BEYOND THE OATH:
An Exploration of the Doctor-Patient Relationship

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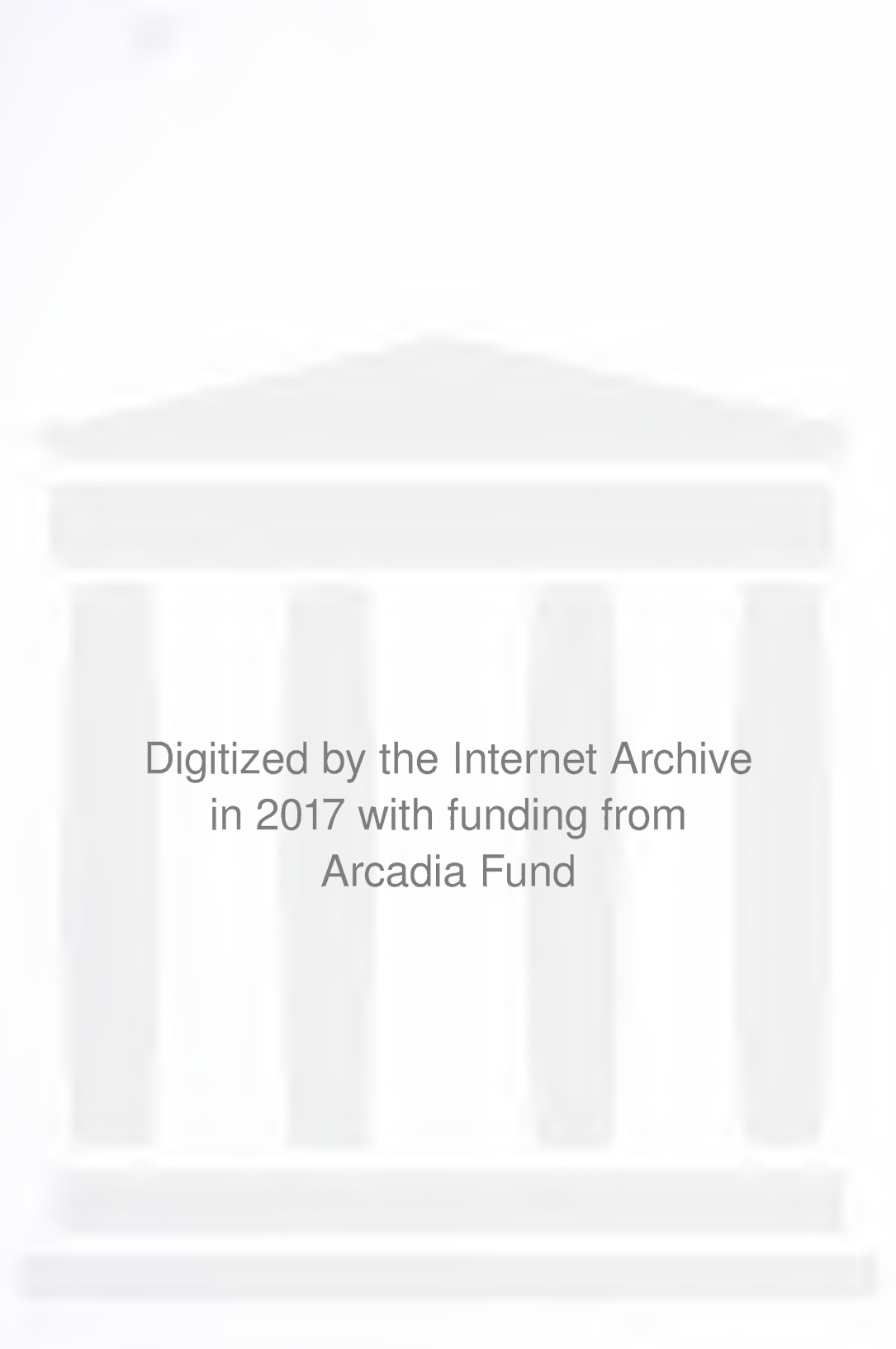

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Introduction

In early 1987, when my father was diagnosed with coronary artery disease and my family, his doctors and he decided that he would undergo bypass surgery, I took part in an intriguing interaction. The night before the operation the surgeon came to meet my father. I sat with my family and listened as the surgeon, a man in his late thirties, described what he planned to do and what he thought the prognosis would be. The discussion seemed straightforward to me and lasted about fifteen minutes. After the surgeon left, my family discussed what he had said for much longer than the actual discussion had taken. We tried to understand what he had meant literally, as well as what he had implied. We tried to determine if he was optimistic, if he was confident, and if he was competent, all based on a brief fifteen minute interaction. At first this seemed strange to me but then I realized that my family's reaction was perfectly normal; we were simply trying to absorb the idea of a scary and dramatic event that was scheduled for the next morning. We wanted to convince ourselves that we had made the correct decision and that everything was going to turn

out all right. For my family, my father's upcoming surgery was an extraordinary event. We were going to trust a stranger to cut open my father's chest, stop his heart--in a sense, rendering him dead--then restart it and suture him back up. My father was going to place his life in another person's hands.

As earthshaking as this event was for my family, it probably had little significance for the surgeon; it was a routine part of his life. He came to my father's bedside at the end of his long day, in his scrub suit, sat down casually in the chair next to my father's bed and explained the operation as though my father's heart were a fuel-pump in someone's car. While we had been discussing my father's life, concentrating on every word spoken during those fifteen minutes, the surgeon probably forgot the discussion by the time he got home that night. Did he understand how significant that interaction with us was? Did he realize that if he had looked upset or distraught for some reason having nothing to do with my father's case, or if he had yawned, it might have changed my family's attitude about the surgery? Did he understand that it might have taken away our hope, that we might have even refused the surgery?

My father's surgery clearly had different meanings for my family and for my father's surgeon. This is inevitable in any doctor-patient relationship, and in fact, is necessary to a certain degree. When I reflected on the episode

that I had witnessed in my father's hospital room, I realized that my father and my family had needs beyond the mechanical problem this surgeon was offering to fix for us. We were surrendering a certain amount of control to this man and leaving ourselves vulnerable. We wanted reassurance and guidance to help us through these events that were leading up to surgery. We wanted the surgeon to understand how traumatic these events were for us, that they were not routine for us and that we did not want them to be routine for him. With this understanding of us, we hoped that he would take better care of my father and us.

At this time I began to understand that the doctor-patient relationship has dimensions that go beyond the image of the physician who listens to a patient's complaints, diagnoses the problem and prescribes a cure. If this were all there were to medicine, a machine could do the job just as well.

To understand some of the other dimensions of the doctor-patient relationship I turned to accounts of illness and treatment in both fiction and nonfiction and to other sources of critical analysis. When we become sick, what we feel is not factual and mechanical but unsettling and frightening. Literature can provide an excellent avenue for exploration of this experience. I chose to examine accounts of illness from the points of view of both the doctor and

the sick individual because of their vastly different perspectives. For the doctor to meaningfully intervene in this process he must realize that when we enter his office, we are not only looking for a diagnosis and a prescription. The issues examined in this thesis could not be explored through empiric studies, but they are just as important for the physician to understand if he wants to truly help us when we are ill.

In the first chapter of this thesis, I explore the meaning and experience of illness, and in the second chapter, I look further, trying to understand what we hope a physician can provide us when we are sick. By examining these issues, some light may be shed on our needs beyond the need to be cured.

In the third and fourth chapters, my emphasis changes to an exploration of the physician's role. First I explore the concept of recognition, the process whereby the physician attempts to view us as more than just a physical problem and offer us the support we desire. In the fourth chapter, I will elucidate the process of accommodation, in which the physician helps us to come to terms with our illness and regain our bearings.

The last chapter uses the concepts developed in this thesis to analyze the doctor-patient relationships in

Alexander Solzhenitsyn's Cancer Ward. Solzhenitsyn's novel has many distinct doctor-patient relationships and is therefore an especially fertile place to apply these concepts.

Chapter One

The Experience of Illness

Illness causes a claustrophobic sense of isolation for us. In the 17th century, John Donne wrote: "As Sicknesse is the greatest misery, so the greatest misery of sicknes is solitude" (p.24). In illness, we feel cut off from others and trapped in a rebellious body that we used to take for granted. Illness compromises our ability to function as we did when we were healthy; it prevents us from achieving our goals and from occupying our usual roles in our families, workplaces and communities. Because these activities make up a large part of how we define ourselves, when we fall ill, we feel as though our very identity is in jeopardy. This adds to our sense of isolation and fear. Neurologist Oliver Sacks writes in his book, A Leg to Stand On, "As a patient in hospital I felt both anguish and asphyxia because I could not be heard" (p.209).

What is it about illness that so terrifies us? By exploring this question, we may uncover what we need and expect of a doctor.

When we fall ill, we become more vulnerable. Our bodies do not respond in the way we expect. This can be frightening. Discomfort or unexplained fatigue may prevent us from functioning physically, mentally and emotionally in the manner we did before becoming ill.

Journalist Paul Cowan made a name for himself in the 1960's by being one of the first practitioners of what is called the "New Journalism," whereby a writer involves himself in the stories he reports on. Cowan is perhaps most well known for his series of articles on West Virginia coal miners, a series he wrote by travelling to West Virginia and living among his subjects for several months.

In 1987, when he fell ill with leukemia, Cowan decided to share his experience with the readers of the Village Voice. In his article he demonstrates the vulnerability we all feel when we become sick:

> When I got back to the city in early September, my body felt as if it had gone out of control. When I walked up the incline from my apartment on Riverside Drive to West End Avenue, I became so winded I had to pause and catch my breath. When I lifted up my eight-year-old niece, I staggered under her weight. (p.27)

Cowan understands that he is ill because his body "felt as if it had gone out of control." He finds himself no longer able to do the things he had once done without thought. His body no longer responds to his will; it has become opposed to him. Physician Howard Brody describes this sort of split in his book Stories of Sickness:

> [A]t the level of immediate experience, I am I, a single entity, not an admixture of mind-me and body-me...It follows from this that, if sickness leads us to see our bodies as being something foreign, thwarting our wills by their intransigence and unmanageability, then sickness has fundamentally altered our experience of self and has introduced a sense of split where formerly unity reigned. (p.27)

Why does this self-body split occur? I use the term "self" to refer to our personalities and minds--both subconscious and conscious--with an emphasis on our perceptions of our experiences of personhood in the world. How then does the fact that Cowan could no longer lift his niece cause a split between himself and his body? If he had described not being able to lift a 200 pound weight, he would have been unconcerned; he would not have called his body "intransigent" and "unmanageable" for not being able to complete this task. The difference has to do with expectations. Cowan does not count among his abilities the strength to lift 200 pounds; he had thought, however, that he was able to lift his niece. When his body does not meet this expectation, he sees it as "thwarting" his will, and standing opposed to him.

