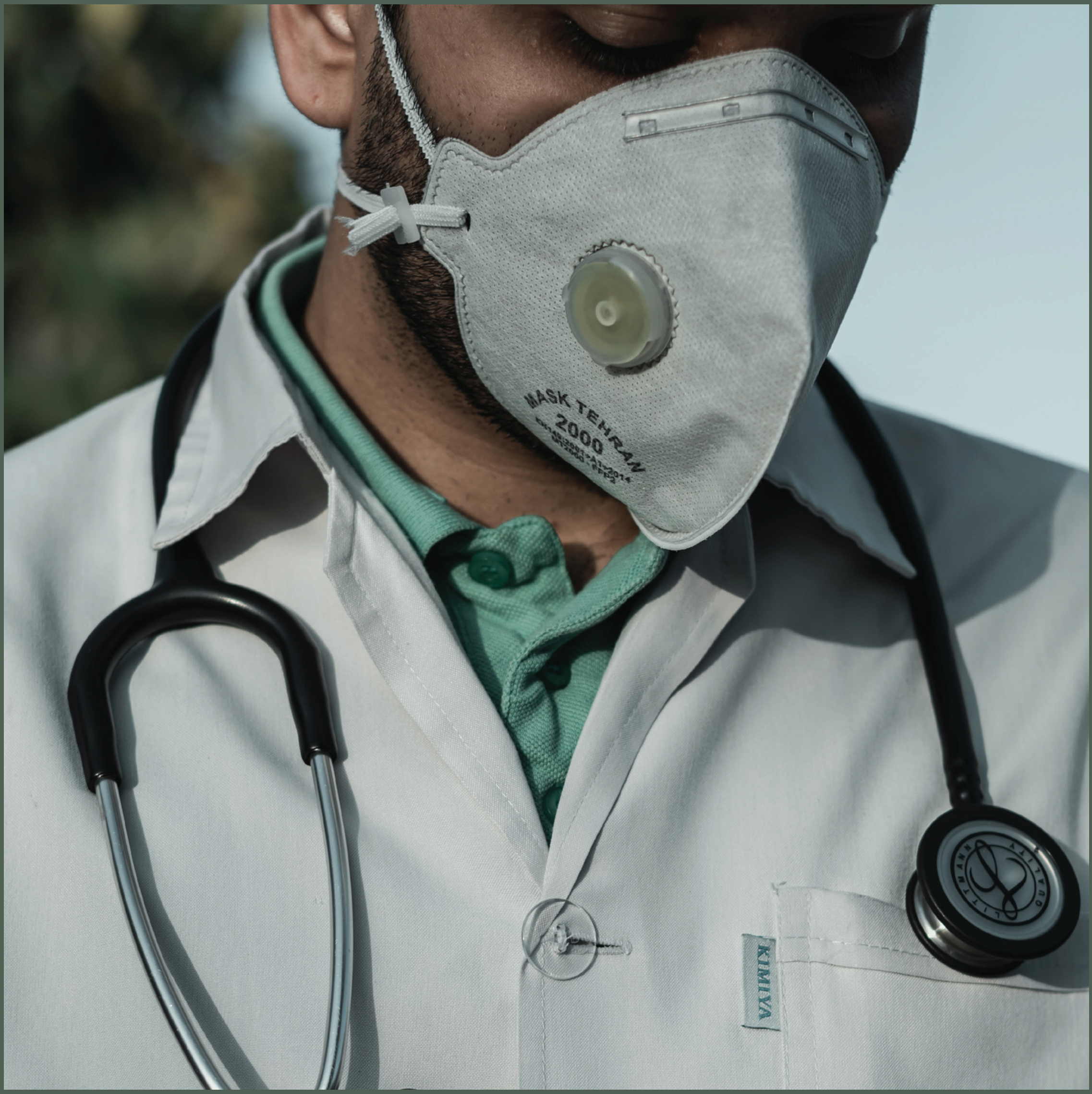
VOICES

PERSONAL STORIES FROM THE PAGES OF NIB

Grieving on the Job:
Stories from Healthcare Providers



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Introduction
Grieving on the Job: Stories from Healthcare Providers

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Abstract. Grief, defined as the experience of a significant loss, is a common experience in healthcare, not just for patients and their loved ones but also for healthcare professionals. In this symposium, we have gathered stories from professionals involved in patient care who report their experiences of grief on the job. Our authors come from the disciplines of medicine, nursing, social work, and chaplaincy. They represent a range of experiences, from students early in their training to experienced clinicians looking back on careers in the healing professions. Many report on what helped them integrate their grief experiences into professional growth. Many also acknowledge that struggle for integration is ongoing. We also have four expert commentaries on these narratives provided by Heidi Walsh (ethics and narratives), Tai Mendenhall (psychology), Debra Oliver (social work), and Erin Bakanas (hospice and palliative medicine).

Keywords. Delivery of Healthcare, Grief, Guilt, Honor, Medical Students, Narratives, Physicians, Privilege, Virtue

Introduction

Grief, defined as a reaction after a significant loss (American Psychological Association, 2018), is a common experience in healthcare. Professionals in patient care regularly bear witness to grief in their patients and their loved ones. While the loss of a life is the most prominent stimulus to grief, death is not the only loss that provokes grief. The recent COVID-19 pandemic brought grief to our common experience in many forms. We grieved not only the loss of lives but also the loss of health with the uncertainties of long COVID. We grieved the loss of jobs and careers. We grieved the loss of financial security and plans and hopes for the future. We grieved the loss of community, experiencing the necessary social distancing as both a remedy and a symptom of the virus. And healthcare professionals were faced with grieving the volume of patients, the burden of the disease, the shortages of medical equipment and supplies, and the isolation that all characterized the pandemic.

Recent work, stimulated by the grief challenges of the pandemic, has turned toward shaping both the understanding of and the antidotes for grief among healthcare professionals. Unresolved grief is a significant risk for healthcare professionals, especially when dealing with the trauma of critical illness. While compartmentalization may help one get through the demands of the day, it also creates a higher risk of moral distress and burnout (Wallace, Wladkowski, Gibson, & White, 2020).

In particular, there is a renewed focus on the promotion of self-care amongst healthcare professionals. This is not a new concept for the caring professions, but the challenges of the pandemic have forced a refinement and a reinforcement of the value of self-care. A case study on physician self-care published in 2009 by Kearney et al. is meaningfully subtitled "Being connected. . . . a key to my survival." The authors note that highly motivated healthcare professionals are at high risk for developing a "psychology of postponement" as they pursue professional accomplishment, which may result in compromise of personal "sources of renewal" like significant relationships. Practical recommendations for promoting self-care include personal practices, like mindful meditation and reflective writing, but also environmental guardrails like a sustainable workload and adequate supervision and mentoring.

In many ways, this recognition of the challenges of grief and the need for self-care for healthcare professionals represents a return to the foundational values of the healing professions. Callahan (1999) wrote that the primary goal of medicine is patient care focused on prevention, healing, and palliation. There has been renewed interest in the virtues of the professions, in particular, a call to recognize humility as a response to concerns for "unenlightened self-interest" driving unprofessional behaviors (DuBois, Kraus, Mikulec, Cruz-Flores, & Bakanas, 2013). In practice, humility requires self-awareness and empathy, as well as a sense of patient care as a profound privilege. Healthcare professionals also deserve to experience prevention, healing, and palliation even as they deliver these priorities to their patients.

The Call for Stories

We sought stories from healthcare providers who have personally experienced grieving on the job. People working in healthcare often deal with death, dying, tragic outcomes, or other significant losses as part of their job. They work in busy and challenging environments that can make dealing with grief effectively even more difficult. Talking with colleagues about grief can be awkward. Healthcare providers may feel hesitant to do so because they fear judgment or the perception that they are weak or unprofessional; however, talking about grief can reduce distress and increase wellbeing and job satisfaction.

Authors were asked to consider the following questions:

- What event occurred that caused you grief?
- How did you respond to this grief? What were the effects of your response? How did your response impact the quality of your work?
- How did past experiences inform your actions in this instance?
- If you spoke to others about your grief, how did they respond? What was helpful about their response? What was not helpful?
- What have you done to cope with your grief? How was this helpful? What could have been improved?
- How would you advise someone faced with a similar situation?

The editors of *Narrative Inquiry in Bioethics* published the call for stories in the *NIB* newsletter and on the *NIB* website. Additionally, the call was posted on several social media platforms, including LinkedIn, Facebook, and X (Twitter). It was distributed through the American Society for Bioethics (ASBH) and the Medical College of Wisconsin (MCW) listservs, through colleagues at Saint Louis University, Washington University School of Medicine in St. Louis, and former trainees, and shared directly with colleagues, family, and friends who work in healthcare.

The Narratives

Here, we share 12 stories from healthcare professionals who have experienced grief on the job, with additional stories available in the online supplement. The authors come from the disciplines of medicine, social work, nursing, and chaplaincy. They also represent a diversity of experience, ranging from students in training to established professionals looking back on their careers. Grief, for these writers, is provoked by a variety of losses—loss of a patient, loss of a family member and its impact on their training, loss through being named in a lawsuit, and loss of confidence in their career choice are some examples. Many authors provide insight into the tools and practices they utilized in effective grief processing. Others acknowledge that their healing is ongoing.

The Commentaries

This symposium also includes four commentaries on the narratives. The commentary authors—Tai J. Mendenhall, Debra Parker Oliver, Heidi A. Walsh, and me—provide unique perspectives informed and enriched by expertise in medicine, bioethics, education of healthcare professionals, health policy, and improving healthcare for vulnerable populations.

Tai J. Mendenhall is a Medical Family Therapist and Professor in the Couple and Family Therapy Program at the University of Minnesota (UMN). Dr. Mendenhall is also an Adjunct Professor in the UMN's Department of Family Medicine and Community Health and works actively in collaborative family healthcare and community-based participatory research (CBPR). He has written about and led workshops on the topic of ambiguous loss.

Debra Parker Oliver is the Ira Kodner Professor of Research in Supportive Care at Washington University in St. Louis. She has a Masters degree in Social Work and a PhD in Rural Sociology. Dr. Parker Oliver has been a Hospice Director and founded two hospice programs. She has more than 200 peer-reviewed research publications on death and dying and is the author of an award-winning memoir on her experience with her husband's death, "Legacies from the Living Room: A Love Grief Equation."

Heidi A. Walsh is a Senior Project Manager at the Washington University School of Medicine, Bioethics Research Center. She manages research projects involving ethical, social, and professional issues that affect healthcare providers and patients. Ms. Walsh co-facilitates narrative education groups with physicians and trainees using excerpts from NIB. As a graduate student, she worked as a patient support associate in the Emergency Department, an experience that sparked her interest in improving the patient and carer experience.

Erin Bakanas received an MD degree from The University of Connecticut in 1987 and completed a residency in Internal Medicine at The Jewish Hospital of Saint Louis at Washington University in 1990. Dr. Bakanas finished a fellowship in hospice and palliative medicine at Washington University in 2019, where she remains a faculty member.

Conclusion

This symposium offers a view of grief on the job by healthcare professionals that honors their dedication as well as highlights the intensity grief brings to the challenges of being in the healing professions. These narratives reflect a generous vulnerability on the part of these authors in relating the emotional force of their encounters. While it is encouraging to read about the successful mitigation of grief by many of these authors, it is also a call to action from those who are still processing their grief. A recent publication proposes a "grounded theory of a five-phase transformative process" by which palliative professionals develop the coping capacity to allow them to experience "inner balance and a transcendent perspective" (Arantzamendi, Sapeta, Belar, & Centeno, 2024). Similar to the NIB authors, this research group notes the value of the interdisciplinary team, a hallmark of palliative medicine. They call for the development of an institutional culture that provides support and educational reforms in undergraduate and graduate training. There is much work to be done.

References

American Psychological Association. (Ed.) (2018) APA Dictionary of Psychology. Washington, DC.

Arantzamendi, M., Sapeta, P., Belar, A., & Centeno, C. (2024). How palliative care professionals develop coping competence through their career: A grounded theory. *Palliative Medicine, 38*(3), 284–296. doi:10.1177/02692163241229961

Callahan, D. (1999). Remembering the goals of medicine. *Journal of Evaluation in Clinical Practice, 5*(2), 103–106. doi:10.1046/j.1365-2753.1999.00201.x

DuBois, J. M., Kraus, E. M., Mikulec, A. A., Cruz-Flores, S., & Bakanas, E. (2013). A humble task: Restoring virtue in an age of conflicted interests. *Academic Medicine, 88*(7), 924–928. doi:10.1097/ACM.0b013e318294fd5b

Kearney, M. K., Weininger, R. B., Vachon, M. L. S., Harrison, R. L., & Mount, B. M. (2009). Self-care of physicians caring for patients at the end of life: "Being connected . . . A key to my survival". *JAMA, 301*(11), 1155–1164. doi:10.1001/jama.2009.352

Wallace, C. L., Wladkowski, S. P., Gibson, A., & White, P. (2020). Grief during the COVID-19 pandemic: Considerations for palliative care providers. *Journal of Pain and Symptom Management, 60*(1), e70–e76. doi:10.1016/j.jpainsymman.2020.04.012

Personal Narratives

Being the Difference

Jake Beery

That day started just like many others. It was a cold, wet day in March spent anxiously answering and reviewing hundreds of USMLE STEP 2 practice questions for my exam just a week away. Except that Sunday would be something different. Looking for any excuse to take a break from my personal mental marathon, I picked up a call from my dad. He had just spent the past six weeks wheeling my mom to near-daily appointments at the Mayo Clinic for treatment of her metastatic ocular melanoma. But now, with them back home, I had hoped for a short reprieve in the story of her cancer journey—for me, and for all of us. Instead, I listened to him explain how, less than 24 hours after coming home, my mom would be entering a hospice house in our hometown. Unable to control symptoms by themselves, my parents made the choice they felt would be best.

Left with more questions than answers, a day later I found myself on a red-eye flight touching down on a snowy Minnesota runway. Inside waiting was the rest of my family, whose happiness to see me was unmistakably weighted down by similar hours of lost sleep. Together we shared as much time as we could with my mom, grateful she was able to meaningfully communicate when most other tasks proved unbearable. And that would be how she passed, surrounded by her closest family. Gone was my mom, my best friend, and the one person who I felt truly knew what it meant for me to be in medical school.

The days that followed flowed in a melancholic blur. While I felt I knew so much about the time before hospice through talking with my mom and reading too many Kaplan-Meier curves, I was lost in the reality of losing a loved one for the first time. But as support poured in, time seemed to ease up. A close family friend who worked with grieving families as part of their profession told me, "In times like these, people will say things that seem strange. That's okay. Just try to listen to how much they care." And listen I did, savoring the minutes-long escape of listening to stories of a life well lived. Each time doing so, I felt the pull from the unknown to a place of unfortunate familiarity. Without much reference to how life feels after the loss of a parent, I cautiously stepped forward to face the rest of life's chores thrown at me.

First came the rescheduling of STEP 2, reworking my study schedule, and yet more practice questions. And with it came my first struggles. While prior to flying home I could answer and review over 150 questions on a good day, I found myself unable to complete more than a single 40-question block. Every ophthalmology, oncology, and critical-care question transported me from the realm of abstract patients back to the beige waiting room of the hospice house. Gone was the joy of memorizing medical minutia. Originally, studying filled me with a sense of pride, furthering my dream of becoming a physician just like my mom had unintentionally inspired me to be. But now I didn't feel any of that. I despised every minute spent with my laptop open. But knowing the weight of board exams on a medical trainee's life, I pushed on. Outside of UWorld questions, I tried to make my world as normal as it once had been. I went on runs, got cappuccinos, and sat with my best friends. I did all the non-urgent things that still felt so important. And while I still desperately missed my mom, multiple-choice questions gradually got easier, and the second chapter of my medical school career came to an uneventful close in a stuffy suburban testing center. And with it came my return to the wards.

As a now 4th year medical student, I was set to begin a month-long rotation on the inpatient palliative care consult team at a busy, tertiary care medical center. As usual, the first day was spent realizing how little I knew about this specialty and, of course, where the bathroom was. I learned, and later began to tell patients as I led consults, that palliative care's niche within medicine was two parts. First, the palliative care team helps patients facing difficult medical situations understand their situation and make choices that best align with their personal beliefs and goals. This could be "simply" a new diagnosis of COPD or deciding between further inpatient surgeries and discharging home to focus on comfort. Their second area of expertise is that of symptoms. Cough, fever, and pain are among the most common, but the list of symptoms they deal with is broad, and so is the list of therapies used to treat them.

"Simple enough," I thought to myself. I had chosen this elective to hone my ability to talk to patients about end-of-life care. And now hearing that I had no byzantine physiology to brush up on was a relief to me. If ever there was a picture in the dictionary for naivete, it surely featured me that day.

So, it was no surprise at the end of my first week that when I met Ms. J, I was knocked down to my knees. I had already read her chart before we walked in. "Metastatic colorectal adenocarcinoma," her notes grimly read. Multiple CT reports showed nearly her whole abdominal cavity was affected by her cancer. Numerous notes of chemotherapy infusions and prior surgeries sat quietly in her chart, en masse telling a story of a long, fraught battle with cancer. But I had seen charts like hers before. What struck me was the person whose story was being told.

Just like my mom, she was in her mid-sixties, married almost 40 years, and accompanied by a husband tearfully seated a few feet away at all times. Now unable to eat due to a blockage in her GI tract, she was faced with the choice of yet more invasive medical interventions or enrolling in hospice. But through it all, she was calm. She and her husband graciously told us what in life mattered to her. Her husband, her children, the friends she made working and volunteering. And all the important, "unimportant" things like the hundreds of baseball games she watched or the quirks of her neighborhood. There was a shift in the room as she talked. She went from a mortally ill patient to a prideful woman sharing the highlights of her life.

"A life well lived," I thought to myself, desperately holding back tears that threatened to soak my paper mask. While she decided with no qualms to enter into hospice care, I found myself again with more questions than answers about what it meant to provide care to patients facing end-of-life decisions. What had she been thinking about in the weeks to months prior to making this decision? What made her point to the decision to shun the offerings of yet more surgery? What was going home going to look like for her? These are all questions I wished I had asked months ago, and again, I was unable to answer as Ms. J was discharged the very next morning.

In the days that followed, she stuck with me. While I tried to continue working as I had been, the change Ms. J had brought to me as a human in medicine was permanent. No longer did a chart belong to "an interesting case of Waldenstrom's Macroglobulinemia," it belonged to a 57-year-old man with a wife and kids who worked in real estate. These were all people first and diseases second—a lesson I had written about in my medical school application essays, but that seemed to be forgotten during my core clerkships as I desperately worked to become fluent in the culture of medicine. I was undoubtedly reminded of the lesson by my position as a learner, where we can explore all that medicine has to give without the ever-approaching responsibility that graduation from medical school brings.

By the time my rotation ended, reflection on it and my first 3.5 years of medical school was bittersweet. I didn't have any regrets, but I was faced with the reality of how much harder medical training was going to be. I wanted to be as good as the staff at the hospice house were at making patients and their families feel safe and cared for, but I wasn't sure what the path to that goal would even look like. And now, in the waning days before my residency match day, I still don't know. But I think that is okay. Just like I don't think I could come up with a definitive list of what makes a physician great, I doubt the great physicians I look up to would be able to give an infallible directive of how to achieve what they have achieved. I think what is more important is the goal itself and the ability to trust the process that we call medical education. As far as I can tell, that is what will make my life in medicine a life well lived.

* * *

Grieving One More Time

Neethi Pinto

> "The deeper sorrow carves into your being, the more joy you can contain."—Kahlil Gibran

I take care of very sick children in the pediatric intensive care unit (PICU). When a child dies, grief strikes in three distinct waves. First, I grieve for the child we couldn't heal, the unfairness, and the complete and utter sadness of a life cut too short. Then, I grieve for the survivors—the families whose lives will be changed forever and who must find the strength to go on. It's not until later, in solitude, that I am able to grieve a third time—this time by and for myself.

As clinicians, we are also survivors. Yet, our culture in medicine rarely affords us the permission or the grace to unpack the depth of the sorrow and grief we regularly witness and suffer. Instead, we must summon up the fortitude to take care of the child in the next room before we can pause and process our grief. As a field, we have been more intentional about having "hot" (soon after the event) and "cold" (days to weeks later) debriefings, but these short conversations about our shared experience are limited. The sheer reality of our day-to-day lives in the PICU is that the next critically ill patient is waiting.

My processing of grief happens when I replay the events leading up to the patient's death over and over and over again. Was there something I missed? Could I have done better? In fact, I teach my medical students, pediatric residents, and PICU fellows that this very questioning makes us better physicians—as long as we don't let our second-guessing or fear of making a mistake paralyze our actions in the future.

Little did I know I would grieve a fourth time . . ."How would you feel if this was your daughter?" These words were harshly spoken by my patient's father, a former police officer, the day his daughter died of respiratory failure. I had cared for her on many occasions during her prolonged admission, including that very sad last day. Undoubtedly, he was grieving, but I could feel his anger when he interrogated me. I wondered if he remembered how he profusely thanked me for caring for his daughter when we first met or the many times our team had resuscitated her, saving her life. I spent countless hours at her bedside, during the day, in the middle of the night, away from my own young family. Sure, these hours—nights, weekends, and holidays—are "part of the job," but I chose a career in pediatric critical care because of a commitment to caring for the most medically vulnerable children—the sickest of the sick—*despite* these hours. As pediatric intensivists, we have a unique opportunity to help children and their families at the most harrowing times in their lives—when they face the possibility of death. Although we know at the outset that some children will not survive, the grief we experience when a child dies still runs deep. It hurts every single time. In this case, my profound grief was exacerbated by the father's hostility. One year later, my sorrow deepened when I answered my doorbell at home to find a police officer handing me a subpoena for a malpractice lawsuit regarding this child's death—a delivery intended to intimidate me. I found myself grieving a fourth time—grieving for the loss of joy—joy that had been central to my identity as a physician.

Then, the feeling of shame crept in and haunted me. I always understood that I entered a high-risk/high-stakes field where children die because of the severity of their illness despite state-of-the-art medicine and technology. Over the years, I've learned that not only is it rewarding to help a child survive critical illness but it is incredibly moving to forge an intense human connection with families when their children are dying. So, my shame was not due to a sense of failure in preventing this child's death but rather due to the dissolution of the relationship with the family. In medical school, we're taught that the likelihood of being sued diminishes if you develop a strong patient-doctor relationship. One of my strengths as a physician was my ability to build trust with my patient's families. Had I failed?

I also felt isolated in processing this grief because we are told by the lawyers who defend us that we cannot discuss pending cases with anyone. It's a secret you have to keep with no confidant. There is no shoulder to lean upon—it's a cross to carry without an end in sight. I had dedicated my life to caring for children and *to saving lives*. Now, I was being accused of actions *causing the death* of a child—accusations that fundamentally cut to my core. I had chosen a career as a doctor not simply as a profession but as a calling to use the life opportunities, education, and skills I had been given for a greater purpose—to help children in dire need. Now I wondered: were the sleepless call nights, weekends, and holidays spent at work, missing everyday events with my family, and the debt worth the sacrifice? Could one angry family irrevocably question my intentions and drain the joy from my work?

Often, in the PICU, we find ourselves on the receiving end of a family's emotions at a time of extraordinary stress; we dig deep within ourselves to find resilience, putting the child's best interest first. This situation was different; the wound was not superficial. Over the next ten years, the other physicians and nurses named as defendants were dismissed. While I was truly thankful that my colleagues were granted reprieve, I felt persecuted. I remembered the father's words: "How would you feel if this was your child?" I read his testimony: "You could just tell who the good doctors were." Only two defendants among the countless clinicians who had cared for the child during her more than 120-day stay in the PICU remained: my fellow South Asian colleague and me. We had been singled out. How could the justice system ignore this glaring fact? How could the family who shared my own faith—one whose central tenants bar bearing false witness—make such claims? The expert witnesses could accuse me of whatever they wanted. I was voiceless.

The hospital reviewed the case and determined that there was no medical wrongdoing. Our lawyers refused to settle the case; going to trial signified that the hospital had unwavering support for the medical care we provided. Malpractice cases move painfully slowly, and the COVID-19 pandemic delayed the trial for an additional three years. During the ten years that ensued since I received the subpoena at my front door, I was obligated to report the claim every time I renewed my medical license. Each time, it stirred up a sense of shame and irrationally made me wonder if my license would be in jeopardy. When I started my new job, I was required to discuss the case with my new Division Chief. I told him this was the worst part of our jobs, but his reply surprised me. He said, "No, it isn't. You want to know what the worst part is? It's when you *actually* make a mistake." My self-pity dissipated; his perspective helped set things straight.

I kept my head up for the next three years until I received an email informing me that a trial date had been set. Suddenly, the trial date had been moved up by a month, and I was told I had to attend the trial in person for an anticipated minimum duration of three weeks—not the two days initially requested. I was overwhelmed. How would I find colleagues to take on my shifts caring for patients in the PICU? And find childcare for my four children for a potentially indefinite period of time, especially with such little advance notice? At that point, the shame resurfaced. The case I wasn't allowed to talk about for a decade was now precisely what I needed to disclose to ask colleagues to cover my assigned time in the PICU and to ask family to care for my children. I also struggled with whether to share this devastating news with my aging parents. In their 80s, did they need to see their own daughter face a malpractice trial? Physicians identify medical malpractice as one of the most stressful life events we experience. I couldn't agree more. I had experienced the stages of grief—denial (How can this be happening?), anger (How dare they ask me how I would feel if this happened to my own child when I had sacrificed so much for their daughter?), bargaining (Maybe, if I had done something differently . . .), and depression (Is being a doctor worth it?). Finally, when I turned to my faith, I found acceptance (I know I did the best I could, keeping this child alive for months).

The morning of the trial, while on my way to the airport, I received an urgent text from my attorney instructing me not to board the plane. When we spoke, he told me the judge had dismissed the case with prejudice. It was finally over and could never be brought to trial again. The depth of my gratitude was unreal. Losing a patient, processing a family's anger, and facing a malpractice suit compounded my grief and had begun to strip away the joy I derived from the practice of medicine. But, in the decade since this child passed away, saving lives as part of a PICU team, witnessing other families' acceptance and peace when faced with the death of their children, and being validated through the litigation process rekindled the deep joy that I will always contain. As a pediatrician, I remain committed to the children entrusted to my care. I will never let grief threaten this purpose and joy again.

◆

Echoes of Grief: Tales from an Emergency Medicine and Critical Care Nurse

Marcia King

Well, I have 42 years of stories from working in ICU and Emergency Medicine as a registered nurse. The first situation that comes to mind on the subject of grieving on the job in healthcare happened about 37 years ago. I had a nice lady in ICU for several days in a row as a patient. She had a bad myocardial infarction (MI) and was critical. We tried all the medications and pain meds, and nothing took her chest pain away. Meanwhile, her husband stayed with her all day, and all night. He doted after her 24/7. He slept in a chair and never went home for about three days, even though they lived just a few blocks from the hospital. I was amazed at what an awesome husband he was.

