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The Awesome Journey: Rites of Passage in Medical Education

Walter W. Benjamin, Ph.D.

Professor Benjamin, chairman of the department of religion at Hamline University in St. Paul, gave the following address to the faculty of a Canadian medical school and its students.

While there are thousands of vocations, perhaps there are but three — the priesthood, the military, and medicine — which directly confront one with the holy, awe, and mystery. In them, the boundary of human finitude is experienced. They confront both birth and death and the moments of ecstasy and tragedy between them.

Although I am not a physician, my father, brothers, and daughter are, and I have been involved in medical education and biomedical ethics for many years. And while mine may not be an existential stance, personal detachment might bring objectivity and coherence out of what are most intimate and traumatic moments.

I believe there are six distinct interior transitions during the pilgrimage through medical school and residency. Prior to that, a "call" to be a healer may not be unlike a classical summons into religious ministry. There may be an experience of the "holy in the common" — a childhood injury, a bond with a family doctor, the death of a friend or animal, a curiosity of disease and healing, a desire to fight against humankind's classic enemy, *thanatos* — all these and others, can be motives for entering medicine.

During high school and college years, one's zeal for medicine seldom falters, for ours is a culture which both idealizes and rewards its healers. There is a sense of satisfaction in declaring "I'm a pre-med". A business major may not experience such satisfaction. Habits both necessary for success and problematic for future well-being can develop — compulsive behavior, perfectionism, over-achievement, denial of campus pleasures, and deferred reward. A view from the chemistry lab might bring mixed feelings regarding the frisbee frolickers on the campus commons. Feeling of subtle elitism born of one's higher dedication may be compounded by resentment over the necessity of scientific servitude. Nevertheless,

membership on the dean's list, a high G.P.A., family support and the awe of peers is enough to sustain one.

Survival: The First Two Years in Medical School

In undergraduate life, one was of the "brightest and best." In medical school, everyone has brains enough to spare. In college, it was easy to master a given amount of material. In medical school, the torrent of data on blood, kidneys, drugs, nerves, liver, brain, and bone is spewed forth by specialist after specialist, each convinced that his department is the most important. It is like trying to drink the water coming from an open hydrant: too late one discovers it is physically impossible to master all of the material and that much of it will be irrelevant to patient care. No one tells you that you don't have to know it all.

It is here that idealism first encounters the soulless mien of Asclepius. One longs for the humility of Hygeia. Undergraduate life is looked back upon with nostalgia and is especially sentimentalized if one came from a small liberal arts college where I-thou relations were prized. How one wishes for a course in literature, philosophy or history as an intellectual oasis amid the arid sands of medical vocationalism!

Of course, all is not gloom. There are caring professors who have students for backyard cookouts, student bar parties, and sensitive assistant deans who listen to student anxieties and fears. But it is during those first two years that fundamental questions thought to have been resolved years ago, now begin to surface: "Is this what I really want?" "Have I made a mistake?" "Will I ever be able to pay back a \$40,000 debt?" "Were my frisbee, 'don't sweat it' friends right after all?" Everyone else seems employed, having fun, and getting on with life. Yet, repressing such feelings, one plunges ahead. It's too late to change; besides, what would parents and friends say? They believe those in medicine inhabit the best of all possible worlds.

Suffering and Death: First Patient Contact

After two years in the classroom, being sent to the wards is an epiphany. One can finally move from the nave to the medical altar, probe and listen, be confidante and comforter. The white jacket, drug book, and stethoscope, however symbolically potent to patients, fail to grant an inward sense of confidence. And when patients call you "Doctor", you feel like an imposter before nurses and the house staff.

It is here that the gap between the hospital as idealized and real is experienced. The image of "Ben Casey, M.D." is confronted by that of "St. Elsewhere." The mythology of television "soaps" portrays hospitals with handsome physicians, curvaceous nurses, nocturnal sexual romps in empty rooms, and the sick always blessing their doctors, arising from beds of pain and returning home. Now one sees institutional "warts and

shadows" — professional conflict, exhausted residents, terminal patients who will not die, terrified relatives, non-compliant patients.

Surprisingly, medical education only minimally socializes students to the reality of suffering and death. Culturally we are up-front with sexuality, almost pornographically so, but we are inside-out on morbidity and death. Strange phobias may develop. Every ache and pain however superficial seems to be connected to the rare disease mentioned in the last lecture! As one interacts with the suffering and dying, one realizes the paucity of personal and empathetic skills necessary in medicine. "To write prescriptions is easy," says Franz Kafka in *The Country Doctor*, "but to come to an understanding with people is hard."

One medical student was frantic as a patient screamed at him:

"I don't want to die! I don't want to die!" The student confessed. "I was terrified. I didn't know what to do. I almost ran out of the room. No one mentioned that I might face this during rounds. I wish I had been God and had a magical drug to give him."

After such an experience, the clergy are seen in a new light. They seem to have the personal, institutional, and faith resources which allow them to speak about death with patients with an amazing degree of serenity.

Abuse: The Medical Student as Victim

For the most part, medicine attracts those with strong egos. They enjoy verbal combat and do not experience stage number three. But for some students who are a bit withdrawn, sensitive, and unsure, their diaries record a sense of victimization and abuse. They feel cowed and made helpless by attendants who sometimes use their knowledge as a form of personal power.

Student extroverts are tough-minded enough to take the grandstanding and "pimping" (the student's term) which sometimes go on during rounds. Sensitive spirits, however, are deeply wounded by public exposure (sometimes interpreted as ridicule) for their lack of knowledge and management of a patient. They are honest enough to know the attending means well; that he must protect future patients against lazy student-physicians who might graduate medically deficient. But they wonder why medical education is so often insensitively hierarchical, why they are treated in an I-it rather than an I-thou fashion. In a word, they hunger for collegiality.

