The International Journal of
WHOLE PERSON CARE
VOLUME 10 ● NUMBER 2 ● 2023 ● 29-31

APATHY SETS IN DURING THE THIRD YEAR

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KEYWORDS: Narrative medicine, Medical education, Psychiatry, Empathy

I met you on a stormy day. I had already been six weeks into my psychiatry rotation and every shift had been confirming my interest. When I heard a young woman was being brought to the emergency by her friends for depressed thoughts and suicidal ideation, I got excited. I wanted to do that consultation; I love this patient population. When I found out you and your friends were second-year medical students, I wondered how it would affect history-taking and therapeutic alliance-building. I did my best at the interview: I made sure to give you space, to validate your experience, while asking all the screening questions. You are going through a lot and life has not been easy for you. I feel for you and want to help. I leave the room, write my report, and come up with a differential diagnosis and plan. Major depressive disorder or adjustment disorder, I think, is not an acute risk to self or others. We discuss a safety plan, red flags to come back to the emergency room, crisis resources and outpatient psychiatry follow-up. Your friends are upset: "This is all you can do for her now? You are going to send her home to wait for someone to call her in some indefinite amount of time while she is currently in distress? This is impossible, we are not leaving until something concrete is done." I had not seen that one coming.

I have always been fascinated by stories; particularly when they have a blurry beginning, unclear progress and unfinished ending. I like stories that can be dissected, analyzed and reconstructed. I like stories that offer space for interpretation. I like stories so much that I considered writing before deciding on medicine.

As it turned out, I was better at analyzing them than making them up. More often than not, my favourite part of medicine remains the "history of present illness" and "impression". *This is what I think it is based on what you are telling me.* I remember very vividly, at the very beginning of our first year of medicine, being warned that "Apathy sets in during the third year." *Not for me*, I thought. I felt like if anything, I would always be connected to my patients' stories.

Back to my patient in the emergency, there was a clear mismatch between the stories her friends and I had told ourselves about the patient. To me, this was a patient with a low suicidal risk presenting to an overloaded emergency system with limited services to offer. To her friends, this might have been the first time they had someone close to them experiencing such intense emotional distress as to express wishes to die. Even after clarifying the functioning of the psychiatric emergency system and validating their frustrations regarding wait times for outpatient referrals, I still felt like something was missing. I could not ignore that the voices of these two friends resonated too close to home: they could have been mine a year ago. Yet, it was as if the transition from learner (as a second-year medical student) to provider (as a clerk) had erased my ability to relate to what it meant to be on the receiving end. It was as if now that I was exposed to clinical practice, I could not recall the experience of "not knowing". I was not able to avoid the third-year medical students' fatality, after all.

It required me to make a conscious effort to be able to step out of my own "post-clinical exposure" perspective and understand theirs. I had initially agreed with my supervisor that the friends were "unreasonable." Yet, when he entered the room to confirm the plan, I felt a switch in my perspective. It was as if the naturally existing hierarchy got me closer to the shoes of the medical students, allowing me to understand that what was unreasonable in this interaction, was not their expectations but those of the treatment team. How can we expect patients to understand that an emergency room is for, "stabilizing," "providing acute care," and "triaging" rather than healing? How can we expect them to know that what may have been their first access to care is not able to care for them?

It is in the philosophy of narrative medicine that I started finding answers – not about fixing our broken medical system, but rather about fighting apathy. Narrative medicine borrows from the humanities and arts to provide us, healthcare professionals, with a framework for approaching patients' problems holistically and understanding how their experience of illness and healing may be anchored into a wider narrative, that of their entire life as well as ours.[1] It may be as a medical student, whose life experiences could be closer to that of being a patient, or as an experienced physician, whose experiences may be tainted by the innumerable patients they have treated – and maybe more so by those they have found "difficult" or "challenging." Why is it that some patients make us want to move mountains when others we look forward to closing the door on? It would be a mistake not to understand how our past experiences, roles and responsibilities in the patient's story influence how we interpret it, how we present it during handover or condense it in discharge summaries.

Concretely, there was little else we could have done for this patient. The medical system being what it is, she would have to wait for a call in an unknown amount of time, telling her it is finally her turn to be receiving the care she needs. Yet, I would argue that a lot more ended up being done. My own positionality as a medical learner ended up being a therapeutic ally: I could both validate my patient's and her friends' incredulity while also explain the reality of the field. I gave her a list of mental health community resources as well as private psychiatrists who offered rating scales. It was not much, and still appeared extremely unfair that one would have to spend money to access appropriately-timed care, but the three medical students left telling me it still felt like "something was being done." What they needed was validation that they had done a good thing by coming to the emergency and that their friend was going to get help. The limitations of this interaction were not that of the system, but my very own, in understanding how it was impacting the therapeutic relationship.

Narrative medicine has not only been reported to have a healing power from patients' perspectives but has also been proven to do so medically. Practitioner narrative skills may alleviate cancer pain, reduce disease in rheumatoid arthritis, improve lung function in asthma and heighten immune response following hepatitis B immunization.[2] In addition to providing better patient care, narrative medicine could also offer a way of making us more empathetic toward our patients. By allowing ourselves to enter our patients' shoes, we could better understand their expectations of care, which more often than not may be as important to address as their "chief complaint". As future physicians, we are going to be perpetually exposed to stories, so why not use them to heal? ■

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Biographical note

Lucie Dubes is a 3rd year medical student at McGill University. She completed her Bachelors of Arts in Human Biology & Society at the University of California, Los Angeles and worked in clinical research for a few years prior to starting medical school. During her medical studies, she became interested in the Art of Narrative Medicine, and completed the Foundation in Narrative-Based Medicine Digital Certificate at the University of Toronto in April 2023.