People of the Whirlwind

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Job is everywhere we go,
His children dead, his work for nothing,
Counting his losses, scraping his boils,
Discussing himself with his friends and physicians,
Questioning everything—the times, the stars,
His own soul, God's providence.
—Archibald MacLeish (Ref. 1, p 13)

To minister to the suffering is the physician's great privilege. In an age of science and information, of industry and commerce, it is too easy to disregard the forging of the physician's craft, the mastery of the art. The wisdom of earlier times must be recalled. In 17th-century France, St. Vincent De Paul instructed the Sisters of Charity to "honour the sick and look on them as your masters" (Ref. 2, p 6). In 400 BCE, Hippocrates wrote: "The physician must . . . have two special objects in view with regard to disease, namely, to do good or to do no harm. The art consists in three things—the disease, the patient, and the physician. The physician is the servant of the art. . . ."[3]

But this art is not so inherently beautiful that we seek it preferentially. Better, of course, one should not stand in need of such art. As Twain quipped, "If ever I am deadly ill I hope you will stand by me and bar out the doctors and let me die a natural death."[4] Many would agree with him.

To be allowed, therefore, at the bedside of the suffering and the dying is a privilege. It is said that on his death bed, St. Vincent de Paul told a young Daughter of Charity, "Charity is a heavy burden. Heavier than the bowl of soup and basket of bread. . . . Giving soup and bread is not everything, the rich can do that. . . . It is only because of your love, your love alone, that the poor will forgive you the bread you give them" (Ref. 5, p 152). Physicians who would be forgiven their medicine might well heed the same advice.

In the wisdom literature of the Book of Job, dating back to somewhere between the seventh and fourth centuries BCE, Job's friends travel from their own homelands to comfort him in his suffering. On reaching him and seeing his condition they tear their robes and weep aloud, joining him in the dust: "They sat with him on the ground seven days and seven nights, and no one spoke a word to him, for they saw that his suffering was very great" (Job 2:13).[6]

The people I write about now are some of those with whom I have shared the dust. We have been together in a silence that has spanned time and space, and they are with me still, many years after our parting. They have come to my mind often, as have many others. I share now part of their stories, breaking only part of the silence. I fear doing little better than Job's friends when they finally presumed to speak. It is my hope to honor their being and their suffering in particular, without revealing their personal historicity. For the sake of striking that balance, I refer to them by first name pseudonyms.

Meg

Meg was the first patient to whom I was assigned to conduct a solo history and physical examination on my medicine rotation as a medical student. I was very anxious at the prospect of this responsibility of invading another person's privacy, especially knowing that there was little good that would come of it for the patient, given my level of training. I had nothing to offer her. Her actual doctors were the ones who could help her, who would bring knowledge and

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experience to the care of her problems. The experience was for my benefit primarily, although looking beyond my anxiety there was at least the prospect that this would be the first of a long series of encounters that would hopefully lead to real help being given to others. But not to Meg!

In part to assuage my anxiety, in part at least not to harm Meg, I had rehearsed over and over my questions, carefully writing them out on the notepad I would take to her bedside. I visualized each of the elements of the comprehensive physical examination, the one that rarely survives early training as we become more focused in our pursuit of physical data and more adept at dynamic hypothesis testing. But in this examination there would be no shortcuts; inexperience makes all things relevant. Poor Meg; she would endure the endless, fumbling investigation of the novice.

The time of our meeting arrived early one afternoon. I engaged the process carefully, deliberately; I hoped that my outer appearance would not convey the inner dialogue of anxiety, questioning, cautioning, and constant nagging not to forget what the next step was to be.

Meg was in the bed closest to the door. She was a young woman, with a pleasant face and a quiet disposition, dressed in a hospital gown, under the covers. She lay there quietly; no television, no book, no visitors. She did not appear to be in any acute pain. The rules of the encounter precluded access to her chart before my evaluation and written documentation. Otherwise, what use would this be as an experience of trying to discover by the encounter alone the nature of the medical problem? I took myself to the *tabula rasa* of our meeting.

