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Wounded Healer: A Story of Resilience through Adversity

Suicide Attempt

This is an account of what happened to me more than a decade ago, and the aftermath of that event. I was in my first year of residency soon after finishing medical school at McGill University in Montreal. As I described my suicide attempt to Myers and Fine in 2006:

“I lost complete consciousness the moment I jumped – I was jumping into oblivion. I was in the intensive care unit for almost two months – it took me one month to regain consciousness. I had no recollection of what happened. I remember asking, “Did I commit suicide?”¹

At the time, I thought my mental health had improved in the face of long-standing struggles with depression. Coming to Ottawa from Montreal was going to be a new beginning where I could finally embrace my full potential unhindered. Little did I realize how wounded I still was.

“... I was beginning to feel overwhelmed and became consumed with feelings of extreme worthlessness and inadequacy. I started to think about suicide all the time. I didn’t have a concrete plan to kill myself; my feelings of wanting to die were more passive, like wishing that I would disappear or no longer exist...

One morning, a short while after I had returned from being on call overnight, I was in my apartment and realized that I did have a way out - I could jump off my balcony. I started telling myself that I wasn’t meant for this life, that the world would be better without me. The rational part of me was not working - I never would have chosen such a public death as jumping onto the street. And at that moment it did not occur to me that I might be unsuccessful at dying.

I went to the ledge of my balcony at least two times, looked down, then returned to my couch. I was very ambivalent. Then, suddenly, the telephone rang - it was my program director. I couldn’t disguise the fact that I was crying, or what I was

contemplating. He asked for my address, saying that he would send the chief resident over immediately.”¹

Hearing his last words, I felt a sharp sense of abandonment and isolation. I didn't expect that he would consider not coming himself, especially after I had confided something so intimate and deeply personal. The chief resident was a stranger to me at the time, as I had only just started residency training in a new program, and in a new city. I was so concerned that I would be perceived as manipulative if I admitted to my program director that I needed him to come himself, possibly because of a bias I had acquired from reading the charts of patients who had borderline personality disorder during my Psychiatry ER rotation. My feelings of despair deepened, and my ambivalence changed to resolution.

“... I didn't want anyone to think what I was doing was manipulation. I told my program director that this is something I have to do and jumped off the balcony.

I thought it was cruel that I was allowed to survive. My apartment was on the sixth floor—I should have realized that there was a chance I wouldn't die. My injuries included pulmonary hemorrhages, rib fractures, a ruptured spleen, abdominal hemorrhages, a fractured jaw, a fractured wrist, fractured vertebrae, and a spinal cord transection at T4 which means that I'm paralyzed from the chest down.”¹

My Mental Health

One of the factors influencing my suicide attempt was my longstanding mental health issues. I have had chronic depression since high school – I used to be paralyzed with self-doubts and consumed by the core belief that I was defective. To give an example, during my pre-university years at Marianopolis College in Montreal, I remember making a trip to the Outer Banks of North Carolina with two of my classmates. At a beach close to where we camped, my friend and I were sculpting the muscular figure of a bodybuilder out of sand, under which our third friend was buried with only his head sticking out. My friends laughed at my efforts.

At that moment, I was overcome with the feeling that nothing good can come out of these hands. It was a powerful feeling of utter inadequacy. This was the manifestation of my belief that I was defective, which had pervaded all aspects of my life for decades.

My life-long difficulty with transitions was another factor that played a role in my decision to jump from my balcony that day. During my transition from kindergarten to grade 1, I used to cry every day before school, and my parents would have to drag me down the staircase. The psychological term for this behaviour is school phobia. My difficulty with transitions later in life extended to the transition from being a medical student to a resident, which carried, perhaps, unrealistic expectations for me about how much a first-year resident should be able to master. Under the veil of my distorted perception, I didn't feel I measured up to those lofty expectations, which intensified my pre-existing feelings of inadequacy. I also experienced a transition in terms of needing to familiarize myself with a new system in a new hospital in a new province. Moving away from Montreal meant losing my usual support systems. I think each of these transitions were aggravating factors in my suicide attempt.

