

I agree that, to the reflective physician-in-training, the doctor in this module stimulates the thought: Could his downfall be my future? Luckily, whether a gene or an internalization of your parents' superegoic function, your responsibility factor sounds as though it will successfully insulate you from this eventuality. Any pleasure you might derive from alcohol consumption will be instantaneously overbalanced by the enormous guilt you will feel in letting down yourself, your spouse, your parents, and probably much of the civilized world. Responsibility one, alcoholism zero.

For me, poor Dr. Taylor suggests another thought as well, this one perhaps less easily solved: ie., under stress, where do my own vulnerabilities lie? From my own experience with the responsibility gene (I think it is widely distributed in Jewish families as well, especially the eat-eat component), often it plays a positive role, but it can have a shadow side as well. For example, it is possible to be so responsible as to be over-responsible, so that commitment to work results in neglect of family, or dedication to family and work causes neglect of self. Perhaps the real lesson we can learn from Dr. Taylor is that most of us have some less-than-optimal ways of coping with the stresses of our lives, and most of us are pretty good at denying we are in trouble. The real trick is to be able to see ourselves as wounded healers, no matter the nature of those wounds.

Not only is it hard “not to bring one’s feelings into it,” it’s probably impossible! I think the best we can do is first recognize and acknowledge our own feelings (in this case, our judgments against alcoholics, or against physician-alcoholics), and then figure out how to work with them (ie., modify, reinterpret etc.) so they don’t impede effective patient care. Since all of us have been trained to and rewarded for making judgments, we tend to do it all the time and be very good at it. It is sometimes helpful to keep in mind the distinction between the behavior, which can be judged (“excessive drinking while functioning as a physician compromises patient care”) and the person (“Dr. Taylor is a louse and a loser”). We are morally obligated to make the first statement; but if we make the second, it is highly unlikely we are ever going to do Dr. Taylor any good.

I think it takes a lot of courage on your part to admit your disillusionment with Dr. Taylor is partly because he is a doctor, and how could he, of all people, be so stupid and in such denial. Medical students and ordinary people tend to expect more of our doctors. But as my daughter’s volleyball coach once told her, “People can be very, very smart in school, and still be very, very stupid in life.” This sentiment applies to physicians as well as to academically gifted, but incredibly smart-alecky high school setters. Perhaps the greatest lesson Dr. Taylor has to teach us is that we are all human, therefore all flawed, *even* physicians.

Despite your misgivings, you struck exactly the right note of support and caring, rather than judgment and attack, in your interview. What you learned from your research about interventions supports the idea that the best way to make headway with such patients is through patient concern and gentle challenge, rather than judgment and condemnation. Paste your essay within easy sight so that next year, when you do your ER or medicine clerkships, you will have something to cling to in the face of patients who may at times seem to invite you to dehumanize them. Trouble is, when you dehumanize them, you lose the humanity in yourself.

JOURNALS MOD 5 

You noticed important aspects about this patient – his intimidating manner, the large age discrepancy between interviewer and patient. I predict you will run into both these problems at least occasionally during your clinical training – you may be confronted by hostile, angry patients; and you may encounter patients or family members who question your ability or knowledge because of your youth (not a “real” doctor). Luckily, you also derived some useful lessons from the interview – how to remain calm and not defensive, staying focused on what will best promote the patient’s interests.

I agree, it is a little unnerving to realize patients have judgments and assumptions about us as well as vice-versa (you might remember that from the Anatole Broyard reading in the pulmonary module, where he expresses some very decided opinions about his physicians). Our job is to try to understand and, as you so nicely state, “penetrate” them in order to take as good care of our patients as possible.

JOURNAL ENTRY: [REDACTED]

I appreciate your faithfulness to the text, a quality I've observed during the litmed elective discussions as well. This is an important ability to have, both in reading and in listening to patients, because it allows you to feel more confidence in the trustworthiness of your conclusions.

In terms of your analogy that dealing with disease is like dealing with grief, I guess the way I see it is that grief is one of the coping responses we have in reacting to the threat and loss provoked by disease (as well as other calamitous events). All disease represents the loss, whether temporary or permanent, of aspects of life as we know it, and ultimately threatens our very existence. Therefore, mourning for what is lost is an appropriate and even cathartic response. Unfortunately, because grief is such a vulnerable emotion, we often mask it with anger, bitterness, or instrumentality. In "Imagine a Woman," the narrator has experienced shock, horror, anger, vindictiveness, and grief. These emotions are still part of her repertoire (I don't know that they ever conveniently disappear completely), but, as we discussed in class, she is on the cusp of creating a new life for herself, one she finds more authentic and meaningful. In this respect, I think she is doing exactly what you hope for —ie., "moving on" and finding meaning in her experience.

J. Shapiro 11/3/00

██████ you raise an interesting question, which is how personal responsibility for illness affects the way we, as health care providers, view our patients. You correctly conclude that all patients are suffering beings who deserve our compassion. You will probably discover, if you haven't already, that it can be more complicated. The woman in Selzer's story is blameless, while Jean Stevens bears some culpability because of her history of high-risk behavior. The emotions we feel toward Jean are likely to be more complex than those we feel toward Selzer's woman. The trick is to learn how to acknowledge judgment, frustration, even anger and then resolve them, so they don't interfere with the relationship we want to develop with the patient.

I was touched by how strongly you appeared to empathize with the narrator of Selzer's story. The impulse "to do everything possible" is what binds us relationally to others, even though realistically there may be much you cannot do. I agree that when a patient feels abandoned and hopeless, it may be up to the physician to provide connection and hope. This not only restores the patient, but, from conversations I have had with physicians I respect, reduces burn-out and provides encouragement for the physician as well.

J Shapiro 11/3/00

I am so impressed with your thinking here! This is a wonderfully perceptive essay. You have explored the theme of clarity on multiple dimensions, each time insightfully. First you note clarity of thought and tone in the narrative voice – a kind of structural and process clarity. Next you note the clarity with which the narrator views her own past – a clarity of content. Finally, you discuss to what end she decides to put this new-found insight – a clarity of purpose. These are all ways in which the author conveys the life-changing understanding this woman has acquired along with her HIV positive status. You are right in the importance you place on the last line of the excerpt. . In times of crisis, it is easy to be overwhelmed by the kinds of negative emotions you cite – bitterness, anger, hatred. By contrast, the narrator in this story sees so clearly that she can even see through the uselessness of grief, as a waste of her precious time. In my opinion, an exemplary physician strives to cultivate a similar clarity in him/herself, so as to be able to serve as an “unclouded” mirror that, in turn, can help patients see themselves more clearly.

J. Shapiro 11/3/00

JOURNAL ENTRIES: [REDACTED]

As usual, a most thought-provoking and penetrating piece. You have some really good insights. Your first point, about the regressive, "self-focused" nature of illness, is one that has been observed and written about by clinicians and patients alike. It is an extremely important aspect of the "patient role" that needs to be remembered when you take care of sick people. Eric Cassell in particular has described in eloquent detail how highly intelligent, assertive, and well-educated individuals become childish, self-preoccupied, and distorted in their perceptions when they are ill. You also make a nice and subtle distinction between the egotism of acute and chronic illness. In chronic illness, I believe the key issue is to what extent patients "become" their disease vs. the extent to which they are able to retain their individual identity despite disease. When the self is threatened, we tend to become embattled trying to defend it, and this results in the "egotism" you identify. In caring for chronically ill patients (an increasingly large part of the primary care physician's patient load), the physician can play an important role in counteracting this tendency of patients to be consumed by their suffering.

Your second point is also perceptive. Illness can have the effect of "clarifying" one's life and priorities. Unfortunately, as you observed in your own experience, these insights tend to dissipate as soon as the immediate threat is removed. In one of his novels, Fyodor Dostoevsky describes an incident of a man facing a firing squad for treason. In what he perceives as the last minute of existence, his life flashes before his eyes, and he apprehends its true meaning. "If only my life were spared, how differently I would live!" he thinks. Then, miraculously, he is reprieved, and determines to carry out his resolve. Twenty years later, a friend asks if he has been successful in living life fully and in the moment. Sadly, the man confesses that after a few days, he forgot his brush with mortality, and relapsed into ordinary awareness. Only a few spiritual/religious masters and enlightened beings have the discipline and wisdom necessary to sustain such insights.

