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Family Medicine

NARRATIVE ESSAY

The Silent Grief in Residency

Kelly McGuigan, MD, MS

AUTHOR AFFILIATION:

Department of Family and Community Medicine, Thomas Jefferson University–Center City Campus, Philadelphia, PA

CORRESPONDING AUTHOR:

Kelly McGuigan, Department of Family and Community Medicine, Thomas Jefferson University–Center City Campus, Philadelphia, PA, United States,
kcm020@jefferson.edu

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As a medical student preparing to become a family medicine resident, I didn't spend much time thinking about death. I imagined myself in primary care, maybe focusing on women's health or maternal-child health. I knew our department included the palliative care team, but death was something I mentally pushed to the back burner, a challenge for another time.

I still remember the first death I witnessed during my third-year emergency medicine clerkship in medical school. I can picture it clearly, and it still brings me to tears: the single family member there holding his brother's hand.

Then residency started.

My first death pronouncements and the first major patient deaths I encountered came during my ICU rotation at one of our community hospital sites. Three of them will forever stay with me: relatively young patients who declined unexpectedly, each surrounded by loving, present families. Each case was traumatic in its own way. I was shaken.

I struggled during those ICU weeks. Like with many intern-year challenges, I could commiserate with my coresidents, but deep down I worried that I was struggling more than others. Maybe I wasn't strong enough. Maybe something was wrong with me.

Then I got a brief and much-needed reprieve: 2 weeks with our amazing geriatricians. I saw patients in clinic and at a senior living facility, and I loved the change of pace. One day, I was talking with a geriatrician I admire deeply about my future career path. What should I do? Should I be a geriatrician?

"I love geriatrics," I told her. "I love the patients, their families, the medicine. But . . . I don't think I can handle death. Maybe there's something wrong with me."

She paused. "That's interesting. I think it's something that comes a bit more naturally to me now. I've found some peace with it. But we all have the things we struggle with."

She added that pediatrics, in particular, especially related to death, might be harder for her. We left it at that, but it gave me hope. Maybe we all just find our niche, the work that we can love and live with.

Months later, those early deaths still stay with me but not in the same way. They no longer keep me up at night. Instead, I carry them with me as reminders of how I want to care for patients and families in the future.

As I write this, I'm on my palliative care rotation, where space is given for reflection and emotional processing. Looking back, I've realized a lot about what it means to witness death as a new doctor. This week, I had the honor of helping multiple families navigate goals-of-care discussions and end-of-life transitions. I saw that death can be peaceful. It can be dignified.

The patients I met in the ICU had families who begged us to save them. They wept as we explained that further interventions might cause suffering or hasten death. I now understand how hard that was—for them and for me—and that it's okay that it affected me.

At the time, I had no space to process. No time to reflect. No one to debrief with. I just had to keep working, keep moving. That was the hardest part.

And then, at the end of intern year, it came full circle.

I was on our family medicine inpatient service caring for a lovely, chronically ill patient in her 70 s. She had dementia and had been declining for months. She was admitted with pneumonia and narrowly avoided the ICU. One Friday morning, she was more alert than usual, asking for ice chips, holding my hand, and talking about her wonderful family, who were coming later that day. I had no idea of the omen in this moment.

Just after rounds, a rapid response was called. It quickly became a code blue. By the time I reached her room, the hallway was packed. She was being bag-ventilated and still had pulses. As her primary doctor, I stepped to her side and held her hand. I remembered her code status, DNR, with clear plans from the family that there would be no escalation to the ICU.

Her pulse soon weakened. Her heart rate slowed. The ICU team looked to me for next steps.

I took a deep breath. "We'll honor her wishes," I said.

I stayed with her. I held her hand as her heart stopped. I declared the time of death, performed her death pronouncement, and prepared to speak with her family. It was one of the deepest honors of my intern year.

That moment changed something in me. I had feared death, but in the end, I could sit with it. I could honor a patient's wishes, hold space for her family, and do what I was trained to do with confidence and compassion. Our team took the time and space to reflect on our lovely patient and her beautiful family. We informed her primary care physician, our colleague, of her passing, and she thanked us for providing care in her last moments.

I wonder how many other residents, especially interns and learners, struggle with death in silence. These certainly won't be the last patients I lose. But I'll never forget them. Their stories help me be a better doctor, a better person, and a better support to my colleagues who also carry these unseen burdens.

We often forget that most people don't go to work and witness someone die. They don't carry grief home, try to eat dinner with their families, and pretend everything is fine. In medicine, especially in family medicine, we care deeply. We feel our patients' losses. That's part of the privilege of this work, but it can also be the weight we carry.

The lesson, I think, is this: Witnessing death doesn't make us weaker. Feeling it doesn't make us unfit for medicine. It makes us human. And it makes us the kind of doctors our patients deserve. We owe it to ourselves and our patients to take time to care for ourselves after these challenging moments, so that we can continue to care for others.