To the Graduate Council:

I am submitting herewith a dissertation written by Cheryl A. Koski entitled "The Autobiography of Medical Education: Anatomy of a Genre." I have examined the final paper copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Communications.

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THE AUTOBIOGRAPHY OF MEDICAL EDUCATION: ANATOMY OF A GENRE

A Dissertation
Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

Cheryl A. Koski
May 2002

VOLUME ONE

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DEDICATION

To my parents,
Art and Sue Koski

EPIGRAPH

My days at school were over. Now I must find a new goal. It was sort of like a little bird that had just learned to fly, being chased out of the nest, but not exactly like that either. After all, why should I be afraid of the world?

—Guy Alexander,
upon defending his dissertation
Chromatography: An Adventure in Graduate School

ACKNOWLEDGEMENTS

For providing guidance while allowing me considerable autonomy, I thank the chairman of my committee, Dr. Mark Littmann, who is not only a mentor, but a friend as well. It has also been my good fortune to work with committee members Dr. Paul G. Ashdown, Dr. James A. Crook, and Dr. Michael Keene.

Several of the authors of the primary sources that serve as the basis for my dissertation kindly responded to my requests for information: David Hellerstein, M.D., Elizabeth Morgan, M.D., Theodore Isaac Rubin, M.D., and Benjamin Winthrop White, M.D. The credit for putting me in contact with Dr. White belongs to Richard M. Ratzan, M.D.

My return to school was facilitated by Martin Marietta Energy Systems, Inc., in Oak Ridge, Tennessee, with the Educational Assistance Program covering my financial expenses and the University Study Program offering flexibility in regard to my work schedule. Moreover, I am grateful to the University of Tennessee for its support, especially the Graduate School for the Hilton A. Smith Fellowship and the College of Communications for the Graduate Student Research Award.

But most of all, I am appreciative of my parents, Art and Sue Koski. It is surely no coincidence that both of their children are Ph.D.s—my brother Doug crossed the finish line last May—and so I lovingly honor the two people who have always been there for me: Mom and Dad.

ABSTRACT

With the publication of *Intern* by Doctor X [Alan E. Nourse] in 1965, physicians began recounting their passage through medical school, internship, and residency in unprecedented numbers. Coinciding with the emergence of the youth culture, the autobiography of medical education became an established genre during the next three decades. Specifically, ten books appeared in the 1970s, fourteen in the 1980s, and six in the 1990s. As insider reports, they have the potential to shape the general public's perception of the health-care system. All of them meet the following criteria: (1) nonfiction full-length books (2) by American physicians writing about their own medical education (3) issued by reputable publishers for the general public (4) from 1965 to the present. Of the thirty-one books examined, nearly one half of the authors graduated from three medical schools: Harvard, Yale, and Tufts. Moreover, nearly one third of the authors are women, all of whom exhibit conflict between gender and occupation. Various specialties are represented, including psychiatry, surgery, pediatrics, obstetrics and gynecology, and internal medicine. Some of the authors are diarists, some are essayists, and some are nonfiction novelists. Developed here is an original typology based on how the authors portray themselves—as observers, outsiders, activists, malcontents, and apologists—with the members of each category sharing a characteristic approach toward medical education. The observers make ethical judgments about it. The outsiders seek ways to adjust to it. The activists try to change it. The malcontents bear a grudge against it. The apologists defend it.

Several patterns are notable in regard to category. First, most of the outsiders are women. Second, all of the malcontents are men. And third, all of the apologists are surgeons. Yet regardless of category, the authors agree that medical education places enormous demands on students, interns, and residents. A few of the authors characterize the process of initiation as one that prepares them to assume an elevated role in society. For most of them, however, survival is the principal objective. And overall, the evidence suggests that for physicians who contribute to the autobiography of medical education, writing serves as a form of healing.

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CHAPTER 1

INTRODUCTION

Rather sweeping claims were made for the historical primacy of *Intern* when it was published in 1965 under the pseudonym Doctor X: "it is the first inside account of modern medical and hospital practice that has ever been presented to the American public," the dust jacket trumpets. The author himself is a bit more cautious. "To my knowledge, no such document has ever before been recorded or published," he says about the journal that captures the year of his internship, "so fiercely crowded and so rich in its content and implications that it should not be lost" (2).

But the fact is that a small handful of physicians beat Doctor X to the punch: Arthur Ames Bliss, M.D., *Blockley Days: Memories and Impressions of a Resident Physician, 1883–1884* ("printed for private circulation" in 1916 by Dr. Bliss's wife, Laura Neuhaus Bliss); Ernest V. Smith, M.D., *The Making of a Surgeon: A Midwestern Chronicle* (1942); Irma Gross Drooz, M.D., *Doctor of Medicine*, which on the dust jacket is subtitled, *The Process of Becoming a Doctor: Medical Student, Intern, Resident in Neurology and Psychiatry* (1949); and Emily Dunning Barringer, M.D., *Bowery to Bellevue: The Story of New York's First Woman Ambulance Surgeon* (1950), the basis for the movie *The Girl in White* (1952) starring June Allyson (Dans 134–39; 327). Having graduated from the medical school at Cornell University at the

turn of the twentieth century, Barringer received her clinical training as "interne, House Surgeon and House Physician at Gouverneur Hospital."[1]

Despite those forerunners, the autobiography of medical education is a genre that has grown most rapidly during the 1970s, 1980s, and 1990s.[2] Until then, it was physicians with distinguished careers behind them who were considered worthy to write books about their lives—men like Morris Fishbein, the editor of *The Journal of the American Medical Association*; Henry H. Kessler, the founder of the Kessler Institute for Rehabilitation; Roger I. Lee, the president of the American Medical

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[1]I examined each of those titles, having culled them from Louis Kaplan's *A Bibliography of American Autobiographies*, which covers the 1800s to 1945, and Mary Louise Briscoe's *American Autobiography 1945–1980: A Bibliography*. Companion volumes that list over six thousand titles and five thousand titles, respectively, both include a subject index featuring occupation. Kaplan lists 195 entries under the heading "doctors," and Briscoe lists 150 entries under the heading "physician" and 46 entries under the heading "surgeon" and four variants thereof ("brain," "neurological," "orthopedic," and "plastic")—for a total of 391 entries (including some repeats). Two of the titles that I examined proved misleading: *How I Became a Homeopath* (1866), which is a story of conversion from the "old school" of medicine by William H. Holcombe, M.D., for as he rightly notes, "I am not writing an autobiography" (4); and *Experiences of a Medical Student in Honolulu, and on the Island of Oahu, 1881*, by L. Vernon Briggs (1926), who is actually a seventeen-year-old Deputy Vaccinating Officer (12–13, 15). Somewhat closer to the mark is *Five Million Patients: The Professional Life of a Health Officer*, by Allen Weir Freeman, M.D. (1946), which is written in the manner of *The Education of Henry Adams*. "The story is told in the third person," Freeman explains in the preface, "and the author is referred to by the capitalized title of the position he held at the time of the event": the Student, the Apprentice, the Journeyman, and the Professor.

[2]My use of the word "genre" to mean a kind or type or category of content is consistent with current scholarship, as illustrated by an article published in *College Composition and Communication*: "the ubiquitous stories of graduate school" constitute what Taylor and Holberg call "a genre" (608). Or as noted by Chamberlain and Thompson, a genre can be established through form, mood, or content (2), with autobiography itself "broken down into a series of genres" based on "story types in terms of subject matter"—such as war stories and hospital stories (11).

Association and the founder of the Harvard School of Public Health; and even Charles W. Mayo, a surgeon whose father was the founder of the Mayo Clinic.[3] And the tradition continues with *Koop: The Memoirs of America's Family Doctor* by the former surgeon general. Lacking notable accomplishments or a famous name, mere longevity (at least half a century) might be enough for a book, as suggested by *Fifty Years of Medicine and Surgery: An Autobiographical Sketch* by Franklin H. Martin (1934); *Fifty Years a Surgeon* by Robert T. Morris (1935); and *Fifty Years a Country Doctor* by William N. Macartney (1938).[4] And what about the novelty of being a physician on a ship,[5] or in the White House,[6] or for Muhammad Ali[7]—angles that were parlayed into books by six different authors. One physician recounts his numerous run-ins with the law, imploring his readers to avoid "that soul destroyer

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[3]See entry numbers 1462 (Fishbein, *Morris Fishbein, M.D.: An Autobiography*, 1969); 2495 (Kessler, *The Knife is Not Enough*, 1968); 2684 (Lee, *The Happy Life of a Doctor*, 1956); and 3019 (Mayo, *Mayo: The Story of My Family and My Career*, 1968), all in Briscoe.

[4]See entry numbers 3748 (Martin); 4109 (Morris); and 3646 (Macartney), all in Kaplan.

[5]See entry numbers 5388 (William D. Spore, *A Peripatetic M.D.*, subtitled *Formerly Surgeon in the Atlantic, Brazil, Pacific, Cuba and Mexican, Red Star, and American Steam Ship Companies of New York*, 1899); 5630 (Nathaniel William Taylor, *Life on a Whaler or Antarctic Adventures in the Isle of Desolation*, 1929, the inscription of which reads, "To My Shipmates by the Doctor"); and 2745 (Rufus W. Hooker, *Ship's Doctor*, 1943), all in Kaplan.

[6]See entry numbers 3083 (Ross T. McIntire, *White House Physician*, 1946); and 4537 (Janet Travell, *Office Hours: Day and Night: The Autobiography of Janet Travell, M.D.*, 1968), both in Briscoe.

[7]See entry number 3486 in Briscoe (Ferdie Pacheco, *Fight Doctor*, 1977).

Demon Liquor'' (56), adding, ''I can trace my downfall to its use'' (57).[8] Another focuses on his unusual patients: *I Knew 3000 Lunatics* is the title of a book by Victor R. Small (1935), who practiced medicine in ''the State Hospital—or, as it is commonly called, the Insane Asylum'' (2).[9] But for sheer novelty, nothing beats the *Autobiography of Andrew Comstock, M.D.* (1857), its seven pages written in verse for A. J. Graham's *Phonographic Journal*:[10] ''I discovered how to cure, sir,/Stamm'ring, and defective utt'rance,/And to change falsetto voices/From the high and squeaking treble/To sonorous *baritono*.''

Notable accomplishments, a famous name, mere longevity, sheer novelty—none of those applies to Doctor X, who argues that his book is at once ''highly personal'' and universal—and therein lies its value, he says:

> It deals with the things that happened to *me*, with *my* thoughts, *my* opinions, *my* reactions. In regard to details, other interns doubtless had other experiences, thought other things or reacted in other ways. Yet over all, I am convinced that my intern year was representative of intern training in general, not very much better nor very much worse than the training of thousands of fledgling doctors in hundreds of hospitals across the country during the year of my internship . . . or

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[8]See entry number 1453 in Kaplan (Arthur Paul Davis, *Life of Arthur Paul Davis Written by Himself*, 1878).

[9]See entry number 5251 in Kaplan (Small).

[10]See entry number 1190 in Kaplan (Comstock).

today. The details in this document are unique, but the message it conveys is universal. (1)

The idea that the general public should want to read about an anonymous intern—one of untold thousands who has done nothing more than manage to secure the letters M.D. after his name—well, it helps to support a contention made by Irving Weiss in the preface to *American Authors and Books: 1640 to the Present Day*. ''The decade 1960–70 was marked by significant changes in literary theory and practice, the uses of language in print, the expressive use of print as a medium, the form and content of journalism, and the publishing of periodicals and books.'' Such changes were driven by others that were occurring in society at large, Weiss contends. ''The so-called alternate, or counter, culture introduced many new trends in reading, writing, publishing, and related means of conveying information in the United States. Developments in politics, religion, art, the humanities and sciences, and the fields of civil, sexual, and human rights introduced others.'' A supplement to *The Saturday Review* entitled ''Education in America'' sounds the tenor of the times. ''Out there, all kinds of people were into learning how to be free'' (Hentoff 61).

It seems that medical students, interns, and residents were no exception, as suggested by Doctor X and a host of other physicians whose voices attracted the attention of publishers—and more importantly, readers. For books like *Intern* have the potential to shape the general public's perception of the health-care system by providing a peek inside it. First-person accounts are ''the mainstays in discovering how people experience life in concrete situations,'' as noted by Robert S. Fortner and

Clifford G. Christians, thus assuming "special significance as inside revelations. They permit us to study intimate facets of human drama that are not directly observable" (377)—such as how physicians are made. Inside the covers of books, at least, medical school, internship, and residency are now accessible to anyone, if only vicariously. A look at some of the changes that were occurring in American society during the 1960s will help to put the autobiography of medical education into perspective—not by establishing causes and effects, but merely by offering some compelling associations.

Background

College campuses were quiet places in the 1940s and 1950s, says Mark Edelman Boren, author of *Student Resistance: A History of the Unruly Subject*. As he notes, "the level of student resistance in the United States in the 1940s and '50s was negligible" (112), hence reflecting the country at large, according to journalist Abe Peck. "Change wasn't exactly blowin' in the wind" (4), he says, describing "America in 1954":

> The country was an antidote for the grinding poverty or political repression many of its families had escaped. Millions of working people drove along yellow brick roads toward new homes in the suburbs. Television beamed out a cornucopia of available, no-money-down consumer goods. Finned dream-mobiles decorated the showrooms. "What is good for our country is good for General Motors, and vice versa" was a statement of corporate truth. (3)

America in 1964 was quite a different place, Boren and Peck agree. ''Students were so numerous that they seemed to constitute a new social class,'' Peck notes. ''By 1964, 'the forty-sixers'—the leading edge of the baby boom—were turning eighteen; twenty million others would do so between 1964 and 1970. Only a minority dissented, but 'I Am a Student, Do Not Fold, Spindle or Mutilate' became a popular button on campuses'' (20).

One of the most volatile was the University of California at Berkeley, where the Free Speech Movement was born on September 16, 1964, the day that an official of the university tried to stop a small handful of students from distributing political literature. Eventually, hundreds of students at Berkeley joined forces, Boren says, ''battling what they perceived as the evolution of the university into a factory intended to produce cookie-cutter students to serve industry'' (143). Most importantly, Berkeley served as a trendsetter. ''At other universities students followed the example of the Berkeley students in an attempt to reform and to humanize their own schools'' (144). All over the country, students couldn't help but take note of their peers on the West Coast, according to the *Report of the President's Commission on Campus Unrest* (better known as the Scranton Commission):

> The mass media gave intensive coverage to the Berkeley events, and Americans were exposed for the first time to a new sort of news story—the tumultuous campus disruption. It was news in a traditional sense because it involved conflict and controversy. It was especially suitable for television because it was colorful and visually interesting.

> Night after night, television film of events on one campus carried the methods and spirit of protest to every other campus in the country. (1/18–1/19)

Summing up, Edward Weeks of *The Atlantic* notes, ''the riots at Berkeley were certainly a symptom of disenchantment,'' and not just at Berkeley, either. He adds, ''the American undergraduate of the mid-sixties was plainly a more tense and troubled individual than his predecessor of the Eisenhower years.'' Even so, dissention was not by any means universal, Weeks contends. ''Among the serious scholars the strain showed in the exhausting competition for admission to the professional schools'' (vii). But even there, some rabble-rousers managed to gain admission. Just listen to what faculty in medical schools around the country had to say.

''The same tide of protest that has swept up so many young people has involved those just beginning their careers in medicine,'' according to Dana L. Farnsworth, M.D. Then affiliated with Harvard University Health Services, he spoke at the annual meeting of the Massachusetts Medical Society. ''Medical students and young physicians are demanding reassessment of the priorities of both society and medicine. They are critical of teaching methods and objectives in medical schools, and angry that too close attention to the problems of individual patients has led to lack of concern with pathogenic social conditions'' (1235). Two other physicians directed their remarks to students themselves.

''We are painfully aware of the discontent of medical students everywhere with their educational experience'' (72), notes Carl V. Moore, M.D., addressing the

Class of 1966 during Senior Awards Night at the Washington University School of Medicine in St. Louis. Providing an example, Moore continues. "A recent graduate of a western medical school, in the May issue of the *Atlantic Monthly*, calls house staff training a kind of continued serfdom"—namely, Stephen M. Creel, who decries what he calls "Our Backward Medical Schools." A newly minted M.D., Creel explains. "Students must be good-natured, obliging, and gregarious if they wish to excel. Above all, whether they like it or not, they must learn to do exactly what they are told, when they are told to do it." Concluding, he tosses out a few more adjectives. "Ideally, they become retiring, docile, and obedient" (48).[11] Moore begs to differ. Of house staff training, he says, "the years devoted to it are not years of medical serfdom" (74).

And then there is George L. Engel, M.D., who begged tolerance from the Class of 1969 at the University of Rochester School of Medicine in New York "on the occasion of the dedication of the yearbook":

> Since your Yearbook Dedication has classified me among your respected teachers, I feel emboldened to raise for your consideration what I consider some of the needs and problems of the faculty. I do so not to conjure up the picture of a life-and-death struggle between faculty and students but, on the contrary, to emphasize the joint nature

[11]Jerry Farber published an essay that was even more inflammatory: "The Student as Nigger." Reprinted some 500 times after its initial appearance in 1967 (7), it served as a manifesto of student rights.

> of the venture in which we are engaged. The faculty, as individuals and as a group, have their needs, just as students do. (351)

The title of his talk? "On the Care and Feeding of the Faculty: A Responsibility for Students," whose demand for "relevance" in medical education, he says, misses the mark. "It is not only that you learn something new, but you become someone new. To learn to be a physician involves a decided modification of your image of yourself, a change in identity. As a physician, you will have certain ascribed rights and responsibilities, and in turn your patients have certain expectations of you" (354).

Only medical schools in the South were immune from "all the uproar" and "all the disturbance"—at least, for the time being, suggests Robert J. Glaser, M.D., Dean of the Stanford University School of Medicine (229):

> Every now and then one of my colleagues will return from giving a lecture at a southern university and say, "You ought to go down there. You will find it very peaceful. The students still call you 'Sir' and behave themselves." But I venture to say that the kinds of changes we are seeing in our schools on the coasts will spread rapidly, and there is no question that they will affect all schools eventually. (184)

Although he doesn't mention the mass media, the lesson of Berkeley clearly wasn't lost on him. Glaser continues. "Most of us who are responsible for the administration of American medical schools have great concern about what may happen in the next few years. It is entirely possible that the enterprise will be severely crippled unless we can persuade our students to be a little less impatient in their search for change. In the

meantime,'' he concludes, ''our job is to try to keep some balance. It is an interesting time but it is not a very happy one'' (184).

But in hindsight, Glaser's worries proved needless. For according to the renowned historian of medicine, Kenneth M. Ludmerer, M.D., the effects of campus unrest on medical schools were fleeting. ''In the last analysis, the protest era was more significant for what it revealed about American medical education than for any specific reforms or changes that resulted''—namely, it revealed ''the fundamentally conservative nature of medical schools and their student bodies'' (237). He explains, ''after the protest era was over, student interest in social issues and the problems of the health care delivery system, in general, waned considerably,'' a trend that continues to this day. ''Such conservatism, on the whole, has persisted,'' he says. ''The fundamental conservatism of the medical school—and medical profession—seemed undeniable'' (243).

Indeed, the same can be said about the university as a whole, according to Morris Dickstein, author of *Gates of Eden: American Culture in the Sixties*. ''For a brief moment the university was turned into a microcosm, a laboratory, for direct democracy in society as a whole. Eventually, after the initial shock, most of our institutions learned how to defuse this democratic thrust, by changing just enough'' (268–69).[12] Even so, the 1960s did not disappear without a trace. ''There is a sense in which certain doors, having once been opened, can never quite be shut again,''

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[12]No doubt administrators like Glaser were much relieved: ''the advocates of participating democracy want every issue dealt with in a mass meeting where everyone can speak. I have not learned how to operate an institution on that basis'' (184), he says.

Dickstein observes, adding, "the sixties are likely to remain a permanent point of reference for the way we think and behave" (272)—and write.

At least, that's the contention of James M. Cox, whose 1971 essay "Autobiography and America" is still widely cited: "something has happened to the whole idea of literature in the last ten years," he says, pointing to Truman Capote's best-selling nonfiction novel *In Cold Blood*, as well as *The Autobiography of Malcolm X*, which is "somehow one of the great imaginative works of the last decade." Both of them blur traditional boundaries between fact and fiction. "Much of this change is, I think, a result of and a response to the revolutionary political attitudes and feelings which have fully emerged in the last five years" (Cox, "Autobiography and America" 252; reprinted in Cox, *Recovering Literature's Lost Ground: Essays in American Autobiography*).

At about the same time that Cox was attempting to account for new trends in the publishing industry, another scholar turned his attention to "Youth: A 'New' Stage of Life," namely, Kenneth Keniston of the Department of Psychiatry at the Yale University School of Medicine: "*we are witnessing today the emergence on a mass scale of a previously unrecognized stage of life,* a stage that intervenes between adolescence and adulthood. I propose to call this stage of life the stage of *youth*" ("Youth: A 'New' Stage of Life" 635). Several factors account for it: "rising prosperity, the further prolongation of education, the enormously high educational demands of a postindustrial society." He continues:

> And behind these measurable changes lie other trends less quantitative but even more important: a rate of social change so rapid that it threatens to make obsolete all institutions, values, methodologies and technologies within the lifetime of each generation; a technology that has created not only prosperity and longevity, but power to destroy the planet, whether through warfare or violation of nature's balance; a world of extraordinarily complex social organization, instantaneous communication and constant revolution. The ''new'' young men and young women emerging today both reflect and react against these trends. (''Youth: A 'New' Stage of Life'' 633)

Or as Keniston writes elsewhere, ''today's students are more likely to challenge, to question, and to think for themselves than were students of earlier generations'' (''What's Bugging the Students?'' 50). The phenomenon is a widespread one, according to Charles S. Davidson, M.D., Professor of Medicine at Harvard Medical School: ''it seems evident to me that these small, vocal, organized groups of radicals are the 'visible' part of a huge iceberg of change in students' attitudes'' (125–26), he says.

Keniston found an ally in Erik H. Erikson. Writing in 1975, Erikson says, ''I must present a few speculations on the *changing ecology of youth* in the present stage of history'' (195), such as ''the necessity for those with some ambition to make earlier commitments to an occupational or professional specialty'' (198). But therein lies a conundrum. ''The revolt of the dependent,'' he says, ''directly challenged all

those existing institutions that monopolize the admissions procedures to the main body of society. These confirmations, graduations, and inductions have always attempted to tie youthful prophecy to existing world images, offering a variety of rites characterized by special states of ceremonious self-diffusion'' (202). One only wishes that Erikson had not cultivated such an opaque style of writing. He continues. ''Yet it must be clear that all puberty rites and confirmations, as well as all inductions and, yes, all graduations, while they establish a reciprocity of obligations and privileges, also threaten with an element of mutilation and exile''—at the very least, he says, ''in the insistence that a person's final identity must be cut down to size: the size of a conventional type of adult who knows his place and likes it'' (223).

Hadn't Dr. Engel admonished the Class of 1969 about that very same thing? ''It is not only that you learn something new, but you become someone new. To learn to be a physician involves a decided modification of your image of yourself, a change in identity. As a physician, you will have certain ascribed rights and responsibilities, and in turn your patients have certain expectations of you'' (354). Or as Mircea Eliade puts it, ''the novice emerges from his ordeal endowed with a totally different being from that which he possessed before his initiation; he has become *another*'' (x). It seems that medical education has held tight to a custom that has largely gone by the wayside. Known worldwide for his study of initiation rites, Eliade notes that they are characteristic of ''traditional societies'' [or ''primitive tribes,'' as Joseph Campbell calls them without today's concern for political correctness (10)]. Eliade explains. ''It has often been said that one of the characteristics of the modern world is the

disappearance of any meaningful rites of initiation. Of primary importance in traditional societies, in the modern Western world significant initiation is practically nonexistent'' (ix)—but not entirely, for according to Dr. Engel, such rites are central to medical education. Finally, according to ''archaic thought,'' Eliade says, ''man is *made*—he does not make himself all by himself. It is the old initiates, the spiritual masters, who make him'' (xiv).

And it is the old initiates who write books about their lives, Erikson observes: ''autobiographies are written at certain late stages of life'' (125). True enough in 1975, but not by the 1990s, according to Albert E. Stone, a leading expert on autobiography: ''the assumption that autobiographies appear at later stages in their creators' life cycles sounds almost quaint to present-day ears, for a noteworthy aspect of autobiography of the past generation has been the numbers of personal histories written by young, previously unpublished writers'' (102). He adds, ''the spontaneous or carefully tended commercial cultivation of life stories continues, as the spate of autobiographies by housewives, penitentiary prisoners, prizefighters, movie stars, retired politicians, and a host of other nonprofessional writers attests. This accumulation of insider reports on ordinary and unusual experiences composes an invaluable historical and cultural resource'' (114). To augment Stone's list of life stories, I have identified twenty-eight medical students, interns, and residents who have contributed to the autobiography of medical education[13]—an invaluable resource

[13]As insider reports, they differ in perspective from outsider reports of medical education by journalists and sociologists. Among the journalists are David Black, author of ''The Making of a Doctor'' (1982), as well as *Medicine Man: A Young Doctor on the Brink of the*

for the reason that Stone articulates. "An autobiography, after all, is but an extended reply to one of the simplest and profoundest of questions: who are you and how did you come to be that way?" (115). It seems that even in the modern world, initiation rites are not dead. For as Jean Starobinski observes, "one would hardly have sufficient motive to write an autobiography had not some radical change occurred in his life—conversion, entry into a new life, the operation of Grace" (78).

Method

Entry into a new life is the common denominator of the twenty-eight authors treated here (and the thirty-one books, given that three of the authors wrote two books each).

Criteria

Four criteria governed my search for primary sources:

- nonfiction full-length books
- by American physicians writing about their own medical education
- issued by reputable publishers for the general public
- from 1965 to the present.[14]

Twenty-First Century (1985)—the story of a third-year medical student, Aaron Kenigsberg—and Robert Kanigel, author of "The Making of a Hopkins Doctor" (1983). Among the sociologists is Howard S. Becker, who led the way with "The Fate of Idealism in Medical School" with Blanche Geer (1958). Three years later, Becker published *Boys in White: Student Culture in Medical School* with Geer as well as Everett C. Hughes and Anselm L. Strauss (1961).

[14]Doctor X published *Intern* in 1965, the year that also marked the passage of Medicare and Medicaid. According to Ludmerer and others, such as the sociologist Elliott A. Krause,

Particularly slippery is the concept of "nonfiction." Postmodernists would like to erase any sort of dividing line that separates it from fiction, for they deny the existence of "a biographical self capable of reflection, or a biographical reality upon which to reflect" (Chamberlain and Thompson 3). More satisfying to me is the work of the French theorist Philippe Lejeune, who offers a clear-cut way of distinguishing autobiography from the autobiographical novel (15). In the former, the author's name and the protagonist's name are identical (hence establishing the "autobiographical pact" between writer and reader), and in the latter, the author's name and the protagonist's name are different (hence establishing the "fictional pact" between writer and reader).

In proposing the autobiographical pact and the fictional pact, Lejeune concedes, "I have especially run the risk of seeming a simpleton" (130) in the eyes of the postmodernists: "what illusion to believe that we can tell the truth, and to

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those pieces of legislation led to a new era. "The period between 1945 and 1965 represented the scientific era at its peak," Ludmerer contends. "If research had once been the master, that role at most medical schools was increasingly assumed by patient care" (221). Similarly, according to Krause, "the rise of the profession in 1930–1965" was followed by "the Medicare/Medicaid fight and the decline in power from 1970 to 1990" (36). He explains that whereas the American Medical Association (AMA) opposed Medicare and Medicaid, academic medicine favored it, as did "a new and powerful lobby"—older Americans. "When it passed," he says, "the AMA had a clear defeat on its hands, and the organization has never since held the commanding position it had before. More important, community sentiment, which had generally been in favor of the medical profession, began to change. People still trusted their own doctors—if they had one—but they began to view the profession as a whole as greedy and heartless" (43). Glaser agrees: "the American Medical Association, the organizational spokesman for a large segment of the profession, has not been, to understate it, the most progressive organization in the country. In fact, the A.M.A. has often opposed social change, especially in the medical area. Inevitably, therefore, the students attribute the A.M.A.'s attitudes to physicians in general" (181).

believe that each of us has an individual and autonomous existence! How can we think that in autobiography it is the lived life that produces the text, when it is the text that produces the life!'' Lejeune continues. ''How do I answer this?'' As follows: ''yes, I have been fooled. I believe that we can promise to tell the truth; I believe in the transparency of language, and in the existence of a complete subject who expresses himself through it,'' he says, adding, ''I believe in the Holy Ghost of the first person. And who doesn't believe in it? But of course it also happens that I believe the contrary, or at least claim to believe it.'' Even though the postmodernists play ''a dizzying game,'' Lejeune joins in momentarily. ''Telling the truth about the self, constituting the self as complete subject—it is a fantasy,'' he says. ''We *indeed know* all this; we are not so dumb, but, once this precaution has been taken, we go on as if we did not know it,'' hence the two pacts. ''In spite of the fact that autobiography is impossible, this in no way prevents it from existing'' (131–32), he concludes.

Based on the difference between the two pacts proposed by Lejeune, all of the following are autobiographical novels about medical education. For that reason, I have excluded them from my analysis[15]: *The Year of the Intern* by Robin Cook (1972); *Extreme Remedies* by John Hejinian (1974); *Woman Doctor* by Florence Haseltine and Yvonne Yaw (1976); *Finally . . . I'm a Doctor* by Neil Shulman [and ghostwriter Carl Hiassen, whose name appears in the front matter (1976)]; *M.D.* by

[15]Even though I have excluded them, I am sympathetic with Roy Pascal, who opens his essay ''The Autobiographical Novel and the Autobiography'' as follows. ''If one starts with the idea that the terms 'fictional' and 'true' will serve to distinguish these two forms of writing, one is doomed to disappointment'' (134).

Neil Ravin (1981); *The Making of a Modern Psychiatrist* by Mark Warren (1986); *The Surgical Arena* by Peter Grant (1993); *The Select* by F. Paul Wilson (1994); and *Bellevue* by Marc Siegel (1998). And finally, Stephen Bergman has published three autobiographical novels under the pen name "Samuel Shem": *The House of God* (1978), *Fine* (1985), and *Mount Misery* (1997).[16] Nor do American physicians have a corner on the market of autobiographical novels. For example, from England comes *The Houseman's Tale* by Colin Douglas (1975).

The title alone was rarely sufficient to determine whether a given book met my criteria, so making extensive use of interlibrary loan, I examined far more than the thirty-one primary sources that made my final cut. One promising candidate came to my attention too late to be included in my analysis: Frank Huyler's *The Blood of Strangers: Stories from Emergency Medicine* (1999). Other books were excluded for various reasons. Among them is the delightful *Call Me Doctor! Cartoon Memories of a Medical Student* by Robert A. McCleary (1946):

> This book is a collection of 57 cartoons drawn from my experiences, sometimes gay, sometimes grim, while in medical school. In as representative a manner as I could conceive, they typify all the situations which tickle the student's always receptive ego, arouse surging waves of anxiety, fatigue him to the point of stupor, plunge him into the depths of despair or raise him to the heights of hilarity. It

[16]There is even an autobiographical novel about dental education: *Open Wider, Please* by Carl Alva Sturdevant (1974).

> is my hope that, for those who are curious, this book may throw a little light on the life of a medical student, that it will serve as an aperitif to those who see medical school in their future—a pleasant reminiscence for those who have it in their past. For those who are students now, this is intended as a mirror wherein they may find their reflection cast. This mirror is selective. The reflection here is humorous for the sake of amusement. (Foreword)

Other finds were also intriguing.

For example, Michael Meyers divides his attention in *Goodbye, Columbus: Hello Medicine* (1976) between his foray into show business—most notably, he played a part in the movie *Goodbye, Columbus*, featuring Ali MacGraw, Dick Benjamin, and Jack Klugman—and his four years in medical school. Rose-Marie Toussaint deals with her childhood in Haiti as well as her story of becoming a transplant surgeon in *Never Question the Miracle: A Surgeon's Story* (1998), cowritten by Anthony E. Santaniello. Then, too, a British physician has published *Milestones: The Diary of a Trainee GP* (Peter Stott, 1983); an Irish physician who did two three-month rotations in the United States has published *In Stitches: The Diary of a Student Doctor* (John Fleetwood, 1994); and a Canadian physician has published *Getting Doctored: Critical Reflections on Becoming a Physician* (Martin Shapiro, 1987). Shapiro delivers what he promises—critical reflections—but in an autobiographical context, as he explains. "I have endeavoured to illustrate the problems discussed with events drawn from my own experience, and these events are points of reference for my analysis" (7).

Several physicians with disabilities have written books that deal in part with the unique challenges that medical education posed for them: *Spirit Makes a Man* by Joseph J. Panzarella, Jr. (whose multiple sclerosis led to quadriplegia), cowritten by Glenn D. Kittler (1978); *Welcome, Silence: My Triumph Over Schizophrenia* by Carol S. North (1987)—''now a respected psychiatrist and researcher at Washington University'' (Begley 49)—and *When the Phone Rings, My Bed Shakes: Memoirs of a Deaf Doctor* by Philip Zazove (1993).

Then there are physicians who have woven their own experiences as medical students, interns, and residents into advice books intended either for potential colleagues [*How to Survive Medical School* by Toni Martin (1983) and *Keeping Hope Alive: On Becoming a Psychotherapist* by F. Robert Rodman (1986)] or for the general public [*To Be a Surgeon* by Richard Furman (1982), which came out in paperback as *Reaching Your Full Potential* (1982)]. Replete with references to Christianity, both of Furman's titles have the endorsement of Billy Graham's son Franklin, the president of the World Medical Mission.

An especially interesting book about medical education is a team effort by Richard E. Peschel, M.D., Ph.D., and Enid Rhodes Peschel, Ph.D., who are husband and wife: *When a Doctor Hates a Patient and Other Chapters in a Young Physician's Life* (1986). Combining ''case histories'' with ''literary parallels'' and ''reflections,'' the book began to take shape, they explain, ''when Richard Peschel was a medical intern. He would come home from the hospital and tell Enid about some of the cases he had treated—those that particularly interested or troubled him—and sometimes Enid

would say, 'That reminds me of something I read in literature''' (ix)—and voilà, they became coauthors. Two books about internship are based on the diaries kept at the request of Robert Marion by half a dozen of his students: *The Intern Blues: The Private Ordeals of Three Young Doctors* (1989) and *Rotations: The Twelve Months of Intern Life* (1997). In a similar fashion, ''Recollections of Medical House Pupils'' at Massachusetts General Hospital were ''gathered and edited'' by Dr. James H. Means during the early 1900s (Washburn 175–98). Another collection is *My Medical School* (1978). Edited and introduced by Dannie Abse, it consists of autobiographical essays by thirteen physicians, most of whom were educated in the United Kingdom.

Two children's books about medical education were published in 1981, both of them semiautobiographical. ''Told mostly in the words of doctors, students and patients, *Early Morning Rounds* is the story of two students in their third year of medical school, a year spent in a hospital instead of a classroom,'' the dust jacket explains. The students are Nick and Jennifer, ''imaginary but typical'' (1), says Burnham Holmes, who devotes one chapter each to the emergency room, internal medicine, surgery, obstetrics/gynecology, and primary care. On the other hand, photographs of Elaine Choy and Steve Pavlakis grace the cover of *The Interns* by Harriet Langsam Sobol. ''This book traces the year of internship, often using Steve and Elaine's own words, as they look back on this important stage on their road to becoming doctors''—specifically, pediatricians, according to the dust jacket. Interestingly enough, Sobol includes a bibliography that lists Samuel Shem's autobiographical novel *The House of God* (which is definitely not intended for

children), as well as two of my primary sources: Fitzhugh Mullan's *White Coat, Clenched Fist: The Political Education of an American Physician* and Elizabeth Morgan's *The Making of a Woman Surgeon.*

Several authors have turned to vanity presses: David Jeffrey Fletcher, *Med School Mayhem* (1980); Twana L. Sparks, *Diary of a Hippocrate: Medical School Years* (1996); and Cynthia A. Foster, *Stop the Medicine! A Medical Doctor's Miraculous Recovery with Natural Healing* (1999), in which she chronicles her four years in medical school as a way of "educating people on the dangers of Western Medicine and on the benefits of natural healing" (34). Foster does hold an M.D., but she lacks the year of internship that is required for licensure as a physician. And then there is the self-published book *Heart Failure: Diary of a Third Year Medical Student* by Michael Greger (1999), who also posted it on the World Wide Web under the auspices of the United Progressive Alumni, "an independent organization of Cornellians" (http://upalumni.org/medschool/). He intends to continue writing. "Currently I'm an intern, kind of like third year squared. I'm afraid the sequel (about this year) will be equally depressing. But I've promised everyone that I'd write a third, a reclamation, a recovery, a resuscitation" (Greger, letter to the author, 26 Dec. 1999). Clearly, the books that did not meet all of my criteria nevertheless constitute a veritable treasure trove themselves.[17]

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[17]Also worth mention are *The Medical Student Diaries* on the Student Doctor Network (http://www.studentdoctor.net/), which features ten contributors: Emily Baldwin; Brandon Barton; Brian J. Hartman; Kim Higgins; Daniel L. Imler; Mark Lee; Ron Maggiore; Jamie G. Taweel; William Trask, IV; and Kristi Marie Whitenton. Then, too, a physician maintains a site on the World Wide Web entitled *Journey of Hearts: A Healing Place in*

Strategies

Tracking down the thirty-one books that met my criteria for the autobiography of medical education involved using a number of strategies, not to mention serendipity. The first place I turned was the online catalog of the Library of Congress (http://www.lcweb.loc.gov). Starting with a handful of books that met my criteria, I used the subject headings on the title pages to locate additional books, which led me to additional subject headings, and additional books, and so forth—in essence, snowball sampling, except that my objective was to identify the entire population. Most but not all of my primary sources appear under at least one of the following subject headings:

- medical students—United States—biography,
- interns (medicine)—United States—biography,
- residents (medicine)—United States—biography,
- physicians—United States—biography,
- physicians—diaries,
- physician and patient,
- education, medical—personal narratives,
- students, medical—personal narratives,
- schools, medical—popular works,
- medical education—United States,

CyberSpace (http://www.kirstimd.com/). On that site, Kirsti A. Dyer posts essays and poems that she and others wrote and published as medical students, interns, and residents (Dyer, "It's O.K."; Dyer, "Toxic Intern Syndrome"; Dyer, "A Cry from Within"; Lipman).

- medical students—Massachusetts—biography,
- interns (medicine)—Massachusetts—biography, and
- residents (medicine)—New York (State)—New York—biography.

Also useful was amazon.com, which I searched using the following key words—''medical students and biography''; ''interns (medicine) and biography''; and ''residents (medicine) and biography''—as well as abebooks.com (Advanced Book Exchange), which is an excellent source of out-of-print books.

Of the available bibliographies of autobiography—most notably, Kaplan and Briscoe, but also Lillard (which lists fourteen books by physicians) and Addis (which lists seventeen books by physicians, all of them women)—only Briscoe is helpful. And only modestly so, for Briscoe includes just four of my primary sources.[18] Other publications are devoted exclusively to physicians who write—most notably, William B. Ready's ''Medicine and Literature: Doctors in Both Faculties'' (1962) and John D. Gordan's ''Doctors as Men of Letters: English and American Writers of Medical Background'' (1964)—but they are solely of historical interest. The year 1982 brought not only Briscoe's bibliography of autobiographies but also *Literature and Medicine: An Annotated Bibliography*, by Joanne Trautmann (Banks) and Carol Pollard. It includes none of my primary sources despite the 140 entries that appear under the heading ''By Doctors.'' According to Trautmann and Pollard, ''the two great

[18]Twelve of my primary sources were published during or before 1980 (Briscoe's end point), so only one-third of them (four of the twelve) made their way into *American Autobiography 1945-1980: A Bibliography*.

physician-writers'' are Anton Chekhov and William Carlos Williams (xiii), and indeed, a generous share of the entries are devoted to their works (twenty-five in all). Favoring ''works of imaginative literature'' (xiv), Trautmann and Pollard note in the introduction to the revised edition, ''we have once again been highly selective'' with regard to autobiography (xix).

Nevertheless, a handful of scholars have taken an interest in the autobiography of medical education,[19] both Ph.D.s and M.D.s. The Ph.D.s include Anne Hudson Jones (''The Medical *Bildungsroman*: The Making of a Physician-Writer'' and ''Literature and Medicine: Traditions and Innovations''); Suzanne Poirier (''Role Stress in Medical Education: A Literary Perspective,'' ''Ethical Issues in Modern Medical Autobiographies,'' and ''Physician-Authors—Prophets or Profiteers?''); Peter Conrad (''Learning to Doctor: Reflections on Recent Accounts of the Medical School Years''); and Kathryn Montgomery Hunter (*Doctors' Stories: The Narrative Structure of Medical Knowledge* 163; 196, n. 35). The M.D.s include John D. Stoeckle (''Physicians Train and Tell''); Louis Borgenight (coauthor with Poirier on ''Physician-Authors—Prophets or Profiteers?''); Daniel C. Bryant (''Telling Tales out of School—Portrayals of the Medical Student Experience by Physician-Novelists''); David Hellerstein (''Keeping Secrets, Telling Tales: The Psychiatrist as Writer'');[20] and Marjorie S. Sirridge (''Through a Woman Physician's 'I''''). Then there is Rita

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[19]It's important to note that many of them co-mingle autobiography and the autobiographical novel, whereas I have excluded the latter from my analysis.

[20]Hellerstein is also the author of one of my primary sources.

Charon, M.D., Ph.D. (''To Render the Lives of Patients''). Not to be overlooked is Ann Jurecic, who briefly mentions three of my primary sources in her doctoral dissertation (1994).

And I confess to there being some madness to my method. For well into my research, I was flipping through rolls of microfilm when the section ''Nonfiction Book Excerpts'' in the June 1973 issue of *Cosmopolitan* happened to catch my eye—and underneath it, ''The Making of a Psychiatrist'' by David S. Viscott, M.D.—''from the brilliant new book'' (174), according to the editors of *Cosmopolitan*. It had escaped my attention despite being listed in the online catalog of the Library of Congress because the two subject headings used to identify it were not among the thirteen that I had checked (''psychiatrists—United States—biography'' and ''psychiatry—study and teaching''). Although his book was a late discovery, it turned out to be one of the best of my primary sources.

Primary Sources

In order of copyright date, my primary sources are listed in Table 1.

Table 1. Primary Sources

Author	Title/Length in Pages	Copyright Date/Publisher
Doctor X [pseudonym]	*Intern*/404	1965/Harper and Row
William A. Nolen	*The Making of a Surgeon*/269	1970/Random House
John MacNab [pseudonym]	*The Education of a Doctor: My First Year on the Wards*/222	1971/Simon and Schuster

Table 1. Primary Sources (continued)

Author	Title/Length in Pages	Copyright Date/Publisher
David S. Viscott	*The Making of a Psychiatrist*/410	1972/Arbor House
Theodore Isaac Rubin	*Emergency Room Diary*/193	1972/Grosset and Dunlap
Theodore Isaac Rubin	*Shrink! The Diary of a Psychiatrist*/237	1974/Popular Library
Fitzhugh Mullan	*White Coat, Clenched Fist: The Political Education of an American Physician*/222	1976/Macmillan
Steve Horowitz (and Neil Offen)	*Calling Dr. Horowitz*/251	1977/Morrow
Laurence E. Karp	*The View from the Vue*/225	1977/Jonathan David
Joni Lynn Scalia	*The Cutting Edge*/257	1978/McGraw-Hill
Donald T. Moynihan (and Shirley Hartman)	*Skin Deep: The Making of a Plastic Surgeon*/339	1979/Little, Brown
Elizabeth Morgan	*The Making of a Woman Surgeon*/368	1980/Putnam's
Kenneth Klein	*Getting Better: A Medical Student's Story*/284	1981/Little, Brown
Charles LeBaron	*Gentle Vengeance: An Account of the First Year at Harvard Medical School*/272	1981/Marek
Michelle Harrison	*A Woman in Residence*/264	1982/Random House
Jane Patterson (and Lynda Madaras)	*Woman/Doctor: The Education of Jane Patterson, M.D.*/217	1983/Avon

Table 1. Primary Sources (continued)

Author	Title/Length in Pages	Copyright Date/Publisher
Dorothy Greenbaum (and Deidre S. Laiken)	*Lovestrong: A Woman Doctor's True Story of Marriage and Medicine*/312	1984/Times Books
David Hellerstein	*Battles of Life and Death*/264	1986/Houghton Mifflin
Stephen A. Hoffmann	*Under the Ether Dome: A Physician's Apprenticeship at Massachusetts General Hospital*/300	1986/Scribner's
Perri Klass	*A Not Entirely Benign Procedure: Four Years as a Medical Student*/256	1987/Putnam's
Melvin Konner	*Becoming a Doctor: A Journey of Initiation in Medical School*/390	1987/Viking
J. Kenyon Rainer	*First Do No Harm: Reflections on Becoming a Neurosurgeon*/299	1987/Villard
Philip Reilly	*To Do No Harm: A Journey Through Medical School*/292	1987/Auburn House
Robert Klitzman	*A Year-Long Night: Tales of a Medical Internship*/242	1989/Viking
Joseph Sacco	*Morphine, Ice Cream, Tears: Tales of a City Hospital*/264	1989/Morrow
Robert Marion	*Learning to Play God: The Coming of Age of a Young Doctor*/267	1991/Addison-Wesley

Table 1. Primary Sources (continued)

Author	Title/Length in Pages	Copyright Date/Publisher
Stephen B. Seager	*Psychward: A Year Behind Locked Doors*/249	1991/Putnam's
Perri Klass	*Baby Doctor*/330	1992/Random House
Robert Klitzman	*In a House of Dreams and Glass: Becoming a Psychiatrist*/366	1995/Simon and Schuster
Claire McCarthy	*Learning How the Heart Beats: The Making of a Pediatrician*/247	1995/Viking
Ellen Lerner Rothman	*White Coat: Becoming a Doctor at Harvard Medical School*/335	1999/Morrow

Although copyright dates are important because they mark the entry of the books into public consciousness, they are not equivalent to the rank order of the dates that the authors attended and graduated from medical school or served their internships and residencies. Of greatest significance in that regard are Doctor X, William A. Nolen, and Theodore Isaac Rubin. Born in the 1920s—specifically, 1928 (Doctor X and Nolen) and 1923 (Rubin)—not only do they predate all of the other authors, but they were the slowest to publish, with a ten-year lag time for Doctor X and Nolen and a twenty-year lag time for Rubin. That is, Doctor X did his internship from 1955 to 1956 (*Contemporary Authors* 1-4: 716), and he published *Intern* in 1965. Nolen completed his residency in 1960 (*Contemporary Authors New Revision Series* 15: 348), and he published *The Making of a Surgeon* in 1970. Rubin published *Emergency Room Diary* in 1972, which is based on one rotation of his internship that

took place in 1952, and he published *Shrink: The Diary of a Psychiatrist* in 1974, which is based on the portion of his residency that took place from 1954 to 1955 (*Contemporary Authors* 110: 439). The next in line chronologically is David S. Viscott. Born in 1938, he completed his residency in 1967 (*Contemporary Authors New Revision Series* 26: 441), and he published *The Making of a Psychiatrist* in 1972—in contrast, just a five-year lag time. And lag time dropped to a minimum with *Gentle Vengeance: An Account of the First Year at Harvard Medical School* by Charles LeBaron. He explains. "The book was written in a ten week period over the summer following my first year and was typed and revised during stolen moments of the second year." It was published in 1981, and according to the *Directory of Physicians in the United States* (36th ed.), LeBaron graduated from Harvard Medical School three years later.

So the books by Doctor X, Nolen, and Rubin appeared when the time was right—in other words, when students began speaking out in the 1960s. "Criticizing 'the system,' an old American tradition, is now a dominant theme in this literature on training" (11), says John D. Stoeckle, M.D., in his article "Physicians Train and Tell." Both Doctor X and Nolen are deceased (as is Viscott), but fortunately, Rubin is available for comment. Although he has not read either Doctor X's *Intern* or Nolen's *The Making of a Surgeon*, he is familiar with the former. "I remember when that book came out," he says, adding, "it did very well" (Rubin, telephone interview, 22 June 2000).

Some patterns quickly emerge from my primary sources: the greatest number appeared in the 1980s (fourteen), followed by the 1970s (ten) and the 1990s (six), with Doctor X leading the way in 1965, of course.[21] "Doctor X" and "John MacNab" are pseudonyms. Three of the authors wrote two books each, as noted previously (Rubin; Klass; Klitzman), and four of the books are collaborations (Horowitz and Offen; Moynihan and Hartman; Patterson and Madaras; Greenbaum and Laiken). According to Stone, "the serial or multiple autobiography is today an accepted alternative to the 'one life/one autobiography' convention," as is "the collaborative autobiography" (103).

Other patterns require some digging. Physicians in various specialties are represented, most notably the following: psychiatry (Viscott; Rubin; Hellerstein; Klitzman; Seager), which is said to attract the ultimate talkers; surgery (Nolen; Moynihan and Hartman; Morgan; Rainer), which is said to attract the ultimate doers; pediatrics (Mullan; LeBaron; Greenbaum and Laiken; Klass; Marion; McCarthy; Rothman); obstetrics and gynecology (Karp; Patterson and Madaras; Harrison); and internal medicine (MacNab; Horowitz; Klein; Hoffmann; Reilly).

Nor do they all tell their stories in the same way: "the conditions of autobiography furnish only a large framework within which a great variety of particular styles can occur" (73), Starobinski notes. Some of them are diarists (for

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[21]Interestingly, the publication of his book *Intern* coincided with two "doctor shows" that aired on television from 1961 to 1966: *Dr. Kildare*—a resuscitation of the character featured in sixteen movies released from 1937 to 1947 (Kalisch and Kalisch 349)—and *Ben Casey* ("Docs on the Box: A Medical History" 51). See also *Playing Doctor: Television, Storytelling, and Medical Power* by Joseph Turow.

example, Doctor X; MacNab; and Harrison; but not Rubin, who wrote his "diaries"—*Emergency Room Diary* and *Shrink! The Diary of a Psychiatrist*—long after the fact); some of them are essayists, like Hellerstein and Klass; and some of them are nonfiction novelists, like Viscott, LeBaron, and Seager.

Three medical schools have produced twelve of the twenty-eight authors: Harvard Medical School (Klein; LeBaron; Hoffmann; Klass; Konner;[22] McCarthy; Rothman); Yale Medical School (Morgan; Reilly; Klitzman); and Tufts Medical School (Nolen; Viscott). The authors most commonly have undergraduate degrees from Harvard University (MacNab; Mullan; Morgan; Klein; Klass; Hellerstein) and Princeton University (LeBaron; Hoffmann; Klitzman); moreover, Sacco graduated from Tufts University. Finally, the training program at Bellevue Hospital is the venue for Nolen's book and Karp's book.

Many of the twenty-eight authors mention that they are Jewish, if not in practice, then by heritage. In regard to sexual orientation, two of the authors are homosexual (Patterson and Madaras; Klitzman). And as noted previously, three of the authors are deceased (Doctor X; Nolen; Viscott).

Of particular significance is the large number of women represented—eight in all (Scalia; Morgan; Harrison; Patterson and Madaras; Greenbaum and Laiken; Klass; McCarthy; Rothman)—for as Eliade notes, initiation rites are specific to gender:

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[22]In addition, Konner holds an M.A. and a Ph.D. from Harvard University. A member of the faculty there from 1974 to 1981 (*American Men and Women of Science*, 14th ed; *Who's Who in the East*, 19th ed.), he had risen to the rank of associate professor when he decided to add an M.D. to his credentials.

''female initiation begins with the first menstruation'' (41). He continues. ''For the woman, the revelation that she is *a creator of life* . . . cannot be translated into masculine terms'' (45). The same idea makes its way into *Women in Medicine* by Carol Lopate: ''the institutionalized requirements of medicine remain at odds with those of wifehood and motherhood'' (130), she maintains, and Ludmerer adds, ''particularly the growing length of time required by residency and fellowship, which made it difficult to combine medical training with starting families'' (256)—not just in the 1960s, but beyond. In particular, he cites ''the reluctance of a male-dominated profession to make structural allowances in medical education to accommodate the special needs of women bearing and raising children'' (257). Even so, ''the organizational dilemmas'' (259), he cautions, ''should not be interpreted as representing the result of universal hostility among men. Almost all women with successful careers, in academe or in practice, have been assisted by men who were willing to help and teach them'' (258).

For men know the ropes, according to Barry J. Schwartz, M.D., and Laurence H. Snow, M.D., psychiatrists whose article ''On Getting Kicked Out of Medical School'' (1974) deals primarily with women ''who hoped to gain readmission'' (575) by seeking psychotherapy:

> Four years of medical school may be thought of as solely the attainment of a degree, but it is really much more—it is training and screening for an exclusive society, the members of which have rights, privileges, and responsibilities not granted to ordinary members of the

> community. In addition to that aspect of medical school which is purely educative, there is a subtle yet all pervasive initiation ritual. As with any rites of passage, the novices must show their resolve by bearing up under a variety of humiliations which, on the part of the faculty, are for the most part unconscious. We believe that there is here a distinct difference between male and female behavior in reaction to this because boys and girls are taught separate social skills as children by their parents and peers. The new boy on the block is expected to endure a certain amount of humiliation and even beatings. Having demonstrated his ability to ''take it'' and endure it without running home to mommy in tears, he then becomes ''one-of-the-gang.'' We believe that in the socialization of girls as children they are not trained to endure humiliations in this way and are permitted to run from a painful scene in tears without losing any status. This failure to comprehend and cope with the rites-of-passage aspect of becoming a doctor may pose special problems for women. (581–82)

They conclude as follows. ''Nowhere have we seen any discussion of the problems from the aspect that women are experientially deprived—that as children they have not endured as many initiation rituals as men, and hence are less prepared for the medical rites of passage'' (582).

Accordingly, every one of the eight women treated here exhibits what Virginia M. Davidson, M.D., calls ''role strain,'' a concept that she explains in ''Coping

Styles of Women Medical Students'' (1978). ''Role strain refers to the built-in conflict that results from the woman's having to choose between the demands placed on her by her profession and those that stem from her obligations as a woman/mother/wife and from her identity as a female'' (903). Even so, there is considerable variation in how the eight women treated here deal with role strain, a topic that has been addressed by Poirier (''Role Stress in Medical Education: A Literary Perspective'') and Sirridge (''Through a Woman Physician's 'I''').

But above all, regardless of gender, regardless of specialty, the twenty-eight doctors/writers are exactly that—doctors first and writers second—the result being that fidelity to medical standards comes first, and fidelity to journalistic standards comes second. For example, confidentiality between physician and patient rules out the use of real names, as Doctor X explains: ''most important of all is the question of propriety. Protection of the confidence and privacy of the patient is the moral and legal obligation of anyone responsible for the care of the sick. This obligation must not be violated'' (2), he says, ''declaring his relationship with the patient a sacred precinct—guarded by confidentiality and not to be intruded upon by anyone beyond the patient and his family'' (158), as put by the philosophers of medicine Edmund D. Pellegrino and David C. Thomasma. To quote Cox once again, ''something has happened to the whole idea of literature'' (252), and Stone agrees: ''the autobiographer was expected to subordinate imagination to the attempt to communicate trustworthy, verifiable, subjective messages,'' he says. ''Proposed terms of individual arrangements are often announced in a preface or introduction, whose

presence once assured readers that they were not beginning a novel but a 'true story.' However, this convention has recently broken down'' (100).

Each of the twenty-eight authors treated here claims to have written a ''true story'' in which all of the names have been changed—except their own.[23] A fallacy of logic, or even worse, a lapse in judgment, one that demands exile in the manner of Janet Cooke?[24] They don't think so. Once again, consider Doctor X. ''The result is a true and valid document'' (1), he says, even though ''in editing this journal no effort has been spared to conceal all actual names, places, dates and incidents from identification. Because of this commitment, the journal that follows must technically be classified as fiction'' (2). The vast majority of my thirty-one primary sources carry a similar disclaimer somewhere in the front matter or the end matter. ''The basic dilemma is how to keep secrets while telling tales,'' as Hellerstein points out elsewhere (''Keeping Secrets, Telling Tales: The Psychiatrist as Writer'' 135).

It's a thorny one. Recently, it was addressed by a senior scholar at the Poynter Institute, Roy Peter Clark, who in his essay ''The Line Between Fact and Fiction'' identifies what he calls ''cornerstone principles.'' Among them: ''Do not deceive.'' Similar to Lejeune and the autobiographical pact, Clark takes the following stand:

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[23]''Doctor X'' and ''John MacNab'' present an interesting problem because the pseudonym substitutes for the name of the author. And the name of the protagonist is absent given that in the text itself, both authors limit themselves to the pronoun ''I.''

[24]Timothy Dow Adams recalls the incident in *Telling Lies in Modern American Autobiography*: ''Janet Cooke, a reporter for the *Washington Post*, lost her Pulitzer Prize, her job, and her reputation when she invented a young black boy called 'Jimmy' to stand for thousands of black children whose lives have been blighted by poverty, racism, and drugs'' (4), for instead of admitting to the composite, she claimed that Jimmy was real.

''journalists should never mislead the public in reproducing events. The implied contract of all nonfiction is binding: The way it is represented here is, to the best of our knowledge, the way it happened. Anything that intentionally or unintentionally fools the audience violates that contract and the core purpose of journalism—to get at the truth. Thus, any exception to the implied contract,'' he concludes, ''should be transparent or disclosed'' (7).

Decades earlier, science writer Nathan S. Haseltine considered the problems specific to reporting about medicine. ''Newspapermen and physicians live in their own worlds. They see the same things, but each views them from his own training.'' He continues:

> Physicians are bound by an oath, and a protective code of ethics. The violation of either brings down the wrath, and retaliations, of colleagues. The violating physician's reputation and income may suffer; in fact his very right to practice may be taken away from him.
>
> In this world of freedom of the press, guaranteed by our Constitution, neither newspapermen nor their newspapers are licensed. The newspaperman and his newspaper that break the ethical code are not penalized, other than by loss of circulation when readers turn from the paper in distrust.
>
> All this is neither praise nor condemnation of either profession. It just shows that the concepts and practices of medicine and of newspaper operations are as foreign to each other as the Eskimos and

the Hottentots. The doctors and the news reporters go their separate ways, each wondering why the other is so strange. (Krieghbaum 8-9)

Even so, there is a critical difference between Janet Cooke and Doctor X (and those who published after him)—namely, she deliberately hoodwinked her readers, whereas the authors of my primary sources freely admit to taking liberties that are ordinarily denied to journalists.

On that basis, *Walden* by Henry David Thoreau—generally considered "the next great American autobiography" after Benjamin Franklin's (262)—is actually a work of fiction, as Cox explains: "it is much more than a making or recording of experience. It was for Thoreau a finishing of experience, and Thoreau's experiment in form is most dramatically evident in his determination to reach a conclusion, thereby completing his life." Cox continues. "There is a cost, of course, for Thoreau in order to complete his life has to take part of it—the two years he spent at Walden Pond ten years earlier—and make them stand for the whole. He went much further. He compressed the two years into one, letting the cycle of the seasons stand for the completed circle of the self" (263). Then, too, *Walden* "appears in 1854, at just the moment the nation was moving toward Civil War" (262), again suggesting that autobiography gains prominence "as politics and history tend to claim dominion over the imagination" (252)—the same sort of milieu in which Doctor X's *Intern* was published. Or as Theodore Solotaroff says, "the sixties have probably been the most cataclysmic decade in American history since that of the Civil War" (x).

Of what good are works that blur traditional boundaries—like Thoreau's *Walden* and, if I may mention it in the same sentence, Doctor X's *Intern*? Recall what Lejeune says. ''In spite of the fact that autobiography is impossible, this in no way prevents it from existing'' (131-32). The apparent contradiction is nicely resolved by James Olney. ''What one seeks in reading autobiography is not a date, a name, or a place, but a characteristic way of perceiving, of organizing, and of understanding, an individual way of feeling and expressing that one can somehow relate to oneself'' (37).

In reading the autobiography of medical education, it was my hope that I would ''discover an integrating scheme within the data themselves,'' in the words of Clifford J. Christians and James W. Carey. They explain: ''the qualitative researcher maps out territories by finding seminal ideas that become permanent intellectual contributions while unveiling the inner character of events or situations'' (370)—or books. Basing my analysis on them, I employed ''the view that holds the literary work to be most significant as an object independent of the facts of its composition, the actuality it imitates, its author's stated intention, or the effect on its audience'' (Harmon and Holman, ''Objective Theory of Art'' 356). It is my contention that the authors of my thirty-one primary sources experienced medical education in five characteristic ways—as observers, outsiders, activists, malcontents, and apologists—and that they portray themselves accordingly. Very few of them represent the ''long-haired freaky people'' who made the news in the 1960s. Nevertheless, as Dr. Davidson noted, such people were just the tip of ''a huge iceberg of change in

students' attitudes'' (126), with ''the quiet generation'' of the 1950s giving way to medical students, interns, and residents who felt free to speak their minds, sometimes in defense of the educational system. And so I end my introduction where I started it—with Doctor X's *Intern* and the other primary sources treated here. Of central interest to me, they serve as the focus for the next five chapters.

CHAPTER 2

THE OBSERVERS

The autobiography of medical education is dominated by the observers, with the nine of them having written just over one-third of the books in that genre. Watching carefully and often arriving at judgments about what they see, they are Doctor X [pseud.], *Intern* (1965); John MacNab [pseud.], *The Education of a Doctor: My First Year on the Wards* (1971); David S. Viscott, *The Making of a Psychiatrist* (1972); Laurence E. Karp, *The View from the Vue*, "the Vue" being Bellevue Hospital (1977); David Hellerstein, *Battles of Life and Death*, which on the dust jacket is subtitled *The Discoveries of a Young Doctor during His Medical School Education* (1986); Melvin Konner, *Becoming a Doctor: A Journey of Initiation in Medical School* (1987); Philip Reilly, *To Do No Harm: A Journey Through Medical School* (1987); Robert Klitzman, *A Year-Long Night: Tales of a Medical Internship* (1989);[1] and Perri Klass, *A Not Entirely Benign Procedure: Four Years as a Medical Student* (1987) and *Baby Doctor*, which on the dust jacket is subtitled *A Pediatrician's Training* (1992).

Of the nine, only one is a woman (Klass), and she comes along at the tail end. Those who published first did so under pseudonyms (Doctor X and MacNab), thus shielding themselves from the repercussions that they expected from their books, and

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[1]An observer during his internship, Klitzman becomes a malcontent during his residency, which is the topic of *In a House of Dreams and Glass: Becoming a Psychiatrist* (1995). Only three of the twenty-eight physicians write more than one book about their medical education (two each for Klitzman, Klass, and Rubin), and of those, only Klitzman's perspective changes appreciably.

both they and two others (Viscott and Konner) conceal the identities of the universities and hospitals where they trained. Unlike MacNab—more on him later—Doctor X left a trail of bread crumbs behind him. Although the *Biography and Genealogy Master Index* lists two physicians who have gone by the moniker of "Doctor X"—Mario E. Jascalevich and Alan E. Nourse—it takes just a little bit of sleuthing to determine that the latter is the author of *Intern*. And as it turns out, it's set in Virginia Mason Hospital in Seattle (*Contemporary Authors New Revision Series* 45: 310) even though Nourse calls it "Graystone Memorial Hospital" in his book—"one of the best training hospitals in the entire Southwest" (8), he adds, piling on more disinformation. He used the pen name "Doctor X" again (see "Abortion: The Doctor's Dilemma")—and according to the *Dictionary of Literary Pseudonyms*, he also used the pen name "Al Edwards" (Atkinson 95, 185)—but for the most part, Nourse published under his given name.

Then there's *The Education of a Doctor: My First Year on the Wards*. The author opens his book by casually tossing out the pseudonym that appears on the cover—"the name MacNab will do as well as any other" (9), he says—and then he disappears without a trace. Interestingly, the author of *The Education of a Doctor: My First Year on the Wards* not only makes reference to his "solid draft exemption" (10), but he was asked to put himself in the following hypothetical situation: "you are in charge of an infant orphanage in Vietnam with crates of US foodstuffs, make up a formula" (22). Turning once again to the *Biography and Genealogy Master Index*, it yields seven different John MacNabs, one of whom was born in 1944, making him

the right age for the Vietnam War. Yet the entry "MacNab, John, 1944–" in the *Biography and Genealogy Master Index* leads only to Volume 9 of the *Biography Index*, which provides nothing but "MacNab, John, 1944- physician," as well as the title of his book, the publisher (Simon and Schuster), the year it came out (1971), and the length (222 pages). Nor is the *Dictionary of Literary Pseudonyms* (or any of its cousins) of any help in tracking down the given name of "John MacNab." Nor do any of the book reviewers provide any clues; in fact, of the three who consider *The Education of a Doctor: My First Year on the Wards* (Beatty; Cray; *Choice*), only Beatty notes that it is "pseudonymous" (2782). And even though the dust jacket of the book features a tantalizing photograph of a young man—presumably "John MacNab"—it only deepens the mystery. For does it not compromise the anonymity that the author holds so dear? "It is impossible for the autobiographical vocation and the passion for anonymity to coexist in the same person" (20), Philippe Lejeune contends. Perhaps, but "John MacNab" comes awfully close to proving Lejeune wrong.

Seemingly at a dead end, I posted the following message on the Literature and Medicine Discussion Group—better known as the lit-med mailing list—which is maintained by New York University:

> A book entitled *The Education of a Doctor: My First Year on the Wards* (New York: Simon and Schuster) was published in 1971 under the pseudonym "John MacNab." I've searched for the author's given name using the standard data bases and reference books, including directories

of pseudonyms, but I've been unable to locate it. If anyone can provide me with the true identity of John MacNab—or any suggestions that might help me to locate it—I would be most appreciative. (Koski)

I hit pay dirt when my inquiry caught the attention of Rich Ratzan, M.D. "If you are talking about the book I think you are, I'll ask him [the author] if he minds disclosure" (Ratzan, 2 Dec. 2001), and then, "I DO know and shall ask if the author minds" (Ratzan, 3 Dec. 2001).

