

Permission to Grieve? “What’s Up With That?”

Recently, a close colleague—a master clinician and teacher to nearly all in our educational community—passed away suddenly at a young age. He was larger than life; his competence and influence belied his young age. After the announcement was made to the residents, there were a few gasps and quick tears, then a hollow silence filled the room.

The designated institutional official (DIO) spoke up: “If Dr O’Brien were here, and saw how quiet we all were, he’d . . .” his voice cracked, and his eyes filled with tears. “He’d probably say what he has always said, ‘What’s up with that?!’” The room’s silence gave way to knowing laughter and more tears.

Many faculty members later approached the DIO to thank him for showing emotion; as a senior clinician at the institution, his public display of emotion “gave permission” for everyone else to do the same.

As the news rippled through our community, the reactions varied: an educator at our institution apologized to those around her when she was unable to stop crying. Another colleague told us about a meeting with his residents during which he consciously debated whether to choke back his tears in front of them or succumb openly to his grief.

We were struck by what these reactions uncovered in our environment: that during grief, our human emotions evoked permission, apologies, and debate. We wondered: Are these reactions symptoms of deeper problems in the clinical learning environment?

Recent emphasis from the Accreditation Council for Graduate Medical Education (ACGME) on the clinical learning environment is grounded in its correlation with residents’ clinical practice years later.^{1,2} This connection has positive effects: great teaching and patient care in the present time make a difference for patients many years down the road. However, the ACGME has also challenged institutions to consider how learning environments may be responsible for less desirable outcomes for physicians,³ particularly given the disturbingly high suicide rate among physicians.⁴

Supporting physicians’ emotions is central to their well-being. The skill of controlling emotions during high-stakes, emotionally charged situations allows them to focus on their clinical skills and to effectively

lead the team. However, it does not change the fact that physicians experience loss in a humanistic way.

We realize that our own very present experience of loss is not dissimilar to that of other institutions.⁵ So we must ask: Do these indicators reveal that graduate medical education has created an environment in which comforting families is essential, but showing our own emotion requires permission? In the wise words of our friend, we ask, “What’s up with that?!”

Across graduate medical education, we need continued, open conversation about how spiritual and emotional feelings should not be neglected. We must ensure that trainees’ and colleagues’ emotional and spiritual health are supported before a tragedy makes the lack of such support explicit. We must all find opportunities locally to affirm that emotion is human and honest. If we act now, the profession of medicine has a chance of changing the toxic trends that are becoming all too common to ignore.

Kevin T. Hinchey, MD, FACP

Interim Chair of Medicine and Chief Education Officer, Baystate Health

Associate Professor, Department of Medicine, and Associate Dean of Education, University of Massachusetts Medical School–Baystate

Rebecca D. Blanchard, PhD

Senior Director of Educational Affairs, Baystate Health

Assistant Professor, Department of Medicine, University of Massachusetts Medical School–Baystate

References

1. Sirovich BE, Lipner RS, Johnson M, et al. The association between residency training and internists’ ability to practice conservatively. *JAMA Intern Med.* 2014;174(10):1640–1648.
2. Chen C, Petterson S, Phillips R, et al. Spending patterns in region of residency training and subsequent expenditures for care provided by practicing physicians for Medicare beneficiaries. *JAMA.* 2014;312(22):2385–2393.
3. Accreditation Council for Graduate Medical Education. Physician well-being: ACGME Well-Being Initiative. <http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being>. Accessed August 31, 2016.
4. Schernhammer ES, Colditz GA. Suicide rates among physicians: a quantitative and gender assessment (meta-analysis). *Am J Psychiatry.* 2004;161(12):2295–2302.
5. Srivastava R. On the death of a colleague. *New Engl J Med.* 2015;372(3):207–208.