Becoming a Real Doctor: My Transition From Fellowship to Faculty

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Sometimes people write to make a point or tell a story. Other times, they write to work through personal problems, exploring ideas and reflecting on experiences to find understanding. This narrative is one of those explorations. Although I had completed my forensic psychiatry fellowship and was on an academic faculty, there were many times when I still felt unsure of myself. When one is new to the profession, new to a department, and new to a location, how does one advance from the position of a beginner? Feeling lost for almost a year, I decided there must be others who have posed the same question. For some colleagues, their transition had taken place long ago, and their advice was more frustrating than helpful. More junior peers were equally uninspiring as they struggled with similar matters. I realized (with the advice of a mentor) that writing would be a good place to start.

I had been retained by an insurance company to evaluate a middle-aged woman who claimed to be psychiatrically disabled following an incident at her place of employment. She apparently had been unable to function after having been reprimanded by a supervisor. This led to treatment for depression and anxiety. Collateral records indicated a history of multiple traumas. I straightened my tie and jacket, stood straight, and called her from the waiting room. There sat a frail-looking woman who cast an expression of suspicion and doubt. Her husband stood up with his wife, signaling his intention to protect her. In the conference room, I introduced myself and explained the purpose of the evaluation. She indicated that she was ready to begin, but I expressed concerns that her husband's presence would interfere with the evaluation.

She started shaking, wrapped both arms around her husband, and yelled, "He's not leaving me! I won't stay here alone with you. You're the enemy. I don't know what you'll do to me."

Despite calm and empathetic explanations, I was unable to reassure her of the safety of the evaluation. I was conflicted. If I allowed the husband to remain, then I might not be able to conduct a thorough interview, and his presence could inhibit her responses. If I interviewed her alone, then I might cause her unnecessary anxiety and distress. I also wondered if I should be cautious about any allegations of misconduct. I stepped out to consult the attorney who had retained me. When I returned, the decision had already been made. She announced that she did not trust me and promptly left with her husband. The case was over before it had begun. I felt that I had failed.

Seasoned physicians often describe cases that taught them important lessons. This forensic examination that never happened was the first of several episodes in which my own feelings of inadequacy began to influence my professional identity. As I was new to the field, I realized I needed forensic cases to

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establish a local reputation, let alone cover my salary. I worked diligently and was proud of my reports.

The next week, however, an attorney who represented a man arrested for a sexual offense left a message saying he wanted to talk. He had previously sounded confident in my abilities to evaluate for pedophilia. Now, he had concerns. After receiving my *curriculum vitae* (and probably doing some simple math to estimate my age), he admitted that he wanted an expert with "substantially more experience." It was time for me to be my best advocate! I spoke of my training and tried to convince him that I was quite capable of performing a thorough diagnostic evaluation. I mentioned my academic pedigree, spoke about the variety of cases I had done, and highlighted the "ideal" mix of clinical and forensic work that I conducted each week. Not convinced, he respectfully asked if I knew of anyone with the experience he needed. My credentials were not sufficient to offset this apparent deficiency. I was too young and had not earned enough battle wounds while fighting in the trenches.

A theme of inexperience began to cloud my confidence. I became angry when patients remarked, "You're too young to be a doctor." I questioned my professional goals after performing ineffectively during a deposition. (Didn't one of my past psychoanalytic supervisors ask me, "What are you going to do with forensics, anyway?") I felt uninspiring when teaching medical students. (Didn't one of my attendings tell me, "Those who can't, teach.") I remembered my struggle in residency to convince my parents that I was capable of treating patients: "Someone else will be there in the room with you, right?" (As an attempt to erase any doubt from their minds, I went to the extent of showing them my office. "Mom, Dad, this is where I see patients. . . . Yes, I'm their doctor. . . . No, just me.")

In each of these scenarios, I claimed to possess a body of knowledge shared by members of my profession. Patients, students, attorneys, and family members wanted to know my clinical impressions and opinions. Nine years of medical training had prepared me for this, but now I wondered if I was ready for the training wheels to come off. How could I convey a sense of confidence if my inexperience filled me with self-doubt? An "expert"? Surely not.

Desperation set in as I considered a variety of options that ranged from practical to fantasy. Work harder, grow a beard, wear a suit (every day), smoke a pipe, complete another fellowship, move to France, become a professional croquet player, become a nonprofessional food critic, or sob. For privacy, I will defer admitting which of these I actually tried. This sense of hopelessness left me in the predicament of struggling to find my identity as a self-confident professional.

So, I began a process of self-reflection and consultation. My colleagues remained hopeful. I surveyed my database of past forensic cases. I was content with the variety of criminal and civil work I had conducted. Perhaps I had fallen into a pattern of black-and-white thinking and overgeneralizing my deficiencies. Was there anything to do but wait?

