The Psychosocial Morbidity and Mortality Conference: Parallel Process in Resident Training

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This article argues that the emotional sequelae of physician trainees in response to unexpected patient death require systematic attention. The article proposes the concept of a Psychosocial Morbidity and Mortality Conference (PMMC) as a useful adjunct in physician education to the traditional morbidity and mortality conference. Understanding significantly unexpected and irrevocable patient outcomes often requires a shift in the analytic paradigm used, and it is suggested that a psychosocial perspective, emphasizing parallel process phenomena, is one such way to deepen the learning of physicians-in-training. In particular, the PMMC can highlight previously missed or trivialized dimensions of patient and family that impact care; reveal linkages and parallels of emotional response between patient/family and physician; and simultaneously help address the physician-in-training's affective distress, which often results from a difficult and painful case. A clinical example, involving the unanticipated death of a patient, is examined, and insights into patient, family, and physicians are summarized.

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DEATH has always been problematic in medicine, primarily because, by its very presence, it appears to challenge the *raison d'être* of the medical profession (8). Earlier generations of physicians, perpetuating an alluring myth of omnipotence by attempting to exercise control and mastery over death, often appeared to take the death of a patient as a personal affront (31). The death of a patient was considered a mark of failure for the physician (32).

Despite the emergence in the past decade of a large literature on death and dying (3, 12, 20, 21), at the stage of postgraduate training, many residents have learned to push aside the death of their patients—through humor, withdrawal, callousness, or platitudes. This sometimes occurs because acceptance of the assumptions of the system may lead physicians-in-training to draw the boundaries of death so as to leave themselves outside (29). Prevailing assumptions of the medical system encourage clearly defined and separated roles for doctor and patient. Thus, models of death and dying currently available to medical students and residents focus on the needs and responses of terminally ill patients and families. The framework is appropriately patient-centered (15), but at times its use may result in ignoring the equally pressing needs and concerns of the putative "helper"—the physician.

But death is an overarching phenome-

non, which encompasses more within its borders than any theoretical model might like to allow. Thus, inevitably, the physician is engulfed in the process of the patient's death (26), wrestling with questions that are rarely raised and less often explored in medical training. In what sense is the life of the physician touched by the passing of his or her patient's life? How is the physician integrated into the dynamic interpersonal system of doctor/patient/family, which has now been modified by death? What does the death of the patient mean to the physician? Although the physician's own losses or feared losses can easily be activated by the death of a patient (14), there is little opportunity to attend to these feelings. The result is residual guilt, remorse, and sometimes anger.

This experience is especially strong when the patient's death is unexpected and unforeseen. One of the benefits of curricular attention to death and dying is that a structure has been created, which imparts a sense of control and manageability to participants in the system (of course, an actual death, even an anticipated one, is often messier and less predictable psychologically than a "model" death). When a patient dies unexpectedly, this framework of normalcy and control shatters. The patient has done something outside ordinary channels. In a sense, the patient has exerted primacy over the system, albeit with devastating consequences. The residents' feelings of guilt, anger, and responsibility, kept in check when events, while tragic, proceed as expected, become vastly intensified when the system swings out of control. It is in such a situation that reflection involving an alternative paradigm can be especially useful.

THE PSYCHOSOCIAL MORBIDITY AND MORTALITY CONFERENCE

A patient who presents enigmatic problems or has a disturbing outcome creates in the physician-in-training feelings of loss of control, incompleteness, confusion, anger, and guilt (28). This is particularly true when the patient has died, leaving a legacy of irreparability (17). The traditional morbidity and mortality conference was designed to provide a structure within which to review, primarily from a biomedical perspective, potentially problematic issues in diagnosis, treatment, clinical judgment, and decision making. It has also been suggested that a clinical analog, the psychosocial morbidity and mortality conference (PMMC) can be useful in helping residents and medical students explore the psychological context of a particularly baffling or upsetting case (25).

