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Anthropology and its aftermath: Humanity in medical training

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Essay/Personal Reflection

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In caring for Mr. Jones, I felt like a phony. For all I had written in my residency personal statement and professed about my desire to be with the sick as I discerned a career in palliative care, I struggled immensely to live up the ideals of compassion, empathy, and patience I explicitly subscribed to and identified with in the course of his care.

It was my intern year, and Mr. Jones was a chronically ill and debilitated elderly gentleman with advanced dementia, heart failure, chronic obstructive pulmonary disease, and prior GI cancer with G-tube dependence hospitalized for acute cardiopulmonary decompensation. I met him shortly into my stint in the Medical Intensive Care Unit as a harried and overwhelmed intern, at which time the decision was made in concert with his family to transition Mr. Jones to comfort measures.

Every day, I would spend time in his room on rounds, apprising him and his family of the daily plan, and then attempt to visit afterward if there was a lull in the afternoon. Given his state and my interest in palliative care, I figured this would be a place where I would find fulfillment and perhaps even joy amidst an intern year which to that point had brought nothing but stress and insecurity.

Instead what I found when I spent time with Mr. Jones and his family alone was an intense discomfort, and an immense difficulty in my attempt to empathize with his current condition, and his humanity more generally. While visiting, my mind would constantly rush to things I needed to do, to my other patients I believe I implicitly viewed as more viable than Mr. Jones. More than this, I recognized that the empathy and compassion I claimed to possess and exercise seemed in such short supply. Whether it was from the fatigue and stress of the intensive care unit or an incipient fear of my own mortality, in caring for Mr. Jones I sensed an immense, seemingly unbridgeable chasm between my experience as the intern delivering care, and his state as an incredibly ill, overtly dependent individual on the brink of death.

While presenting on rounds I could easily enough compartmentalize and distract from this discomfort. But when sitting with him, void of these distractions and obligations, I found the various tubes and lines, his bag of artificial nutrition, his inability to display much in the way of verbal communication, and his frequent moaning almost intolerable to behold. It seemed to me that he and I were so different – in the way we experienced the world, in the nature of our dependence upon others, in my (admittedly attenuated) perception of hope that lay before both of us – which made it nearly impossible to conceive of what his current experience of suffering and impending death must feel like. This discomfort and difficulty empathizing persisted throughout the course of my care for him. Like most uncomfortable things intern year, I filed away this struggle, not reflecting much on its underlying reason or what a beneficial response might look like.

Yet after recently graduating residency, I have been reflecting on the ways that I have been changed by this seminal training experience, a form of change which I think is highlighted by and made manifest in my time with Mr. Jones.

While I'm grateful for the experience of training and the significant progress I made as a clinician, I'm not certain my discomfort in caring for a patient like Mr. Jones lessened throughout the training process; if anything I only learned to make myself more busy to sometimes avoid spaces like this, to neglect those places where I might encounter those seemingly so uncomfortably different from me.

In processing this, I realized that underlying my discomfort in caring for Mr. Jones (and the persistence of this discomfort throughout training) is not simply due to an aversion to suffering, a difficulty in slowing down, or a lack of experience in such settings. Rather, I believe the issue runs much deeper than this. It is due to the fact that medical training implicitly but powerfully cultivates a certain anthropology, or normative view of humanity, which helps us survive the rigors of training, but ultimately complicates our ability to care for and empathize with the sick, suffering, and dependent before us.

This process starts well before we as trainees see our first patients. Medical schools (understandably) select for the talented, industrious, and high-achieving. Those who enter the profession by their very nature have been privileged to avoid certain life challenges or conditions which might render them chronically ill or dependent in the way that Mr. Jones was. When these individuals are placed in a competitive environment in medical school with similarly driven and successful people, the temptation to conflate identity with intelligence and performance only intensifies. Clerkship grades, Step scores, and The Match cultivate an appetite for clinical and technical excellence that ferments in an environment wherein worth is characteristically defined relative to the performance of others, engendering a primacy of individualism and an ever-present sense of competition.

The independent, high-achieving, composed, and comprehensively successful individual then enters residency where this anthropology is further reinforced. Ultimately, we internalize a normative view of a physician-person that is embodied by many of the Chief Residents we lionize – the physician who is independent, autonomous, rational, and competent. This normative view of the person, what makes one successful and worthy, is then systematically reinforced to the degree that trainees achieve success in these domains, creating an intoxicating feedback loop of self-worth which grows insofar as we maintain such success.

And yet, importantly, these characteristics that we view as normative, good, and meaningful in people – those of independence, productivity, technical efficacy, and industriousness – are often the very ones that the sick, suffering, and physically and mentally impaired whom we care for lack by virtue of their conditions and associated life challenges. I believe it is friction between the assumed anthropology of medical training with the actual lived anthropology of patients like Mr. Jones, that created such discomfort in my experience, and difficulty empathizing. I literally couldn't imagine what a life of dependence on others, cognitive impairment, and ultimately imminence of death would be like in my buffeted (and narrow) view of myself and humanity more generally forged by medical training.

Importantly, the problem with this anthropology is not simply that it inhibits us from caring for and seeing and our commonality with the sick, dependent, and suffering like Mr. Jones. It is that it is an anthropology that is patently untrue, and ultimately destructive. Even in our most healthy and robust states, even as physicians with the capacity to care for others, we are thoroughly and irreducibly contingent and dependent on others we work alongside and do life with; we are only better able to hide this dependency due to our high level of function. Moreover, we are only tenuously and temporarily protected from those life-threatening states that foist questions of finitude, embodiment, and death upon the afflicted we care for, often protected by factors largely outside our control.

Thus, to operate as if I am one who only gives, rather than receives care; to take for granted my current physical or mental health and integrity; to fail to see the common fate I share with the ones who are more overtly dependent, or more immediately grappling with their mortality, only consigns me to a present of discomfiting denial and a future of overwhelm when these realities manifest unavoidably, as they will.

One might think that constant exposure to the lives of the sick, dying, and overtly dependent might deepen our understanding and compassion in this realm. But in my experience in training, as my competency, effectiveness, and responsibilities increased, this chasm widened rather than shrank. Rather than seeking out and deepening my common finitude, dependency, and humanity with patients like Mr. Jones, I became more effective at distracting myself from this and validating my worth as a clinician in ways more seemingly tangible than sitting with the suffering.

This diagnosis of the fraught anthropology that medical training instills may sound dire. However, this false anthropology and valuation of competency, efficacy, and seeming independence remains powerful exactly to the degree that it remains implicit, unrecognized, and unstated. Thus, the first step in any constructive response is recognition of the extent to which we come to subscribe to such a vision of human worth and identity during our training, and how it affects the care we provide for patients. It is only with this recognition that we can hope to re-frame experiences in caring for patients like Mr. Jones from those that are stressful and cumbersome to occasions to learn from those who can help us better understand our shared human condition, particularly during moments of immense need which we will all ultimately face.

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