BETWEEN DOCTORS AND PATIENTS

The Changing Balance of Power

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between the lone effort and the organized institute, between fidelity to science's slow, deliberative processes of controlled testing and the desire for instantaneous application of life-saving discoveries, between the allure of basic research with its long-term hopes of momentous progress and the shorter-term gratification of caring for and healing the sick. Such ambivalence also pervades the image of the researchers in the tension between suspicion of their weird, perhaps dangerous pursuits and admiration for their potential power to ease humanity's suffering. Bernard's term "sanctuary" in fact has the capacity to accommodate these disparate conceptions. Although he certainly invested the word with a solely positive meaning, it can also carry other, more dubious connotations. For a sanctuary, a safe place, is also by definition a cloistered space at a remove from the mainstream of daily activity. Its seclusion is a prerequisite for its status as a sanctuary, yet it inevitably has the effect of distancing those within its walls. This applies equally to the laboratory, which is both "the true sanctuary of scientific medicine" and a system that separates doctor from patient. Although it is essential as a sanctum for research, it can nevertheless become questionable if it degenerates into the corrupt instrument of power exposed in these novels.

7.
EYEING THE INSTITUTION: THE TWENTIETH-CENTURY HOSPITAL

> *Doctored,* they say of drinks that have been tampered with, of cats that have been castrated.—MARGARET ATWOOD, *Bodily Harm*

THE INSTITUTIONAL EYE TENDS to become focused on the lung, and it forgets that the lung is only one member of the body."[1] This critique of the hyperspecialization, fragmentation, and consequent disregard for the whole person of the patient was voiced, not within the past ten years, but as long ago as 1927 by Frances W. Peabody, M.D., in a lecture to students at the Harvard Medical School entitled "The Care of Patients." By then patient care had been sufficiently downgraded to warrant discussion as part of an attempt to revive the skills and attitudes that in earlier periods had been regarded as vital to the physician's positive interaction with patients. With the professionalization of nursing into a highly trained occupation and the development of a succession of new therapies and procedures, caring for the patient became assigned to nurses, while the doctors' task was curing. This dichotomization of care and cure is one of the hallmarks—and bugbears—of medicine today.

By the 1920s many of the problems that bedevil the contemporary hospital had already crystallized. The transformation of the hospital from a refuge for the indigent sick into "the temple of science"[2] had as its concomitant its promotion to the central role in medical education, therapeutics, and research: "if the hospital had become medicalized by the 1920s, it must be emphasized that the medical profession had by the same time become hospitalized."[3] The hospital had also attained acceptance as an essential community institution

patronized by patients of all social levels. As the custom of referring difficult cases for diagnosis and treatment grew the hospital came to be seen as the best place for surgery and for treatment of any serious acute ailment. The necessity for hospital admission was no longer predicated on the social criterion of poverty but on the presence of a medical condition requiring sophisticated attention. However, even as "the inmate was becoming a patient,—the patient [became] a diagnosis."[4] For with the elaboration of rigid routines for the sake of efficiency, the hospital tended to lose sight of patients as individuals. Their reduction to physiological, biochemical, and pathological entities is indicated by their frequent anonymity through the habit of substituting the nomenclature of their disease for their personal name.

It is this narrowing of focus and depersonalization that is the object of Peabody's strictures on the methods of the "institutional eye." In an eloquent passage he contrasts the missionary to the bedside with the hospital physician:

> When the general practitioner goes into the home of a patient, he may know the whole background of the family life from past experience; but even when he comes as a stranger he has every opportunity to find out what manner of man his patient is, and what kind of circumstances make his life. . . . What is spoken of as a "clinical picture" is not just a photograph of a sick man in bed; it is an impressionistic painting of the patient surrounded by his home, his work, his relations, his friends, his joys, sorrows, hopes and fears. Now, all of this background of sickness which bears so strongly on the symptomatology is liable to be lost sight of in the hospital: I say "liable to" because it is not by any means always lost sight of, and because I believe that by making a constant and conscious effort one can almost always bring it out into its proper perspective.[5]

The mild nostalgia inherent in this scenario does not detract from Peabody's argument; it is less a critique of the hospital per se than a plea for the incorporation of the valuable aspects of the old style of home-based bedside medicine into the new hospital mode. Indeed, he sees no incompatibility between the two as he asserts: "The treatment of a disease may be entirely impersonal; the case of a patient must be totally personal" (877). Peabody's statement represents an affirmation of the duality of medicine. To revert to the idiom of the nineteenth century: although the scientific ("impersonal") approach is unquestionably the dominant one in this century, the redemptive ("personal") side should not be eradicated.

In the seventy years since Peabody's speech medicine has made unprecedented scientific and technological advances, which have intensified rather than decreased the problem he identified in 1927. The late-twentieth-century hospital has been described as at once "the triumph of modern medical science" and the embodiment of "the most unfortunate features of modern medicine."[6] Public belief in scientific medicine and its curative benefits has fostered increasing trust in the expert authority of the hospital's physicians. Yet this magnification of medical supremacy has not only resulted at times in a shortfall of excessive expectations on the part of patients but also substantively changed the balance of power by making patients totally dependent on their doctors' knowledge, a level and type of knowledge far beyond the grasp of even well-educated people. The early- to mid-nineteenth-century model of consultative cooperation between doctor and patient has been confuted by the many recent innovations in medicine. On the one hand, these are undoubtedly to the patient's therapeutic advantage; on the other hand, they open up a chasm between the medically trained and laypersons that results in a fundamental imbalance of power. The institution of "informed consent," which dates from 1960,[7] is intended to give patients some understanding of what is about to be done to them; however, its ulterior motivation is to protect medical personnel from charges of malpractice in case of mishap by spelling out the potential risks. The very need for such a ritual indicates the covert tensions between doctor and patient and the possibility of their mounting into oppositional clashes in lawsuits.

So the "reign of technology" has had, besides obvious gains, less apparent "losses to the sick patient, to the physician as clinician, and to society." The preponderance of the machine has the effect of blunting both the verbal and the affective aspects of the doctor-patient exchange as purely subjective elements in favor of the preferred objective data: "modern medicine has now evolved to a point where diagnostic judgments based on 'subjective' evidence—the patient's sensations and the physician's own observations of the patient—are being supplanted by judgments based on 'objective' evidence, provided by laboratory procedures and by mechanical and electronic de-

vices."[8] The consequences of this shift for clinical practice are discussed in a textbook whose title reiterates Peabody's phrase, *The Care of Patients.* According to this book, because the "scientific basis for medical practice has placed an unfortunate emotional barrier between some doctors and their patients, . . . meticulous listening, empathic understanding, and compassionate concern for the patient have grown ever more important."[9] As more potent interventions have expanded the range of cure the emphasis on mere care has continued to diminish. So much so that a separate institution, the hospice, has recently been established for those patients who are beyond curative intervention and who need comforting attention.

To counter the mechanism bred by reliance on technology, deliberate efforts have been made to rehumanize hospital medicine. In 1983 Derek Bok, then president of Harvard, devoted his annual report to a survey of the system of medical education at that university and made recommendations for far-reaching changes. Nineteen eighty-three was also the year when the American Board of Internal Medicine issued its "Report of the Subcommittee on Evaluation of Humanistic Qualities in the Internist," a cogent reminder of the importance of qualities other than scientific expertise in the healing relationship between physician and patient. This was followed in 1985 by the same board's "Guide to Awareness and Evaluation," designed to help program directors evaluate and teach candidates in regard to "integrity, respect, and compassion."[10] A program to foster precisely such qualities has been outlined by Rita Charon, a practicing physician and a graduate student in English at Columbia, who underscores empathy as "one of the most challenging and important tasks of medical students. They must learn to empathize without losing their objective stance."[11] To achieve this desired combination, she encourages students to acknowledge their fears, anxieties, frustration, and anger through verbalization; to heed patients' experience, often overlooked in the central drama of health professionals' activity; and to widen their imaginative horizons by both reading and creative writing.

Such attempts to reinject more humanity into American medicine can be seen as part of the thrust to restore an image that has been progressively bruised in the course of the past quarter-century. The vicissitudes of Americans' attitude toward the medical profession are traced by Starr in *The Social Transformation of American Medicine.* After the wariness that prevailed in the early to mid–nineteenth century, devotion to medical authority grew in the

twentieth century with the impressive increases in medicine's curative capacity. But "medicine, like many other institutions, suffered a stunning loss of confidence in the 1970s" (379), which Starr attributes to a multiplicity of factors including the challenge emanating from the women's movement and the abuses uncovered in malpractice suits. Symptomatic of this suspiciousness was a sensationalist book, *Medical Nemesis: The Expropriation of Health Care,* published in 1976 by the radical social critic Ivan Illich, who claimed that medical care actually caused more disease than it cured and that people would be healthier if they liberated themselves from dependence on the entire malignant apparatus of modern medicine. The doctor-patient relationship took a dangerously adversarial turn as each side came to feel that it had to protect itself from the other: the doctors from vindictive lawsuits initiated by patients disappointed by their outcomes, the patients from medical personnel perceived as uncaring to the point of negligence and corrupted by greed. In a curious paradox, the immense increase in the physician's power was accompanied not by a corresponding growth of trust but instead by a wariness prompted by misgivings that could amount to fear.

