Medicine as a Human Experience

The inspiration for much of this book comes from a challenge posed to us by one of our students. We had just finished bedside rounds during which we had interviewed a dying man. The interview had been sensitive. Subsequent discussion was lively but thoughtful. We asked why this suffering man felt compelled to deny how sick he was. The group felt animated and engrossed. Soon, the students began linking events from the man’s childhood to his coping style in the present. The connections seemed to make sense and helped us all to understand the patient better.

Then Jeff, a bright but also skeptical student, pursed his lips.

"Okay," he said. "I buy it. Losing his father as a kid does relate to the way he is coping now. And I feel I understand him better as a person, which is good. . . . But so what?"

Silence.

"Really," Jeff persisted. "I’m not putting this stuff down. I agree it’s nice to understand our patients and that often doctors don’t. But I still say—so what? What can I do practically? Now that I know all this, how do I help him?"

Slowly, several students in the group began to nod in tentative agreement.

As instructors, we had heard this concern from medical students many times. Jeff was not being simple-minded, prejudiced, or oppositional. He really did not understand what we ourselves had come to take so unquestioningly for granted—namely, that empathy, understanding and insight do help our patients, often help them a lot. At that moment, we also realized that failure to comprehend lay less with Jeff than with ourselves. Despite the best intentions, we had failed to make it clear to Jeff why understanding patients is not simply “nice” and “interesting” but absolutely essential to good medical care. And, we must finally confess, the explanation that Jeff needed and deserved turned out not to be so simple to deliver.

An historical perspective is revealing. Clearly, the plea for empathic physicians is not new. It is at least as old as medicine and as new as this text. From this we must infer that the champions of empathy down through the decades also encountered resistance and perplexity from colleagues and students who were just as incredulous as Jeff. Conceptually, this is important for it means that contemporary medical education is not wholly to blame for the problem.

Our purpose in this book is to try to address the essence of Jeff’s question—the “so what?” part. We hope to convey to the reader a principle, one deeply embedded in the way we personally try to practice medicine. It is this: The closer a doctor can get to his patient, the more fully and deeply can he understand another human being’s suffering, the more fulfilling and joyous medical practice will become. It is paradoxical but true. "Burn out" in medicine usually results not from feeling more, but from slowly closing off and gradually feeling less. Herein lies perhaps the most fundamental answer to Jeff’s question. We do these things for our patients and also for ourselves.

Adapted from Medicine as a Human Experience by David E. Reiser, M.D., and David H. Rosen, M.D., published this month. Used by permission of University Park Press.

Human Needs and Healing Experiences

Every so often one hears about some “miraculous recovery” in medicine. A man with advanced metastatic cancer suddenly goes into remission and all signs of cancer seem to have vanished. A woman terminal with a brain tumor defies the odds and continues to live. Often such stories have the potential for sensationalism and are reported in the popular media for dramatic effect. At times they are exaggerated. Yet, such “spontaneous” remissions, though rare, do occur. They have been described in the scientific literature and are not well understood.

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Furthermore, less extreme forms of psychological control over physical processes abound—we all know of the dying man who “made it” to his birthday; of the mother who “held on” until she was reunited with her child. The fact that such phenomena have been regarded more from the perspective of sentiment than science should not discourage our curiosity and willingness to wonder about such things rationally and scientifically. Perhaps if we could stop applying such terms as “miraculous” and “astonishing” to natural phenomena involving healing (extreme and not so extreme), we would begin to understand them better.

And really we should not be so astonished. Healing is basic, a natural integral aspect of all living systems. In truth, what should amaze us is only the extent to which this has been forgotten. As doctors, we too often tend to overestimate our power, to assume that we always can, and should, act. Too quickly at times, we turn to drugs and surgery. Too frequently, we forget that all such interventions—no matter how wonderful in the right context—are only adjuncts to, or substitutes for, natural healing.

Healing is an intrinsic activity in all natural systems. We know that it takes place on all levels of the hierarchy, and that every level or part influences that whole and vice-versa. We know how important the human spirit and will to live are to a patient recovering from an illness. We are aware of the immensely healing properties of human relationships in their own right, whether they are the bond between mother and child, compassion toward a patient or the love of a suffering person’s family.

