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Finding strength in my weakness

A reflection on becoming a patient in medical school

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I sit, suspended in time and space, staring at the needle hovering above my abdomen as the seconds on the clock stretch into eternity. Holding the syringe, I will my hand to make the quick, dart-like motion and get it over with. In my head, I count:

One...

Two....

Three.

Still no movement. I stare harder, concentrating. Just pretend this is a patient's abdomen. This would be easy to do for a patient in the hospital.

I decide counting down might work better.

Three....

Two...

One.

It doesn't. My heart pounding, I exhale. I realize I have been holding my breath. I lean back against the sofa cushions, frustrated and angry. Pulled back into the reality of my living room, my hands have grown cold while the ice pack I prepared, yet unused, has come to room temperature.

It is month two of glatiramer acetate (GA) injections. GA is a first-line disease-modifying drug treatment for multiple sclerosis (MS). MS is a neurodegenerative disease affecting predominantly people between the ages of 20 years and 50 years. The underlying pathophysiology is an autoimmune assault on myelin, the conductive coating around neurons, in the central nervous system.¹

MS is a fascinating disease. It can cause marked disability within days, with symptoms often completely disappearing after several weeks, only to return months or years later, worse than before, or leaving lasting effects. For patients, MS is an omnipresent threat to vitality and livelihood, a game of neurological Russian roulette.

I was diagnosed with MS in the summer of 2016, after my third year of medical school. Though I could not correctly identify it at the time, my first experience, a subtle visual change, occurred while I was studying for Step 1 of the United States Medical Licensing Exam (USMLE). I chalked it up to stress.

My first relapse, a somewhat more worrisome and disabling vision change, occurred as I was nearing the end of my internal medicine rotation. I was terrified to admit something felt wrong, but the medical providers to whom I did disclose reassured me—I remained able to fulfill my clinical duties, and my physical exam was normal. I began to feel like I was going crazy, but eventually the symptoms resolved.

With my second relapse, a more severe iteration of the first, I immediately recognized the symptoms, and the diagnosis was made.

It was recommended I start GA, and, after reading the literature, I agreed. I chose to do the injections manually from the start, as the alternative was a frighteningly loud, spring-loaded automatic device.

At first, the injections were novel, and more intriguing than painful. In the first few weeks, as I rotated through my body's injection sites—hips, thighs, abdomen, and arms—I learned quickly that I would barely feel the 29-gauge needle if inserted fast enough, but the medication itself promised several hours of pain and swelling. The target was subcutaneous fat. Any deeper, into muscle, and the pain was stabbing and relentless. More superficially, and skin irritation would result in a huge, throbbing, erythematous welt. Regardless of depth, I was assured of a tender nodule for at least a day or two—a constant reminder of my diagnosis.

During those first few weeks of injections, a deep, primal instinct began to condition my body; even as every rational part of my brain fought it, the drive to avoid pain betrayed me. It was taking longer and longer, with increasing anxiety, to take the final action and plunge the needle into my skin. I was beginning to doubt that I could do it.

I thought I had understood and empathized with patients on the hospital wards; in reality, I had been a blissfully unaware bystander alongside an ocean of patient experiences.

Wrestling with the diagnosis of a chronic, potentially debilitating disease during the toughest year of medical school was unquestionably a simultaneously challenging and humbling experience. While the clinical years of medical school are known to be isolating for many students, I found that personal health struggles amplified this feeling, as it also presented me with a new, somewhat uncomfortable role as a patient.

Yet, I thought the need to assume a dual student-patient role in medical school must not be unique. Seeking guidance and comfort in camaraderie, I searched in vain for reflections of fellow medical students who lived with a similar reality. I found none.

Pages and pages of reflective essays written by medical students about clinical experiences or memorable patients abound. I began to wonder why it is so difficult to find reflections about personal health struggles written by medical students. Granted, we are a generally healthy cohort, but statistics suggest there will still be those among us struggling with medical diagnoses.

Literature on this topic is lacking, but from personal experience I believe the reason can be found within the hidden curriculum of medical education. Students learn that self-sacrifice in the name of patient care is valued higher than providers' own health and wellness.

I was never explicitly told I could not take time off—I never asked—because the implicit message in medicine is that only true emergencies can justify missing clinical time. Never mind that outpatient clinics are only open at times that are impossible for students and residents to attend.

At the time of my relapse, I was not sure anything truly serious was going on. I wanted to make a good impression with my clinical team, and I did not feel I could justify a day off for a scheduled medical appointment. Thus, I prolonged my access to care, passing up a next-day opening, and waiting more than a month for the next appointment to see an MS specialist.

Possibly more influential than the devaluation of

provider self-care is the generally competitive environment of medical training, naturally resulting in non-disclosure of any potential weaknesses. I have always found it simultaneously ironic, frustrating, and mildly amusing that each level of academic training promises reward at the next in exchange for excellence. This ultimately escalates into an unrealistic level of perfection: excellent high school grades and SAT scores are required for admission to a well-regarded university; a superb GPA and MCAT score in college are required to attend medical school; stellar USMLE scores and clinical evaluations are a necessity to match at a top residency program. The cycle marches on through residency, fellowship, and beyond. It is no wonder medical student reflections on personal experiences with chronic medical diagnoses are limited—to do so may be perceived by some to publicly admit weakness.

I write about my MS diagnosis for personal catharsis—to name my anxieties and fears, and let them go onto the page. I write so friends and family outside of medicine might understand my experiences on the wards. I write to share my thoughts and feelings with other medical students—those who feel isolated in their personal struggles; those who are navigating the waters of learning to be both a provider and patient; and those who hide an illness for fear of being perceived as weak. Despite often super-human expectations, health care professionals are not high-performing medical robots; they are flesh and blood, and carry human heartaches and triumphs throughout medical training and practice.

We all have weaknesses. To pretend otherwise would be a lie. But acknowledging one's shortcomings, and asking for help to overcome weaknesses, is perhaps the truest indication of strength, humility, and self-awareness. Personal struggles, which may be perceived as weaknesses by some, do not necessarily make us weak; on the contrary, they may strengthen us in other ways.

Our suffering, our struggles—our acquaintance with deeply emotional human experiences—will make our empathy stronger, and our relationships deeper. Ultimately, it will make us better physicians for our patients.

References

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