Approximately one month later, Benjamin Winthrop White, M.D., staked his claim to *The Education of a Doctor: My First Year on the Wards* (see Appendix A, "Publishing Agreement,"[2] and Appendix B, "Royalty Statement"). Now on the faculty of Harvard Medical School as a clinical instructor of medicine at Beth Israel Deaconess Medical Center (see "White, Benjamin Winthrop, M.D.," in the *Faculty Directory*), White published his book the year that he graduated from medical school (Ratzan was one of his classmates). Without any prompting, White says that he used a pseudonym because "I felt more comfortable as an observer" (White, telephone interview, 1 Jan. 2002). So why come forward now? "It's not generally known" even today that he is the author, White says, but "if somebody cares this much, why not? Enough time has passed" (White, telephone interview, 17 Feb. 2002).

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[2]When the Publishing Agreement was drawn up, the book did not yet have a title, so White suggested *Lincoln's Doctor's Dog* as a stand-in, the joke being that books about Lincoln, doctors, and dogs can't miss. Simon and Schuster ended up choosing *The Education of a Doctor: My First Year on the Wards*. "Pretentious," White thought. He himself preferred *Big Sky General* (White, telephone interview, 9 Mar. 2002).

And the truth is that he didn't just pick the name "John MacNab" out of a hat, as his book suggests. Instead, he selected it purposefully. The novel *John MacNab*, published by John Buchan in 1925, opens with a chapter entitled "In Which Three Gentlemen Confess Their Ennui," the essence of it being that one of them—Charles Lamancha—decides after some soul-searching that he must undertake something "devilish difficult, devilish unpleasant, and calculated to make a man long for a dull life" (11–12), especially a man like himself—or one like Benjamin Winthrop White, who is an alumnus of Andover, the elite prep school in Massachusetts, not to mention Harvard College. "Perhaps he has got too much too easily" (8), muses a compatriot of Lord Lamancha. It's an assessment with which he agrees wholeheartedly. "I'm out for a cure," Lamancha says, opting for what he calls "sound sporting risks" (17)—that is, "poaching on a grand scale" (12)—by announcing his intentions to the owner of a deer forest. "I'm going to draft a specimen letter" (17), he says. "I propose to kill a stag," he writes, "on your ground." And then—the finishing touch. "'It must be signed with a *nom de guerre*.' He thought for a moment. 'I've got it. At once business-like and mysterious.' At the bottom of the draft he scrawled the name 'John MacNab'" (18).

So it is that White says (as MacNab), "I had a late conversion to medicine" (9). And he wasn't disappointed, for the training that he received was indeed devilish. Even today, he says, it bears far too much resemblance to the Marine Corps with its inculcation of "shame and fear." As for the photograph—the one of a lanky fellow high-stepping it behind a duck—it's him, all right, taken by his former wife, Madi (to

whom he dedicates his book) on their first date on Long Island, New York. It turns out that anonymity only goes so far because when the book came out, White sent copies of it to people he'd gotten to know in medical school, thus becoming something of a celebrity in his social circle. Which medical school? The one at Columbia University (White, telephone interview, 1 Jan. 2002), which is affiliated with Columbia Presbyterian Medical Center (White, telephone interview, 17 Feb. 2002)—"the hospital attached to our medical school" is as specific as he gets in his book (10).

And as the standard reference books reveal, all of the other observers likewise graduated from big-name private universities, specifically, the medical schools at the University of Pennsylvania (Nourse), New York University (Karp), Tufts University [Viscott, who did his residency at the University Hospital in Boston (calling it "Union Hospital" in his book)], Stanford University (Hellerstein), Yale University (Reilly and Klitzman), and Harvard University (Konner and Klass). The last of the observers to dissemble about where he trained, Konner cloyingly alludes to some of the biggest names in medical history: "I chose the Flexner School of Medicine, which was associated with the Galen Memorial Hospital—both world-famous institutions" (14). It's a subterfuge that gets him a slap on the wrist from another M.D., Lewis Thomas. "Konner has disguised Harvard, in his book, for some reason," Thomas says, "and I do wish he hadn't" (6).

There are other similarities. Two of the observers come to medicine having already earned advanced degrees in other fields—a Ph.D. in anthropology (Konner)

and a J.D. (Reilly)—and two others majored in the humanities in college [White, in classics, or as he likes to put it, "dead languages" (9)—Latin and Greek; and Viscott, in English]. And Reilly isn't the only one with an interest in the law, for Viscott spent a year as a fellow at the Law Medicine Institute at Boston University.

While they are training to become physicians, most of the observers are either married (Nourse, Viscott, Karp, Hellerstein, and Konner) or living with a significant other (Klass, who met Larry Wolff when they were both freshmen in college). And of those, more often than not, they're parents, too (Viscott, Karp, Konner, and Klass, with Wolff being the father). Klass has little to say when asked whether they intend to marry. "I don't know. We just haven't" (Smith 61), she replies—at the time, their son was seventeen months old—and since then they've had a daughter. Two of the observers are the sons of physicians (Hellerstein and Reilly), but neither one goes into his father's specialty (cardiology and general surgery, respectively), and Hellerstein eschews his mother's specialty as well (pediatrics). Viscott grew up around medicine, too: his father was a pharmacist. But he'd compromised, as Viscott notes. "I could tell by his glistening eyes how much my dad had wanted to become a doctor himself" (366). So much so that when he has a son, he has a special reason to celebrate: "My doctor was born today" (DeView 484), he says, or at least, that's how family legend has it. White has a younger sister, Elizabeth White, who is an M.D. practicing in the city of New York (White, telephone interview, 17 Feb. 2002). Two of the observers have died: Nourse (in 1992 at the age of 64) and Viscott (in 1996 at the age of 58).

In regard to their own careers, three of the observers choose psychiatry (Viscott, Hellerstein, and Klitzman), and it appears likely that Konner would have joined their ranks had he done an internship and residency after completing medical school: "the most likely possibility for me" (186), he calls it. Two of them expected to become general practitioners (Nourse and White), still an option in their day, but White ended up as an internist. "I realized that the more training you get, the better," he says (White, telephone interview, 17 Feb. 2002). Of the other three observers, one each is an obstetrician/gynecologist (Karp), an internist (Reilly), and a pediatrician (Klass). Two of them decided to specialize in genetics (Karp and Reilly), and their first books deal with the subject: *Genetic Engineering: Threat or Promise?* (Karp, 1976), and *Genetics, Law, and Social Policy* (Reilly, 1977). More recently, Reilly has returned to the subject in *Abraham Lincoln's DNA and Other Adventures in Genetics* (2000). Two of them undertook research projects before and during medical school (Klitzman and Reilly, respectively) that they later turned into books: *The Trembling Mountain: A Personal Account of Kuru, Cannibals, and Mad Cow Disease* (Klitzman, 1998) and *The Surgical Solution: A History of Involuntary Sterilization in the United States* (Reilly, 1991). Four of them are the authors of medical novels—*Labyrinth of Silence* (Viscott, 1970), *The Practice* (Nourse, 1978), *Loving Touches* (Hellerstein, 1987), and *Other Women's Children* (Klass, 1990)—in which art imitates life. Viscott's protagonist is a resident in psychiatry (Dr. Robert Stevens), Nourse's is a general practitioner (Dr. Rob Tanner), Hellerstein's is a psychiatrist (Dr. Pete Roth), and Klass's is a pediatrician (Dr. Amelia Stern). And then for young

adults, there's the fictional *Junior Intern* by Nourse (1955), in which "Ted loses a girl and finds a career during his summer as a junior intern in a city hospital, where he has taken a job to test his decision to become a doctor" (*Children's Literature Review* 33: 130).

Clearly, the observers are a prolific bunch, the lone exception being White, who had just one book in him. "The well is dry" (White, telephone interview, 1 Jan. 2002), he says. On the other hand, Nourse leads the way with over sixty books—science fiction; guides to careers in medicine, science, and engineering; and primers on medicine and astronomy—most of them intended for adolescents. After six years as a practicing physician, Nourse abandoned medicine to write, and Viscott followed suit. "I have embarked on a life of freedom from office hours and appointments" ("Living Together Should Bring Out Best in Both Partners" 484), Viscott says seven years after completing his residency. The author of an autobiography of his childhood (*Dorchester Boy: Portrait of a Psychiatrist as a Very Young Man*, 1973), he also produced nearly twenty self-help books that led the way to his becoming the host of a nationally syndicated radio call-in show, thus earning him the designation "psychotherapist of the airwaves" (Saxon 40). And several of the other observers have found escape routes from the hands-on delivery of patient care. After obtaining his M.D., Konner returned directly to academe without becoming a licensed physician. Before entering medical school, he had published *The Tangled Wing: Biological Constraints on the Human Spirit* (1982)—at the time, he was an associate professor of biological anthropology at Harvard University—and predictably,

he has since produced a handful of additional books as a professor of anthropology and psychiatry at Emory University in Atlanta. Reilly is an administrator at the Eunice Kennedy Shriver Center for Mental Retardation. And finally, Klitzman is an assistant professor of clinical psychiatry at the Columbia Presbyterian Medical Center. "Writing books is what I love most," Klitzman says during an interview with Barbara Kaplan Lane of the *New York Times*. She adds the following comment. "Most telling is the fact that, except for a yearlong fellowship spent working with AIDS patients, Dr. Klitzman has shunned clinical practice since his residency" (17). Not surprisingly, two years after he talked with her, he published *Being Positive: The Lives of Men and Women with HIV* (1997).

But perhaps the most significant feature that the observers share is the degree to which as a group they concentrate on the third year of medical school. To their chagrin, they are still closer at that point to being laymen than to being physicians, the result being that they feel like impostors. Yet it's precisely because they're initiates who have not yet been inured to the ways of the hospital that they harbor doubts about the ethics of much of what they're taught. As neophytes who have yet to acquire any authority, however, they tend to go along to get along in the system as it exists, suppressing their inclination to side with their patients rather than their peers. Still, they manage to have the last word, quite literally, disregarding the Hippocratic Oath in their books so that as observers with front-row seats, they can expose the general public to what generally remains hidden from view.

Consider the purpose that Doctor X [Nourse] hopes his book will serve. "It seeks to provide at least a glimpse into the dynamic process through which a doctor is made" (6), he says, confessing to a certain duplicity, or as he puts it, "a reading of the cards as they fell" (1). Ditto for MacNab [White]. Having accurately predicted, "I should see a panorama of medicine and take a voyeuristic peek at life" (10), he concludes, "I am finding it harder and harder to maintain this double role of skeptical observer and credulous participant" (221). Konner the anthropologist addresses the same issue:

> I frequently found myself watching doctors instead of trying my damnedest to become like them. Most of them didn't notice, but if they had they would have been annoyed, and I wouldn't have blamed them. Medical care and training are not spectator sports. They are hands-on matters of life and death. You are in it or you are out of it; there is no in-between. Or so the arguments go. Yet with all due respect, I *was* in and out of it at one and the same time. That is the paradox of participant observation, and it is also, incidentally, more or less the story of my life. (xvi–xvii)

Appropriately entitling his book *The View from the Vue*, Karp is a Peeping Tom and proud of it: "as medical student, intern, and resident physician, I watched in gratified amazement as great giant hordes of peculiar individuals acted out their scenes before me" (vii). In contrast, Viscott focuses on how his book is likely to be received. "I know people well enough by now to understand that in the end each person will see

whatever he wants to in this," he says, "no matter how decent a person I may be or how accurate my observations are" (16). Hellerstein offers a justification for his book: "by writing," he contends, "one can show the realities of life better than through a thousand surveys or questionnaires" (10). But it's not easy to do. "How could I describe my experiences, all that I had seen and heard?" (222) Klitzman asks himself. It's a question that dogs Reilly, too. "How could I deliver the most accurate report of my impressions? I wanted the reader to stand in my shoes, to see what I saw, to smell what I smelled, to hear what I heard" (xiii–xiv). And going even further, Klass suggests that for her, being a physician takes a back seat to being an author. "In order to write this book I had to go to medical school" (5), she says in *A Not Entirely Benign Procedure: Four Years as a Medical Student*, following up in *Baby Doctor*: "I was in the habit of looking around the hospital, searching for the next article. What would be the right size for a 1500-word column, what point about medicine does this incident illustrate?" (223). She continues:

> What I did, over the years, I think, was make myself into a character and create a situation where I was not quite able to experience my own life directly. No matter how serious the situation, no matter how engaged I was in what I was doing, there was often a little voice in the background transmuting the events into narrative, shadowing my actions and decisions with the whisper of what they would look like on paper. (223–24)

Compared with the other observers, Klass does seem rather self-absorbed. What finally emerges from all ten books is a cluster of key words and phrases—''glimpse'' [Doctor X (Nourse)]; ''observer'' [MacNab (White)], ''observation'' (Konner), and ''observations'' (Viscott); ''watched'' (Karp); ''show'' (Hellerstein); ''seen and heard'' (Klitzman); ''to stand,'' ''to see,'' ''to smell,'' and ''to hear'' (Reilly); and ''look'' (Klass)—which suggest that the observers hope to lay the reality of medical education bare—as Doctor X [Nourse] puts it, ''for better or worse'' (1).

And they succeed, according to the book reviewers.[3] *Intern* is ''authentic'' (Chase 3; Langner 2571; *Choice* 706) and ''intimate'' (*Critic* 81). ''Its candor conceals nothing'' (''Inside Story'' 93), and for that reason Doctor X [Nourse] provides ''the juiciest source material for the uninformed medical amateur'' (Wainwright 19). Nor does MacNab [White] shy away from making ''many personal observations'' (*Choice* 231). Viscott wants his readers to understand that ''there should be nothing mystical or sacred about medicine'' (Johnson 3322). As a result, *The Making of a Psychiatrist* is ''irreverent'' (Adams 146), and ''it gives a frank and revealing inside portrait of a profession that, for better or worse (probably better), has become an important force in American life and that (doubtless for worse) has really not been much written about for outsiders'' (*Saturday Review of Science* 68). Hellerstein fills his book with ''cautionary tales'' (Oppenheim 46). And Konner?

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[3]For some reason, only Karp escapes their scrutiny. Known mainly for his work in genetics, he does manage, however, to sneak a brief reference to *The View from the Vue* into the biographical sketch that accompanies an article that he published in *Natural History* (Karp, ''Authors'' 2).

''Highly critical of medical education and practice'' (Twitchell 171), ''a maverick'' who offers ''impassioned criticism of how doctors are trained'' (*Publishers Weekly* 79). In similar fashion, ''Reilly usually writes—as is his intent—about the dilemmas facing the unempowered medical student'' (Poirier 49). Then there's Klitzman. ''He is not afraid to point up problems in the medical profession'' (Hughes 25), focusing on ''the crises, suffering, resignation, and dehumanization involved in the processes of treatment and cure'' (Chamberlain 79). And finally, Klass describes ''an insidious indoctrination'' (Henig C13), sharing ''its secrets'' (Schwartz 16) with us, including ''some of the most troubling and profound issues in health care today'' (Chitty 162). Such assessments are consistent with how White accounts for the interest in his book: it's about a ''secret priesthood'' (White, telephone interview, 1 Jan. 2002), he says.

But such assessments do not provide a sense of the relative value of the books published by the observers. Especially significant from a historical perspective is Nourse's because it got the ball rolling. From a literary perspective, Hellerstein takes the prize, or a couple of them, actually—the McCord Essay Prize and the Pushcart Prize for Best Essay[4]—and as noted on the copyright page of *Battles of Life and Death*, each of the essays in it first appeared in one of three publications: the *North American Review* [for which Hellerstein has been a contributing editor since 1982 (*Contemporary Authors New Revision Series* 46: 164)], *Esquire*, and *Ms.* By far, Klass has received the greatest amount of popular attention, for she has been

[4]He won the former for ''The Realms of Chance: An Encounter with Margaret Drabble,'' and he won the latter for ''A Death in the Glitter Palace'' (Hellerstein, e-mail message, 28 Jan. 2002).

interviewed by reporters for the *Washington Post* (Span), *People Weekly* (Neuhaus), *Publishers Weekly* (Rosen), and *New York* (Smith), thus earning a spot in *Newsmakers: The People Behind Today's Headlines* (''Perri Klass: Pediatrician and Writer''). Viscott is highly engaging; fortunately, his 410-page book is not only the longest but the most personable. Karp often exhibits a wicked sense of humor. Konner is pedantic, whereas Reilly is an earnest schoolboy. The darkest of them is Klitzman, who fittingly entitles his book *A Year-Long Night*. And finally, the best-kept secret belongs to White (aka MacNab), who maintained his anonymity for three decades—a feat for which he deserves our grudging admiration.

The Third Year—and Beyond

Of the twenty-eight physicians who are represented in the autobiography of medical education, only two give the third year virtually all of their attention—MacNab [White] and Konner—and both of them are observers. ''This journal will cover my third year of medical school'' (9), MacNab [White] announces, for the following reason. ''This coming year looks like the start of the real apprenticeship. I will be in the hospital attached to our medical school for the first time, rotating through each of the services'' (10). Konner agrees: ''the third year is the first of total clinical immersion,'' he notes, adding, ''it is the year in which the most important phase of socialization is largely completed, when the adoption of the values of physicians is effected.'' Nevertheless, it has been ''relatively ignored,'' unlike internship. ''There are at least several vivid, readable, accurate books about

internship,'' he says (xii, xiii), without mentioning any of them by name.[5] Two of the observers cover all four years of medical school with an emphasis on the third. One of them is Reilly, who agrees with Konner. ''Innumerable books have been written about the years a young doctor spends as an intern or a resident,'' Reilly says. ''But despite the incredible intensity of the years a doctor spends as a house officer, I believe that his or her attitudes about respect for persons, about what constitutes sickness and health, and about fears of death and dying, to name a few, are well formed before that first patient is ever admitted'' (xiii). Hoping to fill the void, he devotes three chapters of his own book to ''the third year, the year on the wards,'' calling it ''the critical year in medical education'' (104), and two chapters each to the first, second, and fourth years. Similarly, in her first book about medical education, Klass draws particular attention to the third year. ''The clinical years, especially the third year, are in some ways a very harsh experience'' (*A Not Entirely Benign Procedure* 57), she contends. In other words, medical school is a not entirely benign procedure, hence the book's title. In her second book about medical education, she follows up with reflections on internship and residency. Karp and Hellerstein draw on medical school, especially the third and fourth years, as well as internship and residency. Only three of the observers skip over the third year of medical school altogether, concerning themselves solely with internship (Nourse and Klitzman) and residency (Viscott).

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[5]On the other hand, Konner does cite *Gentle Vengeance: An Account of the First Year of Harvard Medical School* by Charles LeBaron (18).

Milestones

Regardless of the scope of their books, however, the observers view medical education as the price they must pay to become members of the club: ''the proving ground'' (4), Doctor X [Nourse] calls it, whereas MacNab [White] uses the phrases ''the hazing of the profession'' (25) and ''an initiation rite'' (113). Referring to himself as one of the ''initiates'' (xvii), Karp asks a question: ''Who says fraternity initiations are dead?'' (219). Wondering whether he is being subjected to ''a subtle form of hazing'' (91), Reilly nevertheless wants to join what he calls ''the curious fraternity'' (79) of M.D.s., all of whom have completed ''the great passages of medical school'' (63) on their way to what he calls ''the magical becoming'' (207). Right in the title of his book, Konner says that becoming a doctor is ''a journey of initiation.'' And what kind of journey? ''Doctors resemble army officers,'' he says, explaining:

> In the training process, as in the day-to-day functioning of the hierarchy, stress and abrasiveness are considered not merely acceptable but salutary. They help to prepare the members of the hierarchy for uncertain and perilous encounters with the outside world, toughening them up and weeding out weaklings. But of course the function of an army is supposed to be destruction and killing, while the purpose of medicine is healing. (375)

Several of the other observers agree that the military is an apt metaphor for medical education. During medical school, Klass says, ''I have a sense that I am being

initiated into a priesthood'' (*A Not Entirely Benign Procedure* 37). But internship turns her into a soldier. ''It's the baptism by fire, the year in the trenches, or any other bloodstained metaphor you like'' (*Baby Doctor* 151), and Klitzman agrees. ''In the past, people saw suffering and death when they were sent off to war. The closest I had come was this year'' (218), he says about his internship. And finally, Hellerstein calls his book *Battles of Life and Death* because he participates in both kinds. Comparing one of his patients to a battlefield—''burned and blasted terrain, defoliated, napalmed, cratered''—Hellerstein adds, ''I would be a soldier'' (24). And in a chapter entitled ''The Battle for the Dead,'' he describes the tug of war that can occur between a physician and a family who has lost a loved one. Commonly, the former wants to know the exact cause of death, and the latter opposes an autopsy, Hellerstein says, alluding to *The Iliad* by Homer: ''the Achaeans and the Trojans fought over the bodies of dead warriors, an invisible battle that raged and still rages to determine who'll recover the corpse for the end they think best. That battle is yours and theirs, and to either side loss is a kind of degradation'' (122–23).

As newcomers, the observers are still in the process of learning what the role of a physician does and does not entail. To wit: ''*Doctors don't change diapers*'' (*A Not Entirely Benign Procedure* 163), as Klass discovers after offering to do so. ''No, no, said all the doctors. They shook their heads, they motioned to me not to bother. Don't change him. We'll just do our exam, and then the nurses will take care of it.'' Klass knows her place. ''Well, after all, I was only a lowly medical student. So I nodded'' (*A Not Entirely Benign Procedure* 162), she says, eventually coming to the

following realization: "I had offered to do a job that would have compromised my professional status, and by extension theirs, since I was on the same career path as they" (*A Not Entirely Benign Procedure* 163). The same lesson is drummed into Konner, whose patient Evelyn Laquette is in her nineties. "Evelyn was covered with feces, confused, rubbing her hands in it, and bringing her hands to her face. Instead of calling a nurse immediately, I began cleaning her up a bit; I knew a nurse would be along soon. One appeared almost immediately," Konner says. "Together we cleaned the mess up and changed Evelyn's diaper." The resident catches him in the act, and wearing "a look of disgust and impatience on her face," she reprimands him. "You know, you don't have to do that." Konner has learned his lesson. "The implication was clear. I had been through most of my third year: hadn't I learned yet that medical students did not do nurses' work?" (266–67). Interestingly enough, changing diapers comes second nature to Klass, who becomes a mother during the second year of medical school, and Konner, who is the father of two: "allowing my parental responses to take over, I had made a suggestion which was incompatible with doctorly dignity" (163–64), Klass says, and Konner makes a similar observation. "It was a tender exercise that reminded me of changing the diapers on my children" (267)—tender, yes, but unbefitting someone who has undertaken a journey of initiation analogous to that experienced by a soldier in combat.

So nurses are supposed to be the tender ones. Nevertheless, both Reilly and Klitzman exhibit that quality following resuscitation attempts that fail. "The bed and the floor were littered with detritus of a code: gauze pads, needle containers, empty

plastic ampules of cardiogenic drugs. The blood-stained sheet was crumpled in a corner'' (135-36), Reilly observes. ''It had not occurred to me to ask what happens to a patient after he dies. Who takes him to the morgue? Surely, it was a nursing job, but no nurse was about. It seemed unfair for all of us to have left Mr. Malone just lying there in the mess we had made. It would take just a few minutes to clean the place up,'' Reilly says, choosing to put aside doctorly dignity for the moment. ''Then I turned his head away from the harsh hallway light so that his dead eyes could look out the window at the stars'' (136). Klitzman describes a similar scene. ''Discarded syringes cluttered the bed. Squares of bloodstained gauze pads littered the sheets and floor. I slowly helped gather up the flotsam and jetsam'' (135), he says, remaining with the nurses, one male and two female, as they prepare Mr. Otis for transport. ''Four of us—Alan, Anne-Marie, Donna, and I—rolled him over to wrap a white plastic sheet around the body'' (136). And then, forsaking any doctorly dignity that he has left, Klitzman does as a nurse tells him. ''Anne-Marie took three cards out of a package, each with a hole punched in it, through which a string was threaded. 'Here, fill these out,' she said, handing them to me. One read, 'Attach to Outside,' one, 'Attach to Personal Effects Bag,' and the third, 'Attach to Big Toe.' I inscribed the patient's name on each'' (137), Klitzman says.

But performing tasks that are usually relegated to nurses is no way to demonstrate that they're worthy to join what Doctor X [Nourse] calls ''a great and proud profession'' (6)—medicine. Instead, the observers must put certain milestones behind them, and curiously enough, just two predominate in their books. One

challenges them technically, and the other challenges them emotionally. ''I became pretty good at drawing arterial blood gases''—that is, oxygen and carbon dioxide—MacNab [White] boasts, ''at least on this woman'' (212). About another patient, he says, ''her crying would unsettle me and the intern would have to finish the job. Tonight the intern was too busy and this patient was guaranteed not to cry,'' for good reason—she's on a respirator. ''All of my previous blood-taking had been from veins, and arteries are much harder to hit as they are smaller, deeper, and tougher.'' But they offer an immediate payback. ''You can tell if you are getting arterial blood by its bright red color, in contrast to the venous crimson. It always looks beautiful, because it spells success'' (211). Konner tells much the same story. ''As soon as I entered the room I was asked to take arterial gases, and this made me feel important—until I realized that I had been offered an opportunity, not asked to help.'' It's an opportunity to hone his skills on a woman who is comatose. ''I drilled the femoral artery quickly and smoothly (just luck) and watched the bright red blood pump rhythmically into the syringe'' (268). In theory, Klass has the procedure down cold. ''Drawing blood gases means getting blood from the artery instead of the vein. The artery is harder to find than the vein, and the process can be excruciating for the patient—especially if you miss the artery the first couple of times.'' But she hasn't yet mastered it. '''Oh no,' said the patient, 'I'm not letting her near me. She tried the other day,''' thus overruling the resident, who'd said, ''Perri, let's get another blood gas on her'' (60). And finally, both Reilly and Klitzman get the luck of the draw with patients—both of them men—who coach them through the procedure. Reilly notes,

''the first five times I tried to draw a blood gas I was successful. So, when I marched into Mr. Dobzhansky's room, armed both with syringe and experience, I was pretty confident.'' Nevertheless, he says, ''no bright red blood climbed up the glass walls of the syringe.'' He tries again. ''The sweat was beginning to drip from my forehead, and my hand was starting to shake.'' And again. Finally, the patient takes over. '''Sit down, son,' he said. 'Take a break. Get your nerve back. You can do it. It's just a bit tricky''' (123). Likewise, for Klitzman, ''no blood flowed,'' he says. ''Most blood is drawn from veins, which bulge on the surface of the skin. An 'arterial stick,' as it's called, is more difficult and painful.'' Even so, Mr. Draper is a good sport. ''My brow sweated,'' Klitzman admits, while the patient offers some encouraging words. ''Come on. Come on, doc. You can do it.'' Success is theirs. ''Finally, our eyes widened as a track of blood crept up the clear plastic tubing toward my tube. Discovering oil couldn't be a greater relief. The two of us grinned at each other; it was the only time he ever smiled in the hospital'' (70–71).

The other milestone that the observers mention most frequently is that of attending the autopsy of a patient for whom they have provided medical care or, alternatively, the follow-up pathology conference—more commonly known as ''The Man in the Pan,'' according to Klitzman. And as it so happens, Mr. Draper is one of them. ''My mind distanced these piles of flesh from the man who had been my patient, his brown eyes, and the smile I had once seen,'' Klitzman says, continuing. ''The man I knew to be Mr. Draper and 'the man in the pan' were materially the same, yet different—entities related by mere fact'' (74). Reilly has a similar reaction

after he gets over the initial blow. "My first patient had died within hours after I met him. I simply could not believe it. Suddenly, a new duty loomed up. My job was to learn clinical medicine, and in this business your patients were your professors. Mr. Webster still had something to teach me; it was my job to attend his autopsy" (113). Once in the morgue, Reilly says, "I glanced at Mr. Webster's face. It was him alright, but it bore little resemblance to the gentle, dignified man I had talked to yesterday afternoon." And so, Reilly explains, "I was numb; I wanted to feel sad, to mourn for Mr. Webster, but no emotion like that was in me. Death was an awesome fact; like the sun, it overwhelmed. Here in the harsh reality of the morgue I had gotten the knowledge I was after. Now, it was time to go. By the time I had climbed the seven flights of stairs I was almost eager to report my findings to the residents" (114). And then there's Morton Herbert Zabell. "We liked him" (131), Hellerstein says simply. But then the patient dies, and he's up for grabs. "I claimed Zabell for our knowledge" (137), Hellerstein boasts, having obtained permission from the family for an autopsy: "there lay Zabell in a big stainless steel sink, naked, a long Y-shaped incision in his belly, and the top of his skull was sawed off and lay to the side like a beggar's bowl. On a little platform were his liver, heart and kidneys" (136). Likewise, once Mrs. Katzman dies, Karp hopes that she might serve as a learning experience. "Mrs. Katzman was a frequent visitor to our wards" (43), he says. But then one day she's dead on arrival. "I pushed my plate away and just sat for a whole minute without moving. Finally I muttered, 'Well, that's one autopsy I'm going to watch. I've got to know what the hell she had'" (45). Ditto for Jack Kelley, who is

''pleasant,'' according to Doctor X [Nourse]. ''I figured the man would hold for the night.'' But he doesn't. ''I rushed upstairs and asked what had happened.'' As the autopsy shows, ''Mr. Kelley hadn't had a good coronary artery left in his heart; you could feel them like little calcified pipestems even before the heart was opened,'' Doctor X [Nourse] explains. ''Gave me a funny feeling, though; six hours before I'd even been debating whether to do a cardiogram on this patient or not, and now I was holding the pathology right there in my hands, the heart was still warm'' (93).

Impostors

Whatever the milestones they've managed to pass, the observers make a point of admitting that they feel like impostors. Particularly discomfited is Hellerstein. ''Four generations of my family have been doctors,'' he explains.[6] So, he says, ''I thought I *knew* medicine'' (5). After all, from the age of five or six he'd accompanied his father on hospital rounds. ''At eight I could read electrocardiograms in a rudimentary way and hear the swish of a murmur'' (5-6), he notes. ''Yet, entering medical school, and particularly on my first rotations in the hospital, I ran into one baffling surprise after another, enough jolts and shocks to set my head spinning,'' he says, noting, ''there was so much I didn't know'' (7):

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[6]For what Hellerstein describes as ''a history of American medicine as seen through the history of my family'' (*Contemporary Authors New Revision Series* 46: 164), see *Family of Doctors* (Hellerstein, 1994), which covers the Civil War to the present. Much of chapter 9—''Training Years: 1976-1988''—deals with his own medical education, during which ''it was becoming painfully obvious that scientific advances invariably created dilemmas'' (203). And so when ''I had started publishing,'' he says, ''I was particularly interested in the misuse of medical technology, in ethical dilemmas raised by modern medicine, and in iatrogenic disease—disease caused by treatment'' (237)—some of the same concerns that trouble him as an observer in *Battles of Life and Death*.

> The bits of cardiology I had acquired through osmosis represented only a small corner of medicine. There were all the basic sciences—histology and biochemistry and anatomy and pathology. There were innumerable diseases whose existence I'd never suspected—leukemias, lymphomas, diabetes, nephroses, psychoses, autoimmune disorders. There were drugs and radiological procedures and types of surgery I'd never heard of, and everything under the sun had its indications, contraindications, side effects, interactions, complications. Hundreds of chemical tests could be ordered for blood or urine or spinal fluid or just about any liquid that could be drained or squeezed or otherwise coaxed out of the human body. (7)

And the other observers feel much the same way.

Shortly into the second of ten rotations in the hospital, MacNab [White] decries what he calls "my charade as a doctor" (43), adding, "I actually fear for my patients" (45). And for good reason: "if the right answer exists in books," he says, "I can always look it up. Maybe" (19). Nor does it take long for Konner to acknowledge "the basic embarrassment of pretending to be something I was not" (130), for as he's already noted, "patients and families often had trouble telling medical students from doctors" (110). Reilly provides an example from his own experience. Approached by a patient's family—"Doc, could we ask you a few questions?"—he lets his readers know what he is thinking:

> It was at moments like this that I realized how uneasy I was in my ignorance and how I disliked my perch on the bottom rung of the medical ladder. Should I tell these three men, who clearly thought that I played a crucial role in caring for their mother, that in fact I had never been involved in caring for a person with leukemia until I met her, that all I really did was visit her for a bit each day because I hated to think of her sitting alone in her room, restless and scared, that I was not a doctor? (192)

He decides not. ''Again, I compromised,'' telling them, ''I still have a lot to learn, but I'll try to answer your questions'' (192).

It's a conflict that remains with Reilly during the fourth year, when he chooses to do a subinternship: ''everyone from the Chief of Medicine to the senior residents to the 'subs'—everyone, that is, except the patients—realized that the sub was not yet a physician'' (212), as Karp also discovers. ''Giving me the title of sub-resident, they taught me the necessary skills'' (97), Karp says, and soon thereafter a patient tells him, ''I want you to be my doctor.'' But the fact is that he's only halfway through the fourth year of medical school. ''My conscience whispered that it might be proper, after all, to inform my petitioner of my true lowly status, but I silenced the nagging voice'' (99), Karp admits. Deceit doesn't come as naturally to Reilly, who recalls the night before he started his subinternship: ''a sinking feeling filled my stomach. Tomorrow morning I would march out of the house with my little black bag and try to pass myself off to other human beings as a doctor'' (213–14).

Not long after his first foray into the hospital, Reilly attempts to pinpoint the exact cause of that feeling:

> Anxiety is a constant feature of medical students' lives. As months slip away and students begin to grasp the dimensions of their ignorance, the anxiety flowers. As they begin to see patients, the abyss that separates their competence from that of "real doctors" widens. Wearing a white coat, carrying a stethoscope, seeing patients, medical students look like doctors and patients address them as such. Many teachers introduce them as part of the medical team. In their fantasy lives they already are great healers. Lying in bed at night, they ease the suffering of a cancer patient or perform heroic surgery. But walking the wards or talking with patients is a different matter. They are acutely aware they are not doctors. Indeed, this goal sometimes seems to be receding despite forward progress through medical school. For not a few people the anxiety becomes particularly painful whenever they are introduced to patients with the word *doctor*. It is difficult to know whether this discomfort is caused by a genuine ethical concern that patients are being misinformed or (as I suspect) by students' intense feelings of incompetence. (41)

His analysis is right on target, according to Klass, who notes, "the medical student's role in the hospital is a little unclear, especially from the patient's point of view." She explains why:

> Doctors often introduce medical students as ''student doctors,'' or just as ''doctors''—this is contrary to all rules of proper behavior but is done all the time, on the pretext that patients feel more comfortable if they think they are being examined by doctors, no matter how obviously inexperienced. So medical students may feel like frauds. (158)

But she doesn't feel much different during internship and residency, as the title of her second book on medical education suggests: *Baby Doctor*. ''Maybe my first patient and I have more in common than I realized,'' she says, referring to a premature baby who weighs less than three pounds, explaining: ''we are both too immature to be out in the world, but with a lot of help, we may just make it'' (15). Immature indeed. About another patient, a full-term baby, she admits, ''I had just looked up persistent fetal circulation in a textbook, memorized the key details—now I heard myself explaining it earnestly to a room full of stricken relatives'' (21).

Nor are Doctor X [Nourse] and Klitzman exactly brimming with confidence. ''We were very green, and we were very frightened,'' Doctor X [Nourse] says about himself and the other new interns, explaining:

> At medical school our part in the care of sick patients, in diagnosis, examination, treatment, clinical judgment, decision-making, second guessing and post-mortem had always been a sort of intellectual exercise. We had been expected to watch and learn, but the interns had always been the fountains of wisdom, The Men with the Answers, the

> ones who decided what to do and then did it while we debated from the depths of our textbook wisdom whether their decisions were right or not. (15)

For the new interns, he says, "all that vast accumulation of medical school wisdom didn't seem so vast anymore. We may have looked confident as hell that morning, but I don't think we were fooling anybody, least of all ourselves" (16). And after several days on the job, he invokes the Almighty. "God help you poor people if you're stuck with me in a pinch, and God help me, too" (32), he says, having already provided an example:

> I rolled out of bed and struggled into my pants, trying to wake up and remember all of a sudden, right now, just what in the hell you were supposed to do about a woman who started a uterine hemorrhage five or six hours after delivery, and my mind was a blank. All I could think of was Ergotrate and Pitocin (drugs which cause the uterine muscle to contract), and I had no idea of the dosage of either, since in medical school everybody always insisted that you didn't have to pay attention to dosages there because you'd learn all those icky little details during internship. I grabbed the *Merck Manual* off the desk in my room and tried to leaf through it and find something about post partum hemorrhage while I waited for the elevator to come down, but I couldn't even find the right pages; I was still punchy from sleep and

couldn't get my mind to function, so by the time I got to the seventh floor I was damned near in a panic state myself. (30)

Klitzman doesn't feel prepared, either. "Medical school had sheltered me behind textbooks" (10), he says, so he's at a loss when he begins his internship. "I had trouble imagining this ward as my new home. Like the patients, I was just passing through, playing doctor, acting the role, and making up the script as I went along" (18).

And it isn't any different for Viscott even though he is a resident: "by this time I know a lot of book knowledge about psychiatry from medical school" (18). But his specialty had been given short shrift during his internship at Barnes Hospital in St. Louis (*Contemporary Authors New Revision Series* 26: 441), which for the most part taught him "how little I knew about medicine, how little the other interns knew about medicine, and how little some of the staff doctors knew about medicine—and this was at one of the best hospitals in the country. God only knows what was going on at other places" (17), he says. "Still, knowing as little as I do, tomorrow I am going to walk onto the psychiatric ward in Union Hospital and be expected to act and talk like a psychiatrist"—actually, University Hospital in Boston (*Contemporary Authors New Revision Series* 26: 441). But first, he has a question. "What the hell do psychiatrists really do?" (21). The next morning, his first patient throws down the gauntlet—"I demand to know why you think you are qualified to help me" (40)—leading Viscott, like Klitzman, to make the following confession: "I hate *playing* doctor" (41).

The Hippocratic Oath

The observers are well aware that as physicians, they're expected by their peers to inspire confidence in the general public, not undermine it. As an ironic commentary on their propensity to tell all no matter how it reflects on themselves, or more broadly, on medical education, three of the observers either open or close their books by citing the Hippocratic Oath. And by so doing, they anticipate the controversy that their books are sure to generate among their peers.

One of them is MacNab [White]. "And whatever I may see or hear in the course of my profession, as well as outside my profession in my dealings with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets" (7). Admonished by a nurse that he'll have to take the Hippocratic Oath when he graduates from medical school, MacNab [White] demurs. "I suggest that maybe I can cross my fingers" (170), at least during the parts that he doesn't like. And what about his book? "It was originally intended for my friends and grandchildren, but as I began to appreciate the ignorance about what goes on in medical school, I began to think more about letting others read it as well" (221)[7]—regardless of the fallout. "There is bound to be another opinion on the

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[7]White explains that the inspiration for *The Education of a Doctor: My First Year on the Wards* came from his paternal grandfather, an architect, whose typed and bound memoirs constitute "one of the prized possessions of our family." Having seen "what a book could do," White decided to create a family heirloom of his own (White, telephone interview, 1 Jan. 2002). His mother explains. "Skipping the preliminaries here is the story of how my son Ben's journal came to be. When he was about to begin his first year on the wards Ben's father told him he should keep a journal as a record." That he did. "The following summer Ben came home and gave us the journal to read. It was written in pencil and I said, 'This is going to fade into oblivion. Let me type it for you.' He assented and I began to type." She

subject of divulging 'holy secrets.' I will change the names, dates, and other details, but the charge can still be made. My apologies to anyone who wants them.'' Nevertheless, he concludes, ''I think it's worth recording'' (10), as long as he can hide behind a pseudonym. ''I concede that this is a cop-out of the first order,'' he says, offering what he calls ''some excuses'' (221). He wants to protect the hospital, the medical school, and himself. ''But most of all, I want to be a doctor'' (222). Or as he says today, ''I was interested in establishing an identity as a doctor and not as a writer'' (White, telephone interview, 17 Feb. 2002).

Similarly, both Konner and Reilly quote the Hippocratic Oath only to take issue with it, using translations that vary only slightly from the one that MacNab [White] selects. Konner: ''All that may come to my knowledge in the exercise of my profession or outside my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal'' (vii). Reilly: ''And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets'' (295). Going even further than MacNab [White], both of them also include the portion of the Hippocratic Oath

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continues. ''Our good friend and neighbor Alix Nelson, a Simon and Schuster editor, heard what I was doing and asked to see the book. The rest is history. Interestingly enough the book needed almost no editing. In two places I had suggested Ben change something which could have hurt someone's feelings. That was about all'' (Jehanne White, letter to the author, 9 Mar. 2002). As it turned out, the book sold approximately 10,000 copies, ''much better than we thought it would'' (White, telephone interview, 1 Jan. 2002). Having been a member of the Signet Society at Harvard College, he was presented with a rose, the expectation being that he would return it upon the publication of his first book—and he did (White, telephone interview, 9 Mar. 2002).

that specifies a penalty for breaking it. Konner: "If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot" (vii). Reilly: "Now if I carry out this oath, and break it not, may I gain for ever reputation among all men for my life and for my art; but if I transgress it and foreswear myself, may the opposite befall me" (295).

Yet Melvin Konner, Ph.D., and Philip Reilly, J.D., both of whom characterize medical school as a "journey" in the subtitles of their books, end up, like MacNab [White], following the dictates of their own consciences—Konner "to give an objective account of what I experienced" (360), with an emphasis on "things that are closed to others" (375), and Reilly "to compile an honest record about what I thought was one of the most unique 'passages' in our society" (xiii). Both of them seek to present a balanced view. "I wished neither to dramatize those four years nor trivialize them" (xiii), Reilly says, and Konner takes essentially the same stance. "My 'truth,' such as it is, can neither assume the defensive posture typical of physicians nor upbraid in the shrill tone of their most extreme critics," Konner says. Instead, he "stakes out" what he calls the "middle ground. Still," he adds, "this will entail enough criticisms of medicine to alienate me from most American doctors." But perhaps not all. "It is my hope that I will have not only critics but allies." And he attempts to beat his critics to the punch. "They may claim, among other things, that I had my mind made up before I started; that I never progressed far enough to appreciate the value of my training for 'real life'; and that, worst of all, I

may never do so.'' He continues: ''I would still intend this book for another constituency: patients,'' he says, ''because throughout my training I identified more with patients than with doctors'' (xvi).

As it turns out, Konner displays considerable prescience regarding how his book will be received by physicians. To their way of thinking, Konner has committed the unpardonable sin, as Dr. Lewis Thomas suggests. ''Konner finished medical school and wrote his book, and that seems to have been that. He decided against an internship, and is back in place as a professor of anthropology, evidently content'' (11), Thomas says in the *New York Review of Books*. The same point is made by Gerald Weissmann, M.D.: ''What disturbs me about this book is not Dr. Konner's critique of medical education as we now conduct it,'' he claims in the *New York Times Book Review*:

> What is more disturbing is that for reasons that remain unclear, Dr. Konner seems to have missed the romance of medicine, that mixture of fervor and compassion that is the reward for all that 'risk and pain.' Perhaps because he never consummated his affair with the profession, Dr. Konner does not deal with the intellectual adventure of training in medical science at a great university. (2)

Weissmann does seem to have a point, for in a sidebar to his review, John Noble Wilford quotes Konner as follows. ''It became clear in my third year that I was going to write something about it.'' So he turned himself into a double agent of sorts. ''Medical students always carry 3-by-5 cards for making notes. I used mine to write

notes on key events, phrases, my thoughts. Afterward, I sifted through these cards to jog my memory in writing the book'' (2). Konner is also chastised in the *New England Journal of Medicine* by Francis D. Moore, M.D.—''he never did intend to become a physician'' (126)—a statement that evidently bears repeating: ''an atypical medical student who never intended to become a practicing physician'' (127), Moore says about Konner. Likewise for James S. Eaton, Jr., M.D., who notes in the *American Journal of Psychiatry*, ''the author throws in the towel. He wants no part of American medicine anymore, at least as an active player in clinical practice,'' Eaton says, trying to fathom the imponderable. ''What exactly robbed Konner of his desire to be a physician?'' But then Eaton realizes that he may be asking the wrong question: ''it is not at all clear that Konner began medical school wanting to practice as a physician'' (1593). Nevertheless, it's a question that nags at Eaton. ''What now can we understand about Konner's decision to give up medicine? Only that Dr. Konner is on a mission to make the world a better place. And, for this brilliant, talented, and sensitive man who obviously would make a superb clinician, one patient at a time is not enough'' (1594). If Konner is looking for allies, he should start with Walter M. Swentko, M.D., who manages to keep his eyes on the book itself rather than on the trajectory of the author's life: ''*Becoming a Doctor: A Journey of Initiation in Medical School*, by Melvin Konner, MD, is, in a word, outstanding'' (959), Swentko tells the readers of the *Journal of the American Medical Association*.

For some reason, Reilly seems to have less difficulty rounding up allies—possibly at least in part because he ends his book by announcing that he will

be an intern at Boston City Hospital. Certainly, he does have detractors, one who seems to resent the fact that he holds a J.D. as well as an M.D.—specifically, Truce T. Ordoña, M.D., writing for the *American Journal of Psychiatry*: "Dr. Reilly imposed on himself a Spartan regimen of harsh, dogged dissection of himself and, to a lesser extent, his teachers, patients, and fellow students. This he meticulously did for 4 years with the thoroughness and irreverence of a doctor of jurisprudence" (1594). On the other hand, there is Richard J. Pels, M.D., writing for the *New England Journal of Medicine*. "Throughout this work, we are reminded of many of the problems in medical education," he says. "The result is an honest, revealing, and sensitive account of medical school training that should prove valuable to a wide audience interested in medical education. For those who have attended medical school, Reilly's stories will spark important memories. For those who have not, this book will bring them much closer to the experience" (255). The same point is made by Rebecca M. Wurtz, M.D., writing for the *Journal of the American Medical Association*. "His book serves as a frank preview for people contemplating that education and an evocative review for those who have completed it" (2442). Clearly, given a choice between Konner and Reilly, the medical establishment prefers the latter.

Even the observers who don't mention the Hippocratic Oath by name make it clear that they don't intend to be bound by holy secrets. Perhaps the most adamant of them is Doctor X [Nourse]: "I felt that here was a once-in-a-lifetime opportunity to document an extraordinary experience" (2), he says. "Such reporting is taboo" (5),

however, as he explains. ''Over and above the confidential nature of the doctor's relationship with his patient, there is an ancient unspoken code of secrecy surrounding the practice of medicine and the men who practice it. According to this code, what the layman does not know is all to the good; the work that doctors do, the way they do it, the kind of men they are and the way they become doctors must be carefully hidden from public knowledge.'' He begs to differ. ''I am convinced that this attitude is wrong, and unworthy of the great profession that perpetuates it'' (2). And what does Doctor X [Nourse] recommend? ''People need to understand how a doctor becomes a doctor, what the practice of medicine is all about, what it is that a doctor must put into the game; and, above all, they need some insight into the human limitations upon a doctor's powers'' (5). Maybe so, but two book reviewers are afraid for him. ''Some members of the medical profession may question and dislike the unusually frank discussions of lapses in medical ethics occasionally found in patient care'' (Langner 2571), one says, and another agrees. ''Dr. X, a physician now in practice, has no intention of deifying the man in white. Some of his colleagues may conclude, though wrongly, that his purpose is to destroy medicine's meticulously protected public image'' (''Inside Story'' 93). Actually, though, Doctor X [Nourse] was a partner at the North Bend Medical Clinic in Washington from 1958 to 1964, leaving to become a full-time free-lance writer in 1964 (*Contemporary Authors New Revision Series* 45: 310), the year before *Intern* was published. So it seems that he may have been engaging in a publicity stunt when to promote his book he appeared on television garbed in a surgical mask, cap, and gown, and, as an added measure of

protection, with his eyes hidden by sunglasses (''Clinical Details'' 54; Wainwright 19).

The psychiatrists Viscott and Hellerstein also acknowledge that their peers may look at them askance: ''I realize there will be people who will think I'm a discredit to the profession, and fellow psychiatrists who'll race to throw the first stone,'' Viscott says. ''You can't please everyone'' (16), he concludes philosophically. Nevertheless, he manages to find the middle ground, according to the dust jacket of his book: ''to question the shibboleths of his profession while remaining a respected member within it.'' Well, maybe. On the other hand, ''some of Viscott's colleagues may want to toss him from the temple for heresy'' (Cooper 106), one book reviewer says. In one respect, at least, Hellerstein believes that he has more in common with the patients than with his peers. ''Patients often write about their experiences; doctors, trained in silence, rarely do,'' despite inhabiting ''a world that is commonly misunderstood and misrepresented'' (10). Clearly, he hopes that his book will stand in contrast to the mural that adorns one wall of the hospital cafeteria. ''The painting, an idealized view, shows the current hospital right along the banks of the river, as though you might just stroll out to the water's edge for a picnic, without being run over by the careening traffic on the drive or mugged by vandals stripping abandoned cars'' (237).

Television is likewise misleading, according to Karp. ''During the early 1960s, one of the favorite pastimes of the Bellevue house staff was to get together every week and watch Ben Casey, that old TV show about a neurosurgical resident,'' he says. ''We'd crowd around the set and hoot at the stupidity that the credulous

public cheerfully swallowed as reality'' (131). And Ben Casey isn't the only television show that Karp excoriates:

> When I tell my Bellevue stories to non-medical people, I understand why they sometimes ask me, ''Come on—did that *really* happen?'' The reality of The Vue is a long way indeed from what they've seen on *Marcus Welby* and *Medical Center*.
>
> ''Yes,'' I assure them, ''it really did happen. Every bit of it. That's the way it was at The Vue.'' (224)

He's seconded by several of the other observers. ''Most of what I knew about medicine was what I had seen on television; as a child, I had been a great devotee of *Marcus Welby, M.D.*, and *Medical Center*,'' Klass says. ''But I started medical school without any very clear idea of what my training would be like, of what would come after medical school, of what choices I might have in front of me'' (*A Not Entirely Benign Procedure* 17). During her internship, it finally dawns on her: ''this is a long way from Young Doctors in White'' (*Baby Doctor* 80). She'd been misled by ''medical shows on television, with their heroism, their crisp decision ('Scalpel!'), and above all, their neat and symmetrical rhythms'' (*A Not Entirely Benign Procedure* 80). It's a discovery that Doctor X [Nourse] had made decades before:

> People think of surgery as a grim, tense business with the surgeon snapping ''Scalpel!'' and ''Clamp!'' and everything going along in dramatic silence except for the click, click of the instruments. This is just a lot of hogwash. About half the time the surgeon is telling dirty

> jokes with the fixed intent of embarrassing the scrub nurse—who, if she has been in the game any time at all, is the closest thing to a totally unembarrassable female that is known to man—and the rest of the time there is bickering, or gossip, or talk about how things were last winter out in Palm Springs, or how many suction cups on a squid's tentacles, or whether a woman has an orgasm at the instant she is hanged, or other things of dubious relationship to the surgery at hand. (213–14).

The book reviewers seem to be delighted that Klass and Doctor X [Nourse] are intent on providing the general public with a dose of reality not found on television. ''Fortunately, Klass does not see herself as any kind of Marcus Welby,'' says one critic. ''Certainly, Ben Casey and Dr. Kildare would have no truck with her'' (Kaufman 13). Doctor X [Nourse] is commended for the same reason. ''*Intern* is unquestionably genuine; it has the ring of realism and truth absent from the Ben Casey and Dr. Kildare romanticizing'' (Doyle 190). Likewise, the *New York Times Book Review* argues that when compared with *Intern*, ''the travails of Ben Casey and Dr. Kildare seem like kindergarten tales'' (Slaughter 14). Mentioning the same television shows by name, another critic agrees that they are not satisfying: ''the popular appetite for medical education—particularly for what *really* goes on behind those hospital doors—is still voracious.'' Enter *Intern*, ''written by a doctor willing to ignore his profession's traditional reluctance to discuss the arcana of medicine in public'' (''Clinical Details'' 54).

When *St. Elsewhere* makes its debut,[8] Konner is in medical school. ''The situations were certainly more realistic than those I had seen on 'Ben Casey' and 'Dr. Kildare,' the doctor shows of my childhood,'' he says. Even so, ''billed as a true-to-life doctor show,'' *St. Elsewhere* falls short: ''what was completely unrealistic was that the television doctors cared profoundly about their patients, not just as cases but as people'' (125). It's a fantasy that won't withstand scrutiny, as Reilly notes. ''On this, my first official visit to meet a patient, the mirror had envied my white coat. For a moment I had been 'Phil Reilly, young doctor,' as omnipotent and caring as all those television physicians. I could only marvel at my capacity for foolishness'' (83), he says. And that of his patients, Mr. Wilson being a prime example. ''You're all beautiful, all the lovely nurses and handsome young doctors. And you all work so hard for everyone.'' Reilly knows better. ''He had clearly been watching too much television'' (257). Fed up with the pablum served to the general public by television, the observers offer an alternative, one that by necessity entails telling holy secrets.

Just one of the observers comments favorably on the Hippocratic Oath: Klitzman. ''One year ago, I had graduated from medical school. The only meaningful portion of the commencement ceremony was an optional recitation of the Hippocratic oath'' (219), he says. But since then, ''my initial idealism about a doctor's powers had been tempered. I had thought,'' he says, echoing Doctor X [Nourse], ''that during internship, I would cure almost all my patients. I was wrong. The limits of a doctor's efforts became apparent, as did the ranges of possible aid. I had learned to

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[8]It aired on television from 1982 to 1988 (''Docs on the Box: A Medical History'' 51).

expect less, thereby reducing my disappointments'' (241–42). And so like the other observers, he discloses holy secrets known to physicians and medical students but kept as best as possible from the general public. Moreover, he, too, points out that television is far from realistic. ''As I visited patients' rooms during the day, the TV sets were usually on,'' he says. ''When programs set in hospitals were aired—'General Hospital' or 'St. Elsewhere'—nearly everyone tuned in,'' and Klitzman takes the opportunity to determine how he measures up. ''There on the screen were our television portraits. The young doctor seemed less harried than I, unscarred by years of medical training. He was more leisurely, casual, and friendly with his patient than I was,'' Klitzman admits, speculating that patients entertain the hope that such shows might impart holy secrets that are being kept from them. ''Maybe they watched hospital TV because it let them imagine what else went on in a hospital that they couldn't see, like doctors gossiping in the nursing station and nurses complaining'' (108–09).

And finally, Klass appears to have incurred the most serious penalty for speaking out even though she doesn't exactly break new ground. In fact, her books are among the last to have been published. On the other hand, they're the only ones written by a woman. Initially, at least, her gender gives her a jump start. ''Toward the end of my first year of medical school, an editor at *Mademoiselle* suggested that I write an article for the magazine about being a woman in the first year of medical school,'' Klass says. ''I had entered a world which was as mysterious to most people as it had been for me, and it seemed that there were readers interested in hearing the

details'' (*A Not Entirely Benign Procedure* 17). She is happy to oblige despite the penalty that she incurs for doing so. ''I have been accused a number of times, by doctors and medical students, of presenting the medical profession in a bad light'' (*A Not Entirely Benign Procedure* 20), she says, explaining, like Doctor X [Nourse], that doctors adhere to a code of secrecy. ''There are things you aren't supposed to say to nondoctors, things they aren't supposed to know'' (*A Not Entirely Benign Procedure* 22). And then during her internship, Klass becomes the target of an anonymous smear campaign. She is charged with plagiarism by someone she calls ''the crazy person'' (*Baby Doctor* 120), most likely ''someone inside the medical profession.'' And the motive? Klass offers her best guess: ''to deny my right to describe my own experiences—perhaps because they had also been my accuser's experiences, and I had violated them, criticized them, opened them up to nondoctors'' (*A Not Entirely Benign Procedure* 21, 22). And indeed, a profile of Klass that appeared in the *Journal of the American Medical Association* calls her ''a seasoned critic of the medical profession'' (Varma 747). Going even further, a physician writing for the *New England Journal of Medicine* dismisses Klass entirely—''her words offer no perceptive critique of medical education''—expressing annoyance at her for including ''a great deal of grievance against the medical school, the medical profession, and the arrangements for the curriculum'' in *A Not Entirely Benign Procedure: Four Years as a Medical Student* (Moore 125–26). But apparently, Klass derives some comfort by quoting Anne Brontë. ''I do not fear to venture, and will candidly lay before the public what I would not disclose to the most intimate friend'' (*Baby Doctor* 153).

Telling Tales out of School

The ''holy secrets'' that the observers share with the general public reflect their concerns about medical education, and especially how it impinges on patient care. Four such concerns predominate—cover-ups, practice makes perfect, hopeless cases, and comic relief—all of which are dirty secrets kept by physicians from the general public, according to the observers, rather than holy secrets. And the observers give them surprisingly consistent attention from the first book to the last.

Cover-Ups

In regard to Bellevue Hospital, the cat has already been let out of the bag. ''Bellevue has long been associated with medical schools; hence it became known as the place where innocent patients were butchered by students while learning their trade'' (xi), Karp says. But it's an exception. In general, dirty linen isn't to be aired outside the medical profession. Inside, it's another story, as Doctor X [Nourse], MacNab [White], and Reilly note. ''I got to go to the clinicopathological conference,'' Doctor X [Nourse] says:

> One of the bright boys presents a problem case from his files—usually something obscure and exotic, to which he knows the answer, but nobody else does. Then the rest try to work out the diagnosis from the data at hand. It can be a rough exercise, with a whole crowd of very sharp guys bearing down on the man presenting the case and picking to pieces what he did or didn't do. (192-93)

Naturally, the crowd consists solely of physicians. ''Sitting there, I got to thinking of all the complaining you hear about incompetent doctors, and I wondered how many laymen in this city ever even dream that a crowd of about sixty of the city's doctors gather together at 7:15 in the morning once a week, voluntarily, for the sole purpose of keeping themselves sharp and on their toes'' (193). Grand rounds are held for the same purpose, as MacNab [White] points out. ''It was exciting to be in on this surgical council of war,'' he says. ''Questions like 'What's our record on this complication from this procedure?' made me respect the vast number of operations that had been handled by the department as represented in this room'' (105). He continues. ''This is an admirable part of the profession: the advertisement of mistakes in an effort to figure out why they happened and to alert others to the danger''—others being physicians only, of course. ''This is kept within the profession; whether the family or the general public should receive the same reports is a more controversial issue'' (110). And finally, Reilly has the opportunity to attend a morbidity and mortality conference. ''This is a weekly meeting at which the surgeons and other physicians discuss the treatment of patients who had serious complications or deaths during or after surgery,'' with no-holds-barred. ''I had barely settled into a plush seat in the back row of the surgical conference room when I felt the tension in the atmosphere'' (40), he says, and he's glad when it's over. ''I walked out of the room with a knot in my stomach; I just did not thrive in such a hostile climate!'' (41).

In essence, Viscott concludes, the medical profession functions autonomously. ''The doctors acted as watchdogs on each other by being available to help each other out of jams. Sometimes they were not successful, but you rarely heard about that'' (357), he says, explaining:

> The hospital death committees do not make their findings public. You do not pick up your morning newspaper to find what your local surgeon's latest operating mortality rate for any given operation is. Nor do you know what percentage of your internist's diagnoses are correct. There is no way to know how well your psychiatrist's patients do. No one posts the box score on doctors' performances. The only way to know is if you are a doctor yourself, and even then you may not know how bad another doctor really is. (357–58)

He continues. ''Some doctors try to cover up their mistakes by lying to the patient or to his family. It's a conspiracy in which the other professionals remain silent, afraid they might be next. I'd seen too many examples during my training'' (370). But according to Klass, ignorance is bliss. ''It is probably easier, when you are putting your health into another person's care, to imagine that that person does not make mistakes, that that person is a thousand times more conscientious than you are. I know this isn't necessarily true'' (*Baby Doctor* 322), she says. And besides, ''although I have certainly seen my share of mistakes (not to mention made my share of mistakes), they tend to be trivial and boring and not really worth lengthy narration—try and imagine making a story out of some highly technical, momentarily

annoying, and ultimately insignificant screwup in your own workplace'' (*Baby Doctor* 214), she says, becoming awfully proprietary about the hospital all of a sudden. But it's too late. Consider the story that she's already told, one that in her judgment apparently deserves lengthy narration:

> I worked once with a surgical resident who wasn't at all interested in knowing anything about his patients. He lived for the operating room, regarded awake patients as a sort of necessary evil. And there was an unfortunate elderly gentleman on our service who needed to have a foot amputated, and because he wasn't mentally intact, his wife had to be called to get permission for the surgery. So this surgical resident went to call her, and he came back into the surgeons' lounge fuming about how people just don't know what's good for them. Apparently the patient's wife had been quite unwilling to give her consent, and had unwisely attempted to argue with the surgeon. So he had put her in her place, all right. He had told her this amputation was life or death for her husband, and after all he had years of medical school and residency training behind him and she had no medical training at all, and did she really want to question his decision? So she said, no, she supposed not, though really this operation came as a complete shock to her. So anyway, the surgeon concluded, he had permission to amputate Mr. O'Hara's foot. There was a pause. Then two other surgeons said in

unison: ''But Mr. O'Hara doesn't need his foot amputated. It's Mr. Keating who needs his foot amputated.'' (*Baby Doctor* 19)

And the story isn't over yet. '''Oh, son of a bitch,' said the surgeon who had made the call, or words to that effect. He thought it over for a minute. Then he had an idea (after his supervisor told him no, we could not amputate Mr. O'Hara's foot, too). 'I'll call Mrs. O'Hara back,' he said, 'and tell her we've tried a new wonder drug and saved his foot after all''' (*Baby Doctor* 19). Konner tells a similar story about another surgical resident:

> Marty arrived and banged his tray down on the table, shaking his head in disgust. ''I just had a long conversation with a family of a lung C.A., squamous cell. You know, those wonderful conversations you love to have where they find six different ways to tell you you have to be wrong about the prognosis, the diagnosis, something? Well, this was the family of the *wrong patient*. After about ten minutes she said, ''Wait a minute, Dr. Wentworth. We're the *Giulianis*. You know, the *Giulianis?*'' (112).

According to the observers, such stories are deliberately kept from the general public. ''With patients and staff sharing elevators, doctors and nurses are often reminded to keep their tongues still,'' Klitzman says. ''But occasionally staff people will chat about a patient, heedless of the possibility that their subject's family may be standing beside them'' (12–13). It happens to Klass herself:

> I can remember getting on an elevator with another resident, both of us exhausted, in dirty hospital scrubs. "Oh, God," said my friend, "I am just so tired, I can't see straight." And a lady standing at the back of the elevator, the mother of a patient, I suppose, said sharply, "How do you think it makes me feel to hear a doctor say that?" We both apologized, and tried to stand up straight and look alert for the rest of the ride, and left the elevator feeling we had been guilty of an unprofessional lapse—and yet, he really was so tired he couldn't see straight. He'd been on call all night in the newborn intensive care unit and hadn't slept at all, and I knew for a fact that his marriage was in trouble, and that he wasn't getting much rest at home either. (*Baby Doctor* 213)

Klass continues. "And, of course, the patient's mother didn't need to know any of that—but still, what's the lesson when you can't admit to being tired in your own workplace after they've kept you up all night?" (*Baby Doctor* 213), she asks. Answering her, Klitzman offers the following cautionary tale. "Lawyers trying malpractice cases have reportedly donned white coats and eavesdropped on conversations in hospital elevators, overhearing otherwise unobtainable information about a case" (12–13).

And as most of the observers point out, cover-ups often occur in charts because they are not only medical documents, but legal documents as well—as even Klass recognizes:

> Medical records are tricky items legally. Medical students are always being reminded to be discreet about what they write—the patient can demand to see the record, the records can be subpoenaed in a trial. Do not make jokes. If you think a serious mistake has been made, do not write that in the record—that is not for you to judge, and you will be providing ammunition for anyone trying to use the record against the hospital. And, gradually, in fact, you learn a set of evasions and euphemisms with which doctors comment in charts on differences of opinion, misdiagnoses, and even errors. ''Unfortunate complication of usually benign procedure.'' That kind of thing. (*A Not Entirely Benign Procedure* 106–07)

On the first day of his internship, Klitzman gets the message loud and clear: ''patients' charts are legal documents,'' the chief resident says. ''Be careful about what you write'' (5). And the hospital attorney agrees: ''don't make the chart a battleground,'' he warns. ''If you disagree with someone on a case—a resident, a fellow, a consultant, or an attending—talk to them about it. Whatever you do, don't let these arguments spill over into the chart, which may be read by lawyers, the government, and insurance companies. Dispute spells bad news'' (7).

MacNab [White] provides an example. ''This boy had been brought to the ER (emergency room) for some stitches above the eye (he had fallen). The resident had given him a sedative to facilitate the operation, but had given him the dose for a full-grown man, thus knocking him out'' (28–29). The next morning, MacNab [White]

says, ''the attending asked about this patient's chief complaint.'' At first, the answer strikes them all as funny. ''An iatrogenic overdose of sedative!''—iatrogenic meaning ''induced by the physician,'' MacNab [White] explains. ''We all laughed.'' But it's strictly an inside joke. ''The attending then opened the chart,'' MacNab [White] says, ''and was alarmed to learn that the patient's chief complaint was *on the record* as 'iatrogenic overdose.' A serious lecture followed'' (29), one that includes ''the legal angle'':

> If the patient's father decided to sue the hospital over this case, for whatever reason, then his lawyers could request a copy of the chart. This request would have to be met. When the lawyers received this copy, and saw the phrase ''iatrogenic overdose,'' in the first sentence to boot, their eyes would open wide, and they would say, ''OH BOY!'' (the attending's face radiating joy to drive his point home). (30)

And there's no room for argument: ''I'm the attending who is liable in this case, so I'm *ordering* you to change that note'' (30), he tells the medical student who had written it.

