# Dealing with a Modern Crisis: Physicians and End of Life Care

by
Chloe Bowman

A THESIS

submitted to

Oregon State University

Honors College

in partial fulfillment of
the requirements for the
degree of

Honors Baccalaureate of Science in Biochemistry and Molecular Biology
(Honors Scholar)

Presented May 6, 2022
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# AN ABSTRACT OF THE THESIS OF

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As medicine in the United States has progressed, physicians have been posed with a unique task of shepherding patients into the end of their life. This research sought to determine the effect this has on physicians in the form of what has been coined "professional grief." In this, we look at preparation through medical school and residency then support once acting as a practicing physician. In order to analyze the experiences of physicians with professional grief, I performed a literature search and conducted interviews with current and retired physicians. This yielded results that demonstrated a lack of preparatory learning activities at both the medical school and resident levels and lack of subsequent support once practicing. However, physicians have found ways to cope such as community, religion, marriage, and narrative medicine. This demonstrates that this may be a crisis, but it is not an inevitable path physicians must take.

Keywords: Physician Mental Health, End of Life Care, Professional Grief

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I understand that my project will become part of the permanent collection of Oregon State University, Honors College. My signature below authorizes release of my project to any reader upon request.

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Chloe Bowman, Author

## Introduction

Grief was something that I thought I did not have to worry about. Grief was an abstract idea that was reserved for those older than me who had lived more life. As I entered my freshman year of college, I felt my world shifting around me. My responsibilities changed. I could finally feel freedom in the choices I made and the way I spent my time. When my aunt suddenly got sick, I felt this slip away. I did things to ensure I did not feel the pain or think about her. When she passed, I was sad, but I never thought of it as grief. When I returned from her funeral and on the same day had to put our family dog down, I did not think of it as grief. When my collegiate swim team was cut that same year, I did not think of it as grief. As the school year came to an end, I began to feel the weight of my "not grief."

Through the summer I tried to grapple with what was going on inside of me. I could not figure out why I felt the way I did. As school began again, I was in a class that talked about trauma and how it affects mental health along with subsequent motivation and feelings. We all process things differently, although there are some parallels. I began wonder what subsequent traumas do to a person when they do not have time to heal before another occurs. Meanwhile, I was also contemplating my desired profession of physician and what it takes to be happy and successful.

This led me to see parallels between that year of my life and a physician's on a rudimentary level. In being a physician, put in your hands is one of the most sacred things to humans: their lives. This comes with a great weight and responsibility. When lives are lost or a terminal diagnosis is given, I began to wonder what the effects on physicians are, especially in the context of the American culture around

death. I then began to think about how events like this could happen many times a year, month, week, or even every day for some. I wanted to know how they coped and if I could learn to as well.

Considering America culture around death, people often fear death and strive for longevity. The underpinning of this can be seen in that physicians are often taught to treat death as a diagnosis, as if it is something that can be reversed or staved off. However, some influential people in the medical community such as Dr. Atul Gawande and Dr. Paul Kalanithi, have begun to challenge this idea. They question the use of treatment for extension of life without consideration for quality of life. They question the narrative of the "miracle case" and lay out the probabilities associated with a particular patient's illness. They do not want the death of patients to feel like a failure for physicians, as it is an integral part of life cycle as humans.

In analyzing the literature, the goal of this research involved looking into the ways in which physicians have been affected by the death of their patients and how this manifested as professional grief. I also wanted to see if there were trends in what they were taught in medical school about dealing with patient death, how they were and are supported while going through their medical training and while practicing, and how they learned to cope with patient deaths.

My initial intuitions on these topics included that Physicians are given little to no training on how to deal with the death of patients and little support while practicing. I hypothesized that the first death a physicians experiences tend to be the most impactful, leaving a lasting effect on the physician. No initial theories on coping strategies were made as the literature lacked information on more general strategies

used by physicians; however, a few reports state that physicians have adopted narrative medicine, writing about their experience as a physician either in prose or poetry, as a form of coping.

Below you will find the literature review, followed by a synopsis of interviews, and finally the conclusion that will lay out the cycle of professional grief and coping that physicians experience throughout their careers.

## Literature Review

In choosing sources for my literature review, I looked for those that laid out a story and gave a narrative as to the experience of physicians. For this reason, I choose to use *Being Mortal* by Atul Gawande as my first book. This led me to an interesting dynamic considering the physicians patient relationship. It seemed that it was hard to separate the two. Yet at the same time, it could be hard for those on either side of the relationship to understand one and other. I felt that Paul Kalanithi's book, *When Breath Becomes Air*, was able to successfully reveal some truths about this relationship. Kalanithi's unique background played a role in this book being included as well.

The third book I read*, The Healer's Burden*, illustrated the difficulties of working closely with the dying. It does not focus on one profession, nurse, physicians, social worker, etc., but includes short stories from those who heal the human body. It gives differing perspectives and experiences that were important to my thesis. The final book I read*, Physicians Suicide Letters* by Pamela Wible, gave insight into what leads physicians to some of the darkest hours and years of their life

and how their profession plays a role. This was important as it illustrates the ways in which those who heal us sometimes are not able to heal themselves.

