

Literature and the Arts in Medical Education

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Editor's Note: In this column, teachers who are currently using literary and artistic materials as part of their curricula will briefly summarize specific works, delineate their purposes and goals in using these media, describe their audience and teaching strategies, discuss their methods of evaluation, and speculate about the impact of these teaching tools on learners (and teachers).

Submissions should be three to five double-spaced pages with a minimum of references. Send your submissions to me at University of California, Irvine, Department of Family Medicine, 101 City Drive South, Building 200, Room 512, Route 81, Orange, CA 92868-3298. 949-824-3748. Fax: 714-456-7984. jfshapir@uci.edu.

Living Conditions: The Art of Surviving a Life in Science

David Loxterkamp, MD

Do you see him sitting there? He broods over us from the examination table, his body language singing its silent demands. Eyes riveted down, I fumble through a formidable chart. My eye catches a spinal scan mangled by surgical artifact, an allergy list to every drug except schedule II analgesics, and halfhearted reports from halfhearted visits to a dozen different specialists. Must we bother with the examination? Both of us know the nature of the contest. Would I mind refilling a prescription that my partner already conceded? Could I complete disability papers that support his wretched living conditions? He winces. I posture. We are doomed.

Yet in the vagaries of our impasse lie what lured me to medicine. Let

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From Seaport Family Practice, Belfast, Me.

the patients with sore throats and urinary tract infections and those with metabolic syndrome taking 15 prescription drugs and on standing orders have their measurable outcomes, their chronic care plans. I stalk a more elusive prey—crumbs of happiness displayed for me, a view from the verge of change. Tell me of these, brother. You can trust me with their insignificance.

Lay of the Land

I live in a small town on the coast of Maine. It takes no more than 35 minutes to jog the periphery of my community, two minutes to bicycle from hospital to home, 30 seconds to round the well-tread hallways of my office. None of us here is going any place, anyway. Here I have settled in, made a home, learned to limit the burdens that agitate my sleep, and attend to what matters for those who matter to me.

In 22 years of patient care I have made my own bed. I have established or accepted the conditions

for my success. They are not what I grouch about at medical staff meetings or boast about among friends. No, clinical guidelines and insurance forms are merely the crust over meatier matters. Patients are people, which is something more than a meal ticket or an obstacle to “having a good day.” They are neighbours, team mates, and fellow parishioners. Their misfortunes ripple through the organism of our community. Through a hundred handshakes and self-limited illnesses they have earned the audacity to say, “You are more than my doctor; you are my friend.” It is their call.

The conditions that shape my professional life are geographical, where every street corner and public market holds a flash card for a moment of mistaken judgment, clinical oversight, or verbal blunder. As with most doctors in primary care, my need for approval and gratitude has impaired my ability to say no or to concede the

battle lost to disease. Conditions are also economic, forcing me to see more patients on a given day than I can do justice. It is the pace I negotiated for the salary I feel I deserve. I am conditioned by human nature, which makes it easier to report a positive biopsy result or to confront a patient's abusive behavior than to thank my assistant or remind my wife how much I love her. And there is the rule of silence that veils my mistakes for fear that they will lead to a lawsuit, or loss of patient confidence, or breach of confidentiality.

Lessons

As you can see, I have survived. This is not true of my patients, the ancient and unfortunate and quickly forgotten. Or my father, a general practitioner whose heart attack snuffed a promising career. Or the certainty of my convictions, the invincibility of faith, the spotlessness of a reputation. I have survived by adapting to conditions and learning from the mistakes of others, which by abstraction and distance seem more manageable than my own.

Early on I was given John Berger and Jean Mohr's book titled *A Fortunate Man*. It is a classic depiction of general practice and the doctor who mastered it. The doctor, John Sassall, labored a generation ago in the countryside of western England where he tended to every aspect of his patients' lives. They depended utterly on his skill, observations, and insights, in part owing to their backwardness and in part because of his unusual talent and devotion. We are told that the dependence was reciprocal: during bouts of depression, he relied on the minimal needs and tolerance of his patients.

The irony of Berger's tale is that Sassall later committed suicide. It may be that depression overwhelmed him. But his relative isolation, arrogance, and failure to seek or accept collegial support weighed heavily. The conditions that seemed

so suitable to his early labors would later cost him his life.

