Five Views of Medicine

I

So, at the beginning, there was happiness.

But later, I delved into it all much deeper and happiness was replaced by helplessness and only this thought remained to the end: that we had our duty as human beings and that we were there to help. This is why this medicine...although it is all like one great wound, it is the most beautiful thing of all.

Being a doctor sets you apart from normal life. It means that you always have to think of other people's pan as though it is something more important than your own. You are a doctor in order to help people and not in order be sentimental about yourself. In any casse, when there is so much pain around you, enough to fill the world.

Adina Blady-Szwajger, MD

I Remember Nothing More

(Dr. Blady-Szwajger was in her final year of medical school when WWII began in Poland. At the outbreak of the war, she was accepted as a junior physician in the children's hospital in the Warsaw ghetto, and worked there until it was closed after the death of most of the children through starvation and lack of medication, and the deportation of those surviving, together with most of the medical staff to the death camp at Treblinka. The resistance movement engineered her escape from the ghetto, and for the remaining years of the war, she worked as a courier for that organization. While many of her fellow resistance workers were captured, tortured and executed, she survived to complete her training as a pediatrician after the war. The above is excerpted from a memoir of the war years, written 40 years later, at the end of her career.)

II

In the beginning I suppose I had some vague notion about helping people by entering a noble profession. But now, I think I was attracted just as much by the idea that being a doctor would give me a sort of power that other people don't have--a power over people as well as disease...The more I thought about it, the more I wanted a piece of that power...

Anyway, I went on to college planning to become a doctor. Although a lot of new avenues opened up after that, no pressing alternative appeared. So I finally just drifted into medical school, not really having anything else in mind, wanting both kinds of power and realizing I could have them in the medical profession, plus the social status and a reasonable income. Now that I've more or less made it, all those abstract notions have fallen apart on me...[T]he godpower thing seems utterly empty, and as for the power over disease itself--I hope to heaven I never have to undergo any surgery. I know too much about the limitations of medicine....

No, this is definitely not like a priesthood for me...I don't have one consuming goal that shuts everything else out. I want to live, too...I don't want to get involved. My system is not geared for it.

Robin Cook, MD

The Year of the InterN

III

For over a year this infant had spent more of his time in the hospital than out. He had a form of histiocytosis X with immunodeficiency, but no one truly know the prognosis. We had all hoped for the best that he would slowly outgrow his disease while we treated the interminable complications as they arose. He was darling boy, with a round face, a wiling smile, his father's tendancy to crinkle up his nose, and blond hair that stood up vertically on his head. He was readmitted to the hospital because his fever had returned and the eczematous rash had flared up. None of us thought that he would die. But, he developed a right-sided facial palsy, began to choke on his secretions, and had to be intubated. Seizures followed, with coma and eventual brain death due to uncertain causes.

One week before his death, the boy's father brought in a new toy, a stuffed dinosaur emblazoned with swirls of color. As was customary with him, the father began to brandish the animal in order to evoke some flicker of interest from his comatose son. "Hey, bud, look! A dinosaur! Hey, look at it!" Nothing happened. Then, the boy's one good eye opened slightly and fixed on the brightly colored animal prancing so closely to his face. A small smile tugged at the left corner of his mouth, and slowly his right arm reached out to embrace the toy. Within a minute, the smile faded, and the boy lapsed back into coma. We all cried. He died the following week without regaining consciousness.

What fulfills the physician? Certainly, the diagnostic challenge, the financial security, the altruistic glow, and the grateful thanks all provide a measure of satisfaction. But all too often, success becomes bracketed by failure, a deluge of new information erodes the sense of professional mastery, money ceases to compensate fully for the time and toil, the good one attempts to do goes awry, and the thankfulness of patients becomes admixed with fear and suspicion.

No, for me fulfillment comes from the sudden intimacies with total strangers-those moments when the human barrier cracks open to reveal what is most secret and inarticulate. A word can betray the deepest emotion. A look can reflect a world of feeling. Illness strips away superficiality to reveal reality in etched detail. This revelation can fuse together disparate lives in unexpected kinship. Is it the fear of death, the dreaded pain, the sorrow, or the loss? The physician who can see is there to share in it. Is it the joy of birth, of unforeseen recovery, of reunion with one considered lost? The physician who cares can rejoince even as a family member. Who else so often listens to the whispered thought, holds the hand, puzzles over the vagaries of fate, and feels another's moment so personally and powerfully? And who else has such a chance to realize that it matters less whether a moment is one of supreme sadness or supreme joy than it does that the moment itself is supreme?