Medical ethicist Sally Gadow sheds a philosophical light on this concept of split that clarifies it: she introduces the Hegelian concept of dialectic to the problem. She devises four levels, which progress one to the next, to describe the relation between body and self. In the first, "primary immediacy," no distinction is made between the two. "The body is an aspect of the self....Instead, the distinction is that of the lived body in opposition to the world" (p.174). The self-body experiences itself acting upon or being acted upon by the world. Thus, we do our day to day tasks thoughtlessly, climbing stairs or driving a car for example.

We enter the second level when we attempt to perform a task that our bodies lack the ability to accomplish, such as trying to lift a weight that is too heavy for us or to hit a curve ball when we lack the necessary coordination. Gadow titles this level "disrupted immediacy." Here the body becomes an object to the self because it does not automatically respond to our will. It, therefore, becomes separate from ourselves. The split is caused by incapacity or constraint. It is "the experience of being unable to act as desired or to escape being acted upon in ways that are not desired" (Gadow, p.174). At this level, the self is conscious of a particular desire to which the body cannot respond. The body and self stand opposed to each other. The body must be reckoned with; it is an object as much as

any other in the world, something to be disciplined or trained as though it were a sort of instrument.

We cross into the third level when the gap between body and self occurring in the second level is bridged. This next level, "cultivated immediacy," involves reuniting body and self. Here, the struggle is "transcended" through the training of the body. Thus, we develop the skill to hit a curve ball or exercise to gain the strength to lift the weight. "[T]he culmination of training--the free and unconstrained use of the new capacity--recovers the immediate unity of self and body..." (Gadow, p.177). A "new naturalness" emerges out of the struggle. Body and self remain distinct unlike in the first level, but they are no longer opposed as in the second.

Gadow uses the last level to integrate aging and illness into her model. Here the body becomes the subject, not the object. "[T]he body is seen increasingly as an obstacle of the self to the point of appearing no longer passively resistant but actively hostile...It demeans and humiliates the self, refusing to perform basic functions reliably. It dictates prohibitions and destroys possibilities" (p.179). In illness, we cannot simply train our bodies to conquer a particular obstacle. Our bodies demand that we recognize their own reality. A stroke may have left us too uncoordinated to ever develop the skill to hit a

curve ball or a systemic infection may cause us to be so weak that we cannot develop the strength to lift that weight. We may, in fact, lose skills that we had already developed. Thus, in illness, we lose control of our bodies; the illness has caused our bodies to become unresponsive to our wills.

This model provides us with a framework to examine part of the phenomenon we experience when we are ill, that of the split between body and self. But it fails to give us a good sense of the fear and vulnerability that this split causes, the "anguish and asphyxia" that Sacks describes. The alienation from our bodies that we experience can be devastating. Cowan writes that fear is a routine feature of life in the land of the sick:

> For the truth is that we live with uncertainties. We can't control our bodies as we did when we were well. They may betray us, our families, our plans at any time...We don't even possess the minimal security of knowing that we'll be in or out of the hospital on a specific date. We don't control our calendars, our illnesses do. (p.39)

For Cowan, who is struggling against leukemia, part of his fear springs from his fear of death. His body is hurtling out of control toward his ultimate end. The prospect of death as the culmination of an illness is certainly terrifying, but the split between body and self alone is sufficiently unsettling to engender a sense of vulnerability and fear. "Sickness is <u>of itself</u> an

unpleasant disruption of the self, independent of the possibility of death" (Brody, p.29). In A Leg to Stand On, Sacks goes through a traumatic experience after severely injuring his leg and temporarily losing all sensation in it. Never does he worry that he will die as a result of his injury. Sacks experiences a loss of his subjective omnipotence over his body. His leg becomes an alien object:

> To show that it was not serious, I got to my feet, or rather I tried to, but I collapsed in the process, because the left leg was totally limp and flail, and gave way beneath me like a piece of spaghetti. It could not support my weight at all, but just buckled beneath me, buckled backwards at the knee, making me yell with pain. But it was much less the pain that so horribly frightened me than the flimsy, toneless giving-way of the knee and my absolute impotence to prevent or control it... (p.21)

The pain Sacks experiences and the weakness Cowan described are frightening because they lack an apparent explanation. Sacks does not understand what has happened to his body as a result of his injury and Cowan does not understand why he has become so weak. Their bodies have rebelled, and they have lost control. Sacks in the above passage has almost given his leg a separate, inscrutable personality.

The amount of fear and vulnerability we experience as a result of illness, of course, relates to its severity. A common cold does not engender the same reaction as a heart attack, but, nevertheless, the two reactions belong to the same spectrum. Both illnesses are unsettling experiences in

similar ways. Both cause a split between body and self that calls into question our identity.

Before he became ill, Cowan defined himself in part as someone who could lift children. Sacks defined himself as someone who could walk. We all subconsciously or consciously create our own identities. We do it based on our background, abilities and accomplishments, for example, as someone who can jog two miles or has read certain books. In illness, the body usurps some of this power for itself, and by compromising our ability to define ourselves, disrupts our identity. I will return to the concept of how we define ourselves in chapter three of this thesis.

Sickness also disrupts other parts of our identity. Illness may prevent us from working or doing other activities to which we were accustomed. Bob S., a patient with whom I worked, had defined himself as a breadwinner and father to his family. Once he became ill, he could no longer work or occupy the same role in his family. He often spoke about the difficulty of staying close to his family and friends when he was stuck at home or in the hospital. He no longer could share the experiences he had hoped to with the important people in his life. His relationships with those people changed because his body no longer allowed him to interact with others as he had in the past. The way he defined himself in relation to others had been radically

altered by his illness. A simple sore throat can have a similar effect on a much smaller scale: it may force us to stay at home for a few days, disrupting our lives for a brief period of time.

When we become sick, our sense of separation from others is reinforced by our impression that those around us do not know what we are experiencing, not the pain, not the feelings of loss of control and power and not the loneliness. Cowan describes the inhabitants of the "land of the sick" as exiles from the "land of the well." Psychiatrist David Reiser writes of the physical separation and disconnectedness we can experience in the extreme case if we must enter the hospital:

> In hospitalized patients, the separation, in fact, is virtually absolute. People are wrenched from their jobs, from their bedrooms, from their favorite robes and slippers and from their families, coffee cups, books, pipes, and favorite pictures on the wall. They are thrust into the alien world of bright lights, beeping electric monitors, tubes, tangles of wires, and strangers. The effect can be shattering. (p.71)

No one who has never been ill and in an intensive care unit knows what it is like for someone who is sick to spend a night in one. Even physicians and others who work there do not know; they have not felt the vulnerability and the fear. Experiences like this make us feel isolated from the world of the well when we are sick.

Besides feeling separated from those around us, when we fall ill, we also find our attention drawn inward; we focus on ourselves and our illness and cut ourselves off from others. Reiser writes of this phenomenon in reference to his own experience while being sick:

> Early in the course of an illness, an individual finds himself turning inward and becoming increasingly self-absorbed. Early in my own illness, there were many occasions when I would attempt to concentrate on matters outside of myself, trying to pay attention to teaching rounds at the hospital, trying to watch TV without drifting off, or trying to read a book. But always my thoughts would slowly drift back toward my symptoms, toward myself. One experiences a sense of preoccupation and irritability, a self-centeredness that is monotonous and frightening, yet somehow inescapable. (p.64)

This self-absorption adds to the disconnectedness we feel. Not only does illness prevent us from interacting with others as we had before we became ill, but it also causes us to withdraw, unable to concentrate on things other than ourselves and our symptoms.

We now have seen how illness causes a disruption and disconnectedness in our lives. We feel separated from our bodies, from the people around us, from the role we are accustomed to occupying in life, and from the world around us as our attention is focused inward, toward our ailing selves. The disruption is complete; it reaches into all aspects of our lives and is caused by an incomprehensible and uncontrollable force: illness. This disruption leads to

a sense of aloneness, a loss of control and fear. Even more terrifying is that this disruption does not come from outside us. Cowan understands he has become ill when he is easily winded and can no longer lift his niece without effort. These are his failures, his symptoms; he describes himself, not his illness. He does not describe something outside of himself hindering his normal functioning; his illness is a part of him, but beyond his control.

Thus, we may better understand author John Berger in his book about an English country doctor. The book documents part of the life and work of Dr. John Sassall. For Sassall, healing is more than a matter of medicine. It includes simple human understanding. And Berger sees illness not only as a medical issue but also a personal one:

> The illness, in other words, shares in our own uniqueness. By fearing its threat, we embrace it and make it specially our own. That is why patients are inordinately relieved when doctors give their complaint a name. The name may mean very little to them; they may understand nothing of what it signifies; but because it has a name, it has an independent existence from them. They can now struggle or complain <u>against</u> it. To have a complaint recognized, that is to say defined, limited and depersonalized, is to be made stronger. (pp.73-4)

By naming it, the physician has removed the illness from within us and given us the chance to fight it. The next chapter explores this issue further.

Chapter Two

The Need to Be Recognized

Our experience when we fall ill is that of loneliness. In health, we maintain a sort of equilibrium; we know our capabilities and our relationships to others and the world. In illness, we feel isolated from others, unable to participate in our lives as we had in the past. We feel trapped in a rebellious body and self-absorbed, focusing on our own illness and symptoms. All this is the "asphyxia" that Oliver Sacks experiences after his injury (A Leg, p.209). The "anguish" he describes comes from the loss of control we feel over our bodies, our thoughts, our lives, and our abilities to interact with others when we are sick (A Leg, p.209). These feelings stem from a force within us that has thrown us off balance: our illnesses. It is a part of us beyond our control and understanding. These feelings of loneliness and loss of control form a part of the urge we experience when we are ill to seek the help of a physician. We try to communicate our experience to another with the

hope that she will understand and recognize what we cannot. Her understanding of what we cannot understand may be able to rescue us from our loneliness and help us to regain the control of our lives that we have lost due to our illnesses.

