

# Writing and Telling Our Clinical Stories to Improve the Art of Medicine

**W**hy do doctors and nurses write stories? And why tell them to a group of unfamiliar colleagues? People write to learn from their experiences, to express the meaning of their life's work. Although we remember our stories, we may not understand them until we write them on paper, move them out into the world.

## Origin of Spirit Section

In this issue we publish a large collection of original stories, poems, and essays by Kaiser Permanente doctors and nurses, written either during the five Narrative Medicine conferences and workshops *The Permanente Journal (TPJ)* sponsored in 2004-5, or the *TPJ* Portland and Oakland quarterly writing groups in 2005. Barry Lopez, an Oregon naturalist, wrote in his Native American tale, *Crow and Weasel*, "The stories people tell have a way of taking care of them. If stories come to you, care for them. And learn to give them away where they are needed. Sometimes a person needs a story more than food to stay alive. That is why we put these stories in each other's memory. This is how people care for themselves."<sup>1</sup>

## Relevance of Stories

Reading and writing stories of clinical encounters with patients or colleagues can improve the diagnostic and communication components of physicians' and nurses' clinical competence. Physicians and nurses

encounter many dilemmas in their practice: moral, ethical, legal, social, human rights, religious, economic, and personal values. Stories can help with understanding and finding solutions, to integrate and organize complicated situations, and to clear the mind. Writing stories can also positively impact physician mental and spiritual health. Writing is a powerful tool to discover meaning and to promote self-understanding, and because psychological conflicts are linked to specific changes in our bodies, narrative writing can be of therapeutic value to physicians.<sup>2</sup>

## Physician Authors on Writing

Kate Scannell, MD, internist with The Permanente Medical Group and author of "The Death of the Good Doctor," keynotes our writing workshops. She wrote in *Annals of Internal Medicine*, "Writing and speaking about doctoring can save your life. By this I do not mean that they can prolong life, but, rather, that they can prove deeply enlivening. Giving language to what we witness lifts into personal and, sometimes, public consciousness the otherwise unarticulated existential dimensions of experience that permeate our work—whether we name them or not. Consciously narrating these ac-

counts illuminates more of our collective lives as patients and physicians, expanding our felt understanding of human frailty, compassion, strength, love, fear, hatred, and ill will."<sup>3</sup>

Abraham Verghese, MD, MFA, a New York Times best-selling author and practicing internist, gave the keynote address at our first writing conference. He wrote in *Annals of Internal Medicine*, "A sense for the stories un-

folding before us will perhaps allow us to be more conscious of bringing people to the epiphanies that their stories require ... [W]e will remember the voice of the patient, even though it is the voice of medicine that we record in the chart. ... We should be not just 'doctors for adults'<sup>1</sup> but also ministers of healing, storytellers, storymakers, and players in the greatest drama of all: the story of our patients' lives as well as our own."<sup>4</sup>

## Spirit: The Permanente Literary & Arts Journal

*TPJ* has produced three supplements thus far: Weight Management, HealthConnect, and Evidence-Based Medicine. From this issue we will produce a fourth, somewhat different one. We will collect the stories, poems, essays, published in this section, with a spiritual symposium, commentary,



**Tom Janisse, MD**  
Editor-in-Chief

**"Sometimes a person needs a story more than food to stay alive."**

other new stories, and art into an annual periodical, called "*Spirit: The Permanente Literary & Arts Journal*." When published in Summer, 2006, it will be our second book. The first book, published in 2005, was *Soul of the Healer: The Art & Stories of The Permanente Journal: The First Seven Years*. Motivated by our readers' comments, we created this book to bring to-

gether our art and stories they say are so beautiful and uplifting.

The editors hope you enjoy reading your colleagues' never-before-told stories and poems, and that they bring you health. Write and tell us one of your stories, and please attend one of our writing groups, or tell us of your interest in starting your own. ❖

## References

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## commentary

# Restoring Our Humanity: Our Intention to Heal



**Fred Griffin, MD**

Being a doctor can be such a lonely place to inhabit. Our task-oriented approaches to patient care can all too often reduce us to feeling more like two-dimensional characters in someone else's story than three- and four-dimensional people in our own meaningful lives. Never has there been a time in the history of medicine when physicians have had a greater need to find meaning in what they do. When we translate clinical experience into written narratives, we bring to life the physician-patient relationships in which we live. The act of writing helps us to restore our own humanity, and the act of seeing ourselves with our patients on the written page reminds us of what led most of us into medicine in the first place. These stories both humanize the physician-patient encounter and make physicians feel more like the human beings they are than the "human-doings" they sometimes become. And it is only through being more fully human ourselves that we may convey convincingly to patients our intention to heal. ❖

**Fred Griffin, MD**, is a psychiatrist and a professor at the University of Alabama School of Medicine. Dr Griffin has written extensively on literature in medicine, the use of writing in psychoanalysis, and the physician-patient relationship. He presented to and attended the *TPJ* writing workshop in Atlanta, Georgia in October 2005.

# Does Anyone Have a Case? The Balint Group Experience

By Cecilia Runkle, PhD  
Laura Morgan, MD  
Eric Lipsitt, MD

So begins another Balint group for clinicians. Using a case presentation model in a facilitated discussion format, clinicians are invited to explore the clinician-patient dynamic. The deceptively simple process can enable clinicians not only to learn more about the perspectives of the patient but also to foster greater satisfaction in the practice of medicine. This is one possible method of practice-based learning that we are exploring to reinvigorate our vocation.

Since the 1950s, Balint groups have been used in medical schools, residency programs, and among practicing clinicians worldwide. Recent articles document the value of these groups in preparing clinicians for practice as well as provoking insight, personal growth and satisfaction among those clinicians who have been practicing medicine for some time.<sup>1-3</sup> According to the American Balint Society Mission Statement, the goal of the Balint Group experience is “for the participants to transform uncertainty, confusion and difficulty in the doctor-patient relationship into understanding and meaning that nurtures a more therapeutic alliance between clinician and patient.”<sup>4</sup>

For over two years now, the Department of Medicine at Kaiser Permanente (KP) Oakland has sponsored a hybrid Balint/Practice Inquiry group for physicians, which combines evidence-based medicine with the traditional Balint approach. Every two weeks, a drop-in discussion is held, with lunches and meeting space provided by the department. Recently, Eric Lipsitt, MD, and Laura Morgan, MD, from the KP Oakland Medicine Department, with Cecilia Runkle, PhD, from Regional Physician Education and Development and Lucia

Sommers, DrPH, author of the *Practice Inquiry method*, attended a *Balint Leaders Intensive* course in Portland, Oregon.