The primary concern of the PMMC is the exploration and analysis of the subjective, emotional worlds of patient, family, *and* physician. For traditionally trained physicians, such a process requires a significant paradigm shift (13), a willingness to examine and understand the patient *and* themselves from a radically different perspective. The traditional morbidity and mortality conference is predicated on logical-positivist assumptions (18) that a unitary, causal truth can be identified. Its premise is that the investigators can adopt an objective stance, and that findings can be applied in a preventive, curative manner. Even the psychosocial autopsy—a concept that bears some similarities to the PMMC, but has been used primarily with suicides to study risk factors and clarify the pre-mortem intentions of the victim (4, 5)—leaves the inquirers outside the system of inquiry. The PMMC, by contrast, focuses less on hypothesis-testing and proofs, and more on developing a deeper understanding that includes the emotional responses of the caregivers. The purpose of the PMMC is not necessarily "prevention" of a "negative" outcome but, rather, the construction of meanings (9), around the precipitating event, that make more sense

to the participants, increase their sensitivity to and connectedness with patient and family, lessen their own anxiety, and enhance their sense of personal coherency and efficacy.

Clearly, intensive examination of the patient from this vantage point is not always required. However, significant and unresolvable anxiety over the outcome of a particular case may be a sign that traditional modes of assessment and analysis have been inadequate. In particular, the medical Clinico-pathological Conference, while potentially of great educational value for the physician trainee, does not always alleviate the complex reactions generated by disturbing patient-care dilemmas. Too often, this subjective reaction is submerged, only to surface later, perhaps with greater intensity. Under these circumstances, the ability to reframe, reinterpret, and understand problematic situations in a new light becomes crucial (22).

PARALLEL PROCESS IN PATIENT CARE

One of the insights that often emerges from a PMMC inquiry is the presence of parallel process phenomena in a given patient-care situation. Parallel process, or isomorphism, refers to replications of process and affect at various levels of care (6, 19). For example, an angry patient may provoke suppressed hostility and emotional withdrawal in the resident. When the resident presents the case to the attending in an irritated, hostile manner, thus mirroring the patient's presentation, the attending, in turn, is stimulated to reflect the resident's emotionally reactive response to the patient. Investigation and recognition of parallel process issues are particularly useful in situations where the resident seeks refuge from anxiety and distress by excessive empathic distancing from the patient. Such an understanding forces the student to recognize the commonalities of emotion and feeling operating throughout the system (24).

Of course, parallelisms are not to be found in the comparison of every series of interrelated situations, and parallel process will not always be fruitful as a mode of analysis. However, neither is parallel process dependent on coincidental particulars ("My father died the same month as did yours"). Typically, parallelisms of emotional response may lie buried in contexts characterized by high emotional distance and lack of empathic understanding. It is precisely because some aspect of the patient's particularity triggers projective identification in the physician that such emotional protectionism becomes necessary. The point is that these connections are not rare, idiosyncratic events, but occur with significant frequency in therapeutic (and human) interactions. This is because people in pain, in seeking help for their pain, seem to access the root pain dormant in their caregivers. With some discomfiture, the caregivers realize they are more similar than different from those they are attempting to "help."

Some of the possibilities of helping physicians-in-training to deal with the unexpected death of a patient through a PMMC, which examines parallel process issues, may be illustrated through the following case example, which also highlights the ties that bind doctor to patient even in apparently superficial and fleeting encounters.

Case Presentation

Mrs. B was a 72-year-old white female with multiple medical problems, multiple hospital admissions, and a history of insulin-dependent diabetes mellitus, coronary artery disease, ventricular ectopy and tachycardia, myocardial infarction x three, coronary artery bypass graft x four, congestive heart failure, atrial fibrillation, chronic obstructive pulmonary disease, and diverticulosis. However, this admission, for

diarrhea of approximately 10 days duration with consequent dehydration, did not appear to be made under life-threatening circumstances. At the time of the following incident, Mrs. B had been in the hospital for a period of 3 days.

When the patient was presented at rounds that particular morning, there was an air of business-as-usual pervading the group, consisting of three family practice residents, a medical student, an attending physician, and a behavioral scientist. We sipped our coffee, munched our rolls, and listened to the latest developments. We learned that there had been some difficulty the previous night with Mrs. B's husband, who had expressed concern about certain procedures suggested by her physicians. A CAT scan eventually had been performed, although a scheduling delay in the procedure and the resultant missed meal had produced a hypoglycemic episode in the patient, during which she had become confused, disoriented, and weak. Compensatory medical measures had been taken, and the residents appeared to feel that this complication had been dealt with satisfactorily. The general tenor of the group discussion conveyed that the situation was under control, the patient could be stabilized, and additional diagnostic procedures would be performed to determine the cause of her admitting symptoms because earlier provisional diagnoses of diverticulitis and pneumonia had not been substantiated.

