

EMOTIONAL ANESTHESIA: *THE DOUBLE BIND FOR DOCTORS*

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He is bothered by the aesthetics of the sick, Walker mused, by the way flesh distorts itself and accommodates instruments of metal and glass. He gives in to the stirrings of distress. He lets the details of suffering and dying overwhelm him. He has failed to accomplish the main thing required of a doctor. He has not become numb.

from Final Fear by Philip Harper

It is said that the artist most accurately portrays that which society denies. Little attention has been paid to the long-term emotional effects on the physician of medical education and the consequent experiences of practicing medicine. But here, a novelist has noticed something of vital importance in understanding the practice of medicine - numbing, also known as "emotional anesthesia". Numbing is one of the primary symptoms of post-traumatic stress disorder, usually alternating with the intrusive reliving of traumatic experiences.

This is not an entirely new subject. About fifty years ago, Dr. Bertram Lewin, past president of the American Psychoanalytic Association wondered how the education of a young medical student was effected by having a dead person for their first "patient". This question has never been adequately answered. More recently, Dr. Wolf, from the Louisiana State University School has said, "Medical education can be a health hazard for many students, and far-reaching reforms are needed to improve it" (Wolf 1994). If we dare to gaze critically and humanely at the process of medical education it becomes possible to understand how a medical professional could become gradually and insidiously dehumanized as a result of their experiences.

Most medical students enter training in their twenties, years that are, for most people, devoted to the creation of a marriage and family, the most vital of interpersonal attachment bonds after parents. Given the rigors of medical training, students often delay forming these attachments, or families are formed, the young spouses and children suffer the consequences of a husband, wife, or parent who is largely absent. Intimate interpersonal relationships and even friendships are strained both by the excruciating time demands of the student and by the enormity of the experiences that the medical student is enduring.

The first year exposure to the smells, feel, and reality of a cadaver immerse the student in a death exposure that is clinically disguised but is nonetheless, not a neutral experience. This early in the process of medical training the young physician learns how to maintain distance from death, immersed in formaldehyde for months and avoided by others for the noxious odor that surrounds them. First-year students bind to each other in a ritualistic process that is the beginning of an initiatory experience that will continue for several years and often excludes others who are not part of the experiences. The demands to incorporate enormous amounts of memorized material into a meaningful cognitive frame upon which patients' lives will depend, leaves little time for the development of alternative stress-management pursuits, physical exercise, interpersonal relationships, or the expression of creativity throughout the first two years.

Physicians do not spend much time considering it, but the experience of training in and practicing medicine is astonishingly stressful and the exposure to traumatic experience is enormous. A recent study of third year medical students found clinical levels of depression in 23% of the students and 57% endorsed high levels of somatic distress (Mosley et al. 1994). Health care professionals are repeatedly confronted with death and dying, often under horrendous circumstances, are faced with their own shortcomings and failures in fending off death, and are held responsible and accountable for those shortcomings by patients, their families, and their lawyers. Robert Lifton has written about the tremendous toll taken on people by death exposure and the consequent numbing of emotional experience, the sense of alienation from others, from oneself, from personal meaning that attends such exposure (Lifton 1993).

Additionally, physicians are vicariously traumatized by standing as constant witnesses to the pain, suffering, and dying of their patients, expected to relieve such pain but often waiting helplessly by as they reach the limits of modern medicine. The awful reality of the practice of medicine is that physicians could not function adequately if they were unable to turn off their emotional reactions and distance themselves from the pain. The practice of medicine can be said to necessitate the repeated use of dissociation as a protective defense

that is in the best interest of the patient and the doctor. But there is no built-in mechanism to spontaneously heal that carefully learned dissociative split and therefore every physician participates in a lifelong double-bind situation: they are expected to simultaneously feel and not feel. Those who manage to escape this binding situation with their sense of self intact and the capacity to empathically resonate with others, preserved, may be the exception rather than the rule.

As Dr. Wolf has observed, "Healthy medical students are likely to become healthy doctors who can then model and promote healthy lifestyles with their patients. This preventive approach to health care can lead to an improvement in our health care delivery system".

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