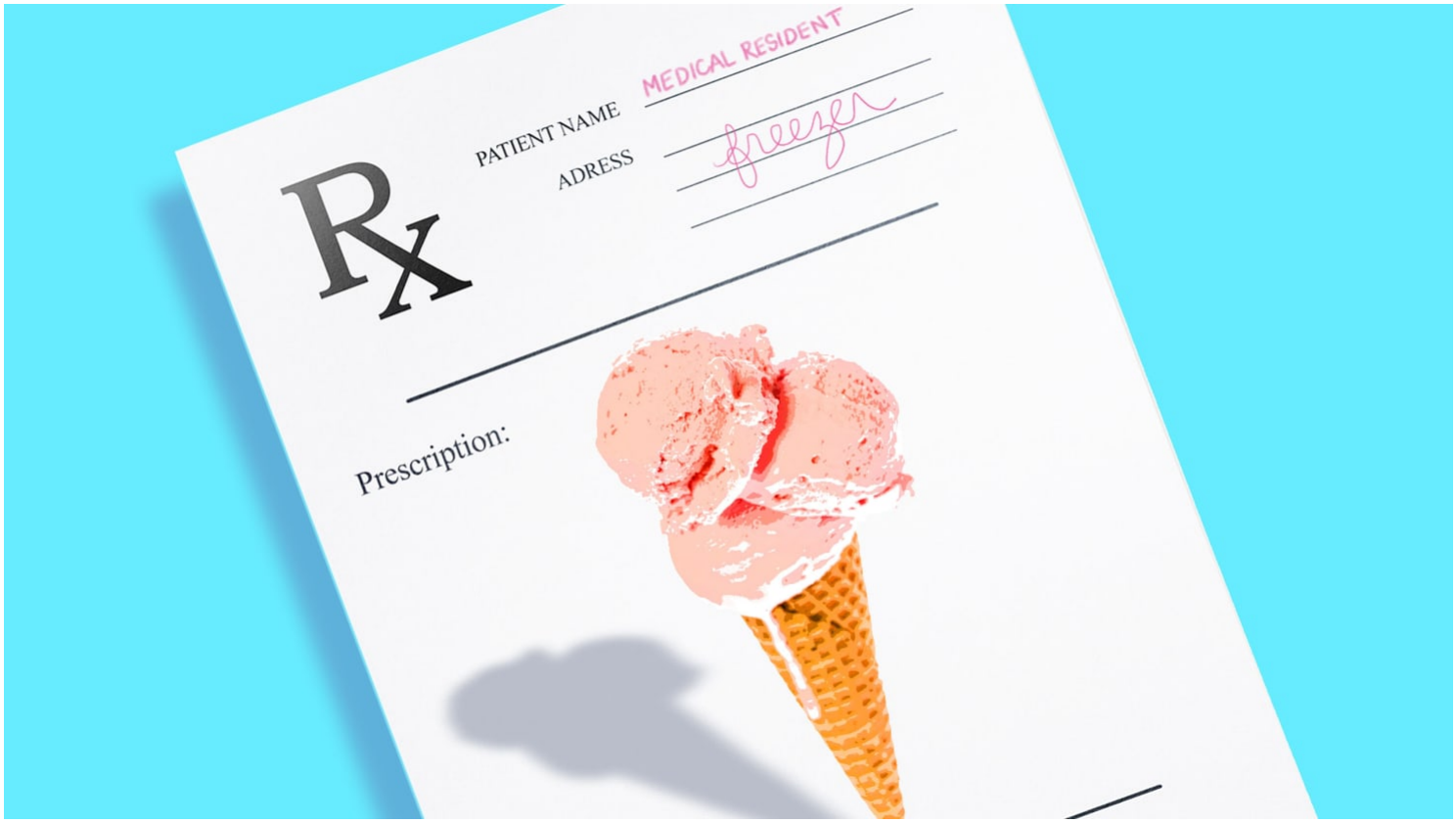

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SACRIFICE

When Doctors Can't Afford to Feel

Medical residents don't need ice cream and wellness weeks to survive grueling schedules and the deep trauma of patients and families. We need the wisdom of the Stoics.