*Being Mortal* created a revolution in the world of medicine in terms of the way we treat death. Utilizing his own experience with patients, in the medical setting he begun to pick apart the western approach to death. Gawande also brings aspects of his own culture to the book through his personal experiences of traveling to see family in India and how they upheld their traditions surrounding the illness and death of their patriarch. He uses these experiences to show how the western world's traditions of death differ from much of the rest of the world. He shows how treatment for terminal illness has grown with the middle class and how this has redefined the way not only patients but physicians experience death. Using these narratives, he speaks to the physician experience while caring for dying patients.

Looking to the foundation for western medicine's treatment of patient death, Gawande takes us to the twentieth century where medicine began its historic transformation into a resemblance of what it is today. Before this time, physicians would tend to you in your own bed, functioning in mostly a custodial capacity with family members doing the majority of care. There began a shift to treatment in the hospital setting. Coinciding with World War II, the shift became more evident with the discovery and mass production of sulfa, penicillin, and several other antibiotics used to treat infections. Other drugs to control blood pressure and treat hormone imbalances were also developed. Surgery became more prevalent and modernized with breakthroughs in heart surgery, artificial respirators, and kidney transplantation. This created a shift in the way physicians were viewed, Gawande says: "Doctors

became heroes, and the hospital transformed from a symbol of sickness and despondency to a place of hope and care."

Following this transformation, communities could not build hospitals fast enough. For this reason, Congress passed the Hill-Burton Act to provide massive amounts of government funded aid for hospital construction. This historic act made it possible for most people to have hospitals nearby for the first time. The change this brought about a shift to the course of our species existence. Gawande leaves us with the sentiment that "the magnitude of this transformation is impossible to overstate." Previously we had been left to deal with sufferings of the body on our own and medicine was yet another tool much like religion or healing rituals that people could try to change the outcome of illness. Medicine and the physicians who practiced it now had power behind them. Modern medicine gave control to the sufferers of the body in an unprecedented way and cured many illnesses that were believed to have no cure. Still, this wasn't always a pleasant process and it involved handing your whole life over to medical professionals.

These advances in medicine only continued and paved the way for modern medicine. Social changes brought about biological changes which in turn created a cultural transformation. People were living longer, more productive lives which changed the way physicians and patients alike looked at medicine. Still, modern medicine has not found a methodology in which we can escape death. These same advances have made aging and dying a medical condition for physicians and a medical experience for patients. This comes with a set of expectations surrounding western medical care for both patients and new health professionals. Medicine is

influenced by the culture that surrounds and aids its growth. This influence has created a system in which physicians feel unhelpful unless their patient has a specific, identifiable problem with a solution. People are living longer, and illness relates more to age than actual disease. Age is not categorized as a disease, nor do we definitively know why we age.

This creates a system where physicians don't want to work with older people, but they also aren't taught care for geriatric patients. We not only have a lack of doctors willing to work with older people, but a lack of understanding of the dying process and the wants of those at the stage where they no longer can care for themselves. This lack of understanding puts pressure on the system and therefore the healthcare workers within. Gawande details his own experiences with patient death as the child of two doctors in a system that does not honor our lifecycle. He thought he had a solid understanding of what occurs in the medical setting, yet he found it to be a new world once he reached medical school and beyond.

In medical school, Gawande spent an hour discussing *The Death of Ivan Ilyich* written by Tolstoy. The book details the death of a man in 19th century Russia from an unknown illness. Gawande says himself "he lives in mounting anguish and fear of death. But death is not the subject that his doctors, friends, or family can countenance. That's what caused him the most profound pain (Gawande 2)." Yet, when he read this story in medical school, he admits that he and his classmates saw it as a failure on the part of the primitive medicine practice and lack of sympathy on part of his physicians. Gawande transitions from his account of reading Ivan Ilyich by saying "Just as we believed that modern medicine could probably have cured Ivan Ilyich of whatever

disease he had, so too we took for granted that honesty and kindness were basic responsibilities of a modern doctor… We did little better than Ivan Ilyich's primitive nineteenth century doctors – worse, actually, given the new forms of physical torture we'd inflicted on our patient. It's enough to make you wonder, who are the primitive ones (Gawande 2,6)."

During medical school, many aspiring physicians experience death for the first time. Gawande explains this experience as profound and impactful experience that can be very emotional or completely unemotional. It can lead to a lot of turmoil and depression. In some cases, it even causes imposter syndrome, much like Dr. Gawande's own experience, "I knew theoretically that my patients could die, of course, but every actual instance seemed like a violation, as if the rules I thought we were actually playing by were broken. I don't know what game I thought this was, but we always won (Gawande 7)." This distorted view of death comes from the societal driven view of western medicine and those who practice it; the problem with this lies in that death is inevitable for all humans as we are mortals. The problems for physicians, as Gawande goes on to explain, is a fear of looking or being considered incompetent. When death is looked at as a medical issue that needs to be solved, it comes as a failure that is related to a perceived lack of competency in cases that lead to imposter syndrome.

In a culture that bases physician competency on ability to treat, even in cases of terminal illness, it important to recognize what this does to the patients. As we stigmatize death and glorify treatment, we have created a system edifice that dispenses the medical equivalent of lottery tickets (Gawande 171). Yet this system

lacks the rudiments to prepare patients to not win. This leads to continued stress on the physician to help make our modern medical system function. One case where Dr. Gawande experiences this was with Sara Monopoli. Gawande speaks to how the circumstances of her diagnosis influenced her treatment and death. She was a 34-year-old who was 39 weeks pregnant when she was diagnosed with non-small cell lung cancer that had metastasized into multiple lymph nodes and her chest lining. It does not currently have a cure and carries a life expectancy of one year. This meant inducing labor and beginning treatment immediately. The medical approach to dying leads to the multitude of treatments tried despite increased fatigue with little to no improvement and the wishes of both Sara and her family members. Sara had wished to die at home surrounded by her family, but she sadly passed at a hospital with none of her family present.