This "desanctifying of the medical profession" following "Americans' gradual disillusionment with technology and paternalism in general" has come to the fore in television serials and films as well as in narratives.[12] For in contrast to the avoidance of the hospital through most of the nineteenth century, in the past forty years it has become a favored setting for works in various media that purport to play out "real-life" dramas. This shift from shunning to what seems like fascination is in part connected to the hospital's changing social position. Once the despised refuge of the down-and-out, it is now a constituent of every community, familiar yet still enveloped in a mystique that evokes a curiosity compounded of trepidation and excitement. With its own rules, hierarchies, and usages, it forms an esoteric world within a world, the site, in Charles Rosenberg's words, of "the most fundamental and unchanging of human experiences—birth, death, and pain." He adds, "It is no accident that both black comedy and soap opera should have found the hospital a natural setting."[13]

Many recent novels and films present decidedly negative images of physicians. The organ snatchers in Robin Cook's *Coma* (1977) are the most lurid and memorable of a string of malfeasant doctors at the center of the enormously popular thrillers by this graduate of Columbia Medical School. The

brilliant surgeon Dr. Thomas Kingsley in *Godplayer* (1984), who murders for the sheer pleasure of his power; Dr. Trent Harding, the anesthesiologist in *Harmful Intent* (1990), who frames a colleague to cover his own crimes; and the mafiosolike web surrounding Dr. Norman Wingate in the in vitro fertilization business in *Vital Signs* (1991) are further examples of gross abuse of medical power out of greed, jealousy, or psychopathology. The debased, perverted doctor is common in films too: the venial Dr. Chris Nichols in *The Fugitive* (1992), who does not hesitate even to murder his colleague's wife because she has discovered that he has falsified his experimental data by switching tissue in order to gain approval of a defective drug in which he has a large financial stake; the demented, drug-addicted twin gynecological surgeons in *Dead Ringers* (1988); the homicidal gasher in *Dr. Giggles* (1992); the negligent anesthesiologist Dr. Tower in *The Verdict* (1982); Dr. Welbeck in *The Hospital* (1971), so deeply engrossed in the management of his proliferating investments that he repeatedly botches surgery; the corrupt administrator of a VA hospital in *Article 99* (1992), who diverts supplies, depriving the patients of necessary equipment; the skeptical, resistant neurologists in *Lorenzo's Oil* (1992), who obstinately block trials of a seemingly promising treatment for a rare fatal disease out of a misguided sense of professional solidarity. What all these figures have in common is a megalomaniacal sense of their own power as exceeding the limits of social and even legal bounds.

These inventive contemporary variations on the theme of the harmful doctor are descended from a long tradition of attacks on the medical profession in literature. But they differ in an important way from their predecessors, which targeted the ineffectiveness and frequently the quackery and pretentiousness of the medical fraternity. The mordant tragicomic satire of medicine in the plays of Molière (1622–73), himself a sick man who actually died on stage, typifies the earlier approach.[14] In the late-twentieth-century instances that I have just cited it is not merely incompetence that is exposed but a moral vileness that undermines the very foundation of the healing vocation by putting self-interest, at times of a pecuniary nature, above service to others. It is as if medical power has an autointoxicating effect on some practitioners. The *New York Times* article on these lapsed physicians, subtitled "A Steep Slide," contrasts the medical delinquents so prevalent in television and film nowadays with their forerunners—Dr. Marcus Welby, Dr. Ben Casey, and Dr. Kildare on the small screen, and on the larger one *Dr. Ehrlich's Magic Bullet*

(1940), about the discoverer of a drug against syphilis, and D. W. Griffith's short *Country Doctor* (1911), which shows a doctor leaving the bedside of his sick son to answer a call from a patient.[15] To this company should be added the newly updated revival of the British series about the Scottish Dr. Finlay and his partners. All these conform to the old heroic model of the doctor as essentially noble, generous, and self-sacrificing. This is as much an idealization, a wishful projection, as the currently fashionable demonization is a grossly inflated expression of apprehension. The endless altruism of doctors always at their patients' beck and call and never sending a bill has to be recognized as an exaggeration in the same way as the unscrupulousness of the self-promoters. What must not be overlooked is the corrective presence among the bad doctors of honest, benevolent counterparts who stake their careers and even their lives to redeem the damage wrought by their culpable colleagues: Dr. Roger Kimble in *The Fugitive,* who is finally exonerated of charges of murder and in clearing his own name uncovers the real criminals; the idealistic young surgical team in *Article 99,* who run the very serious risk of dismissal and disbarment when they steal from their own hospital stores the supplies needed by their patients; the intrepid, imaginative Dr. Marissa Blumenthal in Cook's *Vital Signs,* who fathoms the bizarre crookedness of the infertility clinic; the resourceful Dr. Cassie Kingsley in *Godplayer,* who survives her husband's murderous ploys by ingenuity and enterprise; the determined Dr. Jeffrey Rhodes in *Harmful Intent,* who, like Dr. Kimble, restores his reputation by tracking down the vicious miscreant; the chief of medicine in *The Hospital,* who refuses to be tempted away from his responsibilities. The latest television serials too, such as *Dr. Quinn, Medicine Woman, Chicago Hope,* and *ER,* redress the balance by a return to a far more benign image that admits individual foibles but on the whole stresses integrity.

A blend of "desanctifying" with rehumanization occurs in the film *The Doctor* (1992) through the role reversal a hardened surgeon has to undergo when he becomes a patient in the hospital where he has worked. The drastic change of perspective very quickly makes him painfully aware of the patient's dilemma in having to deal with cavalier physicians as well as with a life-threatening disease. He submits to a sobering transformation as he is subjected without mercy to the callous handling of patients that he himself had previously condoned. The neat plot ends with a humorous twist when he makes his students become patients for seventy-two hours to expose them all to the

tests, humiliations, and helplessness imposed by hospital protocol in hopes of raising their consciousness regarding the proper exercise of the power they themselves will soon have. This ironic wit counteracts the slightly sentimental closure as Dr. McKee's aloof pride in his technical virtuosity is tempered by a measure of sensitivity.

The undeviating imperatives of the hospital's power structure are also shown in Diane Johnson's novel *Health and Happiness* (1990) as they affect a spectrum of patients with illnesses of varying severity. All are without differentiation processed, as it were, by standardized routines. Without exception they are completely disempowered as soon as they come under the sway of the hospital's mechanisms. The aged, moribund Mrs. Tate is "being tortured" (289) by futile interventions that have ravaged her body as much as her disease has. Similarly, Randall Lincoln, who has advanced sickle cell anemia, is heroically resuscitated, kept alive through weeks of coma by sophisticated equipment at extraordinary cost (239), to be displayed at a fundraising event as an exemplar of the hospital's success, while in actuality he is a pathetic, doomed travesty of a human being. These hopeless cases are a foil to the novel's two central characters, both of whose minor ailments are grotesquely overtreated. Ivy Tarro, who turns out to have a clogged mammary gland from breast-feeding, nearly succumbs to the effects of a wholly inappropriate toxic drug infused in response to a misdiagnosis. And when Mimi, a hospital volunteer, is struck by an agonizing pain in her back, she is taken (because her doctor is away) to the emergency room, where she is "rendered virtually immobile all day, strapped, led, wheeled, carted" like "an anonymous log" by people who "were firm, kind, and paid no attention" (259). X-rays, an electrocardiogram, ultrasound, and blood enzyme tests reveal nothing, and she is scheduled for an angiogram when it is noticed that she has "a terrible bruise" (263) on her back. Johnson, who dedicates the book to her physician husband and to "many other friends who are doctors, with affection and apologies," has a sharp eye for the defects in the hospital system and steers with considerable skill between the tragic and the comic. But the sentimental strain of romance between Dr. Philip Watts, a senior professor of medicine, and his patient, Ivy, is an incongruous intrusion that undermines the novel's realism and detracts from serious consideration of its implicit issues.

This flaw is even more pronounced in a narrative that has attained notoriety in the medical community, *The House of God* (1978). Published under the

pseudonym Samuel Shem, it is a first-person, quasi-autobiographical rendition of the experiences of the internship year. Since the author is himself a physician, the account has a basis of authenticated inside familiarity with hospital practices. But the characters and happenings are so grossly exaggerated as to amount to a mockery. The parody is most fully exemplified in the "Laws of the House of God" (420), which are impressed upon the interns: one of them, for instance, mandates: "At a cardiac arrest, the first procedure is to take your own pulse," while another rules: "The delivery of medical care is to do as much nothing as possible." The consistent message is physicians' prior obligation to care for their own welfare instead of being exploited, exasperated, and exhausted by patients' insatiable demands. This representation of patients as predatory aggressors against whom doctors must protect themselves as best they can is a cynical reversal of medical etiquette. Although many of the incidents are hilarious, all too often the humor becomes farcical and salacious. The interns' main objective, apart from self-preservation, is sex with the nurses. As a picture of the late-twentieth-century hospital *The House of God* moves beyond satire to slapstick comedy, where buffoonery dislodges plausibility. Yet does not physicians' overt anger at this image of hospital life perhaps suggest a tiny core of veracity to the parody?

