



PSYCHIATRISTS DO CRY: ADDRESSING PHYSICIAN GRIEF AND BURNOUT

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Objectives

- To describe a clinical framework for considering existential distress
- To list three kinds of "powerful deaths" likely to cause physician grief
- To recognize which patient losses are considered more difficult by physicians
- To identify how "death talks" are transformative learning experiences
- To describe Houston VAMC initiative to address physician grief



Pictures used are not of real patients.

Grief: Definition

- *Grief* is a shared, universal, and natural neuro-psycho-biologic expression in response to loss
- Distinct from *mourning*, a practice that varies in expression across diverse cultures
- Human needs during grief: rest, relaxation, nourishment, a sense of security, trust, hope in the future, and humor

Why is Physician Grief Relevant?

- Sense of loss
- Job-related stress
- High risk for physician burnout (can be 50% in those treating the terminally ill)
 - Emotional exhaustion
 - Depersonalization
 - Low sense of Personal Accomplishment
- Physician depression and suicide

Themes about patient death leading to Physician Burnout

- Uncomfortable feelings
- Grief and complicated grief
- Threatened control
- Suppressed emotions
- These must be addressed to prevent physician burnout

(Sansone & Sansone, 2012; Pantilat & Isaac, 2008; Zisook and Shear, 2009)

Predictors of Depression in Physicians

- Difficult relationships with supervisors, staff or patients
- Lack of sleep
- Dealing with death
- Making mistakes
- Loneliness
- 24 hour responsibility
- Self-criticism

(Bright & Krahn. Current Psychiatry, 2011)

Studies of Grief in Practicing Physicians

- 79 physicians in Scotland: 61 % found their most memorable patient death to be emotionally distressing. 26 % reported recent personal bereavement due to a patient death (Linklater et al, 2010)
- McQuade (1992) interviewed 25 physicians about their experiences with dying patients. Key psychological themes were grief and loss, uncertainty, lack of control, care versus cure, and issues of personal growth.

Granek: Oncologist grief study



Granek : Oncologist Grief

(JAMA Internal Medicine, 2012)

- 2010 -2011 in three Canadian hospitals
- 20 oncologists varying in age, sex, ethnicity
- Oncologists struggled to manage feelings of grief with the detachment they felt was necessary
- More than half reported feelings of failure, self-doubt, sadness and powerlessness
- A third talked about feelings of guilt, insomnia crying.

Granek study

- Grief in the medical context is considered shameful, weak and unprofessional
- Oncologists hid grief
- While oncologists spoke about *burnout*, the single most consistent and recurrent finding in the interviews was the description of *compartmentalization* resulting from patient loss

Granek: “Compartmentalization”

- Involved physician’s ability to separate feelings of grief about patient loss from other aspects of their lives and practices
- A coping strategy
- Also is an impact of continual patient loss
- Physicians used phrases such as “**denial**” and “**dissociation**” in describing this process as patients died.

Granek study: Impact of unacknowledged grief

- **Distraction:** Inattentiveness, impatience, irritability, emotional exhaustion and burnout
- Half reported that grief could affect their **treatment decisions and motivation to recommend care:** more aggressive chemotherapy, referral for a clinical trial, or recommending further surgery when palliative care might be better
- Affected the doctors' ability to **communicate** about end-of-life issues with patients and families

Granek study: Impact of unacknowledged grief

- Half **distanced** and withdrew from patients as patients got closer to dying.
- **Grief spillover** has a negative impact on oncologists' personal lives
- Need to normalize death and grief as a natural part of life,
- Need to make space for physicians to grieve like everyone else.

Crying in Hospitals

- In an Australian study, crying in hospitals was reported by 76 % of nurses, **57%** of physicians, 31% of medical students. Reason was identification and bonding with suffering of dying patients and their families (Wagner et al. 1997)
- Angoff (2001) surveyed medical students about whether they had cried during a clinical rotation. 73.1 % reported crying and 16.5 % reported near-crying in response to suffering and dying of a patient and/or family's associated distress

Photo of an ER MD taken by a paramedic went viral on youtube,
MD just lost a 19 yo patient 3/19/15



Physician Culture about Crying and Expressing Grief

- Historic constraint in expressing emotion for fear of contaminating clinical objectivity.
- Controversy around displaying emotion, often considered “unprofessional” by staff
- Yet many patients and families express gratitude for expressed physician grief.
- Siegel says “Please don’t cry in empty rooms, stairwells, or locker rooms- cry in public and let the patients and staff heal you and see you are human”

(Sansone & Sansone. Innov Clin Neurosci. 2012)

Yet Physicians experience strong emotions as a reaction to patient death

- Sadness, crying, insomnia, exhaustion, feeling physically ill, and sense of personal loss.
- Self-questioning, guilt, feelings of failure and helplessness
- Personal consequences that range from irritability at home, feeling disconnected from family and friends, and becoming more desensitized towards death
- Vs. gaining a greater, more appreciative perspective on life

(Granek et al. *Pediatr Blood Cancer*, 2015)

And therapists do cry....

