# AUTHOR’S NOTE

## From Heart to Head

*Men go forth to wonder at the heights of mountains, the huge waves of the sea, the broad flow of the rivers, the vast compass of the ocean, the courses of the stars; and they pass by themselves without wondering.*

– St. Augustine, *Confessions,* Book X, chapter 8

I am sixteen and it is a fairly routine surgery. To be completely honest, I am not entirely sure what the surgery is even for – that is not the memorable part to me. This is the first surgery I have ever witnessed. I stand in my baggy scrubs with my hands clasped behind my back not knowing what to expect and telling myself that I am going to make it through this. Any doubts running through my mind completely vanish with the first graceful stroke of the scalpel, when a hidden world reveals itself.

As layer after layer of skin, fat, fascia, and muscle are parted from their other half, the abdominal cavity is exposed. It is a pink, moist, maze of intestines and it fascinates me. Surprising myself, it is all I can do to keep one hand intertwined with the other; a strong impulse to touch and explore almost overwhelms me. The surgeon tells me to stand at the end of the operating table near the patient’s feet and gently pushes the intestines to the side of the cavity. As I peer inside, the most incredible breathtaking view greets me: a heart. The beauty and power of the beating heart leaves a lasting impression on me that, to this day, has not been rivaled. I am filled with a sense of awe and wonder at this human body. I yearn to discover its secrets and learn from its wisdom. Does every physician experience this awe while witnessing the human body? Will my wonder fade as the internal organs become part of an everyday landscape?

After a while of watching the surgeon at work, he suggests I spend time with the anesthesiologist to expose myself to another aspect of medicine. At the head of the operating table sits the anesthesiologist. There a multitude of wires, tubes, and beeping machines form a tangled web connecting to the patient. A drape separates the patient’s head from the rest of her body blocking the view of the surgery from the anesthesiologist as well as the patient’s face from the surgeon. It is a different perspective of the same situation.

Glancing down at the head of the table, a face – eyes taped shut and tubes protruding from the mouth – reminds me that the heart resides within a human. A person with feelings, emotions, a life; greater than just a beating heart. Why is the face blocked from view? Would this startling realization interfere with the surgery? To balance the awareness of a human life but to focus on singular portions of the body is not an easy practice. My passion is ignited and my mind is engaged.

Many questions have presented themselves since that day and I am compelled to find the answers. What better place to start than with Sherwin B. Nuland, clinical professor of surgery at Yale University and author of *The Wisdom of the Body*. I jump in, expecting to discover if my wonder is a shared experience, and end up delving into the human spirit that defines us as a species, the aspects that set medicine apart, and empathy.

Throughout this process of exploring Nuland’s work and the wisdom of the body, I interacted with four masters of the art of medicine. Their knowledge and understanding of medicine and the human experience add voice, insight, and truth to this thesis. Dr. David Bliss is a practicing pediatric surgeon in Los Angeles, California. He graduated from medical school in 1990 from the University of California, San Diego School of Medicine. Dr. Bliss is a stand-out physician due to his comfortable bedside manner, sense of humor, and the amount of time and energy invested in each patient. Dr. Philip Miller is a pediatrician who practices in Lake Oswego, Oregon. In 1977 he graduated from medical school from Carver College of Medicine at the University of Iowa. Dr. Miller is incredibly bright and invested in his patients, and truly listens to each patient’s concerns – spoken and unspoken. Dr. David Grube practices family medicine in Philomath, Oregon, and graduated from Oregon Health and Science University School of Medicine in 1973. Dr. Grube’s calm, professional manner complimented by his patience and firm grasp of effective communication, demonstrate his great depth of compassion. A trauma/general surgeon in Santa Clara, California, Dr. Gregg Adams graduated from Oregon Health and Science University School of Medicine in 1988. Dr. Adams carries himself with quiet confidence and performs impeccably under high pressure. He is very professional and an effective teacher to patients and students.

Nuland and the four physician interviewees served as guides along my journey, sharing knowledge, experience, and interpretations of the wisdom of the body. Their involvement has helped answer some of the questions initially raised during the first surgery I witnessed. As they provide answers to the original questions, new aspects of the art of medicine are revealed and more questions emerge.

BEYOND EMPATHY

– A Glimpse into the Physician-Patient Relationship

# SUMMARY: *THE WISDOM OF THE BODY*

## Introduction

Sherwin B. Nuland is a distinguished surgeon affiliated with the Yale University School of Medicine where he taught medical history and bioethics. As an author, he has been awarded National Book Awards and has made the New York Times Best Seller list for his writings on aspects of the physician-patient relationship over the past twenty years. I was first introduced to Nuland’s work through a class in which we read and discussed *The Soul of Medicine*. Written in a format echoing Chaucer’s *The Canterbury Tales*, this anthology is a compilation of stories as told by Nuland’s colleagues. Touching on the challenges, emotions, and dilemmas faced by physicians, it piqued my interest in the complex role of a medical professional, specifically in the context of the physician-patient relationship. *The Wisdom of the Body*, another of Nuland’s books, is a journey through the biology and chemistry that makes us human, venturing through the lymphatic, nervous, and circulatory systems, the heart, and ending in the brain. Each chapter discusses in depth an organ or system of the body embellished with a personal anecdote by Nuland. As early as the introduction he has addressed one of my questions.

The following chapter explores Nuland’s feelings of wonder and awe relating to the human body as described in *The Wisdom of the Body*. To determine if these emotions are shared by others practicing medicine, the physician interviewees’ were asked to convey their initial reactions to the human body. This discussion establishes whether awe of the body is a commonality required of physicians or aspiring physicians, and further investigates if wonder fades as part of an everyday landscape. Furthermore, this chapter explores Nuland’s perspective of the wisdom possessed by the body. The importance lies in that which ties together humanity and this physician to patient. The defining characteristic that sets *Homo sapiens* apart from the rest of organic life plays an important role in medicine.

## Nature’s Most Exquisite Artistry

*The most beautiful thing we can experience is the mysterious. It is the source of all true art and all science. He to whom this emotion is a stranger, who can no longer pause to wonder and stand rapt in awe, is as good as dead: his eyes are closed.*

*–* Albert Einstein, *Strange is Our Situation Here on Earth*

Nuland describes the same fascination with the inner-workings of the human body as I have. Even though he is well into his career in medicine and has been exposed to incredible sights, he recalls an experience much like my own: “I expect to never recover from the thrill of discovery that accompanied my first look into the living body of an anesthetized fellow human being…The multicolored, multitextured fabric of tangible, pulsating reality that is our innermost sanctum represents, to me, nature’s most exquisite artistry. To practice that other art, the art of maintaining and restoring the integrity of its diverse faculties, is the privilege that became the guiding force of my life” [Nuland xx]. This passage is very reminiscent of my first surgery and my own calling to practice the art of medicine. And, like Nuland, I presume to never recover from the sight of my first beating heart. The interconnected, living human body truly is nature’s masterpiece.

I am curious if this is a shared experience beyond Nuland and me. For the answer, I approached my panel of doctors: Dr. Philip Miller, Dr. David Grube, Dr. David Bliss, and Dr. Gregg Adams. Dr. Miller responds with, “As a pediatrician, I never tire or get jaded when I see a brand new newborn.” For Dr. Miller, visiting his brand new patients never gets old; the miracle does not fade. Dr. Grube says, “I believe that all of us have initial awe and wonder at the human body as we begin our work in medicine. Initially it is with the design (anatomy) and function (physiology) of the structure.” My initial reaction is definitely in response to how the body was functioning – the heart beating – and the physical appearance of the abdominal cavity.

Dr. Adams pinpoints Anatomy laboratory during his first year of medical school as the first of many awe-filled experiences:

At one point of the cadaver dissection we turned our attention to the hand. While all of the preceding dissection had been fascinating, I tried to distance myself from the human-ness of the cadaver so as not to become overwhelmed by the emotions of what I was doing. I found that I could not do that when we got to the hand, there is something inseparably human about the hand, in its shape, in its implied function, which made it impossible for me not to link it to a past and a personality for the person upon whom I was working. I dissected with tears running down my face, awed at the opportunity, and honoring the gift of donation that allowed me to learn and gain experience.

The heart was not beating, the abdomen not wet, pink, alive, but the essence of the human body – the humanness – is there in life and death alike. The sense of wonder Dr. Adams experiences is a result from a connection to his cadaver, the human he is dissecting, learning from, and discovering. Perhaps I will share similar emotions as I begin my journey practicing and learning the art of medicine.

Dr. Bliss, on the other hand, did not share our initial fascination. “My first experiences were, in many ways, more mundane. I was so focused on the knowledge required, the technical skill needed, and satisfying the teaching surgeon that I did not have much opportunity to step back from it.” I assume that much of this difference in experience is due to the fact that Dr. Bliss was already in medical school being trained and evaluated during his first surgery. I was in high school merely exploring if medicine would be a good fit for me. During my training I will attempt to remember this, to keep the impressive nature of the body in the forefront of my mind.

At this point I am still not satisfied. Is it merely the novelty of the sight, the newness of the experience that filled us with wonder? I am still in awe with each hernia repair I watch, but will my wonder fade into familiarity after decades of performing these surgeries myself? I do not want to lose my fascination, my wonder at the wisdom of the body.

I receive a comforting response from Dr. Adams. He says, “Everyday there are moments of awe if you look hard enough for them. They may be in the way a family cares for and communicates with a dying patient, in the seamless coordination of complex operations and systems, in the responsibility that is implied when a patient quietly asks ‘What do you recommend, Doctor?’ I am still awed by the sight of a beating heart. And a perfused brain.”

Dr. Grube responds,

…for me, after a few years of practicing medicine, that awe was replaced with the awe and wonder of the human response to disease (pathology) and treatment (therapy). The wonderful ways that the human body responds to medication and surgery; the horrible ways it is torn down by disease and aging. The way that each person responds to another; the way in which a child responds to kindness and care; the mysteries of spontaneous healing; the differing responses to inflammation. How experience and time heal and wound in ways no one could ever imagine. And especially the stories of all of the above.

For Dr. Grube, the awe shifts from anatomy and physiology to pathology and therapy. Although Dr. Bliss’ initial experience is different than ours, his feelings have evolved as Dr. Grube’s. He shares, “As I have matured, comfort and routine have led me to be more reflective. What I think about it is how marvelous the human body is and how resilient children are in particular.”

