COMMITTEE CERTIFICATION OF APPROVED VERSION

The committee for Marissa Anne Gostanian certifies that this is the approved version of the following thesis:

PHYSICIAN, HEAL THYSELF: DESIRE AND IMPAIRMENT IN PHSYICIANS' WRITINGS

Committee:

____
Anne Hudson Jones, Ph.D. Supervisor

____
Michael O'Boyle, M.D., Ph.D.

____
Ronald A. Carson, Ph. D.

____
Dean, Graduate School

PHYSICIAN, HEAL THYSELF: DESIRE AND IMPAIRMENT IN PHYSICIANS' WRITINGS

by
Marissa Anne Gostanian, B.A.

Thesis
Presented to the Faculty of The University of Texas Graduate School of Biomedical Sciences at Galveston
in Partial Fulfillment of the Requirements
for the Degree of

Master of Arts

Approved by the Supervisory Committee

Anne Hudson Jones, Ph.D.
Michael O'Boyle, M.D., Ph.D.
Ronald Carson, Ph.D.

May, 2006
Galveston, Texas

Key words: Medical Education, Addiction, Physician Experience, Literature and Medicine

© 2006, Marissa Anne Gostanian

ACKNOWLDGMENTS

First, to the men and women who have lain bare their imperfections, impairments, and humanity, I thank you for showing me a glimpse of your life, struggle, and journey. To those who have collapsed under the pressures of the medical system and life, I salute your laborious effort and perseverance. And finally, to the wounded healers, thank you for acknowledging your weakness and persevering to become part of the "brotherhood of those who bear the mark of pain."

I want to thank my colleagues at the Institute for the Medical Humanities in Galveston, Texas, who discussed and dissected this project with me, suggested articles, and furthered my thinking about fiction, memoir, impairment, and healing. To my friends who allowed me to be a temporary hermit and then lovingly embraced me back into a life of relationships, I thank you for your laughter, empathy, and reminder of what it is to live a life with and for others. To Michael O'Boyle, M.D., Ph.D., and Ronald A. Carson, Ph.D., I thank you for your careful critique and commentary on my writing that helped me think more deeply about the subject at hand. Anne Hudson Jones, Ph.D., your meticulous eye, sharp mind, and seeming boundless effort have helped turn a young hopeful into a budding scholar. Without your prompting I would not have attempted to delve into this complex subject, and without your encouraging words I would not have completed it.

To my family, I have come this far only because of your love, support, and belief in me that runs deeper than I can describe. I offer this thesis as small token of my appreciation of your sacrifice, friendship, toil, laughter, and love; without you, I am nothing. Thank you.

PHYSICIAN, HEAL THYSELF: DESIRE AND IMPAIRMENT IN PHYSICIANS' WRITINGS

Publication No.____________

Marissa Anne Gostanian, B.A.
The University of Texas Graduate School of Biomedical Sciences at Galveston, 2006

Supervisor: Anne Hudson Jones, Ph.D.

Traditionally medicine and literature have lain on opposite ends of the spectrum, but for some physicians, writing is complementary to medicine. I examine selected works of physician-writers that express the difficulties and triumphs of their journeys through their medical career. Through narratives we can learn not only about the world of medicine, but also about the reasons physicians act and respond as they do.

According to Jacques Lacan, desire is the quality of *more* that leaves us lacking and wanting something else. This quality of *more* is what I will explore in physicians' writings. Lacanian desire is one key to the prevalence of the number of impaired physicians.

This work can be a catalyst for change within the medical profession as instructors see and understand the difficulties that lie ahead for their students. Preventive and treatment plans for impaired physicians may include identifying desire as opposed to simply treating behaviors.

TABLE OF CONTENTS

Page

ACKNOWLDGMENTS	IV
CHAPTER 1: INTRODUCTION	1
CHAPTER 2: LACANIAN THEORY	20
CHAPTER 3: THE DESIRE TO CURE	28
CHAPTER 4: THE DESIRE FOR RELATIONSHIPS	43
CHAPTER 5: THE DESIRE TO ESCAPE MEDICINE'S DEMANDS	58
CHAPTER 6: SOLUTIONS FOR HEALING	73
BIBLIOGRAPHY	84
VITA	

CHAPTER 1: INTRODUCTION

In the summer of 2005, I took a course titled Physician-Writers. My first assignment was to write about anything I wanted regarding the authors we studied in class. As I looked back over my notes and textbooks, one theme continued to show its dominance: the theme of desire. Desire was everywhere—the desire to heal, the desire for relationships, the desire to escape medicine's demands, the desire for sex, for drugs, for power, for money. Arthur W. Frank extrapolated Lacanian desire in his work *The Wounded Storyteller* to show how we are always lacking, that it doesn't matter whether we are given what we want we will still want more.[1] As I looked at these writings, I saw that same absence and the same pull and draw for *more*.[2]

My discovery did not stop with these writings; I began to see this desire for *more* everywhere. It showed up in television shows, religious discussions, movies, and conversation. I began to realize that Lacanian desire is everywhere; it is universal and all-encompassing. When I read Abraham Verghese's *The Tennis Partner*, I began to wonder if desire could lead to impairment, and if doctors had a harder time with addiction of any kind because of the very nature of medicine. As I explored the cycle of desire in both fiction and memoir, I, like Verghese, became convinced that desire and impairment are intertwined. This thesis only begins to explore this connection. It does not cover all memoirs or the works of all physician-writers. I focus on desire within the medical community, but I also attempt to show how this kind of desire is universal as well. I often change back and forth between the pronouns *them*, *us*, *they*, *we*, *themselves*, and *ourselves*. When I use first-person pronouns such as *us* or *our*, I am talking about

[1] Arthur W. Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago: University of Chicago Press, 1995), 36. Subsequent references to this book will be cited parenthetically by page numbers.

[2] I go into detail about desire and its root in Jacques Lacan's theory in my next chapter.

humanity and the universal qualities of desire and humanity. When I use third-person pronouns like *them* or *they*, I am talking specifically about the medical community. I am taking a specific example of humanity—doctors—and applying their experiences to the rest of us.

I spend chapter 2 dissecting my definition of *desire* and specifically *Lacanian desire*, but I want to define here what I mean by *impairment* or an *impaired physician*. The American Medical Association (AMA) defines the *impaired physician* as, "one who is unable to practice medicine with reasonable skill and safety to patients because of physical or mental illness, including deterioration through the aging process or loss of motor skills, or excessive use or abuse of drugs including alcohol."[3] Impaired physicians are further subdivided into three types: the incompetent; the malicious or unethical; and the mentally disturbed. Obviously, these types can encompass any number of maladies, not just drug or alcohol impairment. I use the term *impaired physician* very liberally throughout this thesis: it can include someone with a physical impairment, like a physiological addiction to drugs or alcohol; it can mean someone who is emotionally distant; it can mean someone who overtreats patients and consequently harms a patient; or it can mean someone who copes with the demands of medicine through destructive ways such as sexual promiscuity.

The prevalence of impaired physicians is at about fifteen percent of physicians at any one time.[4] However, this number is not steadfast, and it represents only the number

---

[3] American Medical Association, "Physician Impairment," excerpts from AMA policies, H-95.955, July 2004, https://www.ama-assn.org/ama/publication/category/8153.html (accessed February 16, 2006).

[4] David R. Gastfriend, "Physician Substance Abuse and Recovery," *Journal of American Medical Association* 293, no. 12 (March 23/30, 2005): 1513-15. Merry N. Miller and K. Ramsey McGowen, in "The Painful Truth: Physicians Are Not Invincible," *Southern Medical Journal* 93, no. 10 (October 2000): 966-73, categorize impaired physicians into four main categories: suicide, substance abuse, depression, and divorce. They claim that the number of suicides ranges between twenty-eight and forty per 100,000 physicians, and that there is a twenty-seven to thirty percent rate of depression in interns and that twenty-five percent of residents are depressed. The prevalence rates among physicians for substance abuse vary widely, according to Miller and McGowen, but they claim that there is a ten to twenty percent higher divorce rate among physicians than among the general population.

of physicians who have admitted their impairment or are being treated by impaired-physician services; the actual number is much higher. The AMA encourages each state to provide services to its physicians so that they can be properly treated.[5] Impairment has become a large problem that has drawn much attention both by writers and by policymakers. Scholars must look at this trend in physician impairment and discuss the reasons for its existence and its possible solutions. If Jacques Lacan is correct and the cycle of desire is universal and can never be satisfied, no solution will ever be sufficient. However, if scholars and educators can learn what contributes to making the cycle of desire more treacherous and pervasive, then perhaps there can be more effective measures taken to help prevent and treat impaired physicians.

In chapter 2 I look at Lacan's theory of desire and Arthur W. Frank's interpretation of Lacan's theory of desire. My next chapters are divided by the different desires that they examine: the desire to cure, the desire for relationships, and then the desire to escape the demands of medicine. Finally, in chapter 6, I return to the words of two physician-writers who propose some solutions for healing and discuss how these solutions can be integrated into our current medical education system.

With the recent media coverage of James Frey's "memoir," *A Million Little Pieces*, the question of the difference between fiction and memoir has been in the forefront of many people's minds.[6] Frey sold his book as a memoir, a tale of his own life experience as a recovered drug addict. Only after it had been published, promoted by Oprah, and sold more than three million copies, the truth emerged: Frey's book is more fiction than fact. A huge controversy ensued about what can be learned from his work; people were upset because they felt deceived about a "real life" situation. Does the fact that the book was more fiction than fact mean that lessons cannot be learned from fiction? Or did the controversy ensue because we are upset because we have been lied to and we believed what someone else told us to believe? The line between fact and fiction

---

[5] American Medical Association, H-95.955.

[6] James Frey, *A Million Little Pieces* (New York: Doubleday, 2003).

may be blurry. However, when a person intentionally tricks us into believing that his or her story is truth when in fact it is fiction, we are left angry and bereft of compassion; we feel violated. We have walked through the land of memory with the author and now we find out our guide has been an imposter.

Patricia Hampl in *I Could Tell You Stories: Sojourns in the Land of Memory* discusses the unreliability of memory. In a small vignette, she shows how she lied about a number of details, not because she was intentionally trying to deceive the reader, but because it is the way the writing process works. Why do we invent and why should anybody write a memoir? Hampl answers this question by saying, "I don't write about what I know, but in order to find out what I know."[7] This act of putting our deepest fears, joys, triumphs, and failures on paper is a way to communicate and identify with the *other*. Hampl continues:

> The authority of memory is a personal confirmation of selfhood, and therefore the first step toward ethical development. To write one's life is to live it twice, and the second living is both spiritual and historical, for a memoir reaches deep within the personality as it seeks its narrative form and it also grasps the life-of-the-times as no political analysis can.[8]

Hampl's book illustrates why people tell their stories—it is an ethical act of reliving life. Through her analysis we can see why memoir is a powerful tool for learning about others. I have chosen to use memoirs as a way of understanding the lives of doctors.

But memoir/autobiography is not the only way of conveying truth about a life or lifestyle. Fiction can also communicate the truth about life or a situation. For example, Robert Coles in *The Call of Stories* points out how fiction can be used as a transformative

---

[7] Patricia Hampl, *I Could Tell You Stories: Sojourns in the Land of Memory* (New York: W. W. Norton, 1999), 27.

[8] Ibid., 36-37.

tool for the reader. His wife, an English teacher, relays a conversation she had with one of her students about the transformative nature of literature. The student says:

> I don't know how to say what happens when you read a good story: it's not TV and it's not reading the paper. It's not the movies, because you get into them faster, but you're "out" real fast: you forget what you've seen, because the next flick has come, and you're looking at it. With a novel, if the teacher holds you back and makes sure you take things slowly and get your head connected to what you're reading, then (how do I say it?) the story becomes yours. No, I don't mean "your story"; I mean you have imagined what those people look like, and how they speak the words in the book, and how they moved around, and so you and the writer are in cahoots.[9]

What the student has learned is that the story becomes a part of you and you a part of it. You become an accomplice in the writing, forming, and teaching of the book—you're "in cahoots" with the author because you have imagined the world the writer was trying to create, while adding your own details.

Coles claims that fiction is a way for the reader to get a glimpse into the lives of others. No person can live every type of life; fiction is a way of showing another's life and, by doing so, affects our own. "We all remember in our own life," Coles reflects, "when a book has become for us a signpost, a continuing presence in our lives. Novels lend themselves to such purposes; their plots offer a psychological or moral journey, with impasses and breakthroughs, with decisions made and destinations achieved."[10] The reader can begin to understand the way another person lives his or her life. Henry James

---

[9] Robert Coles, *The Call of Stories: Teaching and the Moral Imagination* (Boston: Houghton Mifflin, 1989), 64.

[10] Ibid., 68.

defines a real novel as "a direct impression of life."[11] Fiction is an impression of life; it is a way of explaining life and illustrating a specific life, time, and place. Even though it is created, it should not be relegated to a second choice for telling the truth.

I have chosen to consider both memoirs and pieces of fiction in this thesis because both genres are helpful in their own way in examining the lives of doctors. Memoirs have the authority to say, "this is my truth," but we must remember that all memoirs are constructed and fiction is an inherent quality in them. The fiction does not lessen their power or authority, but confirms that we must take all "true-life events" with a grain of salt—the retelling of the event inherently reshapes the actual experience. As Coles asserts, fiction conveys truth and can shape a reader's point of view.

I have chosen to use three short stories, one novel based on true events, and four memoirs to illustrate how doctors describe the practice of medicine. After reading twenty-six different books by physician-writers, I have chosen to focus on eight. My primary criteria for selecting specific writings were variety in time, place, and perspective and significance for my inquiry. I have chosen works by two women and six men, three of whom represent minority voices. Some worked in rural areas and others worked in urban areas. Anton Chekhov and William Carlos Williams were chosen as representatives of famous writers who were also physicians, and who wrote in earlier times. Samuel Shem wrote a controversial and significant novel whose terminology has infiltrated the current medical system. David Hilfiker's writings were some of first to address medical error and mistakes. Rafael Campo and Abraham Verghese both still practice medicine and teach writing to medical students and are proponents of medical humanities. Kate Scannell began as an academic medical professional, moved to being a clinical AIDS ward director, and is now currently the co-director of Kaiser Permanente's Ethics Department. Susan Onthank Maters no longer practices medicine. Scannell and Mates speak in different voices than the men and round out the circle of chosen

---

[11] Henry James, quoted in Samuel Shem, *The House of God* (New York: Dell Books, 1978), 7. Subsequent references to this book will be cited parenthetically by page numbers.

interlocutors. I go into detail here in introducing their works because I want to focus more narrowly on the topic at hand—desire and impairment—in my chapters.

Anton Chekhov, who wrote in Russia during the 1890s, is one of the best known physician-writers. From the time I was introduced to Chekhov in high school until today, he has remained in my mind as a significant writer but for no apparent reason. In the introduction to *The Essential Tales of Chekhov*, Richard Ford pinpoints what I could not articulate. He says:

> Chekhov seems to me a writer for adults, his work becoming useful and also beautiful by attracting attention to mature feelings, to complicated human responses and small issues of moral choice within large, overarching dilemmas, any part of which, were we to encounter them in our complex, headlong life with others, might evade even sophisticated notice. Chekhov's wish is to complicate and compromise our view of characters we might mistakenly suppose we could understand with only a glance. He almost always approaches us with a great deal of focused seriousness which he means to make irreducible and accessible, and by this concentration to insist that we take life to heart.[12]

Chekhov's characters in "Ward No. 6" may, at first glance, look like fairly flat characters whose actions are fairly predictable, but when delving deeper into the short story we uncover more depth and uncertainty about their actions. This story is directly about patient-physician encounters, the desire for relationships, and the fine line between genius and insanity. But why include a short story written in Russia in 1892 in this thesis? First, it shows that these themes are not new, nor are they specific to America but rather they are universal. Ford thinks that the reason we enjoy Chekhov today is "because his stories from the last century's end feel so modern to us[; they] are so much

---

[12] Richard Ford, introduction to *The Essential Tales of Chekhov*, ed. Richard Ford, trans. Constance Garnett (New York: HaperCollins, 1998), vi.

of our own time and mind."[13] Why do we read literature for clues on how to live life? Ford says:

> As readers of imaginative literature, we are always seeking clues, warnings: where in life to search more assiduously; what not to overlook; what's the origin of this sort of human calamity, that sort of joy and pleasure; how can we live nearer to the latter, further off from the former? And to such seekers as we are, Chekhov is guide, perhaps *the* guide.[14]

From Ford's introduction, we can see not only why we should read literature—it can be a guide for our lives—but we also see why we should read Chekhov—he is a master of irony, subtlety, and complex characters built in only a few pages. Apart from Chekhov's literary genius, I chose to include Chekhov because I want to show that the problems I soon discuss are universal problems; they have spanned time, location, race, and medical training; they can affect any doctor anywhere at any time.

Chronologically, the next physician-writer wrote and practiced medicine in the poor, industrial part of northern New Jersey in the first part of the twentieth century. Like Chekhov, William Carlos Williams is widely known for his literary work. He is especially known for his poetry. In both high school and college, I read his poems, and they remained with me, particularly "The Red Wheelbarrow." His ability to comment on the mundane, common, and daily interactions of life with reverence and awe has stayed with me as I have read and written over the years. Like "The Red Wheelbarrow," his *Doctor Stories* uncover universal themes and significant moments for patients and physicians alike. I have chosen only one of his short stories, "Old Doc Rivers," for the

---

[13] Ibid., xvi.

[14] Ibid., xviii.

obvious reason—it is about an impaired physician.[15] In the introduction to Williams' *Doctor Stories*, Robert Coles comments on the importance of Williams's short stories:

> These stories are, really, frank confidences extended to the rest of us by one especially knowing, dedicated physician who was willing to use his magical gifts of storytelling in a gesture of—what? We all require forgiveness, and we all hope to redeem our own missteps—hope, through whatever grace is granted to us, to make every possible reparation. Words were the instrument of grace, also, for the rest of us, the readers who have and will come upon these marvelously provocative tales…. He extends to us, really, moments of a doctor's self-recognition—rendered in such a way that the particular becomes the universal, and the instantly recognizable: that function, the great advantage of first-rate art.[16]

According to Coles, Williams wrote in an attempt to redeem his mistakes, to thank his patients, and to give a voice to those who had sustained his work and his art. He had a passion for people and an insatiable curiosity about the innermost workings of people's lives. The portraits he creates in his doctor's stories are ways of working through the injustices, stereotypes, frustrations, and triumphs of medicine. These stories are attempts to situate the universal while simultaneously showing how the particulars extend to humanity as a whole.