Meg accepted with equanimity my introduction and explanation of who I was and why I was there. She displayed a sincere welcoming smile. But she did not express her inner state. Meg was nervous about being in the hospital, about being sick. She did not allow her anxiety to control her response to yet another of a long series of medical encounters in a teaching hospital. Thankful for her demeanor, I began my list of prepared questions.

She was in the hospital because her doctor had found a lump in her breast and suspected it was cancerous. She was to have tests and possibly face surgery, chemotherapy, radiation. None of that future was yet known. She knew the range of possibilities, though. The range included frightening prospects.

We were 10 minutes into the interview, and I was already shaken by Meg's reality. Not a promising start. I already wanted to do something to help her—share some knowledge, some experience, some comfort about her prospects. But even her experienced physicians could not do that yet; it was simply too early. It was that terrible moment when the disease process is acknowledged in all its destructive potential, but before there is a plan, a source of hope for recovery. It was the moment when fear has the stage. And I was in the moment of doing my first history and physical—not a position from which to offer comfort.

Not knowing what else to do, I acknowledged the difficulty of her having to wait for news and asked if she would mind if we went through all the rest of my questions. Meg was quite willing to do so; I figured it was at least a diversion from the thoughts to which she would otherwise be left.

We proceeded through the full history and review of systems, to which there were very few positive responses. She had been a healthy young woman, with no cares about her physical health until the routine examination by her doctor. So we moved to the physical examination.

I conducted the examination slowly, so that I could run the visualization in my head of how to perform each step and what step would then follow. I concentrated intently on what I was doing for fear of missing something. In my sensitivity to Meg's situation and her willingness to permit my gaining this experience, I was also intent on not taking any action for granted. Every movement followed a polite request, a softly spoken explanation. I examined her body gently, slowly, thoroughly—not, of course, with the thoroughness of experienced observation, only with the openness and searching of inexperience. Moving from less intimate examination to more intimate examination as I had been counseled, I conducted the breast examination at the end.

Meg had told me that the lump was in her left breast. I began with the right breast, again following textbook procedure. With my patient's guidance, I eventually thought I felt something in the left breast that was different from the surrounding tissue. But I knew that without her help I probably would have missed the finding. What else, then, had I missed? How worthless an examination had this been, I asked myself.

I gently replaced her gown and the sheets and took a step back from her. I thanked her for allowing me to talk to her and examine her. I told her how helpful it had been to me. I wished her well with her tests and the outcome and prepared to say goodbye to her, feeling somewhat useless and superfluous in the context of her situation.

But Meg sat up and looked me straight in the eyes. She thanked me for having spent so much time with her and for having given her such a thorough examination. She said she had never experienced an examination like that and that she was grateful for it. It had relieved her anxiety to have been examined so carefully and so gently. She felt better and wanted me to know that. Her smile had transformed slightly; it was indeed more natural now, more internal. She was not just trying to comfort me in my anxiety (although she did); she was being open and honest.

I thought about that experience for a long time that day and have thought about it many times since then. The physician's examination is not just data gathering; the doctor is not merely an instrument of probing. Even the mundane examination can be a moment of healing, mediated through respectful touch. I had merely hoped not to get anything wrong. But even my preoccupation with the details of performing the examination had not interfered with the human encounter. The mindfulness and presence of my efforts had allowed me to convey concern and respect, which were received as therapeutic in themselves. What I had worried was too long an intrusion was gladly accepted as time spent caring about the person.

Meg was a gift to me, and the teacher of a treasured first lesson.

William

It was the summer of 1983 when I began my internship at St. Vincent's Hospital in New York City. St. Vincent's is one of the enduring institutions of Greenwich Village and serves a diverse population in a setting that can be charming and boisterous, where people are crowded together among mostly small streets. St. Vincent's was established in 1849 when St. Elizabeth Seton sent four of her Sisters of Charity to New York. (She modeled her Order after St. Vincent De Paul's Order of the Daughters of Charity, establishing it in Maryland in 1809.) During my tenure at St. Vincent's, the position of president of the hospital was still held by a Sister of Charity. She once received me and my entreaties on behalf of a medical patient who I believed was being discharged prematurely because of an overzealous utilization review nurse in the days when managed care was the newest threat to caring. The patient stayed; the UR nurse apologized for her misplaced zeal.