- 72% of therapists report having cried in therapy in their role as therapist
- The act of crying in therapy has less to do with personality or demographic factors
- More associated with the unique aspects of the therapy itself and the therapist's identity
- Older clinicians with more experience cried more in therapy than novice clinicians (higher comfort level with expressing emotion)

(Blume-Marcovici, Stolberg, Kademi. Do therapists cry in therapy? Psychotherapy, 2013)

Blog about 6 reasons why Doctors grieve differently (Dr. Alison Edwards, Sept 11, 2015, kevinmd.com)

- “Most doctors know death more intimately than the general population
- Doctors understand the limitations of modern medicine and the fickleness of life better than the general population
- Doctors are often high-achievers, driven, control-freaks
- Doctors spend most of their time observing
- Acute grief is painful, distressing, heart-wrenching
- Doctors are masters of hiding our emotions, which is a useful skill in some consultations”

Framework for Existential Distress



Kissane's Framework for Existential Distress

- For clinical use, includes issues of:
 - Death anxiety
 - Meaning of life
 - Grief from loss, isolation, loss of control and dignity
- Spectrum of response from successful adaptation to morbid complication
- **Existential crisis** is a moment at which an individual questions the very foundations of their life: whether life has any meaning, purpose, or value.

(Kissane DW. Aust Fam Physician, 2000; James R, *Crisis Intervention Strategies*, 2007)

Existential Crisis (Patient and/or Physician)

- Can occur due to:
 - Major psychological trauma, sudden or unexpected death
 - Sense of isolation
 - New grasp or appreciation of mortality
 - Believing that one's life has no purpose or meaning
 - Searching for the meaning of life
 - Shattering of sense of reality, or how the world is
 - An extremely pleasurable or hurtful experience that leaves one seeking meaning
 - Dissatisfaction with one's life

Kissane's 8 existential challenges

- 1) Death anxiety
- 2) Loss and change
- 3) Freedom with choice or loss of control
- 4) Dignity of the self
- 5) Fundamental aloneness
- 6) Altered quality of relationships
- 7) Our search for meaning
- 8) Mystery about what seems unknowable

Adaptive response to 8 challenges

- An adaptive response to each challenge promotes equanimity, peace, and fulfillment while sustaining engagement with life, creativity, and joy.
- Physicians can do much to nurture courage and maintain each person's (including their own and other physicians') sense of meaning, value, and purpose.

(Kissane DW. Arch Int Med, 2012)

Powerful deaths



Distress in Palliative Care

- Distress in both patients and physicians can occur when there are discrepancies among the involved parties in desired goals of care:
 - 1) Prolonging survival
 - 2) Optimizing comfort
 - 3) Optimizing function.



“Powerful deaths”

- Survey of emotional experiences of physicians at 2 Boston hospitals regarding their most emotionally powerful patient death
- Semi-structured interviews
- Physicians reported “powerful deaths” at all points in their careers.
- “Power” was usually attributed to 1 of 3 general themes:
 - 1) **“Good” death**
 - 2) **“Over-treated” death**
 - 3) **“Shocking” or “unexpected” death.**

(Jackson et al. Acad Med. 2005)

DeVecchio Study about Difficult Physician Losses

- 75 internal medicine physicians
- Researchers found three major themes:
 - 1) Time and process (death expected or unexpected, peaceful or chaotic/prolonged?)
 - 2) Medical care and treatment decisions (rational and appropriate or futile and overly aggressive?)
 - 3) Negotiation (communication with patient's family effective or conflictual?)

(DeVecchio, Good et al. Soc Sci Med, 2004)

Relational Reasons for Oncologist Grief

- Physician felt close to patient/family
- Physician had a transference to the patient
- Patient died young
- Death of a long-term patient
- Unexpected death

(Granek et al. J Palliat Med 2012)



Contextual Reasons for Oncologist Grief

- Patient/ family unprepared for death
- Patient/family had unrealistic expectations about cure
- Excessive treatments were perceived to be used
- Physicians were blamed
- Chaotic or high-needs family

(Granek et al. J Palliat Med 2012)

Contextual Reasons for Oncologist Grief (continued)

- Physician cultural factors:
 - Stigma around death and dying
 - Viewing emotion as weakness
 - Focused on cure
 - Gendered

Sudden Death: Risk Factor for Physician Grief





Death-talks

Death-Talks

- Conversation between physician and patient about terminal conditions
- Social engagements among meaning-making human beings
- Comprise complex grief dynamics
- Opportunities for personal insight
- Physician must be self-aware of own existential standpoint to be more authentic
(Moon. Am J Hosp Palliat Care,2008)