---

[15] William Carlos Williams, "Old Doc Rivers," in *The Doctor Stories*, comp. Robert Coles (New York: New Directions, 1984), 13-41. Subsequent references to this story will be cited parenthetically by page numbers. Many of Williams's other short stories could have been included in a discussion of impaired physicians, but for the sake of space, I chose only one. For example, the physician in "The Use of Force" (pp. 56-60) is so consumed with desire that he cannot stop himself from physically harming his patient so that he can get a throat culture. In addition to physically cutting her to get his culture, the question of sexual desire comes into play. He says that he could have "torn the child apart in my own fury and enjoyed it. It was a pleasure to attack her" (p. 59); but was it his pleasure to attack only her mouth, or was it a rape of the throat? He says that a "blind fury, a feeling of adult shame, bred of a longing for muscular release [were] the operatives [for his attack]" (p. 60). This physician had crossed the lines of an appropriate patient-physician encounter; he was physically and emotionally impaired.

[16] Robert Coles, introduction to Williams's *The Doctors' Stories*, (New York: New Directions, 1984), xiv-xv.

The next work, chronologically, is Samuel Shem's *The House of God*. I have chosen to include this book for a multitude of reasons. The first is that Shem's novel nicely illustrates how desire and impairment are in tandem with one another within the structure of medicine. This book is difficult to categorize because it is technically a piece of fiction, but it is based on Shem's intern year at Beth Israel. Although it has been controversial since its publication in 1978, its merits as an "insider's perspective" on the world of medicine are great. Delese Wear's article "*The House of God*: Another Look" not only describes some of its publication fiascos but also comments on its controversial positions.[17] Wear points out that "there have been frequent attempts to discredit the book's content and, often, the author himself."[18] It has often conjured negative reactions because Shem's descriptions of academic medicine are deeply disturbing, even to the point of one author's claiming that the book's characters "verbally attacked, abused, and berated patients to the detriment, if not the demise, of the latter."[19] But, as Wear shows, the book has been controversial, not disregarded. For many young physicians, *The House of God* mirrors certain aspects of their medical training, and they can identify with Roy Basch and the other interns.[20] One response in the *New England Journal of Medicine*'s letter section shows this type of identification. A graduate of a residency program was

[17] Delese Wear, "*The House of God*: Another Look," *Academic Medicine* 77, no. 6 (June 2002): 496-501.

[18] Ibid., 497.

[19] C. Timothy Floyd, "Attitudes in *The House of God,*" *New England Journal of Medicine* 305 (August 13, 1981): 411.

[20] Kathryn Montgomery Hunter points out in "The Satiric Image: Healers in *The House of God*," *Literature and Medicine* 2 (1983): 135-47, that "those who took their training before 1965 tend to regard the book as an embarrassment or a betrayal or worse" (p. 137). She also claims that it is not a great book, but an important one. She continues, "Shem's image of what the healer should be is not very different from his critics'. Roy Basch's values and the novel's are good ones: first-rate medical diagnosis and treatment, attention to care for the patient as well as to cure, therapeutic minimalism, and health care institutions that make these things feasible" (p. 145).

> [s]topped entirely—not by disgust, but by my own pain…. Shem has done what few in American medicine have dared to do. That is to share an unpolished, unglorified, and amazingly unegotistical experience of that revered institution, the internship. He has revealed the depths of caring, pain, pathos, and tragedy felt by all of us who spend our indentured servitude to our profession in caring for patients who have been rejected by much of the medical system.[21]

Shem manages to deromanticize the practice of medicine, claiming that he is telling the truth about academic medicine. This book, for him, was part of the resistance of the 1960s and early 1970s; the book was his attempt to fight the injustices of academic medicine through non-violence. His particular medium of resistance was literature.[22] Shem says that this book came out of what he calls

> "*Hey wait a second!*" moments—those moments many of us experience every day when we see, or feel that something is unjust, cruel, militaristic, or simply not right. We usually let these moments pass. We do nothing to resist them. But the moments came so fast and furious in the internship, they could neither be ignored nor passed by. We had been brought up to notice, to take "life as it is" and turn it on the spindle of compassionate action to make it more like "life as it should be." This is resistance.[23]

Shem could not allow what he considered to be unjust and cruel moments to pass without saying or doing something. He needed to expose the injustices of academic medicine to

---

[21] Velma Campbell, "More on *The House of God*," *New England Journal of Medicine* 305 (November 19, 1981): 1289.

[22] See Samuel Shem, "Fiction as Resistance," *Annals of Internal Medicine* 137, no. 11 (December 3, 2002): 934-37.

[23] Ibid., 934.

the world. He was "telling the truth, with some art."[24] Can there be too much art in a piece of literature that claims it is telling the truth?

Anne Hudson Jones regards *The House of God* as an important medical *Bildungsroman*;[25] but she identifies the book as more fiction than fact.[26] This is important to her because

> the degree of fictionality in these works is important, not just because it helps determine the reader's "willing suspicion of disbelief," but also because physicians are bound by ethical oaths and codes of confidentiality in regards to patients' medical histories.[27]

We must remember that Shem took real life events and, with the help of art, put them onto paper. Shem's book makes no mention of patients' medical histories or how he has protected patient confidentiality. This begs the question: are the patients real people, or did he create fictional characters? Without any sort of mention of privacy protection, it is difficult to know how much we can take for truth and how much is fiction. This does not, however, discredit Shem's message. Although he has no explicit purpose statement, "the entire novel is an implicit cry for change, for help, for some kind of sane reform that will salvage young interns before they damage themselves with meaningless sex, drugs, or

---

[24] Ibid., 935.

[25] "*Bildungsroman* is a combination of two shorter German words: *Bildung* meaning education, development, or formation; and *Roman* meaning novel…. Traditionally it is the story of a young man's coming of age or to maturity…. By the end of the *Bildungsroman*, the young hero typically has found a philosophy of life he affirms; he has found his life work, and he does it optimistically. He has been saved from doubts by the need for action, and he has accomplished his major task: the shaping of the many facets of his personality into a fully integrated, unified self." Anne Hudson Jones, "The Medical *Bildungsroman*: The Making of a Physician-Writer," *Connecticut Scholar*, no. 8 (1986), 38.

[26] Ibid., 42.

[27] Ibid.

suicide."[28] In his book Shem is resisting "brutality and inhumanity, isolation and disconnection."[29]

There is controversy over its place in academic medicine today. It is outdated and emotionally difficult to read. It was written before the AIDS epidemic and such free sex is no longer an option. Also, medicine's ethical and technological advances have been huge—particularly in regards to end-of-life care. Although the medical profession still faces similar problems as it did while Shem wrote this novel, there have been advances in working to solving these problems. It is clear that it raises important questions for the world of medicine—questions like, Is this still the way the internship works? Can I identify with any of the characters: Basch, Leggo, the Fat Man, Jo? What can I do to fight against the isolation and loneliness? How can I resist? I have chosen to include this work that lies somewhere between fact and fiction precisely because it raises these types of questions. It evokes an emotional response from its readers and it demands some sort of action, whether a dismissal or an attachment to the truth that it exposes. Shem's *The House of God* is used in medical education for the very reasons I have pointed to above: it blurs the lines between fact and fiction, while asking difficult questions and exposing the inhumane treatment of residents and patients; it tells the truth with some art.

With a remarkably different tone and format than that of Shem's novel, David Hilfiker's *Healing the Wounds: A Physician Looks at His Work* lays bear the same themes, frustrations, and difficulties. Although not much is published about this piece of writing, his article "Facing our Mistakes," published in the *New England Journal of Medicine*, stirred conversation about medical error and mistakes.[30] *Healing the Wounds*

---

[28] Ibid., 44.

[29] Shem, "Fiction as Resistance," 935.

[30] David Hilfiker, "Facing Our Mistakes," *New England Journal of Medicine* 310, no. 10 (January 12, 1984): 118-22. G. Gayle Stephens's article, "Physician Failure as Portrayed in Literature: Hilfiker, Arrowsmith, and Lydgate," *Pharos* (Winter 1988): 24-28, points to Hilfiker's memoir as a "new and prophetic voice" and says that he "belongs to the tradition of heroic medical missionaries in seeing medicine as a profession of public servanthood, an expression of the physician's commitment to religious and personal values." But she later criticizes him when she calls him arrogant: "So long as one imagines

is an honest and humble attempt to look at one physician's work, as well as medicine as a whole. It is strikingly different than Shem's angry, satirical novel of resistance; it is much more generous to both physicians and the profession of medicine. That is not to say that it is passive or complimentary to medicine, but its tone and approach are completely different than those of Shem's work. Yet both books have the same goal: to help bring about change in medicine. I chose to include Hilfiker's book for three reasons. First, its themes and accusations of medicine are central to the question of what contributes to impaired physicians. Second, I wanted to contrast it with Shem's novel; while its goals are the same as Shem's, the approach is completely different than Shem's. Finally, I chose this autobiography because of its honesty and humility. This is, chronologically speaking, the first autobiography that I chose. It is a thoughtful piece of work that poses the problems he encounters but also offers solutions for healing.

The final physician-writer of fiction, Susan Ontank Mates, won the John Simmons Short Fiction Award in 1994, the year her collection of short stories was published. Her short stories—particularly the story on which I focus, "The Good Doctor"—address the moral dilemmas that humans face. On the jacket cover to *The Good Doctor,* we are told that our heroine, Dr. Helen van Horne, is torn between "her dedication to medicine and her own requirements as a human being—what many of us might call her weakness."[31] We are again faced with the same question of what fiction can teach us about reality. Mates weaves together the universal themes of sex, passion, death, will, and desire in a rather short but powerful story. Through her characters, the reader is faced with conflicting ethical dilemmas and a powerful tool for reflection. Anne Hudson Jones says "a main feature of medical *Bildungsromans* is the presentation of ethical problems and dilemmas."[32] She also points out that the young hero in traditional

---

oneself to be prevented by circumstances from doing better, one never has to face the intrinsic limits of one's therapeutic possibilities, a defense that leaves the ego deluded but intact."

[31] Susan Onthank Mates, *The Good Doctor* (Iowa City: University of Iowa Press, 1994). Subsequent references to this book will be cited parenthetically by page numbers.

[32] Anne Hudson Jones, 45.

Bildungsromans has "many diverse experiences: he may travel a bit, as in the picaresque novel; he meets many people and hears their life histories; he is exposed to many new ideas; and he is exposed to many women."[33] In a parallel way, "The Good Doctor" is a reversed medical *Bildungsroman*. Instead of a young man, we have an older woman; instead of a young doctor, we have an experienced one. Instead of traveling to new places, she comes back from Africa; instead of a man being exposed to many women, she is tempted by only one man. However, like most *Bildungsromans*, at the end of the novel, Helen van Horne has found a philosophy of life that she can affirm, at least, for the time.

This story forces the reader to examine his or her own prejudices, expectations, and ethical points of view. The reader watches van Horne waver between ethical and unethical, only to have to reassess his or her own conceptions of right and wrong. This story does not paint anything in black and white but leaves the ending ambiguous, forcing the reader to examine his or her own actions and perceptions. Again, we see how fiction can express truths in a powerful story that imitates life.

The next physician-writer is Rafael Campo, a poet and memoirist. I chose his memoir *The Desire to Heal: A Doctor's Education in Empathy, Identity, and Poetry* because he explicitly looks at the desire to heal and how that desire can function in medicine.[34] He does not leave his human desires at the door when he enters the medical clinic; he discusses his desire to heal, his sexual desires, and even his desires not to participate in the healing process. His work is honest, although at times I wish it were less so. His book tells his personal journey and, at times, borders on narcissistic.

Campo is a gay, Latino-American who was educated and now teaches at Harvard, the same institution where Shem was educated. Campo does not talk much about his medical training; he focuses on his undergraduate career and then his actual medical

---

[33] Ibid., 38.

[34] Rafael Campo, *The Desire to Heal: A Doctor's Education in Empathy, Identity, and Poetry* (New York: W. W. Norton, 1997). Subsequent references to this book will be cited parenthetically by page numbers.

practice. The only glimpse we get of Harvard medical school is that it seemed to focus on getting money for AIDS research rather than preparing its students to care for people with AIDS (p. 162). Although the AIDS epidemic had not yet come about when Shem was writing *The House of God* or going through residency, both Campo and Shem express the same dissatisfaction with their training; they are not prepared to take care of patients. AIDS wreaked havoc both physically and emotionally for the physicians on the front lines. Campo shows how he treated many AIDS patients poorly by keeping them marginalized. But through Gary, his friend, he learned to recognize himself in medicine. He admits:

> Not only did I woefully regret the hostility and the destructive impulses I had felt toward my patients with AIDS … I also felt guilty for having been spared. Since Gary and I had so much in common, it seemed tragically unfair that he should be so ill, and I healthy…. All of these similarities, once so unrecognizable, enabled me too readily to see myself in Gary's place.
>
> And yet I had not, until now, found the time to get to know him. The M.D. after my name, so long interposed between me and the world of the infirm … the M.D., the brusque abbreviation of My Desire, only served to heighten my guilt. (P. 140)

It is moments like this, these honest and tragic examples of failing to identify as a physician and then managing to empathize so completely with a patient that make his collection of essays compelling. Campo's memoir is one example of a physician's journey. It does not represent all physicians everywhere, but his insights into practicing medicine are glimpses into the medical world and show how desire can contribute to emotional impairment.

While Campo's memoir chiefly dealt with emotional impairment in physicians stemming from desire, Abraham Verghese approaches impaired physicians from both the emotional and physical point of view. Verghese is an Indian who grew up in Ethiopia and

then practiced medicine in rural Tennessee, El Paso, and San Antonio, Texas. He has a Master of Fine Arts in creative writing and is part of the University of Texas Health Science Center at San Antonio's Center for Medical Humanities and Ethics while still practicing as an infectious disease specialist. His writings on storytelling, impaired physicians, and relational medicine are widely published.

Verghese's *The Tennis Partner* describes his friendship with a fourth-year medical student and then first-year resident who is a recovering drug addict. But Verghese does not just relay the story of David Smith's rise and fall in medicine; he also extends his commentary to physician impairment in general. Verghese has researched physician impairment along with his colleague, Thérèse Jones, and has written about its prevalence and effect in medicine. His relationship with David Smith deeply affected him.[35] Verghese's *The Tennis Partner* was the catalyst for my investigation into desire and impaired physicians. The questions—Do physicians have a stronger tendency toward addiction and addictive behavior than other professionals? And, if so, why?—remained in my head while reading his story. His story reveals the difficulties and triumphs that physicians must face both personally and professionally; the tendency to become emotionally or physically impaired while treating patients is simultaneously disturbing and intriguing.

The final physician-writer whose work I have chosen to include in my thesis is Kate Scannell. The lessons she learned and communicates in her book *Death of the Good Doctor* are worth exploring in the context of desire's relationship to impairment.[36] Like

---

[35] For example, see Abraham Verghese, "Physicians and Addiction," *New England Journal of Medicine* 346, no. 20 (May 16, 2002): 1510-11. Also, see Thérèse Jones, "On Becoming a Doctor," MS IV Capstone Course, Spring 2005, Center for Medical Humanities and Ethics, University of Texas Health Science Center, San Antonio.

[36] Kate Scannell, *Death of the Good Doctor: Lessons from the Heart of the AIDS Epidemic* (San Francisco: Cleis Press, 1999). Subsequent references to this book will be cited parenthetically by page numbers.

Campo and Verghese, she practiced medicine during the height of the AIDS epidemic.[37] And like all of our memoirists, she does not always paint herself in the best light; she admits her failures and imperfections. She chronicles her time as the clinical director of the AIDS program in Oakland, California, after abandoning academic medicine. She can not recall ever seeing a female doctor when she entered medical school, thus giving another perspective on how to practice medicine: from a woman's point of view. She writes the illness narrative of her patients while she herself is going through treatment for cancer. She is telling her own story while telling the stories of her patients. They are intertwined; she cannot write about her patients without writing about herself, and vice versa. She is in relationship with her patients and thus she exemplifies what it means to practice relational medicine.

I have chosen Scannell's memoir for its truth and honesty, and for the themes she brings to life in her book. Particularly her stories "Death of the Good Doctor" and "Sleeping with the Fishes" illustrate how the desire to cure and the desire for relationships can impair a doctor. Many of her other stories also show how desire and impairment are interrelated, but some of them focus on the patient or the patient's family rather than the physician's behavior.[38] Her book is hopeful amidst descriptions of death, illness, and pain. It gives a voice to the nameless and shows how one doctor can influence the lives of many patients. Not only is she a woman, but she is a sick woman, writing about sick people. Her insight and perspective are unlike those of any of my other physician-writers.

These eight writers all discuss similar themes and problems that arise in medicine. It is because of their differences, however, that I find their stories compelling; the

---

[37] Although I have chosen not to look in depth at Abraham Verghese's *My Own Country: A Doctor's Story* (New York: Vintage Books, 1995), it is an important AIDS memoir. Verghese relays his own struggle to identify and treat patients in rural Tennessee when the AIDS epidemic erupted. I chose not to include it as a primary text because I did not want one person's voice to overpower other voices, and I did not always find the connection between desire and impairment in that memoir as I found it in *The Tennis Partner* and the other stories I have chosen.

[38] For example, see "Loving Someone to Death" (pp. 57-78) and "An Ordinary Death" (pp. 127-36), both in *Death of the Good Doctor*.

problems discussed, the solutions offered, and the pain of finding their way are universal. These problems are seemingly inherent in medicine whether practicing in Russia in the late 1890s or being a physician in urban America today. The same problems prevail. The problems encompass men, women, Caucasians, Latinos, Indians, rural and urban practices, and many generations. These are the universal problems of medicine.

CHAPTER 2: LACANIAN THEORY

> "But one has to make some sort of choice," said Harriet. "And between one desire and another, how is one to know which things are really of overmastering importance?"
>
> "We can only know that," said Miss de Vine, "when they have overmastered us."
>
> —Dorothy L. Sayers, *Gaudy Night*[39]

When faced with conflicting desires, we cannot choose one desire until we are overmastered, but isn't the very essence of desire forceful and overwhelming? Doesn't it demand more? According to the French psychoanalyst Jacques Lacan, this force is what continues the cycle of desire. True desire overtakes us and we cannot dislodge ourselves from the choices we have made, for good or ill. The deepest yearnings of our souls continually guide, shape, and force us to behave in certain ways, making satisfaction impossible if we act another way. Tragically, according to Lacan, we will never be satisfied even if we obey our needs, demands, and desires. This is the cycle of desire. Because our desires leave us wanting more, the constant pursuit of satisfaction can lead to the destruction of relationships, jobs, bodies, and selves.

