

## *What I Learned in Medical School: Personal Stories of Young Doctors*

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With a foreword by Jocelyn Elders, former US Surgeon General



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Book review by Anna Luise Kirkengen, MD, PhD

**D**uring a recent voyage from Norway to Rome, I carried five different texts for study purposes. These texts included a study about the increasing self-medication of Finnish physicians during the latest decade; an editorial about Norwegian physicians who, due to alcohol and drug abuse, lost their medical licensure for a given period; a story told by a male physician who, as the father of a seriously ill physician, sees how his own and his son's profession jeopardizes the son's health and future and how his colleagues ignore the father's professional skills and competence; a draft of my own contribution to a critical anthology on health care research; and another book, *What I Learned in Medical School*, a collection of 23 different voices telling about the general-yet-particular experience of studying medicine.

All five texts shared a common theme, the way a physician lives in the world—or, more precisely, how each physician strives to retain his or her selfhood while becoming or being a doctor. This premise may seem strange; after all, there ought to be no tension—let alone mutual exclusion—between being one's own person and being a physician, a helper for other people. Nonetheless, this tension is what all five of my texts—the study, the editorial, the story, the draft, and the book—were about. This tension is exactly what is discussed by the 23 young colleagues in *What I Learned in Medical School*, who reflect about their personal experiences of entering medical school and becoming socialized into the practice of medicine.

In highly different ways, these 23 physicians describe their particular backgrounds, which reflect great variety: A female Korean naval officer strives to unite family life, gender roles, and her own ambitions; a single, black, previously teenage mother encounters humiliating structural prejudices in the obstetrical delivery ward; a Vietnamese boat refugee alienates himself by denying his past until he understands that he cannot heal others unless he heals himself; the grandson of four Holocaust survivors feels obliged to fulfill their lives' purpose; a married young woman from a small town in Texas becomes “different” and strange in familiar

places; a member of Alcoholics Anonymous is always aware of hiding an incontestably abusive past; a Muslim woman tries to define and defend her white coat and black hijab (headdress) in her own way; a former student of anthropology gains a reputation as a “radical” by allowing herself to pose critical questions in medical classes; a self-mutilating young woman learns in psychiatry class how to think “correctly” about something she knows at a deeper level; a Mayan illegal immigrant from Mexico reminds herself that only her seniors—and not Hippocrates—talk about “illegal aliens.” These colleagues are just a few of the remarkable group described in the book.

These young physicians share—and need to express—a conviction that their particular lives matter, that their special experiences are important, and that their being different has an impact for and on the way they will act as professionals. At the same time, however, they are trained to think of these experiences as either “private,” “irrelevant,” or “erroneous” knowledge compared with professional knowledge. This common experience leads each of the physicians to witness how, despite claims of being inspired by objective knowledge and correct professionalism, medical training and the medical community are arenas of strong and discriminating prejudices. Indeed, the physicians are taught that medical practice is the application of value-free, scientific evidence. However, despite being selected to a field in which peers traditionally share a strong loyalty, the physicians learn that they are still “others”—even in a group to which they are supposed to belong. Through this experience, they never doubt that their “otherness” makes them valuable and able to contribute to the demanding task—altruism—that they have imposed upon themselves. Within the framework of professional medical encounters, altruism means nearly unconditional devotion to respectfully meeting other people's needs and responding to vulnerable persons without insulting or exploiting them. In this context, respect for another person's integrity and respect for self are mutually conditional on each other.

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Here, the five texts meet and testify to the fact that medical training and professional standards alienate physicians from themselves, from their lives, and from their needs unless these physicians invest personal effort and awareness into defeating this alienation.

The Finnish doctors described in one of the texts fail to ask their peers for help and advice and medicate themselves increasingly, particularly for certain conditions. In general, this behavior may show that being ill, impaired, or incapacitated is even less acceptable for high achievers (ie, physicians) than for other people. In particular, this behavior may show that even more than other people, doctors are aware of social shame and stigma linked to certain categories of illness. According to the authors of the study, this more acute awareness may explain why the highest proportion of self-medication cases—two thirds to three fourths—are connected to mental disorders, asthma, and gastrointestinal diseases. In contrast, only one out of four doctors who self-medicate do so for cardiovascular disease, apparently perceived as a more respectable condition.

Like their Finnish peers, Norwegian doctors fail to seek help from their own profession when they need it most: during episodes of crisis and “overload.” Drugging themselves without asking for help and counseling, they endanger not only themselves but also their patients. In doing what they never would advise other people to do, they implicitly admit an awareness of shame despite their professional training in nonjudgmental approaches to impairment. In practicing self-neglect, they explicitly reveal an area of conflict engendered by medical training.

This is where the story of father and son (both of whom are peers of the son’s doctors) allows insight into the medical profession’s deepest shortcomings. In the role of seriously sick patient, the son dares not challenge his own colleagues despite the fact that they have endangered not only his future as a physician but his life by overruling or ignoring his wishes and needs. Suddenly, his most salient existential interests begin to conflict with both his training in professional loyalty and his professional confidence in objectivity. The father, in his roles as father (of the patient), colleague (of his son and son’s doctors), and medical teacher, dares not object when his peers insult him by ignoring his professionally grounded reservations and objections to the medical interventions taken. On behalf of his son and himself, he is shaken by the display of power—or, rather, abuse of power—exercised by his peers and linked to presumably objective knowledge, shared by apparent equals.

This phenomenon has led me to contribute a critical appraisal of current health care research with regard to patient satisfaction, quality of care, work satisfaction, and patient empowerment. I argue that numerically grounded studies in the arena of socioculturally structured meanings and values represent categorical mistakes. Thus, information derived from such studies may be quite correct in the sense of statistical calculation yet may be flawed to the point of being irrelevant to social reality. Moreover, by offering to informants options that validate only the surface aspects of current clinical practice, informants are methodologically blocked from criticizing structural phenomena. As long as patients are not allowed to object to being fragmented into organs during medical intervention, no benefit can be found in having a choice between several hospitals; organs, tissues, and cells determine the architecture of our whole medical enterprise, even our most modern clinics. As long as objective knowledge expressed in questionnaires systematically overrules subjective knowledge by presenting only preformulated options for answers, people’s own utterances are literally not given space. As long as the human life-world is, due to medical theory, nearly excluded and eliminated from medical knowledge production, “scientific” interest about people’s experiences and opinions is nothing but pretense.

The aforementioned texts show that Finnish and Norwegian doctors avoid current health care when they have the greatest personal need for it. Perhaps they, better than others, are familiar with the inherent, systematic contempt for disability and the tendency to blame those who are weak. Even doctors, such as the physician father and physician son, experience the discrimination exercised by a powerful system the very moment they, as members and equals, question the legitimacy of this power. These two, and probably many other physicians, have come to acknowledge the structurally grounded insufficiency of medicine when it comes to the core of human existence.

And here are our 23 young colleagues, who believe that not only their own but also their patients’ lives and experiences matter in every medical encounter. We may hope that professional knowledge will soon be brought to a collective awareness that doctors as well as patients are persons. And we may also hope that these young people will not be forced by their own discipline to regret their own contribution to praising diversity and considering human life as a source of medical wisdom. ♦