Maladies, Remedies, and Anthologies: Medicine Taken at Its Word

The Body in the Library: A Literary Anthology of Modern Medicine
Ian Bamforth, ed. Verso (London) 2003, 418pp

By Danielle Ofri

The urge to anthologize seems to be one of those primordial drives, nestled in our genomes alongside the compulsions to eat heartily, imbibe lustily, and slaughter enemies willfully. Or at least that’s how the Greeks appear to have experienced it.

In 90 BC the first known anthologist, Meleager of Gadara, anthologized his own poetry (another ingrained habit, it seems) along with that of forty-six other Greek literary lights including Archilocus, Simonides, Alcaeus, and Anacreon. He described each poem as a flower, and his selection and arrangement of these poems as a woven headband of flowers, and thus chose the title Anthologia, meaning “garland.”

Phillippus of Thessalonica put forth the next garland in AD 40. He, too, did not hesitate to include his own work. But while able to secure a place in history as an editor, Phillippus apparently had limited poetic skills and tended to borrow heavily from those before him, in both style and content.

Five hundred years later, Acathias of Byzantium added a new twist: he organized the selections by topic. Suddenly an editor was not just the person who stapled together the poems she or he liked, but someone who could illuminate particular themes by means of layout and design. Acathias also hit upon into another editorial strategy: start with what readers already know and like, then slip in new stuff where you can. Between substantial selections from both Meleager’s and
Phillippus’s anthologies, he sprinkled in work by contemporary poets who didn’t possess quite the same publishing pedigrees.

Cephalus, in tenth-century Constantinople, continued this noble tradition, snagging poems from Mealager, Phillippus, and Acathius, then weaving in modern ones, including the more risqué homoerotic verses of Straton of Sardis. Cephalus organized his anthology according to type of poem (poems in particular meters, riddles, satirical poems) as well as subject (love poems, homosexual poems, religious poems, morality poems). In 1301, another Byzantine monk, Maximus Planudes, re-edited Cephalus’ anthology with a decidedly heavy hand on the red pen. Rather than adding extra poems as the editors before him did, Planudes mainly deleted the poems he found unsuitable and even bowdlerized some of the remaining ones to suit his taste. (You can probably guess which poems got the axe.) The Planudean collection, along with the Palatine Anthology (named for Count Palatine, in whose Heidelberg library the manuscript was found), make up what is now called the Greek Anthology. While many literary projects are blithely labeled “works in progress,” this anthology, reworked by at least five editors over 1400 years and containing more than 6000 poems, probably takes the cake. (The English-speaking world didn’t catch wind of the anthologizing craze until 1557, when Richard Tottel published a compendium of English poetry called Tottel’s Miscellany, beginning a tradition of eponymous titles carried to totemic status by Norton.)

Why is the urge to anthologize so potent? With the groundswell of writing that started before Meleager and that has grown—with the help of the Internet—into a publishing tsunami, we are awash in words. Books, magazines, journals, and newspapers slosh about our legs as we slog through the literary labors of daily life. And that’s just the contemporary flotsam! Behind us spreads the infinite sea of history. How then to identify the good stuff, the meaningful stuff? How to tease out overarching themes, to trace ancient influences on modern-day thought? How to extract the pith? How to make it possible for the overworked, the underpaid, the
timid, the skittish, and the lazy to scan centuries of the written word in a single sitting?

Enter the garland weavers. While anthologies were once the province of cloistered literary scholars, they have now spread to all disciplines. Medicine is something of a latecomer. Recently there has been a growing interest in the medical humanities, a recognition of the gifts that wielders of the pen, in particular, have to offer wielders of the stethoscope. The sudden “discovery” of the wealth of relevant writings, be they the case reports of doctors, the outpourings of the afflicted, or the observations of chain-smoking novelists, has given rise to a number of anthologies of literature and medicine in the past two decades.

