



# The Universal Doctor

Doctors writing about humanity and resilience in medicine

*What is your story?*

Compiled by Leanne Rowe and Michael Kidd

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## What is your story?

The Universal Doctor is presented an example of the power of doctors' stories. We are seeking more stories from family doctors from around the world to contribute to a new edition on humanity, human rights and resilience. Please send your piece of writing (no more than 2000 words) to us for consideration for volume two to: [admin@medicalconsulting.com.au](mailto:admin@medicalconsulting.com.au).

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*Dedicated to the 500,000 family doctors from 150 countries who, as individuals and as members of medical colleges and societies, come together as the membership of the World Organisation of Family Doctors (WONCA).*

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Patient cases have been changed and de-identified to protect privacy.



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# Chapter 1

## Why write about resilience and humanity in medicine?

*'I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug...I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick...*

**Hippocratic Oath: Modern Version**—Written in 1964 by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University

## 1.1 What kind of doctor do you want to be?

### Adjunct Associate Professor Leanne Rowe

2009 was a very significant year. Professor Michael Kidd and I published a book '*First Do No Harm: Being a Resilient Doctor in the 21<sup>st</sup> Century*', and my young husband, also a GP was diagnosed with an aggressive prostate cancer.

Since that time, throughout my husband's seven year cancer journey back to health, I have been exposed to the best and the worst of the medical profession while sitting quietly on the sidelines of over one hundred consultations. So far, we have consulted many dedicated treating doctors, including generalists and subspecialists, most of whom we are indebted to. In the early stages, the generosity of some doctors was outstanding, including one notable Professor of General Practice, who volunteered to do a locum for our rural general practice, unphased by the three hour return drive to his home.

In contrast, I have also witnessed the cold and arrogant side of many other doctors, who seemed oblivious to the damaging impact of their poor communication skills, particularly when my husband's prognosis was fragile. There were many occasions when like Professor Faith Fitzgerald in her story on page 71, I questioned why idealistic and optimistic medical students sometimes turn into '*insensitive, mechanistic, technocratic, or inhumane brutes*'.

I also identified with Dr Peter Goldsworthy's reflections on page 23: '*Medicine, like any work which involves contact with a lot of human misery - and human stupidity - tends to shrivel the heart*'. The cold lack of humanity and empathy from some colleagues was very painful.

In parallel with this unfolding personal battle, I was involved in developing '*The 2013 beyondblue National Mental Health Survey of Doctors and Medical Students*', which documented high levels of psychological distress (13.4%), suicidal ideation and self-medication in a sample of over 14000 Australian doctors and doctors in training. Certain groups were more affected than others – for example, female doctors were found to have a suicide rate 2.5 times that of women in the general population, with a very high 20% of female doctors reporting suicidal ideation in the previous 12 months. Overseas trained and Indigenous doctors were more likely to report being very stressed by racism and bullying, at the hands of both colleagues and patients.

All of these significant issues must impact on the ability of doctors to care for their patients, and yet, one of the most striking responses to the release of the *beyondblue* study was the silence and inaction from the medical profession. Our book '*First do no Harm*' had been well received by some, but others did not see the need to talk about resilience, depression or suicide in our profession.

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All these experiences led Michael and I towards a deeper search for resilience and humanity in medicine. We asked some inspirational doctors how they transcend adversity and continue to care for their patients, their families and their own spiritual, mental and physical health in times of immense stress. And this book of their stories emerged after we discovered that many of them use writing as a powerful outlet for the inevitable pressures at work.

While the doctors' pieces of writing are brutally honest, poignant, diverse, and as funny as they are tragic, a number of themes about resilience emerged, which have formed the sections of this book on:

- *Seek inspiration and support from mentors and role models*
- *Debrief often about loss and death*
- *Focus on the quality of patient care*
- *Advocate against disadvantage*
- *Remain curious about humanity.*

The optimistic messages in each chapter are for doctors at all stages of their careers, and everyone else involved in the health system - nursing and allied health professionals, medical practice and hospital staff and their patients and families - because the search for resilience and humanity is shared by us all.

And for me, after reading this book of doctors' stories, I now have a very clear picture of the kind of doctor that I strive to be – and this is beautifully expressed in a piece by Anatole Broyard, editor of The New York Times Book Review, writing before he died of prostate cancer:

*'What do I want in a doctor? I would say that I want one who is a close reader of illness and a good critic of medicine...I see no reason or need for my doctor to love me, nor would I expect him to suffer with me. I wouldn't demand a lot of my doctor's time, I just wish he would brood on my situation for perhaps five minutes, that he would give me his whole mind just once, be bonded with me for a brief space, survey my soul as well as my flesh, to get at my illness, for each man is ill in his own way'.*

## What is your story?

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Adjunct Associate Professor Leanne Rowe

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## 1.2 My greatest teachers

### Professor Michael Kidd

*'When a medical student must be converted into a physiologist, a physicist, a chemist, a biologist, a pharmacologist and an electrician, there is no time to make a physician of him (or her)...That will only happen after he (or she) has gone out in the world of sickness and suffering.'* Sir Andrew MacPhail 1930

*'Why do you want to be a doctor?'* It is a question which is asked of most young people who express a desire to study medicine. In my case the answer was simple. I wanted to use what skills I have to help people. I wanted to make a difference.

Following graduating from medical school, like many young doctors, I was initially not at all certain about which area of medicine I was going to choose as my specialty. General practice offered me the chance to cover the breadth of medical practice and work in each of the medical disciplines I enjoyed. General practice also provided me with the opportunity to really get to know my patients, to be my own boss and to practice medicine in the style that I thought would be best for my patients and my community.

Before arriving at that point, I had some great role models throughout my angst-ridden years as a medical student. And I needed a lot of support. Like most medical students I thought I was experiencing the early stages of a number of the serious diseases we studied at medical school.

Throughout my career, I have been inspired by a number of well known international leaders in general practice/family medicine, including my teacher and mentor, Professor John Murtagh (page 19), and my friend and colleague, the late Professor Chris Silagy (page 15), whose personal stories grace these pages. However, when I look back on my journey, I was also influenced by a large number of other quietly dedicated doctors.

In my fifth year as a medical student, I undertook an elective in general practice with the late Dr Donald Cordner, an Australian football legend, who wrote a very special story about his work, included on page 13. Dr Don worked from his surgery in the then-semirural area of Diamond Creek in outer Melbourne. He spent most of his day driving around the community providing palliative care to people who had chosen to spend their last days at home with their families. His kind, gentle manner, practical approach and unwavering commitment had a lasting impact on my own style of medical practice.

After completing my postgraduate training in general practice, I faced the challenge of deciding what sort of general practice I would work in. As it happened, the choice was simple. It was the early 1990s and the HIV epidemic was at its peak in Australia with large numbers of people dying of AIDS. As a gay man, I felt the need to do something to assist my friends and peers who were affected by this dreadful disease. I started working

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at the Gay Men's Health Centre set up by the Victorian AIDS Council. I found I was able to help some people and, in some small way, make a difference. I also began to learn from my patients and I matured as a human being.

Working in general practice with people affected by HIV, I discovered something new about human existence every single day. I couldn't provide everything that my patients needed, but I could do so much more by working as a member of a wonderful, diverse and highly skilled team of health care professionals and volunteer carers. I experienced and valued the camaraderie between general practitioners that supports us in our important work. Being able to assist someone who trusts you and to care for them while they are supported to die with dignity is a very special privilege. I learned it is okay to cry with people who call you their doctor. I also discovered that wisdom came with experience.

My patients of course knew more about their experience of their own condition than I did, and they became my greatest teachers.

I also learned what it means to have a good day in my practice. A good day is when:

*I've asked the right questions and at least one person has cried and at least one person has laughed in my consulting room.*

*I've had at least one person tell me the real reason why they have come to see me.*

*I've increased my medical knowledge.*

*I've cared about what happened to each patient and each colleague I have seen today.*

Over my career I have learned to focus attention on the physical, psychological, social, and spiritual impact of the conditions affecting the people who have trusted me for their medical care and advice. In my current roles as President of the World Organisation of Family Doctors and as a dean, I have recognised that doctors must also consider these multidimensional aspects of their lives to remain resilient and humane.

I am delighted the contributing authors in *The Universal Doctor* have been willing to share their insights with us about the multidimensional aspects of each of their remarkable careers, and I hope you enjoy their stories.

## Chapter 2

# Seek inspiration and support from mentors and role models

*'I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow'.*

**Hippocratic Oath: Modern Version**— Louis Lasagna 1964

The stories in this section are written by prominent doctors, who are our mentors and role models.

A past Vice Chancellor of Monash University in Australia, also known for his leadership in neuromuscular research and clinical neurology, Professor Ed Byrne shares his poetry throughout the book.

Dr Donald Cordner, a legendary footballer, who passed away at the age of 87, wrote about his long career as a dedicated rural general practitioner. Professor Chris Silagy left an enormous legacy through his contribution to the development of the internationally renowned Cochrane Collaboration and was also a much-loved general practitioner. Their inspirational stories describe the joys of being a doctor and the challenges of being a patient.

Professor John Murtagh, a renowned international medical author, educator, and family doctor, was recently voted as the number one hero of Australian medicine and talks about the importance of openness and loyalty in clinical practice.

## 2.1 Loneliness

### Professor Edward Byrne

To be alone with  
Comfort or pain  
No one to attend to  
Except oneself  
Freedom to do  
What one will  
Can be a cell  
How to escape  
The prison of loneliness

## 2.2 The Importance of personal involvement

### Dr Donald Cordner (21 Jan 1922-13 May 2009)

I firmly believe that among the many abilities and attributes necessary to be a general practitioner – some of which are almost intangible – one very important quality is often overlooked: willingness to become involved. I recall several cases where the ability to reject ‘professional detachment’ and become wholly involved proved to be more important than any other.

It was in the early 1960s – a call at midnight from a 60 year old patient of mine who, under the circumstances, was remarkably matter of fact. ‘*Doctor, Ivan (her 65 year old husband) has been in the lavatory for an hour – the radio is blaring – the door is jammed shut, and I can get no response*’.

On arrival 10 minutes later, guided by torch light, I pulled up the rear flap of the ancient outside weatherboard pan lavatory, removed (with difficulty) the pan, pushed up the hinged wooden seat, and managed to clamber inside. On the floor, jammed between the seat and the door, was the dead body I had expected to find. In the very confined space, I struggled to lift the body up onto the seat, then opened the door, lifted the body onto the ground and covered it with a rug, all with the widow looking on. I took her indoors, made her a cup of tea, rang an undertaker, called the woman’s son and daughter at their respective suburban homes, and waited 2 to 3 hours until they arrived to take over.

At 2pm on a Saturday in the mid 1970s, I received a phone call from a 60 year old, rather disabled housewife (whom I knew to be an alcoholic). ‘*Doctor, my husband walked into the orchard two hours ago and he has not returned,*’ she said. Half an hour later I was met by my rather unsteady informant with a fatuous smile on her face. On walking some 300 yards downhill I came across the quite large body of her 65-year-old husband.

I walked back up to the house and telephoned next door (about a mile away) for help. When the neighbours’ strapping 18 year old son arrived, we lifted the body onto an old door and carried it back up hill to the house – completely exhausting me physically and my young assistant emotionally. It was a rather uncomfortable and embarrassing 3 hours spent with the widow before I could contact her only son to come and take over, and I finally arrived home at about 7:00pm.

I encountered another similar situation in the late 1980s. A call came at 1.00am from the home of an elderly, fragile, childless expatriate English couple with few friends. ‘*Doctor, Alan has just collapsed on his way to the bathroom*’. When I arrived, 90-year-old Alan was on the floor, obviously dead.

I lifted the body onto the bed, covered it, and rang my wife to come and collect the exhausted widow (who subsequently spent some 3 weeks with us, recovering), rang an

undertaker and arranged a cremation (as Alan had asked me to do '*if anything happened*'), rang his solicitor to take over and arrived home about 5.00am.

In none of these cases was any medical expertise required, but immediate availability and a willingness to get involved were both essential. Indeed, my involvement with these cases contributed well beyond the incidents described.

In the first case, I looked after Ivan's widow at home for some 20 years after his death. I spoke at her sparsely attended cremation.

I completely lost touch with the second widow. Five years later my wife and I were driving on a weekend when we saw a dishevelled elderly lady, barefoot and clad only in a nightie, tottering confusedly along the footpath. It was my former patient's widow – we returned her to the nearby nursing home from which she had escaped.

In the third case, after recuperating with us, the gallant and indomitable widow returned to the home she had shared with Alan, and managed alone for some 3 to 4 years. Eventually, my involvement also extended to speaking at her cremation.

## 2.3 A view from the other side ©

### Professor Chris Silagy (14 Sept 1960-13 Dec 2001)

I can still vividly remember the day four years ago when I was first told the diagnosis. I had a phone message just before lunch to call the locum physician for the results of a CT scan that I had two days earlier. For the three weeks before this I had been having fevers and sweats together with a strange sort of fleeting polyarthritis. I was in considerable pain and depending on which joints were involved, had difficulty walking or brushing my hair. It was all quite frustrating since I had never given my health a second thought and was generally quite fit. I put everything down to picking up a viral illness as a result of a hectic overseas trip from which I returned some three weeks earlier. I was stressed and tired.

Having diagnosed myself, I put off going to see another doctor, and initially wasn't even sure who I should see. I had no GP of my own and had always tended to rely on either myself, my wife (who is also a GP), or one of my colleagues in the practice for advice. When I finally went along to see the physician, he discovered I had generalized lymphadenopathy (which on reflection I think I had for the previous couple of years) and a 4cm palpable spleen. He mentioned lymphoma as a possibility that needed to be excluded, but I wasn't particularly anxious about this, thinking it could never happen to me. How naïve that was.

I put down the phone. The news was devastating. The abdomen appeared to be full of enlarged lymph nodes. Lymphoma was now the most likely diagnosis. Before I returned to my afternoon's commitments, I rang my wife and told her what had been said. As I spent the next three hours in a meeting talking about the future of the medical curriculum, my mind was racing elsewhere. Every conceivable possibility, scenario, and alternative flashed before me. This was all a nightmare. It couldn't be true. Not to me- a fit 36 year old- and someone who had almost everything he could dream of.

As I drove home that evening I wondered how I would react and what would we tell the children. I walked in the front door, looked at my wife and four young sons and started to cry and cry. When the boys demanded to know what was going on, we simply said: *'Daddy got some bad news today. It explains why I haven't been feeling well lately and haven't been able to play football with you.'*

That day marked the beginning of what has become like a rollercoaster ride. The problem is not knowing exactly what, when or where the next turn will be. Coping with that uncertainty is the greatest challenge in dealing with the illness. Its consequences can be extremely trying not only to me, but to the rest of my family. We never can commit ourselves to planning too far ahead. Schedules have to be arranged, then rearranged, and rearranged again. *'We can't promise you that we will be going on holidays- we only hope so; we aren't sure if we can put that off for a couple of years- our situation may be quite different then.'* Those are the types of dilemmas that now dominate our lives.

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I have learned many things over the past four years. To begin with I am convinced that a diagnosis of cancer should not be seen as an immediate death sentence, which is often what our patients perceive. Even the best statistics in the world cannot predict how an individual will respond or where they will sit on the survival curve. We frequently talk about medians and means, but are never encouraged to look at the tail. But even before we talk about survival, we need to get the diagnosis right (and that's not always easy).

In my case, five local pathologists reviewed my slides and decided I had a low-grade follicular B cell lymphoma. The prognosis I was given was one of a slowly progressive disease with an ultimately incurable course. However, as those first few months after the diagnosis progressed, I found myself deteriorating. My spleen has enlarged to almost 17cm below the costal margin (in fact by the time it was eventually removed two years ago it was over 3kg, about the size of a large soft drink bottle). I had initially agreed to an approach of watchful waiting, but eventually had to begin some oral chemotherapy, to which I responded by promptly becoming neutropaenic and ending up in hospital for the first time in my life. I hated that experience. I spent as much time as I could out of the ward and in my own office (drip stand in tow). By the time of my first Christmas, post-diagnosis, I was thinking it would be my last, barely eight months after being diagnosed. I was requiring steroids just to keep the pain at bay.

After much soul searching I decided to seek a second and third opinion. I first consulted a rather aggressive interstate transplant physician, who told me my only chance of cure was to undergo an allograft (a procedure which has a 40% mortality rate and a substantial associated morbidity). That news on Christmas Eve was totally unacceptable. I tried to make the most of my Christmas holidays, taking my two sons on a trip to Sydney. I desperately wanted to cram 20 years of their life into the next six months in case I wouldn't be around. A month later, I headed off en route to a conference in South Africa via the UK, where I had been given the name of a consultant with a special interest in lymphomas. As requested, I had sent my pathology slides on ahead for him to review. As I walked into his room he announced that the pathology diagnosis I had been given was wrong and that I had a very aggressive form of the disease, which required equally aggressive chemotherapy, but there was a possibility of cure. While devastated, for the first time there was also a flicker of hope. I returned to Australia that evening and within days was sitting in hospital being pumped full of a cocktail of drugs that were known by their acronyms. I started to plan my new look, realising that it was only a matter of time before my hair fell out. I never got to Africa!

Over the ensuing months I was to learn much more about the intricacies of chemotherapy, especially the perceptions and stigma attached to it. With modern anti-nausea drugs I was able to work through it wall. In fact, over the past four years I have had little more than a couple of weeks off work (for my splenectomy and subsequent bone marrow transplant). I have been filled with old drugs, new drugs, drugs that were

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only available under special access schemes. I know my blood counts better than I know my bank balance!