Fifteen or 20 minutes later, while rounds were still in progress, Mrs. B "coded" unexpectedly. All of a sudden we were jolted from our comfortable, normal world. Coffee and rolls were forgotten as we ran, with some desperation, up the four flights of stairs to Mrs. B's room. During the code, the residents and attending responded with vigor and efficiency, but it quickly became apparent that Mrs. B was not going to survive.

A Psychosocial Perspective

A week later, residents, medical students, physician faculty, and behavioral scientist reassembled at the faculty member's initiative to discuss the aftermath of Mrs. B's death. In a sense, under the guise of resident education, we had come to mourn Mrs. B. Compelled by her death, we had also come to seek greater understanding of patient and family. Previously satisfied by our conventional understanding of Mrs. B, her death challenged us to rethink the salient factors in her case. In this early phase of the discussion, there were few overt expressions of either personal grief or self-blame on the part of the residents. The boundaries drawn by the health care providers neatly defined the emotional and psychosocial system as encompassing only patient and spouse (30).

As we talked, the residents began to remember various psychosocial facets of Mrs. B's clinical profile, which had not been mentioned at the previous week's morning rounds. One resident recalled that the evening before her death, Mrs. B had asked plaintively that she "just be allowed to die." As the patient seemed in no imminent danger of dying, the resident had ignored this remark as simply a transitory depressive episode. Now it loomed with larger significance.

Another resident mentioned that Mrs. B's only daughter had committed suicide secondary to lupus several years earlier, and that in fact Mrs. B's current admission fell on the anniversary of her daughter's death. More attention was paid now to the relative lack of severity of her admitting symptoms, and to her early morning appearance in the emergency room, accompanied by a distraught husband who had reached his limit of caretaking. An interview with Mrs. B during an admission a few weeks previously (with a somewhat differently composed medical team) had

revealed her significant feelings of guilt, depression, and anger. Mrs. B talked openly then about having abandoned and failed her daughter. She wondered: Did I do something wrong? Should I have tried harder? Could I have been more attentive? She also expressed anger that her doctors were apparently neglecting her, perhaps a projection of her fear that she herself had deserted her daughter. We began to wonder why Mrs. B had come to the hospital at this particular time. What pain had she, and her husband, sought help for? What illness, in contrast to what disease (11), had her physicians, perhaps unknowingly, been treating?

With retrospective wisdom, we speculated that at least as compelling for Mrs. B as her physical symptoms was the timing of the hospitalization to coincide with her daughter's suicide. Bowen (2) writes of the emotional shock waves that may occur years after a particularly toxic death has unbalanced the family system. In part, Mrs. B's hospitalization may have been a way of coping with the unresolved guilt and anger she still felt about her daughter's death. While this piece of information was known to the residents at the time of her admission, it had not appeared nearly as significant (or treatable) as her suspected pneumonia or diverticulitis. The medical system had defined Mrs. B's problems according to its own diagnostic criteria; thus, the tests and scans had proceeded. We did not seem to notice that Mrs. B had death very much on her mind.

Our discussion also focused on Mr. B, in an effort to enlarge our understanding of his role in the family system. When Mrs. B had coded and it became apparent that she was beyond the ministrations of the residents, they quickly turned their attention to Mr. B. Their efforts became directed toward reclaiming the safety of the physician role of which Mrs. B's death unceremoniously had deprived them. Since they could no longer effectively care for Mrs. B, they attempted to extend their caretaking function toward her husband. They readily acknowledged his potential helplessness and sense of aloneness, and wondered what they could do to support him. They noted that Mr. B had been in a caretaker role toward his wife for many years, in fact since the death of his daughter. But he also had confided to one of the residents that he felt he could no longer fulfill this function. Thus he, like his wife, struggled with feelings of guilt. The daughter's death had triggered remorse and despair in the mother. What might his wife's death trigger in Mr. B? The residents were prepared to defend themselves against the onslaught of Mr. B's possible anger as a reflection both of his fear at having failed his wife as well as the residents' own sense of failure.

