EDITOR'S NOTE:
This is an edited version of Laura McKinnis' Feb. 17, 2017, blog entry, "Dying Inside," on her Medicine as Ministry website.

Extend Healing of Hearts to the Healers, Too

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Working in the emergency room means you never know what's going to happen on any given day. It could be busy, slow or weird. Those of us who work in emergency medicine have a strange addiction to this suspense, but the risk is that something terrible will happen. And because it's the ER, something terrible often happens.

We have to recognize that ER clinicians experience trauma regularly, and we need to develop better ways to help them manage stress and grief so they can continue to practice medicine with their whole heart.

And when clinicians in the ER experience death and the accompanying grief, what are they to do with it? How do we support clinicians through these difficulties and help them stay healthy so that they have sustainable careers in caregiving?

Over the course of my 17 years of work in emergency medicine, there are a few cases that always rise to the top of the list of my memories. They are usually sad. They are usually tragic. I think this speaks to the fact that trauma imprints itself on my brain as a clinician in the moment of someone else's tragedy. It is profound to be in the room when a fellow human moves from life to death. It is powerful. It is humbling. I have to grit my teeth and swallow hard to avoid breaking down and crying. I am always aware that life is delicate, and we really aren't guaranteed anything in this world.

Clinicians experience grief in the moments following a patient's death, but we are not supposed to express it. Sometimes there is occasion to let a tear fall in sympathy with a family, but usually you get the sense that they need to be alone with one another and their lost loved one. Besides, we're supposed to remain strong. We are there to present information, facts and be objective. We are supposed to explain the cause of death and explain all the efforts we took to save the life. And then we are supposed to move on.

But do we move on? Do we really walk away from what just happened, forget about it and never feel the consequences?

BARRIERS TO PROCESSING GRIEF

How can health care systems develop healthy ways to meet clinicians in these struggles and build communities that are supportive and caring? There are a few significant barriers to effectively processing these difficult events. Even if we wanted to express empathy and grieve alongside our human brothers and sisters, there rarely is time. The pressure and demands of work in the ER do not stop.

Not long ago an elderly woman came to the ER feeling quite ill. Her course quickly became critical, and she died within three hours of arrival. I was shaken by how quickly this happened. I took exactly one minute in the bathroom to cry, and then dried my eyes and went to the waiting room to talk with the family. I spent about 10 minutes with them. I spent another 10 minutes completing


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paperwork and order entries.

And then I had to turn on my happy, playful face and move on to the room where my next patient waited, a 2-year-old with a forehead laceration.

Processing our grief can be further complicated because the grief we witness isn't exactly our own. It wasn't our baby, our grandfather, our spouse. It happened to somebody else. But we were directly involved, and we carry the feeling of additional responsibility because it is our job to do everything possible to save the person's life ... and we failed.

The culture of medicine historically has been silence; don't talk about it, just deal with it. And people do deal with it; they have different coping mechanisms. Most of my partners and the nurses I work with say that they take very little time to process the events after a patient has died. Some will go home that night, hug their children a little tighter, and have a glass of wine before bed. Some people go for a run or talk to their spouse. Some people drink too much, or turn to drugs for relief. Most just shove the experience down deep in their heart and try to ignore it. Some don't even seem to remember the events at all.

But these events make their mark.

"We find out that 36 percent of the EPs [emergency physicians] find dealing with sudden death of a young person and traumatic accident/disease involving a young person the most traumatic experience during their work activity."[1]

So what are we doing for the care of the souls of those present, what do we do to check in with doctors and nurses who have witnessed tragedy? What support is available for clinicians? How do we maintain our humanity?

Brené Brown, PhD, a research professor at the University of Houston states, "If you trade your authenticity for safety, you may experience the following: anxiety, depression, eating disorders, addiction, rage, blame, resentment, and inexplicable grief."[2]

So often clinicians trade their full humanity with its wounds and heartache for emotional "safety."