The House of God and *Health and Happiness* both dwell on that staple of popular hospital culture, the romance between members of the staff or between physician and patient. This motif is peremptorily dismissed by Robert Klitzman in *A Year-Long Night* (1989) as a feature of "Hospital TV" (109) and a rarity in real institutions because of the extreme fatigue and time pressures under which doctors often work. Klitzman's book is one of three autobiographical accounts of medical education that appeared in a cluster in the later 1980s: Perri Klass's *Not Entirely Benign Procedure* (1987) and Melvin Konner's *Becoming A Doctor* (1987) are the other two. All of them deal with the rites of initiation into the profession through their hospital service, and all express concern about the dehumanizing impact of this process on budding young doctors. The etiquette of power inculcated in the 1980s is seen as having a deleterious effect on medical practice, especially on the interaction with patients.

These works are particularly valuable for the insight they afford into the contemporary hospital through the eyes of writers who are simultaneously outsiders and insiders. As newcomers to medicine, they still possess a freshness of perception that enables them to see with great clarity the qualities and

deficiencies of the accepted etiquette. At the same time, however, they cannot remain detached because they themselves are being assimilated into the profession. So they record the rituals of entry, focusing on the inner and outer difficulties they encounter as they are socialized into the proper behaviors. All of them come to acquire a better understanding of the rationale motivating the conduct of doctors toward their patients, yet despite their acquiescence in the prevailing professional ethos, they continue, to varying degrees, to question and to resist those aspects that strike them as reprehensible. Their double status as novices being turned into competent practitioners grants them a unique perspective from which to appraise current hospital medicine. That this dualistic vision is the mainspring and prerequisite for their writing is most categorically enunciated by Klass: "I have to see and hear things not only as a doctor, who would take most hospital sights, most medical locutions, completely for granted, but also as a nondoctor" (16). And the exemption of these autobiographical narratives from the necessity of constructing the neat plot expected in a fiction reduces the likelihood of the sort of idealization or demonization common in popular novels and films.

Although these three accounts are fundamentally similar, they differ in several respects. The writers concentrate on diverse segments of their apprenticeship and organize their narratives in disparate ways. Konner centers his on the third year in medical school because he regards it as crucial since it is "the first of total clinical immersion" (xii), when the student is fully involved in daily work with patients. He moves in a strictly linear progression through his rotations in the emergency ward, anesthesiology, surgery, neurosurgery and neurology, psychiatry, pediatrics, obstetrics, gynecology, pathology, and medicine. The symmetry of his design is completed by a chapter entitled "The Fourth Year" and a conclusion, corresponding in reverse order to the opening introduction and the chapter entitled "Basic Clinical Skills." Klitzman opts for a later stage, the internship year, when the newly minted M.D. crosses another major threshold by assuming at least partial responsibility for diagnosis and treatment. Accordingly, each of his chapters turns on a single case even as he too rotates through medicine, emergency room, neurology, and pediatrics. As in *Becoming A Doctor,* the disposition in *A Year-Long Night* is chronological, following the academic year from July to June, although the sequence here is more loosely picaresque and more dramatic in its greater concentration on the fate of patients than on the learning

experience. In contrast to the compact time frame of the year chosen by Konner and Klitzman, Klass's is expansive, covering all her four years as a medical student episodically in a mixture of the chronological and the topical. She is more issue- than case-oriented, partly because she takes in the entire span of medical school and partly owing to the fact that her book originated as discrete pieces for a weekly column in the *New York Times* and occasional articles for journals.

Both Klass's and Konner's viewpoints are decisively shaped by their personal circumstances. Klitzman, however, remains reticent about his identity beyond his professional persona. He divulges nothing about his history or situation, not even his age or appearance. The result of this discretion is a narratorial "I" that is shadowy to the verge of disembodiment. Only at Thanksgiving is he seen in relation to family members, and even then it is above all in his new capacity as a medical man. But what seems at first a somewhat disconcerting lacuna in fact underscores the main point of *A Year-Long Night:* the absorption in the microcosm of the institution so complete as to result in the virtual obliteration of the world outside and the temporary submergence of the self. When he finally comes off his last thirty-six-hour shift he experiences a surprise that is like a rebirth. "My mind was drained, and I felt weak. My legs barely held up my body. I walked into the white sunlight outside and gazed at people strolling up and down the sidewalk, looking healthy and free from IV poles. Familiar yellow taxicabs hurtled down the street uncaring. I had forgotten that the world still existed outside. I was surprised to see it, fresh, again" (222). The renewal of ordinary life in the bright natural light is a metaphoric spring after the year-long winter of darkness and anguish that the internship denotes for him.

Konner and Klass, by contrast, openly address the ways in which their personal lives impinged on their training and directly contributed to the shaping of their vision. Konner was in his early thirties when he embarked on medical training, with a Ph.D. in anthropology, a major book, and a successful teaching career to his credit. He has a good measure of intellectual self-confidence and a secure family base in his wife and two small children and, beyond that, the wider circle of parents, uncles, and aunts. Although he maintains that his age, his "atypical turn of mind," and his "stage of life" make him "not ideal for medical school" (28), it is arguably those very traits that make him an ideal *writer* about medical school. He cites his familiarity

with anthropological methods, which he feels to be in his bones, as his greatest asset in his analytical record of his initial encounters with clinical medicine: "I am an anthropologist trained to study odd and complex social worlds through the marvelous prism of participant observation" (xiv). Konner is fully conscious of, even self-conscious about, this capacity to be at once participant and observer: "I *was* in and out of it at one and the same time" (xvii), he remarks as he finds himself frequently "watching doctors instead of trying my damnedest to become like them" (xvi–xvii). Besides a certain maturity, he has a professional eye that enables him to interpret the ritualistic behaviors he registers. The circumstances of his personal life as a husband, father, son, and nephew are also introduced fairly often, notably as he weighs the pros and cons of his position compared with the relative freedom of his younger fellow students. While his status as a father intensifies his pleasure in obstetrics and his attraction to pediatric endocrinology, it is ultimately his professional gaze as an anthropologist that is the foremost characteristic of the narrator of *Becoming A Doctor.*

In *A Not Entirely Benign Procedure* the family issues that are a backdrop to Konner's training stand in the forefront. Klass had done some graduate work in zoology and spent a year abroad, but the determining factor in her life is the baby she has during her second year in medical school. As a result she has constantly to juggle her time in order to arrange care and feeding schedules between her own obligations and those of her graduate student husband. Like Konner, she sees her embedment in family as both an advantage and a drawback: after long stretches on duty she imagines coming home to a quiet, calm apartment instead of to a noisy six-month-old, but she also realizes how restorative it is to go back to such a sound family life. Klass's role as mother more immediately affects her medical existence than does Konner's as a father. She feels outrage at the lack of instruction about normal pregnancy in favor of concentration solely on potential pathological complications (48–51). In a comical but revealing episode ("Baby Poop," 177–83) she makes the mistake of offering to change the diaper of an infant who is the object of a neurological consultation. The doctors prefer to endure an unpleasant smell for forty minutes rather than to stoop to the indignity of a nurse's work. Klass learns a lesson about the separation she is expected to make between her professional and her private persona, yet she continues to insist on the import on her medical education of her sensibility as a woman and a mother.

The differing emphases of these works are conveyed in their titles. Konner's *Becoming A Doctor* is the most direct and straightforward, while his subtitle, "A Journey of Initiation in Medical School," points to his anthropological perspective. Klass's *Not Entirely Benign Procedure* is much more artful. As an inverted mimicry of medical parlance, it is an irony of understatement that immediately implies a critical, somewhat mocking stance. Even more evocative is Klitzman's *Year-Long Night,* a metaphorical title that is glossed in the subtitle, "Tales of a Medical Internship." The phrase "year-long night," borrowed from William Morris's *Earthly Paradise,* forms one of Klitzman's epigraphs. The other, from Walt Whitman's *Hospital Days,* speaks of "the whole interest of the land, north and south [as] one vast central hospital." Taken together, Klitzman's title and epigraphs project somberness, sorrow, weariness, the perception of the internship as a long dark tunnel, almost an earthly hell. The image is upheld throughout the narrative: toward the middle of the year he says, "I had ceased to believe I'd see the light of day again" (99). The sustained metaphor from the title serves as a substitute frame for Klitzman's "tales" in place of the cognitive reflections characteristic of Konner and Klass. Klitzman's method is more distinctively literary as he uses a poetic motif rather than the personal element as the unifying thread.

