COMMENTS AoD ASSIGNMENT #3 2007

--, thank you so much with entrusting me with this personal story. I am very sorry for the loss of your mom at such a young age. That's very, very hard. Of course you are going to resonate emotionally, perhaps very strongly, to situations that closely parallel what you went through as a child. That is so natural and normal. You know this circumstance not as a physician, but from the inside-out, as a daughter. That makes it really hard to go into the patient's room; to interact with her; and to say goodbye.

You might want to ask yourself, why do I want to cry in this patient's presence? Why am I avoiding her? What is making my own pain so overwhelming? The feelings are the right place to start.

And once some answers start to emerge, then the question becomes, which I hear is what you're asking, what do you do with all this? One thing I would wonder about is, is there still some mourning or grieving to do for your mom? Even though she died a long time ago, it's tough for a little kid to lose her mother, and maybe there's some completion stuff that you need to do – or do again. Maybe seeing this mother of two young children makes you want to reconnect for a little while with your own feelings of loss, and gratitude, and anger, and love. I don't know what the feelings are, but they are probably there. Maybe this is a time to write (or rewrite) your mom that letter, telling her these feelings, telling her how much you miss her; or visiting her grave; or talking to someone close to you who knew her. I don't think we ever close the door on these losses; every once in awhile we need to revisit them; and in this sense perhaps this patient not only forced you to confront a terrible loss in your own life, but also offered you the opportunity to do some further healing around your mom.

So maybe after remembering your mom, recontacting the feelings, acknowledging and regrieving her death, and in the process extending your own healing, you might ask yourself, is there any way these difficult feelings of too much connection with this patient can be softened somehow so that they can actually help your patient. Maybe not this time around, maybe not with this particular patient. But it might be possible at some point to place your very tender, painful feelings in the service of a patient in a similar situation. There are probably very few people who can really touch the devastating grief she must be feeling at leaving her children without a mother. Maybe within all of this suffering, hers and yours, there is something you are uniquely able to give her. Maybe this has something to do with saying how sad you were when your own mother died; how hard it was for you; how much you still miss her; but also how people did rally round you; and how, despite this terrible loss, you have been able to make a good and happy life. I don't mean to put words in your mouth; this is just an imagined example. Only you would be able to figure out, in conjunction with deep listening to this patient, what she might need and you might have to give.

You might also decide that right now you are too close to this woman's tragic circumstances to be fully present with her. That is also an entirely valid and moral position. I would only encourage you to regard it as a starting, rather than an ending point. A terribly unfair, inexplicable thing happened to you when you were just a little kid. There is no way to make that right or okay, and I would never suggest that. But I do believe there is a way to turn some of that loss and suffering to good. The more emotionally "steady" you can be with your mom's passing (which in no way means not grieving, or not missing her), the more you can learn something that can help heal future patients who are facing death and their families.

I hope all this adds up to something meaningful for you, --. I'd be really happy to talk about it further – it's a hard thing to put in an email. In any case, I commend you for noticing what was happening with this patient and for sharing this incident. Best, Dr. Shapiro

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Hi --. Thank you for sharing this very personal story. I am very sorry for the loss of your grandma. I still remember when my maternal grandmother died with utmost clarity, and that was 50 years ago. As you say, these sad events are often engraved in our minds. And to be honest, I can't think of many people who "handle death and dying of loved ones…well." It is certainly one of the hardest emotional experiences we must undergo. In so many ways, you behaved so wonderfully during the time your grandma had remaining. You expressed your love, visited her and wrote her, and let her know how much she meant in your life. You didn't allow your fear of losing her to overwhelm you, cause you to run away, or otherwise abandon her. Not everyone can be that strong and loving.

I think a lot of us, especially smart, well-educated people who have learned to control things and demonstrate competence through the exercise of our mental faculties, tend to intellectualize tragedy. That's how we try to control the uncontrollable. And this isn't always a bad thing. There is a time and place for intellect and a time and place for emotion. In the ER, for example, or in other crises, often you must concentrate on carrying out certain tasks, and you can't afford to release your emotions immediately. Similarly, you were afraid that grieving for your grandmother might lead to an emotional meltdown. Often, we avoid our emotions even when we don't have a Step 1 or its equivalent looming, because we are feeling so frightened and threatened that we worry we will literally decompensate.

