You'll get used to it

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I've often thought that I am the most unlikely physician imaginable. I had a horror of illness and medicine when I was younger, and things didn't change much as I got older. Shortly after I got accepted into med school, I went to visit a friend in hospital. I was in a state of panic: my heart was pounding, I felt dizzy, I was overwhelmed by the smells and scared to touch anything for fear of contagion. How on earth was I going to go to medical school?

It would be nice to have some way to explain how I overcame my anxiety. If I did I could probably write a best-seller (one of my secret aspirations), but I don't know how I did it. I just did. I overcame my apprehension about the blood, the hospitals, the death, the insanity. I got used to staying up half the night on call and working the next day. I got used to touching people in intensely private places. I got used to asking them if they were planning to kill themselves.

I got used to all of it and, it turns out, medicine proved to be a good career choice for me. A very good thing.

But I wish all of the "getting used to it" ended there. At some point in my training, it seemed like getting used to doing all those things meant coming to view people as one-dimensional entities riddled with pathology and lacking in personality. One of the biggest tasks of my psychiatry residency has been trying to unlearn that attitude. Today I wonder if professional aloofness is a necessary part of developing professional distance, or if it is a side effect of the training process that could be avoided. I never totally converted to that mind-set, but I got used to seeing it in some other physicians. Little by little, I became acclimatized to the indifference and even the disdain that can so easily replace compassion.

I remember going to a party of medical students a few weeks after starting my first year. I was excited by the prospect of becoming a doctor and, I suppose, still quite idealistic. I asked another medical student I had just met how he had spent his summer, and can still recall my surprise as he described his trip through the brothels of Southeast Asia. This was a colleague speaking? I still had some profound misconceptions about doctors. When I asked him why he had decided to go into medicine, he shrugged. "My mother's a doctor. I enjoy the collegial aspects of it, such as interacting with other physicians." He took a drink. "I don't really like patients much."

I was angered and bewildered. It had never occurred to me that someone would go into medicine even though he didn't like patients. I left the party feeling horribly disillusioned.

When I think of it now, I'm glad I can still recapture some of my wonderfully naïve indignation. But most of the emotion is gone from the memory. I now wonder why that conversation made me so angry. I know that many physicians really don't like dealing with patients, but this doesn't mean they can't be good at their work. In fact, that student turned out to be an extremely competent specialist, an asset to the profession.

I'm not blameless in all of this. There have been times when other physicians referred to patients as if they were a troublesome composite of lab results and imaging studies, and I found myself nodding in agreement. It was certainly an easier way to get through the day.

But is that really what I want to get used to in others? In myself?

I can't fault my medical school. It tried to attract students from the arts as well as the sciences, and integrated ethics and humanities into the medical school curriculum. There was never a policy to promote emotional detachment on the part of the students; in fact, efforts went in quite the opposite direction. But detachment developed nonetheless.

Perhaps that accounts in part for the disdain other specialties traditionally have had for psychiatry. Not that psychiatry is totally immune from detachment, but no matter how biological we become, we can't totally ignore the human nature of our patients. Even when we try to view a person as an isolated brain, much in the same way another specialist might view him as a lung or a gallbladder, the process tends to fail. Why? Perhaps because we are still forced to let the patient speak if we are to determine the nature of his complaints, and once he speaks his soul comes tumbling out for everyone to see.

Often, when medical students move through their psychiatry rotations, I can tell that they have already grown accustomed to seeing patients as less than whole persons. I feel like saying: "Just try it. Try to understand what this person is really saying to you — experience some of your own feelings toward him. You've grown accustomed to doing so many difficult things in your training. I'm sure you could get used to this, too."

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