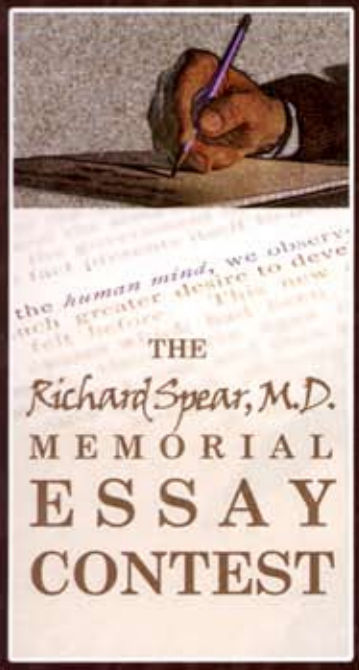

STUDENT CATEGORY WINNER

NOTE TO READERS: The names and identifying characteristics of patients have all been changed to preserve confidentiality. Names of physicians and staff have also been changed to protect anonymity.

Clyde Cohen

Clint Morehead

Imagine for a moment that you are hiking through a forest. Against a thin layer of rubber, plastic and Gore-Tex, you feel the consistency of the forest floor, a trail packed solidly by unknown hikers. The trees rise like cathedrals above your head before the branches begin. Then everything goes dark. The leaves act like filters, altering the dimming light, turning your skin green — green and yellow — until your eyes must strain to make out any color at all. You hear the jostle of leaves high above. As you round a bend, a slit of sky comes into view. It is heavy with clouds — gray and black. The wind has picked up. You find shelter against a nearby rock wall and you watch the storm unfurl.

The thunder moves you. Your heart grows anxious. Fear occupies the space between your heart and your sternum as you tuck yourself into a ball. The trees within your view bend in positions you never thought possible, positions your own body made once before, at a time you cannot remember. Here, in your sylvan asylum, you pray that you will not be found.

The storm now sounds of Howitzers retreating. You return to your trail. It's different. One of the giants has fallen, a casualty of the belligerent wind. Its roots are thrust into the air; its trunk parallels the trail as if a hand had set it down with thoughtful precision so that you may easily navigate around it. Up ahead, its branches are flayed in a half-circle of disarray, defeated, crushed and snarled against the puddled ground.

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Clyde Cohen held his 6-foot-5-inch stature rigidly, towering over the other patients in the psychiatric ward at Norton Hospital. On the morning after his admission in mid-August, his face, expressionless, gave us no indication whether he understood the severity of his illness or the fact that he was ill at all. Frozen in position, muscles at rest, his face resembled a concrete bust, unresponsive to the flurry of movement in the day-room where other patients clipped hurriedly around him, awakening, rubbing their eyes and yawning, orienting themselves as the hospital staff sorted and distributed breakfast. Clyde gazed simply into the air and said nothing. When he walked, he assumed the nature of a machine. He picked up his right foot, held it an inch or so above the floor, and with his knee locked, he moved the entire right side of his body forward, pivoting around the left leg, then the right. With his spine and neck aligned in perfect military stature, I was inclined to imagine him as a tree. Had he extended his arms straight outward, perpendicular to his body, we would have had no trouble passing underneath them.

Clyde was 35 years old. At 19, he was diagnosed with schizophrenia. "Before it all broke loose," his mother said, referring to his first psychotic break, Clyde had been studying engineering at Western Kentucky University. He was an athlete and a musician, participating in his school's cross country team and playing the guitar with his friends. Now, 16 years later, he has retreated into a dismal state of solitude, most days locking himself inside his apartment, allowing only his mother to enter. The day before we met Clyde, his mother had filed a Mental Inquest Warrant, or MIW, which would hold him in

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an inpatient psychiatric facility until it could be proven that he's no longer a threat to himself or anyone else. His mother told the social worker that Clyde had been on a slow, steady decline over the past several months, regressing finally to a point in which, she believed, he could no longer take care of himself. She reported that his thinking had grown increasingly disorganized, that he had begun talking excessively about religious themes, and that he had quit showering. She described how clutter and trash had accumulated in all the rooms of his apartment, making it impossible for anyone to move around without tripping. She also noted that he had positioned the few pieces of furniture he owned in bewildering orientations: feng shui, schizophrenia style. The kitchen was a story in itself: "Canned goods are piling up," she said, "and he has six cartons of eggs in the refrigerator and some in the freezer. I'm worried that he's going to make himself sick."

Dr. Shield, our attending, assigned me to Clyde shortly after we first spoke with him. "This should be a good case for you," he said. "Mr. Cohen is an excellent example of disorganized schizophrenia. Hopefully you'll get to see him improve while you're here."