To me, the important thing is that we don't put our emotions on hold forever. If we pay attention, we'll know when the right time to grieve is. I've often experienced intense emotions of grief and loss in my life. What I've discovered over the years is that, if we can learn to accept our emotions, like everything else in life, they evolve and change. They become strong, and then they diminish. And in the process of just hanging in with them, we begin to really understand what grief feels like, and we can begin to move closer to it without quite so much fear. As the fear decreases, our ability to mourn more wholly and deeply grows.

I don't know that we ever really "resolve" these profound losses, but if we're lucky, we find a kind of peace. I prefer to think of loss and grief as a process, not a single discrete event like a funeral. You can feel – and be – perfectly resolved about a loss, and then it may resurface in another form, for example, when you graduate from medical school; or have your first child. These incidents of reemergent feelings can be painful; they are also opportunities to reengage once again with the work of grieving, to shed some tears, to write another letter. It is also a chance to find a piece of your grandmother in the intelligence and heart that led you to be a physician; or in the eyes or mouth of a baby. Grief is a complicated emotion. It becomes more tender and less angry as time passes; but it does contain both emotions, as well as many others. I think our task is not to be ashamed of any of our feelings, but to understand them deeply. The reason we feel angry when a loved one dies is because we so loved them, and feel abandoned by their absence. What our anger is really telling us is how important that person was and how much we miss them. Thank you very much, --, for entrusting me with this experience of loss. Dr. Shapiro

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--, I was very moved by your essay about the death of your grandma, especially not really being able to grieve for her until you tried to make that soup. That one little detail made me cry too, since one of my grandmothers (who died 30 years ago) was famous for her matzah ball chicken soup; and I still miss her soup.

Denial is an incredibly powerful coping strategy, but unfortunately it's not powerful enough. As you say, it produces a reassuring veneer, but it is "artificial." We think we can shut out our deep suffering, but we cannot; and your tears (and mine) are the proof. As we talked about in class, opening ourselves to suffering can be pretty scary; it can feel, exactly as you describe, like our psyches – maybe even ourselves -- might disintegrate. However, my own feeling is that the more familiar we can get with suffering, the less frightening it becomes, the more able we are to contain it; and the more able we become to connect with and contain the suffering of others. One thing we can discover is that, paradoxically, grieving is not only a sad process. It's also a way to honor the person who has died; and our own love for that person. And so, also paradoxically, grieving itself can be comforting.

Of course, it's also true, as you observe, that sometimes we don't do enough "filtering," although I'd say that filtering involves less shutting out others' suffering than being aware of what's going on within us, and when we are starting to lose our center, are starting to "overflow." Overall, I believe the less fear we have, the more available we will be to ourselves and others; and the less energy we'll have to expend blocking scary emotions. In any case, you are absolutely right that finding the right balance of emotional openness is a lifelong process :-):-).

Btw, if the depth of your love for your grandmother is to be measured by the quality of your mourning for her (which I would question in any case), I for one do not think there

is anything “shameful” about your initial lack of overt grief. Your grieving was hidden, but it was certainly there; and when you were ready to claim it you did so. Thanks -- for sharing this difficult loss with such clarity. Best, Dr. Shapiro

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--, thank you for that felicitous and compelling phrase, emotional amnesia. With your permission, I’m going to incorporate into my AoD vocabulary (with attribution, of course). And thank you so much for this brave essay, which must have been hard to write. I hope you could see from the final poem I read that avoiding patients in difficult circumstances happens all the time in medicine. And understandably so – it seems so much easier to “forget” them. Of course, you also experienced the potential consequences –ruptured bonds, lack of trust, and a sense of abandonment.

As we discussed in class, it’s all about becoming aware of our feelings and reducing our fears. So in this case, you might have thought, “I’m feeling bad because there’s not going to be too much we can do for this nice gentleman. It’s going to be hard to face him knowing this.” And then you might have thought, “I want to make sure that I don’t try to deal with my feelings of helplessness and guilt by avoiding the whole sad situation.” Of course, some days you really will be too busy to see the patient. But by being conscious of your feelings and how they might influence you, you’ll also be able to allow in the awareness of how much your patient needs you; and not use a busy schedule as a rationale for “forgetting” to see him. By becoming more comfortable with emotionally tough situations, we make ourselves as available as we can be (which is still a finite proposition) to others.