Finally, after about three days, she fell asleep for more than 10 minutes. She had said her pain was gone. Her husband didn't want to leave her, but he asked me "if it would be okay" to go home and take a shower, eat a sandwich, and get the mail. He explained that he would be right back.

I said, "Sure, now is a good time since her pain is gone and she's sleeping. You must take care of yourself too."

The husband ran out in a hurry. About 10 minutes after he left, his wife suddenly had pain again and a run of ventricular tachycardia, (V-tach), which is a type of abnormal heart rhythm, or arrhythmia. Even though the V-tach stopped on its own, I called the husband and told him to come back because he wanted to be there if anything happened. A few minutes later, she had another run of V-tach, but this time, she coded and died. About two minutes after she died, the husband came running into the room—panicked and crying and talking to her dead body.

He was saying, "I'm so sorry I left you! I shouldn't have left you!" I felt awful because I was the one who told him it was okay to go. Then I was crying with him and for the poor man.

He then left for home, and their doctor (who was a well-known grouch-ass) appeared and saw that I was upset, and he asked me what my problem was. Why was I so sad about it? I thought, "Jerk, you are in the wrong career."

Thinking about that doctor's reaction at the time, I wondered, "WTF is wrong with *him*!" I had known the doctor for several years because his mom was the head nurse of the surgical floor. I thought for a moment and then said to him, "How could you be a decent doctor if that death didn't bother you?" I was in my 20s at the time—a fairly new nurse—and was just starting to be able to feel comfortable speaking up and being assertive.

I just felt so bad for that poor man. I felt terrible that I told him it was okay to run home. He really wanted to be there if something happened to her, and from what I saw, he was an amazing husband to her. Looking back, she probably was waiting for the minute he stepped out to go.

Another time, while working in the emergency department, a trauma alert was called on a patient who came in by ambulance. We were told the woman had fallen off a hayloft while pushing hay onto the floor in her barn. She hit her head bad in the fall. She wasn't my patient, but I ran into the room to help when she arrived. There was a bunch of staff around blocking my view. Without even looking at her, I grabbed her arm to put in an IV as I had done thousands of times before. Suddenly, I noticed it was weirdly quiet. I looked up, and the ER Doc and tech were looking at me funny. Then the Doc said, "Marcia, you know who this is, don't you?"

I didn't, so I looked up at the patient's head for the first time, since I couldn't see it before. Everyone on the team was staring at me in silence. I then recognized that the patient was a nurse who was a good friend of mine. We called her Auntie Helen. At first, my co-workers couldn't figure out why I wasn't saying anything about it being Helen. Oh my goodness, it was terrible. I knew her, and all of her kids. We went on trips with her, and I had even been in that barn where she fell when I helped her take stitches out of her cow. Her daughter was crying in the back hallway on the way to the ambulance bay. She spotted me, and we locked eyes, which was really sad. We spoke briefly before we transferred Auntie Helen to another hospital in the region, but she died there from the head injury. I had to stay at work and finish my shift after that. There was no going home early, no time to mourn, no time to grieve for my friend or her family. I wiped the tears from my cheeks, breathed in deeply, and moved on to care for the next patient.

* * *

Searching for Peace in Death

Laura Wachsmuth

Disclaimers. No funding was utilized for this manuscript. The author, Laura Wachsmuth, has worked at several hospitals. The opinions contained herein are her own. All names have been changed to protect the privacy of the patient and the patient's family.

I first met Ellen when she was admitted to the Women and Infant unit on a late spring day in May. She was 27 weeks pregnant and was experiencing intense abdominal pain.

As a hospital chaplain, I support patients and their families emotionally and spiritually. Sometimes, this looks like praying with patients; other times, it looks like sitting in quiet because there are no adequate words. Over time, I have developed ways to help me cope with the intensity I witness daily. Still, cases come up that I must grieve. The case of Ellen is one such example.

The first time I met Ellen, she was waiting to hear back about her scans and tests. A quick look at her chart and a conversation with the medical team revealed that she was in her mid-thirties. While she spoke English fluently, she had immigrated to the US, and English was her second language. She, along with her husband, Mark, and their young son, had come to the United States on a work visa.

After knocking on the door and entering her dim hospital room, I noticed right away what a beautiful person Ellen was, inside and out. Lying in bed, her long dark hair piled up on her head, her slim figure was visibly pregnant underneath her hospital gown. She smiled and gently greeted me. Mark was at her side. Clearly, Ellen was in physical pain, and while she and Mark still hoped the doctors were wrong in thinking she may have cancer, the emotional strain of waiting lay heavy upon them.

Ellen and Mark kindly welcomed me and were attentive as best they could as I introduced myself and explained my role as a chaplain. They told me that they were spiritual, not religious, but welcomed chaplain visits. Both exuded a certain peace and kindness, which was striking considering all they were enduring.

As Ellen and her family waited for the results to come back, I waited as well and frequently checked her medical chart, looking for updates. About a week after she was first admitted, the medical team broke the dreaded news: Ellen had stage IV gastric cancer; it was estimated she only had 11 months to live. At this point, the Palliative Care team became involved in Ellen's care, and the chaplain on this team supported Ellen through the shock of her diagnosis and the difficult treatment choices she faced.

Originally, the plan was for Ellen to deliver her daughter at 29–30 weeks and then to receive 2–3 rounds of chemotherapy. After further deliberation, however, it was decided that it was riskier to deliver a baby at 29–30 weeks than it was to undergo chemotherapy while pregnant, so Ellen began chemotherapy while still carrying her baby. Her chemotherapy was not a curative treatment, but there was hope it might give her more time.

While my role became more peripheral at this point, I continued visiting Ellen. She was often tired or in pain, so I was mindful to keep my visits short. Mark, who stayed with his wife day in and day out, was usually in the room when I came by, and I often inquired after his well-being. Since Ellen and Mark's families still lived abroad, Mark was Ellen's primary support, and needed care and support himself.

After two rounds of chemotherapy, Ellen made the decision to stop treatments. She made this decision because she was concerned about the risks of chemotherapy on her baby. It was an agonizing decision, and even after she made it, Ellen turned it over in her mind. During one of our visits, she asked me if I thought she had made the right decision. I told her that I fully supported her, but as I left her room, I wondered if I had done the right thing in affirming her choice. Looking back on it, however, I know that no matter what she decided, I would have supported her. There was no right or wrong in a decision like that.

When I next saw Ellen, it was September. From the medical team, I learned that in between her first hospitalization and now, she had delivered a healthy baby girl at 34 weeks. Following this, Ellen decided to withhold treatment for a month so she could focus on post-partum recovery. Unfortunately, her cancer only progressed, and she was admitted to the ICU because she was now critically ill with a bowel leak. She was too weak to undergo surgery and too sick to receive chemotherapy.

My sense of grief over this case especially came to a head during this admission. I met with Ellen and Mark shortly after the medical team told them there were no other treatment options and death was imminent. They recommended hospice and comfort care measures. Ellen was resigned to the news, and a deep despondency seemed to settle around her.

Shortly after this encounter, out in the hall, Mark took both of my arms, and in a voice full of anguish, he asked me if I could help Ellen find peace with dying. I felt extremely honored that he entrusted me with such a task. At the same time, I wondered how I would go about granting this request.

While I was mulling this over, Ellen's family, her parents, and a family friend arrived at the hospital. They had just flown in from abroad. From what I understand, they had not seen Ellen for years and were now faced with her pending death. The whole situation was getting tougher and tougher.

That night, I went home and could not stop thinking about Ellen and her husband's request. Unsure how to proceed, I reached out to my mom and sisters and asked them to pray. They responded with encouragement. Soon after, while pacing around my apartment, I was reminded of my mom's twin sister, my Aunt Cathy. Though I do not have many memories of my aunt, from what I do remember and from the stories my mom tells, Aunt Cathy, like Ellen, was a beautiful soul, full of light and life. Tragically, when she was in her mid-thirties, the same age as Ellen, she was diagnosed with cervical cancer. Her cancer diagnosis was devastating, and she experienced intense physical and emotional pain. When it became clear her cancer was not survivable, the hardest part for her was coming to terms with the fact that she would have to say goodbye and ultimately relinquish her six young children.

Shortly before Aunt Cathy's death when she was on hospice and spending much of her time sleeping, my mom tells me that she slipped into bed with her twin at which point Aunt Cathy woke up and in a moment of lucidity told my mom: “I can't wait till we meet again in our heavenly home.” Immediately, she fell back asleep. It seems that in the end, my Aunt Cathy came to know that she was going to a good place and that one day she would be reunited with those she loved. As this recollection rose within me, I imagined my aunt helping Ellen find peace, and welcoming her to an eternal place of rest.

I cannot say that everything was tied up with a neat bow, but I can say that this encounter I had with the memory of my aunt helped give *me* peace about Ellen's death and helped *me* hold out hope that Ellen could find a path of peace amid all she was enduring. In the couple of days that followed, I sat with Ellen and her family, held space for them, listened to them, and offered gentle touch. Along with this, I acted as a witness to the love that was showered on Ellen during the last week of her life, e.g. watching her family massage her body, speak gently to her in her native tongue, and offer comfort to Mark. And though originally Ellen did not want her children to come to the hospital, in the end she did request their presence.

It is my prayer that in these little acts of presence and love that I participated in and witnessed, something of the hope I found for Ellen came through. And now, as I think about Ellen's family that is left behind, I hold out that same hope—that they will find a path of peace amid the pain they are surely experiencing in the loss of their beautiful wife and mother.

In the end, Ellen's case reminds me that, like the patients I support, I am human and have a heart that feels deeply. I also have personal scars and losses, which sometimes intersect with the pain the patients I support endure. It is tempting at times to try and just buck up or dismiss feelings of grief that emerge during the sadness of situations I interact with, yet Ellen's case teaches me how strengthening it is, in fact, to reach out during these times and how mysterious and personal the response can be.

“I'd Love to go Off the Grid and Never Come Back”

Alisha

Disclaimers. The author has chosen to disclose only her first name. All other names have been changed to protect the privacy of the individuals mentioned.

I have been a nurse for 18 years. I have dealt with death. I have performed CPR, closed eyes, called families, and bagged bodies. I have taken decedents to the morgue. I knew what I signed up for when I became a nurse, but nothing prepared me for the 2020–2022 pandemic years, and the havoc wreaked on my mental, emotional, spiritual, and physical health. I was then in a managerial position. Patients' accounts of tragedy and families' sorrow, confusion, denial, anger, regret, and fear came across my desk daily at the hospital, nightly to my phone, and over the weekend while at home. In March of 2020, I took responsibility for managing the hospital's morgue, an experience that proved to me that death is no respecter of man.

The morgue had the capacity to hold five decedents. It was my responsibility to ensure that we had space for the decedents that were coming in droves. Though our hospital was hit disproportionally by COVID-19, we were unable to secure a refrigerated truck for the overages. Instead, we had to transfer our overflow across town to another hospital no matter the time of day or night. The funeral homes were overwhelmed and could not meet the mass demands, which caused major delays in picking up decedents from the hospital. Most funeral homes took them in body bags straight to the crematory or the cemetery for burial. Many would not open the bags to confirm identities. Instead, they trusted the information I wrote on the bag in black marker and information on the ID tag attached to the zipper.

As the deaths increased and more transfers were made, my social work supervisor Audi and I could barely keep track of the decedents—let alone which families we had reached. We created a process and checklist that had to be signed off before any transfers were made. My director, who supported us, encouraged me to train others to help. However, I felt an intense duty to own this process because of how easy it could be to misidentify someone. Families were losing loved ones daily. They could not be by their side as they took their last breath. The next contact the family had was picking up the decedent's ashes or burying a closed casket. I refused to be responsible for causing additional suffering by losing a loved one's remains. When I made the decision to control the process, I never dreamed I would do this job for three years, nor did I realize the trauma it would cause.

One day, a lady named Pam asked us if she could see her mother in the morgue. "Of course not!" I thought. We were not opening body bags for any reason. When I spoke with Pam, she explained that her son had been shot and killed and that her mother witnessed his death. Pam's mother suffered a fatal heart attack after witnessing her grandson's murder.

"Ma'am, give me a moment," I said. I reviewed the decedent's chart to verify the information and considered what to do. After discussing Pam's request with Audi and my director, we decided to make an exception for this extenuating circumstance and allow Pam to see her mother. Audi and I viewed the decedent to ensure she was presentable. I closed her eyes and cleaned her. When I closed her eyes, a little fluid came out. When we brought Pam in, she noticed and wiped away her mother's "tears," lovingly looking at her. When walking Pam to the front door, she told us about her other son, who had also passed away recently. Remember, we were not supposed to touch anyone at that time "out of an abundance of caution," but with her heart-wrenching situation, we hugged Pam anyway.

By the end of April 2020, Audi and I had monitored nearly 100 deaths, coordinating with funeral homes to expedite transfers. If they could not promptly pick up a body, we called to notify families that we were transferring their loved ones. As expected, this communication would cause anxiety and fear that their loved ones may be lost. All people knew was what they saw happening on television in New York City. If no family claimed the decedent, which was not uncommon, we would seek out extended family and friends. Many times, we exhausted our efforts to identify proper burial resources. Countless times, we had to transfer decedents to a columbarium that houses unclaimed decedents.

Throughout 2020, all healthcare professionals had to take care of business as normal. I had a department to run and staff to lead, protect, and support so they could keep our patients safe when we sent them back into the community. With the addition of the morgue responsibilities, I never came up for air. But in November 2020, I finally spent an evening with my sister and friends. After nine months, I loosened my emotional hold and discussed work. Back at my sister's home, when it was just the two of us, I fell to the floor and began sobbing profusely. I admitted how sad I was and how sad it was for the families. I have no idea how long I cried. My sister just sat on the floor and hugged me as I let go of all the built-up emotions. The next morning, I readied for work on autopilot and kept moving as if nothing happened. I never spoke of that night again until now. Though I know it shouldn't, that emotional break severely embarrasses me to this day. Like many other healthcare workers, I compartmentalized my feelings and pushed through. I began isolating myself from family and friends and limiting my smile and engagement at work. Of course, I had no idea I was changing in such a way. My family did their best to support me with love and patience. If I shared stories with anyone outside healthcare, they would freak out at what I was telling them. Sometimes, I would look at them and wonder what was wrong. Then it dawned on me that I normalized my work in the morgue. I stopped talking about my experiences altogether.

We cared for a man from another country who died unexpectedly of heart disease. He was in the U.S. working to send money to his family. A local young man—Jared—was willing to help us communicate with the decedent's family so that we could arrange to get his remains home. We brought in a funeral home director and two interpreters for the family, one for speaking and one for translating legal documents. We video-conferenced with the decedent's son because the decedent's widow was too distraught to get out of bed to meet with us. After the director completed the paperwork, Jared wanted to help honor the decedent in a way consistent with his country's culture and funeral traditions. I was determined to be there to pay respects since the family could not be present. I met Jared at a crematory where he said traditional prayers over the body before the cremation. I held the phone with the family so they could hear the prayers and see their husband, father, uncle, and friend one last time. Afterward, I went to find the director. As I entered what I thought was another room, I realized I was in a large walk-in refrigerator with at least 35 bodies. Curious thing—by that time, seeing that many decedents did not faze me. The director had a COVID-labeled body bag open. We stood there having a normal conversation as if we were in a regular office. I had him spray me down with antibacterial spray after we left the room. As we were about to depart, Jared thanked me for being there with him as he had never seen a dead body before.

As the pandemic raged on, we steadily improved at treating the virus. We also learned to predict who would survive. Death was inevitable and a constant discussion in my daily practice. One afternoon, I was in the elevator with a man who was crying, so I leaned in to support him and spoke to him. Andre told me his grandmother was discharged home from the COVID unit that day, but his mother was transferred to the ICU. When I asked his mother's name, I recognized her as one who would not survive. She had no concerning past medical history, leaving Andre confused as to how she'd become sick so fast. I gave him my number to call should he have any questions. Andre called multiple times over the next few days, asking to speak with a physician and informing me that his grandmother died at home. A week later, he called to tell me he could not proceed with burying his grandmother until his mother—still in the ICU—woke up to sign the paperwork. I knew that his mother was not going to wake up. After a couple more days, Andre called with concerns about his mother's renal issues and new dialysis needs. I was with Andre when the provider gave him his mother's grim prognosis. I called that evening to check on him. He asked how he could transfer his mother to another hospital. I explained to him firmly but as gently as I could, "There is a process for transferring a patient to another facility. However, transferring your mother is not possible. Your mother would not survive a transfer. She is too sick." He understood. Two days later, Andre's mother died.

In July 2021, I met a friend who is a licensed clinical social worker, for dinner. I had not seen Anna in over a year because of the pandemic. We talked about our busy lives and how the pandemic had affected us. At one point, she said to me, "I think you have PTSD." My immediate response was, "Yeah, I don't think so." "And that's the problem," she replied. She asked me to go hiking with her that weekend. I declined the invitation because I simply did not want to leave the house. She explained that she wanted to "get me off the grid." My first thought was, "I would love to go off the grid and never come back." My next thought was, "Whoa! Alisha does *not* think like that." That was the moment I knew I needed help.

I soon began counseling. I had become very skilled at blocking out memories, forgetting traumatic details, and compartmentalizing every situation I encountered. While I previously said the room of 35 bodies did not affect me, I was wrong. I had nightmares of the morgue, of being in a large room full of bodies. But the decedents were not dead in my dreams; they were trying to get out of the bags. Some of them got out, sat up, and tried to talk to me. Many of my thoughts and emotions still do not connect. I no longer have nightmares, but I still struggle with sleep. I have anxiety from time to time, but I am managing it well overall. I continue to see my counselor regularly. I surround myself with loving family and friends. They help get me through these challenges.

In the fall of 2021, Audi resigned from her supervisor position and left the hospital. I felt nervous and alone. She had been my partner for so long in managing the morgue. During her time with me, she had minimized her self-care to provide emotional support, education, and advocacy to families. She needed to make her own family her priority again. Unsurprisingly, our work blended into—and often took over—our home lives. She felt the only way she could gain control of her personal life was to leave her dedicated work ethic behind and gain family sovereignty in her home. Audi made a life-changing decision to leave her company of 13 years to begin healing.

By the end of 2021, we had monitored over 1,000 deaths and transferred over 100 decedents. If we transferred a decedent, we were responsible for the remote management, empathic communication with family, and eventual transfer to the funeral home. If we did not transfer a decedent, we were still responsible for making room in our morgue for the next death. During surges, our staff would inform us of anticipated deaths on their units so we could plan ahead. All we talked about was death, not life. It felt like we were in shipping and logistics for death.

During the pandemic, there were no emotional boundaries set. While I remained empathetic and compassionate toward grieving families, I failed to show myself the same. There was no balance. I was all in. And if I had to do it again, I would—I have no regrets. I did my best to help others in their time of need. If I helped someone survive their tragedy and grief and they felt comforted and supported, then I succeeded. While I am still trying to heal, I am slowly returning to a place where I experience emotions in real time again. And as time passes, perhaps more and more of the old Alisha will return.

Recently, I was again talking to Anna. She commented about "the old Alisha." I asked her what the old Alisha was like. She described the old Alisha as someone who had never met a stranger. She was always smiling and genuinely enjoyed the company of others, even if it was just for a few minutes during an elevator ride. She would run into the middle of traffic to help someone if she thought they needed it. She was lively and joyful. "The pandemic Alisha" had her head down. She avoided conversations. Her eyes were dark and empty, rarely making eye contact. She forced smiles. She never laughed. She developed a short fuse. She forgot the personal details of family and friends or did not care to learn them.

But the "new Alisha?" She is a work in progress, and intentionally so. There are good days and bad days. Only time will tell who she will become. I hope she still cares for others and herself. I hope she finds joy in life again.

NIB policy allows authors to publish anonymously when stories considerably contribute to a symposium but contain highly sensitive information that cannot be de-identified. However, stories are never submitted or accepted anonymously, and all authors sign our publication agreement, which upholds standards for responsible authorship.

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"A Mother's Love"

Katie L. Gholson

"Who is going to teach my daughter about becoming a woman?" S said to me. S was 38 and diagnosed with ovarian cancer. She and her husband were high school sweethearts, and she had a young son and a daughter. She had been told that there was no cure for her cancer, and at the point of meeting her, very little was able to be done to manage her symptoms.

As a mother of a young daughter, I was humbled by the question she asked me. Her daughter was 12 and was just beginning to learn about becoming a woman. The anticipatory grief of not having the opportunities to care for one's own children in the crucial moments of their development was devastating to S. Her ability to name what she grieves the most was profoundly sad to me and the other team members who witnessed it.

As a palliative care chaplain, I am used to sad and tragic cases, but this one felt different. S and I had a lot in common. I am also 38, married to my high school sweetheart, and I have a son and a daughter. Of course, it was not just these reasons that I felt a connection to S. It was also the tangible despair I felt when I was with her. As a chaplain, I am trained to meet people where they are and not to hurry them from a place of despair and anguish. I visited with S nine different times and watched the progression of her existential distress. Her distress was not always linear. Some days, it took a backseat and other days, it was front and center, but I was there to be a witness to whatever she was thinking and feeling, and a lot of times, it was inexpressible grief.

S did not want to meet with "palliative care" initially. She was terrified of her diagnosis and believed that there were treatments that would give her back the life she desired. She was fierce and determined. S was also religious and believed that there was a miraculous cure for her that would allow her the time she desired to spend with her children and her husband. S was a softball mom and loved to watch her daughter play. While in the hospital, she missed many games, and this weighed on her.

Along with being an athlete, S's daughter was very artistic and made S a bouquet of paper flowers. Each flower contained an encouraging phrase. S opened one while I was in her room. She had lost her hair, much of her body weight, and was wearing a hospital gown, but when she opened the flower, her daughter had written, "You are beautiful, Mom." In that moment, two 38-year-old women understood that beauty transcends outward appearances. S was beautiful: her story, her life, and her courage.

S loved to walk around the hallway of her unit. I think she felt if she could keep moving, she could stay alive. She was able to take a walk outside a few times while she was inpatient and getting fresh air was very positive to her. These walks not only gave her the ability to widen her environmental space, but they also gave her space to think and consider the difficult situation she was faced with. I accompanied her on one of her walks. It was while we walked next to each other that she was able to finally share with me that she was afraid. She told me that the fear of not getting home, and the fear of death was overwhelming. I find that sometimes people can be vulnerable when they are not feeling interrogated by a medical team staring at them as they lay in a hospital bed. The "normal" activity of taking a walk and being side-by-side humanized the experience and I think S felt that at that moment, she could talk to me human-to-human—like friend-to-friend.

When S finally decided to go home on hospice, I collected some legacy project supplies. I went to the hospital art room, and as I put together a box of craft supplies for S and her daughter, I started to feel the love I had for them. I picked out an art project for S and her daughter to do together and I could feel myself tearing up. I do not often cry at work, but at that moment, I was in a safe place with people who shared empathy for the situation.

I took the art supplies to her room, but the nurse told me she had just left. I ran into the lobby and saw her husband's truck outside but was not able to catch them. I stood on the outside curb of the hospital and called him to see if he would turn around, but I got no answer. As I stood there, holding a bag of art supplies, I felt the freedom to grieve for S and her family. I let myself cry and express the gratefulness I had in meeting her and the grief I had in sending her home on hospice.

In my work in palliative care, I find that as providers we tend to have a controlled and somewhat restrained emotional response to much of our work. This is not because we are inauthentic, but because this is our way of surviving the difficult cases we encounter. At times, though, the deep emotions we feel must be expressed. Being given the opportunity to care for S over the course of a month allowed me to make a connection with her that I am not always able to do.

The frustration of not making it to her room in time to give her the art supplies was just a cover for the deeper emotion of sadness I felt knowing she was going home to spend her last days with her husband and children. As a mother, my heart breaks when I witness the profound unfairness of cancer and other critical illnesses. It reminds me to share the love I have for my own children and embrace them a little bit tighter and a little bit longer.

There is not a "how-to" manual for grief. There especially is not one for how to grieve at work, but to feel sad and feel despair is to be human. Working in healthcare makes us vulnerable. It exposes us to things that seem unspeakable, but it also exposes us to deep emotions. I believe that we *feel* because we care. I will remember S and the impact she made on me. I will never forget the vulnerable moments in her hospital room that we shared, and I am forever grateful for her willingness to open her life and her emotions to me. I learned the importance of sharing my own vulnerability at work and allowing myself the space to grieve. Grief may come when we are not expecting it, like standing on the outside curb of the hospital holding a bag of art supplies. It is best to allow it to come and feel what we need to feel in that moment. This is what makes us human; it is what makes us better caregivers and providers for patients and their loved ones.

◆

Tiny Person, Big Impact

T.S. Moran

I met J on a Tuesday, the second day of my new job as the pediatric oncology social worker. Five days later, he died.

Although J was 8 months old, he seemed tiny, like a preemie. When I saw him, he was snuggled into the shoulder of the attending physician. It was evident that one of his diagnoses was failure to thrive. He also had what was thought to be a low-grade glioma of the optic pathway, and despite months of treatment, he was declining. It was clear that the team cared for J very much. They visited him, held him, played with him, and sang lullabies to him in Spanish. I was so impressed by their compassion.

J had spent about half of his short life at the hospital. He was born prematurely to a young mother, herself in foster care. His mother had numerous obstacles preventing her from visiting often and it did not seem that she bonded well with him. J's mother stated that her boyfriend discouraged her from visiting. She did not have transportation and declined offers of hospital-funded Uber rides. She had little prenatal care or education about becoming a mother.

J's mother seemed guarded in her interactions; hesitant to reveal anything that might show her vulnerability. The team was frustrated as it seemed she was not receptive to their efforts. The team was also concerned that she did not fully understand J's condition due to her poor health literacy, despite the use of a certified language interpreter. Still, when she did visit, she was kind and caring and stated that she did not want her foster mother involved in providing J's care.

Part of my job was to help prepare the family for discharge to home. I had been speaking to their caseworker from Child Protective Services. She was a strong advocate for both mother and baby. After several meetings with the team that included J's mother and the caseworker, J's mother accepted his prognosis. She was willing to provide care at home with hospice support. She came to the unit several times that week to receive training about his care needs. The hospice nursing visit was scheduled, and J and his mother left the hospital on a Friday.

The caseworker called on Monday to tell us that J had passed away peacefully on Sunday. The reaction on the unit was palpable. New residents and seasoned chiefs were teary-eyed and sighing. To some, it seemed like a relief. Given the team's extraordinary care and concern shown to this family, I was not surprised by their emotions.

