Astonished Harvest:

The joy of medicine

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In "Transplant," cardiologist-poet John Stone (ΑΩΑ, Emory University, 1974, Faculty) evokes the scene of a medical miracle. As a recipient lies waiting in an operating room, a donor heart arrives by helicopter. Surgeons remove the recipient's diseased heart and insert the silent, motionless replacement:

> Within the green purpose of the room
> there were ten beating hearts, but now are nine

The poem concludes with the miraculous moment when the patient's transplanted heart comes alive:

> And then the shock, the charmed expectant start
> the last astonished harvest of the heart.[1]

The rapid progress of medicine has indeed yielded an astonishing harvest of improvements in our patients' health. But, I believe Stone also had another harvest in mind, a continuing astonishment at his own experience as a healer. Medical practice provides a rich opportunity to experience empathy, hope, solidarity, compassion, and self-healing. Our profession gives us privileged access to deep bonds of humanity we share with our patients. Traditionally, physicians have considered this fulfillment one of the chief rewards of our profession. As Sir William Osler wrote, "Nothing will sustain you more potently than the power to recognize in your humdrum routine... the poetry of the ordinary man, of the plain, toil-worn woman, with their loves and their joys, their sorrows and their griefs."[2]

These moving moments constitute an astonished harvest of the heart. The way some physicians evoke, record, and reflect on these moments is through poetry, though in a larger sense, clinical encounters can themselves be poetry—at least if we slow down and pay attention. In recent decades, as medical technology has rapidly improved diagnosis and treatment, more and more physicians report dissatisfaction with their profession, an irony that recalls John Knowles' (ΑΩΑ, Washington University in St. Louis School of Medicine, 1951) well-known 1977 book about health care in the United States, *Doing Better and Feeling Worse: Health in the United States*.[3] Technology itself is not to blame for this, except in the sense that its dazzle has distracted medical educators and clinicians from maintaining a focus on caring for the patient. They have tended to withdraw from the poetry of medicine.

William Carlos Williams (ΑΩΑ, University of Illinois, 1908) was a family doctor in Rutherford, New Jersey, for more than 40 years, until his retirement after a stroke in 1951. While devoting his days to medical practice, in the evenings he created the plain-language style of poetry that ultimately made him one of the most influential American poets of the 20th century. His neighbors and patients considered his poetry a strange, but harmless, hobby. In "Patterson" Williams gives voice to their sentiments:

> We're so proud of you!
> A wonderful gift! How do you
> find the time for it in
> your busy life? It must be a great
> thing to have such a pastime.
> But you were always a strange
> boy. How's your mother?[4]

Williams' response came in another poem, "Asphodel, That Greeny Flower," where he wrote:

> It is difficult
> to get the news from poems
> yet men die miserably every day
> for lack
> of what is found there.[5]

It is true we can't get the news from poetry, we can't learn about the latest antibiotics or immune modulators, or about the latest health insurance arrangements, so what does Williams think is so important that we might die if we don't find it?

As a junior faculty member in Pittsburgh, I worked at a community health center in Terrace Village, the city's largest public housing project. With its institutional buildings and drab, cracked streets, the place was nothing like a village. The clinic was one of the few safe places for people to socialize. I remember one woman who had lived in the projects since President Roosevelt cut the ribbon opening it in 1943. This lonely widow had multiple medical problems, and lived in constant fear of the "hoodlums" who had taken over Terrace Village. I hated to see her name on my office schedule because her symptoms never improved, her medications always caused side effects, and, according to her, I was "too young to know what I was doing." I wrote a poem that illustrates what happened when she appeared in my office just before Easter, wearing an incongruous white lace dress.

The Act of Love

How foolish Celia must look
to the Haitian cab driver
on the Medicaid run!

She wears a white communion dress
the week before Easter, a sign
she brings me something more pressing

than the pain in her shoulder
and the son who doesn't talk to her
because his wife is embarrassed.

Her hips creak in conversation,
her knees grind, but even crepitant joints
are modestly silent and stand aside

when Celia hands me a potted plant
for my office—*an act of Christian love*,
she says, *not a sign of being personal.*

As for me, I'm stunned
out of the ordinary anger
at failing to help her

by the waxy-leaves of her gesture
and I receive this wafer of the season,
heartbroken for no reason.[6]

I was caught short by the unexpected gesture of gratitude from this chronically dissatisfied woman. I tried to use the language of poetry as a lens through which to glimpse the deeper meaning of my work as a doctor, and my relationship with Celia. Plenty of days I've been tired and distracted, angry with myself, and my patients. I've often consciously distanced myself from people like Celia. Nonetheless, somehow, on that occasion, empathy poured in, and we connected.

