This reader was prepared for you out of respect for the many constraints on your time. It contains articles from medical sources as well as writings and articles from other sources that may offer stimulating ideas and approaches applicable to the practice of medicine.

This is not a required reader. We hope you enjoy these articles and welcome any feedback you would care to give us.

Rachel Naomi Remen, MD and
The Faculty of *The Healer’s Art* 2014
The Healer's Art 2014 Reader

Table of Contents

Section One
From the Medical Literature

Poem by Vivekan Flint, for special use by The Institute of the Study of Health and Illness.


“Building Cathedrals,” Charles W. Callahan, DO Department of Defense, Tripler Medical Center.


SECTION TWO
Beyond The Medical Literature

UCSF Commencement Senior Address 2004, Teri Reynolds, MD

“Itzhak Perlman Improvises,” Jack Riemer.


“On Being Sick and Being Cared For,” Pat Justis, 2000, Olympia, WA, for special use by The Institute for the Study of Health and Illness.


THREE POEMS ON DEATH

“I Will Not Die An Unlived Life,” Poem by Dawna Markova

“After the Blue,” Poem by Bryce Kellams, MD, special use by the Institute for the Study of Health and Illness, 1997

“Shroud,” Poem by Ellen Mauck Lessy.


“Never Say Die: A List of Euphemisms for Death,” Unpublished. Collected over several years during the course.


SECTION THREE
Reading Lists

Suggested Reading List For *The Healer's Art*

“Detoxifying Death for Physicians,” a CME Curriculum by The Institute for the Study of Health and Illness at Commonweal.
Section One

From the Medical Literature
In the place of silence,
the one who thinks can hear the whisper of the heart.

In a place of trust,
the one who cures, heals.

In a place of acceptance,
a stone can explode into a butterfly.

– Vivekan Don Flint
Former Coordinator
ISHI at Commonweal
Op-Ed

Recapturing the soul of medicine

Physicians need to reclaim meaning in their working lives

In the past 10 years, the culture of medicine in California has changed radically. A study of 454 clinicians by the Sacramento Medical Society indicated that most had felt the effects of these changes deeply. Forty percent of those interviewed were clinically depressed. Most reported that they had thought about leaving the profession at least once in the past 12 months. Even more surprising, many would not want their children to go into medicine nor would they choose medicine as a career again.

This is not a California phenomenon. An unprecedented number of physicians nationwide, many of them young, are dropping out or seeking early retirement. Something unusual is happening among physicians, and those who care about physician well-being may need to broaden their concern from the care of impaired physicians to the care of all physicians. The future of our profession may be at stake.

There is reason to believe that our professionalism—our traditional professional stance, our attitudes, self-expectations, and indeed our training—has made us particularly vulnerable to the kind of stress we currently experience. Year after year in medical schools across the country, the first-year class enters filled with a sense of privilege and excitement about becoming doctors. Four years later, this excitement has given way to cynicism and numbness. By graduation, students seem to have learned what they have come to do but forgotten why they have come. In these times, we need to reconsider the principles by which we traditionally educate physicians. We will need to reexamine our educational goals, objectives, and strategies, to help students to stand up to the stresses of contemporary medical practice.

Finding meaning

Teaching the practice of medicine involves more than teaching its science. Medicine is in crisis, and in crisis we need to find something stronger than our science to hold on to, something more satisfying and sustaining to us as people in this work. Perhaps the answer lies in learning to cultivate the meaning of our work in the same way that we have traditionally pursued its knowledge base. We will need to learn to educate students to find meaning as skillfully as we educate them to pursue medical expertise.

In times of difficulty, meaning strengthens us not by changing our lives but by transforming our experience of our lives. The Italian psychiatrist Roberto Assagioli tells a parable about 3 stone cutters building a cathedral in the Middle Ages. You approach the first man and ask him what he’s doing. Angrily he turns to you and says, “Idiot! Use your eyes! They bring me a rock, I cut it into a block, they take it away, and they bring me another rock. I’ve been doing this since I was old enough to work, and I’m going to be doing it until the day that I die.” Quickly you withdraw, go to the next man, and ask him the same question. He smiles at you warmly and tells you, “I’m earning a living for my beloved family. With my wages I have built a home, there is food on our table, the children are growing strong.” Moving on, you approach the third man with this same question. Pausing, he gives you a look of deep fulfillment and tells you, “I am building a great cathedral, a holy lighthouse where people lost in the dark can find their strength and remember their way. And it will stand for a thousand years!” Each of these men is doing the identical task. Finding a personal meaning in your work opens even the most routine of tasks to the dimension of satisfaction and even joy. We may need to recognize meaning for the resource it is and find ways to pursue it and preserve it.

Restoring a sense of service

Meaning is the antecedent of commitment, and the original meaning of our work is service. Service is not a relationship between an expert and a problem; it is a human relationship, a work of the heart and the soul. Restoring a sense of service to the practice of medicine will lead us to reexamine the process by which we become physicians. Our current training furthers our expertise but not our wholeness. We are trained to value objectivity. We are
taught to view a genuine human connection as unprofessional. But we cannot serve or find meaning at a distance. Learning to serve requires education, not training. The root word of education, *educari*, means to lead forth the innate wholeness of each student. Medical training often wounds and diminishes us. Restoring a sense of service in our students will require fundamental educational reform.

As professionals, we may not be fully connected to our lives. Distance may become a daily habit. In reality, most physicians lead far more meaningful lives than they realize. Proust said, “The voyage of discovery lies not in seeking new vistas, but in having new eyes.” Finding meaning will require us to see the familiar in new ways.

Harry, an emergency physician, tells a story about a woman who was brought into his emergency department about to give birth. As soon as he examined her, he realized that unless her obstetrician was already on his way, he was going to get to deliver this baby himself. He had barely finished his examination when the head crowned, and with nurses on either side of him holding the mother’s legs on their shoulders, Harry delivered a little girl.

She was breathing spontaneously, and he felt a familiar sense of satisfaction at his own competence. He laid her along his left forearm with the back of her head in his left hand and began to suction her nose and mouth. Suddenly the infant opened her eyes and looked directly at him. In that instant, Harry realized that he was the first human being this baby girl had ever seen. Deeply moved, he felt his heart go out to her in welcome from all people everywhere, and for a moment he had tears in his eyes.

All this surprised him. Harry has delivered many babies and has always enjoyed the excitement of making rapid decisions and testing his skills. But he had never before let himself experience the meaning of what he was doing or let himself know what he was serving with his expertise. He feels changed by this moment. In that flash of recognition, he felt years of cynicism and fatigue fall away and remembered why he had chosen this work in the first place. As he put it, “It all suddenly seemed worth it.”