However, the most important thing to remember is that it is almost always possible to recover from these lapses of our best possible selves when they do occur (which at least in my experience is pretty much all the time – welcome to the human condition, --!). You could probably make things right with this patient with a simple apology – “You know, I’ve let you down the past couple of days, and I’m sorry for that. I can understand that you’re upset.” Owning up to being imperfect allows us to move forward – otherwise, we start to compound our initial mistake (continuing to avoid the patient).

In my judgment, it would be sad if the main lesson you took away from this encounter would be to engage less in order to disappoint less. Of course, the logical consequence of this conclusion is not to connect with anyone so they won’t expect anything from you (except accurate medicine). I think we disappoint people all the time; and we also hold them up, inspire them, and give them hope. Truly, I’m usually surprised by how little we can give someone and how much it can mean. Most patients don’t have excessively unrealistic expectations of what you can do for them; and when they do, you can usually work with them – and yourself – to bring them into line. You can’t save this patient; but you can say hello. I suspect that might be enough.

--, I hope you know how highly I think of you; and my unshakeable conviction that you will make an outstandingly humanistic physician. Everything I wrote above is simply an

effort to further reflect with you on a challenging situation that all physicians must confront. You're already ahead of the curve by recognizing that "forgetting" about a patient may indicate deeper conflicts. The lessons we draw from such an encounter are complex; and I don't have the answers, just more thoughts! Thank you for sharing. Best, Dr. Shapiro

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--, you are so right that things are so much clearer in retrospect. And it is also true that when they invent the perfect teenager, I'll be first in line to get one – and be one! I think that what you're describing is your growth from a sometimes "bratty" adolescent to a more insightful and more compassionate young woman. Ask your grandma's forgiveness (at her grave, in a letter, through a poem) for not being a perfect granddaughter; and then forgive yourself. --, the final image of your little essay brought tears to my eyes. You were not capable of holding your grandma's hand as she might have wanted; I guarantee you will have many chances in your life to sit next to someone and hold their hand for a moment. Just take advantage of them, that will be enough. Best, Dr. Shapiro

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EXTRA CREDIT

--, sometimes I find you a completely enchanting person. I will never forget the image of you walking in the rain sans umbrella thinking about your future. Somehow it is soggily obvious that the lack of protection from the rain is the key ingredient to the effectiveness of this reflective process. What a beautiful way to achieve cleansing and clarity. Best, Dr. Shapiro

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--, it sounds as though you were a real blessing to your patient during what turned out to be the last days of his life. No wonder you felt his loss so deeply. I'm glad you had an attending who provided understanding and comfort. There is no shame in tears. I suspect that your patient would have been very touched that his little "bird" cried for his passing.

That having been said, I think you are wise to recognize the importance of limiting the suffering and loss you can absorb in your daily life while maintaining your own emotional health and a humanistic connection with your patients. As you point out, none of us can escape a certain amount of loss and grief in life. But everyone has a different capacity; and although we can work to become more familiar with suffering, we should always honor who we are. Usually it is people who are very tenderhearted who are most strongly affected by the suffering of others. You seem to have embarked on a path that will help you to retain your joy in medicine while not overwhelming you so that you detach from your patients' emotional needs. Best of luck in ob-gyn! Dr. Shapiro

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Hi --. You asked the right question, and I think came up with the right answer. Although I cannot even imagine 3 deaths in one day, loss and grief are all about connection; and your connection with these patients was almost nonexistent. That does not mean that their passing should not be acknowledged with dignity and respect; but I agree that there is no need to "manufacture" emotions without foundation.

From what you say, there was an element of relief in at least one of these deaths. This reminds me that "death" does not mean one thing. Although you're right, you'll have to deal with it often, it will never be exactly the same experience twice. In medicine, death becomes one of your companions – sometimes enemy, sometimes friend, often teacher and advisor if you are paying attention. Best, Dr. Shapiro

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--, I appreciate your sharing so honestly about this difficult patient encounter. You know, psychological research shows that the deaths that are most difficult to come to peace with are the ones of people with whom we have some quarrel or conflict. Why? Because with their death, we've lost the possibility of setting things right. Sadly, that is what happened with you and your breast cancer patient. Something that easily could have been resolved and forgiven became irrevocable through the patient's death.

