Albert Schweitzer, William Carlos Williams, and Managed Care

In this narrative I try to describe the influences, such as Albert Schweitzer, William Carlos Williams, Harold Johnson, and others, that shaped my medical career, my thinking, my poetry—and my perspective on primary care and medical education. The central themes of my narrative reflect on the importance of scientific thinking, patient-physician relationships, and empathy, gentleness and self effacement as core values in medicine, both in caring for patients and promoting a collegial work environment. The narrative examines my understanding of the current cynicism about the future of medical virtue; and I hypothesize that the rapid changes in the medical system within the 1990's in the long run may be beneficial for the future of generalist practice and human values in medicine.

by
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Martin Kohn asked me, first, to identify the persons and situations that influenced me to become a physician and, in particular, to choose a generalist career. Secondly, he asked me to consider whether (and in what ways) these action-guides might be relevant to today's medical students and young physicians. The project also required me to attempt, at least, to avoid nostalgia, a difficult task because epidemic nostalgia is sweeping American medicine. We are being devastated by an especially virulent form of nostalgia that attacks physicians of all ages, rather than just the old and infirm. The clinical syndrome includes an almost irresistible desire to romanticize the past while complaining about the rapid changes in health care that threaten to destroy our profession. Therefore, be cautious. If you encounter even a suggestion of nostalgia in the following pages, proceed at your own risk.

Albert Schweitzer

Reminiscence

I find it easy to identify action-guides from medical training and later (although they don't necessarily point toward generalist practice), but it is much more difficult to pinpoint how I wound up on the doorstep of medical school in the first place. My childhood and adolescence are notable for the lack of any personal experience with physician role models. I completed college without ever having volunteered in an emergency room or hospital. As far as I'm aware, I never had a sustained conversation with a physician about anything. Given that record, a medical school admissions committee today would almost certainly question my motivation and maturity, no matter what my grades were. Since I loved literature, and wrote and published poetry in college, a hypothetical career counselor would

likely have pegged me for graduate study in English.

How then did I choose medicine? As far as I can tell, my first role model was Albert Schweitzer, who entered my adolescence via books and television. In the late 1950's Schweitzer was the Grand Old Humanitarian of the world. He immediately appealed to me because he was a Renaissance man, a man who had the energy and creativity to excel in a multitude of fields—philosopher, theologian, musician, musicologist, physician, and humanitarian. As a teenager in Uniontown, Pennsylvania, I visualized myself by day working at Schweitzer's side in the jungles of Gabon and, in the evening, listening to him play Bach chorales under the African sky. I was infatuated with the romance and intensity of his life. I remember reading (although, in retrospect, with virtually no understanding) his early theological masterpiece, *The Quest for the Historical Jesus*, and struggling with his concept of "reverence for life" in *Civilization and Ethics*. Schweitzer's work ranged from the theoretical to the practical, from the abstract world of ideas to the concrete world of human suffering, from the security of church and university to the risky life of a missionary doctor.

Later, in college I learned about existentialism and read the novels of Camus and Sartre. Dr. Bernard Rieux in Camus' *The Plague* provided a second powerful medical image for me. Here was another man who devoted himself to duty in the face of insuperable odds, who was a humanitarian as well as a physician. Like Schweitzer, he practiced in a distant, mysterious place. Unlike Schweitzer, however, Rieux struggled to affirm life in the context of a chaotic, meaningless world, rather than as a corollary to religious faith. As a young man in the early 1960's, I was keen on creating meaning out of meaninglessness.

In the fourth year of medical school, I spent several months in Jamaica working with Harold Johnston, an elderly Jamaican physician who, in his retirement, had started a new career as the public health officer for his home parish. In his earlier life, Dr. Johnston had been a university physician who spearheaded the campaign to eradicate yaws, a spirochetal disease related to syphilis, from the Caribbean region. This was an accomplishment for which Queen Elizabeth awarded him the Order of the British Empire. Harold Johnston was also a preacher in the Seventh Day Adventist church, a vegetarian, and, most provocatively, a man with a mysterious past. In the long (and very boring) Jamaican evenings we spent at Dr. Johnston's house, my wife and I would construct romantic stories to explain how he came to have a distinctly non-religious tattoo on his right forearm. We imagined our mentor's days as a Jamaican medical student in Edinburgh and, even earlier, his entirely fictional life as a hard-drinking sailor.