Our desire to be recognized is complicated by our fear that we cannot be understood. We are afraid that since we cannot comprehend what is happening to us, we cannot expect anyone else to understand. We believe that our experience is unknowable because it is occurring within us. "[Our experience] would be tolerable," Sacks writes, "or more tolerable, if it could be communicated to others, and become a subject of understanding and sympathy--like grief" (A Leg, p.109). Sacks longs for communication and understanding of his situation. Later he writes, "I had fallen off the map of the knowable...I had lost everything which afforded a foothold before" (pp.110-1). The experience, which Sacks describes here, he terms "the essential aloneness of the patient" (p.88) Thus, not only are our connections to our bodies and our world severed, but because we feel unknowable, there also appears to be no way to repair them. Leo Tolstoy chronicles this in his novella, "The Death of Ivan Ilych." Ivan Ilych mourns because he sees "that no one felt for him, because no one even wished to grasp his position" (p.138).

Ivan Ilych is correct: no one wishes to grasp his situation, and no one can either. We cannot truly experience another's pain, and therefore, we cannot understand that person's situation. We cannot know what it is like, for example, for Paul Cowan to have his strength melt away from leukemia or for Oliver Sacks to be unable to control his leg. Although Ivan Ilych desperately hopes for this sort of understanding, it is impossible. Even if we had a similar illness and felt similar pain, our backgrounds and personalities would change the meaning of that illness and pain for us and therefore, the experience. For example, the experience of a broken leg has different meanings for a professional athlete than it does for a typist. The disruption it causes in each life differs as well and therefore, so does their experiences of the injury. Even Ivan Ilych's kindly servant, Gerasim, does not feel what his master experiences. He tries to comfort his master because he knows that one day he may be in Ivan Ilych's position, and he hopes that someone will do the same for him.

In health, we can command our bodies thoughtlessly, but when we fall ill, we lose this control and are thrown off balance. Our inner experiences become vastly different than those in health and are frightening. In this state of loneliness and fear, we, who in some sense have become unknowable to ourselves, look beyond ourselves for reassurance that we have not "fallen off the map" but are still

knowable. We look to escape our "essential aloneness." Below, a patient that John Berger has written about struggles to communicate his experience to his physician:

> Once he was putting a syringe deep into a man's chest: there was little question of pain but it made the man feel bad: the man tried to explain his revulsion: `That's where I live, where you're putting that needle in.' `I know,' Sassall said, `I know what it feels like. I can't bear anything done near my eyes, I can't bear to be touched there. I think that's where I live, just under and behind my eyes.' (pp.47-50)

Here, what the patient tries to make his doctor understand is beyond language and cannot be truly understood by another, even though Sassall tells the man he does. In order to try to understand his patient, Sassall has had to relate the man's experience to one of his own. This brings him closer to the man, but does not allow him to completely understand. Our pain can never be completely knowable to others. Interestingly, however, the urge to communicate is strong. Through it, we attempt to escape our aloneness. Sacks feels this need also after his injury:

> I had become all of a sudden desolate and deserted, and felt--for the first time, perhaps, since I had entered the hospital--the essential aloneness of the patient....Desperately now, I wanted communication and reassurance....I needed above all to communicate with my physician and surgeon: I needed to tell <u>him</u> what had happened to me, so that he could say "Yes, of course, I understand." (<u>A Leg</u>, p.88)

This need to be understood, together with our desire to regain control of our lives and escape our isolation, gives some insight into why we are willing to submit to a physician and to the indignities and pains of medical treatment. There are, of course, other pressures (e.g. societal, financial), in addition to the desire for cure, which make us willing to submit to physicians. Society creates expectations about how we should behave when we become sick: that we should seek a professional for help and attempt to get better as quickly as possible so that we may continue to function in society. But these pressures alone can not entirely explain our willingness to reveal ourselves to physicians. There are also the internal pressures of the sort I have been describing, which revolve around the need to be understood as a way to escape loneliness and regain control. These pressures combined cause us to grant an access to our lives that we would give no other stranger. John Berger writes:

> We give the doctor access to our bodies. Apart from the doctor, we only grant such access voluntarily to lovers...Yet the doctor is a comparative stranger. (p.64)

The access we give to the doctor is an intimacy. By letting our doctor come so close, we hope, understanding may emerge. Writer and physician William Carlos Williams describes "the inarticulate patient [who] struggles to lay himself bare for you [the physician]" (Doctor's Stories,

p.123). The extent to which we are willing to reveal ourselves can be extraordinary: from an intimate history of our lives to a discussion of our most private bodily functions. We may then even grant an access to our bodies that can include painful and undignifying diagnostic procedures.

At other times, when our experience is less frightening, our drive to be understood by a physician is less pressing and as a result, we may become less compliant with medical care. For example, with a disease like essential hypertension, which has no symptoms in its early stages, we feel less of a need to reveal ourselves since we do not feel ill. Instead, we seek the help of a physician because of our fears about what might happen to us if we do not. Similarly, the threat of developing an illness can provide us with the impetus to grant physicians intimate access to our lives and bodies. Thus, we submit to screening exams such as mammograms and tests for blood in our stool, hoping to avoid becoming seriously ill.

When we fall ill, we are willing to reveal ourselves to a virtual stranger in ways generally unacceptable to a healthy individual. In doing so we hope that we will be able to regain control of our lives and escape the isolation we experience as a result of our illnesses. By revealing ourselves in this way, by struggling "to lay ourselves bare" before the physician, we hope to be recognized. Sacks

described above this drive to communicate, to be understood and therefore, knowable. Berger turns his attention to the doctor's role when we attempt to reveal ourselves to him:

> What is required of [the physician] is that he should recognize his patient with the certainty of an ideal brother....This individual and closely intimate recognition is required on both a physical and psychological level. On the former it constitutes the art of diagnosis....On the psychological level it means support.... (pp.69-73)

Berger advocates here the creation of an intimacy and openness between our physicians and ourselves that maximizes the opportunity for the physician to understand us. But first of all, why do we ask the physician and not someone else to recognize us? Part of the reason has to do with societal norms: when we are sick we are supposed to go to the doctor. Society has given physicians a certain role to play. Also, we expect the physician to have a knowledge of the body and human disease that we do not have. But we have greater expectations and hopes for our interaction with a physician beyond simply describing our symptoms, submitting to a physical exam and a few tests, and then leaving with a prescription. We hope for reassurance and understanding. Literary critic Anatole Broyard describes a minimum of what he looks for in a physician: "To most physicians, my illness is a routine incident in their rounds, while for me it's the crisis of my life. I would feel better if I had a doctor who at least perceived this incongruity" ("Doctor Talk to Me," p.36). For a doctor to be aware of this does

not mean that she must experience the event as earth-shaking, only that she be sensitive to what we are feeling. Our crisis may be as simple as a sore throat or as life-threatening as cancer. Whatever the case, it is more than a scientific problem for us; it is among other things a fear-provoking experience. The recognition we seek is, therefore, more than just physical diagnosis. We function on an experiential level not a mechanical one. When we fall ill, we present to our doctor not merely a physical problem. Thus, Oliver Sacks hopes his physician will understand his anguish:

> If he was a sensitive man he would be instantly aware of the distress and dispel it, with the quiet voice of authority. What I could not do for myself in a hundred years, precisely because I was entangled in my own patienthood and could not stand outside it, what seemed to me insuperably difficult, he could cut across at a single stroke, with the scalpel of detachment, insight and authority...I required only the voice, the simplicity, the conviction, of authority: "Yes, I understand. It happens. Don't fret. Do this! Believe me!" (A Leg, pp.92-3)

What Sacks seeks is not the same understanding that Ivan Ilych sought. Ivan Ilych felt an impossible yearning that we all have deep within us when we feel pain; he longed for someone to know what he was experiencing, to feel his pain and fear; he wanted someone to empathize with him. Sacks hopes his physician is detached from the anguish that has knocked him off balance and out of control. Through his physician's detached understanding, Sacks wants to regain

his lost control. This way he may escape his isolation. If his physician gave up his detachment and were truly able to feel Sacks' experience, he would be just as lost as Sacks.

We come to the physician hoping to regain control of our bodies and our lives and thereby escape the isolation imposed on us by our illnesses. We want to be recognized as a first step toward this goal. Recognition is a means to restoring our connectedness to the world. It is a way to help us understand that our experience is not beyond the knowledge of others. It involves, among other things, giving our complaint a name, as Berger describes here: "...because [the complaint] has a name, it has an independent existence from [the patients]. They can now struggle or complain <u>against</u> it" (p.73-4). By giving the complaint a name, it becomes something separate from us and no longer a mysterious force inexplicably entwined with our own identity. Once Paul Cowan's illness has been given the name "leukemia," he and his physician can battle against it together. Cowan is no longer battling his own body's incomprehensible fatigue and weakness. In naming our complaint, the physician is saying that she has seen it before in others; she has a grasp of what is happening to us.

In a sense, the physician witnesses our experience and recognizes it. In that moment of recognition, she offers us

reconnection to others because she has seen others who have had similar experiences. We are no longer unique and alone. The physician, then, is a bridge to the world because she has witnessed others and is now witnessing us. Berger describes something similar at the moment of death:

> The doctor is the familiar of death. When we call for a doctor, we are asking him to cure us and to relieve our suffering, but, if he cannot cure us, we are also asking him to witness our dying. The value of the witness is that he has seen so many others die...He is the living intermediary between us and the multitudinous dead. He belongs to us and he has belonged to them. And the hard but real comfort which they offer through him is still that of fraternity. (p.68)

To be offered that fraternity is to be no longer totally alone. Since others have had similar experiences, our experience, no matter how isolating it is, is still part of the realm of human experience. This can provide us with some comfort in our suffering.