I anticipate this shift as well. Nuland writes “the mystery of the body’s internal machinery enthralled ordinary people and tantalized the educated” [Nuland xvii]. As I travel along my journey to becoming educated, I feel my curiosity and fascination only grow stronger. As I track the path of unfolded amino acid chains through the cytoplasm to the endoplasmic reticulum and discover the mechanism by which they are pushed inside and then folded, my fascination grows. As I look at how one substrate binding to a receptor on a cell surface triggers a cascade effect sending its message throughout the cell and beyond, my fascination grows. The more I learn the more incredible the body seems. Nuland also recognizes this trend as society uncovers more information: “…the more became known, the more miraculous seemed the intricacies of the whole…” [Nuland xvii]. It is not only awe I feel, but an appreciation for the complexity and interconnectedness of every fiber in the body. During my next step, medical school, I will come to further understand the human aspects, the art of medicine that both Dr. Grube and Dr. Bliss describe.

Nuland presents the unique perspective of a patient who also experiences this wonder. He describes his patient Gloria who has suffered from epilepsy since childhood. In adulthood, she decides to undergo a risky brain operation to remove the section of the brain responsible for her seizures. Nuland describes a conversation between the two of them: “…I asked her what it is like to be free after so many years of living in constant fear of the capricious whims of her disease…there was no mistaking the wonder in her voice. ‘I feel like a walking miracle,’ she replied softly” [Nuland 340]. Gloria feels wonder at her brain’s recovery. This is a unique perspective because it is not the reaction of an outsider, but a response to her own body that heals after betraying her for so long. While it may seem intimate to see inside a stranger’s body, looking within your own body is intimacy of a different nature. Most are only aware of their body when something is wrong: growling stomach, headache, pain. It is easy to lose sight of how incredible our bodies are every day, with the multitude of complex pathways and functions converging just to keep us alive.

It is important to pause here and acknowledge that although scientists have uncovered vast amounts about the intricacies of the human body, there is an equally vast amount that remains unknown. “More than one scientist has expressed frustration with how little is even now known about the organization of our biological faculties, functioning with such an integrated degree of coordination that we are capable of what would seem to be mental and physical miracles, not to say spiritual ones, which would appear to transcend the mere interaction of molecules” [Nuland 72-3]. As far as science has progressed, we are still in the dark about some of the processes and connections within the body – this is the wisdom the body possesses that we have not yet tapped into. “To presume to know defies all logic and flies in the face of reason” [Nuland 367]. We know so little compared to all there is; it is wise to recognize this. As humans, we use our incredible mind’s power of reason and thought to understand that we *do not* understand. This applies to religion, medicine, and humanity in general. Those who claim to know and are open to nothing else are failing to utilize our most powerful gift as humans.

It is clear that wonder and awe are common emotions experienced by physicians. Whether initiated by the first witnessed surgery, exposure to the anatomy and physiology, or developed over time, there is no denying the intricacies and wisdom possessed by the human body. Throughout the course of a physician’s career, the wonder may evolve to encompass different aspects of physiology or the human spirit, but, as Dr. Adams assures me, “…no, the wonder never ceases.”

## The Wisdom of the Body

*We’re more than carbon and chemicals*

– Thrice, ‘Image of the Invisible’

What wisdom does the body possess? In chapter two, “The Constant Sea within Maintains the Constancy Within,” Nuland ties the wisdom of the body to the concept of homeostasis and how highly responsive the vessels in the body are to any changes in the internal and external environment. As more is discovered about the workings of the human body, more of this wisdom is exposed; “…researchers became increasingly impressed with how well integrated is the entire array of apparently disparate activities. They came to recognize the inherent wisdom of the body” [Nuland xviii]. The mechanisms by which the body can react to any stimuli and adapt to countless situations are mind-boggling. Seemingly unconnected pathways and systems work seamlessly together, all without conscious thought or effort. Nuland delves deeper than just anatomy and physiology though; after all, many animals have remarkably similar adaptations and functions as humans. “The direct line of chemical and physical principles linking molecules to cells, to tissues, to organs, to you and me – and to the community of humankind – increasingly reveal themselves as the basis of those products of our anatomy and physiology that we call mind and spirit” [Nuland 207]. Biochemistry and science lay the foundation of our humanity, but it goes beyond that. He explores that which sets us apart from the rest of organic life: the human spirit.

Throughout descriptions of anatomy and physiology, patients, and surgical experiences Nuland weaves the aspect of the body that is “the real secret of our species’ survival” [Nuland]. The human spirit is described to be “how we have made use of our unique biology to travel the long road from creature *Homo* to the human being” [Nuland]. The introduction first mentions the concept of the human spirit from Nuland’s perspective as a force within that defining us as our species. While the thesis of *The Wisdom of the Body* is that humans are greater than the sum of the parts, the actual discussion of the body’s wisdom and the human spirit is somewhat scattered and is not the focus of discussion until the final chapter.

Why do we have a human spirit? Nuland distinguishes that “some see God in it, and some see only Biology. And there are others who will very clearly see both” [Nuland xxiii]. People have been searching for answers for centuries. The Book of Job (38:36) asks “Who hath put wisdom in the inward places?” The answer provided in the Bible is, obviously, one of divine intervention. In stark contrast to the concept of a religious spirit is the scientist’s view of why the human spirit or “will to live” developed: “The natural pragmatism of many of today’s dispassionate scientific researchers persuades them that the primary and perhaps the only driving force of every living thing is the protection of its DNA for transmission to the next generation” [Nuland 28]. In other words, natural selection for reproduction – the passing on of genes – is the sole reason for the existence of a human spirit. However, Nuland disputes this view arguing that “…even the most unimaginative of researchers must surely appreciate that there is a great deal more to life than mere biochemistry” [Nuland 29]. He agrees that there is more, but the human spirit is a result of this biochemistry: “The human spirit, I believe, is something we have created from the fabric of our human body” [Nuland 30]. To Nuland, the human spirit, which personifies the wisdom of the body, is not the result of a religious entity. Even though it evolved over time, the spirit is not necessary for human survival; humans can biologically live without it. The spirit gives value and meaning to our existence.

He expands on this thought: “In its own mindlessly blind way, nature has for eons been treading the path toward one day molding a creature so faultlessly responsive that it is equipped to deal with every peril that might threaten its cells and itself, whether from the world by which its skin is surrounded or the world which its skin surrounds” [Nuland 356]. Multiple parts of this quote stand out. First, Nuland says that humans are the product of mindlessly blind treading. What a juxtaposition of nature’s blind, unknowing, unplanned way of bringing consciousness and reason and inner-sight. Second, he describes the contrast between the mind having consciousness of an inner world and at the same time controlling the body by predicting and reacting to an outer world. Nuland describes this eloquently by distinguishing between the world the skin surrounds and the world that surrounds the skin. Even though there is a biological and evolutionary drive behind each hormone pathway and homeostatic response, there is something else within that sets us apart as humans.

The human spirit is described from a few angles. The first defines the spirit as a will to live. This concept is best exemplified in Nuland’s tale of patient Margaret Hansen in chapter one, “The Will to Live.” Margaret has an aneurysm of a vessel leading to her spleen. The aneurysm bursts and her abdominal cavity fills with blood, masking the source of the bleeding. Upon her arrival to the emergency room, her blood pressure is found to be fifty which is less than half of normal blood pressure. Marge’s last conscious thoughts before she goes into surgery are “…I knew it wasn’t the right time for me. I felt that I might easily have floated away, and I didn’t want to. I was praying to God to give me more time, telling Him that I loved my life and I felt I had a lot. I didn’t want to leave” [Nuland 9]. At the point Marge is wheeled into the operating room, her blood pressure is zero and she has only the faintest hint of a pulse. She is bleeding faster than she can accept blood transfusions and the surgeons state that they are losing her as they page for a general surgeon.

Nuland happens to walk through the hospital doors at this point and rushes to answer the page. The surgery is described as both a high stress and high risk emergency operation and Nuland happens to be at the right place at the right time to save her, although the rest of the surgical team think it is already a lost cause: “The anesthesiologists had already decided, they would tell me later, that I had failed” [Nuland 16]. He succeeds in tracing the bleed to her spleen and performs a risky procedure to remove the organ. Fourteen units of blood, two of plasma, and two packs of platelets later, Margaret is alive. After a very close call with death, Margaret’s case reveals the human spirit’s role in the will to live. “Marge Hansen was saved by that of the human spirit which was in her and in those OR personnel who refused to allow her life to end” [Nuland 25]. This case reminds Nuland of his belief in “a palpable but yet-unexplored factor in human biology that accounts for a patient’s will to live and a doctor’s ability to save her” [Nuland 27]. Nuland is careful to note that will alone cannot always save lives, “We go into medicine with the expectation that we will be helping people…we…always carry inside ourselves the belief that our will and our powerful array of skills will somehow carry the day. When faced with a medical problem that with each new diagnostic or therapeutic measure reveals itself to be increasingly further beyond our capabilities, we lose a bit of faith…” [Nuland 58]. The human spirit is a strong force but sometimes the force of nature overcomes it.

There is an inherent will to live component of the human spirit. This alone fails to set us apart as a species because all living things have the goal to survive and reproduce. Some species of bacteria can even turn themselves into dormant entities called endospores to protect themselves against environmental stresses including heat, cold, desiccation, and chemicals in order to survive. Perhaps the difference is in the wording. “The will” suggests conscious (or subconscious) processing. The brainpower necessary for this is not available to bacteria, or any species other than humans.

*Homo sapiens* has an awareness of the workings of his body unknown to any other animal. We feel the beating of our hearts, we hear the growling of our intestines …as do so many other animals – but only we have a useful sense of what they mean…We are aware of our tissues and perhaps our very cells in ways possible only to an organism with a mind. We persist in life, therefore, by responding and adapting to stimuli not only coming from outside but coming from inside, as well. Only by answering the inner voices can we fortify ourselves to answer those that come from the external environment. [Nuland 214]

Nuland has mentioned from the beginning of the book that humans have something that sets us apart from all other living things. This awareness or reflective capacity defines us as a species. This segues into the second way Nuland analyzes the human spirit – the mind.

Today most people will agree that the soul or “being” of a person resides in the brain, the site of rational thought, feelings, emotion, firing synapses. However, this was not always so. Aristotle places the soul within the heart: “…the heart was not only the seat of the soul but of the emotions, as well: ‘The motions of pain and pleasure, and generally of all sensations plainly have their source in the heart, and find in it their ultimate termination.’ To Aristotle, the heart was the central capital from which our lives are governed” [Nuland 209]. Some of Aristotle’s thinking lingers today with such sayings as “the heart of life” and “it hurts my heart.” Aristotle bases his thinking on his observations of the developing embryo. The first sign of life demonstrated by this forming person is the heartbeat. “With such visible evidence available to him, it is understandable that he would interpret his observations as indicating that the heart is the source of all life” [Nuland 209]. It is no wonder that the spirit was once thought to reside in the heart; the heart is, after all, what first drew me into the human body. Perhaps what sets the heart apart from all other parts of the body is the fact that we can feel it beating; we can feel how it reacts to emotions of anxiety, fear, and love.