[REDACTED] I really like the way you are using the readings to plumb your own depths. I guarantee that your wrestling with the various issues you've raised through your essays will make you a more sensitive and more aware physician.

J. Shapiro 11/3/00

██████ this is a very sensitive and open essay. I respect your efforts to maintain a nonjudgmental, accepting attitude toward the woman depicted in the excerpt. It may be a little hard to understand from the abbreviated version I provided, but in this story, the woman decides to live a whole new (and more authentic) life in the time remaining to her. She chooses to “dissociate” from her old life (which she discovers was based on a lie), but she does so in a very conscious, intentional way.

In your second paragraph, you are admirably honest in describing a phenomenon I think is familiar to most of us, health providers as well as patients: God, let me be okay, and then my whole life will change. Usually this commitment lasts for about a day! Once the immediate threat is past, it is disappointingly easy to fall back into old temptations.

Thank you also for the glimpse you provide into a certain dimension of single gay life. What I understand from what you wrote is that despair at the prospect of ever achieving satisfaction and congruence in a majority heterosexual world is an important factor in risky and reckless lifestyles. What a sad commentary on us all!

On a personal level, I'm so glad you are currently in what sounds like a committed monogamous relationship with a wonderful (and safety minded!) person. The last line of your essay is quite beautiful – “soft, sane, spiritual, and loved” – I think this is what we all want. Keep up your self-exploration – this knowledge of yourself will surely serve to help you better understand and care for your future patients.

J. Shapiro 1/3/00

JOURNAL ENTRIES, MODULE 4

██████, you raise many thought-provoking issues in your journal entry. First is the intriguing idea that the imminence of death can make life richer and more meaningful. Carlos Castaneda, an anthropologist who studied indigenous South American cultures in the seventies, wrote about the importance of “keeping death as your advisor,” the idea being that if you “consulted” with your own death about every decision you made in life, your choices would be much wiser. Fyodor Dostoevsky wrote in one of his novels about a man sentenced to die by firing squad for treason. Just before he is to be shot, his life passes before his eyes, and he understands its true meaning. “Ah, if only I could be spared, how differently I would live!” he thinks. Then a reprieve comes. Twenty years later a friend asks him if he was able to keep his initial resolve to live each day with a heightened appreciation of life. Sadly, the man confesses that after a few weeks, he forgot all about death and returned to ordinary awareness.

Most of us find it difficult to keep “death as our advisor” and instead engage in a massive denial of death. To embrace the inevitability of our own death and to use this awareness to make our own lives and the lives of others more meaningful requires a discipline and centeredness that is almost impossible to achieve and maintain. (A few very wise spiritual teachers do attain this level, I believe). As you (and Richard Selzer) observe, when a person has no choice but to confront his or her death, this can lead to a significant shift in understanding what is important in life, and can have a powerful effect on the way the person lives the time remaining. However, the mere realization of impending death does not necessarily produce this kind of life-altering insight.

The other interesting issue you raise is that of truth-telling. There are a couple of lies in the excerpt you read. One is the lie of omission by the physician. While technically speaking, he is probably able to say truthfully that he does not know how his patient contracted the AIDS virus, you rightly perceive the larger lie: by skirting her question, by rejecting involvement with her, the obstetrician effectively abandons this woman. It is not surprising that she wonders the kind of person can deliver such news. The second lie, of course, is that of the husband’s, which may have been a conscious subterfuge (ie., he knew he was infected and did not inform his wife) or a “lie” produced by willful ignorance (ie., he did not know he was infected because he did not take responsibility for determining his HIV status although he must have known he was practicing risky behavior). In either case, these lies are both morally indefensible. The narrator, by contrast, makes a critical decision that, in the time left her, she will no longer participate in lies, but will seek to discover the truth about her own life..

From a clinical perspective, I would caution you, as a general rule, to allow people facing grave circumstances to find their own silver linings. You’re right, they are often there, but we can sound rather pollyannish if we try to “cheerlead” patients before they’re ready. In my experience, following the patient’s lead is usually a good policy.

J. Shapiro 1/3/00

1999

██████ - You wrote an outstanding essay, straight from the heart. You said many important things which really impressed me, and convinced me you are wrestling with the right issues in PDII. It is certainly a very provocative concept on Broyard's part to suggest that physicians should minister to the "souls" of their patients, as well as their bodies. As I'm sure you understood, he doesn't necessarily mean this in a literal, religious sense, but in the larger meaning of truly making an effort to "recognize" the other person. I am delighted to find you value the importance of incorporating this type of connection (what the theologian Martin Buber called an I-Thou relationship, in contrast to an I-It relationship) into your practice of medicine.

I found your point about the loneliness of the patient's experience very touching. You are right on target again: Illness cuts people off from normal social relations, and often they do feel isolated and abandoned. One of the functions a physician can play is as a bridge reconnecting them (perhaps in different ways) to the world of which they are still a part (this idea is expressed beautifully by the Yale physician Eric Cassell in *The Healer's Art*, and by John Berger in a book called *A Fortunate Man* about a rural British general practitioner).

I also liked the way you tackled head-on the straw-man contradiction between professionalism and empathy. I would agree with your position - *not* feeling, *not* caring about your patient is the unprofessional attitude! When you are unfamiliar with emotions, they can overwhelm you, so that you lose your focus on the patient and become preoccupied with yourself. This response, while emotional, is not actually empathic or caring. However, when you learn to place your natural human feelings in the service of the patient, you will be able to sustain emotional connection with patients in ways that will render your interactions and decisions much more meaningful.

Although you are correct that relationship with another is in part a function of time (which is increasingly limited in managed care practice modes), it is also a function of attitude and intention. If you bring a clear desire to "recognize the humanity" in each of your patients, although you may have limited time to spend with them, usually they will recognize this quality in you, and will appreciate your efforts, no matter how constricted.

I have one final thought about how we cope or respond to serious illness. "Fighting the good fight" is a metaphor that works well for a lot of us - at least up to a point. Often we don't want to give up - we only want to be told there's still something worth fighting for. But it is also true that with a terminally ill patient, fighting may not be a sustainable or meaningful approach after a certain point. Giving patients permission to stop, release, let go, whatever is also an important role the physician can assume. Sometimes one is harder to do than another. Just know yourself, so you can guide and support your patient, without imposing your own needs.

██████ I am very glad Broyard's plea has inspired you - I am sure you will make good use of what you have learned from him.

1999

● this is a sensitive and thoughtful statement about what dying patients need from their physicians. The concept of a "listening ear" is very appropriate. This is certainly an aspect of medicine that requires support and attention, as well as information. Patients do have questions about the dying process that, at some level, you may be able to answer. However, you will also be in the situation of having no certain answers to the most important questions. That is when you must listen very carefully to the patient.

1999

██████████ MODULE 3

██████████ you raise an interesting and, as you rightly predict, probably insoluble question about “when is enough (patient education) enough?” However, I am glad to share my thoughts, and hope D r. Hunt will do the same.

In my view, when a physician enters into a therapeutic relationship with a patient, this assumes a certain fiduciary obligation that extends beyond functioning only as an information conduit. Therefore, even with the most “noncompliant,” “uncooperative” patient (words that usually express the viewpoint of the physician, NOT that of the patient!), it is not enough simply to convey that smoking is bad for your health, especially when the patient has emphysema or lung cancer.

What you need to determine – and sometimes this can only be done over time – is what binds the patient to smoking. Why won't the patient do something that is clearly in her best interest – in this case, quitting smoking? This is the question that you yourself ask and correctly so. When the patient does not follow your suggestions, this is always the first place to start. Answers that emphasize the patient “irresponsibility, denial, uncooperativeness, hostility” may have some truth in them, but are usually not very helpful in problem-solving. Instead, try to determine the root of the problem: Does the patient have high motivation and high conviction (recognizes the severity of the problem) but low self-efficacy? (ie., patient really wants to stop, knows this is a serious problem, but lacks confidence that she can change her behavior). By contrast, does the patient feel she could stop, but that smoking is so important to her she prefers to complicate her disease and shorten her life in order to maintain this pleasure? Try to figure out what smoking means in the patient's life. This will give you some idea about how to explore possible strategies for change.