One of the residents and the attending had held a face-to-face meeting with Mr. B shortly after his wife's death, and this same resident also maintained regular phone contact with him during the following week. Despite the earlier fears of residents, according to the individuals who met with Mr. B, he had not been angry, either at them, his wife, or himself. Rather, he thanked the resident and attending for the care they had taken of his wife, and apologized for taking up so much of their time.

Whereas Mrs. B apparently had wrestled with guilt and anger vis-à-vis her daughter, Mr. B appeared to have achieved a certain acceptance as well as a forgiving attitude toward himself and others. Perhaps for Mr. B, his wife's death was not as unexpected as it was for the medical team; perhaps he had prepared himself better than we had prepared ourselves for the approaching end of her life.

Eliciting Parallel Process Issues

Up until the time of Mrs. B's death, the dynamics of the family had been consid-

ered a process wholly outside the residents and attendings, something of rather peripheral interest in the overall medical scheme of things. They could note that Mrs. B's hospitalization appeared to be an "anniversary reaction," that she appeared to be suffering from "unresolved grief." But these were clinical, professional observations, with the health care personnel having little or no personal connection with the emotions they accurately identified in the family. In the face of her daughter's death, Mrs. B had decompensated, felt guilt, and withdrawn from life. As her physicians, the residents could understand this and even express sympathy. But they still saw themselves as experts in warding off death or, at worst, dealing with death efficiently and appropriately—in a sense, succeeding where Mrs. B had failed.

This perspective of distance was shattered by Mrs. B's death, which catapulted all players, patient, spouse, residents, and attendings, onto the same emotional field. As our discussion continued, it became obvious that the caregivers too struggled with the same feelings of guilt, anger, remorse, and helplessness that Mr. and Mrs. B, in various contexts, had also experienced. Like her daughter's death for Mrs. B, the unexpected nature of Mrs. B's death had been an assault on the physicians' sense of control, on the perceived adequacy with which they fulfilled their primary role of caretakers. They had envisioned a much different, less dramatic scenario for Mrs. B's hospital course, in which they stabilized the patient, controlled and diagnosed her symptoms, rendered appropriate treatment, and discharged her. Instead, she had "tricked" them; in a similar fashion to how a suicide "tricks" the living, she had died. They were left with feelings of self-blame, resentment, and an uncomfortable humility. Now they too found themselves asking the questions Mrs. B might have asked: Did I do something wrong? Should I have been more attentive? Will I be blamed for her death? In a sense, the health care team had become the unwilling psychological "heirs" of Mrs. B's unresolved emotional predicaments. The moment and nature of her resolution had passed. The inheritance for those left behind was an uncomfortably similar legacy.

Ignoring the Warning Signs

Paralleling the impact of her daughter's suicide on Mrs. B, Mrs. B's death had challenged her physicians in a fundamental and irrevocable way. We realized that, just as with Mrs. B and her daughter's suicide, we had ignored certain important warning signs. The business-as-usual air with which Mrs. B was treated initially had as much to do with wish fulfillment as with reality. There had been unexpected problems and complications, and her care had begun to veer out of control. The patient herself kept alluding to her own death. While the medical team stubbornly was maintaining that the situation had stabilized, with cruel irony Mrs. B was literally in the process of proving us dead wrong.

Business-as-usual can be a tempting trap. Our need and desire for things to be in control may blind us to the fact that they are rapidly becoming out of control. Mrs. B berated herself for not recognizing her daughter's desperation. Symbolically, in reflecting on those initial breakfast rounds, the attending wondered whether we should not have held them at Mrs. B's bedside. This action would probably not have saved her life, but at least it would have acknowledged the precariousness and vulnerability of her situation, not only medically but psychologically.

Guilt

Mrs. B at times experienced intolerable guilt over the unexpected death of her

daughter. Resident guilt in response to Mrs. B's death was manifested in different ways. One resident, who remained silent throughout the group discussion, only managed to say softly toward the end, "Yes, I'm feeling guilty." Another resident related poignantly how he had neglected to provide Mrs. B with a bedpan she requested, instead allowing a nurse to help her, because he felt he had "no time to do anything more" for her. It was a small, and understandable, withdrawal from his patient, but one keenly felt later. A medical student defended against his sense of loss and self-blame by announcing glibly that it was important for Mr. B to understand that "death was a part of life." Unwittingly, this student was attempting to bypass the family member's grief, and his own grief as well, through rationalization.