The author Annie Dillard offers us a cautionary tale about the failure to adapt to harsh conditions. In *Teaching a Stone to Talk*, she describes Robert Scott's fated 1910 expedition to the Antarctic. Scott perished in a blizzard after becoming the second person to reach the South Pole, just a month behind his rival, Roald Amundson. But the tragedy lay in the explorer's unsuited sentimentalism.

Instead of storing supplemental coal, his ships carried a library of 1,200 volumes, hand organs, cut glass wine goblets, and sterling silver flatware. Scott never brought himself to use dogs, let alone feed them to each other or eat them. (He struggled with English ponies, for which he carried hay). Notes Dillard, "He felt that eating dogs was inhumane; he also felt that when men reach a Pole unaided, their journey was a fine conception and the conquest is more nobly and splendidly won. It is this loftiness of sentiment, this purity, this dignity and self-control, which makes Scott's farewell letters—found under his body—such moving documents. Less moving are documents from successful polar expeditions. Their leaders relied on native technology, which, as every book about the Inuits puts it, was adapted to harsh conditions. . . . There is no such thing as a solitary polar explorer, fine as the conception is."

Stories to Tell

What is the medical equivalent of spurning sled dogs and native guides? What sterling flatware, what fine traditions must we unload before it is too late? Solo practice is one, especially the kind carried out in large groups, where doctors perform in parallel play, in thoughtless and busied shift work without ever so much as rippling the surface of the collegial unconscious. For another: the glib use of the term "complications" to cover human

error. "System failures" happen to particular doctors and patients, and their emotional liability, when ignored, often spawns needless lawsuits, paralyzing doubt, and self reproach.

"Continuity of care" once trumped the desire for a private life. Doctors were meant to mind their patients not their families. To cope with the excessive demands of the profession we accepted monetary bribes and misused chemicals. Had we been more comfortable at home we might have noticed that the world of medicine was no less chaotic and messy. But we pressed on for greater control, analysis, and order, and so lost track of what patients, through their illness, were trying to tell us.

When asked how to humanize medicine, William Carlos Williams, the great American physician-poet, replied, "I can only come up with my shame, as I remember it, and its sources; and I can only say: let's have some heart-to-heart stories to tell each other." In recent years there has been a resurgence in the sharing of medical stories, such as I offer to you now. Doctors' diaries and personal narratives flood the bookshops; narrative medicine has become a legitimate field of study among academic clinicians and humanists. We talk, we write, and we listen to better situate and see ourselves in the examination room, in sympathy with what Anais Nin, the French-born American author, once said: "We don't see things as they are. We see things as we are." By carefully listening to patients' stories and placing them in context, we find common ground, affection, and a source of forgiveness. "I postpone death," Nin also observed, "by living, by suffering, by error, by risking, by losing."

Reaching Our Limits

I, too, toss in the intensive care unit on cool mitered sheets, pondering our fate. My patient, who paid for the bed, presented the

night before with chest pressure, soaking sweats, and a piercing pain through his jaw. "No, I cannot stay, not without insurance, not under the circumstances," he insisted. "The benefit performance, the one I have been planning for weeks, is three days off and there's too much to do."

Thus he pleaded his case to the empty emergency room in its waking hours. That he still smoked cigarettes drew no pity. That his eldest daughter was now in college, as was mine, that he preferred to

douse his occupational stress with a pint of beer, like me, that we both recently turned 53 gave me sudden pause.

"Can I leave?" he pleaded, having already thought better of the request.

"You are free to go. A hospital is no prison," I replied. "But my advice is to put first things first."

And so he stayed, and we listed his condition as "serious." Today it was downgraded to "guarded," and we shipped him for a cardiac catheterisation, during which a

dislodged plaque triggered the fatal complication.

Time is not unlimited. Will we take stock of conditions and adapt? This is what nature and our patients keep asking us. Adaptation is one of life's insistent demands, one that could yet save us from the lofty sentiments and fatal flaws of our expeditionary careers.

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Editor's Note: This essay won second place in the category of previously published prose in the 2007 STFM Poetry and Prose Contest, sponsored by the STFM Group on Ethics and Humanities.

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