Hippocrates and Plato challenged Aristotle’s thinking and designated the brain as the source of emotions. Even though they take away from the heart some of its mystical and emotional powers, they still acknowledge that there is something about the heart that drives life. Nuland agrees with Hippocrates and Plato. This is alluded to throughout the entire book, but not directly addressed until the final chapter, “Mining the Mind.” The brain is arguably the most fascinating organ of the body, making up only about 2% of the body’s mass but using 20% of the total oxygen we breathe in and 15% of the blood pumped with each contraction. The minuscule 1% difference in the DNA of humans and chimpanzees accounts for an almost incomprehensible increase in potential. Nuland writes “The plasticity of our brain, based as it is not only on receptor-generated stimuli but also on memory, experience, context, emotional content, and value, is what makes us uniquely human. This is the physiological basis upon which we have created the human spirit” [Nuland 353]. The vast potential of the brain provides the opportunity to develop the human spirit.

Nuland makes an important distinction between the brain and the mind:

The mind is a man-made concept, a way to categorize and contemplate the manifestations of certain physical and chemical actions that occur chiefly in the brain. It is a product of anatomic development and physiologic functioning. What we call the mind is activity, made up of a totality of the innumerable constituent activities of which it is composed, brought to awareness by the brain. The brain is the chief organ of the mind, but not its only one. In a sense, every cell and molecule in the body is a part of the mind, and every organ contributes to it. The living body and its mind are one – the mind is a property of the body [Nuland 349].

It is interesting to note that Nuland places the spirit in the mind but does not limit the mind to the brain. The human brain has evolved vast amounts of potential and as a species we have tapped into that potential to create the mind and thus the human spirit. However, the mind is not limited to the brain because of the interconnectedness of every molecule, cell, tissue, organ, and pathway. To further differentiate, Nuland expands: “The human spirit is a quality of the mind. The human spirit is the moral force of the mind” [Nuland 353]. Nuland views the spirit as the aspect of the mind that propels our morality among other rational thinking and judgments.

The potential of the brain unlocks abilities unique to our species. These include the ability to feel, savor, anticipate, reflect upon pleasure, perform abstract reasoning, build and preserve highly organized civilizations, act on a “level of altruism so far removed from simple instinctual self-preservation that it sometimes runs counter to it” [Nuland 29], sacrifice to others, and – as Nuland ventures to say may be the most important – to find a sense of beauty and spirituality. He also brings up love for the first time. Humans possess the ability to feel love for one another and different kinds of love for various relationships. We experience selfless love as well as nonprocreative love, which is very unique in nature because to reproduce is generally the source of any social interaction. “The human spirit and its perpetual search for beauty are the defining characteristics of our humanity at its best” [Nuland 366]. Beauty is sought not just within us and within our incredible bodies but in all that is around us.

This human spirit, the wisdom of the body, provides the framework for human interaction. Despite the incredible interconnectedness and vast abilities of the body, simple errors occur and complex systems can go awry. When nature undermines the wisdom of the body, a physician is brought into the picture to facilitate healing. This unique relationship between patient and physician incorporates the will to live, and utilizes the capabilities of the evolved human mind.

# THE PHYSICIAN-PATIENT RELATIONSHIP

When the body fails or disease, illness, or injury overcome its defenses, a relationship is forged between a patient and a physician. The following chapter discusses different forms this relationship can take, how emotion and physical space can affect it, and the evolution of the physician-patient relationship throughout history. How a physician relates to his patients is crucial to the level of intimacy and healing required in medicine. Balancing an awe of the body with a connection to the human is an art and can be thwarted by physical or emotional barriers. The physician must be conscious of not only his effect on the patient but how the environment influences the interaction.

The relationship built between physician and patient is unlike any other. All four physicians interviewed mention one aspect that sets this relationship apart: intimacy. Dr. Bliss notes that medicine “…is the most intimate of professions. Physicians meet people under some of their worst circumstances, we get access to information that they would not likely share with anyone else, including their own family members. At the same time we give them an implicit promise that we will treat their life and health as precious and will devote our full energies to their welfare.”

Dr. Grube writes of his own experiences, “The practice of medicine is intimate. In no other work does a person (the patient) tell all their secrets, take off all of their clothes (literally and metaphorically), and open all their wounds and hurts to be addressed by another. The practice of medicine is infinitely different. I have been a family doctor for 36 years. Each and every day is different; each and every patient and his or her story are in some way unique.” When a physician meets a patient, it is often because there is something wrong. Anxiety, fear, and depression accompany the patient to the appointment. Dr. Adams adds that “You are privy to a person’s deepest fears, seen through a window that they may not open for anyone else.” Patients share their inner most secrets and are subjected to examination, touch, poking and prodding. As Nuland acknowledges, “To the probing eyes and fingers of a physician, everything is permitted” [Nuland 52]. Each describes a different intimate aspect of medicine. Physically the patient’s body is privy to the eyes and fingers of the physician. Emotionally there are few boundaries – fears, anxiety, and other accompanying feelings are exposed. The physician implicitly promises to heal and intimately care for the patient.

## Metaphors and Models

*The art consists in three things – the disease, the patient, and the physician*

– Hippocrates, *Of the Epidemics*

There is no single physician-patient relationship. Every patient may require something different from their doctor; every doctor may only be able to foster a certain relationship. Dr. Miller states that “The patient comes in for two reasons: anxiety [what’s wrong with me?] and to be heard…Telling them the first appears to fulfill our obligation but we need to be aware of how our words affect the life of the patient and how they accept what we say.” This echoes what Nuland writes. Giving a diagnosis and treatment may be enough to physically cure, but to heal the physician has to support the patient emotionally.

Much research has been done on this unique relationship and there are several widely accepted models. They all show varying degrees of fulfilling the art aspect of medicine. Each model exhibits strengths and weaknesses; each has consequences to the relationship. As health changes in response to treatment or throughout the course of the patient’s life, the relationship shared with the physician may evolve. James F. Childress and Mark Siegler describe five of the following models in the context of patient autonomy in their article, *Metaphors and Models of Doctor-Patient Relationships: Their Implications for Autonomy.* Variations of the models covered by Childress and Siegler are also commonly accepted and the article fails to address two models that Nuland describes in *The Wisdom of the Body.* While most of the following models are, in reality, probably seen in combination with others, each included below has been witnessed in medicine enough to warrant discussion.

Perhaps the most historically and culturally important representation of the physician-patient relationship is the paternalistic model. The paternalistic model places the physician in complete moral power and as the sole decision maker much like the relationship of parent and child. Historically this has been a predominant model in medicine. The physician is placed in a social and cultural seat of power. Full authority falls to the physician to make all decisions that will promote the best interests of the patient. The patient looks to the physician for guidance and direction; the patient is inferior to the physician. While in some cases it may be comforting to have a powerful authoritative figure to fight disease, an inherent problem with the paternalistic model is the vulnerability the patient may experience creating an uninviting environment for questions or requests of the physician. The patient’s time and worries feel insignificant.

Nuland describes the paternalistic effect a physician can have on a patient when entering an examination room: “…the real eminence is the authoritative white-coated, stethoscope-emblazened figure who, even today, is usually a man. Though the worried and self-conscious patient may find difficulty in meeting the physician’s gaze directly, she is intensely aware of every movement made by him and finds significance in each uttered phrase – beginning as early as the initial words of greeting. His physical size seems to expand to fulfill some anxious anticipation” [Nuland 52-3]. The patient is vulnerable and looks to the physician to help and heal. His persona gives the impression of occupying a large physical space. Because of the cultural importance and reverence of the physician, this effect often occurs even if the physician does not intend it to.

The role of ‘parent’ can take one of two forms. If the patient is metaphorically an infant, their role is passive while the physician actively treats and makes decisions for the patient. This is applicable to trauma patients, anesthesia, and certain cases of mental illness. Based on this model, full authority is given to the physician to follow his judgment and take any action deemed necessary or beneficial to the patient. If the patient is metaphorically an adolescent, the physician’s role evolves to that of guide and mentor, providing directions and guidelines that are ultimately up to the patient to follow. The patient is informed that the physician will fulfill his duty during surgery it falls within the patient’s responsibility to lose weight/discontinue smoking marijuana/refrain from playing basketball. While both the doctor and the patient know that these instructions are given with the patient’s health in mind, it is not within the doctor’s power to ensure they are followed.

Nuland describes Sharon who is six months pregnant and presents with breast cancer. Their described relationship provides an example of paternalism. Nuland begins the appointment expecting that everything will be fine due to her family’s lack of history of breast cancer and Sharon’s young age of 35. However, upon examination Nuland discovers a wrinkled thickening of the skin on her breast characteristic of cancer cells blocking the lymph channels. After uncertain results of a needle biopsy, Nuland decides to perform a surgical biopsy: “The grittiness transmitted to my fingertips as the scalpel cut through the tissue removed all doubt about its malignant nature…Not only did the tumor have an aggressive appearance but cancer cells could be seen within the breast’s lymph channels, on the way to their next home, in the axilla” [Nuland 56]. While Nuland tells Sharon and her husband that there is a tumor and she needs a mastectomy, he withholds the information that the cancer cells are actually visible in the lymph channels which drastically increased the probability that the cancer had already spread. Nuland defends this decision with: “I wanted my patient to be in as good a frame of mind as possible when she was wheeled into the OR the next day…It seemed justified, that is, for both of us” [Nuland 57]. He claims this is justified for both of them, patient and surgeon.

The validity of this decision is debatable. There is an intrinsic importance of a positive mindset, but withholding information also violates informed consent. Sharon is unaware of the full extent of her cancer because her surgeon makes the judgment call to keep her full diagnosis from her. While everything turns out well, the patient is kept in the dark about my condition; trust is violated. This illustrates a major weakness of the paternalistic model. The model assumes that both physician and patient share the same values. However, this assumption is proved false time and time again. Nuland assumes that Sharon will value optimism over knowing all of the information (or informed consent). In this case Sharon’s feelings regarding Nuland’s decision are unknown. It is unclear if he even tells her at all. The physician’s values prevail as a result of this model because he holds the power. Childress and Siegler note that paternalism focuses more on medical care than the rights and emotional care of the patient.

A variation of paternalism not discussed by Childress and Siegler is the priestly model which involves the physician in the position of priest or moral superior to the patient. This relationship may linger from the role of most early physicians in ancient civilizations such as the Egyptians, Mesopotamians, Aztecs, and Mayans, as shamans or priests of the healing gods. In these cultures, the sick looked to religious figures to heal through interactions with the gods. With the rise of Christianity in the Middle Ages, disease was viewed as a test or trial from God. Priests acted as healers and moral guides. Medicine and religion were closely intertwined. Much of this connection remains today. While the paternalistic model implies that the physician is always in the right and that the patient has much to learn from him, the idea of a priestly model introduces further stereotypes. If the physician is viewed as a priest or religious entity, it is implied that the patient has sinned and requires forgiveness or exoneration for the sins by someone pure and powerful – the physician. The patient is automatically placed in a powerless, humiliating, fearful position as the physician is looked to for affirmation the affliction can be healed and cleansed.