I think physicians do have a responsibility to keep “working” on a patient, even if she expresses doubt about her ability to change. There are many ways to do this, which I can't elaborate fully now, but none of them involves “nagging.” Instead, look for ways of “reframing” or “reinterpreting” the patient's viewpoint: “You know, even though you haven't been successful at quitting smoking yet, the fact that you have tried so many times suggests there's a part of you that's highly motivated to change.” If smoking is defined as the only thing that brings your patient pleasure, gently remind her of other important things in her life: “Your grandchildren love you, and want you with them as long as possible.”

Sometimes it is a case of looking for the right opportunity. Patients who are adamant about not smoking sometimes will change their minds as their symptoms and suffering exacerbate. This is a chance for the physician to reintroduce the topic without blame or guilt, but as a chance to revisit the whole issue. I strongly believe that it is the physician's responsibility never to abandon hope, although hope in what may change as the situation changes. In the case, the physician should always consider the possibility,

however unlikely, that the patient may at some point try to change, and periodically test these waters.

Although I am not sure you and I would see eye to eye on evangelizing, it is a pretty apt analogy in some sense. Probably the key to being a good evangelist and a good doctor is to start (and end) with trying to understand and meet the person's needs. If the interaction is about imposing your views (whether spiritual or medical) on the other, your activities are probably doomed to failure and you will tend to resort to judgmental evaluations: "This person can't see the light," "This person won't save herself when given a chance." Instead, look for the patient's need – to retain some pleasure in life, to retain some control over their lives, to reduce suffering – and see how your suggestions can address those needs.

You are also right about time constraints. You could probably spend your entire life trying to meet the needs of certain patients. You have multiple commitments, and must apportion your time accordingly, so that caring for one patient excessively does not compromise care for others. However, the important thing is never to dismiss a patient as "not worth the effort." Instead, think that "This patient and I have not yet found a way into her problem. Let's keep trying." Even if the patient abandons hope, you never should. Maintaining a hopeful attitude will also help you in maintaining positive feelings toward your patient.

When a patient very definitively and unambiguously states she does not wish to make a lifestyle change, of course you should respect this wish, at least for the time being. However, by encouraging her to explore why she feels so adamantly, you may learn information that ultimately will help her to attempt the desired change. Patients who trust and respect you will take your words to heart. Usually, eventually you and your patient will reach a workable compromise. Occasionally, you won't, but you will have developed greater respect and compassion for your patient's struggles through the ongoing dialogue you have shared.

Hope this is useful. I'd be glad to talk with you about "personalized strategies" for behavioral change if you'd like.

1999

A very poetic and insightful rumination. I agree that the heart is a highly symbolic organ in most people's minds; therefore, diseases of the heart carry an extra weight of meaning. I liked your metaphor of the intricate web very much and the centrality of the heart within that web. When the heart is attacked, it is often perceived as a threat to our core being, which is one reason heart attacks are often referred to by patients as "wake-up calls." (Interestingly, patients with cancer are less likely to use this particular terminology. I think this difference may have something to do with rapid vs. insidious onset, the sense that a heart attack is trying to get your attention vs. cancer being a kind of self-devouring process).

Your last line is so wonderful: "Not everything in medicine is about medicine." I am going to cherish that. If only we could avoid the dichotomous thinking of which we in the West are so fond, we could avoid the either-or distinctions of body and soul that so often separate us from our patients.

1999

█, thank you for a profound and moving essay in response to the literary selections. You have penetrated to the core ("heart" [!]) of Crichton's excerpt - not only do the patients share many external (age, gender, ses) and medical (MI) characteristics in common, but they also share in the universal human condition of struggle with the vicissitudes of life. Furthermore, Crichton himself (and by extension doctors in general) is not exempt from this struggle. What makes these patients "interesting" is the particulars of their struggles, the uniqueness of their stories that simultaneously differentiate and bind them together.

I very much appreciated your personal response to the Tatarunis poem. It is sometimes tempting to think there are two categories of people - patients (who get sick and sometimes die) and doctors (who don't). One approach to our own mortality is through prediction and control (the two cornerstones of science). It is comforting to think that, although we may not be able to vanquish death itself, at least we can predict the likely trajectory of our demise. When even this foundation is shaken, the assumptions and language of science prove to be of little help. Instead, as you suggest, we must accept that there are limitations to our knowledge and skill, and that sometimes we are helpless in the face of life. But to me the poem also suggests that we are never completely helpless about how we respond to events, even the most dismaying. Perhaps Dr. Tatarunis begins to reestablish a sense of control by humorously warning her traitor heart that they will both go down together! Perhaps she begins to construct new meaning around the issue of mortality by writing this poem.

1999

You've got it exactly, [REDACTED]. Although from the resident/physician perspective, a disease may be "ho-hum," to the patient it invariably signals profound and dramatic effects on their life. I also appreciate your sensitivity to the potential problems of the medical socialization process. Becoming a doctor is by no means a bad thing (you couldn't be a "good" doctor if you hadn't been successfully socialized!), but you're right that you have to work hard to remember that ultimately it is the patient going through this disease, not you. It has been observed that students "start out feeling empathy and love for patients... and end up learning detachment and objectivity." You don't want this to happen to you. Your dictum "It's the first time anything like this has happened to the patient" would be a wonderful reminder to paste on your notebook when you hit the wards next year!

I agree that one issue raised by the EKG poem that often needs to be addressed clinically is patient anxiety at developing an "unexpected" medical condition. Many of us attempt to "control" death by preparing for a certain kind of demise. (I once worked with a patient with advanced ms, who coped courageously with her deteriorating condition, but was devastated when she developed breast cancer. She was "prepared" to die from her original disease, but could not bear the thought of this new threat). The Tatarunis poem shows how we can be uncomfortably jarred loose from our expectations about mortality and forced to confront death on very different terms. This "incredulity" on the part of the patient can have very specific clinical manifestations, as we saw with Mary Morgan, in the form of denying or explaining away potentially serious symptoms.

██████, I very much liked the way you used the patient's predicament to try to "imagine" yourself in a similar situation. This process is the basis of clinical empathy. As you discovered, by being willing to "enter into" the patient's experience, you learned that her denial and dichotomous thinking begin to make sense. Therefore, she ceases to be "other," and you realize "you could be her."

You achieve an excellent insight when you conclude that both extreme denial and extreme fear produce the same negative outcome - avoidance of medical attention. There is actually research supporting this observation, so it is important to recognize its operation in both our patients and ourselves. With Mary Morgan, the trick is to chip away at her denial while not terrifying her so much that she never comes back for treatment. In ourselves, it is probably worth exploring the *source* of these extremes - perhaps it lies in our fear of losing control, or, as we discussed after the elective class, the fear of perhaps having to accept a "whole new life." I think if we can get to the bottom of our own cognitive "games," we have a better chance of playing them well.

Your point about Mrs. Morgan feeling that "she could not allow herself to have...disease" is very profound. Especially for socioeconomic reasons, but also often for psychological reasons, many patients have precisely this reaction: "I have too many responsibilities to be sick..." or "I lack the resources to cope with being sick...therefore I can't be," etc. It is particularly important to identify this type of thinking in patients to make it explicit and begin seeking solutions early.

[REDACTED], I would agree with your rebuttal - Crichton's characterization of the residents he observed is probably "oversimplified and unfair." It is not irrelevant that he left medicine after 4 years at Harvard medical school. Perhaps in many cases the dichotomy Crichton establishes between resident and patient perspectives is a false one. And you are certainly right that the ideal is to retain scientific curiosity while placing the human concerns of the patient at the center of your care. However, I would still contend that often physicians and patients understand events very differently, and eliciting these differences is essential to effective patient treatment. Crichton is probably not the most modest (or objective) of individuals, but his insight that taking an interest in the patient's story helps link doctor and patient explanatory models is a good one.