I have barely gone more than three months since the diagnosis without having a drip inserted or lying in some day care centre. My disease continues to fascinate the medical staff with its failure to comply with any routine texts. Just as everyone begins to despair, some almost miraculous response occurs to a treatment that the books say should never have worked.

I have learned to respect the skill and compassion of the oncology nurses. On many occasions that have made the difference to how I feel. I have also learned that a similar caring and compassionate approach is essential and desperately needed among medical staff. I have been fortunate to have some outstanding clinicians involved in my care. But I have also had my share of arrogant, insensitive and clinically atrocious doctors (right through from interns to senior consultants).

This experience has impressed on me the need for doctors to really listen to their patients. As my disease has gone through remissions and relapses, I have usually been the first person to detect the new small nodes or lesions. At times I have had to almost plead with the medical staff to take notice of my symptoms. Ironically, at one point I was so determined to prove I was right, I designed a small study on myself to confirm the findings and then published them in *The Lancet*!

The experience of having to live with a life threatening illness has been not only personally challenging, but also quite humbling. Yes, it has changed my outlook- both as a doctor and as a human being. I realise that death and illness is something we will all have to face, not just our patients. Similarly, at some time, we will all have to face being on the other side of the desk and experiencing what it is like to be a patient- not in some simulated teaching scenario, but for real.

I now have a doctor whom I trust and who has given me hope and encouragement not to give up. New treatments and approaches for this type of lymphoma are continually under development. When I was first diagnosed, immunotherapy was confined to the laboratory. With my first treatment two years ago, it was only available under a special access scheme, whereas now it is available on the Pharmaceutical Benefits Scheme and used routinely.

I still seek to play an active role in the decision making process. Together with my doctor, we weigh up the evidence, to which I apply my own preferences and values. I will never know whether I have made the right decisions. But I do know that it is more than two years since one senior consultant told me there was effectively nothing more that could be done. I have been symptom free for over four months and have had an exhilarating time travelling overseas with my family. I recognise that my rollercoaster ride is probably far from over. I continue to plan for the future as best I can, always trying to keep my options open and my spirits high. In that way I believe I can maximise the chance of not only seeing my sons grow up, but also of being able to enjoy the experience.

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What your own serious illness can teach you

- Good doctors and nurses listen and listen and listen to their patients
- Trust is essential to a good doctor-patient relationship
- Honesty is important, but so is some hope
- A diagnosis of cancer is not an immediate death sentence
- Treatment choices need to take account of a patient's values and preferences
- Chemotherapy is not always as unpleasant as it is portrayed to be
- Survival statistics are just that- probabilities on what may happen not what will happen
- There is not always 100% agreement on diagnoses made by pathologists
- New and potentially effective cancer treatments are continually emerging
- When in doubt, don't be afraid to seek a second or third opinion
- One can learn to live with uncertainty

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**Adapted and reproduced with permission from The Royal Australian College of General Practitioners from Silagy C. A view from the other side – a doctor's experience of having lymphoma. *Aust Fam Physician* 2001;30(6):547–9.**

## 2.4 On openness, humour and loyalty

### Professor John Murtagh

Ever since entering medical school, my ambition was to be a general practitioner in a small rural community similar to that into which I was born and raised. I loved the sense of belonging and supportive dynamics among rural people. Fortunately my medical and lifelong partner was happy to accept the challenge as we took over a traditional solo practice, which included a new 12 bed hospital.

I was somewhat idealistic, probably naively so, especially after graduating from the brand new Monash University medical course that encouraged lateral thinking and challenging of entrenched concepts and practice. Coming from a Christian background I perceived appropriate medical care as one of dedicated service including caring, availability and advocacy. The Christian ethical ethos fitted comfortably with the now unfashionable Hippocratic Oath model and to that of the great virtues particularly of compassion, generosity and humour as enunciated by Andre Comte-Sponville in his '*A short treatise on the great virtues*'.

In many ways, the first 12 months (now over 43 years ago) was heavy going as we strove to be accepted. We made it clear when interviewed by the Board that a new order would be in vogue and that some traditional procedures, such as circumcision and tonsillectomy would be performed only for valid medical conditions, and prescriptions for antibiotics and anxiolytics would be more conservative. The circumcision issue in particular generated much angst.

Another interesting, eyebrow raising issue was the presence of a very svelte, 25 year old female doctor. This unfamiliar image (to this rural community) led most pregnant women seeking out the male doctor to deliver their babies. Another issue that caught us by surprise initially was the cautious religious biases of this exclusive Christian, but mixed denomination, community. Some people would visit me preferentially because of my particular persuasion, while others would prefer to consult my wife for a similar reason. Nevertheless our planned approach was to be open, liberal and flexible while following ethical standards, which we considered typical of Australian general practice. However our patients' welfare did come first and if a problem or conflict eventuated, patients were encouraged to see another GP or specialist in one of the many practices in neighbouring towns. One practitioner who enjoyed performing circumcisions was delighted, but there was a downturn in the overall number of such procedures.

The interesting and satisfying outcome was that after about 12 months, the patients were generally happy to consult either of us on any issue (perhaps with the exception of Pap tests), as they accepted that the differences including perceived inexperience were

irrelevant. Human issues had broken down artificial barriers, and made practice very rewarding.

The humour and banter that we encouraged seemed to help and soften the stressful hard edge of the serious, emotional nature of illness. The great characters of the bush would come in with their *'one up-man ship'* facial smirk e.g. *'saw a pycost in the bush today doc'*. *'Really, what's a pycost ? 'One dollar fifty with tomato sauce!'* Gazumped again!

Identifying patients with whom you could joke without offending was a challenging skill for example:

*'Jimmy your emphysema worries me as much as it does you. You really must give up smoking'*.

*'I can't doc-too hard- is there anything else at all?'*

*'Well Jimmy the only thing going for you is reincarnation'*.

*'I'll take it'*.

Relatively isolated general practice was a really marvellous opportunity to learn the true nature of medicine through continuity of care. We visited our hospital inpatients at least twice daily and soon determined what really worked. Learning from shortcomings and mistakes was inevitable and this resulted in the publication of *'Cautionary Tales'*, a collection of anecdotes highlighting wisdom that had sometimes been gained the really hard way. The patients were generally understanding, loyal and lovable, even to the extent of unrealistically expecting their doctors to perform almost every known complex surgical procedure in their own hospital.

A vital strategy of the practice was to seek feedback about *'how we were doing'*. Valuable sources of discrete and trusted opinion were our housekeeper, receptionist, district nurse, police and clergy. Many adjustments in our approach to domestic situations followed better insight. After all we had to live and work with our patients in a close community.

## Chapter 3

# Debrief often about loss and death

*'Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty'.* **Hippocratic Oath: Modern Version**— Louis Lasagna 1964

Being exposed to loss and death in everyday practice can take its toll. These stressors in medical practice are often overlooked in studies on why doctors and medical students have higher rates of burnout, depression and suicidality than the general population. We don't we talk about this very often, but we should.

Unfortunately many doctors perceive it is a weakness to ask for support from a colleague, despite the inevitable challenges of medical practice. As doctors, we carry an enormous sense of obligation and commitment to our patients. For this reason, the medical profession has a long and admirable, but often unhealthy tradition of 'self sacrifice' to work. The culture of the medical profession is such that the signs of burnout are often worn as badges of honour. We must challenge the notion that a stressed and miserable medical practitioner is the sign of a dedicated doctor.

In the next section, Professor Ed Byrne, Dr Peter Goldsworthy, Dr Ranjana Srivastava and Dr Hilton Koppe talk about the importance of talking about loss and death.

## 3.1 Meditation

### Professor Edward Byrne

Hazy perfection  
blue sky  
occasional clouds  
green fields  
grey sea  
the scene  
should include  
Wordsworth's daffodils  
bending in  
the gentle breeze  
The inward eye  
can open  
in many places  
to look in  
is compelling  
to lose oneself  
in abstraction  
is a conceit  
Fine line  
between self  
and world  
to be unaware  
of one's heart  
is to be lost  
among the half dead  
whose souls never sing  
To think too much alone  
is good for Trappist monks  
and stylite hermits  
but causes most  
to wither and lose  
the sap of life

## 3.2 Death and the comedian

### Dr Peter Goldsworthy

1.

I once dined with friends at Kinsella's, a Sydney funeral parlour turned restaurant. We were seated in the inner sanctum, the former chapel. Mid-meal, the poet Elizabeth Riddell recalled that her last visit to Kinsella's had been fifteen years before, for a funeral.

Her late husband's coffin, she announced, had occupied the precise spot where our table now stood.

Such ability to look death calmly, even jokily, in the eye, and continue eating, impressed me no end. It also suggested the possibility of finding a narrative tone with which to handle the various stories of death, and grief, and near-death which I had been collecting - or which had been collecting me - for years.

A few weeks before Philip Hodgins' death from leukaemia in 1995, I prepared a newspaper obituary after a request from Philip had been passed on through a mutual friend. Philip had finally decided to discontinue the chemotherapy which had caused him much suffering for many years. I sent him the obituary - he was curious to read it - and a few days later received a bottle of his favourite wine, *Passing Clouds*, accompanied by a congratulatory note: it was '*an obituary to die for.*'

This seems to me one of the great aphorisms, deserving of a place in any collection - and a perfect distillation of Philip's stoic courage, and style.

1995 was a bad year for Australian poetry, with the death of Gwen Harwood after a yearlong battle with what she, also, knew to be a terminal illness. Whatever private demons this forced her to wrestle with, or share with her husband and family, in her letters she remained cheerful and courageous - and as irreverent as ever, her characteristic humour irrepressible.

*I can walk (as if on Jupiter) very slowly, I even look like an alien from another planet; moon-faced and swollen from the medications & decorated with magenta blotches. How uninteresting....*

This from the last letter I was privileged to receive, a few weeks before her death.

Even if given the chance, I doubt I will face my own end with the same courage, and dignity, and tough humour.

I often thought I was dying as a child, suffering asthma attacks at harvest time - but I liked to over-dramatise. I did spend a week in intensive care in my early twenties with a chest full of blood - but I was too drugged to sense any danger, or take proper stock. The days

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passed in a dream, interrupted only by the worried faces of my parents emerging and vanishing through the fog of narcotics. What, me worry?

My experience of death has (obviously) been from the outside, looking on - but as with all doctors, the experience has been all too frequent.

2.

People often ask how I manage to mix working as a writer with working as a doctor. Or - an interesting wording - which are you 'really'. Part of me always resents this: why should the two trades be incompatible, or immiscible? Perhaps the surprise that people express at such a mix - writing and medicine - is due to received notions of an Art/Science Great Divide, notions which are much exaggerated, and usually come as a complete surprise to anyone on the science side of the alleged divide, most of whom read novels, watch movies and listen to music avidly.

Sometimes the question comes from the other side, from an opposite set of prejudices: sometimes it's a logistics question. How can a Busy Doctor Have Time to Write Books? There's a subtext here, an accusation that harks back to that use of the word 'really': the notion that a 'real' doctor would not bother with anything so frivolous.

And another, different part of me sympathises with this. It's a question I often ask myself, as any good Methodist boy would - especially late at night, when the work of Making Up Stories often seems rather silly.

I find it's useful to quote Anton Chekhov in such circumstances, especially to myself: 'medicine is my wife, writing is my mistress.'

Writing is my Golf Afternoon? In fact, I suspect that my temperament is more suited to writing than to medicine. Ever since I treated a fractured right leg in my first year out of medical school by putting a plaster on the left leg I've had a feeling that life held out something else for me beyond medicine. Fortunately no harm was done, except to my ego. I removed the plaster, red-faced, and reapplied it to the other side. Creative medicine? Or gross negligence? I blame a wandering mind, a mind too often occupied elsewhere. I like to jot down ideas between patients in a notebook I keep for that purpose. Recently a chemist around the corner returned a prescription to me with the note that while he enjoyed the poem, he didn't think it one of my best.

And here is one of the advantages of writing as a career: you don't need to be particularly alert to succeed. You don't need to know the difference between a right leg and a left leg for instance. Or if you do, then you've got a few weeks or even months to think about it, and make up your mind exactly which is which.

But if the literary sensibility offers little help in the practice of medicine - and might even prove a hindrance - what of vice versa?

'I don't know a better training for a writer than to spend some years in the medical profession,' Somerset Maugham, a graduate of the Class of 1897, wrote. Perhaps, perhaps not. Medicine, like any work which involves contact with a lot of human misery -



and human stupidity - tends to shrivel the heart. To survive, or at least to sleep peacefully, it quickly becomes essential to maintain some sort of distance between that world and yourself. I think I was happiest during my student years when working in the Emergency Ward of the hospital in which I trained. Emergency ward medicine is medicine at its most personally distant, disproportionately removed from the extreme pain and severity of the illnesses and injuries which ambulances disgorge into that ward at all hours of the day and night. It's a world akin to the Mental Arithmetic tests of primary school (I was good at Mental!), a world of inadequate history taking, too-rapid examinations, forced decisions.

I found Emergency far easier to handle, emotionally, than the protracted problems and pains of patients I came to know in other wards, and in general practice since, daily. There is simply insufficient time in Emergency to worry too much about any single person; there is always another stretcher arriving, another set of rapid decisions to be made.

It's a world oddly free of worry; far too busy for the luxury of worry.

I imagine that many medicos have been in the same emotional boat, if only because the selection processes for medical schools favour (or used to favour) applicants who are good at Mental Arithmetic, and not necessarily good at coping with pain, theirs or others.

That doctors often come to see the suffering, or dying, of their patients as an intellectual puzzle to be solved is one way of handling the pressures of such an emotionally overwhelming world.

It's a mind-set easy to caricature: the heartless medical students of *Pickwick Papers* ; or Herman Melville's Surgeon-Of-The-Fleet Cadwallader Cuticle come to mind: 'He walked abroad, a curious patchwork of life-and-death, with a wig, one glass eye and a set of false teeth...They say he can drop a leg in one minute and ten seconds from the moment the knife touches it.'

Humour, of course, is another way of maintaining distance: medical school gallows humour. We all, supposedly, remember our first day at school with clarity - psychiatrists lay great store in the emotional content of those childhood recollections. I'm sure that all medicos remember their first day at medical school, which is also their first day in the Dissecting Room, with even greater clarity. For some that first visit lasts only a few seconds before they bolt for the door; for most curiosity reaches a delicate balance with nausea.

I managed to resist throwing up until I arrived home to face dinner - when some variant of Murphy's Law ensured there would be cold pork on the table, that night of all nights.

Cold short pork.

Organ fights, or flesh fights, were not unknown in the Dissecting Room - although such irreverence was harshly dealt with by the authorities. I clearly remember being hit on the

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head by a stray human testicle one sun-drenched afternoon. It's not the kind of event you easily forget.

Richard Gordon ('Doctor in the House' etc.) made a fortune out of books filled with such undergraduate pranks - but it's the opposite defence against the unspeakable that is perhaps more interesting to a writer; the defence of coldness, of denial. Over a period of years, working long hours, and with no sabbaticals to allow a refilling of the reservoirs of compassion, the gallows-humour process in many doctors goes too far, and becomes its own caricature: cynicism, indifference.

I've often parodied that too-clinical voice in my own writing - in part such self-parodies are an exorcism, or an attempted exorcism, although this is not always the way reviewers see it. This, from a review of one of my books by Andrea Stretton in the Sydney Morning Herald:

*This sparse and understated prose brings out this reader's bloodlust: the desire for one of these fictional medicos to undergo major fictional surgery - without an anaesthetic.*

A little more favourable, from The Weekend Australian:

*His style has an initial bedside manner before slitting open a dark underbelly of irony.*

Most memorable is this, from a review by Brian Matthews in The Adelaide Review:

*Ask not for whom the bleeper bleeps, it bleeps for thee.*

I find all this use of medical metaphor mildly irritating. But it's probably better to be a doctor reviewed by writers, than a writer reviewed by doctors. This is what happened to Jonathon Swift's Gulliver's Travels when it was discussed in an issue of the Psychoanalytic Quarterly:

*Jonathon Swift showed marked anal characteristics (extreme personal immaculateness, secretiveness, intense ambition, pleasure in less obvious dirt, stubborn vengefulness in righteous causes) which indicate that early control of his excretory function was achieved under great stress and perhaps too early.*

### 3.

If we remember our first day in the dissecting room clearly, we also remember our first day in labour ward. Being present at child-birth is to share in a huge joy - there is so much joy to go around, a little spills over into all but the most jaded heart. It is always, as if for the first time, to experience a thrilling shock - for there is something shocking, and dislocating, in the final emergence of that new small slippery being.

The image in the film Alien, as the pupal-stage alien bursts from the chest of the host human, captures some of the weird other-worldly shock of the first childbirth I ever saw.

Paradoxically, as a doctor, I find my greatest satisfaction now comes from the treatment of, or more accurately the offering of assistance to, the dying. Satisfaction may seem an odd word for this work, which is often emotionally harrowing - but its satisfactions are

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deeply nourishing. Palliative care, in the argot, has recently, and not before time, become a growth specialty. Being present at death - death at home, among loved ones, from which pain has been banished, and in which the dying person has been granted time and space to come to terms with the fact - to be part of this, in however small and peripheral way, is a huge and humbling privilege. To write about it is near-impossible: firstly, to decide if you have the right, secondly, to tread the fine line between mawkish sentimentality, and too-clinical distance.

Several times I've used a female doctor persona to represent the 'feminine' side of these feelings: the caring side. Its opposite, the objective 'masculine' practitioner, has variously been transformed into a pedantic Latin scholar, and, more recently, a mathematician, obsessed by that purest of the sciences, a world free from any human contamination.

In part such representations are another exorcism, and no doubt somewhere between the two is an ideal narrator: a narrator who can handle all the stories of horror, squalor, stupidity, death - and occasional transcendent courage, or love - for which I can't yet find a proper focus, or tone.