## The Intensive

Over a four-day period, we participated in seven Balint groups, with opportunities to co-lead. Each session was followed by a one-hour debriefing of the group’s interaction: what was observed in the leaders’ and group’s behavior? Did facilitators provide a safe environment for presentation and discussion? What could leaders have done to improve the way in which the group addressed both the clinician’s and patient’s perspectives? What occurred unexpectedly and how was it handled? One session was videotaped. Later in the day, the group observed and commented on facilitators’ interventions.

## The Value

The practice of medicine is often referred to as the “art of medicine.” Our experiences in participating in and co-facilitating Balint groups reflect this adage. After a case is presented and clarifying questions answered, the presenter listens while the group verbally shines a light on the case from many perspectives. Gradually, the picture becomes three-dimensional, with many shades and possible meanings. The presenter is then invited back into the group discussion, free to view the picture of their case from new directions. Sometimes, a presenter will put further touches on the picture; sometimes one will paint it over completely; sometimes one will simply contemplate a new picture they’d not been aware of before. In all cases, for all participants, there is a change in perception that leads to finer practice of the art of medicine.

**Cecilia Runkle, PhD**, (top) is a Program Coordinator/Trainer for Group Health Permanente. She is a former Senior Training and Development Consultant with TPMG’s Physician Education and Development Department. In her spare time, she enjoys writing haikus, reading mysteries, and race walking. E-mail: [runkle.c@ghc.org](mailto:runkle.c@ghc.org).

**Laura Morgan, MD**, (left) is a family physician working in primary care in the Northern California Region for the past 13 years. She has authored *Surviving and Thriving at Kaiser Permanente*, a manual for physicians, and continues to seek ways to improve the quality of professional life for her peers.

**Eric Lipsitt, MD**, (right) is an internist and is Oakland’s elected representative on the TPMG Board of Directors. He is also the Chair of the Physician Health & Wellness Committee in Oakland. E-mail: [eric.lipsitt@kp.org](mailto:eric.lipsitt@kp.org).



In the community of shared experience, with sensitive and strong facilitation, we learn to support and trust each other. Cases with “risky” content, such as doubt about our medical knowledge, difficulty setting limits, or negative feelings toward patients, become normalized and safe to share and thus better understood. In this community, we heal ourselves while we practice the art of healing others. We believe that Balint groups provide a forum for the kind of professional development that leads to spontaneous personalization of care. We hope to share our enthusiasm and support for initiating this process with all interested colleagues.

If you’re interested in starting a Balint group, please contact Laura Morgan at [laura.morgan@kp.org](mailto:laura.morgan@kp.org). ❖

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## Finding Meaning in Medicine

By Laura Morgan, MD

Since January of 2004, an extraordinary series of physician gatherings has been taking place at our homes each month. Most participants are from the Kaiser Permanente (KP) Oakland Medicine Department, but the group has grown to include physicians from the Oakland community and other KP facilities as well.

After a reasonably priced, catered dinner and homemade dessert (there’s stiff competition for best baked goods between two of us), we settle down to discuss the night’s “theme.” We follow a format created by Rachel Remen, MD, author of *Kitchen Table Wisdom*.

We contribute writings, drawings, songs, photos, objects or a group exercise that expresses our “take”

on a specific topic as it relates to our practice of medicine. This week, the theme is “silence.” Last month it was “listening.” In prior months, the themes have ranged from “celebration” to “loss.”

Through these gatherings, original writings have emerged, such as Roger Baxter’s haikus, which appeared in *The Permanente Journal* in the Summer 2004 issue. Stories of our experiences with patients easily fit a “narrative medicine” description. If shy or unprepared, group members may simply contribute their attention to their peers.

Distinct from the case-based colleague groups discussed above, “Meaning in Medicine” dinners are purely for clinician renewal. Most

of us practice in busy isolation, take care of everyone but ourselves, and have little time for reflection. These gatherings have created community, self-awareness, and a base of support for needed change in our professional and personal lives (not to mention hilarity and occasional rowdiness!).

Initiation and logistics are not difficult but require either one consistent host(ess) or an agreement to rotate homes. A simple e-mail to your facility or department can identify interested colleagues.

For further information, you may contact me or better yet, see “MeaninginMedicine.org,” or Rachel Remen’s Web site: [www.rachelremen.com](http://www.rachelremen.com). ❖

# Things Happen in the Park

By Steve Long, MD

A boy yelled, "Stop crying!"

As I turned toward him, he pushed his sister. She landed, hard, bouncing on the cement.

Then she stood, head bowed, facing him.

"Why are you f...ing crying?" he shouted. He was thirteen or fourteen, big, sitting on a park bench, a cast on his leg, crutches at his side. His face was red, his hair short.

The girl, maybe five, had flat blond curls, and pale skin.

"Why can't you be happy like all the other kids here? Look around. They're all happy. Everyone here is happy but you. Stop your f...ing crying." He screamed in her face.

I couldn't hear her response. An old gentleman and his wife were sitting on the bench facing the boy. They had a black terrier.

The boy yelled, "Well then go swing on the swings. Have fun." The girl stood still, unmoving, with her head down.

In the twenty seconds this all took place, I had managed to convince myself that my angry stare was somehow going to make a difference.

The old man stood up. His wife stared off into space. The man and his dog walked away.

"Stop your crying," yelled the boy.

I stared.

A young woman walked up from behind the bench. "Where's your parent?" she asked, calmly. She was plain, thin, with glasses and mousy hair.

"My dad's at work." The boy replied.

"Where's your mom?" The woman asked.

"My mom abandoned me." The boy said.

At this point my daughter asked me to pick her up. The woman knelt beside the boy. I couldn't hear anything else said. I carried my daughter to another part of the park. She played while I watched.

After awhile, the boy stopped staring straight ahead and looked at the young woman.

The woman took the sister to the slides. The woman again knelt next to the boy, then disappeared from my view, then came back to sit, at a slight distance, with her own group of friends.

The boy continued to sit on the bench, staring straight ahead. His sister was gone.

As my daughter played, I kept looking back. I wanted to go up to the woman, to thank her. To tell her she is brave and smart and wise.

"Time to go find mom," I said.

I carried my own daughter to our car, carefully strapped her into her car seat, and we drove away. ❖

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**Steve Long, MD**, is an otolaryngologist at Northwest Permanente. He has a wife, Wendy, and two children, Zaidie and Eli. He enjoys film as well as writing.