What surprised me was my level of grief. I had spent the 12 years prior serving adult hospice patients; I understood end-of-life care and death's eventuality. I thought I was well prepared. This experience was different from my past. I was able to cope with an adult patient's passing without much distress, accepting that most adults had lived a full life.

I felt grief for the team who had invested in J, and for his short life filled with illness and pain. I felt grief for his mother, who had experienced a horrific childhood, had lost her innocence too young, and had been robbed of the opportunity to experience joyful parenting.

The chief recognized the team's need for support and quickly organized a "debriefing." A lot of the team participated, even those who only had brief contact with J. Everyone had a chance to reflect on their experience in caring for this child. Because of my hospice training, I was included. I validated their loss, their efforts, and their love for J. I provided basic grief education, enumerating their possible reactions of sadness, anger, frustration, fatigue, confusion, or numbness, and this helped me to feel like I also contributed to his care. I encouraged self-care—from taking time off, to lingering over an extra cup of tea, to speaking about their experience with me or another social worker.

When I spoke about my feelings to my coworkers, they were understanding and acknowledged their own sadness. This was helpful because it showed their trust in me and their caring for me as a new team member. Being able to provide support to the team helped me cope because I was able to be active in my response. Other team members expressed appreciation for my support over the next few weeks. I also kept in touch with the family's caseworker and was able to refer J's mother for bereavement counseling.

I do not remember every patient that I have ever met, but there are some that I do carry with me, and I have tried to learn from them. These interactions have allowed me to be open to making a personal connection despite the admonition for professional boundaries and to embrace compassion and use it to guide the way that we provide care. Thanks, J, for the lessons in caring that you taught us.

* * *

Night Shift

Calvin R. Gross

I don't like working at night anymore. Too much goes wrong when you're alone.

I'm sitting at my desk in the middle of the cardiac intensive care unit, and it's far later than I'd like to be awake—two or three in the morning. Things are calm, almost pleasant. I can hear the occasional alarm going off—an imperfectly positioned blood pressure cuff, a pulse oximeter with a poor waveform, a ventilator with secretions in it. The night's initial frenzied work is done; my new admissions are tucked away, and my overnight to-dos are completed. Now it's just time to sit and wait. I could sleep, but despite the calm, I'm too afraid to leave the unit to rest. The fellow has gone to bed hours ago, and now it's just me. Sure, I'm surrounded by experienced nurses who know their work well, but somehow, *I'm* the one in charge. A brand-new second-year resident, the only doctor there. I'm no intern, that's for sure, but I've never led a code before, and I've only ever placed one central line without supervision. As second years go, I'm as fresh as they come.

The daytime, you see, is far different than nights. There's a large (and even bloated) team of two attendings, two fellows, two pharmacists, and more importantly, multiple other residents. When you don't know what to do for a patient, there's always someone there to bounce ideas off of. When something difficult or surprising happens, there are peers and mentors to process with. At night, it's the opposite—no peers, no mentors, only a group of experienced nurses, whose circle is closed to me, the outsider. I long to be a part of that large and bloated daytime team.

"Can you come into 23? I think his pupils are a different size."

I'm startled out of my thoughts. 23 . . . All I can remember from sign-out that evening is that he's young, close to my age, and supposedly stable. I look at my notes, a catalogue of tragedies: early onset heart failure, multiple prior suicide attempts, intubated because of pulmonary edema, and a left-ventricular assist device (LVAD) that's malfunctioning. I walk over to the room and look at the nurse at the other side of the bed. She's in the early phases of her career too—less than a year on the job—but she's still more experienced than me. I take a flashlight, open his eyelids, and look at the pupils. Sure enough, one of them is much larger than the other. When I shine the light into each eye, the large one doesn't change. When I turn his head from side to side, his eyes stay fixed. We look at each other, she and I. We both know something terrible is happening.

"Should we maybe wake the fellow up?" she asks tentatively.

I nod my head in agreement, glad to have been offered a suggestion. It's the right thing to do. I walk to the fellow's call room, knock on the door, and wake him up. He's set to work 24 hours and would like nothing more than to keep resting. He sleepily comes with me to the bedside, looks at the pupils as well, and says, "With the sedation on, your exam isn't going to be the most accurate. We should start by scanning his head, and then go from there. Wake me back up if you need me, but I know you've got this one."

I don't think that I deserve the confidence he has in me. I walk back to my desk, open the patient's chart, and place the order for an urgent CT scan. The machinery of the hospital starts to rumble as the imaging schedulers find a spot in the queue for the scan, the patient's nurse and respiratory therapist disconnect and reconnect cables and tubes, the technicalities of the scan are ironed out, and he is wheeled down to the basement.

I wait. Everyone else seems calm—this is their normal, everyday experience after all. I am not calm. I spend my time reviewing how to perform a thorough neurologic exam on an intubated patient.

After an eternity, they're back from the scanner. I open his chart and look for the images, but they're not uploaded yet, so I wait again. The phone rings; it's for me.

"Hi this is Calvin in the cardiac ICU."

"Hey, I'm one of the radiology residents. Are you taking care of the patient in 3723?"

"Yeah, that's me."

"He has a subarachnoid hemorrhage. There's subtentorial and subfalcine herniation. This is a huge bleed. Can I have your name to confirm I spoke with you about the results?"

The results of the scan pop up into the EMR with the words, "The urgent results of this scan were communicated over the phone to Dr. Calvin Gross at 4:15 AM." Somehow, I'm the one responsible.

I'm completely frozen, and I don't know what to do. This is not one of the contingencies that the day team prepared me for.

I page the neurosurgery resident on call, asking for an urgent evaluation to guide me. The resident calls me back, and I discuss the situation with her. I order the medicines she recommends to lower the pressure in his brain, prevent seizures, and counteract the blood thinner he is taking. I ask the nurse to turn off his sedation so that we can examine him properly. The resident meets me at the bedside to examine him, and as I watch her, I see that he has minimal brain function. She tells me what I was already afraid of: this is a devastating change with almost no hope of recovery.

As my night is drawing to a close, hers is just starting. I'm here alone, waiting for the day team to arrive. She, on the other hand, is in the hospital with her whole team, a complement of peers and mentors to work with. She leaves to talk with her chief resident and promises that they'll be back. For the time being, there's nothing else that can be done.

It's up to me then to call his family in the middle of the night and tell them what's happening. I pick up the phone and dial. As it rings, I think about how I've never met them before. They know a whole different set of doctors who work during the daytime, not me. I have to call twice. His father finally picks up, and I introduce myself, a complete stranger calling in the middle of the night, delivering a tragedy.

I take a deep breath but still stumble through my introduction. He's sleepy too and doesn't understand me the first time. I repeat myself, laying out the tragedy one more time. Your son, your young son who is only a few years older than me, is lying in a bed, mere feet away from me, dying. His father wants us to explore every available option for him. He wants his young son to live.

"I'm so sorry to bring you this terrible news. Please let me know if there is anything more I can do to help," I say before he hangs up the phone. I lay my head in my hands, and my numb brain shuts out all the noise, internal and external.

When the day team arrives an hour later, they find me still in that position.

"Rough night?"

"Pretty awful," I respond. "The young guy in 23, he has a huge brain bleed. I don't think he's going to make it."

"That's terrible," one of the first-residents adds. "His parents are so kind; I've gotten to know them whenever they're visiting. I can always tell how sad they are."

I wish I had the chance to get to know them instead of relating as disembodied voices, ghosting past each other in the middle of the night. I want to stay, meet his parents, and process with the day team, but they have work to do, and my desire to go home and sleep is far more powerful. I leave, holding it all inside.

My wife is still sleeping when I get home, and I go straight to bed without waking her up. I sleep as long as I possibly can, and I return to the hospital that evening to a slew of updates. The rest of the neurosurgery team has come to see the patient. While he is not officially brain dead, he is precipitously close, without any hope of recovery. There is no surgery that can save him.

The patient's family came to the hospital not long after I left. They spoke at length with the day team about what to do next. Guided by their trust in and relationship with the day team, they decided to withdraw care and donate the patient's organs. They visited him one last time, and when I arrive to the CICU, they have only just left for the final time. I will never meet them.

"Oh, and one more thing," the senior resident tells me before we finish sign out. "They're going to procure his organs for donation tonight; they'll need you to go down to the OR with him to pronounce him."

I accompany his technically still alive body through the elevators and hallways, down to the operating room. A nurse and respiratory therapist pause his infusions and ventilator. My stethoscope peeks out of my synthetic gown and rests on the drape as I listen to his chest for the requisite period of time. No heart sounds. No lung sounds.

"Time of death, 7:46 PM."

* * *

Cracked Armor

Joanne Alfred

Disclaimers. Names have been changed to protect the privacy of the patient and the patient's family.

After three weeks of night shifts, I had built a routine of driving home in darkness and watching the sunrise. It had become my way to push back against a quiet melancholy, the accumulation of loss over time, by remembering that light gently returning each morning. Heading into my last stretch of ten nights in a row, I was intent to hold to this practice, to anchor myself for the challenge. The one-and-a-half years of residency training had prepared me for these moments, opportunities to grow and persist. The first six days of the stretch passed as I had expected, and the confidence and autonomy I had cultivated carried me through. It always had. I had shouldered our neurosurgery service, solitary night shifts at community hospitals, the NICU. I had pronounced a newborn dead on Good Friday, heartbroken by the juxtaposition of life and death. My experiences allowed tears and doubts, but I had always rebounded, chin up and looking onward for the next thing.

I had just received sign out, and needed to check on Nate, a young man I'd known since he was first diagnosed with T-cell acute lymphoblastic leukemia (T-Cell ALL). I remembered our first meeting, a new diagnosis with a white cell count in the thousands requiring PICU admission for plasma exchange, all the way to reassuring him his EKG was normal after an incidental finding of hyperkalemia. He had returned to the hospital with abdominal swelling, and dread filled me as I rounded the corner to his room. Looking down at him and back up at his mother, my own distress reflected in their eyes. We needed help. I quickly found the oncology fellow and attending, and we put our heads together, deciding a blood gas and X-ray would be the next best steps. The results confirmed our suspicions.

Nate was transferred to the PICU shortly. I watched his mother console him, remembering how much they both disliked the PICU. It was not a place of pleasant memories, especially as Nate had been working toward remission therapy rather than returning to the intensive care unit, where he fought through his initial diagnosis. While reassuring him and his mother externally, internally my own dread welled further, because my first night in the PICU loomed two days away. To bolster myself for my seventh night shift, I rounded with the PICU team to learn as much as I could. Nate was on BIPAP now, and the decision inexorably moved to intubation. It was all happening rapidly, and the dread started feeling more like panic. Nate's eyes were squeezed shut, his stomach taut, and his breathing shallow. I truly worried for Nate now. I had hoped the PICU would be a temporary stay, a place where we could make a diagnosis and fill the gap. However, when I joined the private conversation the PICU attending had with Nate's mother and she said, "He may never come off the ventilator. He may never speak again," the finality in her voice had more certainty.

The "never" struck my brittle residency armor and it cracked. I was not ready to believe it. I could sense his mother felt the same, so we walked along the silent halls of the hospital while she remembered Nate with me as a teenage boy beyond the hospital, not as his ascites and acidosis. Maybe to make his turn for the worse untrue. But I knew something awful was going to happen.

On my eighth night, I entered the PICU with trepidation. All I could think about was Nate. He was now on dialysis, struggling with true hyperkalemia. Turning the corner to the unit, my heart racing, begging please don't let him die. It was hard to sense in the moment, but the cumulative melancholy, the sense that it could be held back, was not holding true. So, I defaulted to my splintering armor of persistence, picking apart his labs, discussing his dialysis with the nephrology fellow. I put my head down. Then his heart rate dropped.

I watched from Nate's doorway, the dread evaporating and replaced with overwhelming, chest-crushing denial as CPR commenced. It can't be happening. I had to help him; I had to persist, two minutes at a time. The rounds of CPR. The crushing on his chest. The pulse checks. For 40 minutes, I hoped, perhaps futilely, but I know I did. I believed the fellows, the nurses, the attendings could change this fated end. My round of CPR was the last, my hands slipping away as the ICU fellow called the time. Distantly, I heard his mother on the phone, sobbing.

It was not time. I hung my head, looking down at Nate. I took off adhesives, removed lines with his nurse. I could barely speak. I could barely breathe. I wanted to disappear, so I did. I walked off the unit. I tried to breathe. The weight on my chest was so heavy. I stared at my feet, the tiles, anything. I could not shoulder this.

I defaulted to what time was forcing me to do. I looked down at my patient list and gave my co-residents sign out. I could hardly remember any other patient, the gravity of Nate's death obliterating me. The nephrology fellow messaged about changing his dialysate. I could barely lift my gaze to look at the apology I typed. "I'm so sorry, he just passed away." And in this apology, I realized the claustrophobic weight of grief, which did not have space beneath all my carefully crafted armor, cracking. I had not been trained to carry it. The tremendous pressure hurt in ways I had no prior experience with: isolating, confusing, yet final. Could there not be an alternative solution? Could I work just a bit harder and find that he was getting better? I had to find a way to express these questions. Leaving the hospital in oppressive darkness, I managed to look up and find someone I looked up to, one of the fellows who'd known him as long as me, holding up my faltering gaze. "How do you do this?" I asked her. She said, "It never gets easier, but you never stop caring."

My armor fully shattered then. I sobbed continuously, furiously, terribly. It was not just the first time I had experienced the medically violent death of a dear patient but also the visceral pain of grief as one who spent days and nights caring for them and then must let them go. It felt deeply unfair. I didn't just cry, but I cried out. Why did this horrible, painful thing happen to Nate, to anyone? Residency has trained me to enter this experience fortified against a daunting task, but I did not realize that in doing so, I would be broken, beneath all my protections and preparations. Grief seeps in those cracks. And I let that grief, which I had resisted until this moment, flow in as I drove home, tears streaming down my face and not stopping until I collapsed into bed.

When I woke up, I was surprised to find hopeful, gentle light, the sunrise was streaming in too, and I was not alone. Messages and emails were overflowing, comforting, encompassing. It shattered me to be a part of Nate's life and death. While it initially felt lonely, I realized how if I looked to the right or to the left, behind each message was someone else who had been fractured in some way with that same grief. I was picking up pieces of myself regularly splintered, sharp, fragile and holding them carefully. These pieces were meant to be reassembled, not forged into a new set of armor but something gentler. Waking up after that night, I grieved the loss of innocence I carried in training. That if I pressed and pushed harder, I would create depth. Instead, softening the sharp edges of the pieces I collected after Nate's death would teach me more than all the years of training prior.

24 hours after Nate's death, I pulled up his chart, preserved with his final discharge summary and his photograph, mirroring the young man who nodded, as I reassured him so many months ago. It reflected the hope I had when I rounded the corner just a few nights before. I was grateful that the desperation, the denial, the dread all faded as I rounded on his chart, looking through his final vital signs, the potassium level climbing, his pH dropping. Something about reading his chart in remembrance of him rather than in an effort for him gave me the strength I needed to start replacing broken pieces. Driving home that morning, I realized my persistence had not allowed room for presence. To simply recognize that while we can have confidence that the sun will rise and rush toward it, there is still patience and peace to be found in the darkness.

A few weeks later, I was invited to listen to the pathology report from Nate's autopsy. There was a breath I hadn't realized I was holding, which this invitation brought to my awareness. The questions that had rattled against my chest about whether there was anything we could have done for him now had their moment to be put to rest. Over a Zoom call with dozens of experts and mourners, I listened with a sense of relief: His body had been overcome by recurrent, metastatic T-Cell ALL.

While I was profoundly grieved for Nate's life and death, I ultimately grieved the injustice of suffering that preceded death that night. Death and I had not been strangers, but it had never been so personal. I wished for an option to thwart it at every moment of Nate's admission and denied its inevitability. His death taught me to recognize the small cracks that form each time I encounter suffering. I grieve daily, each child who looks up at me with an IV or a nasal cannula, and in most cases, my reassurances are true: No, this is not the end! You will leave this place, and your suffering will not shatter my soul; it will barely leave a splinter. For Nate, grief began the first night I turned the corner to his room. I had been taught stages of grief, how to distinguish grief from adjustment disorder, and mnemonics for when you knew you would induce grief. Nate lived a terminal diagnosis, and as I stood beside him, from start to finish, I learned that it is not always about pushing against suffering, but acknowledging it, giving it space to soften me. I have deep gratitude to Nate for being my first instructor in this skill.

Residency proceeded, and admittedly, emotionally, I was still in shambles. Yet I had learned how to cradle that softness in strength. To be honest with myself and others about the sharp realities of the brokenness we face daily. I have saved the message from the PICU fellow who guided me through Nate's last moments and called the time of death. Strength comes from knowing that despite suffering, we are never alone; and if we were not broken by the proximity of suffering, we have become too hard. "I don't ever want it to not be hard because that means I'm probably losing empathy and humanity that I don't want to lose."

* * *

Who Tells the Story

Cindy Bitter

Thirty years later, I do not remember her name, but I definitely remember her face, and this is how I remember her story.

She came into the office for her flu shot. She was in her 70s and had a mild case of COPD attributed to years of exposure to pesticides on the family farm. She said she was trying to stay healthy, as the grandkids were due for a visit, and everyone had gotten a cold after Thanksgiving the year before. I was a sub-intern doing a required rural medicine rotation and diligently did an exam, finding asymptomatic new-onset atrial fibrillation of uncertain duration. We admitted her to the hospital and started anticoagulation. My attending also ordered a calcium channel blocker to slow her pulse, which was running 90–100 while she was at rest. The attending insisted that it would convert her back to sinus rhythm. The nurses were not experienced with the medication and were uncomfortable giving it. I was pretty sure the calcium channel blocker was not indicated, and a quick check of my pocket manual confirmed the drug would lower her heart rate and maybe her blood pressure but that it would not fix the abnormal rhythm. I refused to administer it. The attending came in, pushed the medication, and returned home. A few minutes later, the patient was struggling to speak. Her pulse fell to in the 30s, and her blood pressure had dropped dangerously low. I asked for the crash cart and calcium, and my attending, then started CPR when she lost her pulse. Half an hour later, my attending called her time of death.

Hers was not the first death I'd witnessed, but it was the first time I felt like my patient would have been better off without our interventions. As a medical student hundreds of miles from the main hospital campus, I felt powerless to contradict the attending, and did not know where to turn for support in the moment. I rationalized it by saying that I had not actively contributed to her death by pushing the medication, but I held myself morally culpable for doing the exam and finding an asymptomatic abnormality that started her down that path. I felt I should have known the pathophysiology and medication side effects better, or been more assertive, or called for help.

One could argue whether I was suffering from a grief reaction or falling into depression, but I questioned my calling to medicine and seriously considered leaving the field. But I was quite certain that I did not want another patient to be put at risk, or a student to feel cornered into taking actions against their better judgment. After returning to the main hospital, I met with the clerkship director and helped develop a pathway for students to raise safety concerns in real-time. Now I recognize the feeling I experienced as moral injury, but we weren't using that term at the time, or talking about Six Sigma safety, or stopping the line.

Ultimately, I continued through medical school and trained as an emergency physician. My prior reverence for my attendings moderated to a healthier respect that had to be earned. I read voraciously, trying to prepare myself for unexpected situations. I became an advocate for patient safety and was an early adopter of shared decision-making. I strive to be a physician who welcomes questions and respects the concerns of all team members. Many of the principles that ground my career in medicine grew out of my exposure to this patient.

It was always my least favorite of the tropes common to television medical dramas—the circumstances of the patient-of-the-week illuminated some aspect of our main characters' lives, providing a very important life lesson. I felt it positioned patients to be in service of the physician's aims, using patients as a means to our ends, when we should be using our knowledge and experience to further the patient's goals. Very un-Kantian, in addition to transgressing against multiple other philosophers and medical ethicists. As medicine learns more about the power of narrative and the importance of centering patient stories, I realized I left out one important word. That patient was not "merely" a means to my end—respecting her humanity requires that I honor the impact she had on my development as a physician.

* * *

Navigating Hard Situations that Medical School Cannot Prepare You For

Jenna Bennett

I imagined my first experience with grief as a medical student would be peaceful and measured, prompted by the quiet and peaceful passing of an elderly individual who lived a long life, surrounded by loving family members comforting each other and reminiscing. Of course, I knew things would get harder—I just didn't expect it to be during my first clinical experience as a medical student.

My vision for my first experience with grief as a medical student was idealistic, but I was not unfamiliar with grief on a professional or personal basis. Prior to medical school, I was an aide at a long-term care facility. Many patients were on hospice, so end-of-life care and conversations took place daily without fear or shame. Deaths in this setting had happened as I envisioned—a natural course after a long life. Most of the time, the patients and their families were prepared and accepting. It was, of course, a somber occasion no matter how prepared everyone was, but death was almost never unexpected or met with anything other than tearful acceptance. As an aide, I felt honored to provide care at the end of one's life.

In my personal life, I had similarly lost elderly family members. Although it was upsetting to have my loved ones pass away, no matter how much time we had to prepare, my family and I were never blind-sided and had time to discuss final wishes and cherish time together; however, for my family, there was one exception to this. When I was young, my father unexpectedly passed away from a heroin overdose. He was alone when he died, not even 30 years old.

For a long time, I was ashamed of my father's death. I was very young, and I didn't understand the nature of addiction. I was angry, confused, and embarrassed. As a result, I created my own version that I thought was more palatable, for years telling everyone he had passed away surrounded by a loving family after a long battle with lung cancer.

Over the years, I came to terms with my father's death. I learned that substance use is a disease, not a choice. I forgave my dad, along with eventually also forgiving myself for my years of denial and shame. His struggles and death ended up being a large motivation to pursue a career in the medical field, along with being a key part of my identity that I no longer hesitate to share. Despite having matured in this way long before starting medical school, I now recognize I still had some lingering rejection of the wide reality of tragedies that exist in our world.

My first clinical experience as a medical student was a 3-week rotation with pediatric hospitalists. By the halfway point of this rotation, I was having a great time and was excited to finally be working with patients after months of sitting in lecture halls and late nights in the library. Of course, all the children we saw were sick, which was hard to see, but all the patients either had viral infections or chronic, but usually non-life-threatening, conditions. Therefore, everyone in our service rapidly improved with minimal interventions, and almost everyone was able to go home after just a few days. I was also encouraged by how loving and knowledgeable all of the family members of the patients were. Even when family members were upset and occasionally took frustrations out on the physicians I was working with, I was not shaken and empathized entirely, as I knew the families' reactions resulted from love and concern for their children. Overall, these initial experiences with patients and their families maintained my optimism that things wouldn't get emotionally hard for me anytime soon, but life, and subsequently medicine, do not wait for you to be ready.

I was chatting with my attending one morning toward the latter half of this rotation. Another care team came into our small workroom, which was not unusual, but I could immediately tell something was different. In hushed tones and with teary eyes, we learned there was a new patient, a child, who had just been brought into the unit after being violently sexually assaulted by a family member. As the nurses and physicians began discussing the care plan for this patient, my face immediately became hot, and my pulse began throbbing loudly in my ears. I quickly excused myself to the bathroom, where I began to cry for this child alone.

This was not supposed to happen. Unlike death, whether expected or not, this was not the natural course of life. This was the ugliest thing I could imagine. It wasn't peaceful or measured. In school, we had modules and lectures about tragedy, but only in the context of death and adults. No one had mentioned the other tragedies that exist in our world, which added to my anger, though I now know that I could have never truly been prepared for a situation like this beforehand. No animated video or required reading could have captured the gravity of what was happening just a few feet outside the door or prepared me for the complex emotions this brought on.

I was mad and deeply saddened. Imagining the patient broke me. Thinking about the tearful nurses trying to compose themselves before heading back into the room broke me. Listening to the physical and emotional trauma inflicted on this child broke me. But feeling broken left me riddled with guilt. This was not about me. I didn't understand why I was so deeply impacted before even seeing the patient. I felt weak and embarrassed. I wondered if I would be cut out to be a physician. At the same time, I was scared that everyone else would be callous or too cold. I feared that when I left the bathroom, everyone would be back to work like normal and not impacted. If they were not deeply affected, did that mean cases like these happen so frequently you get used to it? I hated that thought. If that was true, I did not want to be a member of such a cynical profession. Did it mean you had to punch back your emotions entirely due to workplace culture or in the name of professionalism? Once again, if that was the case, I did not think I could ever be capable of that, nor did I want to. At the same time, I knew we still needed to be composed and steadfast to help this patient and all the others on the unit. But how could anyone be expected to move on with their day after such a terrible event? I couldn't imagine walking into another room and educating on the importance of finishing all the prescribed antibiotics or taking the brunt of a parent's frustration over NPO (nothing by mouth) orders after this, as everything suddenly seemed so trivial now in comparison. I finally composed myself and left the bathroom to rejoin the team, still devastated by the patient's situation and newly apprehensive at how the care team's reaction may leave a lasting impact on my concept of healthcare, professionalism, and my future career as a physician.

After returning to the workroom, the rest of the day was hard—not just for me but for the entire care team, which I did find relieving, perhaps somewhat selfishly. But despite my worries, no one was cynical or unmoved by this patient's experience. The teary eyes and words of encouragement to get through the day continued the entire shift. Their grief moved me—it conveyed this was something you are never expected to get used to, even as a seasoned physician. Similar to my moments in the bathroom, the care team members were also struggling deeply with this, yet they didn't seclude themselves as I had done that morning. They grieved and mourned together. Instead of isolating, everyone leaned on each other to hold it together—not for the sake of not embarrassing themselves in front of coworkers, but truly in order to help this child and all the others on the unit who came to us for care in their time of need. I was moved when others openly voiced their anger and sadness through teary eyes. I was moved when they dried their tears and immediately got back to work to care for this child. After witnessing such strength, honesty, empathy, and support, I truly felt honored to play a small role in healthcare alongside these individuals. Rather than fearing I was too weak or not detached enough to be a physician, I instead left the shift hoping I could one day be as resilient and open as these incredible providers. I still worried about having the strength to be a physician, but not for the reasons I previously thought. Instead of needing strength to be unphased, I wished for the strength to continue to be phased and express my struggles openly. I hoped for the strength to be vulnerable and to draw on my grief to motivate myself to provide exceptional support to patients and future colleagues alike.

Later that week, all the students were scheduled to meet one-on-one with the physician instructor who oversaw the rotation for a quick check-in to see how everything was going. During my meeting with this instructor, he immediately asked if anything had been challenging or unexpected so far on the rotation. For a moment, I almost slipped back into bad habits. Like I had done for so many years with the truth about my father's death, I tried to ignore the harsh reality of the situation and how deeply it had impacted me. As I had done by secluding myself alone in the bathroom when the patient arrived earlier that week, I almost did not share what had happened in favor of dealing with it alone. Instead, I remembered how vulnerable the physicians and other healthcare team members had been and how they made it through together. I broke down in the instructor's office, telling him we had a difficult patient situation that I was not expecting. I tried to assure him that I still wanted to be a physician as I was momentarily worried that he would question my ability to handle the next three years of school and then a career that was surely going to have tragedies of all sorts. He, of course, was not worried about that at all. By sharing what I had experienced and was thinking about, I was able to get further support and help processing my emotions.

