The Fortunate Physician: Learning from Our Patients

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Introduction

In the 1960s, the author John Berger and the photographer Jean Mohr spent six weeks with an English country doctor, observing him "in his house, in his surgery, and on his night calls."[1] The doctor, John Sassall, lived and worked in an impoverished community in the west of England, near Monmouth. Berger and Sassall had met earlier, when Berger was living in a neighboring village and he had consulted Sassall about abdominal pain. A friendship developed and Berger eventually approached Sassall with his idea to chronicle the doctor's interactions with his patients. Berger recorded the stories he observed in *A Fortunate Man*, a book that presents clinical vignettes of Sassall at work as well as commentary on his professional and personal development, with accompanying photographs by Mohr. Near the end of this remarkable book, Berger explains to the reader that "Sassall, with the cunning intuition that any fortunate man requires today in order to go on working at what he believes in, has established the situation he needs."[2] The "situation" to which Berger refers is the set of circumstances that Sassall created in order to satisfy his need to learn more about the humanity of his patients and to learn more about himself as a physician and as a man.

As a psychoanalyst in my thirtieth year as a physician, I have been reflecting upon how fortunate I am to be engaged in a process that, while constantly challenging me to become a more effective clinician, provides the dual opportunities to better grasp what is essential to the lives of my patients and to comprehend more about myself.[3] My training has taught me to focus closely on what is "written" intersubjectively between analyst and patient as a path to "reading" what my patients are trying to communicate about their lives. In order to do so, I constantly confront my limited self-understanding

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and engage in self-inquiry. This, to my mind, is a fortunate set of circumstances.

Primary-care physicians at the front lines of patient care are also afforded moments in the physician-patient relationship when they can achieve a partnering of self-reflection and self-inquiry with engaged, attuned clinical work. Medical training, however, has traditionally devalued the physician's subjective experience with his or her patients and has failed to encourage a mutual appreciation for the unique experience created by doctor and patient at a particular moment in time.

I sought a way to communicate what I have found in my clinical experience as a psychoanalyst that would be of value both to the practicing physician and to the growing body of literature on narrative medicine.[4] Recognizing that the terminology and frames of reference that psychoanalysts use to speak about their work often seem off-putting, if not irrelevant, to the practicing physician, I knew that if I wanted to enter into substantive dialogue with physicians, I needed to speak in words that were meaningful to them. When I discovered *A Fortunate Man*, I found a medium through which I could convey elements of my training and experience as an analyst in a form that would be accessible to my physician colleagues.

This paper is based to a significant degree upon a series of evening classes titled Conversations for Physicians, for which I used *A Fortunate Man* as a stimulus for discussing the physician-patient relationship, the professional and personal development of the physician, and the practice of narrative medicine. Throughout *A Fortunate Man*, Berger's accounts of Sassall's clinical encounters demonstrate how experiences with patients may be transformed through the practice of narrative medicine. While there are radical differences between the medical culture of an English country doctor practicing in the late 1960s and that of a contemporary medical practitioner, *A Fortunate Man* captures something that is universal and enduring about the life of a physician. I thought that practicing physicians would find these clinical vignettes and descriptions of Sassall's professional development true to their own experience. Furthermore, I recognized that the language Berger uses speaks to the doctor-with-patient experience in a manner that would bring a "psychoanalytic sensibility" to the discussions, thereby providing many opportunities for me to introduce psychoanalytic perspectives—freed from analytic terminology—about the physician's encounter with the patient.[5]

Internal Landscapes

Throughout *A Fortunate Man*, Berger's language is complemented by Mohr's evocative photographs. The opening pages feature bucolic scenes: a winding road amidst forest and field, two men in a boat fishing on a calm river. But as the book progresses, the photographs turn from crisp and sunny to dark, foggy, and barely discernable. The following words appear in the lower right-hand corners of the first two photographs:

> Landscapes can be deceptive. Sometimes a landscape seems to be less a setting for the life of its inhabitants than a curtain behind which their struggles, achievements and accidents take place. For those who, with the inhabitants are behind the curtain, landmarks are no longer only geographic but also biographical and personal. (13–5)

Berger is an essayist of the highest order who most often writes about life from the perspective of the world of art. His collections of essays—W*ays of Seeing, The Look of Things, The Sense of Sight, Toward Reality*, *About Looking*—develop the reader's aesthetic sensibility by suggesting more encompassing ways of perceiving and of understanding what—and more importantly *how*—he or she is viewing. We know, therefore, that when he speaks of "landscapes," Berger refers not only to external landscapes but also to the entire universe of the internal, psychological world.

The frontispiece of the book shows Sassall at the threshold of his office, his gaze directed inside (perhaps toward a patient to whom he is listening) and his hand resting on the outside of the opened door—in the liminal space between inside and outside. This is where the mature clinician knows he or she must live: poised with binocular vision to perceive what originates within but manifests in both the physical and psychological lives of the patient. The most seasoned physician has much the same appreciation for his or her own inner and outer psychic and somatic worlds.

The Doctor's Story: The Development of the Physician

Sassall did not always possess the capacity to see beyond the external presentations of his patients. Early in his career his experience of the physician-patient relationship was simplified by the belief that

the physician was an active, objective agent encountering a passive, subjective patient. Berger writes that Sassall "had no patience with anything except emergencies or serious illness. . . . He dealt only with crises in which he was the central character . . . in which the patient was *simplified* by the degree of his physical dependence on the doctor. . . . [This] made it impossible and unnecessary for him to examine his own motives" (55, Berger's italics).

