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Practical Applications of Literature in Medicine

Prior to my enrollment in this course, I had not been able to see the need for Medical Humanities. I, like many other science students, thought that I could become a physician without having to deeply contemplate such concepts as mortality and the emotional effects terminal illnesses would have upon patients. I thought that as a surgeon, I would just cut people open, remove the problem, and send them on their way. I believed that one of the best characteristics a surgeon could possess was a cold, removed heart, so as not to form an attachment to a patient who was not far from death. Since I have been introduced to the Medical Humanities, my entire definition of health care and what it means to be a doctor has changed. I now know that as a physician I need to confront concepts of mortality, recognize that my patients have a life outside of their illness, and understand that sometimes the best cure, is not a treatment, but a way to manage an illness and give that patient the largest number of good days possible. I have also come to recognize that there is a careful balance between attachment and detachment that is crucial for properly executing a symbiotic doctor-patient relationship.

Upon being introduced to the Medical Humanities, I realized how applicable every text and every concept was to the sequence of events that had been unfolding in my life throughout the past two years. Two years ago, my grandmother had her first hallucination—she told us of a man who had been following her and broadcasting messages into her home. After this, her health experienced a rapid decline. Looking back over the trials that unfolded, I see so many parallels that can be drawn to what I have learned within this course and her healthcare experience. I can now clearly see just how important literature is to medicine: it teaches future physicians the importance of sharing knowledge and reflections on previous cases; it allows physicians to meet death in a detached sense before having to confront it up close, and it

allows both the patient and physician to come away with the best experience possible by fostering an excellent line of communication between patient and physician.

The Epic of Gilgamesh serves as a literary guide for confronting physical mortality for both patient and physician. As a population, we do not recognize mortality until we experience it for ourselves, through the death of a family member, close friend, or we experience a potentially terminal illness ourselves. *The Epic of Gilgamesh* recounts the tale of the Gilgamesh, who is sent a brother to balance out his existence, as he was becoming a tyrant to his people. Though Enkidu was sent to balance Gilgamesh, the reader is never explicitly told how Enkidu will serve his purpose. Gilgamesh still repeatedly went on adventures that put his life in jeopardy even though he now has Enkidu's life to consider, and he still does not recognize that he, and the people surrounding him, will not live forever. Rather, he is obsessed with epic immortality that will allow him to live in the minds of his people forever. "I must travel now to the Cedar Forest, /where the fierce monster Humbaba lives. /I will conquer him in the Cedar Forest. /I will cut down the tree, I will kill Humbaba, /the whole world will know how mighty I am," (Gilgamesh 94). Within this quote we see Gilgamesh's desire for immortality and fame shining through. Gilgamesh only considers mortality from a stance of achieving immortality so that he will be remembered eternally, he does not think about the other half of mortality that is physical in nature. This theme is revisited constantly throughout the epic; "If we help each other and fight side by side, /we will make a lasting name for ourselves, /we will stamen our fame on men's minds forever," (Gilgamesh 120). Here again, Gilgamesh's desire for epic immortality is put on full display. Gilgamesh repeats this line multiple times throughout the story prior to Enkidu's death, but when Enkidu dies, Gilgamesh stops being so concerned with epic mortality and stops repeating these lines about eternal fame. This complete ignorance of physical mortality is experienced by all humans, we are immortal, until we are not. When you are young you believe you will live forever, just as Gilgamesh did.

Gilgamesh's only concern is with epic mortality, rather than the fact that he is inherently, physically mortal and his body will eventually begin to decay, and he will die. It is not until Gilgamesh's epic adventure to slay the monster, Humbaba, dooms Enkidu to death, that Gilgamesh is able to recognize