Of course, death is not easily house-trained; it is rarely so amenable to human management and control - to the schedules of an idealised Good Death. It's more often sudden, or violent, or cruel, or painful, or terrifying.

And its world, and the stories from that world, are almost unfathomable.

A mother injects her baby with poison, repeatedly, to gain it admission to hospital. As soon as the baby is separated from the mother, it improves - back in her care, it deteriorates. She denies everything, and almost certainly believes herself.

A doctor saves a choking friend's life in a restaurant, and the saved friend cannot bring himself to speak to his saviour again - the debt is too great to acknowledge, or even admit.

A woman brings in photographs 'of my accident' - photographs of herself, a seriously injured road victim, being extracted from wreckage, bandaged, loaded into an ambulance. The inevitable question is asked: 'Who took the photographs?' The answer: 'Oh, my husband took the photographs.'

What to make of these true, baffling stories? I'm not even sure that they are my business. They do provide a different scale of priorities of importance; an idea of what is, finally, 'really' important, to borrow back that same criterion I tossed up earlier in this piece.

And perhaps this is part of the reason I cannot get enthusiastic about much of the highly-praised writing in this country - and others - in recent years. So much of it belongs in those underrated literary categories: Plain Silly, or Dead Boring.

Including most of my own. For these are the categories of the puritan, of course: the Methodist boy in me who I have also attempted to caricature, but seem unable to shake off entirely. Too many years of medical training, perhaps, have cemented it permanently in place. If part of me likes to see itself as an upper-case Writer - a narcissocrat, a junior

member of the priest caste of our silly Art-worshipping culture - another part is always accusing: Fine, But What Are You Going To Do When You Grow Up?

And yet turning these stories into fiction might help towards some kind of understanding, towards finding some essence, beyond curiosity, or voyeurism. Fiction is above all a re-ordering process, a sense-making process, even when it's black comedy. 'Undoubtedly the world is, and her riches can never be circumscribed by art' the Polish poet Czeslaw Milosz has written - but we have to make a start, especially under immense pressure from the emotions that surround death. Sometimes, to use an old truism, if we don't laugh, we cry - and sometimes even both at the same time.

### 3.3 Witnessing death

#### Dr Hilton Koppe

I had only ever seen one person die before. I mean, really see them die. Last gasp, and all that. Thirty years of doctoring, and witness to only one death. Until now. Now it is two.

Not that I'm some sort of demi-god super-doc, whose patients never die. Of course, my patients die. For some, I have had the privilege of midwiving them on their final journey. For others, it was all too sudden and all too unexpected. It's just that I never actually saw them die.

I saw their struggle with life. I tried to stem the tide, spit into the wind, keep my finger in the dyke, push the shit uphill, swim against the rip. But as my wise grandmother used to say, *'Mein lieber Gott vergisst niemanden.'* My dear God forgets no one. Despite the best efforts of modern medicine, nature still wins out in the end.

There had been the timed and documented moments of death in the hospitals. The failed resuscitations. But did I see these people actually die? I don't think so. They were already dead by the time the emergency pager went off. We couldn't bring them back to life. They were not Lazarus. We were not God. I did not witness them die. I saw them fail to rise. Just like nature intended.

Rod Stewart was belting out 'The first cut is the deepest' around the time I was cut by a last breath for the first time. It was my first night alone as an intern on the male medical ward. James Ward. Spit alley. Full of public patients, veterans from the days when World War 1 veterans were still around.

Then, I was a young sapling with no firm grounding in the earth of medicine. I was scared. Shit scared. 5.30, 6.00pm, they all go. The day staff. The registrars. The other interns. Leaving me with the nurses, and with the enemy, as we used to call the patients.

The pager goes. An admission from Emergency. *'Old bloke with anaemia. Probable bleeding ulcer. We're sending him up.'*

I enter the ward. Grab his file. Draw back the curtain which separate him from the 30 other inmates of James Ward. As I walk to the bed, a man, grey hair, grey beard, pale face, wide eyes, groans an agonisingly long groan as he reaches a desperate hand towards me. Fear! As he dies in front of me. And there is not a damned thing I can do about it. His final breath. My first death.

Thirty years later, a second death.

After hankering after it for my entire career, I was finally on a palliative care ward. No longer pushing the shit up hill, but helping to assist nature do her thing.

And she was remarkable. Such grace. Such dignity in her dying. Just as it had been in her life. She was ready to die. Not afraid of death. Tired from 20 years of breast and now ovarian cancer. Sad to be leaving her family. But ready to go. Definitely ready to go.

She'd said goodbye to her home. She'd said goodbye to her friends. She'd said goodbye to her daughter who lived overseas, and to all her grandchildren. She'd even said goodbye to her oncologist of 20 years – *'I hope you don't feel I've let you down by dying after everything you have done for me.'*

I was blessed to be with her at the end. To watch her breath change. From laboured grunting to soft sucking. Slowing. Easing. Letting go. It was quite beautiful to watch. Watching her let go. Watching her go.

But which was the final breath? The last breath in? Or the blowing sigh a few minutes later as her body totally let go for the first time in her life?

It was an honour and a privilege to be there with her. To bear witness to the end of a good life.

It has changed me forever.

What a pity that it had to be my mum.

*In loving memory of Ray Koppe, 28/2/1935 – 24/9/2010*

*'Our Ray of sunshine, forever in our hearts'*

## 3.4 Wilful forgetfulness

### Dr Ranjana Srivastava

*'A doctor's best debriefing tool after a hard day is wilful forgetfulness'.*

I recently invited two friends, a neurosurgeon and an anaesthetist, to dinner. My husband is a general practitioner and I am an oncologist – due to our schedules, it took us weeks to find a convenient date. Our friends arrived many hours late. The surgeon had been operating on a brand new mum whose headaches revealed a brain tumour. He inserted a life-saving shunt that night, but her prognosis was grim. The anaesthetist had been monitoring another precarious situation where the patient's life still hung in balance. Earlier that day, my husband's elderly patient had suffered a near cardiac arrest while chatting to him. The waiting room was evacuated and sirens rang out. That same evening, I had received a tearful call from a terminally ill patient. He was in excruciating pain, the hospice was full, there was a long wait in emergency and he was frightened of dying. Could I help?

These were the accounts of our day as we greeted each other. Then the oven beeped, reminding us of a dinner many times reheated. In the course of just one day, we had been witness to serious and tragic life events; yet, as if observing a silent code of conduct, we never once mentioned those misfortunes as we ate. One such event once in a life might have ruined most people's appetite for food and company, but not ours. We were different.

That night, I didn't sleep. My thoughts turned to the young mother who would not see her baby grow up. And I fretted over my sick patient. I suspect we all had a disturbed night, our equanimity fractured by the fate of our patients. But I also knew that the next morning we would return to work, our facade repaired. For in that small space between sleep and wake, we would have consoled ourselves that bad things happen and our job as doctors is to not let ourselves feel too bad about them lest we fail our future patients.

A doctor's best debriefing tool after a hard day therefore turns out to be wilful forgetfulness. If you can minimise or better still, normalise catastrophe, you can keep going. Except, as a recent Australian survey of more than 14,000 doctors and medical students shows, this attitude comes at a great cost. One in 10 doctors entertained suicidal thoughts in the past year, compared to one in 45 in the community. More than a quarter of doctors are highly likely to suffer from mental illness. Oncologists like me, who routinely deal with death, face an especially high risk, as do young women and international doctors. This laudable study has caused a collective gasp in the community, but for most doctors, it has simply put sobering numbers to a problem we are all too familiar with. Far too many of us have lost a dear friend and able colleague to drugs,

alcohol, crippling mental illness or suicide. Many more feel like helpless bystanders as we watch good doctors slowly self-destruct.

Every doctor knows that the very problems we counsel our patients for are those that beset us in far greater measure. So you might ask why intelligent, driven, capable doctors would ignore the warning signs that they know by rote. Again, the survey identifies what every doctor either knows or suspects: the stigma attached to mental illness is magnified within the medical profession. Doctors regard their mentally ill peers with uncertainty and fear. They consider them less capable and are less willing to hire them or work with them. It therefore makes sense to keep problems under wraps in an unsupportive environment.

For me, watching the journey of some of my mentally ill friends has been in turns frightening, unsettling and sad. It's a tightrope to envelope a colleague in understanding while protecting their patients from harm as a result of inattention. As a sympathetic observer, it is tempting to become impatient with at-risk doctors who don't or won't seek help, even though they have access to it. But it is also difficult to convince doctors to appreciate the extent of their problem, because we have been shaped to believe in our infallibility. Disease afflict our patients, they don't touch us. Our patients are defined by their illness, while we are defined by our ability to cure their malady. Medical education shies away from discussing our vulnerabilities. Students and young doctors are rarely reminded that despite their hallowed place in society, they are prone to the same vicissitudes of life as everyone else. It is no wonder that when faced by personal catastrophe, a doctor's first response is to deny the problem exists.

Doctors have a long tradition of being considered different from the rest of society. But when it comes to mental illness, our serious differences are jeopardizing our own health and that of our patients. The culture of medicine demands a change. To do any less would be to short change doctors and patients.



## Chapter 4

# Focus on the quality of patient care

*'I will apply, for the benefit of the sick, all measures (that) are required, avoiding those twin traps of overtreatment and therapeutic nihilism'.*

**Hippocratic Oath: Modern Version**— Louis Lasagna 1964

This is a challenging and exciting time to be a doctor. On one hand, 21<sup>st</sup> century medicine presents many challenges for doctors including increasing patient expectations and litigation, medical workforce shortages, rising rates of chronic disease in aging populations, excessive health system bureaucracy and red tape, and escalating medical workplace violence.

On the other hand, new advances in health care can allow doctors to provide very high quality patient care. However, ethical issues also occur with the inappropriate use of medical technologies and innovations.

The authors in this section courageously describe the ways advances in medicine and subspecialisation sometimes impact negatively on the quality of patient care. Dr Karen Hitchcock highlights the important role of the generalist and patient centred care, and Dr Justin Coleman discusses *'the humanitarian art of doing nothing'*. Professor Helen Milroy, a prominent Australian psychiatrist, defines the true meaning of healing.

## 4.1 The last resort

### Dr Karen Hitchcock

June is 83, lives alone and still drives herself to the shops. When she doesn't answer the telephone one morning, her daughter drops by to check on her and finds her lying naked in bed, in a soak of urine, staring at the ceiling. June turns her head at her daughter's call but does not seem to recognise her, nor does she respond to questions. Her daughter panics and calls an ambulance; she runs to the bathroom, throws June's pills into a plastic bag and gets her into a nightgown. Then she sits on the edge of the bed and cradles her mother's head in her lap. The ambulance officers arrive within half an hour; they note that, apart from a low-grade temperature, all the patient's vital signs are normal and she can spontaneously move all four limbs. They bring her to the hospital where I work as a doctor.

Excepting elective admissions for surgery and the like, beds in a public hospital are guarded by the Emergency Department; if you are sick and need admission you have to come through the ED. Most people have some idea of the drill: the triage nurse ranks the severity of your problem, and that ranking determines how quickly a doctor will see you. If you turn up in the morning and the nurse or ambulance suspects you are having a heart attack, you will be deemed a Category 1 patient and will be seen to immediately. If it is a large, acute heart attack you will likely be on the table having your angiogram and stents within the hour. If all goes well in the angiography suite, by late afternoon you'll be in a large white room, hooked up to monitors, watching the news, swallowing all your new pills and eating dinner. If you are June, or someone equivalent to her on the triage scale – an older person who has fallen down and can't walk, someone who's had a faint, has a fever, is dizzy or delirious or looks starved to death – you are considered a Category 4 or 5. This means that by dinner time you may still be lying on the trolley, perhaps in a corridor of the emergency department if things are really frantic, waiting to be seen by a doctor.

Informally, these patients are known as 'crumbles': they are not crashing towards their death like the guy with the heart attack; they are merely engaged in a slow, crumbling demise. When the elderly and not-crashing patients are finally seen, it will be by the most junior doctor in the department. This doctor may take a long time to work out what is going on. Meanwhile, the inexorable crumbling continues.

In theory, the triage system seems sound and unavoidable: if someone is dying in front of you – exsanguinating from an amputated limb, unable to breathe because they have a hole in a lung – you cannot ask them to lie down and wait their turn. If they are not helped immediately they will certainly die. If you don't immediately help the crumble – June, for example – she will not die, or at least she will not die in front of you. However, according to a report published by the Australasian College for Emergency Medicine, the mortality associated with excess waiting time in emergency departments in Australia exceeds

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1500 deaths a year – more than the national road toll. The crumbles are engaged in slow-motion crashes that we cannot see until the final metres, by which time it is too late.

In 2011, the government commissioned an investigation into emergency department waiting times. The result was the formulation of National Emergency Access Targets. The stated aim was to ‘improve patient safety and quality of care by removing obstacles to patient flow that contribute to emergency department overcrowding’. By 2015, 90% of all patients must move through emergency departments within four hours. I do not know if I can convey how radical this proposal is. It is like telling someone who jogs an easy 5 kilometres in 45 minutes every weekend that in a few years they will be expected to do the same distance in 15 minutes. Changes have been trialled in Western Australia since 2009 and there has been progress. Emergency waiting time targets are being met and patient mortality is down. But these improvements have come at a significant cost. An army of administrative staff spend their days on phones and on the floor policing and pushing patients through the funnel of the ED. Doctors and nurses are exhausted and relationships between medical and administrative staff are strained. Are we sacrificing good training in our desire for efficiency? Meeting the targets within the current triage system is proving extremely difficult. What is needed is a radical new way of running emergency departments so that everyone is seen quickly, so that somehow everyone takes precedence.

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There is no waiting room in front of the ED at the Royal London Hospital. There is no triage nurse. If you arrive sick, no matter your degree of morbidity or your age, you will be seen within ten minutes by the most senior doctor. She will look at you, talk to you, briefly examine you and, though she may not come up with a definitive diagnosis, she will at the very least be able to decide where you will best be managed and thus where you should go: to the medics, to the surgeons, to the ED proper for further stabilisation and investigation, or home.

It makes sense. I have a friend who is an art curator. After completing her basic degree, she hung out at art galleries, volunteered at the Heide museum, wrote a couple of theses and landed a job in a major public gallery. Her visual apparatus from eyes to occipital cortex is different from mine: it has been trained. She sees more and better. Where I see a pretty object on a stick, she sees a complex creation with a place in history, heavy with implication in the present and future. She assesses most of this in the time it takes me to appreciate that the object is suspended from a wire that reminds me of the line my dad used in the '70s to catch flathead. She is the senior emergency department physician and I am the intern doctor. The patient is the work of art.

The idea of adopting this streamlined model in Australia has met with some resistance: it turns the seemingly natural order of things on its head. Senior doctors have done their time; they don't want to be on the ground running with the pack. They want to supervise, offer pre-digested summaries, teach, hand out gems here and there, give some advice, and point out their registrar's blind spots. They are the bosses.

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At the Royal London, if you are the equivalent of a Category 4 or 5 general patient, you will not languish in the ED corridor for five hours before the intern takes your history, your blood, comes up with an interim diagnosis, discusses it with a consultant and then rings a ward medical registrar to come and admit you. At the Royal London the emergency consultant will deliver you directly into the hands of the general medicine team for immediate assessment and treatment in their acute ward.

Of course, there are a number of barriers to the flow of patients from the ED to the ward, such as the numbers of beds available and staff levels. But a major barrier is also the traditional model of what an emergency department does: sort, package and sell patients to teams. These are ugly words to describe sick people with, but they are the words that are used and they represent the practice as it stands. Ward registrars (the most senior of the trainees) will not traditionally accept (buy) any patient who has not been sorted (thoroughly investigated) and packaged (diagnosed or at least had a single organ system nominated as the main problem). This all takes time. After four hours the patient may well remain unseen, undiagnosed or diagnostically undifferentiated – and if you can't nominate an organ system in which the pathology lies it will be difficult for you to sell the patient.

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When I first started out as a medical registrar there would be daily arguments in the emergency department or over the telephone about which teams should accept the care of 'non-differentiated' patients with 'general' or multi-system decline. To be clear, registrars were not fighting to take the patients; they were fighting to avoid taking them. One of the most common arguments I heard was from the sub-specialties that perform interventional procedures such as angiograms (cardiology) or gastroscopies (gastroenterology): 'We won't take the patient as we don't need to do anything for them.' *Doing something* for a patient was reduced to a procedural intervention, as if everything else the patient needed (assessment, monitoring, medicine, care) could be offered by anyone, and therefore not by them.

One of the last times I engaged in this behaviour myself was over a middle-aged patient with a rare neurological disorder – degenerative, untreatable – who came to the ED with worsening confusion and seizures that had probably been precipitated by a urinary tract infection. The neurology registrar and I faced off outside the patient's cubicle. (Neither of us had seen the patient yet, but we knew his story and, when it came down to it, we both knew how to treat him.) I argued that neurology should take the patient as they had cared for him over the years, knew about his underlying disease and could best manage his seizures. The neurology registrar argued that the patient's problem had a non-neurological cause (an infection) and so, even though it had resulted in a worsening of his neurological condition, someone else should manage the patient. 'That's crazy,' I said. 'We're not taking him,' the neuro reg said. The nurse pulled back the curtain and there was the patient, an emaciated man-boy in neat navy-blue pyjamas, his elderly parents sitting anxiously at either side of his bed. They'd heard everything.

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There are many reasons why intelligent, hardworking and generally humane doctors might argue fiercely in order to avoid taking patients: we may have a huge patient load already; we may be working with a less-than-physicianly consultant (boss) who would disparage us for accepting patients with problems outside her organ of interest; we may feel the patient will be better managed by someone else, as we may have no idea what to do. Also, for patients to be moved to a ward bed and be seen by a treating team quickly we need two things: a team to accept the patient and a bed for them to go to.