Meaning is a human need. It strengthens us, not by numbing our pain or distracting us from our problems, or even by comforting us. It heals us by reminding us of our integrity, who we are, and what we stand for. It offers us a place from which to meet the challenges of life. Part of our responsibility as professionals is to fight for our sense of meaning—against fatigue and numbness, overwork, and unreasonable expectations—to find ways to strengthen it in ourselves and in each other. We will need to rebuild the medical system, not just on sound science or sound economics, but on the integrity of our commitment. It has become vital to remember the essential nature of this work and renew our sense of calling to preserve the meaning of the work for ourselves and for those who will follow.

**Author:** Rachel Remen is clinical professor of family and community medicine at the UCSF School of Medicine, cofounder of the Commonweal Cancer Help Program (www.Commonweal.org), and author of *Kitchen Table Wisdom* (1996) and *My Grandfather’s Blessing* (2000), both published by Riverhead Books.

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**Reference**


Tell us your story of how you have found meaning as a physician. Send an eLetter in response to this article on our web site.
WHATEVER HAPPENED TO HEALERS?
Larry Dossey, MD

Medicine men aren't horses.
You don't breed them.
Lame Deer
Sioux medicine man

When I began to explore the world of alternative medicine nearly three decades ago, I discovered that I would have to expand my vocabulary considerably if I wanted to communicate with therapists. For example, they often used the word "healer," which was not part of the lexicon of medical school. In fact, I do not recall the term ever being used in my medical training. I had no feel for this expression and thought it quaint. If my medical colleagues and I had been called healers, we would not have known whether we were being praised or damned. We were training to become surgeons, internists, and pathologists, not healers.

I realized also that alternative therapists used "healing" differently than we did in medical school. We'd learned that healing was something that occurred automatically in wounds and incisions, whereas my alternative therapy friends believed healing had something to do with consciousness. They furthermore differentiated healing from curing, and they mysteriously maintained that "a healing" could occur even in the event of death.

Not much has changed since my encounter with these ideas. The concept of the healer remains virtually absent in medical training, and "healing" continues to be used in a narrow physiologic sense (note 1).

Whatever happened to healers? Have we simply run out of them? Surely not; all cultures seem to have produced them in abundance. They continue to abound—those passionate, idealistic young persons whose desire to be involved in healing is mysterious, powerful, and often inexplicable. They simply "know" they must become healers, and they will do almost anything to fulfill their calling. Harkening to a deep and primal drive, they often migrate to medical schools, the healing path that currently enjoys the most emphatic social sanction. Yet, this can be a painful, suffocating experience for many of them, because most medical schools have a completely different view of the nature of healers and healing than that of the natural-born healers themselves. Thus we encounter a paradox: Our medical schools, which of all our institutions should be most attuned to nourishing and developing the natural healing talents of gifted young people, seem adept at extinguishing them.

THE LETTER

I know this because the young healers tell me so. For years I've received missives from medical students all over the country, which I've come to refer to as The Letter. The Letter always bears the stamp of an individual student's pain and disillusionment, usually beginning in the first year of medical school. The students say that their impulse to be a healer is being snuffed out. Many want advice about medical schools that will nurture their healing instincts, which, they say, is "the reason I went to medical school." Some indicate that they will do anything to transfer to such a school, if only they can identify one. The following letter (written communication, June 1995) is an example from a student, whose name is withheld.

Dear Dr Dossey,

Soon I'll be a second-year medical student. After last semester I began to glimpse some of the terrible realities in medicine today, and I started to question my resolve to be a doctor. I even seriously considered leaving medical school. Lecture after lecture, I heard dry professors and doctors speak at breakneck speed about ways to crush the human person into the spiritless formula of science. At the same time, I saw some second-year friends turn sour and cold with stress, and I began to wonder whether I would end up the same way. I wasn't sure I could nourish my soul in such an environment.

I was chosen by my anatomy professor as a candidate for the summer Anatomy Teaching Fellowship. I struggled with this offer, but eventually listened to my whispering conscience. I refused the fellowship, because I needed my summer to refuel spiritually and to discover new things. This decision ... threw me into a tumultuous questioning as my soul rose to assert itself.

Recently I attended an ecumenical prayer retreat. I felt a deep peace pervade my soul. By the end of the retreat, I felt more at ease with my role as a medical student. I felt that I, as a person, was in the place where I belonged.

Since then, my eyes have been opened. I am slowly emerging from a period of darkness, brooding, uncertainty,
and fear which has hung over me for the past month or so. I realize that, rather than being changed for the worse, I can in fact heal in small ways and change things for the better. I know that the trick lies in humbly nurturing in oneself a perspective of simplicity and beauty.

Tough-minded observers who view medical school as a rite of passage have little patience with the sort of complaints contained in The Letter. They often say these comments originate from a few weak-willed, disgruntled complainers who shouldn't be in medical school in the first place. Medical school is difficult and ought to be; those who can't take it need not apply. Others, including many physicians who have endured the process of medical training, sense there is something terribly wrong with the way we train physicians. For example, San Diego psychiatrist Dennis Gersten reports (written communication, September 1992; note 2).

My medical school class had a 6% mortality rate, not to mention a high morbidity rate. One fellow, who had been free of melanoma for five years, quickly flared up with a recurrence during the first year of medical school and died. One woman killed herself. The week before graduation there was a series of freak accidents. One fellow was fishing in Alaska; his boat capsized and he drowned. Another guy was fishing in a foot-deep stream. He waded across the river, slipped on a stone, hit his head, became unconscious, and was washed downstream and drowned. During gross anatomy the morbidity rate was unbelievable. Students got sick, got in more auto wrecks...

INSTITUTIONALIZED ABUSE?

Medical students also encounter frequent psychological and physical abuse. The problem goes beyond overwork and sleep deprivation. It involves verbal, physical, psychological, sexual, and racial abuse; various forms of intimidation; and being placed at unnecessary medical risk. At one major medical school, 80% of seniors reported being abused during their training, and more than two thirds stated that at least one of the episodes was of "major importance and very upsetting." Sixteen percent of the students surveyed said the abuse would "always affect them." In another survey of third-year medical students, the perception of mistreatment (particularly verbal abuse and "unfair tactics") was pervasive. Three fourths of the students reported having become more cynical about academic life and the medical profession as a result of these episodes. Two thirds felt they were worse off than their peers in other professions. More than one third considered dropping out of medical school, and one fourth would have chosen a different profession had they known in advance about the extent of the mistreatment they would experience. Another study of medical student abuse indicates that the effects of mistreatment are not trivial but are associated with measurable psychopathological consequences.

These problems are not restricted to the United States. The enormous strain and dissatisfaction experienced by British medical students have recently been emphasized by a BBC television series. Because of the stresses, an estimated 18% to 25% of newly qualified British physicians never enter medical practice, or leave medicine shortly after qualifying.

