

It's Time to Talk About Fear

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“Dr. Young, Dr. Deborah Young,” a voice called overhead. It was my first night on call as a neurology resident. I dialed the Neuro-ICU, and my chest began to thrum.

“This neurosurgery patient, do you know about him?”

“No.”

“He had a meningioma resected today. He was awake post-op, but he just went unresponsive.”

“How are his vitals?”

“He’s a little tachy.”

“Ok, be right there.”

I headed down an airless corridor of the Jamaica Plain VA Medical Center. I had never treated a post-op neurosurgery patient. The differential swam through my head. *Edema. Crap, he’s herniating. No, too soon for edema. Septic? Too soon. Aspiration? Nah, he’s sat-ting fine.* I was dogpaddling through the rapids and looking for a foothold.

The patient was intubated, eyes closed, limbs motionless. Pupils were sluggish but symmetric. *Thank God.* I rubbed his chest, my knuckles bumping along the ridges of his sternum, and shouted, “Mr. W!” Nothing. His motor examination was non-focal, toes down.

“Could he have seized?” I asked.

“I didn’t see anything like that.”

I had no idea what was going on. I ordered a stat CT. In 1985, ordering a CT was a huge deal. The tech had to come from home and always gave you a hard time. If the scan was normal, you were permanently labelled incompetent. An hour later the CT scan provided the answer: a frontal vault filled with air, “pneumocephalus” caused by an iatrogenic ball-valve leak in a sinus. Shortly after the CT, he seized. This was the first of many nights as a resident I spent scared and alone, but it was also the first night of many when, despite fear, I did alright.

Fear is endemic to the practice of medicine, yet little is written about it. Literature abounds on anxiety disorders in physicians. Some writers acknowledge physicians’ fear of malpractice or public criticism. But the fear I refer to is sharper, more acute. It is the fear that makes your heart pound and your mind go blank.

It is the normal, walking-around fear that physicians sometimes feel. It is the fear we never talk about.

I entered medical school realizing I would face overwhelming responsibility. I felt excited and frightened, in equal proportions. I trusted that, after graduation, I would know what to do with a patient in cardiac arrest or a woman hemorrhaging during childbirth. On July 1, 1984, I dove off a cliff into the roiling current of internship. Nurses called me 110 hours a week: cardiac arrest, blown IVs, angry family members. I rapidly became exhausted, but I was also scared, even in my sleep. I was afraid of missing a diagnosis. I was afraid of botching a central line and dropping a lung. I was afraid of catching AIDS. What made the fear so corrosive was the loneliness of it. We interns commiserated daily about the workload, but we never talked about the fear. The unspoken code that silenced us? Good physicians are not afraid.

The fear persisted after residency. I dreaded call as an attending and behaved rudely more than once because of it. Then, slowly, over about 10 years, I realized I would never have all the answers. No one does. Instead, I have colleagues and books to help me bumble through. Now we have UpToDate. Most problems respond to fairly simple, practical solutions. True catastrophes are rare. I gradually learned to trust myself, and the fear subsided.

I ask myself, a neurologist who managed to work for 35 years without, I think, injuring a single patient: If I feel fear, doesn’t everyone? Even those who thrive on the adrenaline rush of managing unstable patients are afraid sometimes. I know this because my friend Gene Latorre told me so.

Gene founded our 27-bed Neuro-ICU and covered it every other week for 10 years. I have seen him up to his elbows in blood, looking utterly *nonchalant*. Once, I asked him bluntly, “Gene, are you ever scared?”

“Yes”

“When?”

“When I don’t understand a case.”

He went on to tell me about a patient with stroke who deteriorated overnight: “I got scared and started yelling orders. It turned out to be nothing. After it was over, I felt bad about how I had spoken to my team and came back to apologize.”

There you have it, another reason we must bring fear out of the closet—unacknowledged fear drives a

lot of “bad” behavior. This may include terse orders, aggressive questions, or outright insults. I see fear behind physicians’ rudeness to staff and resistance to consults. I see it in aloofness toward incurable or puzzling patients. Unacknowledged fear hurts us. It hurts our residents. It hurts our patients.

Fear is a normal function of the healthy brain. The amygdalae, almond-sized nuclei in the medial temporal lobes, are our natural guard dogs. They sense danger and activate the body. The pulse quickens, pupils dilate. We are ready for action. However, this limbic surge can hijack cognitive processing. Bravely, Danielle Ofri described running her first “code blue.”¹ She saw peaked T waves and knew they meant hyperkalemia, but she froze. A fellow had to bail her out. When fear is in charge, medical reasoning fails, and the consequences can be dire.

What if we could simply notice and accept our fear? What if we could make friends with it, even laugh about it? Medicine could be a lot more fun. Fear is a mark of our humanity. If we acknowledge it, we are more connected, humbler, and more authentic.

Why is talking important? We learn instinctively as children that when we are upset talking helps. There is a neurobiological reason for this: affect labeling. Lieberman et al² demonstrated with functional MRI that people shown frightening images activate their left amygdala, the guard dog, while their frontal lobes, the command-and-control center, shut down. But when subjects label the emotion accurately, the amygdala effectively curls up and goes to sleep, while the frontal lobes go back to work. Can it be that simple?

We must teach trainees that fear is a normal, healthy part of medical practice and offer strategies to manage it. Do other high-risk professions train their students similarly? Recently, Jerrod Hardy, a veteran police officer blogged, “In law enforcement...we associate fear with cowardice...we leave our students to manage fear on their own with no coaching or even

acknowledgment that it is okay to be scared...”³ You can find similar blogs written by firefighters and EMTs. The armed services do address fear proactively with a process called “fear inoculation.”⁴ It combines confidence-building, arousal control, self-talk, etc. We must build such programs into medical curricula. We can no longer send young physicians into the fray without adequate emotional preparation.

We are engaged in a national conversation about physician burnout. I believe professional isolation, in part due to fear and shame, feeds burnout. The COVID-19 pandemic poured gasoline on a conflagration that was already threatening to consume us. In addressing burnout, we are finally willing to reckon publicly with our limitations, with our humanity. Isn’t it past time to talk about our fear?

References

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