Still, none of us is a perfect human being; and we all make mistakes through exhaustion, thoughtlessness, frustration, etc. Usually we have a second chance. When we don't, I think the best we can do is ask ourselves what we can learn. --, you learned the most crucial lesson of all. In the words of a Buddhist saying, "Life is so difficult, how can we be anything but kind?" Of course, all too often all of us are anything *but* kind; but this small rupture between you and this patient showed you the importance of kindness, even when you least feel like manifesting it. You had a second chance, although not with this particular patient, and you made the most of it. I agree, you "paid her back." Thank you, --, for reflecting on this experience and embracing all it had to offer you. Best, Dr. Shapiro

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--, I agree with your patient. You are going to be (already are) a great doctor. It seems to me you processed the death of this wonderful man very well. You asked yourself what you could learn medically (which sounds to me like something, but nothing that would have really been able to save his life); and most importantly, you allowed yourself a range of emotions, from grief at his death, to gratitude for having known him, to appreciation for his life and beautiful relationship with his wife. As you've discovered, he has become one of those patients whom you will "carry in your coat pocket" next to your heart, not in guilt or unresolved grief, but in honoring his life and what you were able to learn from him. Thank you for sharing. Best, Dr. Shapiro

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--, thank you for sharing the troubling loss of this patient. Yes, indeed, his death does raise a lot of questions, mostly about management over which as a student you had no control. However, it is also painful when we think the worst of someone, and we turn out to be wrong (actually, it can be pretty painful when we turn out to be right too!). Usually, we have time to "correct" our inaccurate assumptions about people in some way; but in this case death snatched away that opportunity.

As we talked about in class, sometimes in medicine grieving for a patient is complicated by guilt. "Should I have, could I have, why didn't I, why did I?" I agree completely that everyone deals with loss and grief differently; and different deaths may require different responses. There are likely lessons in this case about keeping open to many possibilities about patients; and advocating for the best possible care under less than ideal circumstances. And after that must come a way of seeking forgiveness for any shortcoming on your part; and a willingness to forgive yourself and bring all that you learned from this patient forward to your next patient. I respect your willingness not to push aside this man's death. That ability to reflect on uncomfortable experiences is what will make you an outstanding doctor. All the best, Dr. Shapiro

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--, I think you are being very hard on yourself, although I also agree that a very unfortunate combination of events led to an occurrence that would linger in my mind for years as well. What you're describing is the simple immaturity of youth; maybe not entirely admirable, but pretty hard to avoid; and certainly, had X not lost his brother that week, something that would not even have registered on your moral radar. I'm imagining that as a junior in university, you didn't have a very good understanding of either how at-risk the baby was; or how emotionally attached to you X had become. In any case, of course there was no way you could have anticipated the baby's death. Nevertheless, you were not there when you were badly needed; and that has to hurt – a lot. Personally, I think it was very responsible of you to try to find X, which would have been one way of healing your initial absence.

These instances of 20/20 hindsight are very painful. My mother-in-law died 20 years ago; and I still feel guilty that because of work I postponed a visit that would have enabled our family to see her before her death. If only I'd known… For me, eventually it comes down to acknowledging our mistakes and failures; learning what we can from them; and doing our best to carrying it forward into the lives of others. I think everyone has to work out these things in his or her own way; but I hope you can come to peace with this event. All the best, Dr. Shapiro

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--, one of the sentences I loved most in your essay was when you wrote "it was both heart warming and heartbreaking…" That sums up many poignant deaths so well – when people have got past anger, bargaining, futilely searching for a cure, patient and family are able to simply be with each other in love – and yet this is what makes it so

heartrending. I also think you expressed very well the "tangle" of emotions – as you say, there is sadness, relief, even "second-hand" comfort derived from the obvious love in this family. You know, I believe that "small glimpse" into the patient's and family's suffering is all that is required of us. Indeed, it would presumptuous to think that we can fully understand their loss. But we can connect with it – and this is what matters both to families and patients, and to us as compassionate people. Of course you won't feel the same sorrow at the loss of every patient, and that makes perfect sense. But there is always an aspect of death that is hard – usually very hard – for someone (patient, family, friend, and yes doctor). We don't always need to feel this, but we need to always remember it, and honor it. Thank you for this touching essay. Best, Dr. Shapiro

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--, the first thing that struck me when I read your essay was how kind (in an instrumental sense of getting Mr. X new glasses) to a patient with whom you didn't feel particularly close. To me, this is the highest form of clinical compassion, something that is not necessarily a natural impulse, but emerges from a sense of what every patient deserves. And your story just becomes more beautiful. Again, if this is how you treat a patient with whom you never "developed much of a relationship," I can only imagine how caring you must be toward patients with whom you share a bond! It's not that you did so much, but you took actions that at the moment were particularly fraught with meaning (helping a patient already so helpless in so many ways to see; spending a few moments at the bedside and shedding a few tears on the way home).