Lacan takes Sigmund Freud's concepts of drive, desire, and sexuality and expounds upon them. From this, he develops a theory of desire. In its simplest form, the theory states that desire is situated in need and depends upon demand. The demand is a metonymic device symbolizing a need or drive within the person. Therefore, it is clear that the person does not have all that he wants or needs. Regardless of what the person receives, she will still want more, for it is not the stated object that is important, but rather some other internal drive that propels her forward for the demand to be fulfilled.

---

[39] Quoted by Perri Klass, *A Not Entirely Benign Procedure: Four Years as a Medical Student* (New York: Signet, 1987), 138.

"*As far as the object in the drive is concerned*," Lacan quotes Freud, "*let it be clear that it is, strictly speaking, of no importance. It is a matter of total indifference*."[40] The actual object is not what matters; what matters is that we are always left wanting the Other. Both Freud and Lacan use the term *petit a* where the *a* in question stands for *autre* (other) as a way of "differentiat[ing] the object from (while relating to) to the '*Autre'* or '*grand Autre'* (the capitalized 'Other')."[41] Throughout Lacan's writings and lectures, he consistently refers to the *petit a* and how it functions in the formation of a person's desires, therapy, and restoration to health.

The Other is something outside of ourselves: it is what we cannot have; it is what we are always seeking. But it can never be realized. For example, if I were an elementary school teacher who consistently had difficult children in my class year after year, I might complain that all I need is one child each year who would behave properly, turn in homework, and have involved parents. If the following year my wish were fulfilled and I had a stellar child who brought me happiness and relief, then for a fleeting moment I would be satisfied. This satisfaction would last only until my next year's roster was posted and I hoped that I had two angelic children because one was great, but two would be heavenly. The cycle continues, for once I experienced the joy that came from teaching one great child I would want more children like that. And even if I had a perfect class, full of congenial and brilliant children for one year, I would not remain satisfied. I would want a challenge: I would want one child whom I could influence to go above and beyond her current performance. I would not be satisfied with perfection because I will always want the Other. I will always want whatever I don't have. And the closer I come to fulfilling my wishes, the more they change, morph, and become, once again, unattainable.

---

[40] Jaques Lacan, "The Four Fundamental Concepts of Psychoanalysis," in *The Seminar of Jacques Lacan Book XI*, ed. Jacques-Alain Miller, trans. Alan Sheridan (New York: W.W. Norton, 1981), 168. Subsequent references to this book will be cited parenthetically by page numbers. All quoted words in italics are original to Lacan.

[41] Jacques Lacan, *Écrits: A Selection*, trans. Alan Sheridan (New York: W.W. Norton, 1977), xi.

What drives this search for the Other? Needs. Desire. Demands. What is a need? When Lacan speaks of a *need*, he usually refers to an internal need such as hunger or thirst. When a person is hungry, she must go and find a way to satisfy this internal need. Needs are expressed through a lingual demand. Hunger pains turn into the phrase, "I am hungry." Through the identification of my internal need, and then through an expression of my need, I now demand sustenance. I attempt to satisfy my hunger by eating, through which I not only receive oral pleasure but also temporarily satisfy my need. However, my need will return, perhaps with more force than previously, and I will, once again, turn to food to satisfy not only my mouth but also my stomach. I must continue to eat. I will always want more. I can never be fully satisfied, for I desire food not only for my hunger, but also for my mouth, company for my soul, or something Other than simply food. The Other is elusive, not only for the psychoanalyst but also for the analyzand. The wish for the Other may be hidden and clouded by its relation to the sought-after object.

Lacan says that screens cloud and mask our true desires from ourselves. We are reaching for something that is mysterious and dynamic. How do we apprehend that which eludes us? "What is the desire which is caught, fixed in the picture which also urges the artist to put something into operation? And what is that something?" Lacan asks. He continues:

> In this matter of the visible, everything is a trap…. There is not a single one of the divisions, a single one of the double sides that the function of vision presents, that is not manifested to us as a labyrinth. As we begin to distinguish its various fields, we always perceive more and more to the extent to which they intersect. (Pp. 92-93)

The difficulty is that what we fix our gaze upon is not always there; it is constantly changing. As we begin to distinguish our goals, they multiply and turn into intricate webs of tangents all relating to the original goal. The journey to the end goal is a

constant cycle because our vision is always changing and there are screens that hide and morph our supposed goals. Constant change of vision and perception leads toward continual movement and the inability to grasp that which is sought. Even though we may profess one desire, we always want something else, something more, something Other. Our desires stem from an internal drive that Lacan deconstructs in his lectures. Both Freud and Lacan use the term *Trieb* to signify a physical drive. There are four parts of *Trieb* that are crucial to understanding what Freud and, consequently, Lacan mean by drive:

> First, *thrust* will be identified with a mere tendency to discharge. This tendency is what is produced by the fact of a stimulus…. Here … there is stimulation, excitation, to use the term Freud uses at this level, *Reiz*, excitation. But the *Reiz* that is used when speaking of drive is different from any stimulation coming from the outside world, it is an internal *Reiz*. (Pp. 163-64)

Our drive, our excitation, our thrust come from within. There are, of course, external stimuli, but the internal drive is what compels us to act in a particular manner. Lacan quotes Freud's claim:

> The constancy of the thrust forbids any assimilation of the drive to a biological function, which always has a rhythm. The first thing Freud says about drive is … that it has no day or night, no spring or autumn, no rise and fall. It is a constant force. (P. 165)

Because we are continually battling these drives, we cannot escape them. We must move until we can move no further; we must act until we are stopped; we must seek satisfaction until we give up in desperation. And even then, we are not released. We are still in the cycle of drive and desire. There is no escape, only a new goal, a new vision, a new attempt.

Drive does not end with the thrust and excitation; at the other end of the spectrum is satisfaction or *Befriedigung*. But what is satisfaction? "*The satisfaction of the drive is reaching one's* Ziel, *one's aim*" (p. 165). The final element of drive is sublimation. "Sublimation is also satisfaction of the drive, whereas it is *zielgehemmt*, inhibited as to its aim—it does not attain it. Sublimation is nonetheless satisfaction of the drive, without repression" (p. 165). Lacan does not assert that through sublimation our drives are satisfied, but rather, he moves us toward distinguishing between the impossible and the real. He questions whether the opposite of possible is necessarily impossible. Lacan asserts:

> The real is distinguished … by its separation from the field of the pleasure principle, by its desexualization, by the fact that its economy, later, admits something new, which is precisely the impossible….
>
> But the impossible is also present in the other field…. The idea that the function of the pleasure principle is to satisfy itself by hallucination is there to illustrate this—it is only an illustration. By snatching at its object, the drive learns in a sense that this is precisely not the way it will be satisfied. For if one distinguishes, at the outset of the dialectic of the drive, *Not* from *Bedürfnis*, need from the pressure of the drive—it is precisely because no object of any *Not*, need, can satisfy the drive. (P. 167)

These four aspects of drive—thrust, excitation, satisfaction, and sublimation—work together to create this constant force at work within our lives. We are driven by internal needs and, as we attempt to satisfy them, we find them to be indefinable and dynamic. They are outside ourselves, and we can never grasp them because we are always looking for the Other under the pretense of looking for the object. It is only when we accept that we can never appease our drives by obtaining an object that we will ever be able to rest. For, as Lacan says, "the phantasy is the support of desire; it is not the object that is the

support of desire. The subject sustains himself as desiring in relation to an ever more complex signifying ensemble" (p. 185).

We work only through signifiers. In other words, our language structure is only denoting what we are trying to communicate. When we attempt to identify what it is that we want, we are still talking only in symbols and never truly communicating what it is that we need. Because of this symbolic act, we find our goals evading us as we gain a new line of perception or gaze upon the object we are trying to obtain. We cannot ever see what we truly desire. "What one looks at is what cannot be seen," Lacan reminds us,

> If … the structure of the drive appears, it is really completed only in its reversed form, in its return form, which is the true active drive…. The true aim of desire is the other, as constrained, beyond his involvement in the scene. (P. 183)

Things are never as they appear; there is always more, something hidden and unidentified that drives us forward in our search. But we will never attain what it is we are seeking because there will always be more.

Frank in *The Wounded Storyteller* applies Lacanian desire to the experience of illness. Frank's work in illness narratives led him to illuminate how ill persons see and express themselves. His primary interest in Lacan's theory of desire is in relating it to the ill person's physical body and actions. But Frank's application helps to further develop Lacanian desire. He says:

> Desire [is] in a triad with need and demand. The need is fully corporeal and can be satisfied at that level…. The expression of the need is the demand, but the demand differs from the need itself…. The demand's difference from the need enlarges the context: the demand asks for more than the need it seeks to express.

Desire is this quality of *more*.[42]

Frank further illustrates that what we ask for is not necessarily what we need or truly desire, but the Other. When a child asks for one more story, glass of water, or hug at bedtime, he does not desire those objects, but rather more time with the parent, or delayed separation. He wants more. When he gets what he asks for, he changes his request because although his wishes are being fulfilled he is not yet satisfied. And according to Lacan, he never will be. He will always be left wanting more, wanting the Other.

The ill person in Frank's work functions as an example of the different ways sickness is represented through written expression. Lacan also discusses the ill person in his lectures, but he focuses on the analyzand. In psychology, the expressed desire may take precedence over the hidden desire, but there is always a latent agenda. In treating patients, analysts must attempt to uncover the deeper issue and lead the patient toward health.

Lacan examines an article written by H. Nunberg called "The Will of Recovery." In it he defines what he means by *recovery*, *restoration*, and *health*:

> By *recovery*, [Nunberg] means not so much *guérison* (cure), as *restauration* (restoration), *retour* (return)…. What, in the last resort, can drive the patient to have recourse to the analyst, to ask him for something he calls health, when his symptom—so the theory says—is created in order to bring him certain satisfactions? (Pp. 137-38)

Lacan goes further to say that "what motivated the patient in his search for health, for balance, is precisely his unconscious aim, in its most immediate implications" (p. 138). Our unconscious aims are what drive us toward health; we are driven by the force of our desires to find satisfaction. We are forced to find some way to satisfy our needs.

---

[42] Frank, 37.

Satisfying our needs can be a difficult and a neverending endeavor; what we are seeking, we rarely find. Physicians, like the rest of humanity, have needs, desires, and drives that must be satisfied. According to Lacan, desire permeates every aspect of life and can affect every person; there is no escape, only moments of respite. But desire is not intrinsically evil or even necessarily bad. It can be a catalyst for change and growth. The desire to help people is a common reason that many people give for practicing medicine, but it is when the desire to cure turns into an obsession or unwanted practice that it can become harmful. The desire to be alone to work through problems for one's self is not inherently wrong, but when the isolation no longer allows the person to connect and care for others this technique is harmful. The desire to be in relationships with people, to be loved and to love, is one of the greatest attributes of humankind. But when relationships are destructive, this need to be in relationship is no longer healthy. The desire to escape the demands of medicine is not uncommon, but when one can no longer function empathetically or in relationships with others, this escape mechanism is no longer satisfying, but rather devastating. These are the desires that I will focus on in the following pages.

Desire triggers overtreatment, isolation, and addiction. We need to be in community with one another, but physicians often are alone when they treat patients. The burdens of medicine lead many doctors to practice ineffective medicine or to burn out. While they must learn to survive in a field that does not value uncertainty or inefficiency, they must also deal with their own desire to cure and be a good doctor. Under these circumstances it is uncanny that there are any physicians who have not succumbed to the lures of addiction. It should not be surprising that there are many who have fallen prey to the overwhelming cycle of desire and have fallen into addiction. Because of the way contemporary medicine is structured, physicians have a difficult road to travel starting in undergraduate school and throughout their professional lives. There needs to be a change in the medical profession for these demands to dissipate, but until that change is made, physicians must learn to navigate the internal and external demands that drive their education and practice.

CHAPTER 3: THE DESIRE TO CURE

Physicians often conflate the desire to heal with the desire to cure. Medicine is a practice that adheres to these values: treating patients, making them better, and sending them on their way. In a world in which technology has evolved to a point where people are sustained artificially and often diseases have shifted from acute illness to chronic illness, it has become increasingly more difficult for physicians to accept that they cannot cure all their patients. With the increase of technological advances and the continual development of drugs and treatment, doctors are faced with the option of treating an aspect of a disease, rather than the entirety of it, because many diseases cannot be cured. Many ethical quandaries stem from this predicament: What should doctors treat? Can doctors overtreat a patient? Ethical difficulties may arise from the difference of opinions about life-sustaining treatment, especially when patients, families, and physicians disagree about treatment options. These are real dilemmas in present-day medicine and I posit that when a physician overtreats it is because she has not yet learned the difference between curing and healing. In addition to not recognizing the difference between curing and healing, impaired physicians are those who are obsessed with treating. This obsession is not the same as a physiological addiction to drugs or alcohol, but it does impair the physician because he is compelled to continually treat. Not every patient can be cured, but every patient can be healed. The physician has a unique opportunity to promote healing even when curing is no longer an option.

Books and articles published in medically related journals explore the power of healing and its difference from curing. Samuel Shem, David Hilfiker, Abraham Verghese, Rafael Campo, and Kate Scannell all explore the difference between curing and healing in their books. I reserve the term *cure* for a physical return to health whereas the term *heal* encompasses a physical as well as spiritual, emotional, or mental restoration. Verghese in his article “The Physician as Storyteller” says:

> Most of us found out, painfully, that in having no cure to offer, we actually had everything to offer. We discovered what the word "healing" meant and what made the horse-and-buggy doctor of a century ago so effective. By "healing" I simply mean crossing the traditional threshold of a medical-industrial complex and beginning to engage with the patients, with their story, on their turf, in their house, and engaging with their families and loved ones and their stories.[43]

For Verghese, engaging with his patients is the path to healing. As an infectious disease specialist, Verghese was part of the first group of doctors to see and treat AIDS in rural America. In the beginning there was very little to give his patients; he had to depend on healing rather than curing. He had no cure to offer; he had only himself.

His book *My Own Country: A Doctor's Story* (1995) chronicles his time and describes his patients in rural Tennessee in the beginning of the AIDS epidemic. He describes how he failed and succeeded at healing. Rather than offering his dying patients nothing, he offered them his compassion. His actions stem from this thought:

> All illness (particularly AIDS) has these two dimensions: a physical deficit and spiritual violation. And when there is no cure, the one thing we can offer is to really understand the story that is playing out, to aid and abet its satisfactory conclusion.[44]

Illness is not purely physical, and it is crucial for physicians to act and respond in a manner that recognizes the spiritual violation that has occurred. If doctors treat only physical maladies, many patients will return home still feeling violated. If only physical deficits are treated, both doctors and patients will always be left wanting more. The

---

[43] Abraham Verghese, "The Physician as Storyteller," *Annals of Internal Medicine* 135, no. 11 (December 4, 2001): 1014-15.

[44] Ibid., 1015.

patient will eventually have a physical illness that kills him and possibly will die without being healed. And the physician will remain feeling helpless and without any answers. Healing is possible and necessary for both the patient and the physician.

Charles M. Anderson makes a similar distinction between healing and curing in his article "'Forty Acres of Cotton Waiting to be Picked': Medical Students, Storytelling, and the Rhetoric of Healing":

> By healing, I do not mean bodily repair, though bodily repair can, as we will see, become a part of it. Nor do I mean to suggest that the medical student who tells the story was at one point well, that he or she has become ill, and now is on the way to a recovery of that earlier state of wellness. Instead, I point, as I did at the beginning of this essay, to a more realistic, more complex notion of healing, in which pain and confusion serve not simply to wound those who experience them but also to open a rhetorical space in which both new and silenced voices can be heard.[45]

Rhetorical space is what allows healing in health care. Anderson's article tells of a medical student who, by listening about cotton picking, helped heal a cranky, difficult woman. By *being with* the patient, by holding her hand and listening to her talk, the patient was brought from the emotional depths of her disease and began to have her wounds repaired.

Being with a patient is what can bring about healing according to many physician-writers. An excellent illustration of this statement is found in Shem's novel *The House of God* (1978). Shem is a psychiatrist who wrote *The House of God* after his year as a medical intern. This year inspired him to tell the truth as a way of resisting; he was

---

[45] Charles M. Anderson, "'Forty Acres of Cotton Waiting to be Picked': Medical Students, Storytelling, and the Rhetoric of Healing," *Literature and Medicine* 17, no. 2 (Fall 1998): 290.

resisting isolation, detachment, and the current status quo.[46] *The House of God* is technically a piece of fiction, but it based on his experience as an intern; the book provides a glimpse into one institution's residency program. We follow Roy Basch through his year as an intern; we are allowed into his head, house, and heart as he experiences the ups and mostly downs of his year.

One of the most controversial aspects of *The House of God* is the "Laws of the House of God." The final law, "The delivery of medical care is to do as much nothing as possible (p. 420)," is the one on which I will first focus.[47] pRoy's mentor is the Fat Man, also known as Fats, a second-year resident, who imparts his wisdom, mirth, and possibly demented ways on the interns. The Fat Man created the Laws of the House of God; the Fat Man shaped Roy into becoming a competent physician. Fats teaches the interns the term *gomer*, which stands for Get Out of My Emergency Room. Gomers are the elderly patients with both chronic and acute illnesses who never die and never leave. In fact, the first law is, "Gomers don't die." They are a constant part of internal medicine and thus the interns must learn how to treat them, or in Roy's case, not treat them.

Fats has taught his interns that the best way to get gomers to go home is to not treat them and they will improve on their own. When faced with a new patient, Anna, Roy decided to try not doing anything to see if she would recover. Miraculously she did. Roy reflects:

> My heart swung around on its apex with pride and I know that Anna was back and that I had proved scienterrifically that, just as Fats had said, to do nothing for the

---

[46] Shem, "Fiction as Resistance," 934-37.

[47] The Laws of the House of God: (1) Gomers Don't Die; (2) Gomers Go to Ground; (3) At a Cardiac Arrest, The First Procedure is to Take Your Own Pulse; (4) The Patient is the One with the Disease; (5) Placement Comes First; (6) There is No Body Cavity that Cannot be Reached with a #14 Needle and a Good Strong Arm; (7) Age + Bun = Lasix Dose; (8) They Can Always Hurt You More; (9) The Good Admission is a Dead Admission; (10) If You Don't Take a Temperature, You Can't Find a Fever; (11) Show Me a BMS Who Only Triples My Work and I Will Kiss His Feet; (12) If the Radiology Resident and the BMS Both See a Lesion on the Chest X-ray, There Can Be No Lesion There; (13) The Delivery of Medical Care is to do As Much Nothing As Possible.

