Navigating Mental Health in Healthcare with Dr. Jessi Gold (Episode 91) Transcript

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Introduction and welcome

I am thrilled today to have Dr. Jessie Gold on the podcast. She is author of How Do You Feel? And I can't wait to delve into her book and a little bit more about Jessie.

She holds the esteemed position of the first Chief Wellness Officer for the University of Tennessee System, a role encompassing five campuses across the state of Tennessee.

impacting over 62,000 students. She also serves as an associate professor of psychiatry at the University of Tennessee Health Science Center. She's internationally recognized and I've had the honor of meeting her in person.

Dr. Jessie Gold, welcome to the podcast. Thanks for having me. Well, I think it would be most appropriately to start with, how do you feel? You know, I always turn to realizing that I'm gonna answer that with things I wouldn't let other people answer it with.

Like I blocked the fine, but my first thought was exhausted. And then I was like, I don't feel like that describes it enough. I think that I'm proud of the book and everything, but I definitely have been doing a lot.

So I'm like, I can feel my like energy tank not being that high. Yeah, I'm in a similar boat. I'm getting ready to leave for Australia tomorrow night.

And I'm both excited and a little bit exhausted. And so we were just talking before we started recording about how do we navigate kind of pulling back a little bit.

And I think that's pretty apropos for a way a lot of people are feeling right now. We're recording this the week after the election. So maybe let's go there first.

Self-care, boundaries, and managing exhaustion

Could you maybe give some tips to people that are, you know, we're going into the holiday season and some people are going to start thinking about 2025 and new year resolutions.

I think this exhaustion is very relatable to everyone and especially the people listening to this podcast. Yeah. I mean, I feel like there's this desire to assume that you could go to work and forget home.

Like you can just somehow be magically fine, despite the fact that things are going on at home or things are going on with you or things are going on in the world.

And like, that's just not realistic. I think as a psychiatrist, I learned that pretty often because people bring in the world into my office all of the time and as much as you'd like to fight it, it's there all of the time.

And so, you know, for me, it's about transitions, like between patients, between meetings, between things, at the end of the day, giving myself time for like breathing and taking care of myself.

I think people think often that you have to do some elaborate thing for self care. And that would be nice. But I think for the most part, people do something like on the drive home from work or right when they wake up in the morning and it doesn't have to take hours and hours and hours.

So, you know, when I think about how to prioritize myself in the context of the world, it's recognizing that the world can affect you and life can affect you and that's okay.

And you shouldn't beat yourself up about that. And you should have self-compassion around that and in the same time you should build in ways to care for yourself knowing that's part of it right like you might come back refreshed from the holidays and go right back to the same work environment that was burning you out to begin with and so you shouldn't burn the refresh by just going back exactly the same and not checking in on yourself so like if you get a chance to sort of start back at at zero or something, being able to kind of go, okay, well, like now I need to pay more attention to me and check in with me and make sure that I'm doing things to help me as I move along, I think is really important.

I mean, we were talking about boundaries because I think I, you know, this is a perpetual problem for me. And I'm a work in progress, even if I write a book on it, it doesn't mean I'm somehow magically good at all of it.

But I think we, so often think about the reasons to say yes to stuff and it never includes emotional capacity. And I try really hard to include that. So whether something makes sense because it's good for my CV, you're afraid of FOMO and not doing it, you think you have to for whatever reason from your day job, I think it's okay to have that.

But I think you also need a step check of like, okay, I think it passes all of my first checks. Does it also pass my capacity check? And if it doesn't, you can kick it down the road and do it another time.

Like it's okay. You don't have to do all this stuff like at once. I think people worry and I worry that like things won't come back around, but they often do, you know, people get it.

So being mindful of that as you enter a new year, start a new page, whatever you want to call it with some kind of metaphor, I think is important. I love that.

And one of the many, you had so many wisdom bombs there, but one that I'm holding onto is just pick maybe one thing and just a little bit, you know, we think we always have to do these big sweeping changes, but even just incremental change is really powerful.

Yeah. So coming back to how we usually start the podcast, tell us about how, and you do talk about this so eloquently in your book, how you became and why you became a physician.

Yeah. I mean, yeah, it's a lot of chapters in the book, but I think I was one of these kids that was told at a young age that smart kids go into science and healthcare.