When a patient is in the ED, we registrars feel secure in the knowledge that someone is looking after them. The patient cubicles all open to a central area crowded with doctors and nurses. The ratio of staff to patients is high. Once we bring a patient to our ward they become our responsibility. This can be a large burden if our list is already full of patients who are still chaotically unwell. The undifferentiated patient is usually complicated: they take more time to sort out; they are generally older and may be frail, which means more things will go wrong and there is more chance of causing inadvertent harm with any treatment we give. And if we accept them early we must have the staff and the time to work out what is wrong, organise investigations and formulate a treatment plan. One solution to this has been the development of acute medical assessment units. Though these are set up to accept the patients early from the ED, they are still a work in progress at most hospitals in Australia. How many doctors and nurses do you need to look after a group of un-worked-up patients? We do not want acute medical assessment units to become chaotic, crowded holding bays with the atmosphere of a developing-world clinic: people twisted up in sheets and hanging skewed from beds, calling for a non-existent nurse.

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The general physician in Australia had all but died out by the 1980s, everywhere except in the rural and remote hospitals that had neither the workforce nor the need for representatives of multiple sub-specialties. In the '80s and '90s there were virtually no general medicine physician trainees in Australia. The cities were in love with super sub-specialisation. Chapters were formed, training pathways developed. You didn't just become a cardiologist, you became an electrophysiology cardiologist, or an interventional cardiologist, or an echo-cardiologist. You specialised in one kind of lung disease, or at the very least you specialised in a single organ. This was necessary in the face of a vast expansion in knowledge. The physician's bible, *Harrison's Principles of Internal Medicine*, has 4012 pages. It is far more manageable to have to know only 300 of them in detail.

In theory, all physicians receive a solid early training in general medicine: the holistic management of a patient, the focused juggling of the problems. We all sit the same exams after five years of working as a junior doctor, and then we all do three or four more years of specialty training. It is those final years that have become less focused on general medicine. And physicians differ in the extent to which they leave their generalist training behind them. I was on a ward round once, presenting a patient's medical history to the consultant respiratory specialist, when he interrupted me with a huge theatrical yawn and asked when I was going to get to the bit about the lungs. He had no interest in

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hearing about the other things contributing to the patient's decline: her heart, joints, bones and sugars. As far as he was concerned, I (the registrar) could fix them up myself or I could ignore them.

I found it difficult to choose a sub-specialty. I chose neurology at first. I thought I might sub-sub-specialise within the discipline in multiple sclerosis, or acute stroke or psychosomatic disorders. What could be cleverer than specialising in brains? I'd get to carry around gleaming equipment – ophthalmoscope, tuning forks, tendon hammers – in a shiny briefcase. I'd need a Chanel-red hat pin on hand at all times, to check a patient's visual fields. I could be the next Oliver Sacks.

For a year I participated in a general neurology clinic. It took me that long to admit it to myself: I loved my patients, but I was bored. No patient came because they could taste the colour green; no one mistook their wife for a hat. Patients turned up with two things: dizziness or headache. We'd rule out dangerous stuff like venous sinus thrombosis and cerebellar strokes and then give them reassurance or a pill.

I tried nuclear medicine. It sounded very high-tech, and my mum loved that. I got to sit in a comfy wheelie chair in a quiet office with ambient lighting and endless cups of tea in my own cup and saucer, while I dictated reports about fuzzy scans of people with cancer or clots or broken bones. I looked for the black in the scan – that was the cancer. If someone had cancer metastases all through their bones, liver and lungs, we'd call it a Dalmatian scan and know they'd be dead in a few weeks. Lots of the people I scanned were slowly dying, but I didn't know them. I was in another room, and the scanner didn't pick up facial expressions. I would never have to be involved with a patient's actual death – unless someone had a cardiac arrest in my scanner, and if that happened to a passenger on a bus, you wouldn't expect the bus driver to fix her, would you? So there I sat, alone in a dark room with a bunch of fuzzy ugly scans, sipping another cup of tea.

Next up I thought I'd try endocrinology, where I'd specialise in diabetes and out-of-control hormones. I like diabetes, especially the kind you get if you're fat; I can relate to people who are struggling with the consequences of having done stuff they shouldn't have. And I like to intervene in a disease process before the consequences become irreversible. But I just couldn't get excited about the thyroid gland in the way all the endocrine bosses were, keen for treatment breakthroughs, keen to discuss whether we should palpate it, inject it, ablate it, scan it, irradiate it, or just watch it.

There are many advantages to sub-specialisation for the doctor: when you say you're an oncologist, everyone knows you administer medicine that dissolves bone marrow, fat and hair; people will open the door and let you go through first. And there are advantages for certain kinds of patients: if you are going to get an organ transplant, for example, it's probably a very good idea to be treated by someone with expert knowledge of what happens to you when your blood is pumped by a heart harvested from another body and sewn into the cavity of your chest. But what if you are getting old and have a bit of this and a bit of that? What if your kidneys pack it in at the same time as your heart and so you can't get an angiogram and there's more going on than either your GP or the

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nephrologist with a special interest in the autoimmune glomerulonephritides is comfortable with?

That general medicine was the only specialty for me became clear when I was treating an 84-year-old patient named Maria. I was working as a registrar on the respiratory unit and had been asked by another sub-specialty unit to take over her care as, in their opinion, her main problem was a chest infection. Before I met the patient I flicked through her notes. Her medical problems included emphysema requiring her to use continuous oxygen at home, congestive cardiac failure, multiple small strokes that had left her with a weak arm and chronic dizziness, atrial fibrillation, hypothyroidism, chronic daily headache and hypertension, and she had recently sustained a subdural brain haemorrhage in a fall. She was, at the time of my review, sporadically attending five separate sub-specialty clinics for the management of these problems. She lived with her daughter, who took sole care of her.

Maria was lying in the hospital bed. I introduced myself and asked her why she had come to hospital the day before. 'I have a chest infection,' she said. 'Yes,' I said, 'but what did you feel that made you come in to hospital yesterday?' She told me again that she had a chest infection, and that her GP said he couldn't help her, that she needed medicine in her vein. 'But can you describe to me what it was you felt, your symptoms?' 'I felt a chest infection, a chest infection,' she repeated, like I was stupid not to see the obvious. 'When did you last feel well?' 'Why are you asking me all of these questions?' she asked grumpily. I said, equally grumpily, 'You have a lot of health problems and I am trying to keep an open mind about what is wrong, and if you want me to help you then you have to answer my questions and there are going to be a lot of them.' We faced off for a moment. 'Two months ago,' she said. 'And what has changed since then in the way you feel?' I asked. She closed her eyes and sighed, then said she felt very tired and weak, she couldn't walk around the house easily anymore, she'd fallen over a few times, she'd had a terrible cough a few months back but the sputum was now clear, her headaches were bad and she felt her heart palpitating in her chest sometimes. She opened her eyes and looked at me. 'If my daughter was here she could tell you better.' I picked up her hand and told her I would examine her, look at her blood tests and then call her daughter.

Even if Maria did have a chest infection, it was obvious that it was not her main problem: she needed to lose a bit of fluid; her heart rate needed slowing; her thyroid hormone levels needed checking; she needed to stop being prescribed so much prednisolone, which was contributing to her main problem of muscle weakness, which itself was probably a result of the de-conditioning that came with the immobility she had experienced during a chest infection a few months earlier. All of these medical problems needed sorting out, but above and beyond any medical management we could throw at her, what Maria needed was a course of physical rehabilitation if she was to return home with her daughter – which is what they both very much wanted. 'I told Mum,' her daughter said to me on the telephone, crying, 'if you can't get out of bed, I can't take care of you anymore.'

As a representative of the respiratory unit my job was to take Maria under our bed card and prescribe antibiotics for her chest infection, if she had one. If she did not, in my opinion, have a chest infection, then it was my job to reject her, to leave her care in the hands of some other sub-specialty. But I saw that there was no sub-specialty that Maria fitted into neatly. No one would want her under their bed card.

Stories abound about patients who suffer the consequences of being treated ‘sub-specially’ by a sub-specialty. It happens on the surgical wards, too. I know of an elderly woman who recently fell and ripped a huge flap of skin off her elbow. She also had a sore hip. An X-ray of the hip was arranged in ED. The patient was admitted to the plastic surgeons who operated on her elbow. She recovered on the ward and was discharged home, but the pain in her hip worsened so she came back. The hip X-ray was reviewed in the ED – a week after it was taken. The plastic surgeons had taken exemplary care with her elbow. Too bad she had a snapped femur at the same time. They could not see beyond their own suture margins.

The problem is clear enough: in massive hospitals demarcated into care silos there has been a loss of a holistic approach to the patient. This means that the medical care of the elderly and the crumbling has to be artificially fragmented into the care of separate organ systems. From a best-practice perspective, a health resource perspective and from the perspective of Maria’s daughter, who was having to bring her to multiple appointments, what was chiefly needed was a good general physician to look after her, both as an inpatient and as an outpatient.

Some hospitals without a general medicine unit roster on a daily ‘physician of last resort’. This consultant doctor and her team must take all the patients rejected by the other sub-specialist teams; for that day they cannot say no. In other hospitals the registrars just argue and argue until one team gives in and accepts the ‘undifferentiated patient’. Either way it takes a long time for the patient to be admitted to the last resort. This situation is untenable. It is also inhumane and dangerous. Someone needs to *want* to look after these patients – the crumbles, the mysteries. A single team, headed by a doctor with expertise in treating a patient holistically, should direct their care. Yet these doctors – the general physicians – had become almost extinct.

Fortunately, it’s dawning on authorities that the public needs hospitals and doctors to serve an ageing community among whom chronic diseases are on the rise; that hospitals need large general medical units with the staff, facilities and funding to scoop the chaotically unwell and the crumbling patients out of ED, to assess and treat them promptly and to go on caring for them till they are well. In Victoria, every major tertiary hospital has a general medicine department run by a mix of dual-trained physicians, general physicians and sub-specialists who either have a genuine interest in general medicine or who can’t get a job in their chosen field.

Although there is still a dire shortage of committed generalists, there are now almost 300 registrars currently training to be general physicians. This shift in the delivery of specialist and hospital health care in Australia has brought with it a number of challenges. Having

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managed to attract this new generation of doctors to the practice of general medicine, we find we are unable to train them. To train as a general physician you are required by the Royal Australian College of Physicians to work two six-month sub-specialty terms. Finding departments that will employ general medicine trainees is proving extremely difficult, even when the trainee brings funding for most of her own salary. It seems sub-specialty departments on the whole do not wish to foster these strays; after 50 years of rapidly increasing medical knowledge, and the concomitant division of that knowledge into separate areas of practice based on organ systems, they want to produce doctors in their own image. Some sub-specialty associations are even putting in barriers to discourage their trainees from training both as a sub-specialist and a general physician, a combination that is especially valuable in rural areas where there may not be a full-time need for a cardiologist.

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June arrives in my hospital's emergency department. Fifteen minutes later the emergency consultant rings me: 'We have a patient for you. Eighty-three-year-old woman from home alone, found incontinent and confused. Stable, with a low-grade temperature. We've taken blood, urine, cultures and done a chest X-ray. May we send her up?'

We have 15 patients on our list, we've just received two new ones and they want us to accept June too. But yes, he may send her up. This is the rebirth of acute and general medicine as a specialty in Australia. We will see June in our acute assessment unit, start her on fluids and antibiotics and check her test results as they come through. She most likely has a urinary tract infection with associated delirium. Early treatment will increase her chances of getting better and getting home. We split our team and I'm relying on my junior registrar to let me know if anything dire or unexpected shows up in any of the patients I don't have time to see. There's no way my intern's going home on time today; she's juggling pathology forms and X-ray requests and faxes from other hospitals and scribbling like mad in the chart, translating my questions and the patient's answers into a smooth narrative that explains why they're here. Meanwhile her pager is going off and the nurses are harassing her for discharge summaries and scripts for other patients who are ready to leave. I'm thinking that another doctor or two and a few more nurses wouldn't go astray here. The last resort may have had a makeover, but we're still a bit thin on the ground.

## 4.2 The humanitarian art of doing nothing

### Dr Justin Coleman

I like the term *watchful waiting*. It forms the basis of many of my general practice consultations. Often, rather than jumping to intervene with an illness, I watch. And wait. And not just because it makes my natural inclination towards laziness appear purposeful!

Early in my career, a wise physician taught me to use it if all else fails. He called it COMI therapy: Cat-like Observation and Masterful Inactivity. Or, if you prefer: don't just do something; stand there!

Why such an odd, nihilistic attitude from a GP whose patients usually expect more when they walk in the door? Is this doctor anti-doctoring? A snake-oil crank who claims all Western Medicine is a conspiracy?

Not at all. Well, except the cranky bit, at least on Fridays. But I wouldn't even know which end of the snake to squeeze to get the oil. And I think expecting ancient medical traditions to deliver health outcomes is a lot easier when you are essentially healthy, already vaccinated, and have an ambulance on call if you really need it.

Western medicine is a whole lot more credible than any system which preceded it. It's just that, in our desire to intervene—to do something—we sometimes end up causing a lot of harm.

I like to avoid harming my patients. Frequently, this involves doing nothing. Hence my watchful waiting.

#### **A cautionary tale**

Some years ago, 39-year-old Jill Patient was feeling unusually tired and so went to see her GP, Dr Junior. The names have been change to protect the innocent, and also my reputation.

Dr J knew that patients with unexplained symptoms in hospital usually received a large batch of pathology tests, so he ordered 'the usual', which included a test of thyroid function.

Upon review, Jill and Dr J agreed that the tiredness was settling, and was probably due to Jill's hectic life looking after her young children. However, of the forty-odd numbers which came back with the pathology report, one of the thyroid results was a bit high, so Dr J felt obliged to follow it up.

Jill wasn't too worried initially, but became so when the thyroid ultrasound showed a small round lump, or nodule. The accompanying report suggested

seeing a specialist to put a biopsy needle into the nodule to rule out a thyroid cancer.

Jill tried to be brave, but was terrified. Dr J tried to be brave, but wasn't quite sure what to say. He had recently learned in medical school that it's best to be straight with patients, so he answered all Jill's questions about thyroid cancers. By the end of the consultation, Jill was a mess. In the ensuing weeks before the needle biopsy she felt so distressed that she required some time off work.

Jill had the biopsy and after one final, harrowing week, the result came back as normal—she did not have cancer.

If this was a film, Jill would have had cancer and the story would continue from there. But this was real life, and Jill's risk of the nodule turning out to be cancer was less than 5%. There are at least 19 Jills for every person who ends up having thyroid cancer.

Dr J didn't know this, because most text books at the time listed about a 40 % chance of the lump being a cancer, but that was because the early studies were done by thyroid cancer specialists, whose patients are already 'selected' by virtue of the fact that the really low-risk patients never walk through their doors.

The tale doesn't end there, however.

Because Jill had taken 'stress leave', she required a certificate to return to work. During that visit, she pointed out that she remained very tired—the thyroid saga certainly hadn't helped—and wondered whether the tests had ruled out coeliac disease. She had friends whose tiredness had apparently improved on a gluten-free diet.

Dr J had to admit that he hadn't thought to test for 'gluten sensitivity', and figured he owed it to Jill to reassure her, given the worries she had just gone through.

The blood test for coeliac disease came back normal. Just. In keeping with his policy of 'full disclosure', Dr J explained that the result was around the cut-off point between normal and abnormal.

'So that doesn't fully rule out gluten sensitivity?' asked Jill.

'Technically, no. You would need bowel biopsy to be sure,' replied Dr J, beginning to wish he hadn't mentioned the cut-off point.

To Dr J's relief, Jill didn't press for a referral for another biopsy, but he later discovered she spent the next few months on an expensive and troublesome gluten-free diet. This involved travelling to specialty shops and cooking separate meals for the kids. Her tiredness eventually resolved.

When she next saw Dr J, she had stopped the diet because it impacted on her life too much. However, to her surprise, the tiredness hadn't returned.

All in all, with multiple doctors' appointments, one biopsy, another just-avoided biopsy, time off work, complex diets, stress and tiredness, and just possibly a lifelong diagnosis, Jill had experienced a terrible few months.

You might judge that Jill was lucky. She had attended the doctor with a relatively minor, common symptom and had a big scare, but luckily didn't have cancer. A second blood test then showed that she might have coeliac disease, which happily she managed to cure using natural diet methods.

An awful few months for her, sure, but at least it all worked out for the best in the end.

This interpretation is wrong. Jill was unlucky.

Why? Jill was unlucky on that very first day because she was given an appointment with Dr J.

Yes, Dr J: a well-meaning, hard-working young GP whose only concern was for the best outcome for his patient.

Dr J, a perfectly pleasant young man (if I do say so myself), whose appearance precisely matches my own, minus the ravages of eighteen years.

If I had my time again—and thankfully I have had ample opportunities since—the story might have gone a little more like this:

Jill Patient was feeling unusually tired, so she went to see her GP, Dr Senior.

Dr S listened to Jill's story for a few minutes, offering prompts when she described how busy life was balancing her job and the children. During the discussion, Jill recognised that she hadn't been looking after herself as well as she might: she was grabbing fast food for lunch, sleeping poorly and had started smoking again—just a couple per day.

Dr S then asked some pointed questions, which he explained were aimed at a few specific potential medical conditions such as an overactive thyroid. He examined her and did a fingerprick sugar test.

Dr S then explained that a few weeks of tiredness is a common symptom for busy people. Although nothing is ever certain, he felt that if Jill worked on making a few changes to her lifestyle over the next few weeks, things were likely to improve. If they didn't, or if new symptoms developed, he might consider doing some tests.