In chapter nine, “The Heart of the Matter,” Nuland describes a heart transplant operation he has the opportunity to watch. To a general surgeon who spends the vast majority of his time within the pink abdominal cavity, this proves a novel experience. He notes that the seriousness and incredible distance the cardiac surgeons place between themselves and the patient do not seem to arise from a protection of themselves and the patient but rather from their arrogance and knowledge that they are good at what they do and their expectation of success. (This is, of course, merely Nuland’s interpretation of the situation.) He interviews one of the patient’s physicians – although not one of his cardiac surgeons. The doctor says, “I think there is something different about cardiac surgeons, and particularly about cardiac transplant surgeons. There is something about the mentality of a cardiac surgeon – he does play God, and I think he does feel that at some level he can fix everything. The downside of that, of course, is that if things don’t turn out well, it’s someone else’s fault – the cardiac surgeon is not to blame” [Nuland 243]. In this case not only are the physicians placed in power as a priest or moral superior, but as God. They make life and death decisions, believing they can fix anything. This mentality strips even more power and independence from the patient. This could be interpreted as the physician-as-God model.

The technician model, a third relationship, is heavily criticized because of the subjective nature of medicine and health. This model defines the physician as a technician of the human body, an engineer or plumber of sorts, who offers expertise in fixing and maintaining it. The patient’s body is a machine or car that is in need of repair or a tune-up. The physician provides this service. The integrity of the physician is deemphasized because he is merely the mechanic. He does not wield moral superiority over the patient. This model is not sought after and may not even be attainable because it strips the values from health and medical care. While not the most sought after relationship, a technician model may be appropriate in the case of some specialized surgeons who focus on one minute aspect of anatomy. However, this would be undesirable in the case of a primary care physician. The technician model reduces the patient to a machine in need of repair. There is no bond, no intimacy formed between patient and physician. It is imperative for a primary care physician to connect with the patient and create an environment of open communication because the medical problems witnessed here are not seen open on an operating table.

One scenario from *The Wisdom of the Body* stands out as an example of the technician model. Nuland is able to observe a heart transplant, a procedure he has never witnessed before. He notes that the transplant team uses words like “the harvest” and “the graft” to describe moving the heart from the donor and replacing it in the recipient. They are performing this “without a hint of ceremony” [Nuland 240] and Nuland can sense “the rapport of teamwork but no warmth” [Nuland 240]. There is no connection with the patient or even a sense from the surgeons how incredible the procedure they are performing is. The language used distances the surgeons from the patient and seems to mask the fact that they are removing a heart and placing it inside another human being. They, like mechanics, are merely installing a new engine.

The contractual model is a fourth relationship that can occur in medicine. Physicians and patients are bound to each other by contracts through health care providers and hospitals. This relationship is viewed as an exchange of goods (the physician’s services) to the consumer (the patient). This model is considered a realistic alternative to the ideal partnership model because mutual trust cannot be assumed in medicine. Physician and patient are bound by the use of informed consent. This contract can take oral or written form. The physician uses the PARQ acronym as a model for informed consent. This describes the (P) procedures needed or recommended, identifies any (A) alternatives, indicates the (R) risks of the procedure, the alternatives, and of no treatment, and asks for (Q) questions from the patient. By being contractually bound to each other, respect for values is ensured and responsibility is maintained for both parties. A strength of this model is that it not only protects the patient’s values, but also places importance on the physician’s integrity. The physician maintains the right to refuse entering a contract with any patient he feels is in conflict with his values or beliefs. The contractual model poses some problems within health care because medicine is not comparable to any other business. Sick patients do not view complete compassionate health care as the same as other goods they can purchase. Focusing only on the contractual agreement between physician and patient limits growth of companionship, trust, and compassion. The intimacy between physician and patient is lost. The business nature of this model does not leave space for an emotional connection to develop.

Another way to describe the complex interactions between the physician and patient is the military or militant model. This model is addressed by Nuland but not in Childress and Siegler’s article. The doctor is an ally against some outside force rather than a healer. The patient’s body does the majority of the work – which is the case regardless of the model – and the physician is merely in alliance with medicinal treatment. The physician and patient plan attacks and fight against the illness. A version of this model was recognized even in Ancient Greece. Hippocrates wrote: “The physician is the servant of the art [of medicine], and the patient must combat the disease along with the physician” [Hippocrates, Of the Epidemics].

This model makes sense in oncology waging war against cancer. HIV and other viruses could fit this model as well because the immune system never defeats the virus but must continuously battle against it. Injuries or most anatomical problems do not warrant this form of relationship. At one point in *The Wisdom of the Body,* Nuland uses a war metaphor and his language becomes more militant when describing the physician-patient relationship. He begins using phrases like “command posts” in the body receiving “orders to action,” “depletion of resources,” “persevere and conquer,” “invasion by outsiders,” and “hostile environment.” He writes that “Sometimes the forces falter in their attempts to rally when fighting off incipient danger” [Nuland 271]. An outside force, an enemy, has infiltrated the body’s defenses and now the physician must assist the body in fighting and conquering these forces. There may be a sense of intimacy formed between physician and patient but the physician is more of an ally or war official than a colleague or partner.

Nuland mentions that “the purpose of treatment is only to restore nature’s balance against disease. There is no recovery unless it comes from the force and fiber of one’s own tissues” [Nuland 278]. Dr. Adams is conscious of this as well; “The job of surgery is to create damage in order to treat the disease. Our necessary partner is the healing process of the human body which is so multifactorial in nature that it is awesome in its complexity.” The wording “to create damage” falls into the militant model. He cuts, damages the body, removes pieces to attack and eliminate the disease. The doctor does not actually physically heal. He may provide the means to heal, may remove the diseased organ or sew closed a wound but the body does the fighting, the healing, the putting-back-together. “Surgeons are no more than agents of the process by which an offending force may be sufficiently held at bay to aid nature in its inherent tendency to restore health” [Nuland 279]. As Dr. Bliss has matured and grown more comfortable in his career, he realizes “…increasingly, that I am merely a vehicle to facilitate the process of healing.” Dr. Bliss claims that he is a vehicle; Nuland claims that he is nature’s cornerman. Becoming nature’s cornerman or the body’s warrior shifts responsibility away from the physician. Obviously not everything is in the physician’s control – some patients die from unforeseen complications or unfixable problems. These statements serve as humble recognition that the surgeon is merely a tool and not the wielder of incredible power as the body is.

The sixth model is partnership or collegiality where physician and patient work together as partners or colleagues. Patient and physician strive to discover what is in the best interest of the patient; it is not implied that the physician already knows. Each meeting provides satisfying results for both parties. The patient’s experiences provide a background for what is of importance to them and the physician bases the relationship off of this information. Neither has power over the other and they need each other for the relationship to function. It is most often seen in care of chronic diseases or between primary care doctors and their patients who they come to know well over the course of many years.

This model is described by Nuland as the physician’s reaction to the patient during their first meeting in an examination room. The patient sees an “authoritative white-coated, stethoscope-emblazened figure” who physically takes up the whole examination room. Nuland even describes the patient as having trouble meeting the direct gaze of their physician. This is a reaction based on the culturally determined and reinforced paternalistic/priestly model. Nuland proposes that a physician who is any good at what he does will be conscious of this effect and actively counteract it by aiming for a partnership relationship:

For the doctor, the reverse is true, if he is any good at what he does. It is his patient who fills the room, seeming to occupy all of it with the perceived magnitude of her needs and the challenge of her worry…The air is heavy with the awareness that decisions are to be made before that place is quitted, decisions that will affect every succeeding meeting between these two people and might vastly change the future for one of them. The doctor, sensible to the effect his professionalized symbolism is having on the new patient, does what he can to appear unthreatening. He tries to make his presence figuratively smaller, in order not to influence unduly the substance of what is transpiring between himself and the woman who has placed her care and perhaps her life in his hands [Nuland 53].

Nuland describes the patient’s needs and worry filling the room showing a focus on shared values. The physician uses what each individual patient needs from him to foster a relationship. Decisions will be made but not solely by the physician. The physician makes his presence smaller to comfort the patient. In the paternalistic model the physician’s presence remains large and overpowering to the patient but Nuland emphasizes the importance of minimizing that powerful entity in order to avoid influencing any decisions or the relationship.

Another example of the collegiality model is illustrated by the relationship between my youngest sister and her pediatrician. In August of 2010 Kendall fell ill with what appeared to be the flu but it did not pass for two months. She started dropping weight and her doctor drew blood for tests weekly. They discovered that her liver enzyme counts were astronomically high but did not know the underlying cause. She had hepatitis – inflammation of the liver – but whether this was an autoimmune, virus, or antibiotic induced problem, they could not determine. Kendall was jaundiced and swollen in her abdomen. She underwent a liver biopsy that ruled out autoimmune hepatitis and narrowed it down to antibiotic induced hepatitis. This is good news because her liver will slowly self-heal over time. Throughout this period of tests, stress, uncertainty, and fear, her pediatrician exhibited a partnership with my sister. He called our house to talk to her and offered to visit, asking how she was holding up emotionally and mentally. He understands that Kendall is an aspiring professional golfer and how devastating this disease is to her goals and her passions. He, alongside her liver specialists, prepared information for specialists in Ohio (where she will be playing golf next year in college) to inform them of her situation and set up a support system as needed. He was quick to say that there is nothing she can do at this point physically to hurt her liver so she can golf whenever she feels up to it. Kendall’s values and experiences are important to both her and her physician, and they worked together throughout the process of healing. The point of their relationship was to determine what the best course of action for Kendall was keeping her values in mind. As a side note, Kendall’s liver enzymes have shown a downward trend and she is back to her old self. She has won two large tournaments in the last three weeks and is currently ranked 23rd in the nation for female juniors. Because of the partnership and focus on the patient’s values, the collegiality model is often viewed as the optimal moral physician-patient relationship and something physicians should strive to create with their patients.

The final model explored involves a deeper, more intimate relationship between physician and patient, that of friendship or companionship. In the friendship model the patient looks to the physician with trust and confidence that the physician will meet the patient’s needs. The physician seeks to offer medical help and benevolence to the patient. Companionship between two people implies mutual respect and love, as well as a deep interest in the other’s well-being, values, and needs. The model of friendship draws from the caring shown in paternalism while maintaining respect and sharing power equally. Limitations of this model arise because of the nature of medicine. Patients compensate their physicians financially for their work and only the patient’s needs are addressed by the relationship. The friendship model is similar to the collegiality model but offers a more intimate connection. It is commonly used in hospice settings. This intimate relationship is sought and accepted by some patients, but others may prefer the less intense collegiality model.