My dad's a psychiatrist. So it was always something I wanted to do, not psychiatry, but medicine. And I think I, probably for a lot of my life really wanted to do it because like, it just seemed like a field that made sense for me, like to help people, but also like, you know, we never say it out loud, but the prestige wise of it, I think also was just what I was told was a career that had value.

Why Jessie became a physician

And then, you know, as I got older and had a lot of questioning in undergrad and in med school, what drew me to it really is people and people's stories and having the ability to be a support for people in circumstances that they wouldn't have had otherwise.

I think psychiatry is one of those places where people tell you stuff they've never told anybody and it's a privilege to be able to hear that stuff and to be able to support people through that stuff.

I don't know that we always talk about that part of it. And I think probably what was a motivating factor when I was younger that kind of got me through the initial part of this is not why I do it now.

But finding that meaning is important too, right? Like if I was just to tell you that I did this because my parents did it and I did it, Because people who are smart do this, like that wouldn't have sustained my career.

I don't think like as a, I would burn out all the time because it, where is the meaning in that? So, you know, I think

for me, it really is like the ability to support people.

And I really do love people's stories. That is such a beautiful answer. And you anticipated the second question and this really what has, I mean, it's one of the main reasons I do this podcast.

And one of the most interesting things about coaching physicians is often what draws us into medicine isn't going to sustain us. There may be a kernel of that in the story, but medicine's hard right now.

Life is hard right now. So looking at, you know, what can, add more depth and meaning to our careers right now. It's really easy to lose that, even if you come in with a clear meaning.

I think we get caught up in the day-to-day tasks of a job that looks very different than we thought it would look, and you miss the things you get meaning from.

I think one of my things my patients struggle a lot with is saying no to things that would have given them meaning. So when we look at our to-dos or we're asked a question, we go, well, I can't do that.

I don't have capacity. really that thing would have made you feel better. And so you like kicked it off. And then all you're left with is like meetings for work or these things that you have to do because you have to do them, but they don't give you much back.

And, you know, for me, that is the case a lot of times that like, I'll hear from patients like, oh, I'm not mentoring students anymore because I don't have time and I'm burnt out.

Why would I want to mentor students? But really, it gives you back energy and maybe would prevent burnout. And so also being mindful that when we think about meaning, that should factor into our yeses and nos too.

Wow. I just had like this aha moment. I worked in emergency shift on Saturday night and so much of what makes you quote a good ER doc is being fast.

Meaning, burnout, and the limits of metrics

You know, if you look at our metrics, it's door to dock time, door to disposition. But when I think back to that shift and what made me feel good, about being a doctor was taking the extra time to talk with two patients and really explain their diagnosis to them.

And I had the luxury of it because I work at a place with residents. So I didn't have to like churn and burn. I love all these phrases that we have for efficiency in medicine.

So I'm gonna think more about that. EM still leads the burnout charts and maybe we need to push back on these silly metrics. I actually don't think these metrics work anymore.

Yeah. Yeah. Yeah. I mean, I think that metrics miss humans, right? Whoever designed the metric is not necessarily thinking about the person behind them.

And I also think we use metrics maybe give too much weight to them. I mean, like that's what my brain says. Like we see them and that's what we value instead of kind of what it means.

Like for example, duty hours, I think that those studies look at mortality. Like did more people die when we worked less? And they're the same. And so instead of saying that's good, we can have people work less.

People say, people can still work as much because they didn't make it better, right? And like mortality shouldn't be the only measurement of whether people should be working 100 hour, 120 hour work weeks, right?

And so I just think sometimes like statistics people, money people are the ones making those kinds of decisions

about what metrics are used to, and they're not looking at the same stuff they should be.

Yeah. And I just had this thought, like, why don't they use the metric of physician suicide to decide duty hours? I don't know. I mean, it seems like maybe that's worth studying or thinking about because patients care about that.

You know, I just had a call with this really lovely woman this week who's a physical therapist and patient advocate and physician advocate. And she shared that her radiation oncologist committed suicide and how much it impacted her as a patient.

And, you know, I think we got to do a better job of telling this story. And maybe that's something that the AAMC or ACGME know, we seem to be okay with this 80 hour work week because we tied the metric to patients, to patient mortality.

But what about our own mortality? Oh gosh, I mean, even if you don't go that far and say our own burnout it's relevant because if you wouldn't have access to us as providers if we left to right so I think, you know, we look at it so much like this intangible metric.