How can we expect medical students to emerge as compassionate physicians when they are treated so uncompassionately in their training? If one wanted to sniff out the healing instinct and the idealism that students often bring to medical school, one could hardly imagine a more efficient method.

'I CAN TAKE IT!'

The long-term consequences of the medical school experience may involve not just psychological but physical health as well. For almost 30 years, Dr Caroline B Thomas of the Johns Hopkins Medical School performed psychological tests on every incoming medical student. She followed the students over time, and at the end of the study, examined the test scores for correlations between the psychological profiles and the diseases they developed. The findings were disturbing. Students whose psychological tests showed that they could not externalize their feelings—those who kept things bottled up inside—developed fatal cancer of all types later in life at an increased incidence. The implications are chilling. Medical schools in general foster the internalization of feelings—the "I can take it" attitude in which one never complains, no matter how difficult the situation—that correlated in Thomas' study with the eventual development of cancer.

PHYSICIANS FOR THE 21ST CENTURY

As the practice of medicine is being reshaped, we are being afforded the opportunity to take a fresh look at many hallowed concepts and customs, such as how the impulse in medical students to be a healer can be identified and fostered, and how medical education can be made healthier. One of the most admirable examinations of how medical students are selected and trained is the report "Physicians for the Twenty-First Century," commissioned by the Association of American Medical Colleges (note 3). Published in 1984, it remains current. Excerpts:

- [We do] not wish to invoke the hysterical hyperbole of crisis, nor do we wish to impugn the high quality of much [reform] that is being done. However, we perceive a continuing erosion of general education for physicians, an erosion that has not been arrested but is instead accelerating. We see continuing pressures to which we must accommodate with vigor and deliberate determination lest critical and irreversible damage is done.
- [E]very student should be caring, compassionate, and dedicated to patients.... Ethical sensitivity and moral integrity, combined with equanimity, humility, and self-knowledge, are quintessential qualities of all physicians.
- Students are led to think that their education depends upon memorizing as much information as possible.
Consequently, they lack a clear idea of the skills, values, and attitudes that are important... Medical faculties must limit the amount of factual information that students are expected to memorize.

- The priority most medical faculty members accord to research, patient care, and training of residents and graduate students has militated against the education of medical students.
- The traditional objectives of college education—to sharpen one's critical and analytical skills and to investigate the varieties of human experience through balanced studies in the natural and social sciences and in the humanities—are displaced by students' preoccupation with whatever they think they need to do to get into medical school. A premedical syndrome... is often described. Students who exhibit this syndrome take course after course in the sciences but avoid advanced studies in the humanities and in other nonscience fields... By the time their college studies are completed, these students often have forfeited the intellectual challenges and rewards that study in the humanities could have afforded.

In a revealing passage, the authors cite a previous (1932) report that acknowledges something intangible about the training of a healer, something that cannot be brought about by tinkering with the curriculum and reshuffling the same old worn cards:

The medical course cannot produce a physician. It can only provide the opportunities for a student to secure an elementary knowledge of the medical sciences and their application to health problems, a training in the methods and spirit of scientific inquiry, and the inspiration and point of view which come from association with those who are devoting themselves to education, research, and practice. Medicine must be learned by the student, for only a fraction of it can be taught by the faculty. The latter makes the essential contributions of guidance, inspiration, and leadership in learning. The student and the teacher, not the curriculum, are the crucial elements in the educational program.9

BECOMING A HEALER: TRANSFORMATION

Our profession's discomfort with healers, healing, and healing power is a historical aberration. For 50,000 years shamans and native healers of every variety have believed they possess the power to heal and that they were meant to be healers, convictions shared by their cultures. This same inchoate drive lies latent in many medical students, and it beckons them toward medicine. Learning how actually to use this power was never considered just an exercise of the intellect, as it is now regarded. Becoming a healer exercised every aspect of one's being—a process that is vividly captured in the words of an Igliulik Eskimo shaman:

I endeavored to become a shaman by the help of others; but in this I did not succeed. I visited many famous shamans, and gave them great gifts... I sought solitude, and here I soon became very melancholy. I would sometimes fall to weeping, and feel unhappy without knowing why. Then, for no reason, all would suddenly be changed, and I felt a great, inexplicable joy, a joy so powerful that I could not restrain it, but had to break into song, a mighty song, with only room for the one word: joy! Joy! And I had to use the full strength of my voice. And then in the midst of such a fit of mysterious and overwhelming delight I became a shaman, not knowing myself how it came about. But I was a shaman. I could see and hear in a totally different way. I had gained my qaumanEq, my enlightenment, the shaman-light of brain and body, and this in such a manner that it was not only I who could see through the darkness of life, but the same light also shone out of me, imperceptible to human beings, but visible to all the spirits of earth and sky and sea, and these now came to me and became my helping spirits.10

If a single word could describe the process of becoming a shaman, it might be transformation. The transformative experiences described by the Igliulik shaman would cause a modern psychiatrist to shudder, and most faculty members entrusted with the education of medical students would consider them bizarre and pathological. If a student were to report such a transformation, he would almost certainly be scheduled for an appointment in the department of psychiatry.

HEALERS OR FRANKENSTEINS?

In modern medical education "transformation" has been supplanted by "information." The result is the production of counterfeit—physicians who cannot heal and who regard "healing power" as a quaint anachronism.

Hyperbole? Consider the following observations in a provocative essay, "American Medical Education: Has It Created a Frankenstein?" in the American Journal of Medicine:

The present group of recently trained physicians are, in general, insensitive, have poor patient rapport, are deficient in general medical knowledge and examination skills, and have little concern for medicine's impact on society.... Further, few young people in medicine appear to be either emotionally or intellectually satisfied with their profession.... [The] current time-consuming training process often takes bright, creative young adults with a love for helping people, and turns them into cold, distant persons who have lost many of their original ideals regarding the practice of medicine... [thereby] producing a physician with qualities 180 degrees opposite those it states it believes in.11

Occasionally there is a spasm of awareness that something is seriously wrong, and recommendations are made for physicians to do things differently. These suggestions are sometimes surprising, such as the recent suggestion that physicians and
medical students take acting lessons. This would enable them to appear to care and be empathic with patients, whether they are or not. There is also an occasional glimmer that clinical outcomes are connected with something more than algorithms and objectivity. Consider, for example, a recent controlled study dealing with homeless people in an inner-city emergency room. Those patients who were deliberately given compassionate, empathic care—qualities endorsed by all genuine healers—demonstrated fewer repeat visits and greater satisfaction with treatment.

INFORMATION IS NOT TRANSFORMATION

Sensing that something is awry in the way physicians are trained, a common response of medical schools has been to provide students with more information, or with information with a slightly different focus—courses (often optional) in medical ethics, medical humanities, or medical history. But this strategy often makes no real difference, because information is being confused with transformation. The young protohealers are not hungry for more facts, but for experiences that can help them connect with those deep psychological and spiritual urges that have manifested throughout history as a commitment to the healing arts.