both Enkidu and his own physical mortality. Since Enkidu compliments Gilgamesh, and is seen as an extension of him, when Enkidu eventually meets his untimely demise, Gilgamesh is forced to confront the fact that he is also not immortal. When Enkidu dies Gilgamesh says, “O Enkidu, what is this sleeps that has seized you, /that has darkened your face and stopped your breath?” (Gilgamesh 153). Here, Gilgamesh is in denial, it cannot possibly be so that someone who so closely resembled him has died. After this experience, Gilgamesh realizes his own physical mortality; “Must I die too? Must I be as lifeless /as Enkidu? How can I bear this sorrow /that gnaws at my belly, this fear of death /that restlessly drives me onward?” (Gilgamesh 159). We see Gilgamesh arrive at a crossroads with the human condition; we all eventually become patients and pass on. A physician is forced to realize that both themselves and their patients are not immortal, and a patient is forced to contemplate the fact that their diagnosis will inevitably result in death. This is a huge realization that is bound to be emotionally taxing for physician and patient. The emotional burden of mortality can, however, be lessened by exploring it through literature rather than having a true death be your first experience. This is Enkidu’s purpose. Enkidu was sent to Gilgamesh to force him to realize that he is not immortal, to force him to appreciate his life while it lasts, to appreciate the city he has been so honorably selected to serve as the King of. Enkidu’s death allows the reader to experience a feeling like Gilgamesh himself, we realize that no matter how strong we are, or how resilient we may be, no one can escape death in the end. Enkidu and Gilgamesh help doctor and patient cope with this while allowing them to observe from a distance—we can experience these strong emotions while being removed from the situation, which allows us to prepare ourselves for our own mortality before we are faced with death head-on.

In my grandmother’s situation, I felt as though both my mother and I would have greatly benefitted from reading *The Epic of Gilgamesh* before her rapid decline in health. It would have helped us to recognize that eventually she would pass on, so we should cherish the time we had, and make the most of it. My grandmother served a function much as Enkidu did: she helped us realize that life is not forever and that there is more than chasing the immortal dream.

Along this journey of watching my grandmother's health decline and watching her become less independent, I realized that I never stopped to think how this situation had made her feel; I only considered things from my point of view. I now recognize that this loss of independence resulted in an onset of severe depression for her—she was forced to give up her home and many of her belongings to move first to the town we lived in, and eventually to an assisted living facility. Depression is something physicians, as well as patients do not consider as it has been illegitimated by humankind for quite some time. Robert Burton discusses this in his *Anatomy of Melancholy*. "If our leg or arm offend us, we covet by all means possible to redress it; and if we labour of a bodily disease, we send for a physician; but for the diseases of the mind, we take no notice of them," (Burton). Burton addresses the fact that as physicians, we often only address physical ailments, and show no concern for how treatments are affecting a person, or how just the state of general health decline affects our patients mentally. Physicians search for physical ailments, as their treatments prove simple, whereas conditions such as depression take long-term treatment plans and therapy sessions to heal. Through this quote, Burton legitimizes the feelings of patients who are experiencing these emotions, telling them that it is okay to call out for help. As, I read this line I wished my grandmother, or her countless doctors could have read this, and understood that depression, when undergoing medical treatment is common, and should be discussed rather than danced around. After all, how can we expect a patient to be optimistic about treatment when they seem to have lost their will to live. In Burton's *Anatomy of Melancholy*, he also aims to establish melancholy or depression as a universal experience. Burton wants to make it know that depression effects all of us, he is taking on a task that is still being carried out today—making both patients and physicians aware of how widespread depression is: "For indeed who is not a fool, melancholy, or mad? Who is not brain-sick?" (Burton). As physicians we are responsible for our patient's overall health, this means both their physical and mental health. Burton forces us to consider both sides, which is not what we are taught in our conventional medical school curriculum.

Aside from the depression that resulted as a loss of her independence, my grandmother also experienced vivid hallucinations about a man who attempted to steal her things, break into her home, and

ultimately ruin what little time she had left. Since there were no cure for these hallucinations, my mother and I had adapted to thinking of them as real, as there was no point in explaining to her that they were not. We did everything we could to ensure she felt safe in her own home and tried to convince her that the man was trying to help her. This worked great for the most part and made her feel much better, but every time she would go to her routine hospital visits, they would treat her like she was crazy, trying to explain that the man was not real, and her mind was just rapidly deteriorating because of her aging.

> My purpose and endeavor is, in the following discourse to anatomise this humour of melancholy, through all its parts and species, as it is an habit, or an ordinary disease, and that philosophically, medicinally, to show the causes, symptoms, and several cures of it, that it may be the better avoided, (Burton).

