FROM ANECDOTE TO ANTIDOTE

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Medical Musings and Practical Prescriptions from a Humanitarian Healer

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This book is dedicated to the memory of Brian Klein and the sadness of his passing; and to my wife, Caryn—to our family and the brightness of our lives.

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INTRODUCTION

What a Doctor Knows (Could Fill Life's Waiting Room)

AT A CERTAIN POINT IN ONE'S LIFE one can develop a crystalline knowledge. Stevie Nicks of Fleetwood Mac likened this clarity, this crystalline clarity, to the cleanness of water. It's an ability to clearly know and understand life. To learn from its ups and downs. To feel through the experiences of others. If I were to give this development a diagnosis, I would most likely call it, "Knowledgitis."

Best part is, I think I have it! (Okay, okay … it's a self-diagnosis, but it works for me.) After years and years as a successful physician, I believe some of what I've learned should be passed on to make the learning curve for the rest of us so much easier. I believe that patients and their doctors can benefit from what I've observed personally, overheard second-hand, or just plain absorbed in my thirty-plus years in the medical profession.

Gauging from my early beginnings, one would never have thought I would be where I am today. I was born and raised in the tenements of the Lower East Side of New York City. I chose playing hooky to schooling. So I dropped out and joined the U.S. Navy, then the U.S. Marine Corps. By following the flow of the river of life, I wound up a medical student in Italy. There, I ultimately found myself as I fell in love with the country and embraced its culture.

Since then I've volunteered as a physician in two of the Arab-Israeli wars, achieved knighthood, and made an unfortunately unsuccessful run for the U.S. Congress seat for New York's 19th Congressional District. I've met a pope on two occasions, as well as a U.S. president. I've dined with prime ministers, presidents, and generals of foreign countries.

Not bad for a city kid.

My thirty-some-odd years of practicing medicine have taught me about the preciousness of life and how tenuous it is. Life is so, so short to spend our days in the kind of worries and pursuits that, in the face of death, matter very little. Of the many deathly ill patients that I've admitted to the hospital, never did one say, "Doctor, I didn't go to work enough. Doctor, I didn't rearrange my sock drawer enough. Doctor, I didn't pay my bills early enough. Doctor, I didn't watch enough TV." It was always, "Doctor, I didn't take time to smell the roses."

Rabbi David Greenberg of Temple Shaaray Tefila, in Bedford, NY, said it so eloquently this past Yom Kippur. In his Day of Atonement sermon, he reminded all of a bumper sticker he once saw which read, "Don't postpone joy." If I had room enough, I would print up the following bumper sticker (or maybe it should be a billboard in Times Square): "Don't take life for granted. Don't take health for granted. Don't take for granted that you can recapture in the future the goodness and the beauty that is available to you today and, hopefully, tomorrow."

It's a shame that all too often it takes a tragedy or encounter with death to make us want to do something about life. How many families have I heard express regret after a loved one's passing that they never told them they loved them or, if they had, that they hadn't said it enough?

I suppose much of my rationale for putting these thoughts down on paper is to save my readers some of those regrets. Not every anecdote on the following pages is about doom and gloom—there are plenty of hearts and flowers along the way—but every one is a potential reflection upon life versus death.

I agree with the rabbi when he states, "When we look back upon our lives, we will regret the things that we didn't do more than the ill conceived things that we did do. We will recognize that most of our disappointments in life were the result not of efforts gone wrong, but of efforts that were never made." It's upsetting that people don't work to fulfill their dreams, that they procrastinate about their health or their desired vocations, that they hesitate to express emotions or reach out to distant family, friends, or lovers. Some blame others or circumstances for their failures; some just drop out.