My feelings of love and admiration for Dr. Johnston were mingled with more ambiguous feelings—frustration, impatience, anger, and a deep sense of inadequacy. Living and working with such a person was more difficult than I had imagined. I liked to eat meat, for example, and listen to rock-and-roll. I found myself complaining that he was too generous, too uncompromising, and too free with good advice. I was concerned about whether we would get good enough data to warrant publishing a paper, while he seemed to feel that rigorous design was unimportant. Interestingly, Dr. Johnston (like Albert Schweitzer) was a reserved, austere, and rather distant person, a man who in some ways never quite "fit" into the community he served.

Another important influence was the atmosphere of social activism in the late 1960's and early 1970's. I attended college and medical school during the peak of the American Civil Rights Movement, which later blended into the anti-Vietnam War Movement during my clinical years and post-graduate training. Annually at the University of Pittsburgh the fourth year medical class put on a musical satire, which in my year was called *Medic Hair* after the popular Broadway musical *Hair*. We were convinced that the Age of Aquarius had begun and we were about to remedy poverty, racism, and poor access to health care in America. We were imbued with a sense of energy, commitment, and "can do."

While our parents had failed the poor and become addicted to materialism, we were not going to follow in their example. While they had started the war in Vietnam, we were going to stop it.

The social activism of those years also contained the seed that grew into the "personal fulfillment" movement. Flower children throughout the country were dropping out, smoking dope, using acid, and experimenting with various peace-and-love lifestyles. During my internship at the University of Pennsylvania, some close friends decided to leave their university jobs and join a commune in Colorado. I remember feeling a bit ashamed (and definitely defensive) when I explained to them that, instead of joining a commune, I was planning to study public health and then practice medicine on an Indian reservation in the United States Public Health Service. They told me that by working for the government I would be compromising my principles and selling out. They were convinced that any attempt to "do good" within the system was bound to fail. Their solution was to seek personal growth and fulfillment as part of a small community of like-minded people. For some time I questioned whether my decision not to drop out was really in the service of some ideal, or simply represented a lack of courage.

I also encountered another, less idealistic, set of influences in medical training. At the University of Pittsburgh there was little or no exposure to primary care or generalist role models. Family medicine was in its infancy and not yet represented in Pittsburgh. The faculty was hostile to general practice, which it considered to be an inferior craft, lacking dignity and intellectual bite. Internal medicine held sway as the sine qua non of the medical profession; it still seemed possible to become a "compleat physician" in the image and likeness of Sir William Osler. However, it seemed that academic physicians had in-

terpreted the generalist dictum of "treating the whole patient" to mean understanding how all the organ systems function together, rather than approaching patient care from a biopsychosocial perspective. In Pittsburgh Dr. Jack Myers, the Chief of Medicine, exemplified this approach. To me Myers was a frightening man—sharp, arrogant, insensitive, but awesome in his knowledge of pathophysiology and differential diagnosis. Known throughout the country as "Black Jack" because he so often flunked candidates in their oral Board examinations, Myers was truly a master of his profession. That profession, however, was definitely not the day-to-day work of caring for patients. Nor was it necessarily the work of nourishing medical trainees. Jack Myers frequently intimidated and humiliated his students and house officers. Yet, to have a good recommendation from him might well serve as a ticket of admission to the best residencies in the United States.

Perhaps because I was so timid myself, I found this man's supreme self-confidence tantalizing. I went to him with my professional quandary: Should I proceed to become a public health physician? Or should I go into psychiatry, a course that also held a somewhat hypnotic attraction for me? (I was an avid reader of Freud and his followers as well as of Schweitzer.) In any case, "Black Jack" convinced me to finesse the quandary by applying for a residency in internal medicine. He told me internal medicine would be the best basic training, given the uncertain direction of my future plans. Since he considered me bright enough to join the "club," he cautioned me to apply only to highly rated university residencies.

At the Hospital of the University of Pennsylvania where I was an intern the following year, fascinomas like Churg-Straus syndrome and Goodpasture's disease were the stuff of everyday practice. Primary care was performed by "local medical doctors," a strange breed of wannabes who lived outside the walls of the hospital and constantly made mistakes. My colleagues at Penn were mostly "Young Turks," anxious to become a new breed of scientific specialists. Many of them have subsequently become re-

spected figures in American medicine. While I enjoyed caring for my patients in the hospital, I never waxed romantic (then or now) about the long hours, low pay, and barbarous working conditions. In fact, during much of that internship year the most exquisite part of my day was the 14-block walk from my apartment to the hospital, during which I fantasized escaping from Philadelphia with my wife and journeying together in exotic countries.