The incident that MacNab [White] relates isn't an isolated one if Hellerstein and Konner are any indication. ''In my consult note,'' Hellerstein says, ''I wrote that, besides the obvious hyperosmolar nonketotic state, the patient seemed depressed, even suicidal; he should be observed closely; a Psychiatry consultant should be called in. Not bad, I thought—a thorough evaluation, looking at the whole patient, the way we were always taught was so important. I went away very pleased with myself.'' But

he's shortly called on the carpet: "the Endocrine fellow, four years my senior, scowled at my note. Beside my diagnosis of depression he wrote in capitals: DISAGREE!" And why? "The fellow explained. Our professor thought psychiatry was bunk. Whenever he saw a note like this one, the professor would explode, denouncing not only psychiatry but whoever had been unlucky enough to write such nonsense. The best thing to do was to tear up my note and write another one." Hellerstein is stumped. "I thought awhile. The medical record was a legal document, a scientific record as well. My note was already part of the chart. On the other hand, I was just beginning the clerkship, and I was considering applying for residency at this hospital—and it just wouldn't bode well to get off to a bad start." Self-preservation wins out. "Just before the professor came by for afternoon rounds, I rewrote my note from beginning to end, without mentioning depression or suicide—or psychiatry, the field I myself would enter one year hence" (3–4). Konner has a similar experience:

> Suddenly McCormick was flashing his angry eyes at me, saying, "Come outside, I need to talk to you," in as stern and loud a voice as he could allow himself in front of a patient—more so than most doctors would have allowed. In his hand was the blue sheet on which I had written my findings. He waved it in the air and banged on it with his other hand. "Why did you write this? Don't you understand what's going on here? What are we gonna do if the hospital gets sued?" (355)

''McCormick was giving me a lesson in the new defensive medicine that had grown up because of relentless, often frivolous malpractice litigation,'' Konner says. ''Still, to falsify the record by omission of crucial facts? Not only what he was recommending but the way he spoke to me made me wary of his orders. I steered clear of McCormick as much as I could'' (356).

Practice Makes Perfect

''How can a doctor's competence be assured?'' (3) Doctor X [Nourse] asks. The answer is rather disconcerting: ''he learns, for the most part, by committing a long succession of colossal blunders and then having them corrected (if possible) by the experienced doctors looking over his shoulder'' (4). And because practice makes perfect, brand-new M.D.s pose the most risk to patients: ''the interns starting each July are just as green, just as frightened and just as hapless as they ever were'' (404), Doctor X [Nourse] says, and Viscott, Klass, and Konner agree. ''That's the time when the new interns are just starting out fresh from medical school,'' Viscott says, ''and it's not uncommon for the death rate to go up. This is especially true in the first weeks of July.'' He has some advice for his readers. ''If you have to go to the hospital for anything and have a choice, try to avoid going in the summer. Go when the odds are better'' (21). As Klass notes, practice makes perfect for the residents, too. ''Every July the fresh new interns arrive and last year's interns become the junior residents, and the juniors become the seniors—so everyone is facing new responsibilities, new expectations. Except the nurses, of course, and they occasionally have to use their experience to protect their patients from the onslaught of July''

(*Baby Doctor* 10). The fact that Klass gives a nod to nurses isn't enough to pacify Jane Dwinell. ''As a mother and writer as well as a nurse, I had my conflicts with *Baby Doctor*,'' Dwinell notes in the *Women's Review of Books*. But then, Dwinell has already expressed considerable rancor towards physicians in general, saying, ''doctors are just that: Doctors, with a capital D. They have power, they wield power, they make the rules; they are godlike and all-powerful, healing, soothing, curing'' (10). And finally, Konner uses what he knows about July to impress one of his teachers. ''Like the other medical students, I was usually far behind the residents in this exercise,'' he says about the identification of microscopic slides. ''But one day she said, 'This is commonly seen in July,' and I knew immediately that she was showing us a physician error; interns begin service in July'' (293).

More than any of the other observers, Konner is quick to note that although practice makes perfect, the downside is that patient care may sometimes be compromised to accommodate his need to learn. It's a theme that he returns to again and again as he rotates through the various specialties, one of them being anesthesiology. ''Look,'' Konner is told, and he obeys. ''I looked into the man's mouth,'' he says, continuing. ''I had the thought that this man was exhaling the last breath he would have until the endotracheal tube was placed, and the placement was being delayed for my education. It was only a few seconds, though, and I knew that I should not waste them while considering the ethical issues involved'' (77). But he continues to do so when he leaves anesthesiology for ward surgery. ''I had guilty visions of a devastating infection given the patient by one of my own germs,'' he

says, despite having scrubbed, gloved, and gowned in preparation for observing the removal of a gallbladder. "I was a risk without a benefit, a fifth wheel there for my own enlightenment" (94). Nor does he feel any differently about psychiatry. "As usual I was torn between the desire to learn and the realization that I was invading their privacy while offering very little in return" (160). It seems to Konner that his age is a hindrance. "The informed consent signed by patients in a teaching hospital cleared the consciences of my fellow students as to what should be done by whom to whom. I wish I had had the youthful élan to do what I had to do less reflexively" (364), he says.

At thirty-five years of age, he is a decade older than MacNab [White], who also writes about the third year of medical school. And yet consider how similarly MacNab [White] reacts to his own stint in anesthesiology. "I had practiced on a rubber dummy yesterday, but this was a real little girl," MacNab [White] points out. "Soon she was 'deep' enough to try to 'intubate' her—tracheoscope her, put down an endotracheal tube," and MacNab [White] does his best. Unfortunately, his best isn't very good. "'What do you see?' asked the attending after 15 seconds of my fumbling," MacNab [White] says. "I fumbled around for two seconds more, but then realized my patient was unable to breathe as I experimented and thrust the instruments into the hands of the pro" (88-89).

And practice also makes perfect when it comes to rectal and vaginal exams, which are of particular interest to the observers: seven of the nine apparently consider them to be the *sine qua non* of medical education. "I was on my way to being a

doctor, I was different,'' Klass says about learning how to do a physical examination. ''I had rights that no one else had (the inalienable right to the rectal exam). I was outside normal human conventions of behavior and privacy'' (*Baby Doctor* 161). Karp makes the same point but more graphically. Citing a patient named Mrs. Rosenbaum, he describes the procedure that she is about to undergo:

> For a sigmoidoscopy, a patient gets on a table and points her rear end at the ionosphere. A man stands behind her with a ten-inch-long metal tube, which he gradually inserts into her rectum. Then he and his associates look up into the tube. Generally this is called a pornographic, multiple X-rated movie, but when it is performed in a hospital by physicians, it is then considered socially acceptable behavior. Acceptable, that is, except to him or her who is being scoped. For the uninitiated, let me say that it feels as though a freeway were being constructed between the rectum and the belly button. (90–91)

And according to Doctor X [Nourse] and MacNab [White], unwitting patients serve as guinea pigs for medical students and interns who are learning to do rectal exams. ''The proctoscopy is the most utterly undignified of all physical examinations, barring none,'' Doctor X [Nourse] notes:

> The patient stands at the end of an L-shaped table and bends over it, puts his arms down, removes his trousers (the ladies simply hike up their skirts), and a nurse drapes them with a sheet with a six-inch hole

> in it centered like a target. Then the doctor steps on a foot pedal and the table tilts forward so that the patient's head drops down with his legs pointing straight out and his anus pointing upward. The position alone is uncomfortable, and people hate it. But there's an aspect of low comedy, too. These people come into the office and Dr. Smithers says, ''Hello, there, glad to meet you,'' and without further preamble tips the table down and proceeds to thread a twelve-inch rod up their rectums. Then after they are all over with it, sweating and panting and smarting, too, they stand up and Dr. Smithers says, ''Well, splendid, we'll send a report to your doctor today,'' and the patient almost invariably says, ''Thank you, Doctor, glad to have met you,'' and goes out. (98)

''Anyway, today the script was a little different since we were to accompany Dr. Smithers,'' Doctor X [Nourse] says about himself and his resident. ''Smithers trooped into the examining room with Milt Musser and me on his heels'' (98–99), and the patient objects. ''This old girl looked us over and said, 'Well, what's the parade here, anyway?' So Smithers said, 'Oh, these doctors are rectal specialists who are going to help me,' with a perfectly straight face'' (99). Somehow she refrains from verbalizing the obvious: rectal specialists, my ass. Instead, she complies:

> This she accepted, warily, so Smithers put on a glove and did a digital rectal exam first and then turned to me and said, ''Now, Doctor, I'd like you to give me your opinion of the sphincter tone there and feel

> that stricture we find up about two and a half inches.'' So I put on a rectal glove and rendered my ''opinion,'' namely, that I agreed that it was there, and then Dr. Musser rendered his opinion, too. (99)

''Thus we all three finessed a rectal examination on the lady'' (99), Doctor X [Nourse] concludes. MacNab [White] reports a similar experience:

> It was arranged that we practice rectal examinations. Some patients with ''interesting prostates'' were found and talked into ''having some doctors check them over.'' ''Almost done, Mr. Jones, just two more doctors.'' Franklin (who plans a career in neurological research) goes in too roughly, and Mr. Jones cries out as those oh-so-sensitive nerve endings are activated and fire. My sympathies are with Mr. Jones instead of knowledge, and I pass up the chance to join in on this combination gang bang and butt fuck. (85-86)

Well. He certainly doesn't mince words. Yet he endorses the rectal exam wholeheartedly. ''The proctoscope is an unglamorous instrument but an important one,'' he says. Educating his readers, he continues. ''Cancer of the colon is the single biggest neoplasm of both sexes, and two thirds of the time it occurs within reach of this tool.'' His recommendation? ''I tend to shy away from commandments, but I do believe that proctoscopy should be a part of the annual physical exam. There are so many cancers that are hard to spot that it is stupid to miss the easy ones'' (101).

The tradition that Doctor X [Nourse] and MacNab [White] describe has apparently gone by the wayside as practice of the rectal exam has been passed from

patients to medical students and then to paid models and rubber dummies. ''The most difficult of our physical diagnosis sessions occurred one February afternoon when Dr. Pelton taught us how to do a rectal exam'' (78), Reilly says. He and three of his classmates are to practice on each other. ''Perhaps the only thing as uncomfortable as submitting to a rectal exam by a friend is the embarrassment of being the examiner. Suddenly, a good friend with whom you have passed countless hours trying to master physiology is curled up naked before you on a cold, plastic examining table while you are inspecting his anus and preparing to shove a finger into his rectum. This is not an everyday test of friendship'' (79). Hellerstein and his classmates are willing to flunk it, if necessary:

> We were divided into small groups, men and women together, and sent to various examining rooms. Our exams began at the head and worked down. You couldn't get too upset about looking into your medical student buddy's eyes, but by the second session, when we got down to the chest, the protests began. First the women complained and refused to be examined, but as it became clear that genital and rectal exams were also part of the required curriculum, men started to protest as well. Finally there was a full-scale revolt. (71)

It has the intended effect. ''We ended up learning the pelvic exam on professional models and doing rectal exams on plastic dummies'' (71). A similar arrangement is worked out for Konner and his classmates. ''We were practicing everything constantly on each other (with the exception of the two most intimate parts of the physical

examination, the rectal and vaginal exams, which we practiced on hired models)'' (32), he says.

Hopeless Cases

End-of-life issues are particularly troubling for the observers. In fact, five of them freely admit to wondering whether some patients aren't better off dead: the psychiatrists Viscott and Hellerstein, as well as MacNab [White], Karp, and Reilly. And interestingly enough, the latter three doubt the value of treating patients whose problems are mental rather than physical in nature. ''This may seem like a naive question, but did we do this guy a favor?'' (118) MacNab [White] asks about an alcoholic whose life is saved after he jumps off the roof of the hospital. And patients with severe depression don't show much promise, either. ''Rigid on the edge of the chair, head down, immobile, eyes on the floor,'' he says. ''They all had suicidal impulses and I could think of no good reason to stop them'' (157). Then there's the 65-year-old man who is hospitalized after his marriage of three weeks fails: ''you can't have him living alone. He might kill himself,'' the nurse explains. And how does MacNab [White] respond? ''I suggest that maybe he has a right to do so'' (169). Going a step further, Karp implies that mental patients should be put out of their misery. ''The wards for the most serious patients were genuine chambers of horrors. Shrieks, screams, and groans reverberated down the corridors in a never-ending cacophony,'' he says. ''Therapeutic psychiatry being as primitive as it was, all we could do for these people was to keep them fed, relatively clean, quiet, and as far from harm's way as possible. Had they been dogs or horses, we'd have shot them

without a second thought. But they were human beings, so we gave them tranquilizers'' (2), he concludes. And then there's Reilly. Exhibiting more sensitivity than either MacNab [White] or Karp, he's not prepared for hopeless cases, either:

> This patient had had a stroke that had wiped out part of his brainstem as well as tracts of nerves running through that area (as though a bomb had wiped out all but two lanes of the George Washington Bridge). We had all read about CVAs (cerebrovascular accidents), but nobody had anticipated the reality of their devastation. (90)

Not Reilly, not the other medical students, and least of all, not Ivan Modanko himself. ''He tries to kill himself by pulling out his trach tube,'' and Reilly puts himself in Mr. Modanko's shoes. ''For a fleeting instant I thought, 'Maybe we should let him''' (90).

Balancing out MacNab [White], Karp, and Reilly, both of the psychiatrists side with life rather than death even if they do so rather tentatively. Viscott starts by posing a question:

> Should a psychiatrist, should anyone, have the right to prevent someone from taking his own life? I have seen some lives so full of pain and darkness for such a long time that I felt like an oppressor just by asking the patient to endure more of what was horrible to him. Who has the right to tell someone he must live a life of pain and hell? What in my training gave me the right to tell someone to suffer? (176)

His answer:

> I believe that under certain circumstances it may not make very much more sense to be alive than to be dead. We'll all be dead sooner or later anyway. But being alive is all I know. Although one person's life may not always make sense, I believe there is still a meaning to life itself, even if we don't always understand it. Because we are alive and we are part of life, it makes sense to me to find the part of each of us that has meaning and is worth living for. (176)

In contrast with Viscott, who confines himself to generalities, Hellerstein provides specifics. ''For the first time I get a good look at the baby propped in its crib. It is not a baby but rather a small monster, with low ears, a flat, bridgeless nose, a hairline scarcely an inch above its close-set eyes'' (57). He continues: ''I examine the baby. It cries as I touch it, pushing me away with dwarfish thick hands, grunting, moaning, sniffling through its snotty nose—a hairless rodent trapped in a human body'' (58), he says, not even trying to conceal his disgust. He adds, ''when I think of this creature'' and other hopeless cases, ''it seems it would be a mercy to . . . to what? Drown them like cats in a burlap sack, thrown off a bridge?'' He immediately repudiates such thoughts as blasphemous. ''I shake those thoughts away. Ridiculous. We're here to help'' (58). And almost in spite of himself, he comes to the same conclusion as a resident in psychiatry on the burn unit. ''What kind of life am I going to have if I look like this?'' a patient asks Hellerstein. '''How do you know how you'll look?' I say. But seeing him, I wonder, too. What kind of life? How will he

ever walk the street? Maybe death is better.'' Hellerstein quickly pulls himself up short. ''But I'm bound to state the contrary; I'm the doctor'' (190).

Aware that they've been mandated to save lives, the observers take note when they're taught by example to give up on hopeless cases. ''Wait until you get to the state hospital next July,'' the third-year resident warns Viscott. ''No one there *ever* gets any better'' (164). And when Viscott is assigned to Ward D on the male chronic service, he is told the same thing by the best psychiatrist at the state hospital, ''a brilliant clinician,'' Viscott calls him. ''You will all work very hard and expend a great deal of energy this year, and you will believe that you have helped patients and changed them. But if you return in six months or a year you'll find them exactly the way you left them.'' With all due respect, Viscott refuses to give up. ''*I couldn't accept that*'' (220), he says, even though his seventy patients had been in the state hospital for an average of over twenty-five years. Most of them don't even talk, like Mr. Daly, and it's not long before Viscott discovers how easy it would be to lose his resolve. ''I felt badly, powerless and a little ashamed of myself for almost forgetting that Mr. Daly was human. It wasn't difficult to do. . . .'' (224).

Then there's fifty-four-year-old Mr. Garabedian: glaucoma had left him blind, and severe arthritis had left him crippled. ''During the next few days I began to realize how uncomfortable the ward team and nurses were with him,'' Reilly says. ''Unlike our visits to the other patients, no more than two of us ever visited Mr. Garabedian's room at rounds. People seemed unwilling to admit that such horrors had

been heaped on him'' (233). Reilly adds, ''I was one of the few people who were willing to visit Mr. Garabedian'' (263). But Reilly has his limits, too:

> On the other hand, I remember a man whose cancer had invaded his spinal cord. He lay on a metal frame in the intensive care unit, paralyzed from the neck down, fully conscious, waiting to die. I could not bear to look at him. I hated even to think about his illness. He transcended compassion. It was too horrible, and I avoided him and rejoiced when he died. (263–64)

It seems that hopeless cases are routinely avoided. Konner describes another one of them, ''a disastrously mangled suicide attempt. He had drunk a lye-containing corrosive solution and suffered severe destructive burns of his face and mouth. His was the only room we never went into'' (97). Instead, they remain safely in the hallway while they discuss his case. ''As usual we passed the room of the man without a face and rounded on him in the hallway'' (115), Konner adds. And it's not just patients with self-inflicted deformities who are treated as though they are monsters. ''You were looking at his face,'' Doctor X [Nourse] says about a baby with a congenital abnormality, ''but actually were just staring into this great gaping hole right down into his throat, with his eyes separated far apart and hanging loose on their stalks.'' Even after plastic surgery, ''I can't really say that he looks much better to me than he did before they started,'' Doctor X [Nourse] says, admitting, ''I know it sounds dreadful, but I find him so physically repulsive that I just have to brace myself every time I go near him'' (328). Klitzman explains why. ''Built into the brain

is a specialized center responsible for inspecting faces'' (128), he says, and ''the brain intrinsically shuns what is grotesque'' (130). But evolutionary theory doesn't help the patients any.

And consider the precautions that were once taken in regard to patients with acquired immune deficiency syndrome, such as quarantines. ''When the first AIDS patients were admitted to the hospital, they were kept together,'' Klitzman says, adding, ''fear of contagion can become emotional and irrational, even among the scientifically trained'' (64), those who are familiar with ''the medical literature that ruled out transmission by air or by respiratory secretions'' (201). Klass makes the same point: masks, gloves, and even surgical gowns were donned by everyone at the beginning of the AIDS epidemic, Klass says, recalling why: ''we are all terrified of this disease and are not willing to listen to anything our own dear medical profession may tell us about how it actually is or is not transmitted'' (*A Not Entirely Benign Procedure* 185). She continues. ''Every dying patient is by definition a reminder of mortality. When that patient is dying because of an infectious agent, and the mortality is, theoretically, communicable, the need for distance may transcend anything that can be established with emotional dead space'' (*A Not Entirely Benign Procedure* 187).

And what about Mrs. Kunoshi Nakamoto, who has metastatic lung cancer? Distance yourself from her, Klitzman is told by his resident. '''She's dying,' Emmanuel had warned me on my first day. 'Don't spend your time with the dead''' (38). At the beginning of his internship, Doctor X [Nourse] agrees, citing the example of Mrs. Blomberg, ''as classic an example of the grisly fashion in which terminal

cancer patients die as you could ever find'' (94). It's beyond him how anyone ''can justify keeping alive for an extra day or week a woman who is already nothing but a living, breathing, suffering corpse'' (95). But at the end of his internship, Doctor X [Nourse] apparently has a change of heart about hopeless cases. Like several of the other observers, he is told to give up on yet another patient, one with cancer of the ovaries. He wonders, though—what about going on ''the single assumption that *she was going to make it* until she proved otherwise, not just by getting worse or by being in the process of dying, but by *being dead*, and *that* was the time to quit working'' (304). Shortly before she dies, Doctor X [Nourse] asks the fourth-year surgical resident for advice about treating her. ''Called Hank and asked if he had any magic medicine to pull out of the bag, and he said, no, he'd seen her that morning and just about tossed in the sponge, didn't see anything more to do.'' However, the pathologist disagrees: ''if the people who had been taking care of her had been vigorous about doing everything that could be done, instead of tossing in the sponge, she might at least have had *some* comfortable time left.'' Doctor X [Nourse] reflects on what he's learned. ''Well, I've thought about it,'' he says:

> In this case the studied neglect had cheated this woman perhaps of weeks or months. I don't suppose you can blame Hank, yet this case seems to me to illustrate something that happens to me and to other doctors, too, when they are dealing with patients who seem to be very, very sick. It's almost as if we let ourselves be stampeded into hopelessness. (303)

And then Doctor X [Nourse] continues to mull over hopeless cases. ''I wonder if it is ever right for a doctor to quit doing things for a patient because he has become convinced that she is going to die anyway. You can not only be fooling yourself in your interpretation of what you see, but also,'' he says, ''it's neglecting a duty you assume when you take the patient on in the first place. If you don't want to handle that kind of dirty job, you shouldn't take the patient on to begin with.'' In particular, he says, ''I think with cancer patients this is more of a problem, and more of an obligation for the doctor, than with almost anyone else,'' given that they often ''come back with a recurrence'' (304).

As does Cha Nan Chen, a patient whose memory haunts Hellerstein. Treated successfully by means of chemotherapy and radiation therapy for Hodgkin's disease, a cancer of the lymph nodes, she then develops acute myelogenous leukemia (AML), a cancer of the blood cells. She's a goner, according to the attending physician, ''who had seen many of these patients in recent years'' (21). Even so, Hellerstein wants to pull out all the stops, like Doctor X [Nourse], who notes that being in the process of dying is not the same as being dead. ''But her white count's zero point seven with sixty blasts,'' Hellerstein says. ''She's not responding to antibiotics. Unless we do something,' I added, 'she'll be dead in a few weeks'' (21). Subjected to more chemotherapy, however, ''Cha Nan looked worse than ever, and the Med 3 team made briefer and more perfunctory rounds on her. And when alone, often I would just pass by the room, rather than poke my head inside'' (27), Hellerstein admits, feeling guilty because ''she might be getting from our treatment a third disease,

aplastic anemia, worse than Hodgkin's and worse even than AML'' (25). He explains. ''I began to have the horrible suspicion that we were shortening her life, that our vigorous treatment was just killing her more quickly than her disease itself. The anguish of seeing her every day convinced me beyond suspicion, even beyond the facts'' (27), he says, echoing Doctor X [Nourse], who warns of the danger of ''fooling yourself in your interpretation of what you see'' (304). And then, when Cha Nan tells Hellerstein that she wants to die—''I want to go, David. Do you understand, I want to go?''—he pretends at first not to understand. ''To go, Cha Nan?'' he asks, finally agreeing to her request. ''All right, Cha Nan'' (29–30), he says, upping her morphine and bringing to mind what Viscott has to say. ''A doctor who accepts his own humanness, who can admit failure and his own limitations and doesn't demand that his patients undergo a miraculous cure just to demonstrate his wonderfulness, can be very supportive to his dying patients.'' And the alternative? ''If he gets angry, frightened, or suddenly very busy and avoids the patient and his family, he is guilty of desertion'' (369), Viscott says, anticipating the ''Do Not Resuscitate'' (DNR) conundrum.

According to Klass, ''no one is exactly sure what it means'' (*A Not Entirely Benign Procedure* 214), and Konner agrees. ''The legal concept of D.N.R. was relatively new and constantly evolving,'' Konner says. ''You couldn't look it up in a book and be safe, since your future would depend not on what was in the book but on what had been decided by a jury or judge that morning.'' In the meantime, he relies on what his resident tells him. ''Today there are two meanings to D.N.R.'': ''comfort

measures only'' and ''no heroic measures for resuscitation.'' And the worst part? ''Half the time we don't know which is which'' (108–09). Klass makes the same point. ''Most doctors would argue that there are different kinds of DNR. There is the person who stands a good chance of walking out of the hospital, but who wants to die peacefully if his heart stops. And then there is the person who will be dead in a matter of days and is in constant pain.'' In other words, no heroic measures for resuscitation and comfort measures only. ''But,'' she adds, ''it is not always clear that the patient, in agreeing to be DNR, understands where on the spectrum his doctor considers him to be'' (*A Not Entirely Benign Procedure* 215)—or that his doctor will honor his wishes or those of his family, Konner adds. ''It's between us and God'' (142), a resident says conspiratorially to a group of his peers about a patient with a malignant brain tumor: ''he was not D.N.R., a situation that disturbed the residents greatly'' (141), and so they make a unilateral decision, the reference to God notwithstanding.

According to the observers, then, hopeless cases require physicians to perform a highwire act: when are they giving up too soon, and when are they doing too much? It's a question that the observers often raise, particularly when they suspect that hospitalized patients are serving as research subjects. For example, both Reilly and Klitzman find themselves torn when they learn that patients of theirs are to receive experimental chemotherapy: Mrs. Landi and Mr. Kirby, respectively, both of whom have been diagnosed with leukemia. ''Although still a tyro,'' Reilly says, ''I knew that the phrase 'latest protocol' was ominous. It usually meant that the patient was

about to be hit with three or more very potent drugs—in the hope that they would somehow stop a cancer that was rampaging through the body'' (182). For seventy-nine-year-old Mrs. Landi, the prognosis is grim. ''No one had reported good success in treating persons with this illness, and it was considered to be a rapidly fatal disease. Why, I wondered, would doctors or the family want to put a patient her age on a devastating group of drugs if she had almost no chance of surviving anyway?'' (183) Reilly asks. And as Klitzman points out, Mr. Kirby is between a rock and a hard place, too. ''Mr. Kirby could face the natural course of his illness or be a guinea pig for a new and not fully tested 'protocol' of medications. A newfangled drug could attempt to forestall fate'' (52), thanks to the Department of Developmental Chemotherapy as represented by Dr. Rohr. But his motives are not entirely altruistic. ''He wanted to find out whether his concoction worked'' (57), Klitzman notes. After giving it a try, Mr. Kirby decides that he's had enough, but he faces stiff opposition. ''His family and Devo Chemo backed the medicine. The patient was opposed. To whom would I be loyal?'' (56), Klitzman asks, like Reilly before him.

So doing too much can be worse than giving up too soon, as Klass argues: ''doctors do not face the death of a patient with either serenity or acceptance,'' she says, ''and unable to accept death gracefully, they may make a patient's dying hideous with medical invasions'' (*A Not Entirely Benign Procedure* 198). It's a point that Klass makes most frequently in reference to premature babies, tentatively at first. ''I began to worry about the rights and wrongs of saving very tiny newborns'' (*Baby Doctor* 9), she says at the beginning of her internship. Later she expresses herself

with greater conviction. ''I was increasingly troubled by the ethical dilemmas which torment almost everyone who works in newborn medicine. To put it bluntly, we spent a great deal of our time and energy trying to save very tiny babies who were very unlikely to survive intact'' (*Baby Doctor* 228). As Klass recognizes, the counter argument goes as follows. ''Once, not long ago, twenty-seven weeks was too young to save; now it's twenty-four, maybe even twenty-three—and how will we learn to save those babies unless we save them, and practice?'' (*Baby Doctor* 228). In other words, practice makes perfect, sometimes turning hopeless cases into success stories. But like Reilly and Klitzman, who worry about Mrs. Landi and Mr. Kirby serving as research subjects, Klass says, ''I often found myself disagreeing with what I was doing'' (228). On the other hand, she proudly touts the strides that have been made in treating children with leukemia. ''Nowadays, over 95 percent of children with leukemia achieve complete remission'' (*Baby Doctor* 324), she happily reports, unlike MacNab [White], who in the early 1970s has little but sympathy to offer such children and their parents. ''An intern presenting the case of a leukemic stated that a certain symptom is *never* seen in the childhood form of this disease. The old 'attending,' who has made a specialty of this sad field, gently reminded him that *never* is a long time'' (26). So for all Reilly knows, it's possible that Mrs. Landi will fool them all. ''The doctors, trained oncologists, had been taught that cancers must be treated vigorously and persistently. For them medicine was a battleground where victory, if it came at all, came after great struggle. Although they 'knew' her case was hopeless, they also 'knew' that sometimes they won unexpected victories''

(203–04). As it turns out, not for her, but Doctor X [Nourse] makes the same point about the likelihood of saving patients with cancer of the pancreas. ''It seems like a forlorn hope, but who can say? They *do* get cures, sometimes. Not palliations, or prolongation of life, but *cures*. Sometimes'' (204).

Comic Relief

According to Klass, ''one area of medicine I take for granted cannot be offered to the scrutiny of the general public. I am thinking of medical humor'' (*Baby Doctor* 215), she says. More specifically, patients often provide comic relief for physicians, who not uncommonly resort to name-calling. For example, Doctor X [Nourse] talks disparagingly about ''crocks who didn't know themselves what they were doing in the hospital'' (75). It's a term that is more formally defined by MacNab [White] and Karp. ''There are a variety of terms for patients,'' MacNab [White] says. The first one on his list? ''*A crock*—a patient with many complaints and no pathology'' (190). Karp agrees. ''A crock is a non-sick patient, a hypochondriac, a malingerer, or an hysteric. Most doctors are very unfond of them'' (xx), he says with understatement. It's an epithet that's still in use, according to Konner, who includes it in his ''Glossary of House Officer Slang'' (379–90). ''Patient with nothing physically wrong; appears to be short for 'crock of shit,' but the latter full phrasing is never heard; a hypochondriac or somatizer; candidate for 'psychoceramic medicine''' (382). And what's that? ''Treatment of 'crocks;' the phrase ridicules a category of patients and a category of physicians (including the whole profession of psychiatry) simultaneously'' (387). Of course, a patient can't be called a ''crock'' to his face. No

problem. As Konner notes, physicians have an impressive array of slang at their disposal, and some of it, according to Klass, "allows conversations to go on at the bedside that are unintelligible to the patient" (*A Not Entirely Benign Procedure* 75). She provides an example. "You suspected all along that this was what you politely call a 'supratentorial problem'—an anatomical way of saying it's all in his head" (*A Not Entirely Benign Procedure* 119).[9]

And when patients aren't the subject of name-calling, they're often the butt of jokes. Dead or close to it? "Transferred to Big Sky General" (212), as MacNab [White] reports. Reilly is not amused by such euphemisms: "something happened that shocked me. First one intern and then several medical students cracked jokes about Mr. Garabedian's death. They were 'in' jokes from which only house officers can dissect the humor," he says, quoting one of them as saying, "Let's write transfer orders to the ECU"—the eternal care unit. "People were actually giggling about a man's impending death while he lay twenty feet away gasping for air," Reilly says. "I was disgusted and furious" (234). Comatose patients are the targets of vicious humor as well. "Beckman belongs in a vegetable patch," another intern tells Klitzman, clarifying himself. "His diagnosis is Rule Out Vegetable." Having already arrived at his own conclusion about Mr. Beckman—"I think we need an ethics

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[9]The slang term "crock" (meaning "a patient with bogus complaints") even made its way into "60-Second Med School: Doctors' Secret Slang," an article that appeared in the women's magazine *Self*. "The language of medicine is rich and evocative, sometimes outrageous, even cruel," says Diane Umansky. "We're not talking about the Latin-based terms that fill med-school textbooks, but the secret language among doctors—the medical slang interwoven with technical jargon as physicians discuss cases" (96).

consult, stat''—Klitzman does his best to undermine the frivolity without directly providing editorial comment: ''diagnoses are often presented as 'ruling out' a disease,'' he explains to his readers. ''It means that a certain condition is suspected, but that further diagnostic tests are required before proving or disproving the hypothesis'' (163).

It seems that patients in the emergency room are particularly susceptible to being ridiculed. Konner reproduces in full what he calls ''the 'patients may be shot' memo'' (47). Typed on official hospital stationery, it's posted on the inside door of a supply cabinet. It reads as follows. ''Beginning January 20, 1982, handguns will be issued to all Emergency Ward personnel, along with the following instructions for their use. Henceforth, patients may be shot, but only after a careful history has been taken and one or more of the following criteria have been met.'' Twelve items are listed. Interestingly enough, number 5—''Patient reports to the E.W. at 3:00 a.m. for an injury that occurred more than 6 days ago'' (47–48)—is a formal codification of a comment that Doctor X [Nourse] had thrown out decades earlier:

> At 4:30 a.m. Miss Wood called me to see a man in the Emergency Room who thought he had run a sliver of lead into his finger the previous afternoon (he hadn't) and now had decided the time had come to have it looked at. These are the ones that give you unhealthy fantasies about what sheer pleasure it would be just to shoot them through the head. (174)

Then there's the Wheel of Pain, a comedy routine featuring an intern as the host and a senior resident as the contestant during lulls in the emergency room, Konner explains. ''The Wheel of Pain, like the big wheel on a T.V. game show, would be spun to determine which pain medication would be prescribed. Any sort of patient would do, but addicts and other undesirables who were faking symptoms were especially appropriate'':

> The imagined wheel, invisible on the wall, was spun. Freddy followed it, building up the suspense. ''There it goes, there it goes, Perca-, Perca-, Perca—No, sorry, but you do get a choice: enteric-coated aspirin or Tylenol.''
>
> ''Can I have Tylenol with codeine, at least?'' Ted asked plaintively.
>
> ''No, sir, you may not. Next. Perca-, Perca-, Perca-, where will it stop? Where will it stop? Yes! Congratulations! You get Percocet!'' (70)

And on call in the emergency room at 3:00 a.m., Hellerstein gets a new admission. ''Dregs of the earth,'' the charge nurse says, and he wearily thinks to himself, ''I just as easily could do what some of the other residents joke about—give him seventy-five cents for the bus down to Bellevue. Or even four bucks for a cab,'' he says, quickly adding, ''I've never done that, of course'' (219–20). It's called ''the dumping syndrome,'' Karp says. ''What was dumped on the Bellevue doctors was, to be specific, patients. To be even more specific, it was unwanted patients from other

hospitals.'' The practice is not exactly a source of amusement to Karp and his colleagues. ''Bellevue Hospital was never allowed to refuse admission to a patient. Not for any reason'':

> Our irritation arose from the fact that the staff at every other hospital in the city knew the way the game was played, and the rules were all in their favor. Private hospitals or municipal, it didn't matter. They were all aware that the gates of The Vue never swung shut, and that was all the ammunition they needed. It meant that any time they didn't wish to admit a particular patient, they had only to shove him or her into an ambulance and point the vehicle toward First Avenue and Twenty-sixth street. (95–96)

As Karp sees it, the joke is on Bellevue Hospital.

Finally, even Viscott gets into the act, though in truth he pokes more fun at his supervisor at the state hospital than the patients. ''Dr. Jim Sellers was the psychiatrist in charge,'' Viscott explains. ''He was a muscular, spirited man who had played halfback at Penn State in his senior year and had scored the winning touchdown against Boston College''—as his rhetoric suggests: ''our team is a good team,'' he tells Viscott. ''I want you guys to know that I'm behind you all the way!'' Viscott allows his imagination to roam:

> I could suddenly see it . . . the stadium filled to capacity with mental patients dressed in dull hospital-gray pants and shirts or housedresses, obese and braless, toothless and sweaty, with matted or stringy hair,

> and splotches of lipstick put on crooked. On the sidelines, thirteen nurses dressed in freshly starched whites, each of them with a different letter sewn on the back, spelling out S-C-H-I-Z-O-P-H-R-E-N-I-A, waiting for the cry, "Give me an *S*!" and for the doctors to break out of the huddle to face the amorphous foe. Pacing back and forth, Coach Jim Sellers. . . . (211)

The irony is that the patients actually do get outside for a game of football one afternoon. "The patients just stood there motionless," Viscott says, but not Sellers. "He really *could* move. I know his mind wasn't with us. He was back in good old BC stadium again, third down and fourteen to go." And after an hour, Sellers is ready for more. "'How about another game?' said Sellers. 'That really did a lot for the patients.'" Viscott's conclusion? "Sellers, I'm afraid, was an asshole" (229).

Moment of Truth

For all of their willingness to expose the general public to the unadorned truth about medical education, the observers deny trying to change it, at least in part for the reason that Klass articulates: "I've absorbed some pretty strict prohibitions about bad-mouthing other doctors" (*Baby Doctor* 212). Having openly questioned the competence of other physicians, two of the observers are told to mind their own business—Doctor X [Nourse] and Viscott—and they do. "You go pointing fingers and you may find yourself in a very slippery spot sometime with a whole lot of fingers pointing at you" (220), Doctor X [Nourse] is admonished, and Viscott receives the same lecture. "Get off your high horse, David, you'll fall on your ass someday and

there won't be anyone around to pick you up'' (364). Both of them are quick studies. Having initially taken a firm stand—''it seemed to me that the gal should sue for every nickel she could get and that every doctor in town should be with her right down the line'' (220)—Doctor X [Nourse] quickly backs off: ''I don't think *I'm* going to walk in and say to her, 'Gee, you ought to sue that bird for everything he's got,' either'' (221). And the same goes for Viscott, who is told, ''leave these doctors to their patients and start worrying about patients of your own.'' His response? ''That was the best idea I'd heard all day'' (364). But he'd already come to the same conclusion on his own despite having some strong reservations about the medical profession. ''What the hell was going on. This *is* a hospital. These *are* doctors, well *aren't* they? Didn't these doctors have medical school degrees on their walls? Weren't they board certified? Why didn't they pick up the problems with their patients?'' (354). He continues:

> One afternoon I became extremely upset thinking about all of this. I went down to my car and not knowing what else to do I drove to the zoo. At least this zoo wasn't disguised as a hospital. I bought two bags of peanuts, one for the elephant and one for me. I spent an hour feeding the peanuts one by one to the elephant. I like feeding elephants. Their trunks feel like vacuum cleaners. So I have a fetish! Elephants are lovely. They're big and they move with grace. Elephants are charming. . . . I was in a sweat and it had nothing to do with it being hot. (356)

''Shouldn't I do or say something about what I saw?'' he asks himself, answering immediately. ''What do you think, elephant? Stupid elephant! I did not go to medical school to become my colleagues' keeper'' (356).

And neither did any of the other observers, who clearly do not want to be perceived by other physicians as troublemakers. For example, during a discussion about the ethical issues raised by the iatrogenic overdose, what does MacNab [White] do? ''I straddled both sides in silence'' (30). The same goes for Konner, whose mantra is ''K.M.S.,'' an acronym for ''Keep Mouth Shut'' (55–57, 70–71), and for Reilly, who is fond of phrases like ''I held my tongue'' (76, 236), ''I kept silent'' (96), and ''I hung back'' (155). Or as Margery W. Shaw says in the foreword to his book, ''for the most part he played by the team's rules, despite personal misgivings'' (ix). Likewise, both Hellerstein and Klitzman strike a tone of modesty about what they hope their books will achieve. ''A doctor who writes can complete the picture, can show not only the extent of problems,'' Hellerstein says, ''but can also open the possibility of finding solutions'' (10). Yet he doesn't claim to offer any. Nor does Klitzman. ''What I learned during the year was no great single revelation, no prescription for revamping American medicine'' (219). In truth, most of the questions that the observers raise offer no easy answers. For example, Karp is none too happy when he discovers that a baby he has delivered will be taken home by a lesbian couple: '''But my God,' I yelled in exasperation. 'What the hell are those two going to do to a little boy?''' The social worker agrees with him. ''Frankly, I shudder to think,'' she says. ''But you might as well calm down. There's nothing you can do

about it. You just can't set right all the wrongs in this world, so why don't you just relax, and act like a doctor instead of a social worker.'' Like the other observers, Karp knows when he's whipped. ''The next morning, as I stood by and advanced my day of total baldness, Charlene and Paula took their baby home. Since then, I've often wondered what became of him. Probably in a few years I'll be watching him play tackle for the Los Angeles Rams'' (62), he concludes with a note of reluctant acceptance that is typical of the observers. So despite having recounted in glorious detail their concerns about medical education, the observers stop right there.

CHAPTER 3

THE OUTSIDERS

The outsiders are a tentative bunch. Focusing on themselves to a degree unmatched by any of the other groups of physicians, the outsiders give relatively little thought to medical education per se. Instead, they explore whether and how they can adjust to it. Essentially, they perceive themselves as square pegs trying to fit into a round hole, a theme that predominates in eight of the books: Theodore Isaac Rubin's *Emergency Room Diary* (1972) and *Shrink! The Diary of a Psychiatrist* (1974); Joni Lynn Scalia's *The Cutting Edge* (1978); Kenneth Klein's *Getting Better: A Medical Student's Story* (1981); Jane Patterson's *Woman/Doctor: The Education of Jane Patterson, M.D.* (1983), cowritten with Lynda Madaras; Dorothy Greenbaum's *Lovestrong: A Woman Doctor's True Story of Marriage and Medicine* (1984), cowritten with Deidre S. Laiken and excerpted in the magazine *Working Woman* (Greenbaum and Laiken, "Strong Commitments" 143-57); Claire McCarthy's *Learning How the Heart Beats: The Making of a Pediatrician* (1995), excerpted in the magazine *Glamour* (McCarthy, "Through a Mother's Eyes" 236); and Ellen Lerner Rothman's *White Coat: Becoming a Doctor at Harvard Medical School* (1999). Concentrating on their discomfort with medical education, the outsiders succeed insofar as they find a way of coming to terms with it meaningfully. At the lower end of the range is Scalia—the dropout—who quits two residencies and then tries emergency medicine. Next are two medical students (Klein and Rothman) and then two pediatricians (McCarthy and Greenbaum). And finally, two of the outsiders are

primed to become activists later in their careers: Patterson (an obstetrician-gynecologist) and Rubin (a psychiatrist).

The Dropout: Scalia

From the start of medical school, Scalia positions herself on the fringe. ''Biochemistry was very interesting, but not to us'' (14), she says about one of the classes required for first-year medical students. She explains:

> By *us* I refer to the small group of which I had become a member. In medical school you form attachments fast, and like seeks out like. This group to which I am referring consisted of four or five members. We all had several things in common. We had all had so much college chemistry that we could have taught the course; we were all reasonably bright, having skipped every conceivable grade the New York City school system would permit; we all sat in the back row; and we were all obnoxious. (15)

When the professor isn't looking, ''it was out the back door,'' she says. ''We'd head down to the beach and stuff ourselves with Nathan's hot dogs, raw clams, and french fries. After all, we reasoned, we needed our strength'' (15). And what about the students who take medical school seriously? ''Let's hear it for the kids in the first row with the tape recorders'' (27), she smirks, the ones who try to learn from what she calls ''the white-haired bastards'' (23). She's already hinted that she has a chip on her shoulder. ''Finally the double doors at the front of the lecture hall opened,'' she says about orientation day, ''and then, ladies and gentlemen, in walked a white-haired

man in a snow-white coat—the first in a long succession of white-haired men who are the very core and substance of the medical profession. Without white-haired men, there would be no Medicine'' (9), she says, pitting herself against them.

Having attended medical school from 1963 to 1967, and having published her book in 1978, perhaps she assumes that her accusations of sexism will automatically fall on fertile soil. But already Scalia has turned herself into an unlikable character, and so when she begins to have trouble with ''the white-haired bastards,'' it's no wonder that both male and female book reviewers have trouble siding with her. Filled with ''as much vindictive venom as possible,'' Scalia's book ''demands perseverance on the part of the reader'' (1650), Kate Hammell says. Aaron I. Michelson acknowledges that he ''only has the Doctor's words to judge by.'' Nevertheless, he makes it clear that he considers her to be an unreliable narrator: ''some of her misfortunes'' are in all likelihood, he says, ''a reaction against her acerbity'' (355).

Her misfortunes are numerous, and for the most part, they begin during the third year of medical school when she makes her debut on the hospital wards. She gets off on the wrong foot in her first rotation: internal medicine. ''I failed. I just came from Heinrich's office. They're going to make me take it over,'' and she doesn't understand why. ''What is it? What is it with me? What do I have to do? Who do I have to be, just tell me, for Christ's sake, I'll do it.'' It's sexism, she's sure of it. ''Goddamn bastards. Wring the life out of you. You could be a goddamn mediocre know-nothing son-of-a-bitch, but if you were a man you could sail right through. Mediocre and lazy and know-nothing, but it was okay because nobody

noticed and nobody expected anything from you'' (61–62). Then it dawns on her exactly who's to blame. ''The little Greek prick'' (62)—Dr. Doropolis, the professor she'd challenged. '''And now, Miss Scalia,' he said, ostensibly looking at my name tag but in actuality trying to decide whether it was more profitable to look down my blouse or up my skirt. 'What is your opinion of this patient?''' Even as a third-year medical student who by her own admission has cut class whenever possible, she knows more than the attending physician. ''He was emphatic. He was assertive, he was grandiose. He was incorrect. We all knew he was incorrect,'' she claims, and she takes it upon herself to set him straight:

> I did it. I couldn't help it. He was asking for it. He'd done a lousy job; somebody had to tell him. I systematically took apart everything he had said, simultaneously of course supplying him with the appropriate reference source that contained the correct information. I called him on the one pertinent physical finding that he had neglected to discover in his rapid examination, and I arrived at my diagnosis. (57)

So in essence, Scalia says, she has failed the rotation because she knows more than Dr. Doropolis. And he deserves to die. ''Doropolis would go down in a blaze of bullets'' at the hands of ''my Sicilian father,'' she says, implying that her family has ties to the Mafia, ''splattered all over the street, his lunch of moussaka and rice still in his gullet. And when they brought him into the emergency room, with lights flashing and sirens going at full scale, I in fact would be the doctor on duty. The remainder is too disgusting to dwell on'' (63).

And it's not just Dr. Doropolis, either. It seems that Scalia knows more than Dr. Merritt, too. ''Merritt stood in front of the bed, checked the man's dressing, checked his lab work, and ordered whole blood.'' Scalia corrects him. ''Wait a minute; you can't give this man any whole blood!'' (73). And she knows more than a physician she calls the Frog. ''A lot of other people don't think you can justify taking out three-quarters of the stomach for a first-time bleed,'' she tells him. ''The Frog took over. He wanted to know which other people from which institutions exactly, in which journal the reference article was, the year, and the page number. I didn't know. He wanted to know how many people bled again from their ulcers after a vagotomy and pyloroplasty as compared with a gastrectomy. I didn't know'' (77). It's an admission that calls into question her assessments of Dr. Merritt and Dr. Doropolis, and by extension, her belief that ''the white-haired bastards'' are out to get her.

Either unable or unwilling to follow the advice she's received from one of her classmates—''let's have a little less James Dean and a little more Sandra Dee'' (67)—Scalia nevertheless graduates from medical school. But even on that happy day, she's filled with rancor. '''Up yours,' I said very quietly to my tassel, 'up yours''' (104). And predictably, Scalia continues to butt heads during internship and residency. First she tries surgery. ''I'm not really sure when I started having trouble'' (117), she says, but it's clear that her nemesis is Dr. Haver. ''I've only known him two hours and already I'd like to kill the son-of-a-bitch'' (133). There's no point in continuing, Scalia decides, noting how humiliated she feels. ''It was the old fraternity

game, and Haver was only the first in a long line of legs you had to crawl under, being paddled on the fanny all the way along. The mentality was the same'' (140). And then she tries radiology. ''What went wrong this time?'' she asks. ''Where goes the blame here?'' (151). This time it's Dr. Bernstein. ''He told me to do what I was told, I told him to go to hell'' (158), and eventually she decides, ''I'm going to just say adios to these problems and pick up a new set someplace else'' (191)—which she does. ''The emergency room. Now, that just might do it'' (193). But she doesn't exactly hit it off with the head nurse. ''A real bitch'' (205), Scalia says. And soon she's alienated the other nurses, even to the point of threatening one of them physically. ''I grabbed the front of her uniform and pulled her off the stool'' (232), Scalia recollects. ''Several days later, Hancock, the head of our group, came into the ER. 'I want to talk to you,' he said'' (233). So now on top of having two uncompleted residencies on her record, she's lost her job. Unable to find another full-time position, she takes what she can find at a smaller hospital: ''they had some people on vacation and there was practically a full schedule of shifts to work for at least several months'':

> So I went to work, because at least I could feel that what I was doing was still important. And I did feel that way. By now I knew everyone who worked the ERs in town. I had been working ER for a year. We all knew one another; all the ambulance and fire and police personnel, we all knew each other. We had shared many a patient. (237)

But they're outsiders as far as the private practitioners are concerned. "The rest of the profession shunned us," she says. "We were the freaks":

> We didn't have an office and we did the scut jobs that the private practitioners wouldn't come out of their offices to do, partly because they were too lazy but overwhelmingly because they just didn't know how, as I hadn't known how a year before. They didn't know what the hell to do when they had an emergency because they had been high-stepping for a little too long and glad-handing just a few too many patients. (237)

"Even the patients didn't want us," she adds. "'Where's my doctor?' they would say indignantly. 'I want *my* doctor to take care of this'" (237). And then Scalia even loses her place among the freaks. "I called the guy who ran the group," she says. "I told him I wanted to work full time" (248). He stalls. "I didn't hear from Kerner about my job. He was sure taking his time" (253), Scalia says. Eventually the news reaches her via the grapevine. "Joni, they're not going to let you work here, you're not going to get any work here any more" (254). It's those damned nurses again: "they hate you" (254), Scalia is told, and she considers committing suicide with the handgun that she keeps in her dresser. "Where does it all end if you don't end it by yourself? If you let somebody else write your own ending?" she asks. "How do you know when it's over for you? Who tells you, 'Now, it's now, it's today'? The white-haired bastards tell you" (256), Scalia answers, ending where she started. And then she has another question. "Did it matter that I had spent all the years that I had just

to be a member? Did it matter to me? No. It didn't matter. Not any more, I knew that'' (256–57). Having gotten married at the end of medical school to Les Newman, one of her classmates—and now an obstetrician-gynecologist—Scalia has a fallback position. ''I'm going to be Harriet Housewife,'' she'd threatened when she left surgery. ''Sleep till ten, coffee and sweet rolls, watch the soap operas, no more 'Yes sir, no sir, may I kiss your ass, sir?''' (141). Now all that remains is her husband—she hopes. ''And my marriage? Where was that? Was that gone, too? Another sacrifice to the profession?'' (257). Apparently without being aware of it, Scalia reveals throughout her book that she's her own worst enemy—never mind ''the white-haired bastards''—and her lack of insight makes her the most pitiable of the outsiders.

The Medical Students: Klein and Rothman

It appears that if Klein and Rothman aren't careful, they may find themselves on a dead end, too. But the jury is out on them because they're still students, both of them at Harvard Medical School. And they've taken a rather circuitous route to get there. ''I never wanted to be a doctor'' (15), Klein states flatly in the first sentence of the first chapter. Rothman makes a similar admission. ''Medicine was a late discovery for me'' (8), she says. Both of them have contempt for the premedical students they encounter during college and for the same reason. ''The only thing that ever seemed to get them excited was grades'' (17), Klein says, and Rothman agrees. ''I hated the premed mentality,'' she says, adding, ''I thought people were obsessed with their grades'' (9). Moreover, when they finally did decide to apply to medical school, neither one planned to become a practicing physician. Having initially thought that he

would become a chemist like his father, Klein struggled through graduate courses in the subject before he decided to go for the M.D. so that he could do research in neurophysiology. Rothman wanted to be an attorney until she took her first biology course in college, and even then, she anticipated a career in medical ethics. Both of them emerge from medical school with entirely different goals in mind: internal medicine for Klein, pediatrics for Rothman. As they leave us, both are headed for internship and then residency.

Like many twenty-somethings, Klein and Rothman have changed direction. But in their books, both fail to make the case that they want to practice medicine. Indeed, neither one even appears to be content with the decision to attend medical school. Endlessly waffling back and forth, they never seem to make up their minds, the result being that their books become tiresome affairs that lack a clear sense of purpose.

As Klein puts it, "I found myself on a seesaw. A little medical breeze would waft me up to feelings of accomplishment and exhilaration. Then its direction would change and I'd be blown down to frustration and discouragement" (247). Surrounded by the very same kind of people he shunned during college, Klein exclaims, "Only now I was one of them! Again and again I wondered how I had ever ended up in medical school" (32). It's a refrain that appears frequently in Klein's book: "What am I doing here? I kept thinking" (90); "I had so many options after college; how could I have possibly chosen medicine?" (136); "Again and again I wonder why I'm doing this" (153). Having chosen the M.D. over the Ph.D., he seems particularly unnerved by an observation made by one of his classmates. "Medical school is

intellectually the easiest but emotionally the most difficult of the graduate fields'' (136). Occasionally it appears that there may be a light at the end of the tunnel. ''For the first time in my life I can actually imagine myself as a doctor. And I'm looking forward to it. Enduring medical school, it seems, may be worth it after all'' (173). But another crisis of confidence soon follows:

> I realized I had applied to medical school with almost no notion of what it meant to be a physician. And now, three years later, I still wasn't at all sure. It seemed foolish and dangerous to be investing such huge tracts of time in a future that remained almost totally unknown. Maybe, I thought, I should withdraw the letters I'd just mailed requesting internship applications. (244)

By that time, Klein has so thoroughly alienated his readers that they're likely to agree with him, for he's already confessed to wishing a patient dead.

Beginning the book *in medias res*, Klein describes an incident that occurred during his third year of medical school. A patient diagnosed with a stroke arrives in the emergency room and promptly stops breathing. Told to take the patient to the operating room, Klein realizes he doesn't know how to get there. ''For the first of many times that evening I wished that Mr. Hastings had died at home'' (6), he says. Later he explains that he had been panic stricken. ''I recognized that feeling well. It had been there on and off all through medical school. It was there that night in the emergency ward when Mr. Hastings stopped breathing. It had grown stronger and

stronger as I frantically wheeled him to the operating room'' (265), only to watch him die under the surgeon's knife.

Down moments like that occur more frequently than up ones. And at least twice Klein virtually identifies himself as an outsider, his attitude hardening as he makes his way through medical school. As a third-year student, Klein caves in immediately when his point of view is challenged by the chief resident. ''The others at the table agreed with Tom. He's probably right. I'm naive, I'm overreacting. My perspective seems to be so different; what's wrong with me?'' (158). The following year, he continues to position himself outside the group but asks what's wrong with everyone else. ''I had the bad luck to be taking pediatrics at the same time as John Defoe. John was an excellent student. He was bright, diligent, and aggressive—a real pain in the ass. He was going to be a pediatrician and wanted badly to do his internship at Children's'' (234). Early during their rotation, a five-month-old girl is diagnosed with a rare disease, giving Klein another basis for resenting his classmate:

> John was ecstatic. He rushed to the library and in two days had mastered the reticuloendotheliosis literature. . . .
>
> Rounds became a reticuloendotheliosis hootenanny. John would sing on and on about this obscure group of diseases for which there is no cure, and everyone would clap and stomp their feet in time. All the while I sat quietly outside the circle of interns and residents and staff, bored and ignored. I couldn't care less about John and his diseases.

> And I wasn't especially happy for him that he was a shoo-in for the internship. (235)

There is no chance that Klein will be competing with his nemesis for the same spot. "I was going into internal medicine" (233) Klein had already stated, adding later, "I really wanted to go west" (263), so why he should be filled with malice towards John is anyone's guess. But even worse, Klein once again concludes that his own needs will be served by the death of a patient. "As they yapped on and on about their star patient, I found myself hoping she would die. I didn't want to see her suffer, I told myself. But I think the real reason I wanted her to die was to see *John* suffer" (235).

It's not easy to believe Klein when at the end of the book he intones, "I was ready to become a doctor" (282), particularly since even in his moment of epiphany—providing medical help at the scene of a car accident—he is clearly ambivalent. "I had a sudden impulse to run back to my nice warm car and run away" (266), he says, despite the fact that just moments earlier he'd said to a bystander wearing a plaid jacket, "Listen, I'm a medical student. I can help" (264). Upon reaching the injured man, Klein has second thoughts. "Where was the guy in the plaid jacket? He'd *already* run" (266). Well, not really; he'd told Klein that he was leaving to call an ambulance. Then, too, the guy in the plaid jacket presumably isn't training to become a doctor. So when the ambulance crew arrives and Klein twice breathes a sigh of relief, one wishes it were for the patient rather than for himself. "I floated back to my car, free of the burden of responsibility for the injured man," he

says, later repeating the thought: "It was nice to be free of this dangerously injured man" (270, 274).

One reader who becomes frustrated with Klein is a member of Harvard Medical School's class of 1939. Reviewing the book for the *New England Journal of Medicine*, Francis D. Moore, M.D., and his coauthor Laura B. Moore compare Klein unfavorably to the famous American surgeon Harvey Cushing:

> The book commences with a preface telling of the author's terrifying experience in his third year, when he was left alone at night in the Boston City Hospital with a patient who had a severe head injury and an enlarging subdural hematoma. The patient died of cardiac arrest under his very eyes. We wonder whether the author is aware of the fact that Harvey Cushing had exactly the same experience at the turn of the century when, as a medical student, he watched a patient die of cardiac arrest under his anesthetic care. Cushing sensed the defect in physiologic monitoring that had left him unaware of the patient's downward spiral, and from that experience came the anesthesia chart as we know it today. . . . Klein's experience stimulated him to human insights and a critique of medical organizations, thus inspiring him to write this book. But did he take any steps to see that such an episode would not be repeated? The two responses, 80 years apart, possibly help us to contrast the mood of these two widely separated generations. (Moore and Moore 707)

Book reviewers for the lay press are far more generous towards Klein: "there is little doubt that he came to love medicine" (Laubenstein 657), gushes one. Another praises Klein for being "articulate about . . . how a medical student feels when progressing from a neophyte's trepidation to an intern's self-confidence" (*Bulletin of the Center for Children's Books* 174). Both of them would have been well to greet the exclamation on the last page of the book—"I was ready!"—with considerably more skepticism, for it seems likely that Klein is merely trying to convince himself.

Nor does Rothman appear to grow much during her four years at Harvard Medical School. The same patterns that characterize Klein's book emerge in hers, beginning with self-doubt. Having just arrived on campus, Rothman questions herself mercilessly. "What were they thinking when they accepted me? Was it a mistake? . . . How would I measure up? What if medicine was the wrong choice for me after all?" (13). Rothman has more than a bad case of the first-day jitters. In fact, as she anticipates, her doubts intensify as she moves from the lecture hall to the hospital wards. "I knew I could succeed in the classroom, but I had no idea how I would fare in the years to come" (110). Not particularly well, it seems. In the middle of her first year on the hospital wards, at the ripe old age of twenty-four, she asks herself a rather self-indulgent question. "Was I burned out?" (227). And like Klein, she second guesses herself as her internship draws near. "I didn't want this dizzying responsibility. . . . Why couldn't I have chosen a simple nine-to-five job with weekends and holidays off?" (325–26).

Rothman handles the first two years of medical school by distancing herself from the John Defoes of her class. "The more eager of our classmates arrived early to claim seats in the first and second rows, and by the end of the first month the rest of us had also staked out our preferred seating areas" (14), she says, bringing to mind Scalia. And as a third-year student on the hospital wards, Rothman complains about having to compete with the eager beavers now that she can no longer avoid them:

> Ironically, often it was not the clinical staff but our classmates in the rotation who made the experience so difficult. Grades mattered, especially for rotations in specialties that we considered for residency. High honors was a relative score, and we had to perform consistently above our peers to earn the highest grade. (196)

Topping the likes of Alyssa isn't easy. "Rather than the suggested every-fourth-night call schedule for her ward month, Alyssa chose a grueling every-other-night call schedule" (196). In contrast, Rothman, "overwhelmed by the bulk of unstructured hours" that loom ahead of her on weekend call, summons her boyfriend (and classmate) Carlos for a pep talk[1]—something that she does often:

> My worst experience in the hospital was a Saturday-to-Sunday call on the gyn service. I spent twenty-four hours in the hospital and, in all that time, saw a total of two patients. By lunchtime I was on the verge

[1]Like Scalia, by the time that Rothman graduates from medical school, she's married to her classmate.

> of tears. Fortunately Carlos met me for lunch at the hospital cafeteria to cheer me up. I spent our two hours together crying into my bag of animal crackers in the cafeteria. All I wanted was to go home. (198)

Her whining persists. "No one ever told us how to behave: not our course directors at the beginning, or the residents and physicians on our teams, or our classmates ahead of us" (196), Rothman claims. Yet her own account suggests otherwise:

> I was told to be aggressive in pursuing my education. I should make sure to see what I needed to see, ask as many questions as I wanted, perform the procedures I needed to master. And, my intern told me, I should never, ever *never* turn down the opportunity to perform a procedure if offered the chance—no matter how nervous or how unprepared I felt. (121)

It's advice that Rothman does not take. In fact, she demonstrates a remarkably nonchalant attitude during her very first rotation, surgery:

> Medical students helped retract tissue to optimize the surgeon's view and clipped the ends of sutures after the knot had been tied. I found both tasks tedious. Usually a little too short to see the surgical field well, I was too shy to bother the busy nurses for an extra stool. I usually daydreamed, and I often heard, "Cut! *Cut!*" before I realized someone was talking to me. (120)

And when it comes to procedures, Rothman is a master of avoidance:

> After I compared notes with two other classmates . . . it became clear to me that I was not learning procedures at the same rate as they were. One had already drawn blood once, watched two lumbar punctures, and removed stitches. The other, who was particularly assertive about asking to do procedures, had stitched two lacerations, done one lumbar puncture, and inserted a Foley catheter into the bladder of a confused and disoriented alcoholic. I hadn't even drawn blood yet. I felt bad about my lack of initiative. Was I failing in my responsibility to educate myself? (129)

Apparently, yes. Moreover, she is a master of self-deception. For at the end of her fourth year, Rothman pats herself on the back. "Now, nearing the completion of my last year of medical school, I was well versed in the rhythms of the hospital and well acquainted with patient care. Finally I was on the verge of becoming a real doctor. I belonged in this world and I had worked hard to earn my legitimacy" (321). Not quite hard enough, it seems, for in the next breath she admits that she has yet to attempt the procedures that she will be expected to perform when she becomes a pediatric intern. That's a deficit she plans to correct during her very last rotation:

> Learning procedures was my goal. I had spent several months working with children and learning how to examine them, but I had never once tried to draw blood. I viewed their delicate veins with trepidation. I was terrified of their pain and their parents' anguish. But residency was bearing down on me. What would I do when I was alone in the hospital

in the middle of the night and had never learned to place an IV on a child? I needed to learn procedures, and I needed to learn them fast. (322)

At her last mention of procedures, she still hasn't quite got them down. But not to worry. "While not yet successful at blood draws, I was overcoming my fears of learning. After four years I finally felt I had acquired enough skills to be an intern. I could do this" (322–33).

And it's not just procedures that give Rothman pause. Although she claims, "I loved caring for very sick children in the hospital" (301), her reaction to 6½-year-old Jamie suggests otherwise. "Karen, the senior resident, suggested that I take on Jamie as my patient. I was nervous. How could I manage a patient who might bleed at any minute? But afraid to refuse and definitely not one to back away from a challenge, I said nothing." Jamie arrives at the hospital, and the medical team gathers in his room. "Technically, because Jamie was my admission, I should have directed the interview and exam. But I hesitated when we met him, worried I would prolong the admission and certain I would annoy my senior" (205).

Uniformly given high marks for her candor by book reviewers (Beatty; Swanton; *Kirkus Reviews*; *Publishers Weekly*), Rothman nevertheless disappoints. At the beginning of the book she announces bravely, "I looked forward to growing into my white coat" (4). But she abandons the symbol of her medical affiliation at the first opportunity, on her pediatrics rotation. "The children were often terrified of the white coat, and most of the residents and physicians chose not to wear them. I was relieved

to put aside my coat with its uncomfortable power connotations'' (202). And by graduation day, she appears to have become a physician in spite of herself. ''Do I feel like a doctor yet? I'm not sure'' (335). Her book and Klein's fail to satisfy because in neither one does the narrator ever resolve the central conflict.

The Pediatricians: McCarthy and Greenbaum

McCarthy is also a graduate of Harvard Medical School, but, possessing a certitude that both Klein and Rothman lack, she enrolls with her specialty already picked out. ''I had actually chosen pediatrics when I was twelve years old, which was when I'd decided to be a doctor'' (xiv), she says, explaining that her father was an important influence:

> When my sister and I were children, my father would take us out simply to look and listen. . . .
>
> And always, we talked to people. We talked to the old ladies in the park, the man walking his dog, the mothers in the grocery store, the mailman. We knew all their names and where they lived and the latest news about their children. They probably thought my father eccentric, but he was so disarming, pleasant, and interested that they talked to us anyway.
>
> I think those times with my father had a lot to do with my decision to become a doctor. I grew to enjoy meeting people and entering into their lives in even a small way, and I thought that this was what doctors did. I thought they spent their days meeting people and

helping them, helping them in ways that were special and powerful. (xviii)

To this day, she is drawn to the same thing that Klein fears—in her words, the "emotional component" of medicine. She explains. "The faces, the voices, and the moments are the enduring reasons I chose medicine and would never want to do anything else" (xix). It's the emotional component rather than the scientific component—"the tests, the drugs, the experiments, the biochemistry and pathology, and all the information that is readily accessible in textbooks" (xvi)—that makes each physician unique, McCarthy believes:

> There is a curriculum to teach the scientific component of medicine, one that is more or less standard throughout medical schools and residency programs. There is, however, no standard curriculum to teach the emotional component of medicine. . . .
>
> We go about being doctors in different ways because of the differences in the way we practice the emotional component of medicine. (xvi–xvii)

And it's the emotional component that causes McCarthy to become an outsider even while she remains committed to her profession.

A case in point is dog lab. An optional part of the curriculum at Harvard Medical School when McCarthy was a first-year student, it involved studying the cardiovascular system by experimenting on anesthetized dogs that were destroyed afterwards. "It was all anyone could talk about: should we do dog lab or shouldn't

we?'' (24). The majority ended up participating, McCarthy included, her mind made up when she learned that she could also volunteer to help anesthetize the dogs: ''taking full responsibility for what I was doing . . . was very important to me. I was going to *face* what I was doing, see the dogs awake with their tails wagging instead of meeting them asleep and sort of pretending they weren't real'' (26).[2]

But meeting them awake destroys her equanimity. After holding the dogs while they get their injections, McCarthy joins the other members of her team. ''Our dog was brown and black, with soft floppy ears. His eyes were shut. He looked familiar'' (28)—''he,'' not 'it.'' Introducing the emotional component into dog lab certainly doesn't make it any easier: ''every time I had to think about him being a real dog who was never going to wag his tail or lick anyone's hand again because of us, I got so upset I couldn't concentrate'' (29). Too late she decides, ''I knew now that doing the lab was wrong. Maybe not wrong for everyone—it was clearly a complicated and difficult choice—but wrong for me. The knowledge I had gained wasn't worth the life of a dog to me. I felt very sad'' (30). Yet McCarthy does learn something important after all:

> When I started medical school I felt that not only did I have to learn information and skills, I had to become a certain kind of person, too. It was very important to me to learn to do the thing that a doctor would do in a given situation. Since the course instructor, who represented

[2]Interestingly, just one other student joins her: Elise, who ''hung out with the activist crowd. She had always intimidated me,'' says McCarthy. ''I felt as though I weren't political enough when I was around her'' (27).

Harvard Medical School to me, had recommended that we do the lab, I figured that a doctor would do it.