This leads Gawande to a discussion of how as a society we are unprepared for death and how this encourages treatment. Doctors do not have the ability to determine which of us will live and which will die, but they are humans who can form bonds with their regular patients. This can lead to bias in terms of life expectancy. Studies have shown that the better a physician knows a patient the more likely they are to over predict their life expectancy. In Sara's case, she wanted more time with her new baby, so treatment became the only option. Never was the alternative of palliative care considered. Gawande questions what the last months of her life would have been like if she was placed on hospice or palliative care to help balance treatment with enjoying what was left of her short life. Still situations like this can be difficult because people can accept that they have a fatal illness, but not that they are dying.

This brings into question the interplay of hope, reality, and how situations can affect physicians as they treat their patients.

In reading from Gawande's perspective, we are given one view, the physicians. We lack the knowledge of the patient perspective integral to understanding the ways in which death can affect a physician. This is important because when a physicians experiences death it is not their own but the patient they are treating. *When Breath Becomes Air* by Paul Kalanithi brings together the world of physician and patient, living and dying. Diagnosed with lung cancer preceding his completion of residency, Kalanithi struggles between the roles he is given in life. He finds ways to leave the world with the ideas of his great mind, no matter how short his life was. His unique education with his equally unique life experiences enabled him to give us a remarkable perspective on the failures of modern medicine in the way we look at physicians and death.

Kalanithi's acknowledgement of medicine as the intersection of morality, biology, literature, and philosophy were key not only to his realization of the failures of modern medicine, but his calling to medicine itself. Once in medical school, he was confronted by death, suffering, and the work that was entailed. Yet he saw how medical students are shielded from the true responsibility of death and suffering. His soon-to-be-wife and classmate Lucy showed him the true reality of this while studying EKGs one night. She identified a fatal arrythmia from a "practice EKG." Lucy's reaction to her successful identification of the EKG was different than Kalanithi's. Overcome with grief of the death this EKG marked, she began to cry, with no physical connection to the patient, only a piece of paper.

Once in the hospital setting, Kalanithi began to see the contrast between his experience and responsibilities in the classroom setting and those he now had. During his first rotation as a medical student, he had the job of observing and staying out the way, but as he was heading to his first day of his OBGYN clinical, he felt an overwhelming sense of dread that he would be called to deliver a child, only to fail. Once there, seeing a c-section and the natural birth of a child, he found learning to be a doctor in practice would be much different from learning done in the classroom. Wrong choice, wrong moves, and wrong interpretation could lead to permanent damage or even death. Kalanithi tells the story of one his professor's, Dr. Shawn Nuland, who cut open the chest of a patient whose heart had stopped beating and tried to physically pump the life back into him. He was only a medical student at the time and had been left alone in the OR. This story gave him the insight to understand that only certain things can be understood face-to-face.

Moving into his next rotation in surgical oncology, Kalanithi was joined by another medical student named Mari. During this rotation a surgeon was to perform a Whipple where Mari was assigned to assist. A Whipple is a 9-hour surgery where most of the abdominal organs are rearranged to resect pancreatic cancer. Mari was to assist on this surgery, but her exhaustion got the best of her. Before the surgery began, the surgeon inserted a camera to look for metastases; any metastases, no surgery. As the doctor inserted the camera, Mari hoped for METS and upon examination, the organs showed evidence of just that. The surgery was called off and Mari sat in a hallway crying where Paul found her.

Stories like Mari's found footing in Kalanithi's mind. As he went into his fourth year of medical school, he saw how the experiences of his classmates led to decisions to choose less demanding specialties. They decided the idealism of their personal statements was lost, but Kalanithi heard a different calling. One night in the OR, he listened to a pediatric neurosurgeon explain to the parent of a young girl with a large brain tumor how their life has and was going to change, along with the implications of those changes. He began to see the way neurosurgeons not only treat the diseases. They operate and work with the very identity of who we are, and operations can leave people mute, blind, or paralyzed. This forces patients and physicians to beg the question "what makes life meaningful enough to go on living (Kalanithi 71)." This "unforgiving call for perfection (Kalanithi 71)" is what called Kalanithi to pursue neurosurgery.

Kalanithi, now in residency for his desired specialty of neurosurgery, states that "we would grow from bearing witness to medical dramas to becoming the lead actors in them (Kalanithi 73)." As an intern his life mainly consisted of paperwork, yet in the medical world, paperwork often equals patients. It includes partial narratives of the patients that help shape the way doctors treat. He also talks about the paperwork that must be completed after treatment of a patient and how the outcome of treatment can affect that. After a good outcome, paperwork can be easy, but a bad outcome led to different feelings. After Kalanithi lost his first patient in residency, he vowed to treat paperwork as patients and never vis versa.

