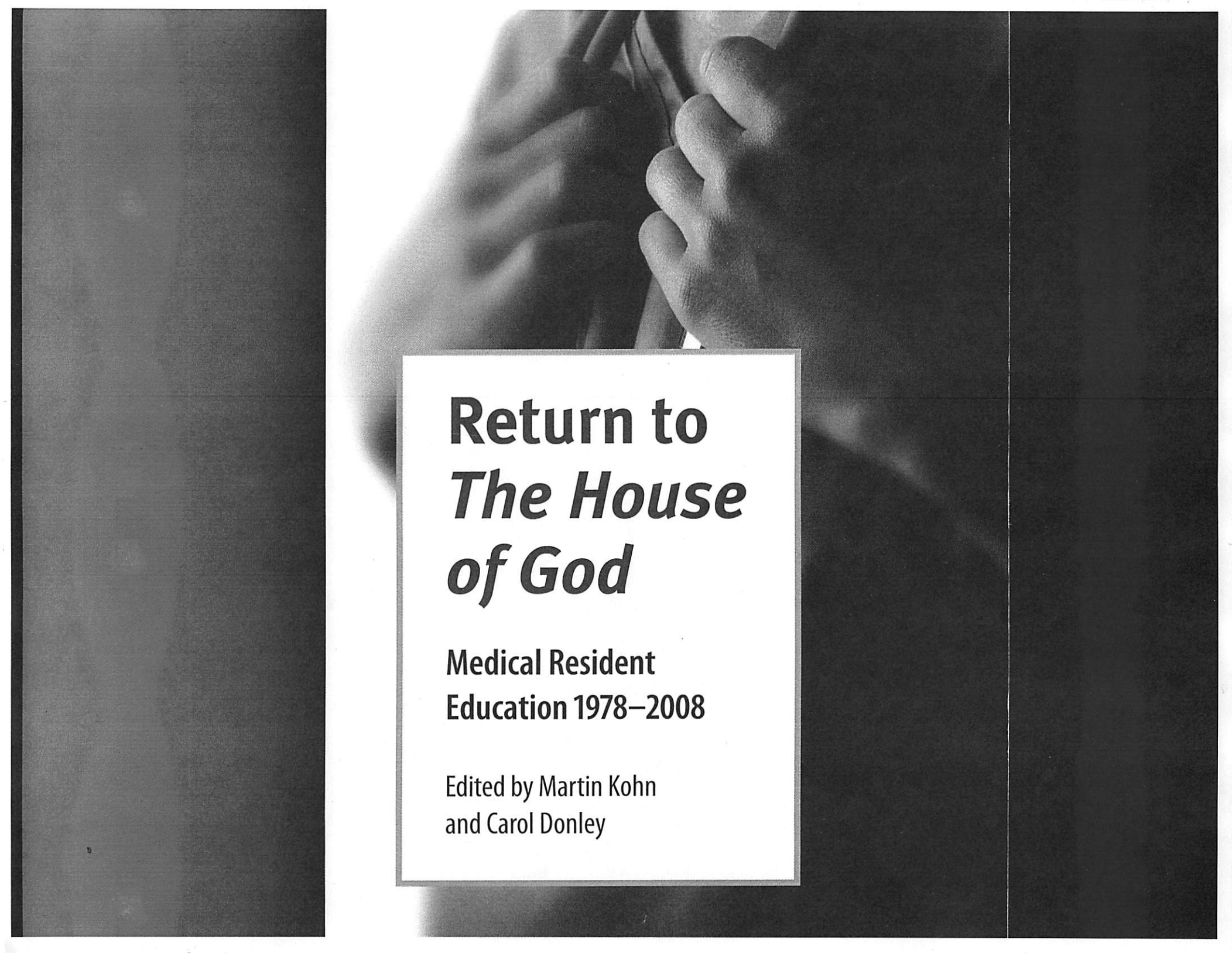

Return to *The House of God*

Medical Resident Education 1978–2008

Edited by Martin Kohn
and Carol Donley

Speaking the Unspeakable

JAY BARUCH

I put off reading *The House of God* until my fourth year of medical school. Even without cracking the cover I still knew about gomers, the laws of the House of God, the Rose Room, the art of buffing and turfing, the O and Q signs. They were the lingua franca of the medical wards. An occasional student would carry the book around, wearing a devious, knowing grin, as if it were forbidden fruit or a magical drug. Even if the book punctured the idealized world sold to us by medical school professors, I made a conscious decision not to read it, wary of what I might discover inside and what it might do to me.

