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The art of doing nothing

Op het WONCA-congres 'The Art & Science of General Practice and Family Medicine' in Wenen hield op 5 juli 2012 dr. Iona Heath, voormalig President of the Royal College of General Practitioners, een indrukwekkende keynote lecture met de titel 'The art of doing nothing'. In dit signaal geven wij u de tekst die zij bij die gelegenheid uitsprak.

The wisdom of others

In his 1994 book *Alone again: ethics after uncertainty*, the sociologist Zygmunt Bauman quotes the German psychiatrist and philosopher Karl Jaspers:

> *Our time thinks in terms of 'knowing how to do it,' even where there is nothing to be done.*[1]

In her 2001 book *Science and Poetry*, the British philosopher Mary Midgley expanded on this point:

> *Out of this fascination with new power there arises our current huge expansion of technology, much of it useful, much not, and the sheer size of it dangerously wasteful of resources. It is hard for us to break out of this circle of increasing needs because our age is remarkably preoccupied with the vision of continually improving means rather than saving ourselves trouble by reflecting on ends.*[2]

Ours has become the age of unthinking doing – keep doing, don't stop to think – there's no time! And there's no time because we are too busy doing.

The American poet William Carlos Williams who was also a general practitioner understood very clearly how easy it is for doctors to succumb to this particular vicious circle. In his 1932 short story about 'Old Doc Rivers' he wrote –

> *With this pressure upon us, we eventually do what all herded things do; we begin to hurry to escape it, then we break into a trot, finally into a mad run (watches in our hands), having no idea where we are going and having no time to find out.*[3]

I suspect that everyone who has worked in general practice recognises this phenomenon. Rushing around all day – no time to stop, to listen, to think, to notice – or even – to go to the toilet!

The Austrian Nobel Prize winning physicist Erwin Schrödinger, most famous for his cat, seems to have understood the importance and the power of the art of doing nothing:

> *In an honest search for knowledge you quite often have to abide by ignorance for an indefinite period. The steadfastness in standing up to [this requirement], nay in appreciating it as a stimulus and a signpost to further quest, is a natural and indispensable disposition in the mind of a scientist.*[4]

He seems to me to be describing the importance of the pause for thought – especially in the conditions of ignorance and uncertainty so common in general practice.

Taking all this wisdom into account, my conclusion is that, perhaps counter intuitively, in medicine, the art of doing nothing is active, considered, and deliberate. It is an antidote to the pressure to DO and it takes many forms and these are just some of them:

Listening, noticing
Thinking
Waiting
Witnessing
Preventing harm

Each is an art in its own right – requiring judgment, wisdom and even a sense of beauty.

Listening and noticing

Doing nothing – but instead – listening and noticing. It is impossible to do and to listen intently and accurately at the same time. Anyone who has tried to listen to their children while also trying to cook a dinner knows this to be true. William Carlos Williams describes the intensity of listening in general practice:

> *It is actually there, in the life before us, every minute that we are listening, a rarest element - not in our imaginations but there, there in fact. It is that essence which is hidden in the very words which are going in at our ears and from which we must recover underlying meaning as realistically as we recover metal out of ore.*[5]

He describes this essence as the nearest most patients come to the poetry of their lives as they struggle to give expression to their deepest feelings and fears in the quiet privacy of the doctor's consulting room.

The Scottish poet Kathleen Jamie thinks that the necessary commitment and concentration of listening and noticing come close to the idea of prayer

> *Isn't that a kind of prayer? The care and maintenance of the web of our noticing, the paying heed.*[6]

And when she describes her experience of bird-watching – it sounds so close to the kind of receptiveness that we need in general practice:

This is what I want to learn: to notice, but not to analyse. To still the part of the brain that's yammering, 'My god, what's that? A stork, a crane, an ibis? – don't be silly, it's just a weird heron.' Sometimes we have to hush the frantic inner voice that says 'Don't be stupid,' and learn again to look, to listen. You can do the organising and redrafting, the diagnosing and identifying later, but right now, just be open to it, see how it's tilting nervously into the wind, try to see the colour, the unchancy shape – hold it in your head, bring it home intact.

Right now – do nothing – just be open to the patient – notice them and hold them in your head. Don't start to analyse – to diagnose – too soon.

And it is Zbigniew Herbert, the great Polish poet who reminds us of our responsibility to those who are sometimes the most difficult to pay attention to – to listen to – to notice:

His only weapon was abuse, the rebellion of the helpless – without hope but precisely because of that, deserving admiration and respect.[7]

Thinking

Do nothing – stop and think instead. Does this patient need a diagnostic label – will it really help them? What sort of care would be right for them – at this time and in this place?

