

SHAME IN MEDICINE: THE LOST FOREST

EPISODE DISCUSSION GUIDES

EPISODES 1-10

the
NOCTURNISTS





How to Use These Guides

Though shame is everywhere in medicine, the topic is taboo, which can make it difficult to discuss. To help, we've prepared discussion guides for each episode of our podcast documentary series, *Shame in Medicine: The Lost Forest*, to facilitate conversations between friends, colleagues, and leaders.

This discussion guide is for all 10 episodes of *Shame in Medicine: The Lost Forest*, which you can listen to [here](#). Individual guides are also available on the episode webpages.

For each episode, you'll find:

- Episode summary
- Notes from behind the scenes
- Discussion questions
- A medical trainee's reflection on the episode
- Links to claim CME Credit (more episodes coming soon).
- Additional resources

Talking about shame can be challenging, emotionally and interpersonally. We recommend checking out our [facilitator toolkit](#) for guidance on leading and organizing conversations around shame. You can find additional resources at thenocturnists-shame.org/engage.



Series illustrations by Beppe Conti



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To access all the episodes, head to thenocturnists-shame.org.

You can find additional discussion resources at thenocturnists-shame.org/engage.



Episode 1. Hello, Shame Summary

The Nocturnists teams up with two shame experts to investigate the nature of shame, and its role in the culture of medicine

Behind the Scenes

This episode came near the end of our creative process. We tried creating it first, but it was hard to know where to begin. How do you introduce a topic as massive as shame? We knew we wanted to lay out some basic definitions, discuss why shame was important, and introduce the team. We also knew we wanted to open with Will's shame story. It felt important that one of our "expert voices" model the courage and openness that our storytellers demonstrate throughout the series.

Discussion Questions

1. Which parts of this episode did you connect with, and why?
2. What physical sensations come up for you when you think about "shame"? What does shame feel like?
3. Can you think of moments in medicine, in your own life or for others, in which shame has been present? Has it been named as "shame," or has it not been named?
4. Do you think that shame is part of medical culture? Why, or why not?
5. Do you think shame has a role to play in medicine?



A Trainee Reflects on Episode 1. "Hello, Shame"

Reflection by a MS1 Student

"I connected with the family medicine resident's story because it helped me realize a fear I did not yet fully materialize – the fear of messing up and affecting someone else's life drastically. I only recently started medical school, so I have little to no medical student experience in clinical spaces. Yet, the story aligns well with the "perfectionist" mentality that I have been observing since my premedical years in the field of medicine. This mentality creates an environment where it is looked down upon to make mistakes, and it is expected of someone interested in this field to limit as many mistakes as possible.

The family medicine resident's story highlighted, for me, the reality that we all make mistakes, and that is okay. Even then, I feel as if there needs to be an open space to discuss shame and our vulnerabilities towards it. For example, later on in the episode, when I realized the speaker was a residency program director at Duke University, an "aha" moment clicked within me. If the program director has gone through episodes of shame and is still looked up as a leader in their field, it must be okay for others to make mistakes and feel shame. Yet, I find it almost rare to hear an attending or someone with many accolades in the medicine field to talk about their shortcomings and failures. If more and more doctors and "successful" medical students talk truthfully about their vulnerabilities and failures, the culture of medicine being a "perfectionist's" career can be dwindled. I often feel imposter syndrome because of this perfectionism, which has caused its own form of anxiety within me. If, perhaps, this culture were to be mitigated and an open conversation regarding vulnerabilities, failure, and shame were to become the norm, the wide issue of imposter syndrome in the medical field may be addressed.

Shame is a part of medical culture, and it provides an opportunity to learn, grow, and become a better physician. If we can be empathetic and understanding towards our patients and provide non-judgmental services, why can't we be empathetic and understanding towards our medical students and residents when they make a mistake and provide non-judgmental feedback and encouragement? I believe shame originates from the unreal expectation that students and residents must be "perfect" in their care, seemingly like their professors or attendings. Shame is normal and creates an opportunity for growth in physician training. This podcast series is one of many steps toward this growth mindset perspective towards shame. If more stories of shame are shared, perhaps we can use these stories to slowly mitigate the knee-jerk reaction that shame is bad and that it can cause an individual to feel unworthy and like an imposter."



Episode 1 Resources

CME Credit:

- Claim CE/CME credit for episode 1 with [VCU Health Continuing Education](#).

Listen:

- [The Nocturnists, Conversations: Cathy O’Neil on The Shame Machine](#)
- [Thales Well Podcast, “On Shame” with Luna Dolezal](#)
- [See Hear Feel Podcast, Luna Dolezal on Shame in Medicine](#)

Read:

- Tomlinson J. [A Better NHS](https://abetternhs.net). <https://abetternhs.net>. (See posts on [Shame, Empathy and Shame](#), [Shame and Redemption](#), and [Empathy, Shame and Medical Professionals](#).)
- Aubin D, King S. [The Healthcare Environment: A Perfect Ecosystem for Growing Shame](#). *Healthcare Quarterly*. 2018;20(4):31-36.
- hooks bell. [Moving Beyond Shame](#). In: [Teaching Community: A Pedagogy of Hope](#). New Delhi: DEV Publishers & Distributors; 2021.
- Ofri D. [Burning with Shame](#). In: [What Doctors Feel: How Emotions Affect the Practice of Medicine](#). Boston: Beacon Press; 2014.
- Davidoff F. [Shame: the elephant in the room](#). *Quality and Safety in Health Care*. 2002;11(1):2-3.
- Dolezal L, Gibson M. [Beyond a trauma-informed approach and towards shame-sensitive practice](#). *Humanities and Social Sciences Communications*. 2022;9(1).
- Gilbert P. [Shame and the vulnerable self in medical contexts: the compassionate solution](#). *Medical Humanities* 2017;43:211-217.
- Lazare A. [Shame and humiliation in the medical encounter](#). *Archives of Internal Medicine*. 1987;147(9):1653.
- Lyons B, Gibson M, Dolezal L. [Stories of shame](#). *The Lancet*. 2018;391(10130):1568-1569.
- Shame in Medicine project. [Shame Glossary](#) (work in progress).

Watch:

- Bynum, W. [The Shame Conversation](#). Duke University School of Medicine.
- UCL Centre for Perioperative Medicine. [Shame... An Interview with Dr Jonathan Tomlinson](#).