> gomers was to do something, and the more conscientiously I did nothing the better they got, and I resolved that from that time on I would do more nothing on the gomers than any other tern in the House of God. (P. 109)

Most of the time Roy and the other interns under Fats' influence began to stop treating their gomers. As a rule of thumb, their gomers improved, went home, and the hospital began to believe that this group of interns was the smartest and best they had ever had. As residents rotated, Fats left them and they were introduced to Jo, a resident who overtreated, overmanaged, and overanalyzed every patient and doctor on her floor. She believed her interns were the smartest and most competent doctors because the gomers got better; she believed they were treating them. Instead, the interns were "buffing" the charts and pretending to do procedures and give medications.

Jo is a prime example of how the desire to cure can become destructive. If the Fat Man and Roy are correct that gomers only get better if no treatment is given, then Jo is harming her patients. But beyond that, Jo herself is being destroyed by her need to cure. Lacanian desire says that a need is formed, then it demands to be satisfied, and finally the desire for more rears its head and the person is trapped in a neverending cycle of dissatisfaction. Jo's whole life is medicine; she has no life outside of the hospital. Shem describes her:

> Like an overeager BMS [Best Medical School Student] trying to make an A, Jo would stay up the whole night writing obscure referenced discussions of the "fascinating cases" in the charts, each BLEEP and shriek and nurse's question echoing off the lonely tile walls making Jo feel real full and needed as she never felt full and needed outside the House of God. (P. 110)

Jo overtreats patients because to do so makes her feel needed in the hospital. She feels fullfilled. She is not satisfied unless she is treating a patient, adjusting doses, changing

tubes, and prescribing more medications. But as Lacan points out, she will never be fully satisfied. She gets temporary fulfillment while treating her patients because once they die, go home, or are transferred, she is no longer needed in that situation. She moves to another patient, another family, another situation and is satisfied until that patient is no longer hers. She continues this cycle through the floor and series of patients, never truly helping or healing. She is treating but they are not getting better. Nor is she. She remains stuck in the cycle of desire.

Roy and the other interns struggle through their first year of residency fighting conflicting directions and desires. Jo and the rest of the hospital hierarchy demand patients be treated and then dissected when they die. The Fat Man tells his interns not to do anything and shows them how to be a good doctor. In a conversation between Fats and Roy, Fats affirms:

> No, we don't cure. I never bought that either. I went through the same cynicism—all that training, and then this helplessness. And yet, in spite of all our doubt, we can give something. Not cure, no. What sustains us is when we find a way to be compassionate, to love. And the most loving thing we do is to be with a patient, like you are being with me. (P. 175)

The Fat Man, unlike Jo, had not fallen prey to the cycle of desire, at least not the desire to treat. He has learned the difference between curing and healing. And not only does he preach about the difference, he acts upon it. The Fat Man shows how to be with a patient when delivering bad news. He manages to do it with grace, honesty, and laughter. This is one of Roy's greatest lessons: watching the Fat Man tell a woman she is dying and then sit with her, hold her hand, play cards, and eventually laugh with her.[48] That woman will

---

[48] Shem admits: "This scene never happened in my reality as an intern. In fact, in those days there was never once any information taught to us on dealing with a dying patient or giving bad news. Rather, everyone but a few brave doctors and nurses was complicit in avoiding meaningful contact with these poor, doomed people. In retrospect, this is why I wrote the scene, to resist the inhumanity toward these patients.

die; she will never be cured; but she will be healed. A doctor sat with her. The Fat Man was not her primary physician, but the attending physician refused to give her the bad news, so Fats stepped in and, in the process, showed Roy how to heal. He showed Roy how to be a doctor. Each physician must learn to navigate the road from the desire to cure to the desire to heal. This is both an individual and a collective struggle. It is individual because each physician has to learn the limits and depth of his own ability to differentiate, and collective because many physicians have read and learned from each other, seeing another way of practicing medicine and learning how to be with a patient.

Like Roy Basch, Kate Scannell had to learn, through trial and error, how to help patients heal. Scannell was the director of the AIDS ward in Oakland, California, in the early years of the AIDS epidemic. She daily faced her inability to cure her patients, but she quickly learned the difference between curing and healing. Her memoir, *Death of the Good Doctor* (1999), depicts her struggle with the difference between curing and healing. Reflecting on her memoir, Scannell claims that writing about her patients became a way of staying alive: "Writing my memoir about that time became an exercise in staying alive—to my patients' stories, to their felt experiences of life near death, to my evolving identity as a doctor, to the changing cultural norms contextualizing medical practice."[49]

Scannell's provocative first chapter "Death of the Good Doctor" provides a glimpse into desire and how it can lead to the formation of a doctor's protocols and actions. In her memoir Scannell, the new AIDS ward clinical director, recalls a defining moment in her tenure as director with detail and empathy. As her confidence grew in her new role, her attitude toward her patients changed. She admits: "I stalked the AIDS ward like a weary but seasoned gunfighter, ready for medical challenges to present themselves; I would shoot them down with my skills and pills" (p. 10). Her weapons (of skills and pills) were in constant use as she roamed the ward with the command and desire to

---

I started with fact—my avoidance—then imagined what 'should' have been done and put it in terms of the imagined Fat Man." Shem, "Fiction as Resistance," 935.

[49] Kate Scannell, "Writing for Our Lives: Physician Narratives and Medical Practice," *Annals of Internal Medicine* 137, no. 9 (November 5, 2002): 781.

eradicate the treatable diseases and symptoms that plagued her patients. Katrien de Moor notes the "detached, distant vocabulary such as *expire* and conventional biomedical battle metaphors, imagery, that is of course added post factum and will serve to underscore the journey made."[50] All this changed in the course of two days when she met Manuel, a twenty-two-year-old man dying of AIDS, who would change her life and her definition of what it means to be a good doctor.[51]

One of his first requests to Scannell was "Doctor, please help me" (p. 11), so she declared war on his body and began to remedy his breathing, reduce the edema, and prepare him for chemotherapy for his Kaposi's sarcoma. All the while, he still pleaded, "Doctor, please help me." After a grueling day of helping him, Scannell left the hospital to return the following morning to find that Manuel had died during the night. When she asked what had happened, a nurse informed her that Manuel had asked the night physician to help him, and the physician responded by

> discontinuing the intravenous fluid and potassium, canceling all lab tests, and terminating the blood transfusion. The physician gave Manuel additional morphine…. Manuel smiled and thanked the doctor for helping him. He died within an hour, finally freed from his suffering. (P. 12)

This was the moment when Scannell's desire and training to cure reigned and instead of helping Manuel, she had prolonged his suffering. She laments:

---

[50] Katrien De Moor, "The Doctor's Role of Witness and Companion: Medical and Literary Ethics of Care in AIDS Physicians' Memoirs," *Literature and Medicine* 22, no. 2 (Fall 2003): 212.

[51] For further insight into Scannell's interaction with Manuel, see De Moor. See also Delese Wear and Lois LaCivita Nixon's "Literary Inquiry and Professional Development in Medicine: Against Subtractions," *Perspectives in Biology and Medicine* 45, no. 1 (Winter 2002): 104-25. Wear and Nixon say that "after this experience, she decided to become a different kind of doctor. For patients like Manuel, she

> My entire body cringed and my soul clenched as I imagined Manuel's agony sustained through my unconscious denial of his dying…. My shame and regret were unspeakable….
>
> Years later I continue to think of Manuel often, and I ask him to forgive me. I tell him that I have never practiced medicine in the same way since his death. After Manuel's disease-ridden corpse finally released his spirit, the classical breeding and customary garb of my traditional medical training fell off me like tattered rags. I began learning—how to recognize the sound of my own voice, listen to my patients, validate the insistent stirrings of my compassionate sensibilities. (P. 13)

The good doctor died that day and she has never been the same since; her desire to cure no longer trumps her compassion and understanding. She has torn off the traditional garb of being a "good doctor" and has learned how to care for her patients in ways that heal them in ways that medicine never can.[52]

Scannell learned how to differentiate the need, the demand, and the desire of her patients and of her self as she practiced medicine. Manuel's need was to be released; it manifested through his plea for help, but his desire was to be whole. He knew he could never be whole on this earth, so his need and demand directed him towards death where restoration might be attained. Scannell's original desire was to cure her patients the way she knew how: with medicine. Even though she knew Manuel would die, she still needed to treat the treatable ailments and prolonged his suffering in the process. Her desire to

---

now puts some of medicine aside and practices different modes of care giving, such as ordering ice cream and French bakery products as principal or even sole therapy" (p. 114).

[52] De Moor notes the change in language from pre-AIDS era medical work to post-AIDS era medical work. She quotes Charles L. Bosk and Joel E. Frader's article "AIDS and Its Impact on Medical Work: The Culture and Politics of the Shop Floor," in *Milbank Quarterly*, 68, suppl. 2 (1990): 257-79, when she says the post-AIDS era narratives "'generally emphasize the tension between care and cure' and provide lessons on how 'care is often more important than cure, and that the human rewards of their medical role are great'" (p. 213).

cure trumped Manuel's desire to be whole. But as Lacan says, desire can never be fulfilled, and Scannell would never be able to see all her patients whole again. Instead of accepting that, she ignored Manuel's obvious agony and impending death, and demanded that his body endure more suffering in the name of curing. Even though Scannell's desire to cure stemmed from pure motives, it still led to destruction and agony.

Rafael Campo, an internist at Harvard, compiles essays in his book *The Desire to Heal: A Doctor's Education in Empathy, Identity, and Poetry* (1997).[53] His book explicitly addresses desire in medicine, particularly physical desire. His compilation is yet another testimony of how the cycle of desire can entrap a physician. Lacan says that we are searching for the Other, for something else, and Campo displays this Other from the outset of his book. He begins his first essay with an unsettling description of an encounter with a male patient who has an erection. He begins his book with the sexual desire that may arise between a physician and his patient.

For Campo, healing is rooted in physical touch and love. He says, "pure physical contact had the power to cure.… Healing had a voice, and seemed rooted in a most potent physical longing, a longing to be with the ones you loved" (pp. 15-16). His first chapter is the most unsettling of the book, for he tells of a time when he is a physician and his patient has an erection, thus drawing him closer to his patient. He discusses the encounter as being natural, but his actions during the encounter show us that this sexual desire, as natural as it may be, unarms Campo and makes him uncomfortable. He recalls when he was a patient while an undergraduate student, and how he dreamt of his doctor touching and releasing the toxins in his body. In this dream, not only was Campo naked, but so was his physician. Neither was embarrassed by Campo's erection. Both as a

---

[53] David L. Kirp's book review "Doctor of Desire" in *Nation* 264, no. 7 (February 24, 1997): 30-32, places Campo in company with Wallace Stevens, Mother Teresa, Richard Rodriguez, and Abraham Verghese. He claims that there are moments when this memoir "shines a clear, bright light on its subject." But he also points out that there are "merely self-indulgent moments," and in the end thinks it is an "intermittently brilliant account of a life in progress."

patient and as a physician, Campo felt the desire for sexual touch and release. In neither scenario was that desire satisfied.

Why, then, does he continue discussing the sexual tension and desire that, for him, is inherent in the physician-patient relationship? He claims that his own psychological and emotional healing came when he had fully given his body to another and had owned another's body. Mutual physical giving and taking is the basis of healing, according to Campo. It is the basis for his book. He learned how to convert that physical relationship into language and into an appropriate action via holding hands, or touching a patient on her back. Physical touch, be it sexual or platonic, is at the very center of the doctor's ability to heal.[54]

Campo takes us through his journey in learning how to distinguish between curing and healing. We watch him transform from a high school student, to a medical student, to a resident, and, finally, an attending physician. We watch him respond sexually to his patients, we watch him deny his friend a healing touch, and we watch him give voice to dying patients who, without his testament, may have been forever lost. For Campo, the intermingling of humanness, the connection in physical touch, the mixing of blood, the recognition of one's self in the other is what binds and what heals.[55] He recalls:

> Perhaps in the mixing of my blood with another person's, I could learn the true meaning of forgiveness, I could understand human failings, I could begin to fathom how we all share original sin. Perhaps in the possibility of dying of AIDS myself, I

---

[54] Campo is not the only physician-writer to discuss the relationship between sex and medicine. I will look at two more examples in my next chapter: Shem's *The House of God* and Susan Onthank Mates's short story "The Good Doctor." Also see Louis Borgenicht's essay "Richard Selzer and the Problem of Detached Concern," in *Annals of Internal Medicine* 100, no. 6 (June 1984): 923-34, which explores Selzer's theme of love. Borgenicht says, "The act of lovemaking is at once violent, sensitive, and ultimately healing," (925). Perhaps healing is why many physicians seek sex as an answer to their problems in clinical medicine. Perhaps healing is why many physicians write about the connection between sex and medicine.

[55] Wear and Nixon also point to his recognition of the other, of someone else, as an ephiphanic moment (p. 5).

> could realize finally and fully my capacity for empathy. Perhaps in a prayer, in a poem, in an embrace and kiss, I could speak again to God. (P. 61)

He learns how to heal only when he learns how we are all interconnected. His desire to heal comes from the recognition that we are all one; we are a part of each other.

For Campo, the desire to heal is the desire for wholeness, for health, for completeness; and thus he not only wants to help his patients, but ultimately himself on the journey from illness to health. Campo has always felt like an outsider in medicine: he is gay, Latino, and a poet. But, as Jean Kim points out:

> Campo finds his connections to the ultimate outsiders, those dying of AIDS, helps him to heal himself as well as his patients…. By fully immersing himself in the suffering of his patients, Campo comes to understand what it means to appreciate life, and in turn he feels joy instead of only anguish in caring for the dying.[56]

Campo's relationship with his patients is what allows him to experience personal healing; through identifying himself in someone else, he can see himself as part of a community. As his book progresses, so does his attitude toward patients and his desire to enter into their weakness so that they are healed if not cured. Healing and curing are two different concepts, and he wishes for healing more than health. He understands and believes in the reciprocity that a patient can heal a doctor in the sense of emotional and internal illness just as the physician can his or her patient. He says:

> I had the strange sense that I was liberating her—from the possibility that she was unclean, from the self-doubt that she was not worthy enough to be bothering a doctor… I was in reality freeing myself from those same insidious questions

---

[56] Jean Kim, "Emotional Detachment and Involvement of Physicians in Literature," *Pharos* 64, no. 2 (Spring 2001): 34.

> about my own human worth and my possibly defective body. In short, I identified with her, I was available to her. I was another human being simply sitting beside her, listening. (P. 208-9)

Campo's greatest lesson on doctoring is the act of listening so that true healing and wholeness occurs. Patients and doctors want the same thing: to be healed, to be understood, and to be heard. This is what humans want as we go through the ups and downs of life. We always want more. We want others to attend to us, to listen, to witness our suffering, and in the end both be healed. It is not enough to merely be cured; no, we want more. And thus the cycle of desire, need, and demand continues.

David Hilfiker is the final physician-writer I shall refer to while illuminating the difference between curing and healing. His book *Healing the Wounds: A Physician Looks at His Work* (1985) relays his experience practicing medicine in rural Minnesota.[57] He tells of the struggles and triumphs of practicing medicine in a small town, where everybody knows you are a physician and you have treated almost everyone in town. He talks honestly and openly about the difficulties of being a doctor and particularly the commitment of one's time and self that such a profession demands.

After being reprimanded for not sitting with a dying patient, who wasn't even his patient, he fights with a nurse about not being able to respond to everybody's needs. He maintains that he could not have sat with the dying woman, not because she wasn't his patient, or he didn't want to sit with her, but rather, he could not sit with her because he simply did not have the stamina to be with her at that moment. His needs outweighed her needs. He comments:

---

[57] David Hilfiker, *Healing the Wounds: A Physician Looks at His Work* (New York: Pantheon Books, 1985). Subsequent references to this book will be cited parenthetically in my text by page numbers.

> At the heart of this conflict lay the simple fact that there were too many patient needs for the time and energy I had available…. It is, in fact, one of the basic dilemmas of the physician—to be caught between a desire to be of service and a need for respite. (P. 32)

This is the perpetual struggle for physicians: How much time and energy do they give each patient? If they give everything they have to one patient, will they have enough for subsequent patients? Do they learn to ration themselves? If so, how do they decide who gets the caring, compassionate side of them that day? Does the physician have another option than to focus on curing rather than healing? Perhaps.

Hilfiker's instinctual practice is to give all he has to his patients. He knows and understands that each patient comes in bearing more than a physical complaint. No illness is purely physical. But he cannot humanly sustain the practice of being completely there with his patients. He laments:

> The blessing and the cure of medicine is that we physicians are privileged to share the most intense moments of life with our patients…. We are privy to the deepest of humanity's experiences. But with this privilege comes the burden of availability, of openness to the needs revealed at those intense times. Not surprisingly, I could not sustain the degree of openness required to go from deepest need to deepest need, and consequently I found myself refusing the very service that a major part of me was committed to giving. (P. 37)

He wants to be with his patients, he wants to participate in the act of healing, but sometimes he simply cannot do so. It is not out of malice or lack of understanding that he withholds himself from the patient, but rather out of survival. Hilfiker understands what it is to comfort a patient and describes many such occasions. He has learned the difference between curing and healing.

Caring for patients in the humanistic manner described is being with patients; it is learning how to heal and not just cure. It can be overwhelming. Shem chose psychiatry because he believed in relationships and stories. Scannell chose to leave the AIDS ward after realizing she was exhausted with death. She could no longer remember how to live life outside the ward because she had given her patients everything she had to give. She needed to reclaim her own life. Campo had to deny care to a friend, Gary, because Campo could not adequately attend to either Gary's or his own suffering. And Hilfiker left his rural practice, went on sabbatical, and returned to practicing poverty medicine in urban Washington, D.C. Each of these physicians learned what it was to give everything he or she could offer in an attempt to heal. They regressed to just treating the disease and not the person when they were emotionally or physically exhausted. They could not sustain a life of practicing medicine that focused on healing.

The attraction of Lacanian desire is that we are tempted to believe that we are attaining what we want. Physicians want to help their patients. Patients want their diseases eradicated. Physician-writers want to give voice to their patients and their experiences. Readers want to be drawn into a world where they can see and understand another way of living. These are only the peripheral wants. What we want is to be known and understood. We want to be whole, healthy, and well. Campo was correct when he said, "to be well meant to be well loved" (p. 15).

