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There's a Limit to Your Love

By Margot Hedlin

"On April 30, 1991 - on that one day - 138,000 people drowned in Bangladesh. At dinner I mentioned to our daughter, who was then 7 years old, that it was hard to imagine 138,000 people drowning. 'No, it's easy,' she said. 'Lots and lots of dots, in blue water.' "
--Annie Dillard, For the Time Being

Imagine this: An operating room, theatrically dark except for the bright lights centered on the surgical field - a square foot of a woman's abdomen. The actors, swathed in gowns and gloves, undergo an orchestrated dance to ensure that the proper parts of their bodies remain sterile.
Or this: soaring operas during a mastectomy, the globular yellow fat of the woman's cancerous breast almost too colorful as a surgeon's asthenic hands carve it from her body
Or this: a man with two holes drilled in his skull to drain a subdural hematoma, the ebb and flow of the oil-slick blood synced with the man's heartbeat.

People have asked me what it's like to watch someone go under the knife. The questions come in different words, but the underlying theme is always the same: Is it painful to watch someone undergo that kind of harm to their body?

A patient bucking as the surgeon touches a tender offshoot of the lumbar spinal cord, shouting to the anesthesiologist to pay closer attention. Screws entering a man's head as he is immobilized for a brain surgery that can't spare a millimeter of inaccuracy.

Back in my first year of medical school I had trouble with anatomy lab; I was unable to make the mental separation necessary to treat the cadaver as it was - inanimate, insensate - a body, not a human. I winced and apologized under my breath as I cut and sawed. The real problem, though, was the intrusive thoughts. I'd see the cut of the sternocleidomastoid as a friend turned his head, and would remember the dry-meat appearance of a cadaver's desiccated neck musculature. Or I'd feel my heart beat against my chest during a run and wonder whether the filigree tendons that hold the heart valves would ever give way.

Yet by the time it came for me to attend an autopsy my second year, it hardly bothered me that the knife they used to cut the man open was a foot long, that they used garden shears to snap open his ribcage, that they weighed each organ on a cold metal scale before slicing into it to look for his cause of death, that by the end he was a blood-soaked husk with ribs all sticking up and a hole where his heart used to be. It was a body, not a human, and bodies don't need your sympathy.

Pinpricks of blood as the surgeon staples the sterile drapes to the patient's unmarred skin. The sensation of fascia tearing under my hands as we pulled an incision open for a stat C-section.

By the time I started my surgery rotation third year, I was even further removed from the first-year student who balked at cutting into a long-dead cadaver. My favorite surgeries were the ones where I got to be first assist, standing across from the surgeon and getting a first-hand view of the surgical field. My guilty secret: during laparoscopic abdominal surgeries, I silently hoped they would be converted to open.

Where did my tenderness go? Was it chipped away by the semester in the cadaver lab, where I became gradually inured to the harm of the human body? Was it worn down by day after 12-hour day of studying all the horrible ways a person can die?

The quiver in the scalpel as the resident reminds the surgeon that the patient wanted him to pray for her before the surgery. The broken spell as we bowed our heads; the collective despair when we saw that her abdomen was so full of metastases that we closed her right up again, knowing our efforts would be futile.

To be honest, I was glad for my newly thickened skin. You can't cauterize if you're immobilized by emotion, can't cut if you are profoundly aware of the humanity of the patient on the table, can't focus on the case in front of you if your mind keeps jolting back to the woman we prayed for, wondering whether her 50 years were enough. There is a movement in Canadian medical schools to make the anatomy curriculum more efficient by having students dissect individual organs rather than bodies as a whole, but I worry they might be coddling their students to the point of stifling their growth as future physicians. To some degree, you need to have the sanctity of the body broken in order to maintain some degree of sanity.

I'm not going into surgery, but I don't think this theme - pain becoming banal - is limited to the operating room. Internal medicine has just as many evocative stories as surgery, though their character is admittedly far less visceral. Say a patient comes in for management of cirrhosis. It is one thing to give him diuretics and lactulose, and another entirely to let your mind wander to the ramifications his condition has on his life, wonder what he thinks about when hepatic encephalopathy clouds his mind, how it feels to have a belly so distended with ascites that it leaves stretch marks, wonder how he will finally break the news to his grandson that he won't be around to see his high school graduation. Multiply this by the twenty patients an internist might see in a day. The mass of human suffering, if you let yourself fully internalize it, is too much of a burden to bear. It's hard to imagine 138,000 people drowning. If anything, there is a greater need for internists to distance themselves than there is for surgeons, seeing as internists don't have sterile blue drapes to put a barrier between the patient's life and their own.

To take it a step further, I think that to stay on top of the constantly evolving medical literature, doctors need to see the body itself as interesting - and to do so, they need to divorce pathology from the personality of the human lying underneath. On my ICU rotation, I read about the protocol for massive blood transfusion so I could understand how they were resuscitating the patient down the hall, whose retching I could hear as he vomited a seemingly

endless quantity of blood. Before you pass judgment, consider this: if you made it this far in the essay, you're either morbidly drawn to (or at least, tolerant of) the descriptions of the human body, or you're reading this out of some sense of obligation.

When I started medical school, I made a pact with some of my classmates. We won't be like those physicians who lack empathy, we promised each other. We won't become those doctors who listen so closely to heart murmurs that they fail to hear their patient's hopes and fears. But I'm starting to question that pact because, as with surgery, I think my emotions may sometimes hold me back. You need to cut through tender skin to reach an inflamed appendix. You need to keep your voice from trembling as you discuss the patient who became floridly delirious overnight, because a sepsis workup can't wait for you to cry in the stairwell.

At the end of my last rotation, I asked my attending - whom I came to respect tremendously both for her medical acumen and the genuine respect with which she treated each patient - for some feedback. She hesitated a moment before saying I might try for more emotional detachment from my patients. "Some of these people are going to die," she said, "and you have to let them go." Lots and lots of dots, in blue water.

Margot Hedlin finished medical school at the University of North Carolina in early 2017 and will soon be roaming the halls of Bellevue as an internal medicine resident at NYU. She is curious about illness identity, narrative ethics, implicit bias, and the questions in medicine that don't really have answers. Her essays have been published in Neurology, the Journal of General Internal Medicine, Hektoen International, and the Journal of the American Geriatrics Society.
