, which launched its "Resilience in the Face of Grief and Loss Curriculum" in 2016, have introduced programs to help their members.[3] Hospitals and health systems are becoming more proactive as well by offering support services, holding debriefings in certain circumstances, and sponsoring periodic memorial services.

Many doctors are taking it upon themselves to explore the issue independently. You said reading Remen's *Kitchen Table Wisdom: Stories That Heal* helped her develop some insights, and she now incorporates writing prompts and "moments of

humanity" into her work with medical students and residents to help them address the emotional aspects of medicine.

Mendiratta launched a book club at his hospital. The group recently read *When Breath Becomes Air*, neurosurgeon Paul Kalanithi's memoir about his battle with terminal cancer, and used it as a springboard to discuss their own experiences. So far, he laments, "Only the nurses have come. They get connected to these patients. A nurse came up to me and said it was really helpful. I think the physicians would benefit too, if they could take off their armor."

Finding Their Way

Despite the emergence of formal programs, many doctors say the most valuable lessons they've learned have been informally from the people around them.

"I gravitated toward oncology because I saw really wonderful attendings at the bedside who showed patients so much compassion at death," recalls Mendiratta. "I would lean on them and ask, 'What do you do at night? How do you cope?'"

Over a cup of coffee one attending said simply to Mendiratta, "I sit down and cry. This is human." Another told him, "You go home and you hug your kids, and you put your life into perspective." A third said he would go into a quiet room, turn off the lights and reflect on one positive interaction he had had with the patient or the family. "Don't ever shortcut that moment," he advised.

Mendiratta says that guidance, professional counseling, exercise, and attention to self-care have all helped him process his grief. However, the most important lesson came just a few months into his medical career when he was reminded that true care isn't necessarily curative.

"I was talking to a patient's daughter about additional chemotherapy and clinical trials and she asked, 'Doctor, have you ever talked to my 84-year-old dad about what he really wants?'" Mendiratta was shocked to realize he hadn't. "I sat down with the man and asked him what he wanted most so that I could try to help him achieve his goal. He said, 'I love to fish. My granddaughter is getting old enough. I want to make it to summer so I can fish with her.' If I'd have given him more chemo, he would have been too weak to take his granddaughter fishing."

Vital conversations lay the groundwork for patients to set their personal goals, which is essential to patient autonomy, according to Mendiratta. Yet it also provides succor for the living. Helping patients achieve what is most important to them enables caregivers to celebrate victories rather than endure defeats.

"The care of the patient doesn't end when we can no longer 'do something' for them," says You, who attended the funeral of the baby girl who died in the NICU and cared for the mother years later when she gave birth to a healthy baby boy. "We need to do for them not as a patient but as a person. It's a privilege to walk with families in the midst of bad outcomes."

Inhabiting that privileged space is hard, she notes, and grief is a natural, unavoidable part of it. Even for the doctor.

"Some people may feel guilty—that it's not their grief to hold—but you need to feel what you feel," she says.

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