To many, our injunctions to this point may seem obvious. Still, the his-
tory of contemporary medicine, and our current practices, make it very clear that we are not always doing what seems obvious. Far from it! Too often we view ourselves as medical soldiers of a sort, waging war against disease. Of course, reality is very different. Illness always occurs in the context of a person’s life—his relationships, work, setbacks, triumphs, hopes, defeats, dreams and struggles. Naturally, one should never be simplistic about this. It would be far too reductionistic to say, “He got cancer because he worried about his son,” or “Her thyroid disease came about because the marriage was breaking up.” But it is equally foolish to deny all such connections and insist that illness is simply a random statistical event.

Viewing medicine as a battle too often reduces the patient to a passive object; he only hopes to be saved. The family of the patient also gets relegated to the role of helpless bystander—worried figures huddling outside the patient’s room, clutching hats and purses, waiting, hoping, praying for the doctor to perform his miracle. With distressing regularity, families are excluded from any substantive involvement with the physician. They hover compliantly in the background while physicians do battle with disease. What a waste of powerful, and potentially healing, resources!

Equally troubling is the discouragement this promotes in physicians. Doctors, conceptualizing their efforts too exclusively in terms of absolute cure, have inadvertently relinquished critical roles, responsibilities and opportunities that could bring considerable reward and meaning. This may be the saddest consequence of all. In our experience, the young physician who thinks solely in terms of cure risks terrible discouragement—it is this doctor people are referring to when they speak of “burn out.” Medicine is stressful; it always will be. But some of the stress is actually the disheartenment that comes from misdirected energy, futile attempts to cure accompanied by an equally unfortunate failure to see the splendor and meaning in the healing work we really can do.

As physicians, we confront life’s greatest challenges; its highest joys, horrors and mysteries. Above all, we confront mortality, our own as well as our patients’. This is truly a rare opportunity. It is also a stress. The practice of medicine is at the heart and soul of human realities that cannot be avoided, denied or cast aside. As physicians, we must come to terms with life and death, and young doctors need guidance and support if they are to master the pain, and realize the opportunities. Too often, medical education has failed to meet this challenge.

Finally, even if we physicians ignore the existential core of what we are engaged in, our patients cannot. Think about it! Patients today are clearly searching for something! Just look at the proliferation of self-help books, holistic health movements, acupuncture, acupressure, naturopathy, iridology, Rolfing and chiropractic. Many physicians look down their noses at all of this. Instead of feeling smug, physicians should be asking: What are our patients seeking? Could the holistic health movement, despite its portion of demigods and quacks, be a response to important, valid human needs that contemporary medicine has ignored? Most of these newer movements emphasize the human needs of patients, including their spiritual and existential longings. We believe that until physicians take these matters seriously, people will continue to turn to those who do meet these needs, sometimes to demigods and quacks, with adverse consequences to their health.

Now we will discuss two patients who were trying to heal. In these cases, opportunities were missed, not because people didn’t care, but because the physicians involved viewed their tasks too narrowly. With these patients we believe that a healing partnership could have been possible, had the doctors been able to see beyond the confines of a strictly biomedical perspective.

Some readers will notice something else. In both cases it was a medical student who first sensed that something was wrong with the care each patient was receiving. Some will find this ironic, but no one should really be surprised. In truth, it takes years of formal education to expunge broad-minded, humanistic attitudes out of students. Fortunately for these patients, the “training” of their student-doctors apparently wasn’t complete.

Mrs. Vincent

Back in her teens, Bonnie Vincent had looked forward to a promising future as a fashion model. Now, 10 years later, only traces of that halcyon time still remain. On the mantle over the fireplace in her small meticulously swept apartment there is a picture—a framed reproduction of a Seventeen magazine cover. Bonnie poses in the center, flanked by other lovely long-legged, willowy girls with sparkling eyes and insouciant smiles. Seven ingenues have been posed together, winners of the magazine’s beauty search. Bonnie is especially stunning—the tallest by several inches and also the only Black. Ten years later, Mrs. Vincent is 27, harder, perhaps wiser. The insouciance is gone. When people allude to that earlier time, she waves it away with a gesture of her hand and admonishes people that “all that was ages ago.”