So I followed Clyde for a little over a month. Every morning after the team completed its their rounds, I headed to his room, knocked on the door, walked him to an unoccupied table in the day-room, and asked him some questions. Dr. Shield instructed me to ask the same questions every day: How had he slept the night before? Did he have a good appetite? Had he noticed any side effects from his medications? Was he in a good mood? Did he have an inclination to kill himself? Psychiatrists routinely ask their patients these questions to assess the ways their minds aremind is working. Clyde never was suicidal. He always reported sleeping and eating well. And when asked his mood, he invariably replied despondently, "Fine, I suppose."

Through this standardized set of questions I made inferences about Clyde's progress by observing how he answered them. Over the course of that month, his responses varied. Before the medications had kicked in, each morning he faithfully led me down a solitary, dizzying loop of nonsense, what psychiatrists call circumstantiality. His mind surfed to a place that only he knew, but with the reliability of a boomerang, he would eventually make his way back to my original question, even if, by then, I had forgotten what it was.

After the first two or three days, I started paying attention to Clyde's tangents, which nearly always gravitated toward the subjects of clarity and nature. They made no sense to me. But these thoughts contained such concrete imagery that it would not have been a stretch to believe that he could have been a great writer or a poet had he the capacity to integrate. Every morning, for example, when I asked him how he had slept the night before, he would begin by answering as anyone else would. "I slept fairly well," he often said. I would begin to think that we were finally making some progress. But he didn't stop at that. Before I could move on to the next question, he would describe the act of waking up. He would say that he rose with the sun, watching its rays engulf the narrow hospital window and strike the wall across from his bed. "The light started in stripes," he said one morning, and described it taking on geometrical shapes: horizontal lines that spread, widened, and blurred against a wall that caught and held them like an artist's canvas. He said he watched the stripes move across his bed, and he resolved not to start his day until they reached his eyes. This was the reason he was late to group therapy that morning. The light in the hospital reminded Clyde of his apartment, which I later learned, he missed dearly. He would describe the light entering his kitchen, striking a chair and crossing its carved woodwork, throwing its shadow onto a yellow wall, and making its way to the living room. Only then, once the light had covered all three walls and disappeared, would Clyde stop reading his newspaper, lace his shoes and leave the apartment for a six-mile run. What a way to live.

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Regardless of Clyde's farraginous intellect, I envied him for his awareness of the world. Even though I knew that all these images filtered through a psychotic mind, I wished that I was more like him, that I paid more attention to my world the way he did his. He remembered everything he saw as if it were for the last time.

Sometimes as a medical student, you come across a patient who enters the thickest layers of your skin and finds his or her way into some of the deepest, most vulnerable places. Clyde became one of those patients. As time passed, I realized that he and I were not all that different. We both played the guitar and loved music. We both took long runs outdoors and had belonged to our high schools' cross-country teams. We both found solitude in nature. I was happy to spend time with him, to try to understand his illness and to watch him respond to the medications. But later I found myself worried that I may have become too involved, paying more attention to him than to the other patients I was following. I wondered whether, in principle, I was giving him better care simply by showing interest and trying to engage him in conversation. Therapists call this natural drive to identify with a patient countertransference. Almost automatically, we find aspects in our patients that remind us of ourselves. In the first and second years of medical school, I was taught that countertransference had its advantages and disadvantages, but the overriding theme of these lectures, I remember, was that it can be a curse, and that for now, to keep things simple, we were to avoid at all costs. If it somehow crept into that doctor-patient relationship (or in my case, student-patient) I was expected to identify it, target it, and annihilate it, for it has the strength, I was told, to break down walls, taking the caregiver down perilous paths of emotional and personal involvement that could be detrimental to everyone.

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There are always stories circulating the wards of how a young doctor, seemingly stable, had completely lost it one day. It was an unexpected complication, an order left unwritten, a patient who died. Any of these could have pushed them over the edge. Then they would leave the hospital sobbing, blaming themselves for what had happened, mourning excessively, and then later, spending hours of sleepless anxiety reevaluating their liveslife, questioning their competence, wondering if they had chosen the right career. To avoid such reactions, I was told, we must keep that nasty countertransference at bay. We must disconnect. We must stay in control.

I saw an oncology fellow once who, apparently, had taken those words to heart, intent on not losing it, though he may not have even known what he was doing. He was sitting at the nurses' station on the cancer ward at University Hospital dictating a discharge summary. A woman was wheeled onto the floor in obvious pain, her screams we could hear before she even came into view. Awaiting a clean room, the transporter locked her stretcher in place directly in front of that fellow who continued dictating into a phone, never looking up, never offering help, completely oblivious to her screams. All I knew just then was that I didn't want that to be me, untouched and distant. I later described the incident to a palliative care doctor. "That fellow," she said, "put up a wall and wouldn't let the patient touch him ··· Here, in this place, it's just you and the patient and your soul. You have to look inside. You have to listen to your soul and just let go. It's like writing a prescription for yourself — one of the hardest things a doctor can do."