To me, such collections are reminiscent of “rounding” on one’s patients in the hospital ward, moving from room to room, hearing one case history after another. When I do my thrice-yearly stints on the inpatient medical wards, it often astounds me how, in the space of three hours (and perhaps only a mere hundred feet), I can walk in and out of so many lives. The variety of background, appearance, voice, temperament, pain, pathology, and pathos is humbling. When I sit with my interns and students, reviewing each of the patients, it is really like listening to a collection of stories—an anthology, if you will. In this light, it is not surprising that doctors are natural storytellers, connoisseurs of plot and character. Unless, of course, they are the stereotypically obtuse type: the rigid, tight-lipped white coat with a bedside manner as humane as a roll of surgical tape. Ah, but even such anal-retentives seem smitten with the pen.

There are now several respectable anthologies of writings by doctors. *A Piece of My Mind* is a collection of short essays drawn from a column of the same name in the *Journal of the American Medical Association (JAMA)*. *On Being a Doctor* is a similar compendium extracted from the *Annals of Internal Medicine*. These essays typically offer insight into the life of a practicing physician.

Casting a wider net are the so-called literary anthologies of medicine. *On Doctoring* (1991) by Richard Reynolds and John Stone was the first of these. A
collection of stories, poems, and essays ranging from the Bible to Ethan Canin, it is geared toward students; indeed the Robert Wood Johnson Foundation has, for the past few years, provided copies to all incoming medical students, with the hope of softening the calluses inevitably acquired in the Dickensian workhouse that is medical training. Meanwhile, Richard Gordon’s *Literary Companion to Medicine* (1993) focuses mainly on the folks you knew from English Lit: Thomas Hardy, George Bernard Shaw, Evelyn Waugh, F. Scott Fitzgerald. But since most medical students and doctors these days probably passed up English Lit for extra biochemistry courses, this serves as an excellent catcher-upper.

A more textbook-like production is *A Life in Medicine: A Literary Anthology* (2002) by Robert Coles and Randy Testa. Inspired by a curriculum initiative from the Association of American Medical Colleges, the book is divided into four sections, each corresponding to a quality that the AAMC deems critical for medical students to acquire before society lets them run amok with live patients: altruism, knowledge, skill, and sense of duty. This book picks up where Richard Gordon’s leaves off, with the current generation of physician/writers—Abraham Verghese, Rafael Campo, Jerome Lowenstein, John Stone—though it also glances back to Lewis Thomas, Albert Schweitzer, William Carlos Williams, and Anton Chekhov, and includes contributions from nurses (Cortney Davis) and non-medical writers (Anne Fadiman, Raymond Carver).

Into the fray comes Iain Bamforth’s anthology *The Body in the Library: A Literary Anthology of Modern Medicine*. What use have we for yet another anthology of writings about medicine? Doctors barely have time to keep up with medical literature (the technical stuff, that is), much less indulge in a four-hundred-page helping of literature (the real kind.) But it would be facile to consider this book only in terms of where it fits in the medical profession. It is more of an anthropological dig through this stratum of society that increasingly absorbs our resources, our obsessions, our time, and our very lives.
Fourteen years before Tottel brought forth his *Miscellany*, Andreas Vesaleus published *On the Structure of the Human Body*. 1543 is what Bamforth calls Year Zero in the history of “medical daring,” when medicine finally decided to look within the body for answers, rather than taking on faith the answers provided by the Church, the ur-physician Galen, and outright superstition, which informed most of the “healing” procedures of the day. Vesalius pioneered the art of dissection, which, more than four centuries later, remains the first real initiation rite for aspiring physicians. Despite CT scans, MRIs, PET scans, and sophisticated computer technology, a medical student does not feel like a medical student until he or she has slit the chest of a cadaver and had the sickening yet wondrous experience of touching the insides of a human being. The student must grasp the paradoxical principle that, as Bamforth puts it, “violation is devotion, mutilation repair.”

Before Vesalius, Western physicians had little to do with the body. Barber-surgeons handled the muck and gore, while the Church handled the soul. Now physicians were going to save the patient by delving—literally—into the body. They were going to palpate, auscultate, percuss, and observe with keenly narrowed eye. Surgical procedures—both diagnostic and therapeutic—were now in the realm of medicine. And if the patient did not cooperate by getting better, the physicians would invade the body post-mortem to elucidate the nature of this uncooperativeness.