## For Carl

By Barbara Gardner, MD

We were in my exam room, where I most always see my patients. This was probably the fourth or fifth time I'd seen Carl. He was always intense, yet despite his intensity, there was a softness to his eyes. I could imagine him having thoughtful discussions with his middle-school students. His voice was soft, but direct and clear and firm.

We finished talking about the latest tack his treatment would take, and for once he didn't seem to have an endless stream of questions.

Instead, he sat and thanked me for always taking the time to answer his questions, and said he really appreciated it, it made him feel well cared for.

I thanked him. If he only knew what a struggle it sometimes was for

me talking to him. He had a bad disease, a malignant brain tumor, and I certainly wanted to take good care of him. I had struggled to make it appear that I had all the time in the world to talk to him.

He subsequently died. The image of his tweed coat, his mustache, his clear gaze, and his words of thanks remain. ♦

## Life Lesson

By Shawna L Swetech, RN

7:15 am. I am sitting at the nurse's station, getting report on my group of patients for the shift. Oh, no—this one is going to be a challenge: 55-year-old male, admitted with Stage IV decubitus ulcer and septicemia. History: paraplegic x23 years from a gunshot wound to the spine, with subsequent bilateral AKA, multiple surgeries, and colon cancer two years ago with colostomy placement. He has a suprapubic catheter, triple lumen central line catheter, extensive Q shift dressing changes, and is on bed rest in supine position only. God, how awful. I can't imagine any quality of life worth waking up to, day in and day out, after all of that. Life is hard enough as it is. Now, the poor soul has weeks of around-the-

clock antibiotics and more surgery to deal with.

8:15 am. I'm at the door to his room now, initial assessment time. Knock, knock, I say as I peek around the curtain, clipboard clutched against my chest. There, floating atop the fluid air mattress, is the upper half of a body: the entire lower portion of the bed is empty. I expect to see a man with a sad, broken spirit—or at least someone with a chronic, sour disposition, rightfully earned from all those years of misery. But no. An infectious smile quickly spreads across his face when he sees me. In fact, he exudes a palpable joy that radiates into the room like a warm light. I am stunned.

This man is not just my patient; today, he is my teacher. ♦



**Barbara Gardner, MD**, (right) has worked as a neurologist with PMG in Sacramento for 20 years, and is also doing work in palliative care. She is married with three children and has many outside interests, which she juggles with variable success.

**Shawna L Swetech, RN**, (not pictured) is a medical/surgical nurse at the KP Santa Rosa Medical Center. She has been studying and writing poetry for five years. Ms Swetech finds the magnificence of the human spirit a constant source of inspiration.

# Mountain

By Laura L Wozniak, LCSW

*Everyone who sits on my couch sees a black and white print of the valley I lived in as a teenager viewed from our mountain. It hangs out of my line of sight, behind me and over my head. I forget it is there most of the time, but it was a gift to my Dad toward the end of his life from one of his art students. They were as eager for his praise as I was—and less frustrated. Above the print hung a ceremonial eagle feather given to me by a Native American elder. I thought it looked great flying above the aerial view. More importantly, it reminded me of hope and higher powers.*

Frank sat there today, looking past me as he dredged up words from his own valley of physical pain and depression. There was a mountain of trouble for this man. He was a tribal policeman laid low; a revered youth hockey coach stopped cold; a mountain of strength to his family, now dependent. Maybe he was a cooling volcano looking for just one reason to glow again.

I remember the mountain I saw rising from the shore of the Connecticut River across the road from my house as a teenager. Mount Sugarloaf looked huge because it was so steep and loomed in striped sunset colors above the flatness of shade tobacco fields and wide water. Pocumtuck tribal history said it was the body of a menacing giant beaver killed by a god, but when I was a teenager you could drive up and park on top with your boyfriend. From my window I could see the lookout tower and all the places where

the fence leaned out dangerously.

Looks deceived. The mountain was made of arkose—coarse sandstone. A handhold turned into handful of miniature rocks of pink, red and gray and ochre yellow. Each bit beautiful and nothing that you wanted to keep in the end. Mount Sugarloaf got smaller every year. It was earth science in fast forward, but it still so dominated human scale that I knew my grandchildren would gasp to see it just as I had when we moved there.

I saw Mount Sugarloaf every morning and every day. It stands over my mother's old garden bordered with chives and marigolds to repel pests. It stands over the tiny Christmas tree farm my Dad planted in front of our house—now tall and shadowing the long driveway. It was my point of reference—always there when I needed to take the long view.

I looked up after my Dad died at home and Mount Sugarloaf was still there when his ashes came back in a cardboard box. The ashes looked like tiny pale rocks—nothing that could hold together in the shape of a tall, tall man with a giant presence.

I got up at the end of the hour with Frank. He moved slowly, so I had time to look around. I was searching for one more thing to say or do to ease his life. My hand flew up and I spoke without hesitation. "Please take this eagle feather. It is meant for an elder." I think of him now every time I see the pinhole in the wall above my Sugarloaf view. ❖

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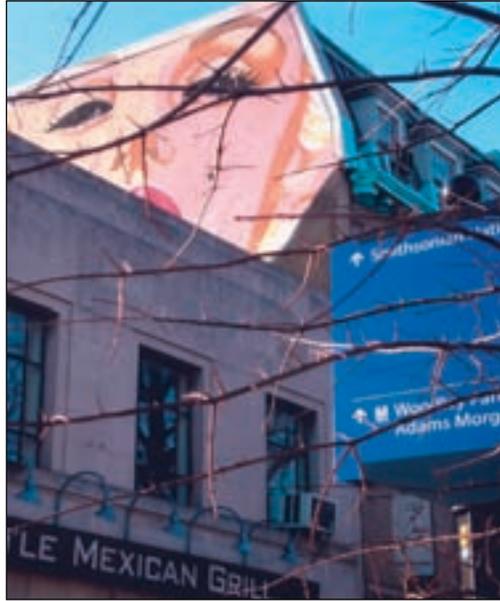
**Laura L Wozniak, LCSW**, is a therapist in the Mental Health Department at Beaverton Clinic as well as the Team Supervisor for the Westside Clinics. She is delighted to be married to Ken and has two wonderful sons, aged 19 and 21. She takes care of herself with ballet classes, gardening and great friends. She thanks her first clinical supervisor, Julia Kling, MSW, who taught her compassion and courage nearly 30 years ago.