Another contributing factor was sleep deprivation, given that I was on call in the hospital for over twenty-four hours on the day of my suicide attempt. I genuinely believe the effects of sleep deprivation influenced my unstable judgement when I attempted suicide.

Although not a direct contributing factor, my diagnosis of obsessive-compulsive disorder (OCD) was also relevant for understanding my mental health at the time. This disorder had really appeared suddenly during my graduate studies in Physiology, and it subsequently continued during medical school. While I always had obsessive-compulsive traits related to a perfectionistic attitude, it had never before descended into a debilitating disorder that interfered with my ability to function on a daily basis. OCD has been called the doubting disease; the doubts that arose

were often accompanied by compulsive checking, which was further exacerbated by a pathological intolerance for uncertainty. While I recognized that my thoughts and behaviour were irrational, I could not put a stop to them. During my medical school training, it would take me hours to read just a few pages of my lecture notes because each paragraph would send me on a tangent. Until I read up on and answered all my questions related to an incidental term I came across, I wouldn't feel at peace and couldn't move on to the next paragraph. Later, during my clerkship years when writing in a patient's chart, I would have to start on a fresh sheet instead of using the same page where the last nurse or doctor had written their notes because of the possibility that I might have to revise what I wrote, discard the sheet and start all over again.

Somehow, OCD wasn't an issue post-suicide attempt. My fall seemed to have extinguished all traces of that difficult to treat mental disorder. Unlike the debilitating obsessive-compulsiveness that characterized my thesis-writing before med school, the thesis I wrote for my MSc. in Epidemiology 10 years after my suicide attempt was actually an enjoyable and strain-free experience from beginning to end. This represented a dramatic change in my mental health and the way I functioned, a harbinger of other positive changes that would eventually come.

Statistics on Mental Health

Depression is the leading cause of disability worldwide and, before the pandemic, suicide was the ninth leading cause of death in Canada.

According to a systematic review published in 2015 in the *Journal of the American Medical Association (JAMA)*, 28.8% of medical residents met the criteria for depression.² Later, another systematic review in *JAMA* found there was a 27.2% rate of depression among medical students compared to a rate of between 7.2% to 9.3% among individuals of the same age in the general population; eleven percent of medical students also reported experiencing suicidal ideation.³ Finally, according to another study,

suicidal ideation was found to increase by a factor of more than four-fold during the first three months of residency.⁴ These findings resonate with my experience. The fact that my suicide attempt happened five days into my residency training is now less incomprehensible than before. I am sure what fuelled my suicidal ideation has a great deal in common with other interns who experience an escalation of suicidal ideation.

I expressed to my cousin, also a doctor, what a textbook case I am. All this evidence validates my experience so completely. The problem is not just individual and personal, it is systemic and collective. I am not alone.

My cousin replied immediately, “Amole, a correction - how much of a textbook case you *were* -those days are long past gone bro! Nothing but a rosy future awaits you.”

Coping with Spinal Cord Injury

Initially, however, I had great difficulty coming to terms with my spinal cord injury. I hated everything about being in a wheelchair. I wanted no part of it. I would cry inconsolably almost every day wishing I were not alive. It took me at least three years to begin to accept my predicament.

As I was struggling with all these issues at the Ottawa Rehabilitation Centre in the months following my suicide attempt, I came across a book called *Learning to Fall: The Blessings of an Imperfect Life* by Philip Simmons.⁵ The title intrigued me. I had fallen and, at the time, I was consumed with self-hatred, acutely aware of my imperfections. I could not understand how imperfection could be a blessing when it was a quality I most reviled in myself. It was an extraordinary book about coping with loss like the one I was facing at that time. The author was very spiritually attuned, borrowing from Buddhist teachings and principles of mindfulness. As an English professor, he was able to articulate his thoughts and experiences clearly, artfully, and with an economy of words.