I was so conflicted and uncomfortable at Penn that I chose to leave before completing the standard three-year residency. This required taking a stand before an incredulous residency director, a younger, smoother version of "Black Jack," who told me I was making a serious mistake. They were unlikely to take me back, he said, when I finally realized the error of my ways. With this encouragement, I went on to study at the School of Public Health in Pittsburgh. There I met plenty of epidemiologists and planners, but again, no generalist physicians. After another two years, though, and in the absence of real-life role models, I found myself practicing primary care at the Public Health Service Clinic on the Navajo Reservation at Lower Greasewood, Arizona.

Let me skip ahead about twelve years to identify two additional action-guides. By this time I was a faculty member at the University of Pittsburgh, facing the personal and professional conflicts that often arise when you reach your early 40's. My interest in creative writing, especially poetry, had never disappeared, but had long lain dormant. The most I ever did was compose a snappy verse for a friend's birthday or to cheer up my wife when she had her wisdom teeth extracted. I also found myself progressively depressed.

One of my patients at the time was a poet named Rosaly Roffman. Through a mutual friend, she learned that I once wrote poetry; each time Rosaly came to my office, she asked to see some of my old poems. Each time, I declined because I was convinced that it would be unprofessional to share something so personal with a patient. Nonetheless, it was tempting. Inexplicably, after a few months, I took the risk of acting on my feelings and showed her a stack of old poems. This was the beginning of a mentoring relationship that lasted several years. Rosaly and I developed a kind of quid pro quo arrangement in which I provided medical care ("professional courtesy") in exchange for her services as a teacher. She gave me assignments—for example, Write a poem about the brother you never had—and then we would meet to critique my work. For me these were extremely painful sessions. How dare she trash my wonderful lines! Doesn't she realize how good this is? But the discipline and pain released a flood of creative energy. The stuff really was bad, but her gentle prodding drove me to make it better. Under Rosaly's tutelage, I became a working poet.

Many of the poems gave voice to a dimension in patient care that I had felt for some time but could never articulate. I felt that being a poet made me a better doctor. My model for this point of view was William Carlos Williams, who said that for him poetry and medical practice were inextricably linked. I read Williams' poetry, but found only a portion of it to my taste. Many other modern poets were more compelling. But Williams' life was another matter. I romanticized it, not only the synergism between medicine and poetry, but also the theme of under-appreciation. Williams had little time to spend on the literary scene because of his busy medical practice. His poetry sold poorly (even for poetry!) and was unappreciated by most critics. Yet, he continued to plug along until eventually he won renown as one of the leading poets of his generation. If this happened to Williams, my romantic fantasy went, perhaps it could also happen to me.

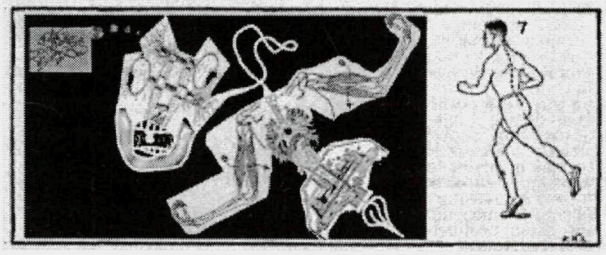
Reflection

Now I need to consider what value, if any, these action-guides could have for today's medical students or young physicians. In thinking about this, I run into considerable resistance. First of all, there is the general problem of drawing morals or lessons from past experience—the lessons are often boring and self-important. My tendency is also to present romantic "takes" on some of them—Albert

Schweitzer, Harold Johnston, and William Carlos Williams, for example—and to minimize the complexities of their lives and influence. As a writer, I suspect the most interesting approach would be simply to tell more stories about them and let the reader do the reflecting.

The second problem has to do with the recent revolution in how medicine is practiced in this country, which leads to the managed care objection. By the "managed care objection" I mean the current cynicism about the future of medical virtue and the belief that human values in medicine have succumbed, or soon will succumb, to corporate greed. Nowadays, physicians tend to argue that patient-physician communication and relationships were relatively good until a few short years ago when corporate scoundrels invaded medicine and started to squeeze the humanity out of our profession.