Nuland describes a sense of ownership over the body and the outcome of his surgeries as well as ownership of some of the patient’s sorrow and pain. He is willing to take on his patient’s pain. A bridging of body and person is illustrated as Nuland shares his tendency to create a sense of companionship. “There are reasons a doctor speaks gently at moments like this – when he is gentle with his patient, he is gentle with himself. It is strangely reassuring to look directly into another’s eyes and share the burden. It helps, sometimes, to hold that person’s hand, as if more than mere words are passing between two people who are, after all, companions of a sort, on a difficult journey together” [Nuland 58]. A companion is deeply invested in his friend. By sharing the emotions and burden the patient experiences, the physician becomes closer to the patient. Dr. Miller echoes this sentiment. “We need to offer to carry their load.” From Nuland’s experience when things do not go as planned, “…it is with a mixture of sorrow for the patient and sorrow for ourselves – and frustration, too – that we have not been able to do better. No matter the number of times I have to tell a patient or a family that things are not as we hoped, I always feel that I have somehow let them down” [Nuland 58]. He is emotionally invested; he feels sadness for the family, sadness for himself, and frustration at the outcome he cannot control. Nuland carries these feelings as baggage, building his relationships off the foundation of this emotional investment.

An example of this intimate connection is Dr. Bliss’ anecdote about a patient of his that left a lasting impression.

She was a beautiful 2 year old with a bad cancer that kept coming back. Each time, the child underwent more taxing operations and chemotherapy, only to have the interval of wellness grow shorter. The family came back to me asking my advice, not as a surgeon, but as a friend and physician. They wanted to know if it was okay to stop trying to treat the cancer and to let her go as peacefully as possible. After our conversation they were able to do so and they thanked me for helping them make peace with the decision.

The family comes to Dr. Bliss in a time of great suffering, hurt, and confusion. They seek counsel – not medical attention. As a friend, Dr. Bliss is able to ease their mind and effectively “carry their load” so that they feel comfortable with their decision about their family. Dr. Bliss responds not as a surgeon who would recommend continuing the fight and treatment, but as a fellow human being, a father, a companion. Dr. Bliss adds “In my view, because patients offer us the most intimate look into their lives, we owe them the sense of our emotional commitment to them. This is not much different than the rest of life – we can hold something of ourselves in reserve in all of our relationships for fear of revealing too much or of being hurt or rejected. On the other hand, one can take risk[s] and perhaps have more profound experiences and, in turn, give more of ourselves to others.” Whether a physician is actively trying or not, his patients will remain with him even after the patient is gone or healed. A good physician will carry part of the burden without even being conscious of it. It is interesting that Dr. Bliss uses the words “we owe them” from a physician’s point of view. The patients come in and reveal their secrets, offering an intimate, detailed history of their life. Because of the level of intimacy they share with the physician, it is the doctor’s responsibility to commit himself emotionally and to give of himself to the patient. This describes a friendship, a meaningful connection between patient and doctor.

In reality, most relationships between patients and their physicians are probably a mixture of the models described above. All have limitations as well as strengths, but it is impossible to pinpoint one model as the optimum of the physician-patient relationship. Relationships like the contractual and technician models are generally undesirable because there is a lack of intimacy and little space for a connection to flourish. The paternal and priestly models are historically important but have strong limitations from the patient’s perspective. The collegiality and friendship models are the most morally desirable because the patient’s values and needs are validated and the physician is viewed as a partner or friend.

Because the art of medicine is subjective and each patient arrives with different needs, experiences, and expectations, no one model fits for all interactions. Dr. Adams explains “…the optimum physician-patient relationship isn’t a static thing. The needs of a patient morph as the disease progresses or gets adequately treated. It is a journey. The key is to figure out what the patient needs. This is done by listening and anticipating.” Not only will a physician’s relationship with one patient differ from that with another, it may evolve with a single patient over time. During progression along the road of disease, testing, diagnosis, treatment, and recovery, needs change. Therefore, the model used when the physician first meets the patient may not be the model used during treatment, or recovery, for example. In Dr. Adams’ opinion, “In the end, the best relationships are with those patients that understand that they have a responsibility in their own care, and we both do our best to further that goal. We may not reach it, but working together, and each taking our share of the responsibility, we can forge a lifelong friendship.”

## The Evolving Role

As Dr. Adams mentions, the relationship forged between a physician and his patient is a journey, changing over time and with the progress of the patient’s health. As individual relationships evolve, so has the idea of the physician-patient relationship with changes throughout medical history. In ancient civilizations medical healing was tied closely to religious beliefs and most doctors sought after were shamans, religious men, or folk healers. With the rise of Christianity during the Middle Ages, priests cast out disease and absolved the sins of patients. Without technology to explain bacteria and viruses, disease was thought to be caused by bad air carried across countries by the wind. In many cultures astrology was used to predict and explain epidemics. Many of the learned physicians were not only experts in medical theory – study of anatomy did not gain much importance until the Renaissance – but also in astrology, alchemy, and philosophy. As basic understanding of science and the human body progressed, medicine began shifting from religious and mystical to empirical.

Nuland asserts that three specific instruments developed in the 19th century “did much to redirect the path of medical progress away from clinical artistry and toward the goal of scientific objectivity” [Nuland 99]. The three medical instruments he mentions are the stethoscope, the microscope, and x-rays. Each has been responsible for major leaps in science and medicine but also create distance between the physician and patient.

With the invention of the stethoscope, the physician is able to clearly listen for fluid in the lungs and to the heart beat of the patient allowing for examination of heart rate and diagnosis of heart murmurs among other conditions. The stethoscope removes the physician’s ear from the patient’s back or chest and his hand from the carotid artery. The warmth and intimacy of the human to human contact is replaced with a cold, metal, sterile tool that allows the doctor to not only have no physical contact with the patient, but to stand a certain distance away from the patient while listening to breathing and the heart.

The microscope provides physicians and lab technicians the ability to physically see microbes and viruses completely transforming what is understood about disease. The x-ray offers a similar contribution of insight to medicine. However, both of these inventions reduce the patient to a sample on a glass slide or to black and white images on a film. They also create new positions like x-ray and laboratory technicians who take the x-ray images or examine the microscope slides, further removing the physician from his patient. Diagnosis and treatment are drastically improved as a result of these tools, but more distance is created between the patient and physician and the mentality of treating the disease rather than healing the person becomes an issue. Physicians place trust in the instruments and test results, listening less to the patient’s experience and voice. This disengagement strips power and trust from the patient.

Dr. Miller brings up that today a problem compromising the relationship is the presence of the computer in the examination room. This adds convenience to the physician or assistant that first meets with the patient: all of the medical records are present, organized, readable, and easily adjusted. However, a laptop on a cart between patient and physician or even on the physician’s lap creates much more distance than a file or paper. Technology is impersonal and can be intimidating. Dr. Miller suggests, “Put it to the side and face the patient and listen.” There is no doubt that technology has advanced science and medical care, but Dr. Miller reminds physicians to be aware of its effect and to go back to the basics of human interaction.

A friend of mine broke his nose a few months ago and provided my first experience with the emergency room. There are many questions, much waiting, and a large medical bill resulting in the answer that nothing can be done at the moment. Weeks later we visit an Otolaryngologist (ENT) to reset his nose. Being pre-medical students, we ask him questions about medicine. He mentions that when he is in the emergency room and needs a consult from a radiologist, he simply calls a number and is connected with a radiologist not even employed by the same hospital. The last time he called, the answering radiologist was working in New Zealand. The radiologist can be located anywhere in the world. He answers calls and looks at the x-rays and images wherever he is. This doctor never meets his patient, never sees his patient, and does not even have to be on the same continent as his patient. As technology’s role in medicine changes and increases, physicians need to be even more aware of how they are interacting with their patients. The physician-patient relationship is one of the most intimate possible between two humans. It requires work, attention, and the ability to adapt to new situations and the changing needs of the patient.

## Emotional Space

One theme of the physician-patient relationship Nuland addresses is anonymity and distance. This is curious because surgeons and specialists are often criticized of treating only the physical disease and not healing the patient as a whole person, mentally, emotionally, and spiritually. This intimacy of human connection is crucial to the subjective art of medicine. But Nuland argues that there are times in which anonymity benefits both the patient and the surgeon. This issue is brought up during his discussion of patient Marge Hansen whom he saved from a burst aneurysm of a vessel leading to her spleen.

In Marge’s case, Nuland claims he protects both himself and his patient by not knowing her name or those of her terrified husband and five children. In fact, Nuland does not ask his patient’s name until after she is stable, he has placed drainage tubes, and has carefully sewn up the incision. He claims he does not want to know it until this point. This way he will not focus on the stress and pressure they are placing on him. Instead he turns his full attention on an artery and a spleen, not a human life. “Her anonymity had cloaked her from me, kept her a creature of organs and tissues, and protected both with an emotional distancing that made somewhat easier the perilous journey we had just taken together. Not knowing who she was allowed my mind to remain free of intrusive personal thoughts” [Nuland 22]. Being unaware of the family waiting in the lobby and unaware of Marge’s personal information reduces the patient on the table to the artery feeding into the spleen. Nuland explains further: “Had I not remained ignorant of that distressed family, I might have been less able to maintain my surgical dispassion about the clinical catastrophe occurring in my patient’s belly and have thought too much about the personal catastrophe occurring in her life, and theirs” [Nuland 22]. It is interesting that he says he is protecting both of them. Perhaps this means that by protecting himself from her personal information and becoming too emotionally invested he is protecting her by focusing only on the surgical procedure in front of him. By distancing himself he is protecting Marge from a potentially fatal mistake on his part, attributable to being too close.

Nuland’s sentiments are understandable; Marge’s situation is one of trauma and life-or-death. A positive outcome is not anticipated or expected. However, the majority of patients have worried families adding pressure to the situation. And the surgeon usually meets the patient and their family during consultations before scheduled surgeries. It seems that Marge’s case is unique because of the severity of her trauma. Nuland does not know her name because she is not his patient until he walks into the trauma room and picks up a scalpel. I have observed multiple level one trauma patients including horrific automobile accidents and burn victims. Each patient’s name, age, and gender are usually known by all in the room before the patient even arrives at the hospital. As soon as they arrive, if they are still conscious, the doctors and nurses communicate with the patient, asking questions and comforting him. The family is notified as soon as contact information can be gathered. While anonymity and distance may aid Nuland in this situation, it is not something routinely experienced by physicians or surgeons.