Anger

Not only did Mrs. B feel guilty and remorseful about her daughter's death, she felt angry toward her as well. Discussion of Mrs. B's anger provided an opportunity to explore feelings of anger among the health care team. One resident disclosed that she felt Mrs. B had betrayed her by dying just when the resident was claiming that her status had stabilized. While anger did not emerge as a dominant response during the resident discussion, it was realized that at times the "anger" of the attending toward the resident, or one resident toward another, may be a way of dealing with helplessness and loss (27).

Other Lessons

By analyzing the parallel process between Mrs. B's response to her daughter's unexpected suicide, and the residents' responses to Mrs. B's unexpected death, as a group we were able to deepen our understanding of reactions such as self-blame, grief, guilt, and anger. But other parallels were operating in the system as well, from which we also had much to learn.

Failed caretaking was a theme characteristic not only of the relationship between Mrs. B and her daughter, but also between Mr. B and his wife. After the death of her daughter, Mrs. B responded by withdrawing into sickness and increasing invalidism. In her own eyes, she no longer deserved to be a caretaker. Instead, Mr. B became *her* caretaker, assuming many of the functions she had fulfilled in regard to her daughter. It was apparent from his interactions with the medical team that, as a caretaker, Mr. B also wrestled with feelings of inadequacy and guilt. Yet, while Mrs. B illustrated a repetitive cycle of guilt, anger, and self-blame, Mr. B's behavior after the death of his wife introduced a new element: forgiveness of self and others. This realization was especially important for residents and students because, like Mr. B, they too had been caretakers of Mrs. B, and like him, they were forced to confront the fact that their caretaking had not been able to preserve her life.

Forgiveness

Thus, the final emotional event introduced into the system of those touched by Mrs. B's death was the possibility of self- and other forgiveness. We had no way of knowing to what extent Mrs. B forgave herself for her daughter's death, or whether Mr. B forgave himself for his thoughts about not being able to care for his wife. But in Mr. B's encounter with the resident, his expressing gratitude rather than anger, thankfulness rather than deprivation, contained an implicit message of forgiveness, to which the resident immediately responded.

"He made it so much easier for me to get in touch with my own feelings," the resident reported, and indeed went on to disclose the feelings of grief that had occurred when his own father had died. It

appeared that acceptance and forgiveness in the response of the surviving spouse allowed at least one resident to begin to accept his patient's demise, and to start the process of relinquishing his own guilt. Interestingly, while this resident felt relief at learning of Mr. B's reaction, there were also further feelings of guilt expressed by some members of the group. There remained some sense that perhaps the physicians involved deserved to be punished by Mr. B's anger; when this was not forthcoming, there was a compensatory intensifying of self-punishment.

The concept of forgiveness in this context does not imply wrongdoing; rather, it is simply asking for and simultaneously extending forgiveness to oneself and to others in the system for being fallible and imperfect (10). Such forgiveness enables acceptance of one's humanity without arrogance or callousness. As we discovered in Mr. B's case, seeking and granting forgiveness may transpire implicitly between physician, patient, and family. However the process occurs (33), forgiveness is an important indicator of emotional resolution (34).

DISCUSSION

Several important lessons were learned from this PMMC. First, there was the value of the group discussion itself. In the constant press of ongoing responsibility, there can be an understandable tendency to postpone indefinitely discussion of the psychological and practical sequelae of a patient's death. But busyness itself is also a way of insulating from emotion, of reinforcing the individual's normal defenses. Simply providing the impetus for such a discussion communicates that this response to the patient's death is also important, as well as tracing the biological "cause" of death.

Second, it became clear that residents participating in the discussion reflected different phases of response to an unexpected patient death, which can also be understood as different phases of one's own individual response. One resident modeled self-disclosure, a concern for the family member, and awareness of personal issues that affected his response to death and dying. Another remained silent and guilty. A third attempted to deal with his anxiety by rationalizing away the emotional impact of death. But as part of a group, these responses became a complete and satisfying whole. One resident could verbalize what another resident might have been afraid to say, but desperately needed to hear.