DR. RACHEL PEARSON 04.30.17 12:15 AM ET

It's Resident Wellness Week at the children's hospital, and one of the coordinators has put ice cream in the resident fridge. Those of us who are working overnight shifts can't make it to most of the Wellness Week events—an aromatherapy session, a free yoga class, a whole hour where the hospital therapy dogs are available for us—so the ice cream is an effort to make us feel included. The coordinator comes by the cluster of computers in the emergency room where we are sitting to tell us about it.

At this moment, I happen to be placing a call to the orthopedic surgeons about a 19-month-old girl with a spiral fracture of the femur. I've already examined the kid, reviewed her x-rays and ordered her a dose of morphine. I have learned the name of her stuffed rabbit—Bunny. And after I talk to the surgeons I'll call the child abuse team.

The surgeon lets me know that they'll plan to place a spica splint in the morning, so I should admit the kid to orthopedics.

"And you're calling CPS?" he asks me. Spiral fractures are a classic sign of child abuse—a wound that is very difficult for a child to cause herself.

"Yeah, CPS is already here," I say.

"Who did it?"

"Her dad, presumably. She was alone with her dad when it happened. And the dude has a history."

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"Is her dad with her?" the surgeon asks me.

This is when the coordinator appears before our bank of computers. "There's ice cream in the fridge for you guys," she says, "so be sure to take a break and get some."

I cover the mouthpiece of the phone with my hand and thank her.

"Happy Wellness Week!" she says, and waves goodbye.

I uncover the mouthpiece. "Yeah," I tell the surgeon. "Her dad's in the room."

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Rumor has it that Resident Wellness Week began after an incident in 2000, when a pathology resident shot and killed his program director and himself. The supposed link between that actual event and Wellness Week may be apocryphal, but it's an apt metaphor: the resident training system responds to tragedy with a week of free ice-cream.

Resident wellness is a lofty goal, and my program actually does more than most to promote it. There is a jeopardy system that enables us to easily take days off when we are ill or in crisis. There is a deliberate effort to connect us with mentors. And there is unlimited, free confidential counseling for both us and our partners. But the fundamental barriers to well-being remain here as in other programs nationwide: our 80-hour workweeks, our massive debt-to-income ratios, and the accumulated grief of years of medical training. The first time I went to counseling was during my first month in the ER, when I had a week of day shifts, followed by a week of nights, then a week of days and then another week of nights. The therapist's first question was about my sleep schedule—the likely cause of my distress, but also absolutely beyond my control.

The statistics about physician wellness are oft-cited and bleak. Over the course of our careers, female physicians are three times as likely as similar women to die by suicide. Male physicians are about twice as likely as other men. One in 75 women doctors have actually attempted suicide. About 30 percent of residents are depressed, and we are less likely than

others to seek help for our depression. We also have higher rates of divorce and addiction than income-matched peers.

Such statistics are trotted out whenever one argues for reform in residency training. When in 2001 resident work-weeks were reduced to 80 hours, for example, it was hoped that we might be less likely to kill ourselves. When people advocate for less bullying of physicians-in-training, or shorter shifts, or more access to the creative arts in medical school, our astronomical suicide rates make a fair bargaining chip.

The goal of preventing physician suicide seems reasonable to me: suicide is concrete, measurable, and important. "Wellness," on the other hand, is fishy and elusive. The duty to promote one's own wellbeing can feel like another burden on our time, and the idea that we residents have control over our wellbeing—or much of anything in our lives—is laughable.

My residency program's individualized learning plan survey asks us what we are doing to promote wellness. I am able to list a couple of things in the box—I walk to work, I have a husband who makes me food—but the fact is I do not believe wellness is available to me. Not in this environment, and not at 80-hour weeks.