Bamforth’s title refers not to a foul murder in the Agatha Christie tradition but to this new primacy of the body in medicine that began in the sixteenth century. “The body was unmistakably the seat of power,” Bamforth writes in his introduction. “The royal body was never without its complement of doctors, who as often as not put it through torture…Medicine was a series of rituals, teachings and practices; a theatre of healing or purgation, in which a doctor hammed it up like most people in public life.”

The devotion to the body and its ills—and perhaps healing them—became a matter of public policy after the French Revolution. Public hospitals were opened at
an unprecedented rate, and health and hygiene entered the realms of societal discourse, urban planning, and municipal law. (Though, as Bamforth points out, the French are often far less good at practice than theory—a shortcoming amply demonstrated by George Orwell’s essay “How the Poor Die,” which details his “convalescence” in a Parisian charity ward, and which Bamforth includes.)

Luckily, in addition to becoming obsessed with the body, doctors and medical observers continued to write—copiously, in fact. This profusion of writing means that the medical archeologist has a detailed set of artifacts with which to study the patient, who in this case is the medical field itself. By assembling a library of artifacts (a garland of artifacts!), the archeologist can trace the growth and change of the patient. Just so, Bamforth traces the path of the “body in the library” to the “library in the body.” No sooner had doctors become passionate about the body than they began to pull back from it, perhaps slightly repulsed by what they observed. This retreat was abetted by the invention of the stethoscope in the early nineteenth century. As Bamforth writes, “René Laënnec discovered that a rolled-up wad of paper offered a better appreciation of internal body sounds (mediate as opposed to immediate auscultation, which required the ear to be directly applied to the patient’s body): his device was to transform what happened at the bedside. Not only that, but the distracting, unreliable and perhaps even unwashed patient could be decisively rebuffed.” The very posture of medicine was radically altered.

The availability of an ever-widening array of diagnostic tests continued the trend away from the body, to the extent that the tradition of bedside examination now seems rather quaint. Why sit with a stethoscope, straining one’s ears, discerning the musicality of a particular heart murmur —its intensity, its diminution or augmentation relative to the body posture —when a cardiac sonogram will provide the anatomical answer in a definitive manner? All the answers, it seems, can be found by means of diagnostic tests that scan the library of information shelved away inside us. “If the digitalized image [of the body] is superior to information gained by bedside examination,” Bamforth writes, “then doctors no longer require
the physical presence of the patient before making a diagnosis.... [I]f we lose touch with ourselves as embodied beings, with the very corporeal source of our individuation, we are likely to end up as tourists in the Library of Babel, which, steadily expanding since Leibniz’s day, now boasts splendid thoroughfares, squalid alleyways and perhaps even lonely squats and shelters. They are all likely to be cold and windy places, inimical to warmth and conviviality.” Bamforth goes on to quote Borges, who, in his famous story “The Library of Babel,” imagines a library that contains all books and promises “extravagant happiness.” The masses swarm into the library, but find themselves clashing with people and books professing contradictory beliefs. Madness, murder, and mayhem ensue in the grand library. “Its curators,” Bamforth comments slyly, “those white-coated people with the angelic expressions, are what people use to call doctors.”

Bamforth himself is one of those doctors. Born in Scotland, he has practiced medicine in both Europe and Australia, and currently lives in Strasbourg. His essays and book reviews appear regularly on both sides of the Atlantic, and he has published several books of poems, but The Body in the Library is his first anthology. The anthology format allows Bamforth to flex his impressive command of arts and letters, with pithy, often acerbic commentary preceding each selection. He even translated, or helped translate, pieces from French, German, Portuguese, Russian, and Hungarian. I wouldn’t be surprised if he assisted in the layout and design of this handsome book, whose 6’ x 8’ squatness makes it look more like it belongs in a Comparative Literature class than a Comparative Anatomy class. But that’s okay, since we doctors tote around enough oversized, overpriced textbooks. It’s good to feel literary again.