The informational approach to solving problems in medical education is immensely seductive. It can also be deadly. As Neil Postman, chair of the Department of Culture and Communications at New York University, puts it, we have created a new problem never experienced before: information glut, information incoherence, information meaninglessness. We have transformed information into a form of garbage, and ourselves into garbage collectors. Like the sorcerer’s apprentice, we are awash in information without even a broom to help us get rid of it. Information comes ... at high speeds, severed from import and meaning. And there is no loom to weave it all into fabric. No transcendent narratives to provide us with moral guidance, social purpose, intellectual economy. No stories to tell us what we need to know, and what we do not need to know."

If our medical schools are once again to produce healers, they shall have to foster transformation of the inner life of the students who entrust themselves to the educational process. Postman’s suggestion: “We will need to consult our poets, playwrights, artists, humorists, theologians, and philosophers, who alone are capable of creating or restoring those metaphors and stories that give point to our labors, give meaning to our history, elucidate the present, and give direction to our future.”

“Transformation” is a robust project, and we should not underestimate the magnitude of this task. “We’re asking a young physician to become a wise old person, and to do it in 4 years of medical school. That’s a lot,” observes molecular biologist and cancer researcher Helene Smith, who believes an infusion of shamanic knowledge in modern medicine would be a good thing. But becoming a wise healer has always been a difficult and lengthy undertaking, even for the shamans. In fact, it was by no means certain that the shamans would survive; the process of transformation sometimes ended in death.

I do not mean to suggest that our medical schools fail completely in their mission. Authentic healers do emerge from them, though not as commonly as they should, and often in spite of the educational process and not because of it. Neither do I wish to imply that the inadequacies we have been addressing are the sole fault of the schools themselves. Medical schools reflect the values of the society in which they exist. If something is amiss in them, the problem can usually be identified as well in the society, as a whole. At the root of the problem lies the fact that we, as a culture, have turned our collective back on healing. We should not kid ourselves: we are all in this together, jointly entranced by a physicalistic approach to health and illness, and dazzled by the promises of technology to right every conceivable misfire of the body. Against this backdrop, healers and healing have been shoved aside and very nearly forgotten, and we are paying the price. Ignoring the role of consciousness, soul, spirit, and meaning—stock items in the arsenal of authentic healers—we have birthed a malaise that permeates not just the healing profession but our entire society. The casualties
have been not just healers and healing, but the soul and spirit of a culture.

'FOR THE HOPE OF WISDOM'

These sorts of observations are often dismissed as unduly pessimistic. Those who continue to have unbridled faith in science and technology say we need more physical science, not less. Perhaps. But even insiders are worried. Typical is the following passage from the late physician-author Lewis Thomas, who was once called the most listened-to physician in America. Here Thomas hints at what we have lost and what we need to recover, not just in medicine but in our society at large.

These ought to be the best of times for the human mind, but it is not so. All sorts of things seem to be turning out wrong, and the century seems to be slipping through our fingers here at the end, with almost all promises unfulfilled. I cannot begin to guess at all the causes of our cultural sadness, not even the most important ones, but I can think of one thing that is wrong with us and eats away at us. We do not know enough about ourselves. We are ignorant about how we work, about where we fit in, and most of all about the enormous, imponderable system of life in which we are embedded as working parts. We do not really understand nature, at all. We have come a long way indeed, but just enough to become conscious of our ignorance. It is not so bad a thing to be totally ignorant; the hard thing is to be partway along toward real knowledge, far enough to be aware of being ignorant. It is embarrassing and depressing, and it is one of our troubles today.

It is a new experience for all of us. Only two centuries ago we could explain everything about everything, out of pure reason, and now most of that elaborate and harmonious structure has come apart before our eyes. We are dumb. This is, in a certain sense, a health problem after all. For as long as we are bewildered by the mystery of ourselves, and confused by the strangeness of our uncomfortable connection to all the rest of life, and dumbfounded by the inscrutability of our own minds, we cannot be said to be healthy animals in today's world.

We need to know more. To come to realize this is what this seemingly inconclusive century has been all about. We have discovered how to ask important questions, and now we really do need, as an urgent matter, for the sake of our civilization, to obtain some answers. We now know that we cannot do this any longer by searching our minds, for there is not enough there to search, nor can we find the truth by guessing at it or by making up stories for ourselves. We cannot stop where we are, stuck with today's level of understanding, nor can we go back. I do not see that we have a real choice in this, for I can see only the one way ahead. We need science, more and better science, not for its technology, not for leisure, not even for health or longevity, but for the hope of wisdom which our kind of culture must acquire for its survival.

WHICH WAY OUT?

Young healers who follow their calling to medical school and who become disenchanted are often deeply affected by the malaise Thomas describes. They are like the canaries in the mine, a distant early warning system alerting the rest of us to the poisonous effects of not just our view of health but our view of reality itself. Without saying so, they are crying out for nothing less than a different worldview, an alternative to the picture of reality served up in medical school.

What might such a worldview look like? As Thomas Kelting recently put it,

The most satisfying and successful model ... would be one which jointly satisfies our three broadest categories of need: practical, theoretical, and spiritual. Practical needs include our desire to predict and shape our world.... Our theoretical need is to make reality appear intelligible to our kind of intellect; we prefer descriptions of reality in which the universe is seen to be a coherent, cognitively penetrable realm of phenomena, to descriptions in which it appears otherwise. Our spiritual need goes well beyond the requirement of the intellect for coherence and intellectual precision, to our need to find a meaningful connectedness between ourselves and the rest of being. We hunger for a sense of purpose, destiny and value, grounded not only in ourselves, but in the larger nature of things. We also seek comfort and love, not just for, and from, one another, but for, and from, this greater realm of being.

The worldview affirmed in medical education tends to be "lopsided and spotty," Kelting says. "We ignore our spiritual requirements, and pursue [exclusively] models of reality that allow us to succeed in manipulating nature." Outside the scholarly environment, we often drift to the other extreme.

[We] pursue spirituality in a vacuum, as if there were no place for the prosaic physical universe, with its discoverable regularities, in a spiritual worldview. But spirituality should not be fueled by a desire to escape the lessons of the discursive intellect—that there are constraints we must live by. And, the preoccupation with physical reality and its exploitation, to which the discursive intellect seems so well suited, must not be allowed to escalate into the obsessive and spiritually astringent materialism that is suffocating Western society.

We should be grateful to the young healers who are so painfully at odds with the medical school environment. They are illuminating the schizophrenic situation we have slipped into as a society, with its divisions between the practical, theoretical, and spiritual aspects of our worldview, and they are challenging us to heal these splits.