Berger informs us that as a boy, Sassall read Joseph Conrad's stories of the sea, through which he constructed a model of what a physician should be. Like the mariners in Conrad's stories who conquer the elements of the weather and the sea, Sassall viewed himself as a heroic figure: the doctor as master mariner who vanquished disease. He and the disease were active, while his patients were passive. He did not consider how the patient's entire personality shaped the manner in which the patient expressed his or her illness or how his own personality and his ways of viewing impacted the sufficiency of his diagnosis and the effectiveness of his treatment.

But Sassall brought something more from Conrad's vision of the hero to the practice of medicine. For Conrad's mariners, the dangers of the sea could only be faced by men who were outwardly controlled, who could encounter the sea without feeling, without a subjective response. The physician whose life is patterned after these mariners must give up his imagination:

> The quality which Conrad constantly warns against is at the same time the very quality to which he appeals: the quality of imagination. . . . It is to the imagination that the sea appeals: but to face the sea in its unimaginable fury, to meet its own challenge, imagination must be abandoned, for it leads to self-isolation and fear. . . . [Sassall] admired physical prowess. He enjoyed being practical and using his hands. He was inquisitive about things rather than feelings. (52)

Then something happened, a sudden revelation that showed Sassall that the truth of his patients' lives was not always what it seemed on the surface:

> They had lived in the Forest for thirty years. . . . The husband said that his wife 'was bleeding from down below'. . . . When he [Sassall] went back into the parlour, the wife was lying on the ottoman. Her stockings were rolled down and her dress up. 'She' was a man. He examined her. The trouble was severe piles. Neither he nor the

> husband nor she referred to the sexual organs which should not have been there. (56)

Shocked and then perplexed by this experience, Sassall was confronted with the fact that he had no way to go about understanding how these two males had sustained a life as man and wife. The obvious yet profound recognition that external appearances may be deceptive leads Sassall to a new approach to his work, an approach that involves understanding what motivates people, what makes them who they are. This experience requires Sassall to span the distance between the external "landscape" presented by his patient and the internal world of meanings that inform the patient's relationship with himself or herself and with others. To do this, he must reject the mariners' denial of imagination and method of projecting inner experience onto the sea:

> He had . . . [used] illness and medical dangers as they used the sea. He began to realize that he must face his imagination, even explore it. It must no longer lead always to the 'unimaginable', as it had with the Master Mariners contemplating the possible fury of the elements—or, as in his case, to his contemplating only fights within the jaws of death itself. . . . He began to realize that imagination had to be lived with on every level: his own imagination first—because otherwise this could distort his observation—and then the imagination of his patients. (56–7)

Once Sassall's imagination comes to life in his work, it not only becomes possible for him to explore his personal psychology and that of his patients, he realizes he must do so if he wishes to become a more complete physician. Allowing his imagination a clinical function, Sassall listens to his patients with better-attuned ears and sees them in a new light. Furthermore, he becomes able to create personal narratives from what he observes of his patients, those who have become redefined by physical disease or by deforming external circumstances. In his attempts to be of service to those patients, Sassall now "*restories* the patient."[6] To understand his patients' stories more fully, and to differentiate them from his own, he must learn more about himself—his character, his motivations, his personal history, his ways of comprehending the world. He reads Freud and enters into a self-analysis that is initially so disturbing that he becomes sexually impotent for a time. He emerges from his six months of self-examination with a different approach to his patients and a more comprehensive understanding of the forms in

which illness manifests.[7] He realizes "that the patient should be treated as a total personality, that illness is frequently a form of expression rather than a surrender to natural hazards" (62).

Sassall, now a more mature clinician, no longer needs to create such emotional distance between himself and his patients, and his therapeutic relationships improve. For example, he now understands that illness deforms the patient's sense of who he or she is, and he imagines how he might help restore to the patient a more coherent sense of self: "Illness separates and encourages a distorted, fragmentated form of self-consciousness. The doctor, through his relationship with the invalid and by means of the special intimacy he is allowed, has to compensate for these broken connections" (69).

Sassall finds that the physician-patient relationship is much more complex than he had believed it to be. He must develop his imagination in a way that will allow him to look inside his patients and inside himself to be more cognizant of what occurs *between* them. Not only do his patients experience feelings about their encounters with disease, their intimate contact with him evokes emotions for him as well. He discovers that his subjective reactions to his patients and to their diseases affect his view of the patient, impact the diagnoses he makes, and, to a significant degree, determine how he proceeds with treatment. Worlds apart from the earlier, less developed model of the physician-patient relationship, this one is a living, breathing two-person relationship that takes into account the subjectivity of both doctor and patient. Rather than denying the patient's emotional impact upon the physician, the more developed physician makes fuller use of his senses and imagination to apprehend his patient and the manner in which the patient's *disease* may present itself in the form of an *illness*.[8]

It is here that Sassall's good fortune begins, with his recognition that his earlier model of himself as the hero, the protagonist of the story who exists to conquer disease, limited his capacities to be a physician in the fullest sense. By listening to his patients' stories and understanding who they are as people, Sassall now grasps that disease expresses itself in unique ways, ways that are shaped by the patient's personal psychology as well as the social and interpersonal context, including the doctor-patient one. Sassall is also fortunate because his work with his patients fosters his own emotional development, allowing him to become more of a human being in the unfolding physician-patient relationship. He becomes a better man as he becomes a better doctor, achieving stronger connections with his own emotional life as well as with his patients. Through his increasing capacity to discern his feelings

and reflect upon personal meanings, he grows more competent in finding words to communicate his understandings of their experience to his patients:

