How We Manage Grief

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Introduction

Extensive literature exists on coping with the death of a patient with cancer, with much of the focus on what to say to the patient's family before and after the death. This focus is certainly appropriate, but what of the oncologist's own repeated exposure to death? Furthermore, what is the cumulative effect of these deaths now that our relationships with patients—which once lasted for weeks or months—are lasting for years? In this essay, we address what the literature has to say about oncologist grief and provide our own insights into how to manage this grief.

What the Literature Says About Oncologist Grief

Oncologist grief needs recognition. The unique challenges of oncology as a profession were well documented in a 1991 study by Whippen and Canellos.[1] This study is known for the statistic that 56% of the oncologists surveyed reported experiencing burnout in their professional life, with the most important reason being the challenges of coping with terminal care. Since then, the relationships between oncologists and their patients have only deepened. Patients are living longer, which extends the duration of the physician-patient relationship, and the number of treatment options has increased, leading to more challenging decision-making. Although several essays have addressed the topic of doctors' grief,[2,3] there is a lack of empirical evidence regarding the grief that oncologists experience.

Surveys suggest that oncologists experience grief differently than other clinicians do.[4] One possible reason is that oncologists might feel an especially strong sense of responsibility towards their patients. Oncologists may also experience a sense of failure or guilt when their patients die. Shayne and Quill described the relationship between the oncologist and the patient as a "meaningful joint struggle," with the patient's death representing "surrender."[5] Shanafelt and colleagues discussed the difficult change in the oncologist's role from a "savior," who is able to provide life-saving treatment, to a "shepherd," who can only offer solace.[6] An essay by Caram used the metaphor of "mother's guilt" to express the feeling she had when she needed to take a leave of absence from her medical practice. She described the fear she had that her patients might not be alive when she returned, and the guilt she felt over leaving patients who were in the most challenging part of their disease course.[7]

Several years ago, I [A. G.] coined the term "gruilt," which I described as a combination of roughly 80% grief mixed with 20% guilt.[8] I further explored this topic in a more-recent essay, in which my coauthor and I stated that this feeling can apply to both the doctor, who may wonder if he or she could have done more, and to the patient's family, who may feel that the outcome would have been better if they had come to our institution earlier.[9] Oncologists may even feel guilty about their feelings of grief, given that the patient's family "has it worse," and will minimize and suppress their own emotions. But as Shakespeare wrote in *Macbeth* (act 4, scene 3), "the grief that does not speak knits up the over-wrought heart and bids it break."

As with most professions, the fields of medicine and academia tend to reward productivity despite hardship, with the ideal of rendering such hardship invisible. As Harrison wrote in an essay, "Academia rewards those who can make hardship invisible, who can be productive amid and despite crisis."[10] This approach can take a toll, however, with one consequence being increased burnout. A study by Granek and colleagues revealed that increased burnout among oncologists, as measured by the Maslach Burnout Inventory, was related to higher negative attitudes toward patient death.[11] The study also asked oncologists to suggest interventions they felt would be useful in dealing with this burnout, with the top 3 suggestions being (1) training during residency or fellowship

on how to cope with patient death, (2) validation that emotions such as grief over patient death are a normal and acceptable part of the work, and (3) more time off to process negative emotions. These results suggest that a variety of interventions should be offered to buffer the culture of making hardship invisible.

An issue that the literature does not often address is the cumulative impact of grief. The term "cumulative" is especially appropriate given that the majority of physicians have experienced a personal loss before they even graduate from medical school, according to a survey of 344 medical students enrolled at the Duke University School of Medicine.[12] The study also found that this loss had long-term effects on health and well-being, with up to 40% of respondents reporting at least 1 psychologically distressing symptom that persisted beyond 1 year.

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A study by Granek and colleagues suggested that not only may patient death lead to burnout, but burnout can trigger "a downward spiral in which events such as patient death may lead to increased grief reactions and emotional distress in the oncologist, who under normal conditions would be able to cope effectively."[13] The authors described a cumulative stress model in which each additional stressor, including the death of a patient, may become the tipping point for more emotional distress.