I can also hear that there were several aspects of mismanagement in Mr. X's case, and that his death may well have been unavoidable. Knowing this as a medical student, and being so powerless to change the course of things, must inevitably lead to a lot of anger and helplessness. In such terrible situations, it is easy to just wash your hands of the whole thing, in effect to abandon the patient because what's going on is so distressing. It is very much to your credit that you did not follow this course of action. Thank you for sharing such a difficult experience, and for including the manner of Mr. X's passing. I must confess, being a great X fan, it gave me a little consolation. Best, Dr. Shapiro

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--, thank you very much for sharing this patient's story. I can hear how heart-wrenching it was for you, let alone the patient and his family. I think you are asking exactly the right, but also a difficult-to-answer, question. Perhaps if the diagnosis was completely unexpected, the patient was simply not ready to move from living to dying; and chemo and radiation were a necessary transition. On the other hand, patients often don't fully understand just how grim treatment can be; and in this case, treatment that was at best only prolonging life slightly and causing a significant deterioration in quality of life might not really have been what the patient wanted. It sounded as though partway through he changed his mind, and hopefully he gained more meaningful time to spend with his wife and children. It is a fine line for sure, but our culture tends to lean toward always wanting to "do something," even if doing "nothing" except managing pain may

benefit the patient most overall. I respect your reflecting on this issue with such awareness and compassion. Regards, Dr. Shapiro

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Oh, this must have been devastating. To see the patient's complete deterioration (and then death), to know that you had previously correctly diagnosed the problem, and then to have it blown off as a soft transfer would be almost unbearable. I am proud of you for continuing to visit this patient in the ICU and continuing to support her husband. It would seem so much easier just to avoid the whole horrible situation. Yet you stayed with them, and also carefully thought through what happened. As you say, the long hospital stay and the size of the embolism might have suggested a fatal outcome no matter what happened. These are the kinds of uncertainties that can never be fully resolved in clinical practice. It sounds to me as though this is one of those patients you will carry close to your heart for a long time; and her presence will encourage you to do all that you can for your patients. --, you are that kind of doctor anyway; and this woman's death will help you stay the course. Thank you for being willing to discuss this with the rest of the class. It was an event that everyone was able to relate to. Best, Dr. Shapiro

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--, I appreciate your willingness to share this difficult experience. What you so honestly describe as your initial reaction to this patient's miscarrying is a response that tempts all of us at different times – minimizing the patient's plight. "I explained what might happen. Why is she still upset?" Twenty years ago, most people, including most health professionals, did not recognize that the loss of a fetus is in many, many ways the equivalent of losing a child. People would callously say to the mother and father, "Well, at least it wasn't a real baby." Ouch. We now understand much more about the parents' psychological responses in cases of fetal demise. It is a devastating experience (when the baby is wanted), one that takes months (or years) not days to come to terms with, and requires the same kind of mourning and grieving as any other death. I have great admiration for your willingness to think about what happened, and to shift your own perspective, rather than demand that the patient shift hers. You did exactly the work that was necessary (which I have seen both in your previous written essays and your in-class comments) to cultivate compassion and understanding. I am very sorry it took a personal experience to bring this home, but I know it's a lesson that will stay with you; and as you say, make you a better physician. Best, Dr. Shapiro

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--, thank you for entrusting me with the tragic story about your brother's death. Four years old. What a terrible loss for you and your family; and what a traumatic event for you to have witnessed. It's the kind of thing that is so hard to process psychologically because you were so young. It just sits there and haunts you periodically, connecting you in strange and maybe scary ways with loss, your own and others (like your basketball rival; or like the families of dying patients).