Episode 2. "The Ideal Doctor" Summary

Medical culture is filled with impossible ideals: the resident expected to work a 28-hour shift without complaint or error, the surgeon with the steel bladder, the doctor with perfect bedside manner, the student with all the answers. How should a doctor look, act, think, speak, dress, feel? What should they value? In this episode, we explore the archetype of "The Ideal Doctor." Where do these "ideals" come from? How do these ideals serve us, or harm us? And what do they have to do with shame?

Behind the Scenes

In this episode, we wanted to explore the tension between the "ideal self" and the "actual self," as this is the space where shame often arises. To start, we did some research into the origins of the concept of the "ideal doctor" and stumbled upon an old Hippocratic text entitled "The Ideal Physician."* Despite being written 2,000 years ago, we were shocked by how familiar it sounded. Deciding which stories to include in this episode was tough, as there were so many to choose from. In the end, we chose to go with a mixture of stories related to endurance, identity, and more.

** The collection of works known as the "Hippocratic Corpus" was written by a collection of physicians who lived around the time of Hippocrates. Hippocrates himself may have only written a handful of these writings.*



Episode 2 Discussion Questions

1. Which parts of this episode did you connect with, and why?
2. What does being an “ideal doctor” mean to you?
3. How does your current sense of self relate to that ideal?
4. Now, focus not on your ideal self but on an ideal environment. If you could imagine an ideal learning and working environment, what would that look like?
5. Medicine, like many professions, requires some form of standardization. Practitioners wear uniforms, communicate information in a particular way, and must follow certain standards and codes of conduct. But where is the tension between reasonable standards, and unrealistic or narrow expectations? How might medical culture allow for more individual and creative expression?



A Trainee Reflects on Episode 2. "The Ideal Doctor"

"The concept of what it means to be an "ideal doctor" has been reverberating through my mind throughout residency. I've looked to my own physician role models and seen elements I'd like to emulate and ones I'd like to do without. The themes discussed in this episode of The Nocturnists of ideals of endurance, self-expression, and altruism and where they come from mirrored many of the ideals with which I've wrestled. Listening to these stories, I felt sadness for the experiences of these healthcare workers and a profound understanding of their plight.

Just a few weeks ago, I had COVID myself and had to quarantine at home for a week. Listening to the story of the first resident, having to see patients and then suddenly needing 2 liters of fluid, epitomized that entrenched feeling of "I have to keep going. My patients and my co-residents need me." Though I was met with unconditional support by my co-residents and department, the guilt and anguish of feeling like I shouldn't have gotten sick persisted longer than any symptoms of the disease itself. This ideal of being superhuman and always oriented to serving others is a potent driver of intense shame experiences..

The challenges of being under constant critique and in high stress situations – as in the stories of the medical student Joy and the unnamed surgical PA – is a hallmark of medical education. For Joy, receiving constant feedback that she is "hard to read" and "not engaged" were proxies for not fitting a model of a certain type of student. I believe this model is formed by those who have been part of the majority group in medicine, and as we intentionally diversify the student body, we must have even more intention to break down that model and widen the umbrella for all manner of student expression.

The final two perspectives of this episode mirrored deep-seated feelings I've had during training. From the doctor who was inspired by her father, a small town doctor, suddenly finding herself in a maelstrom of career goals and expectations that didn't match her values to the student reading through a list of traits he could never achieve, the throughline of "I don't think I belong here" is a major driver of shame. I've had that thought countless times, even on the first day of medical school. I remember thinking I'd look down at the sign-in sheet on the first day and not find my name, knowing that my acceptance was a huge mistake. This feeling has needled its way into each phase of my medical training, though now being met by the evidence of patients who enjoy the care I give them.

I imagine many of these emotions and experiences won't leave us as we move through careers in medicine but knowing that these are shared experiences helps us break down the silos between us. Additionally, I see them as signals as moments to rest and consider where we are going and who we are becoming, with the hope that we can live out the values that brought us to medicine in the first place."



Episode 2 Resources

CME Credit:

- Claim CE/CME credit for episode 2 with [VCU Health Continuing Education](#).

Read:

- Dolezal L, Gibson M. [Beyond a trauma-informed approach and towards shame-sensitive practice](#). Humanities and Social Sciences Communications. 2022;9(1).
- Dolezal L, Rose A, Cooper F. [COVID-19, online shaming and health-care professionals](#). The Lancet. 2021;398(10299):482-483.
- Hippocrates. [The Physician](#). Workman B. K. They Saw It Happen In Classical Times. Oxford: Basil Blackwell, 1964. 64-65.
- Miles S. [Addressing shame: what role does shame play in the formation of a modern medical professional identity?](#) BJPsych Bulletin. 2020.
- Peters M, King J. [Perfectionism in Doctors](#). BMJ Editorial. 2012.

Watch:

- Goldman B. [Doctors make mistakes. Can we talk about that?](#) TEDxToronto 2010.
- Ofri D. [Deconstructing our perception of perfection](#). TEDMED 2015.



Episode 3. "Golden Ticket" Summary

We all arrive at the gateway to medicine carrying baggage from our past. We've had different hopes, hurts, and childhood arcs. How do these early life experiences guide us toward our careers? And once we "arrive," how do they impact the way we experience shame in the workplace?

Behind the Scenes

The train station metaphor really helped bring this episode together. We knew we wanted to discuss the way our pre-medical lives impact the way we experience shame in our profession, since Will's research shows that shame narratives are often set up very early in life – as early as childhood. During an organic team discussion, Will came up with this train station metaphor and we ran with it. It also offered a great opportunity for sound design and worldbuilding.

Discussion Questions

1. Which parts of this episode did you connect with, and why?
2. Imagine the baggage you've brought with you on this trip to medicine. Discuss, draw, or write about what you see.
3. What does the gateway to medicine look like to you? Consider other metaphors, besides a train station, that speak to your experience.
4. How has your healthcare career changed the contents of your suitcase? What are things you've let go of or added? What do you still carry?
5. What are the pros and cons of sharing your life story with others?