It was long ago. The present finds Mrs. Vincent thinner, wan and visibly in pain. She is propped up in a hospital bed on three pillows. At 17, she was light complected and slender. Now, she is ash in color and profoundly gaunt. She is dying.

Mrs. Vincent has an extremely malignant type of leukemia from which there is almost never a successful recovery. At this precise moment, however, and despite her deteriorating condition, she is trying to pack her
overnight case. She is scheduled for discharge in two hours, "Against Medical Advice." She still insists that she does not want to leave the hospital but she silently accepts her fate. Her expression is cryptic. As she packs various items on her nightstand, she bites her lip, shrugs her shoulders and perhaps reveals the faintest hint of a forming tear. There are no two ways about it—sick or not, dejected or not, the staff wants Mrs. Vincent out. She has definitely become persona non grata on ward 7-North.

To understand how this sorry state of affairs came about, one must go back four months, to when Mrs. Vincent was first admitted to 7-North with the diagnosis of Acute Granulocytic Leukemia. At the time, she had been extremely ill with a high white count comprised almost exclusively of immature cells. She also had severe anemia. The residents treated her with transfusions of packed red cells, prednisone, I.V. antibiotics and an aggressive course of chemotherapy. Mrs. Vincent had responded quickly. The treatment had also caused her considerable suffering. During chemotherapy, she lost nearly all of her hair and developed painful ulcerations in her mouth. It became almost impossible for a time to swallow and attempting to eat became torture. She suffered severe shooting pains down her arms and legs and was racked by uncontrollable nausea and vomiting. Nevertheless, she had cooperated with her treatment completely. She believed in the doctors who told her, "This will get you better."

Though she was always cooperative, from the outset she had not seemed especially warm or open. She tended to be standoffish and exceedingly shy, responding to the staff's attempts at friendliness by pursing her lips, shrugging her shoulders and looking away. It was difficult to know whether her icy countenance reflected hostility, fear or depression. But overall, the residents found her to be a difficult patient to warm up to. They performed their duties conscientiously but without much sense of satisfaction or joy.

Frequently, Mrs. Vincent had a visitor—a burly, bearded black man in a peacoat who always wore dark sunglasses. He was unfriendly and when he visited, everyone steered clear of them both. Often they argued, quarreled that ended with the man storming out, and Mrs. Vincent in tears. Mrs. Vincent also had two young daughters, two years and five years, but hospital policy prohibited their visiting. She kept pictures of them on her nightstand.

After the chemotherapy, Mrs. Vincent went into remission and was discharged. She declined follow-up in the outpatient clinic, stating that she preferred to see her own doctor. As time passed, Mrs. Vincent was forgotten. Then, four months later, she was readmitted to 7-North, in severe relapse. Nobody was overjoyed. The rapidity and severity of her relapse spelled trouble. Everyone dreaded the next round of chemotherapy on this silent, emotionally inaccessible patient. Nevertheless, as duty required, they prepared to treat Mrs. Vincent once again. Only this time, they did not get very far. "She's refusing chemotherapy," the intern told his senior resident. "She says she's willing to take the transfusions and antibiotics, but she doesn't want any more chemotherapy."

"We'll see about that," the resident replied. Now it was the resident's turn to strike out. "She says she doesn't want to leave the hospital," the resident later told his attending, "but she refuses any more chemotherapy... she says if God wants to take her, then let God do his work."

"I'll talk with her about that," said the attending.

And he did. Mrs. Vincent refused to budge. Negotiations continued for the next couple of days, but without progress. "I am prepared to die," the patient kept repeating.

Finally, house staff and attending all agreed. If Mrs. Vincent refused to accept appropriate medical treatment, they would discharge her, "Against Medical Advice."

It was in this context that Joe, the medical student on the team, became concerned about his stoic patient's feelings and welfare. He asked us to visit Mrs. Vincent as part of a "Psychiatric Aspects of Medicine" course. Joe had become alarmed when Mrs. Vincent refused a second course of chemotherapy, but even more alarmed when the medical team decided to begin forcing her to sign out "Against Medical Advice."