This is the physician's privilege: to be lifted out of the dross of common days in order to experience such clarity of feeling. The intensity of birth and death, pleasure and sorrow as expressed in the lives of others has the power to nullify personal boundaries in sudden communion. Then, the world is seen in its proper proportions, and the tenuous miracle of existence is underscored. Surely it must profit us to feel this deeply, with the hope that somehow, in the sweep of that feeling, we might yet learn to appreciate the wondrous happening of our own lives.

Michael Radetsky, MD,CM

(Dr. Radetsky graduated from McGill University in 1977. He is a pediatrician, subspecializing in both Pediatric Infectious Disease and Pediatric Critical Care, and currently directs the Pediatric Intensive Care Unit at Denver General Hospital. The above was published in the Journal of the American Medical Association in 1985.)

IV

Surprisingly, after many years as a physician and several years as a patient, my views of what constitutes a good doctor have become simpler.

A good doctor goes through the struggle of an illness with you, providing support while protecting your dignity and independence, and searches constantly for better options for your care. There is nothing fancy about such qualities; all of us hear about them in our medical training, but many of us forget along the way. So, when I speak about a "good doctor," I do not mean only that technically superior individual who can quote the current literature with ease and recite the different prognoses for illnesses as if they were a memorized telephone book. Much more is needed to care effectively for a patient with a major illness. Much more.

As a patient I have learned that just as important as medical expertise and the proper use of new technologies is the ability of the physician to show legitimate concern, to be there during the bad times, and to provide hope even to the incurable. In the first edition of his *Principles of Internal Medicine*, Tinsley Harrison wrote: "The true physician has a Shakespearean breadth of interest in the wise and the foolish, the proud and the humble, the stoic hero and the whining rogue. He cares for people." In cases without easy answers or for which no effective therapy is available, even the simple feeling on the part of the patient that the physician is doing all that is possible has an important therapeutic effect.

I am fortunate to have a caring physician, one who has been at my side during the worst of times, during the unrelenting fevers and the painful medical procedures and on Saturdays and Sundays, one who has shown a timely presence when an acute event arises. Fortunately for me, my physician believes that grave illnesses are to be tackled aggressively. Maybe his working at a cancer center, caring for patients who often cannot be cured, has imbued him with an aggressive attitude toward treating other grave illnesses like AIDS. I can see how physicians used to treating mostly acute, curable illnesses may become frustrated by AIDS. Sometimes, even my kind and dedicated doctor has nearly lost hope.

Two years ago, for example, I was hospitalized three times within a 2-month period. My blood counts were too low to tolerate the additional drop in leukocytes that the needed medications would cause. We were running out of options for my treatment. I could see in my old friend's eyes that he was feeling defeated. It was my turn to instill in him the "no reason to quit now" attitude. At that moment, it became clearer to me that the relationship between doctor and patient must be a reciprocal one. The doctor gives his or her best in taking care of the patient; the patient, whenever his or her condition allows, must provide feedback and participation in his or her own care, not as a passive recipient of services but rather as a protagonist in the struggle to achieve a better state of health. Teaching patients to be participants in their own care may be as important as teaching them to use insulin or to change diet. The practice of medicine should never be an exercise in domination on the part of the doctor nor a total surrender on the part of the patient.

The good doctor, nurse, or health care worker must not feel the need to demand total submissiveness or to elevate her- or himself to a godly status. And that attitude makes a world of difference for the patient. People with catastrophic illnesses need all the support that can be provided, from everyone who can give it. It does make a difference whether the clerks, nurses, technicians, and doctors are supportive or insulting. Their actions do affect your will to fight, the crucial resolution not make concessions to the illness. The feeling of being abandoned, that those "caring" for you may not really care, or that they gave up on you long ago, weakens that resolution immensely. The secret to being a good doctor was captured by Dr. Francis Peabody: " The secret of the care of the patient is in caring for the patient." No amount of technology or technical knowledge can substitute for that.

The process of becoming a doctor is so protracted and arduous that it is easy to forget along the way the initial reasons and ideals for wanting to become a doctor, especially because the current medical curriculum is disease-oriented, not patient-oriented. We need to devote more time and attention to teaching attitudes, skills, and behaviors at the expense of the present preoccupation and fascination with technical knowledge. Because medical school is just the beginning, not the end, of learning to be an effective physician, there is no need to cram ever increasing amounts of information into less time.