My first rotation was on the medical service in one of the hospital's older buildings—well-kept, but with its odd corners and uneven rooms. Among my first set of assigned patients was William.

William was an actor, a young man in his prime stricken with AIDS. He was in the hospital being treated for the complications of his still poorly understood illness. He was in a private room where he could be isolated. Outside his room stood a stainless steel table with a pile of protective gear. To enter William's room, one had to don gloves, gown, mask, and cap. Each visit was like a space mission. AIDS was still mysterious and frightening then, evoking images of plague. It was not yet clear whether the disease could be spread by casual contact, so we wore protection. It was only two years earlier that the first cases had been described. During our clinical rotations then in Binghamton, New York, the medical students were rather urgently called into the x-ray reading room one day by the head of infectious disease to review a chest film indicative of this new disorder—the first patient in that community to be so diagnosed.

William was a handsome man, charming and witty, with a broad and warm smile and a cheerful disposition. He was not an anxious person; he had a confident presence, even amid the prospects of a frightening illness. He welcomed me graciously to his room and we quickly developed an easy rapport. I performed my necessary auscultations, checked the status of his thrush, inquired as to his comfort or needs, and then we talked. The latter is what we did mostly.

He told me about his acting career, about the theater in general. He laughed at its follies, but only in a humble self-examination of a craft he loved. He spoke of the gay social scene of the recent past. He shook his head bemusedly recounting the wild parties and the details of the sexual encounters. He spoke of his friends, some of whom he had already lost to this disease, others who were fighting it like him, others who were waiting their turn. It was a despairing time since no one had yet outlasted the illness,

and medicine had only its acute treatments of opportunistic infections.

William was in no denial about the gravity of his illness, but he did not dwell on these subjects. The world was a wonderful place to him and he held much interest in it. He wanted to talk about acting and wanted to learn about medicine. He was never at a loss for the next story to tell or the next question to explore.

He was alone in his room most of the time. It was too hard to enter his confinement casually; one had to choose deliberately to be there. There were no cheery greetings, no pillow-fluffing, no casual inquiries into whether there was anything he needed or wanted. The interactions were all carefully purposeful.

Before my rotation on that service ended, the Centers for Disease Control lifted its requirements for glove, gown, and mask for those visiting or working with patients afflicted with AIDS. Only certain procedures required such protections. But health care workers remained cautious and suspicious. The long-sleeved yellow gowns with their elastic wrists and the masks we wore over our faces and the gloves we wore to isolate our contact had been our protection against a deadly disease. They had become ritual symbols shielding us from our fears, or perhaps only containing them. And now they were to be abandoned.

But shields are not easily let down. I dropped mine with the defense of reason, trusting in the truth of epidemiology. Without orders to do so, I would not further isolate myself from the people I was called to serve.

William had never seen my face before nor felt the touch of my handshake. The stack of gear remained at his door, and others continued to use them even without the excuse of a medical procedure. But he and I sat and talked, face to face. He had the grace not to be critical of the protections or the shifting policies about their use. He just welcomed our continued meetings. Each new story began with, "Do you have another few minutes?" At some point, he would apologize for keeping me, and shoo me off in a good-humored way.

Among many other things, William was interested in music and literature and eastern philosophies, and palmistry. He had studied the latter quite earnestly and was genuinely interested in his daily visitor. So he asked if he could read my palm. Since I had not yet been schooled in the wariness of psychotherapy boundaries, I consented (although admittedly it made me a little nervous). He was holding my hand, examining it and forming his opinions, when a nurse appeared at the doorway with a rather forlorn and disapproving look on her face. William chuckled at her, dismissing her disapproval, permitting me to do the same. I do not recall all of his palmist formulation of my life, only the amusement he found in telling me that "money runs through your hands like water." There are still times today when my wife quotes William's comment to me, with much the same expression of amusement.

William never complained. He never bemoaned his fate, though the loss of his friends greatly saddened him. His frightening illness never diminished his living, his interest in being, or his exploration of the world and the people he encountered. He never cursed God or the universe. He went on living.