Dog lab changes her perspective. "I needed to be able to make some decisions without worrying what a doctor would do" (31), she says. Reviewing the book in the *Lancet*, physician Annie Fine notes that dog lab causes McCarthy to undergo a "complex metamorphosis" that involves "accepting selected trappings, rejecting others" (1424), a process that continues on the hospital wards.

In the vignettes that constitute the book—a collection of pieces that originally appeared in various publications, including the *Boston Globe*, each one the story of a patient McCarthy cared for—she documents her quest to become a doctor while deviating from what she perceives to be the norm. She serves as an advocate for Mr. Escobar, a Guatemalan who doesn't speak English, by standing up to the senior resident even though she is only a third-year student:

"Could we call an interpreter?" I asked.

"Why?" asked Ron. "The consent's signed, isn't it?"

"Yes," I said, "but I don't think he knows what's happening" (52).

She sympathizes with Mr. Parziale, who is sentenced to six weeks of intravenous antibiotics in the hospital. "The doctors on the team rolled their eyes and shook their heads when they talked about Mr. Parziale's escape attempts. He just doesn't understand, they all said. As I listened, I couldn't help wondering if we were the ones who didn't understand" (82). She grieves over premature babies who are kept alive, at least for a while, but not really for their own sake. For example, Arthur is born at

twenty-three weeks with his eyes still fused shut, and several weeks of medical intervention merely delay the inevitable. ''We should have let Arthur die long before he did'' (152), McCarthy says. Jonny, born at twenty-six weeks, nearly reaches his second birthday. But he spends all but one week of his two years in the hospital, where he is pulled back from the brink time and time again. ''Those kinds of situations galvanize doctors, and tremendous thought, energy, and skill was invested in keeping babies such as Jonny alive. Rarely did we think about what lay ahead of them. We couldn't let death beat us'' (201).

By using the pronoun ''we'' even when she disagrees with standard medical practice, McCarthy does two things at once. While remaining confident that she wants to be a physician, she quietly positions herself outside the mainstream of medicine. Drawing on the lesson she learned from dog lab, McCarthy identifies with her patients ''without worrying what a doctor would do'' (31). The emphasis that McCarthy puts on the emotional component of medicine is atypical, according to Dr. Fine. ''Most physicians, in my neck of the medical woods anyway, do not connect to their patients this deeply'' (1424). Too deeply for McCarthy to remain on the hospital wards treating ''the sickest of sick children; it had simply become too painful'' (245), especially when she becomes a mother herself. ''I saw Michaela's face in every child and imagined myself in the place of every parent'' (244). But McCarthy had begun to recognize her limitations long before the birth of her daughter. As a fourth-year medical student, she manages to take samples of blood, urine, and spinal fluid from a baby, but only with considerable trepidation: ''concentrating very intently on exactly

where I should put the needle," she musters up her courage. "This is my work area, I told myself. This is all of the baby I will allow myself to think about right now" (118), she says, demonstrating the self-discipline that Rothman lacks. Even so, McCarthy doesn't exactly relish doing procedures. "I didn't know if I could get used to this way of caring for children" (121), she thinks to herself when it's all over. And later, as the pediatric resident on call for deliveries, she compares herself with "the nurse, the neonatologists, and the respiratory therapist, these people so used to working with tiny and tenuous lives, so comfortable with the possibility of a crisis or even death. I knew I could never be that way" (197), she concludes. That's why primary care pediatrics is where she belongs, "helping children and their families stay healthy and happy and building relationships with them" (245). McCarthy comes to a rather startling conclusion: she likes everything about medicine except sick people. Defending her preference for well child care, she explains that it poses challenges of its own. "It sounds as though it should be easy, but it's not" (140). Regardless, the book succeeds because its readers have the pleasure of bearing witness to how McCarthy is able to find a place for herself.

So does Greenbaum, whose development as a physician closely parallels that of McCarthy. From the start of her third year on the hospital wards, Greenbaum focuses on the emotional component of medicine. A patient known as "the Kid" is a case in point. "His fingers were completely consumed by gangrene, and most of the nails had sunken in or completely fallen off." Greenbaum nearly faints at the sight. "I felt a blackness moving in slowly from the corners of the room" (123), she says,

explaining why. "He was just a child, and even though I wore a white jacket and stethoscope, I was still very much a mother" (124). Weeks later, his death unnerves her. "I left the room and hurried past the mother, averting my eyes. I didn't want to be the one to tell her" (127). And it doesn't end there. "That evening I carried the Kid's suffering home. I saw his tortured face as I pressed my own child to my breast" (128), Greenbaum says—just one of many passages that reveal "the author's emotional reactions to the drama of medicine" (Velhage 1441).

Her distress notwithstanding, Greenbaum is drawn to specialties like obstetrics. "At least there I would belong, a mother helping other mothers. What could be more natural?" (146). At first, it seems like the right choice. "Obstetrics had everything I loved: mothers, babies, life, joy." Especially babies. "Later, when I had a bit more experience, I noticed I was more interested in and more involved with the baby than with the mother. I began to think about pediatrics. Maybe taking care of children, healing babies, was what I really wanted. I knew I would find out very soon. Pediatrics was my next rotation" (149). And it's not long before she makes the very same discovery that McCarthy articulates. "Although pediatrics came naturally to me and I felt comfortable with infants, children and families, there was one aspect of pediatrics I was certain I would never come to accept." She explains her dilemma to the chief of pediatrics. "'I can't pretend. I can't remain cool and composed while a child is dying,' I said. 'Maybe pediatrics just isn't for me. Maybe I'm too involved. Maybe working with children will hurt too much." Dr. Goldman replies, "it's precisely because you are so involved and you care so deeply that I think you should

consider pediatrics'' (151). And she does. ''I seemed drawn to pediatrics'' (200), she says. ''More and more I was considering pediatrics'' (207).

Not long into her internship, she begins to regret her decision. '''I can't do this,' I say as I wipe away the tears. 'These children are all dying. This is no way to spend my life''' (233). Just like McCarthy, she finds it necessary to restrict her attention so that she can get the job done. ''I wanted to gather his tiny, sick body up in my arms and make him better with kisses and hugs,'' she says about a 2½-year-old boy who has leukemia. ''I couldn't stand the thought of bringing him any more pain. Instead I turned off the volume and the picture. I blotted out the tiny baby,'' she says. ''All I permitted myself to see was his hand and my needle'' (235). So when she begins her rotation in what she calls ''bread-and-butter pediatrics,'' it's a big relief. ''This meant there would be no more leukemics, no more chemotherapy and no more babies dying in my arms. I was ready for a simple diet of bread and butter, eager to treat a sore throat or a case of heat rash, or diagnose an attack of appendicitis'' (258). And for a while, Greenbaum thinks that she's found her niche. ''This is what I had been waiting for, what I had dreamed about when I first decided to become a doctor'' (270). But then a patient named Sharon stirs up her old doubts. ''Maybe pediatrics just wasn't right for me after all'' (286), she wonders after the sixteen-year-old leaves the hospital against medical advice, literally shoving Greenbaum aside in the process. She remains uncertain about pediatrics until her rotation in the neonatal intensive care unit—''premie land,'' as she calls it. ''Instantly, I was accepted as a mother, not 'merely' a doctor'' (290), she says:

> I began to develop an emotional bond with these children. But it was a bond that did not hamper my functioning as a physician. For the first time I felt a comfortable merging of my identities. Being a mother was making me a better doctor.
>
> In this quiet place where children balanced precariously between birth and death, a solution to my own personal dilemma was beginning to emerge. (291)

And when a premature baby dies, Greenbaum finds that she can accept it. "I didn't cry. It wasn't because I had stopped feeling, it was just that I had begun to understand what had always been so difficult to grasp before." Referring to the baby's mother, she explains. "What I had just learned from her child might help me to save another little girl or boy." She adds, "I felt older, wiser" (294), and by the last page of her book, she has finally made up her mind. "Pediatrics is where I belong" (312), she declares—not in well child care like McCarthy, but in premie land.

Despite sharing an appreciation for the emotional component of medicine, McCarthy and Greenbaum are a generation apart. McCarthy was born at about the same time that Greenbaum graduated from college, in the mid-1960s. And when Greenbaum realizes that she doesn't want to be a high-school English teacher anymore, she's already married with a seven-month-old daughter. The result is that she begins her odyssey behind the eight ball, another reason that she's an outsider. "Eddie, I want to be a doctor" (29), she tells her husband, calling to mind the prediction that her cousin Fran had made years earlier: "'Dorothy, you're the

intellectual,' she always said. 'You're going to do something different with your life''' (20). But as Greenbaum notes, ''there were no role models, no established patterns to follow. We had to make our own way.'' And so she and Eddie proceed ''to renegotiate a partnership that had been established upon fairly conventional lines'' (72), as she recalls. ''Eddie, this is a big step—a big risk. We need to discuss *your* feelings. How will you react to doing housework, helping more with Evie than you do now? How will you feel when people make remarks about me being in medical school while you're teaching junior high in the South Bronx? This isn't going to be easy'' (37). Besides, finances are tight: ''we have less than two hundred dollars in the bank'' (29), she notes.

For the most part, however, Eddie isn't flummoxed by any of it. ''Somehow he managed to sound absolutely sure about issues that puzzled everyone else'' (48), such as the reversal of traditional sex roles. ''I enjoy teaching—it's what I do best,'' he says. ''But I can see it just isn't that way for you. *You* want to become a doctor. That doesn't make you less of a woman or me less of a man'' (40). In addition to the support that she receives from Eddie, ''both our families were careful to censor any disapproval that was voiced by the outside world'' (49). So despite the obstacles, she's certain that she wants to become a physician: ''I begin to imagine, to see myself as Dr. Greenbaum—confident, educated, efficient, wearing a white coat, taking a pulse, saving a life. I like this picture of myself, and I freeze it in my mind'' (32).

It sustains her when she feels guilty about neglecting her family. ''I try not to think that my daughter will be seven years old when I become a doctor. I try not to

think about the days and the nights I will miss'' (42). It sustains her when she arrives on campus for her appointment with the premed advisor. ''I feel a comfortable familiarity settle over me as I walk past the admissions building and up the stone path to the advisor's office. This is, after all, my alma mater, and everything is the same.'' Well, not exactly. She's an outsider there now:

> The old brick buildings are covered with ivy. Walkways cut through the brown winter grass like paved gray arteries. The bare trees jut harshly into the clear sky, their branches knotting into thick brown webs. Nothing has changed, but dressed in my teacher's clothes and grasping my leather handbag, I feel strangely grown-up. The other students look like high school sophomores. No one else is wearing high heels and stockings; no one else is worried if her child has been properly fed and bathed. (32)

And it sustains her after her meeting with Mrs. Maloff, ''the woman who helps 'hard-to-place' students get into medical school,'' and in particular, ''older women students'' (73). Having earned straight *A*s in two years' worth of premed courses, Greenbaum is aware that she faces stiff competition nonetheless. ''Two women next to me are talking. One has a master's degree in physics, the other a Ph.D. in chemistry. I think about the résumé in my briefcase: a master's degree in English literature,'' but Greenbaum is certain that Mrs. Maloff will provide her with the key that will unlock the door to what one book reviewer calls her ''impossible dream'' (Meck 95)—that of becoming a physician. ''I explain that I want to take a few more

premed courses at this university, but I would also like her guidance and advice, since I will be applying to medical schools this year.'' Mrs. Maloff doesn't mince words. ''You have a bastard education,'' she says. ''Mrs. Greenbaum, there are women out there with advanced degrees in the sciences, with years of study and training. You come here with a handful of science courses and expect me to help you. You are wasting my time and yours. Mrs. Greenbaum, to be quite frank, you'll never make it'' (74–75). Greenbaum leaves her office without saying a word. ''So this is the final sifting out process. It appears, as I sadly close the door, that I am one of the rough grains, one that has to be discarded'' (75).

When she gets home, however, she is bolstered by her family, and the grain of sand metaphor gives way to another, more positive image:

> Despite Mrs. Maloff's opinion, Eddie and I decide that we must go on. Somehow we believe that I can slip through the cracks in the system. Somehow the medical school applications that we have worked on together will impress someone enough to request a personal interview. My husband and my mother reassure me that after that, I'm in. ''Once they meet you in person, you'll be accepted immediately,'' they tell me as I shake my head, wanting so much to believe they are right. (75–76)

So she perseveres. ''Each application costs twenty-five dollars, and some days the canceled check arrives simultaneously with the rejection letter'' (76). But finally, she lands an interview, with a ''prestigious Ivy League school,'' no less. She prepares for it diligently. ''On the day of the interview I am well rehearsed. I have spent many

hours in front of the mirror watching myself talk, monitoring the expressions on my face until I'm sure I'm ready'' (77). But it becomes clear soon enough that she's an outsider:

> The address is an elegant town house in Manhattan. I check myself out one last time before I press down on the polished-brass door knocker. An elderly man in a dark suit opens the door. ''Mrs. Greenbaum,'' I say. He ushers me past the rich mahogany furniture, the Oriental carpets and the fireplaces that glow with burning logs. Suddenly my suit looks cheap, flimsy. It is obvious I do not belong here. I have never seen a room like the one in which I am now sitting. Leather-bound books are arranged impeccably in a bookcase; a gilt-framed oil painting hangs directly in front of me. There are stacks of medical journals, and strains of Mozart are piped in from a speaker I cannot see. (77)

Her economic and social status aside, she's an outsider for another reason. For two hours, she's grilled about marriage and motherhood. ''What plans have you made for the care of your daughter?'' is the first question, and it's followed by ''how Eddie will react to my elevated status, how he will feel when I make more money than he does, even how I think medical school will affect my 'intimate moments' with my husband'' (78). That interview is followed by others. ''There were more gray-haired men in white coats,'' she says, echoing Scalia, ''who wanted to know what plans I had made for the care of my child and how my husband would feel about having a

doctor for a wife'' (79). The process of going to one interview after another becomes ''grueling and tedious'' (79), and she fears the worst. ''This is a terrible thing. I'm twenty-four years old, I know what I want. I've worked hard and I'm not going to get it'' (80). But finally she hits pay dirt. ''For the first time I am not facing a man with gray hair and a white coat. My interviewer is a woman, and she is smiling at me. I relax. But then I remember Mrs. Maloff, and I feel the tension begin to build''—unnecessarily, as it turns out. ''For an hour, Dr. Elizabeth Wolf and I talk about science, medicine and medical school. Now I am actually saying all the words I have rehearsed in the mirror. There are no questions about my husband, my child or my personal life. I feel that for the first time I am really being interviewed as a candidate for medical school'' (81).

But even after she's admitted, her personal life causes her classmates to perceive her as an outsider. First there's Fern, the only other woman in the five-member anatomy group to which Greenbaum is assigned. ''It was clear she was young and straight out of college'' (91), and she doesn't exactly look up to her older classmate. ''You're *married?* You have a *baby?*'' Fern asks Greenbaum. ''How do you expect to get through medical school?'' Greenbaum is weary of having her personal life scrutinized. ''I dreaded explaining everything again. After those endless interviews, I thought all the questions would be over. I answered Fern as briefly as possible.'' Fern is unmoved. ''A husband *and* a baby. I don't know how on earth you'll make it'' (94). Reflecting on the conversation, Greenbaum says, ''I knew I had not made a friend'' (95), but by the time grades are posted, Fern has a boyfriend and

a new perspective. "I think we're going to have a lot in common, Dorothy" (110), she says, and when they return to school the following year, Fern is married.

Then there's Krissy: "we met in my morning neuroanatomy class," Greenbaum explains. "Krissy and I seemed to have a great deal in common. She was in her thirties, had two children and had also been a teacher. It was almost too good to be true. I needed a friend, and Krissy seemed perfect. She introduced me to a group of older, more sophisticated students. Many were married, and some had children" (138). They also had money, as she and Eddie discover when they're invited over for "a night of studying and socializing":

> I knew it wouldn't work the minute we arrived. Krissy and Ben lived in a fashionable apartment on Manhattan's Upper East Side. The decor was sparse but chic, everything carefully arranged. The effect was cool and sophisticated. The children were occupied with a full-time housekeeper. Ben was a successful lawyer. Krissy and I didn't have as much in common as I had thought. (139)

Her impression is confirmed the following week at a potluck dinner. The chocolate cheesecake that she and Eddie had baked the previous night stands in contrast with the food brought by the other guests. "Everything looked very green. There was guacamole, spinach salad, peas and rice, and several unidentified objects covered with sprouts and soy flakes," she says:

> The cheesecake was barely touched. "Too rich," I heard someone say. As I sneaked a second helping, I continued to pretend I was having a

> wonderful time. Krissy and Ben were chatting about their recent vacation in South America, and other couples were talking about their travel plans for the summer. I mixed, I mingled. I learned about primitive art and the opera season at the Met. Eddie sat in a chair and stared at the guacamole. We made our excuses and left early. (141)

''After the disastrous dinner party, I rarely saw Krissy,'' Greenbaum says. ''Neuroanatomy class was over'' (142), she explains, and their paths don't cross again until Eddie is laid off from his job. '''That's too bad, Dorothy,' Krissy said. 'What are you going to do?''' It's lunchtime, and as Krissy finishes her dessert, Greenbaum drinks a cup of coffee, too upset to eat. '''I guess we'll just have to cut down for a while.' I smiled. 'No more champagne in the afternoon,''' Greenbaum replies, noting, ''Krissy didn't pick up on the sarcasm'' (177). They bump into each other in the cafeteria again, but not before Greenbaum returns home one day to find an eviction notice posted on the door. ''I thought about money almost all the time'' (184), she says, and so she hesitates when Krissy suggests dinner out. ''Oh, I'm not thinking about anything extravagant or fancy. Ben and I know a little place in Chinatown. The food's great—and cheap! I promise you it will cost almost nothing'' (190), Krissy tells Greenbaum. It doesn't quite turn out that way. ''I hope you don't mind,'' Ben says, ''but I took the liberty of ordering appetizers. Two Peking Ducks''—at $25 apiece. ''Krissy was talking nonstop. She was recommending dishes, ordering a second round of drinks'' (192). In the meantime, ''Ben was bragging about his hourly fees. The other couple was laughing and telling stories about their previous

summer in the Hamptons. My rage was building'' (193), Greenbaum says, noting, ''Eddie's face was ashen. Beads of sweat dotted his forehead. His mouth was set in a thin, angry line'' (192). It's the last straw. From then on, ''Krissy and her friends ate at one end of the cafeteria and I sat alone with my yogurt and coffee at the other'' (194), an outsider.

And finally, there's Denise. ''It is my first day as an intern,'' Greenbaum says. ''There is only one other woman standing in the hallway,'' she notes, ''and I am immediately drawn to her. She is tall with short, dark hair. Although she is younger than I am, we do look alike. Her name is Denise, and she nods to me as I take my place beside her'' (227–28). But the work load doesn't allow much time for socializing. ''Since our first day of internship, Denise and I had seen each other only for a few minutes at a time'' (250). One day, however, the two of them have lunch with the resident, Jonathan. The conversation turns to his two-year-old son Daniel, and then Greenbaum chimes in. She now has two children, Evie and Matt. ''Jonathan and I continued talking about our children. It was obvious that Denise was growing increasingly uncomfortable,'' Greenbaum notes. ''Denise was single and never talked about her private life. This was the first indication I had had that she had any feeling about mine, and the feelings weren't supportive.'' It's the same old objection that Greenbaum has come to expect. ''Medicine and motherhood don't mix. Especially not when you're just an intern'' (260), Denise says. But for once, Greenbaum isn't buying it. ''I thought for a few seconds. I remembered all the admissions counselors when I had applied to medical school. But this time the line that marriage,

motherhood and medicine didn't mix couldn't intimidate me. I had come this far, and I knew, even with all my 'distractions,' that I was just as good a doctor as Denise'' (261). And then Jonathan tells Greenbaum that he's gotten some flak about his personal life, too. ''There are lots of doctors, lots of people, who think like Denise. We'll never change their minds, and they'll never change ours. We're just different,'' he tells Greenbaum, making it clear that at least she's not the only outsider. '''Well, Doctor,' he said, 'enough of this chitchat. I believe we have work to do''' (262). But like Fern, eventually Denise questions whether she really wants to devote her entire life to medicine, the precipitating event being the death of Jonathan, who succumbs to lymphoma. ''This doctor thing, it's so much sacrifice. What's the reward? I've given up everything in my life to do this. Now I'm not so sure. I'm going to take a six-month leave of absence. I've been thinking about doing it for a while'' (310), Denise tells Greenbaum. It seems that for Denise, it's all or nothing. On the other hand, Greenbaum manages to integrate the various commitments she's made. ''Roles of wife and mother are interspersed with the role of medical student'' (Meck 95), according to one book reviewer. It's quite a feat, but then again, it's clear that Greenbaum wouldn't have it any other way.

The Obstetrician-Gynecologist: Patterson

The emotional component of medicine is also central to *Woman/Doctor: The Education of Jane Patterson, M.D.*, but for a different reason. Far from celebrating it, Patterson tries her best to do away with it, for as a little girl in the 1950s she had absorbed the zeitgeist of the time. ''As everyone in the medical profession knows,

women are terribly emotional and not very good at controlling their emotions. All through medical school I heard stories about women doctors who 'just weren't tough enough,' who 'just couldn't take it,' who 'broke down,' who 'fell apart.'" If she is to become a member of the fraternity, Patterson concludes, "I had to prove that I was different" (14). But she had already done that merely by being admitted to medical school. She was one of three women in a class of 107 at the University of Pittsburgh, the only woman intern at the University of California Hospital in Los Angeles, and the only woman resident at Kaiser Hospital in Los Angeles (72, 53, 74; *Who's Who of American Women*, 11th ed.), completing her training several years before Greenbaum had taken even one premed course. Even so, Patterson says, "I am not by temperament a pioneer" (74). She probably wouldn't even have considered medicine had it not been for her older brother:

> One day, I must have been ten or eleven, Fred sat me down and asked me what I wanted to be when I grew up. Growing up was light-years away as far as I was concerned, and I wasn't even sure I was planning on doing it.
>
> "Uh, I dunno," I answered with preadolescent élan. But I'd been around long enough to know which way the wind was blowing. I knew the options for females in the fifties.
>
> "A nurse or a teacher?" I guessed.

> My brother, God bless him, had a counteroffer. "Well, why not a doctor or a professor? You know, Janey, just because you're a girl doesn't mean anything. Girls can be anything they want to be." (75)

Fred has just started medical school himself, and Patterson decides then and there to follow in his footsteps. By the age of thirty, Patterson has completed four years of college, four years of medical school, one year of internship, and three years of residency. Moreover, she is board certified in her specialty of obstetrics and gynecology. "It would be years before I would know what it had cost me" (4), she says about her medical education.

Acutely aware that she is a woman in what she calls "a man's world" (76, 77), Patterson tries hard to look as though she belongs:

> I had assiduously cultivated a no-nonsense, authoritative air, reinforced by a hairdo in which every lock was pulled back from my face, straight and severe, and coiled into a precise bun dead center atop my head. This style was intended to make me appear older and more imposing, more professional. It was a look I thought befitting a woman doctor. (119)

In keeping with her appearance—whose only nod to femininity is a pair of eyeglasses decorated with rhinestones—she vows to be "as tough, as unemotional, as professional, as any of my male colleagues. And on the outside I was. No one ever saw me cry. But on the inside it was another story. They were, of course, entirely right about women doctors. I knew, because I knew how it was inside me," Patterson

confesses, introducing a motif that appears throughout the book: the Lady of the Lake.

> Inside me there was a lone woman in long robes, standing at the edge of a darkened lake, wringing her hands in sorrow and weeping in despair. The Lady never did anything. She just stood there crying. I had no use for her and would like to have been rid of her. I never knew but that I'd forget for a moment to keep her quiet and she would cry loud enough to attract attention to herself and then someone might look at me and see her there. Because of her, I lived in constant fear of being found out. (14)

She comes close to being outed one night after delivering two stillborn babies and a third that is deformed:

> It had no legs or feet. The body below the diaphragm muscle had not formed properly; instead, there was a thin, saclike structure where the baby's torso should have been. I could see the barely functioning internal organs through the transparent membranes of the sac. Horror-struck, I gingerly lowered the body to my lap. (16)

That night, she gives the Lady of the Lake full rein, paying a heavy price for it the next morning when she awakens in the on-call room. "The release I'd felt the night before was gone, and all I had left was the memory of having fallen apart, of having broken down, of having acted like all those women doctors whom I had been warned about" (20). But she has learned her lesson. "I would never, never do that again"

(27). Being a doctor demands it: ''this feeling part of me was just too dangerous to have around in the world where I was trying to stake out my territory'' (148).

Even though Patterson never completely suppresses the fact that she is a woman (consider those eyeglasses), she has difficulty integrating ''this feeling part of me'' (148)—the female part, as she perceives it—with the doctor part. As she says, ''the doctor part of myself had been bullying the more emotional, feeling part of myself into submission'' (150), hence the title of her book: *Woman/Doctor: The Education of Jane Patterson, M.D.* The slash between ''woman'' and ''doctor'' is there for a reason. During the entire length of her training—''fourteen long, scrabbling years'' (141)—Patterson struggles to recognize that being a doctor doesn't preclude her from being a woman. As a result, the two parts of herself do not grow together at the same rate. ''As so many women do with their families, I had made too much room for my career. I didn't know who I was apart from my career, mainly because I *wasn't* much of anybody apart from it'' (143). So the education of Jane Patterson doesn't begin and end with her medical training. And as it happens, the nurses inadvertently help to round her out.

By the time she becomes a resident, Patterson concedes that neither her hairdo nor her desperate attempts to keep the Lady of the Lake under wraps will win her what she wants most—a feeling of connectedness:

> The other residents were all guys, and once in a while they'd have a sort of boys' night out, and one or two of the staff doctors would join them. They invited me along a couple of times, but I wasn't one of the

> boys. They'd have a few beers and start talking about this patient who had a "really great set of knockers," or that one who "came on" to them while they were doing a pelvic exam. That brand of shop talk embarrassed me and, once they'd realized what they'd said in front of me, embarrassed them too. I took to politely declining their invitations, which made us all feel more comfortable. (71–72)

Matter-of-factly she says, "I was used to being on the outside of that inner circle" (144). Moving down the medical hierarchy, she takes to slumming with the nurses instead. But having been in the company of men too long, Patterson really isn't one of the girls, either:

> We'd have a few beers and talk about the things women always talk about—lovers, kids, our problems, our jobs, what we were mad about, what we were glad about, how we felt about things. Woman talk was almost an alien language to me. I had been talking medicalese for so long—that objective, bloodless, scientific man talk—that I was tongue-tied at first. I had no language for talking about interior landscapes.

But soon Patterson catches on: "what I was doing in those beer bars with a gaggle of women on Friday nights was learning how to talk to myself again"—and to relate to patients as people:

> When I discussed a case with my male colleagues, we talked about the fibroid tumor in Room 403 or the inoperable uterine cancer in Room 507. But on girls' night out, the fibroid tumor in Room 403 was Mrs.

> Johnson, and wasn't it sad that she was going to lose her uterus and wouldn't be able to have any kids and she was only twenty-seven? And the uterine cancer in Room 507 was Mrs. Jones, and wasn't it terrible that this dear old woman was dying and none of her no-good kids ever came in to visit her? (78)

As a result of her sessions with the nurses and later with a therapist, Patterson begins to listen to what the Lady of the Lake has been trying to tell her. "She insisted that emotion and caring were too much a part of me and too much a part of being a good doctor to be ignored" (159). And then one day, Patterson succeeds in melding the two parts of herself together, the catalyst being a young woman who has a miscarriage followed by hepatitis and then cancer. "The experience of crying with her was like the final untying of a great knot inside me" (160), Patterson says.

And she's only just begun. Grappling meaningfully with her discomfort—which she eases by means of a liberal dose of self-deprecating humor—Patterson undergoes a transformation that continues long after she has completed her medical education. Although the book is not written in straight chronological order (another reason that it commands so much interest), the first two-thirds are largely about her medical education, and the last one-third is largely about what happens afterward. Most notably, during her early years as a practicing physician she "comes out" as a lesbian—first to herself, then to her family, and finally to the public at large—and she becomes active in the women's health care movement.

Neither would have been possible during her schooldays. "It wasn't until I was board certified that I felt secure enough to deal with my homosexuality" (167), she says. "If people were uptight because their kids' teachers were gay, I didn't imagine they'd react very kindly to a gay gynecologist" (201). So she "comes out" only with great reluctance:

> I think here of Rosa Parks, one of my favorite heroines, a black cleaning lady in Montgomery, Alabama, who sat down in the only empty seat on the bus one evening and refused to get up and move to the Negro section at the back, thereby sparking the civil rights movement. I truly believe that the world could not continue to exist without these people, but I didn't want to be one of them, not even in some small way. (202)

And what she calls "the political education of Miss, or rather Ms., Jane Patterson" (189) proceeds by fits and starts. "I was one of the least likely, and certainly one of the least willing, candidates for any kind of involvement in the politics of the women's health care movement, or in any other movement for that matter" (189). She explains: "I was still very much a product of my medical training" (181) even though "now I was no longer a student having to concern myself with aping the behavior of my mentor" (182). But eventually, when atrocities like the Dalkon Shield are brought to her attention, "not by my professional medical journals, but by articles in the popular press" (194), she abandons her white coat—not out of weakness like Rothman, who puts forth only a half-hearted attempt to grow into it, but out of

strength. "I just didn't want to wear it anymore" (205) Patterson says, for she has come to a sobering realization by the book's end. "There was something terribly wrong with the way the medical profession dealt with women. I jumped on the bandwagon and began to speak at symposiums, conferences and other gatherings" (200). Had she written a follow-up book, it seems quite certain that she would reappear not as an outsider but as an activist. She has grown out of her white coat, and the education—or, more accurately, the remaking—of Jane Patterson, M.D., is complete.

The Psychiatrist: Rubin

Preceding all of the other outsiders chronologically, Rubin has produced not one but two books on his medical education: *Emergency Room Diary*, which is about his internship—or, more precisely, the last four months of it—and *Shrink! The Diary of a Psychiatrist*, which is about the first 1½ years of his residency. The titles notwithstanding, neither one is a diary. "I wrote them about a year before publication" (Rubin, telephone interview, 8 June 2000), Rubin says—the copyright dates are 1972 and 1974, respectively—spending "about three or four months" on each of them (Rubin, telephone interview, 24 June 2000). So he lays aside the claim made on the dust jacket of *Emergency Room Diary*. "As he learned . . . he wrote of what he learned." Not so, says Rubin, who wrote of what he learned about twenty years after the fact. "Perhaps I wanted to relive the actual events," he says, explaining, "I had virtually total recall memory for everything that went into those two books" (Rubin, telephone interview, 8 June 2000). Having received "virtually

nothing'' in the way of advice from the editors and publishers on the writing of those two books, they take on the appearance of day-to-day diaries, not with the intent of attracting readers, but rather, ''because my mind works very well that way,'' he says matter-of-factly. ''It was an easy format for me'' (Rubin, telephone interview, 24 June 2000). It seems that Rubin is oblivious to how his readers are apt to feel about ''diaries'' that postdate the events discussed therein by two decades. ''Do not deceive,'' Roy Peter Clark cautions journalists and other writers of nonfiction, ''intentionally or unintentionally'' (7).

By the time that Rubin graduated from college in his hometown of Brooklyn, New York, he had been an ensign for the U.S. Naval Reserve during World War II. Then he earned his M.D. from the University of Lausanne in Switzerland, afterwards returning to the United States to do his internship and residency. Finishing up his internship with a stint in the emergency room at Santa Monica Hospital in California (*Contemporary Authors* 110: 439), he's already decided on his specialty—or has he? ''Can't wait to begin psychiatry,'' he says. ''But have to admit this E.R. work gives me a good feeling, too'' (25). And as his residency draws nearer, he appears to become ever more fascinated by his own navel—er, ambivalence—even to the point of invoking his favorite psychoanalytic theorist, Karen Horney, in order to account for it:

> I've been reading about conflict, and it just occurred to me that maybe I've been in the middle of one: psychiatry vs. medicine! Another insight? I don't know. I want psychiatry. I know that. The hell of it is,

> I want medicine, too, and I think I've been trying to blind myself to that. Jesus, is this what life is always going to be about, giving up things I love? Is this what choice and decisions are all about? A process of elimination because life is so fucking finite? Horney says that conflict creates anxiety. I have been anxious as hell, but mostly I've been too busy and too tired to feel it. But I am eating like a horse, and that with me is sure as shit a sign of anxiety. (78)

Without ever seeming to get anywhere, he rambles on and on:

> Before long, things will be the reverse of what they are now. Now I work in the E.R. and read psychiatry when I can. Some day (am I still inadvertently putting it off with this "some day" stuff?) I will be doing psychiatry and reading medicine. It's hard for me to visualize being an amateur doctor. My whole life has been geared to this thing ever since I can remember. But I suspect (wishful thinking? could be, but may well be true, nonetheless) that once I begin to work with psychiatric patients, things will settle into place. (79)

One book reviewer takes note of Rubin's focus on himself. "It is not surprising that he continually analyzes himself in relation to his profession and his patients, since he eventually became a psychiatrist," says Barbara Lucas. So far, so good. But Lucas goes one step further: "And this self-evaluation makes his book worthwhile" (2722–23). Really? For instead of grappling with the conflict over his life's work, he just shelves it by issuing an ultimatum to himself. "O.K. Let's face it, Rubin, you are

a greedy guy. You eat too much and you also want to have the best of several worlds all at the same time. Neither will work, so come off both once and for all—here and now!'' (79).

Not surprisingly, then, he remains unsure about his specialty even at the end of his internship—at least in part because he has taken an indirect path to psychiatry, his original plan having been to treat the body rather than the mind:

> I guess I've been avoiding it, the home-stretch feeling but it's true I'm almost done. I'm coming to the end of it: the E.R. interning and, I suppose, medicine as I always dreamed of it. Just a bit to go, and then I'm a freshman all over again, this time in psychiatry. Of course I'll miss it, the whole medical thing I've had in my head since I was a little kid. Until college psych it seemed impossible that anything could ever turn me off that road. Maybe it's that I'm beginning to feel a real sense of competency—and I'll miss that. No sooner do I become a kind of senior at something than I find I'm a freshman at something else all over again. The half-assed bitching and woes of the perpetual schoolboy. (166)

He provides a similar outline of the evolution of his career during an interview held in 1982, twenty years after *Emergency Room Diary* was published: ''initially I didn't have psychiatry in mind. I didn't even know that it existed,'' he explains. ''My earliest ambitions about medicine were along the lines of general medicine. The idea of being a general practitioner was the thing that appealed to me most in my early

days.'' It wasn't until college, he says, that ''I became intrigued with things psychological. They had us visit a state institution, and I was terribly impressed with the problems and the people and what was being done and what possibly could be done. I think I was hooked at that point'' (*Contemporary Authors* 110: 440). Even so, his original conception dies hard. ''To this day, I still am very much interested in all things medical'' (Rubin, telephone interview, 8 June 2000), he says. So unlike Scalia, who ends up leaving medicine, and unlike Klein and Rothman, who aren't sure that they want to be physicians, Rubin had planned a career in medicine from childhood (*Current Biography* 350). ''Going to medical school was not a late decision of any kind. I knew that's what I always wanted,'' he says, ''since I was about four years old'' (Rubin, telephone interview, 24 June 2000). On the other hand, he differs from McCarthy and Greenbaum in that he is unable to make a wholehearted commitment to his specialty. By book's (and internship's) end, Rubin is still sitting on the fence, as his last entry illustrates. Now a psychiatric resident at the Veteran's Administration Hospital in Los Angeles (*Contemporary Authors* 110: 439), he is delighted to hear from his old boss, who offers him a part-time job in the emergency room. ''Of course I said yes'' (177), an answer that is likely to elicit a collective sigh of disappointment from his readers, who are denied the satisfaction of knowing whether or not ''things will settle into place'' (79) for Rubin as he had hoped.

At least in part, psychiatry is a source of conflict for Rubin because it contributes to his feeling like an outsider among his peers. It seems that just as the mentally ill find it difficult to command respect in the medical community, so do the

physicians who treat them. Consider what happens when he's spotted reading Horney's *New Ways in Psychoanalysis* during a lull in the emergency room. "Some attending internist, whose name I don't even know, came by and asked what I was reading. He sneered and made some snide horse's ass remark. I've noticed this fairly consistently. There is a deep and wide schism between the psych thing and all the other M.D.s. Who's afraid of whom, anyway?" (46). Having recognized that "the others want no part" of what they call "head stuff" (56), Rubin would like to change their minds if he could:

> I tried to get the guys here involved in a discussion about suicide. Impossible! They just didn't want to know and didn't want to talk. What is this? Denial? Fear? Resistance? Or just simple lack of interest—if such a thing exists. Would love to get into some psychiatric discussions, but it doesn't seem possible around here. Will have to wait until I get to my psychiatric residency. (58)

Having identified what he himself calls "a deep and wide schism," it would seem that he would find it worth plumbing, but instead, he floats a hypothesis that serves mainly to bolster himself. "I wonder," he muses, "to what extent general practitioners and internists function as amateur psychiatrists? Maybe this is what makes them so hostile and estranged from professional psychiatrists—the inner knowledge that they are functioning in an area where they can only be second best" (149).

There are two reasons in addition to psychiatry that Rubin feels like an outsider during his internship: he is foreign trained, and he is Jewish. At one point, he makes a connection between the two. Having learned that he's ineligible for the $1,000 bonus given to interns who graduated from American medical schools in order to attract house staff who are proficient in English, Rubin vents his anger and then darkly considers what the hospital's policy might really mean. ''Screw them all. I want no part of this place. Get done here, then back to New York for sure. Is it possible they're anti-Semitic here? Who goes to foreign schools? Mostly Jews like myself, who can't get into American ones!'' (30). Pointing out that ''my English is perfect'' (29), he becomes fixated on the injustice of it all: ''I'm full of rage again over that $1,000'' (35); ''The $1,000 is still sticking in my gut'' (59); ''Frankly, I'm still good and pissed off about the $1,000'' (136). And the financial slight is compounded by the fact that he's working side-by-side with an intern from Germany who had been a member of the Nazi party. Naturally, Kurt Waggoner isn't eligible for the bonus, either. Besides being foreign trained, ''his English is four-fifths German'' (25).

Yet it's by working through his feelings about Waggoner that Rubin finally triumphs in *Emergency Room Diary*. Whereas he never does seem able to accept that he's ineligible for the bonus—''Maybe the $1,000 is still burning me up'' (177), he thinks to himself on the last day of his internship—it doesn't take him long to recognize that his feelings about Waggoner are uncomfortably mixed. ''I'll be damned: what comes to me now, and I don't like it at all but there it is, is that I

actually am beginning to like that fucking Kraut'' (68). Yet he's not ready to socialize with him. ''I just can't rise above myself and, lousy as it seems, I still see him as a Nazi and I just can't eat at his table in his home and be part of all that implies'' (80). By the time that his internship is winding down, Rubin has softened, dropping the ethnic slur and replacing it with Waggoner's given name:

> Kurt invited me to go home with him for dinner this evening, and I just couldn't turn him down. It wasn't for a future date, so there was no time to think about it. Also, it was to be just for an hour or so, and besides there's only another couple of days to go. Listen to all of these rationalizations—what a lot of crap! I went because I've gotten to like the guy. Nazi and the whole business—and there it is! (176)

Decades later, Rubin was to publish *Anti-Semitism: A Disease of the Mind* (1990), which contains a chapter entitled ''What about Hitler's German People?'' In it, he analyzes them en masse:

> In Hitler's Germany and elsewhere as with Hitler, there were many people whose rational selves were too weak, too small, or even nonexistent. As with Hitler, these people had become their irrational selves and in many cases murderous extensions of their hatred-ridden, megalomaniac leader. In these people compassion and empathy were dead! (112)

Thus, he pursues a line of thought initiated by Waggoner, who takes some time after dinner to justify his involvement in the Nazi party: ''he swore to me that he joined

because of fear and just because he was a conformist and weak and would not be able to make a living otherwise. He said he had no idea what it was all about and never had a political feeling one way or the other in his life. He said he was never a Nazi in thoughts or action'' (176). And then Rubin makes another attempt at sorting out his own feelings, to separate Kurt the individual from the group that he once represented. ''It's easy as hell to be hateful and judgmental, and almost as easy to be forgiving. But it's a lot harder to feel it all at the same time, and that's how I feel—confused as hell. My grandfather was killed by anti-Semites in a pogrom in Russia. Maybe someday I'll understand it but I can't forget it—or forgive it—not yet, anyway'' (176).

It's too bad that Rubin doesn't dig inside himself for answers consistently, as he does in regard to ''the Nazi,'' another one of his designations for Waggoner. Instead, he seems to take the easy way out by latching onto a role model. Less than one-quarter of the way into his book, Rubin attends a lecture on suicide delivered by a psychiatrist by the name of Dr. Arthur Mankowitz. ''Sounds Jewish. Hope it's brilliant! I guess I'm slightly chauvinistic myself'' (56). It turns out that Rubin is in luck. Mankowitz is Jewish, and furthermore, having earned his M.D. from Edinburgh (92), he is foreign trained to boot. ''All of this made me feel considerably better,'' Rubin says with palpable relief, ''and it felt good just to talk to this guy, who is very nice and who is a psychiatrist, which is what I want to be'' (89), he concludes, suddenly unequivocal about his specialty. Warming up to his newfound mentor, Rubin takes to calling him ''Mank'' and imbues him with the ability to move mountains. For

when Mankowitz succeeds in bringing a patient out of her catatonic state by means of electroconvulsive therapy—popularly known as ''shock treatment''—Rubin suddenly decides that being an outsider isn't so bad after all. ''Mank came off like the eighth wonder of the world! (100), Rubin exclaims. ''I guess psychiatry, Jews, Mank and I and foreign schools, we're all vindicated when he pushed the button on that little gadget this a.m. Truth is, at one point I felt like saying, 'Now, don't you all feel sorry—shove the $1,000 up your asses a dollar at a time''' (102). Given that Rubin spends much of the book ruminating about the factors that make him an outsider, his reliance on a *deus ex machina* like Mankowitz to alleviate them literally at the push of a button seems too pat.

The same patterns emerge in *Shrink! The Diary of a Psychiatrist*, but Rubin handles them in a far more compelling way. And he agrees. ''*Shrink!*, I feel, is a more sophisticated book'' than *Emergency Room Diary*, ''and certainly from my point of view it's more interesting, but that stands to reason inasmuch as I eventually became a psychiatrist'' (Rubin, telephone interview, 8 June 2000). As a psychiatric resident at the Veteran's Administration Hospital in Los Angeles (*Contemporary Authors* 110: 439), Rubin remains unsure about his choice. ''I lurked in the background,'' he says, ''wondering whether psychiatry is for me at all'' (19). He is still an outsider, as the epigraph to his second book indicates. It seems that Samuel Taylor Coleridge's *Rime of the Ancient Mariner* provides a pretty good rendering of how Rubin feels. ''Alone, alone, all, all alone;/Alone on a wide, wide sea.'' But his reasons for being an outsider have changed. As an intern, he was the only one of his

peers interested in the mind; as a resident, perversely enough, he is the only one of his peers interested in the body. "I miss medicine, even though I still work the E.R. over at the old place on weekends" (21), he says, hastening to add, "I'm dedicated to the proposition of being a psychiatrist" (46). In large part, he says, he's moonlighting because he needs the money—bringing to mind Greenbaum, who also struggles to make ends meet. "I'm the only guy in this residency program who works every weekend off in a general hospital emergency room" (25), thus giving him another reason for feeling like an outsider. "I'm sick of the seven-day-a-week stink" (51), he complains, posing a couple of questions to himself. "I, Ted Rubin, can't even afford to be home on a single weekend with Ellie and the kids? Could this make me feel like a lunatic and make me feel more closely identified with the helpless people in the hydro room?" (57), he asks, aligning himself with the patients rather than with his peers. Just as Rubin begrudged those who qualified for the $1,000 bonus, he once again finds that money (or the lack of it) separates him from the others. On the other hand, his being Jewish is no longer an issue now that he's begun his training in psychiatry. "This is one specialty we seem to dominate almost completely" (65), he observes.

But as he continues his training, he finds that there's another disconnect between himself and the other residents: whereas he is a devotee of Horney, whose theory lays the groundwork for the many self-help books that he has published (*Current Biography* 349, 351), everyone else is in march step with her mentor. "Freud is God, and his theory is sacred. I'd better damn-well keep my mouth shut.

They're beginning to see me as irreverent and rebellious. Who needs it? I have to live with these guys and, for the most part, they're okay'' (21). Even so, he can't bring himself to become one of them:

> I'm sure there are plenty of sensuous, good feelings evoked long before puberty. But real sexual desire for Mamma—wanting to fuck Mamma at age three or four, and dreams relating back to this—I can't buy, at least not yet. I've been trying to relate my dreams back to that, and I've been trying to relate my feelings and memories back to that, but I just can't. I must be a dream or Oedipal moron of some kind, because the other guys buy all this without question, almost as if they always have active Mamma-fucking memories readily available to them. (27)

As a result of ''closing myself off and bitching'' (30), Rubin says, ''I'm beginning to stick out like a sore thumb. This I don't like—'' (62). The alternative is even worse, however. ''Maybe I ought to stop reading Horney,'' he muses, ''because I can't ever hope to change anyone's mind around here. But I just couldn't do that—it would be like running out on myself'' (87). Just when it seems that Rubin is stuck in a morass with no way of getting out, voilà—it's Mank to the rescue. Almost too fortuitously, he shows up once again to give his lecture on suicide, staying afterwards to talk with Rubin over coffee. It's a conversation that Rubin later recalls as a turning point. ''He said that my feelings about Freud and Horney are crucial because I would always feel like an outcast here'' (93), Rubin says, soon proving Mankowitz right. ''They didn't even listen,'' he sputters after he and Ellie have dinner with the other residents and

their wives. He has once again tried to introduce them to Horney, but without success. ''Here are bright guys, supposedly friends, and the thing that gets to me most is that none of them ever read Horney or, up to this point, anything other than Freud, and yet they have already developed a well-embroidered patronizing, superior attitude toward me'' (109). He continues:

> I remember what Mank told me about being an outsider for the rest of my life. Here are my friends, the people who represent at least a good part of the reason for my staying on out here. What is the point? We are not even anywhere near receiving the same wavelength, let alone operating on it. Tonight I felt that Ellie and I were alone in a vacuum, completely isolated from the others. If this is the way it is going to be, who needs it? The hell with it! Fuck them! I'll be damned it I'm going to occupy the position of some kind of weird, establishment-bucking pariah the rest of my life. (110)

The result is that Rubin decides to make a move with the hope that he'll fit in better elsewhere—specifically, New York, where most of Horney's followers have congregated—at the suggestion of who other than Mankowitz. ''He said I ought to go to New York after this, my first year of residency, is over, and do my last two years over there'' (93). The result is that Rubin becomes even less able to connect with the other residents. ''Today, walking to lunch, I met the guys. Of course they know I'm leaving, but we didn't mention this at all. Being with them felt awkward and even a little embarrassing. I felt a sense of non-belonging.'' And then he aligns himself once

again with the patients rather than with his peers. ''Anyway, I made some half-assed excuse and went over and ate with the patients in the chronic building. It's the same food, but there was no conversation at all'' (124).

Interestingly, Rubin has ignored his own observation. ''So many people seem to come here to solve their problems and most problems just don't solve by changes in geography'' (162), he says about people who move to California to start new lives for themselves. Yet he himself hopes to leave his own problems behind in California. No wonder that by the time that Rubin starts the second year of his residency, the pattern is pretty much set. Now at Rockland State Hospital in Orangeburg, New York—''the place where they did *The Snake Pit*, the movie''[3] (Rubin, telephone interview, 8 June 2000)—it doesn't take him long to realize that he's not ever going to warm up to the place or the people there, an epiphany that has an ironic source given his reservations about Freud—a dream:

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[3]The movie is based on a semiautobiographical novel by the same name—*The Snake Pit*, by Mary Jane Ward (1946)—and both feature a patient named Virginia Cunningham (who is played by Olivia de Havilland in the 1948 movie) and a psychiatrist named Dr. Kik. According to Rubin, ''the main character, Dr. Kik, was my boss at Rockland''—where Rubin was a resident in 1954 (*Who's Who in America*, 54th ed.)—''and he committed suicide eventually.'' Rubin adds that ''Dr. Kik,'' as he is called in the movie, appears in *Shrink! The Diary of a Psychiatrist* under yet another pseudonym. Which one? ''Gee, I don't remember. I don't remember. But he was there. And by the way, he was a very nice man. I was shocked when I heard that he committed suicide. I found out much after the fact. But it was a shocking thing. I'll tell you, the people who work in these hospitals as a career had a hard job, and it's a kind of thankless job. And the worst part is that they don't get too much of a chance to grow'' (Rubin, telephone interview, 8 June 2000). Asked whether Dr. Kik goes by the name of Dr. Henry Franke in *Shrink! The Diary of a Psychiatrist*, Rubin says, ''I think so'' (Rubin, telephone interview, 24 June 2000).

> When I awoke this morning, at first it was with much relief, as it is with most nightmares, but then I felt a desperate surge of loneliness. It was so bad I felt like crying. Just then, Ellie, as though she read my feelings, hugged me close to her and I felt better. But what came to me was the separateness I've maintained from the people here. According to Horney's description, I'm hardly a detached person, but I know that since we've been here, I've been keeping myself separate. It's been a strain, this keeping away from a genuine relating basis with the people here, but in my gut of guts—and I think this is what my dream is about—I just don't want to become one of them, and I suppose the price paid is a deep sense of isolation and loneliness. (160)

He's an outsider once again, having merely traded one set of problems for another. For despite the financial incentives that helped to lure him there—housing is free and food is subsidized—he can't get over the fact that he's sunk to the bottom of the barrel, a state hospital where training is given short shrift: "me, Ted Rubin, that I should not be in a top-notch residency, because of some lousy dollars, yet!" (143). Moreover, despite the fact that Orangeburg is less than twenty miles north of the city of New York, it seems much farther to Rubin, a city boy who grew up in Brooklyn. He explains. "New York gives this feeling of packed density that is suddenly gone once you leave the city limits" (130). En route to Orangeburg for his orientation session, Rubin takes note of the panorama that unfolds through the windows of the bus. "The city at least makes for a warmth generated by the excitement of the cars,

stores, people and buildings. This was just open country, with leafless trees and only a scattering of houses here and there'' (130), he says dolefully. ''We got there after about an hour and a half, but I guess it was all my thinking and depression that made it seem so much longer. That, and the contrast, too, because I could have been a thousand miles from New York'' (131).

His apprehension is well founded. For the place that Rubin describes is so bad that it reminds him of a medieval manor, complete with a baron and his vassals, ''all noble knights, in this case designated by the title of Doctor or M.D.'' Then, of course, there are the serfs. ''The baron and his vassals are most generous to this ragged, quite bestial group'' (140), consisting of psychiatric patients who fill some eleven thousand beds (131). And Rubin is responsible for over four hundred of them (147). ''Seeing all the patients—even glancing at them, let alone actually speaking to them—is impossible,'' he bemoans. ''But who am I to talk? I'm now as much a participant in this charade as anyone else'' (148). Having observed the other vassals, Rubin finds them wanting. ''Tonight I was telling Ellie that the thing that gets to me about all this, more than anything else, isn't the neglect or the waste, or even the hypocrisy. It's the complacency. From what I see, everyone accepts this kind of thing as perfectly fair, normal and constructive activity.'' It's anything but. ''Listen. There was one ward, about three hundred people, men, who were completely naked all the time,'' Rubin says. ''It was Dante's Inferno'' (Rubin, telephone interview, 24 June 2000). And there's a parallel between what he calls ''the fief''—as Rubin recalls, ''it

felt like a concentration camp'' (Rubin, telephone interview, 24 June 2000)—and Nazi Germany:

> I suppose people can just get sucked in to a way of doing things, and eventually they get to believe that it's a normal way of life. Maybe this is the price we humans pay for having such great adaptability, the possibility of so many permutations and combinations as far as ways of living are concerned. This seemed to be true of the Germans. They all just slowly adapted to a way of life, however horrendous, until they perceived it as common and normal. (148)

Armed with that insight, Rubin considers his alternatives. ''I wonder if I can accept my new-found nobility. Is it possible to reject it and still do it? Is it possible to decide that I can't do it, and to make still another change, to leave this place'' (153), he muses, because—well, frankly, it's beneath him. ''Ellie and I both remembered the story about having eyes in the valley of the blind, and this made us feel superior. But it was a comfort, too'' (171).

Unwilling to become one of the vassals, Rubin aligns himself with the serfs instead, thus keeping true to form. ''From what I see, the patient has to show at least some improvement in the major presenting symptom that brought him here (in my case, money shortage) in order to get out'' (173). One patient in particular captures Rubin's imagination: Peter Morrison, who just happens to be Jewish. ''I want to get this guy out of here,'' Rubin proclaims. ''Identification? Equivalent of getting out myself? Could be. Must be'' (171), Rubin concludes, for he has an ally in Morrison,

a paranoid schizophrenic. ''Here is a sensitive, bright guy who actually sees through this place and sees the crazy social structure here, but who is unfortunately crazy himself'' (197). Even so, they're on the same wavelength. ''We spoke about the institution, and it was gratifying to hear him tell it like it is,'' Rubin says. It's ''medieval,'' according to Morrison, who makes that assessment with no coaching from Rubin. ''I was tempted to ask if he thought of it as a fief but managed to hold back,'' he says (163). As it turns out, Rubin finds that being an outsider serves him well in psychiatry. ''My particular thing that I was very good at was—at least, I think I was very good at—was getting into the mind of somebody who was a real outsider,'' like Morrison and other ''really quite disturbed people. Even though I was not as sick as they were,'' he says, ''I could still feel what it must have felt like, what it does feel like to them, you see, because they are really outsiders.'' He continues. ''There are people who just have not ever felt that way, and they don't quite get it'' (Rubin, telephone interview, 24 June 2000).

The fief is too much for Rubin—''eventually, the feeling is that you are one of the inmates,'' he says about the vassals, who are ''the chosen ones,'' but inmates nevertheless (Rubin, telephone interview, 8 June 2000)—and what he calls ''my bitching about this place'' (166) does not go unnoticed. Rather to his delight, he earns a reputation for being ''some kind of rebel—a new experience for me'' (185), he says, reminiscent of Patterson, who by the end of her book seems on the verge of becoming an activist. Like her, Rubin eventually takes charge, starting a journal club for himself and some of the other vassals. And during the staff meeting that ensues,

the baron refers to it obliquely. "The great man got up and spoke," Rubin says with more than a little sarcasm, having already likened him to Hitler. "He said that it has come to his attention that people are unhappy with the residency program, that people have taken it upon themselves to train themselves (our journal club? Could be.)." But it's not the kind of place where initiative on the part of mere vassals is tolerated, much less rewarded. Moreover, they are to understand that they serve at the pleasure of the baron, who adds that "he doesn't need doctors at all and certainly doesn't need agitators" when, after all, "he could run this place with the attendants, nurses and outside technicians" (183). As Rubin explains, "I did turn into an activist. But I must say, it went nowhere at that time" (Rubin, telephone interview, 8 June 2000).

Finding himself in a madhouse, Rubin has nowhere to turn given that Mank is back in California. So enter another *deus ex machina*, Louis Klein, who extricates Rubin from the fief—but not before temporarily stirring up his old doubts. Chief of the medical division at the psychiatric hospital, Klein twice offers Rubin a job treating the bodies rather than the minds of the patients who are institutionalized there. "Who needs this whole God-damned lunatic thing, anyway?" Rubin asks himself. Frankly, he does. "But of course, the answer is no. I'm hooked and I know it and, like other addicts, I'm often miserable about it, but I can't let go" (186)—not exactly a ringing endorsement of psychiatry. Nevertheless, it's clear that he's finally made his choice. And then Klein, like Mankowitz before him, sends Rubin on his way: "he feels that a third year of training in either Kings County or Bellevue would be very valuable, because a chief resident in these hospitals gets much decision-making and teaching

experience'' (193), Kings County and Bellevue being city hospitals for the boroughs of Brooklyn and Manhattan, respectively, rather than state hospitals (Rubin, telephone interview, 24 June 2000). It's advice that doesn't come a moment too soon. For while Rubin is mulling it over, he learns that two of his buddies are flying the coop. ''I felt dizzy and panicky, and as if the walls were closing in on me,'' he says, admitting, ''I ran to find Louis Klein.'' Together they arrive at an interpretation of Rubin's reaction to the news. ''These guys are leaving; I'm staying! It's as simple as that'' (206). But at book's end, Rubin is headed for Kings County, ''brighter, lighter, more cheerful'' (216) than the fief, and ''*it pays seventy-two hundred dollars a year*'' (214)—big money in the mid-1950s. If he crows a bit, well, why not? It's been a hard-scrabble fight whose outcome is foreshadowed when Rubin successfully presents his alter ego to the discharge board. ''Peter is out!'' (221), he exclaims. And shortly thereafter, Rubin is out, too.[4]

But that's where his story abruptly ends. Why? ''I don't know, I kind of thought I had it by then, you know?'' (Rubin, telephone interview, 8 June 2000). But when directly asked about Kings County and Horney's American Institute for Psychoanalysis, where he did his postgraduate training (*Biographical Directory of Fellows and Members of the American Psychiatric Association*, 1968), Rubin acknowledges that things started looking up for him at that point. About Kings County

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[4]Actually, though, he didn't go directly to Kings County. His six months at Rockland State Hospital were followed by six months at Brooklyn State Hospital. The former is covered in *Shrink! The Diary of a Psychiatrist*; the latter is not. The two hospitals ''were quite different,'' Rubin says, Brooklyn State being ''more compassionate'' than Rockland State (Rubin, telephone interview, 8 June 2000).

he says, "I began my training in analysis, you see, when I was there," answering "not really, not really" when asked whether he was still an outsider. And when asked the same question about the analytic institute, he's absolutely certain. "No. In the analytic institute, I found myself, my way, I might say. I belonged. It was my thing." He adds, "I was very good at it. Very good at it. And I thought, 'Ah! This is it. This is it.' You know, when it clicks, it feels awfully good. And it did" (Rubin, telephone interview, 8 June 2000). Finally he's in his element. It's been a long time in coming, as suggested by a book that he published while he was president of the American Institute for Psychoanalysis.[5] "I remember as a child passing people's homes and looking at parties going on through lighted windows and listening to music and feeling like an outsider even then," he says, explaining. "I went to eight elementary schools and two high schools. The result was that in a small way I belonged everywhere, but in a large way I felt that I belonged nowhere" (*Through My Own Eyes: An Awakened Unconscious* 136–37). According to Rubin, the turbulence that he experienced while growing up "makes for a writer." He explains. "If things are too good, you don't feel like writing about them" (Rubin, telephone interview, 8 June 2000). Perhaps that

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[5]As president, Rubin took the opportunity to make a number of reforms. "For example, he says, "our institute took only M.D.s. And I opened it up to psychologists and social workers who I felt could be as good analysts as M.D.s," adding, "that's where I became an activist." So it seems quite certain that like Patterson, he would reappear not as an outsider but as an activist had he written a follow-up book about his training. It's something he's considered. "Periodically I've thought about doing a book about Kings County and the institute—particularly about the institute, which would be interesting because an awful lot happened there. A lot happened there, politically and so forth, which I think might be interesting to people." He adds, "it would not be hard for me to do. My memories of that are very clear" (Rubin, telephone interview, 8 June 2000).

is why his story abruptly ends as follows. ''I've been accepted! I will be a Kings County Junior Psychiatrist,'' with even better things in the offing. ''If I can calm down enough I will write for an application to the psychoanalytic institute tonight'' (222). The question nearly asks itself. Does he think it's possible that he stopped the book at that point because he no longer felt like an outsider? ''That's very interesting,'' he says. ''I never thought of it. But yes, it's possible. It's possible'' (Rubin, telephone interview, 8 June 2000).

CHAPTER 4

THE ACTIVISTS

Changing medical education is the goal of the activists, all of whom take some kind of significant detour on the way to becoming physicians. Fitzhugh Mullan spends the summer following his first year of medical school as a civil rights worker in Mississippi (*White Coat, Clenched Fist: The Political Education of an American Physician*, 1976). Steve Horowitz goes south of the border for the first two years of medical school, attending the Autonomous University of Guadalajara (*Calling Dr. Horowitz*, 1977, with Neil Offen as coauthor). Charles LeBaron enters Harvard Medical School at the age of thirty-four, having previously, in his own words, "worked in semimenial capacities in various hospitals and institutions" (14) during the decade following his graduation from Princeton University (*Gentle Vengeance: An Account of the First Year at Harvard Medical School*, 1981). Michelle Harrison begins her residency in obstetrics and gynecology at the age of thirty-five following a number of other initiatives: two years of training in psychiatry, a stint as a physician serving a rural black population in the South, a hodgepodge of part-time jobs as an emergency room physician, and, along the way, a brief marriage that results in the birth of her daughter (*A Woman in Residence*, 1982). And finally, Stephen B. Seager begins his residency in psychiatry at the age of thirty-eight, seeking refuge from the metropolitan trauma center where he spent nearly a decade as an emergency room physician [*Psychward: A Year Behind Locked Doors*, 1991, excerpted in the magazine *In Health* (Seager, "Tales from the Bin")]. Drawing on those experiences, each of

the activists delineates a group of constituents that serves as the focal point for strategies designed to reform medical education.

The Constituents

Having come of age in the 1960s, Mullan takes up the cause of civil rights for people of color—specifically, African Americans and then later, Puerto Ricans—a development that his childhood years would not have predicted. "Raised in New York City, educated in private schools, I grew up in relative racial seclusion. My principal black acquaintances were an occasional, carefully chosen, scholarship schoolmate, the cleaning lady, the doorman" (5). Against that backdrop, Mullan finds himself holding a shotgun in Holmes County, Mississippi, where he stands nightwatch over a black church that had been firebombed because it served as the meeting place for locals involved in "the Movement." It was medical school that had led him there, as Mullan explains:

> The first year had passed as a long, drab rehearsal—a rehearsal for a time when we would deal with real people and real problems. We practiced for the day when we would be physicians. We learned to memorize; we stockpiled information; we pulled apart a human corpse and we sacrificed a dozen dogs, mechanically reproducing physiological principles spelled out in our texts. But we did nothing real. Where labs had been tedious and stultifying, the South proved combustible. Where school demanded competitiveness and bred alienation, the Civil Rights Movement offered the kinship and warmth of common struggle. I

> suffered through the first year of medicine because it was an investment for the future. I guarded the church because I believed in it. (4)

As a medical student, then, Mullan is ambivalent about the career he's chosen. "Medicine could be counted on. It was a defined, needed, renumerative career" (8), he says. Even so, "the image of the American physician always disturbed me. I could not see myself as a member of the American Medical Association.[1] I feared the white-coat socialization process that awaited me. Was I to become a booster of the country club, plump, Goldwaterite, the darling of stock brokers and life insurance salesmen?" (7). Even though both his father and his grandfather were physicians, Mullan finds himself identifying less with them—"I have approached medicine in a consistently less accepting way than they did" (ix-x), he says—and more with the two black farmers who sit in the dark with him:

> Actually, my reason for becoming a civil rights worker, for guarding the church, were not so different from those of Cat or Mr. Sills. We were all desperate in our own ways. They sought redress from economic and racial oppression; I hoped to escape the intellectual and spiritual oppression which had become my life as a would-be doctor. I needed to find some reason, some cause, to help the study of medicine make sense. Without that I would not be able to go on. (11)

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[1]But ironically, he becomes one: "mem. AMA," according to the most recent biographical information about him (*Who's Who in America*, 54th ed.).

He continues. ''All three of us were locked in a struggle, more with our previous lives than with the arsonists from town. The church was our stand'' (11).

He certainly is earnest. In fact, he overdoes it, as a physician who reviewed his book observes: ''he lacks any ironic humor about his own seriousness and sense of mission'' (Zinberg 6). The result is that much of his book degenerates into a dry historical account filled with irrelevant details. Although it opens like a nonfiction novel, complete with dialogue between Cat and Mr. Sills, just a few pages later Mullan launches into the first of many digressions that add little to his story. It seems that in 1962, Harvard professor H. Stuart Hughes ran for the U.S. Senate, and Mullan ''worked hard'' for what he calls the ''peace candidate''—but to no avail. ''Hughes campaigned well but a week before the election the Cuban missile crisis broke and he was badly beaten by another political newcomer who took a harder line on weapons, Ted Kennedy'' (6). Somehow Mullan manages to tell us too much and too little at the same time. Isn't it at all relevant that the winner was the brother of the president of the United States—not to mention the brother of the U.S. attorney general? If Mullan thinks so, he doesn't mention it. Having been a history major in college (8), he is apparently unable to take the advice of his ''earliest critics,'' those who read the manuscript before it was published. He says that they ''all proved more interested'' in the story of ''a young white physician with firm middle-class roots'' who ends up as an activist than in a ''blow-by-blow history.'' He took their advice, he says. ''As I began to write, the work began to change. . . . So, gradually, the book became my own story'' (ix). Well, sort of. As the dust jacket promises,

"Mullan's story is more than a political manifesto or an impassioned plea for reform in the medical profession. . . . *White Coat, Clenched Fist* is a probing autobiography of a young man." In truth, it's some of both, but Mullan could have used a good editor,[2] as he eventually acknowledges. Although he is "quite clear," he says, about "the events I have described," and although he is "content" with his portrayal of "the radicalism of the past fifteen years and its impact on medicine," he recognizes the limitation that he brought to his book:

> I am least satisfied with my insight into myself and what has happened to me during this same period. It is easier to be psychoanalyst than autoanalyst, and far easier to be a historian than either of the others.[3] Yet it remains important to me, and perhaps to others who have been through similar experiences, to try to understand the impact of these events on the individual. Where, in sum, have my experiences as a medical radical taken me? (218)

For an answer, we have to go back to Mississippi.

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[2]Particularly slow going are portions of chapter 3, "Politics and Medicine" (especially pages 50–67); chapter 6, "The Butcher Shop" (especially pages 117–129); and chapter 7, "Seize the Hospital to Serve the People" (especially pages 139–143). As one book reviewer puts it, "reading his prose is often like wading through treacle" (Hoffman 72).

[3]Mullan makes a similar point in *Vital Signs: A Young Doctor's Struggle with Cancer* (1982). At the age of thirty-two, he successfully underwent treatment for a malignant tumor in his chest. "The role of autobiographer is a hard one. While it requires the precision and discipline of all writing, it enjoys neither the distance of the historian or the biographer nor the dramatic liberties of the novelist" (xv).