Jill suggested a couple of family and work changes she could make, and Dr S's only addition was the importance of cutting out even the two cigarettes, even though Jill didn't consider this made her a 'smoker'.

At the follow up appointment a fortnight later, things were improving, and a month later Jill's tiredness had resolved so she cancelled her third appointment.

Dr S lazily spent his unexpected spare time reading a book on *The Universal Doctor*.

'But what about Jill's thyroid lump, and the possible coeliac disease?' I hear you protest.

Neither would ever have affected her health in any way. Both were crises caused by Dr J's misplaced enthusiasm to do a test to 'rule everything out'. He would have served Jill better by sitting on his hands and doing nothing.

Millions of people walk around with lumps in their thyroid gland or, for that matter, in plenty of other places, too. Modern technology such as CT and MRI scans make us as transparent as jellyfish, so if we choose to look hard enough, something 'abnormal' will almost always be found.

One study looked at a thousand people who walked in 'off the street' requesting screening with a CT scan of their entire body found that 86% of them had at least one abnormal finding. ([Furtado](#)) These weren't sick people who had symptoms or needed any treatment: they just wanted to 'do something' just to check.

The false alarms caused by whole-body CT scans is why no country recommends them as a way of screening well people. The only ones recommending them are private companies who own idle CT scanners.

The private medical-screening industry is a potential goldmine; if you haven't been targeted yet, you soon will be! Order-your-own risk assessments for cancer, genetic disorders and heart disease are already bypassing sensible public health guidelines and being advertised privately, even disguised as 'breakthroughs' in the news and current affairs media.

However, the harms caused by the over-use of medical tests and treatments are being increasingly recognised. A number of excellent books are available, and some of the world's major medical journals are now devoting an entire section to it. ([Too much medicine](#) (BMJ), [Less is more](#) (Arch Int Med)) There is even an annual [conference](#) on 'Overdiagnosis', which can be defined as diagnosing someone with a medical condition which would never have caused any harm or symptom. Hypochondriac says to his doctor

*I'm sure I'm low in zinc. You need to test me.*

The doctor replies

*But how do you know? Zinc deficiency is impossible to feel. It has absolutely no symptoms whatsoever.*

Says the patient

*I knew it! That precisely describes me and my low zinc.*

## The medical consultation

What has all this to do with the humanity of the doctor?

A couple of years ago I started writing a blog called the *Naked Doctor*. Luckily it didn't contain any raunchy 'selfies', which would have been an oxymoron in any case. My concept involved paring medicine back to basic things that we know work.

The *Naked Doctor* probes the places in medicine that would be better stripped bare. Places where the correct option is to do nothing. The 'doctor's bag' accompanying a home visit before the second world war contained no medication which would be considered of any use today, and quite a few dangerous poisons. The physician would have been of more use turning up empty handed—or, given the lack of latex gloves and infection control, perhaps not turning up at all. The modern example of cancer screening via whole-body CT scanning offers as much protection as the emperor's new clothes, and the guileless emperor would be better off naked.

[Naked Doctor blog](#), Jan 2012

Doctors are occasionally tempted to use an intervention just—like climbing Mt Everest—because it's there. My interest in teaching other doctors about the pitfalls of this approach was originally all about reducing harm to patients.

However, soon a second benefit became clear: avoiding wastage. In 2012, the departing boss of the US Medicare system, Don Berwick, estimated that around a quarter of the entire US health budget was wasted; as in, spent on things which did not benefit patients. The first of the five reasons for waste listed by Berwick was over-treatment. This wasted health budget exceeds the entire GDP of many countries.

But, somewhat to my surprise, I discovered a third benefit, which is the focus for the rest of this chapter. I found that 'doing less' can actually improve the doctor's consultation skills.

When we prune back the branches, Naked-Doctor-style, what do we risk exposing? Ourselves.

We are then compelled to fall back on the four essential building blocks of primary health care:

- A thorough **history** that involves plenty of listening. A deep, two-way communication, a narrative explored.
- An **examination**. This involves touch: the laying on of hands. For a child, this can sometimes be a natural extension of the physicality that should already be a part of their world. For some adults, particularly isolated men, this patient-doctor space will be a rare place in their lives where physical touch occurs, and may cause some anxiety.
- A **formulation**, answering the essential question ‘What’s going on here?’ This element is crucial for trust, particularly if we are about to advise against any medical intervention and expect the patient to come with us on that journey. Far harder to gloss over the inherent uncertainty of any medical diagnosis when you have nothing to offer by way of a fancy treatment.
- A **management plan** that is a joint effort between the doctor, who is the expert on which medical treatments may or may not be useful, and the patient, the expert on the effect that the diagnosis, and any suggested treatments, will have on their life.

Do not underestimate how difficult this process is. The doctors I admire are those who have honed this craft over decades. They excel at communication, are comfortable with uncertainty, and have attained a (deserved) trust which allows them to be confident when prescribing ‘nothing’.

Importantly, although they tend not to admit this to lawyers, journalists or politicians, they do not place much stock in the goal to ‘never miss anything’. That idealised goal is, of course, impossible to attain, and the unreflective pursuit of it can cause great harm to patients.

When I teach young doctors starting out in general practice, I discuss two similar consultations they will soon come across. Both involve young children with fever and a cough, but one child has a bacterial infection which requires an antibiotic and another (a far more common scenario) has a viral infection for which an antibiotic is not only pointless but also costly, a hassle for the parents to administer and entails a known risk of side effects or allergic reaction.

I ask which consultation is more complex, and the inevitable answer is the one involving a bacterial infection requiring antibiotics. Their medical training has, quite reasonably, focussed on their knowledge of microbiological types of bacteria, the pharmacological properties of antibiotics and the potential complications of untreated bacterial infections around the ears, throat and lungs of children.

But a month into their job as a GP, when I ask them which of the two they have found more difficult, the story has changed. Their biggest concern is now the child who does not require an antibiotic. The discussion with the parent is in fact considerably more complex when selling ‘nothing’ rather than writing a prescription.

They wonder—will the parent think I have taken them seriously? Will they feel I am dismissing their concerns about their sick child? What if the parent insists on antibiotics?

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Why do parents sometimes request a second opinion here, yet they never seem to when I prescribe something?

Whereas 'doing something' seems so certain, 'doing nothing' leaves the junior doctor feeling vulnerable. Without the whirr of the prescription printer providing an easy closure, the young doctor has to decide how and when to wrap things up and finish the consultation. This can be very difficult, particularly if the parent has not felt listened to, or is not satisfied that their child has been carefully examined.

I have worked in, or taught doctors in, about fifty Australian general practices, and I have observed a few (too many) doctors who practice 'six-minute medicine', where the primary aim is to push patients through the door fast. When feeling pessimistic, I refer to these doctors (privately, until now!) as 'dodgy'. A prime method of maintaining this high throughput is to quickly steer the consultation to the final 'intervention', which is a prescription, medical investigation or referral to a specialist. The printer whirrs and the patient has what they came for; next please!

In contrast, consultations without easy answers test the mastery of the four building blocks—history, examination, formulation and management plan. Just think of consultations involving chronic social problems, recent grief, severe anxiety about a minor symptom, or palliative care. These challenge the doctor's communication skills, interpersonal rapport and empathy far more than their knowledge of the latest medical interventions.

Would it be an overstatement to claim that problems without an obvious medical intervention test a doctor's very humanity? We watchful waiters have a lot of time to ponder our level of interpersonal skills.

*It is an art of no little importance to administer medicines properly: but, it is an art of much greater and more difficult acquisition to know when to suspend or altogether to omit them.*

Philippe Pinel, French physician (1745-1826)

### **Doctor as the drug**

Michael Balint, born in Budapest, became the world's first Professor of Psychoanalysis, and moved to London in 1938. In his seminal book *The doctor, the Patient and His Illness*, Balint examined the patient-doctor interaction at both conscious and subconscious level. He introduced the concept of the doctor acting as a 'primary therapeutic agent'.

Balint realised that, rather than just being a passive dispenser of medication, doctors frequently use themselves as the agent of change: this starts with the act of actively

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listening to the patient's story about their illness. This interaction was coined 'doctor as drug', where the relationship with the doctor became the therapy itself.

Of course, this wasn't a far cry from Freudian psychoanalytic theory, but Balint was more interested in what went on in a mainstream medical practitioner's office rather than on the psychiatrist's couch. Many doctors around the world now regularly attend local 'Balint groups', discussing with their colleagues the emotional content of the patient-doctor relationship.

The typical physician in Balint's era tended to see their role as limited to a dispenser of the right medicinal cure—an extension of this idea is the fallacy that computers or robots could replace doctors using an algorithmic pathway which ends with the correct prescription.

But which headache medication does the robot choose when consulted by an impoverished mother of five whose partner has lost his job and started drinking? In the words of American Steel, *There ain't no cure for a broken heart*. Or if there is, then typing in the precise characteristics of the pain ain't gonna find it!

Balint realised that the GP consultation comes as an entire 'package', which is itself part of the therapy. A medication or a specialist referral may be a part of the package, or it may not.

The therapy starts when the patient walks in the door. Does the doctor greet them warmly, or fuss impatiently with the notes? Does the consultation begin with an open-ended exchange or rapidly home in on technical detail about the first problem the patient happens to mention?

Think of the consultation as a micro world, temporarily inhabited by two (or more) people, complete with its own atmosphere. The two-way exchange reveals something about each inhabitant, and the interaction between the two is crucial.

A friend of mine took five years to complete his physics PhD on two-body interactions, and he assures me that humans are even more complex than protons!

Interestingly, the phenomenal popularity of homeopathy could well be due to its practitioners using this 'therapist as drug' concept. After all, in its purest form, the only 'drug' a homeopath will prescribe is a few drops of plain water, ambitiously labelled as various other things.

In other words, an identical water cure is offered for a wide array of ailments and seems to help far more often than would be expected if the patient instead drank free tap water at home.

The magic ingredient is not buried between the water molecules; it lies somewhere in the interaction between the homeopathic practitioner and their client. Call me a sceptic if you will (please), but I would imagine successful homeopaths spend more time listening and using their communication skills than they do choosing which particular label will grace their vial of water!

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Just as Jung studied the occult, Balint would have been fascinated by the rise and rise of alternative therapies.

### **The non-linear consultation**

When we think of what defines a medical consultation, we quite reasonably think of the 'presenting complaint': the medical problem which the patient brings to the doctor. In movies, literature, common wisdom and jokes, the doctor's role is simple and rather passive—make the diagnosis and treat it.

Some doctors might be more skilled than others—think of TV's Doctor House, who brilliantly diagnoses an incredibly rare disease at the end of each episode—but even then it all boils down to the unemotive application of technical knowledge, much like the robot doctor mentioned earlier.

Doctor, doctor. I get terrible pain when I press my finger here. And here, and down here too...and even when I press lightly, both here and over here. What on earth could be wrong with me?

You have a broken finger.

But most people would be surprised to know how much of the variability between different consultations is due to the doctor's particular approach, rather than to the patient's presenting problem.

This is less of an issue for something simple such as a previously healthy person who has broken their finger. In fact, single-issue, new problems, even if serious, are often quite easy to manage, as most doctors would approach them in the same way. A sportsperson carried into the surgery with a broken thigh bone is a major medical issue, but even junior doctors would usually comfortably set off on the well-signposted path of pain relief, X-ray and transport to somewhere inhabited by an orthopaedic surgeon.

I call these consultations *linear*: each step could be diagrammatically linked to the next by a sequence of arrows heading towards a specific diagnosis. The line of arrows then continues through to the correct treatment pathway.

The poor sod with a broken finger exemplifies a linear problem. Protagonists in 'doctor, doctor' jokes are simple folk—two-dimensional people with one-dimensional issues. 'My hands keep shaking. *Do you drink a lot?* No, I spill most of it.'

But most work in general practices and emergency departments is not so clear-cut. People have complex chronic conditions: diabetes, obesity, depression, drug and alcohol problems, loneliness, chronic pain, confusing symptoms, difficulty telling their story, dementia, overwhelming family responsibilities, a bagful of medications, and nagging problems for which no cause or cure can be found.

These consultations are *non-linear*. Newtonian laws don't apply; instead, they have been supplanted by chaos theory. Because of the underlying complexity and multiple possibilities, each question or reflection from the doctor might twist the next arrow in any direction—even split it into many parts. And, as happens when you follow the arrow of time, entropy only ever seems to increase.

In this rather chaotic, real-world space, the attitude and personality of the doctor can completely change the outcome of any given consultation.

Doctor, doctor. My ex-husband is so ill—is there no hope?

That depends what you are hoping for.

How do we know that so much depends on the doctor, rather than the patient? Gathering evidence is difficult, because to compare different doctors, we would need to somehow expose them to exactly the same patient with exactly the same opening line about their problem, and with exactly the same complex underlying set of real-life issues, some of which will affect the treatment outcome.

Luckily, clever folk have created just such a scenario—albeit a fake one. It is called a medical exam. These mock consultations are specifically designed to tease out how different doctors respond to exactly the same patient scenario. And this is how we know that the variations are extraordinary.

For some years, I have been part of a panel which assesses overseas-trained doctors (OTDs) who want to work as GPs in the Northern Territory. Many OTDs do a fantastic job in very difficult circumstances—often in remote communities which have been unable to attract an Australian-trained doctor. But we need to know the OTDs are competent before we send them there.

Our two-hour assessment involves five medical scenarios where one of us acts as the patient. Only the opening line is scripted, but we have a comprehensive background briefing as to every aspect of the pretend-patient's life, including underlying concerns, other medical conditions, even personality traits.

Generally, the more 'technical' the scenario, the more similar are the OTDs' scores, regardless of how many years they have been working as a doctor, and in which country. Thus, treating blood pressure is pretty straightforward, and even a more difficult scenario like a child with possible meningitis tends to see a fairly even cluster of lower scores.

But as soon as we present a scenario where the patient's opening statement doesn't reflect the most important issue (a common occurrence in real life), the scores start to vary. And where the patient fails to give a clear, structured history of their problem (or would do so, but is not given the opportunity by the doctor), some consultations get very messy.

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Some doctors miss cues, others rush into an early, specific diagnosis which is either wrong or does not cover the most important issue. Or they come up with a management plan which is completely impractical because the patient wouldn't be able to—or wouldn't even intend to—follow it. The doctor has not listened, communicated, negotiated, nor assessed the patient's understanding.

And the greatest discriminator of all between doctors? The scenarios where there is no single obvious intervention at the end. Adding in another blood pressure pill is easy. So is ordering a batch of tests, even though there is a disturbing tendency to order everything under the sun, to 'cover all bases'.

But it is no easy matter to give advice to a young schoolteacher who is struggling to cope in a remote community where she is working alone. Her vague abdominal pains which she first mentions are not the issue here; we ensure there is enough information, if asked, to rule out any physical illness. Many candidates never get to this, diagnosing all sorts of gastric conditions, inevitably with an accompanying prescription or investigation, even though the schoolteacher tells them she doesn't think that is the solution.

High scores are possible, for those who develop some sort of rapport with the schoolteacher, invite her to tell her whole story, recognise her mild depression, give her a chance to have input into her own management plan and arrange to see her again soon to follow up on how she is doing. The doctor's humanity has a chance to shine in this scenario.

But many doctors leave the exam assessment—and would leave the exact same scenario in real life—mistakenly happy that they had diagnosed her irritable bowel syndrome or gastric infection, and had prescribed a drug for it. The real schoolteacher, depending on her degree of faith in the doctor, might accept her new disease label, undergo various further tests on her precious trips into the city, put up with the medication's side effects because the abdominal pains seemed to be improving, but wonder why she was starting to feel tired all the time and losing her usual enthusiasm in the classroom. Could be her thyroid...maybe, like her predecessor Jill, she should go and see Dr Junior in town!

At its best, the therapeutic effect of seeing a good doctor can be extraordinary. George Bernard Shaw's line from 'The Doctor's Dilemma' is only a slight exaggeration: *Even broken bones, it is said, have been known to unite at the sound of his voice.*

At its worst? Well, medical defence companies who insure doctors tell us that a minority of doctors account for the majority of litigation cases. The most common characteristic among that group is not technical incompetence, but poor communication skills. Although anyone can make a mistake or be unlucky, it is highly unlikely that a doctor whose empathy is evident to their patients will ever end up on the 'sued multiple times' list.

### **Humanity-driven consultations**

The concept of *patient-centred care* was fairly new when I was taught the art of medical practice twenty years ago. I couldn't have defined it, but had some idea of what it wasn't:

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disease-centred, technology-centred, the sort of treatment you would find in an intensive care unit. This is quite appropriate if you've been run over by a car: you want to be looked after by someone with a deep understanding of crushed organs and machines that go 'bing'.

The deservedly famous Monty Python skit starring just such a machine (please do watch it again) highlights the dissonance that occurs when reliance on technical expertise is brought to bear on a natural birth. Problems arise when machines, and their accompanying technical mindset, which work so well in a high-intensity environment are therefore thought to be appropriate in a more 'normal' setting.

Not surprisingly, when you ask patients what they want out of a medical consultation, their wish list includes the following:

*Patients want patient centred care which (a) explores the patients' main reason for the visit, concerns, and need for information; (b) seeks an integrated understanding of the patients' world—that is, their whole person, emotional needs, and life issues; (c) finds common ground on what the problem is and mutually agrees on management; (d) enhances prevention and health promotion; and (e) enhances the continuing relationship between the patient and the doctor.*

Stewart, M. Towards a global definition of patient centred care.

I would argue this ambitious list is achievable only during what I'll call a *humanity-driven consultation*. The kind, empathetic, reflective doctor has the greatest chance of reaching these outcomes, particularly *b*) understanding the patient's world, and *c*) finding common ground on management.