When I say medicine needs poetry, I'm speaking of these moments of insight, and awareness. I'm not suggesting that all physicians should write, or even read, poetry. Rather, I'm saying we need to pay attention to those "aha" moments that sustain us and make us better healers, if we respond appropriately to them.

Many years ago, I received an urgent Friday afternoon consult from the general surgery service. The patient, an irascible middle-aged man, 24 hours post-cholecystectomy, had become agitated and combative. The patient was paraplegic secondary to polio as a child, and a heavy smoker with chronic obstructive pulmonary disease (COPD). The surgeons thought he had incipient delirium tremens (DTs) so they snowed him with Serax and thiamine, even though the patient repeatedly complained, in no uncertain terms, that he didn't drink. I wasn't enthusiastic about managing this difficult patient over the weekend.

The patient was restrained in his bedside chair. He had a pockmarked face, long, greasy hair, a big red nose, tattoos on both arms, and a foul mouth. At first he seemed delirious and paranoid. However, when he yelled for me to leave him alone because his mouth was too dry to talk, I went down the hall and got him a carton of apple juice. The man was so flabbergasted that I had responded to his implied request, he began to talk sense. A more thorough evaluation revealed that his agitation and disorientation was caused by an anesthetic reaction, rather than alcohol withdrawal.

Subsequently, I became this patient's internist. Aside from COPD and hypertension, he suffered from a festering case of anger. Every time he'd come to the office he'd ruminate about how badly he was treated in the hospital. "I haven't had a drink in years," he'd grouse. "They thought I was a drunk just because I have a big nose and ain't been educated at Harvard." (He had rosacea.) "Those slick bastards wouldn't listen to me!"

One night I sat down and wrote a poem from his perspective, giving him the voice he needed to express his frustration and rage. This wasn't difficult because I could tap into my own emotional memories of being insulted, ignored, misunderstood, and condescended to—memories I suspect we all have. Thus, the poem "I'm Gonna Slap Those Doctors" turned into a diatribe arising from the speaker's sense of vulnerability and alienation.

I'm Gonna Slap Those Doctors

Because the rosy condition
makes my nose bumpy and big,
and I give them the crap they deserve,
they write me off as a boozer
and snow me with drugs. Like I'm gonna
go wild and green bugs are gonna
crawl on me and I'm gonna tear out
their goddamn precious IV.
I haven't had a drink in a year
but those slick bastards cross their arms
and talk about sodium. They come
with their noses crunched up like my room
is purgatory and they're the
goddamn angels doing a bit
of social work. Listen, I might not
have much of a body left,
but I've got good arms—the polio
left me that—and the skin on my hands
is about an inch thick. And when I used
to drink I could hit with the best
in Braddock. Listen, one more shot
of the crap that makes my tongue stop
and they'll have something on their hands
they didn't know existed. They'll have time
on their hands. They'll be spinning around
drunk as skunks, heads screwed on backwards,
and then Doctor Big Nose is gonna smell
their breaths, wrinkle his forehead, and
spin down the hall in his wheelchair
on the way to the goddamn heavenly choir.[7]

When I showed the poem to the patient, he literally bounced up and down in his wheelchair, although managing to disguise any hint of softness behind a gruff, "Damn right, doc!" In retrospect, the gift of this poem was probably the single most therapeutic act I ever did for this patient. By helping to heal the memories that obsessed him, it created a bond between us. To his further delight, the poem appeared months later in *Annals of Internal Medicine*. For years he carried a crumpled copy of that page in his wallet, never failing to brag about it to his friends.

The moral qualities of a physician

For at least 250 years, medical writers have agreed that physicians need to work to counteract the tendency of medical practice to pervert humane values and virtue. In 1772, John Gregory, Professor of Medicine at the University of Edinburgh, wrote, of the moral qualities of a physician "the chief of these is humanity, that sensibility of heart that makes us feel for the distress of our fellow-creatures…" Thus, he warned his students to maintain "a gentle and humane temper" despite "being daily conversant with scenes of distress."[8]

In 1889, Osler told the medical graduating class at the University of Pennsylvania that they should face "the exigencies of practice with firmness and courage (but) without, at the same time, hardening the human heart by which we live."[2]

In 1927, Francis Peabody (ΑΩΑ, Harvard Medical School, 1906) warned that hospitals create a hostile environment for humanism, and urged his students to consciously commit "time, sympathy, and understanding" to creating a "personal bond" with their patients.[9]

And, Thomas Inui (ΑΩΑ, Johns Hopkins University, 1988, Alumni), in a 2003 report to the American Association of Medical Colleges (AAMC) wrote, "What the literature and rhetoric of medicine lacks is a clear recognition of the *gap* between these widely recognized manifestations of virtue in action and *what we actually do* in the circumstances in which we live our lives."[10]

All of these physicians viewed medical education as a lifelong process of character formation, rather than just an accumulation of facts and technical skills.

