The wounded surgeon plies the steel
That questions the distempered part;
Beneath the bleeding hands we feel
The sharp compassion of the healer's art
Resolving the enigma of the fever chart.

T. S. Eliot
Four Quartets

Prologue A Time for Healing

THIS BOOK IS ABOUT the art of medicine—what it means and the origin of its meanings in the human condition, in history, and in the world around us. It is a book about doctors as healers, apart from their technology and their drugs, and what they can learn from the sick, since making the sick better is the final test of any understanding in medicine.

Many years ago, while in residency training at Bellevue Hospital in New York City, I had a midnight call from the psychiatric ward: an old woman was having difficulty breathing. I found the patient gasping for air, her skin blue from lack of oxygen; she had full-blown pulmonary edema (water in the lungs) resulting from a blood clot in her lung. I sent the nurse for the urgently needed oxygen and drugs, but in those days, because of staff shortages and inexorably slow or inoperative elevators, a critically ill patient on a psychiatric ward in Bellevue at midnight might just as well have been in the East River: the wait for the necessary equipment would be interminable. I stood at the bedside feeling impotent, but the old woman's face and her distress pleaded for help. So I began to talk calmly

but incessantly, telling her why she had the tightness in her chest and explaining how the water would slowly recede from her lungs, after which her breathing would begin to ease bit by bit and she would gradually feel much better. To my utter amazement that is precisely what happened. Not only did her fear subside (which would not have surprised me) but the noises in her chest disappeared under my stethoscope, giving objective evidence that the pulmonary edema was, in fact, subsiding. By the time the equipment came, things were already under control and the patient and I felt as though together we had licked the devil.

I was, of course, immensely relieved and pleased, but I didn't know what to make of it. Now, twenty years later, I understand much better what had taken place in the middle of that night. I had felt helpless because none of the things I identified with a doctor's job of curing the sick were available; I had none of the technology which, to me, was essential to being a good doctor. What I didn't know then was that desperation and fear had led me unknowingly to function as a healer, a role traditionally played by physicians as far back as Hippocrates.

Today in our society the word "healing" has become identified with charlatanism and quackery, and doctors no longer think of themselves as healers. Several years ago, while writing an essay on changing patterns of disease in this century, I used the word "healer" and suddenly realized that I had no idea what it really meant. I began to explore the subject and found that reading what was available wasn't much help. Most of the literature either reported on healing ceremonies in other cultures (usually from a markedly ethnocentric viewpoint) or interpreted

the function of the healer within a psychoanalytic framework as a sort of unlettered psychotherapist—an assumption that seemed to me a simplification concealing more than it revealed.

It gradually became clear, however, that the form that healing took in each primitive society was intimately related to the central beliefs of that particular culture. Such beliefs are concepts of reality but not necessarily, of course, "the Truth." What would turn out to be the central belief, I wondered, if one were to consider doctors trained in Western scientific medicine in the same manner as healers in other cultures? After all, medicine is so important in our culture as to be almost a subculture.

One day, while I was conducting a public-health seminar on cross-cultural medicine, it suddenly occurred to me that the central belief of our medical subculture was disease! Then it followed that modern concepts of disease are not "the Truth" but simply a useful way of organizing observations of reality. The constructs of disease, as physicians learn them, are as surely a belief system as are the constructs of yin and yang found in classical Chinese medicine. They are ways of organizing and thinking about the amorphous manifestations of illness that patients bring to the doctor. Judging from the results of therapy, our belief system of disease is very successful, but it is not the only way of viewing the sick. The ancient Chinese system must also be quite successful, as evidenced by its durability, although judgments of success vary from culture to culture (there is a certain circularity built into the process).

The discovery that constructs of disease are essentially a belief system was a revelation to me, since it tended to contradict the long, intensive technological training

centered around disease that all physicians receive. When examining someone who is ill, every physician is so accustomed to looking for the causative disease that the cause of illness is inevitably confused with the phenomenon of illness itself. But the illness and the disease must really be quite separate entities, since sick people have certain characteristics in common and behave in certain similar ways regardless of whether they are sick with pneumonia or have a fractured leg. Thus it seemed obvious that making the distinction between illness and disease could be extremely useful in helping me understand patients and the role of doctors.

I then realized that there must be a similar distinction between healing and curing. If the sick person indeed presents two distinct aspects of his sickness—the illness and the disease that caused it—the doctor must respond with two separate functions, no matter how closely connected they may be or how the curing function may conceal the healing function. To the doctor who does not distinguish between illness and disease, making a patient with pneumonia better means curing the pneumonia—killing the bacteria, bringing down his fever, enabling him to breathe more easily. Indeed, if the doctor does not do those things, it will be bad news for the patient. But there are other aspects of the illness that the doctor may ignore: the patient may be frightened about what is happening in his body; he may feel cut off from his family and his friends; and he may find himself painfully dependent on other people. Handling those aspects of the patient's pneumonia is also part of the doctor's job, a part of his healing function that can be viewed as entirely separate from his function in curing the pneumonia, even if, in practice, the two func-

tions are interrelated. All too often these days the patient must try to cope with those aspects of his illness himself because his doctor either is unaware of the problems or considers them beyond his competency, since it is likely that he was never trained to deal with them in the first place.