A Trainee Reflects on Episode 3. "Golden Ticket"

"The image of boarding a train, with years of baggage and countless questions about the journey ahead, is a beautiful and apt metaphor for embarking on medical training. I remember hearing my dean during the first days of medical school talk about how we would be taking on a dominant doctor identity over the coming years. I certainly hoped my identity wouldn't be all doctor, as I liked the other facets of myself, thank you very much. Over the coming years, I reckoned with—and continue to do so—all the experiences that made me choose medicine and also make me particularly vulnerable to the pain and suffering we witness. These certainly shape the doctor I am, and it often looks very different from other doctors I see.

The diversity of stories in this episode characterized some of the baggage folks bring to their career in medicine. The first voice mentions how 'markers of class became markers of pathology' and how she wanted to assimilate to 'reduce friction' between herself and her peers. I often think of the minefield our Black and Brown colleagues have to endure, given that the history of medicine has not only excluded them for so long but also considered them to be pathological. The experience of being in a classroom and learning that 'being Black' is associated with a myriad of diseases, when, in truth, race is being used as a proxy for the systemic racism creating conditions that promote illness. The shame that can emerge when that nuance and context is lost is profound.

The other narratives hit on countless important themes as well—the pressure to constantly succeed and strive, the silence that comes with family secrets, and the need to find the language to talk about those experiences. I was struck by the degree of trauma that each of these individuals carry, and I wondered about the trauma we've all packed away in our luggage. Would airing it out be helpful or too overwhelming?

The longer I've been on this train, the more my own luggage contents and weight have shifted. When I'm more tired, the weight is unbearable and I find myself trying to sit on my suitcase of feelings, to keep it all in. When I'm more relaxed, I can open it back up and reorganize the contents, occasionally unzipping corners to show close friends that I, too, packed way too much stuff for this trip.

I believe using this metaphor with learners and diving into the ways life shapes us could bring much needed healing and transformation to medical education."



Episode 3 Resources

CME Credit:

- Claim CE/CME credit for episode 3 with [VCU Health Continuing Education](#).

Read:

- Bynum WE 4th, Varpio L, Lagoo J, Teunissen PW. 'I'm unworthy of being in this space': The origins of shame in medical students. *Medical Education*. 2021.
- Dolezal L, Gibson M. *Beyond a trauma-informed approach and towards shame-sensitive practice*. *Humanit Soc Sci Commun* 9, 214 (2022).
- hooks b. Moving Beyond Shame in *Teaching Community: A Pedagogy of Hope*. 2003.
- Mantoo S. *Vulnerability and Shame in Medicine*. *FemInEM*. 2019.

Watch:

- Ngozi Adichie C. *The danger of a single story*. TEDGlobal 2009.



Episode 4. "Pass/Fail" Summary

On the path to medicine, we're constantly taking tests: MCAT, shelf exams, step exams, boards, and more. What are these numbers good for? What are they not good for? What is the emotional impact of these tests, and their scores, on medical learners?

Behind the Scenes

We didn't expect to create an entire episode about shame and testing, but so many of the stories we received were about this topic that it called out for its own spotlight. Here, we hoped to explore not just the pros/cons of using test scores to predict clinician performance, but also the outsized emotional experiences that test scores incite in medical learners, due to the way those scores are used to assign worth and open/close doors to different medical specialties. This episode felt especially relevant to our team, as one of our medical student producers was in the process of studying for Step 2 as we created this episode, and could speak directly to the extreme emotional toll it was exacting on them and so many of their peers.

Discussion Questions

1. Which parts of this episode did you connect with, and why?
2. What parts of yourself cannot be captured in numbers and external assessments?
3. Describe a time where you studied for an exam that would strongly impact your professional career.
4. What was your emotional experience of the studying process? Did your score impact your sense of belonging in the workplace?



A Trainee Reflects on Episode 4. "Pass/Fail"

"This episode dug up some old anxieties for me. I vividly remember my dedicated study period leading up to Step 1. I can recall sitting in my apartment trying to spend a scheduled evening to relax and feeling my heart beating out of my chest. I could not bring myself to relax even when I scheduled it in. My anxiety got so bad I actually ended up moving my test date sooner because I would rather not achieve my desired score or fail than continue to live in the anxiety riddled purgatory that is preparing for a high stakes exam where my entire potential as a physician would be boiled down to an arbitrary 3 digit score. I did pass but I also started my first SSRI by the end of my 3rd year as my anxiety continued to snowball from that moment on. I would say it was "generalized", but honestly it was related to my medical education which just generally consumed most every part of my life at the time.

Reduction of learners to scores, publications, and institutional pedigrees is common in medical education but the seeds of these fruits are sown much earlier. Growing up in a single-parent working class home in rural Tennessee, most people hoped a lot for me; however, they did not expect much from me. A seminal moment of my life occurred my junior year of high school. A tumultuous year that included my mother's second divorce and a devastating house fire gave me the impetus to change something in my life.

I elected to leave my Title I county school in order to attend the #1 ranked public school in the state (at the time) down the road in the next county over. It wasn't easy to get in the door. When my mom first called, they said they were absolutely full and could in no way accept students that did not live in the district. My mother was able to work into the conversation that I had taken the ACT the previous spring as part of the Duke TIP program and had received a passing score. Something unlocked when they realized this kid from the sticks could get into college as a high school sophomore. My name was passed along and luckily a family friend just happened to know the principal through the local Rotary Club and was able to advocate on my behalf. After 2 weeks of hopeful waiting, I got the call that I would have a chance to attend Oak Ridge High School. It was a ray of hope in an extremely dark time in my life, but it was also fraught with even more anxieties. I knew no one and was going from the proverbial small pond to big pond. I didn't know if I could even hack it given these students came from the families of engineers, PhD scientists, doctors, dentists, and lawyers all the while being afforded every possible educational privilege of a large well-funded school system. (Continued on next page.)



A Trainee Reflects on Episode 4. "Pass/Fail" (cont.)

My first day I remember getting to my 5th period class (AP US history) early. It was the first class after lunch and I felt safer sitting in an empty classroom than I did in the milieu of hundreds of kids I didn't know. The teacher was there, and they looked perplexed when they saw me. He asked if I was the new student from Oliver Springs. I responded in the affirmative.