Kalanithi moves on to talk about the weight of being a doctor. Your choices are the difference between life, death, and fates worse than death. Kalanithi defined a

patient who is left brain dead as a worse fate than one that dies. Whether it was a procedure that was rushed due to time constraints of the patient's condition or a patient's choice, the lack of independence or awareness to their condition often affected Kalanithi. However, he the suffering he saw as a physician was something he adapted to, eventually becoming inured to it. He wondered as to the effect this had on him and whether he made more "moral slides than strides (Kalanithi 84)." Still, he feared losing his human relationality as a physician to his patients. He indicates that this doesn't mean revealing large truths about life but being willing and open to meeting patients where they are. While in residency he shifted his view from that of saving lives, as death is inevitable, to guiding patients and their families to an understanding of disease and illness as deaths' ambassador, not it's enemy.

Still, while the rewards of time spent with patients were plentiful, he found there was an emotional cost. This was especially true amid bouts of devastating outcomes for patients. Kalanithi states that during these times he would be hopeful that the next patient would make up for the previous one, yet this often was not the case. This cost was apparent as he drove home one day and began crying after hearing the dire situation of the droughts in California. As he struggled, he never questioned why he did this work or whether it was worth it. He heard the call to protect the lives and identities of his patients and took on those burdens despite their crushing weight.

In answering this call, Kalanithi understood that good intentions were not enough. He states, "technical excellence was a moral requirement (Kalanithi 105)." In the specialty of neurosurgery, working with the very fabric that makes people who they are requires that skill to preserve identity. In these highly charged fields,

physicians become privy to their patients' deepest thoughts. They are welcomed into their most authentic moments where threats of illness and death determine what truly makes life worth living for them. This often meant confronting the meaning of life for patients. Kalanithi understood that there were limits to his skill as well and he had to be honest with himself. This allowed him to access whether he could save those integral parts of a patient's identity or allow the peace of death. He understood in the pursuit of perfection that "you can't ever reach perfection, but you can believe in an asymptote toward which you are ceaselessly striving (Kalanithi 115)." Kalanithi understood that death will come for us all and perfection is unachievable, yet he continued to struggle towards it for his patients.

Following his own cancer diagnosis, Kalanithi transitioned to the role of patient, he felt his days as a physician fleeting. He jumped to the worst-case scenario after his diagnosis trying to figure out how his wife would survive once he was gone. His cancer had already spread to many organs besides his lungs. His oncologist, Emma, pushed Kalanithi away from being a physician when it came to managing his own cancer, but she opened his mind to being able to return to his own medical practice. This becomes important as Kalanithi chose to return to his residency position and eventually was able to graduate. This is important because at the beginning of residency Kalanithi has the thought that "without that duty to care for the ill pushing me forward, I became invalid (Kalanithi 125)." While the time he ran the line between physician and patient was short, it gave him a perspective that led to a multitude of insightful conclusions.

One day, after meeting with his oncologist, Kalanithi's wife showed concern for the fact that it seemed that she has taken a liking to him and the correlation this has been found to physicians procrastinating for patients in which they are personally invested in. This did not seem to matter to Kalanithi any longer. As he felt his impending death acutely creep within grasp, these things did not matter. It wasn't scientific anymore for him. It was unsettling. He continues to wonder if physicians as a group had adopted the pattern of hoping each patient would fall just above the 95% confidence interval, just above average. He wondered the implications of this as physicians use a curve to define things like hopeful, defeated, realistic, etc. when numbers are just numbers. Yet these numbers can help physicians to rein in unrealistic expectation from patients or family members. As Kalanithi became one of those statics, he felt less conformable with this idea. He states, "the angst of facing morality has no remedy in probability (Kalanithi 135)." Before completing the book Kalanithi became too sick to continue writing and passed away. His wife, Lucy, decided to complete the book in his honor.

*The Healers Burden* is a collection of short stories and poems written by those who are in the health profession. I chose this book to include as it shows a different, more raw side of grief experienced not only by physicians, but all healers alike. Differing perspectives are offered with one common thread: professional grief. When a healer feels a sense of grief toward a patient in their care, whether this be their diagnosis or death, it is defined as professional grief. It manifests itself from many interactions with different patients and emotions felt for their disease state or death. As stated by Dr. Rana Awdish, it is one of healthcare's hidden liabilities. As health

professionals do their intended job of caring for patients, the lives and loss of these patients can leave abrasions that can lead to questions of "why is this so hard when it shouldn't be (Fournier and Pribaz i)?" This leads to feelings left unacknowledged and therefore unhealed.

This leads me to the idea that certain deaths can stick with physicians. Dr Simone Kantola explains this sentiment being by sharing that "every patient I've lost has created a wound. Even after the fresh wound heals over, the scar can be zinged unexpectedly (Fournier and Pribaz 13)." She explains she is not sure whether these wounds will every fully heal. Scar tissue is left behind by patients in those that care for them. These tissues meant to hold and heal them can lead to pain even after wounds are healed superficially. Maybe physicians struggle with these wounds due to rhetoric in medical school, residency, and beyond. In the past, physicians have not been taught how to manage or even acknowledge emotions, leading to hindrances in healing rather than help.

As physicians struggle, focus may be on several things. One example given throughout the collection is that it is not the many things that went right, but the one that went wrong. Rumination leads to feelings of failure, even when a physician's successes are great. Physicians may also turn their focus to feelings of their own mortality leading to worry of what their own family would do if they were to pass unexpectedly or if they have time to do the things they wish. Physicians are tasked with grappling with this, while maintaining a case load and caring for other patients. This leads to questions of where grief and worry go? Does death accumulate in our bodies, minds, or does it give perspective on our lives?

