Do art lovers make better doctors?

so I toss the purplish sleep, gasping, rasping
making noises that no human body was designed to make
each breath now leaves me breathless,
the clock hands circling vultures of the night

the steaming kettle and misty bath give short relief
as I rock and rale in hell, awaiting the morning sun
and the birds at dawn,
to greet them with my rhonchitic song

Night Attack, *by Harold W Horowitz*

Quality of life used to be viewed as a soft measurement, a secondary or tertiary outcome in trials at best. Nowadays, it often takes centre stage in trials of patients with long-term, medically manageable respiratory disease. Medical care for patients with respiratory disease now incorporates their point of view on the illness, including not only quality of life but also expected goals in terms of pulmonary function.

So how can doctors learn what patients want in terms of quality of life? Experience counts, certainly, but the needs of a doctor's first patients should not be forgotten. One possible route to a more empathetic medical training is through an appreciation of the medical humanities. This interdisciplinary field of medicine includes an understanding of the humanities (philosophy, ethics, history, and religion), social science (anthropology, cultural studies, psychology, and sociology), and the arts (literature, theatre, film, and visual arts), and how their ideas can be applied to medical education and practice.

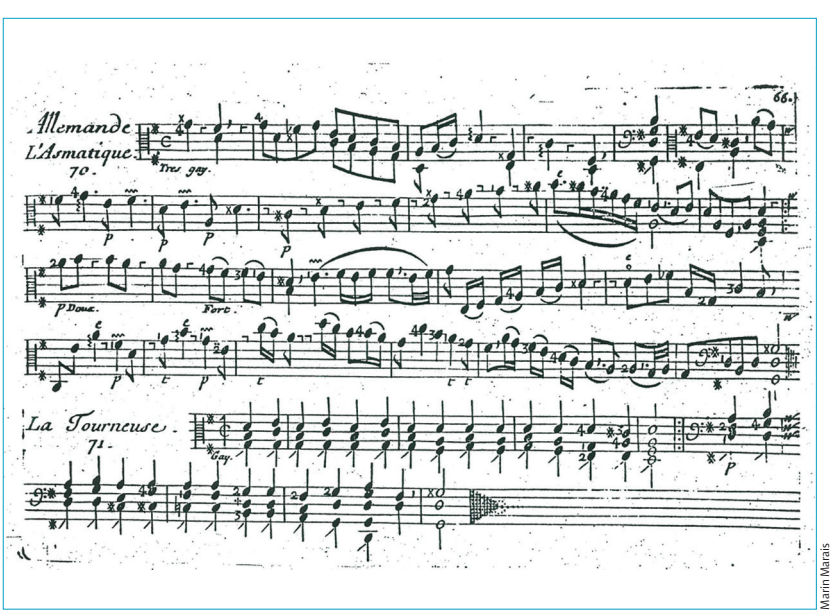
Representation of various respiratory illnesses in novels, poems, movies, music, and paintings shows how patients experience their respiratory disease. For example, in *Allemande l'Asmatique* the cello imitates the audible wheezing during an asthma attack (figure). Studying these representations is intellectually and scientifically satisfying, besides moving and entertaining. However, there is more to it: although clinicians explore the responses of patients to their illness routinely in their conversations with the patients, the information about illness experiences found in various art forms can be richer and more informative. Fiction and art provide detailed pictures and thick descriptions of life and character (and their complexities), the workings of inner life, and pictures of particular people leading particular lives in particular circumstances. Such artistic representations are ripe for inclusion into medical education, and perhaps even for direct provision to patients.

Would such inclusion help? Borrowing from another specialty, medical students instructed by museum staff about how to observe the skin of people depicted on paintings did better than other medical students when examining patients with dermatological problems. Similarly encouraging preliminary findings in terms of physician training or clinical skills have been reported in studies on the effects of reading novels and listening to music related to health.

In addition to perhaps improving clinical skill, empathy, communication, and interviewing skills might be improved after training in (or even through unwitting appreciation of) medical humanities. Popular novels such as *The Magic Mountain* by Thomas Mann and films like *Thank You for Smoking* can tackle complex issues like tuberculosis and lung cancer through portrayal of characters with the disease. The poem *Night Attack* powerfully conveys the horrors of asthma presenting nightly to a patient.

Medical humanities may be directed at medical students and doctors, but can also be targeted at patients with respiratory illness for their own benefit. A structured programme of expressive writing has been shown to be beneficial for patients with asthma.

As part of our investigations into how the illnesses are represented in various art forms, we noted that the prevalence of a disease seems to be a determinant of it being used by artists. Asthma, lung cancer, and tuberculosis have been, and still are, object of artistic representations. Pleurisy, sarcoidosis, and—remarkably, in view of its high prevalence and incidence—chronic obstructive pulmonary disease are rarely (if ever) the subject of the work of authors, poets, film directors, composers, or painters.



