Henry Ford Health System
PHYSICIAN COMMUNICATION & PEER SUPPORT

In Shock, By Dr. Rana Awdish

In Shock is a first-hand account of illness and recovery by a young critical care physician who suddenly finds herself a dying patient. This transformation instantly lays bare for her all the things she had been blind to when she was "only" a physician. After hemorrhaging nearly all of her blood volume, and tragically losing her unborn first child, Dr. Awdish subsequently endures consecutive major surgeries and experiences multiple overlapping organ failures. As each moment passes, Dr. Awdish is faced with something even more unexpected- her fellow doctors' inability to truly see or acknowledge loss and human suffering. The exacting emotional distance was completely at odds with the vision of medicine she had aspired to, yet she recognized herself in every failure. She further identified herself as the product of a culture that had normalized clinical distance and hard-wired self-protective barriers into medical training.

I. Medical Training:

Awdish describes her medical education as being almost exclusively focused on diseases and their treatments. She believes that in many ways it was this paradigm that created a dysfunctional dynamic between doctor and patient, with each positioned on opposite sides.

In Shock proposes an alternate model, which is a more holistic approach; one that acknowledges imperfection, embraces compassion, removes protective barriers, and ultimately, recognizes that medicine has much to do to create resilient systems.

Guided Questions:

1. What is the value in just being present for someone else's suffering?

2. What emotions does attending to someone else's suffering evoke?

3. What would it look like to have the kind of emotional support you need to be the person/physician you aspire to be? What would that support look like in terms of training for physicians?

4. In a compassionate and holistic medical model where the doctor and patient partner in decision-making, what are the benefits and detractors for the patient?

5. From a physician's perspective, what have you experienced that you consider part of the "hidden curriculum" of medicine? Describe how the "hidden curriculum" impacts the physician's perspectives on patient care.

Reflection:

Think about a time when you felt like a healer? Describe that experience. What actions did you take? What did your actions elicit from others?

Resiliency

In Shock recognizes the importance of physicians having safe spaces to openly communicate their feelings, their fears, and their failures. There seems to be awareness on Awdish's part, however, that these spaces are also critical for their patients.

For example, she chronicles a moment where she was speaking with a close family friend about her terminally ill spouse and his impending hospice care:

"I think it's really brave that you are letting him talk about possibly dying…No one ever lets anyone talk about death, you know? Even when it's so close you can almost touch it" (111).

Another example is when Awdish recalls her recovery period. She remembers her colleagues sharing stories of their struggles with patients. Awdish acknowledges that while these disclosures were "framed as irritations or annoyances" she understood that they were really more about feeling helpless in a "flawed system." She explains this shared identity, this feeling of safety in the presence of colleagues, in the following way:

"I saw how much we all hurt in the same vulnerable places. That the shame of doing your best and never having it be good enough left its mark on each of us. And though we'd grown accustomed to never discussing it, there was a grace and a mercy to be found in sharing our pain" (190-191).

Guided Questions:

1. In the course of the book, what tools does the author, as patient, discover she needs to be able to foster resilience? What similarities do you see in what she (the patient) needed and what physicians need?

2. How might medical care change if physicians and patients more openly discussed death?

3. There are some metaphors of illness that are pervasive in medicine. You may have heard, for example, cancer described as a battle, with someone "fighting" the disease. In what ways do these metaphors affect how we talk about diseases?

Reflection:

Reflect on a time that you needed to find a safe space. Describe your safe space. If you could not find one at the time, how could you create one now? How do safe spaces allow for healing? Why do these spaces have value?

II. Barriers to Growth:

In Shock follows Awdish through a number of clinical situations in which she is labeled. In a review by Narrative Medicine Professor, Matthew von Unwerth, he notes, *"These experiences in which she is usually cast as a hypochondriac, a drug seeker, dramatist, difficult or an ingrate, catalyze her awareness of the importance of listening to and bearing witness to one's patient."*

A. Labels: Traditionally, most of the labels physicians assign to patients have a negative connotation.

The patient is belligerent
The patient is unrealistic
The patient is non-compliant
The patient is uncooperative

However, some labels are intended to have a positive connotation.

The patient is compliant.
The patient is positive.
The patient is cooperative.

Guided Questions:

1. Discuss some of the labels that you have used or heard applied to patients. How can positive labels have negative impact?

2. When a physician labels a patient, what does he/she eliminate? In other words, what do the labels leave out?

3. Is there a place for labels in medical care?

4. How did the labels applied to Awdish impact her process or recovery and relationships with her doctors?

B. Identity: At one point Awdish is attempting to put on her socks when she realizes, an hour into the process, how much her life has shifted. The terms she used to identify herself days before, no longer applied. She writes:

"I sat sore and exhausted, staring at the stupid yellow socks on my feet. I tried to integrate what had just happened into who I believed myself to be. I was apparently now a person who took over an hour to put on socks using a sock-hook. And I was a person who found it incredibly difficult… I didn't recognize myself" (80).