The physician is more than just a passive witness, however. As a familiar in what Cowan calls the land of the sick, the physician can act as a guide because of what she has seen before. This is why the physician's word can have such power for us. For us, entering the land of the sick is a disorienting experience. We seek out a physician as someone who can help us regain our bearings. The physician, since she is a familiar in this strange land by virtue of her training and what she has witnessed before, offers

guidance. Paul Cowan provides an example of how medical care providers can function in this capacity:

> I still felt like a foreigner in the land of the sick, and, like most foreigners, I had no context in which to place the information I learned. The interns, residents, nurses, and stray doctors who came into my room were all eager to discuss my case. But they didn't realize that if they offered tentative, pessimistic predictions ...or disturbing stories about other people with leukemia, or looked at each other with sad knowing expressions as they touched a sore part of my body, they could depress my spirits for days. (pp.31-2)

Cowan, in his drive to regain control of his body and his life, has revealed himself to his doctors; he has submitted to them with the hope of communicating to them his experience. He wants them to understand his experience and through their understanding gain comfort, reassurance and control. In the process, he has become extremely vulnerable to their words and actions. Cowan has had to lay himself bare before his doctors; stripped of his defenses, he now depends on his physicians' understanding in order to understand himself. Cowan has sought to be recognized because he can no longer comprehend himself. Unfortunately, his physicians do not understand his needs and goals are and have failed to offer the support he desires. Instead, they have been careless with what they have said, not realizing his vulnerability and the possible effect of their words on him.

Thus far we have seen how illness isolates us and usurps our control over our lives. We then turn to doctors hoping that they will be able to help us escape our isolation and regain control. We express this as a need to be understood and therefore, are willing to reveal ourselves to our physicians. We view physicians as guides in a land unfamiliar to us, people with a knowledge we lack. Our hope is that their detached understanding may provide us with insight into our illnesses that will allow us to return to the world of the well.

Chapter Three

Recognition

In the first two chapters, I have described the experience of illness: the isolation and loss of control and the resulting urge to be recognized and seen as knowable as a means of being reconnected to others. This chapter begins to emphasize the role of the physician and what he can provide us when we get sick.

To begin with, the doctor belongs to the realm of the intellect. For him, disease represents a problem to be unravelled, solved and hopefully answered with a cure. This stands against our primary concerns when we fall ill; we are most interested in what we experience. We belong to the realm of immediate experience. Cure for us represents a means to feel better, to regain control and to escape our isolation. In this chapter I will suggest a means for physicians to try to bridge this gap between our emotional experience and the intellectual puzzle our doctor sees.

The previous chapter began to unravel the concept of recognition, which the physician can offer and which can provide an avenue of escape from our isolation. Recognition can be a first step on the path of regaining control. Berger introduces his discussion of recognition this way:

> In illness many connexions are severed. Illness separates and encourages a distorted, fragmented form of self-consciousness. The doctor, through his relationship with the invalid and by means of the special intimacy he is allowed, has to compensate for these broken connections and reaffirm the social content of the invalid's aggravated self-consciousness...What is required of him is that he should recognize his patient with the certainty of an ideal brother. (p.69)

Recognition can serve as a means to repair our "aggravated self-consciousness," which refers to our feelings of isolation from our bodies and our lives. It involves providing companionship, giving support and maintaining open channels of communication between the doctor and patient. Oliver Sacks' physician does just the opposite; he responds to Sacks' concerns about not having any sensation in his leg by effectively cutting off all communication: "He held up his hand, like a policeman halting traffic. 'You're completely mistaken,' he said with finality. 'There's nothing wrong with the leg. You understand that don't you?'" (A Leg, p.105). Sacks' doctor effectively squashes the conversation and delegitimizes Sacks' experience, instead of being supportive and reassuring. He does not intend to be cruel; he merely makes no effort to understand Sacks' concerns. He

is only occupied with factual reality, not experiential. Since he does not share Sacks concerns, he dismisses them. He views his role to be performing the necessary surgery on Sacks' leg.

Thus we see that the physician's first task is to listen to the patient in a nonjudgemental way. If we are going to trust our physicians enough to grant that special intimacy with our bodies and our lives, they must demonstrate that they trust us enough to take the stories of our experiences seriously. By listening carefully, they can do just that.

Listening carefully--hearing both what we say and what our bodies reveal during physical examination--does more than demonstrate that the doctor takes us seriously. The physician's attention can become an act of witnessing. As we saw in the previous chapter, by witnessing our suffering when we are ill, the physician provides us with connection to others. He is seeing our pain and has seen the pain of others before. Thus, we are not alone. This can be taken a step further when the physician gives our complaint a name, acknowledging that others for whom he has cared have come before him with the same complaint and have been similarly recognized. Therefore, our illness is not unique and poses less of a threat because it belongs to the realm of human experience; since others have had this illness, it cannot

completely isolate us from the world. Oliver Sacks' doctor in the following exchange fail to meet this criteria as well when they suggest that his experience is "unique":

> "I can't be unique," I said, with anger, and rising panic. "I must be constituted the same way as everyone else!...perhaps you don't listen to what patients say, perhaps you're not interested in the experiences they have." "No, indeed, I can't waste time with 'experiences' like this. I'm a practical man, I have work to do." (A Leg, pp.106-7)

When we fall ill, we fear that we are unique and unknowable and therefore, alone. We seek comfort and companionship in our aloneness. The physician, by listening carefully to us can offer us this comfort and companionship.

When the doctor gives our complaint a name, he also validates our experience. It is not "all in our heads"; what we feel correlates with a real process going on in our bodies; it is not only in our imaginations and therefore, inaccessible to the understanding of others. What we feel belongs to the realm of human experience, and therefore, we are not alone.

By listening the physician also offers us companionship. That he takes us seriously suggests that we are worth taking seriously. When we feel isolated and alone, as we do when we are ill, we may believe that our isolation occurs

because we are no longer valued as companions. The physician's attention refutes this concern.

When the physician listens carefully to his patient, he has taken the first step in forming an alliance. By listening, he allows us to vent our frustrations, concerns and fears. The physician's companionship, together with his validation of our suffering, demonstrates to us that he will join us in our battle against illness. He takes the next step by giving the complaint a name, which removes it from us. He approaches the illness from the side of medical science and we approach it from the point of view of what it is doing to us, but we can work together with our physician, against the illness, once it is named and no longer a part of us. When the doctor is able to give a complaint a name, it indicates that we--by means of our story and the physical exam and tests to which we have submitted--have sufficiently communicated our experience to him that he is able to recognize it as a particular illness. He has diagnosed and placed before us what we must fight. Therefore, he has joined us in an alliance, a therapeutic alliance, because the enemy has been identified.

All that I have described above happens when a doctor listens carefully to his patient and his patient's body. By listening he offers support and an escape from isolation. Berger uses the term "listen" similarly and enriches it even more by adding physical contact to its meaning:

> It is as though when [Dr. John Sassall] talks or listens to a patient, he is also touching them with his hands so as to be less likely to be misunderstood: and it is as though, when he is physically examining a patient, they were also conversing. (p.77)

By viewing physical contact as a natural extension of listening, we can expand our understanding of how listening comforts us: physician Eric Cassell views touching in the doctor-patient relationship as being part of what he terms the "tenderness phenomenon" (The Healer's Art, p. 134). For example, in order to allow a physician to touch me I must lower the normal defenses that I have erected to maintain my privacy and ironically, my aloneness. When my physician touches me, provided he does so in a tender and caring way, he crosses that gap which isolates me from others. Similarly, when I share my concerns, fears and complaints with my physician, I have lowered my defenses; by listening my doctor bridges that chasm which isolated me from others. Psychiatrist Irvin Yalom writes about how the patient feels when his doctor listens to the details of his story:

> Details are wonderful. They are informative, they are calming, and they penetrate the anxiety of isolation: the patient feels that once you have the details, you have entered into his life. (p.188)

My term "listening" is therefore close in meaning to the way Berger uses the term "recognition." He defines recognition on the physical level as "the art of diagnosis,"

while "on the psychological level it means support" (p.73). As described above, the act of listening in itself can become an act of support if done in a caring and thoughtful way. The term "listening," however, lacks the more active connotation of "recognition." When a doctor recognizes his patient he has achieved a degree of therapy. Recognition implies that the physician has drawn some sort of conclusion based on what he has learned. Through his skills in physical diagnosis, he interprets the signs our bodies display. This is the first part of recognition. The second involves more than just physical diagnosis. Chapters One and Two detailed the profound and far reaching effects illness has on us and our perceptions of ourselves. For a physician to ease our "aggravated self-conscious," for him to recognize us, he must have an approach to understanding what he hears. This requires an understanding of what we are telling him beyond mere symptoms and facts. In our attempt to escape the isolation imposed on us by our illnesses, we try to reveal ourselves to him and become knowable. We do this by telling him the story of our illnesses and our lives as it pertains to our health. That story, in a sense, defines us; it represents a part our identities.

Through out our lives we define ourselves. We consciously and subconsciously determine and redetermine our identities based on our backgrounds, abilities and accomplishments. We generate identities for ourselves through

our memories of the past and our projections of our future goals. Therefore, I am a student and husband, who is planning to become a physician and father. I have steered my life along a particular path to achieve these goals: for example, I have attended college and medical school. And how I view my past points the way to my future: I believe that I am capable of becoming a doctor because I have the impression that I was sufficiently successful in medical school. Thus, I have generated a story of my life, which is, in fact, how I communicate my identity to others: by telling them my story.

Physician Howard Brody uses this model to explore the doctor-patient relationship. For Brody, illness represents a major break in our life-stories because it thwarts our wills: For example, if I were to fall seriously ill and were unable to attend classes and complete my education, I might not be able to become a doctor.

The centerpiece of Brody's argument is the concept of "self-respect," which is intimately related to viewing one's life as a narrative. For us to have self-respect requires: having "a rational plan of life," that is "the story one plans later to be able to tell about how one's life has turned out" (p.49); "finding one's person and one's deeds appreciated and confirmed by one's close associates, whom one esteems in return"; and "confidence in one's ability, so

far as it is within one's power, to carry out the rational plan of life that has been chosen" (p.50). Thus to have self-respect, we must have a realistic life plan which is endorsed by those close to us and which we believe ourselves able to accomplish. Self-respect is, therefore, a motivating force in our lives, one that allows us to maintain meaningful relationships with others.