To those in medical education who roll their eyes at the mention of "spiritual," take hope. Making a niche for spiritual
factors in medicine is easier today than ever before. The evidence that spiritual factors—a sense of meaning, purpose, and values, as well as religious practice—are important factors in health and illness is abundant and is increasing.¹⁸ Epidemiologist Jeffrey S Levin, of Eastern Virginia Medical School, who originated the phrase “epidemiology of religion,” said in a written communication (June 7, 1995), “This body of work [the religion-and-health studies], I can state confidently, shows a strong, overwhelmingly consistent protective effect for religion; and my own empirical work confirms this finding.”¹⁹ To Levin’s contributions could be added those of Duke University Medical Center’s Harold G Koenig; David B Larson of the National Institute for Healthcare Research; the University of Akron’s Margaret M Poloma; the University of Maine’s Kyriacos C Markides, and many other researchers investigating the health effects of, broadly speaking, a spiritual approach to life. Because most medical schools are unaware of this body of evidence, those entrusted with curriculum design often view with horror any mention of “the spiritual.” But ignorance is no defense. To omit the spiritual element from our medical worldview is not only narrow and arbitrary, it appears increasingly to be bad science as well.

WOUNDED HEALERS

Chiron, the centaur in Greek mythology who taught the art of healing, was wounded by a poisoned arrow. Although he extracted the arrow, he could not remove the poison, which he carried forever in his body. Chiron is immortal and cannot die, but neither can he be entirely healthy. He is the exemplar of the wounded healer, one who paradoxically heals and is in need of healing.

We are collectively wounded—healers, medical schools, and the culture that spawns them. Can we extract the arrow? Can we rid ourselves of at least some of the poison?

Ecologist Paul Ehrlich observes, “The first rule of intelligent tinkering is to save all the parts.”²⁰ Our medical schools have tinkered with young healers for generations. I believe they have saved the parts—vision, soul, and spirit—in medicine have never really died—and can summon the courage required to put them back together in a pattern resembling a healer.

There are signs of healthy change. For example, approximately 30 medical schools have developed courses in alternative medicine.²¹ Researcher Helene Smith offers a hopeful view of medicine’s ability to meet these challenges. “The medical establishment actually is much better at changing than many other institutions,” she says. “If you think about some other institutions, like education or religion, how fast do [they] change? Doctors, for all their getting a bum rap of being conservative, are actually on the forefront of changing quickly.”²²

If our medical schools are to produce healers, they must first stop destroying them. This will require reducing or eliminating the many ways the medical school experience has become dehumanizing. An exemplary step in this direction is the Health Awareness Workshop for first-year medical students, which has been available at the University of Louisville Medical School since 1981. The course was developed by Joel Elkes, M.D., professor emeritus of psychiatry, and Leah J Dickstein, M.D., professor in the Department of Psychiatry and Behavioral Sciences, and associate dean for faculty and student advocacy.

The Health Awareness Workshop rests on the recognition that “the medical student is a person at risk,” that “some of these risks are avoidable,” and that “other-care is best begun with self-care.” This 4-day course is offered to entering medical students prior to enrollment and commencement of studies. Although it is voluntary, more than 90% of freshmen elect to participate. Topics include mode of life as a factor in illness and disability; the psychobiology of human adaptation, stress, and the stress response; the physiology of nutrition, exercise, and relaxation; the psychology of time management and study skills; listening and the give-and-take of relationships; substance abuse and the impaired physician; gender issues in medicine; and introductions to the ethics of medical practice and the place of belief in healing. In addition to the didactic presentation of scientific data, an experiential, participatory, “fun” approach to learning is included in the workshop through involvement in music, art, acting, film, singing, and chanting; a “nutritional picnic” and pizza supper; aerobic exercise, softball, and a “fun run”; and a river cruise on the “Belle of Louisville.” The students learn of the history of the city of Louisville and the University of Louisville School of Medicine.

Second-year students volunteer to be “health tutors” to groups of 16 freshmen. They share their anxieties, coping styles, and lessons learned, and even serve as chefs in preparing healthy foods for the incoming students. Faculty members, usually selected by the sophomore students, play a similar role. Workshop sessions are also held for the spouses, children, and significant others of the incoming students. As a result of these interactions, a social network forms between student and student, and between student and faculty. The resulting message delivered by the medical school to the incoming students is clear and unmistakable: We care about you—your physical, psychological, and spiritual well-being—and we will go to great lengths to help you become a skilled physician and a fulfilled human being.

But in our enthusiasm for change, let us not deceive ourselves. It would be a mistake to suppose that there is a formula for generating healers. There never has been. Becoming a healer remains largely a mysterious process not amenable to manipulation and control, as the above experience of the Igululik shaman illustrates, and as Lame Deer, the Sioux medicine man, warns in the epigraph. We note again the 1932 report by the Commission on Medical Education: “The medical course cannot produce a physician.”²³ Neither can it produce a healer.

Malcolm Muggeridge once distinguished between first- and second-rate pursuits in life. “It is possible only to succeed at second-rate pursuits—like becoming a millionaire or a prime minister, winning a war, seducing beautiful women, flying through the stratosphere, or landing on the moon,” he said. But first-rate pursuits—“involving, as they must, trying to understand what
life is about and trying to convey that understanding," are much more difficult. Becoming a healer is a first-rate pursuit that is exceedingly arduous. So let us not saddle our medical schools with a responsibility they cannot meet, such as producing healers on demand. Let us expect them instead to prepare the soil in which healing can flourish, and from which healers can flower.

THE LETTER REVISITED

I occasionally imagine receiving The Letter from a future medical student. What might it look like? Here's my fantasy, and also my hope:

Dear Dr. Dossey,

In a couple of months I will complete my residency program. May I tell you what the past few years have been like? From earliest memory I have wanted to be a helper. This is inexplicable; no one in my family has ever been involved with medicine. I followed my vision through college, but not until I entered medical school were my deepest intuitions affirmed. I began medical school expecting to be overwhelmed with information and drudgery; instead I encountered wisdom and inspiration. For the first time in my life I discovered genuine healers—professors who course after course seemed to be a combination of physician, scientist, mentor, and shaman. They understood that healing is a special calling, and they honored the tug I had always felt. Because of their unfailing support, my vision has never been stronger.

Medical school was a difficult undertaking; I expected and wanted to be that way. It has also been transformative. I feel I have awakened to something immensely worthwhile, and that this awareness will continue to flower for the rest of my life.

One day I surprised my favorite professor by calling him a Wise Guide. He smiled knowingly and told me that my task henceforth is to pass my knowledge on, healer to healer, as he has conveyed it to me. I was thrilled by his response. It was as if he were acknowledging me as a colleague and welcoming me into that invisible college of healers that stretches from antiquity to the present.