The mantra commonly repeated in medicine, "See one, do one, teach one," seemed to apply to my difficulties. This time-tested oversimplification suggests that proficiency occurs in three distinct steps: observation, practice, and education. Medical students and residents follow these steps as they master the skills of performing a history and physical examination, closing a wound, or intubating a patient. Physicians must be prepared to perform potentially life-saving (or life-threatening) invasive procedures when the stakes are quite high. I was quickly learning that the stakes in forensic psychiatry are also high, and practice is not typically permitted.

I wondered if I had missed some crucial step or lesson in my training. Fellowship is generally the time when forensic trainees gain the most experience with "seeing one," working alongside experienced faculty, observing technique, assisting with report writing, and listening to the trials and tribulations of courtroom experiences.

"Doing one" begins in fellowship but continues after formal training, because there are obvious limitations to what can be accomplished in a single year. The problem with this step arises when the forensic psychiatrist has not done many (or any) of these kinds of evaluations before. A referring attorney typically does not feel comfortable allowing his expert to gain experience with his case. Few fields regard inexperience as an advantage.

Atul Gawande's collection of essays, *Complications: A Surgeon's Notes on an Imperfect Science*[1] provides further illumination on the uncertainty of a physician's training and expertise. Gawande, a surgeon and writer, asks how a novice can learn the art and science of medicine without practice. Our profession requires experience, self-reflection, and some-

times a bit of trial and error. A surgeon's misplaced central line may cause a pneumothorax, but is this any less devastating than a misguided insanity evaluation? There must always be a first time, and sometimes there are mistakes along the way. We must prepare for the question, "Doctor, how many of these cases have you done before?" followed by an honest and transparent response, "None (but I really hope you take a chance with me)."

This is a conundrum in the education of professionals who need training. How does one pretend to have experience without the actual experience? While the completion of medical school earns the degree, it certainly does not make the person a physician. Graduating law school is an accomplishment, but it will be many years before the novice defends a capital case. There must be continued learning and practice after divinity school before one becomes a preacher.

The final step of the educational cycle, "teaching one," becomes problematic when the teacher has little experience to draw upon. When I began supervising the forensic psychiatry fellows just months after I had completed my own training, too many of my examples and anecdotes began with, "I had a case like this during my fellowship," or, "A supervisor once told me. . . ." I quickly learned that a trainee cringes to hear stories in this fashion.

Then, a revelation began to creep into my consciousness. I realized that the way to facilitate my transition from a forensic psychiatry fellow to an attending did not require any fancy tricks. I would treat it in the same manner as I progressed from a clinical psychiatry resident to a clinical attending. This approach was something that was initially difficult to comprehend, because I had spent the previous year focused on developing my skills in forensics—learning the landmark cases, performing objective evaluations, and appreciating the complexities of working in the legal arena.

The ability to understand my patients, however, would continue to serve me in forensics. Of course, the skills required to elicit symptoms and make accurate diagnoses are similar in both clinical and forensic work. I started to see that the lessons I learned from my analytic supervisors and therapy readings were still relevant to my development as a forensic psychiatrist. Recognizing defense mechanisms, for example, may help one understand why an evaluee may be reluctant to tell his story. Conflicts appear as ambivalence or distortions of the truth. Listening for transference may explain why evaluees react in a certain way to our seemingly unbiased evaluations. Awareness of countertransference reactions provides hints that neutrality may be threatened.

This was familiar ground for me. It was comforting to recognize that my forensic evaluees were patients in other settings. For example, the woman described in my initial forensic case had displayed a primitive reaction to me that went beyond the scope of our 10-minute encounter. The fact that I was unable to start the case was not a loss; she was someone's patient who needed help. The principles of forensic and clinical psychiatry seemingly had overlapped.

I also tried to understand the challenge of performing work in areas that are operated by nonphysicians—namely, judges and attorneys. The forensic psychiatrist must prove himself repeatedly for each case. My psychodynamic instructors might have referred to this as a repetition compulsion. Work hard to be retained for a case, perform the evaluation, submit your report, and prepare for criticism. Don't relax for too long, because you do it all over again for the next case. Similar to practicing an instrument, repetition allows an attempt to gain control and mastery over the challenge.

Several months have passed, and the storm of self-doubt has subsided. I passed my forensic board examination, received a teaching award, and persuasively testified in a death penalty case. These events have pushed me into a stage of development where I recognize my weaknesses and have confidence in my strengths. Whether I am treating a patient with psychotherapy or developing my forensic practice, patience is required. I must remember that the training of a forensic psychiatrist is a marathon, not a sprint. And the next challenge is only a case away.

References

1. Gawande A: Complications: A Surgeon's Notes on an Imperfect Science. New York: Picador, 2002