Although for many years I had difficulty embracing my life as someone who is paralyzed from the chest down, it is amazing how we are able to adapt and adjust to even the most difficult and challenging circumstances. I never had fantasies that I would walk again - I knew it would not be possible in my lifetime. After many years, I was able to adjust to life in a wheelchair. It has become my “new normal”, to borrow from the post-pandemic term.

The following paragraph consists of comments I shared with Dr. Michael Myers, a leading expert on Physician Health. He included these quotes in a grand rounds presentation he gave in the summer of 2015 in New York City. They show the tremendous progress I have made over time:

“Following my spinal cord injury, I encountered frequent relapses of depression typically triggered by weddings. Each wedding I went to brought me in touch with old familiar faces that reminded me of where I was before and what I could have been. It was painful because now all seemed lost, my dreams all destroyed. I used to cry almost every day wishing I were not alive. But it is amazing that today I have transformed from that earlier state, and while no one would choose to be in my circumstances, I still feel strangely lucky to be alive. I am no longer consumed by self-hatred or the feeling I am unworthy. It is a remarkable transformation, one that should give hope to others who are suffering. The core belief that you are defective is one of the hardest to overcome, but it is possible, and there is hope through intensive work with a clinical psychologist and optimization of anti-depressant therapy by an experienced psychiatrist.”

I shared these thoughts with my clinical psychologist and let her know that our sessions together were a significant factor in my psychological transformation. She sent me this message:

“Your e-mail leaves me speechless, in a good way. You have come a very long way Amole, haven't you? While I agree that the therapeutic guidance is important (I am a psychologist so what can you expect!), it was you who

did all that hard work, day after day, year after year... and that hard work continues at times, when old buttons are pressed. You did it even when you did not believe that anything could change. That is absolutely the most important piece in this picture. I speak from experience.”

Journey in Medicine Post Spinal Cord Injury

During my adjustment phase to being wheelchair-bound, in the early years following my suicide attempt, I continued to have a strong desire to return to medicine. Despite my self-doubts, I could not ignore the fact that medicine gave me purpose and embraced my vision of a meaningful life, one that is actively involved in the healing process. I have always had a feeling of warmth and love for humanity, and I viewed medicine as a way for me to express that love. When I was in the rehabilitation center, one of my psychiatrists, who had known me during medical school, told me, “You do belong in medicine. You are a healer, and your healing touch will be all the more richer and gentler because of all that you have been through.” His faith in me had a powerful effect at a time when I was consumed by feelings of hopelessness and worthlessness.

If I look back, the following excerpts from my residency application letter, which I wrote during my final year of medical school, several months before my suicide attempt, remind me of what I loved about medicine:

“... My habit for questioning is highlighted by my involvement in basic scientific research... Through my research experience, I have been encouraged to acquire skills in independent learning, critical thinking and problem solving. On the hospital ward, these valuable skills were further reinforced. I became enthralled by the diagnostic process while observing skilled physicians as they elegantly and methodically dissected complicated cases to arrive at the most tenable explanations for each patient’s presentation - not mere algorithm, but a wonderful interplay of knowledge, intelligence, imagination, creativity, and intuition. There is a great beauty and art to medical investigation... I invested great energy in gaining clinical knowledge. At the same time, however, I tried to maintain

an expanded approach, staying attentive to the human face of illness. Looking into the eyes of a sick man, woman, or child, we begin to appreciate their perspective, understand their experience, and sense the wealth of their courage and potential. The physician becomes a privileged witness to a patient's unique and unfolding story and is enriched in the process... As one who has suffered, I empathize with those affected by illness, an attribute that I hope will help me nurture an effective therapeutic alliance with my patients."

