

a computerized POLST registry in our state). I was grateful for his call because it prompted a precious opportunity to visit her that evening and say goodbye. Her son came to our clinic a few weeks later to express his gratitude for the time we had spent over the years discussing her end-of-life wishes. He thanked our team for ensuring that she was more comfortable in her final years and that her advance directive was clear about what he should do at that critical juncture.

As the primary care team entrusted with the care of this patient, our contributions to her health went far beyond helping to manage her medications. Our team's efforts to address her social and emotional needs improved her health and enabled her to be more safe and comfortable while continuing to live independently at home. Our work also ensured she had an advance care plan that reflected her goals and provided guidance to her family at the end of life. Her son was empowered to decline invasive procedures, which she did not want and would likely have resulted in complications given her age and frail condition. Our team's excellent primary care saved unnecessary pain, suffering, and expense. While caring for this patient, I learned so much about how to be pragmatic and population-focused in setting health goals. Her no-nonsense attitude and inspirational way of aging gracefully changed my outlook on how I approach end-of-life care. I often think about her when discussing goals with patients nearing the end of their lives. Remembering her gives me strength to ask the hardest questions, be appreciative of my role as a primary care physician at this time in peoples' lives, and be more present in every one of these precious moments. The coronavirus disease 2019 (COVID-19) pandemic has once again highlighted the essential need for these conversations and primary care's central role in facilitating them.

When I reflect on the patient-centered and personalized care we provided to this patient, I also think about how the rigidity of fee-for-service payment structures made it difficult for us to *choose to do less for her in some areas and do more in other areas*. She wanted us to do less of the care where financial reimbursement was easily available and forthcoming. Medicare would have paid for computed tomography (CT) scans and other surveillance tests that she

did not want; all it would have taken was an order for a discrete service with a code indicating her cancer history. She needed us to do more in areas where there were few (if any) health care resources available. There was no easy way to receive payment for our team's work to address her social determinants of health—the paperwork and extra bureaucratic hurdles were barriers too large to surmount. Instead, this care was undertaken as a labor of love during evenings after busy clinic sessions.

Our home visits and time spent in conversation with her would have likely cost the health care system less money than a couple of CT scans. Our work to understand her goals and ensure she had an up-to-date POLST prevented unwanted and costly interventions at the end of her life. Yet efforts to routinely provide this type of care require creativity and dogged persistence by primary care teams to navigate the gauntlet of rigid health care payment rules. Oftentimes, no payment is ever rendered, which might help to explain why less than 5% of Medicare fee-for-service dollars are spent on primary care.¹ Primary care teams are experts at partnering with patients to do less of what is not wanted (but often covered by fee-for-service insurance structures) and do more of what is needed (but only covered in a small minority of capitated insurance plans). Given that most primary care practices are still reimbursed on a fee-for-service basis, choosing to provide patient-centered care in this way often comes with significant financial losses.^{1,2} The heroic work being done by primary care teams to keep patients and communities safe during the COVID-19 pandemic, while jeopardizing the financial survival of their practices, is shining a bright spotlight on this perverse dichotomy.³ These teams should be trusted with a predictable, prospective budget that makes it easier for them to listen to patients and implement plans that include doing less and doing more at the same time.⁴ Increasing the amount that payers invest in primary care's ability to maintain longitudinal connections with patients and increasing flexibility to allow teams to deliver needed services might just improve the quality of the care provided and the population's health outcomes while also decreasing the downstream costs.⁵⁻⁷

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PHYSICIAN WORK ENVIRONMENT AND WELL-BEING

Medicine and Grief During the COVID-19 Era

The Art of Losing

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In a matter of months, coronavirus 2019 (COVID-19) has transformed not just how we live but also how we leave this world.¹ Physicians and nurses struggle to accompany patients who die alone and support families who cannot follow the usual customs of grief: gathering at hospitals, attending funerals, sitting shiva.²

As a resident physician, I feel unnerved by these challenges. In the poem "One Art,"³ Elizabeth Bishop writes, "The art of losing isn't hard to master." The small losses (like "door keys," "my mother's watch," or "the hour badly spent") are "no disaster." But they give way to greater tragedies. During the long months of COVID-19, our tally of losses has accumulated. First, we lost the intimacy of holding hands or hugging our children after work, fearful of skin teeming with invisible harm. We lost the ability to walk into a patient's room without fretting about the risk hanging in the shared air. And we have lost hundreds of thousands of people to an illness we cannot yet contain.