He feared that such a drastic measure would only compound her current suffering.

We talked with Mrs. Vincent at some length. Though she was not effusive, she was open and honest. We learned that since the last hospitalization she had separated from her husband, the sullen man in the peacoat. She said she was fed up with his infidelity, alcoholic excesses and abusiveness toward her and the children. Yet, regarding her current situation, she was adamant.

"No," she said to us, "No more chemotherapy. Absolutely not."

She wanted the doctors to treat her as best they could. To make her comfortable. But not if that meant she would have to endure the "living hell" of chemotherapy again. She wanted to live, but added, "I'm not afraid to die."

Toward the end of our discussion, Mrs. Vincent revealed a cherished personal goal. She wanted to live long enough—just about three weeks—to complete divorce proceedings. This would ensure that her daughters were safely in the custody of her mother, legally protected from the abusive father.

With tears flooding her eyes, she said, "This is really all I want."

"I'm not afraid of death," she said again.

She told us that she was greatly comforted by her religious beliefs. Indeed, she had a theory about her own passing: God wanted children and beautiful young people in heaven too, so that it wouldn't just be filled up with people who were old and debilitated.

With our support Joe presented his findings to the rest of the team. He was inclined to think that Mrs. Vincent was depressed. He urged the house staff and attending physician to give him more time to form an alliance with the patient. Then, perhaps, he could convince Mrs. Vincent to be rational about accepting chemotherapy. During this discussion, the idea was never seriously entertained that Mrs. Vincent might have a right to refuse the treatment.

The medical team agreed to an extension, but two days later Mrs. Vincent still hadn't budged. She had several more affable conversations with Joe in the interim and expressed increasing confidence that her life had not been in vain. But on the matter of
chemotherapy, she never wavered. Presently, Mrs. Vincent was discharged, "Against Medical Advice." Joe could not convince the team to do otherwise.

She died two weeks later, in another hospital, dejected, with her divorce not yet final.

This clinical vignette raises many critical questions. Why didn’t the health care system at least attempt to respect her stated wishes and support the desires she cherished? Why wasn’t she sent home, not with the hand-washing formula “Against Medical Advice” but with essential medical advice, buoying support and compassionate follow-up care by home visiting nurses and physicians? In a real sense Mrs. Vincent was mistreated not because she had given up on life, but because she had refused standard treatment, a treatment that ironically offered not a trace of chance for cure. She had stepped out of the established “system,” and now, it seemed, had to be punished for it. Joe attempted to recognize her all too human yearnings. Unfortunately, as commonly happens, the medical team found a multitude of reasons to ignore him.

Why did this happen? Perhaps the medical staff was so caught up in their own definition of curing disease that they lost sight of Mrs. Vincent herself, of her real desires at the close of her life, her own goals and needs. We should not condemn the doctors who cared for her. It’s too easy and it doesn’t help. Rather, we must try to empathize. Often, when there is no cure, doctors feel impotent and helpless—as if they have personally failed! This is irrational of course, but terribly common. Far too often, doctors pressure themselves to achieve the impossible. They demand of themselves cures that simply don’t exist and, in the process, forget that even when cure is not possible, there still remain many opportunities to facilitate a healing process.

Acceptance. Listening. Support. Keeping hope alive. Truly knowing what it means to walk in the patient’s shoes and being able to communicate that knowledge. These are human acts, always available to the physician, interventions he can and sometimes must choose to make, especially when the hope for cure is long since past, when, as was true for Mrs. Vincent, the patient seeks not biomedical recovery, but spiritual transformation, final peace—the healing a person seeks when he knows that death is at hand.

Mr. Moore

First our pleasures die—and then
Our hopes, and then our fears—and when
These are dead, the debt is due,
Dust claims dust—and we die, too.
—Shelley

Picture an abandoned farm house. It is rotting somewhere out on a prairie where roads no longer go. Slowly, the skeleton of a place that once held life is baking to death. Perhaps this is transpiring on some parched, waterless, indifferent Texas plain. The windows are shattered and long since devoid of any remaining glass. The rooms of the farmhouse are completely gutted and have been for years. A door still hangs by one rusty hinge. Now and again it flaps idly against its frame, besmirched by some ghostly, invisible breeze.

