Fiction as Resistance

I was a writer before I was a doctor. From an early age I was concerned with suffering and understanding, and I often turned to stories for solace. I loved stories long before I knew they were an essence of good doctoring—shared stories that bring solace, understanding, and healing to others. During summers in high school and college, I worked as a toll collector on the Rip Van Winkle Bridge, and I asked for the midnight-to-eight shift so that I could read. I remember two summers when I went through all the Russians, in those pre-dawn, quiet moments in my warm booth over the Hudson feeling a sense of connection with Dostoevsky, Tolstoy, Chekhov, and Turgenev. Love and death. My early answers to the question, "What is healing?" came from these stories. I still have a piece of an envelope on which I copied part of a letter Chekhov wrote to an editor who had criticized his story "Ward Number Six": "The best of writers are realistic and describe life as it is, but because each line is saturated with the consciousness of its goal, you feel life as it should be in addition to life as it is, and you are captivated by it" (1).

Life as it should be in addition to life as it is. Without realizing it until many years later, this would become the motor of my writing.

I began writing in 1966 when I was a Rhodes scholar at Oxford University. I viewed my time at Oxford not only as a chance to continue my fascination with science—the function of the brain in learning—but also to try to become a writer. I enrolled in a Doctor of Philosophy degree in physiology that aimed to decipher the neurophysiology of memory, but the experiments of which boiled down to a daily challenge of teaching cockroaches to lift their legs. I also started writing—plays, poems, and short stories. Almost 3 years later, after one of those fateful 1960s' road trips to Morocco over Christmas of 1968 involving camel auctions, olive harvests, belly dancers, *kif,* and a fateful meditation at an oasis of copper sulfate and date palms in the Sahara called *Le Source Bleu de Mesqui*, I returned to Oxford realizing that I didn't want to be a scientist, I wanted to be a writer. Unfortunately, my draft board disagreed. I wasn't ready to become an expatriate writer, and so I faced the choice between Vietnam and Harvard Medical School. I realized that if I depended on my writing for my livelihood, I wouldn't be able to write what I wanted—I'd probably wind up in television or film. I chose Harvard. Medicine would be my meal ticket. Somehow I would find a way to write.

From the start I loved the stories I heard, from both the patients and the few humane doctors I met. I loved surgery, but where to find the time to write? When I took my first psychiatry course—taught by a great man named Leston Havens—I woke up. The stories of the psychiatric patients were outrageous and astonishing. I have notebooks filled with verbatim sessions, with ballpoint-pen sketches of patients in the wards. Maybe I would be able to understand people better, understand suffering, widen my scope, learn how to help people heal—and I'd have mornings free to write! Sign me up!

When I graduated from medical school in 1973, one wasn't required to do a medical internship to be a psychiatrist. But as a writer I had to experience it, and I wanted to learn how to really take care of people. Little did I know that the experience of being an intern would light the fire in me to write my first novel, *The House of God*.

Writing got me going and demanded I do an internship; my internship sparked my birth as a writer.

What Is Resistance?

I used to think that at any given point in my life I was fairly well aware of what was going on and that I was making informed choices about what to do. As I've grown older I've come to realize that, in fact, it's only later, maybe 10 years or so later, that I can see I had little or no idea of the unseen historical forces shaping me, which pushed me one way or the other. And so it was with my internship in the Beth Israel Hospital in Boston in 1973–1974, the Nixon–Watergate year.

I and my core group of fellow interns were products of the 1960s, brought up on the civil rights movement and the Vietnam War. We believed that if we saw an injustice, we could organize, take action, and change things for the better. Our generation put the civil rights laws in the books and stopped the Vietnam War. When we entered our internship, we were told to treat our patients in ways that we didn't think were humane. We ran smack into the conflict between the received wisdom of the medical system and the call of the human heart.

