

# Medicine, the Novel, and the Passage of Time

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Doctors and patients move together through time, humble in the face of its dictates. Novelists allow their characters to enter time, revealing in the characters' particular, ongoing lives some universal truths about living. Both the medical chart and the novel capture individual human lives as they change and as they age, finding some meaning in the random events that happen in them. Literary critics who write about the novel provide useful frameworks for doctors who reflect on their practice.

In this essay, I examine the medical charts of two of my patients in detail and describe the experiences I shared with them. As a repository of detail not only about the patients but about the doctors and nurses who cared for them, the charts provide rich and powerful evidence about the insides of practice and the meanings that clinical relationships accrue.

Doctors might discover underlying meaning in their practices that would otherwise elude them by reading their patients' charts as if they were novels, looking for patterns and movements throughout a patient's life, and recognizing the deep connections woven between their patients and themselves. By placing great novels—by Henry James, Virginia Woolf, and Thomas Mann—side by side with actual medical charts, I suggest the usefulness of close readings of medicine's texts. The juxtaposition suggests the utility of brooding about the seasons of our relationships with patients. Perhaps not a luxury but a necessity for effective care, reflection such as this on our patients may restore to medicine some of its passion, its meaning, and its joy.

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The care of the sick unfolds in the face of time. Medical practice abides by time's irrevocable forces—the entropy of disease, the dictates of aging, and the obligate end of life in death. We doctors do our best to slow time down or speed it up, outdo it in power, fool it with interventions. Not grandiose enough to believe we can actually alter the passage of time, we try to lessen its corporeal effects. We grin with delight as we outflank short kids' long bones' growth plates with a little exogenous growth hormone; we restore circadian rhythms to our sleep-disordered patients; we think we commute the premature neonate's sentence. By learning about such processes as apoptosis and senescence, we may soon postpone dementia, retard aging, and extend lives of vigor and health. In our more realistic modes, we might admit that, at best, we manage time or handle it, charting time's consequences on individual bodies and individual lives. We do what we can in the face

of time and death to improve lives, reduce pain, and gain some wisdom ourselves about the meanings of both those passages.

## The Novel and the Medical Chart

The literary enterprise of writing novels is similarly committed to the task of living in the face of time. The first novelists—Daniel Defoe, Samuel Richardson, and Henry Fielding—found literary ways to represent not the gods of myth or the heroes of history who lived in classical epic timelessness (until the 18th century, the only permissible literary subjects) but individual humans who lived in the actuality of time. This new form of writing—now we call it realism—did not repeat traditional tales but captured life afresh as it was being lived; novelists replaced idealized unchanging universals with sharply observed particulars perceived in the day-to-day real world about them.

The novel, the clinical case report, and the autopsy report all arose in roughly the same time period for roughly the same reasons: to inspect and embody an individual human being's life and death within mortal time, giving full account of misfortune and suffering and engendering responses of both sympathy and identification in the reader (1). In his authoritative study, *The Rise of the Novel*, literary scholar Ian Watt reports that the novel, “whose primary criterion was truth to individual experience—individual experience which is always unique and therefore new,” from the start “has interested itself much more than any other literary form in the development of its characters in the course of time” (2).

For both the novel and the clinical report, time is the fundamental and vexing variable: How can human beings relinquish their religious or mythic delusions of immortality to live intelligently and humbly in the shadow of death? “[O]nly the novel . . . includes real time—Bergson's *durée*—among its constitutive principles,” writes Marxist critic Georg Lukács, and “we might almost say that the entire inner action of the novel is nothing but a struggle against the power of time” (3). Critics of the novel are consumed by studies of beginnings and endings—witness Edward Said's *Beginnings*, Frank Kermode's *The Sense of an Ending*, and Rachel Blau DuPlessis's *Writing Beyond the Ending* (4–6). Whatever occurs between these beginnings and endings is the plots of lives, the events that can offer up mean-

ing only when configured out of their chaos into some kind of temporal order.

The parallels between the practices of doctors and novelists—and their resultant texts the medical chart and the novel—bear further inspection. The chart's entire inner action is, indeed, to borrow Lukács's words, a struggle against the power of time. Both the chart and the novel follow individuals or generations over the stretches of time that transform the human beings on the landscape; both genres confront the primitive and ultimate problem faced by humans as their time runs out; both reject universals and instead emphasize concrete particulars. If, in the words of E.M. Forster, the novel is “a narrative of events arranged in their time sequence—dinner after breakfast, Tuesday after Monday, decay after death, and so on,” then the medical chart too is a narrative of events arranged in their time sequence—blastocyst after morula, menopause after menarche, decay after death (7).