The other day, a local high school class graduated. The valedictorian was a girl from Bangladesh. Her family escaped poverty and hunger, coming to their relatives' house here in New York just four

years ago. I thought of how hard that young girl had to work, coming from such a disadvantaged country, to become the top of her class. She was given the same opportunities as all of her classmates, just as all of us in this country are given the same opportunity. Therefore, all of us potentially have the same chance of being successful. And yet many of us fall into the same old ruts, scrambling for purchase high atop the rung of that ladder to success and ignoring the bigger opportunities for personal growth along the way.

In *From Anecdote to Antidote* I try to share my favorite stories from thirty years in the medical profession. I thought I could just arrange them willy-nilly, allowing my pearls of wisdom to string you along from beginning to end, but as I moved forward through the initial draft I found that most of the stories fell into one of three categories, with a special bonus wrap-up section at the end:

PART 1: *People*—covering not only some of the more fascinating people I've met my through my career, famous and not, but delving into the humanity of us all, doctors included, with warts and imperfections fully exposed

PART 2: *Places*—concerning the places I have been on my journey though life and learning; places not just physical, but also existential; places where not all of us have been, but where, perhaps, all of us could go

PART 3: *Things*—a compendium of practical knowledge designed to help you both maintain health and navigate the road of life we all travel, as well as the detours that some of us must sometimes take

Throughout, I do my best to communicate the lessons I've learned along the way from all of these people, places, and things. As you read along, I think you'll find the table of contents useful as the stories tend to lend themselves to the general themes I've mapped out for you. But by the same token there is a universality, I feel, to all of the stories.

Yes, I've grouped them into themes and sub-themes, afflictions and aspirations, but when you're done with the book I hope you'll agree with me that they all fall under that universal condition we call life.

For what is a doctor if not a saver—a reminder—of human life?

PART 1
PEOPLE

Introduction

"It is healthy to be reminded that the strongest might weaken and the wisest might err."

—MOHANDAS K. (MAHATMA) GANDHI

ONE OF MY MAIN GOALS WITH this book is to ease the intimidation I see in my patients' eyes as I consult with them for the first time. Not because I don't enjoy being put on a pedestal (I do), but because of how it influences their behavior while we discuss such important things as their medical history, weight, allergies, past medical procedures, et cetera. I can't tell you how many second opinions I've given, often in complete reversal of a previous doctor's diagnosis, that could have been easily avoided if the patients had simply been more honest and less intimidated by their doctor during their initial consultation.

I can understand the sense of intimidation. Sometimes people feel uncomfortable or insecure around someone who may have had a more extensive education than they have. And, as in any human situation, there is the issue of "power." Think about it: you're entrusting your health and well-being into the hands of someone outside your family, someone you don't know, someone who (in most cases) went to school for an additional eight years after college and regularly cut into corpses as practice for tending to your healthcare needs. On top of which, you're sitting there in his office, on his turf, in a paper dress with your rear end hanging out.

Of course, I could tell you the many ways in which doctors are people. We take out our own trash, do our own shopping, mop our own floors, even stand in front of the over-the-counter drug aisle, just as perplexed as you are, when we have a runny nose or stomach ache.

We forge relationships with patients, develop individual likes and dislikes, and can often both sympathize and empathize with those in our care. We fall in and out of love, go through mid-life crises, keep hobbies, and pursue interests—like, say, writing a book—and we (hopefully) learn something from each interaction and experience. But as my creative writing teacher once told me (or should I say, told me many, many dozens of times), "it's better to show than tell."

So here's where I start. By recounting the people I've met over the course of my career on the following pages, and recounting the things I've learned from them, I will *show* you the many ways in which doctors, mainly myself, are more human than one might expect and far more fallible than people give us credit for. It is not my hope to throw egg on my face or the faces of my colleagues, but instead to inspire you to be more confident, brave, and forthcoming the next time you're sitting across from your own doctor and telling him about your various aches and ills.

I could tell you to picture him in his underwear, but I know that's pretty hard to do when you're sitting there in yours. So instead I'll show you, time and again, that doctors are human too.