The German philosopher Hans Georg Gadamer reminds us just how serious this task of thinking is:

Thinking is the dialogue of the soul with itself. This is how Plato described thinking, and this means at the same time that thinking is listening to the answers that we give ourselves, and that are given to us, when we raise the question of the incomprehensible.[8]

The legacy of the well-intentioned emphasis on the evidence base of medicine has been the proliferation of guidelines which were designed to provide guidance but, abetted by a multitude of subtle pressures and the indiscriminate, and distinctly unsubtle, incentives of performance-related pay, have been slowly transmogrified into tablets of law that make it all too easy to DO without pausing to think.

Waiting

Doing nothing but having the courage sometimes to wait – to use time as both a diagnostic and a therapeutic tool – to see what nature does – to wait and see. These are essential skills of the art of doing nothing that are profoundly important if we are not to fall into the seductive traps of overdiagnosis and overtreatment.

The importance of waiting is captured in one of the poems by the New Zealand doctor and poet Glen Colquhoun:

Increasingly sophisticated methods of divination used in the practice of medicine

By observing a rooster pecking grain.
By the various behaviours of birds.
By balancing a stone on a red-hot axe.
By the shape of molten wax dripped into water.

By the pattern of shadows cast onto plastic.
By the colour of paper dipped in urine.
By the growing of fresh mould in round dishes.
By the magnification of blood.

By the alignment of electricity around the outside of the heart.
By the rise in a column of mercury.
By timing exactly the formation of clots.
By the examination of excrement.

By the placement of sharp needles underneath the skin.
By tapping the knee with a hammer.
By the bouncing of sound against a full bladder.
By the interpretations of pus.

By the attractions of the body to strong magnets.
By the characteristics of sweat.
By listening carefully to the directions of blood.
By waiting to see what happens next.[9]

Waiting to see what happens next is indeed the most sophisticated method of diagnosis and, in the face of the ever increasing availability of expensive and intimidating technology; we would do well to remember this.

Being present

Doing nothing but simply being present – there with the patient – and bearing witness so that the old adage is reversed and becomes: 'Don't just do something, stand there.'

In *A fortunate man*, which is for me the best book ever written about general practice, John Berger writes:

He does more than treat them when they are ill; he is the objective witness of their lives.[10]

And John and Bogdana Carpenter, responsible for the English translations of many of Zbigniew Herbert's poems, write:

Our own freedom and our very reality depend upon the accuracy with which we are able to perceive the suffering around us, to bear witness to it, and to revolt against it.[11]

This doing nothing while witnessing suffering precedes the action of revolting against it and in general practice that action is our responsibility for advocacy. We have an obligation to speak out for those who have no voice and to describe to politicians and policymakers, as often as we can, how their policies play out in the realities of daily life for those struggling with relative deprivation in an unequal society.

Inadequate housing, homelessness, and family poverty are structural issues but are no less amenable to intervention than the health conditions they engender. The

way they differ is in the type of intervention required. Advocacy is structural therapeutics.[12]

In June, I had the wonderful privilege and good fortune of attending a seminar in Rosendal in Norway entitled: 'The nature of humans and the goals of medicine'. At the seminar, I met a young doctor working in interventional cardiology who I had first met when she was a medical student at a similar seminar 8 years ago. She is also a brilliant musician and, for this seminar, she had written a piece of electronica music that she played for us. It had a repeating line in the manner of electronic:

'I know I can see you through this.[13]*'*

As this phrase repeated in the music, I slowly realised how different this statement is from the more usual 'I know I can help you with this' and the difference is about witnessing and about being there when there is little help to be had. It is an offer of companionship, of solidarity and a promise not to run away. It is part of the art of doing nothing.

Arthur Kleinman, the American anthropologist and psychiatrist, says something similar:

...empathic witnessing... is the existential commitment to be with the sick person and to facilitate his or her building of an illness narrative that will make sense of and give value to the experience. This I take to be the moral core of doctoring and of the experience of illness.[14]

And Charles Rosenberg, Professor of the History of Medicine at Harvard, asks:

How does one manage death – which is not precisely a disease – when demands for technological ingenuity and activism are almost synonymous with public expectations of a scientific medicine?[15]

Pointing out the excess of doing in modern medical care and perhaps the deficiency of witnessing.