### Living in Time

Making medical sense of a body or a life is not merely a matter of chronologizing events, and the news to be found in a medical chart transcends a simple timeline. To call the morning in practice “office hours” itself suggests that the hours spent in the office differ in some fundamental way from hours spent elsewhere. The moment during which, standing in front of the viewbox or the computer monitor, a doctor takes in the fact that a favorite patient has developed a lung mass seems infinitely long. When the doctor later conveys the news of cancer to the patient, they both will experience an even greater departure from the ordinary experience of time, for the patient crosses one of those defining temporal discontinuities, her life thereafter divided into “before my cancer” and “after my cancer.”

Time can bend in the opposite direction. The months' or years' lacuna between one office visit and the next is like an instant as doctor and patient sit down together, recalling, reinvesting, recapturing their former connection and its continuance, the one asking the other the question that philosopher Simone Weil considers to be the sign of the fullness of love, “What are you going through?” (8). It is as if they have accompanied one another even through periods of physical absence. An otolaryngologist meets a new patient. In the course of the interview, the patient says, “You used to be my father's doctor.” The doctor vaguely acknowledges this fact, not, in truth, recalling the father. Upon examining the new patient's very hairy ears, the doctor exclaims, “I knew your *father*.”

Novelists understand the plasticity of time. One

hallmark of realist novels is the freedom to reverse, confuse, duplicate, or compress time. In *The Wings of the Dove*, Henry James gives Milly Theale the capacity to see into the future, to preview her own death, while she understands her everyday life through the retrospect of reflection. “[W]hile this process went forward our young lady alighted, came back, taking up her destiny again as if she had been able by a wave or two of her wings to place herself briefly in sight of an alternative to it” (9). Virginia Woolf writes *To the Lighthouse* simultaneously from several points of view, so that redescribed events resemble three-dimensional sculptures in light and shadow instead of linear beads strung on a string. The protagonist Mrs. Ramsay broods to herself “how life, from being made up of little separate incidents which one lived one by one, became curled and whole like a wave which bore one up with it and threw one down with it, there, with a dash on the beach” (10). And in the canon of the timelessness of illness, Thomas Mann allows tubercular Hans Castorp of *The Magic Mountain* to ask, “We say of time that it passes. Very good, let it pass. But to be able to measure it—wait a minute: to be susceptible of being measured, time must flow evenly, but who ever said it did that?” (11).

Banked in time, the elements of medical practice—clearly disease and recovery, but also the relationship between the doctor and the patient—mature through seasons (12). No matter which member of the pair is chronologically older at the start of their allegiance, doctors and patients grow up together, their journey through time marked by advances and reversals, vectored progress and cyclic repetition, bursts of change and lulls of sameness. In relationships that outlast many others in their lives, doctors and patients see one another through major events and stages. A biomedical or technical accounting of time's passage is not sufficient to grasp all that occurs in medicine; what is needed as well is the novelist's brave imagination to seek out meaning, to envision the latent, and to name what will happen to us all.

### Rereading the Chart of Mr. Estrada

One way for an internist to examine the traces of time's passage so as to better understand—and perhaps improve—medical practice is, very simply and profoundly, to reread the charts of long-time patients, not as one would read a scientific document but as one would read a novel. Such a rereading might provide provisional answers to urgent questions about the seasons of doctors' relationships with their patients: How does it happen that somehow, sometimes, doctors and patients develop true

intimacy? How does it happen that some doctors and patients become devoted, faithful, committed to one another for the long haul, able to give and receive care that works? Close readings of the accounts given these relationships might provide, with James's long view of retrospect, some guidance for the elusive goal of living in the face of time.

Mr. Leonard Estrada first came to Presbyterian Hospital because of dizziness. (Names of patients and doctors have been changed to protect confidentiality. Patients or their family members read the following clinical descriptions of them and gave consent for their publication in *Annals*.) In 1966, this 60-year-old Panamanian trumpeter had had headache and lightheadedness for 5 days. His physical examination and laboratory values were normal, and he was discharged from the emergency room with no diagnosis and no treatment. Thirty-three years later, dizziness is still one of his chief symptoms. From the time I became his internist in 1983 until my last visit with him in a local nursing home in 1999 (he knew he liked me but he recognized me not), Mr. Estrada had become old, sick, and ready to die.

He first came to see me—random assignment for us both—with herpes zoster accompanied by inguinal adenopathy. Node biopsy revealed noncaseating granulomata. A chest radiograph documented widespread cystic disease and bilateral hilar adenopathy. My note says that I reviewed the pathology slides, which were consistent with sarcoid: I remember marshaling the surgeons to biopsy, the pulmonologist to bronchoscope: I do not remember gazing at his slides, just as he does not remember the identity of his visitor.

