CLINICAL COMPUTING: A MODERN PARABLE ◆ PHYSICIAN APATHY

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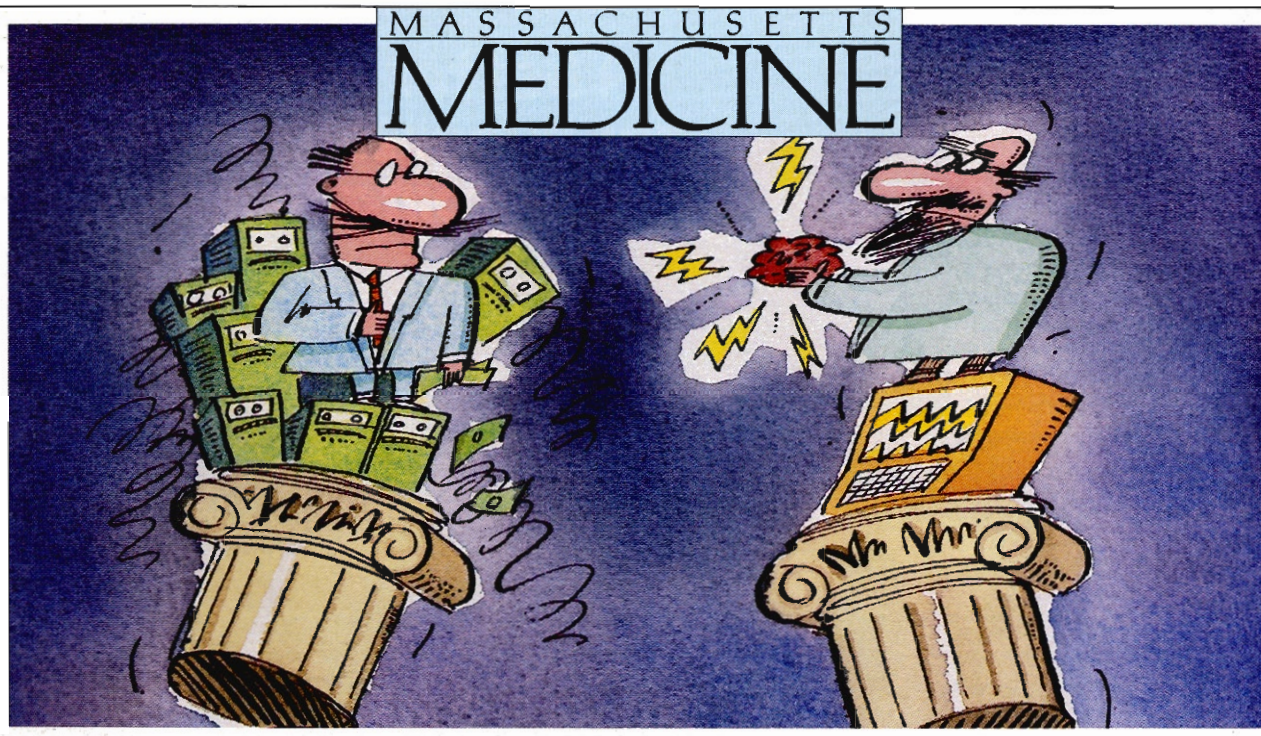

HAL MAYFORTH

COVER ILLUSTRATION BY KATHERINE MAHONEY/PILLARS BY DAVID BIEDRZYCKI

IN THE SOCIAL MACHINE

Taking a needed step backward

It was a long morning in one of the nastiest, busiest, most understaffed, and, especially, poorest medical clinics in the country. Scores of pitiable sick people lined the harsh green-tiled walls, many with IVs in, undergoing complex procedures while they sat up in hard chairs. This is not to mention the beds in the hall, with people seizing, or doubled over their belly pain, or withdrawing from drugs, or awaiting evaluation of their strokes. But most of all, waiting.

I'd had a string of demented nursing-home patients who had, as they say, dribbled off the court, and had come in for one or another sort of buffing, interrupted, I guess, by one or two sullen addicts. Even for a fourth-year medical student used to the fact that fecal matter slides downhill, it had been a bad morning, not just unpleasant (the ER is usually that), but unpleasant and boring, and not, to put it mildly, fun. So when I saw her out of the corner of my eye, I was prepared to do slightly more than just wish that she would be assigned to me.