Illness can have profound effects on our self-respect. It may force a radical revision of our life plans. The illness that Bob S. suffered from left him too weak to continue his studies to become a nurse. His illness forced him to modify his rational life plan; he became incapable of completing his training, and the people close to him would not have supported its continuation, knowing that Bob's goal was unrealistic. Thus Bob's illness forced him to modify his identity and to change the story he planned to be able to tell about his life; otherwise, he would have lost his self-respect.

Bob's doctors helped him through this transition in his life plan. He went to them when he first became ill and lost control of his life plan and therefore, his self-respect. By interpreting for Bob the changes his illness dictated in his life plan, his doctors enabled Bob to modify his life plan and maintain his self-respect. He came to understand, for example, that he would have to give up his

nursing career. This process of accommodation will be explored in more detail in the next chapter.

Brody's concepts offer an especially valuable means for understanding the difficult or noncompliant patient. For example, in Richard Selzer's short story, "Fetishes," Audrey's anesthesiologist tells her that she must leave her false teeth in her room on the morning of her surgery. She protests to the point of considering leaving the hospital because her husband Leonard does not know she has a denture and has never seen her without her teeth. The physician does not bother to listen seriously to her explanation of why she does not want Leonard to see her without teeth and dismisses her concerns. Still, she fears for her marriage. This failed doctor-patient relationship is contrasted to the successful one the intern establishes with Audrey. He listens to her story and her plea:

> "My husband will be waiting for me to come back from the recovery room. He will see me. I can't do that. Please, please." The last words rose like echoes. For a long moment they looked at each other, during which something, a covenant perhaps, Audrey did not know, was exchanged... Then, all at once, deep called unto deep. A rush of profound affection came over her. It was nothing like her feeling for Leonard, but for all she knew, it might have been love.
>
> "Do not worry." (p. 89)

The intern arranges with Audrey to replace her denture before she leaves the recovery room. That the intern makes this arrangement is almost less important than the bond he

forges by taking the time to listen and recognize his patient. By offering this support rather than dismissing her concerns, as the anesthesiologist did, he has allied himself with her and provided her with companionship in her isolation. In this story, by taking time to listen to a sick individual's life plan, a physician transforms an interaction with a potentially "noncompliant" patient into a strong relationship by recognizing the patient and her source of distress. He recognizes how integral Audrey's false teeth are to her life plan.

Selzer's story also points us in the direction of what comes next in the doctor-patient relationship after recognition. The physician attempts to work within the patient's life plan. In this case, the intern is able to accommodate Audrey. Sometimes this is not possible. If you have suffered a stroke and can no longer walk, there may be nothing your doctor can do to return you to the life plan you had occupied before. Your doctor then must help you accommodate your life plan to your new circumstances. Together with him, you must modify your story. Brody makes this clear in his final chapter:

> We are, in an important sense, the stories of our lives. How sickness affects us depends on how sickness alters these stories. Both sick persons and physicians make the experience of sickness more meaningful (thereby reducing suffering) by placing it within the context of a more meaningful story. Physicians, because of their special knowledge and their societal role, have special

> powers to construct stories and to persuade others that these stories are the <u>true</u> stories of the illness. The emphasis...has been that physicians can properly exercise that power only when they attend carefully to the stories their patients tell them and engage them in meaningful conversation, within the broader context of the range of life stories made available to all of us by our society and our culture. (p.182)

When a physician is able to engage us in a relationship characterized by this degree of recognition, an unusually strong alliance can be forged. Bob S. had this sort of relationship with his surgeon, one in which the surgeon made an effort to see Bob as a whole person, not as a medical and scientific problem. Bob underwent a procedure that he credits with saving his life, a procedure that he claimed only his surgeon recommended. The other physicians who consulted on Bob's case thought the procedure would be too risky. But Bob told me that he trusted his surgeon because he seemed to truly care, and he agreed to the operation as long as his surgeon was the one to perform it. Bob described how the night before his surgery, the surgeon took Bob's teenage children aside and explained to them the procedure, just as he had done for Bob, since he recognized how anxious they were.

Paul Cowan describes a similar incident during his battle with leukemia. He had been receiving conflicting advice on whether to have a bone marrow transplant, but he finally decides in favor of it after speaking with his

original physician. Her advice persuaded him because of the relationship that they shared:

> I realized that she knew my body and my cells--and my temperment--better than any of the doctors I'd consulted. I was a theory as far as they were concerned. I was a human being to her. That made her arguments especially persuasive. I decided to have the transplant as soon as possible. (p.37)

Chapter Four

Accommodation

The previous chapter explored the concept of recognition in the doctor-patient relationship. For the doctor recognition provides a means of forging a therapeutic alliance, a way to reach out to us when we are ill and to provide us with companionship. Recognition allows us to escape our aloneness and to reveal ourselves to another in a secure and defined relationship. The degree to which recognition takes place, in fact, determines the efficacy of our therapeutic relation with a physician. Having begun the process of escaping our isolation, we next hope to regain control of our lives, the control to determine our life story. The physician can offer us help at accommodating to our situation. "Accommodation," according to Oliver Sacks, "consists, in effect, of a painstaking exploration of the full range of the real and the possible" (Awakenings, p.234). It involves the effort we make to regain our equilibrium after having been knocked off balance by our illnesses.

When we fall ill and then seek a physician's assistance, we bring to her a list of questions which essentially come down to the following:

(1) What is wrong with me?
(2) What should I do about it?
(3) What will happen to me?

Answering the first question requires recognition, what John Berger terms the "art of diagnosis." The second question asks: what therapies or suggestions does the physician have to offer that will allow me to conquer this strange process going on inside my body; what can I do to regain control of my body? And finally the third question concerns my life story. This question asks whether I will have to change or accommodate my life-plan or whether I will recover completely and be able to pursue the same life-plan as I did before. The second and third questions concern the process of accommodation, the subject of this chapter.

The first chapter of this thesis dealt with how illness disrupts our lives: taking control of our bodies away from us, forcing us to turn our thoughts inward toward our ailing selves, preventing us from performing our normal roles, and isolating us from others. Accommodation provides a means of adapting to all of this. Through accommodation we can regain control of our lives. This new control may come

through a cure that our doctor provides, or it may center on reorganizing our shaken sense of self.

When we become ill, we lose our balance and our usual points of reference. In a sense, we enter a new land, what Paul Cowan called the "land of the sick," and occupy a new and strange role. In this land, the physician serves as our guide. Anatole Broyard writes of this phenomenon: "Just as a mother ushers her child into the world, so the doctor must usher the patient out of the ordinary world into whatever place awaits him. The physician is the patient's only familiar in a foreign country" (p.36). The doctor, for example, may act as our guide through the emergency room if we have been injured in a car accident. The physician is a part of this disorienting land of strange and frightening sights, sounds and smells, but she is also a part of our familiar world since she is our ally.

The land of the sick frightens us because in it we have little control: we do not control our environment, our bodies or our futures. Our physician, in her role as guide in this strange land, lends us her control. Physician Eric Cassell phrases this facet of the doctor-patient relationship this way:

> ...the sick person's loss of control over his world is eased by the healer. He becomes the patient's agent ("he's <u>my</u> doctor"), and his

> control over the environment becomes the patient's control. (The Healer's Art, p.144)

Thus, some of us surrender ourselves into the hands of our doctor, just as Paul Cowan did when he could not make the decision about whether to have a bone marrow transplant: he decided to go with his original physician's advice because she was his guide. Bob S. also chose a procedure that only one doctor recommended, and he credits that procedure and that physician with saving his life.

On the other hand, some of us attempt to force our wills onto our doctors. But even those of us who try to do this by making many demands are attempting to avail ourselves of our physicians' control. By controlling those who appear to have some measure of power in this foreign land, we can convince ourselves that we have not lost control over ourselves and our bodies. William Carlos Williams provides an example of this in his story "A Face of Stone." In it, a mother fears that her child is sick and insists that the narrator examine him:

> Twenty pounds and four ounces, I said. What do you want for a ten month old baby? There's nothing the matter with him. Get his clothes on.
>
> I want you to examine him first, said the mother.
>
> The blood went to my face in anger but she paid no attention to me. He too thin, she said. Look him body.
>
> To quiet my nerves I took my stethoscope and went rapidly over the child's chest, saw that everything was all right there, that there was no rickets and told them so--and to step on it. Get

him dressed. I got to get out of here. (The Doctor Stories, p.83)

Even though the child is healthy, his mother has convinced herself otherwise and thus experiences many of the same feelings of loss of control as if she had been ill herself. The above quotation demonstrates a way that may not be the best one for us to enlist a doctor's help, but when we find ourselves so off balance from illness, we may try anything to regain control.

By using Howard Brody's terminology, which we explored in the previous chapter, we may be able to learn better how our doctors can help us to accommodate to our illness and regain some measure of control. Brody argued that we are defined, in a sense, by the stories of our lives, not only the story of our pasts but also "the story one plans later to be able to tell about how one's life turned out" (p.49). Illness jeopardizes our life plans. An uncontrollable and uninterpretable force interrupts our story and substitutes another story that is inscrutable to us. The doctor, by listening to our story, which we no longer understand, and consulting with our bodies through the art of physical diagnosis, may be able to make an interpretation for us. She acts as a sort of reader, or literary critic, of our story. We termed earlier her act of understanding as the process of recognition. The act of interpretation begins the process of accommodation. By interpreting our story for

us, our physician makes it clear to us and allows us to incorporate it into our revised life plans. As Brody writes:

> Physicians, because of their special knowledge and societal role, have special powers to construct stories and to persuade others that these stories are the true stories of the illness. (p.182)

These powers are evident in John Gunther's book, Death Be Not Proud, a memoir of his son's struggle against a brain tumor. In the following passage Gunther already knows his son's diagnosis; recognition has taken place, but he still is unsure of the interpretation.