It was a series of moments—which I now call "*Hey wait a second!*" moments—those moments many of us experience every day when we see, hear, or feel that something is unjust, cruel, militaristic, or simply not right. We usually let these moments pass. We do nothing to resist them. But the moments came so fast and furious in the internship, they could neither be ignored nor passed by. We had been brought up to notice, to take "life as it is" and turn it on the spindle of compassionate action to make it more like "life as it should be." This is resistance.

And so we resisted. We actually did. We stuck together and used classic, nonviolent methods—including humor—to resist. Not that there weren't casualties. Some interns got suicidal, many got depressed, and a few went through transient psychoses. But we secretly treated people humanely.

I was not aware at the time that we were actively resisting the inhumanity we were immersed in. Nor was I aware of what happened in me next: I turned to fiction as resistance. I started to write *The House of God* for catharsis,

to share with my buddies what had been the worst year of my life. I didn't even think of getting it published at first, but one thing led to another, and after seven rewrites it was, in 1978. I was so naive that I thought just about everyone would like it—after all, I was just telling the truth, with some art. The art part was inadvertently what Wallace Stevens, echoing Chekhov, had suggested that art can at best do, "things as they are are changed upon the blue guitar" (2). Until that time I had never known that I could write "funny." Yet I realized that the year had been so brutal that the only way anyone would want to read it was if it rode on humor—much as we interns had used humor to get through the actual experience. To paraphrase an apocryphal story attributed to George Bernard Shaw: "If you tell the truth, make 'em laugh, or they'll kill you." Little did I know how radical my novel was and the backlash it would create.

Resistance to What?

Simply put, to brutality and inhumanity, to isolation and disconnection.

Occasionally I run into doctors of my generation—trained in the early 1970s—who say they experienced no brutality or inhumanity in their medical training. There is wide variation in medical schools and residencies, and some specialties are more humane than others. Often, the schools and programs that are less geared toward academics and more toward basic patient care are the most kind to their trainees. However, the issue of the abuse of medical students and residents has not gone away. Many articles have been published to describe the brutality of the third and fourth years of medical school and of residency (as recently as the 5 March 2002 issue of *Annals* [3–5]). If a particular doctor can't identify with the hazards, she or he is either remarkably lucky or remarkably insensitive—that is, in pathologic denial.

As one illustration of the brutality and inhumanity, and to further understand the link between stories in medicine and stories in fiction, let me cite a common example: the delivery of bad news to a dying patient. At one point in my internship, I had a patient with metastatic breast cancer whom the surgeons had taken to the operating room, opened up, and then closed again without doing anything—the situation was hopeless. When the patient came back to the medical ward, no one had told her anything about what had happened in surgery. I—like Roy Basch, the intern–narrator of *The House of God*—was reluctant to go into her room and made the excuse to my resident that "It's not my job, it's her private doctor's job, or her surgeon's." In reality, that's as far as it went. I believe that one of the nurses finally told her the news.

But in the novel, something else happens. The resident, called "The Fat Man," offers to do it. Roy describes the scene from the doorway:

> I watched him enter her room and sit on the bed. The woman was forty. Thin and pale, she blended with the sheets. I pictured her spine X rays: riddled with cancer, a honeycomb of bone. If she moved too suddenly, she'd crack a vertebra, sever her spinal cord, paralyze herself. Her neck brace made her look more stoic than she was. In the midst of her waxy face, her eyes seemed immense. From the corridor I watched her ask Fats her question, and then search him for his answer. When he spoke, her eyes pooled with tears. I saw the Fat Man's hand reach out and, motherly, envelop hers. I couldn't watch. Despairing, I went to bed. (6)

Later that same night, returning to the ward after an admission, Roy glances into the room again: "Fats was still there, playing cards, chatting. As I passed, something surprising happened in the game, a shout bubbled up, and both the players burst out laughing" (7).