> Once he was putting a syringe deep into a man's chest: there was little question of pain but it made the man feel bad: the man tried to explain his revulsion: 'That's where I live, where you're putting that needle in.' 'I know,' Sassall said, 'I know what it feels like. I can't bear anything done near my eyes, I can't bear to be touched there. I think that's where I live, just under and behind my eyes.' (47–50)

The patient is telling Sassall what it *means* to him to be penetrated by a needle in that part of his body. Because Sassall now has better access to his own feelings and to his own world of meanings, he is able to make a meaningful connection with his patient. By developing his own human sensibility, he comes to possess a clinical instrument that addresses the patient's interior just as powerfully as a stethoscope and as effectively as medication.

A Failed Connection

Placed among the vignettes describing Sassall at his best is one that illustrates his experience with a case that "failed"—where he felt that his approach was inadequate to the problem that his patient presented. A cautionary tale, demonstrating that the physician—even when his intention to help is most operative—may not always connect with his patient, it reminds physicians that powerful psychological and social forces may stand in the way of their best therapeutic efforts.

The vignette presents a thirty-seven-year-old unmarried woman, now living with her ill mother, who was first seen by Sassall ten years earlier when she consulted him for a cough and a sense of weakness. Her chest film at the time was normal. Sassall felt that she wanted to talk about something, yet she refused to look at him directly, "casting him quick anxious glances as though somehow by these to bring him closer. He questioned her but could not gain her confidence" (21). A few months later she returned, complaining of insomnia and asthmatic symptoms. Berger describes Sassall's observation of the change taking place in his patient in a way that also illustrates the change in the physician-patient relationship:

> Now when he saw her, she smiled at him through her illness. Her eyes were round like a rabbit's. She was timid of anything outside the cage of her illness. If anybody approached too near her eyes twitched like the skin round a rabbit's nose. . . . He was convinced that her condition was the result of extreme emotional stress. Both she and her mother insisted, however, that she had no worries. (21)

Two years later Sassall discovers the cause of her problems through a chance conversation with a woman who had worked with the patient at a dairy. The woman tells Sassall that the manager of the dairy—a member of the Salvation Army—had an affair with the patient and promised to marry her. Overcome with religious scruples, however, he abandoned her. On a house call to see her ailing mother, Sassall, armed with this information, tries again to reach his patient:

> The doctor once again questioned the girl's mother. Had her daughter been happy when she worked at that dairy? Yes, perfectly. He asked the girl if she had been happy there. She smiled in her cage and nodded her head. Then he asked her outright if the manager had ever made a pass at her. She froze—like an animal who realizes that it is impossible to bolt. Her hands stopped moving. Her head remained averted. Her breathing became inaudible. She never answered him. (23)

Thereafter, the woman's asthma worsens, causing structural damage to her lungs. She survives by taking steroids, her face left moon shaped. She rarely leaves the cottage where she lives with her mother; her life has devolved into the cage of her illness. She effectively gives up on life. Sassall recognizes that the manner in which she resigns herself to the role of one-who-is-sick expresses how she feels about herself and what life she believes she deserves. Berger writes, "Before the water was deep. Then the torrent of God and the man. And afterwards the shallows, clear but constantly disturbed, endlessly irritated by their very shallowness as though by an allergy. There is a bend in the river which often reminds the doctor of his failure" (23).

Clearly Sassall is also "constantly disturbed" by the course her life has taken, and he blames himself for it. He does not fully accept that there are times when, even in the hands of the most experienced, determined, and humane practitioner, a patient may fall into his or her own angle of repose.[9] That is, there are elements of character and of motivation that powerfully (even irrevocably) determine one's psycho-

logical response to trauma. These forces may not be overcome by the most seasoned of clinicians.

Moreover, there is something beyond this woman's manner of psychologically managing her painful experience that impairs the physician's attempt to reach her. Perhaps Sassall himself unknowingly contributed to this failed connection because he had not completely given up his fantasy of being the hero who "conquers" disease, or had not accepted that all physicians face limitations in their attempts to treat illness. Frustrated and threatened by his lack of therapeutic potency with the patient, Sassall attempted to force her to "open up" about her experience, ignoring the extraordinary sense of shame and guilt she must have experienced (both in the original event of the affair and in her retelling of the story to her physician).[10] Her sense of humiliation would have been all the more excruciating in her mother's presence. While Berger suggests that Sassall is haunted by this missed connection—he never ceases looking for what it was within him that interfered with his reaching this patient—we never know whether he discovers the manner in which his own personal psychology contributed to the therapeutic impasse.

It is fortunate that our patients may teach us how to be better doctors—how to become more attuned human beings—even through our failures with them. And fortunate, though always painful and humbling for the physician, that they can remind us of our own limitations.

Recognizing the Patient

As Sassall begins to listen more carefully to his patients, he realizes that the forms in which disease are expressed are largely determined by the entire personality of the patient. He now strives to engage in a physician-patient relationship that will facilitate a more comprehensive type of healing rather than simply "conquer" disease. This kind of healing can still take place even if he cannot cure the patient's disease and may take place even as the patient lies dying.