The presence of metaphor as well as such other marks of literariness as patterns of repetition and contrast raises a question that needs to be considered as a preliminary to analysis of the way these writers eye the institution and its power structure: to what extent have the personal, autobiographical experiences been metamorphized into fiction? Clearly, autobiography can offer only a version of a truth because it is filtered through the eyes of the self-beholding author. What is the nature of the interface between the autobiographical and the fictive in these three works, and above all, how does it modify their credibility?

All three writers draw directly on their immediate memories of initiation into the profession. They show varying levels of awareness of a possible tension between the demands of truthfulness, of individual, perhaps idiosyncratic input, and of vivid reportage. Konner, who gives the most thought to this issue, explains in his preface his deliberate choice to steer his narrative between the social-science mode, "cast in appropriate psychologese" (xiii), and "what they call in Hollywood a 'punched-up' docudrama" (xiv). He decides to resort to generic names in an "effort to protect the privacy of the patients, physicians

and other persons who appear in this book, as well as the confidentiality of the proceedings or relations described" (ix); so his is the Galen Memorial Hospital of the Flexner School of Medicine. Apart from this screen, however, he is remarkably forthright, especially in regard to his own reactions and feelings. He makes a fine point about the interplay between objectivity and subjectivity: "I have attempted to give an objective account of what I experienced, but I have not pretended that it is an objective account of what happened; on the contrary, I have tried to describe all events in the light of a full and frank subjectivity: my subjectivity as an anthropologist; as an educator; as a husband and father in his middle thirties; and as a medical student and future physician" (360). Klitzman opts for an entirely different approach: though of the three he is the most inclined to both metaphor and the dramatizing dialogue normative in a novel, he is at the same time largely self-effacing. He tries to extend objectivity by acting as a sort of registering and recording conduit with a minimum of cognitive reflection. By deemphasizing the personal aspects of his internship he underscores their universality as typical of that phase of medical education. Despite his often intense emotional involvement, he chooses to concentrate on his responses as a professional rather than as a particularized human being. Klass is at the opposite pole to Klitzman in her tendency to self-dramatization. In the section "A Weekend in the Life" (249–74) she shifts openly into fictionalization in chronicling two days in the life of an alter ego called "Elizabeth which is, in fact, my middle name" and "who is more than a little like me" (251). Though this "story" is an exception in *A Not Entirely Benign Procedure,* it is indicative of the method whereby Klass moves out of her self in order to watch her own performance. The outer experience is a platform for the elaboration of her inner reactions. This is very apparent in her presentation of her role in the attempt to resuscitate a patient (147–52), where she envisages herself as an actor in a drama. In a corresponding crisis Konner sees himself as a bystanding observer (102). It is precisely his intermediate position as a semi-participating spectator and his explicit admission of the imbrication of the subjective in the objective that makes him the most thoughtful and balanced witness of the hospital scene.

In the arduous process of education and socialization the interaction with patients is central in enabling students to learn both the appropriate medical treatments and the appropriate etiquette. All the apprentices at first feel acute apprehension stemming from their fear of actually inflicting harm on a patient through lack of manual dexterity or as a result of an oversight but also from a deeper anxiety about their own adequacy to their chosen profession. *Terrifying* and *terrified* are adjectives Klass uses again and again to describe her reactions to the ever new challenges she has to face. "The clinical years, especially the third year, are in some ways a very harsh experience. It is frightening to feel yourself very ignorant in a setting where sick people are depending on you for care. It is terrifying to learn on patients how to start an IV. You worry about making a mistake. You worry about hurting someone" (57). The "you" form that Klass uses here is a way of drawing readers into her experiences by appealing to their capacity to identify with her. One antidote to the terror for Klass is the comfort of food, but it cannot counteract the worst of the fears that come with the transition from medical student to doctor, the "terror of responsibility" (149)—and power. Hands-on procedures such as setting up intravenous lines, drawing arterial blood, doing lumbar punctures, or performing minor surgical repairs, initially done under supervision and with advice ("talked through"), rapidly fall to the charge of the novice on the much-quoted principle "See one, do one, teach one," which, as Klitzman ruefully points out, "ignores a beginner's anxiety, doubt, or clumsiness" (94). In his internship Klitzman goes through that most frightening passage from student to freshly qualified physician left solely responsible for the care of desperately sick patients. Though formally empowered by his M.D., he feels bereft of power because of his inexperience. He is especially nervous about making tough decisions on little sleep at night when the senior attending faculty member would hardly welcome a call (112). His anxiety blooms whenever he thinks he hears his name on the pager (9), and he notices the same "nervous insecurity" (112) in his fellow interns. Even on the last day, he admits that "the level of anxiety I felt at the beginning of the year when on call never fully dissipated" (218), although he has come to take for granted certain things and expressions that are alienating to his "timorous" (221) successor. Konner alone writes also of the increasing empowerment that is the reward for the fear overcome. Like the others, he has his "most anxious moment" (23) at his first encounter with patients; he is plain "frightened" (41) as he starts surgery and "more than a little apprehensive" (190) in the emergency room. He is even more categorically aware than the others of the doctor's "ready acceptance of responsibility, with all its practical, legal, and social consequences" (37), a responsibility that weighs heavily on him "although surrounded by people who

could take over if I failed" (76). But the apprehension slowly yields to a sense of his growing competence and confidence, so that fear is tempered by exhilaration. Finally, he understands the power that medical knowledge confers, "the surge of almost spiritual energy that accompanies the successful clinical encounter" (367), and that is compensation for all the terrors and hardships.

Together with fear, all three suffer initially from the disturbing sense that they are merely enacting the role of doctor. The motif of role playing recurs frequently: "as an 'apprentice'" on clinical rotations, Klass explains, "you get to play, more or less, the role of doctor" (155). Klitzman is even more specific: "I played the doctor role and sought cues in following my part as much as they [patients] did. Sometimes more. I uttered lines that I thought a doctor would utter, acting with the model of the discreet, empathic professional in my mind" (111). His model is derived in part from the hospital dramas that patients love to watch on television, although he ruefully notes that the TV doctors seem "less harried than I, unscarred by years of medical training, . . . more leisurely, casual and friendly" (109) with their patients. Klitzman also realizes how he changes his role according to the needs of each patient: "I acted gentler, firmer, or more paternal depending on the patient. The characters influenced each other. The lines that I delivered to a patient affected how he understood his disease and his body, how he felt and replied" (110). Various words here—"acted," "characters," "lines"—are pointers to the presence of an unwritten script innate to the culture and interpreted by both doctors and patients in fulfillment of the expected etiquette. Konner regards the role as "a kind of game-playing, even a kind of lying" (20) as he begins his clinical work. He spells out in precise cognitive terms the cardinal components of the role and its accompanying gestures: "the physician must be firm and authoritative" (108); "in encountering any patient one must do whatever is necessary to give the patient the feeling that one is 'The Doctor'; if for a particular patient, for example, the doctor is the one who takes the blood pressure, then we must take the blood pressure, even if there is no rational reason for doing it" (19). This is an acknowledgment of the etiquette that determines the behavior of doctor and patient alike. The physician must assert power, if necessary by a superfluous act such as taking blood pressure, in order to establish in the patient's mind the image of the doctor in control.

Gradually, with the accumulation of skill and experience and the concomitant increase in self-confidence, the role turns from a consciously assumed posture into second nature. Konner repeatedly writes of occasions that make him "feel like a doctor" (194),[16] of his pride and gratification when he begins to "feel like an integral part of the team" (209), is consulted by relatives, friends, and neighbors, and does a good job of removing a large splinter from his landlady's thumb (296). The same self-assurance comes to Klass as she stitches up lacerations in the emergency room, an act that makes her "feel like a real doctor" (100). Konner concedes as well the comical underside of his new perspective when he zooms in on the good veins on the arms of a young woman sitting opposite him on the bus long before he notices how beautiful she is. Similarly, at a film version of *La Traviata,* one of his favorite operas, he catches himself "unable to banish medical thoughts" about Violetta's consumption (297). When he is consulted by his aunts at Thanksgiving, Klitzman also derives satisfaction from "beginning to think of myself as a physician, growing more confident, knowing what questions to ask of patients, what answers to give and what maneuvers to perform" (121). The absorption of the etiquette is an important concomitant of the acquisition of skills and knowledge in transforming the novice into the adept.