> Then I went to Montefiore for a long conversation with Davidoff, a celebrated neurosurgeon to whom I tried to outline the entire case. I asked him flatly if he had ever known a glioma multiforme to be cured. He hesitantly adduced recessions, but not cures. How long, I wanted to know, had the longest case in his experience lasted. Four years, he replied. (pp.101-2)

The power of the physician's word can be awesome. In this case, it is an inescapable forecast of doom. The life stories Gunther and his son had been writing have lost their grounding. Theirs cannot compete with the physician's version. The struggle becomes apparent in an earlier passage, which appears just after a different doctor has made a similar interpretation:

> The rest of the summer is the story of pillars in a search. There might be some ray of hope

> somewhere despite Penfield's death sentence. But we must act quickly...The thought never left us that if only we could defer somehow what everybody said was inevitable, if only we could stave off Death for a few weeks or months, something totally new might turn up. (p.48)

We see here the fragility that we experience in illness once we have lost the power to determine our life plan and our dependence on our doctors to interpret these critical events for us. Gunther and his wife are so dependent on their physicians' interpretations of their stories that the physicians' pronouncements take on the quality of a sentence. If the Gunthers were still in control of their story, they would have been able to shrug off Dr. Penfield's opinion as erroneous and substitute their own prediction of the future. For example, if they had the conviction that a miracle would intervene to heal their son, they would not have been shaken by their doctors predictions of the "inevitable."

Interpretation thus functions as the first step in the process of accommodation. Having our stories explained to us, however, is not the end of the process. The next step begins almost at the same time as the first. I will term it "reorganization." For the Gunthers, this involves battling the illness with the hope that if they are able to defer the end for even a short time, they might be able to unearth a cure. They have replaced their fragility with the

determination to shape their own story given the realities they face.

The concept of reorganization takes us back to Sally Gadow's fourth level of the dialectic between body and self. Her first three levels described the unity between body and self, its disruption when the body is unable to respond to a demand made on it, and its repair once the body is trained to respond to that demand. In the fourth level, the unity is broken by illness; here the self cannot simply train the body to perform a particular task since it has lost control to the disease. For example, if a spinal cord injury were to leave me paralyzed below the waist, no matter how hard I work to teach my body how to walk again, I would never develop the skill to do it. In this level, the body becomes a subject instead of an object to be manipulated by the self. It demands that its needs and limitations be understood and respected. Thus, if I have a fever, I will feel fatigued and be forced to rest.

Gadow argues that once we enter this fourth level in illness, in which the body becomes a subject, we have several options on how to adapt to the new situation. The self can attempt to master the body and thereby objectify it. This is only possible if an accessible cure for the illness exists, allowing us to resume our original life plan. If no cure is available, the self will remain limited

to the realities of the body, and our life plans will continue to be jeopardized. The next option Gadow suggests involves the self disengaging from the body: the self can negate the body's "'mineness' in emotional and perceptual terms" by mastering "the abstract object body" through scientifically comprehending it (p.179). Thus I can create the illusion that I control my body through my understanding of it; however, my self cannot be reinstated as master through this process. To go back to spinal cord injury example, I may understand all the scientific details of my injury and thereby create the illusion that I have some control when, in fact, I will still be limited to a wheel chair. Accommodation to my new life plan has not occurred; all that I have accomplished is to create an emotional distance from my body by intellectualizing. Intellectualization may serve the physician, who needs to maintain a degree of detachment to be effective, but it does not help us, as patients, to accept and adjust to new life plans.

Gadow argues against attempting to master the abstract concept of the body; she terms this approach "the negative view of aging and illness" (p.179). Instead, she favors adopting the idea that "the body in illness and aging insists...that its own reality, complexity, and values be supported" (p.180). She advocates accepting the body as a subject and another part of the self "with the same intrinsically valid claims as any other part of the self

(emotional, intellectual, etc.)" (p.180). She argues that for the struggle to be transcended, we must accept the body for what itself even with its new limitations. Thus a new equilibrium can be achieved.

If we wish to accept our bodies in this fashion, we must recognize that they continually make demands on our selves in illness and health. The difference in illness is that the body makes additional and different demands. Cassell effectively makes this point about the demands our bodies make in health:

> [The body] cannot be ignored because it continually makes demands for food, warmth, sleep, and so on, demands that must be met if we are to function effectively. There is a certain automatic quality in the demands and in the way they are generally met. We do not consider food, sleep, or warmth a demand of the body; we simply think that we are hungry, tired, or cold and do something about it. The automatic aspect comes about because we have organized our lives in a manner that almost makes the body, as a demanding agent, invisible. (The Healer's Art, p.151)

Viewed in this light, the loss of control in illness that we have been exploring throughout this thesis represents unwanted and unexpected changes in our life plans. Accommodation, therefore, means recognizing the changes and incorporating them into a revised life plans. Thus, caring for a colostomy can become routine and eventually will not seem like concession to an illness.

The physician's role in this process includes recognizing these changes and helping us to accommodate to them. Psychiatrist David Reiser identifies four factors that play a role in how we respond to this reorganization:

(1) the patient's capacity to react flexibly to change;
(2) the severity and meaning of the illness;
(3) the support system; and
(4) the effectiveness of medical care. (p.80)

Each of these factors places its emphasis on different individuals and elements playing a role in an illness. The first factor focuses on us, the patients. Whether we are able to accommodate to the necessary changes imposed by our sick bodies depends on our abilities to adapt. A sickly, elderly person does not have the same resilience as a generally healthy younger person. An elderly woman would face far more severe emotional and mental difficulties in recovering form a broken hip than would an athletic twenty-one-year-old.

The second factor concerns the severity and meaning of the illness for us. The more severe, painful or disabling the illness, the more difficult it will be for us to accommodate it into our lives. Less obvious is how the meaning of an illness can have an impact on us. Reiser provides a good example of this: "A man whose father died of a heart attack will spend his life fearing the event in himself; if

it happens, he may be devastated even when his prognosis, from a physiological standpoint, is good" (p.82).

The third factor emphasizes those around us when we become ill and the support they provide. Paul Cowan in his battle with leukemia derived a great deal of strength from the love and attention he received from his family and friends. He writes in the following passage of the support he received from his mail:

> The mail came at 10:30, and a big stack of letters heartened me even more than a heavy flow of visitors or phone calls. I loved letters from people who had been ill and described their experiences, letters from old friends who recalled events I'd forgotten...letters from people who remembered an article I'd written, a favor I'd done, a joke I'd told. They reached into my frightened isolation and reminded me that I had been important to people in ways I hadn't known. They reminded me that it made a difference, in the world, whether I lived or died. (p.33)

The patient I worked with, Bob S., provides another example of this familial support. He relates that at one point in his illness when his kidneys had stopped functioning and he suffered from severe uremia, he began to feel that he was losing consciousness and that if he did, he would die. He describes that his doctors believed that this would be his end, but he and his wife refused to give up. She sat by his bed for hours reading him baseball statistics from the newspaper so that he could fight to focus his thoughts on something and stay conscious. He says that his physicians

were amazed because all the patients they had ever seen with that level of uremia had died, but Bob managed to survive until his kidneys recovered. He credits his wife with saving his life. The sort of support by family and friends that Bob S. and Paul Cowan enjoyed can make a great difference in how we adapt to an illness.

The last of Reiser's factors turns its attention to the medical practitioners. How effective we find medical treatment to be works on two levels. On a scientific one, with the proper use of medical knowledge and technology, physicians can often cure our ailment, decrease its severity, or lessen our disability. In light of this, our ability to reorganize our lives becomes much easier. The other level concerns the support we derive from our relationships with our physicians. The doctor-patient relationship itself has powerful, though often intangible, therapeutic effects, some of which we have explored in this thesis. Reiser writes:

> Our curing potential should be used to the maximum. We should treat people not syndromes. In order to achieve this, we must begin to redefine what we do. We must begin to see that the medicine of understanding, empathy, and compassion is just as important and must be administered with just as much care as the solutions we inject and the tablets we prescribe. (p.84)

The goal of this thesis is to provide some understanding of the doctor-patient relationship and to sensitize us

to the power and therapeutic value it contains. Unfortunately, no algorithm exists to tell us or our physicians how to maximize these strengths. It rests on our ability to form interpersonal relationships based on trust, openness, empathy and compassion. In all my reading I found that the goal of the doctor-patient relationship was best articulated by Oliver Sacks:

> It is the function of medication, or surgery, or appropriate physiological procedures, to rectify mechanism--the mechanism, the mechanisms, which are so deranged in these patients. It is the function of scientific medicine to rectify the 'It'. It is the function of art, of living contact, of existential medicine, to call the latent will, the agent, the 'I', to call out its commanding and coordinating powers, so that it may regain its hegemony and rule once again--for the final rule, the ruler, is not a measuring rod or clock, but the rule and measure of the personal 'I'. These two forms of medicine must be joined, must co-inhere, as body and soul. (Awakenings, p.251)

Chapter Five

The Doctor-Patient Relationship in Cancer Ward

Alexander Solzhenitsyn's Cancer Ward lends itself well to a discussion of the doctor-patient relationship and the effects it can have on individuals. While the novel lacks many examples of successful doctor-patient relationships, it provides a plethora of ones where the physician and patient work against each other. Still, the novel demonstrates most of the concepts explored in this thesis.

Cancer Ward is set in a hospital in Central Asia in the mid-1950's. The story primarily concerns the story of two patients: Pavel Rusanov, a middle-level bureaucrat in the Stalinist system, and Oleg Kostoglotov, a World War II veteran, who was imprisoned for years in a forced labor camp for an imagined political crime and was then exiled to a remote Central Asian village. The two have been admitted to the same ward to be treated for their cancers. Although the novel provides an allegory for the sickness of Soviet society in the 1950's as seen by Solzhenitsyn, it does

provide a realistic portrayal of its characters and their experiences in a cancer ward.