Manifestations of professional grief have many implications. These “hidden liabilities” are brought about by inadequacies in the medical system that do not make space for the process of grieving. Medicine has lost many to unattended grief. However, it has been easy to ignore and remained unacknowledged, although for some, grief may be the only constant. Knowing it’s invisible nature and the ways it has crept up on others demands we take responsibility for changing the system in place to one that supports physicians through processes of grieving.

Physicians through the book detail their own experiences dealing with professional grief that brought about some common threads. The first is that professional grief often takes the form of hidden grief with no outlet. This results in cumulative grief or what is referred to as bereavement overload. A second common thread is lack of acknowledgment or understanding from mentors, colleagues, or supervisors. Another is not letting others be aware of your grief through the “art of covering it up (Fournier and Pribaz 66).” This could be for many reasons such as patient load or lack of space to express their grief, etc. but the feelings are the same. A final thread is that the “what-ifs” can consume physicians. This can be related to how they treated the patient themselves not how their patient’s family members are doing, but it again leads to the same feelings.

This brings me to coping strategies that are given throughout the book. The most widely stressed is the use of narrative medicine. Narrative medicine is demonstrated as a helpful way for physicians to talk about their experiences that brought about grief. This also gives physicians a practice that can help them develop narrative competence. which is the ability to listen, interpret, and act on the stories of

others. This skill allows physicians to be empathetic and whole humans who can find joy in their work beyond the grief. For example, many of the physicians in the book use narrative medicine as a tool to look at their experiences and learn how to be better humans and physicians. Another strategy given was taking a step away from more demanding specialties that bring about consecutive, cumulative grief to rest and recharge. Sometimes we need time to heal in spaces that do not bring about more grief before we can deal with what is already on our plate. A final strategy was acts of collective grief where patients can be honored by those that cared for them.

From this research, there is one perspective miss; that of those who lives have been lost in the name of caring for other. For this reason, I chose *Physician Suicide Letters* by Dr. Pamela Wible to try to give those who were not able to have a voice toward the issues they dealt with in life one in death. *Physician Suicide Letters* is a collection of correspondence with physicians who have attempted or considered suicide, along with family members of physicians who have committed suicide. Wible splits these stories into two sections, “The Problems,” and “Solutions,” with many subsections. Subsections of “The Problems” include “Post Traumatic Student Disorder,” “Anti-Mentors and Tormentors,” “Death by Debt,” “Occupational Hazards,” “I Lost Myself,” “Existential Inquires,” etc. Throughout these sections, examples of challenges faced by physicians in the workforce are stressed in a unique, raw fashion that shows the darker sides of medicine that many non-physicians do not consider.

There is a stereotypical view of doctors that looks at them as smart, egotistical, and privileged. However, this view does not consider their humanity as

imperfect and fallible. The amount of stress and scrutiny they face is immense as they go from college to medical school, residency, and into being a practicing physician. In this, many physicians feel they cannot take care of themselves. They can feel they are the caretaker who receives no care or like an hourglass that continually lets sand slip to the other side but never is flipped back around to be full again. Sometimes this makes physicians feels as if they are giving at their own expense.

Other times physicians may feel emotionally ill-prepared for dealing with tough situations. One example given was a surgery resident simultaneously treating a perpetrator and their victims with no emotional support from colleagues. Some physicians may confide in their colleagues only to be met with statements along the lines of "suck it up." This also relates to the mental health stigma that is currently present in the medical field. This is blatantly clear when looking at licensing and credential applications with mental health located in the criminality sections. Some physicians have even faced scrutiny from colleagues after suicide attempts. They are ignored and their existence unacknowledged. Some speculate that this due to denial of the reality of the medical system in some cases.

In the later section, "Solutions" there are subsections like "You Are Not Alone" and "Ask for Help," where some strategies for managing professional grief and mental health are given. In one case, a physician talks about how she has always felt the feeling that saving 100 patients cannot cover up the pain of losing one. This is a shared sentiment among many doctors which Dr. Wible expresses to this physician and tells her she is not alone. Many physicians feel the same and there are ways to connect with them online. Others talk about reaching out to their colleagues or

bosses, only to be met with threats of being fired for needing to take a moment to deal with their emotions before returning to work. Dr. Wible goes on to tell this physician that asking for help is never the wrong answer. It was a healthy response and is one of the many ways to start the process of healing.

Illustrated by these four books are the ways in which we not only fail physicians, but also their patients. As physician begin to accumulate professional grief without solid coping mechanisms, their situations become dire and sometimes lead to suicide. There is a clear gap in what physicians learn in medical school and what they face one in the hospital setting. Once in the hospital, their interactions with patients leave marks. I sought to further investigate what these marks look like and how they affect the course of physicians' careers by interview a group of physicians.

## Synopsis of Interviews

Through interviews with eight physicians ranging from urgent care to primary care to hospice, some retired, others recent graduates, I uncovered the ways that physician's cope or heal are very different but there are some underpinnings that are constant as physicians grow into their career. There are also similar critiques of the system as it pertains to preparation in medical school and subsequent support in the field. Where physicians tended to differ was motivation to enter the medical field, yet this did not seem to greatly affect how prepared they felt in dealing with their first patient death or those thereafter. The questions will be organized into themes with first being a unique calling.