Samuel Beckett understood more about futile doing than most. He is described by the literary critic Christopher Ricks as:

The great writer of an age which has created new possibilities and impossibilities even in the matter of death. Of an age which has dilated longevity, until it is as much a nightmare as a blessing.[16]

In *Malone dies*, Beckett writes:

And when they cannot swallow any more someone rams a tube down their gullet, or up their rectum, and fills them full of vitaminized pap, so as not to be accused of murder.[17]

This was written more than 60 years ago and it is frightening to consider how much truer it has become over the intervening years.

'I know I can see you through this' is the commitment doctors can make to the dying when doing has become futile and even cruel. Simply being there and bearing witness is never futile.

Preventing harm

Finally – doing nothing and thereby preventing harm. The importance of this was emphasised in a paper published in the Archives of Internal Medicine earlier this year which came to a somewhat unexpected conclusion.[18]

In a nationally representative sample, higher patient satisfaction was associated with less emergency department use but with greater inpatient use, higher overall health care and prescription drug expenditures, and increased mortality.

In a commentary on this research paper, Brenda Sirovich from the Dartmouth Institute for Health Policy and Clinical Practice noted that:

Practicing physicians have learned – from reimbursement systems, the medical liability environment, and clinical performance scorekeepers – that they will be rewarded for excess and penalized if they risk not doing enough.[19]

She mentioned a study she had done with her colleagues Steve Woloshin and Lisa Schwarz in which they found that nearly half of US primary care physicians believed that their own patients were receiving too much medical care.[20] This somehow exemplifies this statement from Vladimir Nabokov:

The lovely thing about humanity is that at times one may be unaware of doing right, but one is always aware of doing wrong.[21]

I don't think that we in Europe are quite as bad as the Americans in this but we are not far behind and we too know that we are doing too much.

Brenda Sirovich also tells the story of Joseph Epstein, an American essayist, short story writer, and editor. On his 60th birthday, feeling perfectly well, he promised his wife that he would go for a medical check-up. He felt perfectly well, was not overweight, ate a healthy diet, exercised regularly and had not smoked for 20 years. He went for his check-up, had a normal ECG and had blood taken. His total cholesterol was normal but his HDL level was low. This was the only abnormality. In short order he was referred for a stress test, an angiogram and a CABG. He went from feeling perfectly well to having a huge scar, feeling traumatised, vulnerable and weak and wondering whether he would ever recover his previous sense of well-being. We know all this because he wrote about it in the New Yorker in an article entitled 'Taking the Bypass – a healthy man's nightmare'.[22] The truly remarkable thing is his conclusion:

In the long view, I know I have to count myself lucky.

And he expresses himself grateful to his excellent doctors. As Sirovich points

out, 'Satisfaction with seemingly adverse outcomes of potentially excessive medical care appears to be the norm.' But remember where we started this – higher patient satisfaction is correlated with increased mortality.

About 15 years ago, at a research conference, I heard a nurse reporting on a qualitative study of nurses' feelings when they are asked to try to persuade parents to accept infant vaccination. Her finding was a clear conclusion that the nurses thought that a crime of omission causing potential harm to an unvaccinated child was somehow less than a crime of commission – precipitating serious side effects by giving the vaccination. Doing nothing was felt to be less bad than doing something that went wrong. Active harm is worse than passive harm.

Joseph Epstein's story suggests that this has been turned completely upside down – as doctors, we seem to have persuaded ourselves that commission is now much less bad than omission. We seem trapped in an uncontrolled positive feedback loop with doctors convinced they are doing the best for their patients and grateful and satisfied patients feeling that somehow their lives have been saved. It is surely time to step back and reconsider the virtues of doing nothing before the harms multiply and healthcare becomes exponentially more expensive than it already is.

Conclusion

Doing nothing is preferable to leaping to conclusions; applying inappropriate or premature labels; medicalising ordinary human distress; and instigating futile or ineffective treatments. Yet, while aspiring to the undoubted benefits of the art of doing nothing, we must also take heed of the warning from Aimé Césaire, the great francophone poet from Martinique:

> *Beware, my body and my soul, beware above all of crossing your arms and assuming the sterile attitude of the spectator, because life is not a spectacle, because a sea of sorrows is not a proscenium, because a man who cries out is not a dancing bear.*[23]

So let us cultivate the art of doing nothing but never allow ourselves to take refuge in the sterile attitude of the spectator. ■

Dit is een dubbelpublicatie. Het oorspronkelijke artikel zal verschijnen in januari 2013 in the *European Journal of General Practice*. Publicatie gebeurt met toestemming van de uitgever.

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