Indeed, since bacterial pneumonia is now so easy to treat, the healing function may well not be too important in such cases. It would seem that the technical success of our era, when doctors can be more effective in curing disease than at any other time in history, has contributed to the disappearance of healing as part of the doctor's manifest function. In my opinion this accounts somewhat for the increasing dissatisfaction with doctors. While pneumonia and other infectious diseases can usually be cured, the diseases of present concern, such as heart disease, cancer, and stroke, offer many examples in which cure is impossible and the healing function becomes of paramount importance.

One of the reasons healing is neglected today is a basic confusion among both laymen and physicians about what the role of medicine is. The rise of modern technological medicine has so closely paralleled the disappearance of the infectious diseases of the past and the fall in infant and childhood mortality that it is generally assumed that doctors and their technology are responsible for the health our society enjoys today. Unfortunately, there is little evidence to support the assumption that the health of a population is primarily a result of its medical services—and much to contradict it. As I shall try to show in Chapter 2, our pattern of disease comes primarily from the way we live, and changes in the disease burden of a

society are brought about only by changes in our way of life. Simply stated, your doctor with his great technological power may do wonderful things for you when you have a heart attack, but, in order to have a heart attack, you must first have coronary heart disease. People are healthy not because they became sick and were made better but because they didn't get sick in the first place. But doctors and their technology are so effective and so apparent and the intricacies of disease causation are so inapparent that it is natural to relate what your doctor and his technology did for you when you were sick to what doctors and their technology in general do for disease in general.

What is important here is to realize that we, as a society, have come to associate the doctor and his technology so closely and to attribute such power to the association that we have difficulty in seeing them separately when such a separate view is necessary. Furthermore, as a result of the confusion about what doctors and medical care can do for us, we have come to believe that more doctors and more technology will solve our health problems. Increasingly, in the service of that belief, despite some excellent attempts to change the trend, physicians are trained to practice a technological medicine in which disease is their sole concern and in which technology is their only weapon.

But I hope this book will help to make it clear that such a view of the physician's job is extremely narrow, alienating the doctor from his primary role, the care of the sick. The seeming paradox—that seeing their job exclusively as the curing of disease not only prevents physicians from effectively caring for the sick but also reduces their impact on the health of populations—is no paradox at all but results from a failure to perceive the place and func-

tion of concepts of disease in these two different areas of medicine's concern.

I have always led a double life in medicine, and so the perspective of this book comes from two different backgrounds. One is the field of public health. For the past fifteen years I have been a teacher and investigator in public health and preventive medicine. Indeed, it was while doing research on the effects of air pollution that I really became aware of the interaction between society and disease. Lest anyone doubt the power of that interplay, consider the impact of the present environmental movement in reducing the bad effects of pollution on the health of our population—an impact that, I believe, will ultimately be greater than that of all the doctors put together.

The other aspect of this book's perspective comes from the wonderful and exciting experiences I have had in caring for the sick. My entrance into that half of my double life in medicine started much earlier than my work in public health. Scared and awed, I walked into the pathology laboratory of the Jewish Hospital of Brooklyn one Saturday morning when I was fourteen. My job was to clean microscope slides and coverslips, but I would have done anything just to be around doctors, hospitals, and patients, as I have been ever since. Through high school and college I worked in various hospitals, usually as a laboratory technician but doing everything I could con someone into letting me do. (It was easier for a young person to work in hospitals then, especially during wartime.) It is a world I love. I wanted to work in all aspects of medicine—to care for patients and to teach and do research. As my training advanced, I was always told that I would have to settle on one aspect or another—academic

medicine or practice—but I am still doing both. Although I am a specialist in internal medicine, I am happy that a good part of my practice consists of entire families for whom I have cared for years.

This book comes from a love of the profession. It saddens me when medicine is in trouble, and I think it is in trouble now. Through the ages practically every book about the profession written by a doctor has alluded in its introduction to the fact that the profession is in trouble. Perhaps this has always been true. More likely it shows that medicine is a profession that can never fully meet the expectations of its patients, since it must change to fit the world around it but at the same time remain stable because its basic concerns are unchanging. It also saddens me to admit that it is not a very happy profession. That, too, is a paradox: despite the many positive attributes of a physician's life—good education; important, meaningful, and intellectually challenging work; high status and good income—physicians do not seem to be as happy as one might expect. This is not only a personal observation but is supported by some hard data. Physicians as a group have a high divorce rate and the highest suicide rate of any profession, as well as very high rates of alcoholism and drug addiction. These distressing facts are generally attributed to overwork and grinding fatigue; indeed, they may be contributing factors, but I would wager that they are not the whole answer. (The facts suggest that a research study should be conducted without bias, preconceptions, and misconceptions to find out why doctors are not content.)