As it is with most fun things that carry risk or the allure of corruption, I could resist *The House of God* for only so long. I dove into the experience. Reading became a violently physical act. I laughed. I squirmed. I self-righteously shook my head. But I also found the term "gomer" offensive and insensitive, the laws too clever. I didn't identify with any of the interns, which made it much easier to convince myself that what happened to them wouldn't happen to me. The sharp, energized prose and vividly outrageous scenes left me breathless with admiration. But in the end I was disappointed with the book, which was a great relief.

That changed when my emergency medicine residency began. I could no longer pretend the emotions, judgments, and behaviors that I had criticized in the book weren't embedded in me.

New words crept easily into my vocabulary. The demented, moaning Jewish woman was in Oy-tach. The overly theatrical Hispanic woman was in Status Hispanicus. The homeless, chronically inebriated frequent flyer brought into the ER during bitterly cold winters was a Drunksicle. We referred to the unresponsive gomer as gomertose. We'd shake our heads, chuckle furtively. I recognized such objectifying language as insensitive and denigrating. But at the same time, this vocabulary from tired, insecure, frightened physicians-in-training felt necessary and strangely comforting.

I soon discovered there weren't enough rationalizations and pints of beer in the world to help make sense of how, again and again, *I* disappointed *myself.*

Forget the sanitized and deeply moral approach to doctor-patient relationships taught in medical schools, with a focus on neutered patient personalities that serve you well if you're in a classroom, well rested and dealing with intellectual constructions. Some patients evoke uncomfortable feelings in their caregivers—suspicion, doubt, distrust, even dislike. Some yell, smell, or test the limits of the kindest staff. They blame us and we blame them. The 500-pound diabetic with abdominal pain. The two-pack-a-day smoker who comes to the hospital gasping for air on a regular basis. The drunks who fall down, sober up, and get sent home only to come back a few hours later with enough alcohol in their blood to kill most people. Sometimes patients are simply too needy. These patients are the toughest, looking to me for answers when I don't have any.

Such thoughts make me uncomfortable. Confessing them openly feels criminal, unsavory. But it's important to be transparent and blunt. *The House of God* is filled with moments and insights that are so honest they feel obscene. Listen to Dr. Roy Basch on his emergency ward rotation:

> I got competent to handle the big stuff, and the other stuff is just one abusive person after another. It shits. Addicts trying to dupe you for dope, drunks, the poor, the clap, the lonelies—I hate 'em all. I don't trust anyone. It comes from being vomited on and spit at and yelled at and conned. Everyone's out to get me to do something for them, for their fake disease. The first thing I look for now is how they're trying to take me for a ride. It's paranoia, see? (208)

What emergency physician or nurse hasn't entertained such thoughts from time to time? These raw, politically incorrect feelings are difficult for one to acknowledge or discuss without being perceived by others as someone who is unprofessional, burnt out, or short on the commitment or toughness required to work in the Emergency Department.

Critics have accused the book of being racist, misogynistic, and ageist, among other things. There may be passages where these charges have some grounding, but not the work as a whole. If it's judgmental in any way, it's only because doctors and health care providers can't avoid passing judgment, having opinions and prejudices. What's important isn't ridding them of their personal views, but ensuring that doctors and doctors-in-training have the insight and sensitivity to recognize and reflect upon them, and enough equipoise and emotional commitment that it doesn't interfere with patient care.

I loved the scene when Dr. Roy Basch watches the Fat Man shovel day-old blintzes into his mouth while the two of them are on call. The Fat Man is talking, and Roy can't be sure he isn't listening to a ranting madman. "I'm not crazy," Fats says, "it's just that I spell out what every other doc feels, but most squash down

and let eat away at their guts. Last year I lost weight. Me! So I said to myself, 'Not your gastric mucosa, Fats baby, not for what they're paying you. No ulcer for you'" (76).

