A PIECE OF MY MIND

I Solemnly Share

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When I was a little girl, my mom or dad would tuck me in at night. I would make each parent complete the ritual of saying goodnight to my stuffed animals and dolls. There was a giant stuffed bunny whose name now escapes me and a multitude of Beanie Babies. There was my Raggedy Ann doll, and there were two plump handmade dolls named Peppermint and Tom. To me, it was essential that each of these entities be kissed and greeted every night, as a reminder that he or she was loved. I was certain the toys would feel terribly sad if neglected. Looking back, I'm sure my parents found this repetitive behavior tiresome, but they tolerated it out of love. This was the first time I remember feeling responsible for the well-being of someone else. "Goodnight, Peppermint," we would say together. "Goodnight, Tom. Goodnight, Raggedy Ann."

Twenty years later, I was well into my second year of medical school. I had weathered the storm of the first year of basic sciences and was now struggling to understand neuropathology. I had scored very poorly on the first week's quiz, so I needed a much higher mark on the second quiz if I wanted to pass the neuroscience sequence.

The night before the second quiz, I remember scrolling through what seemed like an endless series of lecture slides on movement disorders. Each slide presented testable information on the signs, symptoms, genetics, and pathology of different diseases. Like almost everything else in medical school, digesting and memorizing this mass of information felt like an impossible task. Historically, I had outperformed my own expectations, managing a passing grade on each weekly quiz. There was evidence to suggest that I could do this, and yet viscerally, I knew that I could not—not this time.

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Something happened within me in the previous months, though I lacked the language to describe it. The chronic anxiety and sleeplessness of the previous year and a half had begun to wear on me. The daily struggle to get by had dominated my focus for so long that I could no longer recall the basic love of science that had pushed me toward medicine. As with every prior test of my endurance, I challenged myself to dig deeper and find the strength to keep going. Yet when I searched, I could not locate a reservoir of resolve and I emerged empty-handed and exhausted. As I scrolled to a histological image of Alzheimer disease, I was startled by a droplet of fluid that splashed onto my iPad screen. I picked up the device in earnest and watched the salty tear slide tortuously through tau protein accumulations and neurofibrillary tangles.

I failed the neuroscience sequence. There were other life developments that concurrently clawed at my confidence, but this failure was the main precipitant of my fall. I am tempted to make an elaborate case for the depression that subsequently took me over. I am compelled to defend my feelings with logical reasoning and to list all the reasons I was justified in feeling the way that I did. But depression didn't proceed logically. I was already low and failure brought me lower still so that like an opportunistic infection, depression took advantage of the chance to devastate me. In the weeks that followed, I began to see myself as incompetent, unlovable, negligent. I interpreted each bump in the road as evidence that these were accurate judgments. I remember breaking down when I received an email stating that I was late on my monthly cable payment. Then, afterward, hating myself for being so insufferably unstable.

Once—and I have never shared this before—I stepped into the street on my walk home from the library. I knew that the bus hurtling through the night would not have time to stop before colliding with my darkly dressed frame, fracturing my bones and scattering my belongings. I imagined my head hitting the asphalt and my brain banging around inside of my skull, bruising irreparably with each impact. I imagined the bus driver's horror as he turned off the ignition with shaking hands and leapt out of the vehicle to locate my body. It would be a catastrophe that the trauma surgeons could not salvage. I would die.

"Goodnight, Peppermint. Goodnight, Tom. Goodnight, Raggedy Ann."

These words emerged from somewhere in the depths of my consciousness, and I stepped out almost as quickly as I had stepped in. The warmly begrudging faces of my parents invaded the violent scene in my mind. They believed in my ability to take care of other creatures. I did not have it in me to take that away from them.

I realized after that moment that I needed to ask for help. After almost a year of medications and therapy and taking time off school, I am grateful to feel like a stronger, more grounded version of myself. For the first six months of treatment, I stayed extremely private about the state of my health, confiding only in my family and a few very close friends. Yet as time went on, other people approached me with their problems. I willed myself to be more open about my own struggles. It is amazing what you learn when you open up to your fellow medical students. Depression and its vestiges are everywhere.

Practicing physicians and physicians in training often write about their patients and use writing to make

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sense of their clinical experiences. But in a profession in which subjective evaluation is constant and for which we are expected to be pillars of strength and beacons of empathy at once, it is less popular to use writing to publicly deconstruct ourselves and our own emotions. Writing about our own struggles with natural elements of human experience, like sadness and loss, is painful and risks affecting one's professional image. When physicians' mental health is discussed, it is often done so through an academic lens, with particular attention to trends and statistics. Rarely is the voice of any specific individual emphasized. Paradoxically, the way this topic is presented can make depression seem like a standard emergent property of medical training. An underlying suggestion is that depression is simply something that physicians experience—it is something that physicians *handle*.

Yet I think we do people a disservice anytime we attempt to preserve the belief that medical professionals, stewards of good health, need less help coping with psychiatric disease than do their patients. Depression leaves massive economic and health care costs, and a growing body of evidence suggests that it has a penchant for painful interference in the lives of physicians[1] and medical students.[2] We contribute to the stigmatization of mental illness, furthering the notion that dealing with depression is something to be ashamed of, something that should be kept quiet. A recent study estimates the costs associated with physician turnover, decreased productivity, and decreased patient satisfaction due to self-reported symptoms consistent with burnout, noting that system-level change addressing the drivers of burnout, including institutional culture, is both ethically and financially responsible, with an enormous measurable return on investment.[3]

Depression is not weakness, though depression is a disease that may make you feel weak. Depression is neither laziness, nor apathy, nor a lack of professional fortitude. It is an expression of an underlying neurobiological pathology about which researchers still have many questions. It is a pathology that, like a many-tentacled octopus, grasps at our emotional stability, our cognition, our sleep, our patience with people, and our will to go on. Depression can obscure our personhood, so that it is hard for others—and for ourselves—to see us for who we really are. Admitting to depression is not weakness but rather is further confirmation of an insidious, life-threatening epidemic in the medical profession. On a very simple level, it constitutes an admission of humanness.

Even as I pen these words, a great fear swells and rises in my throat, threatening to take me over. At least for me, shame has never quite relinquished its grip on vulnerability, and vulnerability is deeply uncomfortable. As an aspiring physician, I may be committing professional self-sabotage by telling my story. My prospective employers may judge me to be unstable and unfit to care for patients. But the tears of my colleagues, the tales of deferred suicide attempts my classmates have confided in me, and the tragic deaths of bright minds around the country lend strength to my conviction to write about my experience.

I admit openly that I am just as vulnerable to the elements of life as are my future patients, hoping that others will do the same. I do so in the hopes that the culture of the medical profession will evolve to value imperfection as a harbinger of humanity, and that this value will be exemplified by the way we judge our students and residents. If I have learned anything after spending most of my short life in pursuit of academic distinction, it is that the appeal of the dividends—good grades, high praise, awards—is as ephemeral as the warm glow felt on their receipt. Not so with the call to protect human life; that's something truly worth living for.

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1. Mata DA, Ramos MA, Bansal N, et al. Prevalence of depression and depressive symptoms among resident physicians: a systematic review and meta-analysis. *JAMA*. 2015;314(22):2373-2383.

2. Rotenstein LS, Ramos MA, Torre M, et al. Prevalence of depression, depressive symptoms, and suicidal ideation among medical students: a systematic review and meta-analysis. *JAMA*. 2016;316(21):2214-2236.

3. Shanafelt T, Goh J, Sinsky C. The business case for investing in physician well-being. *JAMA Intern Med*. 2017;177(12):1826-1832.