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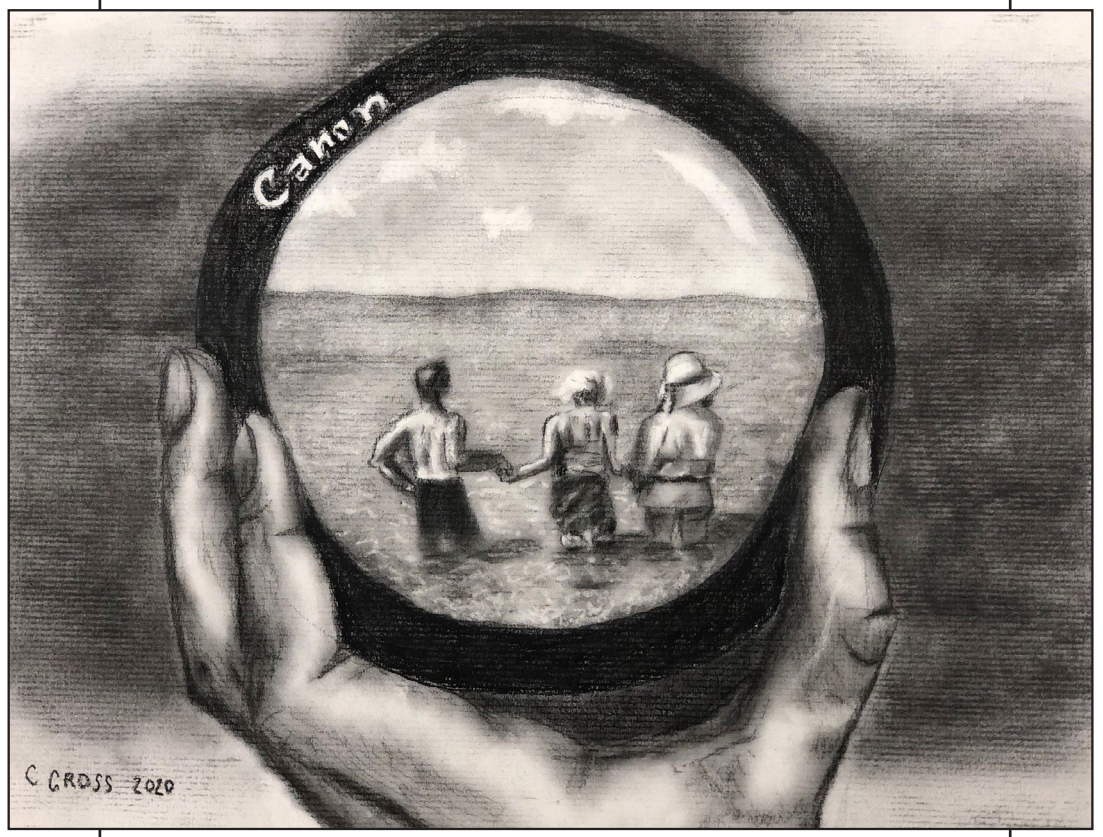
THE DONALD AND BARBARA ZUCKER SCHOOL OF MEDICINE AT HOFSTRA/NORTHWELL

ART & LITERARY REVIEW

ISSUE NINE 2020

# Narrateur

## REFLECTIONS ON CARING

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## The Average of Ourselves

At the end of my fourth year of medical school, I've found myself thinking back to some of the patients I've encountered since I first put on a white coat — the individuals who in a way are the substance of my medical degree. In the experience of listening to them, examining them and playing a role in their treatment, I learned something from each of them, but hindsight reveals lessons of its own. Now, as I prepare for a more rapid pace of clinical judgment in residency, one patient in particular remains in my thoughts. To protect his privacy, I'll call him Mr. Taylor.



His story begins a year before we met, when Mr. Taylor's hemoglobin A1c had been 5.9 percent. The A1c is not considered as accurate as some other tests for blood sugar, but it's a quick and easy way to average it over time. The life span of a red blood cell is two to three months, so at any moment, our bodies contain a mix of red blood cells made today, three months ago and every day in between. Since it takes time for the hemoglobin inside these cells to get coated in sticky sugar, the A1c is a good way of smoothing out the daily fluctuations in blood sugar caused by exercise or meals. Whereas a normal range is below 5.7 percent, a number above 6.5 percent suggests diabetes. Mr. Taylor would have been considered prediabetic.

Doctors had advised him to watch his diet, but, as he confessed, he had a sweet tooth. In time, his wife noticed that he was no longer acting like himself. He developed an unquenchable thirst, drinking up to fourteen glasses of water a day, and he was urinating more often. No matter how much he ate, he could never sate his appetite, and yet he seemed to have lost much of his energy. It was this lethargy that worried his wife most — not just that he seemed to be sitting on the couch more often, but rather the *way* he was sitting. Something about it seemed off. Eventually, she encouraged him to see a different doctor. That's when they came to my preceptor.