The Art of Medicine

AS THEY WERE LEAVING THE OFFICE, a patient of mine, Mr. Davis, proudly pointed to his wife Naomi and announced to the office staff that they were celebrating their 60th wedding anniversary that day. A round of applause went up for the beaming couple.

I asked, "Do you have any words of wisdom as to your marriage's success?"

"Well," he replied, "you have to hear a little less than you really do, and see less than there really is."

These words should not only be the mantra of all newlyweds, but of friends in general.

Conversely, it takes years of practice to realize that it's more important to listen to what a patient is saying than it is to quickly reel off what might be wrong. There is a fine line between hearing and listening. Some people watch the other person's lips move and call it "hearing." Others wait until the other person stops speaking so they can interject and call that "listening." But just as there's a gulf of difference between the individual examples I've offered, there's an ocean between hearing and actually listening to what the speaker is trying to convey. Obviously, listening transcends medicine and is one of the most important tools we have in communicating with our fellow human beings.

Looking back, this might be my greatest lesson of all and, in the early years, my biggest source of mistakes.

During my introduction to Physical Diagnosis in my second year of medical school in Rome, I met my professor, Dr. Antonio Carrozza. Professor Carrozza was as round and comforting as his name (which means "carriage" in Italian), always exuding a fatherly warmth and jovial nature, as well as a perpetual smile. He taught the men and women sitting in his class that ninety-eight percent of a patient's diagnosis would come from just sitting there and listening. And, of course, asking the right questions. Once, when asked what test or instrument he would need to help his patients if he were to set up an office in a small, isolated village, Professor Carrozza answered, "a chair."

Sadly, this basic yet highly effective approach is eclipsed in modern medicine and quite a bit of modern doctoring by a too-strong faith in cold machines performing CAT scans, MRIs, and blood tests. The *art* of medicine still lays in listening and observing your patient. Despite the sound of it, this is not always an easy task. There are times when a patient will ramble on and on about every possible symptom imaginable. "Well, doc, I have this cough. It's kind of a dry hack, and it gets so bad that I get stomach pains from coughing so hard and it makes me see stars. That makes me rub my eyes and shake my head to clear my vision, but then I get dizzy, so I go lie down and, before I know it, I'm asleep. Then I usually wake up an hour later and I'm all disoriented for a few minutes. So I make a pot of coffee but, when I drink it, I burn my tongue. And did I tell you that my right foot hurts?" By the time he's done, the patient is sure he's got lung cancer, glaucoma, narcolepsy, and Alzheimer's disease. Before the eyes start to glaze over, a well-trained physician will refocus the discussion. And the listening should not stop. Though a patient with every symptom under the sun is either a hypochondriac or one sick cookie, each one still requires a diagnosis at the end of his or her rambling.

Unfortunately, there are some patients who have difficulty explaining their symptoms or themselves. Rather than trying a different way to make themselves understood, they raise their voices, thinking you just cannot hear them clearly. I remember spending Thanksgiving in a small Florida town some years ago. We stopped at a gas station, and while refueling I noticed a restaurant that was across the street. The name was "Calypso" and I couldn't figure out by its name alone if it would be appropriate for traditional Thanksgiving fare. I asked the attendant what kind of restaurant it was and he said it was a "good restaurant."

Seeing that this was not quite the type of answer I was seeking, I asked again. This time the attendant raised his voice and said "I said it was a good restaurant and they serve very good food." You could see the exasperation of this young man, forced to deal with an out-of-towner—or a simpleton … after all, how many different types of restaurants are there beyond good ones and bad ones?—who was also hard of hearing.

The problem was obviously one of communication. When faced with such a situation, a good physician should be calming and expert in drawing out the necessary information.