How We Manage Our Own Grief

The current authors have given thought to interventions for oncologists who deal with death on a routine basis. The first intervention, and perhaps the most important one, is to allow the time and space to process grief. The authors have participated in organized physician debriefs that occurred either after a particularly sad death, or to address the cumulative effect of patient death over time. The use of narrative medicine is also a meaningful way to process grief.[14] At our institution, participants in a narrative medicine program are encouraged to write about their experiences. Attendees listen without judgment to the shared narratives, and absorb, acknowledge, and interpret the emotions that stem from these experiences.

Another valuable intervention is "the pause."[15] As Bartels described in a 2014 article, the University of Virginia Medical Center in Charlottesville implemented a policy in its emergency department whereby after a death, the entire staff would stand, be present, and bear witness during a moment of grief—a silent recognition of a lost human life. Could we adopt a similar practice in our clinics, not only for deaths, but also for progression of disease and other bad news? It only takes a moment and has the potential to help the entire staff of our wards and clinics.

On an especially personal note, when I [A. G.] lost my adult son, one of the experiences that augmented my grief was needing to repeatedly explain his absence to friends and colleagues who did not know that he had died. This continued for more than a year. When I expressed to my mentor how difficult this was for me, he carefully considered my position and suggested that a better approach from the institution might have been to hold a "work shiva." In that way, the entire workplace could have found out about the tragedy at the same time, and grief could have been expressed in several planned gatherings rather than in the continuous drip, drip, drip of chance meetings with colleagues in inopportune times and places. We can also envision the use of "grief sabbaticals," in which a faculty or staff member who has experienced a recent loss has time to gradually reenter a workplace that is filled with reminders of death and dying. As Harrison wrote, "Academia must shift the norms and expectations around loss and bereavement leave," much as policies regarding parental leave have evolved.[10]

We believe that increasing education regarding grief and bereavement will lead to a greater acknowledgement of grief, the grace of time to allow physicians to adjust to their loss as much as possible, and the ability of physicians to arrive at a new normal in their work. The need for formal education regarding grief was demonstrated this past year when the Duke University School of Medicine offered a new 8-week elective to senior medical students called "Grief 101 for the Clinician."

A potential call to action would be for more senior oncologists to be available for their younger colleagues and trainees. In many cases, less-experienced physicians have yet to develop the internal architecture—the scaffolding, if you will—on which to hang their repeated exposures to sadness, death, and professional grief. In an essay for intensivists, the authors advised their colleagues that "we care for more than our share of dying patients and, therefore, bear more than our share of responsibility for ensuring that we teach our trainees about the influence these deaths have on them. We cannot help others with this task if we cannot do this for ourselves."[16] Perhaps oncology fellowships could start including sessions on grief and bereavement led by more senior clinicians

who have dealt with cumulative grief. As one expert on trauma-informed leadership wrote: "It is not possible to bear the weight of supporting those on your team when you are not supporting yourself."[17]

Finally, how do we manage the interaction between personal and professional loss? Oncologists have reported "grief spillover," in which they have difficulty separating their work life from their personal life and therefore bring grief home with them. A frequent coping strategy for this is compartmentalization—intentionally separating feelings of grief about patient loss from other aspects of life. But is this a healthy and durable strategy? Instead, we would argue that time and space are necessary to allow for healing. The University of Rochester Medical Center implemented an intriguing strategy whereby staff support group meetings were held 6 times per year. These meetings, which were made mandatory for oncology fellows and were strongly recommended for all other team members, involved the sharing of stories related to patient loss and grief in a non-judgmental and supportive atmosphere.[5]

Preparing patients and caregivers for death may also serve to emotionally prepare the healthcare provider for the loss of life, whether that be the death of a patient or a family member, but this is not always the case. In a personal reflection, one palliative care nurse wrote that preparing others for the end of life and bereavement did not help prepare her for the death of her own mother.[18] Her workplace triggered her personal grief, enveloping her and decreasing the passion she previously had for her work. We feel compassion when we read the words of this nurse, and for others who are experiencing grief. Can we not extend the same courtesy to ourselves?

Oncologist Grief Needs Recognition

The typical oncologist has experienced both personal and professional grief, in a cumulative process that may begin even before medical school ends. The recognition of our own grief allows us to support one another in both formal and informal ways. If we acknowledge that grief has no timetable and will not be conquered, we can envision policies and interventions that allow time and space for our grief. Only in this way can we continue to be truly available for our patients and their families, and to care for ourselves and our colleagues.

Disclosures

The authors have no relevant conflicts of interest to disclose.

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