I'm struck by the fact that you've chosen a specialty in which loss and death are inevitable and omnipresent aspects of your practice (along with many temporary and longterm miracles (:-)). I wonder if your personal experience has given you a kind of attraction/revulsion to death and loss – wanting to move closer to it to understand it, to make peace with it, so as not to be so traumatized by it; but also completely understandably not wanting to be "present" with dying patients as fate forced you to be present at your brother's death.

I am just imagining, not "knowing" about your circumstances. Having experienced much illness and death in my own family as a child, I know that for years and years I was desperately afraid of "disintegrating," losing control in "unexpected" resurfacing episodes of grief. Then once when I was on a silent spiritual retreat, in a safe place, but alone, I spent several days revisiting those early memories. I did a lot of crying; and was probably a big pain to my fellow retreatants. But the important lesson for me was that by spending that concentrated time with my own grief, I got a lot more familiar with it and a lot less scared of it. It gave me strength to be "present" and not too afraid to be with friends and family in their dying. And I no longer worry about falling apart because I trust that I won't usually confuse my personal grief with what the people I am with need from me.

I found what you wrote at the conclusion of your essay very moving – that you could share your mourning for a patient with X. It has been my experience that those who have passed are truly in some way "available" to us as we face and try to cope with future losses. You are right that our grief is triggered by our personal knowledge and caring about others, and by the pieces of ourselves we have shared with them. Caring and connection mean we have to be courageous enough to absorb loss. On balance, I think it is a worthwhile tradeoff. I know you will continue to process these difficult issues with humanity and compassion in a specialty where so many will need your science and your art. Warmly, Dr. Shapiro

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Wow, this must have been scary. My first thought is, thank goodness the patient recovered. My second thought is, how brave of you to keep going, and even remove another chest tube. You processed the event very well from a psychological perspective, despite having to be on call, and not really having much space to reflect. You centered yourself emotionally, released some of your emotions through tears, talked to a trusted peer, and eventually discussed the incident with the intern. You also prayed for your patient. These are all important ways of not burying uncomfortable occurrences.

In a pretty dramatic way, you discovered first-hand one of the risks of a teaching hospital – someone has to be the patient on whom the student learns! Most times it works out pretty well; and your intern was certainly correct that complications can occur for any physician, no matter how experienced. That having been said, I admire that you were able to acknowledge and not minimize the patient's additional suffering, which may have (and

as a non-physician, I can't tell; and possibly neither could anyone definitively) been related to your inexperience. In medicine, you must go forward; but not blindly, callously, or in denial. You did none of these things, and were able to learn what you could from a frightening event, which luckily turned out well for everyone. Thank you for sharing your reflections. Best, Dr. Shapiro

COMMENTS AoD#3 cont.

--, from your essay, it seems that your intuition about Mr. X was quite accurate – he did have a lot to teach you. We throw around this term – QOL – so easily, but it makes a huge difference to see how it actually plays out in someone's life. Death is not the worst thing that can happen to a person.

I was really impressed by the way you handled the hospice issue. In similar situations, I have seen the urgency of the staff to resolve the latest "critical" issue override the patient's readiness to address this issue. I liked the way you didn't lead with this sensitive conversation, but allowed Mr. X and yourself a little time to get to know each other; and for you to earn his trust. I also liked the way you didn't simply dismiss his desire for autonomy as "unrealistic," but understood its deep importance to his sense of self. In the dying process, it is often not possible to preserve so many things that we consider crucially important – autonomy, self-determination, even dignity. But *how* we relinquish them, and the empathy we receive along the way, are crucial. Finally, I admire that you retained a link with this patient throughout his dying process. It sounds as though you were open to all this gentleman had to teach you. Thanks very much for sharing this story. Best, Dr. Shapiro

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You know, --, I always wonder when people use language like "over it" or "getting past it," or "moving on" in conjunction with profound loss. How does that happen? And is it even desirable? I prefer your (ongoing) perspective of "coming to peace." And that too can fluctuate.

Since you have shared with me about your mom's passing, I hope you won't think it presumptuous of me if I tell you that I found considerable comfort in learning the manner of her passing. I don't like to use that phrase, "a good death," too casually, since I don't really know to what extent there is such a thing; but to be surrounded by your loving family, in your own home, with thoughtful last gestures is probably as close as it gets.