# One of Our Stories

Might, Beauty, and Machine Take Flight for “Right” and “Only”:  
Is This Story Too Big to Hear?

By Tom Janisse, MD



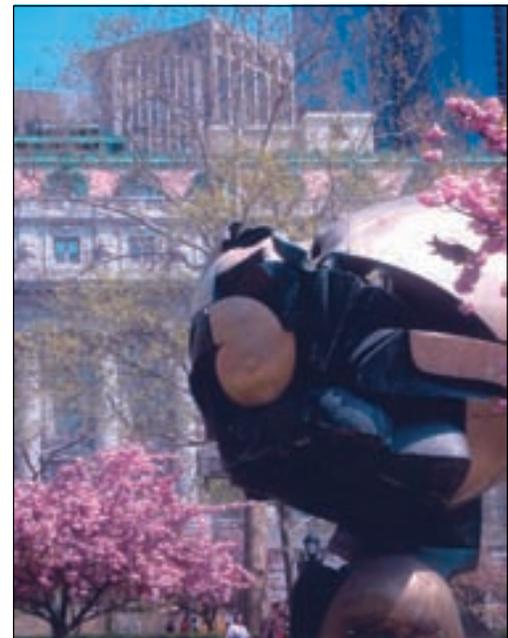
High over heads at the World Health Congress, beauty dazzles and drugs, as does sleek black tech. Washington, DC



“Please do not vandalize this phone booth. I have no place else to change clothes.” —Superman Volcano, California, population 100



One hour before the green flag Tony's orange, 20, Home Depot Chevy is second pole. A brilliant racer, *True Speed* author, he wins at Indy, wins the year, and signs my Stewart hat. Michigan International Speedway



“The Sphere,” a bronze sculpture in the plaza's fountain buried at the World Trade Center, rises altered, a peace monument awaiting return. Battery Park, NYC

## Doctoring My Doctor

By Tom Janisse, MD

I got the call at sundown on Friday five minutes before walking out the door for my first free weekend in three weeks. The ER doctor on the phone said he had a patient with acute radicular low back pain, and hoped I could help. The patient, he said, was Dr Peter Devereaux, one of our internists, who, on exam and imaging, was free of spine abnormalities. He said he knew that I, as an anesthesiologist, was an expert, and did I think an epidural steroid injection would work?

I gulped, more anxious than I would have guessed to perform a spinal procedure, which I had done a thousand times, on a colleague. Afraid for a moment I could hurt another doctor, I wondered what if he was the one-in-a-thousand patient?

What if, while he lay helpless on a white sheet in the fetal position I advanced the 14 gauge metal behemoth through the skin and toward the spinal cord in search of the tiny, potential epidural space, and the needle slipped and I lacerated a lumbar spinal nerve, irreparably.

"Sure," I said, "I'd be glad to take care of him."

When Peter hobbled in, I was at once anxious and confident, concerned and

certain, of my skill. He smiled, and said he was so grateful I would help, and happy that I was the doctor on-call who would perform the spinal procedure he dreaded.

"Well, how was that Peter?" I said, withdrawing the needle. I had performed a flawless epidural puncture and injected dexamethasone and lidocaine bathing the spinal roots to shrink and numb them.

He sat up on the gurney, turned his head side to side, looking into the empty corners of the Recovery Unit and out the windows, now black pictures of night lights, and said, "You know, I think I'm starting to feel less pain already. Yes, the pain is definitely better."

"Great," I said, my heart rate plummeting. "Peter, I have a request." I had just received a letter at home from our Physician Health Committee encouraging each of our medical group to find a personal physician (like patient, like doctor): "Would you be my personal physician?" I said. "Turns out, I don't have a doctor. I was one of the 25% of our Health Plan member population who was unassigned and unbonded."

"I'd consider it an honor," Peter said. ♦

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**Tom Janisse, MD**, founded *Peninhand Press* in 1977, in Volcano, California, and has published: short stories—*All Stories, All Kinds*; California oral history—*The Argonaut Mine Disaster*; and poetry books—*the volcano review 1-6, Peninhand, Falstaff Medical Poetry I and II*, and *Notes of a Cornerman*. His published works include: a poem, "Dying Distant," in the *New England Journal of Medicine*, and a story, "Bring the Bottles," in the book *Emergency Room: Lives Saved and Lost: Doctors Tell Their Stories*. E-mail: tom.janisse@kp.org.

## Evanescence

By Mason Turner-Tree, MD

The cold, damp institutional concrete leapt at me like a prisoner attacking with a fork, ready to extract my radial artery and bite it in half. Fear permeated the minimal throng of people who were just moments before ensconced in laughter, joviality, and irresponsibility. The vague camphor smell went unnoticed until a polyester protector reminded us that the room was last occupied in the early 1960s. Suddenly, as she inhaled deeply, we all followed suit, as if our individuality had been stamped into an 8x8 cell with a regulation coiled, uncomfortable bed and an assaulting jumpsuit. Suddenly, the camphor flowed over me, not in my lungs, but on my skin, across my eyes and through my hair. The collective shudder was more frightening than the camphor. A shared soul is less easy to tolerate than a distant smell leaching from walls that contained such misery. I peered to my companion, hesitant to break the collection of souls marching alongside the polyester protector. It was night. Bleak, cold, wet, and exhausting night. As I broke the camphoria and touched my companion, the bare bulb blew. An echoed scream blinded us, until we realized that it was blackness, not loudness that had burned the retina of our collective. I pulled to the window, and looked at the marshmallow skyline, enveloped by black, moonlit tar. Suddenly, it was 1960-something, and I was trapped. Imprisoned not by concrete walls, but by loneliness and isolation. The smell of chocolate now filled my lungs, but never made it to my brain, stopped on its marginal path by the bleakness of my soul. Snuffed by the camphoria. Blinded by the pale green that I could feel pressing against me. Relief was usurped when a bowl of light fell upon that very same pale green. The polyester protector squashed the collective with her bowl of chocolate-scented fragrance. I stood alone, so close to the moonlit tar that fear permeated my olfactory senses and dragged me, quicksand-like, into the roiling pot of tar, studded with the white, fluffy figures that seemed like heaven. They too, were imprisoned by the sticky filth around us. Suddenly, a solvent hand touched my shoulder, and the collective was gone. The pale green marshmallows were sucked into the moat, and a radiant dragon appeared to damselize me. In the distance, I heard, "That was the room, where Robert "The Birdman" Stroud died ..."