Though Bamforth includes several heart-wrenching patient voices, the writings here are mainly from the perspective of physicians. Several deal directly with the doctor-writer dualism, and one such is Alfred Döblin’s 1927 essay “My Double.” Divided into two sections, “The Neurologist Döblin Talks About the Writer Döblin” and “The Writer Döblin Talks about the Neurologist Döblin,” it
consists of an internal dialogue between the two halves of the man, and reveals a severe imbalance of perception. “Speaking as a doctor,” he says, “I have to confess to only the sketchiest knowledge of the writer who bears my name. To be perfectly honest, I really don’t know him at all.” Not only does the doctor not know the writer, he isn’t even particularly interested; in fact he’s rather disdainful.... [B]ooks bore me stiff and that goes particularly for books by the man who, as you say, bears my name. Once or twice at friends’ houses his books have come into my hands, but what I’ve glimpsed in them...leaves me absolutely cold.”

The writer, on the other hand, is far more impressed with his medical counterpart. He visits the doctor’s practice to meet his namesake, and also perhaps to glean some juicy material. “The gentleman makes a lively and not too bad impression,” he observes. “I saw the oddly compelling work with which he is occupied, and some of his patients have very odd diseases. I’m sure he’s by no means a unique specimen in his line of business, but I was very taken with the way he worked away, quite anonymously. He is my exact opposite, it struck me in passing, the objective way he handles, speaks, attends to things; while I’m a solo dancer, a prima donna, as my publisher once said...A few times I got quite hot under the collar when he gave me one of those psychotherapeutic stares. I have all kinds of quirks, probably complexes, and the expert probably got a whiff of them.”

Miguel Torga, a Portuguese otolaryngologist and general practitioner, takes a decidedly more charitable view of this dualism. In 1961 he wrote, “The pen that writes and the pen that prescribes switch over harmoniously in the same hands.” To the question of why medicine produces so many writers he replies, “It’s not medicine which produces them. Medicine limits itself to maintaining the gift in those who’re born with it....Unlike other professions which stifle in the individual the spirit that accepts and comprehends its kind, medicine does the contrary. The doctor qua doctor cannot close the doors of his soul, extinguish the glimmer of his understanding.”
Oliver Sacks sees these two aspects as even more closely linked. Chekhov famously quipped, “Literature is my mistress, medicine my lawful-wedded wife,” but Sacks specifically rejects such an arrangement. In a 1997 interview in The Lancet (reprinted here) he describes his writing as inseparable from his work. “[I have a feeling] of a single occupation in which the medicine and the writing are fused…. [T]reating a patient and creating a clinical narrative go together very closely for me. And I think this closeness is part of medicine. In a way, the case history…is this intriguing blend of something which is both clinical and human, it’s biologic. I think of it as being on the intersection of biology and biography, and the impact of a natural process on a human existence.”

Several selections in the anthology examine the “role” of the patient, and many of these will elicit frustrated sighs of recognition from the “patients” reading this book. Patients are often blamed—consciously or subconsciously—for their illnesses. Bill Clinton’s coronary bypass surgery provoked a host of tut-tutting news articles recounting his legendary passion for junk food. Patients with obesity, diabetes, and depression are often treated by physicians who shake their heads, bemoaning the lack of willpower to ameliorate these conditions. Samuel Butler takes this attitude to its logical extreme in his 1872 novel Erewhon. The part that Bamforth reprints concerns a twenty-three-year-old man who is placed on trial for contracting tuberculosis. The case is argued impartially before a jury, though the narrator remarks, a priori, that “the case was only too clear, for the prisoner was almost at the point of death, and it was astonishing that he had not been tried and convicted long previously. His coughing was incessant during the whole trial, and it was all that the two jailors in charge of him could do to keep him on his legs until it was over.” After the jury confers, the judge turns to the unfortunate young man and addresses him directly, regretting that he must pass a severe sentence:

“Prisoner at the bar, you have been accused of the great crime of labouring under pulmonary consumption, and after an impartial trial before a jury of your countrymen, you have been found guilty…[T]he evidence against you was
conclusive….It pains me much to see one who is yet so young, and whose prospects in life were otherwise so excellent, brought to this distressing condition by a constitution which I can only regard as radically vicious;...you have led a career of crime….You were convicted of aggravated bronchitis last year: and I find that though you are now only twenty-three years old, you have been imprisoned on no less than fourteen occasions for illnesses of a more or less hateful character; in fact, it is not too much to say that you have spent the greater part of your life in jail.