Berger also describes Sassall's experience with the mother of the patient just described, a woman whose congestive heart failure has forced her to live in her bed. As Sassall enters the house, he finds that she now has pneumonia. He gives her an injection, after which the old woman says, "It's not your fault" (26). Berger captures who this woman is, who she had been, and what the doctor sees and thinks as he examines her:

> He listened to her chest. Her overworked brown arms, her deeply lined face, her creased strained neck were suddenly denied by the soft whiteness of her breast. The grey-haired son down in the yard with the cows, the daughter at the foot of the bed in carpet slippers and with swollen ankles, had both once clambered and fed here, and yet the soft whiteness of her breast was like a young girl's. This she had preserved. (26)

This passage beautifully demonstrates how Sassall comes to recognize his patient by viewing her and her environment as a narrative to be "read." Her story is "written" not only by the presence of her children and husband that documents her life as mother and wife; Sassall reads what is *written on her body*—"overworked brown arms, her deeply lined face, her creased, strained neck"—and this illustrates how her life was lived. The "soft whiteness of her breast" reminds him that the young woman she had been is still a living part of her narrative. Her past and her present are captured in this very moment.

Sassall speaks to the old woman's husband, promising that he will return that evening. When he does so, what he sees disturbs him:

> [T]he parlour was in darkness. . . . He called out and receiving no answer felt his way up the stairs. . . . The room smelt now of sickness. . . . The old woman was paler and a piece of damp rag was laid over her forehead. . . . The doctor listened once more to her chest. She lay back exhausted. 'I am sorry,' she said, not as though it were an apology but simply a fact. He took her temperature and blood pressure. 'I know,' he said, 'but you'll sleep soon and be rested.' (27)

The old woman knows that they have done their best, but the end is near. "I'm sorry" may in part be an apology, for she knows that her physician has a personal need to heal and that he will be disappointed in himself for not saving her. Sassall's response, "I know," communicates many things at once: "I understand how you feel. I know the place, the inner and outer landscapes where you now live in your illness and where you used to live when you were young; I have been here many times before. I will not let you suffer unnecessarily. I am here with you."

Sassall tells the daughter and the husband that his patient has pneumonia and instructs them about the medication. The old man is silent, yet his hands—"clutching and unclutching the heavy material of

the overcoat across his knees" (28)—speak what he thinks, how he feels. As the doctor is leaving, the old man begins to cry. The tears well up in his eyes, and Sassall puts his bag down, leans back in a chair, and asks, "Can you make us a cup of tea?" (29). He speaks with the man about the apple orchard and with the daughter about her father's rheumatism.

The next morning the old woman dies—quickly—after a second attack. Berger chronicles the scene: "In the parlour the old man rocked on his feet. The doctor deliberately did not put out a hand to steady him. Instead he faced him . . . [and said,] 'It would have been worse for her if she'd lived. It would have been worse'" (29). Here Sassall is a fortunate man—the fortunate physician. He has learned from his patients that the individual elements of their lives—physical/emotional, individual/family, external/internal, past/present—contribute to their larger biopsychosocial world and to his role in that world. He can now perceive and respond to the broader dimensions of illness. As he "read" the old woman's "story," he saw that she was part of a larger story that included her husband and her daughter (and now Sassall himself) at the same time that the present narrative was unfolding. Sassall was attuned and responsive to the old woman, and he engaged the husband and daughter as parts of the totality of her "illness."

As a more experienced, more developed physician, Sassall's perceptions extended beyond his recognition of the signs of congestive heart failure and the sounds of pneumonia and beyond his evaluation of the patient's color, pulse, respiration, and temperature. Because Sassall was able to perceive his own feelings, as the particular medical situation emotionally impacted him, he could see the pain that her family felt. And because he could do so, his medical treatment exceeded the reach of the injections he administered and the pills he prescribed. It extended beyond treating this old, dying woman to treating her family. Sassall eased her dying by tending to her family's anguish.

Furthermore, he used his more fully developed capacities for viewing his patient's illness and his sensibility in attending to her pain in a way that pleased him, fulfilled him—actualized him. Through this approach, he too found some modicum of comfort.

In *A Fortunate Man*, Berger demonstrates that Sassall has achieved a kind of narrative competence that allows him to envision his patients' lives as coherent stories, to recognize them as the human beings they are, and to help them restore a sense of wholeness to these lives that have been shattered by illness. Berger speaks about the physician's capacity for recognition and for creating authentic connections that heal:

> What is required of [the doctor] is that he should recognize his patient with the certainty of an ideal brother. The function of fraternity is *recognition*. This individual and closely intimate recognition is required on both a physical and psychological level. On the former it constitutes the art of diagnosis. Good general diagnosticians are rare, not because most doctors lack medical knowledge, but because most are incapable of taking in all the possible relevant facts—emotional, historical, environmental as well as physical. They are searching for specific *conditions* instead of the *truth* about a man which may then suggest various conditions. . . . On the psychological level recognition means support. As soon as we are ill we fear that our illness is unique. . . . The illness, as an undefined force, is a potential threat to our very being. (69–73, my italics)

The physician must recognize the patient as a *person*—one not so unlike himself or herself—in order to be an effective doctor. As if in conversation with the practice of narrative medicine and clinical psychoanalysis in the twenty-first century, Berger asks:

> How is it that Sassall is acknowledged as a good doctor? By his cures? . . . I doubt it. . . . No, he is acknowledged as a good doctor because he meets the deep but unformulated expectation of the sick for a sense of fraternity. He recognizes them. Sometimes he fails—often because he has missed a critical opportunity and the patient's suppressed resentment becomes too hard to break through—but there is about him the constant will of a man trying recognize. (76)[11]