**Mason Turner-Tree, MD**, earned his AB degree in psychology from Dartmouth College and completed his medical degree at the University of Texas Southwestern Medical Center/ Parkland Hospital in Dallas, TX. He joined The Permanente Medical Group as an associate physician in the Department of Psychiatry at San Francisco Medical Center and in Addiction Medicine at the Chemical Dependency Recovery Program in July 2003. He is currently working on his first novel. In his spare time, he also enjoys playing classical piano and attending opera.

## Miracle

By Vicky Van Dyke, CNM

"Do you have privileges at the hospital yet?" I looked up from my computer charting to see my colleague, Julie, standing in the doorway. "Yeah, I was on call last weekend, why?" "Well, I'm supposed to be on call tonight and I just found out that the medical staff office didn't finish processing mine. Now it's past five o'clock and it can't get done today." The impact of what she was saying hit me—we had to have someone available for the laboring women who would surely be arriving at the hospital all night. Our obstetric group had just moved from a hospital that closed to a new facility. All of the members of our group were experienced, competent practitioners but all hospitals have a checklist of information that has to be completed before they allow a practitioner to care for patients. Only a few members of our 11-person group had gotten through the process.

I thought through the reasons I might not be able to do it. Tired from a long day at the office didn't count in this situation. No previous engagements for the evening. No young children at home requiring care. I hadn't been on call the night before. I didn't even have the excuse that too many patients would have to be moved from my next day's schedule—I was scheduled to do some work for our marketing department and therefore did not have any patients to be rescheduled. I sighed inwardly. "Sure, I can do it. I'll just finish up here and head on over." She looked relieved. "Thanks, I'm not scheduled again for a while, so I should be able to get it straightened out."

As I walked through the door of the hospital, I noticed a large group of people gathered outside the door of one of the rooms, some crying, some looking angry. Further down the hall, a small group of nurses was talking with great animation.

Arriving at the call room, I changed quickly into scrubs and went looking for the people who had been on call that day so they could "sign out"—tell me which patients were ours to care for and what their condition was.

I found my friend and colleague, Kristy, standing with the group of nurses. "You're probably going to be sorry

you volunteered for this. You're walking into a powder keg." That could mean anything when you're talking about caring for laboring women. Kristy and I walked down the hall to find a private place to discuss the patients.

"We're not terribly busy," she said, "Only one person in labor, but she's a doozy. She and the family are pretty upset at all of us."

"Why?" I asked.

"Lots of reasons. Have you heard about Camie Bentley?" The name did sound familiar. Then I remembered—the patient screaming at my colleague with the office next to mine a few months ago. Dan had been upset enough about the interaction that he'd talked about it for days after. Apparently he had been discussing a 20-week ultrasound report that showed that Camie's baby had a serious birth defect called anencephaly. This means that most of the brain is absent. Babies with this disorder rarely survive more than a few days after birth and most die within minutes. Carrying a baby destined to die is a burden few women want to shoulder. Dan had started to arrange a termination of the pregnancy, assuming that this was what the patient would want. She had become hysterical. A devout, "born again" Christian, she did not believe in abortion for any reason. The last words I heard her say were, "You don't know everything. Tests can be wrong. They told my cousin her baby would be deformed and he was all right!" With these words she had stormed out of the clinic. Dan and his nurse had contacted her numerous times since, but she refused to come in for any more prenatal care, not wanting to discuss the issue any further. And now she was in labor. I sensed things weren't going well here, either.

Kristy continued. "She came in contracting on her own and has been insisting on having continuous monitoring. We don't want to do that, because we don't want to have to do a crash c-section if we see distress." "That seems sensible—this situation is difficult enough without subjecting the mother to the pain and potential danger of a c-section," I answered. I, too, was mak-

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**Victoria Van Dyke, CNM**, graduated from the University of Washington in Women Health Care and OHSU in nurse-midwifery prior to joining KP ten years ago. She had a private practice and ran a prenatal clinic for medically indigent women. In addition to attending births and providing prenatal care, she also enjoys working with women across the lifespan.



# Spirit

## Narratives

Written over time,  
read at our writers' group,  
revised from group feedback

ing the assumption that the mother's safety should be the primary concern when survival for the baby was impossible. However, when Kristy explained the full nature of the conflict between the woman and her husband and the medical team, it was obvious that what seemed sensible to us was only making the family angry and alienated. Complicating things further, in addition to her family, the patient had her minister and a ten-person prayer support group in the room. None of them were talking to the daytime medical team any more, stating that they did not trust them and they had been waiting for our "change of shift" to have a new person to deal with. Kristy finished up with "That patient's husband is in Holly's office and he wants to talk to you."

I took a deep breath. I consider myself a spiritual rather than a religious person, having difficulty finding any church that "felt right." But I had been raised in a fundamentalist Christian family and know a lot about the common beliefs. I encounter patients whose belief structure impacted their decision making all the time and generally have no difficulty finding a treatment plan that was respectful of their faith and safe for the fetus. This isn't all that common, unfortunately. Many highly trained, scientific medical practitioners find their rationale impossible to understand and try to direct them more. The night promised to be a challenge, but less for me than others in my group. I decided it was good that I was going to be the one here.

I went first to meet with the father of the baby, David. I'm a small woman, and David was only slightly taller than me, slender and muscular, wearing cowboy boots and a big buckle. His dark eyes were flashing and his face flushed.

"Hi, I'm Vicky. I'm the midwife on call tonight. I hear you've been having some troubles. Why don't you tell me what's been going on?"

The story poured out of him. They did not believe that the fetus would be born with the predicted severe life-threatening defect. "We're expecting a miracle. We're expecting God to heal our little girl tonight. That's what we are all praying for and we believe that God answers prayers. So we want her to get the best possible care. We want her to be treated like the healthy, valuable child of God she is and for everything possible to be done to save her. Is that so unreasonable?" He looked

exhausted and on the verge of tears as he pleaded with me. I thought about it. As he explained the situation from his perspective, I could see why they were demanding care for their child. We all, instinctively, want to do everything for our children. A mother myself, I could understand that. I told him so.

"Well, you know, David, I agree with you that there will be a miracle here tonight. I'm not sure I believe it will be the same one you are expecting but I do believe that we will experience a miracle. And I want to give you the same care I would any other family in labor. But I do have to let you know, I'm not a fan of continuous monitoring in any situation. Over the years it's been shown to increase the c-section rate without really improving outcomes for babies. I think the labor would go faster and therefore be easier on both your wife and daughter if she was up walking and we listened to the baby's heart rate intermittently. Intermittent monitoring is an accepted obstetric practice."