For some interviewed, becoming a physician was a calling in which not answering felt like disobedience. For others it was a parent, their own physician, or

professor that initiated their drive toward medicine. There was also another group that felt the job security and promise of steady, healthy income compelled them toward medicine. Once in medical school, many felt beaten down as hours were long and at times, remembering their love for medicine was hard. Preparation for dealing with patient death was minimal. In physicians who attended medical school before 2000, they either read a book, had a seminar, or recalled no training. In those who went to medical school after 2000, many had a class on dealing with emotions. Still, physicians agree unanimously that they would have benefited from more training whether it was related to dealing with their patient's death or talking to a patient and their family member about a terminal diagnosis or death.

The second theme has to with changes to responsibility with physicians out of medical school experiencing responsibility for patients for the first time despite the lack of training they receive. The progression from medical school to residency is a large jump that can be difficult to conquer. This can be taxing on new physicians, especially when their first patient dies. This is most commonly not the first death they are present for, but the first death of a patient they directly care for and have responsibility for. This response can either be exacerbated or alleviated by those that interact with the physician during and after the death of the patient. For some, the patient's outlook on death changed the effect on them noting that the harder deaths were those where their patient struggled against it. Some of the physicians had positive experiences with their first death and others felt disillusioned with the medical system.

It was interesting to see that many of those who felt disillusioned after their first death had similar experiences. This brings me to the next theme, lasting deaths. Many physicians had an older patient that was resuscitated many times. They stated things like “it felt wrong,” “this isn’t medicine,” and “it felt cruel and inhumane.” Others had an experience where the patient was told by another physician that they would survive before surgery. A portion of physicians stated that they feel their reaction to death has not changed much from their first death with each one “leaving a similar mark.” Others had similar situations; however, there was those with patients that passed away later in their career that left more of a lasting mark.

We then shifted our conversation to looking at medicine as a whole and the attitude toward death. This section has to do with the theme of medical culture. I asked questions relating to where they felt medicine had changed for the better through their career and where they felt it still needed improvement. Many stated that the culture around death greatly depends on where you are working. However, some shifts that seem to be productive include the conversation around death changing toward a more patient-focused conversation. This mode of conversation now focuses on what the patient is looking for in their care, whether that is treatment, comfort measure, or some combination of the two. This is evident in the expansion of palliative care.

Another improvement some physicians praised is the Death with Dignity Act. Those who mentioned it stated that it showed that care for dying patients or patients with terminal diagnoses was becoming more patient centered and gives patients more options as they ask how they want to leave this earth. It is important to cite that some

physicians mentioned that there can be religious reasons for patients to suffer at the end. This is important given that goals lie in giving patient control of their death. Other things mentioned by physicians that gave patients more control over this question were advance directives and do not resuscitate orders. Some physicians mentioned that in many foreign countries, intubation does not occur nearly at the same rates as here in the United States, moving into more of their critiques of the American medical system.

Counter this is the theme of medical failures. Physicians were more critical of failures in the medical system including a balance of hope with reality, allowing for treatment, but not perpetuating the miracle patient narrative as this is so rare. In this, physicians mention finding ways to balance life with treatment in a way that in extending a patient's life by a couple months doesn't lead to those months being painful. Another issue physicians saw is that current treatment does not allow it to be tailored to each respective patient. They saw this as a failure to the medical system for a few reasons including that each patient is different in their beliefs, motivation, and to some degree physiology. Other areas for improvement included the removal of religious bias, lack of honesty with patients, accepting death as envitable (and not something that can be treated), health care system creating issues, lack of training for goal coordination, understanding consequences of treatment, and the outsourcing of palliative care. A few physicians went into more detail on the outsourcing of palliative care during the Covid pandemic and how many of the physicians working in this area are now exhausted and burned out, showing that there is need for more training in this area for all physicians.

We then moved on to talking about how caring for dying patients in the American medical system affected them. Many pointed me to patients and what they learned from their passing. Common remarks included seeing a person's true humanity stripped away from money, status, race, education level, and religion. You see their true character and while money may give you options, it does not make up for a lack of character pointing to the grace seen in those with nothing in the face of death. Others pointed me to lessons on how to deal with our inevitable expiration date by accepting it and moving on. In relation to this idea, there was emphasis on the suffering that many patients may deal with outside of their illness. Death can bring up feelings of regret and need for reconciliation, the process is commonly much harder.

Some physicians took this time to talk about their experience working with others in the profession at the end of their family members lives. The cited a lack of respect coming from their family members physicians until revealing themselves as a physician. They spoke on how it showed them how paternalistic the attitudes of physicians can be in lacking respect for their patients and family members wishes. At the same time, they saw how each physician and their subsequent relationship with patients of different kinds differed. This often depended on the role the patient expected to take. Some expected the physician to make choices while others come in with pages of research.

Others saw changes in themselves as they lived through patient death. This brough out of theme of growth from death. They felt humbled, began to see death as less of an enemy, accepted limitations, and began to ask what the reality of medicine is. They no longer felt saddened by the death of their patients, but the ways in which

the system continues to fail them. One physician talked about how it is no longer the death of patients that causes grief in their case, but the state of the world outside of medicine and the issues afflicting the living.

