*Room for a view*

# Medically speaking

"It is generally assumed that doctors take a professional view of suffering and that the process of professional insulation begins in their second year as medical students when they first start dissecting the human body .... Later, other factors are an aid to their self-protection. Doctors use a second, technical, entirely unemotional language .... Increasing specialization encourages an increasingly scientific view of illness. (In the eighteenth century and earlier the doctor was often thought of as a cynic: a cynic is by definition a man who assumes a scientific objectivity to which he has no claim.)"[1] — *A Fortunate Man*, John Berger

"Torment, a canonical subject in art, is often represented in painting as a spectacle, something being watched (or ignored) by other people. The implication is: no, it cannot be stopped — and the mingling of inattentive with attentive onlookers underscores this" (page 42).[2] — *Regarding the Pain of Others*, Susan Sontag

"We are all involved with humankind but we mostly do our best not to know it."[3] — Recognizing suffering, Eric Cassell

Fred Sebastian

The summer of my first year of medical school I went to Kenya to work in the pediatrics ward of a large hospital. Like many affluent, young people setting off for the developing world I carried with me a sense of purpose and adventure, a backpack, an inflatable pillow and more books than changes of underwear. I also brought my stethoscope and a clinical skills manual in the hopes of looking like I knew what I was doing.

Of course, I did not.

The pediatrics ward was enormous. On a busy night, a hundred new babies and children might be admitted, most of them critically ill, most of them having travelled with their mothers from faraway villages.

The ward smelled horrible. The 3 toilets did not flush and were shared by all the children and mothers. Sometimes the hallway sinks, used for washing clothes and dishes, overflowed. Mothers slept on blankets on the floor and babies slept 2 or 3 to a crib. The windows were always open to the luke-warm air and city soot.

We rounded in an enormous pack — 20 or 30 local medical students, 5 registrars (or residents) and an attending physician. Most of the time, we couldn't see the child we were talking about; there were too many white coats in the way.

It did not take me long to realize I knew nothing. Whatever a single year of medical school prepares one for, it wasn't this. I did not know about the infections to which children with HIV were vulnerable. I did not know about malaria or tuberculosis or how to feed children who were starving.

I also did not speak the language. The physicians *did* speak English, but their dialect, like in Canada, was the dialect of medicine. Already in my first year of training I had become accustomed to being foreign, to barely "getting by" in the language.

What struck me in both settings was not so much the jargon (of which there was no shortage), but the unspoken codes that dictated what ought to be said and what ought not. This is the case in any profession: a hockey player does not get off the ice and say to a reporter, *My heart throbs with victory and I tremble with the brute pleasure of vanquishing weaker men.* Instead, he is expected (thank goodness) to say, *It was a good game and we played really hard.*

In medicine we are speaking not of a game, but about the suffering of others. This speaking is viewed as a straightforward process, but for those of us lacking fluency, the interpretive act is hardly natural. What can you possibly say when you see a father sputtering with grief, his child, long sick, grunting for air? I appreciate that one must report the child's oxygen saturation, respiratory rate and temperature. But as a student, this is so hard to do. All you can think of is your own helplessness, the father's pain and the little girl's glassy eyes.

The language of medicine has its purpose: we must speak with efficiency and accuracy about patients' disease, so that we can, if we're lucky, provide treatment. But our translations of patient suffering have limits. Our reports and charting function much like "photographs of victims of war [which] are themselves a species of rhetoric. They reiterate. They simplify.... They create the illusion of consensus" (page 6).[2] This illusion of consensus is the illusion of objectivity, the illusion and widely held belief that doctors' assessments of patient suffering are more valid than the patient's own accounts. As Eric Cassell notes: "It is forgotten that physicians constantly make judgments that can be interpreted in more than one fashion on information presented to them, for example, through their stethoscopes, their examining hands and their reading eyes."[3]

The gift of being a medical student, however, is that we cannot forget. We know all too well that our judgments

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are just that: subjective judgments. Awareness of our fallibility is so sharp and constant that it is easy to question whether our judgments will ever be especially valid, even with years of training. And what a privilege to be left helpless and without words when regarding the suffering of others.

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I was unquestionably helpless in the pediatrics ward in Kenya. There was little I could do but listen and watch. One day I discovered a new room of children on the ward. It was a room that the physicians did not visit on their rounds very regularly. Here were the older children, elementary school–aged children, who were either chronically or terminally ill or abandoned by their families, often because their parents were unable to pay the hospital bills. The room was relatively quiet, compared with others. There were no mothers camped out on the floors, no one cried loudly. The sicker children just lay still in their beds, while the healthier ones brought them meal trays and spoke quietly to each other.

I spent time every day in that room. One girl, 9-year-old Rosemary, was particularly fluent in English, and so we spoke often. Rosemary was very ill: her heart was failing as a consequence of her tuberculosis, and she had tested positive for HIV (though her father did not consent to the test, and refused to believe the results). Breathing was hard for her, and sometimes she could not speak to me without becoming breathless. I learned, sitting on the edge of Rosemary's bed, that she was not only astonishingly bright but liked to read, and so I brought her "story books" as she called them, and read to her, the other children crowding around to look at the pictures.

I so desperately wanted to make Rosemary better. But I could not, and neither could the doctors, it seemed. So I would just try to talk to her, ask her how she was feeling. Sometimes she would reply: "sick." Other times she would ask me to get her a piece of bread, which her father had put in a plastic bag, tied to the end of her bed. Once she told me she needed a new hospital gown. When I returned with the gown an hour later — having been distracted by some other task — and I began to help Rosemary change, I realized that she was wet from top to bottom. "How did this happen?" I asked her. "I fell," she said. Rosemary had gone to the bathroom — trying to avoid the indignity of wetting her bed — but had fallen on the filthy floor beside the toilet. I silently dressed her in a new blue gown and lifted her sick body to change the wet sheets.

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I hope someday that I will have the knowledge and skills to care for sick people. But I am grateful for this experience of helplessness. For being forced to sit at Rosemary's bedside, knowing how little I had to offer, and ask her: "What do you need?"

May we as physicians always remain acutely aware of our own fallibility and may we never be able to "cope well" with the sight of human suffering. I hope to speak the language of medicine, a language that will enable me, like any other second language, to speak in new ways about new things. But may I never forget my mother tongue.

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## REFERENCES

1. Berger J. *A fortunate man: the story of a country doctor.* New York: Vintage Books; 1967. p. 112.
2. Sontag S. *Regarding the pain of others.* New York: Farrar, Straus and Giroux; 2003.
3. Cassell EJ. Recognizing suffering. *Hastings Cent Rep* 1991;21:24-31.

## One thousand words

Jodi Enns

***This photograph is one of the winning entries in a contest held during the 2006 International Women and Children's Health Conference, which took place at McMaster University, Hamilton, Ont. Students in Health Sciences programs submitted photographs taken during their work in developing countries and in rural Ontario.***

In every culture, there is something unique about the love and dedication of a mother. While completing an international nursing placement in May–July of 2006, I had the opportunity to work with many women and children in a rural area in India. Patients with more serious cases are admitted to an indoor clinic for medical treatment. The majority of the patients are young children accompanied by their mothers. The mothers are responsible for all of the basic care of their child during their stay at the clinic, and in the middle of a long hot day, most will lie down for a nap, sharing the bed or crib with their child. Home may be several hours away.
— Jodi Enns, Bachelor of Nursing Science '06, McMaster University, Hamilton, Ont.

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