The apprentice physicians also learn from their occasional assumption of the patient's role. Klass does this imaginatively when she projects herself into the position of a patient at the mercy of a gauche medical student trying to do a spinal tap (118–19). At one point she is so exhausted that she indulges in a fantasy about trading places with the patient by getting into bed and being looked after. Interestingly, she equates the surrender of power with the bestowal of care as if power and care were counter poles, power being the doctor's right and care the patient's. When her pregnancy turns her into an actual patient, she is so informed as to be highly dissatisfied, particularly at the dearth of advice about such ordinary matters as nutrition and exercise. Konner's special interest in "the human dimensions of patient needs and patient care" (x), in addition to his age, inclines him throughout his training to identify "more with patients than with doctors" (xvi). He is himself thrust into the patient's part several times: when he takes his mother to consult a cardiologist, who proves a model of sagacity and courtesy; when his wife has to go to an emergency room because she has developed a high fever during a vacation; and when he himself is struck by agonizing pain on a Saturday evening following root canal treatment. His wife's long wait and his own difficulty in getting pain relief not only reinforce his understanding of the exas-

perated patient's angle but also make him query the prevalent etiquette of power. Only Klitzman cannot "imagine himself ever being a patient" (53), which is surely an unconscious defense mechanism. For as Dr. McKee in the film *The Doctor* reminds his imperious physician, who insists on scheduling solely at her convenience, sooner or later all medical personnel will in turn become patients. And then the tables of power will be turned.

The reminder is certainly timely, for nowhere is the balance of power portrayed in as adversarial a light as in the modern hospital. To grapple with the dominant indifference or hostility to patients is one of the major difficulties facing the initiates into the profession. Klitzman, for instance, is encouraged to regard each new patient as "a potential opportunity to learn" (96), which implies that the patients are there for his benefit, not vice versa. Konner notes quite early "that ignoring patients was normative" (56), for "the patient is on the lowest rung of the hospital ladder of authority" (83). Klass likewise emphasizes the power element inherent in the doctors' view of the patient's position: "Patients can be seen as territory, decisions as power, medical disagreements as personal challenges" (158–59). Consequently, "all too often the patient comes to personify the disease, and somehow the patient becomes the enemy" (81). This association of the patient with the disease underlies the patient's dehumanization and also spawns resentment in the physician if the patient fails to respond to treatment. "When the disease has essentially won and the patient continues to present the challenge, the macho doctor is left with no appropriate response. He cannot sidestep the challenge by offering comfort rather than combat, because comfort is not in his repertoire. And unable to do battle against the disease to any real effect, he may feel almost ready to battle the patient" (82). Although Klass imputes this behavior primarily to the "macho" male doctor, she finds it prevalent throughout the hospital and among women physicians too.

Konner also uses the word "enemy" (373), which evokes a battle between doctor and patient instead of the cooperation and friendship that were taken as the norm in the nineteenth century. If the tension stems in part from the reduction of patients to their diseases, it is also, as Konner grasps, the crux of a vicious circle, for "the sense of the patient as the cause of one's distress contributes to the doctor's detachment" (56). He cites time pressures on residents as a reason for their medical style: "They focused more narrowly on the present illness, showed less concern for the patient's or, certainly, the family's

general health; paid less attention to behavioral and social factors in the patient's illness, were more abrupt and brusque and less responsive to the patient as a human being" (33). Repeatedly he castigates residents whose bedside manner betrays "listlessness, condescension, or patent fakery" (52). A similar exclusion of the human aspect, "tears shed, the slow acceptance of disability or death" as "secondary to the case" (110) is noted by Klitzman in senior physicians too. A woman with a rare progressive disease is demonstrated to students "as a sample of impaired neurological hardware, a malfunctioning computer" (165). Although Klitzman obviously condemns such a stance, he envisages the patient as having been forced to surrender autonomy, for "to be sick means to have used up one's resources" (85). To come to the hospital thus implies a readiness to submit to medical power because one's own psychological and physical reserves are exhausted. This seems like a late-twentieth-century psychologized reiteration of the nineteenth-century perception of hospital patients as self-selected victims of adversity, whose helplessness almost legitimates the churlishness meted out to them. That is certainly not Klitzman's personal view but a rationalization of the power structure he observes in the hospital, with its latent contempt for patients.

The indifference to the patient as a person that is a persistent leitmotif in these three autobiographies is confirmed by testimony from other sources. Twentieth-century doctors are said to have become "so laboratory-minded, so scientific, and so impersonal, that they forgot, or felt entitled to ignore, the patient as a person."[17] From a historicist perspective Starr points to the change from the nineteenth-century doctor's obligation to travel on visits to his twentieth-century successor's static location in office or hospital.[18] This change has both therapeutic and economic advantages for the doctor in that it gives him or her access to clinical equipment and ancillary personnel, as well as increased income because of the time saved. The physician's time becomes a precious commodity to which patients must defer. One of those interviewed in Mark L. Rosenberg's sensitive study complains: "My intern comes in at weird times, like ten or eleven o'clock at night. She seems more concerned about what other people are going to think of her than she is concerned about what is good for me." Medical students breeze in during breakfast and "expect you to do something when and because they want you to do it."[19] The hospital's organized routines have to take precedence over the patient's rhythms. But teamwork and delegation jeopardize the continuity of the doc-

tor-patient relationship. In teaching hospitals, where patients are seen by a throng of "doctors," they often do not know who is in charge, who in effect is their doctor. The interaction of patients with hospital doctors is characterized by the absence of long-term relations. Physicians in training or those engaged in research, Starr points out, "do not require their patients' good will for future business."[20] This factor is mentioned by Konner in connection with Marty, an abrasive surgical resident: at least in private practice "a man like Marty would be as much at the mercy of his patients as they would be at his" (120). Outside the hospital, patients still retain some power as the payees, although with managed care they are increasingly being stripped of that element of choice.

An adversarial attitude toward patients is connected to the necessity for defense mechanisms to protect physicians from the pain they must confront every day. How to develop a proper degree of detachment is one of the main challenges in medical training with which all three writers constantly struggle. Konner is quite shocked that "making fun of patients" in the minor surgery room "was a regular part of the morning ritual" (60) for the residents. In another instance a chief resident makes fun of a patient by asking a series of completely unnecessary questions (135). In the emergency room a game is played, "The Wheel of Pain," on the analogy of television shows, to decide which pain medication to prescribe (70). All these bizarre episodes represent assertions of medical supremacy through unconscious but firm separation from the suffering of patients. Already in the preclinical lecture courses Konner had learned that "vulgar jokes about patients are a ubiquitous feature of medical social life, excused (and perhaps excusable) as a 'necessary defense mechanism' in the face of illness and death" (18). Konner's inner growth in the course of the year is indicated by his deeper understanding of the residents' alienating behavior. "As the days went by, I also began to understand more fully the bitterness and cynicism some of the residents in the field exhibited. It was brutally difficult to face these patients day by day, to see the extremity of their need, to know that they needed you to do whatever you could, and yet to be able to do so pathetically little for most of them" (136–37). Here it is the inadequacy of medical power and the unavowed sense of their own helplessness that underlies doctors' forbidding behavior. To avoid acknowledging the limitations of the physician's power is an even deeper mode of self-preservation than detachment from patients' pain.

Klitzman learns the same distancing "from a visceral reaction" (128) when he comes up against the failure of medicine in the autopsy of a patient of his:

> The pathologist, Dr. Spain, rolled out a cart stacked with what looked like cookie sheets. He pulled them out one by one and displayed them on the table. Each held a different organ. One tray exhibited the kidneys, another held slices of the liver neatly cut and laid out. "Here come the appetizers," Walt joked.
>
> The conference is nicknamed "The Man in the Pan."
>
> A cold air chilled my shoulders. My mind distanced these piles of flesh from the man who had been my patient, his brown eyes, and the smile I had once seen. (74)

This is his most testing experience, and it teaches him to resort in surgery to the intellectualization recommended by the psychiatrist who had addressed the interns during orientation: "I resumed my position, observing fat, flesh, and blood. This conglomeration wasn't soup, I told myself, but was anatomy. I tried to concentrate on how a surgeon must look at it. I began to see it as only 'tissue' and not as something human" (127). Yet he also chooses the word "numbed," in a negative connotation, to describe the process of desensitization (130) and does not conceal his own descent "to a scavenging beast, an automaton" when he gulps down, "emotionless and guiltless" (101), and incidentally unheated, the supper left uneaten by a patient who has just died. The process of taking possession of power exacts its toll.

The counterpart to Klitzman's toughening through pathology and surgery occurs for Klass in the pediatric intensive care ward, where she notices the staff's "self-protective mechanisms" (35). Detachment and the exercise of power are of particular concern to Klass as a woman entering what in the early 1980s was still a predominantly male profession. "Some of the women in my class . . . worry that they aren't tough enough, that they cannot afford to pass up any opportunity to prove, to themselves and to everyone else, that they have what it takes" (32). She herself, like many of the other women medical students, is "haunted by the prospect of crying in the hospital. . . . It seems to hover on the edge of our minds as something we are likely to do, something we must not do because it will confirm all the most clichéd objections to women as doctors. Crying will compromise our professionalism

as well as our strength" (63–64). Nevertheless, she confesses that she did cry because she forgot to do things, or did not know how to do them, or found them to have been unnecessary, as well as out of sheer fatigue or sympathy admixed with self-pity, "but I took great care not to be seen at it" (64). When she asks her male fellow students whether they ever cried, they deny it; she wonders whether men are indeed slower to cry or maybe just too ashamed and therefore lying. To give in to tears is to subvert the image of power quintessential to the healer.