CHAPTER 4: THE DESIRE FOR RELATIONSHIPS

John Donne once said that "no man is an island, entire of itself; every man is a piece of the continent, a part of the main"[58] (1624). What the poet means is that we are all connected to and affected by all of humanity. We cannot live life alone and isolated. We were created for community. The physician-writers in this section write about isolation, loneliness, and the desire for community in different forms. Anton Chekhov writes about how a doctor forms a relationship with an insane patient and is ultimately committed to the same institution. Samuel Shem illuminates the loneliness and detachment that can occur in a residency program. Susan Onthank Mates reveals a physician who has been isolated for so long that she acts in a questionable manner in order to return to relational humanity. Abraham Verghese tells his story and his own struggles with loneliness, friendship, and disappointment, all the while revealing a medical student's own struggle with isolation and detachment. Kate Scannell discusses how she learned to help a difficult patient heal by relating to him, and, in that process, she learned how to be more connected to others.

Anton Chekhov's short story "Ward Number Six" (1892) tells of a Russian physician who is the attending psychiatrist in a dilapidated hospital.[59] Dr. Andrew Ephimich Raghin is an educated man who longs for communication, intellectual stimulation, and companionship. He is unable to satisfy his desire through discussions with his wife or his friends. Raghin is starved for intellectual companionship and withdraws further and further into self and isolation. His friend, Michael Averianich, is

---

[58] John Donne, "Devotion 17," from *Devotions upon Emergent Occasions Together with Death's Duel* (Ann Arbor: University of Michigan, 1959), 108.

[59] Anton Chekov, "Ward No. 6," trans. Bernard Guilbert Guerney, in *Short Novels of the Masters*, ed. Charles Neider (New York: Cooper Square Press, 2001), 386-438.

the only man with whom Raghin discloses his discontent with his world. But Averianich attempts to relieve his suffering through a pleasure trip to Warsaw. Raghin's need is not met by traveling to Warsaw. Instead he is now poor and more emotionally desolate than before.

Raghin goes to see his patients on ward number six without much attention or devotion, but unexpectedly he finds the most compelling friendship and companionship in one of his patients, Ivan Dmitrich Gromov. After a difficult yet intriguing conversation about the arbitrariness of declaring someone insane and locking them away, Raghin returns to discuss his intellectual quandaries with Gromov. Even though he returns to converse with Gromov, as Sally Wolff points out, "Rag[h]in cannot empathize with his patient."[60] He has entered into relationship with Gromov, but still has difficulty showing empathy. He continues to return to the hospital and is confronted daily with Gromov's wisdom and his own foolishness.[61] But through this relationship, Raghin finds solidarity and realizes his patient-physician relationship is mutually beneficial. Wolff quotes Chekhov: "We see each other as people capable of meditation and discussion, and that makes for our solidarity, different as our views may be."[62]

The more that Raghin attempts to satisfy his need for relationship and intellectual stimulation, the more his fellow townspeople and physicians believe that he has gone insane. One night, during a meaningless conversation with Averianich and his fellow physician, Hobotov, Raghin loses patience with their foolishness and commands them to leave. When Averianich and Hobotov observe his behavior, they conclude that Raghin must have gone insane. They strip from him his position as head physician and trick him into becoming a patient in ward number six. They assume that if an insane man is

---

[60] Sally Wolff, "The Wisdom of Pain in Chekhov's 'Ward Number Six,'" *Literature and Medicine* 9 (1990): 136.

[61] Wolff comments that like many Shakespearean characters, Chekhov's reportedly insane character is wiser than the sane characters: "Like a Shakespearean fool who speaks the most wisely, Chekhov's Gromov reasons, philosphizes, and speaks the truth" (137).

[62] Wolff, 137.

meeting his needs for intellectual stimulation, then the physician himself must be crazy. As Wolff points out, there is little evidence against Raghin and he is "sentenced to an asylum without just cause or cure."[63] When Gromov claimed that his declaration as "insane" was arbitrary, Raghin denied it; but now he is in the same predicament.

What Ragin's friends did not understand was that he was trying to fill a need for relationship and stimulation because he was isolated. In his search for fulfillment, he found a friend and an outlet. While Raghin just needed to be part of a community, the others perceived a need for psychological help. Lacan claims that screens can hide our true desires, and either Raghin's desire truly was for help as some claimed or his desire was for relationships. Perhaps we are all insane in our attempt to fulfill our insatiable desires. Perhaps we would be better off if we admitted that we will never be satisfied and thus we will stop trying. Or perhaps we would better off if we can learn to identify our true desires and abet the need for more by finding as much satisfaction as we can in healthy ways.

Like Dr. Raghin, Dr. Roy Basch and his fellow residents in Samuel Shem's novel *The House of God* become isolated, detached, and lonely. *The House of God* (1978) explores the way detachment affects personal and professional roles and relationships. We follow Roy Basch in his first year as an intern while he and his fellow interns learn to navigate the difficulties of patients who are never cured, the pressures of the emergency room, the technology and machinelike qualities of the Intensive Care Unit (ICU), and the strain of learning how to be human in a world that prizes efficiency. *The House of God* is an ominous and emotionally troubling book because it illuminates the difficulties and realities of residency in academic medicine. It is a chronicle of the ups and downs of academic medicine.

Roy enters his residency scared to death. While talking with his girlfriend, Berry, about how frightened he is, he asks, "What should I do?" She replies, "Try denial" (p. 23). Berry's suggestion may be the catalyst for Roy's actions in the upcoming year. The

---

[63] Ibid., 139.

irony is that at the end of the novel, she scolds him for detaching himself and tries to make him see how he needs to be present in order to cope with the trauma of the past year. The interns are about to embark on the most difficult year of their lives and Shem is quick to point out how their isolation contributes to their woes. If Donne is correct and we are all a part of the whole, then Roy and his fellow interns must learn what it is to suffer. They must learn how to practice medicine while remaining present and humane. They must learn how to be doctors without losing their minds, skill sets, or humanity. Roy and the others have a difficult time learning how to do this.

At first, this group of interns is lucky in the sense that they have formed a community with each other. They turn to one another for advice and consultation. But as the year progresses, their friendships erode and become more and more shallow. Roy laments:

> Each of us was becoming more isolated. The more we needed support, the more shallow were our friendships; the more we needed sincerity, the more sarcastic we became. It had become an unwritten law among the 'terns: don't tell what you feel, 'cause if you show a crack, you'll shatter. (P. 288)

As their friendships were strained because they could not manage to reveal their true feelings, Wayne Potts began to crack and eventually shatter. After a critical error that led to coma and eventually death for a patient, Potts was not able to regain his composure, confidence, or confidants. He wallowed in his mistake and the medical hierarchy constantly reminded him of his error. When his patient finally died, Potts could no longer sustain the isolation and desperation. He took an elevator up to the eighth floor and flung himself out of the window. He was alone, desperate, and guilt-ridden. His only escape was suicide. The responses of the House leaders were detached, unsatisfying, and demanding to the other interns. In a time when community, friendship, and relationships could have helped the interns grieve, they were given only more isolation. They wanted the support from each other, but they could not bear to honestly

assess themselves. They could have perhaps survived if they had sought after what they really needed: community. Instead, they chased skirts, showed machinelike behavior, and put up emotional walls.

In their quest for community and relationships, many of the interns turn to sex. They have learned that sex is a powerful tool in their institution. By sleeping with the social workers they can place their gomers (this term is an abbreviation for Get Out of My Emergency Room) more quickly.[64] By sleeping with the nurses their orders are filled and their sexual desires appeased. Roy remains in a relationship with Berry throughout the novel, but he is not committed to her. He has an affair with a nurse, Molly, and is emotionally detached from Berry for the major part of the novel. There are many graphic scenes of sex and sexual promiscuity. One intern, the Runt, has a difficult time practicing medicine until he starts sleeping with a nurse, Angel. In encouragement of this escapade, Chuck, another intern, says, "Look, man … you know unless you get your dick moving a little faster, you never gonna learn medicine at all" (p. 125). For these interns, medicine and sex are entwined. They believe that until they are satisfied sexually they will not be able to practice good medicine. They do not explain the reasons behind this theory, but they practice and believe it wholeheartedly. Anne Hudson Jones in "The Medical Bildungsroman" argues that sex is way of affirming life:

> Sex becomes more important as a way of denying or protesting against the disease and death that surround the young physicians. Sex is a way of affirming life: If I'm having sex, I must not be dead…. These novels [*The Year of the Intern*, The *House of God*, and *M. D.*] present recreational sex as the aid of choice for the impaired intern or resident. Yet in both *The Year of the Intern* and *The House of God*, the protagonists gradually realize that there is something very wrong with

---

[64] Anne Hudson Jones suggests that medical jargon becomes a coping device for young physicians. Although g*omer* is not a technical term, it illustrates her point. She says, "One reason for the use of medical jargon is to demonstrate the rite of passage into an exclusive group. But another reason is emotional insulation…. The jargon and rules of *The House of God* help create the wacky Catch-22-like ambience of the work" (p. 45).

> the use they have been making of women's bodies, and they change their behavior."[65]

They remain in a constant cycle of desire.

The more one has sex the more one wants sex. According to Lacan, our desires elude us and we are seeking the Other. In this context the interns are seeking connection, fulfillment, and, of course, a physical release. But they will never be satisfied with their orgies and promiscuity because they do not truly enter into a relationship and, therefore, still want that intimate connection. Sex can become an addictive act, and if they are never satisfied, but always seeking fulfillment, they may turn again and again to sex. In the end, they may have destroyed themselves and their reputation by this behavior. The power differential between a male physician and a female nurse or social worker may turn into a lawsuit, a scandal, or, at best, gossip. They may become impaired physicians in the sense of never being able to engage their patients, co-workers, or families because they are seeking satisfaction through sex.

This novel clearly demonstrates the difficulties of maintaining relationships with patients and the outside world while an intern. It illustrates Shem's relational perspective, showing that the primary desire of humankind is relational and the further one is isolated, the more he is impaired. The road back to health is through connections. Basch's return to health happens only when he has become isolated and has behaved like a machine. When he finally breaks, it is Berry who helps him see that he has completely detached himself from reality. Their relationship is what slowly draws him back into humanity.

Shem's relational perspective claims that the shift from "the self" to "the self-in-relationship" is a crucial aspect of learning about and understanding healing. Basch had to see and understand that he was not alone. It was not doctor against patient, but rather, a community of people with whom he was in a relationship. It is this aspect of

---

[65] Ibid., 48.

community and desire for relationships that leads one toward health and healing. When doctors try to practice medicine alone they find themselves floundering and dying. When any human tries to live life alone she finds herself floundering and dying. We do not thrive in solitude; life was meant to be relational. And yet, even when we try to form bonds and ties, we will always be left wanting more. This is the cycle of desire.

Shem's interns are not the only ones who see the connection between sex and good medicine. Susan Onthank Mates's short story "The Good Doctor" (1994) also suggests such a connection. Despite there not being many academic articles on this short story, it brilliantly illustrates isolation and the medical power hierarchy.[66] The three main characters, Helen van Horne, Diana Figueroa, and Michael Smith, are all entrapped in the cycle of desire and its destructive forces. This story illustrates how isolation can lead to personal and professional destruction and sexual promiscuity.

Helen van Horne spent fifteen years in solitude and service to the Masai tribe in Africa; through these experiences she learned how to be a good doctor and how to "subjugate her will" (p. 37). She was even called "Sister" by some of the Spanish workers (p. 36) because she devoted herself to the care of others, putting them above herself. This dedication to medicine and her patients is what she thought the medical students needed to learn, and it is what she was determined to teach them. One student, Michael Smith, was the least disciplined, trained, and serious student. He hoped to get by on his good looks and charm, seducing the nurses, patients, and even van Horne. Michael Smith continually aroused van Horne's sexual desires and she found herself involuntarily looking at him (p. 34). Van Horne longed for physical touch and male affirmation. Despite her better judgment, she would think about the dean of the medical school touching her. But she always repressed it. She had to be careful about personal relationships.

---

[66] Although this is the only one of her short stories on which I focus, please see Wear and Nixon and Richard Martinez, ("Professionalism and Boundaries," *Theoretical Medicine*, 23 (2002): 185-89, for commentary on her story "Laundry" (pp. 9-14) in the same collection.

Van Horne was on the hospital wing early in the morning and late at night; she had no life outside of medicine. Like Shem's Jo, she felt needed and fulfilled when she was on the wards. Mates says:

> The meaning of her years in Africa came to her suddenly as if in revelation. Apprenticeship. Learning to subjugate her will. She would dedicate herself to the patients and the students of City Hospital. Her face took on a pregnant glow, and she felt more content than she could remember in her life. (P. 37)

Van Horne had no relationships; her life was full of others' needs: her patients' and her students'. She was seeking the Other, both in Lacan's sense of the word and in the literal sense of the word: she put others' needs above her own and she was not seeking what she truly wanted. Her own desires were not being identified or satisfied, which led to a professionally unethical yet medically productive decision.

In the third week of May the deaths started. The hand of death covered the hospital, sweeping over floors, departments, and specialties. No one knew why the deaths started or if there was an underlying pattern, but van Horne felt that she was somehow responsible. Mates describes the wave of deaths:

> First it was several cardiac failures on the men's ward, then a medication allergy on the women's ward, then one of the drug rehabilitation doctors fell out of a closet one morning, curled in the fetal position with a needle in his arm and stone-cold dead…. The next day *Staphylococcus* broke out in the neonatal nursery…. But the final straw was Henry, the chief of maintenance who sat, sighed, and fell over one day at dinner. (Pp. 37-38)[67]

---

[67] Due to the lack of information Mates gives about the rehabilitation doctor and his death, I cannot spend much time discussing his death and its possible links to desire except to say that he was daily faced with patients who are deeply entwined in destructive and addictive behavior. Drug and alcohol addiction are the embodiment of Lacanian desire, as we will see in Abraham Verghese's *The Tennis Partner*, and they are very common among physicians. This physician may have been trying to satisfy his

After watching Henry fall over dead and then working futilely on him, Michael Smith was in deep need of affirmation and physical release. He was deeply shaken and went to van Horne for comfort. In their mutual need for comfort they turned to each other for sex and physical fulfillment. They both needed another human; they were scared, alone, and upset. And so they attempted to satisfy their need, longing, and craving for another's body. After letting water wash away her guilt by washing over her body for hours, van Horne returns to the wards dressed in white to discover that the babies were plump and healthy, the women's ward had a "new but familiar smell: dust soaked into earth, the beginning of the rainy season" (p. 40). The deaths had stopped. If van Horne was responsible, then did her actions shoo away Death's hand?

Mates leaves the ending ambiguous, allowing the reader to decipher which van Horne is the "good doctor." Her unethical actions with Michael Smith led to the cessation of deaths; does this make her a good doctor? But she still fails Smith—she refuses to be unethical in her teaching duties. Is the pious, isolated, and disciplined van Horne the good doctor? How does desire play into this scenario? In Africa, she subjugated her will and recognized no personal desires other than the health and care of the Masai tribe. In the Bronx she gave in to her passions and could possibly have been fired; yet the waves of deaths stopped. Perhaps her desires were always strong and passionate, but she denied them for years in Africa, ignoring the needs and demands of her body and soul. Because she denied her wants for so long, did they become so strong that they could not be contained any longer? If she had given into her desires at different points over the past fifteen years, would she have acted in such an unethical manner with Michael Smith? I suspect not. Van Horne's desire both led to the possible destruction of her career and to the possible revival of the hospital and to stopping the epidemic of deaths.

---

own desire for drugs as a way of escaping the despair he saw on the wards. He may not have known what his deepest need was and therefore was treating the Other: the identified need instead of the real need.

Each person has a triad of need, demand, and desire. Diana Figueroa, the chief resident under Dr. van Horne, admired and emulated van Horne's discipline, knowledge, and dedication. Diana even left her husband so she could be as dedicated to medicine and helping others as van Horne was. Diana's desire to be like van Horne stemmed from Diana's perception of a good doctor; to her, it was isolation, dedication, and expertise. Imagine Diana's surprise and regret when she finds Smith's hand running up van Horne's leg on a medically bleak day in the hospital. Van Horne gave into Smith's advances and he counted on his sexual relationship to carry him through his medical rotation. Diana was shocked at what her mentor had done. Diana's deepest yearning, to be like someone she deeply admired, led not only to the destruction of her marriage, but also to the severing of a relationship between the women.

Helen van Horne needed to be a good doctor; she needed to be in control of her patients, herself, and her surroundings. She also needed a sexual encounter where she could abandon herself to the pleasures of the body without feeling the weight of the world upon her shoulders as she did in Africa and in the hospital. Diana needed a role model to emulate. So she left her husband to be like van Horne only to find her prized mentor was not perfect and had needs of her own. Michael Smith needed to please and be pleased via sexual encounters. He counted on his charm to pull him through medical school because the demands of his body drew him away from the demands of clinical medicine. Instead of getting what he wanted, a passing grade, he failed. His desire for sex left him without a future. All three major characters destroyed some aspect of their lives for their desires. They were all left questioning, wondering, and unsatisfied. The sex was not enough for van Horne or for Smith, and with Diana's icon broken on the floor, she too, was left unsatisfied and without answers.

Just as each person in Mates's story had different needs and desires that manifested in different destructive patterns, so does Abraham Verghese's memoir *The Tennis Partner* (1998) describe two different sets of needs and desires.[68] It tells a vivid

---

[68] Abraham Verghese, *The Tennis Partner: A Doctor's Story of Friendship and Loss* (New York: Harper Collins, 1998). Subsequent references to this book will be cited parenthetically by page numbers.

and tragic story that reveals how desire can be a destructive force for physicians. Verghese, an internist in San Antonio, Texas, brilliantly paints an unforgettable picture of friendship, loss, hope, and despair. While an attending physician in El Paso, he meets and mentors David Smith, a fourth-year medical student and ex-professional tennis player. They form a friendship over the net on the tennis court that extends into their medical careers and personal lives.

David is a smart and dedicated medical student who has one major problem: he is a recovering drug addict. The cycle of desire is most obvious in this story as we see David struggle with his addiction and compulsive actions. Lacan's triad connects need, demand, and desire together in a neverending cycle. David's need for cocaine manifests itself in different ways: first sexually, and then as compulsory actions for the substance. As the need grows stronger, David eventually gives in, excusing it as just one hit. But he has been caught in Lacan's triad, and he desires more and more cocaine until he eventually kills himself out of despair and addiction. David is a wounded healer, a soon-to-be physician who may be able to be more empathetic towards his patients because he has struggled through disease and despair. Would David's compromised past make him a better doctor than someone who has never experienced that kind of vulnerability and desperation? Perhaps. But his desire for drugs destroys him before we find out what kind of doctor he would be.

