

HEALTH & Happiness

by Alex Lickerman, AB '88, MD '92

Alex Lickerman, AB '88, MD '92, is an assistant professor of medicine at the University of Chicago. Born into the Jewish faith, Lickerman became a practicing Buddhist in 1989 because "becoming awakened to a universal truth that would secure happiness" intrigued him.

I leaned back in my chair and breathed a heavy sigh. My patient, Mr. Rodriguez, noticed my discomfort. "I know I should quit," he told me with a guilty shrug of his shoulders.

"Have you ever tried?" I asked.

"Once," he replied, "but it didn't stick."

Mr. Rodriguez had been a pack-a-day smoker for the past 20 years, something he'd only begrudgingly confessed in response to a standard inquiry I make of all my first-time patients. He himself didn't see it as a problem. Or at least, he hadn't mentioned it when I'd asked him why he'd come to see me at the beginning of our visit.

"Are you aware of all the ways cigarette smoking is bad for you?" I asked.

An alarmingly high proportion of patients know surprisingly little about all the ways cigarette smoking damages the body, but Mr. Rodriguez was able to come up with two of the major ones: heart attacks and lung cancer.

"Why do you keep smoking when you know it causes heart attacks and lung cancer?" I asked him. He shrugged, obviously embarrassed, caught in a contradiction.



Photo by Dan Dry

But even as I tried to shame him into wanting to quit by preying on his need to be consistent, I knew no real contradiction existed. I knew this not because of my medical training or subsequent years of medical practice, but rather because of my many years of practice and study of Buddhism.

The kind of Buddhism I practice isn't Zen or Tibetan, the two most popular forms in the United States, but rather the Buddhism of Nichiren Daishonin, named after its founder, also called true Buddhism. The practice of true Buddhism doesn't involve meditation as do the other more popular forms, but rather something even more foreign and discomforting to those of us raised in the traditions of the West—chanting. Every morning and

every night, I chant the phrase “Nam-myoho-renge-kyo” (translated as “I dedicate myself to the mystic law of cause and effect through sound”) with a focused determination to challenge my negativity in an effort to give birth to wisdom. Wisdom, Buddhism argues, is the key ingredient to happiness.

And wisdom, rather than knowledge, is what my patient, Mr. Rodriguez, seemed so desperately lacking. He knew intellectually he shouldn't smoke, but that knowledge hadn't yet penetrated to become wisdom, to become, in essence, action. Despite his feelings to the contrary, Mr. Rodriguez presented no contradiction because action never arises from knowledge alone. It arises from knowledge that is believed.

How often do we understand with our intellects how we ought to behave but find ourselves unable to do it? Why, for example, do some people know how to set appropriate boundaries with others, but other people can't bring themselves to say no to anyone? Why do some alcoholics figure out they need to stop drinking and stop, while others agree they should, but don't? Why do some people hear advice to quit smoking and quit that very day, while others smoke on even after heart attacks and strokes?

The answer lies not just in what we believe, but also in the degree to which we believe it. Deeply held belief—Buddhism (and psychology) would argue—introduces a critical ingredient necessary for change: motivation. One of my patients tried and failed to quit smoking for several years until his wife mentioned casually she hated coming home to a house filled with smoke, and he stopped for good the next day. He'd finally discovered the motivation to quit: a sudden, burgeoning awareness (that is, a deeply felt belief) of the harm his smoking was doing not to himself, but to his wife—ultimately more capable of believing that his wife's life was at risk rather than his own. Most of us, after all, tend to deny the possibility of our own death more vigorously than we deny the possibility of someone else's.

“How many of your patients actually quit because you tell them they should?” Mr. Rodriguez wanted to know after I told him my patient's story. In fact, studies tell us only two out of every 100 smokers told by their physicians to quit will succeed long-term. It's less clear how many alcoholics or drug addicts who recognize they're addicted and need to quit actually do. But the principle remains the same: Some people can digest intellectual knowledge and translate it into deep and motivating belief, belief that they must change their behavior despite all the obstacles—and some cannot.

Specifically with regard to smokers, 98 of 100 cannot. What, then, is the difference between those two smokers who hear their physician's warnings about the dangers of smoking and for the first time truly understand it's time for them to quit, and the other 98 who agree they should quit, but fail in repeated attempts? Why was my other patient motivated by the possibility of his wife's death to quit, but Mr. Rodriguez wasn't by the possibility of his wife's? Or asked from a Buddhist perspective, why do some people find the wisdom and others do not?

One could argue that Mr. Rodriguez did in fact believe in the dangers of nicotine, both to himself and his wife, but that he was simply too addicted to succeed in quitting. I would argue, however, the problem lay less with the strength of his addiction and more with the weakness of his belief. If those dangers, which he only weakly believed applied to himself, could have in some way been brought home to him—as Ebenezer Scrooge's impending death was brought home to him when a spirit showed him his own tombstone—I am convinced Mr. Rodriguez would have been able to resist the pleasure that smoking provided him and managed the pain of withdrawal that abstention would have produced.

Buddhism argues that the true reason for the emergence in the human mind of new and powerfully motivating belief is mystic—meaning, simply, unknowable—which is why I teach residents and students

to ignore the odds and counsel all of their smoking patients to quit. Despite our preconceived expectations that most of our patients won't be able to listen, clearly we have no way of predicting which two out of every 100 will.

I would argue, therefore, there are two possible approaches to the practice of medicine and that the second of the two is best. The first involves diligently providing appropriate advice about smoking cessation, abstention from alcohol for those who abuse it or pharmacologic management of depression and anxiety (to name only a few of the common maladies that affect my patient population). The second, however, involves becoming interested in the beliefs our patients hold that keep them trapped in harmful behavior patterns. It involves embracing a view of the human mind that fully recognizes all behavior arises out of belief and that if we could only help our patients find their way to wisdom, their lives might then become governed by actions that lead to happiness and joy rather than suffering and pain.

This, then, is how I view the proper role of the physician: not just as an advocate for patients' health, but an advocate for their happiness as well. While I certainly don't believe I have all the wisdom my patients would ever need to solve every problem they face, I am equally certain that they themselves do. My ultimate aim then, and it turns out the most enjoyable part of my day, involves encouraging patients to challenge their deeply held beliefs that, in my view, obstruct their ability to change maladaptive behaviors. Though I often fail, I am never able to predict with whom I will succeed, so I approach every patient as a mystery to be solved, full of hope.

As he left my office no more determined to become a non-smoker than he'd been when he'd entered, I wondered: What do you need to hear, Mr. Rodriguez? What experience do you need to cause some critical piece of wisdom to penetrate deep into your heart and motivate you to save your own life?