"What about resuscitating her after she is born?" he asked.

I answered, "That's not as clear cut to me but I'm willing to respect whatever decision you and Camie make. I just want you to have all the facts. Have you ever seen a full neonatal resuscitation before?" He hadn't. "They can be pretty brutal. The baby is whisked away from the parents, a tube is placed down the throat and another into the stomach. An IV is started in the umbilical vein and medicines are given. It is almost always necessary to breathe for the baby with a bag and most need chest compression. I know you believe she will be healed and not need this but what if it turns out God intends a different miracle tonight? Is this how you want to spend the precious few moments you will share of her life?" I could tell he hadn't thought of this. "Would you explain all of this to my wife?" Of course I would. I sensed the tension that I had first felt from him draining away and he seemed calmer and more ready to face the rest of the labor, whatever it brought us.

I entered Camie's room. It was darkened; there was soft music playing and clusters of people with their heads down and their hands clasped were murmuring prayers. A man who was introduced as the minister was standing at the head of the bed, one hand on a Bible and the other on Camie. She was working with the contractions and appeared to be coping well with them. "Camie, I think you should listen to what the midwife has to say," David started.

"Hi, I'm Vicky and I'm coming on to take care of you tonight. David's been telling me about your difficulties today and I'm wondering if you'd like to hear my opinion of what we should do." She looked at David and he nodded. I repeated my belief that continuous monitoring was not necessary to protect the baby. Again, I said I believed there would be a miracle, but I wasn't sure what it would be. There is a miracle at every birth and I wanted her to have the most healing birth possible. She agreed with me and we took the monitors off. She went to sit with her prayer partner, and they began to pray in earnest, with Camie stopping from time to time to breathe through a contraction. I went out to tell her nurse that we would be using the intermittent protocol and that the family was deciding about the level of resuscitation they would want.

I went back into the room, partially for labor support and partially to get a sense of who was there and what their roles would be. The minister and her prayer partner seemed focused on Camie and genuinely involved in supporting her. Her husband seemed loving, and they seemed connected as a couple and trusting of each other. The reactions of the church members varied—some seemed there for moral support, some to watch the show, others mainly seemed there to share every horrible birth story they had ever heard. I see that often with laboring women and I wonder at the cruelty of it.

The night wore on, and Camie made steady labor progress. She refused all pain medication, fearing it would compromise the baby. We talked a lot in those hours about her faith and the experience of the pregnancy. Finally, I broached the subject of resuscitation after the birth. "If she is anencephalic and your moments with her are going to be limited, how do you want us to spend them?" I could see her mother's heart struggle, then answer, "I want her life to be gentle. I want her to feel our loving arms and hear our words. Don't resuscitate any more than drying and suctioning her." I nodded. That felt right to me, too.

The birth of a full term anencephalic presents other complications that we hadn't talked about but were at the back of my mind. Without a full scalp, it is often difficult to distend the mother's tissue enough to have the head come through the birth canal. Women push to exhaustion. The risk of having the shoulders get

stuck is higher. I'd never done this before and was a little nervous. My backup MD, at home, hadn't either.

Throughout the evening, there had been a video camera filming parts of the birth. Many of my colleagues don't allow cameras to film deliveries but I usually do. For some people this is an important way to be able to make peace with their birth experience. I was pretty sure that was going to be necessary here.

About midnight, it was time to push. We gathered, me to coach her, the minister to bless her and the congregation to pray for the miracle. She pushed with a strength and determination that I had to think was otherworldly. It took hours. Finally, the head was low enough that I could feel it. It was anencephalic—should I tell them? I decided to. "The head I am feeling is shaped in a way that leads me to believe that your baby will be anencephalic." The praying intensified. Camie's eyes met mine and I could tell she was ready for whatever the next few moments gave her. We sat in a halo of light from the exam light, the rest of the room darkened. The soft sound of hymns around us, I reached in, hooked my fingers around the little arms and pulled the baby forward into the world. Other than the lack of fullness at the back of her head, she was a beautiful little girl. I laid her on her mother's abdomen and she cradled her gently. "Welcome to the world, Hope" she said. I felt the umbilical pulse—life-giving blood continued to flow from her mother but the baby made no effort to breathe. Her eyes were open and she appeared to look at her mother and father. "Camie, if I cut the cord, it will stop the flow of oxygen from you to her and that is what is keeping her alive. It will stop on its own soon, but I want you to have her as long as possible." She nodded and continued to explore her baby. The cord continued to pulse for what seemed to me a very long time, then got weaker and weaker. Hope closed her eyes. Her mother kissed her and I cut the cord.

I looked up at the quiet crowd. They were silent, not knowing what to say or do. Who does? Words came to me. "There was a miracle in this room tonight. The miracle I saw was the amazing power of Love. Thank you for letting me be a part of it." The church members slowly drifted away, leaving Camie, David, Hope, and the minister. I left, too, to give them some privacy. Walking out of the light into the hall, it seemed like I was walking into a different world. ❖

## 1970

By Les J Christianson, DO

Verl was born in 1970. He thinks there is something about 1970 that has made him different from his brothers. Not: *Oh, isn't it unfortunate that in 1970 my neurons got scrambled while incubating in my mother's womb?*

But rather, *What is it about 1970 that made me so different from my brothers? I wish I wasn't born in 1970.*

He has said that many times. But who knows whether his neurons were fried in utero or whether my mother simply did not get the Rhogam shot when she should have. My parents were young and scared and this was rural North Dakota. I think all we knew was that there was a new arrival in our house that kept having seizures. Those images are some of my earliest memories. Verl, having one of his seizures next to the TV. Maybe even under the TV with his legs sticking out like the Wicked Witch of the West except that Verl was not crushed because the TV was on four legs.

Two months after Verl moved in with me, and my wife, Kris, I woke up one morning at 3 or 4 am to very bizarre sounding noises coming from Verl's room down the hall. Kris was in Chicago visiting her family so it was just Verl and me. It was April 2000. I went into his bedroom and my first thought was *Is Verl possessed by the devil?* His breathing sounded

very noisy and labored and he sounded as if he were making grunting animal-like noises. One of his arms was stiff and it was extended into the air. He could not respond to me. He seemed asleep but not asleep. I called 911 because I was scared and because I wasn't sure what else to do other than sit next to him on the bed.