During the year and a half of David and Verghese's friendship, Verghese goes through a divorce and longs for friendship and intimacy.[69] David fulfills that need through their tennis games and conversation. Verghese is honest about his jealousy and

---

[69] Verghese's first memoir, *My Own Country: A Doctor's Story*, gives a glimpse into why Verghese and his wife separate. Because he has learned how to be present with his patients, he slowly but continuously pushes away his family. Not unlike Roy Basch who distances himself from his girlfriend so he can detach himself from the traumas of internal medicine, so does Verghese detach himself from his family. Unlike Basch, Verghese detaches for different reasons: Basch detaches because he cannot be in relationship with anyone; Verghese detaches because he cannot be relational with both of his worlds. He has learned what it is to be in a relationship with his patients at the cost of being in relationship with his wife. It is an ironic situation that for Verghese to be a good doctor he had to isolate himself from his wife. Part of this separation comes from his wife not being pleased with his spending time with mostly gay patients.

loss when David dates a girl in El Paso and cannot spare the time for Verghese. We watch Verghese be roped into David's problem and believe that David won't do cocaine again. Verghese even protects him and does not turn him into the authorities. Verghese's needs are different than David's: David needs cocaine, while Verghese needs friendship and intimacy. Verghese's yearning for acceptance and intimacy jeopardized not only David's well-being by not turning him in, but also Verghese's position as an attending physician because he worried about David's work and future. They are both stuck in the neverending triad of need, demand, and desire that prove unhealthy for both of them. David eventually kills himself, despite Verghese's putting himself on the line in hopes that his friendship will be enough. It never is or ever will be.

Another physician-writer who tells about relationships with patients is Kate Scannell. Like Verghese, she is one of the first physicians who battled AIDS. We have seen how she learned to differentiate between curing and healing on the AIDS ward through her interaction with Manuel. "The Death of a Good Doctor" is Kate Scannell's first story in her 1999 memoir, but we see her growth as a physician just two vignettes later in "Sleeping with the Fishes." She learned how to heal through relationships because of Jay. Jay, a cantankerous and harsh patient, turned into one of her greatest teachers during her tenure on the AIDS ward; in an attempt to connect him with something, she finds out that he has an affinity for fish. She wants to help him live life and if the only way that could happen was to allow him to watch the fish swim and float, then she would fight for his right to have the fish in his room. Over a short period of time, Jay begins to change in his attitude toward Scannell, and she begins to change her attitude toward life and Jay. Together they watch the fish swim; together they watch the fish die; together they watch Jay die. And together, in that process of death and life, they learn what it is to be healed. Jay died, never cured, but healed and with friends: the three dead fish floating next to the window and Scannell by his side.

Scannell finally understood what it meant to engage in the art of healing. She realized that we will all die, but it is the way in which we die that makes a difference. Jay needed friendship and to be engaged in the world, but he didn't know how to demand it,

so he was nasty and mean. But once Scannell found the way to his heart, his need was met and he died a complete man. Scannell needed to find a way to change her attitude toward him and to connect with someone she didn't like. She could have never guessed that his love of fish could fuel her to explore nature and help her to become a part of the natural world. This connection and friendship proved to fulfill both of their needs in very different ways.

Her interaction with Jay, a difficult patient, shows how relational care works toward healing even when there is no cure. Jay has fallen into isolation and despair. He is completely detached from the world and others; he pushes away everyone, including his caretakers, making it difficult for anyone to care for him. Slowly, Scannell learns how to bring Jay back into the world of interaction. She does this through fish. She learns what it means to be in relationship with nature and the outside world, while he learns how to be in association with a human being. Because of that connection, because of the fish, Jay is able to move toward healing even though he cannot move toward health or a cure. Their relationship was mutual; they both needed each other to connect and move down the path toward healing. Shem's relational perspective is inherent in all human interaction. He is right when he asserts that our primary desire is to be connected. This need for friendship is what moves people toward health. The more detached one is the more that person is unable to enter fully into life.

These physicians struggle with desire and relationships in very different forms. Chekhov, Shem, and Mates use fiction to illustrate what a physician's life can look like if he or she is not rooted in a community. All three protagonists, Raghin, Basch, and van Horne, desire more than they currently have. They all want relationships and community. Raghin ends up learning what it is to suffer because he was unjustly condemned to the same inhumane hospital that he ran for years. He was then in constant community with Gromov, but he could not live an intellectual life when he was being beaten and punished. Basch and van Horne attempt to ease their souls' longing through physical touch, and both find themselves empty. Basch returns to humanity through relationships: his girlfriend's not giving up on him and the Fat Man's showing how to be a caring

physician. We are left wondering what will happen to van Horne: will she ever learn to join a community so that she will be satisfied? We do not know. We are left with the image of her stalking the wards in a white coat as the beasts of the Serengeti stalk their prey.

While Chekhov, Shem, and Mates use fiction as a way of expressing desire and relationships, Verghese and Scannell use memoirs and personal testaments to show their own battle with desire. *The Tennis Partner* is not about Verghese's time spent caring for AIDS patients but he expands upon some of the same themes that he wrote about in *My Own Country*. Katrien De Moor claims that AIDS physicians' memoirs are a form of "literary care." "[It is the] sort of witnessing that is constructed … as an extension of practices of care and continuation of the caring process."[70] These physicians have learned what it is to be in a relationship with their patients; they understand the difference between curing and healing; they have learned how to heal with relationships. Verghese's *The Tennis Partner* explores the theme of desire in regards to a physical addiction and how it can become destructive to the person and to the surrounding community. Scannell explores how, by forming a relationship, a doctor can help her patient heal and be ready to move on toward death if the illness has no cure. Relationships are the way to healing. We are caught in the cycle of desire: the desire to be a part of something bigger than ourselves, to be attached to others.

These writers, whether intentionally or not, have explored the theme of desire and the part it plays within the medical field. We have all experienced desire in some manner, be it physical, emotional, spiritual, or mental desire; we know what it is to want more and never be satisfied. We can understand why physicians want to intervene to prolong a life. We can understand why a lonely man seeks intellectual stimulation. We can understand why a young resident commits suicide or why people turn to sexual gratification to help satisfy an intrinsic need to be connected to others. We can understand why an older, lonely woman may give into a charming student to be sexually filled and gratified. We

---

[70] De Moor.

can empathize with the divorcee who holds onto a destructive friendship because of the pangs of loneliness. We might even know the cycle of addiction and how it propels us further and further into desire. We have given into the desires of others to satisfy them. Desire has the power to cure, as is seen by patients, who come in, are assessed, healed, and sent home. Desire has the power to heal: a lonely, angry man has found friendship and happiness with fish. Desire also has the power to destroy relationships, bodies, hopes, and dreams. Through these writings, we can learn how to recognize the cycle of desire and attempt to curb our actions before they become dangerous.

CHAPTER 5: THE DESIRE TO ESCAPE MEDICINE'S DEMANDS

> This flight to the woods or something like it, is a thing most of us have yearned for at one time or another…. For in [the cities'] jumble we have lost touch with ourselves, have become indeed not authentic persons, but fantastic shapes in some gigantic fever dream….
>
> With this pressure upon us, we eventually do what all herded things do; we begin to hurry to escape it, then we break into a trot, finally into a mad run (watches in our hands), having no idea where we are going and having no time to find out.
>
> [Rivers] wanted to plunge into something bigger than himself.
>
> William Carlos Williams, "Old Doc Rivers," (p. 26).

William Carlos Williams captures the sentiment of many people caught in a fast-paced world without the opportunities to slow down, evaluate their situation, and compose themselves. Medicine, specifically, is a career that leaves very little room for keeping in touch with one's self. When we realize we are losing touch with ourselves we "hurry to escape it." People behave in many ways as a form of escape. For example, Doc Rivers escapes into Maine to go hunting, and he also escapes life through a deadly drug problem. He is not the only physician to have lost touch with himself either because of life in general or specifically because of practicing medicine. Medicine demands much from its physicians; it demands physical dedication, academic understanding, human interaction, emotional involvement, and, sometimes, a spiritual connection to patients. Because of all of these demands, physicians are likely to become impaired through addiction and/or isolation.

I will use the works of four physician-writers to illustrate how medicine's demands can contribute to physicians becoming impaired. I will first look at William Carlos Williams' short story, "Old Doc Rivers," then Samuel Shem's *The House of God* to illustrate this point. Abraham Verghese's *The Tennis Partner* directly deals with impaired physicians, and the relationship between physicians and addiction and will be complemented by David Hilfiker's book *Healing the Wounds*. With these four physician-writers as my guide, I hope to show how medicine's structure and demands can lead to the impairment of physicians. The demands include, but are not limited to, money, hierarchy, ethical decision making, authority, efficiency, specialty, perfection, and competition. These demands are placed upon physicians during their training and often do not subside in their practice.

William Carlos Williams managed to succeed at being both a practicing physician and an active writer. Although he practiced in an urban setting, he wrote about rural medicine: a horse and buggy carried a physician to house visits, there was often no treatment to be offered, and payment varied from cash to tobacco for a doctor's pipe. He wrote about medicine from an insider's point of view. His short story "Old Doc Rivers" (1932) goes beyond describing a physician's life; the story raises important questions for its readers. For instance, "Is Rivers a competent physician?" The text gives information that he was a great physician, but only when he was high. His vice and gift are intertwined. He could diagnose and evaluate a situation better than anyone in town and yet he was a drug addict. The drugs revived him and brought him to life. He is a wounded healer; he is sick and yet his illness gives him the power to heal. In this light, was he impaired? Can he heal only because he's impaired?

Williams gives no indication why Rivers turned to drugs. But there is a connection between his powers as a physician and his vice of drug use. The connection between disease and healing is perplexing within the context of medicine. Why are there so many wounded healers in this field? Do people enter medicine in hopes of finding answers and cures to their own problems, or does medicine cause illness in its ambassadors? We do not know what led to Rivers's addiction, but we do know how it

was sustained during his practice. He was able to see illnesses and diseases that others could not diagnose, and then stand resolute in that diagnosis: "He was not nervous but cool and painstaking—so long as he had the drug in him" (p. 19). The drug calmed him during technically difficult situations, such as surgery. As to his technical competence, the townspeople were happy to have him around. Being technically efficient and having sound clinical judgment are crucial to being a good doctor. If a physician is technically competent but is under the influence of a controlled or uncontrolled substance while diagnosing and treating, is he an impaired physician? What happens when the drug overtakes him and he stops being a technically adept physician and is only a mystical character, a character who can diagnose but can no longer treat? And why did his fellow physicians not put an end to his tenure as a doctor?

Although his fellow physicians and many townspeople knew that Rivers was a drug addict, no one ever intervened and attempted to either help him or confiscate his license. Williams's narrator says:

> My wife would sometimes say to me, If you know he is killing people, why do you doctors not get together and have his license taken away from him?
>
> I would answer that I didn't know. I doubted that we could prove anything. No one wanted to try. Dr. Grimley, though, did want to do something….
>
> He wanted to have Rivers arrested, he wanted to have him prosecuted for malpractice and to put him out of the way once and for all—said he'd do it.
>
> He never did.
>
> In reality, it was a population in despair, out of hand, out of discipline, driven about by each other blindly, believing in the miraculous, the drunken, as it may be. Here was, to many, though they are diminishing fast, something before which

> they could worship, a local shrine, all there was left, a measure of the poverty which surrounded them. They believed in him: Rivers, drunk or sober. (Pp. 39-40)

If the doctors had banded together to get his license revoked, they probably would have succeeded. But they didn't. Perhaps they didn't because they, like the population, believed that he had some gift: a gift for diagnosis and swift decision-making skills; or perhaps they wanted to believe in something bigger than themselves. Perhaps they did not think they would be successful because they could not prove he ever killed anyone. Perhaps it is a combination of the two. Medicine creates physicians who are expected to be self-sufficient; therefore, doctors have become isolated. Perhaps the community did not intervene because they felt that a doctor's struggle is private and a community of others should not attempt to help. Maybe the doctors did not try to stop him out of selfish motives: they would receive just as much business from the townspeople regardless of his license status. The passage above explains why his license was not revoked. It also shows why people still went to see the wounded healer. Perhaps we all still need something to worship; perhaps we still need a mystical healer in our midst.

Rivers is an impaired physician throughout the entire story, even when he is technically adept and diagnostically brilliant. The AMA defines an *impaired physician* as a person who has "any physical, mental or behavioral disorder that interferes with the ability to engage safely in professional activities."[71] Rivers can safely engage in professional activities until a certain time. Although he is never fully professional, he is, for a long time, not fully impaired. He eventually is unable to treat patients safely, and that has a direct relationship to his drug use. But beyond his drug use, he is impaired because he will never be satisfied. His mental and behavioral disorder is that he is trapped in a dangerous cycle of desire; he will always want more. Lacanian desire says

---

[71] American Medical Association, H-95.955.

that we are always lacking and seeking after the Other. An addicted physician can not remain technically competent forever; eventually he will be so desperate for drugs that the drugs will overtake him and he will not be able to practice any longer. This is Rivers's trajectory. "Of course, it got him finally; he began to slip badly in the later years, made pitiful blunders" (p. 36). This is the cycle of desire; the need starts out small and slowly escalates, then it begins to spin out of control, the demand builds and we want more. We always want more.

William's old Doc Rivers is by no means the only impaired physician in fiction. Samuel Shem's interns in his book *The House of God* (1978) are all struggling with overtreating, isolation, and medicine's demands. Roy Basch and his fellow interns struggle through their first year in residency and do not remain humane or human. Shem begins part 2 of *The House of God* by discussing the medical hierarchy. He first describes it as a pyramid, many on the bottom and one at the top. He says this: "Given the mentality required to climb it, it was more like an ice-cream cone—you had to lick your way up. From constant application of the tongue to next uppermost ass, those few toward the top were all tongue" (p. 21). But, according to Basch, the House of God was "known for its progressiveness." "It was one of the first hospitals to offer free marital counseling, and when that failed, to encourage divorce" (p. 22). By beginning his book in this manner, Shem sets the stage for the type of institution and some of the problems the interns are about to face. To survive in the hierarchy, they must learn the appropriate skill set: pleasing those above them. The institution offers counseling and encourages divorce. But why? Because it will be a difficult road ahead, and the institution does not make it any easier.

The year was very difficult for the interns. During the final confrontation with Leggo, the Chief of Medicine, Chuck asked one of the central questions of this book: "How can we care for patients if'n nobody care for us?" (p. 400). The interns are left isolated, lonely, and without support from their superiors. Leggo believed that they cured; they don't. Leggo believed that they enjoyed their time on the wards; they didn't. Leggo believed that they were happy; they weren't. They were without real relationships

and felt pressured by the medical hierarchy. They became machines; they were no longer humans. Yet they were forced to work in a world filled only with suffering, humanity, and death. Berry, the astute psychologist observed:

> It's been inhuman…. No wonder doctors are so distant in the face of the most poignant human dramas. The tragedy isn't the crassness, but the lack of depth. Most people have some human reaction to their daily work, but doctors don't. It's an incredible paradox that being a doctor is so degrading and yet is so valued by society. (P. 381)

It is no wonder that physicians forget how to be empathetic. They are not allowed to have a reaction to their work; they are expected to form clinical detachment and press forward, never fully entering into relationships with their co-workers or their patients. They face a difficult journey to try to remain compassionate in the midst of the many demands that medicine places upon them.[72]

Abraham Verghese also discusses the proclivity of physicians to be impaired. In the prologue to his book *The Tennis Partner* we follow an intern who has been sent to the Talbott-Marsh clinic in Atlanta, Georgia, for physicians with addictions. We later learn this intern is David Smith, the protagonist, but at that time, we learn only that many physicians fight the disease of addiction. Dr. Doug Talbott, a recovered addict and clinic director, thinks about all the physicians he has helped through his time at the clinic:

> Physicians ha[ve] learned to be self-sufficient, and even to think of themselves as invulnerable, as if they had struck a bargain with the Creator in return for caring for the ill. The very qualities that led them to be doctors—compulsiveness, conscientiousness, control over emotions, delayed gratification, fantasies of the future—predisposed them to use drugs. (P. 5)

---

[72] See Borgenicht's essay, for the ironies and difficulties that can arise by a physician's trying to remain clinically detached.

This passage begs the question: Do physicians have a more arduous struggle with desire than nonphysicians? Are the very qualities that make them good doctors double-edged swords gleaming with desire? Or is this cycle of need, demand, and desire pervasive in physicians' writings because these authors are dealing with humanity and this is inevitable? Does desire lead physicians to be the best and the worst doctors?

Verghese reflects about David Smith and his addiction to drugs. Verghese thinks the medical profession contributes to addiction:

> I cannot help but believe that David's aloneness, his addiction, was worse for being in the medical profession—and not just because of ease of access, or stress, or long hours, but because of the way our profession fosters loneliness.
>
> Despite all our grand societies, memberships, fellowships, specialty colleges, each with its annual dues and certificates and ceremonials, we are horribly alone. The doctor's world is one where our own feelings—particularly those of pain, and hurt—are not easily expressed, even though *patients* are encouraged to express them. We trust our colleagues, we show propriety and reciprocity, we have the scientific knowledge, we learn empathy, but we rarely expose our own emotions.
>
> There is a silent but terrible collusion to cover up pain, to cover up depression; there is a fear of blushing, a machismo that destroys us. The Citadel quality to medical training, where only the fittest survive, creates the paradox of the humane, empathetic physician, like David, who shows little humanity to himself. The profession is full of "dry drunks," physicians who use titles, power, prestige, and money just as David used drugs; physicians who are more comfortable with their work identity than with real intimacy. And so it is, when one of our colleagues is whisked away, to treatment, and the particulars emerge, the first response is "I had no idea." (P. 341)

These are strong words to end a book, and yet Verghese is not the only physician to point this out. As I have indicated, Williams and Shem point to these same themes in their writings. Shem's *The House of God* goes into detail about the "dry drunks" in the medical hierarchy and institutions. Doctors are dying physically and emotionally because they feel forced to hide their emotions when they are daily faced with the suffering of others. They cannot extend humanity to themselves although they are expected to extend humanity to their patients. Chuck's words ring clear: "How can we care for others if'n nobody cares for us?"