Now, try to imagine the incredible physical deterioration that has taken place over the last six months in Mr. Alan Moore. He is six feet three, but weighs only 107 pounds. Daily, he scorches with a body temperature of 101°F or more. Antipyretics and antibiotics repeatedly fail to bring it down. Malignant melanoma has gutted and ravaged him. He is very close to the end. Everywhere, throughout his body, tumor cells proliferate in uncontrolled anaplasia—choking out normal cells the way weeds crowd out healthy vegetation around an abandoned farmhouse. His liver, bowel and lungs are all terminally infested with histopathological chaos. Mr. Moore is 33 but he looks 50. He never complains or makes demands, but from the hallway outside his room one hears wretching and choking, muted moans. Against the stark hospital wall one sees his emaciated shadow, like some ghostly Giacometti sculpture, hunched over an emesis basin, throwing up incessantly. The end is proving to be horrible—there is just no way to soften or romanticize it.

We met Mr. Moore because his suffering affected one of our junior medical students very deeply.

Paul had gone as always on daily rounds with his medical team. The junior resident was presenting the latest laboratory data, all of which confirmed Mr. Moore’s relentless decline. The group spoke well outside the patient’s earshot. One of the residents, after crisply reciting the latest numbers, had put Mr. Moore’s chart back in the rack with a sigh. He had then shrugged his shoulders, turned his palms upward toward the ceiling and exclaimed, “Why isn’t this patient dead!”

He had not meant this with any malice; but, the next thing that happened was dramatic indeed.

Slowly, an intern on the case began to giggle. The attending put his fingers to his lips and tried but failed to suppress his own laughter. Soon, the whole thing broke wide open. Six doctors of varying age, rank, sex and experience were all laughing, repeating over and over, “Why isn’t this man dead?”

Each time the question was repeated, the group would once again shake with laughter.

Doubtless, some would say that such behavior was scandalous. But we believe it was understandable, human. The medical team, in our opinion, was releasing torrents of almost unbearable pain. The tears that were streaming down their cheeks were not just tears of laughter. Prac-

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ticing medicine can be very difficult.

Still, the question disturbed Paul. He presented Mr. Moore's case to us. Quite somber now, Paul again asked, "Why isn't this man dead?"

And it was a good question. An important one.

Why indeed?

The first thing we asked Paul was if the medical team had asked Mr. Moore where he got the courage and strength to endure? Such a question from our perspective was not simply an admiring compliment. We did admire Mr. Moore, but as physicians, we knew it was more important to understand him. Consider this parallel: Almost any doctor would feel comfortable asking his arthritis patient how, despite advanced debility, she still managed to sew and do the dishes. Was asking Mr. Moore how he endured his disfigurement and pain any different? Yet, because of the inhibitions and taboos that people feel about death, no one had asked.

"No," he said, "We routinely discuss his case in the hallway, outside of his room. We only spend brief moments... actually with him."

Paul continued, "When we are with him, it's mostly to monitor his drugs, like his pain medications. We always tell him to let us know if he needs more. Nobody wants the poor guy to suffer. But, you know, we don't get into what's really going on with the guy."

"Let's go in and see him."

Paul nodded solemnly and loosened the knot in his tie.

When we entered the patient's darkened room, we entered a cathedral of silence, a silence broken only by the rustle of bed sheets and a low continuous murmur of pain. Mr. Moore was extremely cachectic. He resembled a survivor of Nazi atrocities. But, as hideous as his physical condition was, his expression was lively and alert. We had hardly expected this! To our considerable surprise, his eyes were bright, engaging and (dare we say?) full of hope. He was in obvious pain. Shortly after we entered the room, he suddenly clutched his abdomen, gasped and began to wretch and heave. He groped feebly for his emesis basin, apologizing meekly, and slumped over it, commencing to vomit.