I am no longer as naïve as I had been a year ago. What my father went through and what this patient experienced should never happen, but it is part of healthcare. Despite that, these cases represent people's lives, often the worst moments of someone's life, and are always worth grieving over. Sometimes, that might mean taking a moment alone in a bathroom to cry on my own, but I also can and should turn to other individuals in my field and personal life for support and strength. This not only allows me to garner the will to keep going, but also maintains humanity and perspective in the face of horrible situations that are part of the job for healthcare providers. By mourning and frequently reflecting on people like this patient and my father, I hope to honor their lives. By learning from them, I hope to establish meaning from senseless tragedies and become a better human, especially as a future physician. Although different than what I had initially imagined facing so early on in my journey as a medical professional, I continue to feel privileged and honored to take part in the care of every patient, especially in the most devastating cases.

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The Wish

Nadia Khan

Like many people who work in healthcare, I have always been a relatively diligent student. For the first two years of medical school, I listened to my medical humanities professors discuss death and dying. I participated in almost every group discussion on the topic. I *cared* about people. I always had, and I always will. It was why I picked medicine as a career in the first place, and I was hoping that I was prepared to empathize and comfort others when I actually saw patients. When I started my first rotation in my third year of school, internal medicine, I thought I was ready to face the loss of a patient—the only true thing I considered that I would mourn on this journey. That is why it really shocked me that the first time I grieved for a patient, she was still very much alive.

The patient was brought to the hospital for atrial fibrillation and had a history of bipolar disorder. That was all I knew when I went to get a history and physical. When I got to the room, I realized for the first time that I was wholly unprepared for the situation. The patient answered all of my questions with single words, and when I talked to her about management, all she had to say was that she wanted to go home. She did not want me to call her daughter. She did not want to talk to me. She did not want my comforting words. More than anything, she wanted to go home and had no explanation or touching story to share about why.

But as the days went on—1, 2, 3, 4, 5—any time I would go visit the patient after rounds, she would answer my questions, but still all she wanted was to go home. She did not want to talk about her daughter or what she was watching on TV or anything that I thought could help create a stronger patient-physician relationship between us. Everything I had learned in school was not working. Eventually, it was decided that she would be transferred to an inpatient psychiatric care facility. The only thing I remember feeling at that moment was a strange emptiness in my heart. When I went to see her for the last time after rounds, I pulled a chair to her bedside and watched cartoons with her in silence for a few minutes. The watcher at her side gave me an update on the television shows that had been on that day, but the patient did not talk to her or do anything else otherwise. That was when I finally started to speak, my voice a whisper. It felt like if I said the words any louder, they would have to be my final appeal to her. I asked the patient again if she wanted me to call her daughter, a plea that I did not realize I was making, and she said *no* once again. So, I walked out of that room, not angry or upset, but with a strange feeling of numbness and loss. After all, my patient was leaving this hospital alive; what could I possibly have to grieve?

I drove home, listening to music. I took my shower and then found myself sitting in front of my mom at our kitchen counter. As usual, she indulged me, listening to what I learned that day and handing me a "veggie salad" sandwich, her new recipe for the week. I was happily telling her about my presentation on heart failure and its resounding success when she interrupted me to ask why I was crying. I paused.

Why was I crying?

I thought about the multiple patients who received a terminal diagnosis of cancer from our team today. I thought about all the people who had no family to reach out to while they were dying who I had seen. But still, the first thing I thought of was the gaping hole of emptiness when I thought about my patient. I excused myself from the table, an old promise for help on my mind. A professor from months ago who taught us clinical skills when we were second years had encouraged us to reach out whenever we needed. I really hoped she meant it. At seven o'clock on a Tuesday night, I was making a call to an attending physician, one of the most intimidating things in the mind of a medical student.

My former teacher answered immediately. I could hear the voices of her son and his friends over the phone as she informed me that they were all over at her house. I felt the guilt and fear grow as I realized I had interrupted her while she was already busy and stressed. I told my story and explained to her how useless I felt. I had expected to be of very little help to patients medically, but I thought I could at least ensure that they felt dignity and comfort in difficult times. It was hard to tell her that I could not even really do that as I watched my patient wither away alone. I cried into the phone, feeling even more useless. What right did I have to cry when my patient was the one who would be suffering alone, her dream to go home just that: a dream. My mentor listened carefully, not interrupting for even one second, and then she said: "What if you guys did your own thing to honor your patients? Like a memorial where you can mourn them?" I thought about the idea and what I had heard from my peers and decided that this was the least I could do. I put aside my goal of answering questions and studying for that night and began brainstorming ideas, from sharing stories to the best location to host such an event. When I went to sleep that night, I finally stopped to wonder what my patient's house was like. In my head, I pictured a house with beautiful flowers exploding from everywhere, a low roof with wooden rafters, and a stone path leading to a bright red door—a secret garden.

The next few days I set about finding a room, dates that worked for everyone, and trying to find ways to best honor our patients. I talked to my peers and mentors, and we made an agenda. When the day came, fellow students and physician mentors all came to talk about their experiences with grieving. A student in the year above me spoke of how she journals to cope with the difficult things she sees while on rotation. Another student talked about how hard it was to grieve coming from a stoic family and how he found his own way of expressing his emotions. I heard about one student whose patient did not want to tell her family about her terminal diagnosis and how the student felt torn up inside watching her patient face her struggles alone every day. Another talked about a patient who decided to enter hospice care and finally felt free for the first time but decided to continue with life-saving therapy after talking to her family and the sadness she felt when she made that decision. One of our physician mentors talked about her experience as a resident with a chief who would not talk to the family of a patient who had passed. At first, she thought he was callous and cruel, but it turned out that he could not bring himself to face them. She explained to be careful not to judge others because everyone grieves differently. Finally, our block director shared with us how she copes with the loss of her patients. She asks every patient she has if they would be willing to share something about themselves unrelated to their healthcare so that she can get to know them more. If they pass away, she tries to remember them by the facts they shared about themselves and their lives rather than by their conditions and diagnoses. Hearing all of this was one of the most moving experiences of my life. I walked away, knowing that I was not alone and that we could talk through our grief when we see hard things. I learned about different ways to cope with losses and sadness while giving patients dignity and respect.

After this, I gave everyone wish paper so that they could write down their reflections from the day and their intentions for the patients they had lost and seen suffer. As I sat there surrounded by these people who had shared in these difficult experiences with me, I thought about the patient who had started all of this. I wrote one thing on my paper: my patient's wish to go home. When we burned the wish paper, I watched her wish fly into the sky. I hoped more than anything that it would come true because now, her wish to return home to that secret garden I had conjured up in my head had become a wish of my own.

* * *

Break

Clarice Douille

"We have low expectations for M3s this early in their clerkships. I'm disappointed in you; I had higher expectations for you."
"Be yourself. But . . ."
"I can see where ____ was coming from. You lack emotional intelligence."
"I expected you to have constant questions because of what's going on with your mom."
"Don't insert yourself into conversations."
"You are a med student; you don't have a reputation yet . . . you can't change medicine. Nobody will listen to you."
"Everyone is going through something. If you knew half the stuff I'm dealing with, you'd cry. So I know what you're going through with your mom right now is tough, but you need to compartmentalize and be fully present with patients."
"We know each other . . ."
I can't get this "feedback" out of my head.

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I can't quite escape my mom's breast cancer diagnosis since it is shoved in my face every day. This is exposure therapy like no other. Immediately after seeing my mom for the first time since her diagnosis—seeing her distressed and supporting her after losing 75% of her hair during the four days I was home for a visit—I was thrust into assisting with three mastectomies on my first day of the breast cancer surgery service.

My third year of medical school has been more than a struggle. I've accepted going through the motions as the best I can do, for I barely have enough energy to make it through each day. Every time I start feeling relief—like I can come up for air—I'm pushed back down and feel myself drowning. I'm constantly waiting for the next shoe to drop. While I can forget about my grief momentarily, as soon as I slow down, the pain returns in unrelenting multiples, pushing me into a dark hole of self-isolation.

All I've been doing is grieving. Grieving my mom's diagnosis and fearing the unknown. Grieving the idea that I'm a subpar daughter. Grieving that I'm a subpar friend. Grieving the idea of medicine I had believed in. I grieve for the medical student I was in the past, who wanted to excel in this setting. I grieve that I cannot be this student because I am frozen in fear. I'm grieving the life I thought I'd have, and the life my mom thought she'd have. I'm grieving the life we lost. Time is standing still and simultaneously going by in a blur. I want to be able to control something in my life. My heart and head are heavy with thoughts of disappointment, overwhelm, anger, guilt, and confusion. This is grief.

I need a break, but I fear a break might make things worse. In medical school, we are given no time to be human, to live a life full of joy, pain, achievement, and disappointment. I feel myself cracking. I'm being pulled in a thousand different directions. *I* might break. I tell myself I should be able to get past this. Everyone has something going
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on. Why can't I be like everyone else—able to tough it out and do medicine?

During clerkships, we are constantly thrown into vulnerable situations where we show up every day and put our best foot forward to impress our team and attendings. We can't miss a beat. It feels like we must be Superman. Every day, we feel inadequate and have to "fake it till we make it." It's soul-crushing. It's exhausting. Every day is terrifying. We worry about getting "pimped"—if we'll be able to answer any question correctly—if we'll present the patient adequately—hopefully not too long, or not too short—so our attending doesn't become annoyed. We don't know when we're allowed to go home, and it feels like we can't even go to the bathroom or eat without asking permission. It feels like we're back in Kindergarten, except with so much more at stake.

I think attendings forget that we're more than students and have lives outside of the hospital. If they're affected at work by things outside their control, how do they expect to judge us by a different standard? We shouldn't have to be completely different people when we are at work and put on a mask; we need authenticity. I wish taking my mask off didn't feel impossible and too exposing.

I'm slowly drowning, and I don't know how much longer I'll be able to stay afloat. Especially when boundaries are crossed, I lose the little strength I had maintained and am rolling downhill again, unable to find the brakes. I don't feel safe sharing my struggles. I can't do what will make me a better future doctor. I avoid medicine whenever I can. I'm sabotaging my future to avoid my feelings. I feel so alone. I am alone.

I feel guilty needing space to grieve in my own life. I'm not even the one directly suffering . . . why do I need space? I have no physical wounds. It's not me who is sick. I don't even want to complain to people about the pain I am experiencing as I walk alongside my mom on her journey because I know others are probably dealing with their own, likely worse, situations.

I am given bandaids to cover up my wounds because doctors shouldn't reveal their pain; we must keep it hidden away. I blame medicine and medical training for hanging me out to dry and encouraging me to suffer in silence. In reality, I know that blaming medicine and my medical education is simply low-hanging fruit. I am angry with the world for putting me through so many personal challenges that I have no control over—my mom's cancer being the most significant source of pain.

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Unfortunately, after a painful interaction, I couldn't discern who would support me. I hid my struggles from most friends, mentors, and loved ones. The doctor whom I initially trusted, used her power against me, shoved me while I was already down, and made me question my worth as a student and as a person. I was convinced I was never going to be good enough.

> *"This is someone's most important person in the world. They deserve for their doctor to know every single thing about their case . . . Wouldn't you want your mom's doctor to know every single thing about her case? . . . This just proves to me you don't deserve to suture."*

What if this was all true? I failed the patient, I failed myself, and I felt like I failed my mom. I felt like I could never do better, that I'd never succeed. I questioned how much I really cared about patients—a poignant reality check. I didn't know my patients, and I didn't care. All I wanted to do was be with my mom. But I had to repress those feelings, only to release them at the end of the day, home and alone. My attempts to talk to the breast surgeons I was working with—who knew about my situation—were all but dismissed. I realized I had done the bare minimum during surgeries. I found any excuse to leave the hospital. I lost what I cared about doing in medicine and felt like everything I did was worthless. I repeated to everyone, "Seeing patients is a formality, not a necessity." I was stuck. I was looking for answers to get out of the hole I was digging myself into. I needed a way to force a mindset shift.

I yell into the void and ask, "What happens in medicine when life gets in the way?" As it currently stands, the response is . . .

Compartmentalize!

This word has been ringing in my ears. I can't navigate around it. It seems to make sense. X marks
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the spot. It's all I need to know. But I can't wrap my head around it being the answer. Not once since hearing this feedback have I ever valued the meaning and symbolism behind the word–*compartmentalize*. I actually now have a disdain for it.

I know we are doing patients a disservice when we ignore our own suffering and don't take the time to grieve—be it a patient we lost, a hard work situation, or something from our personal lives. How can we truly help patients if we feel we aren't allowed the time to take care of ourselves and the important people around us? Are we really being present with our patients when we "compartmentalize?" I don't think we're doing *the* best—even though we may be doing *our* best under this system.

And why is this the expectation? We're all grieving something, yet nobody talks about it. Can we promote talking more about our shared suffering? What we do and see daily isn't normal! People are not meant to experience the suffering doctors and trainees face daily. It is frustrating that within the current system, it feels more valid to take on the suffering of others and talk about their feelings while never addressing our own.

If this is truly the only way to practice medicine, I need to be taught how to compartmentalize. *See one, do one, teach one.* They expect me to know how to compartmentalize, but I don't think it is natural to compartmentalize to this extent—when your whole world feels like it is crashing down. The modeled way of suffering in silence and not addressing issues perpetuates cynicism, burnout, and moral injury in medicine. We need more people to walk alongside fellow healthcare workers and have deeper, more genuine connections.

We can't be good physicians if we can't address our *own* suffering. I've been trying to help myself, which at times feels selfish, but I'm doing it in the hopes I don't close myself off—so I can be there for patients and be a great future physician. I want to be better than the current system; be less toxic, reflect upon things I can change in medicine, and be there for others who are grieving. There is a larger problem surrounding unaddressed grief and our failing of patients.

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I failed myself and gave into the broken system momentarily. Fortunately, I found inspiration in my mentor, who did everything I hope to do for my colleagues in the future. When I was broken, my mentor called me and reminded me that I am not the person the surgeon made me out to be and that I've influenced so many people for the better. My mentor reminded me that I have so much more to offer the world, and if the surgeon can't see it, then it's her loss. She went out of her way to help me through the worst year of my life. I felt heard and supported. I didn't feel as alone anymore. She was there for me when I was traumatized, and wouldn't allow me to mask my grief any longer. She knew it was only hurting me and that I had momentarily "lost the twinkle in my eyes that allowed me to connect with and bring joy to so many others."

It took some time, but working through my grief rather than pushing it off helped me get back on track. I took the break I needed to find myself again, find my spark, and see the best parts of medicine—that I had believed in, which drew me to the field in the first place. I'm no longer focusing on my frustrations with medicine, but I'm reinvigorated to change them. I still have qualms with the current system, but my mindset has changed due to the positive influences surrounding me and molding me during my medical education. I've seen the path I never want to head down again and am using that to fuel advocating for change. Medicine can be beautiful and meaningful—helping people through the toughest part of their lives is an experience like no other. Healthcare professionals need to focus on reconnecting to what matters most and supporting each other through the good times and the bad. We don't have to pretend that only patients suffer. Grief is universal; we don't need to go about it alone.

Taking the time to grieve our own suffering can make us better clinicians. We can better understand what our patients go through. But this only happens if we do the work to face reality, heal ourselves, and emerge more resilient.

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Five More Minutes

Kristen Carey Rock

Five more minutes. How many times have you said the phrase, "I need just five more minutes"—perhaps to finish a note, clean up the kitchen, or read the kids a bedtime story? It is a seemingly insignificant amount of time. But what if you knew that these five minutes were the last five minutes you would spend conscious on this earth? The last five minutes you would spend with your parents and your young children before you would receive a sedative and be transported down to the operating room, where you would be removed from life support and then donate your organs? In a hoarse rasp through his tracheostomy, he kept whispering, "Please. Just five more minutes."

This is the reality that I walked into one Friday morning in 2021 as I took over the ICU service at my hospital. I am an ICU doctor at a busy academic center in the northeast and was on the frontlines of our COVID response, including the care of patients who required ECMO (extracorporeal membrane oxygenation)—the last resort for treating patients suffering from severe lung disease.

I did not have the privilege of meeting this patient until the morning of his death, but I knew he had been in the hospital for close to three months due to acute respiratory distress syndrome (ARDS) due to COVID-19. On the spectrum of COVID symptoms, this problem is the worst of the worst, and it left his lungs in tatters—so much so that he had relied on an ECMO machine to perform the functions of his lungs for many weeks in hopes that he would either recover or become eligible for a lung transplant. During this time, many hundreds of doctors, nurses, nurse practitioners and respiratory therapists had gotten to know him quite well. They met his father, former wife, and his four school-aged children. They learned of his service to our country as a member of the Air Force and his subsequent devotion to his community as a religious leader and beacon in his community. As he recovered to the point where he was able to be awake and interactive with a tracheostomy, allowing him to mouth words, they also got to know him as a kind and gentle man with a fierce will to live and devotion to his family.

Yet, after many weeks of ups and downs, progress and setbacks, it became clear that he could not survive without the help of his ECMO machine. Though it is possible for someone to survive for many months on ECMO, like most forms of life support, it is a bridge rather than a destination therapy. More complicated and invasive than other forms of life support, it is resource-intense and fraught with medical complications. And one day, came the heartbreaking news that due to too many blood transfusions during his illness, he would not be able to receive a lung transplant. He and his care team realized this meant there was no path forward. It came as little surprise to those who knew him that when he realized that he could not live independent of machines or outside the walls of an intensive care unit, his final act would be to help others. He would give others the opportunity for the organ transplant that he so cruelly could not receive.

And so, the date and time were set. The transplant teams from other hospitals began to arrive. His final morning on earth would be spent with his family, except for a last trip outside to see the sunshine. With masterful coordination, his ICU room was recreated on the roof atop our helipad. As an army of caregivers attended to his tubes, pumps, and machines, he was able to feel the warmth of the spring wind as the Air Force sent an honor guard of fighter jets to pay their final respects. I watched him smile as the planes flew overhead, unsure if he could see or just hear them. Even though someone had the foresight to place a pair of sunglasses on his face, he still grimaced at the sunlight after months of artificial hospital lighting.

And then, we waited—waited for him to say goodbye. Silently, crowds of staff lined the halls of the ICU and waited to pay respect to his family and to honor his life. It was not five minutes. Finally, his bed emerged from his room, escorted by his father, whose look of anguish still haunts me. He broke down as he watched the elevator doors leading to the operating room close with finality.

I will never forget this patient, who to me, is associated with so many of the complex emotions I have experienced as an ICU doctor over the past four years. For one, a deep sense of loss. I spent lots of time over the early pandemic years faithfully and analytically charting the numbers—test positivity rates, mortality rates, vaccination rates, ICU bed availability, and inpatient COVID numbers. I hoped against hope that the first wave would be the last, but I quickly realized that this disease was not going away and that it would profoundly alter almost every aspect of our lives. As national tallies flashed across the 24-hour news tickers, the faces of those patients we could not save would flash through my brain. It's always easier to remember your failures rather than your successes.

Losing a patient is never easy. Losing a patient during COVID created a moral distress that was magnified. For the first time, I grappled with the now very stark realities of the ethics of scarce resource allocation. Decisions about care were being made by surrogate decision makers who were either unwilling or unable to make the decision to forego care that was prolonging death rather than preserving any chance of recovery. These decisions were hurting others. They were hurting patients who were suffering and denying other patients the opportunity to receive care. We had four ECMO machines reserved for COVID patients in our ICU, which meant there were calls for help from other hospitals daily. We could not say yes to many of these calls, knowing that this would likely be a death sentence for the patients on the other side of the phone. For years, our health care system has prioritized respect for autonomy over justice. Perhaps reexamining this balance is one of the silver linings that may come from this collective COVID experience. These decisions also hurt caregivers, particularly the nurses, who were tirelessly working to keep these patients alive. I watched many colleagues and friends take jobs far away from an ICU or leave the profession altogether.

This case was one of the more dramatic instances of my moral distress but sadly not the only gut-wrenching one for me in these COVID years. A significant factor in moral distress is helplessness and gosh, did I feel helpless . . . a lot. I felt helpless as I cared for a 30-year-old who died from sepsis due to appendicitis, which had been missed; he had been told over Zoom that his symptoms were probably related to COVID. When not caring for COVID patients, I found myself caring for an ever-increasing number of liver transplant patients. The cause was alcohol. As substance use disorders developed unchecked during the pandemic, our numbers tripled. I felt helpless as I saw the pain on families' faces as I conducted end-of-life conversations over Zoom and in parking lots to comply with hospital COVID visitor regulations. I could only validate their anger when they were not allowed to visit and to say their last goodbyes. Helpless as I had to defend these policies long after it seemed quite reasonable to relax them in the era of vaccination and masking; helpless in feeling that those making the decisions were not on the front lines dealing with the fallout.

I suppose then it was inevitable that my helplessness turned to anger: anger, as I knowingly provided futile medical care, particularly when it involved ECMO; anger at patients who chose not to, for whatever reason, receive the vaccine, which could have prevented severe disease and death; anger watching the management of a disease become a political football and fodder for the culture wars; and anger as I saw an increasingly corporatized health care system prioritize business over both patients and the millions of health care workers "in the trenches." The language of war was used often, and indeed, it felt very appropriate. As the pandemic progressed, we seemingly transformed from the celebrated war heroes leading the charge to the forgotten veterans, nursing our own wounds alone.

The emotion that is hardest to admit was particularly relevant to the patient who pleaded for more time. I was ashamed. You see, I needed that five minutes, too. I wanted five minutes to cry in the bathroom before I had to continue rounding on the 16 other critically ill patients requiring my attention that day. What kind of person begrudges a dying man five minutes? Time was a luxury that I did not have. The amount of work only increased as it was shared by fewer and fewer due to the departure of colleagues, sudden absences due to quarantines, and last-minute mobilizations of surge units. Extra time spent at work was less time spent with my family, who had already been forced to endure sacrifices related to my professional responsibilities.

A family who also needed my time and was increasingly resentful that there was no end in sight to this "new normal." I was ashamed when I knew I was viewed by some professionally as lesser, because others were seemingly able to find a way to do it all without complaint. Though it remained unsaid, an aura of failure was associated with admitting that it was too much.

Fortunately, I believe I have arrived at the last of the proverbial stage of grief—acceptance. Though my career looks different from what I had envisioned before 2020, I remain grateful to be a doctor and continue to find meaning and value in my work. Ironically, prior to the pandemic, I had focused some of my academic work on the concept of resilience. Little did I know how important resilience would become in my own reckoning of the last few years. I hope that in the coming years, I will be able to use my experiences constructively. For now though, after seeing so many struggle for air, I am truly grateful to be able to take a slow, deep breath. And I do not ever take those five minutes for granted.

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I Saw My Reflection

Adrienne Feller Novick

I saw my reflection as I looked through the window of the isolation room. The image caused me to pause and look again. The reflection of sunlight had merged my image and the patient's together. For a moment, we seemed to be one person.

She was pale with translucent skin, her bald head obscured under a colorful scarf. Her three children sat as still as statues, staring at their mother wordlessly. Then, I realized her children appeared to be the same ages as my children. I felt a surge of emotions jumbled together, a mother should not die like this, leaving her young children motherless. She and I shared the exact same birthday; it could have been me in that hospital bed. However, I did not have a terminal diagnosis and my children were safe at home, complaining about doing homework. In the blink of an eye, without even recognizing what had just happened, I was face to face with my mortality.

I tampered my emotions and held them back. I collected myself, and remembered the reason I was there. My professionalism took charge. I am a member of the Medical Ethics consultation service at a large healthcare system. A request was made to help with the ethical dilemma of a patient with a grave prognosis unwilling to discuss a hospice referral. The dilemma here represented two issues in conflict: patient autonomy and provider beneficence versus non-maleficence. Respect for autonomy allows each person the right to make informed decisions about their care that respect their values and personal beliefs. Provider beneficence is balanced by non-maleficence: beneficence is the expectation that physicians make treatment decisions in the best interest of the patient and non-maleficence guides physicians to minimize harm. This case called for analyzing the balance of autonomy with proportionality, weighing the risks versus the benefits of treatment decisions.

I knocked on the door and they all turned and looked in my direction. The patient signaled me to enter. Although she was smiling, the sadness in the room was palpable. I introduced myself to the patient and her children and diplomatically explained the reason for my visit. I turned to the children and asked if there was anything I could get for them. I got three weak "no thanks." I asked the patient if I could stop by later. Then, I went to see my next patient. When I returned, I listened with rapt attention as she described the mosaic of her life story. When she finished, we sat together for a long time, neither of us speaking. Out of the blue, she told me she was not afraid of dying. She said she would welcome death to end her pain. She continued, explaining that her fear was that her children were not ready to accept her death. She was worried about how her death would hurt them, and all she wanted to do was to protect them. She reiterated her wish to be kept alive with all aggressive medical treatment possible. She communicated that she understood and appreciated the severity of her condition. Her reason for continuing treatment was to give her children precious time. She said, "I would lie in front of a car to protect my children." As I was heading towards the door, her eyes welled up with tears. She thanked me for listening and for my kindness. We said our goodbyes. She remained full code and died four days later during cardiopulmonary resuscitation. I walked past her empty room later that day and kept walking.

I was not prepared for how her death changed me. Throughout my career as a healthcare professional, I have primarily worked with patients at the end of their lives. I have seen many empty rooms following the death of a patient and helped countless people journey through their stages of grief towards acceptance. After I complete a consultation, I move on to the next patient. I do this every day. This time, something was different. After she died, I was not sleeping well, I had a hard time concentrating, I was not eating well, and I was feeling nervous for no reason. I never spoke about her death with anyone. I was sure no one would understand my profound feelings of loss for a person I had only met a handful of times. My practice changed; following her death, if I saw children in the room visiting a patient, I would come back later when the children were no longer there. When it was possible, I delayed my visits with patients my age.

Two weeks later, while I was driving home from work, the traffic light turned red and suddenly, I began sobbing. I drove my car to the side of the road and sat in stillness. Something was clearly not right. Why was this happening? Nothing like this had ever happened to me before. I was flooded with feelings and realized I had two distinct compartments for my emotions. As I entered the workplace, I unconsciously tucked my emotions away, tightly wrapped and hidden out of sight. The other compartment was everything else, all the complex feelings of my life. During this case, the compartments collided, and my emotions were no longer hidden out of sight. Intellectually, I know that time passes swiftly, and then I too will die. However, this time, it felt like it was part of me in that bed; it was my children grieving the loss of their mother; it was me being willing to do anything to give my children time to accept my death. I was grieving for the loss of a patient and grieving my own death.

