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Was I Enough? The Threat of Shame in Clinical Care

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Nearly two years ago, I wrote a story about looking after Emily and, more significantly, Emily's family.

I wrote the piece simply for my own reflection, and in the pursuit of closure — in the hope that writing the story would abate the rumination in my head and help me contain my own grief over Emily's death. The story struck a chord with my colleagues and within the community at large. I was moved by the discovery that the community genuinely cared — they cared about us as health care professionals who experience vicarious grief on a regular basis, and they cared about the fact that we truly care about them.

Somehow, in the midst of the tragic loss of Emily, there was a rainbow to be found — that we could celebrate the simple humanity that we exercised as an Emergency Department (ED) team that evening.

However, that same rainbow was accompanied by a vague, barely discernible thundercloud lurking in the outskirts of my consciousness. That cloud consisted of the following thoughts: Had I done enough for Emily? Had I tried hard enough? Had I in fact been enough?

Several weeks after Emily's death, the autopsy and subsequent coroner's report (triggered by her unexpected and unexplained death) revealed that Emily had died because of a sudden and catastrophic mechanical failure of her heart.

By the time Emily got to our ED, the excellent paramedic team had been trying to re-start her heart, or least maintain blood flow to the vital organs, for 45 minutes. When she got to us, an ultrasound showed that her heart muscle was not contracting at all, and a blood test confirmed that the oxygen supply to her organs had already reached a point of no recovery.

When I first received the ambulance call regarding Emily, I phoned our cardiology doctor to ask the question, "This is a young patient in cardiac arrest. Do you think ECMO* might be helpful here?"

> *ECMO is Extra-Corporeal Membrane Oxygenation and refers to a method of bypassing the function of the heart and lungs by using a machine that oxygenates blood outside the body.

The response was that unless we got her heart beating again, this would not be a viable option. Sometime after Emily arrived, and before we ceased our resuscitative efforts with her, (as I always do), I summarized my understanding of what was going on with Emily — that she had suffered a sudden cardiac arrest, that the cause was unclear but did not appear to be reversible, that we had evidence of permanent

damage to organs that were highly unlikely to recover. I asked the ED team if anyone had any suggestions to add to what we knew and had tried already, and then if anyone had objections to us stopping. I specifically asked the ICU doctor present if he had any input to offer. He shrugged sadly and said "No." So, we stopped our ongoing resuscitation and shifted the focus of our care to her devastated family.

In the months since then, I have thought of Emily often. There have now been two Mother's Days since Emily died and I think of her two young children no longer knowing the comfort of her voice, her hand, her embrace, her unconditional acceptance and boundless love for them. I think of her husband Brad — I will never forget the look of pure anguish on his face when I broke the news to him in the relatives' room that evening. I think of her Mum and wonder if the Emily-shaped hole in her own heart may have started to fill somehow. I have vicariously grieved for her.

There have now been two Mother's Days since Emily died and I think of her two young children.

At times, the dark cloud would hover more ominously than usual: Did I do enough for Emily? Did I stop too soon? Was there another option I may not have considered at the time? Should we have thought more carefully about ECMO?

It was more than 12 months later, while I was absently wiping my kitchen counter that the thoughts looming within this cloud were allowed to manifest into the spoken word. My dear friend, Audra Gedmintas**, who is an emergency physician and intensivist, was sitting across the counter drinking her third cup of tea while I was absently wiping it. In a moment of emotional recklessness, I mentioned the thoughts that had haunted me.

She looked at me over the rim of her mug, slowly placed the mug on the counter, leaned over and asked me gently but sternly:

"Shahina, why the f* has it taken you 12 months to talk about this?"

I replied: "Because I was scared that the answer would be yes. 'Yes, you did stop too soon. Yes, there was something different/better you could have done. Yes, you could have saved Emily — but you did not. That is why."

My grief over Emily's death was already immense. To add to it the knowledge that it may have somehow been my fault — that someone else may have been able to save her — would have been overwhelming.

Audra went on to tell me that, at a push, we may be close to having this capability now — to put someone in cardiac arrest on ECMO — but that even then the chances of meaningful survival would be grim. She told me definitively that we would not have had this option back when Emily came in. She told me that there was nothing different or better that I could have done to save Emily.

The figurative breath I did not realize I had been holding was finally released.

When I think about this experience now, and why I suppressed those fears for so many months, I recognize that what I was most frightened of was shame. Guilt that I had not done enough, but shame that I had not been enough.

A recent perspective in *The Lancet*[1] describes how crippling shame can be to physicians. We fear making errors, because we hold ourselves to high standards, but also because we greatly value what others — our

peers and our patients — think of us and our performance. To compound the issue, we even feel ashamed and humiliated over feeling shame and humiliation. As for suffering emotional struggle or mental illness, the stigma which still sadly perpetuates within our circles exacerbates our shame and our isolation.

Brene Brown[2] is a social worker and researcher who has conducted large studies on shame and vulnerability. She says this: "Shame thrives in secrecy, silence and judgement, and it wilts in empathy and connection."

Shame is likely a massive contributor to physician burnout — and empathy is its antidote.

What does empathy look like? It probably looks like the shared stories of struggle. It probably looks like the words "I have been there." It probably looks like the hope that if your now-okay peer or senior had a similar experience to yours, then you would probably eventually be okay also.

It is this outing of our own stories that gives others permission to struggle and it is this permission to fail and to be flawed that diminishes shame — and allows us to try again.

That afternoon in my kitchen, I mustered up the courage to risk failure. My friend Audra was there, and she took my vulnerability into her hands, gave it a gentle admonition for hiding for so long, offered firm and empathetic reassurance, and then assertively put my fear of shame to rest. (Thank you, Audra — "Bless").

**Audra's identity is used in this article with her permission.

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References

1. Lyons, B., M. Gibson, and L. Dolezal. (2018). Stories of shame. *The Lancet*. 391(10130): p. 1568-1569.
2. Brown, B. (2006). Shame Resilience Theory: A Grounded Theory Study on Women and Shame. *Families in Society*. 87(1): p. 43-52.