One of us put our hand on his shoulder. Another held the emesis basin under his chin. We tried our best to comfort him. Finally, Mr. Moore again grew quiet. The paradox appeared to pass. We introduced ourselves. Was he comfortable enough to be interviewed?

"Oh yes! Sure!"

In a raspy voice he said that he had been looking forward to the interview and was feeling "all right."

It was obviously a painful, faltering start. However, once the interview had gotten under way, everyone became quite engrossed, including Mr. Moore.

One of us finally popped the question, "How do you keep going?... It's so severe. Your illness... The way you keep going... It's remarkable.

Mr. Moore smiled. "Maybe I'm stubborn. All I know is, I'm not ready to die. Uh uh! Not yet!"

During the course of the interview, Mr. Moore became increasingly energetic. Especially, his eyes sparkled as he talked lovingly of his wife. He told us also about his parents. It gave him great pleasure that in recent years he had once again grown close to them. "It's amazing how much they've matured in the last few years!" he laughed. He and his wife were planning to spend the summer with them. They had a cottage on Lake Huron. It would be the perfect place to recuperate, draw and paint.

Drawing and painting—these were things he had done much earlier in his life but had somehow grown to neglect in recent years. He had always seemed too busy, too caught up in one thing or another to find the time. Now, just here recently, he had re-embraced his old love. Once again he found himself seized by an insatiable passion to create.

"Art is one of the things I have to live for," he said. "Does that make any sense?"

Several of us nodded.

Especially, he had been drawing and painting nonstop since his most recent admission to the hospital. Some of his drawings were "visualizations" he had done in conjunction with his radiation and chemotherapy. Although his physicians had been skeptical, saying only, "Do whatever you want," Mr. Moore believed these exercises might be helpful. With a psychologist he mapped out a strategy whereby he would draw pictures to aid his own immune system. Many of his drawings depicted his own white blood cells as powerful, ravenous warriors, unstoppable in their appetites, gnawing away relentlessly and finally overpowering the ugly, ill-formed cancer cells.

Suddenly, his face lit up. "Would you like to see some of my work?"

A rustle in the room. Shifting of feet. Then, nods and smiles.

Characteristic of his independence and strong will, Mr. Moore insisted on getting out of bed unassisted. Very painfully and very slowly he hobbled over to his dresser and opened the top drawer where he kept his drawing tablet. Cradling it in his arms, he inched his way back to the hospital bed. But now, back in bed with his artist's notebook open, animation and vigor seemed to return. Enthusiastically he began showing us his drawings, describing them, relishing them. The first was a portrait of a woman he had done prior to entering the hospital. It was executed in charcoal—large gashing strokes, jagged intersecting black lines, bold and incomplete. Starkly, in black and white, the portrait conveyed to us the artist's angst—rage, despair, fury and loneliness, all of these feelings at once.

He showed us this piece hastily and without comment.

"Here's another one," he said, flipping the page, "I think you'll like this one."

He showed us a colorful pastel. This drawing had been completed shortly after he was admitted to the hospital. It depicted how the radiation treatment (drawn as multicolored "rainbow energy") maimed and killed the cancer cells, while his white blood cells victoriously gobbled up the injured and dead cancer cells.

"Here's my favorite!" he said with unmistakable pride.

He showed us a drawing done the day before that was full of softness and tender beautiful detail. The portrait was so realistic it seemed almost like a photograph.

Paul, the medical student, exclaimed with delight, "That's your wife, isn't it? Golly! It looks just like her!"

Mr. Moore turned to Paul and grinned. "Yes, it is. It is my wife. Do you like it? I drew this one with a whole lot of love in my heart! It shows, huh?"