Only on one point in your essay would I like to challenge you a bit. You state the conventional wisdom that "...it is dangerous to be too emotionally attached to patients, because emotion can impair good judgment and also be very physically disabling." This position is a very respected one in medicine, and has been advocated by the likes of Osler and Flexner on down, so it is understandable why you espouse it. Furthermore, if you are talking about attachment in the Buddhist sense of desire and control, I would agree. ("I care about this little girl with Wilms tumor so much that I will not stop treating her very aggressively, even though she has extensive and recurrent metastases and really has no hope of survival"). This kind of attachment is less about the patient and more about attachment to one's own ego and fear of failure. On the other hand, my personal belief is that a certain kind of emotional attachment to patients, in the sense of being willing to be moved by their suffering and to truly enter into their plight, is a very good thing indeed, and has precisely the opposite effects of the ones you claim. As a physician, you will inevitably feel strong emotions in response to patients. In my own experience, systematically avoiding, ignoring, or denying these emotions is what can lead to impediments in clinical decision-making or to physician suffering, apathy, and burn-out. It is our ability (or lack thereof!) to work skillfully and therapeutically with feelings of caring, concern, frustration, and anger that determines positive or negative outcomes for patient and physician alike. If you're interested, I'd be happy to discuss this very non-Oslerian perspective with you at greater length!

██████, I respect your tack of using the literary selections to reflect on aspects of your personal life. I also appreciate your honesty in disclosing (as you are comfortable) details of your family and life situation. Medical school is a good time to explore yourself and your background, because these experiences inevitably filter into clinical practice through countertransference mechanisms (and I'm not even a Freudian!). So I believe you are engaged in a valuable process of self-reflection and examination that will ultimately make you a more aware, and therefore more insightful, physician.

As to your familial situation, I won't touch it! Religious conflicts, communication problems, life disappointments, and on top of everything else - house-rattling snoring! Seriously, however, (and I don't mean to make light of what sounds like a complicated home life) you are probably on the right track in thinking that the best place to instigate change is oneself (and there it seems as if you are doing a wonderful job). Further, it is notoriously difficult for children (even adult children) to modify parental lifestyles because of deeply ingrained parent-child dynamics. I have heard this same complaint from many medical students and residents. To make matters even more frustrating, who do you think your parents will likely turn to when sick - you! The wisest course is probably indirection (dropping subtle hints now and then) and modeling by example. And you are quite right - speaking as a parent of adult children, the best gift you can give your parents is love and acceptance. What else is meant to follow, will.

1999

Yes, I liked that same line. I think clinicians must constantly remind themselves that disease which, for them is boring or ordinary, will probably have profound impact on the individual patient. One important idea to derive from the Crichton excerpt is the existence of explanatory models. As you point out, physicians have their own explanatory models: IHD is "caused by" genetics, diet etc. But patients have their own ideas which, whether "true" or not, (and it is hard to believe that in something as complex as heart disease, it is an either-or situation) can exert profound influences on treatment adherence and rehabilitation.

What is especially striking about the Tatarunis poem is that it is written not only by a woman, but by a woman M.D.! The poem uses irony and humor to indirectly explore the feelings of fear and dread that occur when we are unexpectedly confronted with our own mortality. There is a special sense of loss of control when what we thought we could depend on - the faithful pump - suddenly betrays us.

Thanks for your thoughts.


1999

█, thank you for a thoughtful essay. I agree that the Crichton excerpt highlights the need for physicians to listen to and empathize with their patients. What from the physician's point of view may be boring (*another* patient with diabetes) may signal profound lifestyle changes for the patient, as well as raise frightening issues of future suffering and mortality. It is also worthwhile to remember that most patients have their own explanations for their diseases, that sometimes may be greatly at variance with those of their physicians. It's always a good idea to try to elicit these beliefs, as you will get a lot farther in intervention and treatment (even in ER medicine!).

Your reading of the EKG poem makes a good point about the effect of even relatively innocuous positive findings can have on a patient (even a physician-patient!). In this case, the diagnosing doctor treats things casually and matter-of-factly, sure that his physician-patient will take her EKG irregularities in stride. Instead, what this information triggers is anxiety and loss of control, which the patient deals with by an extended meditation on the means of death. Another insight you hint at is that patients may have expectations about how they will die - and have prepared for this - so that contrary information can have a destabilizing effect.

I really liked your take-home message: "common-place" disease can effect individual patients in very "uncommon-place" ways. Being alert to these effects will certainly contribute to your being a better physician.

1999

, you make good points about the confusing and insidious onset of Styron's depression. I'm glad that you were able to empathize with his disorientation and despair. Depression can be a truly devastating event experienced from the inside-out. You also have some interesting insights about the societal stigma still attached to "mental" illness. Often, by our judgments, we simply add to a patient's suffering. Even doctors can do this by their attitudes.

Nice work!

1999

█, thanks for your thoughtful essay. I liked the way you linked Sandi Somerset and William Styron - I can see that each in his or her own way become your patient for a moment. Nice! You have a lovely, patient-centered approach. I can see your strong motivation to make life better for your patients and their families. I also appreciated your willingness to really "hear" and not minimize or distance from Styron's agony. It really is all right to suffer a little bit along with your patients. Once you learn to work with this emotion, it will not overwhelm you. Instead it will make you a better doctor.

1999

You really penetrated to the heart of Styron's story, by using it to help you make the transition from an abstract, enumerated (5 of 9 Sxs) intellectual construct of depression to a lived, felt human experience. This is exactly what literature (or listening very carefully to a patient) can do for you - allow you to enter into the story from the patient's perspective. I particularly liked your phrase: depression "is a very pure personal trial which inherently has nuances that are perplexing and intricate." You articulate extremely well the complexities and anomalies of Styron's experience - he is not textbook perfect, his depression, while sharing commonalities with other depressed patients, is also individual to him. I also liked the way you paid such close attention to the text - your illustrative example about the inanimate objects was very insightful. This again is precisely what you need to learn to do with patients - pay attention to their language, their nuances, all that they offer you. Finally, I liked the fact that you used (probably intuitively) what is considered a hallmark criterion in qualitative research - ie., credibility, does something ring "true to human experience." In becoming a doctor, don't lose your common sense. This is always a good question to ask.

1909

██████████, Thank you for a reflective and serious effort. I can see you thought deeply about the Styron piece, and extracted many valuable lessons. It was apparent to me you read carefully and empathically, paying attention both to the clinical detail and the *meaning to the patient* of these clinical details. You were willing to risk "sensing," "feeling," "understanding" the plight of the narrator. Your last sentence said it all - and very well!

One further comment: hope is an interesting emotion/construct to work with clinically. I agree with you - the presence of hope is of critical importance in any clinical encounter. With a depressed patient, the challenge is how to convey hope without minimizing his or her felt experience. Saying "things aren't as bad as you think," or "I'm sure you'll feel better soon" has the effect of dismissing the patient's perceptions as invalid (of course, because the patients are depressed, they *do* suffer from distorted perceptions of their situation and life in general, but usually they're too depressed to see this!). Instead you can validate the patient's experience, and insert a little hope as well: "I know things seem very bleak to you right now (acknowledgment of patient experience). But I think there's a good chance things can improve (hope) if we work together (offer of partnership)." See the difference?

You also make an interesting point about reducing distress through stepping back from a situation and viewing it more "objectively." In a way, this is what Styron himself is doing by writing about his experience - and I think for him this process has the effect you describe, by giving him perspective and insight into his suffering, and helping him to order and make sense of it. As you suggest, you can sometimes help patients "step back" from their anguish by labeling it. This is the healing power of diagnosis - the simple act of naming, of recognition, often restores some sense of control.

As you can see, you stimulated lots of thoughts in me!

1999

One challenge in medicine is treating patients compassionately and empathically when we cannot "relate to" or "identify with" their suffering. Thank you for having the courage to admit it is hard for you to "understand" depression. Styron's essay had exactly the effect it is supposed to have - to "bring you closer" to the patient's subjective experience. It was clear your attitude toward the experience of depression significantly enlarged as a result of reading Styron. You made a valid point about the social stigma of depression - and this is a stigma even physicians can convey to their patients, if they have not thoughtfully analyzed their own feelings about depression. I'm glad to see that Styron's evident anguish motivated you to want to help patients "get past this awful disease."

