

start making some calls and left.

We continued to work. It was humid and everyone was sweating. We used the various drugs and maneuvers in the ACLS algorithms, but ultimately the rhythm was asystole, we had no pacing equipment, and the effort had gone on for forty minutes. We agreed to give up. The ship's doctor slipped away without talking to the patient's wife.

Karen and I finally plodded down to the dining room. She was more drained than I was, since pediatric patients rarely suffer such cardiac catastrophes.

No one from the ship had thanked us for our efforts and now the waiters chided us for being late and upsetting the seating schedule. I recalled the prophetic words of a medical school professor, who had advised the students that if it was gratitude we desired, we should buy puppies rather than go into medicine.

The next morning our cabin steward told us it was common for elderly passengers to die in transit and he had never seen such a concerted rescue effort. They routinely stored the corpse

in the freezer until reaching the next port. Karen and I became aware of what should have been obvious earlier. Neither the ship's doctor, nor the captain, nor the cruise line want heroic interventions. It is more cost-effective to let people die. We had witnessed a perversely extreme managed care philosophy. Burial at sea, indeed.

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A fragile web of understanding

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Our ultimate salvation lies in that fragile web of understanding that one human being has of the sufferings of another.

—attributed to John Dos Passos

We've got a consult at the VA." The endocrine fellow paged me at the end of a long afternoon in clinic.

"Type 2 diabetes. Five days post-op after a triple-vessel CABG. His name's Theodore Peters."

I sighed with fatigue and met the fellow in the surgical ICU thirty minutes later. When I arrived, the fellow was waiting for me at the door of the unit.

"Everyone says that he's really difficult," she said.

"What do you mean?"

"They say he's pretty hostile and refuses to take his insulin."

"Well, is he?"

"I don't know. He seemed okay to me. At any rate, his pre-op A1c was 6.5%."

I was relieved that the patient's pre-operative glycemic control was so tight and hoped that we'd be able to keep it that way during his recovery. I was hoping the visit wouldn't take long.

As we entered the room, I saw an African American man in his early sixties lying in bed. His hair was close-cropped and gray, and he had that drawn and haggard appearance that goes with being in the ICU. With the sheet pulled up to his

chin, he eyed us warily. Suspicion and hostility radiated from him, filling the room.

I introduced myself.

"What do you want?" he asked. "Like I told them, I don't want to be told what to do."

"Actually," I said, "I'm not here to tell you what to do. I was hoping you could tell me what works for you and your diabetes."

Distrust still hung in the air like a fog.

Feeling awkward and wanting to establish a connection—any connection—to break through the tension, I asked him, "So what branch in the service did you serve in?"

"The army," he answered.

From his age, I took a guess: "Did you serve in Vietnam?"

"Yeah, I was there . . . for a year . . . a very long year."

I continued to fumble: "If it's worth anything, I respect your sacrifice."

"Yeah, well," he answered, "it wasn't voluntary. It was over a pork chop."

A pork chop?

"What do you mean?"

"I was drafted over a pork chop," he answered, matter-of-factly.

"I grew up in a little town in Missouri back in the fifties and early sixties. One night, my momma asked me to go down to the corner to buy pork chops for dinner. Well, in the butcher shop they had these thick, juicy, pink pork chops. A whole stack of 'em. And right next to them, there was a stack of grey, spoiled meat. Since the price was the same, I asked for the thick, pink, juicy pork chops.

"Well, the lady behind the counter—a big ol' white woman



with a frown on her face—said to me, ‘Boy, you can’t have those pork chops. Those’re for white people.’ She pointed to the stack of rancid meat, ‘Colored people’s chops is those ones.’

“Well, I refused. There wasn’t any way in hell I was going to pay good money for spoiled meat. I insisted on the good ones. The big ol’ white lady’s frown got deeper, and the more we argued, the angrier she got. Finally, the police got called, and I got arrested and taken off to jail.”

“So how did that end in Vietnam?”

“Turns out, she sat on the local draft board, and pretty soon, here comes my notice.”

Mr. Peters went on to tell me about his year in Vietnam: friends killed, always scared, wanting only to go home.

“Afterwards was no picnic either,” he said. Unemployment, no opportunities, struggles with depression and alcohol, and finally, in his late forties, after his second divorce, diabetes.

We sat in silence for quite some time. He seemed pensive, as memories and loss played themselves out and receded. We began to talk. About growing up. About tastes in music. About things to eat and see and do. As he talked, I glanced at him. He looked full of life and words.

Suddenly, we were interrupted. A young surgeon entered the room, trailing a couple of trainees.

“So, Theo,” he declared, “how are we doing today?” I looked over at Mr. Peters. He squinted with a heavy look of suspicion. I felt the fog again filling the room.

After the surgeon’s cursory visit, I struggled again to find that tenuous thread that had linked us. The fog remained. After a while, after talking to him about his diabetes and thanking him for his time, the fellow and I left.

I saw Mr. Peters again several days later, sitting up and watching TV. I asked him how he was doing and he curtly

responded, “Things’re fine.” I asked him whether he needed anything, and he said no. His eyes never left the screen. I said goodbye and left.

Two days later, I left the service. I never saw Mr. Peters again. I later learned that he died some time after we spoke and left no survivors.

For quite a while now, the concepts of compassion, empathy, and social justice have occupied a central place in my perspective on the world and my activities as a clinician and teacher. My encounter with Mr. Peters, however, reaffirmed something that had always lurked at the edges of my idealism: an awareness that seeking justice is, in its essence, the constantly difficult, exhausting task of realizing these ideals in an imperfect world—in what Arthur Kleinman once called “the messy, confusing . . . context of lived experience.”¹ In my visit with Mr. Peters, I saw that my best intentions were met with suspicion, and that my attempts to form a bond between us were no match for the sheer weight of a history filled with unrighted and unrecognized wrongs.

Over the years, I’ve come to realize that achieving justice is not just a matter of simple compassion or sense of fairness. Neither alone is enough. Empathy must cut through the suspicion arising from a lifetime of injuries and indignities, the vast silence of an impersonal, hostile, and demanding system, and my own sense of frustration and powerlessness in response. It is expressed in the effort to slow down and openly affirm the humanity of the person in front of me on the exam table of the clinic or in the bed of the hospital room, to resist the urge to avoid messy social reality by hiding behind technology, lab results, and statistics. It is in the hard work of responding to the hostility of a “difficult patient” and to inequities in the system by striving to understand the causes and work to overcome them, all while caring for the person and addressing everyday clinical needs. It is expressed in listening, amid the discomfort and distractions, to stories of hurt and loss. To seek insight rather than judgment, justice rather than expediency. To weave that fragile web of understanding a single strand at a time.

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Reference

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