How could he have been a trumpeter with such lungs? With a partial oxygen tension of 57? His music career over by the time I met him, he had worked as a lay minister for the local Catholic church, visiting the faithful in their homes, helping out with church services. His activities were liturgically inflected—Lent was the busiest season, patience the most demanding virtue. His stance in life was not penitent but grateful: always neatly dressed, hat doffed, shiny cuff links on well-pressed shirts, soft-spoken, continental in his manners. The social worker described him as “a thin Black and polite man who came alone for the interview.” Indeed, his politeness seemed almost as essential a feature as did his ethnicity, and as did his aloneness. His children lived close by but did not supervise his care or his life. When he became too frail to shop and cook, he ate each meal at the local Woolworth's lunch counter.

Through the middle years, his health was measured in diffusing capacity and blocks walked before fatigue. He proved unweanable from steroids and

suffered cataracts for it. He developed glaucoma. Red and black and green visual field targets alternate with gray spirometry graphs. “Majorly weak and dizzy,” I state in an opaque note. The extremely widespread pulmonary parenchymal infiltrates increase and retreat and then increase again, each relapse costing him strength.

As I review Mr. Estrada's chart, I review the doctors' progress as well. A now-eminent vascular surgeon is in the walk-in clinic 33 years ago dispensing “grippe tabs.” I read an emergency room note written in 1977 by a fellow internist and good friend of mine, and I imagine him 22 years ago, a senior resident, as earnest then no doubt as he is now. Some of the nurses and doctors writing in the chart have retired; one has become terminally ill; one has died. I see my own handwriting decay from rounded and patient to spiky and rushed. I read a note from a fourth-year medical student who is now a respected psychiatrist. I remember—with pride for my little part in her development—her sitting in my office with Mr. Estrada, with my guidance pursuing a productive line of questioning for a then 81-year-old man who had pulmonary sarcoid and was taking steroids. I see how we doctors communicate among ourselves on the ground of patients we share—I slip in a parenthetical “Barbara, can discharge from chest clinic if you like” to the pulmonologist who gets to see the patient every 2 months to my every 4. I recall the meetings in the elevators, the huddles over preoperative chest radiographs in the reading room. When the pulmonologist said to me recently, “But you've kept him alive all this time, Rita,” it felt more confirming of my clinical skills than did specialty board certification or any number of clinician-of-the-year awards.

Events of the world intrude into the patient's daily life. In 1991, his pastoral duties increase because of veterans returning from the Persian Gulf War. Simple mental status examinations remind me of contentious mayoral politics, presidential disasters. I learn that his grandson owns a men's clothing store in the neighborhood where I live. I enter the store, waiting for a moment when the proprietor is alone, and shyly introduce myself as his grandfather's doctor. We gaze at one another mutely over the silk tie display, both of us unsure of what to do with our sudden intimacy.

In 1993, the patient develops papillary squamous-cell carcinoma of the glans penis. Treatment consists of circumcision (is it not fitting for a Eucharistic minister to be healed in such ritual fashion?) and external-beam irradiation, all of which the patient tolerates stoically. Upon recurrence of the lesion, he capitulates to the recommended distal penectomy and suffers what he considers to be a humiliating and disfiguring surgery. The bloodless operative re-

port intones, "A tourniquet was applied to the base of the penis prior to the amputation, and the distal stump was sent for frozen section." Throughout his perioperative care, nurses and doctors leave traces of their feelings toward Mr. Estrada in their chart notes: Nurses describe him as "calm and cooperative," doctors call him "lovely," the two professions' most lavish signs of love permissible. I remember, on our postoperative visit, obeying a scruple and forgoing the genital examination. Let Urology keep track of their operation, I said to myself, let me not shame him too.

His son accompanies him to his next office visit. The family, I discover with near horror, knows nothing about the patient's illnesses, but they had been noticing his difficulty getting around and his fluctuating weight. With Mr. Estrada's permission, I reveal to his son the nature of his pulmonary disease and his cancer, including what prognoses I can furnish. All these years, Mr. Estrada kept his health problems to himself. Was it not to burden his children? To be allowed to continue living by himself in his own apartment? To continue life a reportedly healthy man? Was it courage, hubris, or the rashest form of self-abnegation? I feel shocked by the responsibility I had unknowingly held. This man made me the repository of his secrets, anointing me not just his internist but his confidante, his confederate, his friend.