Linda S. Carr-Lee, in her article "Medical Humanities Meets the Impaired Physician," points out that fifteen percent of doctors will be impaired at any one time.[73] Verghese has found that physicians do not turn to drug addiction for *euphoria*, but relief from the *dysphoria* of their existence.[74] They do not want the high for the sake of the high but rather as an escape from their existence. Obviously, not all physicians turn to drugs or alcohol; but the proclivity for them to be, at the very least, "dry drunks" is high because of the nature of their work. Just as Roy Basch and his fellow interns chased skirts and behaved as machines, David Smith turned to drugs for his escape. These behaviors are a way to gain some distance from a miserable existence trapped in a world where nobody cares for them and they are forced to face the suffering of others. Physicians are caught in a cycle of desire. Lacanian desire says that a need sparks a

---

[73] Linda S. Carr-Lee, "Medical Humanities Meets the Impaired Physician," *Medical Ethics in Utah* 17, no. 1 (January 2006): 1.

[74] Abraham Verghese, "Physicians and Addiction," 20. This article proposes interventions as part of the solution for physician impairment. However, this suggestion was not universally accepted. In a letter to the editor of the *New England Journal of Medicine*, Joseph O. Merrill and G. Alan Marlatt do not believe that interventions are helpful: "Reliance on confrontational interventions may keep physicians or others with addiction problems from seeking help at earlier stages of their addiction, knowing that coercive treatments might be mandated. This may fulfill the prophecy of denial rather than the promise of effective therapy." Verghese responded to that letter in the same section. He claims that "the goal of treatment for an impaired physician who wishes to practice medicine has to be complete abstinence and sobriety. Many physicians do seek help…. For physicians who will not seek help and whose impairment is obvious to others, an intervention is inevitable." "Health Care Workers and Addiction," *New England Journal of Medicine* 347, no. 13 (September 26, 2002): 1045.

demand that eventually turns into a desire. The need for relief drives a person to find satisfaction however she can whether sex, drugs, or alcohol. But those only temporarily satisfy, she is left wanting more. She is now entrenched in the cycle of desire. She has been trying to find a solution to her needs through a façade. The drugs are not what she truly wants; she wants the Other; she wants community, rest, and relief. The drugs are only a symptom of a much deeper need that is not being satisfied. Lacanian desire claims that we will always want more. Our needs will never be met; we will always crave something else because we never really seek what we truly want.

Because of the very qualities that make them good doctors, according to Dr. Doug Talbott, doctors are predisposed to addictive behaviors. As a community, we demand many things from our physicians; we expect them to be technically adept, emotionally aware, and available to us in our time of need. We do not want our physicians to be chemically dependent. But this problem is prevalent enough that the AMA has developed policies in regards to the matter. An excerpt from the AMA's handbook on impaired physicians says:

> (2) The AMA encourages state medical society-sponsored physician health and assistance programs to take appropriate steps to address the entire range of impairment problems that affect physicians, to develop case finding mechanisms for all types of physician impairments, and to collect data on the prevalence of conditions affecting physician health. (3) The AMA encourages additional research in the area of physician impairment, particularly in the type and impact of external factors adversely affecting physicians, including workplace stress, litigation issues, and restructuring of the health care delivery systems.[75]

Obviously, the problem is large enough that the AMA has developed a policy and steps are being taken to help alleviate the problem. At the core of the problem is unsatisfied

[75] American Medical Association, H-95.955.

desire. Physicians' needs are the same as those as nonphysicians. They want to be cared for and treated with respect, especially in times of distress, but many do not receive support from within the practice of medicine and therefore turn to other avenues for satisfaction. They tend to be self-controlled and self-sufficient. These are the very qualities that make them good doctors, but in that control and competence, they may not be able to articulate what they need or how it can be fulfilled. They may not know that they are lacking anything and therefore are not consciously seeking some form of satisfaction. But Lacan says that we are always seeking the Other and that is why we will never be fulfilled.

Williams, Shem, and Verghese are not the only physician-writers who discuss demands of medicine and how they can lead to impairment. The final physician-writer whose work I will discuss is David Hilfiker. One of his memoirs, *Healing the Wounds*, helps illuminate how medicine's demands play a role in creating impaired physicians. Hilfiker practiced medicine in rural Minnesota before taking a sabbatical and then moving to urban Washington, D.C., to practice "poverty medicine." During his time as a general practitioner in rural Minnesota, he treated many patients and observed a medical system different from that of the other physician-writers. But even with all the differences, similar themes emerge about practicing medicine.

Hilfiker divides his book into chapters with titles such as "Clinical Detachment," "Money," "Authority," "Playing God," and "Hierarchy." Within these chapters, he hopes to show how each of these ideas affect his practice of medicine. He often shows how he has failed to be a caring, empathetic, and completely present physician, but by admitting his mistakes, he also describes how difficult it is to practice medicine in our current medical system. For example, the chapter "Efficiency" outlines what a day in the life of his medical practice looks like. He bounces back and forth between the emergency room, his clinic, and minor surgery ward. Patients are scheduled back to back; and because the doctor has to see so many patients, there is the tendency toward spending a limited amount of time with each patient. It is not because he does not want to spend more time

with the patient, but because there is simply not time to do so. Going against his medical training that encouraged asking open-ended questions, Hilfiker admits:

> Open-ended questions are not, however, very efficient. It is much quicker to ask whether a patient has pain anywhere or has a fever than to give her a chance to talk about whatever is on her mind. After all, the patient may need to take a circuitous route to get to the real problem, a route which may bear no relationship to the fifteen minutes the schedule has allotted her. If I am concerned primarily with efficiency, I may never discover the nature of problem that really concerns the patient. (P. 141)

Efficiency may not be his greatest concern, but the reality of his practice may force him to get right to the point as opposed to allowing the patient to tell the doctor of her many woes. It is not out of a hardness of heart that the doctor does not take more time with each patient, but out of necessity. The doctor wants to be empathetic and hear about the patient's problems, but he knows that if he stays to be with the patient, another patient will not be adequately treated. The doctor is now in the cycle of desire. He wants to hear all the stories the patient has to tell, but if he does he may never get to the rest of his patients. There is little doubt that the patient may be relieved for the time being, but telling the doctor what is happening may or may not solve a patient's problems. The patient will demand more time with each office visit, and the doctor will have to decide how much time to give. As the patient-physician relationship deepens, the doctor will feel more obligated to give the patient all the time she demands. Ultimately, the doctor will not be able to fulfill his duties to his community in the same way that the efficient physician will. Will this make him a better doctor or a worse one? Should we measure the physician by the amount of patients seen, treated, and discharged or the amount of time spent with each patient? Does it have to be either/or?

Another of Hilfiker's chapters, "Hierarchy," displays how a doctor may have to play certain roles within a hierarchical system in order to practice effectively. A

physician with private practice is at the top of a hierarchy that gives him or her sole responsibility for the treatment and outcome of a patient. Hilfiker laments:

> Such an organization may help promote efficient functioning, since some person has to take over-all responsibility for coordinating patient care, and the most appropriate person is often (though not always) the physician…. Certainly, it leaves little room for the kind of cooperation that is basic to a supportive work-place or good medical care. (Pp. 159-60)

As a doctor treats more patients and is bouncing back and forth between his clinic and the emergency room, it is natural for him to grow weary and make mistakes. The added responsibility and patient care likely contribute to a physician's inability to be an effective and competent doctor. Physicians are given authority by the community and by their staff: to ask for help would be admitting a weakness. For a group of persons who have had to fight and struggle through medical school and residency, admitting weakness is a difficult task.

After losing a patient, Hilfiker discusses how he should have stayed with the nurse to discuss the situation, but he does not. He is too embarrassed, tired, and afraid to lose the authority he has over her. He shows how it is sometimes more comfortable for all involved if the roles remain as they always are:

> It may feel more comfortable for both parties to stay in a known relationship than to take a chance. The end result is isolation from potentially healing human contact. The physician is left alone with the overwhelming burden of being helper, healer, doer, of conforming to the expectations of "good men" in our dominant Western culture. He is ideally always in charge, not swayed by emotion (yet compassionate), efficient, powerful, omniscient. The possibility of sharing is lost, and the physician goes on his way. (P. 167)

It is no wonder physicians look for a way of escape. The expectations are daunting and difficult to fulfill. They are expected to be all things to all people in every medical situation. There is no person on the planet who can fill those criteria. Due to their training, their natural proclivities, and our culture, they do not feel comfortable turning to colleagues and staff members for help and support.

Just like the rest of the world, physicians make mistakes. Unfortunately their mistakes are not as trivial as other work-related mistakes. Their mistakes can prolong an illness, cause disability, and even kill patients. In addition to their great power to help, cure, and heal, they also have the power to destroy. Combined with the outcomes being more catastrophic in medicine than in many other professions, "a physician is less prepared to deal with his mistakes than is the average person. Nothing in our training prepares us to respond appropriately" (p. 83). Medical school is competitive and takes place in competitive university teaching hospitals. In these circumstances it is not difficult to understand why mistakes are not often discussed. These are embarrassing and can be harmful to a person's career. Unfortunately, if more doctors talked about their mistakes, it would not only lessen their individual pain, but would also prevent other mistakes from happening. However, doctors are caught in the cycle of desire. They desire to be at the top: in the best residency programs and in the most lucrative fields (with obvious exceptions outside of Hilfiker's book). Because of this desire, they must attend to each need and demand placed upon them in order to succeed. They will keep their mistakes quiet and bear the agony alone.[76] They put in the obscene amount of hours and find a diagnosis with or without consulting a second physician. Medical training is cutthroat. It begins in the premedical school screening, continues through the coursework and rotations, infiltrates the internship and residency programs, manifests in finding a prestigious fellowship, and culminates in where and how they practice medicine. Despite

---

[76] However, surgeons have routine "morbidity and mortality" rounds where they discuss mistakes made with the hopes from learning from past errors. The meetings, while useful, are often stressful for surgeons. The intense scrutiny does not necessarily provide the space for understanding and comfort that Hilfiker seeks. See Atul Gawande's *Complications: A Surgeon's Notes on an Imperfect Science* (New York: Picador Press: 2002).

their competitive nature, physicians must consciously learn how to share the burden of medicine with others before turning to escape methods such as drugs or alcohol.

Hilfiker became an impaired physician at the end of his time in Minnesota. He was not addicted to drugs or alcohol; he was professionally burnt out. He had learned to live with medicine's demands and was behaving like a machine: seeing patients very quickly and no longer treating them in the manner that he desired. He knew he had to stop practicing medicine for a while. He recalls:

> Clinical detachment, efficiency, and productivity, prestige, authority, the medical hierarchy, and wealth are all phenomena based on a common value structure in which people are treated as if they were not fully human, as if they were no more than objects to be manipulated. I did not consciously choose that value structure; indeed, I rejected the notion of it, but so much of my life as a physician was spent in its service that it inevitably became mine. (P. 185)

Hilfiker was impaired in the sense that he was no longer treating patients with the same respect and dedication with which he wanted to treat them. He does not blame the medical system for his burnout; he knows he contributed to all those aspects he did not like—clinical detachment, efficiency, and the lure of money inevitably became his because he was a physician in their service. But he could no longer sustain his own set of values or mode of practice while remaining in Minnesota. He had to get out; so he went on sabbatical to Finland.

Just as Old Doc Rivers escaped to Maine, Roy Basch and Berry went to France, and David Smith went to the Talbott-Marsh clinic in Atlanta, David Hilfiker escaped to Finland for restoration and healing. These physicians could not remain in the medical system that demanded so much from them. They could not sustain their own sense of values or sense of self in a system that demanded their minds, bodies, and souls. They all needed more from those around them to function as a whole and competent physician. They could not accept help from their families or colleagues for many reasons. Perhaps

they did not want help like Doc Rivers, whose talent as a physician was tied to his drug use. Perhaps they did not know how to ask or even that there was something wrong, like Roy and his fellow interns. Perhaps they were entangled so deeply by drugs that they could not fashion a life without them like David Smith. Or perhaps like David Hilfiker they did not feel that they could ask because of medicine's structure. But more than all of those reasons, impairment will happen regardless of the help of others, because nothing will ever be enough. The cycle of desire states that we will always want more. Nothing will ever be enough. Relationships and empathy are crucial ways in keeping impairment at bay, as I will show and discuss in the following chapter. We must remember, however, that as we seek for one solution, we will be searching after the object *d'Autre*—the Other. We must learn how to differentiate what we need, what we want, and what we are seeking before any healing begins.

CHAPTER 6: SOLUTIONS FOR HEALING

This thesis has shown how Jacques Lacan's cycle of desire ensnares humanity in many different ways. I have illustrated how the cycle of desire affects physicians. Desire and physician impairment are related. Through both fiction and memoirs, I have given examples of how physicians are trapped in desire and how that can affect their actions toward patients, co-workers, and their selves. But the situation is not hopeless. Two physician-authors, whose work I already examined, propose possible solutions for healing impaired physicians.[77] I will first look at Samuel Shem's relational model and then at David Hilfiker's servanthood approach. These two solutions are not contradictory but complementary.

First I want to look at how Shem links desire to the human condition and how it connects to literature. In his article "Psychiatry and Literature: a Relational Perspective," he argues that psychiatry and literature are both rooted in relationships. Relationships are what move us toward healing; without relationships we are left alone and disassociated from both society and ourselves. Shem's relational perspective comes from work at Wellesley College where scholars have developed a new model of development. He says:

> The basic parts of the model … are these: first, the primary motivation of human beings is the desire for connection; second, the shift of focus from the centrality of *the self* to the centrality of *the relationship* (the relational context defines and

[77] These are, by no means, the only solutions for healing. Abraham Verghese suggests intervention in his article "Physicians and Addiction." Robert H. Coombs, Karen Perell, and Jo Marie Ruckh's article examines how a seminar for premedical students can possibly prevent emotional impairment. They suggest promoting realistic expectations for the upcoming medical students, informing them of the realities of practicing medicine. They also adhere to the belief that emotional support produces real change and help. And, finally, they encourage a balanced perspective and life-style instead of a single-minded pursuit of medicine. See their "Primary Prevention of Emotional Impairment among Medical Trainees," in *Academic Medicine* 65, no. 9 (September 1990): 576-81.

> reflects the self, both in development and in daily life; one can speak not only of a quality of *the self* but also of a quality of *the self-in-relationship*); and third, the seeds of human misery are planted in disconnections, violations, isolation, and domination, and the core of healthy growth is the movement from isolation toward connection.[78]

The rest of the article explains how relationships allow us to see ourselves and others more clearly. He claims that the primary motivation of humans is the desire to be in relationships, to be connected. The relational approach between a physician and her patient is part of the healing process described in some physicians' writings. Shem's relational perspective is important while examining desire and physicians' writings. Shem argues that psychiatry and literature enable the possibility for relationships and thus help to satisfy the patient's desire for connectedness and healing. Through these avenues, the patient begins to feel more attached to the world as a whole, and through that interaction and process, the patient can regain his senses and leave behind the disassociation that has led him to toward a place of isolation and despair. Shem's relational model embraces the relationship between psychiatry and literature showing how literature is another avenue for connecting to humanity: to the Other. Literature not only shows what life is but what it should be. He remarks:

> This vital tension—between life as it is and life as it should be or could be—is the heart and soul of what we mean by a relationship, whether between a reader and a book, a therapist and a client, or, the real point here, one human being and another. Being a tension, it cannot be static, but must, to live, move. Sadness

[78] Samuel Shem, "Psychiatry and Literature: A Relational Approach," *Literature and Medicine* 10 (1991): 43-44.

> tends toward static and grudgery, and can lead to depression; sorrow moves, and heals.[79]

The point here is that relationships are dynamic. It is along this continuum of relationships that physicians can place their relationship to a patient, to a co-worker, and to their families, and find healing for the isolation and disconnectedness they are experiencing. Physicians are forced to live in a world where relationships are condensed to fifteen-minute segments and working with others who are trying to cope with the same pressures as they; it is no wonder that relationships are difficult to foster and sustain in such a world. But as difficult as it may be to be relational in the sense that Shem speaks of—the relationships that move forward—it is crucial for physicians, and humanity at large, to work on being with one another.

The relational model serves as a reminder for physicians that a relationship with a patient is one way to stave off loneliness and impairment. Shem's article "Fiction as Resistance" gives his reasons for writing *The House of God*. It was to resist isolation and disconnection.[80] Like the connection between psychiatry and literature, Shem sees the connection between using literature as a way of exposing the isolation that can occur while practicing medicine. He promotes relationships because he thinks they are central to humanity and, more specifically, to changing the medical hierarchy. Reflecting back on his time at Harvard, he points out that this institution is a power system and there is no common ground. He contends that "the only real threat to the power of the dominant group—a power that may be based on the hierarchical lines of authority, on race, gender, class, ethnicity, or sexual preference—is the *quality of the connection among the members of the subordinate group*."[81]

---

[79] Ibid., 62.

[80] Sameul Shem, "Fiction as Resistance," 935.

[81] Ibid., 936.

Shem's relational approach illustrates how a physician in isolation may be unhealthy and consequently behave in a manner that is detrimental to his patients. But seclusion does not happen arbitrarily in medicine; there are connections between the current structure of medicine and impaired physicians. David Hilfiker and Abraham Verghese both specifically address medicine's demands and how they affect physicians. The very qualities that led them to be doctors predispose them to use drugs. As I have shown through Hilfiker's and Verghese's books, the personality types that prompt people to go into medicine can contribute to their becoming addicted to drugs.

If a physician's personality does not turn her to drugs, she will have to handle the pressures of medical school and residency. Medical school curriculum has been largely focused on facts and figures, evaluating students by test scores and performance. Students compete with each other for the highest grades in undergraduate school to get into medical school. Students compete with each other during medical school for the grade of "high honors" that is only given to a certain percent of each class. They compete with each other for coveted residency positions. In residency they compete with each other for the chief residency. If they remain in academic medicine, they are always trying to move up the ladder in the hierarchy. Hilfiker spends his entire book, *Healing the Wounds*, talking about the pressures of medicine and how they eventually led him to quit his practice, go on sabbatical, and relocate to urban Washington, D.C., to practice "poverty medicine." His book discusses the inherent demands of medicine that can lead to isolation or addiction.