I felt uncomfortable talking to anyone at work about what was going on. No one ever taught me it was inappropriate to have these feelings, and yet I was embarrassed. I thought strong feelings about a patient's death were a sign of emotional weakness. I was not sure about the right course of action. I struggled with my powerful emotions and was unsure of how to proceed. Then, while I was headed to my office, by chance, I noticed the hospital chaplain walking past. In a moment of clarity, I realized he might be a good person to speak with. When I went to see him, I was too shy to tell him the story about the patient or what had been happening with me. Instead, I asked him if he ever feels sad about the loss of a patient. To my surprise, he said without hesitation, of course he does. I felt a tremendous surge of relief that I was not the only one. He explained that over the years he had learned some basic things that had helped him. Upon hearing that, he had my undivided attention. I asked him if he would be willing to share his thoughts.

His message was straightforward. First, understand there will be a time when you see yourself in the patient you visit, you will see a loved one, you will see a friend, it will be someone you know. This will happen and when it does, acknowledge it to yourself before you continue. Second, you are not alone. Many of your colleagues are having similar experiences. Find a trusted person and support each other through your experiences. He told me what my father used to say, "People need people." I felt validated. I knew he understood. He continued, third, take care of yourself. When you are tired, rest. At the end of the day, go home, relax, and enjoy yourself. Leave your work at work; do not bring it home. If you do not take care of yourself, you are doing yourself, your loved ones, and your patients a disservice. The essence of his simple message has guided my career.

My combined experiences at the bedside have given me a new freedom, and changed my practice. I no longer separate my emotions into different compartments. I bring my full range of emotions into the workplace, and I remain a qualified professional who works hard to provide optimal patient care. Additionally, I have the privilege of teaching medical students, residents, nurses, and other bedside professionals. Teaching has given me the opportunity to use my experience to normalize grief and prepare others for when this happens to them. There is no question that recognizing my humanity has been humbling. My awareness has made me a more resilient person and improved my ability to work at the bedside with patients. I am grateful for the opportunity to be a lifelong learner, for the gift of my emotions, and to use my experience with grief to help others.

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The Aftermath

Andrea Eisenberg

The cantor begins, humming softly, gently strumming her guitar. Soon the rabbi starts reading, his voice somber as he recites the traditional prayer on Yom Kippur.

"How many will pass away from this world, how many will be born into it;

Who will live and who will die."

I feel my eyes tearing up. I look down and take a breath, but I can't seem to stop the speeding train of memories.

"I'm sorry, we did everything we could. . . . ." My head was spinning. *No,no, no, this can't be . . . this can't be really happening . . .*

I looked up at my patient. Her mouth was open in a silent scream. Her eyes searching the eyes staring back at her. The nurses, the neonatologist, her husband all surrounded her, reflecting back her shock and incomprehension.

I stopped breathing. My hands felt cold. My fingers were tingling. No one was looking at me. It felt like there was no air in the room . . . I just needed air. Embarrassingly, I walked out of the room.

"Who will reach the ripeness of age, who will be taken before their time."

It all began on an early spring night, the air fresh with new growth and possibilities. Heralding the warmer days ahead, the purple crocuses were just peeking out of the grass. As I walked to my car to make my way to the hospital, the crisp coolness of the melting winter brushed across my face, wiping away the warm touch of my baby's cheek moments earlier. Driving off, my heart tugged me home; my brain tugged me to work.

The dusky sky accompanied me along the drive to work—the gradually fading light behind me, the darkness ahead. My mind began shifting from home to the woman in labor, starting her own motherhood journey. I imagined her excitement as well as her weariness of labor.

The bright lights and the hustle and bustle of a busy labor and delivery department greeted me as I entered the unit. I found comfort in the dimly lit room of my patient. I could make out her blond hair flowing over the pillow and blankets overlaying her body. Her husband, sitting on the bench next to her, was lit up by the brightness of the phone screen he was intently looking at. The quiet beat of her baby's heart on the monitor was soothing in its cadence and reassuring to me.

The rabbi then walks to the center of the bima with the cantor as the choir continues to sing. He begins to hit his chest gently with each line.

"Avinu Malkeninu[1]*, sh'ma koleinu, chus v'racheim aleinu.*

Avinu Malkeinu, hear our voice, treat us with tender compassion."

The cantor and choir respond back, their soulful voices splay open my heart even more.

She was an incredibly strong pusher. But it was her first baby and the trail had not been blazed before. The baby was rocking back and forth in her pelvis, trying to get under the pubic bone and out. With time and effort, I began seeing the top of the baby's head with each push, but then it disappeared in between.

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[1] *A prayer chanted on Rosh Hashanah and Yom Kippur, in which we ask God for healing, sustenance, and to be inscribed in the Book of Forgiveness*

Without looking at the monitor, I could hear the baby's heart rate slow with each push, the heart responding to the head being compressed in the birth canal. "Stay strong," I told her as I saw her begin to tire. But the baby was tiring too, its heart not returning to its regular rate in between contractions.

"Avinu Malkeinu, Avinu Malkeinu" the choir chanted.

Avinu Malkeinu, have compassion on us," the rabbi responded.

After a few more pushes, I knew I couldn't watch this much longer, I knew the baby was really struggling, it's heart rate becoming more alarming. "I need you to stay strong and really push hard. I may need to help you if the baby isn't out soon," I told her.

"No, I can do this!" I could see the determination on her face.

And there we were, my patient, pushing her heart out, wanting to do this "on her own," and me, trying to remain calm while anxiously watching the baby's heartbeat—wanting to honor my patient's birth plan while needing the baby delivered as soon as possible. The baby was crowning for a long time, I don't know how long. It seemed forever. But was it really? We were all encouraging her to push harder. The baby was so close. The tension in the room made time feel so slow. At any second, the baby was going to pop, but then it kept taking more seconds . . .

With the choir and cantor in the background, I began my own prayers.

"Avinu Malkeinu, be gentle with me in my moment of pain."

Finally, the head delivered with a huge cone shape from squeezing through the birth canal. I suctioned the mouth and nose; another push and the rest of the baby was out, but this was not a vigorous, crying baby. This baby was limp and pale. My heart started racing. I quickly brought him to the warmer and rubbed his back, drying him off to stimulate him to breathe. The neonatology team took over, so I went back to the patient. I kept reassuring myself—I had delivered babies stunned and limp, but then easily revived. I chatted with the patient, reassuring her that we would hear her baby cry any moment . . .

Avinu Malkeinu, be gracious and compassionate towards me when I cannot.

But there were no cries, only the frantic sounds from the neonatologist attempting to resuscitate the baby. My heart was sinking. And after some time, what seemed to be a long time, one of the neonatologists came over and began, "I'm sorry, we did everything we could. . . . ."

Avinu Malkeinu, Avinu Malkeinu

I don't know how I drove home, how I got into bed, or if I slept at all. I kept replaying the delivery over and over again. I shivered under the blankets even though I wasn't cold. I don't remember if I told my husband or not. The next day, I was on automatic—I showered, dressed, and held my daughter. Her warmth was the only thing that felt alive. At the office, I sought out my partner to talk. He said he would follow up with the patient later that day. I couldn't face her. I couldn't face myself. It felt for weeks as if my hands were covered in death.

Later in the week, I heard there was another delivery, almost exactly as mine went and the baby died also. I wanted to comfort the other doctor. Instead, I found myself mute. Walking into the hospital for our weekly department meeting, I assumed everyone was staring at me, judging me, talking about me, but the reality was worse—no one said anything. No one approached me at all. I felt invisible, unworthy of their companionship. I assumed I was now known as the doctor who had a neonatal death at a delivery—the biggest fear of every obstetrician.

I remember a stillbirth that occurred when I was a resident. I wasn't present at the delivery, but the rumors spread fast, so I knew about it within hours. I recall the sense of alienation for that doctor, how horrible he must have felt, and I had always wondered how he was able to work again but was too afraid to ask him. The memory felt so vivid; it was as if the years hadn't passed.

As per protocol with any death, there was a departmental investigation. The autopsy showed some minor abnormalities of the baby's heart and other organs. Was this enough to compromise him so he didn't tolerate labor? Basically, the department chairman said there wasn't much to say as he knew I had already judged myself harshly. That was it. I was not put on probation, but also I was not given any support. I was left alone to float in the muddy waters of depression, guilt, hopelessness, and grief. I thought about what it must be like for those in the military, witnessing death and then having to return home and function like they did before. Was I just supposed to go on like nothing had happened?

It did not end there; a year later, the lawsuit came. I couldn't understand why they waited so long. My partner didn't think they would sue, but I knew. I just knew in my bones. Over and over, I had to relive the pain, the guilt, the shame, the questioning. Because of the lawsuit, I couldn't talk to others about the case. I was isolated like a pariah floundering to survive. Over and over, I would try to right myself, only to stumble into the darkness again. I couldn't imagine the depth of pain the parents felt; mine felt bottomless. Each delivery would stir up the fear again and again.

Although this happened many years ago and, over time, I found joy in my work again, the introspection during Yom Kippur rekindles this memory each year. I pray I have been forgiven by that patient, her husband, the baby, and God. I still question why I had to be the one on call: did I do the right thing; what might I have missed? What could I have done differently? I have delivered hundreds and hundreds of healthy babies since; some I remember vividly, some I do not, but this one delivery will always haunt me.

Avinu Malkeinu, help me to find grace to forgive myself.

* * *

Where the Journey Begins

Japmehr Sandhu

As a fresh medical graduate in India, you are first required to go through a year of mandatory internship at your parent institute. Mine happened to start in 2021 at a government hospital in Northern India. There were a series of coincidences at that moment.

To begin with, I started as a physician-in-training in the middle of the second wave of the COVID-19 pandemic whilst staying with my 70-year-old grandmother. This coincided with my hospital being declared a "COVID only" hospital and requiring the transferring of all non-COVID patients—critical or non. The country was seeing a shortage of oxygen supplies in private hospitals and even saw incidents of oxygen cylinders being looted. For my first rotation, I was coincidently allotted the COVID ward, which meant that my very first patient was a COVID patient. This start also coincided with all the second-year residents coming back after recovering from COVID—the confidence and thrill of fresh immunity translated into a shirking of any PPE equipment. With these fortuitous series of occurrences, combined with the fact that I had not seen a single clinical rotation in 2020, being 'overwhelmed' would be an understatement.

This story is about my first shift. The sentinel thing that struck me upon entry was how it seemed I had automatically jumped up an imaginary level across professional hierarchies. Being offered a chair and a cup of tea seemed so surreal, but I welcomed it. It was also a subtle way of making me realise the change in my prefix and the duties that come with it. Armed with this greater power and greater responsibility, I embraced my first job of getting the whole ward's vitals down. Following this, I was told to focus on the patients on ventilators since the hospital did not have enough monitors for all the patients at the moment.

Feeling like a novice doesn't even begin to describe how I felt being the only professional in the ward wearing a bright white PPE kit, resembling a half-filled balloon in the middle of the April heat, walking down the halls making "swish-swish" sounds. I had never seen a working ventilator till that point. I had never led interactions with patient families, and I had certainly not been in a position where they solely looked up to me for information about their loved ones' well-being since the ward did not allow visitors. This sense of responsibility made my tongue feel heavier than usual—like any and all sounds and words made by it would acutely affect the mood and behaviour of many.

One of the people accompanying a patient on a ventilator asked to have us check on their patient. I was sent for the same. The patient was in the same position as the morning, the ventilator continuing its job—obvious from the way the air was rushing through the pipes and making his chest inflate and deflate. The patient, a thin man in his 30s, was sickly and cachexic—I started with the vitals. However, the BP monitor couldn't measure the same, so I started using a manual sphygmomanometer. I couldn't locate the radial pulse and moved to the carotid, but with the tracheal movement by air being pushed in and out by the ventilator, it was hard to ascertain any other pulsation in the area. I decided to call my senior after feeling the patient's hands and feet and finding them cold. When the resident arrived, he immediately concluded the patient had passed away and turned to me and said, "Why did it take you so long"? Followed by, "He was fine this morning. What happened"? He then just went back to the resident room and continued scrolling on his phone after sending a brief message to the hospital group, which read: "One from Ward 6".

My first shift of 6 hours saw 17 deaths. After each death, there was a notification in the group and a continuation of the cycle. Apparently, these patients were too far along to be saved from a disease that did not have a cure or a validated treatment plan. The seniors in the ward would carry on with the remaining work after each death. I wondered if that was a choice or something they felt compelled to do; after all, time moved on. On the other hand, it seemed like a part of me was in suspended animation. After that first patient death, I had positioned myself in the corner of the resident room and was sitting on a stretcher with my feet dangling over the edge, staring forward, trying to unravel my own emotions. After 30 minutes, the senior resident made it a point to tell me that I needed to move on, or I would be useless to those still around. In my sense of righteous anger, I felt like he meant I would be useless to *him* rather than the patients. I was, after all, a glorified errand boy at that point. I did not feel numb or paralyzed in any way; I just felt misunderstood. I merely wanted to understand how I felt in the moment and give that emotion its due. But I wonder if I was overestimating myself.

Once my shift ended, I decided to call friends who also had their first days the same day. But none of them had been allotted the COVID ward yet, so we couldn't talk about the experience with the same vitriol. After reaching home, I entered my room from the back door of the house—something that I had agreed to beforehand so it would minimize any interaction and risk of infection to my grandmother. I would be staying only in my room for the two months I was to work in the COVID ward. This isolation was pragmatic to my independent self. However, at that moment, as I lay down in bed, I realized my need for a simple hug and the vision of a concerned face listening to me, if only for a second. That is how I realized I was grieving.

To ground myself, I turned to introspection and further reflection. My grief extended beyond my first lost patient. It included everyone involved in that shift. I was grieving the way the residents, nurses, and class 4 workers (janitors) on the floor had been through enough of these days to now be capable of moving past their emotions so seamlessly that a new intern could not tell it apart from apathy. It made me question whether this was an ego-defense mechanism for some or an exaggerated reveal of the usually understated extent to which grief is embedded into each healthcare professional's interactions. I grieved the opportunity to learn how to be a healer to someone before failing at it. And with that, I also felt sadness for my entire generation of doctors who would be starting their careers with similar shifts. The beginning of their medical career will always hold these intense emotions mixed with a feeling of hopelessness and misplaced accountability.

With time, I recognized how overworked the team in those COVID wards had been. I retrospectively recognized the significant impact of uncertainty prevailing in these hospital wards (amidst the unpredictability of the disease itself), adding to the enigmatic and surreal essence of practicing medicine at that time. Delving into the literature on physician burnout further affirmed my belief that this reaction mirrored a heightened response to the challenging environment. In discerning these themes, I felt validated in my emotions and grief. I found myself in a position where I could potentially understand my senior's behaviour—both towards myself and the ward as a whole. However, I could not wholeheartedly accept it. Perhaps one day, further into my career, I will. To be reasonable is entirely different from being relatable. Meanwhile, I also felt encouraged to take action and formed a support group of sorts with like minded peers. We motivated new interns to come together, introspect, and engage in dialogue. The discussions were sometimes charged and opinionated and sometimes sober yet whimsical. Dialectable therapy was only something we had read in books till then. Sometimes, it helped the speaker directly, and sometimes, it clicked something in the listener and indirectly helped them, too.

Now, having completed my internship, I can respond to these incidents more tactfully, not because of the increased normalcy of death and grief itself, but because of the congruence of my emotional and practical senses. More importantly, I can talk to myself with more nuance during moments of grief. I found that it undoubtedly helps to know you are not the outlier; not the overthinker. Everyone follows their own pace of processing situations—their own method to the madness. Finding your own may not be easy, but it will always be worthwhile once it clicks into place. After all, you can put in the work, but you are not entitled to the results.

Contrary to what I had thought as a fresh medical intern, the four pillars of medical ethics may translate in a more subjective manner. While it is important to make sure your practice touches all four tenets of beneficence, non-maleficence, autonomy, and justice, it is equally important to ensure that these ethical principles are understood before they are practiced. One way of reaching this understanding is via reflection. As someone responsible for another human's health, we hold the moral duty to do our best; whether we are always successful is another matter entirely. One must remind oneself to make peace with the results, not only for the sake of the next patient but also for oneself. I believe my sentiments on this issue will evolve with time, and I am aware that my early exposure to patient demise has a role in the trajectory of this thought process. I also believe there are many others from my generation of doctors who are on this same journey of reflection and introspection due to the same. It is my hope this will guide us to be a more morally and ethically strong generation than expected.

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Lessons Learned in Room 208

Katherine Bakke

Author's Note. Parts of this story were previously shared here: https://theinterstitium.home.blog/2020/06/01/journeying-to-a-time-of-death/

I remember the first time I saw a patient die. I was a medical student on my surgery rotation. Pushed to the sidelines of the resuscitation bay while the trauma team tended to a teenager injured in a motorcycle crash, my attention was drawn to the drama unfolding next door. There, a team of physicians performed CPR on a man. While a curtain and a comforting social worker separated the patient's wife and daughter from the horrors of the resuscitation, I had a full view of everything. I watched as each chest compression threw the man's belly upward, like he had a bad bout of the hiccups. I watched as each pulse check yielded no return of blood flow. I watched as his wife and daughter clenched their hands in prayer, muttering, "Please, please, please." Then, the physician called the code. The instant the doctor pronounced him dead, I felt the presence of one less person in the room. I was surprised by how visceral this departure felt. It seemed like a sacred moment, a small proof that our bodies do indeed house our souls.

I started paying close attention to how surgeons talked about death. Discussions of death seemed frequent in windowless work rooms amongst doctors, or in hushed conversations at the nurses station. Discussions of death were notably absent when talking with patients or their families. Sometimes, it seemed that the sicker the patient, the less likely their possible death was acknowledged. I was fascinated by how challenging it was to speak honestly about our inevitable mortality. I began reading everything I could find about discussing end-of-life issues. I even conducted and published a systematic review on the subject. When it came time for me to begin my own surgical training, I carried with me a naive confidence, eager to engage in these conversations at the bedside.

My time finally came eight months into my intern year. I was working in the intensive care unit and was "up" for the next admission. I got a call from the emergency department, saying a 68-year-old woman needed an ICU bed for a heart failure exacerbation. Her breathing was labored. They had given her IV Lasix, but I was told she might need BiPAP or other respiratory support while her heart failure was managed.

Ten minutes later, she rolled into Room 208, and the ICU nurses started their work transferring her from the stretcher to the bed, applying EKG leads, a blood pressure cuff, and a pulse oximeter. I stood at the foot of the bed and quickly realized I had never taken care of a patient so ill. Her head drooped to her chest, every ounce of energy used to draw her next breath. She could only mumble indiscernible words; she hardly had the energy to open her eyes. I glanced at the monitor displaying her vitals: heart rate 120, SpO2 84%, BP 70/40. A foley catheter hung at the bedside, and no urine was present. "They gave her Lasix downstairs, right?" I asked the nurse. We both looked at the foley bag, and then at each other. I glanced at the patient's lips, which were dry and cracked. I pinched the skin at the top of the patient's hand, and it tented. I was pleased with my exam skills, and my ability to deduce that she was dehydrated. "This isn't heart failure," I thought, as I considered other reasons for her illness. The nurse awoke me from my self-congratulating stupor and reminded me sternly, "We need orders."

The situation rapidly became more critical. The patient's arterial blood gas (ABG) showed a pattern of impending respiratory failure. Her daughters arrived at the bedside; one was wearing hospital scrubs. I introduced myself to them as the resident doctor caring for their mom. I asked if the daughter wearing scrubs had a healthcare background, foolishly thinking that doing so would build rapport. She curtly replied, "I'm not here to talk about myself. I'm here to talk about my mom."

The atmosphere in the room was tense. I could tell that they were suspicious of me and my abilities as a doctor. So, I decided to stick to the medical facts. "She needs to be intubated," I said, gesturing to their mother's bobbing head and explaining the results of her ABG. The daughters were reluctant to allow intubation, a hesitation I could not understand despite my probing questions. However, they finally yielded, and the patient was placed on the ventilator. Her influenza test came back positive that evening and her chest x-ray demonstrated a superimposed pneumonia.

She stayed on the ventilator for two weeks.

Over the course of those two weeks, I learned about sepsis management. She required 20 liters of fluids, steroids, three pressors, and antibiotics. Somehow, after the tenuous first week, she started to show signs of stability, and then improvement. Her body began to release all the fluids that had been pumped into her veins, the pressors were taken away one by one, and the ventilator's support decreased. She was extubated on a Sunday.

But on Monday, her belly hurt, and I didn't know why.

On rounds, I mentioned this to the attending, who examined her and agreed. We ordered a CT scan, which revealed a large amount of blood in her retroperitoneum. The cause was unclear, but the blood was nevertheless there. As her blood pressure started to fall, we gave her blood, switching our plan from convalescing her from her pneumonia to treating her for hemorrhagic shock. The turn of events was unbelievable.

We debated about whether or not we should get an angiogram. We needed to know where she was bleeding because we needed an intervention to stop it. But the contrast, we knew, would ruin her kidneys, which were already injured from her sepsis. We decided to accept the risk.

I traveled down to the radiology department with her, pushing her bed as the nurse managed the IV pole hanging red cells and plasma. She had responded well to the blood and was alert enough to hum church songs to herself. As we positioned her in the scanner and hooked her IV up to the contrast that would destroy her kidneys, I looked at her and said, "I'm worried about you."

She looked at me, the most serene smile on her face. She said, "Oh honey, don't you worry about me." She had the most delightful voice—soft and sweet with a southern accent. This was the first and only time we were able to speak to one another.

The angiogram didn't show a blush; there was no discrete bleed for the radiologist to stop. She continued to bleed overnight.

The next morning, I arrived to the ICU to find her intubated and on triple pressors again. The attending found me before rounds and said, "I need you to convince her family to make her DNR." I knew that a change in code status was often the first acknowledgment that something was gravely wrong, a cue to the family that the patient may not survive. It was a task I had craved as a medical student and believed I could do well—tell a family compassionately, gently, and honestly that their loved one was dying. I went into her room and started talking.

I could only get so far.

"She's very sick. The blood is helping, but the bleeding hasn't stopped. Her kidneys don't work. She needs dialysis, but we can't do it now with all the pressors. We need you . . . we need you . . . we need you . . ."

I couldn't complete the sentence. I didn't want her to die, and I felt just as stunned as her family by the rapid, unforeseen change in her clinical status.

In a small act of mercy, a senior resident took over the conversation for me. I stood next to him, my eyes burning from tears, overwhelmed by grief.

What I remember most from that day was how out of control I felt. I was impotent against the hemorrhage. Every hour, the lab would call me with a critical result. Every call felt cruel, reminding me of my failure and of the patient's impending death.

She died that night, soon after I left the hospital. The next morning, as I entered the ICU, I was ashamed by the wave of relief I felt when I saw Room 208 empty, the bed made up with new linens, waiting for the next admission.

From then on, I was terrified of death. I made it my mission that no patient died on my shift—and I learned how to take very good care of patients with this attitude. Remarkably, three years into my surgical training, I had yet to pronounce a patient dead.

COVID changed that.

Strangely, for all the death that it wrought, I was not afraid of COVID. I was energized by it. As a medical student, I was oddly envious of the doctors who had cared for patients during the AIDS crisis in the 1980s and 1990s. How interesting it must have been to see the unleashing of a new illness in real-time. How motivating it must have been to use one's knowledge to try to save patients with this strange virus. How noble were those doctors and nurses who cared for patients dying of AIDS when others refused. *This* was the essence of being a doctor, I thought—to run into the fire, to keep looking forward when the future was unclear, to fight for life even when death was almost certain. Now we were facing a similar threat, and I did not hesitate to volunteer to work in the COVID ICU in the Spring of 2020.

During those first weeks in the ICU, our team cared for patients at a breakneck speed. The hierarchies between attending, residents, and nurses broke down as we brainstormed ways to care for patients and keep them alive. We started noticing patterns of what medications and ventilator settings worked, and those that didn't, and used this knowledge to refine how we'd care for the next admission. Morale was high; the work felt important. The goal of medicine had always been to care for the patient. Still, I was surprised how, after a few months into my residency, that goal seemed clouded by the inefficiencies, frustrations, and conflicting interests of working in a big university hospital. COVID allowed me to re-center my mission and return to the fundamentals—work hard, do your best, and take care of the patient.

Soon, I found myself taking care of an elderly man with COVID. He had initially improved with oxygen, but then something catastrophic happened that we didn't understand. In its characteristic way, the virus was suddenly wreaking havoc on every system in his body. His liver began to fail, his blood was clotting wrong, and his kidneys needed dialysis. I had seen this pattern of lab values and drip rates before—during my intern year while caring for Room 208—and I had learned that this was, in all likelihood, not recoverable.

I knew I would have to call his family and tell them that he was dying. These conversations had not gotten easier for me. They always felt like an argument, with the doctors saying, "We can't," and the families saying, "You must." I reluctantly called his granddaughter, an adult woman in her 40s whom he had chosen as his voice.

"He is very sick. His liver is not working properly and he cannot process the lactate. We are doing everything we can, but I'm worried he won't get better."

"We want to give him 72 hours. That's what the doctors said yesterday that we would try dialysis for 72 hours."

"I'm not sure he has 72 hours."

"We want him to fight." I could tell she felt defensive, and the tone of the conversation was antagonistic. Death was not an option. I heard the familiar voices in my head, reminding me that I was failing in my job to keep him alive. Certainly there was something that could be done, the voices asked earnestly and with a slight air of judgment.

"Ok," I said, defeated. "I'll call you later with the next lab results."

That afternoon, the family called to request that a priest come and administer the sacrament of the sick. The nurse and I looked at each other as the priest waddled into the ICU and stood outside his room, peering through the glass door at the dying man inside. We both looked at each other, confessing to our Catholicism like it was a sin and asked, "Should we pray with him?"

Everyone looked at us as we bowed our heads, crossed ourselves, and said the "Our Father." I muttered the words I had said hundreds of times in Sunday services, but something felt different about this prayer. As I asked for deliverance from evil, I realized I had done everything—*everything*—for this patient. I felt comforted.

I called his granddaughter before I went home. There was no good news; the labs were getting worse. "By the way, the priest came by this afternoon. The nurse and I prayed together with him. I wanted you to know that."

The tone of the conversation suddenly shifted. It was no longer a debate. It was as if she knew that I was on her side, and that I wanted what she wanted, which was for her grandfather to live.

She thanked me and relayed that their family would be relieved to know the priest came by.

I signed out to the night team, reporting that this man was surely going to die; it was just a matter of when.

The next morning, he was still alive—a testament to the power of our medicines and machines. But he had made no progress, only worsened. His blood pressure started to dip on the pressors. He was close to death.

I called his granddaughter again. "He survived the night. But the medicines are starting to lose their effect. I'm worried he will die this afternoon."

The granddaughter told me that the family was going to get together that morning to make a decision.