Part of the answer is the discrepancy between what physicians are trained to think is important and what turns out to be important when they start practicing, a dilemma

represented by what I call the Chief Resident Syndrome. At the end of three or four years of post-medical-school training, a young physician may become chief resident, a position to which all residents aspire. To the medical students and interns he is a minor deity, and the professor or the Chief of Service looks to him as his right-hand man in the training program. He is the embodiment of modern technological medicine, with a seemingly bright future ahead. But if and when the chief resident goes into practice, he may also go into depression. He finds that he has few patients with monoclonal macroglobulinemia and his need for bundle electrograms is infrequent. He has been betrayed. The "crocks" and "gomers" (patients with uninteresting diseases) of yesterday are now his daily patients. His skill is called on for the common cold, diarrhea, and vaginal infections. All this is well known and has frequently been discussed by physicians. But what is not discussed is what happens when a patient with monoclonal macroglobulinemia does come into the doctor's office. Making the diagnosis is not sufficient; the patient must be cared for, not only for the time of hospitalization but for the months or years of his survival—and so must his spouse and his parents. Furthermore, efforts must be made to minimize the patient's disability, to maximize his function and work capacity, and to handle fear and dread, because when these things are done well, the patient, quite simply, is healthier for a longer time, and when they are done poorly, the patient does poorly. About these aspects of monoclonal macroglobulinemia the former chief resident is probably a rank amateur; dealing with these aspects of the patient's illness was not part of his training, since the so-called "psychological" aspects of illness are

right mind would want to slow progress or return to a time of lesser diagnostic or therapeutic power. And any doctor who does not keep abreast of new developments and maintain his control of the technology will become its slave. (There is an equal danger, however, that one can become a slave to the technology by embracing unthinkingly the belief system that supports it, even when it begins to evolve past utility.) What I am suggesting is that the balancing force to technology in medicine must be restored. That balance will be found, I believe, by a return to a much wider view of the doctor's job, a view that restores healing to its place alongside curing as a trained and disciplined part of the physician's role.

This goal will not be accomplished by telling doctors what is wrong with them or exhorting them to be good guys. Physicians are not partial to philosophy; they are pragmatists. If they are to change, it will not be because courses in the humanities are added to the curriculum, however desirable that may be, but because they are taught a way that works better. The forces for such change in other segments of our society are growing and cannot help but influence medicine. It is my own deeply personal belief that a return to a more balanced view of the doctor's role will produce not only more effective doctors but also happier doctors.

Finally, a word to those physicians who may find what I have said in this book to be self-evident because they have come to the same conclusions as I have. I hope they will be heartened to realize that someone else understands with them the importance of restoring the art of healing to the medicine of today.

generally relegated to the psychiatrists or social workers. The chief resident has not so much found out that there isn't a lot of challenging disease around (because there really is) as he has discovered that his technical skill and knowledge of pathophysiology are not inappropriate but are only a piece of what he needs to know. If he gives up on pathophysiology and depends on charm, intuition, and business sense, he simply becomes a bad doctor.

In other words, the ideal for which the doctor was trained turns out not to exist, as such, in the real world. But the real world cannot be dismissed, as the cynics would have us believe, as a place where all the patients' troubles are colds and the rest "psychological" (in the sense of not real). The simple fact is that our chief resident was trained to a very high level of performance and excellence, but for the real world he is not excellent. He has been given a good start, but he is not excellent. It is possible that such a situation could make a man unhappy. If he stays in practice and doesn't learn for himself how to carry out his healing functions, he will, I believe, accuse himself of having lost his ideals and either stay unhappy or find happiness elsewhere. As is usually the case, we don't find the ideal lacking; we accuse ourselves of failing the ideal.

Don't feel too badly for the chief resident; even if he goes into practice, he often gives it up and returns to the university medical center to teach other young men about medicine (and about how practicing physicians are money-minded or whatever) and so it goes, on into the next generation.

It is necessary to make it very clear that the picture of medicine drawn in this book is not offered as an alternative to technological medicine. No physician in his

right mind would want to slow progress or return to a time of lesser diagnostic or therapeutic power. And any doctor who does not keep abreast of new developments and maintain his control of the technology will become its slave. (There is an equal danger, however, that one can become a slave to the technology by embracing unthinkingly the belief system that supports it, even when it begins to evolve past utility.) What I am suggesting is that the balancing force to technology in medicine must be restored. That balance will be found, I believe, by a return to a much wider view of the doctor's job, a view that restores healing to its place alongside curing as a trained and disciplined part of the physician's role.

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