Later in the book, Awdish learns that she never actually had HELLP Syndrome. Her diagnosis included tumors that could be removed. She started to reimagine herself as someone who could get pregnant and she explains the impact her physicians had on her changing identity:

"These physicians did far more than engender trust. They were my soil, physically holding my anxiety so that the nidus of hope buried within my debris could grow in the direction of light…. Being buttressed by those physicians let me find the strength to trust my body again" (179).

Guided Questions:

1. Physicians can help patients integrate an acute illness into the context of the patient's life story. How are physicians uniquely suited to do this?

Reflection:

Think about a time when your identity changed so much that you had to work to recognize your new self? What helped you in this process? In what ways did it change how you interacted with other people?

C. Shame: At many points in the book, Awdish describes feelings of shame and the devastating impact they had on her. For example, she was ashamed that her body could not maintain the pregnancy.

Guided Questions:

1. What other experiences of shame affected Awdish??

2. How can a physician help patients see that vulnerability takes courage?

3. Awdish argues that medicine should be accountable for building reliance into its systems. How can we reconcile the balance of personal with institutional accountability?

D. Seeing Disease vs. Seeing People: Awdish views medical school training as doctors focusing on seeing only disease. She suggests, *"The patients were placeholders, positions in space where the diseases would land" (123).*

Another approach in medicine is to recognize the importance of taking time to hear patient stories. This allows physicians to see the whole person and to view each as more than the disease.

Guided Questions:

1. What are the benefits and the risks of focusing on disease as compared with the whole person?

2. In what way can learning patient stories lead to better care?

E. Flawed Models: Models include expectations of how individuals should act and behave. Medical models are no exception. They traditionally pigeonhole patients; frequently causing them to leave behind pieces of who they are.

An example is the way Awdish was treated when she didn't want to hold her deceased newborn. Her nurse, visibly disappointed, tells her she "*thinks it's really sad*" and that she "*won't get another chance*." She later tells her, "*A baby deserves to be held by her mother at least once*" (49). Awdish recalls these moments in detail, explaining the impact this interaction had on her:

> *"It struck me as unnecessarily cruel to ask me to hold a baby that had been dead in my mind for days already…. I felt as if she were asking me to bare a wound she had neither the intention nor power to heal…Ironically, in her attempt to provide me with closure, all she had left me with was an image of my decomposing baby" (49).*

Guided Questions:

1. In what way does the encounter described above display a flawed medical model?

2. What impact did this interaction have on Awdish? In what way was the impact of the message dependent on who delivered it?

Reflection:

Think about an area of your life in which you believe it's necessary to silence a piece of yourself to conform to someone else's "model." What feelings did this elicit in you? What was the outcome?

III. Notable Passages

In Shock contains several profound passages that seem to speak to a secondary meaning. Discuss some of the examples below.

1. There are a number of references to fate in the book, including a line from Haruki Murakami's Birthday Girl, *"No matter what happens to a person, he or she will always be who they were meant to be" (186).*

   In what ways does Awdish argue that fate was responsible for events in her own life? How might you discuss "fate" or "destiny" in the context of difficult situations?

2. Awdish describes believing that in medicine, *"everything matters, always" (63).* There is an unresolvable tension in this statement, given that there is no way to attend to everything.

   If we accept that it is not possible to attend to everything, what is possible? How might you prioritize?

3. The author describes her experience of hearing bad news in the passage, *"There are moments when you know that the words that come next will change your life forever. The challenge is realizing that your life had changed already, changed some time ago, in fact, and you are only just now finding out the details" (144).*

   In "naming" events, we create a "before" and an "after." We make them real. In what other ways does "naming" change the experience itself?

Reflection:

Physicians are often 'the first to know.' Armed with that information they are then charged with delivering bad news. For example, there are minutes between when a patient dies and when the physician actually tells family members of the death. Awdish writes about this when she describes her husband's drive home, when she knows about the tumor, but he does not:

"I had fifteen minutes until Randy came home, and I'd have to drag him into the abyss with me. I'd inhabited those spaces enough times. Times when I knew of a death or a trauma, and the family was still blithely unaware. I'd seen enough to know there was no benefit to foreshortening the space. No one stood to gain anything if I sped up the truth. I preferred to sit very still and wait. Let him enjoy these last minutes without worry" (147).

How does it feel when you are the keeper of a truth that will drastically alter another's life? In what way does HOW you speak impact the course of events? How can one person occupy the role of care giver while also being one who is affected?