That is simply not the case. In fact, if you consider patient-physician relationships the heart of medicine, our health care system has been suffering from progressive heart failure for more than a generation. The changes in the structure and function of medical schools that began in the 1950's with the establishment of the National Institutes of Health and the growth of medical schools as research institutions led, as night follows day, to the contemporary landscape of fragmented, sub-specialty practice. The decline of primary care and, with it, the general deterioration of the physician-patient relationship as a therapeutic tool were unintended consequences of these developments. Long before today's managed care mania, physicians were already spending too little time with their patients, the public was already dissatisfied with medical care, and levels of trust and cooperation were already low. These features, combined with skyrocketing costs (another unintended consequence of subspecialization), led to the demand for dramatic changes in health care delivery.



To counter the managed care objection, I'll go out on a limb and say that the rapid changes we are experiencing in the 1990's may in the long run be beneficial for the future of generalist practice and human values in medicine. In fact, I think shock therapy was necessary. Many features of current for-profit managed care pose serious challenges to the ethical practice of medicine, challenges that will be difficult to resolve, but medicine's need to address these problems may also provide the impetus to refurbish professional values. In the hope that it does so, I want to argue that Schweitzer and the others have something important to say to 21st century physicians.

I would definitely not recommend that future physicians neglect, as I did, getting hands-on experience of medical practice before applying to medical school, nor that future generalists embark on their careers without having good generalist role models. There are also other ways in which my career departs from the "normal range." Over the years my professional interests have developed, partly by accretion and partly by substitution, from public health to epidemiological research, from medical pedagogy to clinical ethics, from patient-physician communication to confessional poetry. Nevertheless, I tend to view all these interests as relevant to my career as a primary care physician. Most academicians would call this variety a terminal lack of focus. I choose to see it as a voyage of self-discovery, but there is no question that embracing so many fields has academic and emotional drawbacks. If I were counseling a young academic generalist, I would encourage her to follow her interests, but caution her against being too diverse. I'm convinced that part of my field hopping resulted from a failure to recognize (or to act upon) what I later realized were passionate beliefs about the relationship of healing, empathy, and poetry. I would try to help the young generalist to be more reflective earlier in her career and perhaps more courageous in acting on her intuitions.

I'm delighted that Albert Schweitzer was the first action-guide who came into my mind.

Although I hadn't thought specifically about him for years, he quickly emerged as the prime candidate for Ur-role model. I've more often reflected and written about Harold Johnston, whom I still consider the "saint" of my early life. Likewise, for better or for worse, Jack Myers is burned into my consciousness as the archetype of the Chief of Medicine. William Carlos Williams has the distinction of being the only one of these action-guides whom I actively sought out; the others simply appeared. These men shared certain qualities. They were strong and fiercely independent. They were steadfastly committed to their distinctive visions. They set their sights on higher goals than "money practice," to use an interesting term Williams coins in his autobiography. Each in his own way was an imaginative and creative person.

One characteristic shared by Schweitzer, Johnston, and the activist milieu of my early medical experience was that a life in medicine could make a difference. By "difference" I don't mean the obvious fact that a physician will help his or her patients get well, but rather that a life's work in medicine may ultimately contribute to the improvement of the community and society in general. They believed that medicine could facilitate social justice and that physicians had a duty to devote themselves to that project. Since the 1960's, the growth of medicine as a "money profession" and our general loss of faith in social action have tended to suppress such beliefs. Perhaps many physicians today would like to speak up for their patients or to work toward making medical care more equitable, but they feel helpless. They see themselves as caught in a web of managed care bureaucracies over which they have little or no control. Other physicians have their activism stunted or blocked by the sense of entitlement they developed in the culture of the 1970's and '80s. Unfortunately, persons who entered the profession during the last 20 years, no matter what their initial motivation was, have practiced medicine only in a high income-low risk environment.

The Schweitzer-Johnston ethic presents a challenge for young physicians entering today's managed care environment. What would either of these men do if faced with the realities of contemporary American medicine? I am absolutely sure that they would not feel helpless. On the contrary, they would pursue courses of moral activism, although it would be risky and uncomfortable to do so.