But it's not, it just requires more storytelling to explain it, right? There are measures of how much burnout costs the system, sure, but I don't know that that means much to people.

So I think trying to link all this stuff together is really important in telling the story, just like you're saying. Okay, so what does it mean if people leave?

that means people don't have access to that person. Radiation oncology is probably one in certain areas. So if that person leaves or they die, good luck getting a radiation oncologist.

Then if you are an area that only has one, is it because it's hard to recruit to that area? I live in Tennessee. Plenty of the schools that are where I live have trouble recruiting to positions, and that's hard.

Then you don't have someone in leadership. You don't have somebody doing it, whatever it is. And so I think we just kind of tend to pass off some of this wellness stuff like fluffy useless measurements that don't matter, but they link to everything and they're like the fabric of our system.

It's just that people choose not to see them that way. Yeah. Yeah. I've been thinking a lot about the problems that we're facing in healthcare and that healthcare professional wellbeing is going upstream.

You know, we all care about patients. I mean, that's the whole reason healthcare exists, but to not care for the people, caring for the patients is so short-sighted.

But it's like, I don't know, it wasn't built in correctly. And so it feels like having to go back and kind of break it up and fix it, which in healthcare especially is not an easy thing to do or even a popular thing to do.

So I wanna turn, I think this is the first time I've had a psychiatrist on the podcast and so I'm super excited. So let's talk a little bit about mental illness in healthcare professionals.

And I don't want to get too far down into the statistics, but with broad brushes, I'm gonna name a few mental health diagnoses and I want you to tell me if it's more prevalent, or the same prevalence as the general population.

So let's start with depression. More prevalent, but different across the lifespan of physicians. So you'll see a pretty high rate in residents, for example, but maybe not later career faculty.

So it does vary across the lifespan, but higher than the general population, for sure. Well, that's kind of great news for attendings. Well, it's control, right?

It's the same thing as burnout. I think we don't measure it perfectly enough, and it's not a young attending. Young

attendings have a lot of lack of control and stuff in the workplace.

There's just different gaps, little steps along the way that get a little better, and it just depends on where you're looking and how you're measuring.

A lot of people don't want to do a full PHQ-9 because it includes the suicide question. So you'll see a lot of studies get stuck with like the two or like some other measure of depression.

And so they're not as good. Like the good studies, like we have a good meta-analysis in residents and it's about 28-ish percent and that's high. Yeah.

All right. What about anxiety? Not enough studies. So, uh, you know, it's included sometimes when it's included, sometimes it's not like overwhelmingly worse, but again, for some reason it's not included enough.

Like obviously went up during COVID. I mean, again, so that's a different specific example, but I don't think that you could, could apply that to us, like sort of as a population exclusively.

Yeah, that makes a lot of sense. What about post-traumatic stress disorder? Depends on, you're going to hate my answers to this. It really depends on how all this stuff is defined because trauma is really complicated and how it's defined kind of broadly.

And even like people who research trauma really like fight over this all the time. we have a significant exposure to trauma in the workforce, whether that presents as PTSD or not really varies.

In nurses, I think we have pretty conclusive data that it does have higher rates in physicians over the pandemic.

Mental health in physicians: depression, anxiety, and PTSD

Yes, variable at times. Otherwise, I think that again, it's like a definition problem and it's such a medicine answer to tell you that like, Some of this is mixed because of how it's defined in certain studies, but I guess that's also sort of like just how it is, right?

Yeah. Well, and I appreciate that, you know, and this is every guest I have on the podcast and that, you know, we want to be evidence-based. We want to try to be as factual as we can, but still acknowledge that, you know, any study doesn't encompass any one person's experience.

Yeah, and again, like, you could argue that if you just took pandemic numbers that a lot of these things are higher right so someone listening could say she's not being evidence based because I saw a study from 2020 or 2021 that showed x y or z and they're right.

It's just that we don't have good like again sort of like longitudinal clear cut measurements of like the lifespan in a lot of ways. So I think that makes it hard, but you can understand why we are exposed to more trauma.

I think that development of PTSD doesn't happen for everybody anyway, and we might be a specific population where it happens less to for whatever reason, including high resiliency.

But again, we don't have good good understanding of that. And I would argue too, like in studies outside of physicians don't have a lot of information either.