These differing responses were not viewed as right or wrong, better or worse, but as reflections of various aspects of response to the unanticipated death of a patient, all of which could be helpful in deepening the understanding and awareness of the group participants. For example, the prevalent response of guilt was related to the physicians' appropriate sense of responsibility and purposiveness in relation to the patient. Similarly, residents' feelings of anger made possible exploration of related concepts such as a fair and just universe (16). The anxiety expressed in the group could lead to an acknowledgment of physicians' perpetual, precarious balance between freedom and power on the one hand and existential aloneness and responsibility on the other (7).

In terms of how residents can respond constructively and humanely to the void left by a patient's unexpected death, the group discussion, as well as followup reports, demonstrated how taking care of, and reaching out to the remaining family can be of critical importance. It was apparent that certain of the residents felt an impulse to hide from the family members, thus avoiding the feared blame.

However, the resident who exhibited the greatest resolution of his own feelings was also the one who had pursued Mr. B most vigorously. Perhaps his caring and concern contributed to Mr. B's healing; almost certainly, Mr. B's gratitude and acceptance of his wife's death contributed to the resident's healing.

The importance of listening to the patient's perspective also took on additional weight during the group discussion. Mrs. B's statements about her daughter's suicide, her own guilt, her desire to die had originally been seen as secondary to her "real" medical problems. In discussion, it occurred to residents that perhaps what needed most attention was Mrs. B's indication that she was ready to die. What had she really been seeking help for? What really needed to be treated? These unanswered questions pointed to the potential discrepancies between how Mrs. B viewed her situation and how it was viewed by the medical staff.

Further, residents, students, and attendings became aware of the similarities that had connected them to the family. They had all been caretakers; they had all lost the one to whom they had committed their help. They had all struggled with the anger of abandonment, and the guilt of survival. They had made at least initial forays toward setting at rest those feelings.

As the discussion progressed, residents struggled to identify, if not resolve, their own feelings about death. They wrestled with the sadness inherent in the loss of a loved one. They verbalized their fear of their own impending mortality. No definitive answers emerged; no complete resolutions were reached. But the residents, each at their own level, had begun to "own" Mrs. B's death. The boundary was at last properly drawn.

The use of the parallel process model also yields some hard questions. Did the unconscious operation of parallel process contribute to the patient's death? If such issues had been anticipated, could Mrs. B's death have been postponed and alternative action taken (1)? It is wise at this point to keep in mind both the limits and the goals of the PMMC. Assuming appropriate medical management, the PMMC does not make the claim that the outcome of the case could, or should, have been any different. What it does suggest is that the process by which that outcome was arrived at might have proceeded somewhat differently, with an expansion in the sensitivity of the treatment team both to the patient's psychological and emotional needs and to their own. Neither does the PMMC attempt to prevent or rescue its participants from past or future complex affect. Rather, by deepening their awareness and understanding, by changing the boundaries and amplifying the meaning of the experience, the PMMC creates the potential for greater therapeutic intimacy between patients, family members, and physician.

SUMMARY

The psychosocial morbidity and mortality conference gave residents and attendings an opportunity to mourn their patient. As Mrs. B passed from their lives, they were able to review her memory not only as a collection of ailments, but from a psychosocial perspective that emphasized her humanity. In so doing, they discovered unsuspected connections that bound them together in surprising intimacy. Through a psychosocial exploration of patient and family, they were able to begin to access some of their own guilt, anger, and remorse. As the process continued, they were able to discover elements of acceptance and forgiveness, which could prepare them to bring greater compassion and insight to their next patient encounter (23).