She was loosely folded in a fetal position on her bed, stuck in what was almost an alcove in the hallway. The first thing you noticed was the pile of redder-than-strawberry-blond curls cascading down her neck and shoulders; then the pretty, English-looking face; the full, strong-looking body that seemed as if it would be, well, statuesque standing up; then, of course, the outfit, which almost looked as if it could be rather stylish pajamas — pale blue and white vertical stripes — until you realized it wasn't of her choosing; and finally, the fluorescent light glinting off the metal of the handcuffs that chained one of her hands to the bedrail.

But I hadn't discerned all that by the time I asked to be the one who saw her. It was the attractiveness of the whole initial image, compared to the ugly hopelessness of everything else in the ER. And I don't think it was sexual, either then or later. But in any case it was reflexive. "Can I have her next?" I said to the junior resident. He glanced at her. I don't think he registered what it was I was thinking. "It's been one nursing-home patient after another all morning," I went on. I knew it was unseemly. But frankly, at that moment, at that point in my fourth year, in that particular ER, after that sort of morning, I didn't care.

He shrugged his shoulders. "Sure, take her." I more or less ran to the bedside.

She decided to charm me. If she thought she had anything to gain by this, I never figured out what it was nor, certainly, did I deliver it. I think she was just accustomed to having men in the palm of her hand. Since the hand was now chained to the bed, the maneuver probably had to be subtler than the one she was used to performing. Very likely, if I had seen her in a bar or on the street, the makeup and perfume would have produced in me at least a tinge of revulsion. But her face and hair were as clean and fresh as a child's.

A policewoman ambled over and uncuffed one of her hands so that I could do an examination. She had been in jail just a few days but may have begun a withdrawal from some kind of not-too-serious street drug polypharmacy — although at no time did she ask for drugs. Her main complaints were nausea and diffuse abdominal pain, but these were put forward in an almost genteel manner. "We weren't doing anything," she said of her arrest. "We were just hanging around outside a club."

Prostitution. I wasn't surprised, of course. A pretty young woman brought to the ER in handcuffs — prostitution and drugs were the most likely explanations, and she had both. She doesn't seem the type, I thought, but this seemed so much like a line from a bad movie that my next thought was, Just get on with it. The sticking point was the requisite rectal examination. I had resolved not to do these in the hall. Of course, the rules said that they had to be done in one of the rooms, but that rule was at least as honored in the breach as in the observance. The damn place is a zoo, we used to say reflexively, but actually it was a sort of Noah's Ark. These people were carried above the devastating flood of disease in the vessel of our ER, and they ought to be damn pleased to have their intimate parts examined more or less in view of the other passengers.

Screw it, I thought. I'm rolling her

MELVIN KONNER

into a room and behind a curtain, even if it takes all morning to find one.

It didn't take all morning. I also tried to get a nurse to come in with me. "Are you joking?" she speculated. I guessed that my request was more of a third-year-student proposal, regarding another rule made to be broken. I did the examination with the utmost discretion — the young woman was grateful for the two minutes of privacy — and none of the possible untoward psychosocial or medicolegal consequences ensued.

We put the stamp of approval on her gut and set her back to jail. I went on to my next nursing-home patient, and thought about what had happened. It had been as much an anthropological encounter, evoking the experience of my prior career, as a medical one. Those handcuffs were the ultimate symbol — no, the ultimate instance — of modern psychosocial reality. What course of events during her growth had placed her on that street corner, under the sway of several drugs, waiting for a strange man to pay cash for the greatest intimacies? What strange social reality did I belong to that couldn't come up with a more interesting reaction than a striped suit and handcuffs? And what sort of medical reality consigned her to a gloved finger in her rectum in a hallway crowded with suffering strangers, and called this "care"?

The first thing you noticed was the pile of redder-than-strawberry-blond curls cascading down her neck and shoulders; then the pretty, English-looking face; the full, strong-looking body that seemed as if it would be, well, statuesque . . . and finally, the fluorescent light glinting off the metal of the handcuffs that chained one of her hands to the bedrail.