One of my dearest friends, Don, is a short, robust, sedentary older man who has been plagued with knee pains for the past few years. He eventually saw an orthopedist and a rheumatologist, and was found to have severe arthritis of both knees. What followed was a series of painful injections, intense physical therapy and, subsequently, arthroscopic surgery. Nothing seemed to alleviate the pain, and he ended up in such discomfort that his orthopedic specialists eventually recommended surgical knee replacement.

One day while we were having lunch together, he told me that despite this latest diagnosis, he never really got truly severe pains in his knees. After walking a few blocks, however, he said they ached. This wasn't the scenario for bilateral knee replacements, so I finally listened and at last started to hear what my friend was really telling me. It seemed that Don's real problem was weakness in his thighs, most probably from lower back disc disease. After our luncheon I arranged for Don to have an MRI of his lumbar spine. Sure enough, test results showed that he had significant disc disease with compression of his spinal cord. This, rather than faulty knees, was the cause of his disability.

Yes, there was arthritis of his knees but that wasn't what was *really* bothering him. He nearly got sold two new knees when all he needed was physical therapy to strengthen his back.

There is an art to get people to listen, whether it's in giving an order to a waiter or telling your mechanic about that "whirr" in the engine. One place you should always feel like you're being heard is your doctor's office. Sometimes, to be heard, there are specific methods to use when talking to a doctor or anyone in a similar position—teacher, clergyman, spouse, or (heaven forbid) a lawyer. One method to employ, perhaps the best, is to do some "homework." A little inquisitive reading about your symptoms and presumed situation can go a long way toward leveling the playing field, as well as show your doctor that you're ready to be an active player in your own upkeep—a situation that is far from universal. Do some research, perhaps draw up a list of questions to ask your doctor in advance.

Beyond that, don't be intimidated by the person or the scenario. Look your doctor in the eye when speaking with him, and don't be afraid to show concern; let him know you're an active partner in this project. And, most important, do not let your questions go unanswered. If an issue hasn't been resolved to the point of you

truly feeling heard and understanding the response, press the matter. If that doesn't get results , or worse, if it obviously irritates a doctor, it may be time for a new doctor. Or at least a second opinion.

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Equally important as both listening and being heard is keeping one's eyes opened to actually observe the situation. Or the willingness to do so.

When I was a medical student and intern, congestive heart failure was a gravely serious condition and very nearly a guaranteed death sentence. Congestive heart failure is characterized by the welling-up of fluid in the lungs and extremities, which then interferes with breathing, blood flow, and the very ability of the heart to beat. Because it is a systemic condition, affecting nearly the entire body, treating it posed a particular difficulty. Short of cutting a patient into pieces and wringing him out like a washcloth, there were few effective treatments for such an affliction. The generally accepted remedy was to place tourniquets on three of the four extremities and then rotate them every fifteen minutes. Imagine treating people with rotating tourniquets in a modern emergency room!

Or imagine, if you will, treating them with some of the most toxic elements occurring in nature. As horrifying as it may sound to some today, heavy metals were used in the pre-antibiotic and pre-steroidal era to treat a number of conditions. Some of these metals, such as arsenic, induced high fevers that killed susceptible organisms (syphilis, for one). Around the time we were treating congestive heart failure with tourniquets, my New York Medical College professor, Dr. George Vogel, and his colleagues noticed that the patients being treated for certain diseases with the heavy metal mercury started urinating a lot.

This observation that mercury induced urination when given to patients with congestive heart failure, thus relieving their breathing by causing diuresis (doctor-speak for increased urine flow), led to the production of one of the first manufactured diuretics: Mercuhydrin. This was quickly followed by many other diuretic drugs. And, of course, we said goodbye to tourniquet therapy.

As we all know (I would hope), the fields of medicine and healthcare are continually evolving, just as the above anecdote illustrates.

Treatments that were previously considered cutting edge, such as lobotomy, Thalidomide and Vioxx, regularly fall by the wayside as the result of diligent observation and inquisitiveness, the true mothers of invention. Unfortunately, these two simple yet effective traits are often shouldered aside when physicians—with the best of intentions, mind you—are so sure of a diagnosis or preferred regimen of treatment that they fail to do the "busy work" that would allow them to see the forest for the trees. Or, in this case, the malady for the symptoms.