As one of my colleagues put it, "Wellness is bullshit. I'm trying to not kill myself."

Later, when I talked to the child abuse physician, she was on her way to the ballet. She pulled her car over to hear the story and write down the kid's medical record number.

"So what does the dad say caused it?" she asked me.

"He says the kid was running to pet a strange dog, and so he scooped her up in his arms, and she started grabbing her leg and crying."

"He scooped her up?" she repeated.

"Yeah," I said. "That's what he told me."

"OK," the child abuse specialist said. "And she's being admitted?"

"Yes," I said.

"Good. That gives me some time," she said. "Have you talked to the social worker?"

"OK," she said. "I'll call you at intermission. I haven't been to the ballet in years. I'm really excited."

"Oh wow, yeah," I said. "Have so much fun."

She did call again at intermission, and I could hear the chatter of the crowd behind her. I imagined her in a portico, on her cell phone, with a plastic cup of red wine beside her. I imagined she was wearing heels.

"What did the skeletal survey show?" she asked me. No bucket-handle fractures, I told her, but evidence of a healed skull fracture.

"Got it," she said.

"How is the ballet?" I asked her.

"Oh, it's beautiful," she said. "I used to dance, you know. I can't believe I've been away so long."

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In ancient Rome, a virtuous man was meant to be ready to serve the empire—as a statesman, or as a soldier—at any time. As the scholar Robert Proctor explains in *Defining the Humanities,* virtue was outward-oriented. Authenticity, which I understand as a sort of alignment of the inner and outer selves, would not emerge as a virtue for many centuries. Indeed, in Rome in 100 B.C. publicly displaying the turmoil of the inner self would've been a liability. A virtuous man, as Cicero wrote, would suppress the lower, emotional, feminine parts of his nature with the higher, rational, masculine parts. Cicero's work would be venerated by the Stoics, who also saw how emotional quieting—stoicism—could allow one to help others. As Marcus Aurelius wrote, "Thou must be like a promontory of the sea, against which, though the waves beat continually, yet it both itself stands, and about it are those swelling waves stilled and quieted."

As frankly misogynist as Cicero's articulation was, I think the model of Roman virtue fits medicine well. My team and I are the promontory; illness and suffering are the sea; the waves are the children and families we care for. For residents, the inner life is secondary to

By studying the Classics, we physicians could almost have coherent models of virtuous lives of service—if only we hadn't been raised in contemporary America. Here, the suppression of emotions is thought to cause mental illness and even cancer.

Addressing this problem in 1889, the physician William Osler argued that equanimity was the most critical virtue of medical practice. Osler revered the Stoics, and he defined equanimity as "coolness and presence of mind under all circumstances, calmness amid storm, clearness of judgment in moments of grave peril." This virtue is surely relevant to medicine—something to strive for over the course of a career. Yet even in 1889, Osler cautioned that equanimity was the quality "most appreciated by the laity though often misunderstood by them." Young physicians, your equanimity may make you seem like a robot, or an unfeeling monster. But it will help your patients in their moments of emergency.

Both Osler and Cicero in fact had emotional crises that demanded they leave their work. For both men, it was when they lost children. Cicero's daughter Tullia died in childbirth, and he became so publicly distraught that his friends suggested he leave work for a while and go to the country, which he did. Osler's son Revere was killed in World War I, and in his grief Osler lost the ability to practice medicine. In fact, he himself died not long after. The ultimate frailty of both men reminds me not only that profound grief impedes the kind of work we do, but also of the many smaller griefs we physicians witness, bear, and move away from to the next patient.

Wellness Week offends me precisely because it suggests that my work does not in fact demand the subsuming of my inner life. I enjoy ice cream; I practice yoga; I often bend to pet the therapy dogs. But I function best as a resident when I check my inner life at the hospital door, and ready myself to serve others. I reject the notion that I need to focus on some necessarily vain effort of cultivating my own "wellness."