Over the last 40 years, medical educators have responded to our diminishing astonished harvest in many ways. George Engel (ΑΩΑ, Johns Hopkins University, 1938) proposed one of the first remedies in 1972 with his biopsychosocial model.[11] He conceptualized a conflict between biomedicine—which was developing rapidly and effectively—and biopsychosocial medicine, a new model, or paradigm, based on understanding of the patient as a whole person, including the psychosocial context of illness and patient care. There was a great deal of talk, and some curricular activity in this direction, but it was unclear what the new model meant in practical terms.

After a few years, a new remedy swept through the halls of academe: communication skills, medical interviewing, and the clinical encounter. Its purportedly radical idea that the medical interview was not just a template filled with questions and answers, but rather an interactive process. The term "poor historian," with which clinicians are still apt to label some of their patients, was perhaps more appropriately applied to the clinician. In fact, the doctor, not the patient, was the poor historian. Medical interviewing courses sprang up throughout the country. Standardized patient programs appeared, and textbooks devoted to clinical interviewing and the physician-patient relationship were written.[12] The new approach—active listening, open-ended questions, facilitative responses—wasn't difficult to learn. Yet, the hospital environment tended to devalue these skills, and students were rarely encouraged to develop them once they entered the clinical setting.

Around the same time, Lawrence Weed argued that medicine had come to devalue the patient's subjective experience. He attempted to remedy this situation by developing the problem oriented medical record (POMR).[13] By creating a structural category called "problems" to replace the narrower "diagnoses," Weed believed the patient's subjectivity—symptoms, dysfunctions, anxieties, and other concerns—could be brought to the forefront and attended to. Henceforth, subjective and objective would be given equal weight. The educational establishment latched onto the structure of Weed's system, and POMR became *de rigueur* throughout medicine. However, in the process, its driving spirit was abandoned: subjective comments became progressively rushed and cursory, while objective data metastasized everywhere.

As the decades progressed, the sense of frustration and personal loss among physicians grew, and the internal satisfactions of medicine continued to diminish. Many attributed this to mounting external pressures, like insurance arrangements, malpractice crises, and endlessly increasing regulations. Physicians began to advise their children to avoid a career in medicine. Medical educators kept trying to capture the lost spirit of doctoring with new concepts, new models, new approaches. Some of the most prominent are:

1. The medical professionalism movement, endorsed by the American College of Physicians, the AAMC, the American Council of Graduate Medical Education, and other professional organizations, which seeks to revive traditional medical virtue in the 21st century context.

2. The narrative medicine movement, most eloquently articulated by Dr. Rita Charon, which teaches physicians

to develop the ability to hear "the narratives of the patient, grasp and honor their meanings, and be moved to act on the patient's behalf."[14]

3. The mindfulness and reflective practice movement, which seeks to teach physicians to listen attentively and reflect on their feelings and behavior.[15]

4. The systems-based concept of patient-centered medicine, which makes the simple, and hopefully obvious, point that medical care is about caring for the patient, and not primarily about doctors, procedures, and diagnoses.

5. The medical humanities movement, which seeks to preserve and enhance our sensibility as physicians by introducing literature, creative writing, philosophy, history, art, and other disciplines into medical education.[16]

Each of these seems to be reaching for the same goal, although their cognitive frameworks and intermediate endpoints are different. What narrative medicine, reflective practice, medical humanities, and patient-centered care all seek is to make us better healers. However, an underlying requirement for this is that we develop our ability to experience "the poetry of the commonplace… the loves and joys and sorrows and griefs" of our patients.[2]

Medical humanities

The term "medical humanities" is often used to reflect the general concept that knowledge of history, literature, religious studies, art, and creative writing can help students increase clinical skills, like empathy, reflectivity, and cultural competence.[16] The label is admittedly vague. Rafael Campo wrote that, as a specific concept, medical humanities seems "utterly exhausted, attenuated by decades of trying to encompass all that the invincible biomedical model of medicine actively ignores; it even risks sounding petty and adversarial, as if medicine were unremittingly inhumane."[17] Nonetheless, Campo states, "Many of us find ourselves looking instinctively to the humanities as a source of renewal, reconnection, and meaning."[17]

A liberal arts education constitutes far better preparation for medical school, and a life in medicine, than does today's typical pre-med science degree. Abraham Flexner (ΑΩΑ, Raymond and Ruth Perelman School of Medicine at the University of Pennsylvania, 1946, Honorary), the man who created the modern medical school curriculum, shared the same perspective. He wrote that a physician should have a liberal educational experience requiring ethical valuation in the social context. He said, medicine "is today sadly deficient in its cultural and philosophic background."[18,19]

Some educators believe this can be remedied by introducing more humanities teaching into the medical curriculum. David Doukas and his colleagues in the Prime Project wrote, "such education should become an essential component of the curriculum because it would equip medical students with the conceptual and clinical tools of professionalism and humane care."[20]

Medical humanities (including poetry!) can provide tools, insights, and directions to follow. The same is true of narrative medicine and other forms of educational and institutional renewal. However, humanism, not new disciplines or techniques, is the goal, and humanism develops from within.