Hacib Aoun, MD

From the Eye of the Storm, with the Eyes of a Physician

(Dr. Aoun was infected by the human immunodeficiency virus (HIV) in 1983 when a tub containing blood from a patient who had received multiple transfusions broke and cut his finger. Except for an acute retroviral illness 3 weeks after the inciden6t, unidentified because HIV transmission at the workplace through blood was not recognized that early in the epidemic, he was well until 1986 when an evaluation for weight loss led to the diagnosis of AIDS. The above is exercepted from an article published in the Annals of Internal Medicine in 1992)

V

...Here at [X medical school] there is a first year course called "Clinical Symposia," which is the "touchy-feely" course that exposes students to an array of issues including the doctor-patient, chronic illness, ethics in medicine, death and dying, and health care policy. The fundamental problem with the course, I found, was that the teachers/role models were not credible to me. I remember one ethics specialist talking to us about how you tell a patient bad news. We were taught to use eye contact, ask open ended questions, tell patients you understand how terrible they must feel (How absurd, you can't understand how terrible they feel!). In patient encounters we were told to always sit at the same level as the patient, touch the patient at least once even in an interview, and keep up the eye contact. All these handy tips.

What disturbed me so much about the teaching of "bedside manners" is that it was so fundamentally artificial and mechanical. By way of contrast, if you actually do care about the person you are taking care of, you develop a therapeutic relationship with the patient that comes naturally. It is based on you seeing the patient as a person who is coping with illness, and you seeing yourself as someone who is trained and committed to help--with just as much opportunity to gain from the encounter as the patient. The privilege of medicine is that you have the opportunity to learn a great deal about human experience and to continue to grow as a person. You are interacting with people in their hour of need--when the superficial trappings

that most of us hide behind fall away and expose us as vulnerable and raw. For the clinician this is a chance to learn and grow.

How you help that person (aside from providing your best technical care) is going to be integral to who you are. If you do not know yourself well, have not developed the capacity to appreciate and connect with people who are suffering, and do not have the professional sense of empowerment to stand back and say "How should I best use my skills in this situation," (and can only ask "What are the things that need to be done today before I leave?") you will at best develop tolerable bedside "manner." Manners are the technique of seeming like you care when you don't know how to care.

...Physicians in training function in a narrow-minded dehumanizing environment, that seems commonplace to those initiated to life in a hospital but would be unimaginable to those who are not. From the perspective of an intern, all that humanistic stuff they heard about is gone. They live by the seat of their pants, moment by moment, just in an effort to get through the day. My intern's beeper goes off almost continually at certain hours. Sometimes it is a nurse calling to say that Mr. G is throwing up again, sometimes its because Mr. L's mother in law is on the phone from Detroit, or it could be because Mrs. C just died. It doesn't really matter to her, it all blends together as interminable harassment, never ending work.

...I'm going through a process of socialization. I'm being taught that what's exciting about medicine is diseases; not that caring for people who are struggling will illness is meaningful and rich. Oh, periodically in professional gatherings where speeches are made you'll hear about how meaningful and rich caring for the sick is, but that is not the atmosphere down in the trenches--on the wards or in the hospital cafeteria--where doctors tell unappealing jokes about sick patients. The humor relieves tension, but it has an ugly side as well.

Most of my classmates don't need a lot of socialization to fit in perfectly. I think a profound problem in medicine is that a lot of doctors and students have limited interest in sick people. Their main interest is in their careers, learning about interesting diseases, and having a good life style. The kind of person who joins a profession (law is another good example) is often looking for an identity that is clearly delineated. As soon as you set foot in professional school you can stop struggling for a sense of self. You almost need to, to focus on all the stuff that has to be learned. In addition to the specialized knowledge, however, you are also given a whole set of values and attitudes to live by. These are generally not the things that are said to you in courses on ethics and professional values, they are the actions and emotions that you witness in the professional arena. Just as I suspect ethics classes are of little use in business schools if the market is an unethical environment, the values taught in medical school classes will at best translate into "put on a good show for patient," as long as the role models are lacking and the atmosphere remains so perversely inhumane.

One positive saving grace about most people in medicine is that they tend to be very compulsive and hooked on working extremely hard. My intern, for example, is very conscientious. Most doctors work tremendously hard to be technically correct. It's a positive character trait in those situations where purely technical, cookbook care is the best thing for the patient, but so often being able to step back and say "Is this really the best situation for this ill person?" is just as badly needed and sorely missed. While there is no reason that good technical training and a compulsive attitude can not go hand in hand with a broad perspective, it is the former not the latter that is taught and cultivated in medical training. Yet it is that broad perspective that makes medicine rich, humane and meaningful.

(Excerpted from the response of a third year medical student to an inquiry from the director of a course on literature and medicine.)

Auster S. Human Context in Health Care, Course Syllabus, Appendix IV. F. Edward Hebert School of Medicine, Uniformed Services University of the Health Sciences, Bethesda, MD. 1995)