WORKING WITH THE WHOLE HEART

We need to start talking about the fact that we, as clinicians, experience grief and trauma too. It isn't to the extent that a family will experience it in the moment of loss, but it happens a lot more frequently. We see death and dying on a regular basis. We try our best to intervene and save lives; but often, we fail. People die, and you can't treat death. But what do you do with the emotions that come along with working in these difficult situations? How can we help clinicians process these events in an efficient and effective manner?

What do you do with the emotions that come along with working in these difficult situations? How can we help clinicians process these events in an efficient and effective manner?

I believe the holistic view of health care must extend to clinicians as well as to patients. Jesus asked, "Can a blind person guide a blind person? Will not both fall into a pit?"[3] How can we ask clinicians who are emotionally traumatized and struggling with burnout to care for the emotionally and physically needy?

Jesus also says in Luke 6:45, "A good person out of the store of goodness in his heart produces good ...."

Physician groups, health care systems and clinical departments must be sure that the hearts of our staff are well tended and have every opportunity to bring forth good fruit. If people are dying inside, they will try to cover over their pain and frustration, and it will work for a season, but eventually their wounds will overflow into their work.

CARING FOR CLINICIANS

Critical incident stress debriefing is an excellent way to begin the process of coping with difficult experiences. In the emergency department, the purpose of such debriefing is to evaluate what was successful during a code, as well as what needs improvement. It is also a meaningful way to begin the conversation about the emotional effects of the code on staff.

An extremely useful tool for clinicians is developing mentoring relationships with people who are perhaps a little older and wiser. A mentor can help navigate difficult clinical events and stressors.

"Finding a suitable mentor requires effort and persistence. Effective mentoring necessitates a

certain chemistry for an appropriate interpersonal match. Prized mentors have 'clout,' knowledge, and interest in the mentees, and provide both professional and personal support"[4,5]

These mentors are a support when a clinician encounters a difficult case or needs to process grief. Mentoring takes time and wisdom and, often, training to implement well. It requires both people to commit themselves to the mentoring relationship, but the value of a trusted adviser to counsel and encourage the clinician through difficult times cannot be overstated.[6]

HEALING THE HEALER'S HEART

We have to start attending to the wounded hearts of clinicians. People who have trained and given their life to the treatment of the sick and dying need support. As a medical community, we need to recognize that the culture of "just deal with it and move on" is crippling us. We begin to build walls to protect these tender places in our hearts, and, before you know it, we are jaded and emotionally disconnected from patients, co-workers and probably even our own friends and families.

The needs of each hospital department and clinic are unique, and one size of intervention does not fit all.

ER people have a skill set, both clinically and personally, to deal with things quickly and move forward. We wouldn't be able to do what we do if we lingered indefinitely over sadness. But we can't ignore it either. As much as we care for people and their families at the moment of their death, we need to take care of ourselves. We need to take care of each other.

Hospitals have many tools that can be implemented to care for people who work under its roof. We have an impressive collection of clinical experts, and we also employ counselors, psychologists, pastoral staff and volunteers who can further their ministry by caring for their own.

The needs of each hospital department and clinic are unique, and one size of intervention does not fit all. For example, the needs of nurses and physicians in an ER are incredibly different from the needs of staff on a hospice floor. But I can guarantee you they all have needs.

It will require sensitivity and creativity and time to get to know these groups and develop relationships so that the vital conversations can begin. Department managers and leaders need to think creatively and sensitively about how to attend to their staff in meaningful and supportive ways.

My work in this area has led me to understand two things. First, there is profound brokenness in the hearts of brilliant and caring medical clinicians. And second, the work of tending to wounded hearts takes time, and it is rooted in relationship. This work of healing must take place in and among people, and it cannot be rushed or systemized. It will look different in every department and every hospital But we must start. We must start where we are, with what we have, and we must start now.

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NOTES

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3. Luke 6:39, *New American Bible*.

4. Vicki A. Jackson et al., "'Having the Right Chemistry': a Qualitative Study of Mentoring in Academic Medicine," *Academic Medicine* 78, no. 3 (March 2003): 328-34.

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