They asked that I speak to him after class. I waited for the other students to filter out, thinking that this was going to be my "O captain my captain" moment where a faculty member saw my previously untapped potential and took me under their wing to help me unlock it. What actually happened was the teacher wanted to express their immense concern to me that I was not academically prepared for their course as it was the most difficult offering in the entire school. They said my coursework at my previous school paled in comparison to what their students had been doing since the time they were in 8th grade. They emphasized that I would be best suited to transfer to the non-advanced placement course. I remember holding back the tears as I simply said that I would still like to try my hand at it. I proceeded to ace the course and got a perfect score on the AP Exam. I made a point to pull the teacher aside at the end of the year and asked them to recount the first time we had met and what they had said. They apologized for thinking so little of me. I thanked them for the sense of spite which fueled my pursuits that year, but I also forgave them and thanked them for such a rigorous course which was the reason I came to the school in the first place.

Learners should never be reduced to one output or to an aggregate of standardized assessments that fail to capture the intricacies of their lived educational experience. They are nuanced and complex. Learners that have matriculated to UME and GME institutions represent the most talented and hardworking among us, however, their test scores and GPAs don't tell their stories."



Episode 4 Resources

CME Credit:

- Claim CE/CME credit for episode 4 with [VCU Health Continuing Education](#).

Listen:

- Academic Medicine Podcast, [Shame Experiences in Premedical and Medical Students](#).

Read:

- Bynum WE IV, Teunissen PW, Varpio L. In the “shadow of shame”: A phenomenological exploration of the nature of shame experiences in medical students. *Academic Medicine*. 2021.
- Bynum WE 4th, Uijtdehaage S, Artino AR Jr, Fox JW. [The Psychology of Shame: A Resilience Seminar for Medical Students](#). MedEdPORTAL. 2020.
- Cuneo C. N. [Make the Step 1 test for medical students pass/fail](#). *STAT*. 2019.



Episode 5. "Indoctrination" Summary

In medical culture, shame is often wielded as a teaching tool. We shame learners for not knowing, for forgetting, for making mistakes. When does this serve us? When is it harmful? Is there a better way?

Behind the Scenes

We got numerous story submissions from medical learners while making this series, and were struck by how difficult it was in many cases to distinguish between shame that resulted from overtly shame-inducing teaching practices, and shame that resulted from generally acceptable teaching practices but a person who was shame-prone for external reasons. It seemed important to at least try and distinguish these cases, and choose stories that mostly fall in the first category, because we were hoping to shine a light specifically on how baked-in shame is as a teaching tool in the world of medicine. In the end, this episode left us with more questions than answers: how do we create healthy learning environments in a high-stakes and public profession where shame is nearly inevitable?

Discussion Questions

1. Which parts of this episode did you connect with, and why?
2. Why do you think shame pervades the culture of medical education?
3. How much of shame-inducing experiences in medical education result from decisions of the learner versus reflect qualities of the teacher?
4. Think of a time you felt shame during your medical training. How did that experience impact your learning, and overall sense of wellbeing in the medical workplace?
5. How do you create an environment of psychological safety for learners?



A Trainee Reflects on Episode 5. "Indoctrination"

Reflection by a MS2 Student

"As a medical student just embarking on clinical rotations, I cling to the reassurances that the culture of medicine is changing, that shame will figure less prominently in my training than it has for generations of physicians before me. I take comfort in the growing attention to medical education as a field of research in tandem with initiatives to foster healthier learning environments by identifying and eliminating mistreatment. Yet, stories of humiliation like those told in this episode are a reality check; I will grapple with shame to some extent, despite well-intentioned teachers and concerted efforts to increase respect for trainees.

Some of these feelings may be experienced internally, like Emily's paralyzing uncertainty about how to react to a needlestick while learning a new suturing technique. I have only spent one day in an OR, but I could immediately relate to her description of feeling under an "aggressive gaze," and "watched like a hawk" by the scrub nurses vigilantly maintaining the sterile field. Imagining this environment dominated by a "swashbuckling" attending and residents routinely mocked by the rough attending themselves, Emily's determination to not interrupt the case or call attention to herself is understandable. The troubling consequence is that her insistence on minimizing the incident could have caused serious harm to her physical wellbeing.

With feedback as a primary teaching tool of training, harsh statements from superiors are another powerful source of shame for learners. One startling example in this episode is a response of a chief resident to an intern mistakenly discharging a patient without anticoagulant therapy. Upon learning of his error from his chief, the intern felt a gut punch. His confidence was then shattered at the conclusion of the call when the chief stated he could not be trusted to make decisions anymore, words that haunted the intern.

Delivering strongly negative feedback is also unpleasant for the giver. This was demonstrated by a later story told from the opposite perspective of a chief remediating an intern whose performance raised serious concerns for months, after which the chief struggled with his sharp critical approach. I hope that other leaders similarly reflect on whether their behavior perpetuates "constant self-critique" and question unkind aspects of medical training that have become normalized and rationalized as helping younger trainees learn from trial and error.

(Continued on next page.)



A Trainee Reflects on Episode 5. "Indoctrination" (cont.)

The argument that intense emotions can etch lessons firmly into our memory is one of the rationalizations used for the practice of putting learners on the spot, or "pimping." The medical student who is berated by her attending when she cannot identify an EKG rhythm as atrial fibrillation emphasizes during her retelling how she will never forget the distinctive rhythm. I, too, can clearly recall answers to several questions I have been asked in the hospital that I was not able to answer in the heat of the moment. However, the questions asked of me thus far have been posed in a gentle manner, designed to help me make connections and actively engage in my learning, in stark contrast to the behavior demonstrated by the attending in this story. There are boundaries of questions that will build a student's knowledge rather than chip away at their fragile confidence. I want to believe that egregious behavior, like that of the overbearing senior resident towards the final narrator during her residency, is an extremely rare occurrence in today's training settings. I will soon judge for myself how much the culture has truly changed."



Episode 5 Resources

CME Credit:

- Claim CE/CME credit for episode 5 with [VCU Health Continuing Education](#).