This humanity-driven consultation doesn't entail anything extraordinary. After all, humanity doesn't require one to be superhuman. The doctor can allow their natural kindness to permeate the encounter, and can also be trained to improve their technique. Most medical schools now explicitly teach consultation skills, although admittedly the word 'humanity' doesn't get much of a run.

*What do I want in a doctor? I would say that I want one who is a close reader of illness and a good critic of medicine...I see no reason or need for my doctor to love me, nor would I expect him to suffer with me. I wouldn't demand a lot of my doctor's time, I just wish he would brood on my situation for perhaps five minutes, that he would give me his whole mind just once, be bonded with me for a brief space, survey my soul as well as my flesh, to get at my illness, for each man is ill in his own way.*

Anatole Broyard, editor of The New York Times Book Review, writing before he died of prostate cancer in 1990.

Patient-centred care does not mean that the patient controls the entire process: the technical expertise still usually rests with the doctor. As in other relationships, being empathetic does not equate to passive compliance. Indeed, occasionally the wishes of the patient must be actively resisted: for example, where they involve inappropriate drugs of dependence, inaccurate statements on signed forms, or an allocation of expensive resources which would be better spent elsewhere.

Studies have shown that when a doctor believes the patient expects a prescription, the doctor is far more likely (up to tenfold) to write one. The medical problem remains the same, but the doctor's desire to fulfil the patient's perceived wishes—sometimes misinterpreted—determines the outcome. It can be difficult to lead the patient reluctantly down the hard road to 'nowhere'!

### **Minimally disruptive, 'slow' medicine**

I believe the skilful art of doing nothing can be judiciously applied to some aspects of every branch of therapeutics, from physiotherapy to surgery. Indeed, even when one tries to think of extreme exceptions, the art keeps popping up.

I mentioned intensive care units where, for someone in a coma following a car accident, the empathy and communication of the doctors might seem inconsequential compared to their skill at managing brain swelling and lung collapse.

But what if the situation becomes dire and the family must negotiate the terrifying path of deciding whether to switch off all the machines that go 'bing'? A choice between millions of dollars' worth of life-sustaining machinery—and nothing.

Suddenly, communication is everything. I have seen tearful families eternally grateful to a caring consultant or nurse who has steered them compassionately through this difficult terrain towards the final destination.

Certain areas of medicine have led the push towards 'paring back' interventions which in the past have been prone to over-zealous application. Aged care and palliative care health providers were among the first to recognise the harms caused by overtreatment with multiple medications, frequent hospitalisation and aggressive life-prolonging interventions. Other notable fields with a significant academic thrust to curtail

overtreatment include obstetric care, public health and mental health care, although there is often a disturbingly slow translation into practice.

Here, I should give a nod to ‘generalist’ doctors in rural areas, those rare locations where being a jack-of-all-trades is still valued over sub-specialisation. Rural doctors tend to be less trigger happy ordering tests and referrals because of the added inconvenience for the patient. Additionally, because they and their patients are stuck with each other, a poor understanding of the patient’s needs is far more likely to come back to bite them.

Clusters of health professionals are forming around the world, teasing out these ideas. Leading the charge are those with an interest in public health. In Australia, one virtual water-cooler they cluster around is the [Croakey health blog](#).

Another group calls for ‘minimally disruptive medicine’:

*Chronic disease is the great epidemic of our times, but the strategies we have developed to manage it have created a growing burden for patients...(inducing) poor adherence, wasted resources, and poor outcomes. Against this background, we call for minimally disruptive medicine that seeks to tailor treatment regimens to the realities of the daily lives of patients. Such an approach could greatly improve the care and quality of life for patients.*

*We need to think more about the burdens of treatment. These are different from the burdens of illness...thinking seriously about the burden of treatment may help us begin to think about minimally disruptive medicine—forms of effective treatment and service provision that are designed to reduce the burden of treatment on their users.*

May, C *et al.* [We need minimally disruptive medicine](#)

Others, particularly in the aged care field, call it ‘slow medicine’.

*Commonly, elders suffer the accumulating burdens of illness and exhausting medical regimens that extract all their available energy and time, leaving nothing left for living beyond a ‘medicalised’ life.*

*But there is another way: ‘slow medicine’ where family, friends, and neighbours team up with an elder and with health-care providers—including visiting nurses and other home-based care providers—to improve the quality of care and avoid inappropriate, sometimes harmful care. ‘Slow medicine’ is not a plan for getting ready to die. It is a plan for caring, and for living well, in the time that an elder has left.*

McCullough, D. [Slow medicine](#)

Whatever the terminology, the common thread is the link between two seemingly disparate fields: the avoidance of over-intervention and the doctor’s focus on the patient’s overall needs and concerns. The former is only sometimes required, but the latter should be universal.

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Combining the two takes some mastery. It involves the brainy science of evidence-based medicine, a sceptic's eye when considering impressive-sounding new technologies, a keen ear for listening, and communication skills which adapt to patients from all walks of life. Gosh, maybe a few superhuman powers might come in handy after all?

But no, a merely mortal doctor can get the balance right most of the time. And unlike the mythical 'best specialist in the city' which some consider their referral-right, these mortal doctors tend to dwell in modest places: the suburban surgery, the small rural emergency department, the nursing home round.

Doctors are gatekeepers to a most powerful, expensive, superb and dangerous health system; we must never forget that sometimes our job is to shut the gate.

Wise interventions test our application, but wise non-interventions test our very humanity.



## 4.3 On healing

### Professor Helen Milroy

Healing is part of life and continues through death and into life again. It occurs throughout a person's life journey as well as across generations. It can be experienced in many forms such as mending a wound or recovery from an illness. Mostly however it is about renewal. Leaving behind those things that have wounded us and caused us pain. Moving forward in our journey with hope for the future, with renewed energy, strength and enthusiasm for life. Healing gives us back to ourselves. Not to hide or fight anymore. But to sit still, calm our minds, listen to the universe and allow our spirits to dance on the wind. It lets us enjoy the sunshine and be bathed by the golden glow of the moon as we drift into our dreamtime. Healing ultimately gives us back to our country. To stand again on our rightful place, eternal and generational. Healing is not just about recovering what has been lost or repairing what has been broken. It is about embracing our life force to create a new and vibrant fabric that keeps us grounded and connected, wraps us in warmth and love and gives us the joy of seeing what we have created. Healing keeps us strong and gentle at the same time. It gives us balance and harmony, a place of triumph and sanctuary for evermore.

## Chapter 5

# Advocate against disadvantage

*.....I will prevent disease whenever I can, for prevention is preferable to cure.....I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.*

**Hippocratic Oath: Modern Version**— Louis Lasagna 1964

As family doctors, we see people all sectors of our communities. We may question the value of our work when confronted with insurmountable social problems experienced by people living in poverty or exposed to domestic violence, patients with chronic disability, indigenous people and refugees. While the futility of providing “bandaid” care in individual consultations is difficult to manage, many doctors have stepped outside their consulting rooms and have discovered the power of their advocacy in effecting social change through writing and public speaking out about human rights and the need for change.

In this section, Dr Bill Bateman talks about his sense of fulfilment that comes with stepping outside routine clinical practice and working with people living on the edge. Leanne Rowe tells a personal story about the disturbing trend for Australian prisons to house people with acute psychosis. Dr Howard Goldenberg describes a tragic case of Aboriginal child suicide. Professor Amanda Howe’s poem advocates for refugees in remote places of the world.

## 5.1 On the edge

### Dr Bill Bateman

Today I'm talking about living on The Edge. And no reader, I'm not referring to stuff like heliskiing, base-jumping or extreme surfing. For me, that's all sooo yesterday. You see I've pretty much moved on from all those childish activities; you know- been there, done that. What, you don't believe me?

Actually, the truth is that the only risky behaviour I've undertaken recently was abusing the umpires at the MCG when my Cats lost to the hated Magpies (devastated, if you want to know), and then travelling home on the crowded tram and not swiping my MYKI card – yeah, I know, right out of control! And, imagine this if you will, less than a week later I went for my 7 km jog *and* did my 1 km swim, ON THE SAME DAY. Actually, it pretty much took all day. And I needed some extra red wine that evening to recuperate. Let's face it guys, these days I'm so far from the edge, I'm almost on the other side.

So reader, what I'm *really* referring to are those peripatetic punters who perpetually live in that chaotic grey zone on the edge of normal society – the fringe dwellers. You see, for my sins, I work one morning a week in a clinic at a community social welfare centre, which feeds a few hundred people a day and provides housing, drug and alcohol, mental health and numerous other supports, for the needy and disenfranchised; and that's where I encounter life on the margins. In fact, and without climbing right onto the soapbox, I reckon that the shortage of decent affordable public housing in this supposedly affluent country is scandalous. Sadly reader, there are no votes in homelessness. My real day job is only a few blocks away, but there the demographic is starkly different – well educated and resourced, largely professional and sitting comfortably in the middle of the middle class – a world away from The Edge.

Yesterday I rolled up to the familiar decaying red brick building and first up, the saintly Nurse Julie and I spent around 45 minutes with Nev – a true inhabitant of that Otherworld. Nev is a man in his early 40s. Dark haired, thin faced, thoughtful and considerate. Very creative and great sense of humour. Oh yeah, I almost forgot to mention – he also has severe chronic schizophrenia. He attends a psych. clinic up the road, where he has a caseworker and receives his fortnightly depot injection, but during the last month had gone AWOL and missed his jabs. He lives in a nearby rooming house, well known for its violence and drug dealing and full of risk for a man like him.

Julie had spotted Nev in the dining hall, looking distracted and drowsy, and enticed him to come into the clinic for a chat. We soon discovered that far from being 'on the nod,' he was very keen to discuss his tightly held conviction that someone out there was coming to get him. Hard to say who exactly, but he definitely knew they were out there. We both sensed that Nev was having some auditory hallucinations as well, but he was canny and experienced enough to keep those to himself, lest he found himself back in hospital

again. In that sense, his paranoia was well founded. We eventually managed to re unite him with his caseworker and moved him a little bit closer to firmer ground.

Next we saw Paddy, a new patient, sleeping rough at 17, who told us he'd just had a 'bad taste,' and felt like he couldn't breathe and was about to collapse. As best as we could gauge, he was suffering from drug induced acute anxiety rather than an overdose or worse and we eventually managed to calm him down, although we went with the slow breathing and calming words approach, rather than the alprazolam recommended by his girlfriend. We then hooked him up with a worker who arranged an assessment and detox and he shuffled out, leaving Julie and I worried and concerned, wondering what had led to him being in this place at this time. We both realized that this wasn't the last we we'd be seeing of Paddy. (Hopefully.)

Our last punter was 19 year old Samara, a local 'working girl', with a long history of mental illness and substance abuse, accompanied by 'AJ' -her boyfriend/supplier/pimp/minder (You need to be versatile on the street reader.) Samara was in an agitated state, claiming that she had been having frequent fits over the previous few hours and proceeded to fall to the floor and convulse in a convincing fashion. So Julie called our friendly paramedics and the local mental health outreach services and I attempted to insert an IV line. As expected, Samara's veins were mostly clotted and very hard to cannulate, but AJ provided expert advice regarding vein selection. (You have to take help where you can get it reader.) Then, just as I got the needle in, two burly ambos and a psych. registrar and mental health nurse all arrived simultaneously and crowded in our tiny office. When Samara looked up (so much for being unconscious) and saw the uniforms she freaked out, rapidly morphing from status epilepticus to swearing banshee; pulled out the drip- spraying her hepC positive blood all over the walls *and* me, and fled the scene with AJ close behind – requesting an oxycontin script over his shoulder. (Worth a try - you never know your luck.)

The other helpers departed, two by two, like Noah's animals, leaving Julie and I shaking our heads, grinning grimly and then we both burst into slightly hysterical laughter. A touch inappropriate I know reader, but a predictable human response to the travails of the morning.

So I had a wash, bade fare well to Julie, jumped on my treadle and headed back to the leafy streets and nice people on the Other Side, before resetting my brain to again tackle the marginally elevated LDLs, frozen shoulders and colicky babies, with the unsettling feeling that I was probably of more use closer to The Edge.

## 5.2 The criminalization of acute psychosis

### Adjunct Associate Professor Leanne Rowe

When the Supreme Court of Victoria in Australia declared that 26 year old 'Sam Benson' was not guilty of the charge of the murder of Dr Khulod Maarouf Hassan by reason of mental impairment, the outcome was barely reported in the media. Unfortunately cases like this are commonplace in Australia, and statistics around the overrepresentation of people with major mental illness in the criminal justice system are not deemed newsworthy. Nevertheless, the story should be told.

My friend, Khulod was brutally stabbed in her Victorian general practice during busy office hours, about nine months after Benson had consulted her for a specialist referral. Despite his deteriorating mental condition and the best efforts of his many general practitioners and medical specialists, Benson fell through the gaps of our fragmented health system. Prior to the killing, he tried to convey his psychotic delusion about a grand conspiracy by the whole medical profession to kill him to many community organisations.

We still do not know why Benson chose Khulod, amongst his many doctors. He did not have an appointment with her on the day of the stabbing and she had no warning of any threat. What we do know is that despite the brutality and irrationality of the killing, Benson was held in a normal prison without any psychiatric treatment for at least seven months. During this time, he displayed florid paranoia in the witness stand after insisting on representing himself at six very confusing committal hearings because he believed the whole legal profession were trying to kill him. The heart broken Hassan family, including Khulod's three young daughters asked many times for the Court to intervene in this unfolding tragedy, but their pleas fell on deaf ears.

A psychiatric assessment for the defendant was finally recommended by a magistrate after the long lonely court process failed to proceed. After being diagnosed as acutely psychotic, Benson waited another three months for transfer from prison to a high security psychiatric hospital because there was a long waiting list for a place. When the case was finally referred to the Supreme Court, the hearings were adjourned on three further occasions, pending further psychiatric assessments because of the defendant's continuing disturbed behaviour. The delays in psychiatric assessment had presumably rendered young Benson resistant to treatment.

Far from being an isolated event, or '*out of the blue*' as many people suggested, Khulod's death was at the tip of the iceberg of some deeply confronting national trends. Rates of major mental illnesses are between three and five times higher in offender populations than those expected in the general community. A number of contributing factors have been suggested to help explain the high numbers of people with mental illnesses in the criminal justice system, including deinstitutionalization of psychiatric care, increased abuse of drugs and alcohol by people with serious mental illnesses, and under resourcing of community-based mental health and welfare services. Whatever the reason, violence

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against medical practitioners and nurses is increasing, with some studies documenting that two out of three general practitioners are subjected to patient initiated violence every year.

Sam Benson is Sudanese. There is no evidence to suggest that Sudanese refugees, many of whom are struggling with their new environment after fleeing a long, deadly war, are more likely to offend or to experience psychotic illness than people born in Australia. They are, however, less likely to receive treatment for mental illness.

We should no longer tolerate a system that allows the most vulnerable in our community to fall through gaps in health and welfare services and end up in prison. The over representation of people with serious mental illness in the criminal justice system is an Australian human rights issue and change requires greater community action.

Over our careers as medical practitioners, we experience many tragedies. For me, the saddest moment was looking into the sea of over one thousand grieving faces, as I gave the eulogy for Khulod beside her open coffin, on behalf of the medical profession, in my then position as Chairman of the Royal Australian College of General Practitioners in Victoria. In the time of immense grief, perhaps the most poignant moment was the silence in the court after the young Sudanese man finished an incoherent ranting with the statement: '*No-one is helping me*'. Because, tragically, his caring, compassionate general practitioner was dead, and he was right.

To view an ABC program on the life and death of Dr Khulod Maarouf Hassan, please refer to:

<http://www.abc.net.au/austory/specials/waitingroom>

To learn more about patient initiated violence, please access:

<http://www.racgp.org.au/your-practice/business/tools/safetyprivacy/gpsafeplace/>

## 5.3 Aboriginal child suicide

### Dr Howard Goldenberg

I am in my small house in Yulara, cooking for Shabbat on a Friday, when the phone ring

A male voice speaks: 'It's Sergeant Benjamin, Doctor, of the Mutitjulu Police ... I'm sorry to trouble you ... there's been a death.'

A pause.

The voice resumes: 'It was a hanging. We need someone to certify the death. The nurses here can't do it; it has to be a doctor. I am sorry, Doctor.'

The voice is careful, it is feeling its way. I don't know the officer. The voice I hear is sober – sobered almost to a halt by the news of a death.

I ask the officer to bring the body to the clinic. We arrange to meet in twenty minutes' time.

It is early evening – 1830 hours in official language – when they pull up at the clinic. Even at that hour the heat is relentless. The sky is painted blue. There are two vehicles, a police car followed by an ambulance in its familiar livery of white slashed with red. A large oblong man steps out of a police car of such startling blueness that the sky pales behind it. The officer's face is deeply creased.

We shake hands.

His offside gets out and straightens. She dwarfs her sergeant. Apart from the odd post-adolescent pimple, her face is smooth. She walks over to the ambulance and commences a laughing conversation with the nurses who have driven the body.

After a time the nurses are free to attend to my questions. I address the older of the two, the one I know from the clinic: 'When was she found?'

She turns to her associate. For a moment, both are silent, then she says, 'I'm not really sure. The family called us an hour ago – when they felt ready to let us take the body, I guess. Someone found her before that and called the family. We don't know when ...'

We release the latches and the heavy door of the ambulance clunks open, revealing a large white bag resting on a collapsed stretcher. Warm air flows from the interior.

The nurses step backward. Fumbling, I try to pull the stretcher a distance from the vehicle's dark interior. The nurses step forward and help, then again retreat. I pull on the zipper and the bag falls open, exposing the head and upper body of a human.