In 1986 I took care of an elderly patient, a former coal miner, who was dying of metastatic lung cancer. He had developed pneumonia, and was hospitalized for terminal care. We had started a morphine drip to ameliorate his air hunger and severe pain. I remember standing by his bedside, and for some reason, his chest X-ray was there in the room, and I held it up to the light to read. The patient reached out, pulled my hand to his lips, and kissed it. He died shortly thereafter. Some weeks later, I wrote a poem about this patient and gave it to his two daughters, who had taken remarkably good care of him during the preceding several months.

The Man With Stars Inside

Deep in this old man's chest,
a shadow of pneumonia grows.
I watch Antonio shake
with a cough that traveled here
from the beginning of life.
As he pulls my hand to his lips
and kisses my hand,
Antonio tells me
for a man whose death
is gnawing at his spine,
pneumonia is a welcome friend,
a friend who reaches
deep between his ribs without a sound
and *puff!* a cloud begins to squeeze
so delicately
the great white image of his heart.

The shadow on his X-ray grows
each time Antonio moves,
each time a nurse
smoothes lotion on his back
or puts a fleece between his limbs.
Each time he takes a sip of ice
and moist chest shakes with cough,
the shadow grows.

In that delicate shadow
is a cloud of gas
at the galaxy's center,
a cloud of cold stunned nuclei
beginning to spin,
spinning and shooting
a hundred thousand embryos of stars.
I listen to Antonio's chest
where stars crackle from the past
and hear the boom
of blue giants, newly caught,
and the snap of white dwarfs
coughing, spinning.
The second time
Antonio kisses my hand

I feel his dusky lips
reach out from everywhere in space.
I look at the place
his body was,
and see inside, the stars.[7]

References

1. Stone J. Transplant. In Music from Apartment 8: New and Selected Poems by John Stone. Baton Rouge (LA): Louisiana State University Press; 2004: 157.

2. Osler W. The student life. In Hinohara S, Niki H, Editors. Osler's "A Way of Life" & Other Addresses With Commentary & Annotations. Durham (NC): Duke University Press; 2001: 23, 314.

3. Knowles J, Editor. Doing Better and Feeling Worse: Health in the United States. New York: W.W. Norton; 1977.

4. Williams WC. Patterson. New York: New Directions; 1958: 114.

5. Williams WC. Asphodel, That Greeny Flower. In The Collected Poems of William Carlos Williams, Volume 2, 1939–1962. New York: New Directions; 1991: 318.

6. Coulehan J. The act of love. In First Photographs of Heaven. Troy (ME): Nightshade Press; 1995: 45.

7. Coulehan J. I'm gonna slap those doctors. In Medicine Stone. Santa Barbara (CA): Fithian Press; 2002: 27, 42.

8. Gregory J. (1772) Quoted in McCullough LB. Laying Medicine Open: Understanding Major Turning Points in the History of Medical Ethics. Kennedy Institute of Ethics J. 1999; 9(1): 7–23.

9. Peabody F. The Care of the Patient. JAMA. 1927; 88: 877–82.

10. Inui TS. A Flag in the Wind: Educating for Professionalism in Medicine. Washington, DC: Association of American Medical Colleges; 2003: 4.

11. Engel GL. The need for a new medical model: a challenge for biomedicine. Science. 1977; 196: 129–36.

12. Coulehan J, Block M. The Medical Interview. Mastering Skills for Clinical Practice, 5th Edition. Philadelphia (PA): F.A. Davis Company; 2006.

13. Weed LL. Medical Records, Medical Education, and Patient Care. Cleveland (OH): Case Western Reserve University Press; 1970.

14. Charon R. Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust. JAMA. 2001; 286: 1897–902.

15. Epstein R. Mindful practice. JAMA. 1999; 282:833–9.

16. Shapiro J, Coulehan J, Wear D, Montello M. Medical humanities and their discontents: definitions, critiques, and implications. Acad Med. 2009; 84: 192–8.

17. Campo R. The Medical Humanities, for Lack of a Better Term. JAMA. 2005; 294: 1009–11.

18. Flexner A. Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching, Bulletin #4. Boston: Updyke; 1910.

19. Flexner A. As quoted in Doukas DJ, McCullough LB, Wear S. Reforming medical education in ethics and humanities by finding common ground with Abraham Flexner. Acad Med. 2010; 85: 318–23.

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