This scene never happened in my reality as an intern. In fact, in those days there was never once any information taught to us on dealing with a dying patient or giving bad news. Rather, everyone but a few brave doctors and nurses was complicit in avoiding meaningful contact with these poor, doomed people. In retrospect, this is why I wrote the scene, to resist the inhumanity toward these patients. I started with fact—my avoidance—then imagined what "should" have been done and put it in terms of the imagined Fat Man. In this way the reality of medical practice can filter into and through creative imaginations to fiction and then, in the reality of the text, serve as a guideline in understanding not only how things are but how things should be. This is an example of how to resist the inhumanity of medical practice, through fiction.

The way we were as doctors was reflected in the way I wrote about it, and then the writing reflected back on the way we—and others—could have been, and should have been, as doctors. It is much like what Tolstoy concluded in his essay "What is Art?": "Art is a human activity consisting in this, that one man consciously by means of certain external signs hands on to others feelings he has lived through, and that others are infected by these feelings and also experience them" (8). Notice that Tolstoy says, "hands on to others *feelings* he has lived through. . . ." He is not referring to a transfer of information or knowledge; he is talking about an infection by feeling. Much medical training is about information and knowledge and less about traveling the more difficult path of feeling. I believe it's crucial for doctors to stay with the feeling, listen feelingly, and not turn away from the pain and suffering in patients and themselves. There is one shining difference between knowledge and understanding: We doctors may forget knowledge, but we never forget what we understand. We understand through feeling. Think back to those vivid memories of our first patients in medical school, the ones we really "let in" and "felt with."

The connection, then, between narrative and practice

is mutually shared feeling. I believe that this connection can offer doctors some way of understanding the stories we hear, read, and tell. This understanding can help us reach our own individual vision of how we "should be" as physicians.

HOW TO RESIST?

From three decades of meeting with medical students, doctors, nurses, and other allied health professionals all over the world, I have been encouraged to think about how to resist the inhumanities in medicine in more specific ways. I've come up with a few basic suggestions. We must:

1. Learn our trade, in the world. We doctors have to be competent, to be compassionate. If we're not panicked about doing a procedure or being with a patient, we will really be able to listen to, and attend to, the person we are with. In addition, we have to be aware of the world surrounding us and our patients. I would guess that we as complicit citizens are causing more cancers than we as doctors are curing. That patient of ours is never *only* that patient—that patient is also the spouse; the family; the community; the toxins in the local air, water, and earth; and the world. Medicine is part of life, not vice versa.

2. Beware of isolation. Isolation can be deadly; connection heals. Many recent studies have shown the beneficial effects of good connections between caregivers and patients, patients and families, and patients and friends. Much attention is now being paid to things that were once thought "alternative" and that we are starting to describe as "the healing environment." Good connection is at the root of it. The hospitals I trained in and wrote about were both large medical hierarchies. In these "power-over" systems, someone always has power over you, and you have power over someone else. The pressure of authority—the dominant group—comes down on people from above, and those of the subordinate group tend to scatter. The result is that interns and residents risk getting isolated. They may become isolated from each other, leading to depression and suicide, cruel actions and insanity. And each may also *get isolated from his or her authentic experience of the medical system itself*—each may start to think "*I* am crazy" rather than "*This* is crazy." And isolation—as when an intern commits suicide—can mean death. As an intern said to me, "How can we care for patients, man, if'n nobody cares for us?" The cycle of abuse goes on. The only real threat to the power of the dominant group—a power that may be based on the hierarchical lines of authority, on race, gender, class, ethnicity, or sexual preference—is the *quality of the connection among the members of the subordinate group.* Isolation is deadly; connection heals. Stick together.

3. Speak up. When we notice injustices and cruelties in the medical system, we must speak up. Speaking up not only is necessary to call attention to the wrongs of the system, *speaking up is essential for our survival as human beings.* If we see something and say nothing, we may gradually be torn apart. But large hierarchical systems are expert at retaliation. Speaking up alone is dangerous. We must stick together, and speak up with others.