Burton's *Anatomy of Melancholy's* sole purpose was to educate the physician on the fact that disorders of the mind do exist. He aimed to structurally take apart these diseases to legitimize the way patients with mental illness were felling, so that doctors could understand. Even though to an outsider these conditions seem impossible, they are very real to the people they affect. To tell someone they are crazy for experiencing something their mind has constructed just furthers the discourse between patient and physician, which is exactly what *The Anatomy of Melancholy* had aimed to avoid. There is a fine line between recognizing and accepting a person's mental illness and calling unnecessary amounts of attention to it. Sometimes the simple acknowledgment is enough, as physicians, we do not need to search for a cure for mental illness, but rather just let the patient's cry for help be heard. Burton's paper serves as a beautiful guide for treating patients with mental illness and should be an essential read for all physicians, as mental illness affects all demographics of patients.

Before her mind began to slip, my grandmother had had a heart condition for a good deal of her life, and she had been taking medication to manage the symptoms for years. When she first began complaining of hallucinations no one really believed her. The physicians seemed only concerned with the state of her heart and her blood pressure which was continually monitored. They seemed to just glaze over

the other symptoms she complained of, either because they were not sure what could be causing them or believed that she was just inventing them in her mind. In *Two Kinds of Decay*, Manguso writes,

> Those symptoms weren't treated because they were unlikely enough to be virtually impossible. My reports of them were their only observable evidence. My symptoms were so unlikely, by the book, that despite my reports of them, they were assumed not to exist, (Manguso 30).

Because Manguso's disease was so rare, there were not many observational case studies that had been conducted on other patients with her illness, and as physicians, if it is not in a textbook, then we assume it must not be true. This is a result of a physicians extensive medical training and lack of training in the humanities. As physicians, we must accept that sometimes novel symptoms do arise, or we may have potentially misdiagnosed our patients, as was the case with Manguso. Manguso's feelings as her doctors denied how she said her body felt must have been exactly what my grandmother was feeling in that moment, and when it was eventually discovered that she had had a minor stroke that was likely causing these hallucinations, it must have seemed equally as frustrating that they had not fully assessed her symptoms, as it had seemed when Manguso was given her actual diagnosis by a new neurologist.

> "After examining me and listening to me for less than five minutes, my new neurologist said I didn't have Guillain-Barre syndrome, but a rarer, chronic form of the disease called chronic idiopathic demyelinating polyradiculoneuropathy," (Manguso 88).

Manguso's new neurologist spent less than five minutes listening to her own account of her symptoms and was able to use this to properly diagnosis her. This goes to show the importance of viewing a patient as a comprehensive whole, and listening to exactly what they are feeling, rather than telling them how they should feel as is described in a textbook. When I look back, I think of my grandmother and what could have been done differently if they had listened to all her symptoms instead of focusing on what they had already known. Manguso's *Two Kinds of Decay* serves as a call for physicians to do better, to improve, to listen to how their patients are feeling instead of prescribing them specific symptoms. As medicine progresses, we spend less and less time getting to know our patients and assessing them as a

dynamic whole, Manguso's anecdote serves as a reminder that communication and valuing a patient's description of their own disease is just as important as being knowledgeable enough to treat the disease.

Two Kinds of Decay also provides another essential lesson for physicians, especially procedural physicians. Proper communication between patient and physician is one of the most important components for successful treatments. Being able to communicate to a patient exactly what you are going to be doing in terms that a patient can understand is an integral part of being a physician. When Manguso was told, she was going to need a central line, she was vaguely told what its function would be, but not how it would be put in: "My hematologist might have thought I'd wanted my parents there to help me feel less fearful, but I didn't know enough about the procedure to feel fearful," (Manguso 37). The physicians ultimately failed her by not informing her of this information—central lines require a lot of care that one should understand before having one placed into their chest. By failing to inform her of how the procedure would go, the physicians set Manguso up for fear upon completion of the procedure and years of care she did not understand until after the line was placed. For treatments to be successful, patients should understand exactly what is going to be happening to them, this establishes an essential line of trust. Patients experience the best treatments when they trust their physician and can be confident that every painful procedure, they are undergoing is going to prove to be helpful in the end. This especially becomes important to elderly patients, like my grandmother, who are often confused to begin with. I remember the look of terror that spread across her face when a nurse began walking towards her with a needle to draw blood. My grandmother did not understand why she needed to have a blood test, and rather than taking the time to explain, as it would have been rather difficult to explain something to my grandmother at this point, she skipped this stage and instead went right ahead with the procedure. After this experience, my grandmother had a difficult time trusting that doctors were doing what was right for her, just as Manguso felt when no one had explained to her the central line procedure. How can we as physicians expect our patients to trust us when we are not explaining procedures to them and instead just charging at them with sharp objects that they feel serve no purpose? Even if physicians view these as common procedures, they are not common to everyday individuals, and this is something that we need to recognize. As physicians,

we have been trained so extensively on these procedures that we believe they are common knowledge, when they are in fact not. Literature allows us to see these procedures from a patient's point of view, and reminds us that this is not common knowledge, but rather something that should be extensively explained. Overall, Manguso's book provides physicians with a narrative which allows them to examine mistakes and correct them in the future. It also allows physicians to place themselves into a patient's perspective, which they do not often experience. This allows physicians to contemplate the best possible way to communicate and treat patients.