I want to ask you kind of a nurture versus nature question. And what I love about this is, you know, the data, and then you've also talked to probably at this point, thousands of patients in a predominance of healthcare professionals.

Is it that a lot of us are just type A? And because of that, we're more at risk for anxiety, depression, or are workplaces making us sick? Both. Um, you know, I mean, I think not everybody's going to come in with a ton of

risks, like sort of at all, but I mean, we're still, first I would say we're, we're still a piece of the regular population, which means we still have the same risks that the regular population has to develop all of these things.

Right. And then we're put in a culture that's more complicated. And so maybe we have higher rates of developing it just because of that culture and workplace.

But you also could say. that the competition and self-selecting nature and the way that you become a physician in particular, self-selects for personality types.

We don't have a lot of good data in pre-med. One of the reasons I included a pre-med as a patient in the story was because I was trying to highlight that.

We don't actually know a lot, but the data would suggest that we're equivalent to age-matched peers depression-wise and med school makes us depressed.

Unclear if that's exactly the thing, right? But the data would suggest we're even when we start and then worse. So it's not depression maybe in terms of prevalence.

That's the big risk factor for us. But maybe it's perfectionism, like maladaptive perfectionism, like the way that we process mistakes. We have a lot of data that suggests that we always are like self-blaming when it comes to mistakes, not like growth learning when it comes to that.

And maybe that comes from like how we're self-selected into medicine and the competition and all of that. And so I think that puts us at risk for more mental health effects of the job.

So I think it goes back and forth with each other a lot, right? So maybe we don't have risks and it's just the environment and the environment brings it out.

Or maybe we have just like enough risks and then the environment's worse and it brings it out right like they kind of play off of each other but of course the system and the way that we train contributes i mean i think the system as i think about it is culture plus like actual systems right so like insurance like documentation like all these things that like as i list off people are rolling their eyes and groaning every single word you know i think that we have a culture that doesn't value like, vulnerability and weakness.

And so we see mental health and needing help as a weakness. And so we push down, push down, push down until we can't. And that mindset makes it hard for us to ever get help, let alone like get help when we need it.

I think that mindset also makes us like less likely to see that our job affects us. Like, because why would it, you know, we're not supposed to let it.

And so when it does, then we're like, I don't get what's wrong with me, right? It's sort of similar to that PTSD question, which is like, shouldn't we all just be okay with seeing all that we're seeing and is that what we see in data sometimes?

Maybe we have that sometimes, but we also have a right to be affected by what we see in our jobs because it almost always counts as secondary trauma if not like some actual primary exposure to it because we see it all the time.

It's just that we don't feel it all the time, if that makes sense. I think a lot about that football player who got CPR on the field. Because I think about how on social people's reactions were like, oh my goodness, CPR is like scary and harsh and intense.

And all the healthcare workers were like, is it? I didn't think about that. Like I haven't thought about that in a long time. Like that's hard to watch.

Just the CPR bit, huh? You know, but we're just so desensitized that we almost don't recognize when something's like obviously an issue. And that means that we don't even feel the hits as they come, I think.

And that makes it hard to then identify need. That was a long winded answer. It was beautiful and really, really important and helpful. And so I want to stick on trauma for just a minute.

So this matters a lot to me because I'm an emergency physician and I'm also a simulation director and educator. And so, you know, we think a lot about like debriefs.

Trauma, debriefing, and moral injury

And so if you had to take a step back and you got to redesign the healthcare system, What does the mental health literature, what would be the consensus or general idea or just Jesse's opinion on when something really F'd up happens, you know, a pediatric death, when something horrific happens, not like the kind of front of the mill trauma that we see.

But the really the cases that shake most people to their core, What would be the right response? Because when I last looked at this maybe five or seven years ago, critical debriefing didn't have great evidence.

And there was actually evidence that it might make trauma worse, emotional trauma, kind of mixing all the trauma we get in the ER. So if you got to design it from the beginning, what would you have a team do after a horrendous case?

Yeah, I mean, you're right, the evidence on like, in the moment debriefing isn't great. And I don't know, I've never really understood that because anytime that's happened for me, I felt like healed, but it could be like the rest of the team didn't or it called out something you didn't need in the moment.

I don't know, but I've always like, and felt helped myself when someone asked me questions in the moment. I think that if I could redesign it, at least in the moment, I would do like the pause or mention it out loud that that might be hard for people.