Berger's phrase—"the constant will of a man trying to recognize"—captures what is asked of the physician when he enters into the physician-patient relationship intent upon discovering the human being who is ill. Sassall describes his entry into his patient's world:

> 'The door opens,' he says, 'and sometimes I feel I'm in the valley of death. It's all right when once I am working. I try to overcome this shyness because for the patient the first contact is extremely important. If he's put off and doesn't feel welcome [recognized as a human being who is ill], it may take a long time to win his confidence back and perhaps never. All diffidence in my position is a fault. A form of negligence.' (77)

The physician must have the courage to cross the threshold into the patient's universe—"the valley of death"—in order to grasp who the

patient *is* as a person and what it might be like *to be* the patient at the very moment of the encounter. Berger describes the kind of physician-patient relationship that Sassall creates through his *recognition* of his patients, his *intention* to understand and to be helpful, and his capacity to *communicate* physically and psychologically with his patients: "It is as though when he talks or listens to a patient, he is also touching them with his hands so as to be less likely to misunderstand; and it is as though, when he is physically examining a patient, they were also conversing" (77). This is the physician as communicator and as healer.

What motivates a physician to engage in such relationships with patients? There are, of course, the wish for excellence and the need to be fully actualized as a practitioner of the art and science of medicine. There are love and respect for humankind and the desire to be helpful to others. But Berger hits upon other traits—attributes of Sassall's character that he believes drive him to such excellence: curiosity and imagination. He writes, "He has an appetite for experience which keeps pace with his imagination and which has not been suppressed. It is the knowledge of the impossibility of satisfying any such appetite for new experience which kills the imagination of most people over thirty in our society" (78). Berger further describes Sassall's ways of listening, looking, and knowing:

> When patients are describing their conditions or worries to Sassall, instead of nodding his head or murmuring 'yes', he says again and again 'I know', 'I know'. He says it with genuine sympathy. Yet it is what he says whilst he is waiting to know more. He already knows what it is like to be this patient in a certain condition: but he does not yet know the full explanation of that condition, nor the extent of his own power. (81)

The Use of Imagination

As Sassall reconceives his role with his patients and lessens the emotional distance between them, he uses his imagination to envision who the patient *is* and where the patient "lives" in the unfolding narrative of his or her life. He does so by imagining what it would be like *to be* his patient within the context of the physical, psychological, social, and existential circumstances in which he or she lives. Sassall is then able to employ his "imaginative 'proliferation' of himself in 'becoming' one patient after another" (143).[12]

Berger writes about an experience between Sassall and a sixteen-year-old woman who enters his office crying. She cannot tell him what is the matter. "I just feel sort of miserable" (31). He gently, but persistently, runs down his list of possibilities:

> 'What's getting you down?'
> No answer.
> 'Sore throat?'
> 'Not now.'
> 'Water-works all right?'
> She nodded.
> 'Have you got a temperature?'
> She shook her head.
> 'Periods regular?'
> 'Yeah.'
> 'When was your last one?'
> 'Last week.'
> The doctor paused.
> 'Do you remember that rash that you used to get on your tum? Has it ever come back?'
> 'No'
> He leaned forward in his chair towards her.
> 'You just feel weepy?' (31–2)

Sassall then asks how she feels about her work. "It's a job," she replies (32). As he continues to explore her feelings about her job—determinedly, for he knows that he is now on the right track—she finally confesses, "It's terrible that laundry. I hate it" (33). He asks the woman what she would like to do. She has always wanted to be a secretary. How much education does she have? It turns out that she left school early. He writes a note to excuse her from work for a few days and asks her to come back to discuss her options:

> 'You can come up again on Wednesday and I'll phone the Labour Exchange and we'll talk about what they say.' 'I'm sorry,' she said, beginning to cry again. 'Don't be sorry. The fact that you're crying means you've got imagination. If you didn't have imagination, you wouldn't feel so bad. Now go to bed and stay there tomorrow.' (33)

In this exchange with his patient Sassall does not perceive her crying merely as a sign of disease or reduce this human expression of

pain to a biological indicator of depression that would prompt the writing of a prescription. He does not ignore her tears, nor does he run from them. This young woman's crying has meaning to Sassall in the context of her illness. Her tears signify that she hates the way her life is going, that she wants more, and that she has sufficient imagination to perceive her plight. But she does not possess the capacity to imagine how she might find her way out, or the resources to do anything about it.

While the patient is able to recognize *that* something is wrong with her life, she needs Sassall to help her identify *what* is wrong and *how* she can remedy it. Sassall recognizes that if she is unable to imagine herself into a new place in her life and to change her life's circumstances, she will likely return to his office time and again with symptoms she cannot explain. He must use his imagination to formulate and put into words "some of what [she] know[s] but cannot think" (109). He moves beyond viewing the external "landscape"—that of an attractive young woman "with her whole life in front of her"—to exploring her internal world. He considers all of the circumstances impinging upon this young woman that contribute to her illness. He imagines who she is and what her life is like. By imagining what it would feel like to *be* her in her particular situation, he achieves a depth of understanding of her plight. Sassall then envisions who she might *become* so that he can assist his patient in taking steps toward a new life. Through this act of imagination, Sassall is able to bring to his patient the words she needs to be able to self-reflect. In so doing, he facilitates the development of the patient's imagination and her capacity to connect what is happening inside with meaning and with outer circumstances.

