The Jewel in the Lotus: A Meditation on Memory for Veterans Day 2019

How are we to reconcile our supreme duty towards memory with the need to forget that is essential to life?

Elie Wiesel

On the 11th day of the 11th month, we celebrate Veterans Day (no apostrophe because it is not a day that veterans possess or that belongs to any individual veteran). Interestingly, the US Department of Defense (DoD) and the US Department of Veterans Affairs (VA) have web pages correcting any confusion about the meaning of Memorial Day and Veterans Day so that the public understands the unique purpose of each holiday. Memorial Day commemorates all those who lost their lives in the line of duty to the nation, whereas Veterans Day commemorates all those who lost their lives in the line of duty to the nation, whereas Veterans Day commemorates all those who lost their lives in the line of duty to the nation, whereas Veterans Day commemorates all those who lost their lives in the line of duty to the nation, whereas Veterans Day commemorates all those who lost their lives in the line of duty to the nation, whereas Veterans Day commemorates all those who lost their lives in the line of duty to the nation, whereas Veterans Day commemorates all those who lost their lives in the line of duty to the nation, whereas Veterans Day commemorates all those who lost their lives in the line of duty to the nation, whereas Veterans Day commemorates all those who lost their lives in the line of duty to the nation, whereas Veterans Day commemorates all those who lost their lives in the line of duty to the nation, whereas 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settings do reduce fear and attenuate the development of PTSD when combined with psychotherapy. Neuroscientists call these more realistic alterations of recall memory dampening. Though these medications are not ready for regular clinical application, the unprecedented pace of neuroscience makes it nearly inevitable that in the not so distant future some significant blunting of traumatic memory will be possible.

Once science answers in the affirmative the question, “Is this intervention something we could conceivably do?” The next question belongs to ethics, “Is this intervention something we should do even if we can?” As early as 2001, the President’s Council on Bioethics answered the latter with “probably not.”

Use of memory-blunters at the time of traumatic events could interfere with the normal psychic work and adaptive value of emotionally charged memory...Thus, by blunting the emotional impact of events, beta-blockers or their successors would concomitantly weaken our recollection of the traumatic events we have just experienced. Yet often it is important in the after of such events that at least someone remember them clearly. For legal reasons, to say nothing of deeper social and personal ones, the wisdom of routinely interfering with the memories of traumatic survivors and witnesses is highly questionable.8

Many neuroscientists and neuroethicists objected to the perspective of the Bioethics Council as being too puritanical and its position overly pessimistic:

Whereas memory dampening has its drawbacks, such may be the price we pay in order to heal immense suffering. In some contexts, there may be steps that ought to be taken to preserve valuable factual or emotional information contained in memory, even when we must delay or otherwise impose limits on access to memory dampening. None of these concerns, however, even if they find empirical support, are strong enough to justify brushed restrictions on memory dampening.9

The proponents of the 2 views propose and oppose the contrarian position on issues both philosophical and practical: Such as the function of traumatic experience in personal growth; how the preservation of memory is related to the integrity of the person and authenticity of the life lived; how blunting of memories of especially combat trauma may normalize our reactions to suffering and evil. And most important for this Veterans Day essay, whether remembering is an ethical duty and if so whose is it to discharge, the individual, his family, community, or country.

To move forward on a clinical application of memory dampening we would need to refine our understanding of the risk factors for chronic and disabling PTSD; to determine when in the course of the trauma experience to pharmacologically interfere with memory and to what degree and scope. More ethically urgent would be determining how to protect the autonomy of the service member to consent or to refuse the procedure within the recognized confines of military ethics. Most crucial for this essay we would need safeguards to prevent governments, corporations, or any other entity from exploiting neurobiologic discoveries for power or profit.

Elie Wiesel is an important modern prophet of the critical role of memory in the survival of civilization. His prophecy is rooted in the incomprehensible anguish and horror he personally and communally witnessed in the Holocaust. He suggests in this editorial’s epigraph that there are deep and profound issues to be pondered about memory and its inextricable link to suffering. Meditations offer thoughts, not answers, and I encourage readers to spend a few minutes considering the solemn ones presented here this Veterans Day.

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References
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EDITORIAL


LETTERS

Reframing Clinician Distress: Moral Injury Not Burnout

To the Editor: In the September 2019 guest editorial “Reframing Clinician Distress: Moral Injury Not Burnout,” the authors have advanced a thoughtful and provocative hypothesis addressing a salient issue.1 Their argument is that burnout does not accurately capture physician distress. Furthermore, they posit the term burn-out focuses remediation strategies at the individual provider level, thereby discounting the contribution of the larger health care system. This is not the first effort to argue that burnout is not a syndrome of mental illness (eg, depression) located within the person but rather a disrupted physician-work relationship.2

As the authors cite, population and practice changes have contributed significantly to physician distress and dissatisfaction. Indeed, recent findings indicate that female physicians may suffer increased prevalence of burnout, which represents a challenge given the growing numbers of women in medicine.3 Unfortunately, by shifting focus almost exclusively to the system level to address burnout, the authors discount a large body of literature examining associations and contributors at the individual and clinic level.

Burnout is conceptualized as consisting of 3 domains: depersonalization, emotional exhaustion, and personal accomplishment.4 While this conceptualization may not capture the totality of physician distress, it has provided a body of literature focused on decreasing symptoms of burnout. Successful interventions have been targeted at the individual provider level (ie, stress management, small group discussion, mindfulness) as well as the organizational level (ie, reduction in duty hours, scribes).5,6 Recent studies have also suggested that increasing the occurrence of social encounters that are civil and respectful decreases reported physician burnout.7

Frustration, the annoyance or anger at being unable to change or achieve something, also can be a leading cause of burnout and moral injury. The inability to deal with unresolved issues due to a lack of skills or inability to create a positive reframe can lead to a constellation of symptoms that are detrimental to the individual provider. Nevertheless, system rigidity, inability to recognize pain and pressure, and goals perceived as unachievable can also lead to frustration. Physicians may experience growing frustration if they are unable to influence their systems. Thus, experiencing personal frustration, combined with an inability or lack of energy or time to influence a system can snowball.

Just as we counsel our patients that good medical care involves not only engagement with the medical system, but also individual engagement in their care (eg, nutrition, exercise), this problem requires a multicomponent solution. While advocating and working for a system that induces less moral injury, frustration, and burnout, physicians need to examine the resources available to them and their colleagues in a more immediate way.

Physician distress is a serious problem with both personal, patient, occupational, and public health costs. Thus, it is important that we