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PALLIATIVE CARE ADVANCES AND REFLECTIONS:

Supporting Patients and Families for the Road Ahead

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GRIEF ON FIRE

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As frontline physicians have navigated this pandemic over the past year and a half, I've been surprised and delighted to see the myriad ways in which my colleagues have manifested their resilience. Even in the darkest days of the lockdown or the midst of our worst surge, I've always known that reliably, walking into the ED on a weekend night, that I'd find someone in a good mood. It was a relief, frankly, that even the ravages of the worst medical emergency of our lifetime (I hope), that human beings have a tendency to, well, survive. And what that looked like in the Emergency Department where I work was a little gallows humor, a little burnout, and a little lighthearted cheer. A vacation here or there, and some good TV. Heads down, don't dwell, and just keep putting one foot in front of the other.

In my other work, as a hospice physician, it looked a little different. I heard a lot, to say the least, about suffering. The suffering of our patients, of course, but the suffering inherent in isolation from colleagues. The sadness of distance from grandchildren; the birthdays missed and the memories unformed. When people gathered in remote meetings, we talked about the heaviness of the time; the toll these waves of grief were taking on us, collectively and as individuals. We talked about what we were doing to cope (walking, meditating, escaping in crappy reality TV) and what worked, or didn't. We talked about the weight (emotional, spiritual, psychological) that so much death and dying might have on us and on our community.

And as we emerge from this awful time, I'm left wondering why processing grief feels like it's often the sole purview of the hospice clinician. As I read stories about healthcare workers across the country mired in PTSD, and considering leaving the profession, I wonder whether at least some component of that is there have been neither opportunities nor structure to process the feelings of loss this year has generated. Loss of patients, absolutely, but loss too of our fiercely held belief that death is a failure, that physicians can prevent or stop it if we're good enough. Not to mention the personal loss—of time with beloved elders, or newly born nieces and nephews, of resources, or of jobs.

The list could go on forever! But rather than sit here and remind you of all the ways that you have left this time with less than you came into it with, I'll propose an alternate activity. I think it's time we, as physicians, learned how to grieve at work. Well, not grieve AT work, necessarily, but grieve OUR work. That we learn how to take the big and complicated feelings that arise with a patient death, or a medical error and begin to apply some well-worn behaviors to moving through them, rather than simply burying them in the sand and forging ahead. I don't know about you, but I wasn't taught in medical school or residency how to do this, and certainly not how to do it well. Let's talk about it.

Step 1: Identify that you are indeed grieving

This is harder than it sounds. Sometimes grief can be a feeling—a tightness in your throat or neck, or heaviness in your chest when you recall a patient encounter, or even some fatigue or nausea. In medicine, we're encouraged to wholly shoulder the shame and blame around an event like a patient death or a medical error and cruise right past the emotion of it into perseverating on the medical details. If you think back to the last time a colleague debriefed with you about a tough case, can you remember what they focused on? Was it the sadness or was it the medical minutiae? It is instinctive for us to dip right into what we should have done—even if the "should" makes no rational sense.

But along these lines, it bears mentioning that you may discover that there was something that you might have done to avert a bad outcome. And it's worth noting that, as well as noting that this can occur simultaneously with grief. You can feel upset that you missed an aortic dissection, but don't forget that you might also be grieving the loss of the connection that you had to that patient, however brief. Guilt and shame don't fully encompass the totality of that emotional experience.

Step 2: Process your Grief

This is something that some people may have experience with regarding their own personal grief. I'm not proposing that we process work grief the way we do personal grief—that would be incredibly draining and time intensive, and frankly, it would make most people not want to do it. So, I propose a few brief steps, pulled from the hospice world, to manage sadness and loss in a work context.

One piece of this is simply the cultural expectation amongst hospice providers that grief processing happens. It's a professional responsibility to manage your grief—in whatever way makes the most sense. While some of the group opportunities for grief processing that happen on the hospice side are not immediately available to ED docs (services of remembrance, group shared recollections in team meeting), I think there are plenty that are. And these include: taking a moment of silence, one-on-one discussion with a co-worker, journaling, or writing a letter. Any of these can take as little as five or ten minutes.

When it comes to one-on-one processing here's what it needs to be: a time to be with your sadness and loss (Not run from it! Not bury it!) with someone who is willing and able to take on this burden. As many of us know—be wary of turning to your partner too frequently for this, or at a minimum check in to see if it is working for them. Colleagues, supervisors, or a therapist are some great choices for this role.

And I'll give a plug (for the criers out there) to put aside a time to cry. It's often challenging to navigate this in the moment, and may be distracting, but a post-shift shower cry can be a great way to release the pent-up emotion and sadness around the event. Personally, I have only two options: plan my crying or let the crying plan itself—the latter results in some awkward Uber rides, so I plan my crying.

Step 3: Finish Processing your grief

This part is key—the only way you can honestly engage with your work grief is with the awareness that it is not an unending spiral of sadness. When grieving for a family member or a loved one, there's a natural and appropriate expectation that it will be a longer, more gradual process of recovery. When it comes to work, however, there must be a more structured and frankly less intensive approach.

It's important to create a boundary for yourself around what you will and won't fixate on. Mostly, you want to be pretty attentive to any "hot spots" of grief that generate a downward spiral of emotion rather than releasing you from it. If you keep perseverating on what the experience was for your trauma patient in the moments before she was hit by a car, and it is distressing, try to focus on other aspects of her experience and care that you can address in a more measured fashion. As I've said—this is ideally not a deep dive. It's a routine ritual.

For many people, it can be helpful to set a time deadline rather than a content deadline. For example, I'm going to let myself really wallow in this for 48 hours, and then I'm going to try and wrap it up. If you've having trouble meeting your own deadline, or find that despite your best attempts you're really being driven to distraction by one element of a patient's experience or care, it's time to call in the pros.

I hope this overview is helpful for those of you finding it difficult to move on from a year awash in unprocessed sadness and loss. As physicians, all too often we have been asked to simply tolerate whatever is thrown our way, pandemic or no. I hope that having a few tools in our back pockets to work through the inherent challenges in our work will make the grieving process feel approachable, manageable, and, ultimately, additive to your experience of medicine.

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