REFERENCES

1. Bloch, D.A. Personal communication, April, 1991.
2. Bowen M. Family reaction to death. In P.J. Guerin (ed.), *Family therapy: Theory and practice.* New York: Gardner Press, 1976.
3. Bowlby J. *Loss: Sadness and depression.* New York: Basic Books, 1980.
4. Brent, D.A. The psychological autopsy: Methodological considerations for the study of adolescent suicide. *Suicide and Life Threatening Behavior 19:* 43–57, 1989.
5. Ebert, B.W. Guide to conducting a psychological autopsy. *Professional Psychology: Research and Practice 18:* 52–56, 1987.
6. Ekstein, R. & Wallerstein, R.S. *The teaching and learning of psychotherapy* (2nd ed.). New York: International Universities Press, 1972.
7. Frankl, V. *Man's search for meaning.* Boston: Beacon Press, 1963.
8. Garfield, C. *Psychosocial care of the dying patient.* New York: McGraw-Hill, 1978.
9. Gergen, K.J. The social constructionist movement in modern psychology. *American Psychologist 40:* 266–275, 1985.
10. Kitchen, L.W. Suicide among medical students. *Western Journal of Medicine 129:* 441–42, 1975.
11. Kleinman, A. The cultural meanings and social uses of illness. *Journal of Family Practice 16:* 539–545, 1983.
12. Kubler-Ross, E. *On death and dying.* New York: MacMillan, 1969.
13. Kuhn, T.S. *The essential tension: Selected studies in scientific tradition and change.* Chicago: University of Chicago Press, 1977.
14. Lamb, D.H. Loss and grief: Psychotherapy strategies and interventions. *Psychotherapy: Theory, Research and Practice 25:* 561–569, 1988.
15. Levenstein, J.H., McCracken, E.C., McWhinney, I.R., Stewart, M.A., & Brown, J.B. The patient-centered clinical method: A model for the doctor-patient interaction in family medicine. *Family Practice 3:* 24–30, 1984.
16. Moses, K.L. On lost dreams and hopes: Parents and professionals as mutual helpers. Presented at Conference on Disabled Children and Their Families, Long Beach CA, 1985.
17. Mount, B.M. Dealing with our losses. *Journal of Clinical Oncology 4:* 1127–1134, 1986.
18. Packer, M.J. Hermeneutic inquiry in the study of human conduct. *American Psychologist 40:* 1081–1093, 1985.
19. Phillips, G.L., & Kantor, C.N. Mutuality in psychotherapy supervision. *Psychotherapy 21:* 178–183, 1984.
20. Rando, T. *Grief, dying and death.* Champaign IL: Research Press, 1984.
21. Raphael, B. *The anatomy of bereavement.* New York: Basic Books, 1983.
22. Schon, D.A. *Educating the reflective practitioner.* San Francisco: Jossey-Bass, 1987.
23. Seravalli, E.P. The dying patient, the physician, and the fear of death. *New England Journal of Medicine 319:* 1728–1730, 1988.
24. Shapiro, J. Parallel process in the family medicine system: Issues and challenges for resident training. *Family Medicine 22:* 312–318, 1990.
25. _____, Larsen, K., & Jacokes, D. The psychosocial M & M: A tool in reinterpreting problematic medical situations. *Family Medicine 22:* 437–442, 1990.
26. Slaby, A.E. Cancer's impact on caregivers. *Advances in Psychosomatic Medicine 18:* 135–153, 1988.
27. _____, & Glicksman, A.S. *Adapting to life-threatening illness.* New York: Praeger Press, 1985.
28. Smith, R.C. Unrecognized responses and feelings of residents and fellows during interviews of patients. *Journal of Medical Education 61:* 982–984, 1986.
29. Stein, H.F. The boundary of the symptom: *Whose* death and dying? *Family Systems Medicine 2:* 188–194, 1983.
30. _____, & Mold S.W. Stress, anxiety, and cascades in clinical decision-making. *Stress Medicine 41:* 41–48, 1988.
31. Taubman, R.E. The physician and the dying patient and his family. In C.

Garfield (ed.), *Psychosocial care of the dying patient.* New York: McGraw-Hill, 1978.
32. Weissman, A.D. Understanding the cancer patient: The syndrome of caregiver's plight. *Psychiatry 44:* 161–168, 1981.
33. White, L.P. The self-image of the physician and the care of their dying patients. *Annals of the New York Academy of Science 164:* 833–831, 1969.
34. Worthington, E.L., & DiBlasio, F.A. Promoting mutual forgiveness in the fractured relationship. *Psychotherapy: Theory, Research, Practice, Training 27:* 219–223, 1990.