I pause. No sound, no movement.

There is a moment of reverent peacefulness. The skin of the person whom I stand and regard is brown, the same brown that glows from the earth and the many heads of rock in the early sunshine during my early morning run. That colour has penetrated me, claiming me like a mother.

I place the back of my gloved hand against the brown skin. It is still warm. Just as shocking, the face is very small.

I straighten and ask the nurses, 'Do you have a date of birth?'

One shows me a file. She points upper left, where I read, '19 November, 1991'.

I look again at the small face. There are a couple of blotches of acne. The child has buckteeth. The body is short and slender, the body of a girl who has scarcely begun the journey to womanhood.

I have no doubt, I feel no hope, but I rest my fingers lightly over her carotid artery. It is still.

I check her eyes. Dull now, pupils wide, fixed and unresponsive to the light – those are pearls that were her eyes.

I apply my stethoscope to her chest. The silence of death is drowned in a distracting chorus of inanimate rustling and chafing sounds. These are the artefacts of my examination. I hear no heartbeat. No air moves in or out of the chest.

This is the body of a fifteen-year old girl whose life is extinct.

No motion has she now, no force;

She neither hears nor sees;

Rolled round in earth's diurnal course,

With rocks, and stones, and trees.

I have another question for the nurses: 'What do you know of her health before today?'

'Six months back she was sniffing, but not since then; there's been no sniffable petrol in the community since then ... There were some family problems. She had been seen by Mental Health ...'

The answer is unsatisfactory. Any possible answer would be unsatisfactory. It all boils down to one thing: we do not know.

On an afterthought I lean forward again, peering past the fine cheekbones and the slender jaw, peering at the soft tissues beyond. There, on her throat I see what had to be seen, a bracelet patterned in her flesh, a curvilinear design that is unexpectedly graceful. It is the embossing in her skin of the fatal rope.

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## 5.4 Stranger welcome

### Amanda Howe

I love visiting strangers.  
With whom I have much in common -  
We share values, life experience, training, and sometimes status  
We live in hope, expect dreams to be realised, take calculated chances

As do pilgrims.  
Seeking the place of meaning  
Beyond the dark night and the blue morning  
The blue sea and the yellow land  
The white wave and the whiter mountain.  
When they arrive at the goal, it is meaningful

And then the wanderers.  
No lodge in the cold, just  
The clinging to exhausts  
And bus roofs  
And lorry tailgates

Refugees, asylum seekers.  
Hard to play the system after 60 days at sea  
Or a hard night in a doorway  
Or under bright lights with men shouting  
In a language they don't understand

So why am I breezing through these borders?  
Fast track welcome to a stranger  
Into a safe car with a kind driver  
And a warm bed and a set of new friends.

Neither fate nor fortune nor corruption brought me here  
But neither did my brain and effort and emotional intelligence  
It was the kindness of strangers who had faith in me

We hope for a stranger to welcome.  
Meet, listen, help, enable,  
And not judge -  
Let me sleep and feed, and then you can ask the difficult questions  
In a kindly way

Give me help in a foreign city  
Show me the way back  
Help me to endure the uncertain future  
And welcome me home.

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## Chapter 6

# Remain curious about humanity

*'May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help'.*

**Hippocratic Oath: Modern Version**— Louis Lasagna 1964

Medicine provides doctors with deep insights into humanity and inhumanity. Even in its darkest moments, there is always something new to learn about human existence. The following stories are about what we can learn about ourselves in difficult times. Ed Byrne, Leanne Rowe and Howard Goldenberg have again contributed pieces.

We finish our book with the wonderful piece on curiosity by Faith Fitzgerald, Professor of Medicine and Associate Dean of Humanities and Bioethics at the University of California, Davis, School of Medicine. And a favourite quote by Albert Einstein:

***'Not everything that can be counted counts, and not everything that counts can be counted'.***

## 6.1 On difficult times

### Professor Edward Byrne

Sometimes  
We have to do  
Quite difficult things  
We don't choose them  
Duty, fate or bad luck  
We are in the firing line  
How we live in  
The difficult times  
Tells us  
Who we really are

## 6.2 The man who cut his hands

### Dr Howard Goldenberg

A commotion from the waiting room. Raised voices, female voices, one shrieking, another, less frantic, also raised.

The frantic voice cries: *Get him something for the pain. He's in terrible pain. Get a doctor, he's in pain.*

*Please don't scream. Try to be calm. I'll go and call the doctor... Here's the doctor now.*

The man who is in terrible pain lifts his hands, which are bleeding. Tall, in his mid-twenties, he has a scar that runs obliquely upward from his lower lip to the left hand corner of his upper lip. His eyes look yellowish. He bleeds from transverse lacerations on the *backs* of his hands. Both hands.

Odd.

In the treatment room the wounds are swiftly cleansed and anaesthetized. The man's companion leans over the doctor's shoulders squawking, *He's in terrible pain. Give him something for the pain!*

By this stage the doctor is busily suturing the numbed skin. The lacerations are jagged, roughly parallel, two on each hand.

Odd.

The young man's companion is tall and thin, younger than he, agitated and relentlessly noisy.

The doctor looks up from his suturing, engages his patient's gaze, asks confidentially, *What happened?*

*Punched the windows. Both hands.*

The doctor looks over his shoulder towards the injured man's companion, still highly audible. He raises an eyebrow, asks: *Was there a disagreement?*

*Blood oath! It was her or the windows. I punched the windows.*

The doctor suppresses the urge to say '*wrong choice*'.

The young man's skin is tough. It resists the doctor's pressing needle. The doctor pushes harder, the skin abruptly gives way and the needle penetrates the doctor's left index tip.

He pulls off his glove, washes the finger vigorously, asks over his shoulder – *You're not using any drugs are you?*

*Nah... hardly anything. Not now.*

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*Are you injecting?*

*Nah. Not since I was inside.*

The doctor scrubs harder.

The man adds: *Look, you don't need to worry. I haven't got HIV. They test you before you leave.*

The doctor looks unconvinced.

*Look Doc, I'm clean. The only thing I've got is Hep C.*

The doctor surveys the man's hands: three lacerations down, one to go. He asks the nurse for a syringe and a test tube, he draws blood from the wound, fills out a pathology slip, and sends the man's blood for serological testing for a range of blood-borne infections. In exasperation and in defiance of the law, he does not seek consent from the patient. He scrubs again, re-gloves and resumes his suturing. He speaks: *I'm testing your blood. I'll give you the results when you come back to get the stitches out.*

The wounds look tidy now, four curving rows of small black bows sit pretty as a flower bed against the thin red lines of closed lacerations.

The man and his lady friend leave without paying.

Only now does the doctor read the patient's surname on the chart. He recognizes the name: he used to treat the man when he was a small child. His battling single mum did her best with the children. The sister turned out alright. Until today the doctor had lost track of the son.

The doctor sends off his own blood and learns that he has no antibodies against HIV, Hepatitis B, Hep C or syphilis. His patient does indeed have Hepatitis C. Now the doctor must wait three months to discover whether he has caught the incurable - and at this time, largely untreatable - liver virus.

The man who had cut hands never returns.

In the course of those very difficult months the doctor spends a lot of time in meditation. You may ask what the results of my tests were, but that is not the point of the story.

The man who had cut hands was born in July 1972. I was curious about the history of the young man. '*Who delivered him?*'<sup>1</sup> asked of my friend and celebrated senior partner, Dr Donald Cordner, a believer in the importance of personal involvement in all situations, who said:

*I did... his sister too. What became of them?*

(See Dr Donald Cordner's story on page 13.)

## 6.3 The blurring of work and life boundaries

### Adjunct Associate Professor Leanne Rowe

My country rotation as a medical student was overshadowed by a heated argument between the general practitioner and his wife. She was sacrificing her life in this 'hole of a place' and angrily stormed out to visit her children in boarding school in Melbourne. One quarter of a century later, I now understand the frustration and challenges of rural general practice for a doctor, who is also a mother:

Being ignored in the street by the sister of someone I reported for child abuse. Remaining professional when my child was victimized at school by one of my patients. Being called out to a cardiac arrest in the middle of lunch with best friends, whom I had not seen for a few years, and leaving them to baby sit my children. A knock at the door at 2am by a tearful, teenage boy who requested the morning after pill for his girlfriend, as the condom broke twenty minutes before and 'her father would kill him'. Listening to my baby screaming for a breast feed while I was resuscitating a choking child, who was rushed to my home by his frantic parents. Having my supermarket shopping prolonged by a patient who asked my advice about his haemorrhoids. Taking my children on a long awaited outing and stopping at a motor car accident, where instead they were entertained by fire engines, police, ambulance and a helicopter, unsupervised in the back of my car. Stopping at the next accident and praying we wouldn't know the family this time. Unbandaging my neighbour's hand at my kitchen table at 11pm and finding that he amputated his finger, when he fell off the haystack that morning. ('Well who else was going to milk the cows') Trying desperately and unsuccessfully to resuscitate a teenage boy after an accident in the Main Street in front of his mother. And having to counsel a community's grief when you feel you can't contain your own.

Then I remind myself of so many other stories of courage and resilience in the face of chronic illness, child abuse, family breakdown and death. These are mostly the rich images of people from very diverse walks of life, who have taught me what my life career requires of me beyond my work.

Receiving a letter a thanks from the abused child who is now a thriving adult. Catching a glimpse of my neighbour on another lonely drive home from work: the seventy year old farmer riddled with arthritis throwing hay off the back of his driverless truck which is chugging across the paddock with a brick on the accelerator (the day after being discharged from hospital for repair of his amputated finger). Sharing a tearful moment with the mother who lost her son years ago in the Main Street accident, and feeling like my insight into life is more valuable than gold.

And because parenting is more difficult and wonderful than any of this, most of all it's the image of my 18 year old son (who has previously noted that I am an overly anxious, ageing woman with a weird sense of humour and a big arse), saying to career advisor: '*I want to be just like my mum*'.

## 6.4 On curiosity

### Dr Faith Fitzgerald

About 15 years ago, when I was dean of students at the University of California, Davis, School of Medicine, yet another of the periodic paroxysms of 'holism' in medicine occurred. Several important politicians called to tell me that, in their opinion- which presumably reflected that of their constituents- medical students, by selection or by their isolation by the medical curriculum, were insensitive, mechanistic, technocratic, inhumane brutes. The solution, these politicians insisted, was the intercalation of humanities courses into an already crowded curriculum.

I had several concerns about this. The first was that the addition of required courses in literature, drama, sociology, music and art might actually limit students' opportunities to read, go to the theatre, be with friends and family, and attend a symphony or go to the museum. Even if one argues that students would not have done these things anyway- possessed as they were by the intricacies of glucose metabolism- the addition of these courses would cut down on contemplative time, volunteerism in free clinics, hobbies and sleep. Second, I wondered what evidence supported the idea that being well versed in the humanities made one more humane. I was encouraged in my skepticism by the knowledge that perhaps the most broadly educated of physicians at the beginning of this century practiced in Germany. Moreover, I could not understand why science- a most human pursuit, the exercise of which is one of the defining characteristics of our species- should make students 'inhumane'. I decided to do a 'scientific' study of the effects of humanities courses on humaneness in medical students.

Several colleagues and I read more than 10 years worth of the subjective descriptions of performance of third- and fourth- year medical students on their clinical clerkships. We looked for adjectives suggesting humane behaviours: 'caring,' 'warm,' 'concerned,' 'good with patients and families.' Each of these descriptors got 'nice' points to the total number of units taken in the humanities in the student's premedical career.

What a shock: we found a direct correlation. I still thought it did not make sense. These were adults, after all. Was fundamental character, which is usually well formed by adolescence, changed by a class? I did what confused scientists have done for centuries to nonconforming data: I reanalysed them. This time I ran a correlation between 'nice' points and premedical units taken in science. Surprise again! Another direct correlation. Those students who had taken most units in science had the highest number of 'nice' points. In fact, in this idiot-driven experiment, 'niceness' correlated directly with the total number of course units taken, regardless of the category.

What did it all mean? I did not know, but I wondered: What is kindness, as perceived by patients? Perhaps it is curiosity: 'How are you? Who are you? How can I help you? Tell me more. Isn't that interesting?' And patients say, 'he asked me a lot of questions'; 'she

really seemed to care about what was going on with me.’ Is curiosity the same, in some cases, as caring?

Curiosity is the urge to investigate, to discover. It can be seen in all small mammals; just watch a kitten explore a paper bag. Evidently, although curiosity can be dangerous (‘What’s down this dark hole I wonder? What does this bright pill taste like? What’s the funny looking black animal with the white stripe down its back?’), it also has a redemptive adaptive function that exceeds the risks. Otherwise, puppies and small children would be wiped out. Curiosity is how we learn about our world.

Dr Erich Lowey, in an unpublished paper, points out that curiosity, this primal ‘wonderment’ that stimulates exploration, engages both imagination (conceiving the alternative explanations of new phenomena) and intelligence (mapping out the best way to determine which explanation is likeliest). Both imagination and intelligence are integral to humanities, science and the synthesis of the two, which is clinical medicine. Rather than stating that the study of humanities makes one humane, I propose that humane people are curious and therefore choose to explore the humanities as well as the sciences.

An endowed lectureship at my medical school allows us to invite Nobel Prize-winning scientists to visit and lecture for several days. What impressed me most about my conversations with these luminaries was the extraordinarily broad range of their interests, their enthusiasm, and their thought patterns. One thinks science has a sequential and controlled pattern of logical ideas, firmly grounded in antecedent principles and constantly cleansed of intellectual debris by the abrasion of skepticism. Listening to Nobel laureates in medicine was revelatory. No linear thought here. The uninhibitedly threw forth multiple ideas in their observations, the connections between which were often invisible to me. As if the ideas were the small bright stones of a mosaic, forming many possible pictures, these scientists looked at them and rearranged them until they found a picture they liked. Dr Baruch Blumberg, for example, explaining how he found the hepatitis B virus, told me stories of Australian Aboriginal people, roof thatch, wombats, guitars, bedbugs, the Babylonian Talmud, and manned space flight. No doubt the disciplined thought of scientific proof came later.

The scientists seem oblivious to intellectual constraints and unconcerned about being seen as naïve or unknowledgeable. I suppose being a Nobel laureate means that one has little left to prove of one’s inadequacies as a thinker, but I have no doubt that these thought patterns preceded and were the reason for these people’s Nobel Prize-winning discoveries, not a consequence of the prize. Curiosity without constraint, no preconceived image to emulate, no need for the façade of competence, opening inquiry into any area that stimulated their interest- these qualities seemed common to them all.

In fact, the best clinical diagnostic thinking is more like forming a mosaic than linear thinking: it requires the physician to constantly alter diagnoses as each new piece of data enters the picture. One conceives constantly of many possible diagnoses, narrows down, re-expands, and generates an ever-evolving flux of ideas; the more information gained

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from patients, the better. For example, a 30-year-old woman with shortness of breath and fever (maybe a virus: pneumonia, of course) for three months (tuberculosis, multiple pulmonary emboli, lupus, sarcoidosis) recently returned from India (malaria, hepatic abscess, weird tropical disease) where she was visiting her mother, who was dying of breast cancer (anxiety; metastasis from breast, ovarian, or colonic cancer; maybe she visited a guru and got toxic herbal medications), and so on.

What does curiosity have to do with the humanistic practice of medicine? Couldn't it just convert patients into objects of analysis? I believe that it is curiosity that converts strangers (the objects of analysis) into people we can empathize with. To participate in the feelings and ideas of one's patients- to empathize- one must be curious enough to know the patients: their characters, cultures, spiritual and physical responses, hopes, past, and social surrounds. Truly curious people go beyond science into art, history, literature, and language as part of the practice of medicine. Both the science and art of medicine are advanced by curiosity.

One problem for medical students and physicians is that they must already have two things before engaging in uninhibited curiosity: a sense of competence (without which one tries to cultivate the appearance of competence, which generally means having more answers than questions) and time to think. The former is threatened by modern medical education and the latter by modern medical practice.

How is curiosity suppressed in medical students and physicians? It is. I have discovered, in nonclinical settings, that students who, on the wards, seem totally without curiosity or culture- dolts, in short- were, in their private worlds, avid poets, artists, musicians, and craftspeople's of exquisite skill, vitally interested in a wide range of topics. They just did not think it wise to let anyone know because they had received a message from house staff, faculty, or peers that interest in anything other than purely biological medicine was inappropriate for a medical student.

Medical education itself suppresses the expression of curiosity, emphasizing examinable facts rather than more ineffable thought processes in order to provide reproducible experiences for students. It may even substitute virtual patients (case discussions, simulations, CD-ROMS, and syllabi) for real ones. Patients languish on the wards wondering who their physicians are while their physicians discuss abstract patients in small rooms or play diagnostic games on the computer. Acting as a preceptor to second-year students, I discovered to my dismay that they gave up a physical diagnosis session to study for the written examination in physical diagnosis. Does this make sense?

Efficiency, in which patients are seen as 'work units,' also suppresses curiosity. One senior resident once presented a patient in morning report and, as part of the physical examination, mentioned a scar in the patient's groin. When I asked how the scar had been acquired, she said, 'he told me he was bitten by a snake there.'

'How did that happen?' I asked.

'I don't know,' she said.

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How could that be? How could one not ask? The imagination runs riot with the possibilities of how this man got bitten by a snake in the groin. But the resident was too busy (or not curious enough) to ask!

The sacrosanctity of print and the ancient human belief that what is written is more true than what is said suppress curiosity. A third-year student presenting a patient to me at the bedside told me that the patient had had 'BKA (below-knee amputation) times two.' Standing there, I saw that the patient had legs. I asked the student, 'did you find legs on your physical examination?'