Dr. Sassall's Practice of Narrative Medicine

In *A Fortunate Man*, Berger's commentary about Sassall's work captures the substance of narrative medicine: he creates stories out of Sassall's clinical experience. These are stories about the patient, about Sassall himself, and about the physician-patient relationship. Information is transformed into words and words into new knowledge—narrative knowledge. Narrative knowledge provides a way for physicians to gain a fuller grasp of their patients' illnesses beyond the identification of the bioscience of the disease with which they present, and it may also lead to more meaningful experiences in the practice of medicine.

Berger shows how Sassall brings together his curiosity, his imagination, and his self-knowledge to enter into a patient's world more fully and discover the story that is being presented there. He uses himself as a diagnostic instrument: "Sassall accepts his innermost feelings and intuitions as clues. He confesses to fear without fear. He finds all impulses natural—or understandable. He remembers what it is like to be a child" (108). "He does not believe in maintaining his imaginative distance: he must come close enough to recognize the patient fully" (113).

Sassall achieves narrative competence only after he reenvisions the physician-patient relationship as one between two human beings—an intersubjective experience where each has his or her own distinct role. He comes to recognize his patient as a human being experiencing an illness, not an object in possession of a disease. The physician who can develop such extraordinary diagnostic skills and who can refine his treatment to fit the human being in need of help is, indeed, fortunate.

Transformations

Physicians who use themselves in this manner to explore the patient's inner and outer worlds and to learn what it is like to be the patient must engage in a disciplined process of self-inquiry that leads to better self-understanding. It is physicians' good fortune to spend their lifework engaged in a profession where—hand in hand with developing proficiency in helping others—they may deepen self-understanding, increase their own humanity, and learn how to grapple with the dilemmas that they too must face in life. One physician describes this as a process of being granted "access to knowledge—about the *patient* and about *myself*—that would otherwise have remained out of reach."[13] By entering into their patients' worlds, discovering the stories that live there, and reflecting upon those stories, physicians avail themselves of the opportunities for professional and personal growth that can exist within the physician-patient relationship. Such experiences may be transformative. As Berger says of Sassall's professional life: "He cures others to cure himself" (77).

When physicians are willing to engage in this process, they are much more likely to find their work meaningful; they are less likely to become "burned out" by the daily impact of the suffering of their patients and of the emotional demands placed on them. This statement is only apparently paradoxical. The conventional wisdom that doctors

must achieve great emotional distance from patients in order to protect themselves has led to the creation of a physician-patient relationship that often proves to be emotionally deadening for the physician. Doctors who function predominantly as detached observers often feel more like human "doings" than human "beings."

Most physicians enter medicine because they wish to engage in helping relationships with patients, but years of clinical practice as "objective" participants in the physician-patient relationship may lead to robotic interactions with patients and fewer opportunities for professional and personal growth. The physician who is emotionally present and sufficiently attuned—while at the same time maintaining his or her psychological separateness from the patient—is more likely to find clinical work satisfying over time.[14]

The Doctor's Story and the Patient's Story

Though written nearly forty years ago, *A Fortunate Man* affords an extraordinary introduction to elements of contemporary psychoanalytic practice and of narrative medicine that illuminate the physician-patient relationship. This text demonstrates to today's practicing physicians an approach to their professional lives that may assist them in creating situations in which clinical practice may be meaningful and self-sustaining. By listening to the patient from the perspective that a narrative can unfold through the physician-patient relationship, the physician gains the capacity to create stories from what may appear to be the disparate elements of the patient's history and physical examination as they emerge in the clinical moment. The narrative act transforms an identified patient into a human being.

Undoubtedly, primary-care physicians are constantly confronted by the *subjective experience* that is generated by the emotional impact of their patients' "anguish of dying, of loss, of fear, of loneliness, of being desperately beside oneself, of the sense of futility" (113). In order to creatively make use of such moments, the physician must identify his or her own subjective experience with the patient and have sufficient understanding of his or her own emotional life. Knowingly or unknowingly, the physician may feel that the patient's story too closely resembles his or her own life story—or the story that the doctor fears his or her life might become. As a consequence, the doctor may *react* (through withdrawal or overinvolvement) rather than *reflect* upon the experience. By the disciplined practices of self-reflection and self-inquiry

that lead to self-understanding, difficult clinical moments may lead physicians to learn more about themselves.[15]

Berger describes Sassall as a physician who has become acquainted with his own inner world: "He can lose his temper and then talk about the true reasons, as opposed to the excuse, for why he did so. His ability to do such things connects him with aspects of experience which have to be either ignored or denied by common-sense" (108). Sassall's openness to and acceptance of his feelings allow him to listen less defensively to his patients' feelings.

Physicians who are acquainted with and accepting of their own emotional life may use their emotional experiences as a point of entry to understanding the patient. Berger writes, "Sassall accepts his own innermost feelings and intuitions as clues. His own self is often his most promising starting point. His aim is to find what may be hidden in others" (102). The physician who encounters patients knowing full well that he or she will be emotionally impacted is more capable of creating narratives out of what the patient brings to the clinical situation. Meaning is created and exchanged by paying attention to both the patient's and the physician's subjective emotional experiences. The physician who does not deny his or her own emotional reactions to the patient may be able to "feel" his or her way into an understanding of what illness means for each individual patient.

Conversations about *A Fortunate Man*

Before I conclude this paper, I would like to present something of my experience in the Conversations for Physicians class. I did not approach the class as a "teacher" of psychoanalytic concepts (for example, unconscious motivation, psychic conflict, transference and countertransference, empathy and intuition, therapeutic alliance, and the use of the self as a clinical tool) to my physician colleagues. Rather, I sought to facilitate a discussion and to illustrate certain approaches to the physician-patient relationship that I have learned through my years of analytic practice.