Transformative Learning

- A theory of adult learning
- Offering a rationale for physicians to exercise critically reflexive learning
- Towards formulating more meaningful medical and human care
- For dying patients and their grieving families
- Death-talks are an opportunity for transformative learning

(Moon. Am J Hosp Palliat Care,2008)

Case Study Mr. A: Death-talks

- 79 yo Caucasian male
- Dying of advanced lung cancer
- Weeks to live
- Rumination and remorse about a “great sin”
- Illicit sexual relationship with a family member
- Belief in illness as punishment



Mr. A (continued)

- Obsessive thoughts, panic attacks
- Pain, shortness of breath
- Several death-talks with oncology and psychiatrist discussing his wishes, medications, O2
- No immediate relief
- Healing service with chaplain
- Finding meaning in life mistakes
- Peaceful death



Addressing Psychiatrist Grief

Psychiatrist (VA) Unique Issues

- Difficult deaths: Suicide, violence, young patient deaths, unexpected deaths, long-term care
- Transference and countertransference
- Cumulative trauma with multiple suicides, combat issues
- Physician culture: compartmentalization, isolation, discomfort with revealing grief
- Burnout and high physician/psychiatrist turnover rate

Psychiatrist (VA) Unique Issues

- OIF/OEF Veterans have 21% higher suicide rate than the general population (VA Office of Environmental Epidemiology)
- Stigma
- Litigation (Suicide is the #1 cause of lawsuits against mental health providers)
- Media coverage
- Providing life-long care
- Complex care, eg. geriatric, terminally ill, chronic pain, transplant

Physician Coping Strategies for Grief

(Zapffe, 2008)

□ Adaptive

- Anchoring: provides individuals with a value or an ideal that allows them to focus their attentions in a consistent manner (God, Church, State, morality, fate, laws of life, people, the future)
- Sublimation: refocuses energy away from negative outlets, toward positive ones

Physician Coping Strategies for Grief

□ Maladaptive

- Isolation: dismissal from consciousness of all disturbing and destructive thought and feeling
- Distraction: focuses all of one's energy on a task or idea to distract oneself from grief

A Healing Environment

- ❑ Family and friends
- ❑ Time to grieve and process “powerful” or traumatic deaths
- ❑ Administrative support, debriefing
- ❑ Reach-out by peers
- ❑ Limited work hours, time off
- ❑ Avoidance of drug or alcohol abuse



7 Strategies for Addressing Physician Grief (Sansone & Sansone, 2012)

- 1) Death-talks
- 2) Adequate professional grief support
- 3) Didactic preparation such as end-of-life curricula in medical school
- 4) Death rounds
- 5) Self-attunement or personal awareness (being attentive to personal needs, acknowledging feelings of grief and loss, pursuing healthy coping strategies)

7 Strategies for Addressing Physician Grief

- 6) Writing clinical obituaries (drafting informal summaries of benefits gained in the relationship with the patient in an effort to celebrate his or her life)
- 7) Incorporating humor

(Sansone & Sansone. Innov Clin Neurosci. 2012)

Houston VAMC Mental Health Care Line Initiative

- 5 Suicide prevention coordinators, senior psychiatrists available and supportive
- Reach-out to psychiatrist/team especially after patient suicide or traumatic death
- Education about difficult patient deaths
- Encourage verbalization of clinicians' feelings and normalizing grief reactions
- Providing opportunities for personal insight and growth

Supportive reading

- Peer articles.

- Gitlin M. A psychiatrist's reaction to a patient suicide. Am J Psych 1999

- Blume-Marcovici, Stolberg, Kademi. Do therapists cry in therapy? The role of experience and other factors in therapists' tears. Psychotherapy, 2013.

- American Association of Suicidology Weblink "Clinicians as Suicide Survivors"

http://mypage.iu.edu/~jmcintos/therapists_mainpg.htm

Bibliography

- Sansone & Sansone. *Innov Clin Neurosci*. 2012
- Pantilat & Isaac, *Med Clin N Am*, 2008
- Zisook S, Shear K. *World Psychiatry* 2009
- Bright RP, Krahn L. *Current Psychiatry*, 2011
- Granek et al., *JAMA Internal Medicine*, 2012
- Granek et al. *Pediatr Blood Cancer*, 2015
- Kissane DW. *Aust Fam Physician*, 2000
- James R, *Crisis Intervention Strategies*, 2007
- Kissane DW. *Arch Int Med*, 2012

Bibliography (contd.)

- Jackson et al. *Acad Med*. 2005
- DelVecchio, Good et al. *Soc Sci Med*, 2004
- Granek et al. *J Palliat Med* 2012
- Moon. *Am J Hosp Palliat Care*, 2008
- Boston PH, Mount BM. *J Pain Symp Management*, 2006
- Ofri D. *What Doctors Feel*, 2013