1999


[REDACTED], You are quite right that in some respects, Styron is a psychiatrist's dream because he is able to articulate his experience so precisely and, as you said, so vividly. On the other hand, I suspect he would have been a pretty difficult patient to treat! You also perceptively picked up on Styron's sense of helplessness - so often people say to a someone suffering from depression, "Just don't give in to your moods," as though it were a matter of will-power, when what the patient feels is a complete sense of loss of control. Your final point was quite profound - I think you are saying that, for every patient, telling their story is in some way an act of courage, and deserves the full respect of the physician, no matter how "crazy" or "annoying" their story is. You might also be sensing that the simple act of telling one's story - stepping back into that omniscient stance - can be a healing process in itself.

1999

██████ - Thank you for such an honest, personal essay. Knowing a little of your background and your struggles helps me understand you a bit better in the here-and-now. I honor your courageous efforts to reconcile sexual orientation with the narrow strictures of your religious upbringing; and your impressive (and successful) fight against what sounds like a debilitating depression. I am glad that you appear to have found a measure of peace on both fronts.

It is a profound experience when a patient's story touches deep personal cords. On the one hand, we risk having our own struggles, fears, and anxieties activated by the patient, and becoming "lost" in our own ongoing saga. However, and I believe more importantly, we can also use the insights (and suffering) of our own experiences to give us additional insights and help us truly empathize with our patient. The trick is always to keep the patient uppermost in our minds.

Despite not wanting to "create a story of depression," you have very beautifully and authentically done just that - offered a story of despair, transformation, and redemption. You see, we are "storied" creatures, and it is by telling, retelling, and reworking our stories that we have the possibility of developing greater meaning - and happiness! - in our lives. I feel privileged to have shared in this small piece of your story.

PDII * MODULE 8 * GERIATRICS


I agree with you that the sense of “disorientation” at the start of the story is probably intentional, a way the author has of “showing” not “telling” what it might be like to spend time with a person with dementia. It gives us, the readers, a much more immediate, experiential sense of the nature of this experience.

I also agree that the story portrays accurately a dilemma of many older couples. What it helps us to understand is why, in the face of such apparent hardship, one spouse chooses to stay with the demented other to be nurse, caretaker, and guardian. Often it is impossible for one partner to say, “I can’t do this any longer.” At this point, the family physician can be helpful in facilitating problem-solving and in normalizing alternatives.

I liked your observation very much that there are really *two* patients in the story. This is a good example of how a family physician might differ from an internist.

Your final point is an excellent and humane one. In cases of diminished capacity, I believe we must do everything in our power to protect the waning dignity and autonomy of the patient. Even at the point when such patients can no longer participate meaningfully in decision-making, their previous life history requires that we engage in this process with as much understanding and respect as possible.

2000

● You clearly paid a lot of attention to Styron's devolution into the depths of despair. That awareness of the details of the patient's experience will prove very useful to you in developing empathy for actual patients. You really made an effort to understand Styron deeply, not only what he described, but what lay behind the describing. This is an excellent way to try to reach the "meaning" of the patient's experience. I liked many of the insights you obtained in this manner, including Styron's unwillingness to admit he was caught up in a process he could not self-correct, and his progressive isolation and self-preoccupation (very characteristic of many seriously ill people). And your final observation touched on an essential truth: some of the suffering of depression arises from the patient's sense of being lost, alone, unable to make sense of or interpret an increasingly alien and terrifying experience. This is where the physician's role of "education and awareness" can extend a lifeline.

Qddd

PDII MODULE 8 * journal

[REDACTED]

[REDACTED], you hit a lot of issues essential for good geriatric care: resources, support, activities, depression. Awareness on all these levels will enable you to be a successful coordinator of care for your geriatric patients. And yes... geriatric patients can often feel overwhelming, and they do like to chat like our patient Mrs. Smith. However, most of the problems you're dealing with are chronic, not acute, so you do have time to tackle things bit by bit. Also, one of the most precious gifts you can give older patients is your time. By being interested in their stories and their lives, you might find out you will learn a great deal!

0000

PDII * MODULE 8 * GERIATRICS

█ thanks for sharing your experiences working at an Alzheimer's Center. It takes courage to do that precisely because, as you observe, it is such a demoralizing and debilitating disease. I agree that the worst imaginable fate is to watch not merely your intellect but your very self slowly slipping away.

I was also intrigued by your associations with physicians as "immortals," "protectors," high status, intellectually acute figures invulnerable to the assaults and suffering that plague ordinary humanity. Of course we all know this isn't a true image, but I wonder sometimes whether physicians might believe in some recess of their amygdalas that they are striking a Faustian bargain – if they dedicate themselves sufficiently to others, perhaps the Fates will leave them alone.

The phrase I loved best in your whole essay was this one: "...it is difficult to remain positive and optimistic about putting our best foot forward...when we are not quite sure which foot is our best." What a funny and humble turn of phrase! I think if I read this sentence correctly, you were referring to the present inability of modern science to "solve" the riddle of Alzheimer's or substantively "relieve" the suffering it engenders. You are right in that all we can do is continue to conduct (and support) more research.

In the meantime, Alzheimer's raises profound philosophical questions about what it means to be human. When we can no longer recognize our loved ones, no longer story our own lives, who exactly are we? In response to these questions, science has little to offer. Instead we must turn to philosopher-clinicians like Oliver Sacks who can help us find humanity in the most deficit-ridden of individuals.

Q000

PDII * MODULE 8 * GERIATRICS

[REDACTED] I am deeply impressed with the honesty and authenticity of your essay. You are asking difficult questions: imagine a doctor actually wondering whether he or she will be “repulsed” by patients. Yet the fact is that, as human beings, revulsion and other negative reactions are feelings on our emotional continuum that almost inevitably will occur in relation to some patients. If we ignore or repress them, we are probably doing more damage to our patients and ourselves than if we bring them into the light of day, air them out a little and get them to lose their influence, then move on. It is humbling indeed to recognize that, as members of a healing profession, we are not necessarily impervious to the baser human reactions. However, it is only by first recognizing such emotions that we can harness them and bring them into the service of the patient.*

As usual, your insights are extremely perceptive. It is precisely because we do not have “foreknowledge” of certain patients (ie., do not know their life history and did not experience them at a different/higher level of functioning), that it is easy for us to think of them as less-than-human. Aha! This is precisely why I forced you all to read *literature* this year, because this is the point at which science can no longer help you; only *imagination*, honed through a consideration of fictional literature, can help you fill in the gaps.**

However, [REDACTED] I disagree emphatically that, when love is lacking, the only substitute is professionalism (which, of course, is not a bad thing in itself). Obviously, as the physician, you cannot nor should you want to feel the love of a son for a mother. On the other hand, Christian theologians talk about *agape* love, a kind of brotherly love that can suffuse man (and woman!) kind. When you feel you have only your “aura of professionalism” to offer, take three minutes to gaze into the faces of even your “ugliest” patients, until their human beauty emerges. I guarantee you will find it there.

*For example, when I notice frustration or irritation arising in me toward a patient, I try to use that as a cue to become *curious* about what is making the patient act in such an “obnoxious” manner. Thus I remove my focus from me, and return it to the patient. I find that as I explore and better understand my patient’s behavior, my anger diminishes.

**When you are on the wards next year, and have a “gork” of a patient about whom very little is known, and for whom there is very little hope of recovery, I invite you to imaginatively fill in the blanks of that person’s life: Imagine a life for this patient in as much detail as possible. You may not get the specifics “right,” but I guarantee you will start to have a compassionate curiosity about him and you will start to see him in a more humane light!

2000

PDII * MODULE 8 * GERIATRICS

[REDACTED]

Your grandmother sounds like a remarkable woman. Interestingly, my own background shares some similarities with yours. I also had a grandmother who was incredibly vital, tutored in a ghetto until she was eighty, played violin till she was 85, and died in her sleep at 89. She was fiercely independent and not very nurturing. Her husband, incidentally, whom I never knew, died of an MI at 38. She also never liked my mother who was not Japanese but, probably even worse in my grandmother's eyes, was a Gentile (strange, huh?).

You know, [REDACTED] one of the most hopeful things that we can aspire to relationally and generationally is to acknowledge the strengths of those who have gone before (ie., independence, vitality), while committing ourselves to filling in some of the gaps they were unable to complete in their own lives. When I think of Dr. Cahn and his wife, I imagine you and your wife, completing a cycle.