As a medical student, I was taught to learn from my mistakes, but it was infinitely better to learn from the mistakes of others. When I first read *The House of God,* I didn't know what to make of the Fat Man. My opinion fluctuated from awe and amazement to deep-seated concern. He seemed too hip, too distracted—an operator. But the second time around I snapped to attention whenever he appeared on the page. He has a sharp, cutting eye on the many storms the young doctors faced and knows how to negotiate them to preserve his sanity and his life. Roy Basch is fortunate to have Fats, who has not only practical wisdom and insight but the interest and desire to share it. And what to make of all his sarcasm? "So who isn't sarcastic? Docs are no different from anyone else, they just pretend they're different?" (192).

And time hasn't dulled the bite in his sarcasm. One can argue that some of the Fat Man's exhortations—for example, that sometimes it's better to do nothing, and "the cure is the disease" (193)—are ominously prescient thirty years later, with widespread antibiotic resistance to common bacteria; the emergence of methicillin-resistant staphylococcus, a once hospital-based infection, in the community; and the U.S. Institute of Medicine report that illuminated the shocking number of deaths that occur each year in hospitals due to medical error.

The veracity of the Fat Man's perceptions isn't what I admire most about him now. It's his ferocious honesty. His balance, his integrity, his authenticity. His courage to break ranks with the establishment. Roy Basch tells him at the end, "But you showed me that a guy can still stay in medicine and still be himself" (338).

You can't become a doctor or a nurse and think that all the sharp edges in your personality, the trapdoors and dead ends that complicate your opinions of others, will suddenly vanish or smooth out. If anything, the stresses of being intimate with people and their lives and problems will only test the strength and validity of your beliefs.

I remember frantically treating a patient, Mr. X, who was barely breathing. His skin was gray, moving toward blue. We couldn't get an IV in his scarred veins; there were surgical scars on his neck. Intubation, placing a breathing tube in his trachea, must have been as difficult in the past as it was now. He had pinpoint pupils. We assumed he was a narcotic overdose. But the intramuscular nalaxone wasn't working. A second-year medical student was shadowing me for the day, and I could feel the force of his gaze as everything I did failed, and confidence bled from the room. The nurses and I spoke in tense, sober glances.

I ordered a last dose of nalaxone. Anesthesia was on the way. I set up for a cricothyroidotomy. I tried to hide the white fear, the cool trembling in my bones.

Mr. X might die. The nurses were two of my favorites. Caring, funny, clinically outstanding. They were all business now, their tone fraying with panic.

Then Mr. X bolted upright on the stretcher, coughing, red eyes bulging. The nalaxone had finally kicked in. He scratched himself, shivered. The hairs on his arms stood at attention. All signs of narcotic withdrawal, which is what we precipitated by giving the reversal drug. He denied overdosing. He denied using heroin or any other narcotics. He scoffed, appeared offended by our questions.

A grateful sigh swept through the room like a cool, easy breeze. Then one of the nurses mumbled under her breath disgustedly, "I know him."

"Oh," said the other nurse, recognizing Mr. X.

The mood took a dark turn. Mr. X had overdosed on heroin several times in the past few months. I now recognized him, too.

"He overdosed once in front of his kids," someone said. "He's real trash."

"Trash?" I thought to myself, cringing.

We were standing at the nursing station now, shaking our heads, a fair distance away from the patient. I feared for the example we were setting for the medical student, who had been with us, listening to every word. Did we seem regretful that our diligent work had saved this particular man, or that we cared so intensely for a man whom we later learned couldn't care less about himself or his family? Did we give the impression that saving this man's life was a bad outcome?

We shared our private thoughts in an impromptu and surprisingly candid dialogue, shattering all pretense of sensitivity expected of health care providers. The nurses knew Mr. X's wife and other family members. They shared stories too harsh and heartbreaking to be true. When the conversation was over, I felt closer to my colleagues. We weren't any more accepting of Mr. X, but we achieved enough workable resignation to allow ourselves to shrug our shoulders, take a deep breath, and reclaim our compassion.