A few hours later, they called, saying that they had decided to withdraw care. I gowned up, donned my N95, and slipped my cell phone into a plastic biohazard bag. I set it by the patient's ear. Each family member took turns to say goodbye. We disconnected the patient from the ventilator and stopped the pressors. The color drained from his face, his breathing slowed and ceased, and his heart stopped. The nurse stood by his side, and we each held his hands as he died.

I spent the next hour completing the paperwork that is required to get a dead person out of the hospital, but I was grateful for the time alone. I thought of all my conversations with patients and their families about death, and how this one felt different. I had never expressed my own hopes for a patient's health, recovery, and return to normalcy. I had never expressed my own sadness that return to health was something I could not provide. As a doctor, I had not allowed myself to be human in this way—to grieve alongside another. Instead, I did as I had been taught, which was to shield myself with the impenetrability of medical facts. But in a highly emotional situation like death, why would I ever expect rationality to comfort and soothe?

I called the granddaughter one last time to confirm the name of the funeral home she had chosen for her grandfather. At the end of our conversations, she thanked me and said, "This must be so hard for you."

It was hard. And yet, I was so grateful.

* * *

Joint and Grief Aches

Heer Hendry

Something that surprised me when I started my clinical rotations in medical school was how often we discussed proper footwear. In the lulls of rounds, I've heard healthcare providers talk about how worn-down shoes or inadequate arch support have caused them joint and back pains. We spend hours on our feet and bring the aches home with us, a reminder of our workday as we walk our dogs or grocery shop. Embarrassingly, this is what was on my mind as I was starting a 12-hour shift wearing a new pair of shoes that an ICU nurse had recommended.

It was the third day of my emergency medicine rotation, and my team received descriptions and plans for the 23 patients in the department precisely at 0700. I scribbled notes about each patient on my notepad, learning to distinguish which aspects of each patient were important to carry into this next shift for good continuity of care. For one patient, my note read: "aspiration, sepsis, hospice."

My resident and I walked into each room and introduced ourselves, confirmed their story, and updated them on the next steps that we would be working on. The 4th patient on our list was the one I noted above—an 87-year-old male who was brought in after repeated bouts of emesis (vomiting) and choking. This was his fifth hospital visit this year for similar chief complaints, two of which resulted in ICU stays. Hours earlier, his two sons and two daughters had made the decision to place him on hospice.

Upon entering the room, I saw an elderly patient lying on a stretcher with his eyes closed, grimacing and breathing rapidly. There was a younger man at his bedside staring at the patient while drumming his fingers on a coffee cup from a gas station next to the hospital. He didn't notice us walk in and was startled as we began to introduce ourselves. He identified himself as the patient's son, telling us he had just arrived at the hospital but had been on a conference call with his other siblings and palliative care earlier. His eyes darted between us and his father's rapid, shallow breaths.

We updated him on his father's condition, explaining that we'd been making him comfortable with morphine and benzodiazepines. We talked about his blood lactic acid, his electrolytes, and his feeding tube. He continued drumming his fingers on the cup and nodding as we discussed trying to find an inpatient bed for his father. We informed him about the unpredictability of how much longer he would be alive and the unlikelihood of discharge. We asked if we could answer any questions for him, and he shook his head, but as we opened the door to leave, he asked: "So, the morphine is shutting down his body, right?" We clarified the purpose of the morphine, explaining that the morphine was making him comfortable and pain-free, but that his body was shutting down on its own.

"But in a way I'm still killing him?" he asked. My chest squeezed tight at that question. My goal for this patient immediately changed from getting him a bed in the inpatient unit to convincing his son that he was not harming his father. We started from the beginning and explained the lab markers and prognosis once again and asked if he'd like to speak to palliative care in person. He simply nodded as we exited to give him privacy.

Leaving that room, it was barely 7:00 am. We still had 19 other patients to check on. My chest was still tight, but I could not allow my mind to remain in that room while the other patients were still pending exams, workups, and admissions. I acknowledged to myself that reflection would have to occur later, and yet, as we walked to the next room, I wondered if the resident I was with had lost anyone in his life as I have in mine. Seeing the son trying to process and understand the situation in real time triggered my memories of past times when I had felt similar shock and confusion surrounding death. I struggled at that moment to separate that family's experience from mine. Carrying the weight of emotions related to my loss, I walked into the next patient room to examine a 32-year-old female with abdominal pain. I experienced this difficult dichotomy of the analytical nature of medicine and the emotional component of patient care for the remainder of this shift.

A few hours later I was on the phone consulting internal medicine for another patient when I saw a nurse find the attending and watched them both walk into this patient's room. When he returned, he told the resident he'd performed a death pronouncement and asked me to call the chaplain to pray with the family.

Several acute diagnoses, treatments, and admissions later, I walked out of the hospital. My mind briefly remembered that the focus that morning had been my shoes. Aches and pains related to footwear are discussed constantly, but where do we find the space to talk about the uncomfortable pain of losing a patient, grieving with a family member, lending our own experiences to help patients, and offering ourselves up to be the best for our patients? The appropriate time is surely not in the middle of a shift where you know your colleagues have to continue working as well, and where you don't know what kind of feelings you'll invoke in them.

I am still working on figuring out the right time to decompress and process these heavy emotions. Looking ahead at a career in neurology, where I will often be the one having to give heavy, life-altering diagnoses, this is a skill I am likely going to spend my life honing. There will continue to be days in my career where I face heavy feelings of my own that I have to put aside for the benefit of my next patient. So, the question stands—when is the right time to process?

* * *

My First Loss: Carrying His Legacy

Karan K. Mirpuri

I love listening to my mentors recount memorable cases they faced in their careers. While they do not always remember the details, the most vivid stories were always those of the first patient they lost. They shared that this was a difficult but important experience in every physician's career. While I prepared myself for the reality that I would eventually lose a patient, I did not expect my first loss to happen two months into my first year of medical school.

As a college student, I was intimately exposed to the topic of death through volunteering at a local hospice center. While I had not witnessed a patient's passing, I supported patients and families each week as they faced different phases of their journeys, offering them food, blankets, and a listening ear when needed. Though my volunteering had equipped me with new coping skills and language to navigate my emotions surrounding death, grieving the loss of my first patient was incredibly difficult.

**

I was nervous but excited as I entered my first shadowing experience with Dr. X in the emergency department. Beyond my previous volunteering at the hospice center, my clinical exposure largely involved watching routine wellness visits or low-risk procedures. While I had seen patients in critical condition before, the rapidly paced and chaotic environment of the ED felt like a completely new world that I looked forward to entering.

While Dr. X applied a compression wrap on a woman's sprained ankle about an hour into the shift, a blaring sound echoed through the ED. I was confused as all the providers around us simultaneously checked their phones. Dr. X shared that they had been paged about a trauma patient who was arriving in 10 minutes. A 71-year-old man had sustained serious injuries in a motor vehicle collision and was in cardiac arrest. Given that he needed resuscitation, his case was labeled a "code blue."

After Dr. X finished wrapping his patient's ankle and answering her questions, we quickly went to set up for the incoming trauma. Not knowing what to expect, I marveled as a legion of nurses, physicians, and respiratory therapists filled the room. As they rapidly wheeled in a crash cart, prepared instrument trays, and yelled terms that I only recognized from television shows, I felt overwhelmed, but began to appreciate the organized, intentional nature of each person's actions. What initially appeared as chaos became an intricate orchestra conducted by the senior resident, with each section tuning their instruments and taking their places before the performance. I found a spot in the corner of the room and waited in anticipation of what would come next.

I heard the wheels of a gurney approaching as EMS rushed in and the symphony began. Our patient lay unconscious while a large, black piston repeatedly crushed his chest. Although initially alarmed, I later learned that this was a LUCAS® device administering continuous chest compressions to preserve his circulation. Before I could blink twice, the device was gone, and the team surrounded the patient. The senior resident firmly gave orders from the foot of the bed as others inserted chest tubes, intubated him, and administered CPR. Although tensions were high and the clock was ticking, each team member worked calmly and announced when each task was complete to maintain closed-loop communication.

As I watched providers line up to administer chest compressions, Dr. X came over to ask if I would like to join the team in providing CPR, given that I was certified. Prior to the shift, he shared that this was a valuable way for medical students to contribute during codes, although the choice was ultimately mine. While I was prepared for the possibility, I was shocked that a code had happened, especially in the first hour of my shift in the ED. Despite my fear, I felt a strong desire and compulsion to offer my support so I could hopefully help save this man's life.

Comforted by the confidence in Dr. X's gaze and the knowledge that I was surrounded by a team of trained providers ready to assist if anything went awry, I agreed to help. I closed my eyes and took deep breaths as I recalled my training, reminding myself to let the patient's chest recoil after every compression so his heart could fill back up with blood. When it was my turn, I stepped onto the stool and stared at the man's body, now inches away. My mind went blank, and I felt paralyzed by the sights and sounds in front of me: the blood flowing from his chest to his face, the sounds of the monitors and providers, and the blinding lights illuminating the trauma unit room.

I was brought back to reality as the senior resident clapped in my face and yelled at me to begin. I apologized and quickly started pressing on his chest in the rhythmic way I was taught. His chest felt firm, but easier to compress than I expected. Secretly, I was thankful that the LUCAS® device had already broken his ribs so that I didn't have to feel them crush underneath my palms. The senior resident guided me to stay on tempo, telling me when to adjust my pace and pressure. I felt the initial soreness in my wrists subside as adrenaline surged through my body, and my emotions were replaced with a determination to regain a heart rhythm.

Each minute felt like an hour as my will remained steadfast, but my energy quickly dropped. Just as I prepared to call for a switch, the sounds of the monitor indicated that his heart was beating again, filling me with relief and gratitude. I backed away from the gurney and followed Dr. X's lead as the team rushed our patient for a head CT. While waiting for the scan, I overheard a nurse and social worker discussing the case, revealing that our patient's name was Gregory, and two of his loved ones were in the waiting room. Before I could learn more about him, Dr. X called me to look at the results. He pointed out the pale, light gray spots indicating that Gregory had a subarachnoid hemorrhage: he was bleeding into his brain as we spoke.

The providers discussed possible solutions, like calling a surgical consult or conducting further imaging, but Gregory's condition continued to decompensate as we moved him back to the room. He continued to receive blood, but his heartbeat started dropping. Before I could mentally prepare myself to perform CPR again, the senior resident announced that despite our interventions, Gregory's prognosis continued to worsen. His carotid arteries had clotted off, indicating that his brain could no longer receive oxygen, and still he had severe internal injuries. The team determined that continuing to use our resources would likely not revive him. Time of death was called.

Prior to medical school, I expected myself to feel distraught, angry, or even confused when I lost my first patient. I would eventually feel all these emotions, but as I stared at Gregory's blood on my gloves, I felt numb. Not only was this the first time I had ever performed CPR on a human being, but it was also the first time I watched someone die right in front of me. The senior resident then called for a moment of silence to honor Gregory's life. As I looked around at the team, my mind raced with questions.

Who was going to tell Gregory's family that we couldn't save him? Why did I get to be with Gregory during his final moments instead of his loved ones? Why am I not crying right now? Is something wrong with me? What do we do next?

As I pondered these thoughts, the team cleaned up the room to prepare for our next patient. I was struck by how (almost) casually this was handled, as if a man had not died in front of our eyes moments ago. Dr. X took me and another student aside to debrief with us and check how we were feeling. While I could not find the words to describe my emotions, I was grateful for his concern. I tried my best to maintain focus while he reviewed the details of the case.

As we continued to see patients, my mind kept returning to Gregory. Simultaneously, my body began to feel exhausted as the adrenaline rush I felt began to fade. While watching one of our next patients be evaluated for a potential pacemaker placement, it suddenly felt more difficult to breathe under my mask. My heart started beating rapidly and my legs began to feel weak. My thoughts raced faster than before, and my chest felt heavy.

Worried I might faint, I excused myself and found a chair outside. I had never felt anything like this before. Panicking, I texted my parents, a close friend, and my partner about what was happening, and they encouraged me to take some deep breaths, drink water, and let my feelings take their course. As I decompressed, I realized I had not eaten in hours and was thankful when Dr. X came moments later and handed me a granola bar. The senior resident also checked in, apologizing for her harsh tone during the code and affirming my efforts in providing CPR. They told me that what I was feeling was common for medical students after seeing their first trauma, but encouraged me to make an appointment at student health the next day just in case.

Gregory's passing hit me in waves over the following days. When I closed my eyes, I still remembered the details of his face. I thought a lot about his loved ones, whose cries I heard from a distance when they learned of his passing. During a palliative care lecture the day after my shift, I learned that while the majority of people in the US wish to die in the comfort of their own homes, this is often not the reality. While I did not know Gregory, I was saddened that he was denied a comfortable death in his own home and his family was not with him in his last moments.

As I continued to face many complicated emotions, I turned to storytelling—my usual response to challenging situations. When thoughts about Gregory returned, I wrote them down as bullet points or short phrases. Drawing on my experiences in hospice, I found that writing helped me slow my thoughts down and put words to my emotions. Even while writing this piece, my eyes welled up as many of my emotions resurfaced in a difficult but cathartic way.

Aside from writing, I talked about this experience with trusted members of my inner circle—friends, family, and my therapist. Not only did these conversations provide me with a safe, affirming space for me to voice my feelings, but they also helped me better understand my own grieving process. While reflecting on Gregory's death and other experiences of loss, I realized that my immediate response to loss was often physical. I often felt my stomach drop and began sweating much earlier than I processed and labeled my emotions. But with each retelling, I felt a sense of relief and gratitude as I shared a piece of Gregory's memory with someone else.

Although healthcare is filled with difficult moments, it affords us incredible privileges. As medical students and providers, we have opportunities to welcome patients as they take their first breaths and to hold their hands during their last ones. Although we may occupy small moments in patients' lives, we can play an important role in honoring their legacies and learning from their stories.

With each new clinical concept I learn, I carry the story of Gregory and other patients, taking time to grieve but holding close the lessons they taught me. I did not know Gregory for long, but I have many things to thank him for. His case introduced me to many foundational tenets of emergency medicine, including the "ABCs" of emergent traumas and the intricate response to a code blue. As a CPR instructor, my memories of resuscitating Gregory guide how I demonstrate the proper technique and rhythm to students. While reflecting on the ways I navigated my grief after his passing, I also find myself better equipped to advocate for my needs in clinical settings by asking for a few minutes to eat a snack or take a walk after a difficult case.

While grief is a universal experience, it looks different for everyone. There is no formula or correct way to respond to loss. Regardless of where you are in your clinical journey, I encourage you to recall moments when you encountered loss and reflect on how you responded during and after them. While this can be a difficult and long process, I challenge you to lean into the discomfort, advocate for your needs, and find solace in your community. If you are comfortable, I would also encourage you to share your patients' stories with your loved ones, your mentees, or even just on paper. In doing so, I hope you are able to find ways that best help you process your feelings, find peace with difficult circumstances, and uphold your patients' legacies, whether that means putting words to their stories or honoring their untold stories through silence.

With that, I would like to share an excerpt I was introduced to during my first training in hospice. I still return to this passage on difficult days, as it anchors me to the values that compelled me to pursue medicine.

"And every time we do [the work], it will be enough, for we cannot give more than we have, and for us, we give what we can when there is nobody else to give. And that is enough. And so are you. You are enough. We are always enough.

May it be well with you today, and may it be well with those souls entrusted in our care, for however fleeting a moment. May it be well."

* * *

Grieving the Loss of What Medicine Was Supposed to Be

Katerina V. Liong

I attended a conference this year. The timing was less than ideal because it was held the weekend before the Internal Medicine clerkship exam. But as with all things, especially during medical school, there is never a "right time" to be doing anything. It was fortunate that I attended the conference anyway because I met an incredible doctor there. She had given a talk called "The Myth of Physician Wellness," and somewhere in our lengthy discussion, she asked me this:

"Have you ever considered that since entering medical school, you've never been able to stop and really grieve the loss of what you thought medicine would be?"

I am writing this in the downtime during my surgery rotation, regretting that I didn't wait until I got home to fully feel the feelings of writing this because I cannot cry here in front of others. At the same time, I feel guilty spending time writing at all; I should instead be doing UWorld practice questions for my upcoming exam. I can feel it in my body, the feeling of being plugged up—I have allowed tears to leak out too many times this year.

The first time was in Internal Medicine, after seeing an elderly patient with a terminal rectal cancer that was so far along you could see it grossly. The bulging mass was so obvious during the patient's digital rectal exam that the senior resident was able to take off his still-clean gloves mere seconds after putting them on. The patient had come in for abdominal pain and difficulty defacating; the only management he'd been able to receive for his known cancer was multiple hospitalizations in the last few months for emergency blood transfusions when his Hemoglobin level, indicating blood loss from the cancer, got too low. As I was taught to do, I gave a summary statement: "So you're here because you had a primary care appointment for a regular checkup, but they wouldn't see you because they didn't take your insurance? And they sent you to the county hospital, but even though they take *un*insured patients, you *are* technically insured, just under a terrible plan . . . so they transferred you here. Is that right?" Unfortunately, the man's *sí* of affirmation was enough to make me lose composure, and I had to step out to let the resident finish the interview.

After that, all it takes recently for the tears to well up is for an attending to pull me aside for feedback and ask, "How is third year going for you?" or even "What do you feel you've done well?"

I almost wonder if holding in tears is like constipation. In medical school, we learn that sometimes what we *think* is diarrhea in patients is actually constipation—the stool is so impacted that the only thing that can leak past the plug is liquid. We see the leakage and first interpret that as diarrhea. I have to wonder if people interpret the same about me—emotional lability? Or is my inability to prevent the tears from leaking out simply a product of all the plugging up I have been doing all along? My inability to properly grieve the loss of what medicine was going to be? Maybe the first step in processing that loss is identifying it:

> *I thought medicine meant caring for patients. Why am I going through 7+ years of training if insurance companies are allowed to undermine us so easily?*
>
> *I thought medicine meant connecting with patients. Why am I spending 30 minutes seeing my patients and 2 hours writing notes?*
>
> *I thought medicine meant leadership. Why are others bypassing two-thirds of my time in training and ending up with almost the same job . . . but the only "leadership" left is that their liability falls on physicians?*
>
> *I thought one must be well to take care of others. Why are students working all day and studying all night, residents too overworked to take a lunch break, and attendings made to work while visibly sick and diaphoretic?*
>
> *I thought preventative medicine was important. Why does our society prioritize selling patients more problems so that they can then sell them more solutions?*

So then, why are we told we are not resilient enough?

Why is it the fault of pre-meds for not being exploited harder and longer until they can convince medical schools that, yes, they've experienced enough pain and "know what they're getting into?"

And when will I realize that nobody will give me guilt-free time to go to the bathroom or eat lunch? And nobody will give me the time I need to grieve. I have to take it for myself. And because this is not an individual quest—this is a quest of our community—I need to do what one of my interns did for me and fight for my team members, too, no matter the level of training I am at. Together, we are all stronger.

We ask patients, "Are you eating, drinking, peeing, pooping, walking okay?"

The better question is, are we?

Commentary
Grief and Re(dis)covery

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Abstract. Grief is an emotion that reaches across multiple disciplines in healthcare. In this series we hear from medical students, residents and fellows, physicians, nurses, chaplains and social workers. Writers share their challenges with vulnerability, uncertainty, and emotional exhaustion. Many identify a sense of isolation within the very system they are seeking to support. While not all are confident, they have reached a new grounding after grief, these authors do offer a sense of hope for recovery and rediscovery of the joy in the privilege of the practice of medicine.

Keywords: Anger, Delivery of Health Care, Grief, Guilt, Honor, Medical Students, Narratives, Physicians, Privilege, Virtue

In this series of narratives about the grief experiences of healthcare professionals, we see that grief is an emotion that reaches across multiple disciplines. We hear from physicians at various levels of training—medical students, residents, fellows, attending physicians—nurses, social workers, and chaplains. We hear very clearly that grief is profoundly felt and impactful on the practice of these professionals.

I write from my experience as a practicing clinician. After 28 years in general internal medicine, I made a pivot and completed a hospice and palliative medicine fellowship. I have now finished five years practicing in this capacity, half of my time on inpatient palliative consults and half of my time as a physician at an inpatient hospice house. From this perspective, I engage these narratives in the themes that resonate within them. The striking themes throughout these narratives serve to remind us of the great privilege that is fundamental to patient care. These are stories not only of recovery after grief, but also of rediscovery after grief.

In the following I will explore how grief is often a gateway to growth in the professional-patient encounter. Grief is also a foundational experience in healthcare encounters. I will describe one significant education intervention that specifically targets medical student wellness and resiliency as a remedy for the toxic environment many of our authors experience. I will use these narratives to describe further initiatives our authors designed to move toward recovery from grief. Notably, our writers describe efforts to recover "joy" in their work, and I will relate this to the privilege of the practice of medicine. Finally, the serious impact of COVID is noted to give an honest appraisal that recovery and rediscovery of the joy in healthcare is not a guarantee but requires mindful practices.

Meeting Patients Opens Us to Experience Grief

It is well-known that patients who share "likeness" with us have the potential to affect us deeply—whether that likeness is professional, as in sharing the same occupation, or personal, as in sharing a role such as a parent, or reminding us of someone we love like our own grandparent (Meier et al., 2001). Our writers recognize this in the stories they tell. Beery relates his deep grief experience of the death of his mother during his medical training. He then sees in his patient a woman "just like my mom," and this becomes the gateway to his experience of the patient as *person*. Gholson sees in her patient a woman of her same age, the same experience of being married to her high school sweetheart, and the same experience of being a mother to two young children. And yet while very different, because the patient is terminally ill, Gholson connects by being "witness . . . to her inexpressible grief."

Early Experiences of Grief Make Lasting Impressions

For those beginning on their training path, these experiences can threaten to be de-railing. Bennett writes, "I wondered if I would be cut out to be a physician." Douille (supplement author) describes her struggles as a medical student navigating her mother's critical illness while taking care of patients facing the same disease process. She notes, "While I can forget about my grief momentarily, as soon as I slow down, the pain returns in unrelenting multiples," further described as "soul-crushing . . . exhausting . . . terrifying." And Gross notes his experience taking care of a critically ill ICU patient, "Somehow, I am the one in charge. A brand new second-year resident. Somehow, I'm the one responsible. I am completely frozen."

More experienced clinicians also reflect on their early training encounters with grief. King, from her perspective of 42 years as an RN, writes of the death of a patient early in her career. She recalls her shock and disappointment by the reaction of the physician of a patient of hers who had died: "(He) saw that I was upset and asked me what my problem was. Why was I so sad about it?" And King remembers her response, "How could you be a decent doctor if that death didn't bother you?" Bitter recalls her distress as a medical student when a patient dies after being given a medication by the attending physician, a medication she knew was not indicated. "It was the first time I felt like my patient would have been better off without our interventions. . . . I felt powerless to contradict the attending. . . . I questioned my calling to medicine and seriously considered leaving the field."

I have my own similar recollection from my time as a young trainee. I was on my gyn rotation as a third-year medical student and assigned to do the history and physical ("H&P") on a patient in anticipation of a gynecologic surgery. While the procedure was successful, the surgery was complicated by persistent bleeding that was ultimately controlled. However, this appropriately prompted a hematology consult. At the conclusion of the consult, the hematology attending made a point of announcing they had discovered the patient had a partial clotting disorder after questioning her further (from the perspective of her now-known surgical complication). In front of the team, he pronounced, "Even a medical student should have been able to identify this." I was horrified that I had failed this patient.

Remediating Our Broken Systems

Can we healthcare professionals mend our environment? There is reason for hope.

Clinician burnout has been cited frequently in the literature (Murthy, 2022). There are, however, promising innovations that have had a positive impact on improving the well-being of trainees. Stuart Slavin, now the Vice-President for Well-being at the Accreditation Council for Graduate Medical Education, has published an account of the wellness initiative he spearheaded while associate dean for curriculum at Saint Louis University School of Medicine (SLUSOM) (Slavin, 2019). While he initially had the impression that the student body was a content and balanced group, a more deliberate assessment through validated depression and anxiety scales revealed a concerning trend. Student mental health scores started out positive at orientation, but then dropped consistently over their subsequent years of training. The changes he put into place stemmed in part from focus groups and surveys with the students. As a result, the curriculum was restructured to address the issues students had reported. He describes these as "information overload, excessive class times, and unreasonable academic demands." In addition, the curriculum restructuring included a required resilience curriculum, designed as a longitudinal experience across the four years of training (Slavin, 2019).

The SLU SOM innovation resulted in measurable improvements in medical student mental health. For example, Slavin (2019) reports a reduction in students self-reported moderate to severe depression (using the Center for Epidemiologic Studies Depression Scale). Pre-intervention levels had been reported as 27% at the end of the first year and 31% at the end of the second year. Post-intervention, the level had been reduced to 4% at the end of the first year and 6% at the end of the second year. At the same time, academic performance scores also improved. Slavin attributes this in part to developing a culture of listening, support, respect, responsiveness, and compassion. But he also cautions that the improvements noted did deteriorate once students entered their clinical training years, traditionally the third and fourth years of medical school. He attributes this to "exposure to unhappy residents and faculty" and recommends that programs to improve faculty and resident mental health be given high priority. Nonetheless, he concludes that the biggest success of the initiative was not simply an improvement in student well-being. He notes that in the post-intervention cohort, students had a positive response to the AAMC Graduation Questionnaire when asked if their medical school had "done a good job of fostering and nurturing my development as a person." The national response was 33.8% strongly agreed; the SLU SOM response rate was 65% strongly agreed. Slavin concludes, "Students felt listened to, valued, and respected. They found purpose and meaning. They grew not just as future doctors but as people" (2019).

In my own medical student vignette, I went to my attending physician and apologized for letting him and the patient down. I will never forget his response. "The intern missed it. The resident missed it. My chief resident missed it. I, the attending physician and leader of the team, missed it. Why would anyone have expected the medical student to have uncovered this?" Why indeed?

Our authors chronicle their own process of recovery, which mirrors Slavin's hope that trainees grow both as doctors and as people. Bitter reaches out to her clerkship director and helps establish a pathway for medical students to raise safety issues as they encounter them. From her perspective, many years after the patient event she describes, she recognizes that what she experienced was "moral distress." It is that experience that prompted her to become a patient safety advocate and an enthusiastic practitioner of shared decision-making.