Another such situation where anonymity may prove beneficial is when working with premature infants. Some of the premature babies in the NICU are not yet named, but rather called “Baby Girl Jones” or “Baby Boy Smith,” for example. Whether this is something recommended by physicians or something the parents decide to do on their own, I do not know. However, my interpretation is that during that period of uncertainty and unknown outcome, not naming the infant provides some distance between parent and child. I am not a parent, nor have I ever experienced pregnancy, so I can merely speculate, but it seems unlikely that a mother would be able to distance herself from a person she nurtured and carried for months by simply not naming it. Perhaps it helps ease some of the pain.

In the majority of the surgeries I have witnessed, the patient is fully draped with only a small area of skin exposed where the incision will be located. There is a vertical drape clipped up to block the patient’s face from the surgeon’s view – obviously the anesthesiologist needs access. Part of this is done to maintain a sterile field so that only a reasonable portion of skin is disinfected. However, the draping may serve to provide some sense of anonymity for the surgeon. It may be a different experience to operate with the patient’s face in plain view. On the other hand, anesthesiologists work at the patient’s head with the face directly in view. Specialists like maxillofacial surgeons and otolaryngologists operate directly on the face and head. Nuland writes about this issue as I speculate: “There are reasons both medical and emotional that surgeons drape an incisional site so closely that nothing else of the human can be seen, as well as hide the patient’s sleeping face behind a cloth screen. Those reasons go far beyond the prevention of infection, and the most critical of them is to maintain detachment from the intimidating reality of what they are doing to a man or woman made very much like themselves” [Nuland 22]. It seems ironic that after working so hard to connect and understand each patient individually Nuland feels the most critical thing is to maintain distance and ensure detachment at this point.

Dr. Adams does not agree with this view: “Nonsense. He is using surgical draping as a trite metaphor. Many of my patients are awake during procedures, and I talk with them. The distance Dr. Nuland creates may serve him for his need to control his own emotions. It may not be necessary for all physicians.” Dr. Adams works as both a general surgeon and a trauma surgeon. Many of the patients admitted to the trauma room are awake and talking with him while he stabilizes them. One patient I witnessed him operating on was a patient who was allergic to the regular anesthetic so he was given an epidural and kept awake during his surgery. A drape separated the patient from focusing on what was happening to his body, but he spoke to us and could hear what was going on. In this case it is nearly impossible for the surgeon to block out the humanness of the patient and focus only on a portion of anatomy; there is no distance.

Dr. Adams admits, “It is necessary to set expectations and limits, and to relate honestly…The distance I tried to create during Medical School between me and the cadaver was protection for me while I discovered that I did indeed have the ability to negotiate the humanness of the process. To maintain dignity and to relate to your patients does take skills, but they are of respect and tact, not necessarily distance.” When Dr. Adams first navigated the humanness of medicine, he created distance between the cadaver and himself to emotionally and mentally guard himself. Throughout the process he discovered that he could handle the emotions and so the emotional wall was able to come down. Dr. Adams protects the patients and himself with respect and honesty, allowing himself to emotionally connect.

Dr. Miller agrees with Nuland that “There has to be a certain distance in order to practice medicine objectively.” Medicine is incredibly intimate. Deep connections and relationships are formed and emotions or feelings can, at times, distract from medical care. Even if the physician makes an effort to distance or shut out emotions, the patient will still have an effect on the physician’s life. Dr. Bliss asserts, “Whether *good* physicians wish it to happen or not, they carry part of each patient with them. By this I mean that caring doctors should connect with their patients.” Learning to manage and confront these emotions that arise will prevent this emotional distance from interfering with the relationship between physician and patient.

Dr. Grube suggests compartmentalization as a method of emotional distancing:

The best physicians that I have learned from and known do a great job compartmentalizing. That means keeping things in their correct place. In the face of hemorrhage, not getting excited. In the face of too much work, knowing how to prioritize. In the face of personal issues and anguish, not bringing it to work. In the face of confusion, knowing what you know and having the other attend to that which you do not know. In the face of fear, remembering that the patient is the one who is ill.

Despite Dr. Adams disagreement with Nuland’s views on distance, he responds in a very similar way to Dr. Grube when asked what the best method to deal with emotions is; “Compartmentalization. I store the emotions up and let them out later on. I cry at silly movies and old songs. I have watched *Casa Blanca* more times than I can count. I also write periodically and I talk with friends. Some emotions are too big and several options may be necessary. Some just leave scars that never heal.” Compartmentalization is a common method for keeping emotions appropriate and not allowing personal feelings to interfere with the physician’s job. There is a balance crucial to practicing the art of medicine and being an effective compassionate doctor. Compartmentalization creates distance, but not to the extreme that Nuland describes with Marge. The physician must still connect with the patient but to protect against uncontrolled emotions interfering healing, managing and segregating feelings that arise while forming an open relationship with patients will maintain professionalism. Dr. Grube expands upon this, “Be present, be connected, but do not allow the patient’s problems to disrupt one’s work or one’s life. It is a very difficult skill/talent/personality trait. But necessary in order to be a healthy healer.”

As Dr. Adams acknowledges, some of the emotions he bottles up at work expose themselves later as he is watching or doing something completely unrelated. Even if the emotions are not appropriate to express at work or are merely repressed, it is important to note that they will not hide away in their compartment forever. If a physician is truly invested in his connection with his patients, these emotions will eventually arise so they need to be confronted and dealt with.

To ensure his emotions do not interfere with his medical judgment but also are not repressed and ignored, Dr. Bliss expresses his emotions “…within the limits of appropriateness. Sadness, joy, uncertainty, compassion are all reasonable. It would not be appropriate to express hatred or inappropriate anger, sexual feelings, or judgment regarding their choices.” Dr. Bliss maintains that it is appropriate, and necessary as a good physician, to experience emotions. The physician should not be afraid to express feelings within reason.

A good physician cares for and connects with patients. When there is a partnership or friendship relationship, the physician feels attachment to the patient and strong emotions can arise during critical situations. In order to make unbiased decisions not strongly influenced by emotions, the physician must create some professional emotional distance. The best method for this may vary from physician to physician, and as Dr. Adams pointed out with his tale of the cadaver, it may be necessary for the physician to place more distance between patients and himself until he has learned that he can handle the intimacy and emotional relationship. Compartmentalization is a method of emotional distancing that does not separate the physician from the patient but rather gives the physician a tool to keep emotions in their appropriate places. Compartmentalization also allows emotions to be expressed within reason while interacting with patients, which leads to a real human relationship.

## Physical Space

The impact of technology and medical inventions on the physician –patient relationship has been briefly explored. Now we shift to the influence of the physical environment in which this relationship develops including examination and operating rooms. The physical surroundings can create an interesting dynamic between two people. Implications of power and authority are presented; sterility can breed fear and discomfort. Guidelines to examination rooms and operating rooms are mandated at the hospital, state, and federal level.

Because he is a surgeon, Nuland spends the most time describing a surgical exam room.

A surgical examining room is a small enclosed space. Empty of its sparse clinical furniture, it contains not much more than cabinets, a wide shelf, and a sink. The focal eminence of the stark little chamber is the narrow padded table on which all of the significant physical and emotional transactions take place. Suspended over the table like an unblinking cold-eyed Cyclops is the movable surgical lamp, ready with the flick of a plastic switch to throw the intrusive scrutiny of its narrow circle of all-seeing light into places usually hidden by modest propriety [Nuland 52].

Words like small, sparse, stark, cold, and intrusive emphasize the negativity that can be expressed in this environment. The metaphor of the all-seeing surgical light plays off the intimacy of the physician-patient relationship; nothing is hidden from the doctor. From the patient’s perspective, the dangerous-looking sterile metal instruments hint at invasive procedures yet to come. Perhaps the worst, in my opinion, is the thin paper laying on top of the exam table that sticks to the nervous patient and crinkles loudly with every shift of the body.

Dr. Grube has much to say about this: an exam room “…should not be ‘cold’ but it should be neutral. It should not seem sterile but it needs to be clean. It must be universal but it should not offend. It, at once, must be appropriate for the child, the elderly, the mentally ill, the religious, the agnostic, the woman, the man. And most of all, it should not distract.” This is where the challenge lies. For practical reasons, the exam room must be sterile and easy to clean. The easily replaced paper is necessary on the table so that it does not have to be disinfected between every patient. However, because diseases do not discriminate, patients with vastly differing beliefs, experiences, and needs will all use this same exam room. Therefore, it cannot be tailored to one specific sex, age, belief system, etc. Dr. Grube believes that we have overcompensated for the coldness of the exam room, and it can be just as disruptive if not more. “I think Nuland spoke of the past, but current excesses are just as bad as the old gray metallic room. While the ‘new’ exam room may not be cold and sterile, sometimes it is more like a Hilton Hotel. We have not improved the exam room with superficial excesses (fountains, different paint on every wall, flat-screen TV’s, etc.) in my opinion.” The over-stimulating decorations distract both the patient and the physician from the important exchange going on. The room should be simple and unobtrusive in order to facilitate open communication and connection.

In agreement with Nuland’s remarks, Dr. Bliss adds, “The reasons for the room designs are largely practical, but that does not mean they may not be modified. This is why I have toys, pictures, colors, etc…to make it feel less threatening. I would love to have comfy furniture, but OSHA essentially precludes that.” Dr. Bliss is a pediatric surgeon. His patients are all under the age of eighteen and the majority that I have witnessed are infants or toddlers. Having toys in the exam room is acceptable in this case because it is not interfering. If the young child is playing with a truck on the floor while his parents and the physician discuss the diagnosis or treatment options, it is actually helpful to occupy the child’s attention and make them feel safe. Unfortunately, there is only so much colors and toys can do to dispel the anxiety that accompanies a visit to a doctor’s office. Dr. Bliss remarks that “The remainder of the environment is about creating a mood of comfort and welcome. This comes from the attitude and communication styles of the office staff and physicians…” This is true of any environment in which the physician meets with his patient. The patient’s nervousness and concern can be reduced by a personable, confident, comfortable physician.

Dr. Adams explains his experiences,

My patients often come back to clinic post-operatively with wounds and drains, which make cleanliness an issue. A sofa would have to be routinely replaced...an initial consultation…might be held in a different site than the sterility of an exam room. Many physicians will examine a patient in an exam room, but move that patient to a more comfortable space for a discussion of options or to deliver bad news. This site is usually the physician’s office, which has other disadvantages, such as being a ‘powerful’ space for the doctor, and a site of ‘weakness’ for the patient. That may be good in terms of wanting your physician to be a ‘powerful ally’ in the fight against your disease, but it does not always allow questions to be forthcoming from the patient.