The first patient we meet is Rusanov. He has entered the hospital because of a large, fast-growing tumor on the right side of his neck, which he still believes is not cancer even though he has been admitted to a cancer ward. The chief physician for the ward, Ludmila Dontsova, encourages his mistaken belief by assuring him he does not have cancer. She practices under the principle that "the patient must never be frightened, he must be encouraged" (p.78), even if it means deceit. In addition, she believes that doctors have the right to make decisions for patients; "without that right there'd be no such thing as medicine" (p.77). This posture cuts off meaningful communication between doctor and patient. Instead, Dontsova expects her patients to silently submit to her treatment plan for them with a blind trust that she will do what is best for them. Conversation between doctor and patient becomes meaningless since no decision-making can occur then. Physician/ethicist Jay Katz addresses this passage from Cancer Ward and its implications when he writes, "For conversation to be meaningful both parties must be entitled to make decisions and to have their choices treated with respect" (p.xv). Katz argues that this sort of communication leads to mutual trust. Without it, doctors may not tell their patients the truth or even speak to them at all; the doctor-patient

interaction then comes down to a scientific problem that the doctor must solve. To have respect for the patient, Dontsova believes, compromises the physician: "There was no place left for such feelings in the squares of logic" (p.445).

In this environment, patients on the cancer ward struggle to have their needs met: they must fight on their own to escape their aloneness, grasp at their doctors' words while knowing they may not be true, and wrestle to accommodate to their situations with only the support of their fellow patients. Left on their own, some patients seize on unrealistic expectations about their diseases and prognoses.

Dontsova's ideal patient is Ahmadjan, a young Uzbek, who translates for his fellow tribesmen on the ward who do not speak Russian. He believes absolutely what the physicians tell him: that while he has cancer and it is serious, it can also be cured. Ahmadjan devotes most of his time to trying to be cheerful and agreeable and to learning the routines of the ward. Fortunately, he has an early cancer that responds well to treatment.

Rusanov, on the other hand, is less than Dontsova's ideal. His demanding and uncooperative nature, along with his preoccupation with social status, makes him difficult for Dontsova, her staff and the other patients on the ward.

Rusanov only agreed to enter the hospital when the mass on the side of his neck had become so large that he could not turn his head. It had taken control of his life:

> The hard lump of his tumor--unexpected, meaningless and quite without use--had dragged him in like a fish on a hook and flung him onto this iron bed--a narrow, mean bed, with creaking springs and an apology for a mattress. (p.9)

Rusanov has been separated from his life outside the hospital by his tumor, separated from his family, his work and his social status. This is the isolation we experience from the world around us when we fell ill, which was explored in Chapter One. Rusanov's tumor has interrupted his life story: "...the tumor was growing like a wall behind him, and on his side of it he was alone" (p.15). He cannot even distract himself from thinking about it. Rusanov experiences the same self-involvement that David Reiser described earlier in this thesis.

> But affairs of state did not succeed in diverting him or cheering him up either. There was a stabbing pain under his neck--his tumor, deaf and indifferent, had moved in to shut off the whole world. There again: the budget, heavy industry, cattle and dairy farming and reorganization--they were all on the <u>other</u> side of the tumor. On <u>this</u> side was Pavel Nikolayevich Rusanov. Alone. (p.16)

Though Rusanov searches for a way out of his loneliness, the means available to him are not optimal. His physicians do not offer him honest recognition. Instead, he

latches on to denial of his problem, something Dontsova has encouraged by assuring him that he does not have cancer. By denying his illness, he does not have to admit he has left the world of the healthy and entered that of the sick. His goal of eliminating his unsightly nuisance as quickly as possible indicates that a concern with appearance dominates his thinking. When one of the nurses seems not to notice the mass, he is delighted: the wall which he imagines between them has been denied; he really has not entered the land of the sick. Ironically, the nurse does not appear to notice his tumor precisely because Rusanov now lives in the land of the sick: such a sight is commonplace there.

Rusanov has been left by the staff to interpret his story for himself, to recognize his plight without their honest guidance. They are concerned only that he cooperate with the treatment regimen they design for him. He, however, has no clear understanding of the seriousness of his condition (Dontsova continues to tell him that he does not have cancer and manages to hide the truth from him by giving him the diagnosis of lymphoma, a medical term he does not understand) and as a result, balks at their treatment proposal of intravenous chemotherapy. Dontsova manages to get her way by bullying Rusanov into agreeing; she suggests that even though it is not cancer he could still die. This does not constitute a therapeutic alliance. Dontsova and Rusanov have joined forces only to the extent that they

agree on what they are fighting: his disease. Dontsova has no understanding of Rusanov's needs in addition to his desire for cure. She does not offer him recognition or help at accommodating to his situation.

Without the staff's guidance, Rusanov flounders; he doesn't know how to determine his life story. When his injections do not immediately resolve the tumor, Rusanov becomes despondent. The injections make him feel ill instead, and he confuses this with a worsening of his overall condition, believing that his death is imminent:

> Death, white and indifferent--a sheet, bodiless and void--was walking toward him carefully and noiselessly, on slippered feet. Stealing up on Rusanov, it had caught him unawares. He was not only incapable of fighting it; he could not think, make a decision or speak about it. (p.255)

In fact, Rusanov's tumor does respond to the therapy, and within weeks it begins to melt away. Failure to appropriately recognize his situation then leads to a failure of appropriate accommodation. Rusanov's observation that his tumor has begun to disappear leads him to believe that he is cured; he soon begins to demand that he be discharged. On the other hand, Dontsova knows that she cannot cure his lymphoma; she can only prolong his life a little. She agrees to discharge him admitting to herself that he will be dead within a year. He leaves believing that his disease has been vanquished and he will be able to resume the life

he led before he became ill. In reality, he will not be able to continue in that life plan for long, and he is no better prepared to face his illness than when he first entered the hospital.

These sorts of failures of accommodation abound in Cancer Ward. Aysa, a lively, pretty, seventeen year-old girl tells Dyomka, one of the other patients, that she has only entered the hospital for a check-up. She peppers her conversation with Dyomka him with stories of her life outside the hospital and how she will return to that life shortly. In fact, she has breast cancer and will require a mastectomy. When she learns this she is devastated, believing that being disfigured in this way will end her life. She tells Dyomka of the mastectomy and her fears about it, just after she has heard what her physicians have planned for her. She cries on Dyomka's pillow, convinced that no one will ever love her. In her hysteria, she pleads with him: "Listen to me, you'll be the last one! You're the last one who can see it and kiss it. No one but you will ever kiss it! Dyomka, you at least must kiss it, if nobody else!" (p.394), and as he does, she begs him to "remember it." To lay the blame for this pathetic scene at the feet of Aysa's physicians for failing to help her accommodate to her situation may be unjust: possibly, no physician may have been able to better guide her through this illness. However, the physicians in Cancer Ward did nothing to mitigate

Aysa's inability to effectively adjust to her circumstances. Different physicians might have been able to help her adjust to the realities of her disease and the changes she must make in her life plan to accommodate it.

Another patient, Shulubin, has similar difficulty adjusting to his situation. He has cancer of the rectum and is scheduled to have a colostomy procedure as part of the resection of his tumor. Shulubin's physicians prior to his admission initially failed even to recognize his illness for themselves, let alone communicate it to him. They diagnosed his rectal bleeding and pain as hemorrhoids and dysentery. Shulubin made his own diagnosis when he felt the tumor in his rectum with his own finger. Now that a course of treatment has been determined, Shulubin despairs more: not only does he fear that he will die but he also fears that to survive may be worse than death because of the unpleasantness of his colostomy. He convinces himself that if he lives he will lose the company of all others since they will be disgusted by him. What his physicians offer him, therefore, does not rescue him from the isolation imposed by his illness and allow him to regain control over his life. Instead, he believes that his cure, a colostomy, will make permanent his residence in the world of the sick. His attitude does not constitute accommodation to his situation since it does not allow him to adapt better to the facts of

his lot: he has cancer and his best opportunity for cure involves a colostomy.

Other characters in Cancer Ward do manage to be recognized and to accommodate to their situations. Sibgatov, with an incurable tumor on his lower back, an open, smelly, running sore, has been left no other life plan by his illness. He has come to realize that he will die and that nothing can be done for him. In fact, if being recognized is a way to escape isolation, Sibgatov has achieved a degree of this: he interprets the attention he has received during his many treatments and the few extra weeks he has been given as a result of those treatments, as an expression of caring from his doctors; they have not abandoned him:

> But even this miserable life, consisting of nothing but medical treatments, orderlies' quarrels, hospital food and games of dominoes, even life with that gaping wound in his back was good enough for his pain-racked eyes to light up with gratitude every time the doctors came on their rounds. (p.451)

Sibgatov understands the truth of his situation and has been able to adjust to it. He has a life plan. He not only sees his disease clearly but also sees what his doctors, especially Dontsova, have tried to achieve with him. "They peered at each other in silence, defeated but staunch allies..." (p.431). The relationship they share has helped him to accept his fate. They have a therapeutic alliance even though it failed to vanquish his disease.

Kostoglotov also manages to come to terms with his fate. He demands that his physicians enter into meaningful conversation with him and see him as an individual, not a scientific problem. He feels similarly to Paul Cowan who writes that it was important to him that his doctors see him as "a person who mattered, and not as an inert body on a hospital bed" (p.32). Kostoglotov does this by challenging his physicians, and forcing them to justify every decision they make concerning his treatment. "Kostoglotov had learned how to be ill, he was a specialist in being ill..." (p.143). He defies his physicians' logic; he refuses to be a scientific problem for them to solve. He arrives at the hospital nearly dead and after twelve radiation therapy sessions returns to life. But, although he realizes that he is far from cured, he demands to stop treatment. This baffles Dontsova when he is doing so well.