Every hospital has an attending who takes his student down a "medical memory lane": his recitation would be humorous if he didn't take himself so seriously. "Now when I was a medical student, we really had it rough, for example ..." Then comes the tale of woe. Fortunately, such attendings are few but their psychic damage on the fragile student is real. Such students inwardly promise never to treat others as they have been treated, if in the future there should be a role reversal.

Because of years of passive receptivity and mastery of technical and quantitative subjects, students often throw themselves with abandon into involvement with patients. They hunger, in the words of Martin Buber, for "authentic meeting and dialogue." However, their mentors criticize them for being "overly emotional", "unable to distance appropriately", and "immature." Sometimes their teachers do not understand that this is their attempt at psychic survival. Often they have only each other to turn to in the affirmation of their being and values.

The First Fatal Mistake

Angst reaches its apex as an intern. One feels sentenced in a "House of God", working 90 hours a week, on call one night in three. Going without sleep for 36 hours at a time is not unusual. Neither is being called out of a blissful sleep to a patient whose distress a nurse could have managed.

Under such conditions, quality of judgment is diminished, sometimes with an unfortunate result. If this happens, there is a flagellation of the self as one re-examines the data base, alternatives in diagnosis, drugs, dosages, and side effects. Fledgling physicians often internalize the medical perfectionism of our culture. To err is human for other mortals, but we hold our physicians to superhuman standards. The super-ego of a resident who has made a fatal mistake can be very punitive.

This crisis can be resolved only if forgiveness is mediated. That graceful word and act can be extended by the patient's family, an attending, fellow resident, a nurse, or the chaplain. The physician is in need of healing; he must be affirmed in his being in spite of his doing. For the resident of mature religious faith, perhaps, such acceptance is easier. He or she knows that his or her existence is of grace rather than merit; that "all have fallen short" of medical ideals as well as of those spiritual. All physicians, whatever their fame or pretensions, have made mistakes. It is sheer serendipity if a human attending confessionally relates a mistake. The bonds between those with the strength to confess a medical trespass are far stronger than those between perfectionist *prima donnas*. A resident forgiven, accepted, and renewed, can speak with greater empathy to patients. A physician, wounded by medical misjudgments forgiven, but not forgotten, is a chastened and compassionate healer.

Medicine's 'Dark Night of the Soul'

Sometime during the middle of residency there may be, as monastics used to say, a "dark night of the soul." There can be a loss of meaning generally and in medicine in particular. Hopefully brief, it is a period of personal fragmentation, emotional torpor, and psychic ennui as one confronts the meaning and purpose of life. The question will not go away: "To *what* and to *whom* shall I devote my life?" Residency burn-out is a real danger. There are moments when only the impotence, not the miracles, of medicine are seen. Then, medical ignorance, iatrogenesis, and helplessness seem over-powering. Chronic disease and intensive care units testify to

scientific limitation. There are days when medical ritualistic behavior seems futile.

Medical colleagues lose haloes and have feet of clay. The political conservatism and moralism heard in the physician lounge against the marginalization of society begin to grate on the soul. Necessary medical humor which serves as a barrier against psychic collapse in confronting tragedy no longer seems funny. One begins to be aware that the necessary socialization to become a physician can endanger the self.

An inner metamorphosis must take place, but one risks changing from a spontaneous, idealistic, and enthusiastic medical student to an emotionally flattened and often arrogant professional. A few drop out, even in residency. Witness the confession of an Ivy League surgery student:

They have a way of making you feel worthless. Where they're coming from, or why they feel so superior, I don't know, but I think it's ironic. We work like slaves, get very little sleep, and have no formal didactic teaching ... and if we don't perform well on standardized tests — there is no explaining — there is no help — there can be no suggestions. We just get degrading letters in our mailboxes about how poorly we have performed ... Well, they've 'taught' me to feel afraid, worthless, ashamed, and often that I don't 'deserve' to be a doctor. Physicians don't have the respect they once had. It's our own fault; we have dehumanized ourselves. In two months, I'll pack up and go home — by my own choice. I know that I am a good, caring doctor. But, my self-worth and sense of competency have had to come from within. They've done everything they can do to tear it down.

S. Walker, M.D., *JAMA*.

"A Piece Of My Mind," March 15, 1985.

Resolution: Professional Completion; Personal Integration and Victory

Just as the entire world is shrouded in darkness, there are moments of beatitude. One begins to experience moments of medical grace. On repeated trips past a room of a lonely old lady dying of cancer, one finds a resident sitting with her, playing cards and chatting late into the night. One sees "another way" and discovers quiet heroism in all echelons of medical rank. As competency deepens, one becomes less brittle and critical. Compliments from nurses and patients are now accepted without feeling guilty. Intuitively, you know you have gained on yourself and that the attendings respect your judgment and treat you as a member of the fraternity.

A hazardous professional journey of over a decade has been successfully negotiated and you have come through, psychic integrity intact, and feel confident in facing future medical unknowns. Only by looking back and remembering those fumbling attempts early in medical school and in residency, is one able to realize how far one has come. A professional armor is in place, sensitive yet resilient, empathetic yet disciplined. Medical art and medical science have their own domain and properly compliment each other. Teachers and attendings who earlier appeared as demanding, uncaring, and harsh are now viewed in a kindlier light. Some may even be remembered as role models.

Those residents of religious faith can see theological linkage — sin, suffering, atonement, confession, acceptance, redemption — which gave depth to their pilgrimage. Many discovered, in the words of Victor Frankl, that they had to have a meaning, a “why”, in their profession in order both to endure and to serve. With the end of residency, a new integration of self has occurred: medicine changed from institutional servitude to personal ministry; from burden to loving mistress.

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