Thank you for entrusting me with a piece of your story.

9000

PDII * MODULE 8 * GERIATRICS

Very insightful comment about what really holds the story together – as in life, it is the “underlying emotions” that give meaning to all our stories. You are empathically attuned to both the poignancy and the beauty of Dr. Cahn’s story, and sensitively detect its many nuances. From the perspective of the physician, it is often easier to see the diminishment and decline of elderly patients than it is their “ever present humanity.” Yet both are there. In this regard, I very much like your use of the word “reverence” in connection with the elderly. In our disposable culture, once people are no longer young, beautiful, and productive, it is easy to discard them. In a small way, the physician has the opportunity to send a different message to his or her older patients: you matter and your life has mattered. That can indeed be a gift.

2000

JOURNAL * MOD 7 * [REDACTED]

[REDACTED] your journal entry displays a notable awareness of the power of language. The first part of Mairs' essay is a meditation on what human realities can be created by language: cripple vs. disabled vs. differently abled vs. handicapped etc. This speaks to the importance of choosing our words carefully and paying careful attention to the language of others, including of course our patients. Your further reflections are extremely insightful. I especially appreciate your point that our goal in using language is twofold – both precision and compassion (this reminds me of Jack Coulehan's prescription for ideal physician attributes – steadiness and tenderness – same idea).

One of the values of ordinary (as opposed to scientific) language is that is complex, rich, multi-layered. This means you may have to be an archeologist as well as a physician, digging with your patient to find agreed-upon meanings and interpretations. But even though this process may seem unnerving because of its inevitably uncertainty and imprecision, it can also lead to remarkably satisfying “constructed” outcomes for both patient and physician. As your concluding paragraph points out, life itself is not completely understandable. But I suspect that we are able to create coherence in our lives by struggling in community with others toward agreed-upon understandings of difficult, traumatic events that are useful and make sense. Anyway, it's a thought!

A very profound and well-crafted essay.

JOURNAL.MOD7. [REDACTED]

Great line: "...as if labeling a person with handicap makes them less handicapped." I think you got the point exactly. Mairs has found a way to liberate herself (at least at times) from the prison of MS, but she is not about to say it's been fun, or easy, or even always successful (note her reaction to her relapse). And she won't let us (the "temporarily able-bodied," as the disability community sometimes refers to us) get away with such euphemisms either, because as you rightly deduce, these become simply ways of distancing and hiding from her reality.

Amazingly, Mairs is able to take time out from her own predicament not only to have insight into, but also to extend compassion toward, the poor conflicted physician, supposed to be omnipotent but really just a suffering soul like anyone else. This enlarging of her vision, to recognize that suffering occurs in all humans, in the doctor unable to effect a cure as well as in the patient who cannot be fully healed, is one of the most powerful lessons she has derived from MS. But, with the "brutal honesty" you accurately identify, in the next breath she turns around and says she'd trade not having MS for all the wisdom she's gleaned. And there it is: Mairs does not have a choice about MS, but she's decided to have a choice about what it will mean in her life.

JOURNAL * MOD7 * [REDACTED]

[REDACTED] I so much appreciate how readings “out there” become connected for you to experiences “in here.” You are a master of think global, act local; and see exceptionally clearly how the personal is the professional and vice-versa.

You also ask questions I often wonder about myself. Is the admirable courage we see in some people who have endured great suffering an accurate reflection of an inner state of wisdom and acceptance they have achieved, or is it a persona that we (the “temporarily able-bodied,” as the disability community sometimes likes to call us) inflict on them? In other words, is this demeanor an authentic expression of their hard-won voice, or is it a prison in which society traps them? (ie., “Well, if you’re all disabled and funny-looking, the least you can do is be cheerful about it”).

Kenneth Zola, a sociologist who had polio as a child, suggests in his writing that it is some of both. He’s written an essay (that would actually make a wonderful companion piece to Mairs) about wanting to throw off the shackles of positive, upbeat attitude. On the other hand, Mairs’ scrupulous honesty about her disease, and the misery it has inflicted on her and those around her, suggests that she is not just posturing. In my reading, she has cut through a lot of the platitudes about disability to discover important truths that work for her.

Q000

JOURNAL * MOD 7 * [REDACTED]

[REDACTED] ty, you listened carefully to [REDACTED] and heard her clearly. Yes, she is a brave and courageous woman with a terrific sense of humor. And yes, she is also scrupulously honest about her reactions to her disease, and sugar-coats nothing. Part of her honesty, as you note, is her unwillingness to accept the euphemisms of language that often serve to protect us, the “temporarily able-bodied” as people in the disability community sometimes like to call us, from the harsh realities of the afflictions of others. Minimization of suffering, denial of difference can be just as alienating as stigmatization and ostracism. The underlying problem is the same: we fail to see the person for who he or she truly is. Fortunately, I can see you are not making this mistake.

I'm glad you liked this essay. And I agree wholeheartedly that, after anatomy and biochem and Step 1, this is what it's all about: in your role as a physician, helping to sustain courage, sharing in humor and hope, ameliorating suffering, and helping patients find their way toward meaning. Surprisingly enough, these can all happen even when you're treating an otitis media. Go to it (and good luck on your boards)!

Q000

JOURNAL * MOD 7 * [REDACTED]

Excellent insights, [REDACTED] Your sensitivity to the tremendous disruption in sense of control that occurs following the diagnosis of a serious chronic illness is impressive. This, and the inevitable accompanying losses, I think constitutes the core nature of this experience. And thank you for seeing that sometimes incorporating such random events can be disturbing, even threatening, to medical students (and most everybody else). A good part of society I think believes implicitly in the rules you cite – the universe is orderly and predictable; goodness is rewarded; the world is a just place; and we can control the course of our lives. Much of the time these rules do seem to be operating pretty well. But life is less predictable and sometimes less fair than we would like, and dealing with its unexpected and sometimes devastating deviations requires great courage. As you suggest, Mairs uses her MS as a metaphor for understanding all suffering inherent in the human condition, and I think it's a pretty good one.

You really said a lot in a pithy journal entry.

JOURNAL * MOD 7 * [REDACTED]

You have an important insight that nothing is written in stone about reactions to serious illness. People may respond very differently from one another, and their feelings may also evolve significantly over time. That is why it is important not to categorize or label people too simplistically, but give them the opportunity to grow and change and learn from their disease.

Your idea of “bibliotherapy” for Amber is wonderful. In fact, one of the common reactions to a serious diagnosis is a sense of isolation. People often comment that they feel as though they have “stepped into another world.” Support groups are one way of reducing isolation. Reading about others’ experiences, and even writing about one’s own, are also often extremely healing. Again, as we discussed in class, to some extent you want to match the needs of the patient with the intent of the writer.

Finally, how open of you to acknowledge that you found Mairs’ stance toward physicians personally “comforting.” I agree! It is a very true, but often overlooked aspect of this relationship, that patients can facilitate the healing of physicians’ wounds and suffering by their gratitude, understanding, and compassion. Doctor-and-patient is not a mutually therapeutic relationship in that its primary goal is the well-being of the patient, but neither is it a one-way street. As for being godlike, as I know you already know, while there is a certain exhilaration in this attitude, ultimately relationships of support and partnership that acknowledge frailties and limits on both sides are more real and sustainable for all concerned.

JOURNAL * MOD 7 * [REDACTED]

You bring up an interesting point about “lessons learned.” I agree with your observation that many people seem to have difficulty learning these valuable lessons. I also agree that we would all be better off if we could consistently adopt such a wise attitude toward the vicissitudes that life sends our way. Often, however, suffering seems so overwhelming, so pointless, so unbearable that it is almost impossible to find the faith and resolve that Mairs eloquently demonstrates. I do not think “learning lessons” is an inevitable outcome of disease and disability. Sometimes suffering remains just suffering. Rather, I see it as a conscious decision, an act of will on the part of a affected person (and often the family) to choose to find meaningful lessons amidst awful circumstances. In our supporting roles as health care providers, all we can do is be patient, caring, and hopeful, and trust that each person will find his or her way.