Despite being a graduate of Harvard University and a medical student at the University of Chicago, Mullan fancies himself one of the downtrodden of society—"I could see no idealism, no humanity, and no pleasure anywhere" (11), he says about his courses in anatomy, biochemistry, and physiology—but with a difference. Unlike Cat and Mr. Sills—"poorly schooled, ill fed and badly cared for in a generally wealthy country"—someday Mullan expects to have the wherewithal to effect change:

> The Mississippi system foreordained the poverty of blacks. To overcome that poverty the system had to be changed and that was a struggle which had become very important to me. In Holmes County, in the Civil Rights Movement, I experienced a cause and felt a love that helped medicine make sense to me. The Movement needed what I had to offer. It was no longer irrelevant how well I did in school; I had people to work for, people who needed what I could learn. In the woods of Mississippi, away from the medical center, far away from the labs and lecture halls, well outside the standard avenues of medical approbation, I discovered why I wanted to be a doctor. (19)

But, he emphasizes once again, "not a doctor in the old mold" (222). Although he himself makes no mention of it, perhaps it's worth noting that his mother was a social worker (*Contemporary Authors* 69–72: 445). And as it turns out, Mullan remained true to his ideals: "a physician who treats the uninsured at the Upper Cardozo Health Center in the District of Columbia," as *Consumer Reports* describes him in a special report on "Uninsured America: A Health-Care Crisis" ("Second-Class Medicine"

43). The other activists take up a cause as well. Like Mullan, they graduated from college in the mid-1960s and the early 1970s. Moreover, they too count themselves among the downtrodden, and they too hope to reform medical education by representing a group of constituents.

For Horowitz, it's medical students themselves, and then later interns and residents. In contrast with Mullan, "I didn't come from a 'medical' family" (41), Horowitz notes. "But somehow, early on, I assumed that I would be a physician. I guess that was mostly the work of my grandparents." He explains: "To be a doctor, to my grandparents, was the best, the ultimate. It was an honor, they thought, to have the opportunity to help people. And it fit in perfectly with their immigrant, Eastern European consciousness. Their son would be a teacher and his son would be a doctor. Just like that" (42). The only stumbling block is that Horowitz himself doesn't really share the same ambition—until it's almost too late. In high school, he says, "I couldn't connect all this crap, this studying and this ass-kissing with being a doctor." And in college, it's not any different. "I'd rather have done anything—and did—than grind away at organic chemistry" (43). He's just a product of the times, he explains. "I went to college in the midsixties, when the world seemed to be upside-down, and my friends, the people I felt closest to, had all dropped out, turned on and were body surfing in Hawaii" (44). Nevertheless, Horowitz dutifully applies to several medical schools. "After all," he says, "medicine was where I had thought I was going for so many years." But his grandparents don't serve on the admissions committees. "One by one, the rejections flowed in" (44), and as one book reviewer rightly chides him,

''poor unlucky Steve'' (Kozlowski 211) makes a last-ditch effort to salvage what he had once considered his birthright. ''My grades weren't *that* bad,'' Horowitz assures himself, and so he applies to the medical school at the University of Guadalajara in Mexico. ''Guadalajara would take almost anyone, I was told'' (45), even Horowitz, who makes sure that his grandparents are the first to hear the news.

It's in Guadalajara that Horowitz takes up the mantle of activism. He starts his second year of medical school in 1968, and events that year conspire to awaken his social consciousness. ''This was the time when the Summer Olympic Games were being held in Mexico City and rumors of terrorism, political kidnappings, assassinations and bombings filled our conversations'' (58), he notes, adding the following understatement. ''It was not the most congenial atmosphere in which to learn medicine'' (59). Nevertheless, he resolves to try. ''Which meant minding your own business, keeping your nose clean, going to class, not getting involved, studying, going to sleep, going back to class. Don't wear your hair too long. Don't dress in unusual clothes. Don't speak when not spoken to'' (64). But one day, Horowitz can't remain silent any longer. A local politico appropriates the lectern from his physiology professor for a ''conferencia'' about the evils of Communism and the originators of it: ''Jews, of course'' (66). When the local politico asks the students from the United States for their opinions about the conferencia, Horowitz initially offers a ''no comment,'' but when pressed, he takes the bait. ''The point of the conferencias was to anger the North Americans. We were supposed to become so fed up with all the shit, the distortions, lies and venom that we would start yelling for revolution. Those

who couldn't take it would be exposed as activists, as Communists, as workers against the school. Then they'd have us'' (65).

And Horowitz falls right into the trap, which in his mind had been set long ago, way back in high school. ''Eight years of hearing that I should keep my nose clean grated on me,'' and so he begins to talk—''to sputter, really, for nearly fifteen minutes'' (67)—to the delight of his compatriots: ''the U.S. contingent, seated in a clump at the back of the room, started cheering and yelling and stamping their feet. What had been cathartic for me had obviously done the same for all of us'' (68). But it was much more than cathartic for Horowitz; it changed the course of his life. ''I had made a final, irrevocable step away from the route all the would-be doctors were supposed to follow, he says, explaining. ''I had always been on the outside of things, but now I was at the center, a mover and shaker. I think I was where I wanted to be. It was where I was going to stay.'' And it's not long before he has a group of constituents. ''Other students began to look to me,'' he says. Elected vice president and then president of the North American Students Association, he becomes what he calls ''an officially branded activist'' (70) charged with filing a lawsuit against the American Medical Association on behalf of foreign medical graduates from the United States who sought to do their internships and residencies back home. And even though he is soon thereafter admitted to New York Medical College, he continues to buck the medical establishment with impunity, leading one book reviewer to conclude that Horowitz has a bad case of ''know-it-all-itis'' (Hoffman 72).

Whereas both Mullan and Horowitz complete medical school, internship, and residency during their twenties, the other three activists are on timetables of their own. Of the three, LeBaron is the latest bloomer of them all, entering medical school at the ripe old age of thirty-four. He's pulled off quite a feat. ''Among applicants over thirty,'' he notes, ''an average of one out of fifty got in'' (29). But as he sees it, his age is an advantage. ''Whatever madness betook us now, at least we knew that the world outside existed. What of those who, from the day they'd started college at eighteen, had disappeared forever from the ranks of men and become thralls in this strange realm?'' (30). The other two also recognize that they aren't exactly spring chickens. Harrison is thirty-five and Seager is thirty-eight when they change gears. Having already practiced medicine, they decide to start over again at the bottom in new specialties—despite their acute awareness that they're out of step. ''I found myself wishing I were younger and had the chance to get more training'' (19), Harrison says. As a single parent, she can't manage a full-time residency position, but she eventually finds a hospital that will take her part-time. Likewise, when Seager makes his first appearance on the psychiatric ward, Nurse Givens sizes him up immediately. ''You're too old,'' she says, to which he feebly replies, ''I'm young at heart'' (16). In contrast with Mullan and Horowitz, who cover the entire gamut of medical education and training in their books, LeBaron, Harrison, and Seager all focus on just one year. For LeBaron, it's the first year of medical school, and for Harrison and Seager, it's the first year of residency. And their constituents reflect

their motives for remaking themselves at least a decade after most physicians have already settled into their careers.

"I've been screwing around long enough" (141), LeBaron finally decides. An English major in college (Lehmann-Haupt C21), he'd later published a novel: *The Diamond Sky* (1975), which is about "an erotic and youthful love affair," according to the dust jacket. It had been panned by the *New York Times Book Review*. "No good can come of this, and it doesn't" (Levin 37).[4] And his Ivy-League education notwithstanding—a bachelor of arts degree from Princeton and a master of arts in teaching from Harvard (*Contemporary Authors New Revision Series* 9: 329)—his work experience is far more prosaic. He returns to Cambridge to enroll in medical school after having spent some time in the trenches: most recently, the Lower Manhattan Rehabilitation Center (or Manhattan Developmental Services, according to *Contemporary Authors New Revision Series* 9: 329), where he was an aide for three years. And as a conscientious objector to the Vietnam War, he'd served instead as an intake worker for two years at a large public hospital in San Francisco (specifically, San Francisco General Hospital, according to *Contemporary Authors New Revision Series* 9: 329). So despite having placed in the fourth percentile from the bottom on a science aptitude test he'd taken in high school, LeBaron signs up for premedical courses at Columbia's School of General Studies with the intent of becoming a

[4]About a decade later, LeBaron tried his hand at fiction again. While he was completing his internship in Denver following his graduation from Harvard Medical School, he came out with *Fragments of Light* (1984), "a novel about a young doctor's quest in the wilds of Africa and Asia," the dust jacket says.

physician, preferably like the one he once saw driving a red van—"oh what a lovely van, all red and simonized and big and purring" (140)—nothing at all like the old, worn-out Volkswagen that was LeBaron's mode of transportation at the time.

None of it's easy to explain when he interviews for a spot at Harvard Medical School. Asked about his novel and whether he might become another Michael Crichton—a graduate of Harvard Medical School who threw away the opportunity to practice as a physician for a career in publishing that eventually landed him in Hollywood[5]—LeBaron hastens to demur. "I've been working in hospitals and institutions for the poor. I suppose I could change, but I just can't see myself doing anything different, whether I'm a doctor or not. I'm sure I'll want to keep working with the same kind of people that I know" (261). But they're not easy to explain to the medical establishment, either. "Could I tell him about those Chinese children with TB bawling in the night while their mothers, with masks on, tried to feed them mashed potatoes with chopsticks?" LeBaron wonders to himself. In the hospital, rice is rarely served even though many of the patients are accustomed to eating little else. "Or Percy with his clogged shunt?" (261). Admitted to the hospital with an IQ of 160, Percy ends up brain damaged because of a resident who has neither the time nor

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[5]The year after completing his M.D., Crichton published *Five Patients: The Hospital Explained* (1970), his first work of nonfiction. Written in the third person, it isn't autobiographical despite being an account of what he observed at Massachusetts General Hospital as a fourth-year medical student. However, in a collection of essays called *Travels* (1988), Crichton finally gets around to dealing with what he calls his "medical days," even though the book is mainly about his trips to exotic places. He explains. "There were also some episodes from medical school that I had always intended to write about. I had promised myself I would wait fifteen years, until they were thoroughly ancient history. To my surprise, I find I have waited long enough, and so they are included here" (x).

the inclination to check on the results of some tests. "Late for grand rounds," Dr. Devlin tells LeBaron, who tries to serve as Percy's advocate. "Got to run." LeBaron is undeterred. "I charged down the stairs after him. I was used to the fact that doctors don't stand still for anyone but other doctors, and I was so low on the hospital pecking order I couldn't get an orderly to stand still for me" (117). But eventually LeBaron admits defeat. "We were at the door to the auditorium. Inside I could see a blizzard of white coats, while someone was up front with a pointer. That was privileged territory. I stopped" (118). And what about Enrique and others like him—"retarded kids that researchers had shot up with hepatitis, leaving them sick or carriers for life?" (261). Would they be able to help open the doors of Harvard Medical School for him? LeBaron decides not. And the red van, well, "I'd learned long ago that talk of money in medicine was taboo" (261), he says.

But somehow, LeBaron finds himself holding an acceptance letter from Harvard Medical School even though he has "just the minimum background in science" (21)—presumably, scoring in the ninetieth percentile on the Medical College Admissions Test doesn't hurt a bit (Lehmann-Haupt C21)—and it's not until he arrives in the fall that reality starts to sink in. He has it tougher than most. "Both my parents were dead; I had no brothers or sisters, no rich relatives, and no money of my own" (23). And the road ahead is a long one: four years of medical school, then "round-the-clock shifts" during internship and residency. "When I get out, I'll be in my early forties and have to start paying off a thirty-thousand-dollar debt. But, after that, the red van and all its attendant Technicolor pleasures! Thing is, I mused," as

he takes a study break in his nine-by-thirteen dorm room, "I wonder if this might not be a pretty roundabout way of buying a car?" (141). Of the activists, LeBaron is the only one who demonstrates the ability to laugh at himself.

Even so, it's not long before he starts to feel at odds with the faculty and the administration, whose mission eventually reveals itself to him. "This place was to produce generals," LeBaron concludes, adding, "generals do not fight in the trenches" (97). That's why, he realizes, "there was no danger of my finding any answers at Harvard to the problems of Lower Manhattan Rehab" (96), where he had once gotten himself "twisted up with a retardate in some ungodly looking wrestling hold down on the floor" (93)—specifically, Enrique, whose hepatitis makes it unlikely that he'll ever be placed in a foster home. "No," LeBaron continues, "Harvard did not dabble in that sort of thing—though it was more than happy to make use of the Staten Island hepatitis experiment," the one for which Enrique was recruited:

> The different kinds of hepatitis, I learned later in a virology handout, had been the subject of "controlled human transmission studies." While such studies had been "criticized on ethical grounds" (what these quibbles might be was anyone's guess),[6] such human experiments

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[6]Mullan covers "these quibbles" in some detail, thus corroborating LeBaron. "Numerous critics have challenged the ethics of the research," Mullan says, "decrying the use of essentially defenseless retardates in potentially dangerous experiments for the betterment of the rest of society. The researcher, however, defends his work neither in terms of medical innocuousness (he admits that hepatitis is a dangerous illness to contract) nor in terms of social utility (the society is more important than the individual so these retardates must be risked), but in terms of a grim pragmatism. In the institution for the retarded,

''have established the basic epidemiological facts,'' which were then detailed for our memorization. (96)

For that remark and others like it, LeBaron is rebuked by the medical establishment, specifically, book reviewers for the *New England Journal of Medicine*. ''He does not seem to understand that what they are teaching him will ultimately relate to the sickness that he has already seen and known, nor does he mention the fact—obvious to most students—that learning basic biologic science will help him take better care of patients'' (Moore and Moore 707).

Regardless, the virology handout is far too sanitized for LeBaron, who is at Harvard Medical School to seek vengeance for the Enriques and Percys he's known. ''But now only a revenge of gentleness to others like them would suffice—be kind where everything demanded harshness, haste, cruelty—have the strength to exact that kind of revenge'' (261). As one reviewer of *Gentle Vengeance* puts it, ''he approached his experience with both cynicism and idealism'' (Sutton 788). And so he attempts to reconcile as best he can ''the world I'd left and the world I lived in now'' (96) during his first year at Harvard Medical School.

Harrison echoes LeBaron. ''I am living in two worlds'' (93), she says partway through her residency in obstetrics and gynecology at what she coyly refers to as

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hepatitis is rampant, he notes. Virtually every inmate contracts it sooner or later. His administration of the disease under controlled circumstances, therefore, is not unscrupulous but merely a scientific variation on what would happen anyway. This indeed is an accurate marshaling of the facts about these children and their institution. This practical argument blunts much of the criticism of his research. Yet it ignores, it comfortably forgets the much larger and more compelling conclusion about the care of the retarded'' (95), Mullan argues.

''Doctors Hospital, a prestigious teaching institution in Everytown, USA'' (4), more specifically, she says, in the Midwest (22)—actually, Beth Israel Hospital in Boston (*Contemporary Authors* 109: 180–81). Sympathetic with the home-birth movement, she has long been at odds with the medical establishment. ''Home birth is child abuse'' is the mantra of the American College of Obstetrics and Gynecology, which has taken steps to censor physicians like her. ''Throughout the country, doctors attending home births were being threatened with loss of both hospital privileges and malpractice insurance. Residents attending home births either had been expelled from their training programs or were being threatened with expulsion'' (18–19). Despite the fact that she's stopped attending home births by the time she begins her residency, she's well aware that she won't fit the mold at Beth Israel Hospital:

> There is a way in which physicians are made to resemble one another. Learning to act like a doctor is a less obvious part of the long educational process, and one which seems to happen spontaneously. Although I have been deeply committed to the work of medicine, I have never been a product of that mold which makes all doctors seem the ''same'' rather than ''other,'' and which would cause other physicians to think of me as the ''same'' rather than ''other.'' (119)

Nevertheless, she says, ''I felt I could become an obstetrician and that my hands and arms could still hold women in labor'' (21), as they had during the home births she'd attended as a family physician. Then she'd provided mostly emotional support to her constituents. Now, she says, ''I want to know the technology, to understand it and be

able to use it when necessary.'' But at the same time, she says, ''I worry about what it will be like to be a part of the highly technological childbirth practiced in the hospital'' (78). Ambivalent at best, she infiltrates what she calls ''the system,'' all the while attempting to cope by surrounding herself with women's health activists she'd met at conferences before moving to Boston. ''Fran and Laurie and Gail are using my den to work on some resource booklets on women's health,'' she explains. ''At home I am in the world of women, self-care, consumer control.'' It's a different story altogether at Beth Israel Hospital. ''I drive the five miles to the hospital, where the doctor's word is law, the patient's proper attitude is submission. Somewhere between these two worlds I search for a truth, a balance, and a place for myself'' (93–94). As at least two book reviewers have noted (Elam; Coghlin-Strom), she doesn't find it. ''It was as though these two worlds of birthing that I knew could not exist at the same time'' (99), and again she echoes LeBaron, albeit with far less optimism. ''I was removed from my own gentler self by this ungentle profession'' (259), she says, finally repudiating what she calls ''the medicalization of childbirth'' (110). But then, she's long had reservations about what she's been taught. ''In medical school I quickly found out that caring was not part of the curriculum; indeed it was discouraged. Patients, primarily black and Puerto Rican, were bodies on whom we, white and privileged, practiced,'' she says, à la Mullan. ''Racism among the doctors contributed to the treatment of patients as objects. My medical school memories are of patient after patient for whom I cared, but whom I felt helplessly unable to defend

from the impersonal nature of hospital care'' (5), she says, presaging how her residency will unfold.

And finally, there is Seager. No longer able to function as a critical care specialist—the topic of two books he'd published in the early 1980s, one nonfiction [*Breathe, Little Boy, Breathe! An Emergency Room Doctor's Story* (1981), a book that contains three chapters about his medical education: 6, 9, and 12] and the other fiction [*Emergency!* (1983)]—he turns to what the dust jacket of his book calls ''a gentle new specialty: psychiatry.'' His old specialty was anything but gentle. ''Gunshot wounds, stabbings, overdoses, and heart attacks'' (11), he recounts. ''Day in and day out. Week after week. Month after month. Year after year.'' As one book reviewer says, he's become ''a disaffected emergency-room physician'' (Flanagan 1991). That's putting it mildly. For after nine years, the ''severe stress'' (150) of life on the front line becomes too much for him. In essence, he develops combat fatigue, or to put it in psychiatric terms, post-traumatic stress disorder (149–50). ''The bad dreams were first. Every night I woke up sweating. Then I developed a tic in my neck. My hands shook. I became frightened of the telephone. The sight of a hospital or the sound of an ambulance made me hyperventilate'' (151). And then finally, he says, ''everything came crashing down'' (11). A man has died, leaving behind his wife of fifty years, and it's up to Seager to deliver the bad news. ''I opened my mouth but nothing came out. Tears filled my eyes. My heart was suddenly racing. I thought I was going to faint. Maybe I did faint. I don't know. The next thing I remember was being back in the small call room sitting on the edge of the bed crying

like a baby.'' It's his last shift as an emergency room physician. ''I phoned the hospital from home that night and said I wouldn't be in for work the next morning. Or ever'' (151).

And so he ends up at County General, a mental hospital in Los Angeles commonly known as ''The Bin'' (11)—not as a patient, but as a psychiatrist-in-training, once again ''low man on the totem pole, a sea slug in the evolution of a specialist'' (16). Having discovered for himself that vulnerability is a normal part of the human condition, he aligns himself with his constituents. ''Many had once lived lives exactly like you and I,'' he says about the people who fill the hospital wards. ''They'd owned homes, paid taxes, had weddings. They have children and parents. They once had hopes and plans for the future just like us'' (110).

But then they got sick and started to drift, like Mae Peterson. The wife of an attorney and the mother of two children, she was in her early thirties when she first became clinically depressed. The first thing to go was her marriage. ''Who wants a wife that spends half the year in bed sobbing?'' she herself notes. Along with her marriage went the house in Palos Verdes. When her two children went off to college, she lost contact with them, and two hospitalizations later, ''the drift had begun.'' After a stay with her sister, ''Mae rented an apartment by herself. Drift. She tried to hold a job but couldn't. Drift. She was evicted. Drift. Alimony checks stopped coming. Drift. She applied for public relief. Drift. A move to a board-and-care home. Drift'' (112). And finally, like Seager, she ends up at The Bin along with plenty of others—Martin Braga, for example. ''Martin had been a good son, a college student

with many friends and a bright future''—until he became schizophrenic: ''he'd begun to speak of laser beams and the CIA. He said he was receiving messages from outer space. He believed his food was poisoned'' (31). And Abdul Aziz, who is diagnosed with bipolar disorder, also known as manic depression:

> A well-to-do rug merchant originally from Iran, Mr. Aziz had found his way to The Bin after abruptly leaving his downtown store one afternoon and drawing the majority of his family savings from the bank. He was arrested after showering the ghetto streets with bills from the window of his moving car. The sheriff estimated Mr. Aziz was traveling in excess of eighty miles an hour. (101)

And Benny Darling, who has obsessive-compulsive disorder. ''Mr. Darling had a Ph.D. in engineering from Berkeley. He'd worked at a major aerospace firm for five years. Then one day the paper clips on his desk didn't look right'' (224–25), and he, too, ends up at The Bin. ''Those people weren't 'feebs' or 'loonies' or 'crazies,' they were just people,'' Seager says about his constituents. ''Like you and me'' (18). Ironically, having drawn in his readers with a title that smacks of sensationalism—*Psychward: A Year Behind Locked Doors*—he displays genuine sensitivity towards his constituents, thus setting an example for the general public to emulate.

And then, after putting a human face on illnesses like depression, schizophrenia, bipolar disorder, and obsessive-compulsive disorder, Seager proceeds to demystify them further. With the clear intent of reaching the general public, he does a superb job of translating the language of psychiatry into plain English. ''I'll

give you my spiel on depression just as I give it to all my depressed patients, just as I gave it to Mae Peterson that night'':

> Depression is not a moral failure. It's not something over which you have control. You cannot say, ''If only I had been a stronger and better person this wouldn't have happened.'' You're not to blame. You are not being punished. You don't deserve this.
>
> Depression is a biochemical disease of the brain just like diabetes is a biochemical disease of the body. And just as diabetics need insulin, you will require medication as well.
>
> I can't guarantee anything, but I believe and I want you to believe that you're going to feel better. And, hopefully, stay better. (112)

And he educates the general public about schizophrenia, bipolar disorder, and obsessive-compulsive disorder as well.

''Schizophrenia is an inherited disorder. It runs in families. It's not caused by bad mothering,'' he says, laying to rest the theory that once dominated. And then he corrects a common misunderstanding. ''It doesn't mean split personality. The disease, so holds current theory, is a problem with dopamine transmission in the brain. Dopamine is one of the body's many neurotransmitters. Neurotransmitters are chemicals that brain cells, neurons, use to communicate with one another'' (193). Continuing, he explains what the science means in human terms:

> When a person's dopamine network goes haywire, they develop the symptoms of schizophrenia. Their brain is either sending or receiving the wrong message. That's why schizophrenics are so bizarre. Their head wiring's all tangled up. They hear voices when no one is speaking. They believe unusual things. They have trouble forming a coherent sentence. They forget to bathe and shave. Understandably, this makes normal social intercourse a difficult proposition. It's terrifying just to think about. (193–94)

And then Seager provides even more information. "Schizophrenics fall into five basic categories: catatonic, disorganized, paranoid, residual, and undifferentiated" (194), he says, proceeding to define each term clearly.

Bipolar disorder, Seager notes, "used to be called manic depression" (123). He continues. "'Bipolars,' as they are called, suffer from either too much mood or not enough and often, in a periodic, predictable way, will swing, or cycle, between the two extremes—mania and depression. It's a rhythmic disease. Sort of like the coming and going of the tides or the regular changing of seasons" (124), he says, effectively using the known to illuminate what is for most of his readers the unknown. The human toll of bipolar disorder is enormous:

> It can be a ruinous disease as Mr. Aziz would soon find out. During a manic break, normal, church-going people will suddenly buy six cars or fly around the world or have sex with a dozen people a night. They run up unbelievable debts and start lots of bar fights. When things

> finally settle down, generally due to medication, there is suddenly the piper to pay. Notes from MasterCard arrive asking how you plan to handle that $200,000 balance. The risk, of course, when these people get depressed, is that they'll take a gun to their head. (124)

Seager concludes by providing a two-paragraph primer on the "mainstay treatment" for bipolar disorder: lithium (124).

And finally, he puts his readers in the shoes of someone with obsessive-compulsive disorder:

> Benny Darling suffered from obsessive-compulsive disorder, OCD for short, a disease much more prevalent than previously thought. It works like this. Intrusive thoughts come to a person's mind, generally concerning impending harm to a family member, global disaster, or some such thing. The person doesn't want the thoughts, recognizes them as foreign, yet is powerless to control them. That's where the compulsions come in. The person discovers that by performing a specific ritual in a specific way he can reduce some of the tension. Soon the connection is made that performing the ritual will prevent Grandma from dying and the cycle begins. (224)

Seager adds, "OCD can be an extremely disabling disease. It's difficult to hold a job and shower twenty times a day" (224). And then he again uses the known to illuminate the unknown. "You have a sense for OCD if you've ever changed your path to keep from walking under a ladder" (225).

The Strategies

Having identified various downtrodden groups—people of color; foreign medical graduates; the poor; pregnant women; and mental patients—Mullan, Horowitz, LeBaron, Harrison, and Seager look for ways to level the playing field for their constituents. For Mullan, it's participating in a coup d'état; for Horowitz, it's leading a demonstration; for LeBaron, it's signing a petition; for Harrison, it's operating underground; and for Seager, it's organizing a voter registration drive.

By the time that Mullan completes his internship and begins his residency at Jacobi Hospital in the Bronx, he and others like him are becoming restless. "We were learning a lot of medicine. We knew that. But weren't we becoming an indistinguishable part of the system?" He continues, sounding very much like "a political animal and a medical activist," as one book reviewer calls him (Hoffman 72). "And where were we headed personally? We were rapidly completing our second year of pediatric training, a milestone on the road to Pediatric Specialty Boards. But what of our earlier commitment to social change and medical progressivism?" (96). Those questions lead Mullan to Lincoln Hospital—"a small, ancient, dilapidated city hospital in the South Bronx, serving one of New York's most oppressed neighborhoods"—where he helps to establish the Collective, a radical group of house officers who "attracted national attention," according to a physician who reviewed his book (Stewart 92).[7] And just what does the Collective hope to

[7]See also *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*, in which Kenneth M. Ludmerer describes him thus: "Fitzhugh Mullan, a former student activist who has written thoughtfully on the subject" (239).

achieve? ''The single issue that united and motivated politically active interns and residents more than any other was community involvement in medical centers,'' Mullan says, meaning that ''the people served by an institution should have a major say about the policies and the directions of that institution'' (91). He continues. ''And Lincoln's community was in no way a theoretical concept. Day and night, week and weekend, the people came. They arrived from the adjacent streets, walking with their children or traveling a few stops on the bus or subway. For the most part, they were black or Puerto Rican'' (97–98), Mullan notes. He's in his element. There's just one little thing that bothers him. ''What justice was there in the accident of birth that gave me a month in Europe in the middle of my work at Lincoln or enough money to buy a new car with no loans, no creditors, no layaways?'' (208). It's a question that gives rise to the misgiving that to some extent at least, Mullan is slumming on the pretext that he's there to help.

By the time that Mullan arrives, Dr. Arnold Einhorn has been the Director of the Department of Pediatrics at Lincoln Hospital for over a decade. ''Starting with a tiny house staff, few other attending physicians, minimal nursing, a decrepit plant and a penny-ante budget, Einhorn began to build *his* department. Gradually things improved'' (101). Somewhat grudgingly, Mullan gives him his due:

> Over the years Einhorn performed a Herculean feat for which I respect him medically and, I cannot deny it, politically. While several generations of physicians sought and found lucrative jobs in private practice or prestigious jobs in medical schools, Arnold Einhorn devoted

himself doggedly to the care of the children of one of America's worst slums and the medical education of several hundred young physicians from all corners of the world. (102)

And Mullan recognizes what the hospital means to Einhorn. "For him Lincoln was not a job; it was a creation, a part of his being" (170), no less than his "Belgian Jewish ancestry" (100).

At first, Einhorn welcomes the Collective. "I have worked here at Lincoln for many years in the hope of improving medical care for the poor," he tells its leaders. "Finally there seems to be someone else who agrees with me" (102–03). But it doesn't take long for Einhorn to become disenchanted with his new house officers—and for good reason. "When he lectured or presented cases from his experience (always a good show), the sessions were often poorly attended—a marked departure from the past," Mullan says. "The Collective was simply not a very academic group of physicians in training" (167), he adds, indicting himself and his peers. But then he turns the tables, finding fault with Einhorn for objecting to "our reluctance to attend his teaching sessions, sweep after him on rounds, and generally honor him as the supreme Director of Service" (199). Sounding like a smart aleck, Mullan undermines his own cause by engendering sympathy for Einhorn, who appears to be the target of a bunch of bullies. "Egalitarian reforms in the medical routine were agreed on even before we started at Lincoln," Mullan says, continuing in the passive voice. "It was decided that much of the division in duty between intern and resident and resident and chief resident was artificial hierarchy" (199–200). Decided by whom? The Collective,

of course, which has not consulted with Einhorn. It's not very egalitarian of the Collective to keep Einhorn out of the loop, is it? And even more importantly, it seems quite certain that patient care suffers as a result:

> Rounds themselves differed from the standard. Normally, the most senior resident leads rounds. The interns each update the team on their particular patients and keep track of new plans or diagnoses. Not us. We took turns, with the most bewildered intern often leading the group, trying to keep track of all the patients, or attempting to ask erudite questions on diseases he had never seen before. (200)

It appears that the Collective is more committed to its ideology than to the people of color it claims to serve. For as Mullan himself says about the Collective, "we were a setup for anyone with radical rhetoric and/or affiliations with a community group of which we approved" (195)—most notably, the Black Panthers and the Young Lords, who promote themselves without regard to patient care at Lincoln Hospital.

It's an abomination of medical training as far as Einhorn is concerned, and when he won't tolerate it, the Collective decides that he has got to go. His replacement is Dr. Helen Rodriguez. "She had a cultural legitimacy at Lincoln that he did not" (169), Mullan notes, even while insisting that "Einhorn's racial identity had simply not been an issue" (172). It's not one that can be dismissed casually. Consider an article that Michael G. Michaelson published at the time in the *American Scholar*. A medical student and a graduate student in sociology at the University of Pennsylvania, he makes reference to "a demand by community forces that the new

administrator of Lincoln Hospital in the Bronx be a Puerto Rican'' (Michaelson 704, 706). And during the last two months of 1970, the *New York Times* covered Einhorn's ouster in detail, publishing nine articles (three of them originating on the front page),[8] one editorial,[9] and six letters to the editor[10] [one of them by Einhorn himself, in which he states, ''my removal from a post which I held for twelve years resulted primarily from ugly political pressures and was due partly to ethnic considerations'' (42)]. Central to many of those pieces was a statement that had been read during a meeting of physicians at Lincoln Hospital. In fact, it appears in the very first article about Einhorn's ouster, leading to a furor that was to last for weeks. ''The department of pediatrics finds it essential at this time to have a director of a different ethnic background'' (Sibley, ''Pediatrics Chief out at Lincoln Hospital; Puerto Rican Named'' 37).

Nevertheless, an examination of all sixteen pieces that appeared in the *New York Times* suggests that the principal reason for Einhorn's ouster was not ethnic but generational. In a review article entitled ''Lincoln Hospital: Behind the Conflict Over the Pediatric Post,'' Harry Schwartz portrays the Collective as follows: ''a group of

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[8]Sibley, ''Pediatrics Chief out at Lincoln Hospital; Puerto Rican Named''; Sibley, ''Hospital Ouster Laid to Politics: Lincoln Memo on Einhorn Stressed Ethnic Change,'' an article in which Mullan is described as a ''prime mover'' of the Collective (42); ''Ousted Pediatrician: Arnold H. Einhorn''; Sibley, ''Rights Commission Investigating Removal of Pediatrics Chief at Lincoln Hospital''; ''Mayor Will Study Physician's Ouster at Lincoln Hospital''; McFadden; Sibley, ''Einhorn, 'Restated' at Lincoln, Indicates He May Not Go Back''; Schwartz; Kaufman.

[9]''Polarized City: Lincoln Hospital.''

[10]Present; Kelly; Buttenwieser; Oxenhorn; Einhorn; Kamelhar.

bright, radical interns and residents, all of them white and many of them Jewish''—and unlike Einhorn, very much a product of the 1960s. ''Defying convention, they sported the abundant hair, bell bottom trousers, love beads and other symbols of the disaffected young, and began making plain they intended to practice a new kind of medicine'' (8). They not only look the part, but they sound the part, too, as suggested by another review article: ''he really got uptight and freaked out,'' one member of the Collective says about Einhorn, prompting a response from the medical establishment. ''We have some very idealistic young people who have to remember they are in training'' (Kaufman 43). Their style is incompatible with that of Einhorn, according to Mullan. ''He was impossibly authoritarian while we were outrageously antiauthoritarian'' (174), Mullan says in his book, more or less consistent with Paul A. Buttenwieser, M.D., who had trained under Einhorn at Lincoln Hospital six years earlier. Consider what Dr. Buttenwieser has to say in a letter to the editor that was published by the *New York Times*. ''Many people feel that doing their best under atrocious conditions represents an idealism that gives weight to less militant protest. That is not today's style, but it has been a genuine one for many,'' Dr. Buttenwieser says, adding, ''Dr. Einhorn was one of these'' (30)—thus coming to the defense of his former mentor without exactly contradicting Mullan.

And one month before Einhorn's ouster, the *New York Times* quotes Mullan himself on the front page. Identified as ''chief resident in pediatrics at Lincoln Hospital,'' he issues a call to arms against the medical establishment by rounding up support among his like-minded peers. ''Traditionally we have said nothing about the

abuses of patients, but now young doctors must take up the cudgel of the patient,'' Mullan says. ''Times have changed,'' he adds, continuing. ''Young doctors are beginning to identify with their patients, especially in poorer communities where the city hospitals are located'' (Campbell 1, 54; see Sibley, ''Deaths Here Laid to Lack of Nurses,'' for a follow-up story that makes reference to Mullan). He explains why age is such an important factor in an article that he'd published in the *American Journal of Psychiatry* ten months into his internship. ''A rare activist springs forth fully developed from the comfortable and traditional ranks of the adult profession'' (Mullan, ''A House Officer Looks at Medical Student Activism'' 136), he writes, building on a statement he'd made while he was a medical student. ''The essence of our radicalism,'' he'd told the National Assembly of Student Health Organizations, ''will be found in our sustained efforts to change ourselves, our schools, and our professions. We have the tremendous advantage of our youth'' (McGarvey, Mullan, and Sharfstein 79).

Eventually, the Human Rights Commission issued a report about Einhorn's ouster, one that dismisses ''ethnic discrimination'' as the reason for it, attributing it instead to ''a rebellious pediatric staff and community unrest'' (Narvaez). But regardless of why it took place, the coup d'état is a failure, Mullan himself concludes:

> To many observers we had become a group of mutineers who had captured their troubled ship, dismissed the captain, and set sail themselves. The question that flowed from that analysis and that dogged the Collective for the rest of its existence was, ''Can you do a

better job than Einhorn?'' That was a question we had never intended to answer. (175)

And why not? The answer rings hollow. ''The Lincoln Project as it was conceived and the Collective as it emerged were never designed as an alternative to Einhorn,'' Mullan says, proceeding to whine. ''His departure, to be sure, freed us in many ways but it also burdened us.'' Among other things, about one-quarter of the house staff resigned when Einhorn was forced out, all of them foreign medical graduates who had come to the Bronx to do their internships and residencies. The upshot of Einhorn's ouster? ''Mostly, in fact, it left us with a badly disorganized, understaffed department, an uninitiated new chief, and Lincoln's same old problems. We were hardly victorious'' (175). And then what? ''A smaller number of residents continued as 'the Collective' until 1975, when the name was finally dropped'' (Avorn 71), says a physician who reviewed *White Coat, Clenched Fist*, which itself represents an attempt by Mullan to reform medical education. ''My writing was an invitation to change things,'' he says about his book nearly a quarter of a century later (''Me and the System: The Personal Essay and Health Policy'' 119).

It's back in Guadalajara that Horowitz first gets himself elected to office by his fellow classmates. He continues to do so as a resident at Ditmars Hospital and its affiliate, East Manhattan Hospital, becoming the vice president and then the president of the House Staff Association. But now his constituents are no longer foreign medical graduates; they're interns and residents at the two hospitals where he's doing his clinical training, his specialty being internal medicine. And Horowitz leads them

in a demonstration in sympathy with what he calls "the first wide-scale strike by doctors in American history." The issue is hours. "Long hours are part of being a doctor" has long been the party line. But a federal board of inquiry has turned up some startling statistics: workweeks that total one hundred hours and workdays that last fifty consecutive hours. "When I was a boy we worked much longer hours," counters the medical establishment. Nevertheless, a strike is called by the Committee of Interns and Residents (CIR), a union of house staff from the municipal hospitals in the city of New York, and Horowitz does his part. "Periodically we marched with our picket signs through the halls and the administration offices" (234), he says about himself and his constituents. In the end, however, they're defeated:[11] "the National Labor Relations Board ruled that house staff doctors were not professional employees, but were instead students, and as such could not unionize or strike over issues like hours or wages" (243).[12]

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[11]On November 26, 1999, the National Labor Relations Board (NLRB) reversed itself in a ruling that was dispersed on a listserv for medical students (Med-Students-L), as well as by means of an electronic newsletter for the medical establishment [the Association of American Medical Colleges (AAMC)]. "NLRB Rules that Interns and Residents Are Employees," according to an online posting forwarded to Med-Students-L. "This decision opens the door for interns and residents to collectively bargain with their employer. The ruling overturns two previous NLRB decisions issued in the 1970s, in which the Board ruled that 'house staff' interns, residents, and fellows were primarily students and therefore not employees" (December 1, 1999). Shortly thereafter, AAMC covered the same story as follows. "AAMC Disappointed by 'Potentially Damaging' NLRB Ruling," it announced. "The AAMC has long held that residents are students and should not be allowed to unionize, and that the right to strike is incompatible with the medical education process" (December 6, 1999).

[12]Having served as a delegate to CIR and later as its president, Mullan validates Horowitz. "The CIR has become much more activist in recent years," Mullan says. "The house officers themselves have been clear that at this point they are not looking for higher salaries but want to see some sort of ceiling put on their work load—both for their benefit

But no matter. Horowitz has already come up with his own solutions to long work days. First, lots of coffee. "It's what keeps me going," he says. "Some doctors use speed. Coffee is cheaper" (25). And second, sex, when he can get it. "But for me the biggest release, the biggest escape, was sex," he says, "mainly with nurses." Remembering one named Alice, he explains. "When your superiors are off playing golf somewhere while you're working your ass off, you have a feeling like, 'Why can't I have some fun?' You think, maybe she has the feeling, too" (96). Apparently she does, and they end up in his on-call room. "It was hectic, but it was also terrific. I felt refreshed, tensions had been released. I could face another day" (97). Score one for Horowitz. Unfortunately, his book is punctuated throughout with tales of his adolescent sexual escapades (34, 79-84, 164)—one book reviewer characterizes Horowitz as "offensive and self-centered" (Hoffman 72)—which have the effect of trivializing his central message: that patient care is compromised by the long hours required of interns and residents.

And as Horowitz discovers, patient care is also compromised by the sort of community control espoused by Mullan and implemented at East Manhattan Hospital. "Dr. Vincent Solomon Nobile had been chosen to head it," Horowitz says. "Dr. Nobile was part Spanish, part Jewish, dark enough almost to be black and there were rumors that he had some Chinese blood in him. He satisfied almost all blocs" (202), unlike the interns and residents. "A community hospital may want to staff itself only

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and for the well-being of their patients. In the winter of 1975 the CIR went on strike—a new experience for the CIR, New York, and the nation" (89).

with members of the community, but on day one you can't reach into the air and pull out seventy-five Chinese-Cuban-black-Jewish physicians. So a deal was made with the larger, established Ditmars Hospital. Ditmars would supply the house staff on a rotating basis'' (207–08), and for all other positions at East Manhattan Hospital, ''local people with a minimum of training or experience were hired'' (209). Frankly, it's a mess:

> The house staff, which had been used to a reasonably high level nursing and technician staff, was faced with the necessity of compromising the quality of care so the right people could be hired. Racial and ethnic criteria had frequently taken precedence over knowledge and ability. And what was worse, despite whatever was done—whether or not people gave a damn or knew anything or did anything—it was almost impossible to fire them. Firing was looked upon, almost inevitably in the volatile community, as having been decided on racial grounds. (212)

Providing quality medical care is more important to Horowitz than being politically correct. ''I believe in the concept of community control,'' he says, echoing Mullan. ''But at East Manhattan, I found that concepts don't always work out'' (203). To his credit, Horowitz is willing to ''tell it like it is.''

At orientation to medical school, LeBaron is pleasantly surprised by his classmates. ''There seemed none of those flippant, harsh, cynical expressions I'd gotten to know so well on the faces of doctors from my days in the hospitals. In fact,

the principal spirit seemed to be freshness and enthusiasm'' (19). If only something could be done about the scheduling of classes on Saturday morning. ''Awful,'' LeBaron says when Michelle asks him what he thinks about it. ''Nine till noon. Messes up the whole weekend'' (16). So he agrees wholeheartedly when Robin suggests that they send a petition around to the entire class. ''The undersigned wish to inquire if the possibility might be explored of investigating the feasibility of transferring Saturday classes to some other time period, if such a rearrangement of schedule could actually be effected at this time'' (19–20). And soon they're joined by Ron. ''That Saturday-class business is ridiculous'' (20), he agrees.

Little do they know what they're up against—that is, until LeBaron mentions the petition to a physician who is firmly entrenched in the medical establishment. '''You're only here two hours, Charley,' he'd said, slapping my arm and laughing. 'Revolution already?''' LeBaron is taken aback. ''This isn't revolution'' (26), he says. Maybe not in his eyes. But when he, Michelle, Robin, and Ron meet with the administration to discuss the petition, they find themselves up against an immovable object—tradition: ''we've had Saturday classes since Harvard Medical School was founded two hundred years ago,'' Dr. Stone tells them. He's backed up by Dr. Chanesohn, who says, ''we'd like to hear a little more from you exactly why it is so urgent that we change this two-century tradition for you'' (57). In reply, LeBaron gives an impassioned speech about the physicians who treated his constituents—Percy, for example. ''Always in a rush,'' he recalls:

> I don't want to become that kind of doctor. And what's particularly strange to me is that the people in my class here don't seem that way at all. Perhaps a little competitive, but that's about all. So the question in my mind for the past two weeks has been, what's the hamburger machine that chops up nice kids and turns them into the doctors I got to know? (58)

The answer has something to do with "starting off by not having weekends like everyone else, then moving on to continuous round-the-clock work shifts on the wards," LeBaron has decided. "Isn't there some way we can figure out how to make a tiny inroad into that process, like switching a Saturday class to give people weekends?" (58) he asks—"a soldier from the trenches sitting down to tea with the generals" (Lehmann-Haupt C21) is how one book reviewer describes him. And the generals aren't in the mood to negotiate with a bunch of enlisted men and women. "We never heard another word from Chanesohn or Stone," LeBaron says, "and Saturday classes remained" (79)—apparently to the detriment of the first-year medical students. They'd been assured that they were "the best and the brightest" (17), but LeBaron is dismayed by what Harvard Medical School does to them: "those expressions of flippancy, cynicism, the sarcastic smiles that had been so conspicuous by their absence back at orientation were already starting to spread through the class like some sinister psychological tide" (213), he observes. Not surprisingly, he's chastised by Elizabeth Morgan, one of the apologists who is perfectly happy with the status quo. Author of *The Making of a Woman Surgeon*, she's at a loss to understand

why LeBaron ''somehow blames Harvard'' for what happened to Percy ''years ago, miles away from Cambridge'' (''Med School: Getting a Second Opinion'' 14).

But then, Morgan doesn't like much of anything about his book, including the portions in which LeBaron—''with the vanishingly small time I have at my disposal'' (65)—struggles to extract as much as he can from the curriculum at Harvard Medical School. His take on biochemistry, for example, is far too radical for her taste. ''I knew the letter of biochemistry. But had I understood the spirit? Since it was a rare lecture that mentioned anything but the isozymes of rabbit muscle aldolase, I was on my own.'' The professors, LeBaron says, ''kept us busy with the details of one synthetic pathway after another'' (72). As far as he is concerned, such an approach towards science only serves to ''defile it'' (137). ''Memorizing the seven steps of pyrimidine synthesis just to memorize them doesn't give me any sense that I'm doing anything but wasting my time and developing a contempt for the subject matter and the people who are teaching me'' (109), he says. And so ''now in my first contact with science, occasionally inebriated by concepts, mostly floundering in endless sloughs of facts'' (144), he looks back: ''I spent three years working in an institution for the retarded.'' Since then, his life has taken an ironic twist. ''And there was never a time there that was as intellectually deadening as now'' (107).

Determined to find out for himself ''what biochemistry is all about'' (65), LeBaron embarks on his own ''private alternative curriculum'' (66):

> There seem to be assumptions underlying the whole discipline of which I'm entirely ignorant, most deriving from a branch of physics called

> thermodynamics, which is the study of heat, and more specifically, a concept which relates to the way heat flows, called "entropy," or disorder. So while I dutifully memorize everything that's placed in front of me, I also begin trying to read up a little on this entropy business and related matters—if no one will explain them, perhaps I can learn about them on my own. (65–66)

He continues. "And what little I do discover astonishes me: there seems to be emerging a unified scientific model for the nature of life, a phenomenon which has hitherto resisted all efforts at rigorous analysis. A revolution in science was taking place all around us, and no one ever bothered to mention it" (66), at least not at Harvard Medical School. Apparently, there's no room in the curriculum for "a law that is rather obvious, at least to big-city dwellers, that things tend to get more disorganized as time goes on. Entropy increases. Mountains, skyscrapers, billboards tend to fall apart after a while. Smoke drifts away, bicycles wear out, fires burn themselves cold," he says. "In fact, everything around us appears to be following a progress toward structurelessness"—with one exception. "This minute *negentropy* rebellion against the universe is life" (66–67), he says, especially "the human brain and the symbol-based society it created" (70):

> With its hundred trillion synapses, the human brain offers the highest density of order and information, or negentropy, of any object in the known universe.

> From the cyanide molecule which formed the building block of amino acids to the human frontal cortex in three and a half billion years, evolution is the most complicated, extended chemical reaction known. (70–71)

And when a brain is removed from a jar during anatomy, LeBaron takes a good look at the frontal lobes:

> Yes, these three pounds of cellular circuitry could be the creator of epic poems, grand jetés, reflecting pools, symphonies, moon landers, zippers, demolition derbies, integrals, fugues, hanging gardens, steamboats, ogive arches, rock 'n' roll, even blitzkriegs, gas chambers, and napalm, but fudge sundaes, sonnets, and cathedrals too. All self-organized on a flow of negentropy from some cyanide molecule three and a half billion years ago. (246)

LeBaron's conclusion? "So what I was so diligently studying, like a half-literate medieval scribe copying out the New Testament, barely reading or understanding it, did have scope, grandeur, even a terrifying beauty" (72), even if Harvard Medical School doesn't acknowledge it. "So much of the last year had been arid meaninglessness, but there had been moments of awe, wonder, and I wanted somehow to explain both the meaningless and the awe" (240).

He succeeds—and admirably—exhibiting what the *New York Times* calls "raw writing talent." Praising him for "recapturing the sense of wonder that the school's curriculum very nearly killed: wonder at the power of evolution to defy entropy, for

instance'' (Lehmann-Haupt C21), the *New York Times* stands in direct contrast with Morgan, who says that ''LeBaron and his writing falter. He tries to explain in cozy terms and at length thermo-dynamic flux'' as though such subjects are ''light reading. They aren't.'' Virtually holding her nose, Morgan tells the readers of the *Washington Post* to forgo LeBaron's ''doomed attempt.'' In favor of what? ''The interested reader should consult the standard textbooks on the reference shelves of a medical library'' (''Med School: Getting a Second Opinion'' 3), she admonishes—a task that would be forbidding as well as redundant given that LeBaron has already done the hard work for us, and with style, too.

The tactic that appeals to Harrison is operating underground. It's not the first time. ''Years before,'' she says, ''I had attended home births, but when I tried to tell my friends at work about what I was doing, I was usually warned that I could lose my license. It upset me that women were having babies in a field unattended, so I did it anyway'' (16–17), on the sly. So when she starts her residency at Beth Israel Hospital, she believes that she can keep quiet about what really brought her there, at least for the time being. ''I know the rules of the game,'' she says. ''I've told myself I'll take whatever I have to in order to make it through'' (25).

But it's not long before she recognizes that she can't keep that pledge. For example, is she at Beth Israel Hospital to learn how to do Caesarean sections—or isn't she? That's what supposedly brought her there. ''I want to be able to do my own Caesareans, and not have to turn over women in trouble to doctors whose childbirth philosophies may be so different from mine or that of the woman'' (78), she claims.

And at one point, she notes, "I feel so comfortable doing sections" (171). But it's not easy to believe her, for just three pages earlier she says emphatically, "I hate all these babies coming out through holes in the belly instead of through the vagina" (168). Moreover, she has already likened Caesarean sections to pornography:

> The process of birth and the continual emergence of one person out of the belly of another continues to overwhelm me and mystify me. It's a sacred act that has been turned into an ugly ritual, not just because of the procedures—which are sometimes necessary and lifesaving—but because of the attitude with which they are performed. It's like considering the beauty of those moments when sexuality takes on a spiritual quality and comparing that with fucking, with pornography. The medical birth is pornographic. The woman is degraded. The physician intimidates her and forcefully takes from her both the act of birth and that which she herself has nurtured. All day long I watch women who have been violated and who don't even know it. (110–11)

Sexual imagery continues to dominate Harrison's perception of how her constituents are treated at Beth Israel Hospital, even those who give birth vaginally. "The delivery of the head by the obstetrician reminds me of men who boast of being able to make a woman come on command" (159–60). And then there's the D&C—dilation of the cervix followed by curettage or scraping of the uterus—which is considered to be "the 'bread and butter' of gynecologic surgery" (35), she says. "I have been watching a lot of D&Cs and noticing the motion used to scrape out the inside of the

uterus. The curette is jabbed in and out of the vagina repeatedly, held in the surgeon's hand as if the force of the thrust is coming from his/her body. Watching the procedure, I found it difficult not to think of the word 'fucking'" (66), she says, finally concluding, "at work they do not speak the same language I do" (196).

Apparently not. In a book review that appeared in *Time*, one of her supervisors takes issue with her "inflammatory rhetoric" (Wallis 82). Moreover, the statistics that Harrison cites do not withstand scrutiny. Specifically, her claim that "33 percent of women" (89) deliver by Caesarean section at Beth Israel Hospital is inaccurate: "the hospital records show a 19% rate" (Wallis 82). Nor is there a "spiraling increase in Caesareans" (125), as she charges. The national rate is about 17%, according to Dr. Warren Pearse, executive director of the American College of Obstetricians and Gynecologists, who adds that "with efforts now under way," it should drop to 12% to 15% (Wallis 82). And when she's not overstating the case, Harrison is often just plain goofy. For example, having listed the "standardized set of criteria" used to evaluate the condition of a newborn baby—heart rate; breathing and crying; reflex irritability; muscle tone; and color (84–85)—she proposes that they be scrapped. "What are the questions we should be asking as we try to describe the emergence of one human being out of the body of another?" she asks. Her answer: "Was the baby smiling in the birth canal?" (85–86). As one book reviewer has noted about Harrison, not without reservation, "she is all empathy" (Fels 344). For example, she claims to know how babies feel as they are being born. "I do not believe they have just been through trauma," she says. "There is a myth shared by

doctors and mothers that a baby suffers during its passage through the woman's pelvis'' (86). Harrison knows better, of course. ''Are those her hugs the baby feels as it is pushed by the uterus and by the mother's pushing, hugs and squeezes along the way?'' (105) she muses sanctimoniously.

It's clear that Harrison has not come to Beth Israel Hospital merely to learn ''the hospital way of delivery'' (97). At first, she just hints at her real ambition. ''There is so much more I'll be able to do for women's health if I can get this training'' (124), she says. But eventually she owns up to what she calls ''my fantasies of rising through the ranks of the American College of Obstetrics and Gynecology and then being able to speak from a stronger position.'' It's an ambition that goes unfulfilled, however. ''I'd have to stay here another four years, then I'd have to practice in acceptable ways and not offend anyone in order to get my board certification'' (195), she says, giving credence to the charge that she strikes ''an occasional whining tone'' (Bertsch 7). She continues. ''I realized that what they at the hospital define as the cure—i.e., the technology and surgery for childbirth—is what I define as the disease'' (195). Having reached the conclusion that she is furthering her education at the expense of her constituents, Harrison explains that the ends don't justify the means:

> I couldn't say indefinitely, ''Well, I'll just do these things for four years and then I won't have to . . .'' I didn't trust myself, because one can always find ''reasons'' to justify immorality: there are standards, peers, economics. Once justified, they no longer seem so bad. I was

afraid that the lures which had caught the others would snare me too—that I couldn't take just a little of the poison. (258)

But in the meantime, she seesaws up and down from one day of her residency to the next, as her book reveals. Initially a tape-recorded diary, most of it consists of numbered entries. Day 1: "I feel so incredibly fortunate to be getting this training" (54). Day 45: "I no longer believe women can get proper care for labor and delivery in hospitals" (110). Day 51: "I think that the acute crisis is over and that I will be doing all right with obstetrics" (118). Day 98: "I wondered why I was here macerating women's uteri and how I could go on with this and why I had ever decided to do this to begin with" (167). Day 113: "I have to keep sight of how valuable this training has been" (185). Day 117: "I am more and more worried as I become aware of my differences with the methods of hospital childbirth" (189). Day 145: "I'm not sure if I can make it here but I will be very depressed if I have to quit. Maybe I never should have tried, but now that I am here, I do not want to leave" (216). Eventually, the decision is taken out of her hands. Put on a leave of absence by the head of the department on Day 192, even then she vacillates. Day 194: "I know I cannot stay in this program and I want relief from the daily battering to my sense of morality and integrity" (250). Day 199: "I don't want to leave" (253). But soon thereafter—having completed just seven months of a four-year residency—she walks out of Beth Israel Hospital, never to return. "Recalcitrants who challenge the system confront enormous pressure either to conform or to withdraw from training," according to a review of her book in *Contemporary Sociology* (Levy 102). Conform is

not possible for Harrison. "It would be good and it would be easy if I could just accept what they say and learn their protocol and do what they tell me to do, but I can't" (170). So withdraw she does, but she's proud of herself for having spoken out. "One difference between my book and the ones other doctors have written is that mine is by someone who *didn't* make it through. Most people, if they don't stay in, don't even talk about it" (Slung 15).

A member of the Church of Jesus Christ of Latter-Day Saints—the Mormons (*Contemporary Authors* 139: 397)—Seager was born in Ogden, Utah. Yet he remains mum about his religion, only hinting at it by means of an epigraph to his book, specifically, Matthew 25:40, a verse attributed to Jesus Christ. "Inasmuch as you have done it to the least of these my friends, you have done it unto me" (9). It's a pipe dream when it comes to those who reside at The Bin. "To understand the mentally ill and their care, as I was learning to do, it's necessary to be clear on a few basic points," Seager says. "In general, society doesn't care anything about the mentally ill, never has, never will. The insane behave erratically, they don't vote, and they don't pay taxes. People simply don't want them around. At best, they are ignored, at worst, abused" (28). So when the county board of supervisors proposes a budget cut at The Bin just a couple of months into his residency, Seager isn't surprised:

> The county, through whom all our mental health funding flowed, had experienced an unexpected shortfall in revenue. Corners, they said, would have to be cut. And, like pack animals responding to instinct,

> they instantly turned on their weakest member. The proposal was to slash our already pitiful budget in half. Apparently they didn't expect much reaction. Mental health money had been cut routinely over the years and, excepting larger crowds at supermarket trash bins, nothing much had come of it. (52–53)

The district in which The Bin is located has been represented for years by Marvin "Big Daddy" Benson—"a large, jowly man of sixty and thirty-year member of the county board"—one who, "everyone agreed, had always served his constituents well; at least he'd served well those constituents that mattered. He hadn't seemed to care much, however, for our local army of garbage bin eaters. But, truthfully, no one else had, either." Up for reelection, Big Daddy has long understood that the mentally ill are poorly equipped to defend themselves. "A history of mental illness is not an exclusionary criterion for voting," Seager points out, continuing. "The mentally ill tend not to vote, however, because it takes an organized effort and organization is not their long suit. It also takes some degree of commitment to the system. For most of our patients, however, the system was strictly the means by which society exerted its profound indifference upon them" (53).

Not if Seager has anything to do about it. "This time, however, we vowed that things would be different," Seager says. "Enough was enough. We decided to mobilize. We decided to answer back in a language the board of supervisors would understand. We organized a voter registration drive" (53). And it's not long before Seager gets some help from none other than his constituents: "the patients never

looked better,'' he says. ''During the day they happily lettered signs, stuffed mailers, and addressed labels. Each time I saw them line up for their medication, I began to have a twinge of uncomfortable doubt. I wasn't entirely certain what made people well any more'' (55), particularly when eighty-three-year-old Minnie Osbourne takes charge despite having been diagnosed with Alzheimer's disease. ''Have you contacted the families?'' she asks Seager. ''Remember, every patient has parents, brothers, sisters, aunts, uncles, and cousins. They're all voters, too. Have you called the media?'' (54). Seager gives her credit for leading them to victory—reversing roles as he often does—but it's a temporary one. ''The Bin is still The Bin and the county board is still the county board. A month ago, they proposed another round of sweeping cuts in our mental health budget. As of now, no formal response is in the offing'' (249). In his book, Seager ''remains indignant'' (Stuttaford 44) about our ''treatment of the mentally ill'' (Mroz 106)—or more precisely, our mistreatment of them. Yet two years after the publication of his book, Seager is laconic at best when asked about his politics. ''As little as possible'' (*Contemporary Authors* 139: 397), he responds flatly.

The Final Tally

Having uniformly failed to level the playing field for their constituents, each of the activists reacts in a different way. Mullan becomes wistful. ''If only I had come to Lincoln quietly,'' he says. Perhaps he would have been ''more effective and happier'' had he limited himself to ''minor internal hospital reforms'' (208). Horowitz sounds a self-righteous note: ''it will surprise me if one in one hundred will put his

neck on the line to buck the system'' (240), he tells the new interns when he becomes chief resident. LeBaron steels himself against further assaults by the medical establishment by drawing on the nineteenth-century physiologist Claude Bernard, ''who had reflected on the ability of different organisms to survive under conditions of desiccation and imbalance''—like those at Harvard Medical School. '''The stability of the internal environment,' said Bernard, 'is the condition of the free life''' (15). It's a lesson that LeBaron takes to heart. ''If I were to lead a life free of the influences they seemed determined to inflict on me, if I were ever to exact that gentle vengeance, it would require some extraordinary stability in my internal environment, I thought'' (268–69). Harrison remains ambivalent even as she's shown the door at Beth Israel Hospital. ''A battle rages within me between fighting to stay and seizing the offer of freedom'' (249), she says. Forsaking her constituents, she opts for the latter. ''I want to go swimming at the Y, to see my friends, to spend time with Heather,'' her six-year-old daughter. ''With spring and summer ahead, and some money left to live on, the possibilities seem infinite'' (252). And Seager is wracked with guilt because he got ''a seat in the lifeboat'' (222), whereas his constituents ''slept outside and ate garbage and stood in traffic babbling'' (223). So all of the activists come up empty-handed even though each one serves a different group of constituents and employs a different strategy for changing medical education. It's a tough nut to crack.

VOLUME TWO

CHAPTER 5

THE MALCONTENTS

A quartet of male physicians constitute the malcontents: those who bear a grudge against medical education. Hailing mostly from the Ivy League and other prestigious universities in the East—including bachelor's degrees from Princeton and Tufts and medical degrees from Harvard and Yale—they lament their lot in life, performing what amounts to an upper-crust rendition of the blues. In fact, any one of them could have subtitled his book, "Nobody Knows the Trouble I've Seen": Stephen A. Hoffmann, *Under the Ether Dome: A Physician's Apprenticeship at Massachusetts General Hospital* (1986); Joseph Sacco, *Morphine, Ice Cream, Tears: Tales of a City Hospital* (1989); Robert Marion, *Learning to Play God: The Coming of Age of a Young Doctor* (1991),[1] portions of which first appeared in different form in *A Piece of My Mind: A Collection of Essays from* The Journal of the American Medical Association (Dan and Young, 1988);[2] and Robert Klitzman, *In a House of Dreams and Glass: Becoming a Psychiatrist* (1995). The malcontents focus primarily on their clinical training in the cities of New York and Boston—specifically,

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[1]In another book published one year earlier [*The Boy Who Felt No Pain* (1990)], also nonfiction, Marion tells stories about patients whom he has encountered throughout his career, starting with "my earliest days of medical school" and ending with "my life after training" (viii).

[2]Specifically, "In the Back of the Ambulance" (Dan and Young 161–65) is an early version of a portion of chapter 3, "Life and Death 101" (43–49); and "A Dip in the Pool" (Dan and Young 208–12) is an early version of a portion of chapter 17, "One Morning in Pool" (203–14).

Hoffmann and Sacco on internship, Marion on internship and pediatric residency, and Klitzman on psychiatric residency.

In all four books, the narrator starts off as an idealistic young man (and they are all young, in their twenties—no late bloomers or mid-life career changers in this bunch) who rushes headlong from college to medical school.[3] (Even the year that Klitzman spends after college doing epidemiological research in Papua New Guinea is an extension of a project that he began as an undergraduate and a postponement of his prior admission to medical school.) It's not until internship and residency that each one comes to a disconcerting realization: being a physician, or at least a physician-in-

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[3]A special note is in order for Marion, who has more trouble getting out of the starting gate than the other malcontents. "Although it was true I'd screwed around in college," he says, "I believed I had a lot of other things going for me. For one, there was my brother, Les" (7), who'd earned an M.D. from Tulane University. It isn't what you know; it's who you know—right? "Surely, in spite of my mediocre record, my brother's pull at Tulane would be more than enough to put me over the top" (8). It isn't, even though Les is on "a first-name basis" with the chairman of the admissions committee there. Uniformly rejected by a number of American medical schools, Marion spends one semester at the Royal College of Surgeons in Dublin, Ireland—at the suggestion of a business acquaintance of his father—where he contends with challenges like mandatory attendance at lectures and laboratories. But then by means of a connection made through a friend of the family who is the assistant dean at what Marion calls the Albert Schweitzer School of Medicine [actually, the Albert Einstein College of Medicine, or so says Norman Nelson, the archivist at the medical library (Nelson, e-mail messages, 18 Oct. 2001)], "I'd been given the chance to study medicine at one of the most prestigious medical schools in the entire world" (14), Marion says, and he heads home to the Bronx. During medical school, he marries Beth Schoenbrun (*Contemporary Authors* 130: 299), whose father was a physician [Marion, *Rotations: The Twelve Months of Intern Life* (v)]. And eventually, Marion becomes a professor of pediatrics at the Albert Einstein College of Medicine, where his mother had been named a member of the Society of Founders and a Guardian ("Marion, Anna" B9), meaning that she had donated $100,000 or more to the college [according to Abraham Habenstreit, the Director of Public Affairs (Habenstreit, e-mail message, 18 Jan. 2000)]. In his book *Learning to Play God: The Coming of Age of a Young Doctor*, Marion talks as though he's pulled himself up by his bootstraps. But it all adds up to something less than a Horatio Alger story.

training, isn't everything that it's cracked up to be. And each of the malcontents ends up asking himself the same question: what have I gotten myself into? Victims of what they perceive to be a bait-and-switch tactic, the malcontents all respond in the same way to having been duped: they become angry in Dr. Jekyll and Mr. Hyde fashion.[4]

The Dr. Jekyll Phase

In chapters bearing the titles "Beginnings" (Hoffmann), "The Caring Doc" (Sacco), "It's 3 a.m.: Do You Know What Your Doctor Is Thinking?" (Marion), and "Buds" (Klitzman), the malcontents are careful to establish that they began medical education with the purest of motives and the best of intentions. The only one who unleashes his anger immediately is Sacco, whose book apparently serves as a form of catharsis for him. "School, and any bright-eyed eagerness that may have accompanied it," he says on the first page of the first chapter, "lay a thousand years in my past; the end of internship, still almost a year of 80- to 120-hour work weeks ahead, a thousand years into my future" (11). The sardonic tone persists:

> When I was an intern, I remembered a time four impossibly long years before, when I'd entered medical school all bright-eyed and bushy-tailed and believed right in the pit of my much younger soul that yes, by God, I was going into all of this because I did indeed want to help people. I miraculously survived the cutthroat competition of college,

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[4]It's a theme that Marion had explored a half-dozen years earlier in a novel about internship: *Born Too Soon* (1985). "In order to succeed as an intern," says the protagonist Dr. Bob Sharon, "it was necessary for me to make a transition; a transition from the idealistic, sensitive observer I had been in medical school to the hardened, slightly jaded physician I had to become" (2).

> cruising along and getting good grades as though I were being guided by a guardian angel. My liberal, eggheaded parents supported me every step of the way, all the time nurturing the sentiment that my motivations were good ones, that in the end I'd be well prepared to help my fellow man. I came out of college with little hate, still eager to be of use to people. (151)

But internship is a real eye-opener for Sacco, a former honors student who graduated *summa cum laude*:

> Somebody should have told me, way back when I made the decision to become a doctor, somebody should have sat me down and said, ''Kid, think twice. It ain't what it seems to be from the outside, this medical business. It has nothing to do with the hype, or the status, or the media image, or Ben Casey, or Marcus Welby, or any of that crap. The fact is that it can get very ugly and very uncomfortable, so give it a good long think before you get involved.'' (39)

The other malcontents take a more cautious approach. Initially shielding us from their anger, they introduce us to Dr. Jekyll before we ever get a glimpse of Mr. Hyde in the hopes that we may get to liking them before the monstrous change occurs.