You describe very well the complexity of your feelings at the time of your mother's death. I think very often with protracted deaths that have involved a lot of suffering over months or even years, relief that the suffering has at last come to an end has got to be part of one's reaction. And then, as you so poignantly write, comes the irrevocable, gut-wrenching sense of loss. Indeed, everything you share is insightful and nuanced. You

acknowledge the immense value of spending that summer organizing your mom's poetry; but you don't simplistically assert that you were "healed." You note that your mom's death influenced your response to patients, but not always for the better, as it raised feelings of anger and resentment as well as compassion.

This essay shows all the painful but invaluable wisdom you've extracted from your mom's passing. You deserve great credit, --, for taking on this excruciatingly hard work. As you say, there's some good in everything; but I would add, not necessarily, only if you are brave enough to find it. You've allowed yourself to take in the joy and beauty of your mom's existence, and not see that as somehow disloyal to her memory. Working to release the very understandable anger and despair, you are left with a yearning based on your great love for her; but also the awareness that your mother is always in your heart. You are a very strong, as well as sensitive person, and your future patients (not to mention that future husband!) will be very lucky to have you in their lives. All the best, Dr. Shapiro

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--, I'm glad you decided to spend more time with this essay – and Mr. X. He sounds like a lovely gentleman, and I can see why you fell a little "in love" with him. The quote from Dr. Y (whom I deeply admire) is very apropos. I think all good doctors sometimes (even often) feel a kind of "love" for patients – from a kind of universal, agape love to a more personal kind of closeness. It makes sense, because patient and doctor, even if they only know each other in one dimension of their lives, can often share a special intimacy. To feel that love also raises questions of professionalism and boundaries; but I believe there is definitely a place for love within a relationship that is also completely professional.

It is a terrible thing Mr. X died; and also terrible that the third year student was the one who felt compelled to shoulder most of the responsibility. I wonder if what you experienced regarding Mr. X was not some variant of survivor guilt. Of course I know nothing about sterile fields, but I'd be shocked if your presence had the least bit to do with Mr. X's death. What seems to me much more likely is that it was an early (perhaps your first?) confrontation with death as a member of the profession supposed to stave off death; and that understandably Mr. X loss raised a lot of emotions and confusion for you.What seems tragic is that the team was only able to process his passing as a problem, a medical puzzle, when he deserved more. He deserved you mourning him at the ocean. And his family deserved more comfort and clarity than they received. Yet I can't help but feel sad that as a third year student you were delegated this overwhelming responsibility, all alone, without support or guidance. It is hardly surprising that you couldn't find the words you, or they, needed.

--, your tenderness and sensitivity I see as great assets in a physician. I'm sorry that the hard macho ethos is still so prevalent. As a future psychiatrist, you probably recognize this for what it is – a (not all that effective) defense mechanism. By turning patients into objects, and giving up their capacity to connect with others, so many of your peers are relinquishing a great part of what it means to be human. And it's not easy to turn it on

and off. Learning to work with your emotions as we've talked about in class is not easy either; but I know you will develop a balance between responding to the suffering of your patients and being strong enough to absorb their suffering without collapsing yourself. Then you will be one of those unique and precious physicians who can show medical students and residents how to feel fully but without fear.

Finally, I hope you have been able to release your guilt, if not your grief, over Mr. X's passing. I think most patients deserve a moment of recognition in their moment of death; and your willingness to witness his loss, and the connection you had with him, is both appropriate and commendable. I just wish you'd been able to share that moment with some of your team. Perhaps in the future that will be a practice you will bring to a team of your own. Thanks for sharing this story! Best, Dr. Shapiro

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--, thank you for sharing this story. It has many elements of a potential disaster – cultural and language differences, the often-difficult transition from curative treatment to palliative care, lots of pain, a very green medical student facing his first dying patient. It turned out much better than it might have, thanks to a family that was able to overcome their understandable distrust; a patient who was generous in his dying; and a very green medical student who thrust himself into this very tough experience with a lot of heart and as much Vietnamese as he could muster (and probably lots of other people also doing very good jobs). I am always reluctant to use the phrase "a good death," since I'm not really sure I know what that means. But in this case I agree that the patient had the death he wanted. In a way, although undoubtedly the experience had plenty of "bizarre" elements, it was not such a bad introduction to how to approach the impending loss of a patient. Best, Dr. Shapiro