I really appreciated your honest soul-searching about curing vs. caring. I don't think it is only about ego for physicians who emphasize cures. To be the instrument of a restitutive healing can often be a humbling experience. Conversely, even physicians in more “process” specialties can find plenty of things to boost their ego if this is their goal. Instead, it may be more about how we look at the world. If we define success and satisfaction in terms of a “find it and fix it” model, then oncology or neurology would be frustrating indeed. I suspect physicians who practice in these specialties have found other yardsticks, other evidence of finding reward and fulfillment in their work. I am curious to see where all these questions lead you. I hope you let me know.

qddd

JOURNAL * MOD 7 * [REDACTED]

What I found charming in Mairs' comments about her relationship with physicians is that she was able to enter into their perspective and find compassion for their frustrations. By so doing, she also equalizes the relationship – doctors may be powerful, patients may be vulnerable, but at the end of the day they are just two suffering souls. It may not feel completely comfortable to have a patient see one's own vulnerabilities in this manner, but ultimately I think it leads to much more satisfying therapeutic interactions.

Just a comment about the “wisdom” gained from suffering (as in illness, disease, disability etc.). While I agree that such an experience can be “eye-opening,” let's not forget that, from Mairs' perspective, given the choice of personal growth vs. never having MS, there's no question but that she'd choose the latter. What we choose to wrest for the good from devastating circumstances in no way justifies these circumstances. I don't think this was your point, but we all sometimes have a tendency to say: “Isn't this great! Look how much you've learned from cancer” as a way of trying to reestablish our own sense of control. Obviously, this is not what patients need to hear.

When we think of disability, social stigma is not far behind. One of the psychological mechanisms “well” people use to protect and distance themselves from “sick” people is to make attributions of blame and punishment – “You had a heart attack because you're too stressed” and assumptions of defect - “That little boy in the wheelchair must be retarded.” Beneath these responses is the message, “You are different from me. Therefore I will never be you.” This can feel reassuring to the person thinking it, but it is the exact opposite sentiment from empathy.

You know, if we had to boil down the coping response (for both patients and physicians), I suppose you could say it is all about knowing when to assume active control of a problem, and when to let go and let God as they say. I think we are much more comfortable in this culture with the former than with the latter, but the most important thing is finding the proper balance for each situation.

Thanks for an interesting and reflective essay.

2000

JOURNAL.MOD 6

[REDACTED] I was struck by your observation that you connected so closely with the module because "Jessica was actually my patient." One problem with PDII is that it is only a successive approximation (and very successive and approximate at that!) of patient care, and at some level we all know it. In one sense, this lack of reality is very useful, because you get the opportunity to experiment with and explore what it's like to interact with and assume some responsibility for a patient with no real consequences if you miscalculate a growth curve or don't pay attention to possible environmental factors for lead poisoning.. The negative aspect is an unavoidable sense of play-acting. Next year you will feel a much more authentic closeness to you patients, and this may be both a desired intimacy and a difficult burden.

You echo the thoughts of many pediatricians by focusing on the hopeful elements of caring for children. Most of them get better, and there is a real opportunity to influence both their physical and emotional development. I have also noticed that many medical students refer back to their childhood doctor (whether family doc or pediatrician) as having been an important role model in their lives.

JOURNAL.MOD6

[REDACTED], you dissect thoroughly and thoughtfully the reverberating effects of an uncaring physician on a vulnerable child patient. You make many good points, including the need for patient education at all levels (including pediatric), the uniqueness of the illness experience for the patient, and the often disproportionate impression a physician can make on patients desperately trying to make sense of their condition. The key, as you rightly observe, is empathy, being willing to take a few moments to put yourself in the patient's shoes, to risk seeing the world (including you the doctor) through her eyes. From that vantage point, your question is a wonderful one: What can be done to restore confidence, trust, hope, communication, whatever has been inadvertently threatened or lost?

In terms of specifically helping a child (or anyone, for that matter) cope with a frightening and painful situation, you are correct (and empirical research, cf. Pennebaker et al, bears you out) that expression of emotion is usually the healthier strategy, psychologically and physically, than repression. The very act of showing emotion can be pretty terrifying for many people, because it gives them a feeling of being out of control. A good way to release feelings that can't seem to be discharged spontaneously (ie., crying, verbalizations) is through writing or drawing. This works well even with fairly young children.

What is interesting in the Grealy excerpt is that, although her parents are not particularly helpful to her, they seem to be doing the best they can. The mom hopes to make her daughter brave enough to endure this ordeal by encouraging her not to indulge her emotions. The dad cannot face her suffering, but buys her toys instead. They are not so much bad parents as struggling parents (like most of us), and they too may need support and guidance from the physician.

Nice dream interpretation! One approach to dreams is to imagine that the dreamer is **all** the characters in the dream. That method would support your interpretation very nicely – Lucy is trying unsuccessfully to save herself, and the ultimate consequence will be death. It is what we call a “vulnerability” dream, and probably results from the excessive burden of responsibility that Lucy's parents, perhaps unwittingly, have placed on her.

Apropos of lab rats, thought you might enjoy this poem:

**The doctor who sits at the bedside of a rat
Obtains real answers – a paw twitch
An ear tremor, a gain or loss of weight,
No problem as to which
Is temper and which is true.
What the rat feels, he will do.**

**Concomitantly then, the doctor who sits
At the bedside of a rat
Asks real questions, as befits
The place, like where did that potassium go, not what
Do you think of Willie Mays or the weather?
So rat and doctor may converse together.**

- Josephine Miles (1911-1985)

JOURNAL.MOD6

It's nice to hear about your past work with children at Casa de los Ninos. How badly some kids need role models, especially male role models. I'm glad you were there for them. And what a good experience for you to have assumed such a nurturing role.

You're right about the freshness and immediacy of children's perceptions. Especially young children who have not yet been contaminated by social, cultural, and educational preconceptions (although with tv and advertising, this socialization occurs at younger and younger ages) tend to see things directly, as they are, rather than as socially determined expectations of how they are. I was once in a mall when I heard a little boy say to his mom, "Look mommy. That man has no legs!" That was how things were. But the mom replied, "Hush. It's not nice to point," inferring that the social expectation was that her son should pretend he hadn't seen anything unusual about the legless man. In Zen Buddhism, there is a maxim that states: "See the flower the five hundredth time the way you saw it the first time." Children can help us see the world in this way. This skill of close and appreciative attention, needless to say, is invaluable as a physician.

I'm also interested in your observations of *resiliency* in the children you worked with. There is a large psychological literature documenting this phenomenon, and exploring what psychological and social attributes enable some children to cope with and even thrive in emotionally and physically oppressive environments. Having even one person who believes in that child's potential, and offers hope, encouragement, and alternatives, can make a big difference.

I really like your idea of periodically "rekindling the spirit of childhood"! As you intimate, what is often lost in the process of maturity is playfulness, imagination, creativity, freshness, and joy. What a mistake to think that these qualities are not essential parts of surviving the "stings and arrows of outrageous fortune," the blows and challenges life sends our way. Yes, by all means tell your patients occasionally to be kids again, and as their doctor, follow your own advice. Remember Patch Adams! (although we all have our own ways of being playful – clown noses are not for everyone).

JOURNAL.MOD6



Nice work, Karen! I'm impressed you were able to have such a multi-level interaction with Christopher. It shows that there is much to be learned even from a young patient, if we approach them playfully, respectfully, and patiently. It sounds as though you conducted a very skillful and empathic interview.

It is easy to make dismissive assumptions about children ("He can't understand – he's just a kid"). By entering into this little boy's worldview, you were able to access both his compassion and sensitivity as well as his fears and anxieties. As you discovered, children are very attuned to adult emotions, and often hold themselves responsible for parental tensions. This does not mean that parents should never express disagreements in front of their children, but rather that they should learn to argue "well," (thus setting a model for children for handling conflict), and that they should take time to clarify the meaning of disagreement for their watchful little audience.

JOURNAL.MOD6


Bill, I really like your approach of synthesizing the DSMIV criteria for conduct disorders with real-life situations you've experienced. It is always a good idea to "put a human face" on diagnostic categories and see how well the labels match the person (usually not as perfectly as the textbook would like).