> "Obviously, there's no logic." Kostoglotov shook his shaggy black mane. "But maybe there needn't be any, Ludmila Afanasyevna. After all, man is a complicated being, why should he be explainable by logic?...Yes I did come to you as a corpse, and I begged you to take me in...And therefore you make the logical deduction that I want to be saved <u>at any price</u>! But I don't want to be saved at any price!...I came to you <u>to relieve my suffering</u>!...And you did....I'm grateful and I'm in your debt. Only now let me go. (p.75)

For Kostoglotov, living means having some measure of control over your life. Not having control means not being free; this is what made life in the labor camps so horrible and

why he cannot surrender total control to his doctors. Instead, he resists and negotiates over every treatment they suggest. Kostoglotov realizes that this is not the ideal therapeutic relationship and mourns about this in a letter to fellow exiles in his village:

> Generally speaking, no one will condescend to discuss such methods with me. There's no one willing to take me on as a reasonable ally. I have to listen in on the doctor's conversations, make guesses, fill in the guessed parts, get hold of medical books--this is how I try to establish the situation. (p.294)

That Kostoglotov maintain some control becomes even more critical when he learns that part of the treatment of his seminoma has been injections of Sinestrol, a female hormone that will make him impotent. He finds this out on his own by piecing together information he has read and overheard. He believes that this treatment may be too high a price to pay for his health. He searches for an ally to help him with the decision. Since the typical doctor-patient relationships on the ward do not offer this sort of alliance, he turns to one of the doctors with whom he shares a romantic interest. The doctor, Vera Gangart (Vega), is the only one he trusts because of their special relationship. At one point in the novel, he adamantly refuses a blood transfusion until Vega appears to give it. Then he immediately submits:

> For a man like Oleg who had to be permanently suspicious and watchful it was the greatest pleasure in the world to be able to trust, to give himself to trust. And he trusted this woman, this gentle ethereal creature. (p.328)

During the transfusion, Kostoglotov manages to connect with Vega; for a moment they are united in purpose and means of achieving a particular goal. "The bottle, the needle and the transfusion formed a task that united them in a common concern for someone quite apart from themselves, someone whom they were trying to treat together and cure" (p.331). At this point, Kostoglotov brings up the dilemma he faces concerning his hormone therapy and the price he must pay if he continues it. Their conversation leads him to agree with Vega that there is more to life than sexual intercourse. For the time being he decides that impotence is not too high a price to pay for living. His resolve evaporates, however, once the sexual tension he feels towards Vega surfaces again; and it does as she is about to leave the procedure room where he has been receiving the transfusion and he feels a strong desire to kiss her hand. Vega's resolve collapses as well after she leaves him and experiences a similar passion for him.

Kostoglotov then turns to one of the male doctors, a surgeon named Lev Leonidovich, for advice. Leonidovich understands better than most of the doctors at the hospital the power of the doctor-patient relationship. He knows that if he listens to patients and gives them a reassuring word,

he can have a profound effect on their outlook, even if his reassuring comment is deceitful:

> But another patient sounded the alarm.
> "Tell me," she said "why do I have these pains in the spine? Perhaps I have got a tumor there as well?"
> "O-oh no-o." Lev Leonidovich smiled as he drawled out the words. "That's a subsidiary development." (He was telling the truth: a secondary tumor was a subsidiary development). (p.358)

Leonidovich counsels Kostoglotov sincerely that life holds more important things than relationships with women; they are only a distraction. He seems to be speaking from experience; in fact, he appears so engrossed in the memory of that experience that he does not see that he has failed to recognize Kostoglotov's concern. To Kostoglotov, right now preoccupied with his thoughts of Vega, nothing is more important than relationships with women. Relationships with women are a part of Kostoglotov's identity, something he has been denied since his imprisonment and exile. The treatment therefore represents a threat to his identity, one that none of his physicians has tried to recognize.

Kostoglotov finds that he has to wrestle with this dilemma alone and accommodate his life plan accordingly to the results of his decision. He nurses his feelings toward Vega and weighs against them the impossibility of him ever having a life of the sort he dreams given his exile and his illness. Finally, he decides he wants to leave the

hospital. He has mixed feelings for his physicians because "in one sense they had saved him, in another sense they had destroyed him" (p.454). He is alive but has been robbed of his sexuality, which is for him an important part of his identity. He tells Dontsova: "All in all, I feel I've been doctored to death. I want you to let me go" (p.455). She agrees, but he takes no pride in having regained control of his life. He still has not discovered what his new life plan will be.

Kostoglotov hurries to make arrangements for his discharge. He is pleased with himself for being able to manipulate all the details to his advantage: he plans out all the paperwork he needs so he will not get held up and arranges for his clothes to be taken out of storage early. He has regained control of his life. The promise of a new beginning becomes more vivid when Vega invites him to spend his first night out of the hospital at her apartment.

Kostoglotov leaves the hospital rejoicing in his new life. He feels like he has been reborn, like he has been given an extra piece of life. He still, however, has not come to terms with his fate, with what life plan he must adopt. After several episodes of self-doubt about whether he belongs in the world of the free with Vega or in the world of exile, he finally makes it to her apartment, only to find that she is not home. He retreats ready to

surrender to his fate. A rumor that his political exile may end sets him off after Vega again with renewed hope of being able to have a life together with her. But while pressed up against an attractive young woman on a crowded trolley, he realizes that the sexual tension he feels is the limit of the relationship with a woman to which he can aspire, given the hormone treatment he has gone through, and this would not be enough for him in his relationship with Vega:

> They had come to a high-minded agreement that spiritual communion was more valuable than anything else; yet having built this tall bridge by hand together, he saw now that his own hands were weakening. He was on his way to her to persuade her boldly of one thing while thinking agonizingly of something else. And when she went away and he was left in her room alone, there he'd be, whimpering over her clothes, over every little thing of hers, over her perfumed handkerchief. (p.522)

Kostoglotov has finally accepted that his life has limitations. He must eat and sleep; he has been exiled and can not move around his country freely. Similarly he is ill and as a consequence of his treatment he has become impotent. He has now learned to accept this just as he accommodated to the other limitations in his life. He has, in a sense, achieved Sally Gadow's fourth level by accepting the limitations of his body. He must now make the most of what has available. He does just this by using his position as someone just released from the hospital to finagle his train ticket and getting a good seat on the train. He has

accommodated to a new life plan, one that includes senseless pain and suffering from his illness.

Thus far it seems as though Cancer Ward lacks any positive images of physicians who are able to recognize their patients and help them to accommodate to appropriate life plans. This happens not to be the case. It develops part way into the novel that Dontsova herself has fallen ill, most probably with cancer. When she can no longer deny that she has become sick, she goes to her teacher, Dr. Dormidont Oreshchenkov, as her own physician. He is an elderly, distinguished man from an earlier time, who no longer practices. He belongs to a different school of thought than Dontsova about the doctor-patient relationship. He believes that doctors should "treat each patient as a subject on his own" (p.425), in other words as a whole person, not a specific organ system with a problem: "the patient's organism isn't aware that our knowledge is divided into separate branches. You see the organism isn't divided" (p.425).

Oreshchenkov puts his teachings into practice in the way he treats Dontsova. He listens to her story in a room where patients would come and "sit through long painful conversations on which their whole future depended" (p.415). While listening,

> Dr. Oreshchenkov would never look to one side without good reason. His eyes reflected the constant attention he gave both patient and visitor; they never missed a moment for observation, never wandered toward the window or stared down at the desk or the papers on it. (p.415)

Here the process of recognition occurs. Dontsova immediately feels that she has an ally and that she no longer has to struggle with her fears alone.

> She looked straight at Oreshchenkov, glad that he was alive, that he was there and would take all her anxiety upon himself. He stood upright without the faintest stoop, shoulders and head set as firmly as ever. He always had this look of confidence. (p.414)

Dontsova much to her chagrin, but with ironic justice, has become like one of her patients. She tells Oreshchenkov her story, confides her fears and then hangs on his every word, attempting to decipher their hidden meanings. He suggests that she take sick leave for a bit, and she thinks to herself: "He had chosen the mildest term of all! Did it mean, did it mean that there was nothing wrong with her?" (p.419). Like her patients, Dontsova has lost her balance because her life plan has become jeopardized. She has lost control of her body and her life and, as a result, feels isolated just as Rusanov did. She tries to think about other things and not her illness, but winds up thinking about it "all too much" (p.416):

> The moment she admitted the disease existed, she was crushed like a frog underfoot....Her world

> had capsized, the entire arrangement of her existence was disrupted. She was not yet dead, and yet she had had to give up her husband, her son, her daughter, her grandson, and her medical work as well...In a single day she had to give up everything and suffer, a pale-green shadow, not knowing for a long time whether she was to die irrevocably or return to life. (p.446)

Oreshchenkov senses her plight: he listens to the cues she gives him about when she is tiring of a conversation and about how much she wants to know of her illness. For example, he gently suggests that she might want to take a look at her own x-ray but does not push when she refuses. He understands how defenseless she is and chooses his words carefully so as not to deceive or mislead her and also not to overwhelm her. He suggests she go to a clinic in Moscow for additional consultations and possibly treatment. She wonders if this means that he believes her case is so serious that they cannot handle it at her own hospital; he quickly assures that she is mistaken and not to look for hidden meanings in his words. He only wants to be sure that she gets the best attention.

In this way Oreshchenkov gently nudges Dontsova into accommodating to her new life plan. She will have to leave her old life behind: "Her ties to life, which seemed so strong and permanent, were loosening and breaking, all in the space of hours rather than days" (p.449). But at the same time she finds that she can function still. She efficiently makes arrangements for Vega to take over in her

absence and makes her final rounds on the ward. She realizes that she is "getting acclimatized to her misfortune" (p.450). In this new life, Dontsova learns she cannot treat her patients as she had before.

> She no longer had the authority to pass verdicts of life and death upon others. In a few days' time she would be lying in a hospital bed, as helpless and as dumb as they [her patients] were, neglecting her appearance, awaiting the pronouncements of her more experienced seniors, afraid of pain,... She might even...long to get rid of her hospital pajamas and go home in the evening, as most people do, as though this were the greatest happiness in the world. (p.450)

With this new sensitivity she has discovered, Dontsova views her patients differently. She agrees to Rusanov's and Kostoglotov's requests to be discharged. She realizes that their treatments might constitute needless suffering--she admits to herself that Kostoglotov's hormone treatment is "barbarous" (p.456)--and that patients have a right to an opinion different than what medical science dictates. She now understands that those opinions have just as much validity if the patient has been presented the truth. As a result, she lets Kostoglotov decide whether he will stay after she finally admits to him what the side effects are of his hormone treatment.

Dontsova has gained this new insight because her illness forces her to see her patients' perspective. It has been the goal of this thesis to help my readers and myself

to develop a similar sensitivity without having to fall gravely ill. The literature of illness, both fiction and nonfiction, is well suited to this task. It allows us to glimpse the experience of another without having to actually stand in their shoes. Armed with this sensitivity, we may be better prepared to recognize another's anguish, keep him company in his lonely plight and help him to accommodate to his new situation.

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