When I had expressed an interest in returning to residency several years after my suicide attempt, the residency program requested that I have neuropsychological testing done to assess my cognitive status because of concern about the impact of my fall. Although my IQ was found to be at the upper limits of high average to superior range, the testing revealed deficits in working memory, especially under conditions of distraction, and deficits in speed of information processing. My performance in those areas was well below average. It was the neuropsychologist's conclusion that this was due to the effects of mild traumatic brain injury. She expected that, as a medical graduate, I should have performed better, and she considered this a change from my pre-morbid level of functioning. My hypothesis was that these deficits could be the result of the effects of depression. I reviewed with her the considerable evidence that depression can cause cognitive deficits comparable to those produced by traumatic brain injury. This interpretation left open the possibility that the deficits were reversible with effective treatment for the depression and gave hope that a return to residency would be possible.

Return to Residency

Eventually, I was given the green light to return to work, after a favorable Independent Medical Assessment concerning my psychological fitness to resume residency. I brushed up on my history-taking and physical examination skills under the guidance of senior residents and staff in the internal medicine department, but without official resident's status. I bought an expensive wheelchair that could move me into a standing

position, thinking it would help me function better, but I never found it any more useful in my work at the hospital than my regular manual wheelchair. I had to re-learn how to perform a physical exam from a seated position in someone without trunk control. I did lots of troubleshooting. For example, I bought a chest strap from former Paralympic wheelchair basketball star, Chantal Benoit, to help fix my trunk to the back of the chair, freeing my arms to function without falling on top of the patient when I performed various maneuvers such as percussing to assess the liver span or reaching to listen to the opposite side of a patient's lungs with my stethoscope. Eventually, I was able to perform a full physical exam without difficulty. My role models in terms of physicians who functioned effectively despite their disabilities were Dr. Williams, a quadriplegic pediatric radiologist at Montreal Children's Hospital, who I knew during medical school; and Dr. Lawson, a paraplegic pediatric endocrinologist in Ottawa, who had first showed me how a disabled person performs a physical exam from a wheelchair. I was also a member of the Canadian Association of Physicians with Disabilities for several years, where I met with other disabled Canadian physicians.

When I regained enough knowledge and skills to bring me back on par with other first-year medical residents, after a seven-year hiatus, the question came up of whether I would be able to officially resume my residency training. At that point, the internal medicine co-program director said it would require herculean efforts on my part, and on the part of the program, if I were to consider returning to internal medicine. He was particularly concerned about my ability to handle emergency situations while on call. The Associate Dean of Postgraduate Medical Education suggested I apply instead for residency in Community Medicine, now known as Public Health and Preventive Medicine, given my recent research experience in epidemiology, and since unimpeded physical functioning was not necessary in this field. I applied and was accepted.

When I first officially re-started residency in 2009, I continued to suffer from crippling self-doubts and feelings of extreme self-hatred, but these

feelings eventually softened as the years went by and ultimately disappeared altogether. I managed to put the core belief that I am defective permanently behind me. The positive feedback I received from supervisors after returning to residency training was instrumental in this process. I was able to finally realize that I was good enough, smart enough, and capable, a perspective which was so elusive in the decades before. In addition to the positive feedback I received professionally, my recovery was equally due to the therapy I received from my clinical psychologist, Dr. Sterner, and my psychopharmacologist, Dr. Blier, who, after a long period of trial and error, eventually found the right combination of medications to stabilize my disturbed neurochemistry. Prior to that, I was one of 50%-60% of patients who are labeled treatment-resistant because of an incomplete response from at least two adequate trials of antidepressants.⁶

My performance as a resident was definitely above average. I proved that a doctor with a serious disability can practice medicine if given the chance. In my first year as a Public Health and Preventive Medicine resident, I did clinical rotations in all areas of medicine - it was a true internship year. Occasionally, I needed the help of nurses to clear access to the bedsides, which were often clogged by tables, chairs, and IV poles. Otherwise, I was independent. My ten best clinical and public health evaluations were nothing short of stellar, including clinical rotations in general internal medicine, three internal medicine sub-specialties, and two ER rotations. As for emergency situations on call, I wouldn't have been able to bag and mask a patient who went into cardiac arrest or perform chest compressions, but I could run a code. There are other able-bodied nurses and respiratory technicians who can do the physical part. Also, before starting my clinical rotations, I successfully completed an advanced cardiac life support course offered to residents, which gave me the tools to resuscitate patients appropriately and competently. I could not, however, intubate a patient.