The most effusive of them is Hoffmann. ''No intern could have been more enthusiastic at the start of the year'' (288), he assures us—an understatement if there ever was one. As one book reviewer observes, ''Hoffmann's early descriptions of himself evoke an image of a wide- (at times wild-) eyed zeal'' (Poirier, ''A

Physician's Metamorphosis'' 50). In an almost desperate show of the innocence with which he begins his internship, he rather incongruously piles one metaphor on top of another. By turns, he feels like a soldier, a moth, a newlywed, a novelist, an actor, and a substance abuser during his first night on call and for some time afterward:

> I wanted nothing more than to be on call. For four years I had labored toward this occasion. I knew that I was not ready, but I also knew that no beginning intern could be. Night call would be a baptism of fire, a process of trial and error that no amount of preparedness would spare me. . . . Like a moth drawn to a candle, I was fascinated by the glow of the challenges and dangers to come.
>
> This time on call, my first as a physician, I wanted to be up all night. I wanted to be called to see people who were having chest pain, who were bleeding, or who had arrested. I wanted to cure the ill and comfort the dying, but most of all, I wanted to be tested. I wanted to be paged by the Emergency Ward to admit a patient at 3 a.m., when I was dead on my feet, and to have to push myself by whatever strength I could find to make it through the night. (36–37)

He wanted to be Florence Nightingale. The metaphors continue:

> I have no recollection of the following morning, and even of the next two weeks I can summon back very little. I know only that I was infatuated with my job. Like a honeymooner, I viewed the world around me through rose-tinted glasses. No task was too dull or time-

> consuming, no night on call was too long or hard to bear. Despite being nervous, even terrified, at the start of each day, I nonetheless experienced a thrill when I put my white coat on in the morning and headed off to work. . . .
>
> Each day on call was a novel waiting to be written, a novel in which I would figure as both narrator and participant. Perhaps I could influence the outcome, I would tell myself, author favorable changes in the turn of events. . . . If the day was a novel in the making, morning rounds were the opening chapter, and as soon as my colleagues had assembled, the book would begin. (39–40)

Just two more metaphors, and he's done. "My love for the job was genuine, and I enjoyed playing the role of intern to the hilt. In fact, the attraction verged on addiction. I couldn't get enough of being an intern on call" (49). But even as Hoffmann waxes eloquent about being "thrilled at what a doctor could do," he notes ominously, "my attitude would change later in the year" (43). And as his "ingenuous enthusiasm fades" (Poirier, "A Physician's Metamorphosis" 50), anger takes its place.

Marion and Klitzman also strike an earnest if less frenetic tone in the early pages of their books. As a third-year medical student, Marion looks on while an exhausted intern throws a temper tantrum upon discovering that an eighty-six-year-old woman requires treatment at 3 a.m.:

> ''I hate this,'' Al muttered. ''I just hate it. Look at what's happening here. Look at what I'm doing: it's three o'clock in the morning; I have a full day tomorrow; I have all these sick patients to get squared away in the morning, and then I have clinic all afternoon. There's no way I'll get out of this hospital before eight o'clock tomorrow night. I should be asleep now; that's the only way I'll be any good for anything tomorrow. I should be sleeping, but what the hell am I doing? I'm trying to get blood out of the arm of a woman who should be dead. I'm supposed to be doing a fucking sepsis workup on somebody who's got no prognosis, no chance of surviving for more than a few days or a few weeks or at best maybe another month or two, somebody who we'd be leaving alone now if her fucking family hadn't come all the way from California to tell us we had to do everything possible to keep her alive. None of this makes any sense, does it?'' (27–28)

But Al doesn't get any sympathy from Marion—at least not at the time. ''How can you be so cruel?'' Marion asks, vowing on his way home that night, ''I would never allow myself to think about a patient the way Al Barrister thought about Mrs. Schwab.'' He's no Al, he wants us to understand, thus preparing us to accept the admission that rather predictably follows. ''It's a promise that, I'm sorry to say, I have not been able to keep'' (28–29).

And finally, Klitzman begins his residency at a psychiatric hospital, he says, ''filled with excitement and idealism and a sense of intellectual adventure'' (354), and

the *New York Times* concurs. "He makes it clear in the book that he eagerly anticipated his psychiatric residency" (Lane 17). In fact, his choice of specialty is one that he began thinking about as a high-school senior. Even then, "addressing larger, important issues" was his life's ambition, and once he got to college, he says, "I found myself liking courses in biology as well as the humanities, and was particularly inspired by the works of Freud, Jung, and Nietzsche. These writers seemed to raise the most moving and critical questions" (31–32)—but not the one that confronts him during his first night on call: what to do about Jimmy Lentz, a seventeen-year-old schizophrenic who refuses to take his medication. A contemplative man, Klitzman has tried his best to make a reasoned choice among several branches of medicine:

> Neurology seemed the field that would have the most exciting discoveries in the future—about how the brain worked—though possibly not for decades or even in my lifetime. Pediatricians seemed the nicest specialists as a group, choosing their specialty because they loved children. But the residents and faculty in psychiatry seemed the most interesting. These residents were the only ones who still talked about going to films and reading books, both activities I enjoyed. (37)

Yet his decision is based on incomplete information. Psychiatry, he admits, "attracted me from the little I knew about it." He adds, "I also thought I'd be good at what psychiatrists appeared to do: talk with people, find out about their lives and thoughts, and try to understand the mind and the brain. If the unexamined life was said not to be worth living, then examining lives was certainly a worthy pursuit" (32). Oh,

goodness. He's read Socrates, too. Exuding both sincerity and naïveté, Klitzman is by far the most sympathetic of the malcontents.

The Metamorphosis

The malcontents offer startlingly similar descriptions of how internship affected them. "When I emerged from internship, I felt badly wounded" (300), Hoffmann says. Sacco counts himself among those "whose souls had been cracked by internship" (99). Marion contends, "my spirit and my heart had been broken" (185). And finally, Klitzman isn't any better off: "The experience had in many ways bruised me" (354). He's no longer the same man who wrote *A Year-Long Night: Tales of a Medical Internship* (1989), a book that is "so different in tone and style" from *In a House of Dreams and Glass*, according to an article in the *New York Times*, "that it does not take a psychiatrist to see that he underwent dramatic changes between his internship and residency" (Lane 17).

Wounded? Cracked? Broken? Bruised? What accounts for such a string of adjectives? Disappointment, for the most part. Eight years of college—for this?—they seem to ask. Sacco explains: "The race to become a doctor begins in high school, where students compete to get into the big-name colleges. Not getting into an Ivy League school is considered a major screwup because the big name is naturally going to be a plus on medical school applications" (39). But even interns who have graduated from prestigious universities can't avoid making frequent contact with various bodily substances—as Sacco puts it, "piss, shit, or vomit" (16), depending on the patient involved.

Knee-deep in the stuff of life, they are introduced to the limitations of modern medicine. ''Our teachings in college and medical school did not prepare us for what we encountered when we finally arrived on the Cloud Pavilion,'' Sacco says, choosing not to reveal where he did his internship (nor does the *Biography and Genealogy Master Index* offer any clues). ''What we yearned for, what we had been trained for in medical school, was a patient we could cure. The curable patient was the medical ideal. The curable patient was the one described in the medical journals.'' And, he says, the curable patient was ''few and far between on the Cloud Pavilion'' (60). Instead, he and his cohorts find themselves treating illnesses like pneumonia in chronically ill and terminally ill patients, and finally one day it dawns on them that pneumonia was not really the problem:

> We discovered that chronicity was the problem, incurable disease was the problem, hopes and dreams stifled by illness was the problem. And, because no one had taught us how to cope with chronicity, or incurability, or hopes and dreams stifled by illness, we spent our time continually trying to cure the pneumonia and wondering why we were so unhappy. (61)

Consider a patient whom Sacco nicknames ''Uncle Melvin.'' He has pneumonia on top of what Sacco calls ''a cornucopia of chronic, debilitating disease,'' including multiple strokes, colon cancer, and severe senility. It's Sacco's job to treat the pneumonia—''poking, prodding, irradiating, poisoning, and sticking him with every imaginable gauge of needle,'' a process that Sacco compares to ''torturing a hapless

slug on the beach''—merely so that Uncle Melvin can be sent back to ''the nursing home that was his usual site of incarceration'' (11–12). Sacco concludes: ''It should come as little surprise that we eventually reacted to this by ceasing to care. How could we care when it was so obvious that our actions had very little to do with the emotional and spiritual lives of our patients? Instead, we simply focused on getting rid of our patients as quickly as possible, and getting the hell out of the hospital'' (61).

And then insult is added to injury: sleep deprivation and other forms of abuse are meted out to them by those in charge. Typically, interns work from 80 to 120 hours per week, and every third day they ''take call,'' meaning they're on duty from the morning of that day until the evening of the following day. ''Rendered stuporous by lack of sleep,'' Sacco says, ''the intern finally staggers home when the day and night and day of on-call ends, and is lucky to get undressed before collapsing unconscious in bed'' (17). And the psychological abuse is as bad as the physical abuse: ''the intern is told that everything he is doing is totally wrong, the handiwork of a complete asshole. He will be berated by virtually everyone in the hospital, from the chiefs of departments who insist on knowing why such a moron thinks he has the right to call himself 'doctor,' to lab techs.'' Why, interns could hardly do worse if they were slaves on an antebellum plantation:

> By his superiors, the big-cheese, hot-shot docs, those who are responsible for the shaping of the intern into a real doc, the intern is told, ''You're a doctor now, boy! These patients are your damn responsibility! If you don't keep your nose to the grindstone until it's a

> bloody mess you're going to kill 'em, boy, and it'll be your damn fault! Better stay up till you're ready to drop and then some 'cause if you don't, well, you're just a *bad doc*, boy! Now don't give me any back talk or guff about this, boy, because I've got to go home now, the wife's got dinner on the table. See you in the morning, boy! (141)

Making reference to the "scut work" that is the intern's bane, Sacco continues in the voice of his superiors. "I expect you'll have looked under the microscope at all the snot on all your patients by then. Well, damn, if you haven't, well you know what that means about what kind of doctor you are! A *bad doctor*! Keep up the good work, boy, and I'll see your sorry ass in the morning!" (141). Sacco's assessment? "I wasn't sure that terrorism was an effective means of producing humane and skilled physicians" (81), he says dryly.

The other malcontents agree with Sacco's grim diagnosis: the work is hard, the rewards are few, and the hours are long. In fact, they are so long that sooner or later, just about everything except work and sleep are crowded out of the young physician's life. It's a highly circumscribed existence, Hoffmann wants us to know:

> I thought back to all the forsaken opportunities, the invitations I had missed out on: a concert on the Common, a dinner party at a friend's home, a weekend at a beach on Cape Cod, a chance to go bicycling in the country. Not only had it been difficult to get together with friends, it had even been hard to buy food, do laundry, and obtain stamps. If I was out of cash and couldn't make it to the bank, I sometimes had to

> go without lunch. Unable to find time to go to the barber, I wore my hair to the point of looking disreputable. Sometimes I was able to laugh at how I looked in the mirror, but at other times it made me embarrassed or angry. My apartment was chronically in need of neatening. I seemed always to be down to the last shirt (the awful green one I had received as a Christmas present), and I was always behind in something: payment of rent, taking out the garbage, or sending out a wedding gift. (216)

He continues with his litany for a while and then concludes: ''Privation announces itself gradually during internship, making itself felt in a hundred small ways, and resentment steals up slowly, until it suddenly builds into anger. Only now was I in touch with my feelings about the year. Only now had internship really begun'' (216–17).

The result of such privation is that after several months of internship, Hoffmann's ''I wanted nothing more than to be on call'' (36) evolves into ''I came to live in dread of my nights on call'' (291). The hours are not only long, but they often appear to have been wasted:

> I often wondered whether I was achieving any good, and eventually I came to doubt the value of my efforts altogether. I would be chastened, for example, when months later I would meet up with the crippled survivors of resuscitations I had been so proud of at the time. Whenever I had felt good about something I had done, it seemed, the

> future would prove me to be a fool. I could wrest few sure satisfactions from my nights on call. All too often the only consolation for having spent the night in the hospital was being able to go to bed the following day. Sleep is the intern's great redeemer, the balm that cures and absolves all, restoring the peace of mind that a night on call undoes. In the sea of doubts that beset me, sleep was the single certainty to which I could cling. (292)

Ironically, it's often after having been up all night that Hoffmann recalls how he initially felt about medicine. "Looking out on the city in the early morning hours, I have often experienced a deep sense of privilege at being a physician. This elevated view of medicine, the view from above, has always seemed lovely to me, even tender. It is the only view of medicine I held before I began my internship." Eventually, he is able to incorporate another perspective into his original conception. "As an intern I learned to see medicine in another light. I have come to accept, side by side with the long view, the view from up close. Working inside the hospital day and night lends a different perspective to what we do, and from the vantage point of the wards, medicine rarely looks romantic" (298). Even the medical community comments on how much Hoffmann changes during the course of his internship. Consider what book reviewers for the *New England Journal of Medicine* and the *Journal of the American Medical Association* have to say about him. One physician observes rather cheerfully, "here is an opportunity to share in the transforming encounter of a new physician with the raw realities of his chosen profession"

(Stanbury 256), whereas another sounds a note of dismay: "Hoffmann sees his initial enthusiasm, his passion for excellence, corrupted" (Wurtz 1728).

At first "idealistic" (Fels 20; Sokoll 166; *Christian Century* 284), Marion succumbs even more quickly to what Hoffmann calls "the awfulness that is internship" (293). It seems that Marion draws an especially tough first rotation, the neonatal intensive care unit (NICU). The morning after his very first night on call, Marion literally cries on his wife's shoulder:

> I cried for those babies in the NICU. . . . I cried for the children's parents. . . . But the longest and loudest wail, the most sustained and gut-wrenching moan, the heaviest and hardest cry I cried was for me. Suddenly, for the first time since I had begun medical school four years before, I came to realize that this was not what I wanted out of life. I didn't want to spend every third night awake and at work; I had neither the strength nor the intelligence to manage such critically ill patients; I didn't have the willingness, the patience, or the perseverance to watch these children grow sicker and sicker, to watch them and their families suffer, to stand by doing nothing as they died and their parents mourned. (103–104)

He concludes, "I felt trapped and deceived, trapped in a career for which I had never been prepared emotionally, caught in the reality when I'd only known the idealized version, deceived by a training system that had allowed this to take place" (104).

The long hours serve as the catalyst for his discontent. ''Sleep deprivation can take a reasonably well-balanced, relatively intact person and transform him into a maniac'' (101), he says. But it's not just the long hours that get to him. Despite the title of his book, *Learning to Play God: The Coming of Age of a Young Doctor*, he is nagged by the growing realization that physicians are really rather impotent. ''I'd come to see clearly how limited medicine and the physicians who practiced it were. The things that happened to people, the medical ailments that afflicted them, were either simple and easily treated or so complex and critical that their outcomes were virtually out of our hands'' (260).

In the end, though, Marion is finally undone by his superiors. One incident in particular stands out. Paged in the on-call room where he'd been trying to get a little sleep following a night on call that he characterizes as ''brutal'' (127), Marion gets dressed. ''Cursing, I retrieved my socks and pulled them back on over my unwashed feet.'' He puts on his shirt, ''stained by my sweat and the blood shed by my patients during the long night'' (129–30), and reknots his tie. Seething with anger, he leaves the on-call room: ''once again I'd been abused by one of the people in charge''—specifically, by Dr. Kevin Donohue, dressed as usual that morning in a ''long, heavily starched, spotlessly clean white coat'' (131). A professor and department chief, Donohue outgrew the telltale short coat of an intern some time ago. And it goes without saying that he spent the previous night at home in bed. ''Dr. Marion, how nice of you to show up! I understand you were off taking a nap. I hope my needing to speak with you hasn't inconvenienced you all that much'' (132). It goes from bad to

worse. ''You didn't check the echocardiogram? You have a patient who might have a pericardial effusion, whose life might be hanging in the balance, and you didn't even check the results of this one measly test?'' And it's not over quite yet. ''He hesitated for a moment and then, shaking his head, concluded: Dr. Marion, how can you even call yourself a doctor?'' (134).

It's a question that Marion is asking himself by the end of the year. He yearns for ''the old me, the pre-internship Bob Marion who had wanted to be a doctor because it might make a difference in people's lives, the Bob Marion who had been eager to read and learn about the conditions that afflicted his patients, the Bob Marion who had cared.'' After signing out for the last time, Marion walks out of the hospital and heads straight for the nearest bar. ''What had gone wrong? Why had it turned out this way?'' he asks himself. Three beers later, he comes up with the answer. ''Too many nights on call, too many hours spent in the hospital,'' and one other thing: ''Too little humanism.'' Moreover, there is no excuse for the ''sleep deprivation and chronic exhaustion'' that are the intern's lot, he says—''no excuse except hospital finances; the system was dangerous to patients and destructive to doctors'' (193-94).

Sacco couldn't agree more. Picking up what one book reviewer calls his ''vitriolic pen'' (*Publishers Weekly* 64), he poses a question. ''Why is the system of medical training the way it is? Why are interns and residents worked to the bone for forty hours at a shot, three times a week, five years at a stretch, leaving their egos ragged and sometimes unsalvageable? What is the purpose of all of this bullshit?'' (167). It depends on who's doing the answering. ''When asked why this system of

medical training exists, hard-nosed American Medical Association types preen and strut like peacocks, gravely announcing, 'It gives the boys balls! Teaches them to function under stress!' as though 'the boys' were about to assault a beachhead on Guadalcanal.'' Sacco begs to differ. ''In fact, the explanation as to why the system exists is very straightforward, and has nothing to do with the reproductive organs of doctors in training. As with much else in the cold, cruel world, it has little bearing on the needs of people. The reason is money, plain and simple'' (18). For when calculated on a per-hour basis, the salaries of interns and residents amount to less than minimum wage, thus allowing hospitals to keep down costs, or as Sacco puts it, ''to provide twenty-four hour medical coverage with a minimum of staff'' (16). Slave labor practices ensure that the money goes to what Sacco calls ''the private docs,'' physicians in private practice, whose interests are threatened by legislation that would limit interns' and residents' hours. An example is an internist Sacco once met.

> The private doc I was talking to was wearing a silk jacket, a silk tie, and a gold-plated stethoscope. After a brief discussion about the legislation, an idea that should have been made law decades ago, he asked me, wide-eyed, ''I think it's a great idea, but where are they going to get the money?'' (170–71)

Sacco's response? ''I could only laugh'' (171), for taking action is not in his repertoire: ''I lack the energy even to try to change the system'' (261), he admits, noting, ''I went to medical school, rather than political activist school'' (264).

The only psychiatrist in the bunch voices the same complaints that preoccupy the other malcontents. But there's a ready explanation for Klitzman's failure to thrive, says Malcolm B. Bowers, Jr., M.D., of New Haven, Connecticut. Writing for the *American Journal of Psychiatry*, he proposes that Klitzman must not have been properly introduced to "the inherent grandeur of psychiatry and the privilege of membership." What else could account for his being anything other than "optimistic and enthusiastic while enduring the rigors of training" (567)? Well, for one thing, Klitzman is hard-pressed to make room for anything in his life except the hospital and his bed at home. Sounding just like Hoffmann, he explains:

> Many things I previously enjoyed went by the wayside. For months I hadn't bought or read a newspaper during the week. I used to love reading the Travel section of the Sunday paper. As a resident, I stopped even looking at it, not having time to read, much less travel, and feeling stuck, unable even to envision traveling again in the future. That part of my life felt lost, and I feared never being able to return to it. At home, some of my houseplants slowly dropped their leaves, withered, and died because I didn't have time to water them. I lost touch with numerous friends. (214)

Residency exacts a heavy toll from him. "At times I began to hate the whole field and even life itself" (214), Klitzman admits. "This dark hopelessness and bleak futility are difficult to convey. For the first time in my life, I felt like I was going off the deep end," he says, noting, "this work was proving intolerably embattled and

unrewarding'' (215). Or as a book reviewer for the *New York Times* puts it, ''he found that he had fallen from the ivory tower into the cuckoo's nest'' (Lane 17).

To Sacco's trinity of piss, shit, and vomit, he adds another bodily substance. Paged to the emergency room at 2:00 a.m., Klitzman reaches out to shake hands with a delusional patient whose ''Fuck off, buddy'' is punctuated by a flying glob of saliva. ''Suddenly, a cold, slimy glob smacked my face and rolled down my cheek. I was shocked. My finger reached up and touched the goop clinging to my skin, which had landed fractions of an inch from my eye. He had spat in my face. Good God!'' (197). Retreating to the men's room, Klitzman tries to pull himself together. ''Should I wash my eye out? What if he had some infectious disease—TB, syphilis, or AIDS? Luckily, it hadn't gotten directly into my eye.'' But the real damage isn't physical; it's psychological. ''My heart pounded. I felt assaulted, barely wanting to be there at this hour and being brutally repaid for my labors. It made it even harder to care about patients. But here I was with a job to do'' (198)—one that requires him ''to struggle with the fact that knowledge about the mind and mental illness was limited, treatments were frequently only partly successful, and faculty often didn't support and sometimes undermined residents'' (221), often to the detriment of patients.

Far from atypical is the case of Isabelle Dupree, a medical student who is assigned to Klitzman for outpatient therapy. Based on his initial meeting with her, Klitzman thinks that he understands what has prompted her to seek help. ''She had gotten so anxious in medical school that she had taken a leave of absence last year after a few months and now thought she'd try school again, with therapy to help her''

(278). It seems to him that supportive psychotherapy is indicated. ''She was struggling to get through medical school with its grueling rigors and demands, and she sought some support, a chance to allay her anxieties by talking about them and getting some feedback'' (289).

But a few months later, he's overruled by his supervisor, Dr. Larry Schoen, who recommends insight-oriented psychotherapy when Dupree reveals that she's thinking about trading in medicine for a career in research. '''For her to leave medical school and a lucrative career in medicine,' Schoen said, 'would be crazy. Really crazy. Lunacy. This is real pathology. Get her to talk about her past and her family.''' Gamely, Klitzman does as he's told. ''What were things like for you growing up?'' he asks. ''I felt comfortable in my family,'' she responds to his repeated interrogations. When that approach doesn't go anywhere, Dr. Schoen tells Klitzman to remain silent. ''Then whatever she says is a free interpretation that we can interpret.'' Klitzman carries out the order. ''I sat three feet away, facing her in my tiny office, looking at her, saying nothing. 'Why aren't you saying anything?' I nodded at her but kept my mouth shut, trying not to appear a complete fool.'' Dupree doesn't like the new Klitzman one bit. '''What's happened to you?' she asked, bewildered, at our next session. 'Why don't you say anything? You used to be supportive and helpful, and I liked that. Can't you do that anymore?''' Soon thereafter she begins arriving late or not at all, and Dr. Schoen puts the onus on her. ''She's failed the treatment.'' Although he's never met her—''Well, I don't know if I

have time for that,'' he tells Klitzman—he's got her pegged. ''She's a no-goodnik. I would drop her. Terminate her'' (287–89, 310).

Klitzman is reminded of what he observed in Papua New Guinea, where for several decades the fatal virus known as ''kuru'' had been transmitted at cannibalistic feasts. ''Satuma, the witch doctor, had blamed patients who failed to improve on his treatment, which I knew to be ineffective against the kuru virus. Moreover, like Satuma, Schoen remained confident, though to others looking on from outside, the treatment wasn't effective'' (290; Klitzman, *The Trembling Mountain: A Personal Account of Kuru, Cannibals, and Mad Cow Disease*). The lesson is clear: ''I had to tease out whether problems in a case resulted from my inexperience while at the same time trusting my own judgment when supervisors, who knew a patient less well, recommended tacks that didn't seem right'' (213). Even so, Klitzman's disappointment is palpable. ''I had anticipated entering the highest reaches of man's soul. Instead I often felt imprisoned in a dungeon of narrow-minded, callous, and oppressive professional pressures'' (214), as represented by the person of Dr. Schoen—ironically, a pseudonym that translated from the German word ''schön'' means ''beautiful.'' Some months after Klitzman completes his residency, he has a chance encounter with his former supervisor. '''Hello,' I said broadly, stepping toward him, leaving the bus stop to greet him and shake his hand. But he didn't stop.'' It's not the first time that Klitzman's handshake has been rebuffed, but at least Dr. Schoen stops short of spitting. And as he walks away, Klitzman takes a good look at him. ''He tightened the corners of his mouth in an icy grin, which he dropped as

he passed. His face then hardened as dark, heavy lines on either side of his mouth fell from the corners of his lips. He hurried on. I watched him as he disappeared down the block. He never turned around'' (313).

The Mr. Hyde Phase

If they're not careful, the malcontents could turn into monstrous Dr. Schoens, and they know it. Of the four, Klitzman seems to be most aware of the importance of guarding against such an outcome, and even he finds it a struggle. ''Psychiatry was in many ways much more personally difficult than other medical specialties,'' he contends. In the latter, ''the battle lines were clearer—other doctors, patients, patients' families, nurses, the institution, and I all cooperated, united together *against* the disease. Not in psychiatry'' (356). A case in point is Nancy Steele, who is hospitalized after making a suicidal gesture. ''She was getting me angrier than any patients in medicine ever had'' (81), Klitzman notes. As it turns out, though, she's taught him something valuable. ''I had expected to be learning how to help patients by working together with them, and had assumed that patients would be interested, eager, and cooperative, as they generally were in the rest of medicine. But I had been mistaken. Psychiatrists got paid to deal with difficult people and situations'' (81–82). The result is that Klitzman finds himself changing in ways that don't necessarily agree with him:

> As a result of these stresses, I had at times seen the need to distance myself personally from the work, as other psychiatrists did. I didn't always like this response and fought to remain as warm and concerned

> and emotionally available to patients as possible, but I often had little choice and had to achieve a balance, incorporating both concern and detachment. We were forced to construct a professional self and muster whatever personal resources we could to maintain a cool demeanor at all times. To adopt a professional self disturbed and disappointed me. I sometimes felt like an actor playing a part. We often hid behind our white coats, as if behind a costume, a mask. (356–57)

And he observes what happens to others. "Some of my fellow residents became harried and hardened," he says, adding, "I was saddened to see some colleagues lose part of their warmth and sensitivity" (357). A gentle soul, Klitzman finds certain aspects of psychiatry especially troubling. "Tying patients up, for example, went against my emotions. I had to suppress my qualms, since the profession dictated that such actions were for the greater good of the patient" (214). His own feelings tell him otherwise. "Physical violence had always scared me" (28), he says, recalling that he'd been beaten up by a gang in a subway station when he was just eleven years old. Despite his reservations about psychiatry, it's not his style to tilt at windmills. "I couldn't change the structure of the educational process or the system" (217), he decides. And giving up is out of the question. "It would be important to complete this process somehow and to evaluate it afterward" (216). As it turns out, "somehow" entails seeking therapy himself—a step, he hastens to add, that puts him in sync with most of the other residents. "I began to work on my frustration with residency and with, for example, patients who didn't cooperate with my efforts to help them. I had

felt it was inappropriate, professionally, to be angry at those under my care. I was there to help them, to be available to them, and had to separate how I felt like acting from how I should act toward them, and also learn to use my emotions in the treatment'' (222). If the comment made by one patient is any indication, Klitzman not only finds a way to sublimate his anger, but he avoids another insidious trap, that of indifference: ''you were the best,'' a patient says, comparing him with other doctors she's had over the years. ''You cared the most about me'' (352).

The distinction that Klitzman makes between psychiatry and ''the rest of medicine'' would be lost on the other malcontents because they are also inundated with ''personally difficult'' patients. In contrast to the profile thought by Klitzman to fit patients outside his specialty—''interested, eager, and cooperative''—Hoffmann, Sacco, and Marion offer a few adjectives of their own: unconscious, demented, and intoxicated. Such patients are so frustrating that unlike Klitzman, who is repelled by the practice of putting patients in physical restraints (it amounts to hospital-sanctioned violence as far as he's concerned), the other malcontents confess to deriving some kind of perverse pleasure from exercising brute force against those whom they profess to help. It's a phenomenon that Hoffmann calls ''righteous savagery'':

> Whenever a patient opposes his plan, an intern may become stubborn and insistent in pursuit of his goal, working all the harder to prevail regardless of the cost to himself or to the patient. When such a conflict arises, it is usually not worth the cost of continuing. Any rational observer would say that the doctor should simply desist. The truth is,

> however, that at such times he has often become irrational. Compelled by motives other than simple concern for the patient, he wants to succeed at any cost, and in his lust for success he may resort to near-violence. (177)

That's especially true, Hoffmann notes, "if things had been going badly for me—if I had been thwarted by other failures and misadventures, large and small. A doctor, charged with the protection of life, begins to feel threatened when he loses his handle on it." In fighting to maintain control, Hoffmann says, "the battle does not take place so much between the doctor and the disease as between the doctor and his patient" (177). He remembers "many instances in which this was the case," one involving a man whose heart attack lands him in the emergency room:

> Because he was unable to breathe on his own, we slipped an endotracheal tube into the upper region of his lungs so that he could be ventilated by a machine. As soon as we succeeded in restoring a heartbeat, the man awoke, and the first thing he did was to go for the tube, trying his best to yank it out. He was a strong man, and we were barely able to restrain him. Although keeping the tube in place for a while longer was the conservative thing to do, the need for the tube was in all likelihood safely past. Despite this, five of us struggled forcefully to preserve the object of our handiwork. (177–78)

But in the end, they have to admit defeat: "the man finally succeeded in yanking the tube free, and in a gesture of pure triumph, held the bloodied piece of plastic high in the air for all of us to see" (178).

It's an incident that is fraught with ambiguity. "Were we afraid to expose the patient to the small but definite risk of going without the tube, or did the battle represent something less reasoned and more instinctual—a refusal to concede our symbolic advantage?" (178). But another one is not:

> It happened late one night, shortly after I had gone to sleep. I was awakened by a knock on the door and told that Mr. Harding, one of the patients on the floor, had torn out his IV. Mr. Harding suffered from a severe case of pneumonia and needed an intravenous line to receive antibiotics, but he also suffered from dementia and had a habit of pulling out his IVs. As I roused myself, I realized that I would be replacing the line for the fourth time that day. (294–95)

And to top it all off, his efforts go unappreciated by the very person they are intended to help, the patient. "'Goddamn it,' he shouted, 'get out of here!'" Hoffmann suspends his efforts, allowing Mr. Harding to fall asleep:

> I took his arm again, as gently as I could, but suddenly he turned around. Before I realized what was about to happen, he swung at me and my glasses were knocked off. "You goddamn bastard!" he yelled at the top of his lungs. It happened in a flash. I struck him broadly in the center of the chest, a smack more than a blow, a gesture more than

an assault. ''Don't you ever call me or anyone that again!'' I yelled back. I didn't care if he was demented. I was trying to help him, it wasn't my fault that he had ripped out his IV, and I had worked hard all day in the hope of completing my work and getting some sleep only to be awakened minutes after going to bed because of this cantankerous man. (295)

Although Hoffmann is mortified by what he's done—''I had struck a patient! How could I have done such a thing?'' (295)—and concludes sadly, ''I felt as if I had reached rock bottom'' (296), he doesn't seem to recognize the irony of what has just transpired. For one thing, it appears that even a demented patient doesn't enjoy having his sleep disturbed. For another, Mr. Harding is not the only cantankerous man in the room. Hoffmann does see to it that the incident is an isolated one—''I never struck a patient again''—but the anger that precipitated it lies just beneath the surface: ''It was often a struggle, however, to keep from indicating my irritation'' (296).

The concept of ''righteous savagery'' is also familiar to Sacco and Marion—as well as to a teenager who ends up in the emergency room having overdosed on something. Exactly what, Sacco isn't sure:

I sat him up and yelled into his face, ''What did you take?!''

He opened his eyes halfway. ''Nothing.'' He slumped back down on the stretcher.

Suddenly, I became furious. An idiot kid who'd just started shooting up in total disregard to both himself and his family, who'd probably come within minutes of losing his life, and who was now slobbering all over his shirt, was telling the doctor he had done "nothing." I sat him up again and, holding him by the collar with one hand, slapped him hard across the face.

"Wake up!" I yelled. "What did you take?!"

He didn't answer so I smacked him again, much harder, making him flinch. I was about to yell again when I realized that I was shaking. The nurse who'd been assisting with the patient looked up at me. Her eyes said she knew what I was feeling, and that she was feeling it, too, but that it was time to stop. (93)

It's not just old men and teenagers who are the victims of "righteous savagery." Even babies get the same treatment.

There's "Shorty," for example, Sacco's nickname for a patient who at nine months is the size of a three-month-old because of a congenital heart defect. He needs some blood drawn from an artery so that the oxygen or "gas" content can be measured—in short, a blood gas. It's not an easy task, as Sacco explains. "I took an itty-bitty little 26-gauge needle, not a whole lot bigger than a coarse hair, and stuck it into his itty-bitty little wrist right over the spot where I felt his itty-bitty little pulse, and poked it about in search of his itty-bitty little radial artery." Five or six needle sticks later, Sacco loses it. "I yelled at him, 'Where the hell is your goddamn little

artery, you little shit?! You think I like hurting you?''' He calls his supervising resident, and another five or six needle sticks later, they call the third-year resident:

> Unfortunately, sticking someone twelve or fifteen or twenty times creates a kind of self-feeding cycle of entrapment in which determination to succeed seems to outweigh the cost, even if the cost does not logically justify the result. Our assault on Shorty was our little Vietnam, we were determined to get the gas no matter what, like the United States was determined to stomp the commies no matter what, no matter how high the cost. (232–33)

And Shorty isn't the only questionable war being fought. Marion is drafted one night to start an intravenous line in three-month-old M/C O'Hara, the acronym M/C standing for ''male child''; born prematurely, the baby had been abandoned by his parents. Their assessment must have been similar to Marion's. ''M/C O'Hara was little more than a human pincushion, a tiny object with essentially no prognosis and almost no remaining usable veins'' (108). After four unsuccessful attempts to find one, Marion says, ''I began banging my fist against the table on which I had laid out all the supplies'' (113). He turns a deaf ear to the nurse's suggestion that he call the resident:

> I was too frustrated to stop now: I had to start this IV myself. I tied a new rubber band around the baby's left leg, carefully searching the area a second time, but again, no vein was visible. That's when I decided to try a blind stick. From the anatomy course I'd taken in the first year of

> medical school, I remembered the exact location of the long saphenous vein as it coursed its way upward from the foot. Unwrapping yet another needle, I jabbed its tip under the skin right near the inner malleolus, the bone that forms the bump on the inside of the ankle, and rapidly advanced the needle forward. Nothing happened. I pulled the needle back and rammed it forward again. Still no blood appeared. I tried a third time, and then a fourth, and then a fifth, just jabbing that needle forward and pulling it back, again and again. Never did any blood enter the tubing; never was a functioning intravenous line established. Barbara stood by watching me, horrified, as I jabbed the baby's leg over and over again, until at last she commanded, "Bob, enough is enough! Take out that needle right now, and call the resident!" (113-14)

Looking back, he acknowledges what happened—"here I was," he says, "sadistically stabbing needles into the skin of a severely damaged infant"—and why. "The truth of the matter was that I had come to hate this patient" (115).

When they're not mistaking their patients for punching bags or voodoo dolls, Hoffmann, Sacco, and Marion disengage from them emotionally. It's a strategy that Klitzman tries halfheartedly at one point. "It's only a job," he tells himself without effect, for he remains "vexed" (304). In contrast, the other three malcontents stop feeling anything at all about their patients. Indifference is worse than anger, according to Marion. It was during his internship that he tortured M/C O'Hara. But that was

nothing compared to what came later. ''The situation only becomes worse during residency,'' he says, explaining, ''we find ourselves becoming numb, working like automatons, accomplishing what needs to be done with a minimum of emotional engagement. By the end of our training, not only do we no longer have the desire to help others, we don't want to be bothered by anyone'' (262).

Hoffmann and Sacco become just as numb, however, and they're still just interns. ''On a busy night I often found it difficult to process what was happening around me and all but impossible to feel any sympathy for my patients,'' Hoffmann says. ''Even during a quiet night it might be difficult to care. I would find myself numb to the pain a patient with a heart attack was experiencing or unaffected by someone's sudden turn for the worse, or perhaps the unfortunate story of a patient in the Emergency Ward would fail to move me'' (290). Going a step further, Sacco decides that caring about patients is optional. ''The reality was that it wasn't important to be a caring doc. It wasn't important to give even the slightest drab of a shit about anyone. What was important was to *behave* like a caring doc, to take excellent care of the patients *as though* you really did give a shit, even if you didn't'' (151). And he didn't: ''let me assure you that as an intern, I really didn't care. I didn't care, for example, about the Lady with Lung Cancer'' (152). It's a point worth emphasizing. ''I commenced the work-up of the patient without the itty-bittiest trace, not an inkling, not a drab of a sense of caring'' (154). Eventually he meets the patient's daughter, who introduces herself to him. ''I'm the Lady with Lung Cancer's daughter, Mrs. Pregnant with First Grandchild. You must be Dr. Intern. Dr. Cancer

told us you'd be taking care of my mother while she is here'' (158). At that point, Sacco's duplicitous nature emerges. ''For the family,'' he says, ''I would straighten my back and shoulders, remove my hands from my pockets, change 'yeah' and 'nah' to 'yes' and 'no,' and bend myself into my 'caring doctor' best. It was an image that said, 'I'm doing everything I can for your relative and will keep you informed. You can count on me''' (157). Yet Sacco doesn't really enjoy being cold-blooded. ''Later, when life became a little more normal, when one's hours became those of the almighty senior docs, those of us who survived with our egos intact, those of us who hadn't been transformed into the next generation of egomaniacs, could rebuild our sense of caring and compassion'' (151).

But do they? It's a question that Marion raises in the epilogue of his book. Now a professor of pediatrics (*Writers Directory*, 15th ed.) whose students tell their own stories in *The Intern Blues: The Private Ordeals of Three Young Doctors* (1989) and *Rotations: The Twelve Months of Intern Life* (1997), Marion couches his discussion in generalities, remaining silent about his own denouement:

> Medical education in the United States today takes people who enter the system filled with humanism and idealism and ultimately forces them to surrender these ideals by the very process that turns them into technically competent and intellectually capable physicians. Even the medical educators who support the system, those who believe that interns and residents, in order to become good physicians, must work a hundred or more hours a week with shifts lasting thirty-six hours at a

> stretch, acknowledge that this schedule may temporarily obliterate the good qualities medical students bring with them. But they also argue that physicians' desire to help their fellow man quickly returns once the training process is completed. This argument may be true in many cases, but it certainly isn't true in every case. (262–63)

The other three malcontents are more forthcoming about what has become of them. Now board certified, Sacco doesn't seem to have changed much. In the coda of his book, he says, "I remain hardened, and haven't yet been forced to skip lunch over a patient's or family's pain" (263). Hoffmann sounds much the same note. "Even now," he says, "I practice often on the verge of discontent" (xvi). The boy wearing a sweater and flashing a toothy smile on the book's dust jacket has been replaced by someone quite different if a more recent photograph in *Newsweek* is any indication. All grown up in a coat and tie, Hoffmann is now a man whose mouth forms a straight horizontal line (Hoffmann, "The Doctor as Dramatist" 10).

The most resilient of the malcontents seems to be Klitzman. Without minimizing the ill effects of his residency—its psychologically violent overtones leave him feeling "as if I had been punched in the stomach, beaten, and left gasping for breath, collapsed in some shadowed alley" (356)—he manages to weigh the costs against the benefits. "I had paid a price for the skills I learned in my residency but, as time passes, increasingly feel that it was worth it. I wish the process were different and see many areas for improvement in the field. But psychiatric training had got me to where I now am and had become an important part of me" (365). Having become

disabused of the notion that he might want to practice outpatient psychotherapy, which, "though touted in our society as a veritable cure-all, doesn't always work well" (308), he turns to public psychiatry. As he notes, medicine can't be practiced in a vacuum. "We spent time adjusting medications for patients who might not continue them once they left the hospital, living on sidewalk benches or cardboard boxes on the street, alone" (154), Klitzman says, and the other malcontents couldn't agree more.

"Maybe we can squeeze out a few extra months for the patient with cirrhosis, improve breathing a little in a person with emphysema, or soften the end for someone with heart failure due to hypertension," Hoffmann says. "But what if we could have helped the first patient stop drinking, compelled the second to quit smoking, or encouraged the third to lower blood pressure through counseling about diet, stress reduction, and the importance of taking medication?" (207). Sacco makes the same point: "it remains clear to me that the vast majority of medical problems I see, my 'bread and butter,' remain primarily social, and not medical, in origin. Cigarettes, alcohol, and drugs; obesity; alienation; violence; and air, water, food, and land pollution remain by far and away the number one killers of Americans" (264). He remembers a young homeless woman he once discharged from the hospital:

> The social worker said she'd help the patient get onto welfare, but that it would take a while. I asked her if there was some . . . well . . . *place* the patient could go until then. As an intern I did not yet fully comprehend the world's cruelty. It seemed to me that there must be

> *something* to do for someone like that, some way to bridge the gap from being unconnected to being at least marginally connected. I was told that the patient could be given a subway token for getting to the women's shelter (naturally, this would require completing a form). That was it, a subway token and the women's shelter. (114)

And as Marion points out, even when patients do have a place they call home, it doesn't always amount to much:

> Our patients lived in apartments with no heat or hot water or electricity; they ate the paint and plaster chips that fell from the ancient walls and ceilings and got lead poisoning; their only pets were the mice and rats who ran unrestricted through the kitchens and bathrooms, eating whatever they could find, and when no food was available, knawing on the fingers and toes of the little ones who hadn't yet learned how to fight them off; they watched as junkies shot up and died before their eyes, on the stoops and in the alleyways; they sweltered in the summer and froze in the winter. (213)

''And we, the interns and residents,'' Marion adds, ''we who served as their doctors, were supposed to try to keep them healthy in spite of all this. At times, our job was as frustrating and unrewarding as that of Sisyphus'' (213).

Rolling a rock up a hill for the rest of his life doesn't appeal to Klitzman, so he makes a commitment to doing something about the social and cultural issues that have a bearing on the practice of medicine, particularly as they affect patients who

have tested positive for the human immunodeficiency virus [Klitzman, *Being Positive: The Lives of Men and Women with HIV* (1997)]. It's significant that Klitzman aligns himself with a disenfranchised group that includes a high proportion of gay men. For years earlier as a medical student considering a career in psychiatry, he attended "Psych Night," where a speaker told a cautionary tale—one involving "an applicant who decided to reveal his homosexuality if personal questions were asked. Yet everywhere the applicant discussed it, he was uniformly rejected. Surprisingly, the field was much less open-minded than I would have thought, which disheartened me" (39). That's the closest he comes in his book to revealing that he's gay, a fact that emerges unambiguously during an interview with the *New York Times*. As it turns out, he's come to believe that his homosexuality gives him a professional advantage. "You understand the experience of people who are different," he explains. "It helps with being able to empathize with patients or families who feel their needs not being fulfilled by the institution" (Lane 17). No longer a resident, no longer one of the disenfranchised, Klitzman is free at last to take his career in a direction of his own choosing. He says it best: "I glanced back toward the tall medical center building in the distance one final time, then climbed into the driver's seat and drove off" (363).

CHAPTER 6

THE APOLOGISTS

Defenders of the status quo, the apologists have something else in common as the titles of their books reveal: *The Making of a Surgeon*, by William Nolen (1970); *Skin Deep: The Making of a Plastic Surgeon*, by Donald T. Moynihan and coauthor Shirley Hartman (1979);[1] *The Making of a Woman Surgeon*, by Elizabeth Morgan (1980); and *First Do No Harm: Reflections on Becoming a Neurosurgeon*, by J. Kenyon Rainer (1987). All of the apologists are surgeons, and just as notable, there are no surgeons to be found in any of the other categories—the observers, the outsiders, the activists, and the malcontents—all of which accommodate physicians in various specialties.

As a group, the apologists have enjoyed considerable success in capturing the public's attention. Specifically, condensed versions of three of the four books have been featured in *Reader's Digest*: Nolen's (November 1970), Morgan's (June 1980), and Rainer's (November 1987). Particularly well known are Nolen and Morgan, both of whom have written extensively for the general public—eight books and four books, respectively, including one each on life after training (Nolen, *A Surgeon's World*, and Morgan, *Solo Practice: A Woman Surgeon's Story*)—and they were once popular guests on the talk show circuit. Also, both were longtime medical columnists for women's magazines: Nolen wrote "A Doctor's World" for *McCall's* from 1971 to

[1]Five years earlier, Hartman collaborated with another physician, Dr. Walter P. Ellerbeck, on a novel entitled *The Surgeons*.

1983, and Morgan wrote "Your Body" for *Cosmopolitan* from 1973 to 1980,[2] as well as "Ask Dr. Elizabeth" for the Register and Tribune Syndicate in 1977 ["William A(nthony) Nolen," *Contemporary Authors* 121: 321; "William Anthony Nolen," *Who Was Who in America*, vol. 9; "Elizabeth Morgan," *Contemporary Authors* 108: 330; "Elizabeth Morgan," *Who's Who in America*, 54th ed.]. Moreover, when Nolen died in 1986 (from the heart disease that led him ten years earlier to undergo bypass surgery and to write the book *Surgeon Under the Knife*), the lead sentence of his obituary in every major newspaper and news magazine in the country made reference to his 1970 best-seller, *The Making of a Surgeon* (the *New York Times* B6; the *Washington Post* B4; the *Chicago Tribune* sect. 1: 15; *Newsweek* 62; *Time* 64). An earlier version of chapter 2, "The First Appendectomy," appeared in *Esquire* (Nolen, "The Appendix Is Where You Find It"; see also Nolen, "Happy Days at Bellevue"), and when the book itself was published, it sold more than 1.5 million copies in paperback during the first year alone (McMurran 115). It received considerable attention—from the *New York Review of Books*, the *New Yorker*, *Time*, and *Newsweek*, for example—and the *Chicago Tribune Book World* carried the review of a young Michael Crichton, M.D., who was already making a name for himself as a writer.

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[2]Reference works are in conflict over the starting date of Nolen's column in *McCall's* (variously citing 1970 and 1971) and the ending date of Morgan's column in *Cosmopolitan* (variously citing 1980 and 1981). According to my own examination of the two magazines, the first installment of Nolen's column appeared in 1971 (Nolen, "When You're 'All Tired Out'" 20), and the last installment of Morgan's column appeared in 1980 (Morgan, "Your Body" 74).

Following a well-worn path, all four of the apologists are the first to admit that they are not the first members of their families to join one of the professions. They all have somebody who can show them the ropes. ''My father was a lawyer,'' Nolen says. ''When I was a boy he often said to me, 'Billy, if you're smart, when you grow up you'll be a doctor. Those bastards have it made.' I took my father's advice, and I dedicate this book to his memory'' (v). Moynihan comes from an entire family of lawyers. ''My father is a judge and law professor who has written a textbook used in universities throughout the country. My brother, Neil, is a lawyer practicing in Boston and his wife is going to law school. Even my sister, Anne, is a paralegal, and married to an attorney, yet'' (17). The daughter of two psychologists in private practice (19), Morgan certainly isn't harmed any by the fact that her father's Ph.D. is from Yale, where she decides to attend medical school (26). Even so, she reserves her highest praise for her mother. ''She really supported me all the way along. My father did, too, but I'm not as close to him, naturally'' (*Contemporary Authors* 108: 331). And finally, Rainer's older brother is a dentist (284). So the ranks of the apologists are filled entirely with surgeons from similar bloodlines who—more than physicians in any of the other categories—embrace medical education as they find it. And all of them develop their books around a set of six interrelated themes.

Be True to Your School[3]

Surgery is the Holy Grail of medicine as far as the apologists are concerned. No other specialty will do for any of them. "I really wanted to be a surgeon," Nolen states unequivocally. "I enjoyed doing the tonsillectomies, the hernias and the appendectomies. I didn't enjoy delivering babies, treating measles or listening to patients with neurotic symptoms." He concludes, "I acquired enormous respect for the G.P. who could do a little of everything and do it well, but it was just not for me" (134). Although Nolen is rather magnanimous toward the general practitioner, the pathologist and the internist don't fare nearly as well by him. Neither one has as much on the ball as the mighty surgeon, despite the adage that cuts them all down to size: "Internists know everything but do nothing; surgeons know nothing but do everything; pathologists know everything and do everything, but too late" (204). Having spent part of his residency performing autopsies and interpreting slides under the tutelage of the pathologists, Nolen has them pegged:

> In my six months on pathology I decided that a lack of self-confidence was an endemic disease among pathologists. Instead of exercising the reasonable caution the pathologists ought to apply, they would become unreasonably irresolute and indecisive, unable to make up their minds even in clear-cut cases. The lack of pressure for immediate decisions

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[3]I am using the word "school" in a general sense to mean "people forming a distinguishable group or class and sharing common principles, canons, precepts, or a common body of opinion or practice" ("School," entry no. 3, *Webster's Third New International Dictionary of the English Language Unabridged*). And of course, "Be True to Your School" is an allusion to the popular song of that title by the Beach Boys.

> was probably what attracted some of them into the specialty in the first place. Surgeons were used to making weighty decisions immediately; you couldn't sit back and think about a possible perforated ulcer for twenty-four hours. You weighed the pros and cons, made a decision, and for better or worse, took action. Doctors who couldn't take this sort of pressure gravitated to specialties like pathology. (117)

And to specialties like internal medicine. ''Surgeons look upon medical men as doctors who lack decisiveness. Internists hem and haw for hours over whether to give a patient penicillin or aureomycin; they'd be lost if they had to make up their minds in minutes whether or not to open an abdomen'' (204–205). But then, there's no love lost on either side. ''Medical men regard surgeons as technicians: not too bright, but show them what has to be done and they may have the dexterity to do it'' (204), Nolen reports dispassionately. It's clear where his loyalty lies, however. For example, consider how he characterizes George Vachon: ''a good sound medical man—a rare bird'' (207), even if not extinct. In fact, most of Nolen's compliments are rather backhanded. ''It takes a smart surgeon to realize that a medical man, a good one, can sometimes manage a postoperative patient better than he, the surgeon, can'' (156), Nolen grudgingly admits. And he remains true to surgery throughout his career. ''After twenty-six years in the business, I can tell you what makes life as a surgeon so appealing,'' he says. ''A surgeon can cure people. Not all of them, but many. And quickly.'' Then, too, ''surgery is exciting,'' he says. ''The exhilaration that comes with the successful completion of an operation is as satisfying as anything I can

imagine experiencing in this life'' (Nolen, ''The Big Knives'' 58). And although Nolen began writing because, he says, ''I wanted my 15 minutes of fame,'' it would never supplant surgery. ''I've never wanted to give up surgery for writing,'' he tells *People Weekly*. ''One, I get a lot of satisfaction from it, and two, what the hell would I write about?'' (McMurran 112, 116).

An apologist for more than just surgery itself, Nolen champions the hospital where he chose to do his clinical training: Bellevue, located in the city of New York, and more specifically, the borough of Manhattan. Its infamous reputation is well-founded, according to Nolen. In fact, he's attracted to it for that very reason: ''Bellevue, despite all its monstrous problems, offered the ultimate in challenge to anyone in the medical profession. If you climb to the top of Mount Everest you know that you've accomplished something; if you get to the top of some grassy knoll the feeling isn't there'' (8). Bellevue is anything but grassy. ''It's all brick, asphalt and cement'' (3), Nolen observes when he arrives for his interview. No less foreboding is the chief resident, who greets him as follows: ''I don't want to try to talk you into anything because, I warn you, if you come here you'll work your ass off. If you don't like the idea, go somewhere else.'' Nolen doesn't just like the idea, he loves it. ''I was eager and anxious to go to work'' (7), he says, and Bellevue doesn't disappoint him: ''even the simplest of tasks was complicated by the shortage of help and lack of equipment'' (18), he observes—better make that ''boasts.'' Of particular challenge are the patients, many of them vagrants from Lower Manhattan's famous skid row, the Bowery. ''With our patients,'' Nolen points out, ''complications were the rule rather

than the exception, and that might easily delay the patient's convalescence. Malnutrition, for example. Our patients had no idea what a balanced diet was like. For many of them the bulk of their calories came from alcohol.'' And malnutrition was only one of many possible complications. Another one was tuberculosis, and even without complications, Nolen says, ''we were often licked before we started. A disease we were treating was apt to be quite advanced before we ever got to see our patient—too advanced to cure'' (40). No wonder Nolen's wife questions his choice. ''She couldn't see why I insisted on Bellevue. It was impossible to explain. You had to be there—sensing the challenge of the place, being part of the constant battle against overwhelming odds—to understand why we didn't want to leave. It couldn't be put into words'' (139). Why does anyone want to climb Mount Everest? Because it's there. And Nolen's affection for Bellevue doesn't fade as the years pass, either. On the contrary: at the age of 58, he waxes eloquent about it. ''There was an esprit de corps at Bellevue that I haven't seen matched since I last walked out of there on June 30, 1960. I love that damned hospital; and so, I believe, does virtually every resident who has ever been part of it.'' Bellevue has just turned 250 years old, and Nolen couldn't be happier for her. ''Happy Birthday, Bellevue, baby,'' he croons (Nolen, ''Bellevue: No One Was Ever Turned Away'' 43).

Unlike Nolen, who became a general surgeon, the other three apologists specialized further: Moynihan and Morgan in plastic surgery and Rainer in neurosurgery. Regardless, they express the same delight at having made exactly the right occupational choice—while avoiding the wrong ones. From the age of seven,

Moynihan says, ''I'd known I had to be a doctor.'' It's not something he agonizes over: ''medicine was for me. I just knew it.'' During his third year of medical school, Moynihan discovers that he feels just as strongly about surgery:

> I decided I wanted to be in a field that allowed direct therapy for curable problems. Surgery offered this, and gave the satisfaction of immediate results—unlike, say, psychiatry, where I would never stop wondering if any permanent improvement was ever effected. Or internal medicine, where many of the problems were chronic and, with rare exceptions, the treatment was supportive rather than curative. Yes, I would be a surgeon! (17)

His reservations about internal medicine and psychiatry are typical, Moynihan notes: ''the loyalty of each member of a specialty is directed to his own department rather than the hospital as a whole'' (57). He explains:

> Competition is real, and a kind of tongue-in-cheek antagonism is always present. For instance, surgeons refer to Internal Medicine residents as ''the herbs and roots boys.'' We imply that they've risen just one step above witchcraft with their potions and treatments. They retaliate by saying that our motto is ''If it can't be cut, it can't be cured!'' Even Psychiatry's electrotherapy treatment center wasn't immune. At our hospital, it was known as the Thomas Edison Memorial Wing. (57)

So it's surgery for Moynihan, and not just any kind of surgery, either: only plastic surgery will do. It's a choice that Moynihan makes while assisting during an operation performed by his future mentor, Dr. Lawrence Parmenter, on a girl of about twelve who had been in a car accident:

> The girl's face was a horrible mess. From her gums to her eyes, the skin and muscles of the cheeks were torn away from the underlying bones. Her lips were shredded in a number of places, and loose flaps of skin hung in different directions. I helped Dr. Parmenter clean each wound with sterile soap and water, and watched with awe as he meticulously sutured the tissue back into place. He closed the lacerations with very fine stitches, cutting away dead skin with precision instruments. He put the skin flaps back into place and tacked them down with great care. By five a.m., a face that four hours before had been a disaster had undergone a metamorphosis, and now, considering the injuries, looked relatively normal.

For Moynihan, it's a revelation. "Next to this technique," he says, "all other operations I had witnessed seemed gross. It was at that precise moment that I decided to become a plastic surgeon" (19), even though he realizes that not everyone would applaud his choice.

One of the youngest specialties, plastic surgery is sometimes called "a bastard field," Moynihan explains, "because it is directed to no particular area, organ, or disease. The skin and all it covers—the human body from head to toe—is included in

the domain of the plastic surgeon'' (vii), who performs both reconstructive and cosmetic procedures. It's the latter that Moynihan most often has to defend, even on a vacation to Northern Ireland, where he looks up some long-lost relatives:

> They were intensely interested in the fact that I was a plastic surgeon, but weren't sure exactly what I did. I explained that I treated burns and birth defects and skin cancers. They were impressed. I should have stopped while I was ahead, for when I told them I also did cosmetic surgery, the oldest male member of the family shrugged.
>
> ''Well, I tell you, Cousin Donald. The way I look at it—if a person can't get through life with the nose God gave him, maybe he doesn't deserve to be here in the first place!'' (246–47)

It's a sentiment that isn't unique to laypeople. ''Nose jobs have often been the subject of jokes,'' Moynihan observes. ''Even other doctors sometimes chide plastic surgeons about this so-called frivolous surgery. What's frivolous about correcting a serious defect in appearance that can negatively affect social life and personality?'' Moynihan would like to know. ''All I can say is, if you're the one with a honker for a nose, it's not so funny'' (8). Despite how often he's called upon to defend ''the seemingly mysterious field in which I specialized'' (7), Moynihan himself has no reservations about what he calls ''happy surgery.'' He explains: ''Although I felt great personal fulfillment in repairing congenital defects and traumatic wounds, I had to admit there was something special about cosmetic surgery. The results were usually so dramatic, and usually the patient was so very pleased afterward'' (34). Moreover, both cosmetic

and reconstructive surgery are resistant to becoming obsolete, unlike other fields of medicine. ''Eventually scientists will come up with cures for most of the illnesses that presently concern many specialists: cancer, high blood pressure, heart diseases. But injuries, congenital defects, pride, vanity, and concern with appearance will always be with us'' (24), he asserts. His conclusion? ''The bastard has now found its legitimacy'' (vii).

Perhaps he spoke a bit too soon because eight years after publishing his book, Moynihan again found himself defending the bastard—this time in response to an article about cosmetic surgery published in the *Wall Street Journal*. ''In the lucrative field of cosmetic surgery,'' says staff reporter Bowen Northrup, ''a handful of medical specialties are in the throes of a turf war.'' He continues: ''Plastic surgeons, for their part, are apt to point out that they are certified to do plastic surgery as an exclusive specialty'' (25). Moynihan proves Northrup right. In a letter to the editor, Moynihan charges that ''there has been a concerted attempt on the part of some doctors who perform cosmetic surgery to camouflage the true identity of their specialty.'' That's why Moynihan wants the general public to know that *real* plastic surgeons like himself are certified by the American Board of Plastic Surgery. He concludes, ''specialty identification based on accredited residency training programs and recognized specialty boards is of bedrock importance to the medical community and to the consumer public'' (33).

Even before starting medical school, Morgan has made up her mind: ''I wanted to be a surgeon'' (26) she states emphatically, recalling her interview with the

dean of admissions. Yet she acknowledges, "I was not sure where the idea had come from." As a medical student in the late 1960s and early 1970s, she had to find her own way because female role models were scarce.[4] "There were no women surgical residents or faculty at Yale, and no women surgeons in private practice in New Haven" (47), she notes [and only one at the teaching hospital where she did her internship (150)]. But the fact remains that "surgery fascinated me"—so much so that when one of her classmates announces that he's going into psychiatry, she says, "Lenny puzzled me. I couldn't see how anyone could want to be anything but a surgeon" (46). And her initial foray into surgery during her third year of medical school is everything she'd hoped it would be and more. "It was July 4th weekend and we spent almost the whole three days in the operating room. I loved it" (54). Having already absorbed the mores of the surgeons around her, Morgan knows how to comport herself. "I decided to spend most of my time in the O.R. and leave studying for later," she says, explaining: "recommendations for a surgical internship depended on the opinion of the residents as well as the professors. Good recommendations are given to students who work hard and help the residents. Students who disappear to the library to study are fit to be fleas (internists) or shrinks, but not surgeons" (52).[5]

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[4]When Morgan started her training, "only 8 percent of all American doctors were women"—a statistic provided by the *Washington Post* in a review of Morgan's book—"and a great majority of this minuscule group were pediatricians, psychiatrists, or general practitioners. A surgical specialty was simply no place for a nice girl" (Ramey B12). Citing a study that is based on interviews with male and female medical students, Carol Lopate makes the same point: "both sexes agreed that surgery was a man's field" (126).

[5]Note that Morgan trots out medical slang to disparage internists—known as "fleas" because they're "the last to leave 'a wounded dog'" (Coombs, Chopra, Schenk, and Yutan

And her later rotations do nothing to disabuse her of the notion that surgery rules. While she claims that she finds internal medicine "fascinating," she adds, "I became a little restless. I missed the action of surgery. The internal medicine working day began at seven, which seemed a late start after surgery" (76). And psychiatry is just plain silly. Assigned to write an in-depth analysis of one patient, Morgan consults with her mother, who recommends that she add some references to Freud:

> I went to the library and took down Freud's *Complete Works* in twelve volumes from the reference shelves. I opened each volume at random and selected the first sentence of the first paragraph of the page at which the book happened to open. I inserted the quotations, one every three pages, and one on each of the last four pages of my psychiatry paper. (96)

Score one for Mom. "The psychiatrist assigned to teach me had previously noted that I did not seem enthusiastic about psychiatry. My paper completely changed his opinion," owing to what he calls its "unusually pertinent, insightful quotations from Freud" (96). It's interesting that Morgan singles out internal medicine and psychiatry

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990)—as well as psychiatrists (whom she calls "shrinks"), whereas she refrains from using the slang term for surgeons: "blades." Interestingly, two of my primary sources are cited by Coombs et al.—Perri Klass's *A Not Entirely Benign Procedure: Four Years as a Medical Student* and Melvin Konner's *Becoming a Doctor: A Journey of Initiation in Medical School*—as being repositories of medical slang (988).

for criticism, like Moynihan, for both of them end up in the same specialty.[6] "I loved plastic surgery" (317), Morgan gushes, proceeding to count the ways:

> Plastic surgery appealed to me because the results are visible. Plastic surgeons always take before and after photographs of their patients, and if you have done a good—or a bad—job, you can see it and study how to do an even better job the next time. I also liked the fact that this was a broad field. Every operation is different, no deformity is exactly like any other and a new operation has to be planned for each patient. Also, the psychology of plastic surgery fascinated me. I liked to try to understand why one patient might be obsessed with a minor scar and another patient not troubled at all by a deformed ear or grotesquely crooked nose. (317)

Neither she nor Moynihan seems to appreciate the irony of having chosen the surgical specialty that is more closely aligned than any other with psychiatry.

And finally, there's Rainer, the neurosurgeon of the group. He had also considered becoming a general surgeon, like Nolen, or a cardiac surgeon. But as he explains, "I didn't enjoy sewing up bullet holes in intestines all night on the general

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[6]Morgan, though, expresses reservations about cosmetic procedures (as opposed to reconstructive procedures). "My greatest fear when I opened my own office was that I would 'sell out' to cosmetic surgery," she says, explaining. "Cosmetic surgery fees are high, paid in advance, and surgery can be scheduled at the doctor's and the patient's convenience—the surgeon does not have to get out of bed in the middle of the night as he does in cases of severe trauma." She continues. "I had often thought that cosmetic surgery tended to be done at the patient's request, with too little attention paid to why the patients wanted cosmetic surgery and if the results for them would be worth the time and expense" (364–65).

surgery service, and I got bored with bypass surgery on the cardiac service. That left neurosurgery'' (72). And besides, Rainer takes pride in its being ''the hardest residency'' (61), gravitating to it after being told by a neurosurgeon what to expect: ''Long hours, long years, difficult operations to learn, and lots of dead patients.'' The conversation is a turning point for Rainer, who confesses to having been ''buoyed by his interest in my future plans'' (61).

Like the other apologists, Rainer is acutely aware of the conflict between surgeons and other specialists. First he echoes Nolen. ''Internal medicine doctors taught us how to diagnose disease and surgeons how to treat it,'' he says, ''confirming the adage, internists know everything and do nothing, surgeons know nothing and do everything, pathologists know everything and do everything, but it's too late.'' And then he takes aim at psychiatrists, reminiscent of Moynihan and Morgan. ''Psychiatrists taught us nothing (except that frequent masturbation improves self-esteem) and confirmed my impression that all psychiatrists were either crazy or becoming crazy.'' Well—so much for them. Even dermatologists annoy Rainer, who reveals that neither tact nor modesty are among his strong suits. ''And in four weeks,'' he says, ''I learned the entire dermatology specialty: if the rash is wet, put something dry on it; if the rash is dry, put something wet on it; if you don't know what the rash is, biopsy it'' (16).

Above all, however, Rainer has no use for neurology. ''There's not a lot I can do except talk to patients,'' Rainer complains about his six-month rotation on neurology, which encompasses epilepsy, multiple sclerosis, stroke, Parkinson's

disease, Alzheimer's dementia, and other conditions that are managed medically rather than surgically. ''I'll be bored to death without operating for that long'' (109), the budding neurosurgeon whines. And sounding just like Morgan, who has a hard time adjusting to how late the internists get going—7:00 a.m.—he takes a dim view of the neurology schedule. ''Neurologists get to the hospital about eight a.m.,'' the chief resident of neurosurgery tells Rainer. ''They eat breakfast and read the newspaper until nine-thirty. Then they make morning rounds, break for lunch at noon, attend conferences from one to three p.m., and leave for home about four''—banker's hours, or at least that's what Rainer would have his readers believe. ''It's going to be a boring six months'' (110), he repeats.

But being a resourceful soul, he's able to rustle up at least some patients who hold his interest. Consider Bud, for example. The neurologists have diagnosed him with Lou Gehrig's disease, but Rainer demurs. ''I think you've ruptured a disc in your neck,'' he says, and Bud takes the bait. ''What kind of doctor should I see?'' Rainer's answer is not only predictable but rather smug: ''A neurosurgeon.'' And the exchange doesn't end there. ''Is there one here at the V.A.?'' Bud asks hopefully, explaining that he can't go to another hospital because he doesn't have medical insurance. ''Yes,'' Rainer admits, ''but you can't see him.'' And why not? Because as a resident, Rainer has to cover his ass: ''the doctors on this floor will find out I told you I thought they had the wrong diagnosis,'' he says, referring Bud to a neurosurgeon at another hospital. Estimated cost: $30,000, Rainer says, the

alternative being paralysis and death. Bud complies. "Okay, Doc, I'll borrow the money and give it a try" (115–16). Has Rainer no shame?

The good doctor continues to pooh-pooh his colleagues in neurology. "Several residents trying to start IVs were bent over Ruth," he says, keeping mum for the moment about what kind of residents. As it turns out, they're specializing in neurology—a fact that virtually predestines what happens next. "I pushed the neurology residents out of the way," Rainer says, pinpointing the problem that they missed. "She's in shock, so her veins are collapsed. You'll never get an IV in her arm. Get me a subclavian IV" (123), he orders, and once he brings up her blood pressure, he wheels her into the intensive care unit. He may as well hop onto his horse Silver and gallop off in a cloud of dust.