In his book, *The Poetry of Healing*, Rafael Campo also proves that communication is one of the most crucial elements in being a good physician. He reflects upon previous experiences with patients that he neglected and how these reflections allowed him to arrive at what it means to be a good physician and transform himself into the best version of a doctor that he could be.

> My own interactions with patients, which until that time had consisted primarily of subjecting them to tests like this one, returned to me as the scanner hummed and whirred. Instead of sitting down at their bedsides to hear the stories I knew they contained, I had tried to tell them what the results of the tests meant. I tried to know more than I felt, (Campo 246).

When Campo himself becomes a patient, he can realize how important it is to listen to the stories that have unfolded throughout a patient's life. When one becomes a patient, they look for someone to confide in, to tell the stories of why their life mattered and why their existence was important. They often turn to their doctors to listen to these stories, as they are the ones who are around when a patient is forced to confront their mortality firsthand. When in the MRI machine, Campo realizes why his patients wanted to recall their lives to him, and he understands the importance of listening. If, as physicians, we attentively listen to their stories, and validate that their existence was in fact important, it helps the patient come to terms with their prognosis. Sometimes as a physician our role is to listen, not to become obsessed with curing and only see our patients in terms of their symptoms. My grandmother has accepted her death for a long time. Her husband died at the age of 66, and ever since she has said she is ready to go. Due to this acceptance, when she visits the doctor, she is often not concerned with the treatments they are

prescribing. Rather, she just wants someone to listen to her, she wants to share her stories that she is unable to share as a result of living alone. Therefore, the best physician for her, is one that will just listen, as Campo explained.

“Having stood blinking in the quiet surrounding so many failed resuscitations, I knew that to lose one’s own voice was tantamount to death,” (Campo 176). Campo again reiterates the importance of being able to share one’s stories and having someone to listen to them. When one of Campo’s patient’s voice is forever taken away, he realizes how important the sharing of his stories was, as they would be the only pieces of him left in existence after his inevitable death. He again explains why it is so crucial for a physician just to listen to a patient, even if the stories they tell do not seem important to their conditions. Campo’s book proves to be another essential piece of literature for aspiring physicians, as it explains the importance of anecdotes in medicine as well as the importance of using literature for an outlet from medicine.

As previously mentioned, my grandmother has been telling my mom and me that she has wanted to pass away rather than continue living in her current state. Her husband and most of her friends have passed away and she felt as though she had fulfilled her purpose here on earth and was ready to be with her husband again. However, even though she had made this clear to her physicians, they continued to force her into painful treatments and to try new experimental medicine to fix her heart condition and her blood pressure. The medications made her tired and forced her to deal with incontinence issues that made her feel like she could not leave her house for fear of embarrassing herself. In *Being Mortal*, Atul Gawande writes, “In almost none does anyone sit down with you and try to figure out what living a life really means to you under the circumstance, let alone help you make a home where that life becomes possible,” (Gawande 76). Gawande recognizes that there becomes a point in every patient’s lifetime, where they are no longer seeking treatment, but rather management of the symptoms of their conditions. They want to be able to manage their symptoms to give them the best possible last days of their lives, and then slowly drift painlessly into death. Gawande believes that this is a transition that a physician must be aware of and must be able to help a patient achieve; it is why he believes that each new physician should

be trained in geriatrics at some level. “If a patient had larger, underlying issues--if, for instance, the broken leg had been caused by dementia—his job was to ignore the issues and send the person somewhere else to deal with them, such as a nursing home,” (Gawande 111). Gawande highlights a physician’s lack of caring for issues that are not simply cured. My grandmother no longer needs the medications that are trying to treat her, she needs to be able to go to family gathers while she still can without being anxious the entire time she is there. This is something we as physicians must come to terms with, Gawande explains that we must recognize that we cannot cure all illness and no matter what treatments we prescribe we cannot fix everything. As physicians, we must know when it is time to give up.