A new set of labs was drawn, and the disease was found to have progressed faster than anyone had thought possible. His A1c had soared to 14 percent. Other measures of blood sugar were also

alarmingly elevated. He had not just crept into the diabetic range; he had shot past it and was close to a crisis.

Mr. Taylor was crushed. As my preceptor informed me later, he seemed too depressed by the news to discuss the details and implications of long-term treatment. Regular injections of insulin can be a jarring, unfamiliar and expensive lifestyle change. More crucially, if insulin is administered inconsistently or incorrectly it can lead to another kind of crisis in which the blood is starved of sugar, potentially leading to coma. He needed time to absorb the news, so to tide him over, she gave him a prescription for Metformin, a cheap and convenient bottle of pills with fewer potential dangers. She counseled him on diet modification, taught him how to monitor blood sugar levels on his own and asked him to come back soon.



I was present at the next visit. On the way to the exam room, my preceptor briefed me about Mr. Taylor's story, and though I had very little information to work with, I tried to picture what he might look like and anticipate his mood. At that point in my education, in an attempt at empathy, I thought it might be possible to reassemble a human narrative out of the fragments of charts and notes. In the way that physicians develop "illness scripts," patterns of signs and symptoms with which to diagnose disease, I imagined that I could try to formulate a "patient script," a way to see through a set of data into someone's personality. If I understood something about who they were, perhaps it could be helpful in thinking about the underlying causes of their illness and suggesting an approach to treatment.

In the exam room, I met a kind, middle-aged African-American man in a bright orange T-shirt. The brightness surprised me; it seemed too sunny for the circumstances. Until I laid eyes on him I didn't realize that for some reason I had expected him to be heavier. My preceptor introduced us and then left us alone to talk. I extended my hand and he shook it slowly, smiling.

When I asked him about what had happened over the past year, he told me he'd had a few hard weeks and had already been feeling down when one day he noticed a sale on Mountain Dew, his favorite

soda, at the grocery store. In his words, it seemed like a sign that he should treat himself to something during a difficult time, and he bought case after case. In answering my questions, I noticed that he was speaking slowly, and I began to wonder if he was still feeling lethargic or whether this slowness was normal for him. Knowing that diabetes was associated with poor diet and exercise, I wondered whether this slowness was part of a more general apathy or inactivity that had accelerated the course of his disease.

*Share of throat* is a term used by beverage companies to denote how much Americans as a whole drink any given brand. It's a phrase that conjures up an image of disembodied anatomy that corporations are clamoring to drown. The phrase suggests that there's only so much a person can drink — how can we convince customers to replace water with what we sell? But while it's easy to pick on corporations, medicine has also been accused of objectifying patients. After all, the word *clinical* means both *of the clinic* and *coldly detached, without emotion*. The physical exam removes intimacy from touch, and history taking can reduce pain into boxes that can be easily checked. Emergency medicine physicians talk of "moving the meat"; in doing so, we depersonalize individuals in a similar way, albeit purportedly for their benefit rather than for corporate gain.



For centuries, medicine pathologized personal qualities in attempts to find associations with disease. In her classic work *Illness as Metaphor* (1978), Susan Sontag notes that in 1881, a year before tuberculosis was found to be caused by a bacterium, a medical textbook ascribed the disease to "hereditary disposition, unfavorable climate, sedentary indoor life, defective ventilation, deficiency of light, and 'depressing emotions.'" Linking diseases to personal traits led easily to blaming patients for their own diseases; this blame then gave way to the notion that disease was a form of punishment — and not simply any punishment, but the perfect kind of punishment in both form and degree. There were religious undertones to this kind of thinking, and when religion became less widely practiced, the justification for disease was substituted for a more psychological rationale, in which an inability to deal with

stress or a tendency to repress emotions was seen as the culprit. "Widely believed psychological theories of disease," Sontag wrote, "assign to the luckless ill the ultimate responsibility both for falling ill and for getting well."

Looking back on my visit with Mr. Taylor, I wonder if my attempt at imaginative empathy inadvertently fell into this trap, and whether I was fair to him in my thoughts. I have a sweet tooth myself, and so on some level I felt that I could relate to him. But when I empty a carton of ice cream after a stressful day, I have to admit that, like many people, I admonish myself for weakness, thinking that it's a lack of discipline. Is it fair then to associate type II diabetes with those qualities? Without realizing it, in thinking about Mr. Taylor's "slowness," I had already begun asking myself the question of how this quality may have played a role in his disease — that it was possibly a sign of laziness. The question expressed itself not as overt judgment but rather as genuine curiosity, an attempt to fit this patient into a pattern I might apply to others. After seeing his lab results, I had unconsciously — and rapidly — formed a bias that he would be overweight, too. What other biases had I subconsciously formed? Was I trying to create a patient script of a person whose choices were to blame for his disease? Perhaps my naïve attempt at understanding him was in fact a misappropriation of empathy, a back door into constructing a stereotype of the very person I was trying to help.