I feel blessed to have experienced medical school. It's been a spiritual experience. I wanted you to know.

Larry Dossey, MD
Executive Editor

Notes
1. Although the focus in this essay is on the problems facing medical students and physicians, I trust that the readers of Alternative Therapies realize that these issues extend to all professional training programs—nursing, dental, and even alternative therapy schools. I speak here about the system I know best, and invite readers to make their own extrapolations.
2. Dr. Gersten is the editor of Atlantis, a newsletter that explores the use of imagery in medicine. Address: 40th Floor, 3 Third Avenue, San Diego, CA 92103.
3. The report has the formidable subtitle, "Report of the Panel on the General Professional Education of the Physician and College Preparation for Medicine." Copies may be requested from the Association of American Medical Colleges, One Dupont Circle, NW, Washington, DC 20036.

References
THE MEDICAL USES OF HOPE

William M. Buchholz, MD

The Physicians' Desk Reference (PDR) is the standard text for medical personnel to consult when prescribing a drug. It contains information on how the drug works, when to use it, and potential side effects. Too frequently patients will complain, "The doctor gave me no Hope," as if it were a sample or prescription that should have been offered along with the rest of the treatment. If there were an entree in the PDR for Hope it might look like this.

HOPE
(orphan drug, generic name)

Caution:
Hope should be used by all personnel, especially those who are dealing with the despair found in terminal illnesses like cancer, AIDS, ALS, or end-stage cardiac or pulmonary disease. Because of the possibility of severe reactions to becoming aware of one's own mortality, personnel must be prepared to be vulnerable to their own feelings.

Description:
"Hope is the thing with Feathers
That perches in the soul and sings the tune without the words
And never stops at all."
Emily Dickinson

"Hope is what gets us out of bed in the morning."
Anonymous

Clinical Pharmacology:
Hope is a naturally occurring substance created by man's ability to project himself into the future and imagine something better than what exists in the present. It serves as a co-factor for most purposeful behavior and is necessary for coping with fluctuating feelings of despair, depression, fear, anxiety and uncertainty.

Hope has three components: There is the individual hoping; the projection into the future (expectation); and the object, event, or state desired. "Hope is that pleasure in the mind which everyone finds in himself, upon the thought of a profitable future enjoyment of a thing which is apt to delight him." John Locke

Individuals experiencing Hope vary with respect to the density and binding constants of Hope Receptors. There is both up-and-down regulation of receptors depending upon the danger of the circumstances that require Hope, the individuals' sense of vulnerability, and the support system available. Certain individuals have a pathological need for Hope and are susceptible to False Hope (see WARNINGS).

Expectation is composed of the sub units Credibility, Attainability, and Projection. It is conveniently measured as a vector having units of distance and difficulty (X,Y). Even if there is a strong belief that a goal is possible (Credibility), if the individual perceives it to be
too difficult to attain, or that it is impossible to project himself into the future, Expectation will be low. There are both intellectual Expectancies and emotional Expectancies. Both must be above threshold levels for Hope to be effective.

The Object Desired is the most visible aspect of Hope and may be expressed concretely or implied, e.g. "I hope the surgery will cure the cancer." "I hope everything turns out all right." The strength of Hope often depends upon the meaning or importance (Preciousness) of the Object. Individuals vary considerably in ascribing meaning to objects but there is a common hierarchy of Hopes ("Vital Hopes:" longevity, relief of suffering, security, love) that must be perceived as attainable before other Objects are hoped for.

**Pharmacokinetics:**
After administration, either verbally or visually, Hope enters cortical and thalamic pathways where it is processed for Credibility, Attainability, and Importance. If receptors are blocked by depression, anxiety, or distraction there is no binding and Hope dissipates immediately. Depending upon the number and avidity of open receptors, there is an immediate effect that has a half life (T 1/2) of minutes to hours. Longer effects require repeated administration. Both sensitivity and tachyphalaxis can develop depending upon how often the Desired Event occurs or does not occur.

**Indications.**
Hope is indicated in the treatment of Hope, Deficiency, Depression and Anxiety, and to increase Motivation and Compliance with treatment. It is useful in relieving fear, pessimism, and a sense of vulnerability. It increases energy and courage in all individuals, resulting in greater likelihood of difficult goals being accomplished.

Hope should be given at the initial diagnosis of a potentially fatal disease, at the first relapse and when the disease is terminal. It should also be used when dealing with chronic "benign" diseases such as arthritis, diabetes, hypertension, etc. It should be given whenever despair is noted or anticipated, even if full therapeutic doses cannot be administered. (See Dosage and Administration.)

Hope Deficiency (Hopelessness) is a state of despair characterized by the inability to anticipate any positive outcome. Patients are generally unable to act decisively, make decisions, have meaningful relationships, or experience joy or meaning. They experience depression, lack of motivation, increased anxiety, spiritual angst, and decreased self-esteem. They are described as having "given up." The Will to Live is diminished in proportion to the degree of hopelessness.

**Contraindications:**
There are no known contraindications for giving Hope.

**Mechanism of Action:**
1) Depression: Depression is characterized by the inability to imagine anything different from the present. Hope, because of the component of Expectation, relieves the inability to project into the future. Hope allows such individuals to create a possible future, thereby relieving the onus of living in the present. Because of the anticipation of pleasure it acts as an
anti-anhedonic and increases energy (anti-abulic). By focusing on the possibility of a positive outcome it relieves pessimism.

2) Anxiety: An increased sense of control is achieved by predicting a desirable future event, thereby providing an anchor for the individual in the midst of free-floating anxiety. The sense of aloneness is relieved by anticipating allies or help. Fear, which consists of projecting into the future an undesirable event (helplessness, pain, etc.) is redirected by the expectancy of a positive rather than negative outcome.

3) Motivation/Compliance: Motivation to accomplish goals and compliance with medical treatment are increased by a sense that the goal is attainable. Encouragement from the self or environment is permitted to act on behavior to increase the likelihood of achieving that goal.

**Warning:**
False Hope is the intentional or inadvertent creation of the expectancy that a low probability outcome is likely. It is a violation of medical ethics to intentionally deceive a patient for the purposes of manipulating their behavior (i.e., violation of informed consent denial of patient autonomy, paternalism, etc.). Because of the danger of malpractice suits, physicians and nurses generally avoid any appearance of False Hope and may generate False Despair instead. Certain individuals, because of a high need for Hope based upon the seriousness of their condition or their premorbid personality characteristics, are prone to misinterpret information given and develop False Hope or False Despair even when none is intended. Patients generally use False Hope to diminish the full emotional impact of an intolerable situation.

