

Reflections

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Reflections on healing

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Forty-eight years ago, as a young faculty member at SUNY Buffalo, I became a patient in a respiratory care unit, on a respirator, in a coma, and not expected to live through the night. I was diagnosed as having encephalomyelitis with paralysis of the respiratory and other cranial nerves. Fortunately, within a matter of days, the process which came on rapidly, began to recede and I recovered. My physicians could describe what I had, but they did not know the cause or the reason why I acquired it and why it had disappeared. One of their roles was to give me life support through a period of extreme uncertainty until the body's healing potential took over.

My physicians' other role was to provide emotional support and comfort in dealing with physical aspects of my loss. I reflect on the progressive decrease or loss of function that I experienced—eye movements, sensation, chewing, and breathing. It was disturbing to lose important body functions that I took for granted.

I often reflect on the efforts to relieve my discomfort from double vision early in the disease process, and the many other intangible things my physicians did. Their caring and concern were reassuring. I reflect on the hallucinations and poor sleep. I reflect on what it was like to be in an intensive care unit, bombarded by activity 24 hours a day, day after day. Just the fatigue of that process, no less the illness, was exhausting.

I reflect on my discharge after recovery. In those days of prolonged hospitalization, I was released early, only because my physicians were willing to see me at home. After discharge, they recognized, to their chagrin, that they had underestimated my utter weakness and what it would take for me to climb the stairs to the second floor of our house. It felt like I was climbing a mountain. I reflect on what true

fatigue is like; when I was up for two hours, it felt like I had been awake for two days.

The experience had a profound influence on my life, my outlook, my career, and the way I understood and dealt with patients. Having been a patient helped me to better understand what the patient is experiencing. In his best selling book, *Love, Medicine & Miracles*, Bernie S. Siegel, MD (ΑΩΑ, Weill Cornell Medical College, 1956), writes, "I think a few days as a patient on a busy ward should be an integral part of every physician's training, including, as one patient recently added, 'an IV in his arm and a tube up his nose.'"

I recall that after my hospitalization, I had a different attitude about starting IVs and NG tubes. However, the memories of those experiences can fade unless refreshed. Thus, when confronted with a patient who has hemiplegia, it helped me to reflect on what it was like to be paralyzed, as it was with the young woman with a brain lesion who entered my teaching service. Reflections such as these were important reminders that influenced my approach to patients.

I reflect on being asked by a house officer to see a young teenager in the ICU with a problem similar to the one from which I had recovered. That visit gave comfort and encouragement to a frightened patient.

We are steeped in the interventional and non-interventional aspects of medicine, the surgical and the non-surgical treatments. We tend to think of ourselves as the healers, but is that really the case? In 1994, I was privileged to attend an ecumenical worship service as part of the graduation exercises at the University of Medicine and Dentistry of New Jersey School of Osteopathic Medicine. This was a moving experience, in which a Jewish Rabbi, a Hindu Rabbi, a Catholic priest and a Protestant minister each gave brief reflections on healing. The overriding theme was the inherent, God-given capacity of the body to heal itself.

Larry Dossey, MD, in his book, *Meaning and Medicine* calls it the "Secret Helper." Physicians facilitate the healing process. Thus, as healers, we are there for the patient, to

intervene as appropriate, to sustain life as appropriate, to avoid doing harm, and to allow the natural healing processes to proceed.

In the midst of all of our amazing and increasing scientific abilities, there is so much more to the healing process than we understand. In Proverbs, 17:22, we read, “A merry heart does good like medicine.” This ancient wisdom was reawakened by a lay journalist and editor of *Saturday Review*, Norman Cousins, who subsequently became a senior lecturer at the David Geffen School of Medicine at the University of California, Los Angeles UCLA Medicine. In an article published in *The New England Journal of Medicine*, December 1976, and in an expanded version of that article in a book, entitled, *Anatomy of An Illness*, he describes a partnership between him and his physician, in which the physician fully engaged his own capabilities for recovery. He emphasized the powerful impact of laughter as one of the factors that enabled his healing.

In a graduation address to the senior class at UCLA Medicine, Cousins included the following comments that are recorded in his book, *Head First*:

There are qualities beyond pure medical competence that patients need and look for in doctors. They want reassurance. They want to be looked after and not just looked over. They want to be listened to. They want to feel that it makes a difference to the physician, a very big difference, whether they live or die. They want to feel that they are in the doctor's thoughts. The physician holds the lifeline. The physician's words and not just his prescriptions are attached to that lifeline....

I pray that you will never allow your knowledge to get in the way of your relationship with your patients. I pray that even as you attach the highest value to your science, you will never forget that it works best when combined with art, and indeed, that your art is what is most enduring in your profession.

Modern medicine can accomplish wonderful things. Disease processes can be reversed or arrested with specific therapy. The intention of these reflections, however, is to focus attention on the other aspects of medicine, and to remind us that as we treat illnesses we do not understand, supportive care allows the healing process to proceed.

I have used these reflections to emphasize my belief in certain intangible contributions to the healing process. This aspect of medicine is poorly understood, but it is extremely important. It is our challenge to engage our

patients in a way that reflects our concern and fosters those intangible, inherent forces—the “Secret Helper,”—in the healing process.

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Nursing in a Coronary Care Unit: A doctor-patient's view

C. Henry Kempe, MD (AQA, University of California, San Francisco School of Medicine, 1962), deceased, was professor of pediatrics and microbiology at the University of Colorado Medical Center. The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect was named for him.