You are raising some deep and difficult philosophical as well as clinical questions. At what point does someone need "help"? What is the fine line between helping someone to realize their full potential, reduce their suffering, versus molding them to fit certain societal standards? It is interesting that behavior that may be considered "creative" or "amusing" in second grade can become "disruptive" or "wild" as our age-appropriate expectations change. As you correctly speculate, often familial and/or interpersonal stressors can tip the balance from "high spirits" to "mania" or "craziness." There is also the issue of "harm to others," which does not seem to have been much of a problem with the two boys you mention, but is usually a significant component of the conduct disorder diagnosis, and adds a more disturbing layer to the concept of social deviance.

Your most provocative question may be, "What is success?" In your essay, you catch yourself from automatically making the (natural enough) assumption that career achievement equates with life success. Maybe, maybe not. You are right to consider more subjective criteria such as being "truly happy" and finding "what he wanted to do," even though these may not be societally valued markers. Ultimately, perhaps, success is about "finding a place" in the largest sense – within oneself, relationally, in the world of work, and spiritually. Needless to say, for those who are constantly at war with society (and often themselves), this is a great deal more difficult.

2000

JOURNAL.MOD6

I agree, kids are great, and the Montessori philosophy provides a wonderful environment in which they can flourish (my younger daughter teaches 3rd grade at a Montessori school in Tucson). It is worth noting, however, that not all kids thrive in the Montessori system because of its emphasis on independent learning and lack of structure. And you're right, sick, suffering kids are a lot harder to be with. But as you've already heard, they have much to teach, if you can be open to receiving it. Perhaps the key here is to pay attention to the emotions that arise in you around kids who are seriously ill or dying, and learn to work with them so that you are not overwhelmed, but remain compassionate and empathic. In this way, these emotions will then serve to draw you closer, rather than push you farther from, your patients.

P.S. I noticed you didn't mention if *you* got the line length test right!

Q000

JOURNALS: Module 5 [REDACTED]

As usual, [REDACTED], you are not afraid to take the big plunge and actually think about what something might have to do with you personally. I really admire your ability to “bring home” issues that can be unsettling or troubling. Speaking as a psychotherapist, there is much good evidence that repression and avoidance, although they may have some short-term benefits, are not effective coping mechanisms in the long run. As you relate your own personal experience with alcohol, it reminds that, if it didn’t work, people wouldn’t use it! It’s just that, after awhile, the cost is too high.


P.S. Speaking as someone for whom 60 is not that far off, jaded, no, but maybe just a wee bit cantankerous!

JOURNALS: MODULE 5 [REDACTED]

[REDACTED], excellent grasp of the fine line between enabling and alienating the substance-abusing patient! I'm glad you are also thinking about the assumptions we make about patients – and people – based on social class, education, ethnicity, gender etc. All of us need to be careful not to make judgments that ignore the individual person.

I agree that the thought of intoxicated physicians roaming the hospital corridors is pretty disturbing. I hope as you move into practice you will be able to maintain a compassionate, but aware, stance on this issue. The medical profession, with some justification, claims the privilege of being largely self-policing. However, for this to be successful, it means everyone within the profession has a responsibility to pay humane attention to the struggles of their colleagues. Knowing that we are all “wounded healers” can help remove the stigma attached to imperfection. Unfortunately, I think medicine still has a long way to go in this regard, although much progress has been made. We need young, idealistic physicians who are willing to struggle with the “fine line,” both with patients and colleagues.

Qddo

JOURNALS: MOD 5 

Thanks for sharing about this presentation, which I heard about from other students as well. It sounds very powerful, thought-provoking, and not a little unnerving (you mean, this really happens?!). It led you to ask all the right questions. Substance abuse or a destructive lifestyle is by no means a given in the medical profession, but being a member of that community does put you at greater risk. It is probably not sufficient to simply say, *it won't happen to me*. Probably the better lesson learned is that anyone can take a wrong turn, and that, once taken, it is hard (though by no means impossible) to extricate. *Know thyself*, said Socrates, and boy, was he on to something! Know your vulnerabilities and breaking points, know what nourishes and sustains you. Practice asking for help. Then you have a good chance of navigating the dangerous shoals of medicine.

Re your friend: I wish you success in reaching out to her. Perhaps you got some additional ideas from the module. Sometimes an intervention-like approach of significant caring friends can help break through denial. As you will discover as a physician, it is also true that you can only do so much. Don't abandon her, don't nag her uselessly, and don't give up hope. That's pretty good for a friend, and for a patient as well.

This sounds like a somewhat bizarre experience. Was the purpose to “trick” the medical students? That must have made you all feel very helpless and “taken in.” Of course, a small minority of patients are actually malingerers, individuals who consciously “fake” symptoms in order to deceive their physicians, usually for secondary gain (disability, time off, perpetuating sick role etc.). Most of these patients are not as skillful as your SP, in that they usually present at least some symptoms (or lack of symptoms) inconsistent with the diagnosis they are simulating. Even with these patients who intentionally trick, manipulate, and deceive, it is worthwhile to look behind the behavior for its explanation. Often they are patients who themselves feel so powerless, so frightened, so abandoned, so desperate that they attempt such ultimately futile stratagems to regain some control of life in the only way they know how. I am not condoning such acts by any means, but it is sometimes useful to understand their source.

More commonly, patients are likely to unconsciously manufacture symptoms as a cry for help, or to somatize psychological distress because their culture and belief system attaches less stigma to such a presentation. If you say *I'm unhappy* long enough, people may eventually start saying you're crazy. But if you say you have stomach pain and back pain and dizziness, people will feel sorry for you and try to help you (at least for awhile). My point is that, if you want to understand people and help them change, you have to look underneath their behavior, no matter how distasteful it appears, and experience the world from their point of view, if only for a moment.

Some have called this approach a “compassionate misreading” of the patient. It assumes the best, rather than the worst, of people, whether or not this is actually the case. It assumes most people act out of hurt or fear, rather than meanness or cruelty. It assumes most people are doing the best they can with a difficult or overwhelming life. Sometimes (not always of course) by believing the best about someone, that person begins to believe a bit more in themselves, and even to act a bit differently. Of course, this doesn't mean naively allowing yourself to be duped by a drug-seeking patient, for example.. But it may mean stopping long enough to figure out another way of thinking about such a patient.

█, it was clear from the length and content of your essay that you spent much time and thought on this assignment. I appreciate both the sincerity of your efforts and the wisdom of your insights. Your discussion of the “tone” of the TC Boyle story was particularly sensitive, and perhaps you can see how close reading of a “text,” like this short story, can translate into careful reading of your patients. In this case, the message is that the “tone” people use to tell their stories conveys important information. Often, as you suggest, a light-hearted tone is adopted to mislead or to protect, or to convey a sense of control. Perhaps Tiller, as a child of hopelessly alcoholic parents, is trying to say, “My life isn’t so bad. It’s almost like a normal life.” Perhaps his father adopts a light tone to mislead us, the readers, and himself, into thinking, “Maybe he’s not really an alcoholic. Maybe he can turn his life around anytime he wants.” Patients use modulations of tone for similar reasons (not necessarily consciously): “I may have cancer, but I can still laugh about it, so things aren’t too bad.” This may be a constructive coping mechanism, or it may devolve into dysfunctional denial.

I also very much liked the way you thought about the story and its lessons from a physician’s point of view. I admire your admission of doubt as to whether alcoholism is really a disease in the same sense as AIDS, hepatitis, diabetes. I also have asked the same question. Perhaps it is less important whether alcoholism is actually an organic reality or simply a useful metaphor that makes it easier for people to accept support and treatment. Ultimately, we will probably conclude its causes are multifactorial – genetic predisposition combined with familial/cultural/environmental influence. You successfully identify one way in which alcoholism seems identical to AIDS and other STDS, (ie., from a preventive perspective), and this is certainly points to an important educational role that physicians can assume with their patients.

Finally, I liked your comparison of the student-doctor and the patient. I would suggest that the ability to *always* see some part of yourself in your patients, no matter how experienced and knowledgeable you become or how irritating or despicable your patients may appear, is an important element of doctoring. Without doubt, you will be helping your future patients “learn new things...to turn around their lives.” Surprisingly, it will be your ability to allow these same patients to teach you new things every day, that will keep medicine interesting and exciting, and keep you a good and compassionate doctor.