Pecking Order

At each step on the way to becoming full-fledged surgeons, the apologists are acutely aware that before they can climb up the rungs of the hierarchy, they first must demonstrate that they know their place in it. That's no less true for Morgan than for the male apologists, but the fact that she's a woman does complicate matters for her. In contrast, the male apologists are normative for the very reason that the system of medical education was created by men for men. Even the term of address for the house staff is gender specific: "boys," used in reference to interns and residents—all but the chief—"to remind them they weren't fully trained doctors" (7), Rainer explains. Clearly, the term "boys" isn't limited to the hospitals in Alabama and Tennessee where Rainer did his clinical training because all of the apologists use it.

''The bartenders always set up every third beer for the boys at Bellevue'' (132), Nolen recalls fondly. Eventually he grows out of the term. ''The house staff—the A.R.'s [assistant residents] and interns—were good boys'' (244), he says rather patronizingly about his underlings once he has become chief resident. ''As he shows us,'' one book reviewer notes, ''status improves with seniority'' (*Choice* 578). Agreeing that it's a fine thing to have ascended the pecking order, Moynihan writes almost exclusively about the last two years of his clinical training:

> I knew that most of the cases in plastic surgery did not require more advanced technical skill than I already had acquired from my four years in general surgery. It was not a case of a fledgling trying his wings; I was an experienced, adult bird, simply flying alone for the first time over slightly different terrain. (87)

The bird metaphor is particularly apt. But he's not allowed to forget entirely what it's like to be at the bottom of the pecking order. During a twelve-week rotation away from the hospital that serves as his home base, Moynihan reports to Dr. John Anderson, a junior resident:

> As we waited, he deliberately studied me from head to toe. ''What are your qualifications?'' he asked bluntly. I ran through them quickly, touching the salient points.
>
> ''Well, in terms of surgical experience,'' he admitted, ''you've got a hell of a lot—more than Ted and me put together.'' I saw the

resentment flicker in his eyes. ''But don't kid yourself; here, you're low man on the totem pole.''

While resenting his crudeness, I realized he was probably right. It was the old story of leaving your own domain and power structure, and invading someone else's. (251)

So when Moynihan has the audacity to ask a question, Anderson doesn't hesitate to put him in his place. '''Look, boy,' he sneered, ignoring the fact that I was at least five years his senior'' (251), Moynihan observes. Nevertheless, to placate those above him—Anderson and Dr. Ted Bently, the senior resident—Moynihan does his own scut work. ''In a gesture to prove that I was 'one of the boys,' I drew the blood myself'' (263), he says. Morgan is no stranger to the designation ''boys'' either. An interviewer uses it when she visits one of the hospitals where she has applied to do her internship. ''Our boys—we don't have any women—spend too much time cutting to have time to think'' (108), she's told.

For Nolen, Moynihan, and Rainer, there's no incongruence to being expected to turn themselves from boys into surgeons (that is, into men). Although all of the male apologists make the transition in much the same way, it's Nolen who puts the greatest emphasis on it.[7] And as it turns out, he makes the perfect foil for Morgan. Two contrasting scenes serve to illustrate how straightforwardly Nolen completes the

[7]The most likely reason is that compared with Nolen—a general surgeon—Moynihan and Rainer give short shrift to the internship year, when the pecking order assumes an exaggerated importance. Instead, the two specialists focus on their residencies in plastic surgery and neurosurgery, respectively.

passage: one from his first day on the job as an intern and one from his last year as chief resident.

> Less than one minute after I put in an appearance the day after my arrival, I got the first chewing out of my Bellevue career.
>
> "I'm Eddie Quist," said a doctor who was sitting at a small metal desk at the front end of M5, the female surgical ward, my first assignment. "You must be Bill Nolen. Where the hell have you been?"
>
> "Eating," I answered. I had just finished a leisurely breakfast in the doctors' dining room.
>
> "Around here we eat after we draw the blood. Where do you think you are, at the New York Hospital?"
>
> "Gee, I'm sorry, Dr. Quist, I didn't think I was supposed to be here till eight." (10)

As chief resident, Nolen finds himself on the other end of the stick. "It was easy for an intern to slip into bad habits, like getting to the ward late in the morning," he says, and now it's his job to do something about it:

> Bob Card had become an offender, so I decided to get after him. I wasn't operating the next morning and got to Bob's ward at seven forty-five, hoping to arrive before Bob. I did. I sat in the kitchen drinking coffee as I waited to attack. Bob arrived at five minutes after eight.

''Where do you think you are,'' I began, ''at the New York Hospital? You think we're running this place to suit your convenience? What's the idea of getting here after eight o'clock? Where the hell have you been?'' I gave him both barrels.

''I'm sorry, Bill,'' he said. (233)

It's while he's chief resident that Nolen comes to a most startling conclusion: only God has more status. ''I wasn't God by a long shot,'' he acknowledges, ''but as far as power was concerned, I was closer to Him than anyone else at hand. I had to play the role'' (257)—leading Nolen's harshest critic, Michael G. Michaelson, to question rather scathingly ''the mind of a doctor who enjoys the grandeur of his position as much as any other aspect of surgical practice'' (39).

But before he reaches the exalted state of chief resident, Nolen does as he's told, even by the nurses. ''Look, Nolen,'' Miss Riley says, ''I don't want to tell you your business, but you're new here, so I'm going to make a suggestion. You can kick me in the ass if you don't like it. Admit this old geezer.'' After hearing her out, Nolen says, ''I admitted him'' (70). And he even finds it worth listening to those who fall beneath the nurses in the pecking order: the patients. ''One thing I learned as an intern was to trust the patient's reaction more than my own immature judgment,'' he says. Mr. Swanson is a case in point. ''Stop,'' he screams while Nolen uses an electric saw to remove his cast, ''you're cutting me!'' Nevertheless, Nolen proceeds full steam ahead. ''Nonsense, Mr. Swanson,'' Nolen says, putting his faith in the equipment rather than the patient. ''The blade didn't rotate; it simply vibrated rapidly.

Theoretically, it should be nearly impossible to cut anyone with it''—famous last words, as Nolen learns when he sees the ''beautiful incisions'' he's made on Mr. Swanson's legs (81–82).

The nurses and the patients notwithstanding, it's those above Nolen in the hierarchy who most often serve him humble pie, and if he doesn't exactly savor it, he at least manages to get it down with a minimum of fuss. For example, there's the time that Nolen is brought up short during a pathology conference. Having announced to all those present that the slide he's projected on the screen shows a prostate gland that is benign rather than malignant, Nolen continues. ''Now I'll show you a real cancer,'' he says, when ''a voice from the corner'' speaks up. ''That is a cancer,'' says the voice, calling attention to the ''bizarre pattern'' on the slide. Taking a quick peek into his slide box, Nolen makes a mortifying discovery. ''He was right. I had picked up the cancer slide rather than the benign slide. Fortunately the room was dark; my red face didn't show.'' Virtually prostrating himself, Nolen does his best to recover from the mistake. '''I think you're right, at that, sir,' I said quickly. 'I hadn't noticed that before. In fact, I'm certain you're right. Thank you for correcting me.''' It's only later that Nolen learns who the voice belongs to—''a visiting pathologist whose specialty was genitourinary diseases. It was hardly fair'' (115–16), Nolen protests feebly.

Even when subjected to verbal abuse from his superiors, Nolen finds a way to excuse it. Dr. Grove has a particularly memorable temper, as Nolen learns one day in

the operating room. "I had no sooner picked up the scalpel than he began shouting at me," Nolen says, recalling the episode:

> That's the way it went for three long hours. He wasn't satisfied with the way I tied knots, or the method I used to free the artery leading to the gall bladder, or the way I sutured the gall bladder bed. When I used the scissors to cut the gall bladder duct, he fairly screamed, "For Christ's sake, Nolen, you're a surgeon, not a veterinarian. Use a knife. Give me those goddamn scissors." He grabbed them out of my hand and threw them on the floor. "Now get back to work." (170–171)

By the time the operation is over, Nolen says, "I could have strangled the man with my bare hands"—mere bravado, for in the next moment, all's forgiven. "When he said, 'Not too bad, Nolen—I'll make a surgeon out of you yet,' my resentment melted away" (171). And when he's not taking his lumps, Nolen is earning brownie points:

> Every night before I turned in, I'd stop at the nurses' station on the surgical ward and tell the charge nurse, "When Dr. Loudon shows up, no matter what time it is, call me."
>
> At six-fifteen or so, just as he was stepping in to see his first patient, I'd materialize at his elbow.
>
> "Good morning, Dr. Loudon."
>
> "Well, hello, Bill. Up early, aren't you?"

''Just wanted to tell you about Mrs. Patterson. When I changed her dressing yesterday I noticed her incision was a bit red at one end. You may want to take out a stitch or two.''

''Let's have a look,'' he'd say, and I'd complete his rounds with him. (168–69)

Nolen is certainly a smooth operator. Or as Michael G. Michaelson bluntly puts it, he's adept at ''the 'ass-kissing' that getting to the top of the surgical pyramid requires'' (40).

Eventually, though, there comes a day when Nolen decides that he's justified in breaking rank. And in telling the story, Nolen is even able to get in another plug for Bellevue. It's a city hospital that's long on patient care and short on book learning—to the delight of Nolen and to the chagrin of Sam Marity. ''He had been trained in a university hospital and knew surgical theory cold, but he was frightened to death of operating. He gave his cases to us because he was afraid to do them himself'' (180), Nolen says. It so happens that one of Marity's patients is a six-year-old boy who has swallowed a spike. After three days, the radiologist alerts Nolen to the situation. ''Every day he gets an x-ray, and every day the spike is in the same place. I'm no surgeon, but I think someone should go after that thing.'' Even in going over Marity's head, Nolen is careful to observe protocol. ''I agreed wholeheartedly,'' Nolen says. ''But this created a delicate situation. I could hardly tell Marity what to do—after all, I was only a resident—but someone had to persuade him to operate. I decided to work through Loudon,'' who picks up the phone:

''Sam? Jeff Loudon. Say, one of the residents was just showing me an interesting x-ray—that kid with the spike. That's a beauty, isn't it?'' There was a pause as, I presume, Marity agreed.

''I was wondering,'' Dr. Loudon continued, ''if you were planning to take that out tonight or first thing in the morning. I'm kind of betting you plan to do it tonight. Am I right?''

Pause.

''That's fine, Sam. I'd like to hang around and watch, but we've got dinner guests. Ask the resident to show it to me tomorrow.'' (181–82)

It's a win-win situation, for by protecting the patient's welfare, Nolen benefits, too. ''You've got yourself your first stomach case, Bill,'' Loudon tells him after hanging up. ''Have fun'' (182).

Compared with Nolen and the other male apologists, who blithely make the transition from boys to surgeons, Morgan is a tortured soul. More than anything else, she longs to be one of the boys, who outnumber her. ''There were only seven women among ninety men in my medical school class,'' she says, ''and on the first day we all went to a room in the old administration building and lined up to register.'' At first, she's uncomfortable. ''Many of the men around me had been Yale undergraduates and already knew one another. They were joking and laughing casually and I felt out of place and terribly shy.'' Then one of them breaks the ice. ''You must be Elizabeth,'' he says, adding, ''I saw your photograph on the

registration desk. I'm Frank'' (28). She breathes a sigh of relief. ''After that the men in line included me in the general conversation. I was no longer a complete outsider. Medical school had begun'' (29). So far, so good.

Then, after the first two years of medical school, she does her first clinical rotation: ten weeks of surgery. ''I was still interested in being a surgeon, but I had been warned that surgeons did not want women in the field and that physically, women did not have the stamina needed for surgery,'' she says. ''If I couldn't take it, I wanted to find out now'' (49). As it turns out, her fear of being an outsider vanishes the first time she steps into an operating room. A little bit of friendliness from one of the nurses goes a long way, Morgan notes. ''She kept me from feeling that because I was a woman, I didn't belong'' (53). And then there's Dr. Chase. ''You must be the medical student and I am very happy to see you'' (53), he says. ''I want you to be a surgeon. We need more women surgeons. We men are too crude'' (54). Morgan happily reports, ''I was part of the team'' (54), an insider rather than an outsider. Yet she's not simply a surgeon in training; she's a *woman* surgeon in training. And later, she's not simply a surgeon; she's a *woman* surgeon.

As it turns out, the difference is a significant one in terms of the pecking order. Even though the title of Morgan's book is superficially similar to Nolen's *The Making of a Surgeon*, it seems that the making of a woman surgeon is a contradiction in terms. For Morgan expends tremendous effort trying to reconcile her inherently low status as a woman with the high status that she hopes to achieve as a surgeon. As she explains, ''many of the non-M.D. workers in a hospital are women—nurses,

licensed practical nurses, dietary workers'' (*Contemporary Authors* 108: 331). They know their place. She wants to rise above it. It's not going to be easy.

Six weeks into her ten-week surgery rotation, she repeats proudly, ''I had become part of the team''—well, yes, but as what she calls its ''mascot, being the only woman medical student in years with an interest in surgery'' (65). Then, having discovered the reason for a patient's abnormal white blood cell count simply by reading the old hospital records, she's complimented—sort of—by Dick Callahan, an intern. ''Good girl. I'm really embarrassed that a female medical student had to teach me to read the medical chart. I'm proud of you. It makes me feel I taught you something this summer'' (86). And when she begins her internship the following year, she's greeted with the following news. ''Elizabeth, the private surgeons really objected to the idea of working with a woman, but don't let it bother you'' (115). Has she just been warned or reassured? It's hard to tell, but either way, her status is uncertain. The same cannot be said about her fellow interns—Mark, Eric, and Zach—whose presence is taken for granted. So by the end of the year, she is justifiably proud of having survived. ''I knew how the system worked,'' she says. ''I was a woman, but I had worked hard, taken orders and criticism, and done the scut''—in other words, I was a woman, but I knew my place in the hierarchy—unlike the ''short cocky young man'' who replaces her. The pecking order be damned: ''I'm not going to bust my ass for anyone'' (187), he announces to his peril, for he washes out.

tell me about this patient Clarkson, would you? How very kind of you.'' (229)

As that incident suggests, it's not uncommon for men to throw their weight around—not only figuratively, but literally as well—as they resort to intimidation in an attempt to establish dominance over others.[8] In that respect, 130-pound Morgan isn't on a level playing field, and she knows it. No problem, she insists characteristically. ''As a woman I was not tempted to use physical strength to assert myself. The tempering influence of women was, I thought, a good change for surgery'' (304–305).

But at the same time, Morgan acknowledges that as a woman, she is automatically more vulnerable than the men with whom she's competing. Having interviewed at a couple of big-city hospitals in order to decide where she would like to do her internship, Morgan doesn't like what she hears. ''We have a lot of violence in this city,'' one surgeon tells her. ''Now, in the hospital itself a few people have been shot, but only two people killed. One patient was gunned down standing right by the front elevator. We have not lost a doctor yet.'' The hospital is armed to the teeth, as Morgan notes. ''Security officers with guns stood at every hospital entrance.'' She reconsiders her priorities. ''I had thought I wanted a hospital with a lot of trauma but

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[8]Rainer shows how it's done in a confrontation with the senior resident—or, at least, how it's done by a man. ''In December the normally smooth running of the brain team was interrupted by an argument between Pete and me. For months he had performed all the difficult brain operations, leaving the easier spinal operations for me with the explanation that tradition allowed the senior resident first choice on operations and the privilege of bumping junior residents from doing surgery'' (87). Enough's enough, Rainer decides. ''I walked over to Pete, stood inches from his face, and said in a low, monotone voice, almost a whisper: ''Let me tell you something. I'm going to operate on Shirley Roberts, the charity aneurysm case scheduled tomorrow''' (88). Pete backs down. ''Okay, you do it'' (89).

I hadn't realized that a lot of trauma meant a lot of violent crime. It was bad enough at Yale where you had to be careful after dark, but in these places, a woman couldn't walk on the street safely in daylight. I had to think again'' (108–109).[9]

And the men aren't oblivious to the advantage that they hold over Morgan. It's an uneven contest, as they're well aware, so apparently in an attempt to handicap it, they frequently come to her aid—and Sean isn't the only one. Another one is Alf, who takes on the role of big brother to her. ''The kid is going to Boston for a residency interview,'' Alf tells the chief resident, who initially turns a deaf ear to her request for a day off. ''Don't give her a lot of grief. We can manage without her for a day.'' The chief resident reminds Alf who's boss. ''On this service, Alf, I am the chief. Get that straight?'' Morgan stays out of the fray. Alf refuses to budge. '''Big deal. I could beat you up any time. Look at this.' He flexed his biceps. 'You may be bigger, but I have speed.''' And then Alf turns to Morgan. '''You should work out on the punching bags, Liz, and pretend it's Chief Groucho here,''' he recommends, only half joking. ''The chief resident gave up,'' she reports, ''and we started evening rounds'' (211).

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[9]No such qualms deter Rainer, who matter-of-factly describes the hospital where he has chosen to do his internship. ''Many of the patients brought to the hospital had knives and guns in their pockets and occasionally razor blades hidden in their hair, an additional weapon if grabbed by the head in a fight. Policemen stationed at the front doors of the E.R. disarmed patients before they were brought to us for treatment, but sometimes a patient slipped through who still had a knife or gun. Patients tried to keep their weapons, hoping for a chance to retaliate against the person who had shot or stabbed them, should that person also be in the emergency room. At times a knife or gun was pointed at an intern, ensuring prompt medical service. No one was ever seriously hurt, though'' (36).

But there comes a time, Morgan says, when "I had no protector." Another resident takes it easy while she runs herself ragged—except when there's something in it for him. "When a good operation came up," she says, "he would rouse himself and elbow me out of the way." At first, the black resident who replaces Morgan is subject to the same treatment. "He started on me because I was black, just as he did to you because you're a woman. But I stopped him." Size matters, even in an elite domain like surgery: "a big man who had played tackle in college football," the black resident takes charge. "I just told him how it would be and he knew I'd beat his face in if he didn't play fair" (161). And it's not just talk, either. When violence erupts between two members of the house staff—both of them men, of course—the chief of surgery issues a reminder: "football is football and surgery is surgery" (304).

Whereas life becomes easier for the male apologists as they climb up the rungs of the hierarchy, the opposite is true for Morgan. "It is often easier to be a woman in surgery during the internship and early residency years," she explains in the introduction to her book, "because the men think it is sweet for a woman to try to be a surgeon. Later on it is harder, because most men don't like to be subordinate to a woman surgeon, who is telling them what to do, or who is right on a diagnosis when they are wrong" (9). Once she makes chief resident, Morgan is subject to constant reminders that her presence in a man's world makes the people around her uneasy—a fact that she highlights by beginning her book *in medias res*. It's 2:30 a.m. on New Year's Eve in Boston, a stabbing victim has been brought to the emergency room,

and she's in charge. ''One of the policemen grabbed my arm. 'Hey, listen—you aren't the surgeon, honey, are you?' He was grinning as if it were all a big joke. His buddy next to him was grinning, too.'' And they're not the only ones. ''An ambulance driver standing by the vending machines in the hallway stared at me in disbelief, shaking his head'' (15). Morgan reflects on the episode:

> I am accustomed to it but I still feel self-conscious when strangers stare at me as though I am a performing mouse. They don't expect a five-foot-five long-haired girl of twenty-eight in an ugly green cotton shift to be the surgeon. They cannot believe that in a code room filled with blood and a dying stab-wound victim the other doctors are shouting for a girl. (15–16)

The same attitude is often conveyed by the patients, and she knows where they fall in the pecking order: ''students, interns and residents came next to last. Last came the patients'' (52). Nevertheless, many of them give her a run for her money throughout her residency.

Having been called ''honey,'' ''sweetheart,'' and ''dear'' by a patient in his mid-40s, Morgan sets him straight: ''don't speak to me like that. I am Dr. Morgan. It is here on the name tag. M-O-R-G-A-N. Would you like me to write it down?'' (201). It's not an isolated incident, either. ''What's wrong with being a wife and mother?'' another patient asks while Morgan tries to examine him. ''Are you married?'' he continues. When she won't answer his questions, he adds, ''You'll never catch a man with that attitude, my dear'' (229). And she's board certified in

general surgery and well on her way to completing her residency in plastic surgery when she encounters Mr. Warren:

> I introduced myself. He roared with laughter.
>
> "You're a cute little girl I'd like to get to know. Do I call you Girl, Miss, or Ma'am?"
>
> "Just call me Doctor Morgan."
>
> He laughed again. "Call you Doctor? Yes, Ma'am." He laughed uncontrollably.
>
> My friendly façade faded. My face froze. "Why did you come to the hospital?" (349)

Little wonder that the exchange between her and Mr. Warren finds its way into a chapter that she wearily entitles "Eleven Years for This" (345). But notably, Morgan verbalizes her disappointment only when she has nearly completed her training. And even that chapter ends on positive note as she recalls the first time she repaired a cleft palate. "Before the operation you could look from the mouth directly into the nose. Now the hole was closed, and the palate was reconstructed. It was miraculous. I was always exhilarated after an operation went well" (351).

As usual, Morgan ends up dismissing the fact that she's treated like a second-class citizen[10]. No wonder one book reviewer (a woman) does the same:

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[10]Today she sums up her book as follows: "actually, the system is really okay. Everybody with a few exceptions was wonderful. And it was very, very hard, but here I am. And it's all fine." In other words, she played the role of what she calls "the female enforcer: the woman who takes on the values of the system she's in and upholds them." Why? "The abusive nature of what I was experiencing was not clear to me," she says,

> What makes a woman surgeon's experiences in the male-dominated medical profession unique? According to Dr. Morgan, not much. Although she recounts incidents of sexism, readers will be surprised at how infrequent they are. Her experiences are no more and no less harried, exciting, depressing, and challenging as her male colleagues'. (Flannery 172)

One who prefers to go along to get along, Morgan finds that changing the system—any system—is not in her repertoire. "I could not in any sense be described as an activist," she says in reference to one of the defining events of her time: the Vietnam War. "The TV and newspaper accounts of the war horrified me so I tried to avoid them" (38), she says. Her reaction is in marked contrast to that of some of her classmates. "The leaders of the anti-war group at Yale were Peter and Ruth who saw themselves as leaders of a radical new breed of doctors who would 'liberate' medicine" (38), Morgan says, and she wants no part of it. Moreover, she claims to be in good company. "Most of us were alternately amused and irritated by Peter and his radicals" (39), she adds.

Even when Morgan faces an extra year of training, she remains mum about the reason for it:

> I had now been a resident for six and a half years. I had hoped to finish my plastic surgery residency in another six months, in July, but

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adding, "the price that I paid was by diminishing my willingness to be assertive within the system" (Morgan, telephone interview, 14 Feb. 2002).

> it did not look possible. I had had a disagreement with one of the plastic surgeons in the first few months of my residency a year and a half ago. I knew that he had tremendous political power and had recommended to the Plastic Surgery Board that my time with him not be approved. I would have to take an extra, unforeseen, eighth year of residency, if the Board denied me credit for my time with him. I sent in my application for approval with letters of recommendation from other plastic surgeons, but I did not think my application would be approved. I had enjoyed my training, but an eighth year of residency seemed too much to take. (345)

Yet she resigns herself to it. "The Plastic Surgery Board had not replied to my request for approval of my first-year residency. It seemed hard that a disagreement with a plastic surgeon in the first three months of my residency would force an extra year of training on me, but that was the way it was going to be" (356). A disagreement? What kind of disagreement? She doesn't say, but as it turns out, approval is granted: "the Board sent me a letter," she says. "My residency would end July 1. I was Board-eligible!" (360).

It's not until *Solo Practice: A Woman Surgeon's Story* that Morgan reveals the nature of the "disagreement" that threatened her career. To make a long story short, while attending a meeting of the American College of Surgeons (ACS), she rejected the sexual advances of one of her former teachers, Dr. Arnold Tewkesbury. But she's willing to share the blame. "My two years of plastic-surgery training were almost

stretched into three years, partly through my own folly." She explains. "At the ACS convention, the evenings began with reunions." For one of them, "a formal affair," she wore three-inch heels and a floor-length dress "slit up one side. For the first time in months, I didn't look like a limp, sexless resident," she says, adding, "Dr. Tewkesbury gave me a curt nod over his double scotch." She continues. "The next morning I sat studying the convention program in an almost empty auditorium," and he makes his move. "'You don't know what you did to me last night, Elizabeth.' He put his hand out, squeezed my knee suggestively, and gave me a seductive smile. 'You don't know what you did to me,' he repeated, massaging my knee. Confidently, he moved his hand up my leg." Morgan has a ready explanation for his behavior. "Dr. Tewkesbury had never thought of me as a woman when I worked with him, but, dressed up for a cocktail party, I had caught his eye." And again, she's willing to share the blame: "I knew it was partly my own stupid fault." Fortunately, another surgeon steps in: Dr. Jacques Villiers. "You get Forbes and Thierry and Flint to write to the Board, petitioning approval for your residency to end this July. I'll write for you as your Chief. We could blow Tewkesbury off the map. You don't need a third year. You want to get out of the trenches"[11] (Morgan, *Solo Practice* 12-16). Four good guys—Villiers, Forbes, Thierry, and Flint–and just one bad one. Not a bad

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[11]And indeed she does, but Tewkesbury—or "the Tarantula," as Morgan's brother Jim calls him (44)—doesn't let up even once she's in private practice. The *Los Angeles Times* offers some highlights from *Solo Practice: A Woman Surgeon's Story*: "he's gone out of his way several times to make it difficult for her"—for example, "trying to fix it so she can't operate at local hospitals, talking trash about her to other surgeons. And the boards are coming up—he's bound to be involved with those" (See 8). To Morgan's chagrin, the Tarantula is a powerful man.

ratio for someone like Morgan, who even serves an apologist for the behavior of what book reviewer Carolyn See calls an "old coot" (See 9).[12]

Morgan isn't exactly what anyone would call a women's libber,[13] a point that the dust jacket of *The Making of a Woman Surgeon* captures perfectly. "Hers is a woman's story—not a feminist lament about discrimination," despite its central theme: "a talented young woman's initiation into an exclusive club whose rules are as rigorous and tradition-clad as they were twenty years ago." Several female book reviewers agree. "This is not an analysis of the female medical experience or a feminist diatribe" (Flannery 172), says one. Another makes the same assessment. "This is no doctrinaire tract that strains to show all male surgeons as chauvinist brutes making life a misery for the fragile flowers of femininity in their midst," says Estelle Ramey. "Nevertheless, there are special burdens in being a woman in a man's domain" (Ramey B12), she adds. Ramey ought to know: she is a professor of physiology and biophysics at the Georgetown University Medical School. And finally, a third book reviewer chimes in. "Happily, Elizabeth Morgan is no entrenched feminist, clawing her way up; she is a dedicated healer who nonetheless knew the score and made it in her quiet, self-assured way" (Veach 190).

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[12]Back then, the thinking went as follows, Morgan says. "Guys do what they want, and women either keep guys under control, or it's all a woman's fault." It's a perspective that she no longer holds (Morgan, telephone interview, 14 Feb. 2002).

[13]"At the time," Morgan says, "I was very much out of sympathy with a feminist viewpoint. I had a conventional male viewpoint" (Morgan, telephone interview, 14 Feb. 2002).

Despite her reluctance to find fault with the system of medical education, Morgan concedes that it takes a toll on women who aspire to be one of the boys. She recalls an incident that occurred back in medical school. Told by the senior resident to start an intravenous line in a patient, Morgan does as he says. "Her hand felt cold but I had found a vein and was trying to get the needle in—my hand was shaking—when a group of medical interns and residents arrived to help." One of them immediately pulls rank. "A woman intern slapped me on the shoulder and told me to get out of the way. 'They shouldn't let medical students clutter up a code,' she said to no one in particular." Morgan does as she says. "I stood with my back against the wall, watching," and when the patient is pronounced dead, the woman intern blames Morgan. "You should never answer a code unless you know enough to help. A well-meaning incompetent can cause enough delay to kill someone." Everyone scatters, and as for Morgan, "there was nothing for me to do except go back to the dorm. I was crushed." The next day, Morgan's conscience is eased by the senior resident. "It was a shame we lost Mrs. Jones," he says, "but she was cold when the nurse found her. She must have been dead for fifteen minutes already" (81). It seems that Morgan threatens the status of the women who have preceded her:

> There were very few women doctors at Yale, or anywhere, and they were intelligent, efficient and severe in looks and manner. My dream then was to become as sharp, cool and commanding as they were. It took me many years to learn that their manner—and their overly critical attitude toward women medical students—reflected their insecurity and

jealous protection of their own uncertain position in a man's world.

(81)

It's a trap that Morgan herself falls into unawares.

By the time that she becomes a resident, she says, "I was getting as tough and quarrelsome as the men" (257). She comes to that realization during her rotation on cardiac surgery, a service that is headed by Dr. Anjou. He makes it perfectly clear where everyone stands. "If you have a question," he tells Morgan, "ask him," meaning Dr. Firenze. "If Firenze has a question, he asks him," meaning Dr. Norland. "If he has a question, he calls me. That is an unchangeable hierarchy" (252). As Morgan discovers to her chagrin, one of the attending physicians is a micromanager. "Dr. Firenze would correct me constantly during an operation," she says, but if Dr. Anjou was there, he'd put a stop to it: "Oh, leave her alone. She's not the intern" (253). This time her protector is the chief of cardiac surgery. But Morgan is a big girl now, and she's ready to take care of herself: "if Dr. Firenze wanted to give me a hard time," she says, "I was ready to fight with him." The day finally arrives. She and Dr. Firenze are working alone together when all hell breaks loose. "It takes a man to do this right. You better let me take over," he says, his actions matching his words. "Dr. Firenze put his left hand over mine and tried to take the needle holder away from me with his right hand." Wrong move. "I snatched my hand away and turned on him," Morgan says:

''Don't you touch me. Don't you ever touch me. I'm not your wife. Don't you ever grab anything out of my hand. You ask me for it. Don't you ever put your hands on me again.''

''What do you mean by speaking to me like that? You're a resident. You wouldn't speak to Dr. Anjou that way. You can't speak to me that way.''

I put my hands on my hips and glared at him. ''Dr. Anjou doesn't put his hands on me as though I were a tart off the street. He treats me like a doctor, and I respect him. I don't respect you at all, and I'll talk to you any way I want.'' (257-58)

Later Morgan retreats, apologizing to Dr. Firenze and the nurses who had witnessed the ''disgraceful scene,'' as she calls it. Blaming herself once again, Morgan says, ''I expected to be fired, or at least thrown off the service.'' As it turns out, the consequences aren't as bad as she fears—a scolding from Dr. Anjou is all. ''Attending *and* resident staff should behave like doctors, not children'' (258), he tells the entire team.

Still, that event and others like it leave Morgan questioning herself. For by stepping out of line, she has failed not only as a surgeon, but as a woman as well. Consider how she feels after cutting another man down to size—he's just a patient, but even so, a man's a man:

I went to the kitchenette to pour out a cup of coffee, and sat down to think. The man had been stupid, provoking and rude, I told myself. All

the same, I wasn't proud of the way I had behaved. It didn't seem right for me to speak like that, although all the men surgical residents around me talked the same way whenever they were tired and irritated. I resolved to be a better doctor. I didn't like to think I was becoming unfeminine, but I knew I would not have spoken like that a year ago. (202)

Others notice the change, too. "Both of my brothers complained to me that I wasn't as agreeable as I used to be." True enough—but what do they expect? "'It's not my job to be nice,' I agreed. 'I'm a senior surgical resident and my job is to see that things get done, and done right'" (280). But then she's brought up short by Dr. George Woodruff, a surgeon at the hospital: "you are getting hard, impatient and critical," he warns her, and even Mom agrees:

I was not on call for a few days so I had time to think about what Dr. Woodruff had said. I thought of nothing else all weekend, in fact, and on Sunday I called my mother.

"Am I getting hard, impatient and critical?" She hesitated. "Mother, I need to know the truth."

"Then the answer is yes."

"Masculine?"

"Definitely not, but less feminine."

And for the first time in a long, long time I started to cry. (307)

It's a side of herself that she keeps hidden, or tries to. "Elizabeth, long time no see. How does it feel to be a surgeon?" asks one of her classmates, Marshall—a resident in psychiatry, of all things. "Fine" (202), she replies. He doesn't buy it:

> "You look unhappy. Pretty, but unhappy."
>
> "I'm tired."
>
> "It's more than that. It's something about being a surgeon. Come out to dinner with me tomorrow and tell me about it." (202)

He tries one more time. "The woman in you is struggling to come out," he says. "Tell me about it tomorrow night." Pleading a heavy work schedule, she declines while engaging in some internal dialogue. "I would never tell a male doctor that being a surgeon was hard for me as a woman," she vows. "Never" (203).

So when Morgan learns during her seventh and final year of her clinical training that a new woman surgical intern has just started, she responds with the empathy of one who's been there. "I could only hope that she would learn, sooner than I had, and with less struggle, how to be a surgeon and a woman at the same time" (330), Morgan says about Melissa Smith. But it appears to be a forlorn hope. For one thing, Smith is surrounded by male surgeons who are determined to eradicate her traditionally feminine characteristics. "We have to do something about Melissa Smith," one of them says, explaining: "She's a very nice girl but she's not like a surgeon." And it doesn't take long for Smith to catch on. "Two weeks later there was an edge to Melissa's voice," Morgan notes, taking her aside to offer some unsolicited advice. "Don't complain. Don't get mean. It's the worst mistake you can

make'' (330). Morgan speaks from experience, for despite having compromised her femininity, she still isn't one of the boys. In fact, one book reviewer concludes that she offers ''a chronology of the entry of a complete female into surgical practice'' (Veach 190).

If by ''complete female'' Veach means ''heterosexual female,'' then she is correct. Morgan is careful to point out that she is attracted to the opposite sex. For example, ''after graduating from Harvard,'' she says, ''I had spent six delightful months in Oxford going to parties and meeting men'' (74). Despite her sexual orientation, however, her gender keeps getting in the way. Her caution to Smith notwithstanding, Morgan provides little evidence to suggest that she herself is able to integrate the two conflicting parts of her identity—woman and surgeon—except for the fact that she's eschewed the uniform. ''It was asking for trouble not to wear a white coat,'' she admits, ''but I hated those coats.'' The explanation is simple: ''I needed to feel feminine and different from the male surgeons'' (227), who try their best to bring her back into line. '''You have to wear whites,' said one of them. 'It's a surgery department rule. Otherwise, no one knows you're a doctor. Especially being a woman. You're a professional now, a surgeon, so dress like one''' (116). They almost have her convinced when one of them dissents from the others:

''Fantastic,'' he said. ''I like it. I like it.''

''What do you mean?''

"Your clothes, your street clothes. You look like a woman again, Elizabeth. Don't let those turkeys tell you what to wear. They're not your mother."

"I don't look like a surgeon in street clothes."

"Wrong, dear, you mean you don't look like a male surgeon. There are no female surgeons. You can wear anything you damn well please." (116)

Having one man take her side is more than enough for Morgan, who decides to continue wearing street clothes. But ironically, both the front and the back of the dust jacket feature photographs of her wearing a white coat—although in a nod to her femininity, she's wearing it over a flowered dress, and with pearls, her long, brown, wavy hair cascading over it.[14] She may be a surgeon, but she's definitely not one of the boys.

An Apple for the Teacher

The teacher is anyone who is at least one rung higher in status. For a medical student, the intern and anyone above is the teacher; for the intern, the resident and anyone above is the teacher; for the resident, the chief resident and anyone above is the teacher; and for the chief resident, the teacher is the chief of the department. All

[14]About the dust jacket, Morgan explains, "it's sort of a struggle to come across with the right visual image." Why a white coat? "It made the statement that needed to be made for the book" (Morgan, telephone interview, 14 Feb. 2002)—that she is a woman and a surgeon, too.

of the apologists reserve their highest praise for the men—and they are all men—at the top of the hierarchy.

For Nolen, it's Dr. Russell Stevens, the chief of surgery of Bellevue's second surgical division, which is affiliated with Cornell University (4). For Moynihan, it's Dr. Lawrence Parmenter, the chief of plastic surgery (22). For Rainer, it's Dr. Richard T. Harkness, the chief of neurosurgery (65). And for Morgan, whose clinical training consists of three distinct parts—(1) her internship and the first year of her general surgical residency in New Haven, Connecticut; (2) the last three years of her general surgical residency in Boston; and (3) her plastic surgery residency at hospitals in two locations, specifically, New Haven and Cambridge, Massachusetts (*Who's Who in America*, 54th ed.)—three men serve as her role models, one for each phase of her clinical training. They are Dr. Hillebrand, the chief of private surgery (138), Dr. Baker, the chief of the emergency room service (231), and Dr. Berenson, the chief of plastic surgery (269).

Morgan chooses wisely. For even before her "disagreement" with Dr. Tewkesbury, she had learned to be wary of men who would prey on her. "Women medical students were considered fair game by some of the married faculty" (31), she observes. And then there's the time that she attends her first national convention. On the shuttle bus back to her hotel on the day she arrives, a 60-year-old surgeon introduces himself to her, and eventually, like Dr. Tewkesbury, he makes his move. "I'm very adventurous, surgically and sexually. You should see me operate" (264–65), he suggests. Morgan declines. Even so, for the remainder of her stay in

Miami, she finds herself preoccupied with "dodging" him (266). Wryly alluding to Helen Gurley Brown's *Sex and the Single Girl*, Morgan entitles the chapter "Sex and the Single Surgeon." Morgan is no Cosmo girl despite the column that she writes for the magazine. On the other hand, Morgan herself can't help but notice some of the men at the top of the pecking order. "Dr. Vincenzo was an incredibly handsome Italian with seductive brown eyes and a charming smile" (40), she says, confessing to having a "crush" on "Enzo" (46). He is an infectious disease specialist, though, and in general Morgan prefers surgeons, whom she characterizes as "more attractive as men than most other doctors—more dominant, more decisive and more masculine" (52). But they're out of bounds:

> I kept my distance from the faculty surgeons, all of whom were married. Hospital gossip loves to link any woman—nurse, medical student or doctor—in a love affair with a married man on the faculty, and there were many such affairs. I knew that if I had a love affair with a surgeon, I would no longer be part of the surgical team, but labeled "so-and-so's girl," a woman who got ahead by sex, not ability. As a consequence, few of these men knew me well. (208-209)

Unlike the male apologists, Morgan always has to watch her step.

Consider that when she first introduces Dr. Hillebrand, Dr. Baker, and Dr. Berenson, she omits their first names. In so doing, she emphasizes the difference in status between herself and her mentors: they may call her either "Elizabeth" or "Dr. Morgan," but she may only call them "doctor." The same holds true for the male

apologists—it's always Dr. Stevens, Dr. Parmenter, and Dr. Harkness to them, never Russell, Lawrence, or Richard, as Nolen points out: "I think I'd have fainted on the spot if I had ever seen Dr. Stevens buddying up to the house staff; and I'd have dropped dead if I had ever heard someone on the house staff call him 'Russ.' He just wasn't that kind of a person. Not, at any rate, with us" (227). Even so, Nolen, Moynihan, and Rainer make a point of supplying the first names of their teachers, thus bringing them down to human proportions at least somewhat. And Moynihan goes one step further by reporting conversations in which those higher in the pecking order than himself refer to Dr. Parmenter as "Larry" (71–72; 143).

Superlatives are the order of the day for the apologists as they describe their teachers. Nolen on Dr. Stevens:

> By keeping a certain distance from us, being friendly, helpful and courteous but never buddy-buddy, he gave our division, at least in our minds, a decorum that the other divisions lacked. We felt he was the best director of surgery at Bellevue, and since he had chosen us for his house staff, we were naturally better surgical interns and residents than any others in the hospital. It may not have been true, but it was a good way to feel and we owed it all to Dr. Stevens. (240)

He not only made a positive impression on Nolen, but a lasting one, too. A quarter of a century after Nolen completed his residency, he was still singing the praises of Dr. Stevens, calling him "a man of experience and common sense" (Nolen, "Medical Zealots" 50). Moynihan on Dr. Parmenter:

> Undeniably a handsome man, he stood six feet tall, with dark brown curly hair, sparkling blue eyes, and a smile that revealed teeth so white and even that I've only seen their likes in the mouth of a merry-go-round horse. And he was a charmer. His patients adored him, not only because he was a topnotch plastic surgeon, but he was affable, caring and sensitive to their needs. He was equally popular among his own; his colleagues sought his advice and friendship. He was only forty years old and had married money. He and his wife belonged to the best clubs, resided in the most elegant suburb, and entertained lavishly. His car was the flashiest in the doctors' parking area; his clothes were specially fashioned by the most expert tailors. (19–20)

Ditto for Morgan. "Dr. Hillebrand was wonderful" (210), "Dr. Baker was as close to a saint as a surgeon can be" (242), and Dr. Berenson is no slouch, either. "He was not only a remarkable surgeon, but able to inspire people" (360).

Of the four apologists, Rainer appears to have drawn the worst hand: Dr. Harkness. It's unclear whether in his casual moments Dr. Harkness shortens his first name to "Dick" just as Dr. Stevens shortens his to "Russ" and Dr. Parmenter shortens his to "Larry." For only twice does Rainer ever use the first name of the chief of neurosurgery—Richard—and both times it's accompanied rather formally by his middle initial:

> You have been appointed junior assistant neurosurgical resident at Methodist Hospital effective July 1, 1976. Report to the senior resident,

> Dr. Peter Bone, for further instructions. Congratulations, Richard T. Harkness, M.D., Professor and Chairman, Department of Neurosurgery, The University of Tennessee Center for the Health Sciences. (65; see also 97)

It's a no-nonsense acceptance letter from a man who proves to be equally so:

> "Come here," Dr. Harkness barked when I passed him in the hall outside the operating room. He was a tall, muscular man with a commanding voice and a threatening scowl. I stopped immediately and turned to face him, almost as if I were standing at attention. "Dr. Walters canceled his talk for the journal club next Tuesday night. You fill in for him, and talk on trigeminal neuralgia.
>
> "Yes, sir," I answered, but Dr. Harkness wasn't listening. He expected no other reply from a resident. (97)

If his bedside manner leaves something to be desired, oh, well. "A winner doesn't have to worry about his image" (167), Dr. Harkness says in his own defense. And the senior resident stands up for him, telling Rainer, "the truth is, Dr. Harkness is interested in only one thing: graduating residents that are superbly trained neurosurgeons" (100). In other words, he's guilty of nothing more than borrowing a page from Vince Lombardi's playbook. Besides, Dr. Harkness is himself a virtuoso in the operating room. "Often he operated twelve to fourteen hours, but he never complained of fatigue. Each patient, whether first or seventh on the schedule, received the same intense attention" (145–46). And when it comes to the extracranial-

intracranial bypass operation, Dr. Harkness can't be beat. ''The slightest tremor in a surgeon's hand made the operation impossible because the work was so precise. Dr. Harkness was one of three neurosurgeons in Memphis with the ability to perform the surgery'' (147). Having assisted Dr. Harkness on the operation, Rainer is suitably impressed. ''The surgery was so delicate, the movements of his hands so slight, and the needle and suture so difficult to see that, to the uninitiated eye, he looked as if he was sewing the Emperor's new clothes'' (149).

Now, it's true that Dr. Harkness is fond of a particular expletive, often directing it towards Rainer. '''Goddammit!' he said. 'You didn't record the weakness in this patient's right biceps muscle. That's a sure sign of a ruptured cervical disk, and you didn't even pick it up. You've got to be more thorough!''' (144). '''No, goddammit!' he yelled. 'My [surgical] tie won't slip!''' (155). '''Goddammit!' Dr. Harkness exploded. 'You're telling me you had an open, contaminated wound, and all you did was close the skin? That's malpractice!''' (159). Put off by what he calls ''verbalized anger'' (154), Rainer is won over by Dr. Harkness nevertheless—at least, if it's true that imitation is the sincerest form of flattery. ''No, goddammit!'' Rainer shouts at the anesthesiologist during an operation. ''Don't you think I'd see blood pouring out of her brain if she were bleeding?'' (192).

The Right Stuff

Like the test pilots in Tom Wolfe's *The Right Stuff* (1979), the apologists are very quickly disabused of the notion that they're ''simply going to acquire a certain set of skills.'' Instead, they're ''all at once enclosed in a fraternity. And in this

fraternity,'' Wolfe explains, ''the world was divided into those who had it and those who did not. This quality, this *it*, was never named, however, nor was it talked about in any way. As to just what this ineffable quality was . . .'' (Wolfe 24)—well, it manifests itself in a variety of ways, but distilled down to its essence, ''it seemed to be nothing less than *manhood* itself. Naturally, this was never mentioned, either. Yet there it was. *Manliness, manhood, manly courage* . . . there was something ancient, primordial, irresistible about the challenge of this stuff, no matter what a sophisticated and rational age one might think he lived in.'' Moreover, it's all or nothing. ''A man either had it or he didn't! There was no such thing as having *most* of it'' (Wolfe 29). And the apologists are intent on establishing that they not only have it, but that they have it in abundance—Morgan included.

It's a claim that few women can make, or in all probability, would even want to make. ''Fewer than one half of one percent of all surgeons in this country are women,'' Dr. Estelle Ramey observed in the *Washington Post* when Morgan's book was published. ''Surgeons have been the ultimate Walter Mitty fantasy of masculine control—cool, commanding and quintessentially male. They have 'the right stuff.''' She continues. ''Those women who chose to knock at the door of the fraternity house of surgery had to be strongly individualistic and prepared to take the flack that goes with pushing into inhospitable places'' (Ramey B1, B12). And that's especially true for the fraternity house of plastic surgery. ''Dr. Morgan is a plastic surgeon, and the training for plastic surgery is long and bitterly grueling. The survivors are to the

medical profession what hot-shot fighter pilots are to the flying profession'' (Rovner B1).

The anthropologist Joan Cassell makes the same point in *The Woman in the Surgeon's Body*:

> When I began studying surgeons in 1983, I was struck by the martial, masculine ambience of surgery. Several of the men I interviewed compared themselves to astronauts. The legendary Chuck Yeager, who emerged unscathed from plane crashes and became the first man to fly faster than the speed of sound, might well be the surgeons' heroic ideal. Yeager's characterization of test pilots as ''a breed apart'' could have been uttered by a surgeon. (17)

Significantly, neither test pilots nor surgeons welcome women in their ranks:

> In each of these vocations, we find ritualized ordeals for initiates, active male bonding, and profound distrust and exclusion of females as participants. And in each, we find the threat of death. What is it about the ''ancient, primordial, irresistible'' challenge that women would pollute, destroy, negate? What is it about the association Tom Wolfe notes between ''the right stuff'' and death—about heroism, in short—that makes it something men do *to* and *for*, not *with*, women? (18)

Cassell answers her own question. ''Although men resist their participation on an equal basis, women are essential to these death-haunted vocations: so that they can

provide admiration, sex, service, and, perhaps even more important, *so that they can be excluded*—from rituals, knowledge, camaraderie'' (18).

There's little question that the test pilots would sniff at the idea that there is any similarity between them and mere earthbound surgeons, even male ones. But then, is there anyone with ''the right stuff'' who believes deep down in his heart that anyone else really possesses it? Nevertheless, just as the test pilots perceive themselves as being at the top of the heap—for after all, ''the right stuff,'' says Donald S. Lopez, Assistant Director for Aeronautics at the National Air and Space Museum, ''appears in increasing amounts in pilots, fighter pilots, combat fighter pilots, test pilots, and research test pilots'' (83)—in similar fashion, the apologists are certain that they, as surgeons, tower over physicians in all other specialties. And certainly Wolfe himself exalts the test pilots—''Wolfe is, rightly, very impressed with Chuck Yeager, who spent many years at the top of the ziggurat'' (83), says Lopez—maybe even with the hope that by writing about them, a little bit of ''the right stuff'' might rub off on him.

At the very least, Wolfe has come to be associated with ''the right stuff,'' even if the concept isn't original with him. ''The British were using this phrase a century ago to describe good soldiers, mainly in the form of 'the right sort of stuff.' American author Tom Wolfe made it popular again with his book *The Right Stuff* (1979), which described the character, intelligence, etc., needed by U.S. astronauts'' (Hendrickson 573). It's a phrase whose meaning has broadened over time, according to the definitions of it that appear in standard dictionaries. From the *Random House*

Webster's Unabridged Dictionary: "the necessary or ideal qualities or capabilities, as courage, confidence, dependability, toughness, or daring (usually prec. by *the*)." And from the *American Heritage Dictionary of the English Language*: "Essential abilities or qualities, such as self-confidence, dependability, and knowledge, necessary for success in a given field or situation." Surgeons aren't test pilots, so the parallels between them are just that—similarities or analogues. Even so, Wolfe is the go-to guy when it comes to "the right stuff," for there is no definition of it more complete than the one he provides.

Wolfe: *". . . a man should have the ability to go up in a hurtling piece of machinery and put his hide on the line and then have the moxie, the reflexes, the experience, the coolness, to pull it back in the last yawning moment—and then to go up again* the next day *and the next day, and every next day, even if the series should prove infinite—and ultimately, in its best expression, do so in a cause that means something to thousands, to a people, a nation, to humanity, to God"* (Wolfe 24). Medical school isn't exactly a cakewalk, Moynihan notes with pride. Instead, it's an infinite series of never-ending days (and nights):

> The first year of my study program permitted about four and a half hours' sleep a night. Classes and lab sessions at school ended around five p.m. I'd rush to the fraternity house for a quick twenty-minute dinner and before six I was back at the medical school library for a night of intensive studying until it closed at one a.m. Then I'd go

across the street to take advantage of the University Hospital's library until three a.m. (29–30)

And if medical school is a grind, residency is even more so. As a junior resident, Rainer asks a question of the senior resident: ''How do you find time for all the work?'' He answers without a hint of complaint:

> I've followed a schedule for two years that works well. I make charity rounds at four-thirty a.m., before the staff neurosurgeons get to the hospital and begin calling me. I make private practice rounds for the staff surgeons from five-thirty to seven a.m. before I go to the operating room at seven-thirty. Usually I get out of the O.R. around three p.m. and do a few histories and physicals before the five o'clock afternoon conference. I eat supper from five-thirty to six and then go to the E.R. to see the patients that have been waiting during the day. At eight p.m. I finish the ten or fifteen histories and physicals I have left, and about ten p.m. I make evening rounds and check all the post-op patients. From midnight to one a.m. I write orders on patients going to surgery or having myelograms and arteriograms the next day. I go back to the E.R., check for patients, then try to sleep from two to four a.m. before starting the next day's work. (73)

Rainer responds with an understatement: ''That's a full day'' (73), he says.

Moreover, it's one that is devoted to ''a cause that means something'' (Wolfe 24), even if the general public doesn't appreciate it. ''They knew nothing about the

right stuff, of course'' (Wolfe 37). Consider the conversation that ensues after Rainer successfully removes a spinal cord tumor from Lee Hampton:

> ''Doc,'' he said, smiling and patting me on the back, ''you've got it made. Thirty-five hundred dollars for one day's work. No one else does that good!''
>
> I looked at Ham, now restored to health. I started to tell him about all the weekends away from home because of emergencies and how little time I spent with my children. But it was easier just to shake his hand and wish him well. (218)

Moynihan also discovers that it's unrealistic to expect the general public to appreciate those who have the right stuff—like himself. Having spent both Christmas Eve and New Year's Eve answering emergency room calls, he takes objection when the press focuses on what he portrays as merely a faux pas—regrettable, to be sure, but nothing that impinges on the right stuff. It seems that a murder suspect who is treated at the hospital manages to ''amble out'' (205) before he is turned over to the authorities:

> The story hit the front pages of every newspaper the next morning. The reporters were scathing, and the hospital staff was severely criticized. We had it coming, I suppose.
>
> I found myself scanning the front page and the pages that followed. I read headlined articles and almost buried paragraphs. Nowhere was there any mention of the lives we had saved, the hours we had toiled, or even the backaches we'd sustained.

> I guess there wasn't any place in the tabloids for our success stories. But during the short holiday span, a handful of dedicated people in University Hospital's Emergency Room had attended seventeen hundred and thirty-one human beings. (205–206)

It's lonely at the top.

Wolfe: *''Nor was there* a test *to show whether or not a pilot had this righteous quality. There was, instead, a seemingly infinite series of tests. A career in flying was like climbing up one of those ancient Babylonian pyramids made up of a dizzy progression of steps and ledges, a ziggurat, a pyramid extraordinarily high and steep: and the idea was to prove at every foot of the way up that pyramid that you were one of the elected and anointed ones who had* the right stuff *and could move higher and higher and even—ultimately, God willing, one day—that you might be able to join that special few at the very top, that elite who had the capacity to bring tears to men's eyes, the very Brotherhood of the Right Stuff itself''* (Wolfe 24). Not everyone makes it: *''At every level in one's progress up that staggeringly high pyramid, the world was once more divided into those men who had the right stuff to continue the climb and those who had to be* left behind *in the most obvious way''* (Wolfe 25). ''On our division at Bellevue,'' Nolen says, ''we had what is known as a 'pyramid' system'':

> We started with seven interns on general surgery, and five years later one would become chief resident. The pyramid was narrowed by several methods. Some of the interns might decide to go into one of the subspecialties, and after two years of general surgery, required by most

> subspecialties, they'd move into a different program. Others in the starting group would decide that the pace at Bellevue was too hectic and the competition too great. They'd drop out after a year or so. (xiii–xiv)

And then there's the third method. ''Some of the starters would be fired. If the guy was obviously a goof-up, this wasn't too painful; but if he was a nice fellow who just wasn't quite as good as the man with whom he was competing, it was sad'' (xiv). Nolen himself is one of ''the elected and anointed ones'' (Wolfe 24), he happily points out. ''The day that Dr. Stevens called me into his office and told me I was to be the next chief resident ranks with the day I received my acceptance at medical school, and if my wife will excuse me, my wedding day, in my personal list of great moments.'' He explains:

> In our pyramidal system, with seven interns, twenty or so assistant residents, and only one chief resident, those of us who wanted the job as chief lived in a perpetual state of anxiety: Will I ever get to be chief resident? The question wasn't always foremost in our minds, but it was there all the time. Now I had the answer—the job was mine. I felt ten feet tall. (241)

According to Michael G. Michaelson, who is openly contemptuous of Nolen, there's no great mystery about what makes the man tick: ''it becomes clear that what Nolen wanted to climb and conquer was neither Everest nor Bellevue but the rigid surgical hierarchy,'' as further suggested by several of the chapter titles: ''Assistant Resident:

One Step Up,'' ''First Assistant Resident: Next to the Top,'' and ''Chief Resident: Final Responsibility'' (39–40). Making chief resident is a big day for Rainer, too. ''I beamed at the announcement but controlled my excitement so Dr. Harkness wouldn't think I hadn't been confident about receiving a chief resident appointment'' (179), he admits.

Wolfe: *''When a fighter pilot was in training, whether in the Navy or the Air Force, his superiors were continually spelling out strict rules for him, about the use of the aircraft and conduct in the sky. They repeatedly forbade so-called hot-dog stunts, such as outside loops, buzzing, flat-hatting, hedgehopping and flying under bridges. But somehow one got the message that the man who truly* had *it could ignore those rules—not that he should make a point of it, but that he* could*—and that after all there was only one way to find out—and that in some strange unofficial way, peeking through his fingers, his instructor halfway expected him to challenge all the limits* (Wolfe 30). And that's exactly what Moynihan does. ''I guess every intern and resident, sometime in his career, gets to the point—a point brought on by the tedium of many menial tasks, constant exhaustion, and the pomposity of his senior associates—where he has to do something to assert his independence.'' As it turns out, Moynihan decides ''to challenge all the limits'' (Wolfe 30) at a surgical conference:

> ''My first case for presentation today is a sad one. The subject is a two-year-old male with multiple congenital facial abnormalities. He has drooping eyelids, a flattened nose, sagging jowls, a widened face, teeth

> that overlap, and floppy ears.'' For the first time in weeks, I noticed several surgeons straighten up in their chairs and begin to listen with full attention. ''His family history is that he is an orphan,'' I continued, ''born of English parents, but adopted by a Polish family. I'd like your opinion as to what we may be able to do for him.'' (224–25)

''With that,'' Moynihan says, ''I flashed a color slide up on the screen. The doctors stared, and the delightfully ugly face of Mister Magoo stared back''—the ''patient'' being an English bulldog owned by Moynihan's neighbors, the Rotowskis. ''Most of the physicians laughed, but several,'' Moynihan says, ''felt that my actions had desecrated the field of medicine'' (225).

Wolfe: *''. . . it was not uncommon for some eager jock to try too tight an outside turn and have his engine flame out. . . . The other side of this impulse showed up in the reluctance of the young jocks to admit it when they had maneuvered themselves into a bad corner they couldn't get out of.''* Wolfe explains: *''to declare an emergency, one first had to reach that conclusion in his own mind, which to the young pilot was the same as saying: 'A minute ago I still* had *it—now I need your help!'''* (Wolfe 31–32). Nolen is a prime example. ''I had watched Eddie do a cutdown just a few days earlier,[15] so when I brought the minor-surgery set down to the ward and he wasn't around, I decided to go ahead with it myself.'' Big mistake.

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[15]Nolen is especially good about defining unfamiliar terms for his audience, the general public. ''A cutdown, I should explain, is a procedure whereby, under local anesthesia, an incision is made in a vein and a plastic tube inserted through which fluids can be given to the patient. It can be left in place for several days'' (24).

''After half an hour, soaking wet with perspiration,'' Nolen finally admits defeat. ''Eddie had known I wasn't ready. He had specifically told me to wait and that he'd help me with this job. But my pride—my arrogance, whatever you want to call it—got the better of me'' (25). And it's not the last time, either. ''No, I can handle it alone'' (63), Nolen tells the chief resident, Jack Lesperance, before an operation. Again, big mistake. ''Mr. Salvatore barely made it'' (64), Nolen admits, ''because of my pigheadedness. It was my stupid false pride that had made me turn down Jack's offer of help. I swore I'd never be such an ass again'' (65). That's highly doubtful, according to Wolfe. ''Believers in the right stuff would rather crash and burn'' (Wolfe 32).

Wolfe: *''Slowly, step by step, the ante had been raised until he was now involved in what was surely the grimmest and grandest gamble of manhood.''* Sometimes a player decides to fold. *''Occasionally a man would look coldly at the binary problem he was now confronting every day—Right Stuff/Death—and decide it wasn't worth it and voluntarily shift over to transports or reconnaissance or whatever. And his comrades would wonder, for a day or so, what evil virus had invaded his soul . . . as they left him behind''* (Wolfe 33). Generally, the ''evil virus'' (Wolfe 33) is equated by the apologists with emotional instability—sometimes on the part of an intern or resident, sometimes on the part of his wife. It can result from attempting to live on the pittance doled out by the hospital, according to Nolen, who puts the blame on the individual rather than finding fault with his beloved Bellevue. ''Steve Drew,

for example, refused to borrow the money it would have taken to get his wife and children out of the slums,'' Nolen says, continuing:

> The apartment in which he lived was in the shabbiest section of the Lower East Side. His wife didn't dare let her children so much as step out the door unless she was with them. He bought day-old bread at the bakery and even refused to buy a newspaper; instead, he'd pick one out of a trash can on First Avenue on his way home from the hospital. It was a mistake. His wife couldn't take this kind of life. He came home one night to find her in hysterics. She was lying on the bed sobbing wildly, completely irrational, while her children, unable to understand what was going on, sobbed on the floor beside her. She had to be hospitalized, in a sanitarium, for three months. When she got out, Steve quit Bellevue. He went to a private hospital where he could earn a living wage. He should have made the move earlier.[16] (138)

The other apologists tell similar tales. ''One of the first-year residents quit and moved home,'' Rainer learns from a second-year resident, who speculates on the reason. ''He told everyone he was homesick, but Dr. Harkness thinks he's depressed and

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[16]But as Nolen learns decades later at a national convention attended by some ten thousand surgeons, Steve Drew ends up doing all right for himself anyway, thank you. ''One of my Bellevue friends mentioned a Second Division surgeon we both remembered well,'' Nolen says. ''At the time we knew him, he used to pick up his daily newspaper from the trash can that stood in front of Bellevue, on First Avenue, as he walked home by way of a bakery on the Lower East Side, where he regularly bought day-old bread and, on holidays, day-old cake. This fellow has subsequently developed a thriving practice in Manhattan and, my friend reported, had recently been given a new Rolls-Royce by a grateful patient'' (Nolen, ''The Big Knives'' 68).

needs psychiatric help.'' At about the same time, another resident decides that neurosurgery isn't everything it's cracked up to be. ''Nancy Barton is quitting at the end of this year. She's going into emergency room work; says she doesn't want this lifestyle'' (138–39). Whereas she is willing to ''voluntarily shift over'' (Wolfe 33) to another specialty, Cathy Flynn has trouble visualizing herself as a physician at all. ''Patient care is frightening,'' she confides to Morgan while they're still in medical school. ''More than that,'' she adds, ''I wonder if I can be a doctor. I really have my doubts'' (77). Rather than leaving medical school, she allows it to destroy her. After two overdose attempts (96), she puts a bullet through her head (106). Morgan doesn't get it. ''I had often felt oppressed by the pressure of medical school and isolated as a woman but Cathy's suicide was too much for me to understand. And medical school was three-quarters over when she died'' (107).

Being a woman doesn't preclude Morgan herself from having the right stuff, she insists. If anything, she has to have even more of it than the men. Or so says Janet Rome, ''the neurosurgery chief resident and the only female surgeon I knew'' (150). Interestingly, whereas Morgan refers to male physicians above her on the pecking order by prefacing their last names with the title ''Dr.,'' she is on a first-name basis with Janet. ''Always do your best,'' Janet tells her. ''Especially as a woman. You have to try even harder. You can't be satisfied with being as good as the men. You have to be better. Otherwise they won't respect you'' (180).

But that's something Morgan has already figured out on her own. Having made a mistake that will soon result in a patient's death, Morgan resists her original

impulse. ''I wanted to quit right then'' (118), she says, but then she thinks about the inevitable fallout. ''The private surgeons' reaction would be 'typical hysterical female' and I wasn't going to give them that satisfaction, or leave the rest of the interns in the lurch to do my work'' (119). Another time, Morgan assists during an operation while she is severely sleep deprived. ''My eyes fell shut. I yawned and swayed backwards.'' Her exhaustion doesn't go unnoticed by the surgeon. ''How do they expect me to operate when the only help I have is a sleeping woman?'' he asks. The question isn't a fair one, Morgan thinks to herself. ''It wasn't because I was a woman, and I wasn't weak. I just hadn't slept for three days'' (145). It's important for Morgan to put as much distance as possible between herself and women who don't have the right stuff—Patsy Glover being a prime example:

> Patsy complained about things in general, and was a bit of a joke among the residents on the surgical service. Most surgical residents, male or female, become toughened by residency, but it seemed Patsy survived less by being tough and struggling through, and more by depending on chivalrous men to come to her aid when she felt tired or overworked. (305)

Patsy is notable because she's an exception, not the rule. For as a female physician notes, ''Morgan's book is a tribute to the many doctors-in-training who persevere in the face of tedious 'scut' work, inhuman hours, demanding patients, and condescending staff'' (Coghlin-Strom 1625).

One time, though, Morgan does wonder whether being a woman puts her at a disadvantage. It's when she's working in an animal research laboratory in Oxford, England. "I was startled to find that I had spent an hour playing with the mice," she says. "They reminded me of my brother's pet hamster, Snuffy, and I didn't like the idea of skinning an animal that looked like Snuffy and then putting it through a meat grinder. I also was not attracted by the idea of infecting the mice with *Trichinella*" (102). Her qualms do not seem to be shared by the men. "I wondered if there was a sex difference when it came to animal research. The men didn't mind but I hated killing the animals, or watching them sicken with *Trichinella*" (104). Nevertheless, she reaches deep down inside and summons up the right stuff: "if I was going to stop my research because the mice reminded me of Snuffy, I would get nowhere. I started on my project the next day" (102).

As much as Morgan is a true believer in the right stuff, she sometimes chafes at it as being too masculine for her taste. "I was being trained by good male surgeons to act like a good male surgeon" (154), she observes during her internship. Early in her residency, she says, "I was getting tough" (187), and later, when she tries to soften her approach, she gets a mixed reaction from the male surgeons. "I tried to remember to let my assistants leave for a break during a long operation," she notes. "That's probably not a good idea, Elizabeth," one male surgeon tells her. "The essence of surgery is training your team to work without a break"—something that Morgan calls "the 'Die in the front line of battle' warrior tradition." Another male surgeon defends her. "Elizabeth is very thoughtful. She runs a service differently

than we do, and I don't think hers is a bad way'' (297). Morgan appreciates the support. ''It was nice of him to intervene,'' she says, ''because I didn't like to argue.'' At any rate, she ends up sticking to her guns. ''I was evolving my own style of being a surgeon—considerate of my team whenever that was possible'' (297). For Morgan, then, having the right stuff does not preclude demonstrating a little sensitivity from time to time. Her approach is deemed ''feminine'' by the male surgeons. But that's all to the good, Dr. Estelle Ramey contends. ''Elizabeth Morgan's book reflects insights into patient care that are in part the result of her socialization as a woman, and these insights amplify her surgical expertise. Male and female surgeons may indeed be different. *Vive la difference!*'' (B12).

As it turns out, though, Morgan isn't the only apologist who departs from the warrior tradition; so does the other plastic surgeon, a man, also at his peril. ''It's very difficult getting through an extremely long operation without some nourishment, but that's exactly what most surgeons do,'' Moynihan notes. So during an operation that takes over eight hours, he tries something different: ''we broke for a ten-minute lunch,'' thus putting his manhood on the line. ''In some high-powered medical centers, such action would be considered sacrilegious'' (282).