Editor's note: The following is an excerpt of an article published in *The Pharos* Winter 1979.

I had a myocardial infarction complicated by severe adult respiratory distress syndrome and spent more than five weeks in the coronary care unit of Bellevue Hospital. I arrived at a New York hotel in the evening after a hectic day. I experienced increasing shortness of breath and hemoptysis. On calling a close friend at New York University, I agreed to meet him in the emergency room of the New York University Hospital, and a colleague took me there by cab. The coronary care unit at the University Hospital was full, and someone asked me if I would mind going to Bellevue, the other teaching hospital. By that time, I thought I was drowning and agreed.

My serious pulmonary dysfunction led to difficulties in oxygenation, which required intensive, intrusive instrumentation over many days. I have no memory of the first two weeks of my stay, but the subsequent weeks are very clear in my mind.

When I first emerged from a haze of pain and confusing procedures, each nurse coming on shift in this large 12 bed unit would introduce herself by her first name, tell me what day and time it was, and, almost without fail, hold one of my hands in her two hands while looking straight into my eyes. I found this very comforting because I was aware of having lost not only considerable intellectual ability, but I also was having frightening hallucinatory experiences. These were immediately wiped out by this personal contact. The nurses would explain what they called “scary dreams,” and reassure me about the frequency of hallucinations. They said that everybody who had lost a lot of REM sleep was likely to hallucinate; that it was a routine experience in their patients; that these images invariably

went away; and that I was neither stupid nor going crazy. During those days the repeated reassurance about regaining intelligence and sanity was perhaps the most important event of the daily nursing contact.

I shared a room with an emaciated seventy-six-year-old man who was totally obtunded, intubated, and on the respirator. Because he was totally unresponsive, he received stimulation by touch and cheerful words every two hours, day and night. My rest was disturbed by all the noise resulting from the intensive care he was receiving, but I was cheered by the persistent and hopeful attitude of the staff. They were all determined to bring him back.

All nurses coming on duty tried to make their own assessments of their patients' emotional level as well as their physical status. At times I would try to be falsely cheerful, and they would see through it. On one Monday, I was obviously depressed, and my nurse, coming on duty, asked me gently what was wrong. I didn't have a clue. I wept buckets, something I don't usually do. I felt unashamed but puzzled. She said with some confidence, "We'll figure this out," and then went on to ask a few questions.

She wanted to know, "Is the sound outside disturbing you?" I realized that it was.

After some further thought she said, "That is the wrecking ball knocking down the rest of the old Bellevue. You didn't hear this noise Saturday and Sunday, but you did hear it Friday when your aortic balloon came out. That was a bad time. You remember not only how painful that was, but you also remember how the balloon sounded inside you during all those rough days. I bet you are remembering all that pain."

My distress disappeared.

Another time when I seemed to be made uneasy by piano music played on my cassette player, a nurse pointed out that the same cassette had been played for me during one of my painful early weeks and that, again, it might be reminding me of those days. It was several more weeks before I was able to listen to any classical music without apprehension.

As time went on, I had fewer and fewer of these flashbacks, and seeing either the nurse or my wife at the bedside would wipe them out immediately. The nurses taught me to ring the bell as soon as I had a bad dream. They would then turn on the light and hold my hand.

I was also impressed by the fact that the nurses seemed to be willing to do just about anything to make me comfortable. Registered nurses, nursing technicians, and nurse aides who cared for me did not seem to be restricted by the hierarchical structure that usually decrees that some

tasks belong to one group, others to another group, and that there shouldn't be a sharing. Rather, whatever was at hand that needed to be done, they did. Nurses were given considerable responsibility. They oversaw my many cut-down sites for arterial and venous lines and supervised the eventual healing of the wounds associated with these procedures as well as making individual judgments on medication.

They had a wonderful relationship with other health professionals. In all my time on the unit I never heard a cross word between the house officers and the nurses, although they were always dealing with 12 critically ill patients, each one of whom seemed to be in terrible trouble most of the time.

I gradually accumulated a treatment schedule that resulted in my being repeatedly disturbed for blood drawings, medication, portable X-rays, janitorial services, etc. It seemed that each hour; around the clock, somebody wanted to take, give, or do something! The nurses finally worked out a four-hour schedule that allowed me to sleep at night with only a 2 a.m. break. I became so accustomed to that 2 a.m. break that it followed me home; for the first month at home I would spontaneously awaken, right on time, to have vital signs taken and medications given even when the need for them had disappeared.

Toward the end of my stay, when I probably should have been transferred to the medical wards, I was totally unwilling to leave the security provided by a nursing staff I had come to know and admire; I was thoroughly bonded. A few days before I went home, a nurse suggested to the intern that I should come off the monitor for 48 hours before leaving so that I would not have anxieties when I was without it at home. He looked puzzled but said, "Sure, take him off."

She seemed to realize that I might have had some fantasized notion that not only was the monitor measuring my functions, but that, in some way, it acted as an umbilical cord and brought something good the other way. When after five weeks on the monitor I was disconnected, I was quite anxious for the first few hours, but the duty nurse checked me hourly to help me be reassured that the monitor was no longer needed.

I shall never forget the total exhaustion I saw in some of the nurses when they were going off shift. This occurred on several occasions when they had patients who were not doing well.

I cannot say, of course, that it was only the coronary care unit nurses at Bellevue who pulled me through, but I am certain that they kept me sane.