Nowadays we have grown leery of virtue. Not long ago I was discussing Albert Schweitzer with a physician friend in Kansas City. He immediately threw up his hands and his face turned sour. "Why that man was a total fraud," he exclaimed. "You wouldn't believe how dirty his hospital was. He didn't even believe in germs." He went on to tell me what a racist Schweitzer was. Granted, Schweitzer's hospital was not the most antiseptic place in the world. This was partly because of his "reverence for life" philosophy and aversion to unnecessary killing, even of insects. It is also true that he was sometimes a distant, irascible, and paternalistic man. I think these features reveal the complexity of his character and make him more interesting. They may puncture a hole in his sainthood, but they certainly don't make the man a fraud. Schweitzer's virtues are no less worthy of emulation just because he also had weaknesses. I suspect our passion to discover everyone's innermost weakness is simply a defense mechanism to avoid feeling like we ought to emulate his or her virtues.

Let me move on to "Black Jack" Myers. I can frame his influence on me in positive ways; for example, he was a champion of clear thinking in medical decision making. Early in the era of multiple and excessive diagnostic testing, Dr. Myers was a strong spokesman for clinical reasoning based on observation and logic. In light of what has happened to medicine in the ensuing 25 years, I can fully appreciate his distinction between true scientific thinking and the mere application of technology, which, even in the late 1960's, he claimed was damaging the quality of medical care. Long before the term "Evidence Based Medicine" was

coined, Jack Myers insisted upon it. He was also a champion of the general internist, as modeled along the lines of Sir William Osler. Had physicians through out the country adopted Myersian logic, subspecialization and the costs of health care would have increased much less rapidly. Another positive influence was the power of his role as teacher. It's quite possible that Jack Myers' teaching skill made me realize how much influence a teacher could have and may be responsible in part for my choosing academic medicine as a career. His uncompromising adherence to his own vision of medicine was another admirable trait.

What fascinates me more, however, is Jack Myers' counter-influence, specifically my strong conviction—perhaps formed by reputation even before I met the man—that the way he behaved with students and staff was unacceptable. I could never really believe that he cared about the whole patient when he seemed to care so little about the whole student. Paradoxically, my time with "Black Jack" served as an important background to my thinking as I came to see that empathy, gentleness, and self-effacement were core values in medicine, both in caring for patients and in promoting a collegial work environment. Later, as a young faculty member at the University of Pittsburgh, I went to Jack Myers to ask if he would present several sessions in the new Clinical Skills course that I was directing. By that time he had retired from the Chairmanship of Medicine to work on an artificial intelligence system, a powerful aide to diagnostic reasoning which he hoped would ultimately cover all of internal medicine. He was gracious and helpful and, of course, wonderfully impressive in his lectures. Nonetheless, my 1968 image of "Black Jack" humiliating his medical students remained. I can sum up his influence in three words: logic, discipline, and distance. I have tried to embrace the first two and reject the third.

What can I make of William Carlos Williams and Rosaly Roffman as influences in my professional life? One simplistic way of looking at this is to draw a lesson about cultivating interests outside of medicine by stating that physicians should be humanistic and well rounded. However, "interests" is a weak word, which does not capture the importance (to me and potentially to others) of the Roffman-Williams phenomenon. It is not a question of simply diversifying your interests, or of finding alternative ways to let off steam. Nor is the subject important—I can imagine another physician getting turned on by a jazz musician, carpenter, or priest.

The important issue is that I was a 40-plus year old man who unexpectedly experienced a new direction in life. The new direction asserted itself against considerable resistance. (Otherwise, it would have probably arrived a lot earlier.) Like most physicians, I value being in control—being on top of situations, minimizing risk, maximizing efficiency. This style promotes organization and detachment, which in many ways are valuable traits but are not particularly helpful for personal growth. I can't articulate why I was finally able to let down my defenses when Rosaly Roffman pestered me about showing her my work. In retrospect, it seems clear that the desire to make poems is a part of me that should not have been suppressed. Poetry became an avenue of self-discovery. In fact for me, writing poems is a type of centering or meditation. I'm grateful that poetry opened new horizons for me. Others will find their avenue to self-discovery elsewhere.

I'm not sure what will happen to medicine in the next 25 years, but I think the profession will look a lot different than it did circa 1980 or 1990. To me this isn't a dire prediction because many of the virtues we associate with medicine—compassion, integrity, courage, and fidelity, to name a few—are currently practiced more in word than in deed. We have compassionate and courageous physicians, but not enough of them. The profession as a whole these days seems (at least to the public) less than compassionate, less than courageous. Clearly, we are going to need a new breed of doctor. Strange though it may seem, as a result of today's health care revolution, stories like those of Albert Schweitzer, Harold Johnston, Jack Myers, and William Carlos Williams may end up having more, rather than less, relevance to young physicians than they did a generation ago. □