Listen:

- Academic Medicine Podcast, [Shame Experiences in Premedical and Medical Students with Dr. Will Bynum](#).
- Educator's Podcast, [Shame Resilience in Medical Education with Dr. Will Bynum](#)

Read:

- Bynum WE IV, Teunissen PW, Varpio L. [In the “shadow of shame”: A phenomenological exploration of the nature of shame experiences in medical students](#). Academic Medicine. 2021.
- Bynum WE IV, Adams AV, Edelman CE, Uijtdehaage S, Artino AR Jr, Fox JW. [Addressing the Elephant in the Room: A Shame Resilience Seminar for Medical Students](#). Academic Medicine. 2019.
- Bynum WE IV, Artino AR Jr, Uijtdehaage S, Webb AMB, Varpio L. [Sentinel Emotional Events: The Nature, Triggers, and Effects of Shame Experiences in Medical Residents](#). Academic Medicine. 2019.
- Bynum WE IV, Artino AR Jr. [Who Am I, and Who Do I Strive to Be? Applying a Theory of Self-Conscious Emotions to Medical Education](#). Academic Medicine. 2018.
- Bynum WE IV, Varpio L, Lagoo J, Teunissen PW. [‘I’m unworthy of being in this space’: The origins of shame in medical students](#). Medical Education. 2021.
- Bynum WE IV. [Filling the feedback gap: the unrecognised roles of shame and guilt in the feedback cycle](#). Medical Education. 2015.
- Bynum WE IV. [Assessing for Learner Shame Should Be a Routine Part of Remediation for Unprofessional Behavior](#). Academic Medicine. 2017.



Read (cont):

- Davies O, Dolezal L, Bynum WE IV, Wu C., and Berry H. [Needlestick](#). New England Journal of Medicine. 2022.
- Lindström UH, Hamberg K, Johansson EE. [Medical students' experiences of shame in professional enculturation](#). Medical Education. 2011.
- Lycette JL. [Shame Runs Deep in Medical Training; We Can Release It by Owning Our Own Stories](#). Medscape. 2021.
- Markman JD, Soeprono TM, Combs HL, Cosgrove EM. [Medical student mistreatment: understanding 'public humiliation'](#). Medical Education Online. 2019.
- Mumby H. [The Shame Spiral](#). The Shame Conversation. 2022.
- Shaw G. [What 'Learning by Shame' Does to Young Doctors](#). Emergency Medical News. May 2019.
- Ofri D. [Ashamed to Admit It: Owning up to Medical Error](#). Health Affairs. 2010.
- Whelan B, Hjörleifsson S, Schei E. [Shame in medical clerkship: "You just feel like dirt under someone's shoe"](#). Perspectives on Medical Education. 2021.
- Whelan B, Schei E, Hutchinson T. [Shame in medical education: A mindful approach](#). The International Journal of Whole Person Care. 2020

Watch:

- Goldman B. [Doctors make mistakes. Can we talk about that?](#) TEDxToronto 2010.



Episode 6. "The Mistake" Summary

For most clinicians, the idea of harming a patient is a worst nightmare. But in a high-stakes profession, practiced by humans in a dysfunctional system, errors are nearly inevitable. So how do we deal with the shame that follows?

Behind the Scenes

From the very earliest days of this project, we knew we wanted to create an episode about shame and medical error. The first cut of this episode was so emotionally devastating it was almost painful to listen to – which speaks volumes to the challenge and responsibility of working in a high-stakes profession like medicine. In our team conversations, we often referred to the concept of the “second victim,” a term coined by Dr. Albert Wu in 2000, which helps illuminate and address the severe psychological impact of medical error on clinicians. Since Wu’s article was published, the term “second victim” has been criticized by some who argue that it minimizes the fundamentally different impacts that error has on patients and families compared to clinicians. We sought in this episode to both affirm the humanity and emotionality of physicians, and acknowledge that these exist in concert with, not in opposition to, the struggles and pain of patients and their families.

Discussion Questions

1. Which parts of this episode did you connect with, and why?
2. What narratives have you been taught about error in medicine? How has this affected the way in which you think about your own practice? How could medical education be designed to teach the value behind mistakes (as opposed to the hidden curriculum that mistakes = personal shortcomings)?
3. Think about a time when you were involved in a medical error. What was your experience? Who did you lean on for support? What would be a part of your “emergency plan” the next time you make a mistake?
4. When we do make mistakes, how do we navigate the tension between individual responsibility and systemic issues?
5. How might we create more space in our culture to talk about shame and error? What are ways in which making mistakes and coping with them can be a formalized part of training?



A Trainee Reflects on Episode 6. "The Mistake"

Reflection by a Medical Resident

"Listening to this episode was at once both incredibly comforting and profoundly terrifying. I was comforted by the fact that I wasn't alone in the utterly unpleasant concoction of guilt, self-doubt and self-hatred that seeped through my entire being every time I made mistake as I started residency. The more I allowed that mixture to brew – the more isolated I felt. To hear my fellow colleagues in medicine (attendings no less) share heartbreaking (yet all too familiar) descriptions of the stupor they found themselves after their mistakes brought a much-needed relief. Their reflections helped me start to internalize that I am anything but alone in the medical errors I have made. However, given I am acutely aware that with more responsibility will come more mistakes – this episode sent my mind spiraling about all the future mistakes ahead of me. The problem solver in me makes me wonder – I know I will make many, many more mistakes, so what "emergency plan" (as one of the speakers eloquently put it) can I lay out for myself when they happen?"

The incident the IR attending shared with us about accidentally puncturing the patient's heart struck me in a way I didn't anticipate. What was most surprising to me about that story was not the mistake itself, but rather that the attending immediately disclosed his error to the patient and their family, without talking to risk management. He told them plain and simple – he made a mistake, how exactly he made the error, and he was sorry. In the aftermath, at least from what was shared in the episode, it seems the patient and their family moved on. They saw this IR attending as what he was – a human being – and moved on. In our day-to-day non-work, non-medical lives – when we make a mistake that impacts a person that trusts us and we care about – don't we apologize to them directly? And, most of the time, doesn't that person end up forgiving us? I strongly believe that a significant propagator of shame around medical errors is the teaching that we are to firmly draw "personal barriers," with patients. Granted there are some basic barriers that need to be drawn for the protection of all parties, but at what point did these barriers make us out to be these superhuman entities that were programmed for 100% success? If I was a patient and was taken care of by a provider that was never once vulnerable with me, I would of course be frustrated with them when I found out they made a mistake. If the expectation is 100% success, anything less is met with overwhelming disappointment. *(Continued on next page.)*



A Trainee Reflects on Episode 6. "The Mistake" (cont)

I have thus started to try to balance the act of not only being confident with my patients about my medical assessments and plans, but also appropriately vulnerable so that they can see my limitations. Sometimes that sounds like me saying something as simple as, "It's 9am and I am on my 3rd cup of coffee!" I'll be the first to admit my "n" is pretty low compared to my senior colleagues – but so far, that's worked! That outflow of vulnerability my patients are receiving engenders an understanding of my limitations as a human being.