“We had this quite agonizing conversation where he said—and this totally shocked me— ‘Well if I’m able to eat chocolate ice cream and watch football on TV, then I’m willing to stay alive,’” (Gawande 183). Everyone has different ideas for what they want the end of their lives to look like; some are comfortable eating ice cream and watching TV for the rest of their existence while others are not. We see this when Gawande’s father falls ill; “Otherwise, he kept on driving, playing tennis, doing surgery, living life as he had been. He and his neurosurgeon both knew what was coming. But they also knew what mattered to him and left well enough alone,” (Gawande 199). Gawande’s father’s idea of what the end of his life would look like was much different, he wanted to play tennis and be able to walk around and socialize. Patient’s priorities are different, and as physicians our responsibility is to find out what our patient wants the end of their life to look like and deliver on that vision in the best way we can. Gawande emphasizes this when he compares the two neurosurgeons him and his father had consultations with—one was able to understand what was important to the father, while the other was only concerned with curing, and that is the difference between a good physician and a great physician. Sometimes the cure is not a prescription or treatment.

> Our most cruel failure in how we treat the sick and the aged is the failure to recognize that they have priorities beyond merely being safe and living longer; that the chance to shape one’s story is essential to sustaining meaning in life; that we have the opportunity to refashion our institutions,

> our culture, and our conversations in ways that transform the possibilities for the last chapters of everyone's lives, (Gawande 243).

Gawande's overall message throughout his book is that there is much more to life than just treating illnesses, sometimes as physicians, we get too caught up in diagnosis and treatment, and we forget the entire reason we decided to go into medicine in the first place—which was to help people. When we no longer consider a person's priorities, we are no longer helping then efficiently. Instances of ineffective treatments are seen in countless places throughout the text: "She had chosen to forgo treatment, but her oncologist pushed her to change her mind, and she was put on a ventilator and antibiotics," (Gawande 154). Here, we watch an oncologist push a patient to pursue a treatment with no guarantees when she was already content with a previous decision to stop treatment and live out the rest of her days peacefully. In Sara's case her illness was terminal, and she had undergone two previous rounds of chemotherapy, and the third round she was currently undergo had almost no chance of working, and if it did it would give her maybe three months: "They'd washed hands scrupulously, limited visits by people with young children, even limited Sara's time with baby Vivian if she showed the slightest sign of a runny nose," (Gawande 173). Instead of telling Sara that there was likely nothing that could be done to stop the spreading of her cancer, the doctors kept pushing her forward into a treatment that deprived her of holding her newborn child in her arms during her last days. These cases force us to ask ourselves as physicians, was the last round of treatment worth it? This was the point of Gawande's piece, to share cases and their outcomes with fellow physicians so that they can assess the effectiveness of the prescribed treatment. When we reflect on these cases, we can clearly see that pushing treatment was practically useless, and only deprived these patients of good final days. It allows us to not make the same mistake when faced with a similar situation the next time, and that is the power of literature in medicine. Literature creates a space to be critical of fellow doctors' decision, it allows one to remove themselves from a situation and see it for what it really is. When we are not attached to Sara, we see that her treatment should have stopped months ago; making sense of this through literature is much simpler than trying to make sense of this when dealing with a patient you have developed an attachment to.

The evolution of medical humanities permits an avenue through which fellow doctor's decisions can be analyzed, critiqued, and subsequently learned from. The literature bred from this portion of the humanities promotes improvement throughout the entirety of the medical field. The very nature of this kind of analysis elevates the importance of having challenging conversations among medical professionals. Given the opportunity to confront historical and contemporary texts about the more nuanced aspects of patient care including mental health, sympathy, and mortality- a doctor finds themselves better equipped to deal with those in critical condition. As provided thus far anecdotally, it is evident to me that had these truths found in this field of the humanities been applied to the geriatric care of my grandmother, the outcome of where she is today may have been drastically altered for the better. My grandmother's care could have been exponentially improved upon, had we integrated humanities courses into medical school curriculums sooner. Reading the texts has allowed me to paint a picture of the physician I want to be, and I hope that I can learn from the wise words of the physicians and philosophers we have read and their extensive case studies, how to be the best possible physician for my patients.

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