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Guided Questions:

1. Which book passages stood out for you? Why did they leave an impression?

2. What was a defining moment for Awdish? How did it change her?

IV. Narrative Medicine:

In Shock displays an evolution in Awdish's understanding of the role of listening in healthcare. In the beginning she conveys an unspoken axiom: if a physician asks the right questions, the diagnosis will follow. Later, though, Awdish begins to understand that *"the emotions of the patients are encoded in their behavior" (69).*

This newer model acknowledges the benefits of honoring each patient's stories. Thus, the story becomes as important as the illness. This act of compassionate/active listening; ultimately reduces psychological distress, aligns patient with physician, increases adherence to treatment plans, and results in higher satisfaction with care**.**

Narrative medicine has been proposed as a possible antidote for many issues facing medicine today. Simply stated, it helps place 'clinical' value on the patient story. It is grounded in the belief that by listening, care providers invest in the patient's illness and recovery by developing trust and shared understanding. Narrative medicine has proven to be a powerful and effective method for achieving emphatic and effective patient-physician relationships.

Art and Medicine:

Awdish includes many references to art and poetry in her book. For her, art is a mechanism that allows the intangible (illness and suffering) to be visible. She explains, *"I would spend hours transforming illness into relic, in effect separating it from my lived life. This thing happened to me at this time, and this is what it felt like, now it's over and here, you can hold it. We can both look at it together*" (99).

Guided Questions:

1. Awdish describes art and literature as a first pass at making sense of emotion. What do you do to make sense of seemingly incomprehensible circumstances?

2. When viewing an image in print, we look for clues to provide insight into meaning. By examining pieces of the whole and decoding embedded symbols, we are able to expand our understanding. This may include color choices, positioning, facial expressions, etc. How might this practice of close attention be applied to our expanded understanding of people/patients?

3. The image that follows was created by Awdish, after a hospitalization when she was critically ill. What do you think she is portraying by the imagery?


Not Poison

Reflection:

Why do you think Awdish made this artistic choice? How might it relate to her practice of medicine?

V. "The Wound is the Gift"

In the final chapter, Awdish relates the story of divine light as told to her by one of her patients; it culminates in the phrase, "*The wound is the gift."*

The wound is literally the gift for Awdish. Only through her illness and recovery was she able to see the disconnects around her. It is ultimately this wound that enables her to fashion a call to action. She presents physicians with a new paradigm and rationale for embracing the emotional bond between doctor and patient. Her illness allowed her to contribute to an ongoing dialogue in the medical community around communication, empathy, and connection. Her book identifies resources that benefit both physicians and patients.

Guided Questions:

1. In what way does Awdish display her understanding of the statement: *The wound is the gift*?

2. What are qualities of care that Awdish believes would contribute to significant improvements in the practice of medicine?

3. Describe an event in your life that revealed itself to be a gift, though you initially would not have categorized it in that way.

Reflection:

Describe a time when someone close to you shifted your perspective on a difficult topic. What was memorable about that conversation. How did it alter your perceptions and future actions?

VI. Stylistic Considerations:

1. Awdish begins by letting the reader know that she survived her ordeal, has had a child and is still be practicing medicine. How would you have experienced the story differently if she had not made this stylistic choice?

2. Chapter titles, while short, each infer multiple meanings. What are different meanings that can be attributed to chapters entitled *Broken Vessels*? *A Hollowness?*

3. Use of vivid imagery to describe physical experiences is one way to share the un-sharable, or make visible, the invisible. What examples were particularly powerful? What resonated with you?

4. *In Shock* includes multiple references to water. How is water positioned as transformative within the text? What might water symbolize?

5. *In Shock* suggests an interesting duality. Awdish addresses the "wisdom of the body" in that it knew things she could not possibly know. She also highlights the body's incredible weaknesses and susceptibility to failure. In what way does this duality come full circle by the end of the text?

6. *In Shock* toggles between multiple perspectives. There are shifts from doctor to patient, patient to caregiver, doctor to parent. Which shift seemed the most difficult for Awdish and why? Describe a shift in your own life has been difficult.

7. Awdish employs dark humor even while depicting difficult situations. What do you think this narrative style does for the text?

8. *In Shock* delivers a number of universal messages. For example, the redemptive power of hope, the resilience of the human spirit, and the importance of compassion. Which of these messages resonates most with you? Why?

9. *In Shock* sends a strong message to the medical community; *"we can do better."* It suggests that there is reciprocity in empathy; that compassion is not depleting. From Awdish's perspective, compassion and empathy empower physicians to embrace a better healthcare model. How might patients participate in the adoption of this type of model?

10. Awdish describes the defining moment when she looks at the ultrasound screen and sees her unborn child no longer has a heartbeat. To this, the resident doctor, asks "*Can you show me where you see that?" (26).* In what way does this event serve to embody the main message of the book?