Ellen

In my next rotation, I was assigned to a more modern building of the hospital, one that evoked more science, and uniformity, and sterility, like many modern health care environments. What transformed that environment into a healing milieu was the tone set by the nursing staff. There patients received very human caring, and interns could learn a great deal about the art of medicine. It was there that I was introduced to Ellen.

I was on call the evening that a nurse called me to see Ellen. It was after visiting hours had ended and the floor was quiet. The nurse told me that Ellen was dying of her metastatic cancer and wanted to see a doctor. By her tone and the look of concern in her face, she conveyed that Ellen was quite close to death. She was in need of a physician's ministration. That's all I knew. And of course, I doubted whether my ministration was the thing she needed or that it could be helpful in any real way.

I introduced myself to Ellen in my standard manner, but already with a heightened sensitivity. Ellen was a young middle-aged woman. She was physically weak, but not outwardly scarred or debilitated by her illness. Despite her hospital attire and surroundings, she possessed an elegant grace and a calm, peaceful demeanor. Like the other persons by whom I had been touched in my early training, she welcomed me warmly, though weakly, inviting me to sit in the chair by her bedside. She thanked me for coming to see her, but stopped without offering a further complaint or request. After a moment's pause, I asked if

she needed something. Was she in pain? Did she need any medication? No, she was not in any great pain. She was just a little lonely, and a little frightened, and wanted to talk, if I wasn't too busy. Of course I wasn't, and so we talked.

She explained a bit about her illness and how she had come to be in the hospital. Her illness had raged quickly and too quietly through her interior. She had not been burdened with platitudes or false promises by her doctors; she knew she was actively dying. She did not rage at her death; she accepted it with quiet courage. But she was not ready to stop relating to other people; hence, her call for the anonymous doctor who was available.

Ellen did not want to dwell on her life or her illness. She did not want to be focused on herself in this end time. For some reason, she wanted to know about me: where I was from, who my family had been, why I had chosen medicine, why I was at St. Vincent's. She explored my attitudes about patient care, about people. She wanted to know how the work of training and the work of medical care affected me—whether I was the better for it or not.

This went on for some time, and I answered all her questions as well and as honestly as I could. We spent about an hour together. She was pleased with our conversation and had become absorbed in it, such that her questions and comments were filled with an energy that belied her underlying illness.

I, too, had enjoyed our conversation. I am normally not comfortable talking about myself this way and would never presume to do so with a stranger. I had merely followed the course of the path she set for our time together.

Ellen's final comment to me was, "You should write." I did not say anything, but my face must have expressed doubt or questioning, a nonverbal "huh?" "Yes, write. You should do it. You have to do it." She took my hand, and pressed, "Will you?" Yes, I assured her, not knowing how or when or what.

Then Ellen invited me to take my leave. She was tired, she said, and would go to sleep. We released our hands, exchanging mutually warm and tender smiles, and said goodbye.

Sometime in the early morning, the same nurse called me again to tell me that Ellen was now dying. I arrived at her room to see her unconscious, her skin marked everywhere with the bleeding out of her capillaries, her breaths sporadic and paroxysmal. The nurses had attached a cardiac monitor to her; her heart beats were also irregular. And they were slowing.

"What do we do?" I asked the nurse. Nothing. Watch and wait. The nurse taught me about agonal heartbeats. The beats would become slower still, and eventually stop. I sat on the edge of Ellen's bed, and picked up her hand again as I watched the monitor and her dying breaths. After a few minutes, I had to leave to attend to others. Less than an hour later, the nurse called me again to tell me that Ellen had passed and I had to come pronounce her death.

I knew Ellen for one hour of her life, for one hour of my life. She has been with me ever since. All these years later, I am finally keeping my promise to her, in my small way honoring her life and what she gave to me that summer night in 1983.

John

I call him John, but already that is a pretense. I did not know his name. I did not know him. John was a homeless man I encountered one day during my residency in psychiatry at St. Vincent's. I did not encounter him clinically. Nor did I even encounter him personally.