At this point, naturally, the argument that 100% success should be the expectation when human lives are at stake emerges. But realistically, should it? As human beings, we are all inherently fallible. Nothing makes us less so. Not as on organic chemistry in pre-med, not 250+ scores on Step 1 or 2, not perfect OSCE grades. Yet again and again in medical education we are fed this lie that perfection is and has been attained by running the race of "who can make the least mistakes?" So when it comes to my emergency plan I'll remind myself of two things – 1) I am equally as likely to make mistakes now as I was before medical school and 2) vulnerability with patients allows for realistic expectations of me. So, when the time comes that I make my next mistake – my patient will hopefully attribute that to the inevitability of my humanity. And maybe, just maybe, one day I'll see the inevitability of my humanity for what it is too. It doesn't make me less so, or less than, it makes me – me."



Episode 6 Resources

CME Credit:

- Claim CE/CME credit for episode 6 with [VCU Health Continuing Education](#).

Read:

- Clarkson M D. Haskell H. Hemmelgarn C. Skolnik P J. Abandon the term “second victim.” *BMJ*. 2019.
- Davies O, Dolezal L, Bynum WE IV, Wu C., and Berry H. Needlestick. *New England Journal of Medicine*. 2022.
- Mumby H. The Shame Spiral. *The Shame Conversation*. 2022.
- Ofri D. Ashamed to Admit It: Owing up to Medical Error. *Health Affairs*. 2010.
- Ofri D. My Near Miss. *New York Times*. 2013.
- Ofri D. *When We Do Harm: A Doctor Confronts Medical Error*. Boston, Beacon Press. 2020.
- Wu AW. Medical error: the second victim. The doctor who makes the mistake needs help too. *BMJ*. 2000.
- Zabari ML. Southern NL. Effects of shame and guilt on error reporting among obstetric clinicians. *Journal of Obstetric, Gynecologic, & Neonatal Nursing: Clinical Scholarship for the Care of Women, Childbearing Families, & Newborns*. 2018.

Watch

- Goldman B. Doctors make mistakes. Can we talk about that? *TEDxToronto* 2010.
- Ofri D. *Deconstructing Perfection*. *TEDMED* 2015.



Episode 7. "On Trial" Summary

1 in 10 physicians will get sued at some point in their career – but physicians rarely discuss this, much less prepare for it. How do we bring litigation, and all the stress and shame associated with it, out of the shadows?

Behind the Scenes

In October 2021, Emily came across a post from a physician on social media describing a time she had been so overworked that she would trap her ponytail in her car window in order to keep herself from falling asleep while driving home. Emily reached out to this physician to see if she would be willing to submit a story for our series, and in her response, she told us she had actually started her own podcast, “The L Word,” which focuses on helping physicians navigate the practical and emotional challenges of malpractice litigation. Dr. Gita Pensa was such a compelling storyteller that the entire episode came to rest on her personal story, with some additional contributions from other clinicians who have faced lawsuits.

Discussion Questions

1. Which parts of this episode did you connect with, and why?
2. To what extent have you received education in your medical training about malpractice and lawsuits? What kind of education?
3. How does the messaging about lawsuits impact the way you view yourself, your colleagues, and your patients?
4. In the episode, Dr. Gita Pensa talks about the gray areas that healthcare workers inhabit in every day, despite the culture's expectation of perfection. How do you navigate this gray area?
5. What would it take for physicians to feel psychologically safe discussing litigation, and the stress and shame associated with it?



An Attending Reflects on Episode 7. "On Trial"

"One of the first (of many) images and talking points that resonated while I listened to the episode was Dr. Gita Pensa's noting that she felt like Alice in Wonderland. In my professional career, I have never felt so unmoored and disoriented as I did during my experience with a malpractice suit.

Along with a changing roster of physicians (all trainees at the time) and nurses, I was named as a co-defendant in a suit alleging a delay in diagnosis that resulted in the death of a 7-week-old infant. We went to trial with an amazing attorney team that coached us individually and together (after depositions), sought out additional support (witness consultant) and even set up a mock trial to allow us to practice. We were able to prove that we provided the best possible care and that the unfortunate outcome could not have been avoided at the time of the baby's presentation to the emergency department. There was no subsequent appeal. Unlike Dr. Pensa's drawn-out saga, a little over four years elapsed between the time I was named to the end of the trial, with the case occurring over 1.5 years earlier.

I wrote the above paragraph calmly and relatively dispassionately which is a far cry from my actual experience. When I was first notified, I was in the throes of an incredibly busy first year of fellowship. I had just started dating my now-husband. Similar to Dr. Pensa's experiences, I had never received any formal or informal education about being involved in a case and was devastated. I couldn't legally talk to anyone in detail; in retrospect, I should have advocated for myself and carved out time for therapy. The overwhelming shame of letting new mentors and colleagues know (would they doubt my acceptance into the program?) or talking to old ones (would they want to acknowledge that a former trainee was in this situation?) made me start conversations only to have them fade away like the Cheshire Cat, or not even start them at all. This was the one and only time I truly doubted my decision to become a doctor, and I wondered if I should even continue. What was the point? Like Dr. Pensa, I didn't know that I too was suffering from "textbook litigation stress" and that it was appropriate to feel lost and not know my next steps. I also appreciate her noting that her sadness was both about her patient and her (sense of) self.

Continued on next page.)



An Attending Reflects on Episode 7. "On Trial"

Alice struggled with new words and new language puzzles especially in Through the Looking Glass – Why are the borogoves mimsy in the poem Jabberwocky? Did the White Queen ever eat jam if she only ate it yesterday and tomorrow, but never today? Similarly, Dr. Pensa captured the feeling of not having the right skillset or language. For physicians used to explaining everything, answering deposition questions with a “yes” or “no” and actively refraining from providing additional detail is extraordinarily difficult and disorienting. How does one explain “bread and butter” pediatrics to a jury of one’s peers who are not in fact one’s medical peers? Similar to Alice stating at the end of her own trial in Alice’s Adventures in Wonderland that they were “nothing but a pack of cards”, I reframed the jury as 12 parents to whom I was explaining their children’s care, focusing on them and not the plaintiff’s attorney.