“It is all very well for you to say that you came of unhealthy parents, and had a severe accident in your childhood which permanently undermined your constitution; excuses such as these are the ordinary refuge of the criminal; but they cannot for one moment be listened to by the ear of justice.”

After dutifully acknowledging his guilt in a barely audible whisper, the prisoner is led to the prison “from which he was never to return.” Scattered applause accompanies these actions and the narrator concludes, “Indeed, nothing struck me more during my whole sojourn in the country, than the general respect for law and order.”

But it can also be the case that patients blame themselves for their illness, viewing it as a mark of character, or the lack thereof. This is a phenomenon that Susan Sontag dissects mercilessly in *Illness as Metaphor*, excerpted in this collection. Also excerpted is Jerome K. Jerome’s comic novel *Three Men in a Boat* (1889), whose narrator, “J.,” suffers from a condition known to teachers and students of medicine as “medical students’ disease.” Though not a student himself, J. finds himself in the British Museum reading a book on diseases—and growing progressively more ill:

“I came to typhoid fever—read the symptoms—discovered that I had typhoid fever, must have had it for months without knowing it—wondered what else I
had got; turned up St. Vitus’s Dance [Huntington’s chorea]—found, as I expected, that I had that too,—began to get interested in my case, and determined to sift it to the bottom, and so started alphabetically—read up ague [malaria], and learnt that I was sickening for it, and that the acute stage would commence in about another fortnight. Bright’s disease [nephritis], I was relieved to find, I had only in a modified form, and, so far as that was concerned, I might live for years. Cholera I had, with severe complications; and diphtheria I seemed to have been born with. I plodded conscientiously through the twenty-six letters, and the only malady I could conclude I had not got was housemaid’s knee.

“I felt rather hurt about this at first; it seemed somehow to be a sort of slight. Why hadn’t I got housemaid’s knee? Why this invidious reservation? After a while, however, less grasping feelings prevailed. I reflected that I had every other known malady in the pharmacology, and I grew less selfish, and determined to do without housemaid’s knee. Gout, in its most malignant stage, it would appear, had seized me without my being aware of it; and zymosis [fungal infection] I had evidently been suffering with from boyhood. There were no more diseases after zymosis, so I concluded there was nothing else the matter with me. (p 118).

J. seeks advice from his doctor. After a brief examination, he is handed the following prescription:

1 lb. beefsteak, with
1 pt. bitter beer
every 6 hours.
1 ten-mile walk every morning.
1 bed at 11 sharp every night
And don’t stuff up your head with things you don’t understand.

“I followed the directions,” J. concludes, “with the happy result…that my life was preserved and is still going on.” Sometimes, it seems, all it takes is a good kick in the butt, though it’s hard to argue that a ten-mile walk each day wouldn’t put a dent in many modern-day illnesses.
There is not much poetry in Bamforth’s collection, but what is there is pithy and well chosen. Gottfried Benn, described as a “dermatologist-venereologist” from Berlin, in 1912 wrote a brief poem that conveys the “pragmatism” and cynicism of the medical profession, ever so slightly tinged by empathy, more effectively than any seven-pound treatise on modern medicine and its ills:

CIRCULATION
The only molar of a whore
who’d died without next of kin
sported a gold filling.
(As if by tacit agreement her other teeth
had all decamped.)
It was swiped by the mortician’s assistant
and pawned, so he could go dancing,
for, as he put it,
“only dust should go back to dust”. (p 151)

Prima facie, epidemiologists wouldn’t seem to have the kind of access to grisly war stories that, say, trauma surgeons or ER doctors enjoy. But Peter Goldsworthy, an Australian GP doctor and poet, demonstrates that even those who deal with “just the facts” can easily raise the hairs on our necks. His poem “A Statistician to His Love” (its title a wink at Christopher Marlowe) comments on how doctors’ professional lives spill into their personal ones, infecting how they speak, think, and interact with “lay” people. More than one physician has botched a romantic encounter by opening his or her mouth without first applying an etiquette editor to their rambling hospital jargon. One might imagine the following scene taking place over cocktails in a candle-lit restaurant. Perhaps it’s a second date and the pressure is on to impress:

Men kill women in bedrooms, usually
by hand, or gun. Women kill men,
less often, in kitchens, with knives.
Don’t be alarmed, there is understanding
to be sucked from all such hard
and bony facts, or at least a sense
of symmetry. Drowned men—an
instance—float face down, women up.
But women, ignited, burn more fiercely.
The death camp pyres were, therefore,
sensibly women and children first,
an oily kind of kindling. The men
were stacked in rows on top. Yes,
there is always logic in the world.
And neatness. And the comfort
of fact. Did I mention that suicides
outnumber homicides. So stay awhile yet
with me: the person to avoid, alone,
is mostly you yourself.

But the gruesomeness seen by doctors pales beside that experienced by
patients. The horrors of the treatment of the poor and other undesirables are
described with blood-curdling specificity by Orwell. His harrowing interment in a
charity hospital in Paris in 1929 is recounted in terms far more Dickensian than the
Dickens story that opens the anthology. Orwell wrote the essay twenty years later,
but the traumatic memories of his “care” were etched with painful accuracy into his
mind. His induction into the hospital takes the form of interrogation-style
questioning, which he endures while tottering on his feet with a 103 fever (which he
struggles to re-calculate from Réaumur to Fahrenheit). This is followed by the
compulsory bath, which involves the patient shivering in 5 inches of water while his
clothes are whisked away and replaced with a flimsy hospital nightshirt. Then he is
marched 200 yards outdoors—in the dark, barefoot, bare-legged—to the distant
charity ward of the hospital. (Orwell wryly observes that this frigid trek probably
brought down his fever). He sits on his pathetic bed, and watches, horrified, as a
ward-mate gets cupped, a treatment he had “vaguely thought of as one of those
things they do to horses.” Then it’s his turn:
The next moment …the doctor and the student came across to my bed, hoisted me upright and without a word began applying the same set of glasses, which had not been sterilized in any way. A few feeble protests that I uttered got no more response than if I had been an animal. I was very much impressed by the impersonal way in which the two men started on me. I had never been in the public ward of a hospital before, and it was my first experience of doctors who handle you without speaking to you or, in a human sense, taking any notice of you.

Orwell hopes that this is the last of his degradations, but no, the mustard poultice follows immediately afterward. Two nurses slather his chest with the compound and then bind him tightly with bandages to keep it in place. The inhumanity extends from the medical staff to the other patients, who are so thoroughly demeaned that they no longer are capable of empathy toward their fellow sufferers:

I learned later that watching a patient have a mustard poultice was a favourite pastime in the ward. These things are normally applied for a quarter of an hour and certainly they are funny enough if you don’t happen to be the person inside. For the first five minutes the pain is severe, but you believe you can bear it. During the second five minutes this belief evaporates, but the poultice is buckled at the back and you can’t get it off. This is the period the onlookers enjoy most.

The days pass with abominable care, inedible food, general disregard for the patients’ welfare. Each afternoon, a “tall, solemn, black-bearded” doctor strides through the sixty-bed ward, a troop of eager students following. But most patients are ignored, day after day, unless they are lucky enough to have contracted an illness of academic interest. Orwell’s bronchial rattle is sufficiently intriguing to attract the students and their stethoscopes, but their attention remains resolutely focused on his bronchioles, never on him.
After watching a gentleman with cirrhosis—Numéro 57, as he was known—die a slow, painful, and anonymous death, Orwell is struck by the fact that “this disgusting piece of refuse, waiting to be carted away and dumped on a slab in the dissecting room, was an example of ‘natural’ death.” He concludes that “it’s better to die violently and not too old. People talk about the horrors of war, but what weapon has man invented that even approaches in cruelty some of the commoner diseases?”

Care for the poor has improved somewhat since Orwell’s day, but in many places in the world his account would seem contemporary. Certainly the horrors of common diseases like tuberculosis, HIV, and diarrheal and parasitic illnesses that are treatable or even curable in Western countries, devastate poorer countries with the same ferocity as war.