After talking about these difficult experiences, we began talking about how they were professionally supported in dealing with the death of their patients. Many physicians stated that professional support was minimal. A few worked in specialties or hospitals where they did debrief after each patient death. Those who work in palliative care or hospice have learned to take a different look at death as their patients are the dying. They look to learning from the death of their patient, but also celebrate their life. Many stated they look for ways to make their colleagues laugh and in turn, they do the same for them. This was something stressed by all physicians in that having good colleagues is one of the best ways they have been supported professionally. Others were able to reach out to mentors to find good methods of coping and grieving. One physician stated that he tries to be this for new or younger physicians that he works with since as a male he often feels that he and colleagues of the same sex feel they cannot express their emotions as freely. He encourages his colleagues to not only express their feelings, but also find ways to cope outside of medicine. I saw this as theme of differing professional support.

Some physicians had to leave larger medical centers to open a private practice to receive the support they needed. One physician interviewed opened their private practice with their partner. There they have created a community where instead of grieving the loss of a patient, they toast their life. Having a partner who understands what you are going through is something that was stressed by many of the physicians,

whether that is just in the form of a compassionate partner, one that you work with, or someone that is also a physician.

As some physicians received little support in the workplace, many discussed the ways in which they were supported outside of the workplace. All physicians talked about having a life outside of medicine that helps them center themselves. One physician stressed “mundane acts of faithfulness” in relation to their religion such as going to church, practicing spiritual discipline, and having friends they know from their faith who challenge and encourage them. Others found a similar solace in their children, family, and friends or exercise. One physician stressed a balance of all these coping methods as what helps them heal.

The final question I posed to physicians was “what have you learned from your patients about dying, about living, about yourself?” This question offered a wide range of answers with many common sentiments. One in particular was that the way we die is closely tied to the way we live our lives. If we live out life well, nurturing our relationships, finding our community while living with character and integrity, death is often much easier and more graceful. Still, exceptional people can be undone by what advanced illness does to the body and mind. In the end, none of us truly know how we will react in the face of death. However, death is a fact of life we must learn to cope with and prepare for. Pain relievers can be given in the end, but it cannot change or ease the pain of what their life has looked like up to that point. This displayed a theme of lesson learned from death

Major findings from these interviews include that it is often not the first death that has the largest effect on a physician but first one in a patient they have

responsibility for. For some physicians, this reaction does not change with any of their patients that die. Yet they are still able to cope with this though religion, community, partnership, narrative medicine, and balance. These physicians were also able to learn from patient death about themselves and the way they would like their death to occur.

## Conclusion

This literature search in conjunction with the interview a few of my initial hypothesis were confirm, while other only captured part of the story. First it was confirmed that physicians have received little to no training in dealing with death during their medical training. However, physicians have been able to find way to deal with this on their own by taking with colleagues and their own partners. These coping methods included narrative medicine, religion, partnership, and community. The part of my hypothesis that was partially refuted was the it was the first death that a physician experience that leaves the greatest effect when in reality it has more to do with the level of responsibility that the physician has for that patient. When their first patient dies that they have responsibility for, this tend to leave the deepest abrasion.

Displayed by the interviews, professional grief has affected most physicians. Some have found effective ways to deal with it to the point that they no longer feel affect by it, while others still struggle with it from patient to patient. This makes it clear that each physician is different, making each experience different. However, this does not undermine that fact that there is a lack of preparation for patient death in medical school. It was emphasized by all physicians that they feel they would have benefited from more education in this area.

One important finding of this research study is that it may not be the first death that has the greatest impact for physicians, but the first they feel a responsibility for. Responses to this first patient death varied greatly as well. Some physicians had a more effective support system that allowed them to grieve while others struggled in silence. The circumstance of this death also had a large impact with physicians whose patient had successive codes with resuscitation indicating a greater impact that those with other situations. For physicians who did not feel the weight of each patient death similarly, there were often patients later in their career that also created turmoil.

Coping strategies also varied with some physicians turning to religion, family, exercise, community, or a collection of these methods. One thing I found was left out of these coping strategies is that no one mentioned talking to a mental health professional. With some physicians working in hospice or palliative care, they have social workers there that would be included in community. However, Dr. Wible discussed the mental health stigma present in the medical system and this could be a contributing factor. It is also important to recognize that physicians may not have felt comfortable mentioning this in our interviews.