Khan writes of being motivated by her grief for a patient she felt she could not help. She was encouraged by the support of her mentor to create a memorial service so she and her fellow students could honor their patients. She also writes of a habit she learned from her mentor: "She asks every patient she has if they would be willing to share something about themselves unrelated to their healthcare so that she can get to know them more." It seems quite simple, maybe even obvious, except it is not part of traditional healthcare history-taking training, particularly for those in medicine. Even the "social history" has often been diluted to simply a catalog of substance use: "tobacco-no, illicit substances-no, alcohol-yes." If a little more robust, maybe "Who is at home with you now, and how is that for you?" could be added. Our colleagues in social work and chaplaincy certainly embolden us to dive a little deeper. Palliative medicine practice recognizes the importance of the "Interdisciplinary team," with an emphasis on the team supporting the value of all the disciplines supporting the care of our patients. In my own training in hospice and palliative medicine, one of my mentors taught me a similar way to invite more connection. I now often ask patients and their families "What are you/they famous for?" Usually, this is followed by a look of surprise, then a smile, then a laugh. And usually, a catalog of legacy follows: "his kindness," "her love of animals," or "my spaghetti!"

The Need to Balance Dedication

What makes these healers keep going? When faced with unfathomable loss in multiple forms, what sustains these caregivers? In a recent NY Times article (Nagourney, 2024), there is an account of a young surgeon, Dr. Ihor Kolodka, who was operating on a child in the Ukrainian city of Kyiv when the air-raid sirens sounded. The hospital was hit by bombs. The power went out, and the surgery had to be stopped. There is a photo of Dr. Kolodka outside the building helping move debris in the search for survivors. His clothing is bloodied, having been injured himself during the bombing. He received stitches to his wounds before joining the rescue and recovery efforts. He told the reporter "I could not *not* help. It's my hospital, it's my people. I'm a doctor."

But this same sense of dedication may also be experienced as burdensome. In her narrative, King shares a second experience from her time working as a nurse, this time caring for an ED patient who was a beloved friend. In the urgency of the situation, she does not realize the patient's identity until her team members ask her to pause. She then comforts the patient's daughter before the patient is transferred to another hospital, where we learn she later dies. King writes, "I had to stay at work and finish my shift after that. There was no going home early, no time to mourn, no time to grieve for my friend or her family. I wiped the tears from my cheeks, breathed in deeply, and moved on to care for the next patient."

Pinto writes about a similar realization in her work as an ICU physician. "As clinicians, we are also survivors. Yet, our culture in medicine rarely affords us the permission or the grace to unpack the depth of the sorrow and grief we regularly witness and suffer. Instead, we must summon up the fortitude to take care of the child in the next room before we can pause and process our grief."

Patient Care as a Privilege

It is important to note that these authors recognize that the stories they tell do not use their patients as a means to an end. Bitter writes, "Thirty years later, I do not remember her name, but I definitely remember her face, and this is how I remember her story." And in telling her patient's story, Bitter is mindful of the inspiration she still feels from her patient. "Respecting her humanity requires that I honor the impact she had on my development as a physician." Pinto writes "By mourning and frequently reflecting, I hope to honor their lives". And, in Wachsmuth's account, "It is my prayer that in these little acts of presence and love that I participated in and witnessed, something of the hope that I had found for the patient came through." In this, they speak of the privilege of patient care.

Coulehan further explores patient care as a privilege in his perspective on humility that engages three critical aspects of this virtue (Coulehan, 2010). He proposes that humility requires three qualities:

- "Unflinching self-awareness"—an ability to know your own strengths as well as a willingness to confront your weaknesses.
- "Empathetic openness to others," manifested by good listening skills and the ability to be present to the needs of others.
- "A keen appreciation of, and gratitude for, the privilege of caring for sick persons."

Recovery and Discovery Are Not Guaranteed but Require Intentional Pursuit

Not all stories come to a positive conclusion. There could not be an authentic collection of stories about grief that always end in happy resolution. The impact of COVID looms large in our collective memories. Alisha writes "I knew what I signed up for when I became a nurse, but nothing prepared me for the 2020-2022 pandemic years." In addition to her usual duties as a department manager, she took on the responsibility of managing the hospital's morgue, working with her social work supervisor Audi. She writes "I never dreamed I would do this job for three years, nor did I realize the trauma it would cause . . . With the addition of the morgue responsibilities, I never came up for air." When she is finally able to spend some time with family and friends, she notes, "After nine months, I loosened my emotional hold and discussed work." And at this point, she collapses into tears, comforted by her sister, who simply holds her as she cries.

Alisha reflects that emotional release was only a temporary relief. "Though I know it shouldn't, that emotional break severely embarrasses me to this day. . . . Like many other healthcare workers, I compartmentalized my feelings and pushed through." It is only after connecting with a friend who happens to be a licensed clinical social worker that she is gently nudged to seek counseling herself. This realization of the need for help comes after she has the thought that titles her narrative, "I'd love to go off the grid and never come back." And while she recognizes that she has no regrets for doing the work that had to be done, she also knows she has paid a personal price for her dedication. "While I am still trying to heal, I am slowly returning to a place where I experience emotions in real time again." She is building the "new Alisha," with the hope "she finds joy in life again."

It is here, with this kind of cautious hope, that we are left looking forward. Grief in healthcare is inescapable. Our authors beautifully share their grief encounters. Many describe the progress they have made in recovering from grief. And it is in the discovery or rediscovery of the privilege of patient care that the portal to healing may be found.

References

Coulehan, J. (2010). On humility. *Annals of Internal Medicine*, *153*(3), 200–201. https://doi.org/10.7326/0003-4819-153-3-201008030-00011

Meier, D. E., Back, A. L., & Morrison, R. S. (2001). The inner life of physicians and care of the seriously ill. *JAMA*, *286*(23), 3007–3014. https://doi.org/10.1001/jama.286.23.3007

Murthy, V. H. (2022). Confronting health worker burnout and well-being. *New England Journal of Medicine*, *387*(7), 577–579. https://doi.org/10.1056/NEJMp2207252

Nagourney, E. (2024). The surgeon. *The New York Times*. https://www.nytimes.com/2024/07/08/world/europe/ohmatdyt-hospital-surgeon.html

Slavin, S. (2019). Reflections on a Decade Leading a Medical Student Well-Being Initiative. *Academic Medicine*, *94*(6), 771–774. https://journals.lww.com/academicmedicine/fulltext/2019/06000/reflections_on_a_decade_leading_a_medical_student.27.aspx

Commentary
Navigating Loss in Healthcare Teams: We Are in This Together

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Abstract. This commentary highlights the vulnerability, lived-experience, and wisdom gained by providers who have navigated extraordinary stress and painful loss(es) at work. Their narratives serve to remind us that we—physicians, psychologists, nurses, chaplains, and others—are just as human as the patients and families that seek our help. The stoicism indoctrinated into us through our training is not helpful. Instead, as we reach out to each other, providers are able to offer and receive support from loved-ones and professional peers, colleagues, and mentors in a myriad of ways. As we do this together, we do better—personally and professionally.

Keywords. Burnout, Compassion Fatigue, Ethics, Narratives, Physician Wellness, Provider Wellness, Self-care

Introduction

The calling that many of us feel to devote our lives and careers to easing others' suffering is explicable. Put simply: it is a natural extension of our innate human drive(s) to help (Bott et al., 2017; Goštautaitė et al., 2020; Westerman, 2014). What is more is that we receive a lot of support for it (adoration, even) because healthcare is socially construed as both a difficult and noble pursuit (Cruess & Cruess, 2004; Temple, 2014; Weaver et al., 2020). Our friends and families tell us that they could not do what we do. The time that we sacrifice to learning and advancing our crafts is too much for many of them. While they complete 40 hours of work each week by Friday, we complete this by Wednesday—and then keep going. They tell us that the things that we see every day would be too hard for them to see. After all, most folks do not bear witness to others' pain, suffering, or death as often as we do.

The irony in all of this is that we inhabit an environment that does not tend to allow us to be (or at least show that we are) vulnerable. Stoicism is highly valued in healthcare training and culture (Brown et al., 2022; Sarkar & Cassel, 2021). Asking for and receiving help is seen as a sign of weakness, despite the fact that providing it is literally our job-description. While humans need each other (reciprocally) to survive, the help that we—as providers—offer is a one-way street. We do not tend to take very good care of ourselves, either, and many of us function in ways that can feel intolerably lonely. And all told, it is not until we break the rules by talking about our struggles, and by supporting each other in our shared grieving, that we begin to reclaim our own health and humanness and everything that this means.

The narratives offered in this collection, submitted by colleagues across a broad range of care disciplines and experience levels, speak powerfully to these themes. We are prepared through our textbooks, classroom teachings, and on-the-ground training to do good work (technically)—but are then reminded about how unprepared we often are for the realities of what that work encompasses (emotionally, relationally, spiritually). We are stoic until we cannot be stoic anymore. We function in isolation (in our own heads) until we cannot function that way any longer. As we reach out to each other, we begin to heal, and we grow together. Like the social creatures that we all—as human beings—are.

We are Prepared for this Work . . . Right?

As a behavioral health provider and educator situated in a family medicine residency, a doctoral family therapy program, and my University's mobile trauma-response teams, I have the honor and privilege of working with trainees across both mental health (e.g., medical family therapists, psychologists, social workers) and biomedical (e.g., physicians, nurses) specializations. We often talk together about how easy it is to read a book about how to ride a bicycle, but how different it is to actually get on a bicycle in "real life." In our formal training (textbooks, lectures, etc.), everything sounds logical, ordered, smooth, and predictable. We're ready! And then we get on our bikes—and fall off.

Losing patients (or bearing witness to their suffering sans death) is something that is promised to all of us from the moment we sign up for careers in healthcare. We can, and we do, talk about it, normalize it, and prepare for it. But it doesn't really matter. Beery's account of having learned everything that he thought he needed to know through his studies aligns with this reality. He shared how his first day in a palliative care rotation "was spent realizing how little I know about this specialty . . . [and] If ever there was a picture in the dictionary for naivety, it surely featured me that day." Gross's account of losing a patient echoed this: "I'm completely frozen, and I don't know what to do. This is not one of the contingencies that the day team prepared me for."

Authors shared, too, how much harder some of this can feel when the patients who are hurt, suffering, or die are children. Put simply: it isn't fair. Whether the hurt, suffering, or death is due to an adult having done harm unto an innocent, or because Life's (or God's) seeming randomness has centered destructively on them, at our core, we do not believe that children should be victims. Bennett made this claim unequivocally: "In school, we had modules and lectures about tragedy, but only in the context of death and adults." As she and her team offered care for a victim of child sexual abuse, she maintained that "I now know that I could have never truly prepared for a situation like this . . . [or] for the complex emotions this brought on." Bridging this and many of the narratives shared with us for this issue, Khan summarized a widely felt sentiment: "Everything I had learned in school was not working."

Second-Guessing

The existential crises (plural) that are paired with not knowing what to do for a patient, not knowing how to navigate loss in the workplace, and not knowing how to manage one's own suffering along the way were commonly shared by authors who contributed to this issue. Having had one's confidence in their competence shaken, a variety of narratives followed that called into question whether an adverse outcome was one's own doing, and even whether the decision to serve in healthcare was contraindicated.

Pinta described repeated wonderings of "Was there something I missed? Could I have done better?" and how her prolonged grieving eventually included a "loss of joy . . . that had been central to my identity as a physician." Bitter shared how she beat herself up because she "should have known the pathophysiology and medication side effects better" for a patient under her care, and she ultimately "questioned [her] calling to medicine and seriously considered leaving the field."

Suffering in Silence

Much of the pain inherent within the struggles described by our contributors was exacerbated—at least at first—by the presumption that they could not show it, talk about it, or otherwise engage with anybody for support. Stoicism—not revealing pain, stress, or other signs of "weakness"—is highly valued across many medical- and other professional- education and training circles. Pinto characterized healthcare as a field that "rarely affords us the permission or the grace to unpack the depth of sorrow and grief we regularly witness and suffer." Gholson echoed this in saying that "as providers, we tend to have a controlled and somewhat restrained response to much of our work . . . this is our way of surviving the difficult cases we encounter."

And so we (all) charge forward, working on what Alisha, a nurse who disclosed only her first name, described as "autopilot." That is, until we cannot. "After nine months," Alisha shared, "I loosened my emotional hold and discussed work . . . I fell to the floor and began sobbing profusely." Finally, "I admitted how sad I was and how sad it was for the families. I have no idea how long I cried."

Alisha's word choice here of "admitted" is powerful to me. She did not say that she "acknowledged" her pain, or that she "honored" it. Instead, she "admitted" it—like it was some kind of secret or something to otherwise feel ashamed about. Later, Alisha described an exchange with a concerned colleague: "[She] said to me, 'I think that you have PTSD.' My immediate response was, 'Yeah, I don't think so.' 'And that is the problem,' [the colleague] replied." After some tough reflections, Alisha finally "knew I needed help" and sought it. Gholson similarly described the value of breaking stoicism's silence: "At times . . . the deep emotions we feel must be expressed." And indeed, "to feel sad and feel despair is to be human."

Supporting Each Other

No narrative shared with us described effective grieving as a solo enterprise. In fact, it was not until our authors connected with others that they were able to honor—not "admit"—their vulnerability and humanness. Wachsmuth explained how "It is tempting at times to try and just buck up or dismiss feelings of grief . . . [but it is] strengthening . . . to reach out during these times" of need. Sometimes this reaching out is to others in our personal lives, e.g., Alisha shared how she learned to "surround myself with loving family and friends . . . [to] help me get through these challenges." Other times it is more structured and formal, like how Moran's "chief recognized the team's need for support and quickly organized a 'debriefing' [wherein] . . . Everyone had a chance to reflect on their experience" and explore "reactions of sadness, anger, frustration, fatigue, confusion, or numbness," or how Khan's "fellow students and physician mentors all came to talk about their experiences with grieving" to eulogize lost patients, share strategies in self-care, and affirm "that we could talk through our grief when we see hard things."

Most often, though, it seems that healthcare providers' support in grieving for patients evolves through an organic process of connecting with others who are (or who have been) similarly in-the-trenches. Alfred, for example, poignantly recounted asking one of her fellows "How do you do this?" When she received a response confirming that on-the-job losses like what she was undergoing do not, in fact, get easier, she shared how her "armor fully shattered . . . I sobbed continuously, furiously, terribly." But in so doing, Alfred discovered that she was not alone. She explained how "While it initially felt lonely, I realized how if I looked to the right or the left . . . [there] was someone else who had been fractured in some way with that same grief." She maintained—and I agree!—that "Strength comes from knowing that despite suffering, we are never alone" in this work. Bennett similarly shared how she and her teammates "grieved and mourned together" and that "By sharing what I had experienced and was thinking about, I was able to get further support and help processing my emotions."

Across providers' narratives about their work to navigate grief, too, it is important to note how they gained insight and wisdom into the utility of not "getting over it," not getting "back to normal," and not learning strategies to "be tough" or otherwise impervious to the losses they encountered. The opposite, in fact, was true. Bennett concluded her account by noting how leaning on others for support "not only allows me to garner the will to keep going but also maintains the humanity and perspective . . . that are part of the job for healthcare providers." Alfred echoed this in saying, "I don't ever want [this work] to not be hard" because that would mean "I'm probably losing [the] empathy and humanity that I don't want to lose." Bennett reiterated this, too, in describing her wish "for the strength to continue to be phased and express my struggles openly . . . to be vulnerable and to draw on my grief to . . . provide exceptional support to patients and future colleagues alike." Gholson maintained that "This is what makes us human; it is what makes us better caregivers and providers for patients and their loved ones."

We are all Human

Breaking through our stoicism in communion with others humanizes everyone involved in the sometimes heartbreaking losses we encounter in healthcare. Reading these narratives reminded me of a powerful meeting I had with one of my mentors during my own training many years ago. A couple of students asked her if it was okay to cry with our patients sometimes. Without missing a beat, she said, "Something is wrong with you if you don't." I have never forgotten this, and the permission her words bestowed onto us to be human.

King's story about crying with a patient's mourning husband brought me back to that class, and to the untold numbers of good cries that I have had in examination rooms, waiting areas, chapels, gardens, hallways, parking lots, and other shared spaces with patients and their families—and to the ones with colleagues, trainees, and supervisors in the same spaces, alongside break rooms, precepting areas, supply closets, over the telephone, and via Zoom. Gholson shared how walking with a patient on her unit served to do this, "human-to-human" and "friend-to-friend." Alfred walked, too, with a patient's mother "while she remembered [her son] as a teenage boy beyond the hospital, not as his ascites and acidosis." Alisha shared how, during COVID, "we were not supposed to touch anyone . . . but with her heart-wrenching situation, we hugged [our patient] anyway."

Our patients are not the "3:15 appointment" on our day's schedule, the "diabetic in Room 4-A" of our unit, or "the difficult case with medically unexplained symptoms" that we bring to a group consultation or team-huddle. They are people with lives outside of the hospital- and clinic- walls that surround us. They have stories, rich with joys and struggles, and more complex than anything captured in our intake forms or documented in our EMRs. Khan recounted a mentor's wisdom: "She asks every patient . . . if they would be willing to share something about themselves unrelated to their healthcare," and that if they die, "she tries to remember them . . . by their lives rather than by their conditions and diagnoses." Beery shared how one of his patients forever changed him. "No longer did a chart belong to 'an interesting case of Waldenstrom's Macroglobulinemia,' it belonged to a 57-year-old man with a wife and kids who worked in real estate." He goes on to remind us that our patients "are all people first and diseases second," which is a good adage to recall vis-à-vis the myriad of scientific facts, figures, statistics, and related phenomena that we all learn about in school.

What Goes Unsaid

While this collection highlighted a number of important foci related to grieving within the healthcare profession, some other salient topics did not appear very much or at all. My sense is that these warrant mention and I thereby raise them here.

To begin, biomedical providers (physicians, nurses, etc.) outnumber mental health providers (e.g., psychologists, social workers) within most arenas of healthcare. This fact is paralleled here by nature of the unevenly distributed disciplinary backgrounds of contributing authors (i.e., three mental health providers vis-à-vis nine biomedical providers). This scenario is likely familiar to readers of this journal. However, what might not be recognized is the presumption that mental health providers should support biomedical providers (but not vice versa). When debriefings on a unit are indicated, when a practice wants to establish a Balint group[1], or when an individual provider is decompensating and needs immediate support, it is usually a mental health provider who is asked to take the lead or facilitate something (as evidenced in Moran's account as a social worker). And while this is alright on the surface, it is important to ask: *Who takes care of mental health providers*?

Mental health providers often struggle with a sense of professional isolation at baseline (again, because there are not very many of them in most medical units). Their struggles with workplace stress and losses can be exacerbated by (a) their biomedical colleagues' presumption that they are okay and (b) a paucity of other mental health providers who are available to lean on. It is thereby important for health systems to recognize and support their mental health providers, too—not just the biomedical ones—across the formal- and informal-sequences intended to help team members through difficult times (Dreison et al., 2018; Mendenhall, 2021; Rivera-Kloeppel & Mendenhall, 2023).

Another key thing to recall is that self-care, in a general sense, is not just a warm-and-fuzzy thing to do on its own merits as a way to allay stress. Indeed, it is an ethical mandate to attend to the needs of the person we are with 24-hours per day. Every healthcare discipline has a formal ethics statement or dictate regarding this. The American Medical Association (2024), for example, maintains that "physicians have a responsibility to maintain their health and wellness . . . including mental illness, disabilities, and occupational stress" (Standard 9.3.1; Physician Health & Wellness). The American Association for Marriage and Family Therapy (2015) similarly affirms that providers "seek appropriate professional assistance for issues that may impair work performance or clinical judgment" (Standard 3.1; Professional Competence and Integrity). The American Nurses Association (2015, p. 6) says that "nurses have a duty to take the same care [as they do for their patients] for their own health and safety" (Provision 5.2; Promotion of Personal Health, Safety, and Well-Being). The American Psychological Association (2017, p. 5) maintains that its licensees "take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties" when they are struggling (Standard 2.06; Competence; Personal Problems and Conflicts). Similar positions are outlined by the governing bodies of chaplaincy, psychiatry, counseling, medical assistants, and others. We must take care of ourselves. To do so ensures our own well-being, and equips us to perform at our best in the care that we provide to patients and their families (Irvine, 2009; Shanafelt, 2021).

Conclusion

I appreciate the vulnerability, lived-experience, and wisdom shared by the authors who contributed to this collection. Their narratives serve to identify and challenge several elephants-in-the-room that often go unacknowledged in our healthcare training and practice. We, as providers, are human. The stoicism taught to us by the Academy to value is not helping anyone. It is okay to hurt, to cry, to question, and to struggle. We can (and we should!) reach out to each other, offering and receiving support while we navigate the painful losses and other stressors that

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[1] *A Balint Group is a professional development group for healthcare professionals that meets regularly to provide a supportive space to present clinical cases. The group aims to improve and understand the emotional and psychological aspects of the participants' work and, ultimately, their ability to provide empathetic and patient-centered care.*

are front-and-center part of our work. Attending to our own health and well-being should not be an individual, isolated, or low(er)-priority effort. We are in this together, and together we do better.

References

American Association for Marriage and Family Therapy (2015). *Code of ethics*. https://www.aamft.org/Legal_Ethics/Code_of_Ethics.aspx

American Medical Association (2024). *AMA code of medical ethics*. https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-health-wellness

American Nurses Association (2015). *Code of ethics for nurses with interpretive statements*. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

American Psychological Association (2017). *Ethical principles of psychologists and code of conduct*. https://www.apa.org/ethics/code/ethics-code-2017.pdf

Bott, E. M., Duffy, R. D., Borges, N. J., Braun, T. L., Jordan, K. P., & Marino, J. F. (2017). Called to medicine: Physicians' experiences of career calling. *The Career Development Quarterly, 65*(2), 113–130. https://doi.org/10.1002/cdq.12086

Brown, M. E. L, MacLellan, A., Laughey, W., Omer, U., Himmi, G., LeBon, T., & Finn, G. M. (2022). Can stoic training develop medical student empathy and resilience? A mixed-methods study. *BMC Medical Education, 22*(1), 340-352. https://doi.org/10.1186/s12909-022-03391-x

Cruess, S. R., & Cruess, R. L. (2004). Professionalism and medicine's social contract with society. *Virtual Mentor, 6*(4), 1–4. https://doi.org/10.1001/virtualmentor.2004.6.4.msoc1-0404

Dreison, K. C., Luther, L., Bonfils, K. A., Sliter, M. T., McGrew, J. H., & Salyers, M. P. (2018). Job burnout in mental health providers: A meta-analysis of 35 years of intervention research. *Journal of Occupational Health Psychology, 23*(1), 18-30. https://doi.org/10.1037/ocp0000047

Goštautaitė, B., Bučiūnienė, I., Dalla Rosa, A., Duffy, R., & Kim, H. J. (2020). Healthcare professionals with calling are less likely to be burned out: The role of social worth and career stage. *Career Development International, 25*(6), 649-670. https://doi.org/10.1108/CDI-10-2018-0255

Irvine, C. (2009). The ethics of self-care. In T. Cole, T. Goodrich, and E. Gritz (Eds.), *Faculty health in academic medicine* (pp. 127-146). Humana Press. https://doi.org/10.1007/978-1-60327-451-7_10

Mendenhall, T. (2021). We are in this together: Maintaining our healthcare teams' wellness during challenging times. *Families, Systems, & Health, 39*(3), 541–543. http://dx.doi.org/10.1037/fsh0000650

Rivera-Kloeppel, B., & Mendenhall, T. (2023). Examining the relationship between self-care and compassion fatigue in mental health professionals: A critical review. *Traumatology, 29*(2), 163-173. https://doi.org/10.1037/trm0000362

Sarkar, U., & Cassel, C. (2021). Humanism before heroism in medicine. *JAMA, 326*(2), 127-128. https://shorturl.at/k5RiM

Shanafelt, T. D. (2021). Physician well-being 2.0: Where are we and where are we going? *Mayo Clinic Proceedings, 96*(10), 2682-2693. https://doi.org/10.1016/j.mayocp.2021.06.005

Temple, J. (2014). Resident duty hours around the globe: Where are we now? *BMC Medical Education, 14*(Suppl 1), 1-5. https://doi.org/10.1186/1472-6920-14-S1-S8

Weaver, M. D., Landrigan, C. P., Sullivan, J. P., O'Brien, C. S., Qadri, S., Viyaran, N., Wang, W., Vetter, C., Czeisler, C. A., & Barger, L. K. (2020). The association between resident physician work-hour regulations and physician safety and health. *American Journal of Medicine, 133*(7), e343-e354. https://doi.org/10.1016/j.amjmed.2019.12.053

Westerman, M. (2014). Reflections on having a 'calling' as a medical doctor. *Perspectives on Medical Education, 3*(2), 73–75. https://doi.org/10.1007/s40037-014-0112-5

Commentary

Practicing Death: Depriving Death of Its Strangeness

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Abstract. We live in a death-denying culture where, despite the fact death happens to everyone, individuals prefer to deny death, facing it only when necessary. There exists a myth that death can be delayed, or perhaps redefined, or controlled in some fashion. The stories in this issue serve as examples of how healthcare professionals encounter death and how they learn to cope with it.

Keywords. Bioethics, Culture, Death, Grief, Hospice, Narratives

Introduction

Even though death will happen to all living beings, the experience of death and the emotions surrounding it have been of interest to science, religion, art, and philosophy for centuries (Seale, 2000). One of the most influential philosophers in the French Renaissance, Michel de Montaigne, wrote about death in his essay titled "That to Philosophize is to Learn How to Die," first published in 1580. The below quote is very applicable to the narratives in this journal issue.

> *To begin depriving death of its greatest advantage over us, let us adopt a way contrary to that common one: let us deprive death of its strangeness, let us frequent it, let us get used to it; let us have nothing more often in mind than death . . . We do not know where death awaits us: so let us wait for it everywhere. To practice death is to practice freedom. A man who has learned how to die has unlearned how to be a slave.* (Michel de Montaigne 1533–1592)

Historically, death was a public event. Without institutions such as hospitals to hide death, it happened in the family home. Funeral services were also held in the family home, often photographed with the casket in the living room, surrounded by family members. However, with the modernization of healthcare and the building of institutions whose role was to fight death, dying moved out of the home and an entire funeral industry developed (Starr, 1982). Today, most people obtain their understanding about death from either a personal experience with family and friends, books, or television and movies (Longbottom & Slaughter, 2018). At the same time, the culture tends to frame death as a sudden event, an accident, or an act of violence. Grief is not usually a part of the script other than perhaps a short-term experience involving tears, a visitation, and a funeral. The survivors are seen returning to normal after a few days (Longbottom & Slaughter, 2018).

Similarly, this denial is supported by employment bereavement policies that allow only 3–5 days off, depending on the relationship with the deceased. Death is often seen as something that can be avoided with a heroic action, including some pushing on the chest doing CPR. However, health professionals understand the trauma and physical results of things like CPR (Puri, 2023). Healthcare providers work in the backstage of the places where people die, hospitals, hospices, nursing homes, and people's homes. Death can look and feel much different than what is depicted in our entertainment. The reality of death is that it is not always sudden and grief takes a substantial time to recover from and is often complicated by the circumstances surrounding it.