I recently reviewed a malpractice claim where a family physician wrongly treated his patient for a urinary tract infection. The patient had undergone a prostate biopsy one week before and now had fever. The physician noted that there were red blood cells in the patient's urine, which is very common after a prostate biopsy. He did not note, however, any white blood cells in that same specimen, which is a sign of infection. Nor did he confirm any infection by obtaining a urine culture. The prescribed oral antibiotics did help, but two weeks later the fever came back. Again, without checking the urine, another series of antibiotics was ordered, and then a third. The patient ultimately suffered a massive stroke after an infected piece of fibrotic tissue broke loose from his heart and clogged a major brain artery.

The patient originally was suffering from an infected heart valve, which became infected at the time of the prostate biopsy. The prescribed oral antibiotics were no match for this serious infection. The physician also never got his head out of the sand. He thought the patient had a urinary tract infection, but never observed proof of this.

As another example, last year my wife's grandmother Ruth developed fevers and swelling around her recently replaced artificial knee following a fall. Her local small town orthopedist guessed, correctly, that she suffered with a knee infection and immediately started her on intravenous antibiotics. The treatment lasted six weeks, which was appropriate. What was not appropriate was the fact that the doctor never did any culturing; he believed the infecting organism was due to a particular bacteria and that's what he treated her for. When her fevers returned after the six weeks of treatment, his treatment was to repeat the same antibiotic again.

Trying to gently encourage an elderly patient to get another opinion is extremely difficult, if not impossible. Ruth lived in this small community for years and was loyal to her physicians. As far as she was concerned, they could do no wrong. (If only she had read the

previous anecdote!) The family knew things were amiss, but nobody could convince grandmother. Ruth did agree to our suggestion that she see an infectious disease consultant, but the first consultant called by the orthopedist wouldn't see her because the convalescent home Ruth was being treated in was too far away. The second I.D. doctor should have staid away. Much to my chagrin, she continued the same therapeutic course. After four months of the same see-saw regimen with no results, Ruth finally gave in. She was transferred to an orthopedic hospital where all antibiotics were stopped for two weeks. Cultures were then obtained which revealed the real culprit, which was quite different than that assumed by her community physician. The infection was finally eradicated and Ruth can walk and dance once more. Stubborn loyalty to a physician, who was stubborn himself for not getting his head out of the sand, led to an unnecessary four-months of suffering.

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Since we've already established the importance of being heard by your doctor, I also want to emphasize how important it is to be proactive in the maintenance of your own health to add strength to your voice. We're just as responsible as our physicians, and must know as much as we can and must stay informed about issues that relate to our health. You and only you are the best barometer of the goings on in your own body, you know best when you feel normal and when you don't. But a doctor is almost always the best source of help if and when something does go wrong. And though our skills are many (if I do say so myself), we are not mind readers and can't just look at you and tell what you're thinking, what's bothering you, and what exactly is wrong. So you should never be afraid to ask your doctor a so-called "stupid" question, make a "dumb" suggestion, or offer an observation that seems so "obvious." Do not hesitate to share any information you've discovered, hunches you may have, or "scuttlebutt" you've heard about relevant health issues with your doctor.

As difficult as it is to suffer with a malady, or even the fear of one, it is more difficult to suffer in fear of the unknown. It is an unfortunate fact of life that disease happens. Fortunately, most diseases are curable if found early. If you take a positive approach to disease and are open with your doctor, you have a much higher chance of being

one of the fortunate. You may or may not open the door—and your doctor's eyes—to a new avenue of treatment, but you'll demonstrate your own level of commitment to your own health (something doctors appreciate and welcome), and go a long way to livening up those dry, clinical conversations.