I wasn't blaming doctors; I was too good an anthropologist for that. The doctors were only a few cogs in a cultural machine of incredible complexity that ground on relentlessly, processing people. But I did think that we might have raised our voices. And I couldn't help thinking of the much simpler social machine I had lived in association with for two years in Africa, the culture of the !Kung San of Botswana. There, prostitution, in the sense that we know it, could have no meaning. Of course, there were young women who might be considered easy, who might accept a gift of beads from one man too many, in a way that made it seem a transaction instead of a gift. But there was no such thing as selling it. As for drugs, there were a few plants with reputed psychoactive properties, but these were used in ritual contexts only.

Could a young woman become marginalized in this primitive social world? Of course, and there were suicide attempts and fugue states to prove it. There was also the tragedy of chlamydia- or gonorrhea-induced infertility, a not unlikely consequence of promiscuity. But what didn't exist were the handcuffs, and all that they imply. And the functions of medicine, instead of being distinct from the functions of social control, were inextricably bound up with them. Indeed, medicine itself was in a sense the product of the whole body social. Individual healers — large proportions of the adults — could go into trance and attain one or another degree of healing power. But most healers, and all during the formative phases of their careers, could not enter trance without the central healing ritual, the trance dance. Virtually everyone in a

band would participate. A fire blazed in the center of a circle. Women sat around it singing eerie, yodeling songs, and clapping in complex syncopated rhythms. Around them the healers, mostly men, danced in a circle — nothing fancy, just a relentless rhythmic progress, always in one direction, enhancing concentration on the trance. When it worked, the healer would go around laying on hands and crying out, drawing the illness out of the patient's body. And anyone could be a patient, whether sick or well; the healing effect was also preventive.

But above all it was social. It came from and returned to the group as a whole. And of course there were no strangers here. Our young woman — let us say she has had an affair, fought with her husband, run off into the bush, and eaten some mildly toxic leaves — would rest at the center of a circle that consisted of her whole social world. Everyone who knew her, with whom she had grown up, would be joined in the effort to heal. And the healer, himself, would know her situation. He might leave his body to go to the village of the spirits, and find out, say, that the young woman's dead aunt disapproves of the marriage, or that her husband's father is angry because his son was betrayed. In any case, the response would be what we doctors call integrated, but what in plain English we would simply call whole.

So I mused on the plight of the modern doctor, trapped in a tiny corner of the social machine, making the best of a bad situation. I thought, there must be more to medical care than a gloved finger and a hemoccult slide and a psychiatric consult in the rare cases when we can't completely ignore the psychosocial segment of reality.

Could we do better? Could some of that family-of-man spirit of the !Kung San be a model for a more complete and modern sort of wholeness? Community health programs, proposals for national health insurance, the new Violence Epidemiology Branch of the CDC, and encounter groups for impaired physicians, even an extra few minutes with a patient or a patient's family, just for kindness, all seem to me somehow appropriate, a needed step backward toward the !Kung healing dance. But all were too expensive, and in an era of cost-cutting, benefit would not happen soon or often or strongly enough.

In any event, I knew that I could try to light my own corner. Out in the main hallway of the hospital, beyond the hall of the ER, I was trying — unsuccessfully of course — to retrieve some patients' charts that were supposed to have been sent up on the dumbwaiter, charts with information about unknown patients, without which treatment would have been a fool's errand. I was flipping through the charts, cursing the nameless clerks in the bowels of the hospital who were part of those patients' lifelines — and who, probably, were doing the best they could — when I saw her again, upright this time, pretty in her striped blue suit, her unmade-up face framed by the red-blond hair. She seemed a bit wobbly, yet somehow poised as I'd predicted, handcuffed to the policewoman walking along beside her. She waved a little, and her wan, coy, grateful smile, across the tangle of wires and churning cogs of the machine, said that I had done something right. □

Melvin Konner, a graduate of Harvard Medical School, teaches at Emory University, and is a contributing editor of The Sciences. *His new book,* Becoming a Doctor: A Journey of Initiation in Medical School, *was published by Viking–Penguin Inc. in August.*