In some ways I can understand why those preclinical educators said what they did. We deal with life-and-death situations every day. There's bound to be a complication, something that no one had expected to happen, and we must try to remain composed. Furthermore, when we meet a patient who vexes us to no end, we are naturally inclined to avoid them. This reaction in particular we must watch out for. But is it truly possible to give the best care to our patients if we must also maintain strict indifference toward them? Such a cold view surely would level the playing field, removing the purging of emotion or the favoritism or neglect that countertransference may bring, but at the same time, it would prevent us from caring. Compassion would disappear.

We, doctors and students, are people too. Fear, confidence, desire, anger, sadness and pity are welded into us by nature. To completely detach ourselves from one another is a sad prospect. Unless we want to view our patients as bags of organs and conduits of fluid rather than as persons, as real as you and meme, we must allow room for attachment. Determining where the line that separates attachment from detachment and setting it down every time I meet a new patient, for a young medical student like myself, is where the trouble is. I do not claim to know how to connect with a patient, how to feel without feeling too much. I just know that I need to come up off the bench, get in there, do it and learn: for. For me and for them. Thoreau knew the frustration involved in wrestling with our identities.who we are to be. In a light passage from his journals written when he was only 23 years old, he writes, "I think if I had had the disposal of this soul of man, I should have bestowed it sooner on some antelope of the plains than upon this sickly and sluggish body."

I am flawed, I know it. I dance clumsily with these heavy matters of the soul each time I encounter a patient. I'm not sure whether my questions dig too deep, whether they cause their recipients to shuffle nervously in their chairs. I've stationed myself in unfamiliar territory. I feel locked-in, watching from above with a discerning eye, seeing my mistakes as I make them. I must grow into this skin. I must learn how to be both a care-giver and a companion, a role I've never known. I must look inside. I must write that prescription every day.

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On the last day of my psychiatry rotation, the unit received word that one of the patients who had been discharged a few days earlier had committed suicide. A heavy curtain of sadness fell as the news spread. I had not been assigned to follow him as I did Clyde, but I had seen him each morning on rounds during his two-week stay with us. He had been admitted for an acute depressive episode. He was bipolar. I observed how the unit responded to the news of his suicide at our team's meeting that morning. Silence drew around us all as the nurses and doctors gathered their thoughts. Then Dr. Shield put forth his hand. Trying ineffectively to hold back his tears, he blamed the insurance companies for restricting doctors from caring for their patients the way the doctors see fit. I was astonished to see this aged man so affected. Silently, I hoped that one day I would respond the same way. There is no glamour in grief, but it is real, and to feel it shows that we are real.

I felt for those around me, but I was unable to conjure a visceral reaction myself. But that's the place of the student, all this time sitting in the periphery, observing, learning how to feel. For the student, this is a unique position. We have here the opportunity to spend time with the patients without the pressure of efficiency, without endless admissions and discharges, without issues of billing and fights with insurance companies. Those, for now, are the jobs of others. The student reads the patient's history, studies the chart, researches the diagnoses and therapies and sees the illness as it presents in a person rather than in a textbook. The student also learns how to interact with that person, experimenting with diction and tone, with schemes and tropes, with how to express concern and compassion.

With Clyde Cohen, I tried all this. Although his reaction to my words was difficult to interpret at first, I eventually found him sharing his thoughts with me, thoughts that he didn't want to discuss with his doctors. He looked at me one day, nearly four weeks after his admission, his thoughts

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clearer now, and said with some frustration that was difficult to tease from his expressionless face: "I have an open mind, and I'd accept whatever they have to tell me. I just want to know why I'm here." I tried to imagine what it must feel like to be exquisitely ill but not to have the slightest idea that you are sick at all. Unimaginable, I thought.

Before my time with Clyde, I had never known that a patient with schizophrenia could have such a distinctive personality, just as we all have. It just takes work and time to find it. "Indeed, the innermost core of the patient's personality is not even touched by a psychosis," says Viktor Frankl. "An incurably psychotic individual may lose his usefulness but yet retain the dignity of a human being."

It is sad to look at the history of a schizophrenic like Clyde and to trace his regression. Clyde's case is typical. A young man a few weeks into college, away from home for the first time in his life, suddenly recoils, loses interest in his classes and his friends, starts to think that people are coming to get him, to steal his neurons and such, and almost as quickly as a strike of lightning, he is gone, and for the rest of his life, no one except his family and his doctors knows he exists.

No one really knows what triggers someone to fall suddenly into a mental illness as precipitously as Clyde did. It might be genes that cause some of us to lose control and others to remain unscathed, but there are probably many other factors. Who knows the ones who among us who might have a slightly weaker psyche than the rest? Everything's fine, then it all breaks loose. From there, like death, it drives them down an irreversible course deep through the mud and the mantle of society, shunned and forgotten, lost forever. All it takes is a little stress, a blow of wind. What an incredibly thin line it is, almost invisible, that separates him from us. $\mathbf{L_M}$