Marin Marais

Figure: **Allemande l'Asmatique by Marin Marais**

For the **full poem** see *Lancet* 1996; **348:** 252

For more on **humanities in undergraduate medical education** see *Acad Med* 2010; **85:** 988–98

For more on **formal art observation training and visual diagnostic skills** see *J Gen Intern Med* 2008; **23:** 991–97

For more on **expressive writing and the patient experience** see *JAMA* 1999; **281:** 1304–09

Overall, examination of how illness is represented in various art forms might help patients and their health care providers in coping with the illness and in humanising medical care. Medical students who are well versed in medical humanities might be better doctors. If not, their training might help to enrich their own lives at least.

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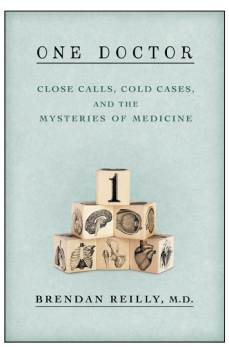
Book

The specialty of generalism



One Doctor
Brendan Reilly, Atria Books, 2013. pp 448. £17·29. ISBN: 978-1476726298.

Mr Principo is a retired film director who had had chest pain and shortness of breath for several weeks. He had a left lung full of fluid, hollow cheeks, and a drooping left eyelid. Diagnosis? Lung cancer, obscured by the fluid on a chest CT scan, but strongly suggested by a head CT scan showing brain metastases. This is one of many cases featured in *One Doctor*, a memoir by Brendan Reilly about the meaning of patient care in modern US medical practice.

The book covers two eras: Reilly's practice as a primary-care physician in New England working out of Dartmouth College in the mid-1980s, and his present job as a hospitalist and administrator at New York Presbyterian Hospital. In Dartmouth, Reilly went to wherever his patients were, whenever they needed him; to a 4 am house call on his vacation, or to their hospital bedside. Reilly describes primary care as being about long-term relationships—doctors who know their patients, and follow their care from the clinic to the doors of the operating theatre (or the mortuary), and back to their homes again. Family doctors must be diagnosticians, counsellors, and experts in 90% of every other specialty. By contrast, hospitalist medical practice in New York is relentless, a constant stream of very sick patients with very complex medical disorders. Reilly posits that, in the modern reality of specialisation and proceduralism, lawsuits, frequent handovers, and perverse financial incentives, patient care becomes like "swiss cheese"; full of holes, and not very satisfactory.

Reilly and his second year resident Tina examine a patient with chest pain, Mr Tosca. CT scans, electrocardiogram recordings, and physical examination showed no sign of myocardial infarction or heart failure. Tina agrees that his history doesn't point to a diagnosis of angina, but still wants to admit him even though she thinks his risk of a serious cardiac event is tiny; if he were her father, she explains, she'd want to take no chances. Reilly explains to the reader that Tina's decision—made absolutely in the best interests of her patient—and thousands others like it mean that huge amounts of resources (money, time, capacity) are spent monitoring patients who almost certainly are not having heart attacks, to the detriment of the health-care system as a whole. He thinks that Mr Tosca is having panic attacks with somatic symptoms—certainly not trivial for the patient, but not something that needs to be treated in the emergency department—and sends him home. "Gutsy", says another doctor, grimacing. "What if you're wrong?"

End-of-life planning and care is particularly poorly served in modern hospital practice, says Reilly. He describes caring for his parents, both in their 90s with chronic, disabling disorders. His father, a retired doctor, is blind and in the final stages of bladder cancer; his mother has dementia and needs a pacemaker fitted, but her end-of-life directive states that no "heroic" measures should be taken to prolong her life. Reilly struggles with the decision, weighing early death against the inevitable suffering of progressive dementia, and tries not to project his reasoning onto his patients. He meets Mr Atkins, a patient with metastatic pancreatic cancer that has spread to his liver. Mr Atkins, a father of two young children, has seen dozens of oncologists, and received many different experimental treatments, but Reilly is the first one to tell him that he is going to die. It comes as a shock. It should not. By contrast, Mr Principo is emphatic in his wishes—no extraordinary measures, no machines, no surgeries. "I've seen death watches, doc. No thanks. Not for me." However, in order to drain the fluid in his lungs and take biopsy samples, surgeons must suspend his advanced directive and put him on a ventilator that after the surgery he is too weak to come off from.

Reilly follows his stories about patients with detailed analyses of both their medical problems and the health-care systems in which they are treated, interwoven with autobiographical anecdotes. At times the book is an angry call to arms for primary care and one-doctor medicine; at others, it is defeatist, and offers few solutions to the issues that he has pointed out. Nonetheless, it is an astonishingly moving and incredibly personal account of a modern doctor that asks how should patients be served in the confusion of modern medicine.

Hannah Cagney