Wolfe: *''Civilian life, and even home and hearth, now seemed not only far away but far* below, *back down many levels of the pyramid of the right stuff. A fighter pilot soon found he wanted to associate only with other fighter pilots. Who else could understand the nature of the little proposition (right stuff/death) they were all dealing with? And what other subject could compare with it? It was riveting!''* (Wolfe 34). He

continues: *''to describe it, even to wife, child, near ones and dear ones, seemed impossible. So the pilot kept it to himself, along with an even more indescribable . . . and even more sinfully inconfessable . . . feeling of superiority, appropriate to him and to his kind, lone bearers of the right stuff''* (Wolfe 38). Surgery is riveting only to those who have the right stuff; everyone else is soon bored to tears, as Morgan tacitly admits by quoting her brother, Rob. ''You don't have anything else to talk about, except surgery'' (280), he bluntly informs his sister. Moynihan's wife, Patsy, is a bit more tolerant, going so far as to invite another resident and his wife over for dessert and coffee: ''we discussed politics, economics, the merits of the Dodgers, and the world situation in general,'' Moynihan says. ''But, as usual, sooner or later, our talk turned to the hospital'' (125), with the two men trading stories with scatological themes. Their wives are considerably less fascinated by diarrhea, presurgical enemas, and rectal suppositories, and eventually Boyd Falmouth's wife Maryanne speaks up. ''The party's getting rough,'' she observes (after all, she married into the Falmouth family; she wasn't born into it), and Patsy agrees: ''*Gross*, in fact'' (126). Actually, the party's almost over. The telephone rings with news of an airplane crash, and the two residents are out the door to the hospital. Upon learning that seventy-seven of the seventy-eight passengers and crew are dead at the scene, Moynihan has an opportunity to reflect on how doctors are better than everyone else:

> The television station, determined to milk the disaster, had sent a ''man on the street'' interviewer to talk to eyewitnesses. I have never been able to understand the morbid curiosity that disasters generate. Perhaps

it is because people do not have an intimate encounter with death very often, and are fascinated by a preview of their own ultimate end.

Doctors are different, I suppose. We see so much death. Life and well-being are so damned precious to us. I was suddenly struck by the Herculean efforts we expend to save even one life. The surgeon who sweats six or eight hours to prevent death, or to repair or to reconstruct, is only the visible tip of a metaphorical iceberg made up of hundreds of teachers, researchers, technicians, nurses, administrators, and a vast armamentarium of equipment. I thought of the elation we experience when we save a single patient—and our outrage and frustration when we fail. We habitually recruited an army to save just one life—yet the loss of seventy-seven was turning into a circus. (129)

The same ''feeling of superiority'' (Wolfe 38) is conveyed by Rainer, who shuts out his wife as a matter of policy. ''Julie always asked about my day, but I remained vague. There was no remedy in reliving the death of a patient; no compliment necessary for saving a life'' (119). And like the Moynihans, the Rainers seem to associate solely with other ''lone bearers of the right stuff'' (Wolfe 38). What could be more natural? ''Our friends in Memphis were also in residency'' (87), Rainer says. Presumably they could also make friends at Memphis State University, where Julie teaches (119), but then, such people would lack the right stuff.

Wolfe: *''Not only the washed-out, grounded, and dead pilots had been left behind—but also all of those millions of sleepwalking souls who never even attempted*

the great gamble. The entire world below . . . left behind. *Only at this point can one begin to understand just how big, how titanic, the ego of the military pilot could be''* (Wolfe 39). At the end of his residency, Nolen offers up the following litany: ''I knew that with my knowledge and experience, any decision I'd made was bound to be a sound one''; ''I knew I had the knowledge, the technical dexterity, the experience to handle any surgical situation I'd ever encounter in practice''; ''I knew that even if the case was one in which it was impossible to anticipate the problem in advance, I could handle whatever I found''; ''I knew that if I wasn't able to avoid a mistake, chances were that no other surgeon could have, either'' (264). A monstrous ego just goes with the territory, according to Nolen:

> This all sounds conceited and I guess it is—but a surgeon needs conceit. He needs it to sustain him in trying moments when he's battered by the doubts and uncertainties that are part of the practice of medicine. He has to feel that he's as good as and probably better than any other surgeon in the world. Call it conceit—call it self-confidence; whatever it was, I had it. (264)

So does Moynihan. ''Happiness, to me, was being a plastic surgeon—having the experience and knowledge that I could competently treat any case in my specialty—as well as or better than any other surgeon. It wasn't ego or conceit, it was self-confidence'' (316), he says as he's about to go into private practice. As a junior resident, Rainer is indoctrinated by the senior resident to think the same way. ''Do

you ever worry you've made the wrong decision?'' he asks Peter Bone, prompting the following exchange:

''I can't waste time worrying.''

''But what if you're wrong?''

''It takes sixteen years to become a neurosurgeon,'' Pete answered. ''If I'm wrong after that much training, anyone else would have been wrong too.''

''Is that confidence or conceit?''

''A surgeon without confidence is dangerous.''

''A conceited surgeon is too.''

''It takes both to be a neurosurgeon.''

''Why?''

''Confidence keeps your hands steady; conceit keeps you confident.'' (82–83)

Rainer doesn't comment on the circularity of Pete's argument. As for Morgan, there comes a time when she knows she's arrived, too, yet she remains comparatively down-to-earth about it. ''I was confident to the point where I didn't have to put M.D. after my name every time I wrote out a check to pay a bill'' (188), she says, shying away from the puffery favored by the male apologists.

The Bad Egg

Lest their books serve as nothing more than paeans to medical education, all of the apologists identify at least one bad egg: a physician who doesn't have the right

stuff. ''A tiny fraction of doctors'' fall into that category, Morgan hastens to assure us. Even so, ''these few attract public attention and create ill will against the profession.'' As an apologist, she's careful to emphasize that they are aberrations. Except for ''a couple of stinkers,'' she tells *People Weekly*, ''I got superb training'' (Clayton 46). She elaborates on the thought in her book. ''Most doctors are interested only in helping their patients, by treating them directly, and through teaching and research. Ever since Hippocrates, good physicians have struggled to protect the sick by keeping medical standards high, and by keeping charlatans and quacks out of the profession'' (9-10). But there are some who manage to sneak in anyway—''doctors who misdiagnose or mistreat a patient because of carelessness, incompetence, or just plain stupidity''—as Nolen acknowledges in his column ''A Doctor's World'' (''Why Doctors Make Mistakes'' 159, 160). And the apologists have no use for them. Most commonly, the bad egg is careless, lazy, greedy, or downright sadistic, and few of them last long, say the apologists.

An intern at Bellevue pays a heavy price for being careless, Nolen observes. ''That cast may be too tight,'' Lou is told by the chief resident. ''But Lou was off that night and he had a heavy date. After rounds he went down to his ward, looked at Mr. Baden's cast and decided to hell with it.'' The next morning he finally attends to his patient, discovering dead tissue underneath the plaster. ''Lou, you come with me,'' the chief resident orders. ''Half an hour later Lou was back on the ward, white-faced and shaken.'' It's the end of him: ''when the year ended he left Bellevue,'' Nolen recalls. ''Lou had goofed off. He had put himself ahead of his job, and that

was simply not tolerable'' (26–27). Negligence costs Chen Lee his job as well: ''only his pale complexion gave a hint of his emotion,'' Rainer says. ''His stoic expression remained unchanged'' as he explains why he'd been fired that morning:

> ''A general practitioner called me last night from Jackson, Tennessee,'' Chen said. ''He wanted to transfer a patient with back pain to the Baptist charity service. I was home with my family, so I told him to have the patient call the outpatient clinic on Monday and make an appointment. Apparently the G.P. is a good friend of Dr. Harkness, and he called him at home to complain that I wouldn't accept the transfer.'' (134)

Chen makes a good object lesson for the residents who remain. ''I watched from a window of the hospital as Chen's navy blue VW slid down snow-covered Madison Avenue as he headed home'' (135), Rainer says.

Laziness is another one of the deadly sins, and Art Thompson is guilty of it. In the morning, Nolen says, ''he'd be rolling up his sleeves ready to get to work. However, when I got back to the ward in the afternoon, I found that nothing, or next to nothing, had been done.'' And when questioned, he always has an explanation—a lame one. He's definitely not Bellevue material. ''Dr. Stevens knows about him. He's all through after this year'' (126–27). But in the meantime, Nolen has to do Thompson's work. ''I would have liked to say, 'To hell with it. Get Thompson.' But you can't do this in medicine. The job has to be done. If one guy goofs off, someone else has to pitch in. If you've got any conscience at all, you won't let a patient pay

for the sins of a fellow doctor. Fortunately, guys like Thompson are rare birds,'' Nolen says, echoing Morgan. Another consummate slacker is John Anderson, the junior resident who takes pleasure in hazing Moynihan. The similarities between Thompson and Anderson are striking. ''Anderson, I discovered, was a professional goof-off—a 'ghost,' as the nurses and interns call a doctor who can never be located. Wherever the hell Anderson hid, he ignored the page. There were times, after a crisis when we would have sold our souls for an extra pair of hands, that I physically went searching for him.'' Eventually he'd reappear, and always with the same excuse: ''I was at a meeting'' (265).

Then there are the greedy doctors, who take refuge in private hospitals. Having rotated to that less sanctified realm after having done most of their clinical training, respectively, at a city hospital and at various teaching hospitals, Nolen and Morgan take a dim view of surgeons who operate just for the money. ''It came as a kind of shock to me,'' Nolen says, wide-eyed, ''that every surgeon wasn't always honest.'' As one book reviewer observes, ''Nolen makes no secret of his contempt for surgeons who perform unnecessary operations'' (Stoler 76). For example, there's Dr. Small. ''Hopeless, I'm afraid,'' he says after opening a patient's chest. Removing a small piece of lung tissue, he laughs when Nolen asks why. ''Something for the pathologist, Nolen. Insurance companies pay better for lung resections than they do for in-and-out cases.'' Even worse is Dr. Lund, who schedules an ''obviously terminal'' patient for surgery. ''The bastard,'' Nolen says in an aside to his readers (187–88). The same could be said about Dr. Kerwin. ''He liked to hold philosophical

chats with me,'' Morgan says. ''The decisions can be very hard,'' he tells her. ''Look at a surgeon's indications for operations. When there's money in the bank, you'll find you operate less. When you need a car, want to go to the Bahamas, there's a psychological instinct to operate. You find you do more surgery at those times'' (282–83). Always the apologist, Morgan is quick to add that he's a rarity. ''Of the hundreds of surgeons I have worked with, Dr. Kerwin was the *only* surgeon who operated for money alone. It is the few surgeons like him who give surgery a bad name'' (284).

And finally, there are the downright sadistic surgeons. '''Chaperone me,' said Dr. Chester one morning as I walked down the hall. 'I have to do a pelvic and there's no nurse around. You'll do.''' Morgan complies. ''Till then I had had my doubts about Dr. Chester, but now I watched him carefully. He broke into a big smile and pressed unnecessarily hard and deep, even as his patient squirmed between his hands and screamed with pain.'' From then on, Morgan says, ''I avoided him'' (134–35), but she derives some satisfaction from knowing that he hasn't escaped the attention of one of her mentors, Dr. Hillebrand. ''He kept an especially close watch over Dr. Chester'' (139). Likewise, she says, ''I began to wonder if Dr. Sharman was such a good doctor'' (224), and for the same reason. ''Go ahead and kill yourself,'' he tells a nineteen-year-old girl who is depressed after having had an emergency colostomy. ''No one would care'' (224). He takes a similar approach with an elderly woman who is dying of cancer. ''I don't want to waste my time looking after a nasty old woman like you,'' he informs her when she refuses physical therapy for her other problem—a

broken leg (225). "The only people Dr. Sharman disliked more than his patients were the residents," Morgan says. "He once confided to his nurse during a party that the greatest pleasure in his life was watching a resident squirm" (225). One of them nicknames him "Count Maligno" (226) and predicts that he's a goner. "I've told Anjou he's a bad egg. He may be a good surgeon technically, but I think he has to go. Wait and see, Lizzie" (284), Mark Lehman tells her. And he's right: "the Count is looking for a new job" (301), he gloats not long thereafter.

Missing in Action

All of the male apologists get married during or shortly after internship (Nolen, 131; Moynihan, 53; Rainer, 23), and all of them become fathers during residency (Nolen, 132; Moynihan, 317; Rainer, 139, 179). In contrast, Morgan remains single (and childless) throughout her clinical training. Regardless, all of the apologists are so devoted to their work that as far as the rest of the world is concerned, they're missing in action.[17] For the men, at least, marriage is "a nice arrangement" during the few off-duty hours they spend outside the hospital, or so

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[17]Stephen R. Covey appears to have met the apologists or people like them. "If your center is work, these are alternative ways you may tend to perceive other areas of your life," he says in *The Seven Habits of Highly Effective People: Restoring the Character Ethic*. Work itself? "Main source of fulfillment and satisfaction. Highest ethic." Spouse? "Help or hindrance in work." Family? "Help or interruption to work. People to instruct in work ethic." Money? "Of secondary importance. Evidence of hard work." Possessions? "Tools to increase work effectiveness. Fruits, badge of work." Pleasure? "Waste of time. Interferes with work." A friend or friends? "Developed from work setting or shared interest. Basically unnecessary." Enemy or enemies? "Obstacles to work productivity." Church? "Important to corporate image. Imposition on your time. Opportunity to network in profession." Self? "Defined by job role." Principles? "Ideas that make you successful in your work. Need to adapt to work conditions" (from Appendix A, "Possible Perceptions Flowing out of Various Centers" 321–24).

says Nolen. ''We needed a change. We needed a home. We needed wives'' (131). Yet, he adds, ''it wasn't a very attractive job for the wives'' because frankly, it's a rather one-sided arrangement:

> We were in the hospital much more than we were at home. Every other night and every other weekend we were on duty. Half of Saturday and all day Sunday we were free every two weeks. Even on the nights when we were off call, we rarely got out of the hospital before six o'clock. At least one night a week we'd go to a medical meeting or an anatomy lecture and wouldn't get home until nine or ten. And then we were often exhausted. All we wanted to do was eat and go to bed. (131)

Hours like that just go with the territory, as Nolen is well aware. ''The *rites du passage* of medical training stipulate that healers must suffer,'' Michael G. Michaelson says with a note of scorn, ''if they are to be certified'' (40). But the healers' wives must suffer, too, and the men know it. ''Most of us made sacrifices of one sort or another to keep our wives content'' (132), Nolen says. For example, to shield his wife from what he calls the ''drunks on the sidewalk and punks in the street,'' he moves from Manhattan to Eastchester, a twenty-five mile commute to Bellevue. But his motives are not entirely altruistic: ''when Joan was upset it affected my work'' (135), he explains, ending with a paean to her. ''I can only thank the Lord that my wife was willing to take the five years as part of the total package of our marriage. Some guys weren't as lucky'' (139).

Moynihan expresses many of the same sentiments. Arriving home from the hospital one night at about seven-thirty, he says, ''I glanced at the table and felt soothed.'' He explains why: ''candles spread a soft glow over the table, glinting off our wedding-present goblets of crystal. Tea was steeping in a bone china pot. Trust Patsy to understand what a welcome change such elegance was after the blood-and-guts atmosphere of the hospital'' (84). He'd made a vow to himself when he'd gotten married. ''Medicine is a jealous mistress, and I was determined that although it might have most of my time, it wouldn't get all of it'' (53).

It's a vow that he finds hard to keep, however. For example, there's the time that he and Patsy have dinner reservations at a French restaurant. But as it turns out, he's summoned to the hospital that night not just once but twice, and by the time he's finished in the emergency room, he says, ''Patsy and I congratulated each other on being lucky enough to find a pizza joint open. After that,'' he adds, ''I just didn't plan anything for the nights I was on call. It was easier that way'' (55). And then there's the night that he and Patsy have tickets to a popular musical—Row E, no less. ''All I had left to do before going home was to stop in the lobby and check on tomorrow's scheduled admissions,'' he says. ''Tonight was the night, and with an eight-thirty curtain, we'd make it in time'' (146). But again, fate is not on their side because it's also the night that the hospital receives an anonymous bomb threat. Over nine hundred patients have to be moved from their rooms into the corridors to comply with the hospital's emergency procedure, and Moynihan stays to pitch in—meaning that seats 127 and 128 in Row E are empty that night (150). Like Nolen, he wisely

gives credit where credit is due. "So many people had helped me earn my M.D.," Moynihan says. "Way at the top of the list was my wife, Patsy, who'd put up with my moods and crazy schedules" (316–17)—usually. But one time, Patsy has big news—she's pregnant with their first child—and before she can tell him, he rushes back to the hospital for an emergency. "For the first time during our marriage, I saw resentment, even anger, in her face. It surprised me. She'd always been completely understanding of the demands before" (85).

Equally tolerant is Rainer's wife, Julie—at least, up to a point. "The months quickly lapsed into a routine: long days in the operating room; nights working on the wards. Off nights allowed library time for studying and preparing for conferences, and weekends provided either a Saturday or Sunday afternoon, but never both, to spend a few hours away from the hospital" (87). At home, he falls into a rut, too. "On off-duty nights I arrived home about 8 p.m. Julie and I ate a light dinner—soup, salad, or a sandwich—then walked around the block before going to bed" (119). One such night, Julie tells him that she's pregnant with their first child:

> "Great!" I exclaimed. I held her at arm's length and then added, "I wonder when that happened."
>
> "I have a good idea," Julie laughed, opening her sweater and wrapping it around me as she pulled me to her. "You've only been home once in the last six weeks." (120)

The body language between the two is prophetic: "I held her at arm's length," Rainer says, while "she pulled me to her." For a long time, she's grateful to her

husband for the few crumbs of attention that happen to fall her way. One night after their second child is born, for example, Rainer manages to squeeze in a little "quality time" with his family:

> Laura was now seventeen months old, John two months. I loaded Laura into her red wagon and pulled her down the sidewalk while Julie pushed John's stroller. After a walk to the park, Julie fed and bathed the children while I cooked hamburgers outside on the grill. By 8 p.m. I had fallen asleep in the den with my plate still on my lap. Julie guided me to the bedroom, helped me undress, and tucked me into bed. She kissed me on the cheek and whispered, "Thank you for a wonderful day." Four hours, I thought to myself as I drifted off to sleep. She doesn't ask for much. (187)

But eventually she does ask for a divorce. "I had not provided what she wanted most—a home and a family" (230), Rainer admits. For unlike Moynihan, who at least tries to carve out some time for Patsy, and Nolen, who makes an hour-long commute each way "for the sake of my wife and kids" (134), Rainer—well, he's the brain surgeon without a heart (which may help to account for his wooden writing style),[18]

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[18]It's interesting that Morgan comes to the defense of Rainer, a fellow apologist. "Most doctors think that good writing is fancy writing, and make their readers battle through a forest of purple prose. Dr. Rainer does not. He writes well," she says in a blurb on the dust jacket of his book. "His simple, forthright and vigorous style suits his subject and lets his own energy carry his readers through one crisis and on to the next." Methinks she doth protest too much. Compare that endorsement with her attack on *Gentle Vengeance: An Account of the First Year at Harvard Medical School*, by Charles LeBaron—an activist (Morgan, "Med School: Getting a Second Opinion"). For a discussion of Morgan's review of *Gentle Vengeance*, see chapter 4, "The Activists."

at least as far as his own family goes. His work schedule is "marriage-wrecking" (*Publishers Weekly* 76), one book reviewer notes, as does Rainer himself. "Medicine *is* my entire life" (99), he assures Dr. Harkness. "Either you want to be a neurosurgeon, or you want a smooth home life. You can't have both" (200). And as for Dr. Harkness, he sets an example by keeping his own office devoid of family pictures (101).

All but abandoning his wife and children, Rainer calls home so infrequently that "I couldn't remember the phone number" (197), he says. And it doesn't take much to keep him in the hospital, either. For example, a plaintive glance from the wife of one of his patients does the trick:

> It was clear from the look in her eyes that she wanted me to stay and take care of her husband. But I also knew my family was looking forward to spending the Christmas holiday with me. The decision flowed naturally as I touched his wife's arm, reassured her he would recover, and told her I would see her in the morning.
>
> "See you in the morning." Words of reassurance to her but words, I knew, which closed the door on the holiday trip. I offered several excuses for missing the vacation, but the children couldn't hide their disappointment. I helped Julie pack and continued to wave long after the car had rounded the corner. I went back into the house, ate a sandwich, showered, and went to bed early. (220–21)

There's no question that he's missing in action, according to book reviewers: ''he devotes little space to his estranged wife and children'' (Knopf 34), says one. It's an observation that applies both to his book and to his life. Another agrees: ''no room is left for wife or children'' (Schmid 90). Yet he somehow finds the time for at least one extracurricular activity, as noted by the senior partner of a group of neurosurgeons that Rainer joins following the completion of his clinical training. ''Other residents have told me you're a writer and you've kept a journal of your patients throughout your residency'' (210). Yes, indeed, and what an elaborate journal it is:

> For years I had written an hour or two each day and had accumulated over five hundred essays on patients and medicine. I had organized my journal into broad sections, including a study on death, surgical complications, surgical successes, patterns of disease within families, and long-term effects of disabling disease on marriages and children. (278)

But for some reason, he doesn't make anywhere near the same kind of commitment to his own children, who have moved from Memphis to Atlanta with their mother. Having received a letter from Laura, his eight-year-old daughter, Rainer makes a promise to himself—''I've got to let her know how much I love her''—and immediately breaks it. '''My dearest Laura,' I began my letter, but I was interrupted by the phone ringing.'' It's the hospital, and he's on his way. ''Tomorrow, I thought. I'll write Laura and John tomorrow'' (298-99). To make up for it, he throws them a

bone by dedicating his book to them. "For Laura and John—I'll see you Saturday." That is, unless work calls.

Unlike the male apologists, Morgan is on her own. It's a choice that she makes deliberately because men are in plentiful supply. "Medical school was a crash course in dating," she says. "There were no women undergraduates at Yale then, and fewer than forty women in the medical school for the four hundred men to date." And date she does: "at medical school I went out with a different man every week." They're seriously looking—"most of the men at the medical school were looking for wives," she says, bringing Nolen to mind—but she's not ready for marriage yet. "I knew I wanted a husband and children, but not right then" (31). She knows where her priorities lie: "I want to be a doctor first" (24), she firmly decides when she's a seventeen-year-old student at Harvard. Flash forward to the end of her residency: she's lost the resoluteness of her youth. "Some days I became quite depressed. From the time I was twenty, I had been in medicine. I was now thirty, and although I had known various men who liked me, and whom I liked, I had been too busy in the past six years to become involved in anything permanent." Like the male apologists, she says, "I still spent most of my time working in the hospital." Although she nearly married another physician during her residency, work got in the way. "While he was getting serious," she tells *People Weekly*, "I was so tired I couldn't think about anything except getting through the day and sleep" (Clayton 46). But unlike Nolen, Moynihan, and even Rainer—who claims to have "weathered the years well" (285) despite losing his family—Morgan second-guesses herself. "I began to feel socially

stunted,'' she admits. ''I began to resent the time I had given to my residency, and I wondered if I had wasted the entire decade of my twenties'' (345–46).[19] She's missing in action, too, but she has always been alone—except for the mouse that shares one of her apartments and the cockroaches that occupy another one (313)—so it doesn't much matter to anyone but her.

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[19]She explores the same theme in *Solo Practice: A Woman Surgeon's Story*. ''I wanted to be a woman and a person again, not a resident'' (15), she says. But several years post-residency, Morgan remained single (and childless) and determined to make up for lost time. Eventually, she succeeded—well, sort of. *People Weekly* explains: ''after years of attention to school and studies, she was looking for romance.'' So she embarked on a whirlwind love affair with an oral surgeon named Eric Foretich, became pregnant with his child, married him, left him, gave birth to their baby, a girl named Hilary, and divorced him—in that order, starting in September 1981 and ending in November 1982 (Chin, Podesta, and Kramer 113–115, 117). And the saga continues. After charging in 1985 that Foretich had sexually abused their daughter, Morgan spent over two years in jail—from August 1987 to September 1989—for sending Hilary into hiding and then refusing to disclose her whereabouts, a story that made the cover of *People Weekly* (Podesta and Chin 78, 83). For an account by Morgan herself, see *Custody: A True Story*. [It's not exactly the book that she had hoped to publish, one entitled *Surgeon, Wife and Mother* (*Contemporary Authors* 108: 330).] For an account by an attorney-turned-journalist, see *Hilary's Trial: The Elizabeth Morgan Case: A Child's Ordeal in America's Legal System* (Groner).

CHAPTER 7

CONCLUSION

Developed here is an original typology for the autobiography of medical education that proposes to illuminate the genre by focusing on how the authors portray themselves in regard to medical school, internship, and residency. The observers make ethical judgments about it. The outsiders seek ways to adjust to it. The activists try to change it. The malcontents bear a grudge against it. The apologists defend it. Listing my primary sources by category reveals some interesting patterns in regard to copyright date, specialty, and gender, as shown in Tables 2 through 6.

Table 2. The Observers

Author	Copyright Date	Specialty	Gender
Doctor X [Nourse]	1965	general practice	male
MacNab [White]	1971	internal medicine	male
Viscott	1972	psychiatry	male
Karp	1977	obstetrics and gynecology	male
Hellerstein	1986	psychiatry	male
Klass	1987	pediatrics	female
Konner	1987	none	male
Reilly	1987	internal medicine	male
Klitzman	1989	psychiatry	male
Klass	1992	pediatrics	female

Table 3. The Outsiders

Author	Copyright Date	Specialty	Gender
Rubin	1972	emergency medicine	male
Rubin	1974	psychiatry	male
Scalia	1978	emergency medicine	female
Klein	1981	internal medicine	male
Patterson and Madaras	1983	obstetrics and gynecology	female
Greenbaum and Laiken	1984	pediatrics	female
McCarthy	1995	pediatrics	female
Rothman	1999	pediatrics	female

Table 4. The Activists

Author	Copyright Date	Specialty	Gender
Mullan	1976	pediatrics	male
Horowitz and Offen	1977	internal medicine	male
LeBaron	1981	pediatrics	male
Harrison	1982	obstetrics and gynecology (preceded by emergency medicine)	female
Seager	1991	psychiatry (preceded by emergency medicine)	male

Table 5. The Malcontents

Author	Copyright Date	Specialty	Gender
Hoffmann	1986	internal medicine	male
Sacco	1989	emergency medicine	male
Marion	1991	pediatrics	male
Klitzman	1995	psychiatry	male

Table 6. The Apologists

Author	Copyright Date	Specialty	Gender
Nolen	1970	general surgery	male
Moynihan and Hartman	1979	plastic and reconstructive surgery	male
Morgan	1980	plastic and reconstructive surgery	female
Rainer	1987	neurosurgery	male

Note that Klitzman is listed in two categories: as an observer for his first book and as a malcontent for his second. Moreover, each of Rubin's books and Klass's books is listed separately. And given that LeBaron was in the second year of medical school when he published *Gentle Vengeance: An Account of the First Year at Harvard Medical School*, it does not include any mention of his specialty. However, according to the *Directory of Physicians in the United States* (36th ed.), he eventually chose pediatrics.

The observers dominate (nine representatives), followed by the outsiders (seven representatives), the activists (five representatives), the malcontents (four representatives), and the apologists (four representatives). For both the observers and the outsiders, a span of twenty-seven years separates the first book published from the last book published. Next are the apologists with a span of seventeen years, the activists with a span of fifteen years, and the malcontents with a span of nine years.

Although physicians in various specialties are represented, only surgery is associated with one category and one category only: the apologists. It's a phenomenon that hasn't escaped the attention of Anne Hudson Jones, professor of literature and medicine at the University of Texas Medical Branch at Galveston. In an article that treats five of my primary sources [Doctor X (Nourse); Nolen; Morgan; LeBaron; Harrison], as well as several autobiographical novels about medical education, Jones notes the following. ''Nolen and Morgan write the most positive accounts of their residencies. They are both surgeons. I do not want to indulge here in the common stereotypes about surgeons, but I will venture,'' she says about Nolen and Morgan (for whom the shoe fits), ''they are saved from doubts by the need for action'' (''The Medical *Bildungsroman*: The Making of a Physician-Writer'' 49).

By far, women are most likely to be outsiders. Five of the eight form a cluster in that category (Scalia; Patterson and Madaras; Greenbaum and Laiken; McCarthy; and Rothman), with Rubin and Klein keeping them company. One woman each is an observer (Klass), an activist (Harrison), and an apologist (Morgan). So even though all of the women struggle to reconcile the two parts of their identities—female and

physician—they do not all negotiate medical school, residency, and internship in the same way.

Nor do the men, of course. All of the malcontents are men, but at the same time, men are represented in every other category as well. Apparently, the malcontents are not unique in "being frank, that is, willing to admit things that might not redound to their credit in the reader's eye" (29), as the sociologist Diane Bjorklund suggests. In her book *Interpreting the Self: Two Hundred Years of American Autobiography*, she considers the motivations that can come into play for such authors. "In some cases, they may have reason to acknowledge traits that are not generally valued, such as weakness of will, but it will probably be for the greater gain of excusing untoward behavior. Or they may explain the circumstances that justify an action," she says. "The autobiographers may reveal misgivings about past conduct, but they can frame such accounts in the context of an 'I'm older now and wiser' argument that attempts to rectify their reputation" (21). And is honesty the best policy? It depends:

> If their memoirs are to stand, in effect, as the lasting records of the achievements of notable persons, then candor and descriptions of their personal lives may not be advisable. But if they are to serve as records of the experiences of a wide range of persons, then frankness and descriptions of "private" life may be acceptable or even obligatory. (29)

Sins involving "misdeeds" and "unseemly emotions" are among those often confessed, Bjorklund says (29), calling to mind the malcontents, who speak not only for themselves but for other interns and residents like them.[1]

Another book met all of my criteria, but I excluded it from my analysis nevertheless: *Family Doc: The Making of a Family Practitioner* (1998) by Robert E. Brown. He falls into a category of his own, that of the egotist. The only thing he lacks is a healthy dose of humility, as a brief excerpt will serve to illustrate. "I swelled with pride as I thought of all the hard work and sleepless nights I had put into my career in medicine; now, I was being offered a staff position at the distinguished and world-famous Peabody Clinic," he boasts. "My fate was sealed and my search was over—in my mind the hard-working, young fella from Lexington, Kentucky who never lost sight of his goals had reached the top" (165). Bjorkland has some advice for authors like him. "Favorable comments about the self," she says, "should not be blatant, since they can be construed as bragging" (21). And then she quotes Mark Twain. "Good breeding consists in concealing how much we think of ourselves and how little we think of the other person" (Bjorklund 31; Twain 345). It's altogether possible that Brown doesn't think any more highly of himself than many of the authors whose books are treated here. But even if he merely lacks the grace to hide

[1]"Another way that autobiographers have enhanced their claims of truthfulness has been to attest to the reliability of their faculties of memory" (28), Bjorklund says. It's a strategy that Rubin employs. "I had virtually total recall memory for everything that went into those two books," he says about *Emergency Room Diary* and *Shrink! The Diary of a Psychiatrist* (Rubin, telephone interview, 8 June 2000).

his vanity, it is the most prominent feature of his contribution to the autobiography of medical education.

Although it is my contention that the observers, outsiders, activists, malcontents, and apologists experienced medical education in five characteristic ways, there is one point on which they stand united: it places enormous demands on the initiates—students, interns, and residents alike. Ideally, according to both Mircea Eliade and Joseph Campbell, the initiates undergo a process that prepares them to assume an elevated role in society. ''In philosophical terms, initiation is equivalent to a basic change in existential condition'' (x), Eliade says. ''The majority of initiatory ordeals more or less clearly imply a ritual death followed by resurrection or a new birth'' (xii)—hence the subtitle of his book, ''The Mysteries of Birth and Rebirth.'' In other words, ''the novice has attained to another mode of existence, inaccessible to those who have not undergone the initiatory ordeals, who have not tasted death'' (xiii). Campbell offers a similar description: ''the mind is radically cut away from the attitudes, attachments, and life patterns of the stage being left behind,'' he says. ''Then follows an interval of more or less extended retirement, during which are enacted rituals designed to introduce the life adventurer to the forms and proper feelings of his new estate, so that when, at last, the time has ripened for the return to the normal world, the initiate will be as good as reborn'' (10). From caterpillars come butterflies.

While it's true that all of the twenty-eight authors treated here are M.D.s, relatively few portray themselves as having been reborn: ''survival does not go

without saying,'' says Anne Hudson Jones, whose conclusion is based on her analysis of the books by Doctor X [Nourse], Nolen, Morgan, LeBaron, and Harrison, as well as several autobiographical novels. ''Suicide is not uncommon among medical students, interns, and residents. Survival is difficult; survival intact—that is to say, without emotional or intellectual impairment—is even more difficult'' (48–49). Given that the autobiography of medical education is sown from the ''seed of difference,'' its authors do not constitute a random sample—and therein lies its value, Jones points out. ''It's that difference—their extra artistic sensitivity—that sets them apart and makes them physician-writers'' (''The Medical *Bildungsroman*: The Making of a Physician-Writer'' 49). Peter Conrad agrees, having dealt with four of my primary sources in his article ''Learning to Doctor: Reflections on Recent Accounts of the Medical School Years'' (LeBaron; Klass; Konner; Reilly). He explains. ''These four authors are a self-selected group and are not 'typical' medical students,'' he contends. ''They are self-selected because they chose to chronicle their experiences by writing a book. They are atypical in other ways as well.'' For example, ''they attended elite medical schools'' (324). And aside from them? A sociologist, Conrad describes the transformation that ordinarily occurs. ''Through the rigor and the tension of medical education, students' beliefs about medical care change as they increasingly adopt the dominant clinical perspective that pervades medicine. Most adopt it readily, while others must be converted; some accept it only uncomfortably; a few resist it actively'' (329).

Even those who adopt it readily sometimes emerge worse for the wear, as suggested by two of the apologists: Morgan and Rainer. At the end of *The Making of a Woman Surgeon*, Morgan announces, "I was a Real Doctor" (363)—and a real woman, too—the other theme that dominates her first book? Following it and her second book, *Solo Practice: A Woman Surgeon's Story*, her "work in progress" was *Surgeon, Wife and Mother*, "publication expected 1984" (*Contemporary Authors* 108: 330). But it was scrapped—or as she rather delicately puts it, "retitled" (Morgan, e-mail message Feb. 2002)—and in its place came her third book, *Custody: A True Story* (1986). Looking back today, Morgan says about her medical education, "I was incredibly lucky and sacrificed far too much" in the attempt "to survive the system." She explains. "What I managed to achieve in my training was to remain a woman and to become a surgeon but without integrating the two." Back then, her viewpoint about the system was more pragmatic: "it works." The proof? "I got spat out as a surgeon" (telephone interview, 14 Feb. 2002).

Two psychiatrists comment on women like Morgan in "Medicine: A Career Conflict for Women": Malkah T. Notman and Carol C. Nadelson, both of whom are affiliated with Beth Israel Hospital and Harvard Medical School:

> It is impressive to see how many women do not recognize the pressures under which they operate and the compromises that they have made and continue to make. They feel guilty about making *any* demands on a profession that has been "generous" enough to accept them. Little anger may be expressed at this early phase because the woman

> represses or denies her perception of her second-class position when applying for internship or residency. (1126)

What kinds of "pressures" and "compromises"? Notman and Nadelson explain. "All students share a common goal—to develop an identity as a physician. The woman student has an additional task: she must define her identity as a woman in a 'man's world' and cope with the myths about her ability to remain 'feminine' and be a doctor" (1124–25). They continue. "Those women who handle the challenge by attempting to be 'better men' and to perform as 'one of the boys' find themselves able to function well academically, but often, after a few years, they perceive that their social relationships are not as satisfying as they would like them to be" (1125).

And then there's Rainer, who willingly sacrifices his wife and two children on the altar of his career. "Either you want to be a neurosurgeon, or you want a smooth home life. You can't have both" (200). And when he ends up alone, well, all the better. "At 5 p.m. I stretched out on the sofa in the surgeons' lounge to rest my throbbing feet. I wasn't in any hurry to go home. Thirty minutes to rest and unwind after nine hours in the operating room was more important to me than a date or a dinner out" (297). As both Rainer and Morgan suggest—perhaps unwittingly—the price of success is sometimes too high. Recall what Anne Hudson Jones says. "Survival is difficult; survival intact—that is to say, without emotional or intellectual impairment—is even more difficult" ("The Medical *Bildungsroman*: The Making of a Physician-Writer" 49).

The other two apologists end on quite a different note. "I was looking forward to the challenge of private practice but I knew I would miss Bellevue as long as I lived" (269), Nolen says, echoing Campbell: "at last, the time has ripened for the return to the normal world" (10). And then Nolen adds, "it had been a wonderful experience, one I wouldn't have missed for the world." Leaving Bellevue "for the last time," he ends with the following anecdote. "As I walked out the back door to the parking lot a kid with a suitcase was just getting out of his car. 'Excuse me,' he said, an eager smile on his unlined, cheery, rested, innocent face, 'but do you have any idea where the Second Surgical Division might be?'" (269). How does Nolen respond? "I didn't know whether to laugh or cry," he says. It's clear that he's no longer a kid himself: "now, at the end of my five years of training, I had reached the point where the attendings on our staff no longer looked upon me as a 'would-be' surgeon whom it was their duty to instruct, but as an equal," he says. "It was just this recognition that I had worked so long and so hard to achieve. I could stand on my own two feet in the surgical world. It was time to go out and do something for others with what I've learned. I didn't need Bellevue any more; some other would-be surgeon did" (266). He's an exemplar for Campbell: "the initiate will be as good as reborn" (10).

The same can be said about Moynihan. "I was excited about the challenge of private practice. There was a horde of people out there with problems and deformities I could help. And I would, too. I was looking forward to it. But I'd miss University Hospital. The years I had spent there had been wonderful ones. So much had

happened.'' He continues to sound just like Nolen. ''Now I was leaving for the last time. I looked back at the hospital. Then up at the sky. Shouldn't the sun go in, or something? Maybe an earthquake—just a little one? Something—anything—to announce the making of a plastic surgeon?'' (338-39). It's a question that brings Eliade to mind. ''In philosophical terms, initiation is equivalent to a basic change in existential condition'' (x).

As suggested by the apologists, survival intact is not guaranteed; nor is it limited to certain categories. True, guarded optimism is the best that any of the activists and the malcontents can muster—LeBaron and Klitzman being especially good examples. One month into medical school, LeBaron says, ''I still couldn't shake the feeling that this wasn't a question of doing well, but of survival'' (63). Klitzman says much the same on the last day of his residency. ''In the end I had made it—had graduated and survived'' (*In a House of Dreams and Glass: Becoming a Psychiatrist* 355). And the observers are so detached, even cerebral—Konner especially—that survival—intact or otherwise—does not seem to be the central issue for them. Instead, they most commonly turn outward, posing ethical questions that offer no right answers. Perhaps intellectualization serves as a survival mechanism for the observers. In contrast, the outsiders seem to be concerned with nothing but survival—or its opposite. Scalia, for example, feels so depleted that one solution seems to be taking her own life with the revolver that she keeps at home. ''It was a stupid idea,'' she finally decides—or at least, one that comes from being severely depressed, especially considering that she takes no pleasure from her accomplishments. ''The wall opposite

the fireplace was lined with diplomas. They were all mine. A whole wall full of diplomas. Paper. I had sweated for every piece. I stood there and shook my head. It had not been worth it. I had lost more than I had achieved. There was very little of me left; my quality, my essence, they were gone'' (256).

And yet, some of the outsiders emerge with their sense of self not only intact but enhanced, particularly Rubin and Greenbaum. Interestingly, neither one attended ''elite'' medical schools (324), as Conrad puts it. In fact, Rubin and Greenbaum have trouble finding medical schools that will take them at all—Rubin because he is Jewish[2] and Greenbaum because she is already a wife and mother with nothing but a stint as a high-school English teacher behind her.[3] Remember, for him, it's the early 1950s, and for her, it's the early 1970s. And once they're in, both endure financial hardship. Yet from a rather prosaic start, they report a triumphant end.

''I've been accepted!'' exclaims Rubin upon receiving word from Kings County. ''Imagine us leaving the fief,'' he says about Rockland State, where he and his family are housed on the grounds, ''living in a real place, going to work and

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[2]Rubin explains: ''at that time, the medical school quotas in the United States were firmly in place.'' And he graduated from Brooklyn College. ''It was known for being radical and Jewish.'' The combination, he says, ''was enough to make it very, very tough,'' noting, ''and nobody could refute me on that.'' Rubin goes on. ''With me, it's ethnicity. And I am a Jew, and I'll die a Jew, and so on, but religion is not for me'' (Rubin, telephone interview, 24 June 2000).

[3]Notman and Nadelson comment on women like Greenbaum, too. ''The decision for medical school must be made early. Often, by the time a woman has had enough life experience to evaluate the direction in which she would like to go, it is too late to catch up on premedical courses, or she may be told that she is a poor risk because of age, marital status, or children'' (1124).

coming home from work'' (*Shrink! The Diary of a Psychiatrist* 222). Or as Campbell says, ''at last, the time has ripened for return to the normal world'' (10), and for Rubin it means a step up: ''Junior Psychiatrist status'' (*Shrink: The Diary of a Psychiatrist* 215), he notes proudly. ''We *really* did it!'' (223), exclaims Greenbaum, sharing the credit with her husband Eddie upon her graduation from medical school. And then as she finishes her clinical training, Eddie echoes her. ''You know something, Doc? We really did it!'' (312). Greenbaum explains that his role is essential: ''Eddie says the words that work. He says the words that transform me from fat Dorothy, the girl from the Bronx, into Dr. Greenbaum, the pediatric resident'' (6).

Ideally, then, ''the initiate will be as good as reborn'' (10), as Campbell puts it. But by no means universally. ''Medical school, after all, can be a pretty negative experience,'' says Joanne Trautmann [Banks], who made history when she accepted ''the first medical faculty appointment in literature in 1972'' (Hunter, Charon, and Coulehan 788) at the Pennsylvania State University College of Medicine in Hershey. She continues. ''Students work long hours. In their basic science years they are frustrated by seeing things in parts and not in wholes. On the wards they deal with discontent, pain, deformity, grief and death. Everywhere there is death'' [Trautmann (Banks), ''The Wonders of Literature in Medical Education'' 31]. Some of them don't make it through, either. Having studied such a group, two psychiatrists offer the following:

> They failed, not from lack of motivation, but because they were *too* serious. What they take too seriously, is the process of becoming a physician which can create major upheavals since the metamorphosis causes major changes in one's self-image. These people seek to adhere rigidly to their current notions about themselves and tenaciously cling to their precious self-image in the face of the enormous narcissistic insult imposed by attending medical school and the process of becoming something new. It is an experience vastly different emotionally and qualitatively from undergraduate education. Survival in medical school seems to require relatively flexible defenses and the rigid character structure that may have been adequate as an undergraduate, perhaps even helpful in creating an aura of excellence, is sorely battered in medical school. (Schwartz and Snow 575)

And for those who graduate from medical school, internship and residency await.

"Internship: Preparation or Hazing?" asks Norman Cousins, who followed his thirty-five years as editor of the *Saturday Review* with a position on the faculty in the Program in Medicine, Law, and Human Values at the University of California–Los Angeles School of Medicine (see Cousins, *The Physician in Literature*). Posing his question to readers of *The Journal of the American Medical Association*, who are invited to submit contributions to a column entitled "A Piece of My Mind," Cousins speaks his freely:

> For the past two years, I have been privileged to visit medical schools and hospitals in various parts of the country. I have been able to meet with medical students and physicians at various stages in their training and their careers. The weakest link in the entire chain of physician training, it seems to me, is the ordeal known as the internship. More specifically, I refer to the theory that it is necessary to put medical student graduates through a human meat grinder before they can qualify as full-fledged physicians. Putting it more delicately, the theory holds that anyone who wants to go into the medical profession must be given a rigorous and systematic exposure to the realities of the physician's life. (377)

Noting that interns are on duty for 32 hours at a stretch, Cousins concludes as follows. "The custom of overworking interns has long since outlived its usefulness. It doesn't lead to the making of better physicians. It is inconsistent with the public interest. It is not really worthy of the tradition of medicine" (377). The article produced "an avalanche" of mail, says the editor of the column, Lawrence D. Grouse, M.D., Ph.D., who ran three pages of it—twenty-two letters in all (Grouse, "Internship: Physicians Respond to Norman Cousins" 2141–43)—most of it against Cousins (specifically, sixteen to six). Offering a précis of it, Cousins notes that a "powerful argument" in favor of internship is based on "rites of passage"—that is, "aspiring physicians should be prepared to undergo a reasonable degree of hardship in their ascent to a profession built on a tradition of personal sacrifice." Cousins

agrees—to a point. "I do not see, however, that this tradition would be seriously weakened if it took into account the health needs of the interns and not just the patients" (2144).

And it's not just literature and medicine types who have expressed reservations about the toll paid by the initiates—and as a consequence, their patients. "Indeed, a number of factors in the medical educational system could mitigate against the development of patient-oriented physicians," according to Camille Lloyd, Ph.D., and Ann Gateley, M.D., both of the University of Texas Health Science Center in Houston, who serve, respectively, as Director of the Student Counseling Service and Associate Director of House Staff (xiii-xiv). "To identify these factors, one can begin by assembling what is known about the process of the present medical educational system and by what is known about the impact of this system on the medical student and resident" (96). Having reviewed some fifty studies conducted from the late 1950s to the late 1980s on medical students, interns, and residents, Lloyd and Gateley support Cousins by commenting on "the dissonance students experience as a result of a curriculum that emphasizes the promotion of health and concern for the sick but fails to address the human needs of the students" (99). And as Cousins noted, sleep is one of them:

> In sum, available knowledge suggests that both the medical student and the house officer, particularly the intern, are subjected to considerable stress. The training years seem to (1) impact negatively the medical trainee's own health habits such as proper sleep and eating habits, (2)

> decrease substantially the time available for meeting personal and social needs, and (3) show an association with an elevated risk for psychiatric symptomatology, particularly depression. (105)

Despite the large number of studies conducted, a gaping hole remains. "There is a paucity of empirical data regarding how these stresses in the training years actually impact the quality of patient care delivered, particularly with regard to humanistic aspects of care delivery" (105). Even so, Lloyd and Gateley find it reasonable to suppose that "the lack of humanistic behavior in physicians stems at least in part from their own experience in a less than optimally humane medical educational system" (110). Or as noted by Suzanne Poirier, Ph.D., William R. Ahrens, M.D., and Daniel J. Brauner, M.D., medical students "struggle to hold on to elements of themselves (idealism, optimism, innocence) as they encounter a world that seems, variously, to diminish or dehumanize themselves and the patients they meet" (473).

Another viewpoint is offered by Rita Charon, M.D., Ph.D., an associate professor of clinical medicine who also teaches literature and medicine at Columbia University College of Physicians and Surgeons. "The process of dehumanization in medicine has been explored from many directions and has been described as a process affecting both patient and health care provider" (60), she says, citing two of my primary sources: Fitzhugh Mullan's *White Coat, Clenched Fist: The Political Education of an American Physician* and Charles LeBaron's *Gentle Vengeance: An Account of the First Year at Harvard Medical School* (73, n. 2). While acknowledging "the needless pain currently associated with training" (70), Charon objects to those

who "focus on the experience of the medical trainee as the central drama in health care. Medical students and residents do in fact suffer during training. One cannot trivialize the demands and abuses they endure." But, she says, "the difficulties of the trainees" pale in comparison with "the greater difficulties of the patient" (71). Even so, she claims "no stake in the current structure of medical education or in adapting students to its rigors" (72). The essence of her argument seems to be that the system is flawed, but regardless of the cost to the initiates, their patients must come first.

The twenty-eight authors treated here "focus on the experience of the medical trainee as the central drama in health care" (71), as Charon puts it—and as David Hellerstein concedes. The author of one of my primary sources, *Battles of Life and Death*, he has also published an essay about the act of writing itself. But as he notes, it was a patient who led him to pursue a dual career. "My life as a physician-writer began with Cha Nan," he says, "my patient on the oncology ward where I was doing a medical school rotation":

> Every day I talked to this articulate young woman, and I drew her blood when she spiked fevers, listened to the rales in her chest that indicated pneumonia, and tried unsuccessfully to get marrow out of her fibrosed hipbone. And finally, when there was no hope left, I wrote the order for the morphine that helped her die. (Hellerstein, "On Being a Physician-Writer: Giving Yourself Permission to Write" 7)

He continues: "her death haunted me. Finally, being of a literary bent, I began writing"—and publishing. "The essay I wrote about Cha Nan, 'A Death in the Glitter

Palace,' was eventually published in a literary magazine, the *North American Review*, and later became the opening chapter in my first book, *Battles of Life and Death*. And it launched me on a strange sort of career as a physician-writer.'' Although the piece about Cha Nan won him the Pushcart Prize for Best Essay (*Contemporary Authors New Revision Series* 46: 163), the medical community wasn't quite sure what to make of him. ''Today many medical schools have courses on medical humanities,'' he says. ''But when I was a medical student 20 years ago, the idea of having such a career was, at the very least, unconventional.'' Nevertheless, he says, ''I did receive some encouragement from teachers and colleagues. More common, though, were reactions like that of the hospital administrator who stopped me in the hospital lobby one day. 'Who gave you permission to write?' she asked. If she had any say in the matter, she said, no more writing physicians would ever get admitted for training at *her* hospital.'' He continues:

> I took her question very seriously at the time; I didn't want to get thrown out of my residency program. And I still take it seriously today. Why should a physician consider being a writer? Why should he write about the experience of doctoring, about caring for patients, about working in hospitals and in other health-care settings? Is writing a frivolous pursuit? Is it somehow subversive, as the administrator's accusation implied? Or is it somehow important, central to the purposes of modern medicine? (Hellerstein, ''On Being a Physician-Writer: Giving Yourself Permission to Write'' 7)

But he's already explained why: "her death haunted me," he says of Cha Nan. "For months afterward, I struggled with Cha Nan's death" (7). And when healing her was no longer a possibility, Hellerstein began to focus on healing himself through writing.

It's an idea that can be traced all the way back to Aristotle, who in the *Poetics* postulated that the spectators of Greek tragedy benefited "through pity and fear effecting the proper purgation of these emotions" (Harmon and Holman, "Catharsis" 82). But catharsis is not limited to the spectators: "literature offers healing in both active and passive ways," according to Anne Hudson Jones. "The active way is by writing: catharsis is provided by the act of expressing oneself," she says. "Paying attention to one's experiences and feelings and recording them regularly in a journal relieves one of the negative effects of emotions and leaves one better able to understand and deal with problems and conflicts. The therapeutic value of this kind of writing has long been recognized" (Jones, "Literature and Medicine: Traditions and Innovations" 16).

It has been touted in both of the leading news magazines: *Time* (Kalb, "Pen, Paper, Power! Confessional Writing Can Be Good for You") and *Newsweek* (Mitchell, "Thanks for the Memoirs: There Has Never Been a Better Time to Write the Story of Your Life"). Also for the general public, there is Louise DeSalvo's *Writing as a Way of Healing: How Telling Our Stories Transforms Our Lives.* Moreover, an entire scholarly book has been devoted to it: *Writing and Healing: Toward an Informed Practice* (Anderson and MacCurdy). Survivors of trauma all have one thing in common, according to Anderson and MacCurdy: "having stepped

outside the 'normal,' they have seen, experienced, and have come to know things that others do not'' (4)—a description that fits medical students, interns, and residents. ''Healing arises from just such confusion and psychic pain, never from peace. It is when we are overloaded with past and present trauma that we are motivated to take on the difficult work of healing,'' which for many survivors can be facilitated through writing (5). For the same reason, Suzanne Poirier suggests that the autobiography of medical education ''may even be a sort of survivor narrative'' (Poirier, e-mail message, 6 Jan. 2000).

So writing is the active way. ''The passive way in which literature offers healing is through reading rather than writing,'' Jones says, paraphrasing the position taken by Trautmann [Banks]: ''one of the main reasons for teaching literature to medical students is to provide them with an affirmation of life that can help counterbalance the prevailing negativity of their medical school experience'' (Jones, ''Literature and Medicine: Traditions and Innovations'' 17). Now, it's clear that by ''literature,'' Trautmann [Banks] means ''great works'' by the likes of Anton Chekhov and William Carlos Williams. Having recommended both of them, she explains. ''I think anyone who teaches literature to medical students must use almost exclusively first-rate material, must continue his or her search for the best that has been thought and said'' (Trautmann, ''The Wonders of Literature in Medical Education'' 29, 30).

What about the autobiography of medical education? Is it the best that has been thought and said? Jones says no, having reviewed five of my primary sources—Dr.

X's *Intern*, William A. Nolen's *The Making of a Surgeon*, Elizabeth Morgan's *The Making of a Woman Surgeon*, Charles LeBaron's *Gentle Vengeance: An Account of the First Year at Harvard Medical School*, and Michelle Harrison's *A Woman in Residence*—as well as three related works, most notably, the autobiographical novel *The House of God* (''an underground classic'') by Samuel Shem.[4] ''None of these eight works is great literature,'' Jones says. ''That does not mean that they are not worth reading and considering seriously. They are important for the physicians among us; they are important for the public; they are most important for those of us who have any connection with medical education'' (Jones, ''The Medical *Bildungsroman*: The Making of a Physician-Writer'' 50).

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[4]In fact, the pseudonymous Samuel Shem is the author of a trilogy of sorts: *The House of God* (1978), a novel about internship that has sold upwards of two million copies (Updike 8); *Fine* (1985), a novel about psychoanalytic training; and *Mount Misery* (1997), a novel about residency in psychiatry. It's on the dust jacket of his third novel that Samuel Shem reveals himself to be Stephen Bergman, whose M.D. is from Harvard Medical School (where he is now on the faculty), and whose Ph.D. in physiology is from Oxford University. A recent mention in *Newsweek* attests to the staying power of *The House of God*. ''Every trade has its traditions—how to dress, how to talk, even which books to read to learn the secrets of the society. Though some of the insider tomes are little known to outsiders, initiates plow through them like a high rite of passage.'' Among them is *The House of God* by Samuel Shem (''Got the Job, Read the Book'' 8), even if its appeal is limited to members of the younger generation: ''elders in the profession—those who took their training before 1965—tend to regard the book as an embarrassment or a betrayal or worse.'' Why? ''*The House of God* attacks the profession itself and its sacred center: the process by which ordinary young men and women become expert practitioners of highly technologized Western medicine'' (Hunter 137). Four years after it came out, Trautmann [Banks] commented on its popularity. ''Is there a literate medical student or house officer in the country,'' she asks, ''who has not read *The House of God* (1978), by Samuel Shem?'' Nevertheless, she judged it thus: ''Shem's book is simply too transient to merit lines in a restricted space'' (Trautmann and Pollard xix). So far, though, it has yet to fade from the scene.

In fact, some of them have served as texts in courses on literature and medicine for undergraduates at Indiana University and the University of North Carolina. Specifically, John Woodcock has assigned Elizabeth Morgan's *The Making of a Woman Surgeon* to his students, calling it "fairly well balanced" (Woodcock 48), and Lilian R. Furst has used what she calls "a fine cluster" of texts: Perri Klass's *A Not Entirely Benign Procedure: Four Years as a Medical Student*; Melvin Konner's *Becoming a Doctor: A Journey of Initiation in Medical School*; and Robert Klitzman's *A Year-Long Night: Tales of a Medical Internship* (Furst 61). Not surprisingly, both courses have attracted premedical students (Woodcock 47; Furst 56).

And in a course called "Reflections on Gross Anatomy" that is offered to first-year medical students by Douglas R. Riefler at Northwestern University, one of the readings is an essay published in *Triquarterly* by Perri Klass entitled "Endings," which is virtually the same as the conclusion to her book *Baby Doctor*: "Storytelling" (323–30). Then there's the anthology *On Doctoring: Stories, Poems, Essays*, which is given to all incoming medical students in the United States by the Robert Wood Johnson Foundation (Hunter, Charon, and Coulehan 791). Edited by Richard Reynolds, M.D., and John Stone, M.D., the most recent edition includes excerpts from David Hellerstein's *Battles of Life and Death* (Hellerstein, "Touching" 354–57) and Perri Klass's *A Not Entirely Benign Procedure: Four Years as a Medical Student*

(Klass, "Invasions" 368–72). Moreover, a piece by Melvin Konner is preceded by a reference to *Becoming a Doctor: A Journey of Initiation in Medical School* (337–42).[5]

It appears that undergraduates and medical students are being introduced for the most part to a few representatives of the category that I call the observers—Hellerstein, Klass, Konner, and Klitzman (specifically, *A Year-Long Night: Tales of a Medical Internship*)—and to one of the apologists—Morgan—thus leaving the outsiders, the activists, and the malcontents untouched. Adding some of them to the curriculum would make it more representative of the autobiography of medical education as a whole. The ones who have the most to offer are those who provide reasoned assessments of medical education. Among the outsiders, they include Rubin, *Shrink! The Diary of a Psychiatrist*; Patterson and Madaras, *Woman/Doctor: The Education of Jane Patterson, M.D.*; Greenbaum and Laiken, *Lovestrong: A Woman Doctor's True Story of Marriage and Medicine*; and McCarthy, *Learning How the Heart Beats: The Making of a Pediatrician*. Among the activists, they include LeBaron, *Gentle Vengeance: An Account of the First Year at Harvard Medical School*; and Seager, *Psychward: A Year Behind Locked Doors*. And the most thoughtful of the malcontents is Klitzman, *In a House of Dreams and Glass: Becoming a Psychiatrist*. (For details about each one of those books, see chapter 3, "The Outsiders"; chapter 4, "The Activists"; and chapter 5, "The Malcontents.")

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[5]In addition, Hellerstein, Klass, and Mullan are among the contributors to *Recognitions: Doctors and Their Stories* (Donley and Kohn), which is described on the title page as "a collection of original works in celebration of the tenth anniversary of the Center for Literature, Medicine and the Health-Care Professions." Also included is a piece by Samuel Shem [Stephen Bergman].

Of course, it's not just students who are reading the autobiography of medical education. Suzanne Poirier and Louis Borgenight, M.D., comment on "the seemingly endless public fascination with the medical world, especially the process of medical education and training" (Poirier and Borgenight 212). And it's not just the medical world that has been the subject of popular books by initiates. The legal world has had its share of the attention, too. For example, consider the autobiographical novel *The Paper Chase* (1971) by John Jay Osborn, Jr., and its main characters—the protagonist Hart and the antagonist Professor Kingsfield—as well as the autobiography *One L* (1977) by Scott Turow, who announces, "this book is not a novel" (5). Graduates of Harvard Law School, one writes an autobiographical novel (Osborn), and the other writes an autobiography (Turow). So while the counterpart to Samuel Shem is John Jay Osborn, Jr., the counterpart to the twenty-eight authors treated here is Scott Turow.

Consider some of his opening and closing words, which apply to medical education as well as legal education. "In baseball it's the rookie year. In the navy it is boot camp. In many walks of life there is a similar time of trial and initiation, a period when newcomers are forced to be the victims of their own ineptness and when they must somehow master the basic skills of the profession in order to survive" (3), Turow notes in the preface. And in "Exams (Last Act)," he concludes as follows, calling to mind what Norman Cousins had to say about medical education. "A more humane and humanistic education in the law strikes me as far more fitting than a schooling characterized by terror and the supression of feeling for those persons who,

in time, will become this society's chief custodians of justice'' (273). When it comes right down to it, *One L* is about students who spend most of their time cramming for tests and scheming to make the Law Review. It's not exactly life-and-death stuff, but we eagerly read about it anyway, just as we want to know the inside scoop about medical school, internship, and residency. In short, we turn to the autobiography of medical education because we hope that it will inspire us to be survivors ourselves.

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APPENDIXES

Appendix A: Publishing Agreement

The Education of a Doctor: My First Year on the Wards,
by John MacNab [Benjamin Winthrop White]

SIMON & SCHUSTER, INC., *PUBLISHERS*
630 FIFTH AVENUE, NEW YORK, NEW YORK 10020

Publishing Agreement

SIMON & SCHUSTER, INC.

(hereinafter called the "Publisher")

and

Benjamin White
Box Hill, Moriches Road
St. James, L.I., New York 11780

(hereinafter called the "Author")

agree:

FIRST: The Author

A. shall deliver to the Publisher two copies of the literary work now entitled

LINCOLN'S DOCTOR'S DOG

(hereinafter called the "Literary Work") in final form on or before November, 1971 and will contain approximately 125,000 words.

B. makes the warranties and representations set forth in Part Two (36-45) of the Basic Agreement, except as otherwise specifically stated in *THIRD* (C) of this Publishing Agreement;

C. grants and assigns to the Publisher.

(i) the trade edition rights;

(ii) all other primary rights; and

(iii) the shares, provided in *THIRD* (A) of this Publishing Agreement, of the proceeds received on disposition of the secondary rights; and

D. agrees that the Publisher shall have the first opportunity to consider the Author's next full-length work for publication on mutually satisfactory terms. If within 60 days following submission of the final manuscript to the Publisher, Publisher and Author are unable in good faith to agree upon terms for publication, the Author shall be free to submit the manuscript to other publishers, provided, however, that the Publisher shall retain the first option of publishing the work on terms no less favorable to the Author than those offered by any other publisher.

SIMON & SCHUSTER, INC.

(hereinafter called the "Publisher")

and

Benjamin White
Box Hill, Moriches Road
St. James, L.I., New York 11780

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(i) the trade edition rights;

(ii) all other primary rights; and

(iii) the shares, provided in *THIRD* (A) of this Publishing Agreement, of the proceeds received on disposition of the secondary rights; and

D. agrees that the Publisher shall have the first opportunity to consider the Author's next full-length work for publication on mutually satisfactory terms. If within 60 days following submission of the final manuscript to the Publisher, Publisher and Author are unable in good faith to agree upon terms for publication, the Author shall be free to submit the manuscript to other publishers, provided, however, that the Publisher shall retain the first option of publishing the work on terms no less favorable to the Author than those offered by any other publisher.

SECOND: The Publisher

A. shall publish in book form the Author's work on or before Fall , 19 72 , for sale at a catalog retail price of not less than $ 3.95 in the trade editions;

B. shall copyright the literary work in the United States in the name of the Author;

C. shall pay the Author $2,000.00, payable as follows: $500.00 on signing and $1,500.00 on delivery of a complete and satisfactory manuscript, such sum to be an advance against

(i) royalties at the following rates, for sales of the trade edition:

10% of the catalog retail price on the first 5,000 copies sold and 12½% of the catalog retail price on the next 5,000 copies sold and 15% of the catalog retail price on all copies sold thereafter, less returns;

(ii) 50% of the net proceeds received on disposition of the other primary rights, except as otherwise provided herein;

(iii) in accordance with the special provisions in Part Five of the Basic Agreement, for sales by mail order, at special discount, as unbound sheets for export from reduced printings, to book clubs, or as excess stock, or for any mass market paperback reprint, quality paperback or textbook editions of the literary work published by the Publisher itself under one of its own imprints or for publication of part of the literary work by the Publisher in another work;

(iv) notwithstanding anything to the contrary in this or any prior agreement between the parties, the Author shall in no event be entitled to receive hereunder more than $ no limit during any one calendar year. If in any one calendar year the total amount accruing to the Author under this or any other agreements with the Publisher shall exceed such amount, he shall be entitled to receive the excess amount, up to the maximum stated herein, in any succeeding calendar year in which the sums accruing to him under this or any other agreements with the Publisher do not exceed said maximum.

THIRD: The Publisher and the Author

A. agree to share the net proceeds received on disposition of the following secondary rights as follows:

Dramatic Rights	90 % to Author	10 % to Publisher
Motion Picture Rights	90 % to Author	10 % to Publisher
Educational Picture Rights	90 % to Author	10 % to Publisher
Radio Rights	90 % to Author	10 % to Publisher
Television Rights	90 % to Author	10 % to Publisher
First Periodical Rights	90 % to Author	10 % to Publisher
Commercial Rights	90 % to Author	10 % to Publisher
Foreign Language Rights	75 % to Author	25 % to Publisher

B. agree to be bound by all of the terms and conditions of the Basic Agreement which follows and which is made a part of this Publishing Agreement; and

C. agree to the following special provisions, which shall prevail over any conflicting provisions in the Basic Agreement:

1. Should the Publisher deem unsatisfactory or unacceptable either any manuscript installment or the final manuscript itself, then and in that event:

a. Publisher shall not be obligated to make any further payment to the Author hereunder; and

b. Author shall be free to place the literary work elsewhere; and

c. Author shall repay to the Publisher, from the Author's share of the first proceeds of the literary work, an amount equal to the total amount previously paid by the Publisher under this Agreement. The term "first proceeds," as used in this paragraph, shall mean the first monies received or paid (other than any advances paid under this Agreement) as for royalties, licenses, permissions and/or advances, or any other amounts paid to the Author in connection with the sale, lease, license or publication of the literary work or any right thereto as defined in Part One of the Basic Agreement.

SIMON & SCHUSTER, INC., PUBLISHERS

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AUTHORIZED SIGNATURE

Dated ....May. 4,.....19 70

..... (L.S.)
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Appendix B: Royalty Statement

The Education of a Doctor: My First Year on the Wards,
by John MacNab [Benjamin Winthrop White]

ROYALTY STATEMENT

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STATEMENT WITH CHECK

VITA

Cheryl A. Koski was born to Arthur E. Koski and Sue Rose Koski (née Newman) on April 4, 1957, in Milwaukee, Wisconsin. She attended public schools in the nearby suburbs of Shorewood and Brown Deer, graduating from Brown Deer High School in June 1975.

She enrolled at the University of Wisconsin-Whitewater in August 1975. With a double major in English and psychology, she was awarded a Bachelor of Science degree *summa cum laude* in May 1979. Continuing her education at Iowa State University in September 1979, she held a teaching assistantship while seeking a Master of Arts degree in English, which she completed in May 1983.

From August 1983 until December 1987, she was an instructor of writing in the Department of English at Louisiana State University in Baton Rouge. Since January 1988, she has been employed at the U.S. Department of Energy science and engineering facilities in Oak Ridge, Tennessee, as a senior technical editor.

She began doctoral studies in the Science Communication Program at the University of Tennessee in Knoxville in June 1994. In addition to publishing three articles in the *Journal of Technical Writing and Communication*, she has placed her freelance science writing in several major daily newspapers. The degree of Doctor of Philosophy in Communications was conferred upon her in May 2002.

Her leisure pursuits include traveling and figure skating. Especially memorable was the trip that she made to Italy in November 1998, touring Rome, Florence, and

the ancient city of Pompeii. In March 2002, she participated in the 33rd Annual Mississippi Valley District Invitational Team Competition hosted by the Robert Unger School of Ice Skating at the Ice Chalet in Knoxville, winning two first-place medals.

Recently selected for the Summer Institute in Medicine, Literature, and Culture offered by the National Endowment for the Humanities, she will be a Visiting Scholar during the summer of 2002 at the Pennsylvania State University College of Medicine in Hershey.

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