Cause I think that that's the first step is not just like having things happen and not acknowledge them or not acknowledge that they might affect you.

It might not mean that you debrief in the moment. I do think that having conversations later matters. You know, moral injury is, is this concept of like doing things against your morals or witnessing things against your morals and that looks like a pre PTSD kind of thing and the way to prevent against that is to know that other people would have done the same thing or reacted the same way right is like this normalization of what happened And so I do think that that helps.

It might not have to be in the moment, but just having a conversation with the team or with other people if that's more structured and they weren't on the team about what happened and why that affected you and why that's okay and how they had something similar and that affected them and that's okay, right?

This like just sort of normalizing of the experience I think matters. I don't know when it would happen. It doesn't have to happen. in the moment if that is really so bad, evidence-wise.

But I do think in the moment, either doing a pause and letting people have time to process it internally in their own way or calling attention to the fact that that was a really tough case.

and just like giving space for that and talking about it later or like, and I'm here if you wanna talk more about it. Like, I think that if someone chooses that, that's a choice than forcing a debrief, right?

I also think there's settings where we already have built-in sort of M&Ms or like, you know, we look at cases where things went wrong and we never asked the people presenting like how that made them feel.

And I think that that would be a powerful addition because you're already going through the motions of the case and the errors of the case and the challenges of the case.

And it becomes very academic that way as a trauma response, to be honest, where people are just recounting what happened and they don't have emotions associated with them.

And I think forcing people to pause and recognize that, yes, those steps happened, but presenting those steps and having those steps happen made you feel a certain way is relevant.

And so there are a lot of places and times for those conversations that I think should be happening. And they don't have to be huge or take hours or even rocket science.

Sometimes when I suggest that to people, they're like, that's stupid. It's so simple, it's the answer. But I think that that could make a big difference.

Yeah. And I think what I've taken from the literature on debriefing, and I've seen the power of debriefing, is it needs to be a choice. So the first rule is if people don't want to participate, they get to opt out.

And it seems like people tend to have a pretty good sense of that if that's not what they need at that moment. So honoring that. I want, it's actually Veterans Day today and I'm a veteran and certainly I've always kind of wanted to know, but not know what the Venn diagram is between physicians and veterans on like what is actually my risk for mental health.

Hi. But you know, there were some really awesome parts about being in the military. And one of the things that I'm most thankful for is I get free mental health care.

to this day and I actually get my care at the Vet Center. And I'll be quick to say, you know, I only know my Vet Center in San Diego and I only know the therapists that I've seen at my Vet Center.

So I'm not, you know, saying that every Vet Center is the right fit for every person. But a little bit about the Vet Center is it was founded by Vietnam Vets that felt like the VA wasn't taking care of them.

And over time, the Vet Center actually now is funded by Congress. So it gets money from the VA now, but it doesn't report to the VA. And actually, when you're a veteran at the Vet Center, your chart is locked down.

Veteran mental health and a care model for clinicians

If you don't want it to be shared with the VA, it will not be shared with the VA. or anybody else. So I've had really great experiences at the Vet Center.

And again, I love that it's free. So now it's funded by the VA. This very long-winded setup is, I actually think this provides a model for healthcare professionals.

Because one of the issues with healthcare professionals is if your insurance is tied to the place that you work, maybe you don't want to get mental health care at the place that you work.

So what do you think about in this post-pandemic era with the amount of challenges healthcare professionals are facing, if healthcare entities essentially had to pay into a fund in which there was something like the Vet Center for healthcare professionals, that it's an entity that sits outside the system, but it's funded by the system that largely makes us sick.

Yeah, I mean, I would wonder, you know, with the VA, it's like service connection counts. And so I would wonder, you know, if you're listening and you have no idea what that means, it's like they evaluate how much of what you're, you can correct me if I'm wrong on this, but I did do VA stuff in residency, like how much of.

your PTSD that you're experiencing is in direct result of the job, right? And so I would wonder what that would look like in an application for healthcare and knowing our people would think that for the most part, they'll try to show that you had it before and that they don't have to pay for it.

But if we live in a world where they're able to see how the job links to what's going on with people, and we wouldn't have to do service connection, it would be simply like, do you work in health care?