The parallel of illness and war, however, can seep even into “first-world” medicine. In an excerpt from The Dressing Station: A Surgeon’s Odyssey (2001), Jonathan Kaplan describes his swank medical practice in London’s financial district. Having earlier done medical duty in Eritrea, Kaplan finds that the corporate world is itself a sort of war zone:

I’m accustomed by now to dealing with the victims of war and crisis; swept away by forces they cannot escape, or crushed by the realization of their own helplessness. But in this new conflict—perhaps the strangest I have seen—my patients are under an attack far more insidious: from the very elements of the lives they have constructed for themselves. These brokers, bankers and traders are hard-working, productive individuals trying to survive in a ruthless environment. They are driven relentlessly by the pressure to succeed, and are laid low by the diseases of success: heart attacks, ulcers, anxiety, attacks, addiction. When the financial tides go against them they suffer the terrors of failure; the sleep disorders, depression, impotence and alcoholism. In advance or in retreat the threats are endless. (p 407)
One of Kaplan’s patients is a trader whose “incandescent performance” has mesmerized his coworkers, and whose “eccentric behaviour [is] taken as clear evidence of his genius.” The man happens to be suffering from schizophrenia, and Kaplan is dumbfounded “at the sort of environment he works in where no one has apparently found anything odd about his paranoid delusions.” In the financial markets, as on the battlefield, madmen and geniuses are often one and the same.

Much like rats in their experimental mazes with hidden shock bars, these traders live in fear of unpredictable markets, mergers that may “dissolve” their jobs, and the legions of hungry wannabes who can replace them at any moment, should their performance lag. A patient to whom Kaplan administers a stress test had earlier seen a colleague leaving the medical office, and is eager know how his results compare with his colleague’s. Another, when told that his stress test results might indicate coronary disease, pleads with Kaplan not to tell his company, because he would be removed from the trading floor. Kaplan is shaken that his patient seems to find “failure more frightening than death.”

Another of Kaplan’s patients is a director of an international banking group, and Kaplan speculates that his salary probably “exceed[s] the entire annual health budgets of some of the ragged countries in which I’ve worked.” (If Kaplan worked in New York, his patients’ salaries might exceed the GNPs of those same countries.) The man’s opulent lifestyle is beyond imagination. But he is now visited at night by a ghost who paralyzes him in his bedsheets. “It was my death looking at me,” he says. Kaplan tries to talk to him about depression, fear, motivation, hope, and the need for psychiatric help, but none of his words penetrate:

The man’s desolation is as complete as that of a conscript who has stepped on a landmine and now stares endlessly at his stumps. I realize that, tucked away in a sidestreet near the Bank of England, I am seeing the same pathology, the same shock of dislocation that I have encountered on other battlefields….
‘There is no rush,’ I tell him. ‘Some try to avoid their deaths, others go out to find it. All will reach it at the same time.’

‘What do you know about it?’ he asks, perhaps forgetting my profession. ‘What do you know about death?’

What do doctors know about death? Sometimes precious little, at other times too much. Martin Winkler, in his comic but often truthful Little Medical Afflicationary, defines death as an “irremediable breakdown between a patient and doctor….It is only a stage—often inevitable—in the doctor-patient relationship which ought to be delayed as long as possible in order for it to be fully receipted.” For his part, W.H. Auden ventures, in a provocative aphorism, that “The Doctor and the Public Hangman require the same qualifications.” In his poem “The Art of Healing,” however, Auden feels the humanity of his own physician, who has died:

Most patients believe
dying is something they do,
not their physician,
that white-coated sage,
ever to be imagined
naked or married….

Bert Kreizer’s essay “My Father’s Death” eloquently reinforces Bamforth’s thesis about the body in the library being replaced by the library in the body. A Dutch physician, Kreizer is able to look at this trend as both an insider and an outsider. He admits that medicine has done much to help us live well. The seminal discoveries and innovations of nineteenth- and twentieth-century medicine—the anatomic basis of disease, antisepsis, antibiotics, anesthesia—have allowed phenomenal cures and treatments. But only for some diseases. Kreizer writes of “a small bright circle at the centre [of medical practice] where a number of treatments are gathered that have been proved to be efficacious. Beyond this centre we stumble
into a twilight zone, where we find a number of treatments that might some day justifiably be placed in the bright centre but have as yet not earned that place. Beyond this zone, darkness reigns.” The problem, Kreizer continues, is that “Doctors place many more of their doings in the hallowed centre than is scientifically justifiable. Patients are hardly aware of the murkier zones at all. They reckon all is in the centre, or almost there anyway.”