Dr. Adams emphasizes the practicality issues of the exam room. They need to accommodate minor procedures requiring cleanliness and an examination table. Another interesting concept brought up is that the physician’s office conveys power and authority over the patient even if the physician is attempting to make the patient more comfortable. If aiming for a collegiate or partnership model, this perceived power difference is counterintuitive. However, if the physician has a paternalistic relationship with his patient or, as Dr. Adams points out, the physician wants to come across as the patient’s powerful ally against disease, the physician’s office may be a good choice of environment. Nuland writes of the effect the physician has on his patient and how he must actively work against that influence. By making himself approachable and ‘smaller’ in the room, he can create an atmosphere of comfort and show the patient that they work together with the patient’s best interests in mind.

Different specialties or procedures warrant different atmospheres. This is demonstrated by the toys and pictures and large stuffed bears in Dr. Bliss’s pediatric surgical exam rooms and the window stickers and picture books in Dr. Miller’s pediatric clinic. It is also seen in the neutral, unobtrusive décor of Dr. Grube’s family medicine clinic which must adapt to a variety of ages, genders, and backgrounds. Much has been done in modern clinics and exam rooms to increase comfort and create a warm, welcoming environment. Whether this is helping or is actually an excess perhaps differs from patient to patient. However, no number of paint colors, TV’s, or pictures on the wall is going to change the fact that visiting a doctor can be a stressful time. It is the doctor’s responsibility to utilize whatever space he has at his disposal and utilize communication skills, humor when appropriate, and compassion to put his patients at ease. Bedside manner must overcome whatever environmental obstacles the room creates. To counteract any effects the physical environment may have, the physician must utilize a set of skills or personality traits that will put the patient at ease.

# KEY VIRTUES OF A HEALER

In order to facilitate an open and honest relationship between physician and patient, the physician must actively counteract any paternalism perceived by the patient and overcome physical and emotional obstacles. Skills developed during training or personality traits already instilled in the physician serve a large role in creating a physician-patient relationship. Some are learned and some may be ingrained, but all are crucial to practicing the art of medicine. Each of the four interviewees share the most important aspects that play a role in the physician-patient relationship.

Dr. Adams simply identifies curiosity and compulsion. Curiosity is also mentioned by Dr. Bliss: “Curiosity – the desire to learn and understand more even when you think you’ve learned all you need to.” A sense of curiosity is important in medicine because the physician is a life-long student. Medicine is ever evolving with more understood about the human body and its capabilities every day. Physicians must remain interested and up to date on the newest information and procedures. Curiosity also comes into play while taking a medical history for a patient. The physician must have a genuine interest in knowing the patient as a person in order to heal. The importance of compulsion is not so much the force aspect but rather being firm and clear in a medical decision. This goes along with the confidence and sense of leadership that Dr. Grube brings up, “A healer should have a strong ego, but it should not be known.” Whether delivering a good or bad prognosis, the physician must be confident and secure with the diagnosis and proposed treatment. The credibility of the physician may be hurt if there is no compulsion.

Communication skills are the foundation on which the physician-patient relationship is built upon. Failure to create an open trusting environment will result in an undesirable model between patient and physician. Dr. Grube says, “A healer should use language that is not only understandable, but that is not judgmental or paternalistic.” Dr. Miller agrees, “Be honest, which may be difficult if there is a bad diagnosis to give or an error has been committed. The patient will know sooner or later and soft-pedaling this will destroy the bond between physician and patient. One must try to talk openly with the patient in language they understand.” Both physicians highlight using understandable language. The level of detail and medical jargon acceptable during conversation will vary from patient to patient. It is the physician’s duty to determine the patient’s level of comprehension and adapt the language used to ensure understanding.

Dr. Grube includes more imperative traits: “A healer must have the patient’s needs foremost in her or his work. A sense of humor, when appropriately used, does wonders…A healer does not hurry. A healer is thorough. A healer is always kind and gentle.” Selflessness, humor, patience, and compassion are mentioned here. These skills facilitate the emotional connection between patient and physician. A sense of humor stands out because it may not seem appropriate in medicine. On the contrary, humor is shared between generations and cultures. It can serve as a comforting or bonding agent in appropriate situations.

In addition to curiosity, Dr. Bliss discusses three more key characteristics for physicians. The first is humility: “…the understanding that you are not as important as you, your friends, and your patients might believe you to be. No matter what we do, we will all make grievous errors and fail. Indeed, the only inevitability in human life is death. So, by definition, we must all fail.” Dr. Grube brought up the strong but unseen ego. Humility transforms a visible ego to that which is unknown by the physician. Being humble prevents the relationship from following a paternalistic or priestly model. It helps maintain the humanness of the physician-patient relationship. Similarly, Dr. Bliss asserts that physicians must have recognition of their own limitations: “…the ability to know when doing nothing is the best thing.” Humility will allow for the recognition of limitations. Finally, Dr. Bliss emphasizes commitment, “…the willingness to give more time, energy, or whatever else you have to offer to solve the soluble.” Due to the intimacy and high stakes of medicine, the physician must demonstrate a tremendous level of commitment to the patient and the art of medicine.

While all of the mentioned traits hold importance to practicing medicine and developing close connections between physician and patient, one key quality that physicians must either embody or acquire is crucial to forming the optimal friendship or collegiality relationship. The following trait is especially important to the physician-patient relationship because it creates a connection or bond deeper than the surface; it generates intimacy. The capacity to experience the characteristic is unique to humankind and binds the species together.

## Empathy and Beyond

Empathy – that elusive, difficult to define key virtue of physicians. The Merriam-Webster Collegiate Dictionary defines empathy as “the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another…*also*: the capacity for this.” The word is derived from the Greek *empatheia* meaning passion. Empathy is often confused with sympathy. Dr. Grube offers his distinction: “*Empathy* is a connection between two people who have experienced the same thing. *Sympathy* is trying to understand and connect to someone who has a problem that you know about but have not experienced.” Empathy is rooted in a shared experience, the extent of which will be discussed later. Based on these definitions it is possible to feel sympathetic toward anyone but empathy requires a deeper connection. As an example, Dr. Grube offers, “I am empathetic to a son who has lost his mother because my mother died this summer; I try to kindly connect to a woman who is depressed, but can only be sympathetic.”

The capacity to understand and be aware of another’s feelings would not be possible without the evolution of *Homo sapiens*. Along the journey from single cell to complexity the human brain develops vast potential. The ability to feel emotions, to rationalize, love, value, to distinguish right from wrong, are a few of the many unique capabilities of the brain. Nuland argues that empathy biologically evolved in order to perpetuate our species. This theory claims “…that the physical problems caused by the difficulty of childbirth make empathy and close communication valuable assets, for without them, very few deliveries would succeed.” [Nuland 207]. Childbirth is a logical place to start because if offspring are not successfully delivered the species cannot continue in the long run. This is an interesting theory but Nuland does not supply more details than above. If this is true, then humans are biologically inclined to support each other and form close relationships with open communication. It is not individually beneficial to help others of the same species that do not carry the same DNA. This could be considered an incredibly rare form of kinship. The kinship theory maintains that closely related individuals of the same species will help each other to ensure copies of their DNA continue within the population. Humans are the only species that will self-sacrifice to assist others who are not related. This ability to sacrifice and to experience love arises with the evolution of our brain. Perhaps most important to empathy is the development of imagination.

Nuland ties imagination directly to empathy. “Our gift of imagining allows us to understand what is within them, and thereby to perceive what is lacking that only we can provide.” [Nuland 141]. Dr. Bliss also mentions imagination: “Empathy, by definition, requires some understanding of the person’s situation or at least the ability to imagine oneself in their circumstance.” Because the patient’s thoughts are closed off to the physician, understanding and awareness of their emotions starts with external or verbal cues, but imagination helps to complete the picture. Imagination leads to better understanding.

Empathy plays an important role in many religions and cultures. Nuland notices that “It seems commonplace to observe that understanding another person requires the ability to imagine oneself in his place, to see the world through his eyes…With minor variations, one culture after another has weighed in with its own version of the doctrine that the basis of morality is to be found in imagining oneself to feel the emotions of another, to go a step beyond empathy” [Nuland 140]. A step beyond empathy – in medicine merely being aware of the patient’s emotions is not enough. To see the world through the patient’s eyes will proceed beyond empathy and allows the physician to *feel* what the patient feels. As Dr. Miller says, “We need to offer to carry their load.” A good physician will not only understand, be aware, but will take on the patient’s pain or joy as if it is his own. Only then will a deep connection be forged between patient and physician. He owes this to his patient. Nuland says that “‘the pains and pleasures’ of those who need us must become our own if we are to live up to the expectations they and we ourselves have of us” [Nuland 142]. Through this process the physician becomes invested in his patients, living up to their expectations. However, Nuland implies that this serves not only the patient but the physician as well. In addition to the expectations that the patient has for their physician – compassion, skill, intellect – the physician maintains a set of expectations for himself. This probably varies from physician to physician but I would venture to say some of my expectations for myself will include connecting with my patients, protecting my integrity, and performing procedures to the best of my abilities.

Nuland quotes poet Percy Bysshe Shelley’s *A Defense of Poetry*: “A man to be greatly good, must imagine intensely and comprehensively; he must put himself in the place of another and of many others; the pains and pleasures of his species must become his own” [Nuland 141]. Even as early as the 1800’s Shelley recognizes the importance of taking on the “pains and pleasures” of other people in order to understand them and to be *good*. This is the step beyond empathy – making the joy and sadness your own. But imagination is not enough for this. To “… imagine intensely and comprehensively the consciousness of another, we need some similarity of experience in which to base our imaginings. Without it, we lack a path of insight into the perceptions and interpretations of those whose world we seek to enter” [Nuland 142]. To move beyond empathy requires shared experience. How can a physician imagine a cancer patient’s feelings if he has never been diagnosed with cancer himself? The inherent problem with this is that the physician cannot possibly have experienced undergoing every surgery he performs or being diagnosed with each disease he diagnoses. Is it enough to experience being a patient in general at some point or does the shared experience need to mirror that of the patient’s?

Imagination allows empathy to develop despite minor differences in experiences. I can empathize with a family member of someone who is ill because I have been in that position and I have experienced the fear, sadness, and hope. It is not necessary for the patient to have the specific illness or injury that I have experience with; this is where imagination comes in – to bridge the differences. However, empathy is not necessarily easy if the circumstances are the same; there are still obstacles.

A problem can arise when acknowledging and accepting a situation as a shared experience. Personality differences and a person’s past will color how they view the situation. Two people in the exact same circumstances can react in entirely different ways, interpreting the experience differently. People are shaped by what they have been through and their own experiences shape how they perceive the experiences of others. There is danger in assuming that, due to similarity to what you have experienced, someone else will have the same reaction or feel the same emotions.