4. Resist self-centeredness. Or, to put it another way, learn empathy. How do we learn to see, in our patients, ourselves? How do we learn in doctor–patient interactions to transform our role from "power-over" to "power-with"? How do we play our part in those moments that heal, those moments of what I call mutual empathy—when not only do we see the patient clearly, and the patient sees us clearly, but *each of us senses the other feeling seen?* Those moments in which you can almost hear the "*click*" of healthy connection? These are healing moments, and not just in my specialty, psychiatry. Think of a surgeon discussing with a patient whether or not to have an operation. In the old days, a paternalistic surgeon might say, "I'm telling you, you need this operation." Lately this has changed to "I've given you all the information, and now *you* have to decide." A few surgeons have gone further toward a more mutual approach, saying, "What are we going to decide to do?" Note that using "we" does not take the decision away from the patient; rather, it lets the patient know that the surgeon is *with* him or her in the decision-making process. Such a statement empowers not only doctor and patient but also *the relationship* between doctor and patient.

How to learn empathy? Try living through suffering with someone—*really* living through—an opportunity we doctors have every day. Try life.

CONCLUSION

The healing essence of narrative is not in the "I" or the "you," but in the "we." J.D. Salinger, in *The Catcher in the Rye*, has Holden Caulfield say: "What really knocks me out is a book that, when you're all done reading it, you wish the author that wrote it was a terrific friend of yours and you could call him up on the phone whenever you felt like it" (9). Like the Tolstoy quote, this suggests that what "works" in fiction is the writer's ability to fashion a "self-with-other" experience, the ability to create a sense of mutual relationship with the reader. How is this done? The writer, through his or her particular qualities of being-in-relationship, cannot help but express these qualities of relationship in the writing; the writing carries these qualities to the reader; this sparks a sense of mutuality between reader and writer, a sense of relationship based on shared understanding.

As I've gotten older, I understand how conditioned I am to see the world in terms of "either/or," "I," or "you"—the adversarial world-view that makes lawyers rich and science, in its narrow view, seem triumphant. From time to time I've been offered glimpses of what now seems a more authentic world, the world of "and" (which includes and affirms "either/or") and the world of "we" (which includes and affirms "I" and "you"). This is the world in which

subatomic particles can *only* be known not in themselves but in their relationships with other particles; it's also the world in which I cannot see you or me with clarity and understanding unless I can see the connection between us. Sometimes I find myself in a shift from seeing people only as individuals to seeing the connections between people that mirror and inform each person. I've come to see healthy growth not so much as the growth of a self, but as the growth of a self-in-connection. Mutuality is a more authentic description of humans and nature than dichotomy.

Finally, a word about how my specialty, psychiatry, plays into my lifelong quest to write a fiction of resistance. My question in psychiatry has always been, "How do people change?" In my novel *Mount Misery*, the sequel to *The House of God*, Roy Basch tries to describe what heals. At the end of the year he is having a difficult time in a therapy session with a patient. She is a troubled young woman who has always made him feel inadequate.

> "Terrific," she said to me sarcastically, putting me down. She looked sullenly into her lap.
>
> In the past I might have gotten angry at her, but suddenly I understood. The issue wasn't me, or her, but us. The "we" in the room, which seemed so solid right then that you could shape it, yet so ephemeral that it was the unseen historical forces shaping you . . .. My job right then was to hold this "we," this connection with her, hold it for both of us. That was my job as a doctor. To use my experience with others who had suffered and my vision born of that experience to bring someone who is out on the edge of the so-called 'sick' into the current of the human. To take what seems foreign in a person and see it as native. This is healing. This process is what the healing process is. This is what I signed up for, years ago. This is what good doctors do. We are **with** people at crucial moments of their lives, healing. How hard it had gotten . . . to get back to authentic suffering, authentic healing. How much we have lost. (10)

The great themes of fiction are love and death. Death is always a theme in medicine. So too, I would argue, in its many spirits, is love. And one of those spirits is resistance. Love and death. How lucky we are.

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Note: Samuel Shem is the author's pen name. The author's real name is Stephen J. Bergman.

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