The “war on cancer” Kreizer compares to the coming of “true socialism” in the former Soviet Union—it is always “just around the corner.” But patients and doctors are ever optimistic, and ever overconfident of medicine’s prowess. Kreizer understands this, because nobody wants to die, but he feels that physicians aren’t doing enough to explain to patients—and themselves—the limits of medicine, and when to stop. His father’s experience in the late 1990s was all too typical. His hospitalization was almost as degrading as Orwell’s, although the techniques, and perhaps the motivations, were different. “One of the most ill-starred meetings in modern medicine,” Kreizer writes, “is that between a frail, defenceless old man nearing the end of his life, and an agile young intern at the beginning of his career.” His poignancy hits home for me, as I spend my days training these agile young interns.

Every symptom begets another specialist. Every specialist begets another test. Every test begets another treatment. Every treatment begets another complication. In a sequence horribly familiar to any physician who has worked in a modern hospital, the patient is reduced, in less than two weeks, to a babbling, incoherent, incontinent, bed sore-ridden shell of a man, with another consultant waiting around the corner, suggesting yet another “work-up.”

Looking back at two centuries of medical progress, Kreizer observes that, “Its success in alleviating suffering was so immense as to leave us all over-impressed. However, not all physical suffering can or ever will be taken away by medicine, and yet we act as if medicine can do this, or will soon be capable of doing this. Paradoxically, this leads to increased suffering, especially in the hour of death,
when the scientific analysis of bodily events ignores the sadness of parting from life.” Or, as he suggests Beckett would say, “You’re human, and there’s no cure for that.” (p 390)

Kreizer notes that when a patient asks, “Why am I to die?” the doctor often launches into a discussion of the pathophysiology of disease. And when the patient interrupts and says, “I meant why me?” the doctor seems unable to understand, in Kreizer’s view, the existential nature of the question. “Usually…the patient is dismissed,” he notes, “the why-me question is buried under a deluge of diagnostic moves. The sad misunderstanding being that a blood test, an X-ray, a scan, can never tell us anything about why we are here. Since God left the premises, also somewhere in the nineteenth century, we have been lumbered with a certain ignorance about the purpose of life. It seems to me that this ignorance is eagerly buried underneath a pile of tests, none of which can show us why we suffer.”

This is a depressing note on which to wind down a four-hundred-page tour through modern medicine. Aply so: While Bamforth chronicles the switch to “the library in the body” with scientific dispassion, it’s clear from the way he organizes his selections —the way he weaves his garland—that he laments it. By the time one gets to the end of the book, one almost mourns the very progress of medicine, for the scientific good seems outweighed by the humanistic bad. Yet in choosing to end with Kreizer’s and Kaplan’s essays, Bamforth is also being slyly optimistic. We can’t change many of the physical realities of illness. (For doctors who need hard numbers to live by, Kreizer computes the exact percentage of patients who will die: 100%.) We can do little to alleviate poverty, war, epidemics, and addiction. But we can change how we think about them. The cynic might say that this means nothing to the dying patient desperate for a cure, but in fact it might be such a patient to whom it means the most.

Admitting to the limitations of medicine, accepting that there is no “cure” for the frailties of being human, realizing that death is inevitable, might help us to face reality. Sometimes that is what a dying patient needs most, along with a generous
dose of morphine and a duly notarized DNR. These lessons aren’t typically taught in patho-physiology courses in medical school. We often find ourselves looking toward “softer” sciences like literature to broaden our understanding of these great medical truths. Caught up in the frenetic business of illness, pain, and dying, doctors (and patients, for that matter) often don’t have the energy to survey several centuries of writing and pluck out the gems. Thank goodness, then, for the garland weavers. Bamforth is one of the finest.