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Letters

South Africa

Your article on medical education in South Africa ("Crossroads-Cape Town, South Africa," TNP July-August 1984) graphically captured the squalor of contemporary black urban existence. As abhorrent as these conditions unquestionably are, the real tragedy of health care delivery in South Africa resides not so much in the abominable standard of medical care afforded blacks, but in the juxtaposition of that system with the demonstrably superior and technologically sophisticated one enjoyed by white South Africans. It is instructive to reflect for a moment on a comparison by race of some indices of health care delivery in South Africa. (See table)

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<th>White</th>
<th>Asian</th>
<th>Coloured</th>
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<tr>
<td>Average hospital expenditure/day/patient² (R1.00 = $0.61)</td>
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<td>N/A</td>
<td>R20.54–R106.47</td>
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<tr>
<td>Number of doctors/population³</td>
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<td>N/A</td>
<td>N/A</td>
<td>1/44,000</td>
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<tr>
<td>Education expenditures/child⁴</td>
<td>R1,169</td>
<td>R390</td>
<td>R234</td>
<td>R78</td>
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The following are the consequences of the delivery patterns depicted above:

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<th>Infant mortality rate per 1000⁵</th>
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<th>Asian</th>
<th>Coloured</th>
<th>African</th>
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<td>Mortality per million persons⁶ from measles</td>
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<td>34.7</td>
<td>104.0</td>
<td>100.2</td>
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<tr>
<td>% children 9 y o. &lt;80% of average height⁷</td>
<td>Boys</td>
<td>8.5</td>
<td>49.0</td>
<td>40.0</td>
</tr>
<tr>
<td>Girls</td>
<td>11.0</td>
<td>53.0</td>
<td>55.0</td>
<td>42.5</td>
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</tbody>
</table>

Peter Lurie
Washington, D.C.

REFERENCES

Still other questions: Does the will to live help one to go on in the face of death? This notion has long been entertained anecdotally. Is it true? If so, how does it work? Why haven't we studied it?

Do creative pursuits, such as Mr. Moore's drawing and painting, conceivably decrease the experience of pain? How does this happen? Does being creative somehow promote healing? If so, how does this function at the level of brain chemistry? Do the intangibles of hope, love, faith and belief reinforce a person's will to live? What is the effect of loving? Of being loved? How did Mr. Moore's deep love for his wife affect him? His rapprochement with his parents?

What of prayer, meditation, faith and belief in God? Over and over our patients tell us that these things are very important. Yet they are mentioned with extraordinary infrequency in the medical literature. Is this because they are actually unimportant? Why haven't such phenomena been considered more carefully? How has such a fertile field of investigation gone uncultivated and allowed to lie fallow under our scientific noses for so long?

Human Experience

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"Wow!" Paul said, drawing closer. "I mean that's really something!" Without thinking about it, Paul now reached out his hand and touched Mr. Moore. With the index finger of his left hand, he very delicately traced the drawing. With his right hand, he now clasped his patient's shoulder.

"You like it?" Mr. Moore asked, looking up at Paul, visibly beaming.

"Yeah!" Paul replied. "Oh, yeah, oh, yeah. . . . Really!"

Several years have passed now since that day when we all talked with Mr. Moore. We still muse from time to time and wonder, "Might he still be alive?" It's unlikely. And of course if we really wanted to find out, we could. Perhaps we prefer to remember him just as we last saw him, with Paul's hand on his shoulder, his eyes full of excitement, joy and pride.

Who can assess the true worth of a human being's effort to communicate the meaning of life, even as he is leaving it? Our meeting with Mr. Moore had been remarkably meaningful for us all. As human beings, we were touched. As physicians, a number of things struck us as quite remarkable. During the interview, Mr. Moore never once grimaced with pain. He showed no sign of feeling nauseated. He did not once vomit or wretch. During the period when he showed us his art work he especially appeared to be utterly pain free. . . . Why?

Equally noteworthy was the lack of awareness among Mr. Moore's physicians that he drew and painted at all. . . . Why? The residents knew vaguely about his "visualizations." Because he had insisted upon being allowed to try, they had even given their begrudging permission. But they acted as though such endeavors were trivial and slightly far out. . . . Why? It is true that scientific evidence supporting the effectiveness of visualizations so far remains scanty. But, so what? To Mr. Moore, this therapy clearly meant a great deal. Why was this trivialized and ignored? In one phase of the interview, Mr. Moore talked about his spiritual life. He was a member of an Eastern religious sect. Part of his worship included daily prayer and meditation. Yet none of this was deemed at all important by the medical staff. . . . Why?

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