

PHYSICIAN, HEAL THYSELF

Megan Persson

Department of Family Medicine, Faculty of Medicine and Health Sciences, McGill University, Montreal, Quebec, Canada
megan.persson@mcgill.ca

KEYWORDS: Vulnerability, Crisis intervention, Self care, Family practice, Emergency Medicine, Mental Health

I found the patient sitting on a stretcher between two walls that served as a temporary room. It was a busy night, and the sounds of raised voices and ringing alarms ebbed and waned throughout our conversation. I closed the curtain behind me in an attempt to give some visual privacy, even if it couldn't block out much of the noise, and sat down beside them. I apologized for the limitations of the circumstances, knowing that I couldn't completely keep the conversation we were about to have from being overheard by those nearby.

They looked great for their age. Although in their nineties, they stood upright, mobilized easily without aid, and appeared comfortable. They were mentally quick, and physically well. In spite of this, they were now a patient in the Emergency Department after admitting to someone in their senior's home that they felt that they had nothing to live for.

They didn't have a plan to take their life, but they felt very alone since their spouse died. They admitted that a number of physical symptoms took a toll, even though it was considered normal aging. Nothing was easy anymore, and they wished that "we could just go at the time of our choosing".

As they spoke, I reflected on other patients I had met who seemed more at peace with their situation in much worse states of health. What was the difference between the two? Was it a clear division between health and mental illness? Was it the circumstances of loss? Could it stem from personality traits or outlooks on life?

© 2024 Megan Persson. This article is distributed under the terms of the Creative Commons License [CC BY](https://creativecommons.org/licenses/by/4.0/).

When they finished their story, I laid out our options, and they agreed to speak to psychiatry voluntarily. The next steps were obvious. Treat their grief and depression, and they should feel better. I left to write the consult, and while I saw other patients, psychiatry decided that they needed admission. They prescribed talk therapy, and medication.

In the scope of my shift, this was a memorable patient interaction, but one among many. It was a familiar story, and my decisions were straight forward. Once the details of their case were settled and handed over to the admitting service, I didn't think about them again until later. I might not have remembered them if I wasn't reflecting after my shift, having parallel thoughts of my own.

I was healthy and comfortable. I had social activities and pastimes that kept me active and engaged. I had work that felt valuable, friends and family that I loved, and things to keep me busy for my lifetime and beyond. I didn't feel anxious or depressed. The trouble was that I had reached the same conclusion that my patient had voiced. I just didn't feel like I had anything to live for.

Delayed gratification has always made perfect sense to me. Discipline. Sacrifice. This is how I achieved many things I am proud of. It's how I did well as a student and got into medical school. It's how I worked 24-hour calls and got through 100-hour work weeks. It's how I trained and ran a marathon, how I paid off a mortgage, and how I save for retirement. It's how I got to be where I am today.

I have started work needing to pee, only realizing at the end of my shift that the need had only gotten more urgent. I have felt hungry at work, but not touched the food I had brought upstairs in my locker, prioritizing the long list of pressing tasks amidst the chaotic interruptions that challenged my leaving the department. Only after handover of patient responsibility to a colleague would I consider my physical needs, and take the time to eat my lunch, often at supper time. I see others around me doing the same. The human body and mind are resilient. This is what needs to be done, and I have done it before. Others do more or have it worse. I can use my time off to rest and recover. This is a marathon, not a sprint.

For years following divorce, I found myself either working or caregiving. Any free time was spent recovering. I was exhausted. My sleep was irregular thanks in part to shift work's disruptive pattern. When my schedule had a series of day shifts, my mood improved, but I often couldn't sleep through the night, and I never woke up refreshed. In my physician brain, this was still explainable by multiple causes; negative life events meet pre-menopause, and an undeniable feeling of burnout from work. I was increasingly struggling with recurrent binge eating in my free time.

Still, I felt grateful. I enjoyed being in nature and hanging out with friends. I had proven over years that I could survive for an indefinite period of time like this, and I was certain that I could continue to do the same. I was surviving, but I longed to thrive again.

I engaged in psychotherapy to try and find a better way to live what was increasingly feeling like a chaotic work life. It became clear that I didn't have much control of taking care of my needs on shift. I did start to eat lunch as close to lunch as possible, justifying the time away from the needs of others with the analogy of fuel being needed for an engine. I concentrated on the control I had over the rest of my life after work. I ate when I had time and opportunity. I slept as much as possible.

I discovered that I had lost the ability to tell if I was hungry or full, tired from lack of sleep or fatigued for other reasons. I had such a narrow range of sensations that I couldn't even tell if I was happy or sad. I could no longer neglect my own body's sensations for the sake of everything and everyone else. I was consciously retraining myself to take notice of subtle changes that were important in acknowledging my mental, physical and social needs, as often as life allowed.

It took a weekend of reflection to lay it all out in my mind. Despite this self-care, on every shift that I worked, the needs of others were always greater than my own, until it had its cost on my mental and physical wellbeing. My state of mind mirrored my patient's, and it was reasonable to colleagues that they be admitted to hospital. I gave myself the same empathy and concern that I had given this patient.

I reached out to my family doctor's clinic and asked for an appointment. A few days later someone emailed to say that my doctor was not available, and asking why I needed the appointment. "Depression", I wrote, self-diagnosing, but it was obvious to me that it was true. I was called back, and given a twenty minute appointment at the end of the week with an available doctor.

I noted the time allotted, and reflected on how best to use it. I had interviewed enough patients to know exactly how to tell my story in the most succinct way. What a challenge for those who don't have the same experience and capacity to summarize with clarity and brevity. I considered potential outcomes to the conversation, and was open to start medications. I wondered whether or not this new doctor would be ready to do the same.

The interview was straightforward, and I surprised myself with tears while relaying the information with clinical focus. The physician responded with suggestions, clearly considering all the aspects of my mental state that I had relayed. As they wrote the prescription, I commented that I wasn't sure they would be comfortable to treat me so quickly since we just met. They shrugged their shoulders, smiling gently, and reframed the comment back to me. "I am sure you do that all the time in the Emergency Department".

I had to laugh at myself. It was true, but I had to acknowledge that I felt uncertain on how they would respond. In this quiet well-run office with ample light and closed doors, I was relieved to be met in a safe private space. Although the time was limited, it was enough.

There is an intimacy needed in medical interviews that can be elusive and the bond between doctors and patients can seem fragile. I do my best to honour these unguarded moments as a physician, and I am moved in learning how it feels to be on the other side of the equation.

Although the environments where these two interviews took place were very different, the needs and responses were similar. I suspect that my patient had the same concerns and hopes that I did as a patient. I wanted to feel I was listened to as I shared my truth. I wanted to be validated and wished for a plan to a better state of mind. I did not expect a guaranteed outcome, but it meant a lot to be understood and met with care. I hope that I met my patient's fears with reassurance, and that I too was *enough*, in their moment of need. ■

Biographical note

Megan Persson is a family medicine trained emergency doctor, and teaches for the McGill University School of Medicine.

She spends significant amounts of time thinking, reading, listening, and writing about the health care system and its impact on patients and health care workers in the intersection between community and hospital known as the ER.

She is grateful to work where those who seek care and those who serve them come together every day to provide the safest, most equitable, and humane service possible amid challenging circumstances with incredible creativity, perseverance, generosity, intelligence, and humour.