Entering "The Left Atrium"

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"… the end is not knowledge but action."

Aristotle, *Ethics*, I, 3

To speak of medical *practice* is to acknowledge that, however much it partakes of the sciences, medicine is also an art. But the physician who declares as much to a new patient is likely to be rewarded by some rolling of the eyes if not frank dismay. Patients do not seek out physicians for their artistry, but for an explanation of what is happening to them. It is *science* that patients think physicians are in the business of delivering, in the form of diagnoses and treatments. In our society, which labours under the belief that all problems are surmountable, medical science is expected to perfect itself, to solve mysteries and find cures. Yet, despite its often dazzling sophistication, the science of medicine is far from complete; moreover, it is deployed in the realm of human action and emotion. It is a *practical* science and thus requires the practitioner to exercise judgement, to put some faith in intuition and to become reconciled to imperfection.

As Kathryn Montgomery Hunter writes in her study *Doctors' Stories*,[1] our society's expectations of medicine are "exorbitant." In addition to being a flawlessly well-informed clinician, the physician must be a paragon of empathy and tact, sensitive not only to psychological dynamics but also to every nuance of the patient's social and cultural context. At the same time, patients are demanding greater self-determination in their interactions with the health care system. While physicians are measured against the dual ideal of the well-informed and empathetic healer, they have in a certain sense been demoted in the public eye to the role of service provider.

In tempering these expectations we must realize, as Hunter argues, that medicine is first and foremost an interpretive activity. The primary text upon which this interpretation is practised is the patient, and skill in interpretation is developed iteratively, case by case, reading from particular symptom to general law and back again to the particular, and by reasoning analogously from the details of one case to another. As Hunter describes, patients gain admission to the society of the unwell by presenting with a story: an account of symptoms and events that they hope their physicians will interpret for them. Patients seek medical advice in the hope that their illness may be described with reference to biological laws, from which one may accurately and reliably map a course to a remedy. Physicians transform the patient's story into the official narrative of etiology, diagnosis and prognosis. This narrative may not be at all what the patient had in mind, whether because the news is ominous or because patient and physician construe the language of symptoms differently.

Even a grim diagnosis can bring some comfort in so far as it validates the patient's experience ("No wonder I felt so terrible") and identifies the enemy ("I'm going to fight this thing"), surrounding which there is likely to be some kind of lore and perhaps a culture of patient advocacy. A diagnosis gives the patient as well as the physician something to *work with*. In the growing literature of the experience of illness, a genre that Hunter describes as "pathography," there is a creative tension between an impulse to explain the commonalities of an illness (e.g., editor Robert McCrum's account of his recovery from stroke is addressed to readers who might find themselves in similar circumstances[2]) and an attempt to articulate how that experience is not accounted for adequately by the medical narrative (otherwise, why write?). It is one of the challenges, if not the ironies, of medical practice that patients desire from their physicians a definitive, scientific understanding of what is ailing them at the same time as they feel that their own predicament is unique: their illness has never happened to anyone else in the precise way that it is happening to them. The "patient history" is but the first step in a collaborative exercise in which patient and physician reconstruct events, try to make sense of them and, ultimately, attempt to take command of the plot. Part of the art of medicine lies in helping the patient to repossess the medical narrative and to derive meaning from the journey through illness — if in fact the metaphor of a "journey" is one that the patient will accept.

What sustains the practice of this art? The best available information, certainly, but also tradition, experience and contemplation. With this issue of *CMAJ* we open the door a little wider to such contemplation by launching "The Left Atrium," a new section of book reviews, arts features and creative writing. Its common ground is the experience of illness, the material on which both patients and physicians work, and against which they measure and, in times of crisis, redefine themselves.

Atrium: the central hall in a Roman house or, in mod-

ern buildings, an area into which other rooms open. The architectural metaphor suggests spaciousness, an entry way, a meeting place. A space that admits air and light; a pleasant place for reflection. The political connotation of "left" was, although not uppermost in our minds, not unwelcome; in various ways "The Left Atrium" will examine the social and economic determinants of health, as in the photographs of child labourers by Minneapolis physician Robert Parker (highlighted in the next issue), and public health concerns will never be far away. Our revamped book review section will oxygenate the reader's clinical preoccupations by covering topics as wide-ranging as the ethics of blood donation, the history of mesmerism and the human catastrophe in Rwanda. Under "Lifeworks" we will explore the representation of illness in the visual arts; art galleries across the country have been invited to draw our attention to works from their permanent collections and from ongoing exhibitions, and we have been astonished to discover the extent to which the experience of illness is being explored, and the practice of medicine cross-examined, by contemporary Canadian artists. With a nod to Susan Sontag, patients will be given a voice in brief literary excerpts tagged "Illness and metaphor." Brief and often surprising excursions into the history of medicine, and of medicine in art, will be made by Wolf Seufert and by Max and Arty Coppes, and archival photographs will give glimpses into the medical and social evolution of this country.

And what about the physician's own narrative? The stresses of the "exorbitant expectations" of medical practice require their own catharsis; like other medical journals, *CMAJ* has provided readers with a forum for reflecting on significant junctures in their professional lives in our Experience section. In "The Left Atrium," these memoirs will now appear under the heading "Room for a view," which we hope will invite submissions that until now have been difficult to categorize. We welcome brief memoirs, poetry, fiction, essays and "creative nonfiction" from all comers: our main criteria will be the quality, relevance and originality of the writing. Brevity is a virtue — articles and reviews should be no longer than 1000 words — and we ask contributors to bear in mind the Horatian standard: that writing be *dulce et utile*, sweet and useful, entertaining and instructive. Indeed, it needs to be entertaining before it can hope to instruct.

Ms. Todkill is Editor of The Left Atrium; Dr. Hoey is Editor-in-Chief of CMAJ.

References

1. Hunter KM. *Doctors' stories: the narrative structure of medical knowledge.* Princeton (NJ): Princeton University Press; 1991.
2. McCrum R. *My year off: rediscovering life after a stroke.* Toronto: Knopf Canada; 1998.