False Despair is the intentional or inadvertent discrediting of any probability that a desired outcome is possible. As mentioned above, in order to avoid any suggestion of False Hope, some medical professionals will purposely lower patient expectations to avoid any chance of disappointment. Patients likewise may avoid the disappointment of unrealized hopes by purposefully keeping their expectations low, feeling it is safer to expect the worst. It is a violation of compassion and the Hippocratic oath (to alleviate suffering) to purposely withhold Hope of a low but finite probability outcome from those patients who desire it. It may be pointed out that even under the bleakest of circumstances there are some survivors.

Given the varying demands of patients and circumstances a flexible balance between Hope and Information (see Administration below) should be maintained. This requires the ability to maintain Expectancy and transfer this ability to project into the future to a more obtainable object. If a patient's Hope is for cure, it may be necessary to redirect Hope gently towards remission or relief of symptoms. Considerable practice is necessary to become proficient and creative in maintaining True Hope in the face of professional and/or patient despair.

**Precautions:**
Hope is safe during Pregnancy and, while it may cross in the breast milk, is known to be safe for infants. Hope may be used in pediatric patients, adjusting language but not dosage according to age.

**Adverse Reactions:**
Adverse reactions occur when the physicians or nurses, out of a desire to please the patient, try to appear more powerful than they are and manipulate patient behavior by substituting False Hope for True or Realistic Hope. Patients, likewise, may distort ethically administered True Hope out of an inability to cope with reality. False Hope leads to persistent denial of reality and poor judgment. It causes 1) persistent goal oriented behavior toward an unobtainable goal; 2) distraction from necessary activities; and 3) delay in resolving emotional issues. There are no adverse effects from True Hope.

**Over dosage:**
Individual's capacities for Hope vary considerably. Excess True Hope is very rare. More common is the medical personnel's assessment that the patient's estimate of outcomes is "unrealistic." The definition of "realistic" is often personal. Conflict arises when the patient's need for Hope differs from the nurse's or physician's. If over dosage is suspected, however, the patient must be assessed carefully and the consequences of acute Hope Deficiency considered. Acute Hope Deficiency may precipitate sudden depression, increased anxiety, spiritual angst and decreased self-esteem. Withdrawal of Hope must be done slowly and gently.

**Withdrawal:**
If it is determined that the patient is using False Hope and suffering one or more of the above mentioned adverse reactions and the danger of the continued False Hope state is greater than precipitating Acute Hope Deficiency, the patient may be withdrawn carefully. Efforts should be made to substitute another goal for the previous unobtainable one, preserving the positive expectancy while the goal is shifted. This may be done more easily if it is recognized that the patient is actually in a Hope Deficiency state of fear and depression.

**Dosage and Administration:**
Dosage and duration of treatment must be individualized. The only limit on maximum dosage is the patient's ability to receive and the professional's ability to administer Hope at an appropriate rate. In the face of overwhelming external events it may not be possible to administer adequate Hope to cope with all of the despair and suffering. Smaller amounts may be given with the understanding that some is better than none.

Hope must be administered in a form compatible with the patient's receptor system. Requests for Hope are often phrased as information questions, although the real need is for reassurance. Unless the patient has received Hope from another source one should assume Hope is needed before information can be assimilated.

The patient's ability to receive technical and factual information versus their need for emotional reassurance should first be assessed. Because of the frequent high need for Hope (anxiety, fear, depression) distortion of information is frequent. Phrases such as "50% response rate" may be interpreted as "50/50 chance of pulling through surgery," "you promised me I will live for another 50 years," or "I've only got 6 months to live." These bear no relationship to the intended meaning, "There is a 50% chance that if surgical resection for cure is attempted you will live 5 years without recurrence."

Certain patients have a predominance of Factual Hope Receptors. Hope is best administered in the form of facts and statistics, phrasing them according to "the glass is half full" philosophy.
Other patients have predominantly Emotional Hope Receptors. When patients manifest emotional symptoms of anxiety and depression, hope should be administered in a form that can be digested emotionally. "Living proof" stories about other patients who have done well in similar circumstances are more easily accepted and can be applied directly to emotional wounds.

1) At the time of diagnosis. Because excessive information may block receptor sites for Hope, patient's needs should be determined before either Information or Hope is given. Open-ended questions such as "What have you been told?" or "What do you think is the matter?" will elicit responses that will indicate primary needs for information (intellectual) or encouragement (emotional). Just as radiation therapy or chemotherapy is delivered in fractions to avoid toxicity, Information should be given in amounts that will not overwhelm the patient's ability to incorporate it. Such overload increases the distortion of the Information and produces either anxiety or numbness. Unless specific actions based on this Information must be taken immediately, attending to emotional needs by giving Hope first before Information will create a more credible doctor- or nurse-patient relationship.

2) During therapy. Hope is more easily administered along with a technical intervention. Generally the medical personnel are optimistic the treatment will work or would not be giving the treatment. Sometimes a patient's Hopes exceed the professional's Hopes. If Hope is necessary for the patient to cope and there is no contraindication (see False Hope above), then Hope should be maintained as long as possible.

3) When nothing else can be done. This is the most critical situation in which Hope must be administered. It is also the most difficult. Both medical personnel and patient must shift the object of Hope to something that is more credibly obtainable. Physicians are trained to consider longevity or disease control the only worthy objects of therapy. When neither is possible they may feel hopeless unless they can maintain a positive expectancy and change goals. Generally it is possible to offer Hope for comfort. It is always possible to offer the commitment to be there for the patient as they die. Often that is enough.

How Supplied:
There is no standard dose. Individual patient needs and individual personnel styles determine how Hope should be given. Listening carefully to both verbal and non-verbal communication will often suggest the best preparation of Hope to use. Sometimes it is pointing out that even though the chances are slender, there is a chance, and why shouldn't it be you? Sometimes it is repeating again and again that the treatment has a good chance of working. Sometimes it is just being there, with a gentle smile and a promise not to abandon the patient. Sometimes the greatest challenge is keeping a sufficient supply on hand for the personnel dispensing it.

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The health professional is confronted daily with the emergence of human suffering and risk. How do we use our expertise to help the human condition, a multifaceted and profound phenomenon, through the lens of health care? Full to the brim with advanced knowledge and skills, health professionals are in a position to help individuals and communities improve their health and well-being. However, the health care system faces significant challenges in achieving this goal, including but not limited to: access to care, financial barriers, and cultural barriers.

The role of a nurse in health care is multifaceted, requiring a deep understanding of the patient's needs and preferences. Nurses are often the first point of contact for patients and their families, providing emotional support and guidance. In this capacity, nurses work closely with other healthcare providers to ensure that patients receive the best possible care. The nurse's ability to communicate effectively, listen actively, and provide compassionate care is crucial in building a trusting relationship with patients.

The adoption of a view of human nature as dynamic and resilient is foundational to the practice of collaborative care. This perspective recognizes that individuals have the capacity for growth and change, and that healthcare professionals can facilitate this process through interventions that support self-care and promote health. In this way, the nurse plays a vital role in empowering patients to take charge of their own health and wellness.