Over the next few years, the patient slowly declines. He develops pleural effusions and severe desquamating dermatitis (not, on evaluation, related to either the sarcoid or the cancer), treatable but sapping. Woolworth's closes its lunch counter. Mr. Estrada retires as church deacon. He falls twice, needing sutures for lacerations. He tends to run out of prednisone and feels the worse for it. Dementia work-ups reveal no treatable problem, confirming my suspicion of probable Alzheimer disease. I arrange for heightened surveillance at home.

As I reread my notes, I recall him sitting there in the office—so formal, so tender, so grateful for the little care I have to give him; I compare this vision to the last time I saw him. He had been hospitalized after sustaining an injury at home, and it had finally become clear to me and to his family that he was unable to remain safely at home alone. I arranged for him to be discharged to a good nursing home and paid him a visit several weeks thereafter. Only when he mistook me for a niece and told me about trips downtown that had not occurred did I take the full measure of his dementia. The house doctor I anxiously paged confirmed that the patient had been deeply demented upon admission to the nursing home. According to my recent review of his chart, I "knew" about his dementia—litanies of TFTs, B<sub>12</sub>s and folates, head CTs, RPRs, and the

like—and had referred him for neurologic evaluation. And yet, he had not become in my mind a demented man, as Milly Theale, despite her fatal illness, appears healthy to the man she loves, "different, younger, fairer . . . Milly was indeed a dove" (13).

I sat next to him in the nursing home as he sat over a brown Formica rectangular height-adjustable table carrying the remains of an institutional lunch. As I scanned the so-called recreation room in the home (the walls were aqua), finding a dozen disheveled women and drooling men sheeted into their wheelchairs, I gave in to my dread. Were these not the remains of the day in the contemporary sanatorium outside of the stealth of time? "These people," not unlike the patients in *The Magic Mountain*, "were inwardly attacked by well-nigh resistless decay . . . [L]iving consists in dying, no use mincing the matter" (14). I had partitioned within myself the secret of Mr. Estrada's dementia, seeking care for his neurologic problem but at the same time continuing to *regard* him as the elegant and kind man he used to be. Now, the truth out, I was the one bereft.

[A] downpouring of immense darkness began. Nothing, it seemed, could survive the flood, the profusion of darkness which, creeping in at keyholes and crevices, stole round window blinds, came into bedrooms, swallowed up here a jug and basin, there a bowl of red and yellow dahlias, there the sharp edges and firm bulk of a chest of drawers. Not only was furniture confounded; there was scarcely anything left of body or mind by which one could say, "This is he" or This is she. . . .

Mr. Ramsay, stumbling along a passage one dark morning, stretched his arms out, but Mrs. Ramsay having died rather suddenly the night before, his arms, though stretched out, remained empty (15).

### Interpreting a Medical Narrative

This story about Mr. Estrada is not a dramatic medical thriller. His diseases are not presented as mysteries that doctors have to solve, but rather as the ground of personal relationships. In rereading the record of his care as an account of medical actions, I find some satisfactions (prompt diagnoses, effective marshaling of specialist care) and some major lapses (the delay in talking with his family and in facing the extent of his dementia). In rereading the record as a story of lives in time—as a novel—that indelibly alter one another, my retrospect nourishes my sense of commitment to this formal yet earthy gentleman. His stateliness and independence were so profound and yet so modest that, undeclared, they infused all he did. His faith, too, was an earthy faith, rooted in human life, in the messy apartments in Washington Heights into which this man would bring the sacraments. While I lived

through my own apprentice years in medicine, and while we all aged through the decades, Mr. Estrada dignified us as he did his parishioners by his trust and his authenticity. A privilege and a gift, caring for him through the years replenished us with courage and with love. Yet to come (and visible in our medical preview), his death will diminish us all.

What is it that doctors and patients go through together? These relationships are indeed technical relationships, but they also carry the gravity of meaning. Both doctors and patients travel through time toward some realization of self, of goals, of the principles by whose light a life is led. Examining the lives that doctors and patients lead together—and recognizing the meaning accrued in both those lives by their mutual experience—offers knowledge and insight that make of clinical relationships a communion of sorts (16). Although some doctors and patients may be alarmed by the breach in the container of objectivity and detachment implied by such examination, all must admit that—with or without inspection—these doctor–patient relationships cannot but be intersubjective, mutually resonant, inflected with what it means to be human.

Contemporary medical practice is evolving in a direction that tends to prevent such personal searches for meaning. Rather than more time and more reflection in the doctor–patient relationship, current practice has conformed to economic forces that dictate less time and less reflection. Medicine follows such dictates at the peril of the doctors and patients engaged in its practice, for to relinquish the capacity to develop clinical relationships and to reflect on them is to limit the ability to deliver fully effective care. Although medicine seems captive to marketplace requirements and financial constraints—and, indeed, cannot do its work without recompense—it has the obligation to advise its underwriters about the desperate consequences of continued shrinking—through shifting patient panels, shortened time of medical visits, and the like—of the grounds of the clinical relationship.