In the first class, we discussed the vignette where Sassall fails to make a connection with his patient who has been jilted by her Salvation Army boyfriend. We explored the patient's unique manner of coping with psychological trauma and the doctor's specific (countertransference) responses that led to impasse in this case. More importantly, the participants in the class were moved to tell stories of their own

connections with patients. A pulmonologist read a piece of narrative writing that described his puzzlement over why his patient with end-stage lung disease expressed such gratitude to his physician, who was absolutely incapable of reversing the disease process:

> Dr. B: I received a letter from Joe's wife after he died. She told me how important I had been to him and how much he valued his monthly visits to my office. I can't understand it. I feel like I did nothing to deserve that kind of gratitude.
> I: John (Dr. B), just imagine for a moment *what it would be like to be* the patient and to have come to the doctor's office once a month.
> Dr. B: I've got it! That visit may have been the most important event of the month for him. Near the end, he never left the house except to see me. I listened to his chest. I touched him. I told him that things were going as well as they could. And I told him that I would see him next month.

Dr. B's story about his patient allowed us to talk about empathy as it results from a kind of trial identification with the patient. It prompted a discussion about how physicians' guilt and shame about not "curing" their patients may interfere with recognizing how much they are actually doing to help their patients and about how this reaction, in turn, may interfere with creating and sustaining a connection with the patient. The participants spoke about the value of self-awareness and talked about ways to foster the capacity for and the space for self-reflection when living in the trenches of primary care.

Sharing the reading of this beautifully written text set the stage for such a conversation and for the narrative writing that accompanied it. The language that Berger uses to tell the story of Sassall and of his experience with his patients created an ambience whereby participants were encouraged to bring their own experiences to life. This kind of discussion group experience is akin to the psychoanalytic situation where an environment that is conducive to patients telling their stories is created and where a process takes on a life of its own. Reading and exploring *A Fortunate Man* provided a safe and liberating environment for these physicians.

In the second evening of conversation we discussed the passages of *A Fortunate Man* that describe Sassall's professional and personal development. This prompted the participants to speak of their own journeys as physicians—spanning the years from medical school to a time nearing retirement, when they will no longer have contact with

patients. I was not only struck by the openness and genuineness of the discussion but also by the process that unfolded as this group became more cohesive. An environment was being created where these seasoned clinicians could actually talk with one another about what it is like to be physicians. One participant, a retired 1947 Harvard Medical School graduate, wrote in a course critique: "I have spent decades talking with other physicians about cases, about business, . . . [b]ut I have never talked with other doctors about what it is like to be a physician. Keep up the good work!"

In preparation for the third class, I asked the class to read portions of the text that address Sassall's "recognition" of the patient. I hoped that these passages would stimulate discussion about how physicians may use their own emotional responses to their patients as a way to discover who their patients are and what they are trying to convey about their experience with their illnesses. The readings also included Sassall's case of the old woman dying of heart failure and pneumonia. About ten minutes into this discussion, Dr. T hurried into the class, breathless and obviously embarrassed about being late. We greeted her and resumed our discussion until Dr. B turned the conversation to Dr. T:

> Dr. B: Julie, are you okay?
> Dr. T: Yes. Just a difficult patient.
> Dr. H: Do you want to talk about it, Julie?
> Dr. T: (Tearfully, angrily, ashamedly) I've just come from a patient who has been mutilating herself with a razor blade. This time it was her genitals.
> Dr. B: I don't know how you do it! I've had some tough cases, but not crazy like this.
> Dr. T: Well, she refuses to see a therapist. And I know she needs to go into the hospital and that I can't treat her for these problems. But, it is so confusing. I haven't been able to make the referral—at least not successfully.

We spoke briefly about the borderline personality pathology this patient was presenting. The confusion induced in Dr. T by encounters with her patient (created by the mechanism of projective identification) is frequently found in the clinical process with such a patient and is diagnostic of this type of psychopathology. The patient was unconsciously communicating the quality of her chaotic inner world, which induced confusion in Dr. T. Dr. T's inability to refer the patient was

related to her own conflicted feelings of anger and guilt evoked by the sadomasochistic nature of the patient's internalized object relations that lived within the patient herself and that were being played out between the patient and the doctor. I refrained from giving an in-depth tutorial on borderline personality disorder, focusing rather on the intensity of the emotional force field in which physicians often have to live and how these reactions may be used to inform clinical work. These discussions led the participants to tell stories about their own experiences with patients, ones where suffering and death deeply impacted the physician's own emotional world.

The last class was entitled The Doctor's Imagination: Learning from the Patient. The participants read passages from *A Fortunate Man* where Berger speaks of Sassall's having "established the situation he needs" (158) and those referring to the doctor's use of his imagination. Themes that emerged focused largely on the dialectic between the emotional and physical toll that medical practice exacts from the physician and the enrichment that clinical work may provide to one's life. A focus on the deprivations clinical work creates for self and family oscillated with discussions about how much these doctors had learned from their patients and how they could not imagine their lives without this unique way of relating to other human beings.

The participants were grateful for this rare opportunity to talk openly about these matters with their colleagues. They expressed appreciation for my taking the time to create the course, which one doctor credited with "meeting unmet needs for doctors," and they spoke of a desire to have more classes.