Mr. X began barking, demanding to go home. The nurses screwed on smiles and dutifully attended to him. I spoke with the medical student about what he had witnessed, treating Mr. X and the conversation that followed. Then we walked over to speak with Mr. X, who didn't want to talk with me. He didn't care that we had saved his life. If anything, he seemed pissed about that. I let him scream and yell. The nalaxone would soon wear off. Ideally, he'd soon drop off to sleep and still breathe comfortably.

The great challenge educating physicians-in-training is balancing hope, optimism, and encouragement with an appropriate dose of realism and honesty to adequately prepare them for the demands of patient care in the current health care environment.

Medical school and residencies are often approached as time-limited experiences to be endured, but many of these issues follow young physicians far

into their careers. The doctor-patient interaction can be beautiful, fragile, and unsteady, a source of comfort, frustration, or fireworks.

When Dr. Sanders is dying, he says to Dr. Roy Basch, "What sustains us is when we find a way to be compassionate, to love" (156). Later, Roy recognizes that "I knew that I could not do what Dr. Sanders had told me to do, to 'be with' others. I could not 'be with' others, for I was somewhere else, in some cold place, insomniac in the midst of dreamers, far far from the land of love" (287).

Doctoring places great demands on the brain but asks more from the heart. It's an emotional contact sport. Medical students, residents, practicing physicians, and other health care providers should never feel "somewhere else." A vital part of medical education must be devoted to nurturing reflective skills and shaping the space so they can share feelings and experiences that often are passed over in doctoring. Medical educators must learn to "be with" students and residents in a way that is pragmatic and honest. A reversal agent has yet to be invented to treat the "insomniac." Until then, we're left with *The House of God,* and all its breadth, wisdom, and heresy to help guide us. It might offend some people, maybe even be considered obscene by teachers and students alike, but it's offensive and obscene because, like medicine, it's filled with humanity.

NOTES

Citations in the text refer to the Delta Trade Paperback, 2003 edition.

Shem Redux: Is It time?

STEVEN HYMAN

My return to Samuel Shem's *The House of God* after a period of many years elicited potent memories of my medical internship and of the general hospital of the late twentieth century. The vivid descriptions of the experiences of medical intern Roy Basch and his colleagues at a Boston teaching hospital in the mid-1970s remain emotionally evocative today. Shem portrays a series of disturbing episodes across the calendar year of internship, including an intern's suicide, and conveys the interminable grind of an intern's life. As *The House of God* takes one through various inpatient wards, the emergency ward, and the intensive care unit, there is a devastating cumulative effect. The growing fatigue, the growing distance between the interns and their outside lives, the growing dehumanization of patients all take a severe toll. From some perspectives the internship portrayed by Shem can seem like its own chronic illness. For those of us who lived through similar "schooling," the book has the power to bring back not only cognitive recollections but also visceral experiences that have been stored away somewhere in our brains: feelings of intense fatigue or of the emotional disinhibition produced by sleeplessness, foul smells, and close contact with agony and death.

On the surface this is a sardonic exposé, complete with Joycean commentators in the persons of the clever policemen, Gilheeny and Quick, lest we miss any dark detail. At its heart, however, *The House of God* is a bildungsroman in which Basch passes through a kind of hell to reach a new level of understanding and maturity, albeit not without lasting scars. The theme of a passage through hell necessarily contributes to the selection of stories told. These are stories of the dehumanization of elderly demented patients, of the intern Potts being driven to suicide, of the need for Basch to drive over the stains left by Potts's fallen body to park at the hospital every day, of the mercenary motivations of some of the private physicians. While a selection, not the totality, of the internship, these stories are not wild fantasies, and the experiences of internship would provide much grist for Shem's trip through hell.

For Shem's approximate contemporaries, of whom I am one, the 1970s setting, with the Watergate hearings as a riveting foil to all else, brought with it a heightened distrust of authority. In medicine, as in all professions, this distrust