My trial ended over a decade ago. The shadows are long but I have tried to find a silver lining among the clouds. In my state, I no longer have to include the malpractice case in my re-credentialing and licensure paperwork. It was a simple matter (a few lines of explanation that I drafted with my lead attorney and have duly copy and pasted each time) but the lifting of that small shame burden (more people will know about this and doubt me?!) was not to be underestimated. The fear that Dr. Pensa discussed arising from that shame also led me to overdocument my thought processes in written notes. However, a few years after my case ended, I began offering an interactive session with the lead attorney for junior residents (and occasionally others) telling my story and providing information about what trainees should know about malpractice. The feedback has been overwhelmingly positive; residents express gratitude for my sharing such a personal narrative and for an attorney sharing her time and expertise.

Being on trial will always be a part of my medical career. I am grateful for Dr. Pensa’s outlining our similar trajectories through shame, fear and acceptance and that this experience can be a teaching opportunity for others."



Resources

CME Credit:

- Claim CE/CME credit for episode 7 with [VCU Health Continuing Education](#).

Listen:

- [“Doctors and Litigation: The L Word”](#) podcast with Dr. Gita Pensa. For more information on Dr. Gita Pensa’s work, head here.

Read:

- Dodge AM. [When Good Doctors Get Sued: A Practical Guide for Physicians Involved in Malpractice Lawsuits](#). 2015.
- Mehlman MJ. [The shame of medical malpractice](#). *Journal of Legal Medicine*. 2006.
- Ofri D. [Owning Up to Medical Error](#). *Health Affairs Journal*. 2010.

Get Support:

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You can also [call or text 988](#) to reach the [Suicide & Crisis Lifeline 24/7](#).

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Episode 8. "In Hiding" Summary

When healthcare workers put on their uniforms to go to work, what other roles, masks, or disguises do they put on as well? The norms and standards of our workplace culture are often more implicit than explicit, but many of us still go to great lengths to present a curated version of self at work that fits into this unspoken code of conduct. The right mask, we tell ourselves, will win the respect and trust of our colleagues and protect us from painful judgments and feelings of alienation. But what are the side effects of hiding parts of ourselves at work? And what about the parts of ourselves that remain exposed?

Behind the Scenes

We received several stories from women that focused on shame and the body, so when we started imagining this episode, we believed we might be making one about shame and gender. But once we started cutting together the episode, we realized that even more than being about gender, these stories were about shame as a result of needing to hide something about oneself, or the flipside — being exposed in a way one cannot control. In each of these stories exposure, or the threat of being exposed, have tangible (and often harmful) impacts on the lives of the clinicians, which may come into conflict with the universal human desire to be seen and loved just as one is.

Discussion Questions

1. Which parts of this episode did you connect with, and why?
2. What are the norms and standards in your workplace culture that influence how you present yourself?
3. How do you decide which masks to wear in your professional environment? How do those masks hold up in other spaces, and when do you take them off?
4. Reflect on the following quote: "My disability feels like a flaw or a deficit. And in a field like medicine where perfection is so highly prized, there's always this feeling that's lurking in the background that I am not good enough, and when others find out, I will lose everything that I've worked so hard to attain." (24:09).
5. How do shame and embodiment intersect with the expectation of the "ideal doctor?"



A Trainee Reflects on Episode 8. "In Hiding"

Reflection by a MS2 Student

This episode truly felt like a warm hug. It was proof of something that has not been very apparent in medical school thus far, as I am taught by expert clinicians with 5 faculty positions, unique hobbies, and smiling family pictures included on their "About Me" slides – that doctors are like me: flawed, messy, and struggling through the trials and tribulations of adult life.

While I am grateful for the escalated attention on physician wellness and the resulting addition of sessions like "patient reflections" and "physician identity formation" to my class schedule, I wish that personal topics beyond difficult patient encounters and exam stress were similarly ripe for discussion. Group "check-ins" at the start of classes limited to "surgery or medicine?" or "favorite Thanksgiving foods" do not quite set the stage for unburdening the heart. As a hopelessly bad compartmentalizer, I struggle to meet the expectation that my personal life must disappear in the clinic and classroom, when my professional life takes over. The breast milk vignette in this episode perfectly captures the shame that arises when these two lives intersect. I felt a similar sense of shame when I said I was "sick" instead of admitting I was too heartbroken to come to class after a breakup, or suffered in the back of a classroom, hesitant to excuse myself due to excruciating period cramps. The illusion that vulnerability is at odds with professionalism keeps me, as the title of this episode articulates, "in hiding" during my work life.

In medical school, the importance of the social history is frequently emphasized; we are taught that the social, spiritual, emotional, and intellectual components of wellbeing are as important as the physical. Yet during training, we spend 10+ hours a day hiding our own fear, heartbreak, loss, and pain. I would love to experience the same inviting, nonjudgmental atmosphere I have felt doctors establish in patient exam rooms in classrooms, on-call rooms, and breakrooms.

As the vignettes shared in this episode highlight, sharing of deeply personal issues like eating disorders, physical disability, and addiction is not only shameful, but may also be dangerous professionally. I myself have chosen to see a therapist in private practice after hearing horror stories of medical students forced to abandon training after sharing sensitive information with campus health services. The response to mental and physical distress among medical professionals needs to change – it should result in rehabilitation of caregivers, rather deeming them unfit to work and making recovery all the more difficult.



Resources

CME Credit:

- Claim CE/CME credit for episode 8 with [VCU Health Continuing Education](#).

Listen:

- [“Docs with Disabilities”](#) podcast

Read:

- Dolezal L. [The Body and Shame: Phenomenology, Feminism and the Socially Shaped Body](#). 2015.
- Gordon E. [Doctors With Disabilities Push For Culture Change In Medicine](#). NPR. 2018
- Piepzna-Samarasinha LL. [Care Work: Dreaming Disability Justice](#). 2018.
- Taylor SR. [The Body Is Not An Apology](#).