These 12 stories, from an interdisciplinary group of healthcare providers, show the wisdom gained as they have deprived death of its strangeness, facing it both personally and professionally, learning from it, being changed by it, and feeling free from the slavery of the ignorance of it. A diverse collection of narratives illustrates individual lessons on death. These stories show death as a raw emotional experience. These individuals have "practiced death." Death is not a stranger and has given them the special freedom Montaigne described.

Cultural Expectations and Workplace Reality of Death

Despite experiencing professional or even personal loss, these authors explain to us that they must move on to the next patient, save the next life, and practice death yet again. Marcia King, an ER nurse, finds herself as the nurse for her friend. Without realizing who she is treating, she reacts, seeking to prevent death, to save someone's life, and then she realizes this is her friend. Unsuccessful in preventing death, she must push her feelings aside and go practice it again with someone else. Powerfully sharing,

> *I had to stay at work and finish my shift after that. There was no going home early, no time to mourn, no time to grieve for my friend or her family. I wiped the tears from my cheeks, breathed in deeply, and moved on to care for the next patient.*

Similarly, Alisha shares the personal struggles of the overwhelming practice in death that health professionals had during the COVID-19 pandemic.

> *Like many other healthcare workers, I compartmentalized my feelings and pushed through. I began isolating myself from family and friends and limiting my smile and engagement at work. . . . During the pandemic, there were no emotional boundaries set. While I remained empathetic and compassionate toward grieving families, I failed to show myself the same. There was no balance. I was all in.*

Practicing Death and Finding Role Models

While the narratives focused on experiencing grief due to death, dying, tragic outcomes, or other significant losses that happened with patients, some of the stories touched on grieving personal losses, too. As a medical student, Dr. Jake Beery lost his mother and takes us into the practice of death with the story. By witnessing the way other professionals practiced death, the young medical student finds a paradigm for dealing with death in the future, "I wanted to be as good as the staff at the hospice house were at making patients and their families feel safe and cared for . . ."

I have personally had a similar experience as my mother died in a hospice house a few months ago. Indeed, hospice physicians, nurses, social workers, and chaplains practice death every single day. They have learned to wait for it, and expect it, and they teach family members this as easily as they breathe. Familiarity with death has taught them compassion and respect, giving them the understanding that it is not predictable, cannot be avoided, and is best dealt with openly, honestly, and with a sacred reverence. Hospice houses are entire environments and systems of care with death in mind, the center of attention, the very reason for their existence. Yet, death is not treated as routine but instead as a quiet understanding, as all aggressive treatment is aimed only at comfort. Death is not the enemy; symptoms are the enemy, and in death comes freedom, as noted by Montaigne.

Practicing Death with Children

Several of the stories in this issue demonstrate that death does not have any regard for age as children, including infants, also die. Dr Pinto, a pediatrician, experiences firsthand the anger of those unskilled in death, unaware and unable to accept that despite our best efforts as healthcare providers, children can die. Grief leaves a powerful and confusing lens for parents to understand the experience, and physicians can be seen as either the hero who avoided death, or the villain causing it. Dr. Pinto not only shares her grief over the loss of a young patient, but also the professional grief she experiences when a malpractice suit is the outcome of death.

> *. . . saving lives as part of a PICU team, witnessing other families' acceptance and peace when faced with the death of their children, and being validated through the litigation process rekindled the deep joy that I will always contain. As a pediatrician, I remain committed to the children entrusted to my care. I will never let grief threaten this purpose and joy again.*

Similarly, we learn from a pediatric social worker, T.S Moran, in a powerful statement,

> *What surprised me was my level of grief. I had spent the 12 years prior serving adult hospice patients; I understood end-of-life care and death's eventuality. I thought I was well prepared. This experience was different from my past. I was able to cope with an adult patient's passing without much distress, accepting that most adults had lived a full life.*

Katie L. Gholson, a Chaplain, shared the grief of one mother and the lessons she provided.

> *Grief may come when we are not expecting it, like standing on the outside curb of the hospital holding a bag of art supplies. It is best to allow it to come and feel what we need to feel in that moment. This is what makes us human; it is what makes us better caregivers and providers for patients and their loved ones.*

Emotional Boundaries to Practice Death

Despite practicing death, knowing its inevitability, and understanding its biology, the emotions are still complicated. Those who practice it often try to establish emotional boundaries to protect themselves, and yet these boundaries are often made of dotted lines where the grief, in some cases, cannot be kept out. These stories illustrate that healthcare providers, despite their "hero" status, are human. There are times when the stories of patients collide with our personal stories, and the results are a different kind of relationship, a new lesson bringing yet again a different type of freedom.

Laura Wachsmuth, a chaplain, notes:

> *I am human and have a heart that feels deeply. I also have personal scars and losses, which sometimes intersect with the pain the patients I support endure. It is tempting at times to try and just buck up or dismiss feelings of grief that emerge during the sadness of situations I interact with, yet Ellen's case teaches me how strengthening it is, in fact, to reach out during these times and how mysterious and personal the response can be.*

And in "Cracked Armor," author Joanne Alfred shares:

> *Death and I had not been strangers, but it had never been so personal. . . . His death taught me to recognize the small cracks that form each time I encounter suffering. I grieve daily, each child who looks up at me with an IV or a nasal cannula, and in most cases, my reassurances are true: No, this is not the end! You will leave this place, and your suffering will not shatter my soul; it will barely leave a splinter.*

The Importance of Community Support as We Practice Death

Finally, another set of stories shares the need we have for community and support while practicing death. Dr. Calvin R. Gross shares the tremendous challenges of being a lone witness to death on a night shift, especially as an inexperienced young physician. "*At night [there are] no peers, no mentors, only a group of experienced nurses, whose circle is closed to me, the outsider.*"

In a completely opposite experience, Jenna Bennett, a medical student, learned the value of community by experiencing it.

> *Instead of isolating, everyone leaned on each other to hold it together—not for the sake of not embarrassing*

> *themselves in front of coworkers, but truly in order to help this child and all the others on the unit who came to us for care in their time of need.*

This was also reinforced by Adia Khan, who shared,

> I *walked away, knowing that I was not alone and that we could talk through our grief when we see hard things. I learned about different ways to cope with losses and sadness while giving patients dignity and respect.*

Above all, many of the authors shared the impact that bearing witness to dying had on them. They each shared the responsibility they felt to share what they had learned as a way of respecting those who had died. Cindy Bitter, in "Who Tells the Story," writes,

> *That patient was not 'merely' a means to my end—respecting her humanity requires that I honor the impact she had on my development as a physician.*

Jenna Bennett verbalizes Montaigne's point by discussing the benefits of practicing death, the freedom that comes with knowing it, the course that this wisdom puts you on.

> *By mourning and frequently reflecting on people like this patient and my father, I hope to honor their lives. By learning from them, I hope to establish meaning from senseless tragedies and become a better human, especially as a future physician.*

Conclusion

May we practice death also by experiencing it through the eyes of others. Storytelling is a powerful way to learn about experiences we do not have firsthand. As children, we learn many things from stories like "Pinocchio" and the "Three Little Pigs." So, can stories such as these teach us about death? By sharing their experiences with grief, healthcare professionals may learn from each other about effective coping methods. Death is complicated. By observing others as they practice working in the midst of it and hearing from colleagues, we may be less afraid and strive for Montaigne's freedom.

References

Longbottom, S., & Slaughter, V. (2018). Sources of children's knowledge about death and dying. *Philosophical Transactions of the Royal Society of London. Series B, Biological Sciences*, *373*(1754). https://doi.org/http://dx.doi.org/10.1098/rstb.2017.0267

Montaigne, Michel de. (2024). *That to Philosophize is to Learn How to Die. (Trans.; HyperEssays.).* HyperEssays.net. (Original work published ca. 1580.)

Puri, S. (2023). The hidden harms of CPR. *The New Yorker*. https://www.newyorker.com/news/the-weekend-essay/the-hidden-harms-of-cpr

Seale, C. (2000). Changing patterns of death and dying. *Social Science & Medicine*, *51*(6), 917–930. https://doi.org/https://doi.org/10.1016/S0277-9536(00)00071-X

Starr, P. (1982). *The social transformation of American medicine: The rise of a sovereign profession and the making of a vast industry.* Basic Books, Inc.

NARRATIVE SYMPOSIUM

Commentary

Healing the Healers: Exploring Grief in Medicine

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Abstract. In healthcare, grieving on the job is common and often goes unaddressed, leading to prolonged and compounded emotional distress among healthcare professionals. Reflecting on personal narratives written by healthcare providers and trainees working in emergency medicine, pediatrics, and other medical specialties, I highlight how grief can be prolonged when anticipated, chronic, delayed, or inhibited and how it may be influenced by the closeness of the patient-provider relationship, relatable circumstances in the patient or family's life, and the level of support provided by colleagues, peers, and institutions. The NIB narratives emphasize the need for better support systems, particularly for early career-stage workers, and stress the importance of addressing grief to foster well-being and job satisfaction. Fewer narratives by more experienced professionals were included in the narrative symposium, hinting that as a coping strategy, healthcare professionals may eventually develop enhanced compartmentalization skills to deal with emotionally difficult cases. Finally, I highlight how, for many of the authors, their experiences with grief have been professionally formative, and I briefly reflect upon my own personal experience with grieving on the job while working in the emergency department at a level-one trauma center.

Keywords. Bioethics, Compartmentalization, Coping Strategies, Grief, Healthcare, Narratives, Peer Support, Professionals

Introduction.

In my early twenties, I worked at a level-one trauma center emergency department (ED) as a patient support associate. I had no prior medical experience, but at the time, I was considering a major in nursing. The job provided a fast and furious introduction to the healthcare profession, and though I didn't end up going to nursing school, the lessons and knowledge I gained in the ED have helped me understand and connect with the people who I now assist as the managing editor of *Narrative Inquiry in Bioethics*.

My ED duties entailed answering phones, relaying to the clinicians when a trauma patient was coming in, entering physician orders, and helping in many other ways to care for the patients who came through our doors. The desk where I sat was just across from the trauma bays, so I had a front-row view anytime a critically ill or injured patient was admitted. The trauma patients had often been injured in motor vehicle accidents, incidents involving farm equipment or all-terrain vehicles, falls from ladders, roofs, or horses, and sometimes gun violence. I typically worked evenings and often left the hospital feeling emotionally exhausted, yet not able to sleep due to the adrenalin pumping through my body. Though I did not physically treat patients, I was part of the team. The injuries and deaths I witnessed affected me, though largely, I felt alone with my feelings. No one prepared me for the intensity of working in the ED, and no one ever discussed grief or suggested who I might speak with should I need help processing what I witnessed. Apparently, this is not uncommon. According to Marcella & Kelley, healthcare support staff who provide assistance to patients, families, and clinicians are often overlooked when it comes to recognizing grief and bereavement (2015). In my experience, there was never any debrief, nor did it feel like there was time. We were always moving on to answer the next call and to care for the next patient.

Like the authors of the NIB narratives, there are patients whose cases stand out in my memory. I found myself relating to many of the authors, whom I thank for sharing their experiences of grieving on the job—I wonder how many felt vulnerable doing so and how many others wanted to share but, for whatever reason, did not. Physicians may be especially reticent to share their feelings of grief for fear of being perceived as unprofessional (Barnes et al., 2020), or perhaps out of shame (Leeat Granek, 2012). As Granek points out in a 2012 New York Times article, “Physicians who are dealing with end-of-life issues are right to put up some emotional boundaries: no one wants their doctor to be walking around openly grief-stricken.” Furthermore, healthcare providers may compartmentalize their feelings of grief either as a coping strategy or because continually witnessing trauma and death normalizes these (Granek et al., 2012). In this commentary, I identify and explore the themes I observed in the stories and consider how we can better support healthcare professionals in managing grief.

Prolonging Feelings of Grief

Grief is a normal “emotional reaction to bereavement” (Stroebe et al., 2008). It differs from depression in that symptoms of grief diminish over time as the person grieving adjusts to the loss (American Psychiatric Association, 2022; Barnes et al., 2020). However, the normal grieving process can be interrupted or prolonged when grief is anticipatory, chronic, delayed, or inhibited (Barnes et al., 2020). These factors that affect the normal grieving process are all present in the NIB stories and can lead to prolonged grief disorder, which is characterized by intense and persistent grief that can interfere with daily life (American Psychiatric Association, 2022).

Anticipating grief

Laura Wachsmuth, a hospital chaplain, writes about “Ellen,” a woman who, at 27 weeks pregnant, was admitted to the hospital for symptoms that ended up being caused by stage IV gastric cancer. Ellen is told she likely has less than a year to live. Wachsmuth visits Ellen many times over the course of several hospitalizations and forms a warm relationship with her and “Mark,” Ellen’s husband. Wachsmuth writes, “My sense of grief over this case especially came to a head during Ellen’s final admission. There were no other treatment options, and death was imminent. Mark took both of my arms and asked me if I could help Ellen find peace with dying.” Understanding how the story would end, my heart ached for Wachsmuth, who undoubtedly anticipated Ellen’s fate long before her final admission.

Joanne Alfred, a resident, also touches on anticipating grief. Nate, an adolescent patient who Alfred has cared for since his initial diagnosis of leukemia, returns to the hospital, now seriously ill after being in remission. Alfred learns that Nate has been admitted to the PICU and writes, “My dread welled further because my first night [working] in the PICU loomed two days away. All I could think about was Nate. Turning the corner to the unit, my heart racing, begging please don’t let him die. [T]he cumulative melancholy, the sense that it could be held back, was not holding true.”

Chronic loss and delayed or inhibited grief

The impact of continual patient loss on healthcare professionals may compound their grief, and due to job demands and expectations, they may be forced to suppress or delay dealing with grief (Barnes et al., 2020). This was the case for Marcia King, an ED nurse who realizes that a trauma patient she is caring for is her dear friend. After the patient is transferred to another hospital with a grim prognosis, King must stay and complete her shift. "There was no going home early, no time to mourn, no time to grieve for my friend or her family. I wiped the tears from my cheeks, breathed in deeply, and moved on to care for the next patient."

Alisha, a nurse who managed the hospital's crowded morgue during the COVID-19 pandemic, writes, "I finally spent an evening with my sister and friends. After nine months, I loosened my emotional hold and discussed work. Back at my sister's home, when it was just the two of us, I fell to the floor and began sobbing profusely. I admitted how sad I was and how sad it was for the families. I have no idea how long I cried. My sister just sat on the floor and hugged me as I let go of all the built-up emotions."

PICU Physician Neethi Pinto shares, "Our culture in medicine rarely affords us the permission or the grace to unpack the depth of the sorrow and grief we regularly witness and suffer. Instead, we must summon up the fortitude to take care of the child in the next room before we can pause and process our grief. The sheer reality of our day-to-day lives in the PICU is that the next critically ill patient is waiting."

Calvin R. Gross, a second-year resident, writes about a young man who is supposedly in stable condition but suddenly develops a huge brain bleed on the night shift when Gross is the only physician on the unit. Gross is charged with the regrettable task of calling the patient's family, who he has never met or seen. "I wish I had the chance to get to know them instead of relating as disembodied voices, ghosting past each other in the middle of the night. I want to stay, meet the young man's parents, and process with the day team, but they have work to do. I leave, holding it all inside."

Compounding Feelings of Grief

Several factors may compound feelings of grief. The closeness and duration of the patient-provider relationship, circumstances that are in some way relatable to the provider's own life, or the support (or lack thereof) that the provider receives from their organization may all affect the intensity of grief (Barnes et al., 2020; L. Granek, 2012; Harrad & Sulla, 2018).

The closeness and duration of the patient-provider relationship

Over half of the NIB stories had to do with grief brought on by a situation with a patient or family member for whom the author felt a special affinity for or had a prolonged patient-provider relationship with.

Pinto "had cared for her [patient] on many occasions" and had "spent countless hours at her bedside, during the day, in the middle of the night, away from [her] own young family." One of King's patients had a husband who "stayed with her all day and all night. He doted after her 24/7, slept in a chair, and never went home for about three days." King was "amazed at what an awesome husband he was." Wachsmuth spent many hours with Ellen and her husband, and T.S. Moran, a pediatric oncology social worker, and her team cared for 8-month-old "J" for "half of his short life."

Circumstances that are relatable to those of the healthcare provider

In her story, Katie Gholson, a palliative care chaplain, shares an experience she had with grieving when the mother of a young son and daughter was dying from terminal cancer. Gholson mentions the many things that she had in common with the patient but relays, "It was not just these reasons that I felt a connection to [her]. It was also the tangible despair I felt when I was with her."

Jake Beery, a medical student, begins his story by sharing a personal tragedy. His mother, who he was incredibly close with, succumbed to metastatic ocular melanoma after a short time in hospice. Later, Beery begins a month-long rotation on the inpatient palliative care consult team and meets Ms. J., a patient whose situation mirrors that of his mother's. "In the days that followed, Ms. J stuck with me." She shared the highlights of her life and what mattered most to her. "A life well lived," Beery thought as he desperately held back tears.

Patient Ellen reminds Wachsmuth of her Aunt Cathy, who, in her mid-thirties, died from cancer. Wachsmuth finds comfort in the memory of her aunt, which she shares "helped give me peace about Ellen's death and helped me hold out hope that Ellen could find a path of peace amid all she was enduring."

Alone in grief versus supported by colleagues

In her opinion piece "Shared Grief," Nursing Professor Karen Alexander ascertains that grieving is easier when we are supported and surrounded by love (2021). The support (or lack thereof) that a healthcare provider receives from their workplace or colleagues can significantly affect grieving (Barnes et al., 2020). Social support can be significantly helpful in overcoming grief (Kostka et al., 2021) and some of the NIB authors wrote about the remarkable support that they received from mentors, co-workers, and fellow students.

During her first medical school rotation, Jenna Bennett is grief-stricken when a child is admitted to the hospital after being violently sexually assaulted by a family member. Hiding in the bathroom, she worries that the rest of the team will not be impacted. However, she finds other members of the care team are also struggling deeply. "They grieved and mourned together. Instead of isolating, everyone leaned on each other to hold it together."

In her story, Nadia Khan describes seeking support from a former clinical skills professor who encouraged her students to reach out whenever they needed. Khan calls her after a difficult case in which she cannot break through to a patient who is in much need of treatment but only tells Khan that she "wants to go home." About the phone call, Khan writes, "My mentor listened carefully, not interrupting for even one second." Khan takes her mentor's advice and organizes a memorial for her fellow students and physician mentors so they can all share their personal experiences with grieving. She says the experience was one of the most moving of her life.

In AAMC's Viewpoints, Wynne Morrison writes that providers need the opportunity to acknowledge loss. Morrison feels that hospitals have a responsibility to help providers process feelings of grief and loss (2023). As a social worker, Moran participated in a team debriefing that the chief of their unit organized after an 8-month-old baby died. "Everyone had a chance to reflect on their experience in caring for this child. When I spoke about my feelings to my coworkers, they were understanding and acknowledged their own sadness." By encouraging providers to reflect on feelings of grief as Moran did, institutions could circumvent burnout and disengagement and improve providers' abilities to compassionately support patients (Morrison, 2023).

Many NIB authors suffered alone, however. The gravity of Alisha's responsibilities caused her to have nightmares and PTSD symptoms. When Alisha's morgue supervisor and confidant resigned, she "felt nervous and alone," and she had no one to talk to about what she was enduring. "If I shared stories with anyone outside healthcare, they would freak out at what I was telling them. I stopped talking about my experiences altogether."

When the doctor notices that the death of a patient saddens King, he asks her "what her problem is" rather than providing support and empathy. And after receiving a subpoena for a malpractice lawsuit regarding the death of one of her patients, Pinto feels isolated in processing her grief. "We are told by the lawyers who defend us that we cannot discuss pending cases with anyone. It's a secret you have to keep with no confidant. There is no shoulder to lean upon—it's a cross to carry without an end in sight."

Guilt, Shame, and Remorse

In "Haunted Doctors," Catherine Belling compares the *haunting of a place*—when an apparition frequents a dwelling or location repeatedly after it is no longer expected or welcome—with that of *a person who is haunted* by remorse or guilt (2020). This metaphor may resonate with several of the NIB authors who seemingly *are* haunted by their grief, though Pinto is the only author who articulates that she is.[1] For years, the grief she felt over the death of a pediatric patient persisted as she was sued for medical malpractice by the child's parents and the case dragged on in the courts. Each time something occurred with the case, "the feeling of shame crept in and haunted me." Ultimately, a judge dismissed the case, finally exorcising the ghosts of Pinto's grief and "rekindling the deep joy" she previously felt as a pediatrician.

As a medical student, Cindy Bitter determined that one of her patients had asymptomatic atrial fibrillation. The patient died when the attending ordered and pushed a drug that was contraindicated. Bitter feels responsible since she found the abnormality. "I felt powerless to contradict the attending and did not know where to turn for support." Though Bitter did not push the medication, she held herself morally culpable for the patient's death, and her feelings of remorse are palpable.

About the child who was sexually assaulted, Bennett writes "Feeling broken left me riddled with guilt. This was not about me. I didn't understand why I was so deeply impacted before even seeing the patient. I felt weak and embarrassed. I wondered if I would be cut out to be a physician."

Alleviating Grief and Coping Strategies

A study of health professionals found that focusing on the positives and allowing time and experience to assist with coping leads to improvements in the experience of grief (Barnes et al., 2020). Several of the authors wrote about strategies they use to alleviate grief, either consciously or subconsciously.

Moran says she "validated her team's loss, their efforts, and their love" for an infant patient who died and "provided basic grief education and encouraged self-care—from taking time off, to lingering over an extra cup of tea, to speaking about their experiences." Moran shares that being able to provide support to the team helped her cope with the infant's death because she was able to be active in her response.

Alfred writes, "Nate lived a terminal diagnosis, and as I stood beside him, from start to finish, I learned that it is not always about pushing against suffering, but acknowledging it, giving it space to soften me. I have deep gratitude to Nate for being my first instructor in this skill."

Compartmentalization as a coping mechanism

Granek et al., conducted interviews with oncologists to examine their grief over patient loss and found that compartmentalization—the ability to separate feelings of grief from other aspects of one's life—was one of the most common themes (2012). However, compartmentalization in the NIB stories was not as ubiquitous. Perhaps the further along someone is in their career, the better they become at developing coping mechanisms, such as compartmentalizing. If more advanced professionals have developed better ways to cope, this might explain why all but three of the NIB narratives detailed experiences from when the authors were students or residents (Beery, Gross, Alfred, Bitter, Bennett, and Khan), just starting out in their careers (King), or taking on new duties or jobs (Alisha & Moran). Gholson, a more seasoned palliative care chaplain, explains, "As providers, we tend to have a controlled and somewhat restrained emotional response to much of our work. This is not because we are inauthentic but because this is our way of surviving the difficult cases we encounter."

Conclusion

Most of the authors shared how their experiences with grieving on the job ultimately shaped their careers. After her patient's death, Bitter doubted her calling to become a physician but, in the end,

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[1] *Andrea Eisenberg, author of one of the online supplement stories, also writes that her experience haunts her. Of note, both Pinto and Eisenberg wrote about experiences that caused them to grieve and which involved being sued by a child's parents.*

completed medical school. She became an emergency physician and, in honor of her patient, an early adopter of shared decision-making and an advocate for patient safety. Wachsmuth shares, "It is tempting at times to try and just buck up or dismiss feelings of grief that emerge during the sadness of situations I interact with, yet Ellen's case teaches me how strengthening it is, in fact, to reach out during these times and how mysterious and personal the response can be." And Pinto vows, "As a pediatrician, I remain committed to the children entrusted to my care. I will never let grief threaten this purpose and joy again."

As for me, my time in the ED was the launching pad for my career in public health and bioethics research. Though I transferred from the ED to a less intense department in the hospital after a year, I would never trade my short time there for anything. I formulated a great respect and admiration for healthcare workers, who, despite witnessing terrible tragedies daily, often push their grief aside, and persevere in caring for the next patient. Out of continually witnessing anguish and loss, I found a mature perspective about the things that matter most and eventually developed a passion for helping patients, their families, and healthcare workers share their stories.

References

Alexander, K. (2021). Shared Grief. *JAMA*, *325*(4), 349–350. https://doi.org/10.1001/jama.2020.25000

American Psychiatric Association. (2022). *Prolonged grief disorder*. Retrieved August 23 from https://www.psychiatry.org/patients-families/prolonged-grief-disorder

Barnes, S., Jordan, Z., & Broom, M. (2020). Health professionals' experiences of grief associated with the death of pediatric patients: A systematic review. *JBI Evidence Synthesis*, *18*(3), 459–515. https://doi.org/10.11124/jbisrir-d-19−00156

Belling, C. (2020). Haunted Doctors. *Perspectives in Biology and Medicine*, *63*(3), 466–479. https://doi.org/10.1353/pbm.2020.0034

Granek, L. (2012). Grief in health care professionals: When screening for major depression is needed-reply. *Archives of Internal Medicine*, 172(22), 1768–1769. https://doi.org/10.1001/jamainternmed.2013.2096

Granek, L. (2012). When doctors grieve. *The New York Times*. https://www.nytimes.com/2012/05/27/opinion/sunday/when-doctors-grieve.html

Granek, L., Tozer, R., Mazzotta, P., Ramjaun, A., & Krzyzanowska, M. (2012). Nature and impact of grief over patient loss on oncologists' personal and professional lives. *Archives of Internal Medicine*, *172*(12), 964–966. https://doi.org/10.1001/archinternmed.2012.1426

Harrad, R., & Sulla, F. (2018). Factors associated with and impact of burnout in nursing and residential home care workers for the elderly. *Acta Biomed for Health Profession*, *89*(7-s), 60–69. https://doi.org/10.23750/abm.v89i7-S.7830

Kostka, A. M., Borodzicz, A., & Krzeminska, S. A. (2021). Feelings and Emotions of Nurses Related to Dying and Death of Patients—A Pilot Study. *Psychology Research and Behavior Management*, *14*, 705–717. https://doi.org/10.2147/PRBM.S311996

Marcella, J., & Kelley, M. L. (2015). "Death is part of the job" in long-term care homes: Supporting direct care staff with their grief and bereavement. *Sage Open*, *5*(1), 2158244015573912. https://doi.org/10.1177/2158244015573912

Morrison, W. (2023). Coming together to grieve when a patient dies. *Association of American Medical Colleges, 2024*. Retrieved November 15, from https://www.aamc.org/news/coming-together-grieve-when-patient-dies

Stroebe, M. S., Hansson, R. O., Schut, H., & Stroebe, W. (2008). Handbook of bereavement research and practice: Advances in theory and intervention. In S. Barnes, Z. Jordan, & M. Broom (Eds.), *Health professionals' experiences of grief associated with the death of pediatric patients: a systematic review*. https://doi.org/10.11124/JBISRIR-D-19-00156

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