My friends who have survived residency tell me that it is better on the other side. On the other side, there is leisure. Cicero called leisure *otium*, and argued that no serious thought could occur without it. In the Judeo-Christian traditions, the Sabbath—a weekly day of rest, reflection, and family activities—is crucial to the moral life. Wellness might be available to me if I could have *otium,* or a Sabbath, or—in contemporary American language—weekends off.

But in the absence of serious and much-needed reform to the residency education system, leisure is unavailable for me. I want to fight for that reform, but in the meantime I have two more years of 80-hour weeks. If I am going to survive them, I don't need ice cream. I need a coherent moral system.

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The girl with the femur fracture was still in the emergency room when my shift ended at 4 a.m. Most of her paperwork was done, so I didn't feel bad handing her off to the resident who would be there till seven. I had managed to send most of my kids home or get them tucked into the hospital. I sewed up the face of a kid with a dog bite, gave a couple little wheezers their asthma medicine, coordinated safety planning for a suicidal teen, explained to the family of a puffy toddler that we would probably be able to fix her kidneys with steroids, and pumped epinephrine into a sick, immunosuppressed infant—a kid with cancer—who tried to die on me. One baby did die in our ER that night, but I was not taking care of her. Towards the end of my night, the mother of a desperately ill 15-year-old—also with cancer, also with trashed kidneys—explained to me that her daughter would not need dialysis.

"She has begun to urinate again," the mother said. "Her kidneys are working."

"It's a very good sign," I said. "I'm so glad about it. But I want you to know she may still need dialysis."

"No," the mother told me, firmly. "We brought her in because she wasn't peeing, and now she is."

"I am so glad she is," I said, wearily, trying to be gentle. "Right now, the medicines are helping her pee. We will hope and work to support her without dialysis, but I don't want it to be a surprise if she needs that support." I worry I'm being too vague, and I repeat myself. "She may need dialysis."

"No," the mother said again.

"OK," I said, giving up. It was 3:30 in the morning. It was my tenth month of working 80-hour weeks. I had done my job, made no false promises, and I would let the kidney doctors carry on the conversation. We both looked quietly at the 15-year-old, who had fallen asleep.

Her face was covered in an angry rash because her immune system was attacking the bone marrow that was transplanted last year.

"She has…" the mother began.

"She has?" I asked.

"She has such a strong will to live," she said.

And I knew and she knew in that moment that her daughter probably would not live—not for long, not to adulthood, not like she wanted to. I sat a moment longer in that silence, sharing that unspoken knowledge, before I rose to leave.

The 15-year-old finally got a bed upstairs and left the emergency room, so the only patient I had to sign out was the girl with the broken leg. She'd been held up a long time while her custody was being transferred to CPS. But her pain was, as we say, "controlled," and she too had fallen asleep.

I told her story to my co-resident and explained that she'd already been signed out, so there wasn't much to do.

"Poor kid," my colleague said. And it occurred to me that I hadn't thought about that. I hadn't felt sad for the kid. I hadn't paused to feel anything at all. I do know that I was able to perform a service that the child needed, and similar services for a dozen other children that night. But even so, even to me, such smoothness in the face of suffering can seem monstrous.

"Yeah," I said. "Poor kid." And I went home, to sleep and then to wake to an empty house that I would leave again before my husband made it home from work. I never had that break to enjoy the ice cream in the resident freezer. I'm not sure if anybody did.

Rachel Pearson, MD/PhD, is a resident physician who also holds a PhD from the Institute for the Medical Humanities. A fifth-generation Texan, she is currently training as a pediatrician. Her book No Apparent Distress: A Doctor's Coming-of-Age on the Front Lines of American Medicine *is forthcoming in May from W. W. Norton & Company.*

Editor's note: The original version of this story incorrectly stated that William Osler's son died in WWII. He died in WWI. The Daily Beast regrets this error.