As an immigrant, I am well practiced in the art of losing. For me, our present uncertainty is intertwined with a history of departures. My parents relinquished the bustling warmth of Kolkata, India, seeking an expanded world of possibilities. I was just a baby. Ten years later, we left the green hills of Wellington, New Zealand, for the flat brush of Houston, Texas. With each flight, I said goodbye to people and places I knew and loved.

Finding strength in one another, my family survived: we adapted to eating new foods, driving on a new side of the road, speaking with a new inflection to our words. There were some goodbyes we could not bring ourselves to say, the dangling ties to our lives back home. *Back home*: even in the phrase we concealed our muffled grief, until home became a concept as unfamiliar as an infant eyeing her shadow.

Newly emigrated and feeling unmoored, I sought solace in the work of medicine. Frank Netter's *Atlas of Human Anatomy* unfolded before me like a map; I exchanged lost towns for new citadels. The cul-de-sac behind our home in Wellington where my sister and I chased sheep was replaced with *vallecule* (the place popcorn gets stuck). Te Whanganui-a-Tara, the harbor stretching along the southern coast, was swapped with the *aorta* (the pulsing central artery). A hemisphere switched for a *hemidiaphragm* (the domed muscle that delivers breath).

Dare I say, I have gotten better at goodbyes over time; I have had the chance, in Bishop's words, to "practice losing farther, losing faster."³ I have been harried by residency training and fallen out of touch with close friends. Abandoned dancing, a passion I once felt down

to my bones. Lost a first patient—heartbreak for a young physician—then a second, and a third.

In the pandemic's wake, I find myself revisiting memories of my most personal losses. When my paternal grandfather, *dada bhai*, abruptly died, I was unable to take leave from medical school in California, so I mourned from afar. He was cremated at the banks of the Hooghly River, a tributary of the holy Ganges that carries souls to eternal life. Over Skype, I watched his body disintegrate to ash on a pyre while a priest shaved my father's head for the last rites.

A few years later, my maternal grandmother, *didi ma*, passed away in her bed. Through FaceTime, I witnessed her expression harden to wax as the color left her face. Mourners streamed through her room, wailing, decorating her body with wreaths of white flowers. Both were losses that I faced at a distance. The membrane between virtual grief and everyday life is thin: beyond the glowing laptop screen that framed the rituals of my grandmother's funeral, a leafy houseplant made mockery of my sorrow and a bowlful of oranges blinked too bright. Far from lost keys or lost continents, the loss of a loved one was gutting, no matter how hard I tried—following Bishop—to avert the pain:

—Even losing you (the joking voice, a gesture I love) I shan't have lied. It's evident the art of losing's not too hard to master though it may look like (Write it!) like disaster.³

I would not wish distance grieving on anyone. Physical rituals of mourning promise catharsis: dressing the body, lighting candles, sprinkling dirt on a casket. Yet there are ways to make meaning in this peculiar mode of distanced grief, by participating in a virtual funeral or continuing well-worn customs belatedly or at a different location.⁴ In the Hindu tradition, this involved hosting a *puja* across the ocean, where guests joined my family to sing, pray, light incense, and share sweets.

It was also important for me to develop my own rituals. I ordered kebabs from a takeout counter to savor Kolkata on my tongue. I climbed a mountain to find peace amidst groves of towering redwoods, a place neither grandparent had been. These rituals were intimate. They were mine.

Despite attempts to heal, loss remains a wound, reopening in the strangest places: while drinking an ice-cold soda in Bangladesh during a summer research trip and recalling *didi ma's* voracious appetite for sugar, or on a vacation to Iceland to chase the Northern Lights and suddenly sobbing at the night sky—after many years, feeling the pull of *dada bhai's* spirit.

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The pandemic has made us contend with loss in new and unexpected forms. Calling primary care patients for virtual appointments, I walk into sudden eruptions of grief, like minefields—entire families who succumbed to COVID-19 infection, elderly adults confined in isolation and fear, and patients whose treatments for other illnesses have been deferred to disastrous effect. With distance pre-

cluding the comfort of community, we bear witness to these casualties through private rituals, whether a postshift shower to wash away the enormity of pain or a moment of stunned reflection after hanging up the telephone. Ultimately, we must make peace with the volatility of grief and its messy presence. In medicine, the art of losing is still the hardest one to master.

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