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Episode 9. "The Unwell Doctor" Summary

According to medical culture, clinicians must be invulnerable. A clinician's job is to "fix" illness, not have it – especially mental illness. But in reality, mental illness is incredibly common, and a huge source of shame, which may prevent us from seeking help. In this episode, we'll hear stories of sadness, "madness," stigma, grief, and the potential for healing. If you are struggling with mental illness, you are not alone.

Behind the Scenes

Of all the episodes in the series, this was one of the most difficult to choose stories for. The theme of shame and mental illness came up over and over in the submissions we received. Sometimes it was explicitly named, and other times it was a more peripheral notion. What seems clear through listening to these stories is that emotional struggle and mental illness are inevitable side effects of a medical culture that expects perfect performance in a broken system, with few structures or outlets for dealing with the emotional impacts of this work. In the end, we selected a mix of voices that we hope gives a taste of the wide variety of stories we received. While this topic is incredibly important, it's also intense, so we recommend taking good care of yourself before, during, and after listening.

Discussion Questions

1. Which stories in this episode did you connect with, and why? How did you respond when you were in similar situations?
2. In the episode, one individual shares how medical providers often perceive that "sickness is out there in the patients, and as doctor-medical trainees, we're totally immune." How does this belief impact healthcare workers' identities? How do you think it impacts patient care?
3. How do you see the current culture of medicine with regards to its stance on mental illness? What experiences have led you to this viewpoint?
4. How do you think we, within the medical community, can more fully and openly support each other with regards to mental health, shame, burnout, and need for self-care? What are things that stand in the way?



A Trainee Reflects on Episode 9. "The Unwell Doctor"

"Shame, as the topic of the podcast, discussed through different trainees' experiences, is ever present in medicine. It is present in the fear that in asking for help, we will never again be seen as competent. It is present in the assumption that to prioritize diagnosis and treatment as we've been taught, our emotional and spiritual experience can simply take a backseat. It is even encouraged in the reward of self-sacrifice in exalting this behavior as exemplary, which therefore names any self-care as inferior.

During my training, there have been times of explicit and weighty shame, but more persistent is the shame that lives in the shadows and assigns value judgement to my every choice, action, and conversation. On clinical rotation, I was proud of myself for taking steps to promote my mental health – scheduling regular appointments with my psychologist, asking for time off to attend meaningful events with family and friends, and communicating authentically with my seniors when I didn't feel well or simply had various other, non-clinical-care needs.

What I didn't expect was that as I prioritized maintaining some semblance of balance in my life, I would feel a guilt that at times led to intense shame. Was I grateful enough that my seniors would make time for my learning in the midst of their responsibility, if I was also occasionally asking to leave during the work day? Was I honoring the privilege of knowing other individuals, including patients, if I didn't appreciate the opportunity tirelessly? Was I respecting the fact that other trainees were facing many of the same difficulties yet accepted their lot and fought through with grit – why did I feel that it was acceptable for me to prioritize my needs, which was outside of the status quo?

With all of this, it is no surprise that shame is present and often heightened when providers experience mental illness. From listening to each experience in this podcast, it was made clear to me that it is not just the shame of medical training at play here, but the shame of being a patient, as well. Current medical care, no matter its emphasis on patient centered care, often continues to other the patient, who is sick and requires our help, and from these roles is seen as intrinsically different. This was clear in the experiences of these individuals, who shared feelings that they would be seen differently if they shared their symptoms and subsequent needs such as medication or inpatient hospitalization. Fulfillment in providing good care to a patient is why many go into medicine and should not be vilified, and sometimes this does require temporary dissociation.



A Trainee Reflects on Episode 9. "The Unwell Doctor" (cont)

However, when a provider's ego employs defense mechanisms, telling them that they have more knowledge, they are healthier, and somehow they are therefore better than their patient, it separates the two, who without their labels are simply two human beings. This encourages shame for medical professionals when they themselves are sick; for individuals with mental illness specifically, the thought that one can just think, or meditate, or talk their way out of it only compounds this shame. As Alice Flaherty points out, we are making strides, and continuing to have these conversations give us the opportunity to have some reassurance and improvement. However, until medicine regards patients differently, it will not treat physicians differently either."



Resources

For a curated list of resources on prioritizing healthcare workforce well-being, check out the [ALL IN Solutions Library](#).

CME Credit:

- Claim CE/CME credit for episode 9 with [VCU Health Continuing Education](#).

Listen:

Spitzer G. “[Meet The Doctor Who Saves Doctors.](#)” KNKX Public Radio. 2016.

Read:

Henderson M, Brooks SK, Del Busso L, Chalder T, Harvey SB, Hotopf M, Madan I, Hatch S. [Shame! Self-stigmatisation as an obstacle to sick doctors returning to work: a qualitative study.](#) BMJ Open. 2012.

Dr. Lorna Breen Heroes’ Foundation. [Remove Intrusive Mental Health Questions from Licensure and Credentialing Applications.](#)

Get Support:

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Episode 10. "Until We Meet Again" Summary

Over the last nine episodes, we've listened to dozens upon dozens of clinicians tell their stories about shame. For this last episode of Shame in Medicine: The Lost Forest, we let the series fold back in on itself. What have we learned? What can we take away from all of this? And where do we go from here?

Discussion Questions

1. Which stories in the series did you connect with, and why? How did you respond when you were in similar situations?
2. Reflect on the statement, "our stories have a process...they're not meant to be shared prematurely, perhaps. And that when we do share them, and it's the right time, they can be profoundly healing for other people."
3. In this episode, Luna Dolezal notes how once you begin to see the common defenses of shame, you notice a "fundamental human pattern everywhere." What kind of patterns have you noticed in yourself, or in society?
4. What's one step you might take to shift medical culture at your institution? What's happening already, and what's missing?



Resources

To continue the conversation, head to our [engagement page](#) where you can find the full series discussion guide, facilitation toolkit, additional recommended resources, events, and more. You can follow Luna Dolezal and Will Bynum's research at the [Shame & Medicine Project](#) and [The Shame Space](#).

Read:

Dolezal L. Gibson M. [Beyond a trauma-informed approach and towards shame-sensitive practice](#). Humanities and Social Sciences Communications. 2022.

Watch:

Goldman B. [Doctors make mistakes. Can we talk about that?](#) TEDxToronto 2010.

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