Perhaps even this short description of Mr. Estrada, his doctors, and his illnesses suggests that it is helpful to articulate the otherwise hidden feelings and bonds between doctor and patient, helpful to look full in the face at the power that inhabits these profound relationships. I have given myself the luxury to brood about one patient for a while; it may be only prudent to allow all physicians the opportunity for such clinical reflection. For only with the knowledge available through such examination and acceptance can the care that obtains between doctor and patient be accurate, informed, and deep enough to be of help.

A physician just out of residency receives into her practice a patient referred from a retired partner. Noticing that the patient's year of birth is the same as her own, the physician mentally lines up her life experience with that of her new patient. At age 32, the doctor is unmarried, childless, and at the threshold of a promising profession in academic internal medicine. At age 32, the patient has three children, a live-in boyfriend with health problems of his own, a steady though paltry income from Social Security disability, with no changes for the better in sight. As the doctor learns of the patient's cerebral palsy, migraine headaches, hypertension, asthma, iron-deficiency anemia, uterine fibroids, degenerative joint disease, and depression—and of the boyfriend's alcoholism, the oldest child's asthma, the middle child's hyperactivity, the youngest child's seizure disorder—she tries to imagine a life so short filled already with so much challenge.

They meet every few months for close to two decades, the doctor's sense of the promise of the future contrasting with the patient's blunted present tense. Sure of much hard work and pain to come, the doctor can also be sure of continued growth in her knowledge, power, income, status, and maybe happiness. Her future is vectored, pointed toward her chosen goals, and loaded with the force of her ambition, her chairman's good will, her alma mater's good name, and her own good luck. In contrast, the patient does not believe that better days are in store. She knows that as soon as one child graduates high school, another will get hit by a cab or will get pregnant at age 15. She knows that the gas and electric might get cut off a couple of times a year for overdue payment or that the parole officer will drug-test her boyfriend's urine on the wrong day. The best she can hope for is that things get no worse.

Now both close to 50 years old, the internist meets her patient to clear her for a total hip replacement. The patient's alcoholic boyfriend has died, but not before having inflicted steady psychic injury on the patient. Never having finished high school but having achieved his own disability check, the epileptic son lives with his mother still. The hyperactive girl was arrested and imprisoned on drug charges when she was 19. Her two kids, ages 11 and 9, live with their grandmother awaiting mom's release. The 11-year-old is deaf, the 9-year-old unruly. The oldest child is healthy, estranged from the family, and living in the Midwest. As the patient has lurched from one crisis to another, she has gathered around herself a power of great dimensions—the power of tolerance, of disillusionment, of having seen worse.

The internist finds her patient markedly obese, wheezing, crepitous, and hypertensive to a diastolic pressure of 105 mm Hg. While she listens to the patient's hard-working heart, the internist thinks how often in the past 18 years she has worried about this patient's future. She thinks of her own lapses in patience in the face of the patient's urgent demands. She thinks of all she will have to do to get this patient in shape for surgery, of all that will be necessary to get her through her recovery. She is taken aback by the turmoil of the patient's life, the troubled children, the special-needs grandchildren, the early deaths, the nights spent in the emergency room. She cannot help but compare the disorder to the relative calm of her own life blessed with health, nurtured by a loving and stable marriage, protected by a good income, and invigorated by a rich life of the mind. There is little she set out to do that has not been done on schedule. She feels she deserves all that she so amply reaps from life.

And yet, after she peels the thigh-sized cuff off the patient's upper arm, she leans back against the sink in the office to ask the patient, "How do you do it? How do you endure?" And the patient, lowering her baggy sweatshirt sleeve, answers. She describes how the crises no longer surprise her, that she never expects weeks and months to spare her. "I take one day at a time," she says, knowing full well the source of this bromide. "At least there's a limit to how much each day can hurt you." And the internist bows her head to acknowledge that her patient has achieved a level of saintliness far beyond her own reach. She bows her head in respect and in prayer, seeking her patient's intercession with whatever powers confer grace.

### Coda

Reflecting on practice can grant to doctors time's ultimate dividend—second sight. In *Time and Nar-*

*rative*, Paul Ricoeur notes that "to narrate a story is already to 'reflect upon' the event narrated" (17). By brooding seriously on this journey they take together with their patients through time, doctors can enrich their vision of individual patients—and of themselves—so as to be all the more helpful, all the more attentive, and all the more able to care.

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