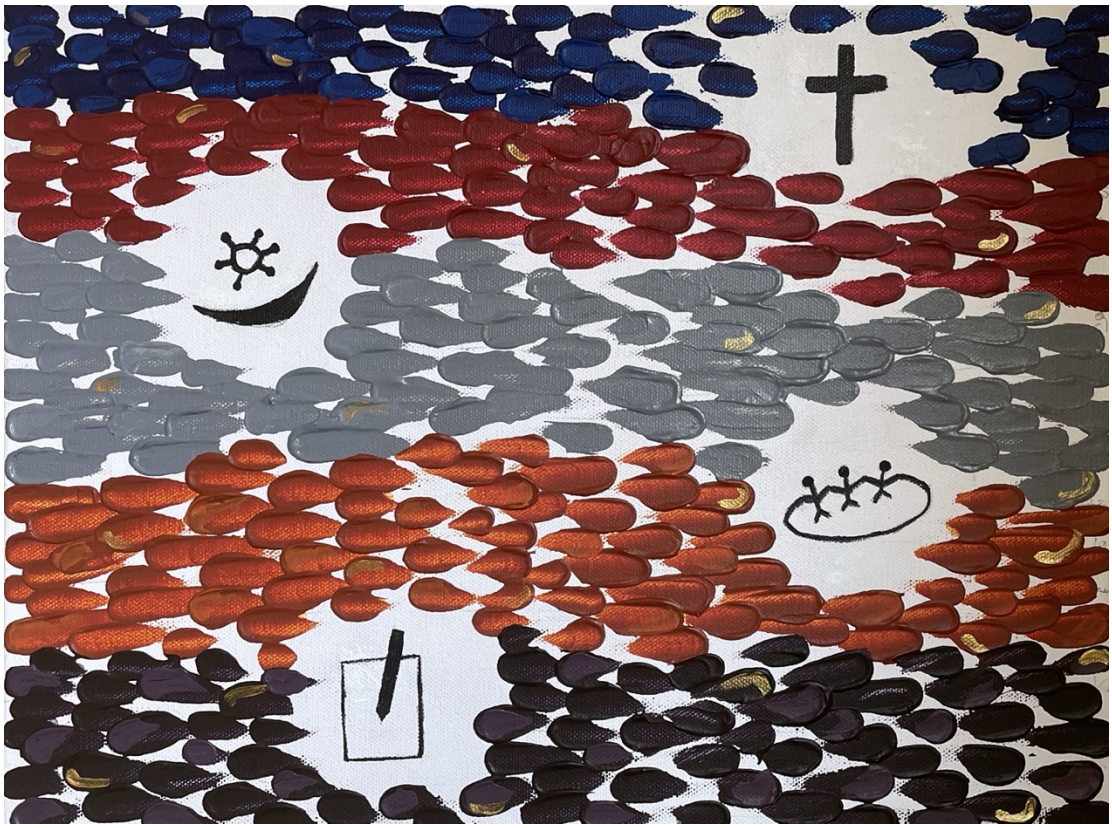
This leads into the many limitations of this study. First, this is correlation and not causation. As not enough physicians were interviewed, while the information gathered may be useful for future studies, we cannot take these as universal truths. We also did not have a physician from every specialty which means we may be missing some key perspectives from those who are oncologist, surgeons, and cardiologists, who are a few among the many left out.

Another key thing to keep in mind when thinking about this study is that it is not all encompassing of all healers. This is restrictive as all those affected by patient death are not included as interviewees. Nurses, social workers, medical assistants, therapist, and all kinds of people working in the medical profession that were not interviewed. This leads me into the final limitation and that as the person writing this thesis, I have a limited experience with professional grief, and I am not a physician. In this sense, I think it can be difficult for me to make these assertions without the experience of medical school or having patients under my care. However, I hope that these finding may help inform other prospective medical students as to some of the realities of medicine that we often fail to consider before we find ourselves in the situation itself.

Future directions for studies searching for similar answers may be looking at all specialties or healers and their experience with death. These experiences can then be used to help design a solution or a curriculum that medical students can take to aid in grappling with the death of their patients. A final thing to keep in mind is that having whole physicians who know how to grapple with grief is important for improving patient care, as they are the driving force for medicine and at the root of it purpose.

As I started with where I began, I decided to finish with where I am now, at the end. Writing this thesis was an extremely emotional process for me. There was time where I question my desire to be a physician and my ability to deal with the emotion and hardships that come along with the profession. In the end, my calling to be a physician has prevailed and I hope to attend medical school in the near future.

Another thing that came out my research was a painting that show the experience of physicians as they deal with professional grief. The background in white to represent the white coat. Then there is an over lay of colors to represent grief including grey, red, purple, orange, and blue. This represents the sea of grief that physicians experience with patient death. There are breaks in this over lay with symbols inside that represent coping methods that physicians use such as religion, partnership, community, and narrative medicine. These coping methods offer physicians relief from their ever-turbulent sea of grief and give them time to heal in order to be the best provider and human they can be.



Appendix 1

## Interview Questions

1. What was your motivation to go into the medical field?
    a. What advice would you give a prospective medical student like myself about preparing for this profession?

2. During your medical education, what kind of training did you receive in caring for dying patients?
    a. Do you think you would have benefited from more or less?

3. During your medical education, what kind of training did you receive in dealing with death?
    a. Talking with the family?
    b. Your own personal response?
    c. Do you think you would have benefited from more or less?

4. Many physicians say the death of their first patient is unforgettable. Can you tell me the circumstances of the first patient of yours that died?
    a. What was your personal response to this death?

5. Physician Atul Gawande is the author of a very influential book, Being Mortal, in which he is very critical of the approach 21st century medicine takes to dying and death.
    a. This approach emphasizes use of available technologies, treats death as an enemy, and tends to neglect conversations with patients.
    b. What changes have you seen over your career regarding how medicine addresses dying and death?
    c. What do you think medicine currently does well in caring for the dying?
    d. Where do you think medicine fails or needs improvement?

6. In your professional career, how has dealing with dying patients affected you?
    a. Do you have a particular experience with a patient that you could share with me?

7. How have you been supported professionally (or in other ways) in dealing with the death of patients?

8. Physicians often say that dying persons are their teachers. What have you learned from your patients are dying, about living, about yourself?

Biography

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