Illness and metaphor

Contagion

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... [T]he calamity was spread by infection; that is to say, by some certain steams or fumes, which the physicians call effluvia, by the breath, or by the sweat, or by the stench of the sores of the sick persons, or some other way, perhaps, beyond even the reach of the physicians themselves, which effluvia affected the sound who came within certain distances of the sick, immediately penetrating the vital parts of the said sound persons, putting their blood into an immediate ferment, and agitating their spirits to that degree which it was found they were agitated; and so those newly infected persons communicated it in the same manner to others. ... I cannot but with some wonder find some people, now the contagion is over, talk of its being an immediate stroke from Heaven, without the agency of means, having commission to strike this and that particular person, and none other — which I look upon with contempt as the effect of manifest ignorance and enthusiasm; likewise the opinion of others, who talk of infection being carried on by the air only, by carrying with it vast numbers of insects and invisible creatures, who enter into the body with the breath, or even at the pores with the air, and there generate or emit most acute poisons, or poisonous ovae or eggs, which mingle themselves with the blood, and so infect the body: a discourse full of learned simplicity.

From chapter 4 of Daniel Defoe's account of the Great Plague of London (1664–1665), *A Journal of the Plague Year*, published in 1772.

Achilles' heel

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Have you ever experienced an uncontrollable visceral response on seeing a patient?

I had such a reaction during my very first encounter with medicine from the physician's side. I was 15 years old and shadowing a general surgeon for a high school career day. The first procedure of the day I was to witness was a second-trimester therapeutic abortion performed by one of his colleagues. I entered the room when the patient was already under anesthesia, her feet in stirrups facing the door. I had never had a gynecologic exam myself at that point, and had certainly never seen female anatomy so exposed and up close. There was the physician, sitting on a stool at the patient's feet with the vacuum in her vagina. Hearing me, he turned around and said, "Come closer for a better view. Some women seem to use abortion as a form of birth control. It's this woman's fourth time here; she can't seem to keep her legs shut." He continued thrusting the vacuum. I swear to you, the sight of an unconscious woman in such a vulnerable position, the sneer in his voice and the angry jabs into her made it look like he was raping her. I fainted on the spot.

I recovered without permanent sequelae and managed to make it to medical school three years later. One becomes tolerant of quite a lot during medical training: the sight of someone in excruciating pain, the distinctive sound of vomiting, the unique smell of melena, the rubbery feel of a cold corpse. Since then, in medical practice, I have been untroubled by visceral reactions. A notable exception occurred a few months ago, concerning a patient at a medical obstetrics clinic. She was 30 weeks pregnant and receiving care for gestational diabetes. I called her in from the waiting room; she walked into the office with her youngest child — a cute boy of about four, the only one of her five children who had not been placed in foster care. She was quite a sight to behold: her bleached hair with long dark roots, her sunken cheeks and the many excoriative lesions on her face made her look much older than her years. She removed her old leather jacket, which was wet with rain and reeked of stale cigarettes, to reveal arms with small scars that I would later learn were burns inflicted by her partner.

I asked my patient to take a seat. She was twitchy from her cocaine habit. I handed some paper and a pen to her son to keep him occupied, and began the interview. How had her glucose control been over the past two weeks? She explained that she'd had difficulty remembering to check it, given that she and her partner were in the midst of separating. And, really, how could I blame her? It almost felt ridiculous, trying to discuss mild gestational diabetes in the global context of her social situation. So we deviated to discussing this topic, which was in the forefront of her mind, while her child sat quietly drawing.

All of a sudden, in mid-sentence, she stopped, turned to her son and swatted him — *hard* — over the back of his head, knocking him out of his chair. *Stop swinging your legs in the chair, would you!* she growled. Incredibly her son, sprawled on the dirty hospital floor, did not cry. Presumably this was his mother's best behaviour. I then understood that the bruises I now noticed on him had likely been formed though something other than harmless play, and that he lived in a home that smelled like the damp, stale tobacco odour that had rapidly taken over my office. I could not bring myself to resume our conversation. I made sure the child was unhurt, reproached my patient for her actions, and quickly sent myself a false page.

I excused myself and walked straight to the bathroom, where I vomited. I washed my face and raided the clinic fridge for a glass of orange juice. Then I went back to complete the clinical encounter, and sent my patient and her child with a nurse to their pre-arranged visit with the social worker.

I finished writing the chart, walked out of the room, and called for the next patient.

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