It was a sunny day in the spring, warm enough to be comfortable outdoors in shirt sleeves. I walked out of the hospital to get lunch at a little delicatessen on Seventh Avenue. John was sitting on the ground near the intersection of Seventh Avenue and 12th Street, his back up against the brick wall of the corner pharmacy. He was probably middle-aged, but looked older, his clothes layered and stereotypically tattered. He wore a crumpled hat and had long and unkempt facial hair. His head was down. He was not watching passers-by, nor begging for money. He had no cardboard sign asking for help. He was just sitting there, alone, on a busy corner. An angle of sunlight was upon him, with the sun now high overhead.

Another homeless person lying on the sidewalk. Another anonymous face in a sea of anonymity, but this one, like so many others, unengaged in the walk of life. It was not possible to face this every day without some feelings of guilt, but also not possible to be the Samaritan to each of these lost souls. One could only halfheartedly rely on the availability of various social services in the community to rationalize walking past these people each and every day.

Hours later, I once again had to cross 7th and 12th to go to my outpatient appointments in another building. John was still sitting there, in that same

spot. He must have had a tough night, I thought. And I went about my business of outpatient psychotherapy.

At the end of the day, I walked back across the street to the residents' lounge. John was no longer there. Another day sleeping in the sun on a busy sidewalk, another night to be spent wandering. A shame.

"Did you hear?" another resident greeted me immediately in the lounge. "That man was dead."

Many of us had seen him lying there all day. We all knew who "that man" was. There had been something different about him, but not so different that it prompted any attention.

John died alone, while hundreds of people passed by him, lying a hundred yards from the entrance to the emergency room of a fine medical center. While he suffered in his urban Gethsemane, we all slept in the busy-ness of our daily lives.

It was most likely a police officer who finally approached him. It might have been a brusque, "Hey, buddy, move along," or a gentler, "Hey, buddy, you okay?" There's no way to know. Neither is there any way to know what brought John to that state or what took his life.

What can be known is the terrible irony of John's death in the shadow of a great medical center founded for charitable care and the pain of knowing that I, and so many others, walked by him during his hour of death—and did nothing. It is a haunting knowledge.

Charles

A couple of years after completing my forensic psychiatry fellowship and beginning my career as an attending psychiatrist in our state's maximum security psychiatric hospital, I was led to do private work in a series of death penalty cases throughout the south. In each of these cases, I was retained by a death penalty resource center attorney in the phase of post-conviction relief, during which new attorneys with more resources at their disposal looked for errors and omissions in the original trials of individuals on death row. Often those omissions involved an absent or minimal investigation of mental health factors that might have mitigated the original sentence or, more rarely, warranted a new trial on guilt.

My first experience with this work was in one of the states of the "death belt." The prison was an old structure that held many hundreds of inmates. A guard escorted me through the labyrinth of corridors and steel gates leading to the death row section of the prison contained deep within its structure. After crossing more antechambers and passing through more security checks, I was brought into the cell block of death row.

This space was like a plate from Piranesi's etchings, *Le Carceri* (The Prisons).[7] Although this structure was more modern than Piranesi's 18th-century images of lofting and imposing stone dungeons, it had no less of its sweeping drama or foreboding chill. Row upon row of barred cells lay on top of one another, directing the eye upward. The cells were like open cages, stacked high to the ceiling. The noise inside was deafening, with one man shouting louder than the next to be heard by another. On the ground floor were some showers and a telephone, each enclosed by another cage of steel, each only slightly bigger than an upright coffin. When prisoners were allowed to shower or use the phone, they were brought out of their cells and placed in these locked enclosures, in full view and hearing of everyone else.

Off to the corner of this ground floor was a small, enclosed area huddled under a stairwell, with a single door. This was where I would conduct my interview. I was told that this was the area used for professional visits and for church services.

It was a dark room, with a damp cement floor. Water dripped from pipes overhead and found its way into gutters at the base of the walls. Around the walls were three old wooden benches. In the center of the room a single light bulb hung from its cord, the only illumination in this dank and windowless room. There were two old school desk chairs, the kind with the metal frames and the fixed wooden writing surface; on one of them, the writing surface was missing. I sat in the chair with the whole desk, took out my pad, and waited for the guards to bring Charles to me.