When the crew arrived Verl was coming out of it but was still pretty confused and couldn't walk on his own. We stood him up and half-walked/half-carried him into the hallway where he pissed in his underwear. They took him to Kaiser Sunnyside Medical Center because that's the location where I worked at the time and because I had enrolled Verl as a KP member when he moved here. I thought it would be better for Verl to be enrolled in the Health Plan where I worked. A nervous control thing on my part.

Pulling out of the driveway to follow the ambulance, I couldn't control my tears crying most of the way there. Twelve miles. Sobbing is probably more accurate. But it's only a seizure. Seizures don't seem to kill many people. The threat to life seems to be somewhere between sneezing and a heart attack. But his seizure scared me. I think I was crying because he seemed so helpless and vulnerable and so much like a child—he was starting to seem like *my* child. ♦

# Insight

By Kurt Smidt-Jernstrom, MDiv, MA

"I asked to see you over an hour ago!" she complained as I entered her room and introduced myself. Judy looked slightly older than her 44 years with thick gray hair that had been styled short in preparation for the surgery. A volatility that had plagued her most of her life, manifested itself in the furrows on her brow. Annoyed that she was missing work because of her surgery—to remove a tumor that had engulfed an ovary—and aggravated by the pain she was experiencing, she tyrannized the nursing staff activating the call light continuously as if the mere act of pushing on the device would palliate her impatience.

"I came as soon as I could," I replied, trying not to become defensive. "Anyway, I'm here now."

"I can't reach anyone on this phone! What's more, the doctor says I'm ready to leave the hospital tomorrow. I am not ready to leave yet." The tone of her voice betrayed a hint of something besides frustration ... anxiety, perhaps. I pulled up a chair next to her bedside table and sat down.

She recited a litany of unmet expectations: family and coworkers not visiting more often, hospital staff seemingly unable to figure out what she needed, even God had let her down. "What kind of God allows a person to get cancer?" she demanded to know. Judy was angry with the hospital staff; angry at her illness and the limitations it had imposed on her, angry with her family and coworkers, and angry with herself. She had always been able to wield her anger effectively; and it bothered her that lately her anger had seemed to be losing its power. She had used it to break through institutional as well as relational barriers—"getting things done," "get-

ting people to move," and this in turn, enabled her to foster the semblance of control in her life. Judy abhorred uncertainty and tentativeness, and resented having to wait for anything or anyone.

A recent divorce had left her feeling embittered. Furious about the settlement, she blamed the judge for being biased and not understanding the rationale of her side of the suit. One of Judy's colleagues argued the case and was quite persuasive Judy thought. The whole contentious process created a deep resentment in her that grew as time passed, as if it were something alive inside of her.

After the divorce was finalized, Judy became sullen and irascible. At work, the least frustration provoked her and she lashed out at whomever was closest, which created resentment and anxiety among her colleagues. At some point, she began to have a sense that something was amiss, something was happening with or to her, but it was all so vague. She had been feeling under the weather: a cold, a fever, a slight discomfort—or rather a sense of fullness in her abdomen—none of which were going away. She was finding it difficult to concentrate on her work so she decided to get to the bottom of it all and see the doctor. The appointment was inconclusive; the doctor wanted her to return for a test. She became suspicious. *Why not just prescribe some medication and be done with all of this? Why was it taking so long to figure out what's wrong?*

At a follow-up appointment she was told the diagnosis: a tumor was growing on one of her ovaries, and it was uncertain if, or how far it had spread. "Tumor? You mean cancer?" She was not aware of raising her voice.

Rattled, she left quickly without making any decisions about the next step.

A few days afterward, Judy vaguely recalled the doctor having mentioned SURGERY saying that the need was URGENT. She was unsuccessful in attempting to compartmentalize these troublesome words. They would not remain in her mental file cabinet that she could open and close at will. Finally, in order to settle the matter, she decided to call the doctor. Presenting the evidence, the doctor convinced Judy of the need for surgery, and she reluctantly scheduled time off from work. She thought: *Why does it feel as if I'm admitting that I'm wrong?*

As I sat beside her, listening to her recollections, I noticed that the tone in her voice was changing. I sensed in it something like regret. When I asked her how the surgery went, she replied thoughtfully, "Fine, I guess, but it seems the cancer has spread. She looked down and then looked directly at me. "I have a question for you. Do you think ..." she began, "... that anger can cause cancer?"

Momentarily taken aback by her question, I wondered: *Is she really seeking a medical answer to this question, or is there something on a deep level that is working its way into her consciousness?*

"Are you wondering if perhaps *your* anger might have caused *your* cancer?" I asked.

She fought back tears as she began recounting instances in her life when her angry outbursts had alienated others—family, coworkers, friends. Her illness was forcing her to confront the limits of her control, and when she allowed herself to think about it all, she could begin to see the destructiveness of her anger. ♦

**Kurt Smidt-Jernstrom, MDiv, MA**, is currently a chaplain at Kaiser Sunnyside Medical Center in Clackamas, Oregon. He has previously worked as a pastoral counselor with KP Northwest Hospice.



## Silence

By Laura Morgan, MD

Maggie taught me about silence. Three years ago, with a nasty case of laryngitis, I went to clinic as usual and let patients know that I would be essentially silent during their visit. Most appointments went smoothly, in fact, more smoothly and quickly than usual, which should have been a hint. But Maggie's visit, to this day, stands out in my memory most powerfully.

I knew her as a type 1 diabetic, accident-prone, morbidly obese, self-deprecating woman who lived in a trailer with her chronically ill, demented mother and her troubled sister and niece. Every previous visit with her had brought reports of conflict, injury, frustration, poverty, and sometimes theft. On the day of laryngitis, I resigned myself to listen passively instead of actively trying to make a difference for the better in this unfortunate woman's life.

I indicated to her that I wouldn't be able to speak during our visit and, with that, she was off and running. For the first time since our first visit, ten years ago, Maggie told me the story of her abusive father, her "silent" mother, her deliberate decision to gain weight in order to repulse her father's advances after she heard him express an aversion toward fat women. She told me about protecting her younger sister, with whom she was now living, by offering herself as bait to her father until her sister was old enough to defend herself. She imitated the words and voice he used to initiate physical contact and how, to this day, despite his death, she can still hear his voice.

I think it took her all of ten minutes to explain her life to me. She expected nothing in return but my attention. She left the office in what seemed a remarkably lightened mood and told me it was

the best visit she had ever had with me.

Since that day, Maggie is still my patient, now taking two hours to travel by bus one way to my new office. She never complains about the distance and she's never late.