The fact that I functioned so well as a resident indicates that I must have compensated for the deficits in working memory revealed by my earlier

neuropsychological testing. After presenting my assessment of a patient, I recall my supervisor telling me that I displayed tremendous brain power. In multiple clinical rotations during my first year of training, supervisors evaluated my basic medical knowledge as exceeding expectations and, in several cases, even outstanding. But the neuropsychologist, who had assessed me early on after my spinal cord injury, did observe in her testing that my deficits in memory could be compensated for by repetition. Perhaps reviewing my material on a daily basis, as I would do every night, helped reinforce my memory. One also cannot exclude the possibility that brain plasticity played a role, where, after a stroke or traumatic brain injury, neural connections reorganize to compensate for loss of function in affected areas of the brain.

During my first year of residency, I remember being shocked when a patient walked into the room at a family medicine clinic and said, when I greeted him, "You're in a wheelchair. I wished they had told me." It was the first time I was treated differently because I was disabled. But by the end of the visit, the patient tapped me on the shoulders before leaving and said, "You are going to make a great doctor."

Later, at the start of an internal medicine rotation, one of the first-year emergency medicine residents on my team said, "I don't know how you can possibly function with your disability." Toward the end of the rotation, after demonstrating that I was an above-average resident, despite my disability, he asked me whether I was into video games and if I wanted to join him sometime, indicating to me that I had earned his respect.

During my involvement with the Canadian Association of Physicians with Disabilities, I mentored an undergraduate student with a unilateral congenital hand deformity, who was thinking of applying to medical school, but was concerned about not being able to perform surgery. He wondered if he could even manage to get through medical school from a physical standpoint. I explained how I dealt with some of those challenges, given my physical limitations, and he drew inspiration from

my example - a resident who succeeded in his medical training, despite significant disabilities. After getting accepted into medical school, he sent me a thank-you letter, which was very gratifying.

Reckoning with Failure in My Specialty Oral Exams

My return to medicine was not without setbacks. A few years ago, after multiple previous attempts, I failed the oral exam component of my specialty exams for Public Health and Preventive Medicine. I was deeply disappointed, but I eventually came to terms with it, as shown in this note that I sent to colleagues at the time:

“This is another test in the road of life.

If better opportunities come my way that further increase my abundance, I will welcome those opportunities with open arms.

This is bouncing back after a fall.”

My reaction to my failure in the oral exams was a sign of my developing maturity. I noticed I alluded to the title of the book that I had read at the Ottawa Rehabilitation Centre, which affected me so deeply, as well as to the way I fought back from a catastrophic “fall”.

Quiet and introverted, I am much less comfortable speaking than writing, so I guess it was fate that I wouldn't do well in the oral exams. I have to be totally scripted when speaking formally in public. Somehow, I am unable to think as I talk, or improvise on the spot. Does it have to do with my deficits in working memory and speed of information processing that my neuropsychological testing had revealed? I also have a bad habit of saying “uhms” and “ahs,” especially when I'm struggling to think of what to say next. I believe those issues played a role in my failure in the oral exams. During the pandemic, I have marveled at how well-spoken some public health leaders have been - they have given very articulate, spontaneous,

and unscripted responses to, sometimes, challenging questions. I'm not sure I would have been able to do that as well as they have.

Today, I continue to work in the public health field, but not as a Royal College-certified public health specialist; I earn half the salary I would have if I had passed my specialty exams. As I reflect on my journey in medicine, even though I haven't become the physician I envisioned, I'd like to think that, through public health, I still do meaningful work informed by my medical training.