Hilfiker's book is an honest look at the difficulties and frustrations of medicine, but it does not end without hope. Throughout the entire book, Hilfiker displays his own humanity for the world to see: he admits his medical errors, his lapses in judgment and in empathy, and his frustrations with co-workers and patients. After reading his memoir, one can see a more complete picture of practicing medicine. His final chapter, "The Wounded Healer," describes his new life as a poverty physician juxtaposed to his life and work in Minnesota. Before, he felt solely responsible for curing his patients, but he now feels part of a medical team. He, like Verghese, draws our attention to being with

patients—to recognizing them and sitting with them. The physician is not an ultimate healer, a person who can sustain all the pressures of medicine and life and still cure all who are under his care; rather, the physician is a wounded healer who can attempt to heal, but with limitations. Hilfiker summarizes the purpose of his book:

> I have tried to show in this book that American doctors, whether rural family practitioners or high-tech surgeons, face expectations from their patients, from their own profession, and from the society at large that are utterly unrealistic on a day-to-day basis. They are asked to be Renaissance men and women in an age when that is no longer possible; they are expected to be ultimate healers, technological wizards, total authorities. (When a physician refuses to accept those expectations and limits herself to areas of special expertise, she is criticized for being too narrow, or from being concerned only with disease and not with health. When she tries to be a generalist, she is criticized—or sued—for her lack of expertise.) Such expectations add to a rising tide of suspicions of and accusations directed at doctors and medicine, as well as a growing feeling of uncertainty among doctors themselves about the nature of doctoring and of medicine in our society. No wonder that—despite her prestige, her salary, her power—the physician today is a wounded healer. Who could live up to such a world of expectations without either crumpling or hiding behind the masks of omniscience and omnipotence? (P. 197)

In this paragraph, Hilfiker explicitly lays out his frustrations with medicine. The expectations placed upon physicians are too great and no person can sustain them without eventually crumbling in one form or another. They eventually become impaired, be it through physical addiction, burn out, emotional detachment, isolation, overtreating, or through some other coping mechanism. Medicine does not promote a holistic life for its physicians; it is no wonder that physicians have a difficult time promoting it for their patients.

However, Hilfiker does not leave us without hope. He offers possible solutions for healing:

> The first step is to allow ourselves to know we can't do it all. Recognizing our limitations, we can begin to tailor our work to our individual gifts. Second, we must recognize that we cannot deal with the stresses of our work alone. The hierarchy, the competitive ladder, needs to be changed into something at least more closely approximating a circle of peers. Third, if we are to begin to regain our balance, we must recognize that inherent in the work of doctoring is the concept of servanthood. This is ultimately a mystery: we will always be at odds with ourselves and our world unless we accept the mantle of servanthood along with the role of healer. Finally, each of these beginnings will drastically alter the economics of medicine. Money is the linchpin. (P. 202)

Hilfiker's solutions, like Shem's, center on being in community but they do not say that relationships are going to heal the wounded healer. Hilfiker thinks a change is required in the structure of medicine. Specifically changes are needed in the service, salaries, and society of medicine. While Shem does not directly address the problem of money, Hilfiker spends many pages discussing the tension that lies between serving society and taking what he considers exorbitant amounts of money for the services rendered. Both Shem and Hilfiker express their frustrations with medicine, and while Shem chooses psychiatry because he believes in relationships, Hilfiker chooses to remain in the trenches of general practice, battling all the external and internal pressures of medicine. The solutions set forth by these men are just a beginning. There will always be problems and solutions; there will always be more to address, more to lament, and more to fix.

We desire more. This is the basis of Lacanian desire; we want more than we can ever have. When facing illness, either as a physician or as a patient, one functions either in community or alone. Arthur W. Frank says it is an ethical *choice* to live in relationship with one another during sickness (p. 37). Humanity must make the choice to live

dialogically; we must choose to live with others, experiencing each other's pains. It is only through community that we can learn how to function both in society and in a relationship to our selves. We function both as selves and as selves-in-relationship; we cannot separate the two.

But we will always want more; we can never be satisfied. Where does this leave us? If we will never be happy with ourselves or our relationships, what hope is there for any sort of solution for healing? This is a difficult question. How can we ever escape or heal from the cycle of desire? The answer is no, we will never be released from the cycle of desire. However, this does not mean that we should not aspire to heal and be aware of our motives and desires. Frank thinks an ill person who has the best perspective on himself and on his world is what he calls a "communicative body." This body type

> accepts *contingency* as part of life … it is fully *associated* with itself … association and contingency are contextualized by the quality of *being dyadic* and *producing desire*, and these qualities crystallize the body's ethical dimension…. The communicative body realizes the ethical ideal of existing *for* the other. (Pp. 48-49)[82]

Frank focuses on the ill person's body and experience. One could assert that an emotionally blocked physician is not ill, but he is. Without communicating and being in deep relationships, we are sick. We are relational beings and without being connected we are isolated and alone. We cannot function very long in this state of being.
The cycle of desire dictates that we will never be satisfied, so the desire for connection will never be complete. We will always lack what we want most. We can satisfy those

---

[82] Frank, 48-49. *Association*, for Frank, means understanding that "the body-self exists as a unity, with its two parts not only interdependent but inextricable…. Thus no distinction between corporeal disease and illness experience can be sustained: a problem within the tissues pervades the whole life" (p. 49). I also assert that a problem within the self, such as emotional or mental impairment in physicians, affect and is connected to the body. The associated body is completely intertwined; there is no separation; just as the corporeal body affects the illness experience, so does the illness experience affect the physical body.

cravings only for limited spans of times. When the patient finds healing through the care and relationship with her physician, the patient will still want more. Even though the patient will desire more, by being in a relationship, he can help to curb some of those desires. We will never rid ourselves of the desire for more; that cycle will always exist, but by being aware of the desire and knowing ways to help appease the cycle, we can learn to be healthier in all aspects of our lives.

For Hilfiker, the fact that there is no true solution to the problem of impaired physicians is not troublesome. In fact, Hilfiker asserts that physicians must be wounded healers because there is no other way. In order to heal, they must first take on the suffering of others:

> We all feel or have felt the distress and the isolation. Ultimately, I believe, there is no solution to the problem. All of us who attempt to heal the wounds of others will ourselves be wounded; it is, after all, inherent in the relationship. We can try out new attitudes, share the burden with co-workers, free ourselves from the idolatry of money, but eventually we reach the nub of the issue: in healing, we ourselves take on those others' wounds.
>
> Only by recognizing and accepting his or her own wounds can the healer minister to others. It is our wounds that make us human, that bridge the gap between patient and physician. When we have done all we can to improve our situation, when we have created the best environment possible, there will still be the pain that comes from meeting others deeply. At that point we can either fight against the pain, and in so fighting, bring ourselves to a numb cynicism or a fragile despair, or we can accept it, become one with it, and allow it to minister to others. (P. 207)

There is no true solution to our problem of desire, to the tension in medicine, but by accepting our own limitations and our own wounds we can truly relate to others. Physicians must bear witness to the suffering of others without being able to feel the pain

or be attended to in the moment, as has been illustrated by the works in this thesis. There is not a healthy catharsis built into the structure of medicine, so physicians must learn to navigate the wards filled with disease, illness, and death without the proper skills. Society and medical education must be more lenient and provide additional training to our wounded healers. We must first recognize that there is a problem in medicine; that cancer has yet to be cured is not the problem, but rather that a profession that deals with humanity gives little room for its professionals to be human. They are not allowed to have bad days, to be tired physically or emotionally, or to have needs of their own. Society must give physicians the freedom to be wounded healers. As Hilfiker claims, it is only through their wounded status that true healing can be found.

Like Hilfiker, Kate Scannell is frustrated with the structure of medicine. She says that medicine has moved into becoming a "corporate paradigm." She says, "the new paradigm unsettles me because its shallow purview fails to accommodate all operative elements of the healing interactions that occur between physicians and patients."[83] She then describes a metaphor of a warehouse full of the discarded parts of the medical practice that can no longer be accommodated in this new paradigm: the stories, the details, the relationship between patients and physicians, and the relationship between physicians and physicians. For Scannell, writing is one way to move through the warehouse and reclaim the discarded moments. Writing is a way of staying in relationship and in the moment. Physician-authors have the ability to move toward healing because they are reliving those moments; they have reclaimed the emotions, frustrations, and details of their life. They have the opportunity to give a voice to those who have been silenced. Katrien De Moor says that there is a literary form of care: "the sort of witnessing that is constructed, implicitly or explicitly, as an extension of practices of care and a continuation of the caring process."[84] Writing stories, fictional or not, not only gives a voice to patients but also is a way of saving the lives of physicians; it is a

---

[83] Scannell, "Writing for Our Lives: Physician Narratives and Medical Practice," 80.

[84] De Moor, "The Doctor's Role of Witness and Companion," 208.

way to continue building relationships and remaining alive in a field that does not give much leniency or care to its own.

Through the writings of physician-writers we see the struggles and triumphs of this profession; we learn about a life we may not lead. Reading physicians' writings is just one way of teaching and helping the upcoming generation of physicians. Using memoirs and stories medical educators can discuss the pressures that they face and their students will face. They can help teach students about relationships, servanthood, resistance, and connection with the hope that future students will be able practice medicine with a sense of what is wrong and how to change. Students, residents, and attending physicians do not only need to know the technical information about medicine, but they also need to know how relate to others and how to function as wounded healers. It is time for society to help our wounded healers as they help us.

This thesis has been only a preliminary look at physician impairment and its relationship to desire; there is much more to examine. Does reading literature make any sort of difference for its readers? Is physician impairment diminishing as there are more clinics and programs for impaired physicians? These questions remain unanswered in this thesis, but I laid the groundwork for examining these connections and possible solutions. Like Hilfiker, I do not think there will ever be a solution to physician impairment, but I do think there is merit in being a wounded healer. There is merit in being part of the "brotherhood of those who bear the mark of pain." Albert Schweitzer, in his most famous passage, says:

> Whoever among us has learned through personal experience what pain and anxiety really are must help to ensure that those out there who are in physical need obtain the same help that once came to him. He no longer belongs to

> himself alone; he has become the brother of all who suffer. It is this 'brotherhood of those who bear the mark of pain' that demands humane medical services. [85]

It is the community of the wounded that show what it is to relate with and recognize one another. Physicians must demand humane medical services because they are part of this "brotherhood." Society must be willing to embrace them with the same empathy that we demand from them; healing must come from within and outside of the medical community. We will always want more than what we have, but we must recognize first that we are desiring the Other. Secondly, we must identify our drive's object is. Finally, through recognition and understanding, we can move toward a way of living that is conscious of our wounded status. The community of those who bear the mark of pain is large; let us not forsake it when we need it the most.

---

[85] Originally published in Albert Schweitzer's *On the Edge of the Primeval Forest*. Quoted by Schweitzer in *Out of My Life and Thought: An Autobiography*, trans. Antje Bultmann Lemke (New York: Henry Holt, 1990), 195.

BIBLIOGRAPHY

American Medical Association. "Physician Impairment," excerpts from AMA policies, H-95.955, July 2004 https://www.ama-assn.org/ama/publication/category/8153.html (accessed February 16, 2006).

Anderson, Charles M. "'Forty Acres of Cotton Waiting to be Picked': Medical Students, Storytelling, and the Rhetoric of Healing." *Literature and Medicine* 17, no. 2 (Fall 1998): 280-97.

Borgenicht, Louis. "Richard Selzer and the Problem of Detached Concern." *Annals of Internal Medicine* 100, no. 6 (June 1984): 923-34.

Bosk, Charles L., and Joel E. Frader. "AIDS and Its Impact on Medical Work: The Culture and Politics of the Shop Floor." *Milbank Quarterly* 68, Suppl. 2 (1990): 257-79.

Campbell, Velma. "More on *The House of God*." *New England Journal of Medicine* 305 (November 19, 1981): 1289

Campo, Rafael. *The Desire to Heal: A Doctor's Education in Empathy, Identity, and Poetry*. New York: W. W. Norton, 1997.

Carr-Lee, Linda S. "Medical Humanities Meets the Impaired Physician." *Medical Ethics in Utah* 17, no. 1 (January 2006): 1.

Chekov, Anton. "Ward No. 6." Translated by Bernard Guilbert Guerney. In *Short Novels of the Masters*, edited by Charles Neider, 386-438. New York: Cooper Square Press, 2001.

Coles, Robert. *The Call of Stories: Teaching and the Moral Imagination*. Boston: Houghton Mifflin, 1989.

———. Introduction. *The Doctor Stories*. Compiled by Robert Coles, vii-xvi. New York: New Directions, 1984.

Coombs, Robert H, Karen Perell, and Jo Marie Ruckh. "Primary Prevention of Emotional Impairment among Medical Trainees." *Academic Medicine* 65, no. 9 (September 1990): 576-81.

De Moor, Katrien. “The Doctor’s Role of Witness and Companion: Medical and Literary Ethics of Care in AIDS Physicians’ Memoirs.” *Literature and Medicine* 22, no 2 (Fall 2003): 208-29.

Donne, John. *Devotions upon Emergent Occasions Together with Death’s Duel*. Ann Arbor: University of Michigan Press, 1959.

Floyd, C. Timothy. “Attitudes in *The House of God*.” *New England Journal of Medicine* 305 (August 13, 1981): 411.

Ford, Richard. Introduction. *The Essential Tales of Chekhov*. Translated by Constance Garnett. Edited by Richard Ford. New York: HaperCollins, 1998, vii-xix.

Frank, Arthur W. *The Wounded Storyteller: Body, Illness, and Ethics*. Chicago: University of Chicago Press, 1995.

Frey, James. *A Million Little Pieces*. New York: Doubleday, 2003.

Gastfriend, David R. “Physician Substance Abuse and Recovery.” *Journal of American Medical Association* 293, no. 12 (March 23/30, 2005): 1513-15.

Gawande, Atul. *Complications: A Surgeon’s Notes on an Imperfect Science*. New York: Picador Press, 2002.

Hampl, Patricia. *I Could Tell You Stories: Sojourns in the Land of Memory*. New York: W. W. Norton, 1999.

Hilfiker, David. “Facing Our Mistakes.” *New England Journal of Medicine* 310, no. 10 (January 12, 1984):118-22.

———. *Healing the Wounds: A Physician Looks at His Work*. New York: Pantheon Books, 1985.

Hunter, Kathryn Montgomery. “The Satiric Image: Healers in *The House of God*.” *Literature and Medicine* 2 (1983): 135-47.

Jones, Anne Hudson. “The Medical *Bildungsroman*: The Making of a Physician-Writer.” *Connecticut Scholar*, no. 8, 38-51.

Jones, Thérèse. “On Becoming a Doctor.” MS IV Capstone Course, Spring 2005, Center for Medical Humanities and Ethics, University of Texas Health Science Center, San Antonio.

Kim, Jean. “Emotional Detachment and Involvement of Physicians in Literature.” *Pharos* 64, no. 2 (Spring 2001): 34.

Kirp, David L. “The Doctor of Desire.” *Nation* 264, no. 7 (February 24, 1997): 30-32.

Klass, Perri. *A Not Entirely Benign Procedure: Four Years as a Medical Student*. New York: Signet Press, 1987.

Lacan, Jacques. *Écrits: A Selection*. Translated by Alan Sheridan. New York: W. W. Norton, 1977.

——. “The Four Fundamental Concepts of Psychoanalysis.” Vol. 1, bk. 11 of *The Seminar of Jacques Lacan*, Edited by Jacques-Alain Miller. Translated by Alan Sheridan. New York: W. W. Norton, 1981.

Martinez, Richard. “Professionalism and Boundaries.” *Theoretical Medicine* 23 (2002), 185-89.

Mates, Susan Onthank. *The Good Doctor*. Iowa City: University of Iowa Press, 1994.

Merrill, Joseph O., and G. Alan Marlatt. “Health Care Workers and Addiction.” *New England Journal of Medicine* 347, no. 13 (September 26, 2002): 1044.

Miller, Merry N., and K. Ramsey McGowen. “The Painful Truth: Physicians Are Not Invincible.” *Southern Medical Journal* 93, no. 10 (October 2000): 966-73

Scannell, Kate. *Death of the Good Doctor: Lessons from the Heart of the AIDS Epidemic*. San Francisco: Cleis Press, 1999.

——. “Writing for Our Lives: Physician Narratives and Medical Practice.” *Annals of Internal Medicine* 137, no. 9 (November 5, 2002): 779-81.

Schweitzer, Albert. *Out of My Life and Thought: An Autobiography*. Translated by Antje Bultmann Lemke. New York: Henry Holt, 1990 .

Shem, Samuel. “Fiction as Resistance.” *Annals of Internal Medicine* 137, no. 11 (December 3, 2002): 934-37.

———. *The House of God*. New York: Dell Books, 1978.

———. “Psychiatry and Literature: A Relational Approach,” *Literature and Medicine* 10 (1991): 42-65.

Stephens, G. Gayle. "Physician Failure as Portrayed in Literature: Hilfiker, Arrowsmith, and Lydgate," *Pharos* (Winter 1988): 24-28

Verghese, Abraham. "Correspondence." *New England Journal of Medicine* 347, no. 13 (September 26, 2002): 1045.

———. *My Own Country: A Doctor's Story*. New York: Vintage Books, 1995.

———. "Physicians and Addiction." *New England Journal of Medicine* 346, no. 20 (May 16, 2002): 1510-11.

———. "The Physician as Storyteller." *Annals of Internal Medicine* 135, no. 11 (December 4, 2001): 1012-17.

———. *The Tennis Partner: A Doctor's Story of Friendship and Loss*. New York: Harper Collins, 1998.

Wear, Delese. "*The House of God*: Another Look." *Academic Medicine* 77, no. 6 (June 2002): 496-501.

Wear, Delese, and Lois LaCivita Nixon. "Literary Inquiry and Professional Development in Medicine: Against Subtractions." *Perspectives in Biology and Medicine* 45, no. 1 (Winter 2002): 104-25.

Williams, William Carlos. *The Doctor Stories*. Compiled by Robert Coles. New York: New Directions, 1984.

Wolff, Sally. "The Wisdom of Pain in Chekhov's 'Ward Number Six.'" *Literature and Medicine* 9 (1990): 134-41.

VITA

Marissa Gostanian was born on October 23, 1981, to Armen and Marilouise Gostanian. While at graduate school, Marissa participated in the National Student Research Forum, at the University of Texas Medical Branch in Galveston, Texas, presenting a paper based on this research titled "Physician, Heal Thyself: Desire and Impairment in Abraham Verghese's *The Tennis Partner*," April 27, 2006. She also conducted an Institute for the Medical Humanities Brown Bag titled "Physician, Heal Thyself: Desire and Impairment in Abraham Verghese's *The Tennis Partner*," March 28, 2006.

Marissa gained teaching experience while at the University of Texas Medical Branch. She participated as a teaching assistant in the Practice of Medicine 2 summer course in Humanities, Ethics, and Professionalism (July-August 2005).

Marissa can be contacted through her parents at 10026 Fieldcrest St, Spring Valley, CA 91977.

Education

B.A., 2002, Azusa Pacific University, Azusa, CA