Since that day, Maggie exercises and diets on her own and has lost over 100 pounds. She is highly compliant with her medication regimen and her chronic disease is in optimal control. She has not fallen down or injured herself accidentally again. Maggie placed her mother into skilled nursing care, helped her sister raise her daughter, set and enforced behavioral guidelines in their home, and became a fine seamstress. I treasure the pillow she made for me; I try to imagine placing it firmly over my mouth whenever I feel the urge to tell someone how to live without first understanding something of his or her life. ❖

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**Laura Morgan, MD**, is a family physician working in primary care in the Northern California Region for the past 13 years. She has authored *Surviving and Thriving at Kaiser Permanente*, a manual for physicians, and continues to seek ways to improve the quality of professional life for her peers.

## Harpooning the Vein

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By Shawna L Swetech, RN

Are they prominent and soft, or fine  
like dark thread? Are they hidden  
beneath spongy layers of adipose?  
And the skin, is it thick like tanned leather,  
or thin like a white veil separating  
the inner and outer worlds?  
Should I use a tourniquet?  
Will the vein distend and harden,  
roll from the needle's probe?  
Or will binding pressure burst  
the thin blue line, ecchymosis  
purpling the tissues.

*Take a deep breath*, I say,  
imagine your vein is a caterpillar,  
*fat and juicy*. I swipe antiseptic  
across the target, twirl the steel  
stylette in the cannula.  
Please, God.  
Please let me get in, first stick.  
I can't think of this as real now,  
can't think of causing pain, injury.  
The angiocath becomes a harpoon,  
the arm a lifeless fish.

I pierce the flesh —  
*Don't move now!* and wait  
for crimson flashback in the needle's hub.  
Score, there it is. I hook up tubing,  
chevron the paper tape over and under,  
place a see-through dressing.  
Blue lights flash, the IV pump  
beeps to life.

Yes. I have been granted the power again.

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**Shawna L Swetech, RN**, is a medical/surgical nurse at the KP Santa Rosa Medical Center. She has been studying and writing poetry for five years. Ms Swetech finds the magnificence of the human spirit a constant source of inspiration.

## The Wheezing Cherub, Her Earth Grandmama, and OUR LOSSES

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By Ed Ruden, MD

Natalie is my sonorous Wheezer—The Orchestra in her chest is rarely  
in Tune—Alveolar Anxiety  
She will come in with Raucous Cacophony and  
appear to have just finished a 50-yard dash  
unsuccessfully  
I Treasure her serendipitous visits  
Rosey Cheeks, the Thickest Light Brown Ponytail,  
Those Gifted Round Eyes  
The Heavenly Angel Reads to US while being  
NEBBED with OUR Misty Solutions to relieve the  
Frothy Rigid PULmonary MILKSHAKE ...  
BOOKS Of Joy, OF HOPE, of HUGS and Kisses, of  
Teddy Bears and Soft, Fluffy Creatures ONE would  
like to crawl into bed with when our Bones are damp  
and aching  
Grandmama is Her most capable Caretaker since the  
young one's earliest years  
Such a Tragedy—MOM's death from a Lymphomatous  
Lecher in her prime  
The mid-50s SAVIOR is a bundle of nurturing energy,  
a 60s lady grown wise, mellow, with Rainbow  
vestments and Iridescent fingernails  
I unveil the recent Demise of my own Father  
We weep together and Breath out Long Serene, Unobstructed  
Exhalations to Placate our Grief ...



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**Ed Ruden, MD**, has been a pediatrician with Northwest Permanente for the past seven years. He enjoys writing snippets as an aide to inner reflection, preventing burnout, connection with families.

## The Young Father's Imperfect Gift of Life

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By Ed Ruden, MD

He gave part of his liver to his Infant Son ...  
I was there at the Start of this Ugly Bilioous Disease  
Unfortunate "Draw of the Straw" plagued by Biliary Atresia  
Paternal "Fois Gras" Sucked out ... but nurturing the young babe and  
recapturing this childhood vigor and joy  
Yet, the Sequellae of the Donor Impairs DAD's life Abysmally  
Robbing the prime of Paternal 20s  
HOLES/CAVITIES/Abdominal Fenestrations years after "The Taking"  
Haunt him  
Swiss Cheese of the Peritoneum and Rectus Abdominus  
This Vaporizes his Vitality—Suspends his LIFE  
Nonetheless, I know you Treasure the Gift you Gave and I honor you  
In your Ultimate HOLY Sacrifice ...

## Hypochondriacal Atopic Derm Adolescent

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By Ed Ruden, MD

His body is like crocodile skin – every Angstrom of it  
A scaly mass of crustaceous keratin  
A warty six-foot toad of a teen  
Intense use of fluoridated steroid ointments,  
Petrolatum baths, antihistamines q4h, and  
Newer Immunmodulator agents have little effect on his intense pruritis  
The true cause of his eczema lies not in the superficial layers of his body;  
but deep in his somaticizing mind  
The "boy" tortures himself from within  
Perseverating in his brain about this malady or that  
"If only there were another blood test," "A Radiographique"  
"A serum porcelain level to pinpoint my illness!"  
He stammers/agitates  
I present this theory – "The mind-skin" gap!  
If you "soothe" your mind, you will surely "soothe"  
your alligator dermis  
In theory, he takes it in but never really engulfs the reality of his tortured cerebrum  
Fitfully, the young lad wallows in his "crustiness" and painstakingly  
relentlessly scratching as he exits my exam room!

## Poetic Moments

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By Cecilia Runkle, PhD

Yellow green leaf drops  
Thin stalks, white bark, like slow rain  
Still, no whisper

Light glances red maple leaves  
Green intertwined with red  
Not Christmas, just nature

Red maple on burnt coals  
Dead yet still beautiful  
A life after death?

## Disbelief

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By Kurt Smidt-Jernstrom, MDiV, MA

Doubting the diagnosis  
she listened apprehensively  
for the sounds  
of marrow exploding  
deep in her bones,  
portending the disintegration  
of her life.

Hearing nothing  
and buoyed  
by an infusion of packed cells  
she insisted  
that it was  
a mistake.

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**Cecilia Runkle, PhD**, is a former Senior Training and Development Consultant with TPMG's Physician Education and Development Department, Northern California Region. She joined Kaiser Permanente in 1981 and in her spare time enjoys writing haikus, reading mysteries, and race walking.

**Kurt Smidt-Jernstrom, MDiV, MA**, is currently a chaplain at Kaiser Sunnyside Medical Center in Clackamas, Oregon. He has previously worked as a pastoral counselor with KP Northwest Hospice.