It can be even worse to rely on imagination to put yourself in the patient’s place when there is no common ground. Some differences may be too vast to overcome with imagination. Dr. Bliss acknowledges this problem: “…there are some differences that cannot be bridged. How could I, a male physician, REALLY understand pregnancy, miscarriage, etc…?” There will always be dissimilarities in age, gender, culture, and past experiences that seem vast. To assume clarity is ineffective. I can assume that I understand what my sister went through as a patient, but the truth is I am not the patient; I am not the one who was poked by needles multiple times a week, rushed to the emergency room, whose life was falling apart. While I may be able to grasp some of what she went through, a large part is unknowable to me as an outsider. I can imagine, but the closest I can get to truly understanding is by relating to her emotions. I cannot know what it is to lose a child because I am not a mother. I have never witnessed the grief of a mother losing a child first hand. To act like I do know what she is going through takes away from the pain of the mother. Does this mean that I cannot empathize with my sister or my patient? No, because I *can* relate to loss and loneliness and anxiety. Dr. Bliss recognizes this as well, “…I can understand happiness, fear, pain, loss, fulfillment, satisfaction, and other basic human feelings. I can understand the loneliness and lack of control of illness.” This connection may not be as deep as if we share the same experience but because of our human capacity of feeling emotions, a connection can still be forged. Emotion – the ability to feel – can act as the shared experience empathy is rooted in.

A wonderful portrayal of the development of empathy is seen in Randa Haines’ movie, *The Doctor*, staring William Hurt. Hurt plays Dr. Jack Mckee, a callous and arrogant surgeon. He has no respect for his patients, whether they are conscious or unconscious, and his inappropriate jokes earn him little respect from patients or colleagues. For example, when examining a frightened female patient for the first time, he walks into the room, immediately pulls off her gown to examine her breasts with no conversation, and proceeds to brush off her concerns about scarring with a joke about Playboy Magazine. At this point in the film, Jack fails to connect with his patients because he does not desire to. Below is a dialogue with the medical students he is teaching:

Jack: “There’s a danger in feeling too strongly about your patients. There’s a danger of becoming too involved. Surgery is about judgment and to judge you have to be detached.”

Student 1: “But isn’t it unnatural not to become involved with your patients?”

Jack: “There’s nothing natural about surgery. You’re cutting open someone’s body. One day you’ll have your hands around someone’s heart and its beating and you’ll think ‘uh oh I shouldn’t be here.’”

Student 2: “Well then all the more reason to care what the patient feels.”

Student 3: “The patient feels sick.”

Jack: “A surgeon’s job is to cut. You’ve got one shot. You go in, you fix it, you get out. Caring is all about time. When you’ve got 30 seconds before some guy bleeds out, I’d rather you cut straight and cared less.”

This shows Jack’s attitude toward connecting with his patients. Compassion and caring take up too much time. He shares Nuland’s idea of “the greater the danger, the greater the need for distance”. Jack is correct in saying that there must be some level of detachment in order to judge, but in the subjective art of medicine, each judgment is based on what is best for the patient and that will vary from patient to patient. As previously discussed, there are methods to ensure emotions do not interfere with the surgery, but complete detachment is neither healthy nor conducive to medicine.

It is not until Jack coughs up blood and becomes a patient himself that his transformation begins. His first experience as a patient is fitting because he is treated very similarly to how he treats his own patients. At his first appointment with the otolaryngologist, Dr. Evans, she walks in and immediately washes her hands saying “Sorry to keep you waiting. Busy day” in the same manner Jack does with his patients. Jack holds out his hand and says his name as an introduction but his doctor glances at him indifferently and says “Yes, I know.” Without talking him through anything she sprays his throat with anesthetic and looks in it with a periscope. She callously informs him that he has a laryngeal growth and walks out of the room. This treatment leaves Jack feeling confused and frightened. After forging a friendship with another cancer patient, June, his perspective on life and his relationships with his patients shifts.

One of the first noticeable changes in Jack occurs when he overhears an intern calling a patient “terminal patient.” He challenges the intern to tell him the patient’s name and then yells, “Either Mr. Winter is alive or dead. Now is he alive or should we advise the morgue? You call another patient terminal and that’s how you’ll describe your career.” This is a glimpse at growing compassion, deeper understanding of what it is like to be a patient. Later Jack confronts Dr. Evans:

Dr. Evans: “Look, Doctor, I know how you must be feeling.”

Jack: “That’s the problem; you don’t have the first idea what I’m feeling…I think you ought to brush up on your act, Dr. Evans, because today I’m sick. Tomorrow or the day after or thirty years from now you’ll be sick. Every doctor becomes a patient somewhere down the line and then it will hit you as hard as its hit me…If I had a patient like me when I was a doctor like you.”

This exchange is important because it demonstrates Jack’s newfound understanding of illness and humility because everyone will be sick at some point in their life. His last statement, “If I had a patient like me when I was a doctor like you,” shows that he acknowledges and recognizes his faults as a doctor. He is aware of how he made his patients feel. By the time Jack is well again a profound change has taken place in his treatment of patients and in his attitude. During a heart transplant surgery his holds his patient’s hand and speaks to him even though he is under anesthesia. He calls the heart ‘sweetheart’ to coax it into beating on its own. Obviously each patient carries different baggage and will react to situations differently, but he now has a much better understanding than he did before. His ability to empathize with his patients has grown exponentially. With the profound importance of his experience, Jack decides to pass on his wisdom to the medical residents:

Arthur, you have spent a lot of time learning the Latin names for diseases your patients might have. Now it’s time to learn something simpler about them. Patients have their own names: Sarah, Allen, Jack. They feel frightened, embarrassed, and vulnerable, and they feel sick. Most of all they want to get better. Because of that they put their lives in our hands. I could try to explain what that means until I am blue in the face but you know something? It wouldn’t mean a thing. It sure as hell never did to me. So for the next 72 hours you will each be allocated a particular disease. You will sleep in hospital beds, eat hospital food, and be given all the appropriate tests – Tests you will one day prescribe. You are no longer doctors. You are hospital patients, so good luck. See you on my rounds.

Jack has experienced this fear, embarrassment, and vulnerability. He know what it is like to rest his life in someone else’s hands. He also knows that merely explaining this is not enough for his students. They must also share this experience to truly understand and in order to connect with their patients. This brings up an interesting point: Can empathy be taught? Jack learned empathy by becoming a patient himself. When he returned to his role as doctor, he had understanding of what his patients felt. He was able to take on some of their emotions because he had also experienced them. Empathy is not something easily taught if it can be taught at all. Jack’s method may be somewhat effective but the reality of the situation is that they will still be healthy medical residents laying in hospital beds. Perhaps the tests that they will receive will make the situation more real, but there is a lack of fear faced by the patient.

Dr. Miller writes, “I’ve thought much of empathy…and have come to the conclusion that it can’t really be taught but we should be instilled with an awareness at all times.” Perhaps this is true and empathy cannot be taught to medical students. But to be aware of your patients, to be aware of your effect on your patients is a start. Acknowledging your own emotions and not being afraid to connect with and become invested in your patients will open the door for empathy to develop. Dr. Adams adds, “Empathy might be practiced, but it is one of those skills learned best in kindergarten.” The ‘best’ doctors – that is, the most compassionate, open, and caring – have empathy ingrained in their character already. An awareness, an understanding, but, even further, a willingness to carry some of their patient’s load will come naturally. Dr. Adams says that the best way to develop empathy is by “Recognizing your own prejudices and biases…and practicing listening skills.” These are good first steps. Dr. Bliss hints that empathy comes more readily with life experience.

Regardless whether empathy can be taught or not, it is a crucial aspect to developing trust and a close relationship with a physician’s patients. Each patient will react differently to similar situations based on their life experiences, age, gender, and culture. Connecting and forming understanding based on shared experiences will forge a tight bond between physician and patient, but this is not always possible. Drawing from their own experiences, physicians must find shared emotions to connect to patients with whom they have little in common. Thanks to the incredible evolution of the human brain, all humans have the ability to feel emotions. Being aware of and trying to understand the patient’s thoughts and feelings are important, but moving beyond that and taking on some of their burden is what will set the great apart from the good.

# CONCLUSION

## Just the Beginning

In a matter of months I will be transitioning from undergraduate biology student to medical student. Nuland has enlightened me to the art of medicine, the deviations from methodical thinking and objectivity. He clarifies, “…I am not a scientist. I am a clinician and my natural interest lies in people” [Nuland xx]. Scientists have nothing but time to research and readdress all of their steps and methods; physicians must act at times quickly and without all of the facts. Science is objective and relies on both reproducibility and an emotional distance while medicine, as an art, functions exactly the opposite.

Medicine, while based in science, involves the basics of humanity. The level of intimacy established between the physician and his patient sets medicine apart from other professions. There is a recognition of and connection to the human spirit and will to live of the patient. The physician owes the patients full commitment – emotional and intellectual. Sometimes this entails the physician being honest and admitting his limitations. The feelings that arise during times of joy or trial are natural and, when addressed appropriately, have an important role in medicinal relationships. Connecting with each patient and forging a relationship that fits the situation is crucial to forming trust and openness. Patience, honesty, humility, compassion, and humor will facilitate this bond. To achieve this I must be aware of my effect on the patient as well as the effect of the physical environment we occupy. Most importantly, I must care deeply, listen attentively, and ease their burden by taking on some of the pain myself.

I doubt that I will ever recover from my first experience viewing the beating heart. However, I do anticipate the wonder I feel to grow to encompass not only the anatomy of the human body but the vast capabilities of the human mind. The ability to imagine, feel emotions, and think rationally set humans apart from all other organic life. As the abdominal cavity or exposed brain – wherever my career in medicine may take me – become part of the everyday landscape, I must be mindful to appreciate the intricacies and remember that I am merely a tool facilitating healing. As long as my mind is open to discovery and my heart is open to healing, my awe and wonder will not fade. With incredible mentors and role models by my side, and valuable knowledge gained, I confidently step forward into my passion for medicine.

# BIBLIOGRAPHY

Childress, James F., and Mark Siegler. "Metaphors and Models of Doctor-Patient Relationships: Their Implications for Autonomy." *Theoretical Medicine* 17.30 (1984). Print.

*The Doctor*. Dir. Randa Haines. By Ed Rosenbaum. Screenplay by Robert Caswell. Perf. William Hurt. Touchstone Pictures, 1991. DVD.

"Empathy." Def. 2. *Merriam-Webster*. Encyclopedia Britannica Company. Web. 6 Apr. 2011.

Hippocrates. *On the Epidemics*. Trans. Francis Adams. Comp. Dr. John Braun. Print.

Miller, Dr. Philip, Dr. David Grube, Dr. David Bliss, and Dr. Gregg Adams. "Thesis Questions: The Wisdom of the Body." E-mail interview. 29 Jan. 2011.

Nuland, Sherwin B. *The Wisdom of the Body*. New York: Knopf, 1997. Print.

Porter, Roy. *The Greatest Benefit to Mankind: A Medical History of Humanity*. New York: W. W. Norton, 1997. Print.