Yes, no. You can use this stuff. I think access is part of the issue. It's not the only issue. We'll never therapy our way out of this stuff. Same with college mental health.

It's just like, that can't be the only thing we're doing. cost, timing, when it's offered, ability to go in nights and weekends, things like that that I think you could set up to have in a specific focused place would be helpful for people.

I think having specific people who are experts in the area also matters. We don't have a training or certificate program or anything for healthcare worker mental health.

You just do that. I know it because I've been doing it for a long time. that makes me more of an expert than someone else who hasn't seen this population as much as I have, but there isn't like a training for that.

And people always ask me for like me somewhere else, right? And I don't know how I find a me somewhere else, but if they had a set up way to find that, that would also be helpful for folks, I bet.

But I could, I mean, it feels a little fantasy to me in that way, just because I think even setting up internal clinics that they fund had to be through accreditation, like ACGME, GME accreditation saying, like, you need to have access.

And then they were like, oh, we can only get access if we make the access. And so then they made the access and had access, like hired people internally to do it.

Right. So I think it would need a lot of policy to push it and support to push it. But I do think that we are a subculture and should be viewed as a subculture.

We are affected by work. And a lot of this stuff is like, we're never going to sue for workers' comp, but kind of workers' comp. And so I think having that in mind isn't a bad option.

I just don't know. I worry sometimes about hoping that things could be different when it's so hard to shift the system even a little bit. Yeah. Well, let's shift gears a little bit.

And I want to pick up on a thread that you mentioned there that we're not going to mental health care our way out of this. And I think that's something that gets lost a ton.

I'm pro therapy. I love therapy. And I talk about this a lot with the military to is there isn't enough mental health, and we're not going to be able to hire enough people to do mental health.

If our culture is destroying people. Yeah. I mean, I think you can take care of yourself in the context of things you can't control, but I think it feels a lot harder.

You know, I'm a serenity prayer fan in that like we spend a lot of time focusing on the things that we can't control, but like we can control our reactions.

We can control how we support other people. We can control how we talk about this stuff. We can control the culture we work in. And so trying to find places you can control stuff can help with when the world feels messy and you You don't have control over it.

You know, I had to get to a place with that with over covert, especially because I would be like seeing patients and

thinking like, none of these people are getting better because I can drug cove it away.

Like what? This is not a thing that I'm doing, but I had seen meds work. I know meds work. And so like it feels like meds work, you know? And if you don't see them doing anything because the world is like, you know, falling apart and all those people are going on the front lines of it, like it makes sense that you're not seeing change.

And I had to remind myself that like they're still coming, so they're getting something out of it, that like there's more than just disease improvement, the end, it's the listening part matters.

being a space for someone matters. And so all of that is to say that I think there's still things you can do in the context of things that feel heavy and challenging and hard.

Why therapy alone is not enough

I think finding hope and like trying to find ways to go towards hope can be helpful too. I think the meaning and purpose stuff we talked about can be helpful in this circumstance too.

I think it's very easy to feel like you can't do anything, but there might be something you can do for you or someone else that might feel doable and like you're making a change and that can help for sure.

I was just my Suzy Sunshine answer to that. Well, we definitely need some sunshine. This is a question that's been on my mind. Adverse childhood events, aces.

I am kind of flabbergasted that this isn't more widely taught in medical school. And maybe it is now, you know, I graduated in 2011. What's your advice for healthcare professionals out there?

Do you think it's worth doing your own ACEs score? Because part of my burnout I think was tied to unprocessed childhood trauma and getting reactivated through the weird things we see in medicine and the hard things.

Yeah, I mean, I think you can get there sometimes through journaling. Like, it's really just like wanting to be curious about yourself and understanding the way you're reacting to things, right?

And recognizing that we are not just people who got plopped in medicine and had no history before it, right? So, like, you can talk about, you know, only the stuff that happens in your workday.

And I see plenty of people who go to therapists and that's all they talk about what I did today, how it stressed me out. But if you don't want to look back or you don't try to look back and you can't tell like a consistent narrative, You're missing stuff.

And so I would just say, what does that look like for people? I don't know, but be curious about yourself. Ask questions about yourself. Wonder why you react a certain way.

And don't just assume it's because that day was hard, right? That a lot of things contribute to how we view things and how we do things. And being curious is like very important to that.