I had already read much of his history, gathered by his new law firm. He was raised in squalor in a vermin-infested home with no plumbing, where human excrement littered the floor. His mother was severely disturbed psychiatrically and drank alcoholically. Her behavior toward him was bizarre and frightening.

Charles was drinking beer by his grade school years and using marijuana and LSD before grammar school. He was seriously abused both within and outside of his home. By the time he reached adulthood, he had learned to stay drunk or high most of the time.

He arrived with a guard, without shackles. The guard directed him into the room, closed the door and took his post on the other side. Charles was a thin man with long hair and beard, dressed in his own street clothing, looking older than his years. He greeted me pleasantly and remained friendly throughout our meeting, though not really connected to our encounter. He was permitted to smoke in this setting, which he did nearly continuously.

What animated Charles were his beliefs, which were grandiose and delusional. He interpreted ordinary and unrelated events as bearing special significance for him. He believed he had special powers and expressed beliefs in his own divinity or holy-man status. He was not easily diverted from his own rambling ideas and preferred them to answering specific questions about his life and actions. He had little interest in his imprisonment or death sentence; he believed he would be delivered from these forces in a kind of apocalyptic victory.

In his many writings, he referred to scripture repeatedly and incoherently with great passion and conviction. He spoke fervently of God's power and wrath, which would right all injustice. Chapter and verse references from the Bible were scattered about the pages of his letters without connection or explanation. When he did draw inferences, they were thoroughly idiosyncratic and illogical.

Charles was clearly suffering from a serious mental disorder. The weight of collateral informants and court transcripts confirmed the span of this disorder through the years back to his trial, arrest, and the years before.

Even with all the evidence of his long-standing psychosis, he was treated as if his decisions to reject his attorneys' advice through many court proceedings were made knowingly and intelligently. None of the evidence of his mental condition brought any relief from his death sentence.

Charles was a man of God, trapped in his own private and psychotic religion. He was a man who had had next to nothing all his years. He did not rail against his imprisonment, nor did he question God's judgment. He knew that God would deliver him.

Charles was like Job turned inside out, a man whose suffering was obvious to others, but mostly hidden from his own perception. Officially, that suffering was counted as irrelevant and without meaning.

Epilogue

Elihu enters the story of Job at its end. He is impatient and angry with Job and his friends: the former for pressing his claims against God, the latter for their inability to comfort Job with any true answers to his suffering. But through six chapters of further speech, Elihu seems to do little better. At the end of his monologue, Elihu announces to Job, "The Almighty—we cannot find him" (Job 37:23).[6] That point having been established, God makes his appearance:

> Then the LORD answered Job out of the whirlwind. . . (Job 38:1).[6]

But as frustrating as a psychotherapist, God answers Job's questions only with more questions:

> "Where were you when I laid the foundation of the earth?
>
> Have the gates of Death been revealed to you, or have you seen the gates of deep darkness?
>
> Where is the way to the dwelling of light, and where is the place of darkness, that you may take it to its territory and that you may discern the paths to its home? (Job 38:4,17,19–20).[6]

As Daniel Berrigan has interpreted this passage, "God rejects every attempt on the part of humans, even the most favored, to win a clue as to the divine Intent. Job, for all his dogged virtue and forbearance and fidelity, is granted no exception. Nor are we." (Ref. 8, p 313).

In the face of the unyielding mystery of suffering, Job's friends retreat to the comfort of their religious orthodoxy. In medicine, we often retreat to the orthodoxy of our science, which holds no more satisfactory meaning than the rhetoric of Job's counselors. We must recall that all who suffer are people of the Whirlwind. Those who minister to them must do better than Job's friends. And they must be forgiven their ministry.

> *Blow on the coal of the heart*
> *And we'll see by and by. . .*
> *We'll see where we are.*
> *The wit won't burn and the wet soul smoulders.*
> *Blow on the coal of the heart and we'll know. . .*
> *We'll know. . .*
> —Archibald MacLeish (Ref. 1, p 153)

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