Because diabetes in many patients responds to discipline, exercise and nutritional coaching, I wonder if those who are unable to manage the disease will acquire the stigma of being undisciplined or sedentary, with all the moral valence attached to those qualities. If COPD, heart disease, obesity, hypertension and gout are understood to be consequences of our actions, are they then subject to the moral judgments of those actions? It's easy to withhold our sympathy for those who seem to have caused their own problems, and in a busy hospital where we have to make quick judgments, sympathy can seem a limited resource. When two patients complain equally or demand our attention, a mental calculus can

influence our thinking as to who is more deserving of help first. I have seen this kind of mental calculus on the wards.

In a recent op-ed on an impoverished region of Oregon, the *New York Times* columnist Nicholas Kristof notes that Americans have historically subscribed to a notion of "personal responsibility" that blames the poor for being poor. But while it's true that personal responsibility does matter in certain areas of both health and wealth, Kristof notes that "when you can predict wretched outcomes based on the ZIP code where a child is born, the problem is not bad choices the infant is making."



After I had been talking with Mr. Taylor for a while, my preceptor joined us in the exam room. We were thorough. We reviewed his records. He kept something like a checkbook with him, and every morning at about the same time, just after breakfast, he pricked his finger and recorded his sugar level. Surprisingly, these numbers looked good, almost all within the normal range. With his wife's help and coaching, he had cut out almost all carbohydrates and was eating mostly chicken salads. Exercise? He was trying to jog more. Thirst? He was drinking less, especially since it wasn't summer any more. We asked him to take off his boots, and we poked his feet and toes with a gentle brush to see if the disease was affecting his sensation. We asked him about his vision and looked in his eyes.

Finally, my preceptor left the room to get the results of his A1c, and when she came back, she was beaming.

"Good news," she said.

Mr. Taylor reacted slowly. He seemed to be trying to decide how happy he should be. He was shy, almost sheepish, but I'd been with him for almost an hour, and I could tell he was brightening.

"Anything less than 14 would be fine with me," he said.

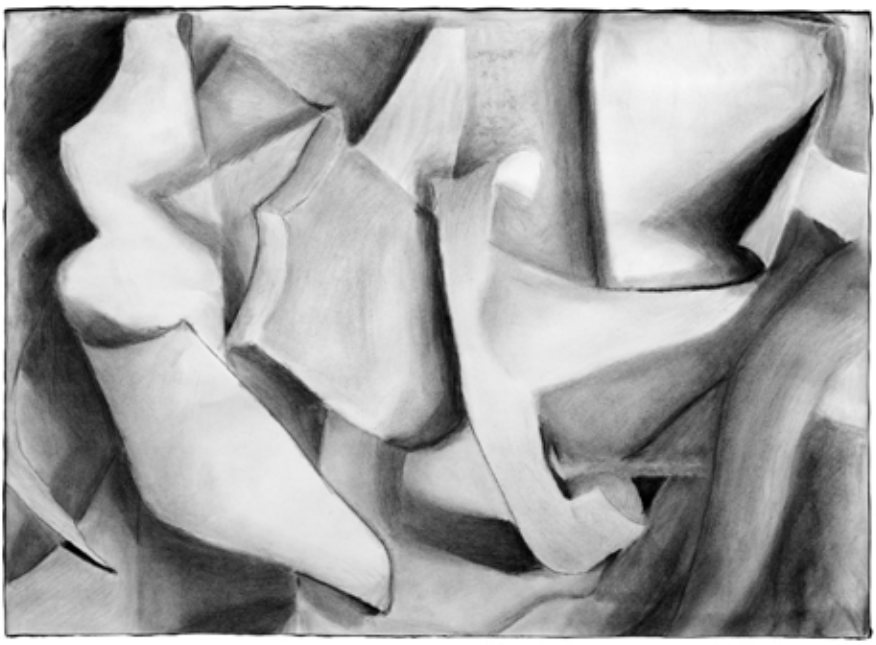
It was 7. As fast as his A1c had risen, it had plummeted again, and though it was still within the range of diabetes, it was an accomplishment nonetheless.

The appointment wasn't over, but my preceptor and I shook his hand as though we were meeting him for the first time, as though

the good news had made him a new person whose acquaintance we were just now making. And in a way, he was a new person. Like our red blood cells, we have the ability to be remade. We are not weak. We are not strong. We are made of who we are today, three months ago and every day in between. We are the average of ourselves, and even that average can change.

*Adam Lalley is a fourth-year medical student at the Zucker School of Medicine at Hofstra/Northwell who plans to specialize in emergency medicine. He is a winner of the Michael E. DeBakey Medical Student Poetry Award and the William Carlos Williams Poetry Competition. His poetry has been published in the Journal of Medical Humanities.*





## Outlook of Shadows

*Alexander Jaksic is a fourth-year medical student at the Zucker School of Medicine at Hofstra/Northwell. He started drawing with charcoal as a medium in college and has found the fluid nature of drawing with charcoal to be a relaxing and rewarding process that he plans to continue throughout his career.*