In the process of creating detachment from the patient language plays an important role. With her practiced writer's awareness of words, Klass has special insight into the function of medical jargon "to help doctors maintain some distance from their patients. By reformulating patients' pain and problems into a language that the patient doesn't speak, I suppose we are in some sense taking those pains and problems under our jurisdiction and also reducing their emotional impact" (76). Klass sees the translation of illness into professional terms of disease as an assumption of responsibility by physicians and at the same time a manifestation of power as knowledge and vice versa. For this reason all three writers insist upon the urgency of picking up colloquial usages as an essential facet of their initiation. Klass has a section entitled "Learning the Language" (73–77), Konner appends "A Glossary of House Officer Slang" (379–90), and Klitzman elaborates on pathology's preference for food names in describing diseased organs: "nutmeg tumors," "blueberry muffin lesions," "Swiss cheese endometrium" (76).

Hospital slang, which consists largely of acronyms and neologisms often derived from abbreviations, has a signification beyond its primary purpose as a kind of shorthand communication. It replaces the Latin formerly used in the medical world and now present only residually, for instance in "stat" (for *statim*, "immediately"). Like Latin, the current idiom satisfies the need for a private language that can be freely used in the presence of patients to discuss their problems openly but secretly. Besides this exclusionary purpose, it also has an inclusionary dimension in bonding those privy to the esoteric signals. Precisely because it is a mark of membership, it is pervasive among junior physicians, for whom the acquisition and adoption of this casual lingo is a step toward attaining professional empowerment. Mastery of this language denotes a particular sort of understanding that unites the medical community and endows it with the authority of knowledge.

A few of the acronyms have been absorbed into everyday parlance: "IV," "OD," and "D and C," for example, have become common terms, although laypeople may be unsure what the abbreviations stand for. Many belong simply to the conventions of record keeping: "sx" for "symptoms," "Nl" for "normal," "NAD" for "no apparent distress," and so forth. Others are more technical, pertaining to diagnoses or to procedures: "MI" for myocardial infarction, "COLD" for chronic obstructive lung disease, "BUN" for "blood urea nitrogen," a measure of heart failure, ""CHF" for congestive heart failure, "PCP" for "pneumocystic carinii pneumonia," and "FTT" for "failure to thrive." Procedural acronyms include "NG" for "nasogastric tube," "LP" for "lumbar puncture," "PFT" for "pulmonary function tests," "ECT" for "electroconvulsive therapy," "EKG" for "electrocardiogram," "CABG" (pronounced "cabbage") for "coronary artery bypass graft." More complicated are those acronyms with a didactic function, designed to help students to learn what ought to be done in case of certain symptoms. Konner calls these "alphabet soups," (344), citing "SOB = EKG + CXR + ABG," for "shortness of breath equals (requires) electrocardiogram plus chest x-ray plus arterial blood gases," or "AVUP" for "a cursory neurologic exam: A is Alert. V—not alert but responds to vocal stimuli. P—doesn't respond except to painful stimuli. U—unresponsive" (55). The same letters can also stand for "Awake, Vomiting, Pupils, Urination," important indicators of the level of brain or spinal cord damage.

More revealing than these technical abbreviations are those that drift from the denotative to the judgmental: "FLK" for "funny looking kid," "LOL" for "little old lady," "007s" for "licensed to kill," that is, bad doctors, "GOK" for "God only knows," an admission of inability to establish a diagnosis, and "gomer," originally an acronym for "get out of my emergency room," applied to any old, decrepit, hopeless patient whose care will be a thankless task. Like "gomer," many of the slang terms are indicative of the doctors' perception of patients, often crossing quite inventively into the realm of metaphor. Drawing on sporting terminology, every patient is a "player," and one who has a problem difficult to remediate is deemed "hard-wired." A "hit" is a newly admitted patient whose workup may well take a good hour; a "wall" is a house officer on duty in the emergency room who knows how to prevent unnecessary admissions; a "sieve" is the opposite, one who easily permits admission, and a "pump" pushes for the hospitalization of patients who do not

really need it. To "buff" and to "turf" mean respectively to make patients look so much better that they can be transferred to another service. If the "turf" is unsuccessful, the patient is said to "bounce," like a bad check. Black humor creeps in when a patient given to hematomas is described as a "hematomato" or when an extremely rare disease, read about in textbooks and much in the minds of medical students, is called a "zebra." Much of this medical slang, like the judgmental acronyms, expresses feelings, generally of a negative nature, about those so designated. Apart from "gomer," various other terms of contempt are used to characterize patients: a "dirtball" may be a chronic alcoholic, drug abuser, bag lady, or street person who rarely washes, has frequent infectious contacts, and is likely to be host to a multitude of threatening microorganisms; a "worm" is a hateful, treacherous, dishonest patient; a "boarder" is one who has been "turfed" from another unit; a "crock" is a hypochondriac or a somatizer; and a "dud" is one with no medically interesting findings. The only grudgingly benign term for a patient is "rose," for one who is completely "buffed," not necessarily well but ready to be moved on. The striking feature of this vernacular is the barely repressed aggression against patients who are seen as challenges or even threats to the physician's rule. The subtext is one of discord between doctor and patient in which the doctor has to fight to maintain sovereignty.

The power structure within the profession is also formulated in slang: a "twit in the pit" is a house officer in the emergency room; "fleas" is the term applied by surgeons to medical doctors because they are thought to be the last to leave a dying body; a parallel pejorative used by surgeons of nonsurgeons, "mope," is, like "gomer," a neologism developed from the acronym MOP, for medical outpatient physicians, who take care of trivial conditions by slow and uncertain methods under no pressure; "money changers" are private physicians, often in prosperous group practices, whose work cannot be trusted because of the profit motive. A slightly self-aggrandizing image is projected by the terms "metabolic rounds" for food breaks and "liver rounds" for a social gathering. Though humorous, both terms suggest that medical personnel, while in the hospital, are always engaged in patient care, so that eating and socializing are turned into another kind of "rounds."

Much of this "deleterious terminology" centers on bad occurrences in treatment that disempower the doctor.[21] There are multiple euphemisms for dying: she "boxed"; he is "crumpling on me"; she "coded," that is, required

full emergency measures for resuscitation. A patient close to death may be said to be "circling the drain" or, in another phrase derived from the arena of sport, "dribbling off the court." Less catastrophic happenings are conveyed in the same style: he "dropped his pressure"; she "bumped her enzymes"; he "failed chemotherapy"; she "blew her IV." The crucial factor in all these locutions is the active tense of the verb, with the patient as the subject. In other words, the patient is cast as the actant, as the responsible and culpable agent for any turn for the worse. By this means the physician is, by syntax and so by implication, absolved of any blame as the grammatical construction imposes it on the patient. The resort to the active voice of the verb at one and the same time exculpates the physician and expresses an unmistakable hostility toward the patient for failing to respond positively to medical interventions. Hospital language is, therefore, not only a convenient means of rapid communication and an oblique defense mechanism but also a robust affirmation of medical power.

The detachment and the struggle for domination discernible in hospital slang do not, however, exclude genuine caring allied to the primary purpose of curing. How to achieve the necessary equipoise between distance and humaneness is another recurrent problem for novices to the profession. Despite their explicitly or implicitly critical stance, all three of the accounts contain heartening examples of humane solicitude for patients through the tactful use of medical power. Konner expresses admiration for a number of the senior teaching faculty, notably the "simple human decency" of one excellent internist: "He was simply *with* patients. . . . He had a penetrating gaze that was medically critical yet full of convincing practical warmth. . . . He cared, professionally, about the nonmedical aspects of his patients' problems—their characters, their families, their situations, their incomes" (38). He has similar praise for both a pharmacological psychiatrist whose bedside manner "*was* wonderful" (162), putting some of the most seriously ill patients at their ease, and the pediatric endocrinologist who is "the most sensitive clinician" (203). He also notes the considerate neurosurgical resident who carries a flashlight pointed at the ceiling on 6:00 A.M. rounds "instead of flipping the lights on and parading in with the troops to a dazed, half-asleep, psychologically stunned patient" (128). He contrasts the "curt officialese peppered with medical jargon" (300) used by one woman doctor in speaking to the daughter of a recently deceased patient with the conduct of another physician who, in a

parallel situation, "went to the waiting room to talk with [the family]. He sat down close to them, facing the wife directly. He spoke slowly and softly. He looked straight into her eyes. And . . . he took her hand" (315). This genuineness is the opposite of the mechanistic behavior of those who "smile at their patients, when they can, in something like the way flight attendants smile at their passengers" (375). Konner very much emphasizes the value of listening, and his belief that medical students, because they have more time, can give significant support to patients by a willingness to lend an attentive ear: "I sat down and listened to him" (145); or with a patient who is facing the prospect of imminent death: "You just sit there and stay there and listen and say a few words. Mainly you listen" (153), sitting back in the chair and not looking at one's watch.

