

Old Men and the Sea

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Man is not made for defeat. A man can be destroyed but not defeated.

Ernest Hemingway, "The Old Man and the Sea"

It was late on a Friday when I got the call: "New patient, trouble breathing. Too sick to see the doctor. Could you come to the home?"

New in town, I was anxious to fill an empty afternoon.

His wife met me at the front door and led us to the living room where Mel was propped in a portable bed. He had become stranded there three weeks before when his water logged legs would no longer take the stairs.

Before I could open my bag, Mel dictated the terms of our engagement: Hospitalization would be brief: he had no insurance, and refused to let an illness exhaust his children's college fund. And whatever the cause, expensive tests and treatments must wait until he could purchase insurance through the window of open enrollment. It became clear that Mel had fixed ideas, and that his decision to accept medical care triggered a crisis of faith.

We thus began our quarter-century journey together, negotiating the obstacle course of his obsessive-compulsive disorder, marital affair and subsequent divorce, intentional drug overdose, complications from alcoholism, congestive heart failure, and the need for another prosthetic valve. We came to an understanding. We forged a friendship that survived his many troubles and my frustrated attempts to fix them.



Bud had complained of weakness in his left leg for months. Now it kept him from playing on the curling team that had occupied his Wednesday evenings for the past twenty years. He wanted his leg working again; he wanted to recoup his old life and its involvements. So we agreed that he should see a neurologist for further testing.

I had known Bud since moving to town. I cared for his mother-in-law in the nursing home, then his wife when she, too, became crippled by a stroke. Bud had been a pillar of strength and congeniality throughout it all, always at their side in quiet support through every crisis.

The neurologist ordered an MRI that would pinpoint the cause of Bud's weakness: spinal stenosis. He passed him off to a neurosurgeon, who recommended a routine operation to relieve the impingement. I discovered the chain of events when the nursing home called. Something had gone wrong, and now Bud was unable to move his arms and legs, protect his airway, or pull himself out of an emotional sinkhole that had drained his will for rehabilitation.



These men are bookends to my medical career in a small, working class, New England community. They are two of the many I have befriended over the years, through their ailments, yes, but also on school board committees, in checkout lines, at wakes and weddings and benefit suppers, or along the sidelines at my daughter's soccer games. They are more than the sum of their episodic illnesses or a case number on the registry of chronic disease. Like me, they are looking for purpose and connection in their lives. They have found an intangible worth in their labors, and know marrow-deep the meaning of Marge Piercy's words, "The pitcher cries for water to carry and a person for work that is real."

Yet there are days of endless, droning complaints when I begin to question my patients' motives. Why do they bring me their sniffles and aches, true confessions, or sagging bodies for an annual exam? Yes, they occasionally need treatment, but mostly they are shuffling through life. It is during these banal encounters that I sense the urgency in their voice, as if their visit were an investment in the future.

Patients are preparing for the day when they are no longer visible, when illness or age robs them of their identity. "They" disappear, the persons in the mirror, the ones who traded their souls for a paycheck. The Golden Years collapse under the weight of a layoff or disability, widowhood or terminal diagnosis, or the slow encroachment of dementia. Who will stand by or speak for them now?



I visited Bud in the nursing home after the surgery and found him tangled in his sheets. When I inquired about his condition, he said there was nothing I could do. Couldn't I see what had become of him, a burden to his family and friends? But I refused to believe it or acknowledge the excuse. Because I *knew* his history, his family, his friends, I knew he was no burden because- deep down- he knew it, too. I wrote a prescription for an anti-depressant and gastric feeding tube; put the physical therapy staff on notice that time was of the essence; coordinated meetings with his rehabilitation team that included his family. Bud eventually walked out of rehab, and three months later abandoned the feeding tube that others had convinced him he would always require.

Mel found himself on the edge of a second divorce and- faced with another halving of his self-worth- decided to take his life. It devastated his daughter, who felt the failure of not having loved him enough to save him. And frustrated his son, who conquered the alcoholism that destroyed his father, and- repelled by their likeness- distanced himself. At the funeral, I was startled by their physical

similarities, son to father and daughter to first wife. We exchanged e-mail addresses and emptied our pockets of the grief, pity, and profound sadness that joined us to Mel's life. I was forced to confront my own sense of failure. But I realized, too, what he had accomplished in raising two decent children and providing them with a genuine if imperfect love. He had fended off the demons for as long he could.

Continuity of care is a pillar in the portico of primary care. But it promises more than customer satisfaction or improved health outcomes. When all we measure is the ratio of user provider continuity, we miss the point. The tragedy is not when others care for our patients, but when no one cares for them at all. Our ministerial role, our vow of hospitality requires a certain amount of stability, patience, and desire to welcome the patient in whatever condition he arrives.

Some say that the era is over when physicians can know their patients and live among them. Conditions have changed; the country has moved on. And they would be half right. But so are the patients who miss having a connection with their physician, and the thousands of medically orphaned communities who would welcome any physician with open arms.

Even where you are, it is possible to know your patients in situations that may never cross geography or time. Continuity does not define the professional relationship. It often deadens it, or burdens it, or merely adds to the efficiency of the transaction. The purpose of continuity is to deepen our relationship with others, something that is utterly impossible if it never begins. It begins in every encounter where the patient feels known and- despite it- loved, or at least respected and cared for by another human being.

In Hemingway's classic novella, *The Old Man and the Sea*, a fisherman named Santiago sails on an epic journey into the Gulf of Mexico in search of marlin. He confronts a vast and capricious ocean, referring to her lovingly as "La

Mar." He knows that the sea has always given and taken away, and that fishing "kills me exactly as it keeps me alive." Yet, on the ocean, a man is never lost or alone, and silence is practiced as a virtue. Though Santiago returns to the village empty-handed, his feat of endurance has guaranteed his triumph.

We physicians are like the sea at city's edge- a point of orientation. We are a beacon for patients in crisis and the final repository for their sunken past. We gather the flotsam from their foundered dreams.

Knowing this is to know something of our duty, something about the worth of continuity of care. It is not a tactical goal. It has strategic aim, which is more far-reaching and purposeful. It cannot be enforced, taught, or measured. It must be lived and experienced in the cross-connections of real community. As physicians, we are chosen to witness the self-destruction wreaked by illness and age. Our challenge is to see the patient who has lost sight of himself. Thus, we are called to live where we serve, anchored against the currents of geographic mobility and "professional distance." How else can we relocate those who have been dislodged from their identity? What we gain is an appreciation for ordinary lives that reawaken in quiet conversation, over a shared cup of tea, or through vigilance at the bedside when the others have gone home. These are ordinary lives like our own. Twenty five years of living in community has taught me that our differences empty into an indifferent sea where death will inevitably find us, but it cannot defeat our will to endure.