And so even if you go to therapy for six months and the first three are spent yelling about your work day, give yourself some time to look at where that came from in the past too.

That's such good advice. The other question, I'm like rapid firing all the questions that I've wanted to ask a psychiatrist. is this idea of counter transference.

This is one of the most important things I took away from your book is that psychiatrists are taught that patients, the way they act, the things that they say can transfer to you and cause an emotional reaction.

And it seems obvious and in emergency medicine, we don't really talk about that. And we have these really rapid

interactions with people and some of them are incredibly intense.

ACEs, curiosity, and countertransference

And kind of the way I was taught is like, well, to be a professional, you have this barrier and you don't let the patient cross into you. But after watching, you know, hundreds of emergency physicians at this point, that's not what's going on.

So can you give us a crash course in how to deal with counter-transference? Yeah, I mean, it's like, how does what the patient is experiencing and talking about affect you based on your own experiences?

And it's not obvious. Like some people give these examples, like they remind you of your mother, and then you're like, oh, it's not that obvious, I don't think.

Like some people, sure, like there could be something like that. But for me, again, it goes on to this curiosity, right? If every patient annoys you that does a certain thing, what is that thing and why is it annoying you?

If every patient that you meet that says something you can find yourself not wanting to believe, what is it about that that makes you not believe them or distrust them?

And what is that pulling at for you? For me, having been asked that question by supervisors and stuff, it's been helpful to then use it to be better. So like you might not catch it otherwise and you might not notice that it's like actually an implicit bias or making you not want to take those cases or making you read their case a certain way or feeling frustrated about it.

And I think sometimes it's the systems contributing and not actually the patient. So when I'm mad, sometimes it's just about the fact that like they're back and they couldn't get care in the, in the like community.

And I can imagine that happens in ER a lot and you're not really mad at that person, but the person has become sort of like a personification of a broken system.

And so you're just like, how can they not be, you know, like, ah, and, and you have to kind of step back and disconnect the person from that, but understand where your reactions are coming from to better inform your conversations and care moving forward.

Yeah. So what I'm really taking away from this is curiosity and this capacity to reflect. Yep. I think that both of those things are really important in your day, in your week, in whatever it looks like for you.

Like being curious about yourself as a person because you were a person before you were in healthcare matters. and giving you space to reflect reminds you of your humanity, right?

Because otherwise you're just going through the motions. Well, as we wind down, a few questions I like to ask guests is what are you looking forward to in 2025? Sleep.

I feel like I've had a lot of changes in the last year. I switched jobs. I released a book. I think I need a little bit of like a resettling. And so I'm looking forward to getting to spend more time on my day job and getting to feel like something I worked three and a half years is like out.

And I don't have that anxiety about that, but getting to spend more time on me. I love that. And what's a conference that you love going to and it's Uh, bonus points, if it's one that, you know, any physician could go to.

Looking ahead, resources, and closing

Oh, so, okay. Yeah. I mean, I don't, I don't go to a ton of time. I always go to psych ones. So I like ones that aren't psych that I've been to and like, there's a physician health conference.

It's there's an international one every other year and a local one every year. If you're interested in these topics, like that's a cool place for it. Cause all the people who do it go, I think that's a cool conference.

Ooh, I love that. I'm going to look for that. And how can our listeners get your book and connect and follow you? Sure. I'm at Dr. Jessi Gold across platforms.

Jessi is spelled like Jessica without the CA. I also, all my stuff's on my website, which is just drjessigold.com. Like you can contact me through there if you want me to speak or things like that.

And then the book is anywhere you get books for the most part, Amazon, not Amazon, local stores, libraries. If it's not there, you can request it and they probably can order it.

So feel free to do that if you go somewhere and they don't have it. I love that. And thank you so much for being on the show and for everything that you're doing for everyone's mental health.

Oh yeah. It's an honor. And I realized I never said the name. Maybe I didn't say the name of the book. It's called, how do you feel if we forgot to mention that part, but you know, you can find it by my name too.

I love it. How do you feel? Definitely be in the show notes. And I love the way you opened at women in medicine summit talking about how Feeling fine is not a feeling that acronym feeling a name only that's really stuck with me.

And I'm trying to like dig in when, when my residents say fine to, you know, go one step further. Yep. Fine feelings. I'm not expressing. Awesome. Well, it's been an honor and we hope to have you back on the show.

Thanks for having me.