Klitzman too appreciates the importance of listening.[22] He shows a compassionate understanding of difficult, noncompliant patients and far exceeds the call of duty in tracking down the background of an aphasic old woman whom he later even visits in a nursing home. Like Konner, he encounters a wide spectrum in physicians' attitudes, ranging from the chief resident who is "looking for good patient material" (31) to present as teaching specimens to the neurologist who urges: "Don't treat lab tests or CAT scans. . . . Treat the patient first" (158). Klitzman evolves his own compromise: "I divided my work up by individual patients and thought in terms of a disease acting itself out in somebody's body" (30), but there are occasions when his desire to deal with patients as persons is frustrated by sheer time pressures. Klass, who seems far more competitively minded than Konner or Klitzman, has least to say about humaneness, writing it off with a certain flippancy as an insoluble problem: ". . . what about the students who are simply incompetent at dealing with people? That, after all, is a much harder skill to teach. In medical school my classmates used to joke about taking up a collection for a scholarship fund to pay all the future training expenses of a certain student, as long as he went into research and promised never to talk to or touch a patient" (121). It seems as though Klass, because she is a woman, needs throughout her training to demonstrate the toughness that makes her fear crying.

In these three works talking to patients emerges as a crucial and largely neglected aspect of care. Konner, probably because of his consciousness as an anthropologist of verbal exchange, dwells most insistently and most critically on the problem of communication. He sees the primacy of technological procedures as leading to an atrophy of human contact through speech. The maxim taught as "a categorical imperative"—Touch the patient—even if it is not strictly necessary, is drained of its communicative meaning in the hurly-burly haste of hospital routine: "The laying on of hands was reduced to the carrying out of procedures, and words exchanged with the patient were basically viewed as tools to make those procedures go more smoothly" (26). One of the most shocking incidents Konner records is the visit of the medical group to a woman who had attempted suicide and now

> lay completely constrained, weak and helpless, in a lower body cast and in one arm and shoulder cast, with tubes in her nose and in her free arm. Her face was nonetheless distressingly alert.
>
> Mark presented her to the group, and Marty asked a few perfunctory questions. No one spoke to the patient, touched her, even met her eyes during the five minutes we spent in her room. Marty was making a move to gesture the group out when she began speaking. She was looking around at the white coats in abject fear and confusion. She said wanly, in a thick regional working-class accent, "Can I have something for the pain?"
>
> Marty stopped and looked at her from where he stood about four feet from the bed. "You bet!" he barked. This was the single exchange that occurred between this patient and a physician during the daily period at bedside. (115)

The psychological interaction is complicated here by the fact that the patient's abject condition is self-inflicted, probably both provoking guilt on her part and further goading this physician's notorious insolence. In another case, an old woman hospitalized with heart disease is discharged with appropriate medications but without adequate instructions about dangerous symptoms, so that she delays returning to the emergency room until it is too late. Konner spells out the lesson that *"an act of communication can sometimes be a life-saving intervention"* (277); full treatment requires words to accompany drugs and procedures. In the laments of a demented ninety-five-year-old man, "Why you do this to me? What I did to you? I never did nothing to you," Konner reads "a superb ironic commentary on the doctor-patient relationship and . . . an exaggerated symbol of failure of communication" (292).

Hospital etiquette, in Konner's eyes, comprises brusqueness, embarrassment at "acts and gestures that are other than completely instrumental" (26), attention to the immediate disease without heed to the patient's or the family's general health or to behavioral or social factors, and unresponsiveness to the patient as a human being. All these, though attributable in part to immediate time pressures, add up to a distinctive style of medicine: "humane acts not directly affecting 'care'—a word meaning neither more nor less than medical and surgical intervention for the purpose of favorably altering the course of an illness—are in short supply in the hospital world; . . . the patient's mental status is only marginally relevant to the effort at helpful verbal or nonverbal communication" (26). The quotation marks surrounding the word "care" here and the carefully interpolated explanation of its limited meaning reveal how perverted and drained the concept has become. Konner admits to being himself tongue-tied with a young paraplegic waiting in the hallway to be demonstrated to a class; although he recognizes that "patients almost always want to be spoken to by doctors (including medical students)" (24), he is at a loss what to say and relieved when an athletic-looking fellow student exclaims: "Pretty tough break." The patient's face brightens perceptibly as the emotional tension is broken. The soothing impact of a few words is vividly brought out when Konner recalls an acute, alarming illness some years back that finally led his wife to call the emergency room. "Yes, that's the flu that's going round this season. It causes nausea and vomiting. It lasts a few days" (202). "A transfer of the simplest information had healing power," Konner comments (202). The value of the "'therapeutic alliance'—a doctor-patient relationship tending to promote understanding of the illness and compliance with the treatment" (130) is a grossly underestimated factor in the balance of power within and beyond the hospital.

This atrophy of communication between doctor and patient can be traced back to the development of a specific medical discourse. As the patient's subjective story is rewritten into the ritualistic, standardized format of medical records the discrepancy between the patient's experience of illness and the doctor's perception of disease becomes an obstacle to colloquy. What Fissell describes as "the disappearance of the patient's narrative" is abetted by current conventions of medical writing as much as by the primacy of the objective evidence of tests. In the eighteenth and early nineteenth centuries "the patient's and the doctor's words are one. It is easy to hear the patient's voice

in the doctor's case report."[23] By the twentieth century, however, the patient's individuality has been effectively squelched by the formal conventions of medical charting. Physicians themselves have in several recent instances commented trenchantly on the pejorative effect of the prevailing mode of case presentation. The formulaic format "turns the sick person as *subject* into *object,*" Arthur Kleinman laments in his penetrating study of a series of personal narratives by the chronically ill, which he compares to the stark medical account of them.[24] Like Konner, Kleinman is an anthropologist as well as a psychiatrist. Another physician with anthropological leanings, Oliver Sacks, is even more emphatic: "There is no 'subject' in a narrow case history; modern case histories allude to the subject in a cursory phrase ('a trisomic albino female of 21') which could as well apply to a rat as a human being."[25] In translating illness into disease the physician is indeed taking the patient under medical jurisdiction as a step toward cure or alleviation. Klass conceives of this practice as a benign acceptance of responsibility on the doctor's part. But it has an equivocal concomitant since patients' transposition into medical power results in the discounting of their personality.

The change in the way the patient is described has been examined in two recent studies that analyze contemporary models of medical discourse. In a comparison of the writing of case history and literary biography, Anne Hunsaker Hawkins observes that the "depersonalizing focus on the disease rather than the diseased person" immediately becomes evident.[26] She characterizes the case history as "nomothetic" (6), that is, directed to the apprehension of general laws, and biography as "idiographic" in its interest in uniqueness. So the physician's medicalized report is episodic, pragmatic, and rational, in contrast to the patient's personal story, which is holistic, historical, and imaginative. The hospital, where most likely an acute crisis is handled, is conducive to case history. On the other hand, the family practitioner or, even more, the psychiatrist, while still remaining within a stylized format, is at greater liberty to adopt a longer-term, more comprehensive view that partakes of both case history and biography.

More extensive research in this field is presented in *Doctors' Stories,* by Kathryn Montgomery Hunter, a medical humanist who accompanied hospital teams on their rounds, attended conferences, and scrutinized the ways in which patients' illnesses were discussed and charted in order to ascertain how the actual narrative structuring of medical knowledge affects the etiquette

between doctor and patient. Even more than Klass, Klitzman, and Konner, she is "an outsider, far more observer than participant" (xii) in the processes she analyzes, a listener par excellence. Her ulterior purpose, namely, to investigate "the interaction between patient and physician" (xiv) in a teaching hospital, makes her book a singularly illuminating cognitive commentary on the incidents related in the three autobiographies. Hunter gives a clear definition of the aim of medical discourse as always "to eliminate or control the purely personal and subjective, whether its source be patient or physician, so that the physical anomalies that characterize illness can receive the attention their successful treatment requires. Illness is a subjective experience, and the examining physician faces the task of translating it, locating the malady in the medical universe and conveying its characteristics and their meaning to others who know the medical language well but this particular patient not at all" (52). Hunter here relates medicine's scientific character directly to the necessity for a deliberate disregard of patients as idiosyncratic individuals in favor of their existence as one of a series of similar cases. Thus the identification with science has adverse consequences for both the education of physicians and their interaction with patients, two facets that are interdependent. Physicians and patients alike are encouraged "to focus narrowly on the diagnosis of disease rather than attend to what is even more necessary, the care of the person who is ill" (xix). This conflict between cure and care is a continuation of the tendency already apparent in the nineteenth-century hospital of treating diseases rather than diseased people. The mistaken underlying assumption is that the two are mutually exclusive.