Extended Hospitalization

2020 was eventful not only because of the pandemic, but because I had been hospitalized for seven months due to complications from two severe pressure ulcers over the left heel and the left ischial tuberosity (the sitting bone), both of which had eroded to bone. I was diagnosed with Fournier's gangrene on admission to the hospital, a potentially life-threatening form of necrotizing fasciitis or "flesh-eating disease" of the perineum, that developed as a complication of the deep wound over my buttock. A CT scan confirmed the diagnosis. My white blood cell count had risen to 64 (the upper limit of normal is 10.5) and I had fever and severe chills for weeks, despite previously being on two antibiotics at home to cover the bacteria that grew in earlier wound cultures. The surgeons proceeded to serially debride the necrotic tissue. I made four to five trips to the operating room for this surgical debridement, and I was put on IV antibiotics. Things settled down after two months, but I was left with a large, gaping crevice over my left buttock where muscle, fat, and skin used to be.

Over time, my wounds improved dramatically. Both the pressure ulcer over my heel and the deep pressure ulcer on my left buttock have healed almost completely, which is truly amazing.

I realize at this point, after experiencing multiple complications from my spinal cord injury, including frequent episodes of incontinence (the worst

aspect of having a spinal cord injury), and now severe pressure ulcers, that I would not have been able to work as a clinical physician for long even if I pursued a clinical path. I was able to support myself during my extended hospitalization only because of generous benefits from working for the federal government, benefits I would not have had if I were a clinical physician working in a group practice or hospital. I have always had people tell me, ever since I suffered my spinal cord injury, that everything happens for a reason and the universe always unfolds as it should. As difficult as it was to see things that way then, I am able to appreciate that possibility more now.

Comparison to Other Colleagues and Reassessment of My Self-Esteem

I read about the accomplishments of colleagues from time to time, people who have become leaders in their fields, heads of departments with academic appointments and hundreds of publications to their name. I am not really sure what my reaction to this is. I'm definitely very impressed, but do I feel comparatively inferior in any way? I am struggling to answer that. What perspective can I have after reading about another person's vast accomplishments that doesn't leave me feeling less worthy? On paper, in comparison to them, I am a total failure, but, somehow, it doesn't affect me as much anymore. I might be making progress in terms of my mentality compared to how I used to think in the past.

When I look at some people, they seem so perfect as they are, so grounded and secure in their own value and worth; they seem to have it all together. I am not quite there yet. Even though I have come a very long way in the last twenty years, I am still not completely secure in myself. I continue to carry traces of my old beliefs that I am a failure, unworthy, and ugly; they are only traces now, but they are still discernable.

I do recognize that my image of others probably doesn't reflect their actual inner experience; in reality, everyone probably has some self-doubts and insecurities. My friend once told me that we are all fumbling our way

through life, and that might be true of everyone, no matter how much success we have achieved.

Reflections on Mental Health

A colleague working as an Associate Medical Officer of Health for the city public health department recently asked me what public health can do to support mental health. I responded that it is important for public health to both continue to raise awareness about mental illness and continue to find ways to reduce stigma.

The other issue is that there need to be more health care resources devoted to mental health, including psychotherapy services from a clinical psychologist. There are many studies demonstrating that psychotherapy and antidepressants have additive benefits and, for me, personally, that has been an important reason for my recovery from severe, chronic, treatment-resistant depression.

Another important thing for a person with mental illness to have is a meaningful connection with one or more people – someone that they can reach out to for help when they are in severe distress. For me at the time, those people were my psychiatrists in Montreal. When I was actively contemplating suicide, I could not reach them. Had I made contact, things may have been very different today.

I conveyed to my colleague that I was struck by a Maya Angelou quote which reads, “Every storm runs out of rain.” It suggests, using a powerful image, that bad times never last forever, that everything is impermanent. If I truly had this awareness back when I was actively contemplating suicide, I would not have followed through on my suicidal thoughts - a lesson we all can hopefully learn from.

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