I will always remember the first time I interviewed a patient with suicidal ideation.

I (P.A.) was a third-year medical student on my pediatrics rotation.

The patient was a teenager recently admitted to our service for an intentional overdose.

I was a few months into my clinical clerkships, already feeling the exhaustion of perpetually changing services, preceptors, and expectations.

The patient was a few years into high school, already feeling the exhaustion of life, puberty, relationships, the COVID-19 pandemic, and all that it means to be an adolescent in today’s world.

The attending physician allowed me to conduct the interview while he documented the interaction. I asked questions; the patient answered. My father, a geriatric psychiatrist, always says that “patients are usually as comfortable talking about something as you are comfortable asking about it.” So, I tried to ask about everything that was relevant. What’d you take? How much? Why this way? Why now?

After the interview, the attending and I signed out to the night team and left the hospital. I cried in my car on the drive home, shocked by the words and experience of this fellow stranger. However, as every medical student knows, time is of the utmost importance. So, once home, I unpacked my lunchbox, repacked it, ate dinner, went to bed, and was back at the hospital by 6 AM. Processing that experience was simply another item on my checklist for later.

I (D.R.) was also a third-year medical student on my surgery rotation when I got called to the trauma bay. The incoming patient had a gunshot wound to the head. Adrenaline flowed as I did chest compressions for the first time and watched advanced life support protocols being activated. Gradually, the initial rush faded as the patient was declared dead and the wound appeared self-inflicted. As the patient’s parents arrived at the hospital to say a final goodbye to their child, who was close to our age, their agonal wails of sadness, disbelief, and recollection were seared into my memory. After the event I ate lunch alone, feeling numb. Before I could finish the last bite, I got a message: time to go; we have another case.

The concepts of burnout and compassion fatigue are nothing new to the field of psychiatry. In 1974, psychologist Herbert Freudenberger defined the term burnout out of his own experience: “exhaustion, disillusionment and withdrawal resulting from intense devotion to a cause that failed to produce the expected result” [1]. In the 1990s, Dr. Charles Figley coined the term compassion fatigue in an effort to better define a related phenomenon in practitioners [2].

While burnout is a long-term process, compassion fatigue arises more acutely. Patients experience a traumatic event primarily, and deal with the subsequent ramifications. Physicians experience this trauma secondarily and must also deal with a separate set of mental and emotional ramifications [2].

Our experiences are not unique. Nearly every physician has a story with a similar theme. Moreover, self-harm and suicide are patient outcomes which students are likely to encounter during a psychiatry rotation. But were any of us well-trained in how to respond to these experiences? Considering the increased frequency of these stressors afforded by the COVID-19 pandemic, how can medical schools effectively teach their students to deal with impending compassion fatigue?

Many institutions have launched “wellness initiatives,” updated their grading and ranking paradigms, and even the USMLE Step 1 exam has moved to pass/fail. Alternatively, some schools have taken a resiliency approach, attempting to teach students how to deal with inherent stressors. Though valiant, the efficacy of these changes, limited to imperfect assessments, remains to be seen [3].

There likely is not a one-size-fits-all approach. Regardless, the authors insist that students and trainees need to be pushed to recognize, reflect, and process these instances of compassion fatigue on a regular basis. We have independently found
sharing and processing our wide range of emotions with fellow medical students over coffee or dinner to be incredibly cathartic. Is there a way to replicate and teach this model that helps trainees identify and normalize their experiences? Existing models seem to show promise. A biweekly discussion group at the Mayo Clinic facilitated by internists demonstrated “improved meaning and engagement in work and reduced depersonalization, with sustained results at 12 months after the study” [4]. Balint groups, facilitated small group discussions for physicians invented in the 1950s, have shown success in improving the physician-patient relationship through identifying and processing relevant emotions. A recent randomized controlled trial demonstrated significantly increased empathy scores for medical students that attended Balint groups [5].

Checking on one another is also incredibly powerful. Two weeks after my (P.A.) interview with the suicidal teenager, my attending physician pulled me aside and checked-in on me. I was stunned. In that time, he had probably seen hundreds of other patients, put out countless fires, reasoned with unreasonable parents, and cared for other intentional overdose patients. Nevertheless, he remembered how hard I had taken that first interview and he checked back in. Getting to debrief that experience with my instructor was both affirming and formative. It was freeing to explain why I had taken that interview so hard, and to hear that he had also struggled with previous patient encounters. I grew professionally as I learned his approach to treating patients with compassion without getting too emotionally engaged.

Compassion fatigue is negatively impacting daily interactions with patients and leading to physician burnout. Instead of fiscally irresponsible initiatives that fail to address root problems, medical students need to talk about and normalize the distressing things we see as part of our training. Learning does not come from experience alone, but also from a reflection on that experience. Another simple way for each one of us to actively combat compassion fatigue is by checking in. With peers. With instructors. With students. But it is retroactive. Combating compassion fatigue is now, more than ever, of the utmost importance. And it needs to be proactive and institutional.

**Declarations**

**Disclosures** On behalf of all authors, the corresponding author states that there is no conflict of interest.

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