Conclusion

The story of Dr. John Sassall teaches us that medical practice characterized by the approach to the physician-patient relationship I have described can create a very fortunate situation for both patient and doctor. It is certainly fortunate that the same process designed to create diagnostic and therapeutic stories from what the patient brings to the doctor—and one that fosters engagement with the patient as a fellow human being—may teach the physician ways of being a more complete clinician. And it is fortunate that interacting with patients in this manner may lead to more meaningful and satisfying clinical work. It may even be true that this process can come to assist the physician in achieving better self-understanding and a richer grasp of his or her own life story.

NOTES

1. Huntley, "In Search of A Fortunate Man," 546.

2. Berger, *A Fortunate Man*, 158. Subsequent references are cited parenthetically in the text.

3. In "Resistance, Enactment, and Interpretation," Smith says this about the self-inquiry required within the process of understanding the patient: "In analysis we are continuously doing 'two things at once,' consciously or involuntarily, as we proceed with the analysis of the patient, which is our aim, and simultaneously extend our own self-understanding, which is our good fortune" (29).

4. See, for example, Charon, "To Render the Lives of Patients," "Medical Interpretation," "Narrative Accuracy in the Clinical Setting," "Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust," and "Narrative Medicine: Form, Function, and Ethics"; and Greenhalgh and Hurwitz, *Narrative Based Medicine*, and "Narrative Based Medicine: Why Study Narrative."

5. In "The Psychoanalytic Sensibility," McWilliams organizes these elements of sensibility under the following themes: curiosity and awe, complexity, identification and empathy, subjectivity and attunement to affect, attachment, and faith.

6. Weinstein, *A Scream Goes Through the House*, 160 (Weinstein's italics).

7. It is likely that Sassall's systematic self-inquiry through reading Freud was of immense benefit to his understanding of his patients and, to a degree, to his understanding of himself. However, such solitary self-examination has its limitations and can only rarely achieve the results similar to what may be accomplished by engaging in a therapeutic process with a psychotherapist or psychoanalyst. The latter may not only lead to an expansion of one's self-understanding, the physician may also learn ways of listening to oneself and to others that can be valuable in work with patients.

8. In *A Scream Goes Through the House*, Weinstein, while discussing problems of contemporary Western medicine, makes a distinction between *disease* (the biological or physiological event) and *illness* (the social and existential dilemma posed by the disease in the context of the individual's personality and social network): "The sights of medicine are focused on your somatic makeup, not on your hurt. . . . [A]t issue is invariably your *disease* (the bio-science problem you present), not your *illness* (the existential dilemma you experience). . . . [N]ever has there been such a sophisticated scientific grasp of disease, and never has the individual patient, the person who hurts, felt more out of the loop. . . . [N]ot only is the individual *story* elided here, but so too are the larger social and ethical dimensions of illness beyond the scrutiny of science proper" (xxvii, Weinstein's italics).

9. The term "angle of repose" refers to "the greatest angle between two planes which is consistent with stability" (*Shorter Oxford English Dictionary*, 5th ed., s.v. "angle of repose"). It is an apt metaphor for solutions patients may discover when encountering the forces of internal conflict (such as the wish for a fulfilling life in conflict with the need for punishment) and corresponding internal representations of the self and others. These are resolutions that may create psychic stability but often lead to a degree of emotional deadening.

10. See Williams's story, "The Use of Force," for a moving example of how—even in the context of a desperate wish to heal—a challenge to a physician's therapeutic potency may generate powerful emotional forces within the doctor that compel him to overpower the patient.

11. In "Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust," Charon describes the recognition of the patient within his or her own life story as a "therapeutically central act" (1898). She likens it to the clinical process found in psychoanalysis: "As in psychoanalysis, in all of medical practice the narrating of the patient's story is a therapeutically central act, because to find the

words to contain the disorder and its attendant worries gives shape to and control over the chaos of illness" (1898).

12. This description of Sassall's use of imagination—shaped by the intersubjective experience within the physician-patient relationship—as a vehicle to capture the patient's experience and "write" it into a narrative reminds me of the words of the physician and poet William Carlos Williams, who writes in "The Practice": "I lost myself in the very properties of their minds: for the moment at least I actually became *them*, whoever they should be, so that when I detached myself from them at the end of a half-hour of intense concentration over some illness which was affecting them, it was as though I were reawakening from a sleep. For the moment I myself did not exist, nothing of myself affected me. As a consequence I came back to myself, as from any other sleep, rested" (356, Williams's italics).

13. Charon, "Narrative Medicine: Form, Function, and Ethics," 84 (my italics).

14. A recent study by Horowitz et al. describes what physicians who engaged in narrative writing about their clinical experience found most meaningful in the practice of medicine: "[N]early all the doctors . . . described a nontechnical, humanistic interactions [sic] with patients as experiences that fulfilled them and reaffirmed their commitment to medicine. Rather than recounting tales of diagnostic and therapeutic triumphs, they uniformly told stories about crossing from the world of biomedicine into their patient's world. They described how relationships deepened through recognizing the common ground of each person's humanity" (773–4). These comments are not unlike what Berger writes about Sassall.

15. In the introduction to *The Doctor Stories*, Coles quotes Williams eloquently speaking to what the physician may learn from such clinical experiences: "There's nothing like a difficult patient to show us ourselves. . . . I would learn so much on my rounds, or making home visits. . . . [It was] the *force* of all of those encounters. I was put off guard again and again and the result was—well, a descent into myself" (xiii, Williams's italics).

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