'Yes,' he said.

'How then did he have bilateral below-the-knee amputations?' The student was confounded. He could not understand it. He was struck mute. He reached out and touched the legs: warm, hairy, clearly the patient's own and not prosthetics.

'I don't know,' he said.

'What makes you think the patient had bilateral below-the-knee amputations?'

'It said so in the chart.' We got the chart, and indeed, for this patient's past three admissions, 'BKA times two' was listed under history. It was only after looking at the past five admissions that the transcriptionist's error became clear. The patient had previously been admitted twice for diabetic ketoacidosis (DKA). But once typed, BKA became enshrined in chart lore and was repeated by every subsequent house officer as if it were true, even in the face of the evidence of their own senses.

Technology is wonderful and seductive, but when seen as more real than the person to whom it is applied, it may also suppress curiosity. When I was a house officer and installing one of the first right heart catheters, the machine that showed intrapulmonic arterial pressures was enormous and was equipped with strain gauges rather than computer chips. Making it work was difficult. After the line was in, the attending, the nurse, and I tried desperately to adjust the machine to show the pulmonary arterial pressure waves. We could not get them. The line on the screen remained flat. We manipulated the toggle switches for about fifteen minutes. Nothing. Finally, I glanced at the patient: He was dead. We had been so engaged with the machine that we had missed this significant clinical event, which explained why the pulmonary arterial pressures were unobtainable. We assumed that the answer to the question lay in the machine and explored no further until it was too late.

What is the reward of curiosity? To the patient, it is the interest and physical propinquity of the physicians, which is therapeutic in and of itself. To the physician, curiosity leads not only to diagnoses but to great stories and memories, those irreplaceable 'moments in medicine' that we all live for. When I was a young attending at San Francisco General Hospital, morning rounds usually consisted of briefly going over the 15 or 20 patients admitted to the team the night before and then concentrating on the 'interesting' ones. I was righteous and was determined to teach the house staff that there were no uninteresting patients, so I asked the resident to pick the dullest.

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He chose an old woman admitted out of compassion because she had been evicted from her apartment and had nowhere else to go. She had no real medical history but was simply suffering from the depredations of antiquity and abandonment. I led the protesting group of house staff to her bedside. She was monosyllabic in her responses and gave a history of no substantive content. Nothing, it seemed had every really happened to her. She had lived a singularly unexciting life as a hotel maid. She could not even (or would not) tell stories of famous people caught in her hotel in awkward situations. I was getting desperate; it did seem that this woman was truly uninteresting. Finally, I asked her how long she had lived in San Francisco.

*Years and years, she said.*

*Was she here for the earthquake?*

*No, she came after.*

*Where did she come from?*

*Ireland.*

*When did she come?*

*1912.*

*Had she ever been to a hospital before?*

*Once.*

*How did that happen?*

*Well, she had broken her arm.*

*How had she broken her arm?*

*A trunk fell on it.*

*A trunk?*

*Yes.*

*What kind of trunk?*

*A steamer trunk.*

*How did that happen?*

*The boat lurched.*

*The boat?*

*The boat that was carrying her to America.*

*Why did the boat lurch?*

*It hit the iceberg.*

*Oh! What was the name of the boat?*

*The titanic.*

She had been a steerage passenger on the Titanic when it hit the iceberg. She was injured, made it to the lifeboats, and was taken to a clinic on landing, where her broken arm was set. She now was no longer boring and immediately became an object of immense interest to the local newspapers and television stations- and the house staff.

For whatever reason- economics, efficiency, increased demands on physicians for documentation, technology, or the separation of education from patient care- curiosity in physicians is at risk. I believe it is our duty, as those who now teach young physicians, to identify medical students with a gift for curiosity and take infinite pains not to suppress but to encourage that gift. Not only will patient's care be enriched, but so will the lives of these physicians and the vigour of our art and science. Besides, it will be much more interesting.

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## What is your story?

The Universal Doctor is presented an example of the power of doctors' stories. We are seeking more stories from family doctors from around the world to contribute to a new edition on humanity, human rights and resilience. Please send your piece of writing (no more than 2000 words) to us for consideration for volume two to: [admin@medicalconsulting.com.au](mailto:admin@medicalconsulting.com.au).

Please also join 'The Reading Room' to share other great books and promote the title of your own book to <https://www.thereadingroom.com/Leanne%20Rowe>.



## Helpful books:

*First Do No Harm: Being a Resilient Doctor in the 21st Century*, by Professors Leanne Rowe AM, Michael Kidd AM

*Flourish: A Visionary New Understanding of Happiness and Well-Being*, by Martin E. P. Seligman February 2012

'*Keeping the doctor alive*' available from [www.racgp.org.au](http://www.racgp.org.au)

## Helpful websites:

Learn cognitive behaviour therapy skills for preventing and coping with depression  
<https://moodgym.anu.edu.au>

Beyond Blue: the national depression initiative  
<http://www.beyondblue.org.au/>

*Life Surfing Life Dancing* free ebook by Professor Grant Blashki  
<http://www.futureleaders.com.au/ebooks/life-surfing-life-dancing-ebook.php>

*Mindfulness Meditation In Everyday Life* Professor Jon Kabat-Zinn Open iTunes to download meditation exercises.  
<https://itunes.apple.com/au/album/mindfulness-meditation-in/id433982579>

Keeping your Grass Greener: Australian Medical Students Association and New Zealand Medical Students Association  
[http://media.amsa.org.au/publications/keeping\\_your\\_grass\\_greener\\_2011.pdf](http://media.amsa.org.au/publications/keeping_your_grass_greener_2011.pdf)

Canadian Physician Health Institute  
<http://www.cma.ca/living/centrephysicianhealthwellbeing>

Australasian Doctors Health Network  
<http://www.adhn.org.au/>

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## Biographies of authors

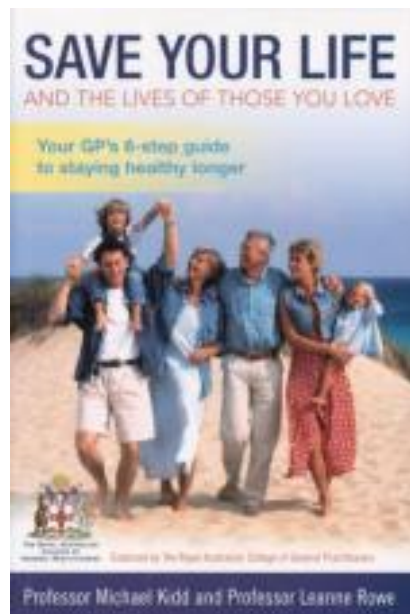
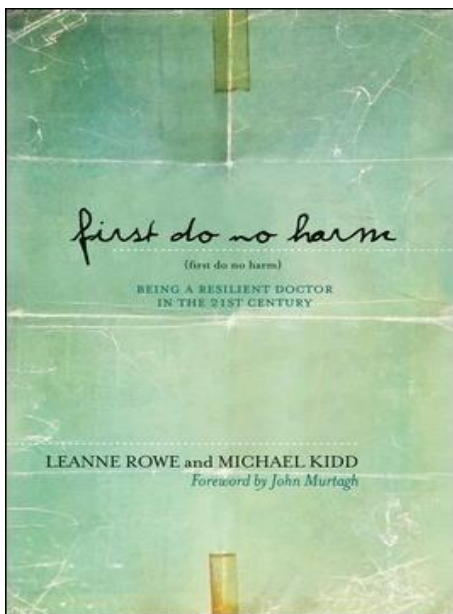
### Adjunct Associate Professor Leanne Rowe

Adjunct Associate Professor Leanne Rowe, is an Australian general practitioner, director of a number of health and medical boards, and past Deputy Chancellor of Monash University and past Chairman of the Royal Australian College of General Practitioners. She was awarded an Order of Australia for service to medicine.

### Professor Michael Kidd

Professor Michael Kidd, is an Australian general practitioner, Executive Dean of Medicine, Nursing and Health Sciences at Flinders University in Australia, President of the World Organisation of Family Doctors (WONCA), and a past President of the Royal Australian College of General Practitioners. He was awarded an Order of Australia for service to medicine.

Michael and Leanne have also co-authored '*First do no harm: being a resilient doctor in the 21<sup>st</sup> century*' published by Mc Graw Hill, and '*Save your life and the lives of those you love: your GP's 6 step plan for staying younger longer*', published by Allen and Unwin and available as ebooks on google play.



## Professor Ed Byrne

Professor Ed Byrne is currently Principal and President of King's College London and past Vice-Chancellor and President of Monash University. His past leadership roles include Vice Provost (Health) at University College London (UCL), and Dean of the Faculty of Medicine Nursing and Health Sciences at Monash University.

Professor Byrne, a neurologist, was a founding director of the Melbourne Neuromuscular Research Unit and the Centre for Neuroscience, and he was also a Professor of Experimental Neurology at the University of Melbourne in Australia. In 2014 he was named a companion of the Order of Australia for eminent service to tertiary education, particularly through leadership and governance roles with Monash University, to biomedical teaching and research, as a scientist and academic mentor, and as a contributor to improved global health. He is also the author of '*Transit Lounge*', a book of poetry recently published by University of Melbourne Press.

## Dr Donald Cordner

Dr Donald Cordner (21 January 1922 – 13 May 2009) was an Australian rules footballer who played with Melbourne in the Victorian Football League (VFL) during the 1940s.

Dr Cordner also played for Melbourne University prior to joining the VFL, studying medicine when not on the football field. Cordner made his debut for Melbourne in the 1941 finals series, playing in their winning grand final in just his second appearance for the club. Rarely injured, he played 144 consecutive games between 1942 and 1950. Dr Cordner was Melbourne's best and fairest in 1943 and was a Brownlow Medal winner in 1946. He was club captain in 1948 and 1949, the former in a premiership season. In 2000 he was named in the back pocket in Melbourne's official 'Team of the Century'.

Our highly respected colleague and friend, Dr Don Cordner passed away on 13 May 2009 at age 87.

## Professor Christopher Silagy

Professor Christopher Silagy AO (14 September 1960 – 13 December 2001) was an international advocate of evidence-based medicine and an evaluator of health care programs. He was Professor of Public Health and Foundation Director of the Monash Institute of Health Services Research at Monash Medical School in Australia. He was actively involved in supporting the development of the Cochrane Collaboration both in Australia (where he was director of the Australasian Cochrane Centre from 1994 to 2001) and internationally (where he was chair of the international steering group from 1996 to 1998). In the 2000 Queen's Birthday honours list he was made an Officer in the Order of Australia for service to medicine, particularly in the areas of research and education, and in developments in the field of evidence-based medicine.

Our highly respected colleague and friend, Professor Chris Silagy passed away at the age of 41 of Non-Hodgkin lymphoma.



## Professor John Murtagh

Professor John Murtagh is Emeritus Professor of Monash University and Professorial Fellow in the Department of General Practice, University of Melbourne. He is also Guest Professor at Peking University, Beijing and Adjunct Clinical Professor at the Graduate School of Medicine, University of Notre Dame, Western Australia. He is Senior Examiner-Australian Medical Council and Patron of General Practitioners Registrar's Association. He is the author of several internationally adopted textbooks including *General Practice, Practice Tips, Patient Education* and *Cautionary Tales*. Murtagh's *General Practice* has been translated into 13 languages and has been adopted by the Russian and Chinese Ministries of Health. He was awarded an Order of Australia for service to medicine.

## Dr Peter Goldsworthy

Dr Peter Goldsworthy worked for many years as a doctor in alcohol and drug rehabilitation in Australia. He has divided his time equally between writing and general practice, and he has won major literary awards across a range of genres: poetry, short story, the novel, in opera, and most recently in theatre. His novels have sold over 400,000 copies in Australia alone, have been translated into many European and Asian languages; *Three Dog Night*, won the FAW Christina Stead Award'; in 2003 his first novel *Maestro* was voted by members of the Australian Society of Authors one of the Top 40 Australian books of all time. He wrote the libretti for the Richard Mills operas *Summer of the Seventeenth Doll* and *Batavia*, the latter winning Mills and Goldsworthy the 2002 Robert Helpmann Award for Best New Australian Work, and a Green Room Award for Special Creative Achievement. *Maestro*, *Three Dog Night*, *Wish*, *Honk If You Are Jesus*, and the short story *The Kiss* have been adapted for the stage. *Honk* won the 2006 Ruby Award for Best New Work. The short film of *The Kiss*, adapted and directed by Ashlee Page, also won a number of prestigious awards. He was recently awarded an Order of Australia.

## Dr Ranjana Srivastava

Dr Ranjana Srivastava graduated from Monash University with a first-class honours degree and several awards in medicine. In 2004 she won the prestigious Fulbright Award, which she completed at the University of Chicago. She was admitted as a fellow of the Royal Australasian College of Physicians in 2005 and started practicing oncology in the public hospital system.

Ranjana's writing has been published worldwide, including in *Time magazine* and *The Week*, and in medical journals *The New England Journal of Medicine*, *Lancet*, *Journal of the American Medical Association* and *Journal of Hospice and Palliative Care Management*. In 2008 her story 'Ode to a Patient' won the Cancer Council Victoria Arts Award for outstanding writing. Ranjana's inaugural Melbourne Magazine column was featured in the Best Australian Science Writing of 2012. She has received a number of awards for her books 'Tell me the Truth' and 'Dying for a Chat'.

## Dr Hilton Koppe

Dr Hilton Koppe has worked as a rural GP since 1988, and an educator of family medicine doctors since 1997. In addition to this, he speaks at conferences and runs

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workshops on burnout and compassion fatigue prevention for health practitioners. In recent years, the focus for this has been on the use of creative writing in medicine.

## Dr Karen Hitchcock

Dr Karen Hitchcock is a general physician in a public hospital in Australia. She holds a PhD in Literature and is a writer of fiction and medical essays. She writes a regular prominent column for the *Monthly* magazine in Australia. Her collection of short stories *Little White Slips* won the 2010 Queensland Premier's Steele-Rudd award. Her contribution to the *Quarterly Essay*, 'Dear Life: On caring for the elderly' also received international and national accolades.

## Dr Justin Coleman

Dr Justin Coleman has worked as a general practitioner in Victoria, the remote Northern Territory and, for the past eight years, at Inala Indigenous Health Service, Brisbane in Australia. He has been a medical writer and editor for two decades and is President of the Australasian Medical Writers' Association. He has been published in around 25 Australian and international newspapers, magazines and journals. He is the author of two book chapters, three regular newspaper columns, and more than a thousand published articles. He has won various awards for his medical writing and for his fictional short stories and a play.

In addition to his medical degree (Uni of Melbourne, 1992) and FRACGP, Justin has completed a Masters in Public Health (Uni of Qld, 2009, first class honours) and a Writing and Editing course (Uni of Qld 2009, first class honours). Justin is a senior lecturer at both University of Queensland and Griffith University, and a member of the Queensland Health Clinical Senate.

## Dr Bill Bateman

Dr Bill Bateman is a dedicated Australian general practitioner, who has mainly practised in rural areas of Australia throughout his medical career. He writes a regular column for *The Australian Doctor* called *The Last Word*, and is currently writing his first novel.

## Dr Howard Goldenberg

Dr Howard Goldenberg is also a dedicated and long serving Australian general practitioner and the author of *"My Father's Compass, a Memoir"*, *"Raft"* and *"Carrots and Jaffas"* (Hybrid Publishers). Howard reads poetry, eats voraciously and is a bold experimental cook. He has run 43 marathons and 68 circuits of the sun. His late mother was proud of him.

*"Life is like a marathon"*, says Howard, *"an undistinguishing passage made rich by the encounters along the way"*. Howard blogs at [www.howardgoldenberg.com](http://www.howardgoldenberg.com)

## Professor Helen Milroy

Professor Helen Milroy is the Commissioner for the Royal Commission into Institutional responses to Child Sexual Abuse in Australia. She is a Consultant Child and Adolescent Psychiatrist and Winthrop Professor at the University of Western Australia. Commissioner

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Milroy has been on state and national mental health advisory committees and boards with a particular focus on the wellbeing of children.

Commissioner Milroy is a descendant of the Palyku people of the Pilbara region of Western Australia, and she was Past President of the Australian Indigenous Doctors Association (AIDA). She is conjoint award recipient of the World Council for Psychotherapy's Sigmund Freud Award 2011 for contributions to the field of psychotherapy. She was also 2011 Yachad Scholar.

Professor Milroy's work and research interests include holistic medicine, child mental health, recovery from trauma and grief, application of Indigenous knowledge, Indigenous health curriculum development, implementation and evaluation, Aboriginal health and mental health, and developing and supporting the Aboriginal medical workforce.

### Professor Faith Fitzgerald

Professor Faith Fitzgerald is an internist, and a professor of medicine and associate dean of humanities and bioethics at the University of California, Davis, School of Medicine. She earned her MD at the University of California, San Francisco, in 1969, was board certified in internal medicine in 1973, and has been teaching medical students and residents ever since. She has written on a wide variety of topics in medicine, including protean disease states, medical education, physical diagnosis and bioethics. She has received over three dozen teaching awards

### Professor Amanda Howe

Professor Amanda Howe was elected as WONCA President-Elect in Prague in June 2013. She will become the first woman to be WONCA President in 2016. She practises at the Bowthorpe Medical Centre in Norwich, England, has been Professor of Primary Care at the University of East Anglia since 2001 and was an Officer of the U.K. Royal College of GPs from 2009-2015. She feels very fortunate to have had so many life opportunities - as a family doctor she has often been aware that doctors live relatively privileged lives compared to many, and that our speciality is particularly important in addressing the health consequences of socioeconomic inequalities. Her poem was written in a dark winter's night while reflecting on the current refugee crisis across the Middle East and Europe - and other journeys.