Hunter draws on terms derived from the nature of vision to render the shortcomings in physicians' view of patients: she writes of "professional shortsightedness that sees maladies rather than people as the objects of medical attention" (61) and of "the sort of epistemological scotoma in medicine" that has created the "hope of achieving a minimal, streamlined scientific account in every instance of disease" (104). The minimalism stems from the ideal of the chart as a "regular, patterned, self-effacing plot" (63), whose essence resides precisely in the eradication of personal detail as intrusive and distracting from the medical picture. So "the chart refuses awareness of the pain of human existence" (91); it strives to be a variant on the scientific report in its "plain and flat and dry" style, which seeks to banish personal involvement and to keep the medical face calm by controlling—or, in fact, repressing—"the subjectivity of the observer" (90). Consequently, the patient's and the doctor's versions of the malady are "fundamentally, irreducibly different narratives" (123). Once it has yielded its diagnostic information, the patient's version is often ignored, for much subjective experience of suffering, uncertainty, helplessness, fear of death, and anxiety over loss of autonomy is dismissed as medically irrelevant. The frequently noted proclivity in hospitals to think and speak of patients as if they had become their diagnoses, "an object with only a medical existence and only a diagnostic meaning" (137), is a direct outcome of the scientific approach predominant in twentieth-century practice.

Hunter paints a discouraging, indeed frightening picture of the patient's reification. She steers a careful if somewhat tricky course between reification and impersonality, which she characterizes as "a virtue of medicine" (82). "Impersonality is not inattention" (133); similarly, "the objective gaze," whereby the patient is "flattened" and the narrative made "relentlessly passive," far from being "cruelty," is exactly what the patient has come for in order to have established "with relative certainty what the matter is" (162). The argument is convincing to a point, yet the cumulative weight of Hunter's evidence contravenes it. The imperative of the objective gaze is beyond question, but it has a "tendency to hypertrophy," which, she avows, "is potentially harmful" (136). The complement to objectivity is not its opposite, subjectivity, but the kind of compassion that Konner in particular finds in the most outstanding of his teachers.

The precarious contradictoriness of hospital medicine in its dual allegiance to science and the patient emerges from the conflicting statements made by Klass. At one moment she insists that "there's a thread-fine line that good doctors must walk, a desperately sensitive balance to preserve, which consists of understanding for each individual patient" (214), especially in imparting deadly diagnoses. This endorsement of humaneness stands uneasily next to her jubilation at a scientific rarity: "A great case is a great case, even when it's dying" (71). Klass concedes that such an attitude "can be disturbing to a medical student who has come to see the patient as something more than a teaching exercise" (71). In her own resolution of such dissonances, she comes to realize that in the first two years already, along with the basic science and pathophysiology, "values were being taught, though not explicitly" (27). Significantly, she applies the same adjective that she uses to describe a medical

student's response to a great case, "disturbing," to her own reactions to being socialized into medicine. Although she feels anger at being "at the very bottom of a fairly rigid hierarchy, . . . being treated like someone who doesn't matter, . . . being made to wait constantly" (57), she soon accepts these humiliations, along with such hardships as sleep deprivation and isolation, as integral to the toughening process "intended . . . to divide me from ordinary normal people" (32). She shows a streak of pride in likening it to an initiation "into a priesthood" (36). "Like any other subculture, medicine develops its own internal systems of values, its own hierarchies of prestige and power. And these don't necessarily have anything to do with helping patients" (69). Klass's evolution confirms Lipkin's observation: "Most students enter training intending to learn how to take care of patients. By the time they graduate, many have become more interested in the mechanisms and diagnoses of disease than in all the other activities involved in the care of the ill."[27] Put even more cynically by the dean of the medical school in *A Year-Long Night:* "Students enter medical school wanting to do good. They leave hoping to do well" (6).

Klitzman, as an intern already on a slightly higher rung of the ladder, is less concerned than Klass about hierarchy. He mentions "the politics of medicine" (5) and is aware of the tensions in the power structure, but he does not seem to be personally involved in issues. His major anxiety is how to survive the "year-long night," and his primary orientation is toward his patients. He comes across as more of a loner than the two medical students, Konner and Klass, who write of their work as members of a team. Klitzman sees the hospital as an exclusive and exclusionary microcosm with "the laws and language of a foreign country" (6). The priority of scientific pursuits over patient welfare is a reiterated theme: one instance is the physician who refuses the dying patient's wish to go home with the announcement: "I'm not giving her up now—not yet" (47), as if she were his possession. Even more crass is the doctor who persists in continuing his chemotherapy research, "indifferent" to both the patient's suffering and the fact that the treatment is ineffective (59). Usually so reticent, Klitzman interjects this laconic, unvarnished statement: "He didn't want to lose his research subject. He wanted to find out whether his concoction worked. Research studies require research subjects" (57). Strictly speaking, such practices are not misuses of medical power, but they are abuses of patients, whose personal well-being is subordinated to a

stubborn pursuit of treatment literally to the bitter end. These physicians put their own interests—and pride—above those of the patient, and they are technically, if not ethically, authorized to do so by the etiquette of power, which puts them in control. For a patient to defy such control takes more energy and courage than most very sick people can muster. And it entails a challenge to the conventional wisdom that "the doctor knows best" that is tantamount to a resistance to scientific medicine and its prestige.

Of the three, Konner is by far the most troubled by the system and the most trenchant in his criticisms. "American medicine," he concludes, "is a spiritual wasteland and its practitioners impotent to confront matters of life and death other than with a test or a scalpel" (361). His previous training in social science and his maturity enable him to place experience in a wider context and to probe the values motivating the actions. His assessment of the hospital comes closest to Jewson's conceptualization of it as a collective order where authority is inherent in occupational status rather than in individually proven worth, so that moral and personal qualities recede before "strictly prescribed patterns of deference" in a hierarchical etiquette.[28] The defining thrust toward certainty and order is immediately evident to Konner in the contrast between a good graduate seminar, "arguing generously with itself, teaching itself, learning," and the single-mindedness of hospital instruction, "rigid, authoritarian, intolerant of ambiguities and constantly searching for certainties, reliable rules, unchallengeable procedures, incontrovertible facts" (56). Such stringency can result in "bad teaching" and "bad medicine" (97), a lack of flexibility detrimental to patients. Konner follows for some time a patient he names Charlotte (299 ff.), who has an organic disease for which she refuses a treatment antagonistic to the severe, active bulimia she also has. The gastroenterologist in charge resolutely denies her a psychiatric consultation—which does finally take place while he is away attending a conference. Even then he rejects any suggestion of a connection between her eating disorder and her colitis. The entire staff, from the nurses upward, are contemptuous of the treatment he orders yet obliged to carry it out. This is the grossest example in these three autobiographies of a power structure pushed to its extreme as patient and medical personnel are all coerced by the will of a single imperious physician obdurate in imposing the supremacy to which he is in fact entitled.

Konner is glad to leave internal medicine, with its "interminable hairsplit-

ting conferences, without humane sensibility and without ethics beyond legally defensive medicine" (310–11). Yet however sharp his criticisms and however negative his ultimate verdict, he never loses a sense of proportion. His hospital comprises simply "the usual mix of marvelous, terrible, and ordinary people" (208): the terrorizing resident is neutralized by another who is "full of kindnesses" (279), and within "the emptiness of hospital medicine" he finds reassuring examples of physicians who are "real" (295) in their warmth. As if in response to the common reproach that doctors like to play God, he characterizes them as "healing artisans": "Doctors are craftspeople of the highest order. Sometimes, like engineers, they lean very heavily on science. Sometimes, like diamond cutters, they seem to be coasting along on pure skill. And occasionally, like glassblowers or goldsmiths, what they do verges on art" (xvii). The striking images in this passage affirm the possibility that, when practiced in an ideal manner, medicine can transcend its own internal contradictions in a confluence of science and art.

8.
BALANCING THE POWER

> In default of health, we manage by *care,* and control, and cunning, and skill and luck.—OLIVER SACKS

PATIENT EMPOWERMENT. Need help understanding your disease and treatment options? Yale University trained physician reviews case and provides synopsis of world literature search with simple, clear, unbiased explanation of your choices. Reasonable rates. Call (619) 535-1313." This announcement appeared on 25 June 1992 in the *New York Review of Books* under the heading "Services." The advertisement is quite startling for a number of reasons: it reflects an acknowledgment of patients' bewilderment in the face of a proliferation of possible treatments; it propounds the need for a wholly new type of professional advice to mediate between patients and their personal physicians, thereby insinuating that those physicians are in default in their counseling obligations; and it unabashedly envisages the doctor-patient interaction today as pivoting on power.

The power element is much less prominent a constituent in traditional definitions of the etiquette between doctor and patient. The Hippocratic oath, indeed, binds physicians to a series of limitations on their power: to desist from giving deadly medicine on request, to desist from providing an abortive remedy, to desist from cutting persons laboring under the stone,[1] and to desist from taking advantage of access to homes by instigating mischief or indulging in seduction. Taken as a whole, the Hippocratic oath devotes a surprisingly large proportion of its imperatives to prohibitions.[2]

A more positive line was taken by the British physician Thomas Percival in *Medical Ethics,* which he was asked to compile in 1791 by the trustees of the Manchester Infirmary to settle a dispute among its staff. Printed for private circulation in 1794, it appeared in 1803 under the title *Medical Ethics; or, a*