Collaborative Care
The professional image is being generated by the health care system in a way that fundamentally changes the way the physician experiences practice. The practice of medicine is no longer a patient-focused, doctor-centered endeavor. The patient's perspective is often ignored, and the physician's actions are driven more by the needs of the system than by the needs of the patient. This shift in focus has led to a devaluation of the physician's role and a loss of respect for the patient's experience.

The question then is this: Is it possible for people who work in medicine to feel satisfied with their work? Can they find meaningful and rewarding work without giving up their personal lives and well-being?

The concept of micro-experiences is not new to the medical profession, and many healthcare professionals struggle with the challenge of finding a balance between their personal and professional lives. Micro-experiences are small, everyday moments that can have a significant impact on a person's sense of well-being and satisfaction with their work.

My own previous human experiences come to focus with each rotation of the medical experience. The micro-experiences are expressed in the context of the environment in which the Medical Caretaker performs their duties. The environment is filled with stressors, and the Medical Caretakers need to find ways to manage stress and maintain their well-being. This is not an easy task, but it is crucial for the long-term health and success of the Medical Caretakers.

Therefore, the medical profession needs to be redefined, and the focus needs to shift from the technical aspects of medical care to the emotional and human aspects. The Medical Caretakers need to be supported and valued for the work they do, and the patients need to be seen as individuals with unique needs and experiences.
The human patient, the health professional, and the health care professional's role in the health care system are all integral to maintaining the health of the patient—many times an emotional, physical, or spiritual process. The health professional, along with the patient, is responsible for ensuring the health and well-being of the patient. This requires a comprehensive understanding of the patient's condition and the ability to provide appropriate care. The health professional must also be able to work effectively with other health care providers to ensure the best possible outcome for the patient.

The health professional's role is to provide treatment and care to the patient in a manner that is consistent with the patient's needs and goals. This may include providing medication, performing diagnostic tests, and developing a treatment plan. The health professional must also be able to communicate effectively with the patient and other health care providers to ensure that everyone is aware of the patient's condition and the treatment plan.

The health professional's role is also to support the patient's family and friends. This may involve providing information about the patient's condition, answering questions, and offering emotional support. The health professional must also be able to work effectively with the patient's family and friends to ensure that everyone is aware of the patient's condition and the treatment plan.

The health professional's role is also to ensure the patient's safety and well-being. This may involve providing education about the patient's condition, ensuring that the patient is taking their medications as prescribed, and providing guidance on how to prevent complications.

The health professional's role is also to work with other health care providers to ensure that the patient receives the best possible care. This may involve coordinating care with other health care providers, such as specialists, and ensuring that the patient's care is consistent with the patient's goals and needs.

The health professional's role is also to work with the patient's insurance provider to ensure that the patient receives the best possible coverage. This may involve providing information about the patient's condition, answering questions about insurance, and ensuring that the patient is aware of their insurance coverage.

The health professional's role is also to work with the patient's legal representative to ensure that the patient's rights are protected. This may involve providing information about the patient's legal rights, answering questions about legal issues, and ensuring that the patient is aware of their legal rights.

The health professional's role is also to work with the patient's family to ensure that the patient's needs are met. This may involve providing information about the patient's condition, answering questions about the patient's care, and ensuring that the patient's family is aware of the patient's needs.

The health professional's role is also to work with the patient's employer to ensure that the patient's work is not impacted by their health condition. This may involve providing information about the patient's condition, answering questions about work-related issues, and ensuring that the patient's employer is aware of the patient's condition and the need for accommodation.
The human patient is not a passive recipient of treatment but a partner in the process. The physician is not a machine programmed with the voice of authority, but a facilitator who helps patients understand and manage their health. The relationship between patient and physician is one of mutual respect and collaboration, where the physician's role is to guide and support the patient's autonomous decisions. Healthcare is an interactive process where both parties contribute to the best possible outcomes. The human patient is active in the treatment process, making informed decisions and taking responsibility for their health. This active role not only enhances the therapeutic relationship but also empowers the patient, making them a vital participant in their own health care. The physician's role is to facilitate this process, providing education, support, and guidance, rather than imposing the decisions of others. The human patient is an active partner, not a passive recipient, in the healing process.
BUILDING CATHEDRALS

Charles W. Callahan, DO LTC, MC, USA*

The "code" page interrupted the departmental Christmas party program. Well-dressed pediatricians in holiday ties and sequined dresses rushed back to the hospital ward. A young child with inflammatory bowel disease had suffered an arrest. Hours before she stopped breathing, she had been out of the hospital on pass Christmas shopping with her mother. Moments before, she was joking with her nurses. Now, the on-call physician was doing CPR. And, within an hour, she was declared dead. It was completely unexpected. A staff physician wept with her mother as the remainder of the team wandered through the postmortem duties in a daze, still wearing what had become bizarrely inappropriate party clothes.

As a group, we began the soul-wrenching process of second-guessing and wondering until the autopsy was completed. And there remarkably, on the post, clogging the pulmonary artery like the remains of a venomous asp, was an embolus. The tragedy was only slightly softened by the knowledge that it could neither have been anticipated nor prevented.

The unexpected death of a child under one's care is the single most difficult aspect of pediatric practice. It is an experience that everyone who cares for children will eventually know. It causes a measure of pain that can lead even dedicated clinicians to wonder why they should continue to expose themselves to the hurt. The memory only gradually hurts less, even though eventually it hurts less often. A sense of anguish may come rushing back, however faint or fleeting, each time we stand at the bedside of a dying child.

Solomon, the third king of Israel, renowned for his wisdom, wrote in the Book of Ecclesiastes, "He who quarries stones may be hurt by them" (Ecclesiastes 10:9). Quarry work, stone-cutting, and masonry are dangerous professions. A stone that shifts accidentally, moves in an unexpected direction, or drops and shatters without warning can injure the worker. The stone can crush, crippling the mason's ability to skillfully work the stone. Or it can kill, so the profession of working stone is left to others. However, if no one had the courage to quarry stones, and if there were no one to work in quarries, there would be no cathedrals. In pediatrics, we are in the business of building cathedrals. A child who overcomes an acute, life-threatening illness or accommodates to a chronic disease and grows to maturity is a cathedral.

In caring for children, heaven alone knows how many acute and chronic illnesses are avoided through the crucial, though somewhat monotonous business of anticipatory guidance and preventative care. These masons are the dedicated men and women who labor in countless clinics and offices, like workers in quarries, battling a sense of fruitlessness, as they daily hammer stone. And they are the fearless others, dangling precariously on the fragile scaffold of critical care and specialty practice in an era of managed care. The results of their tireless efforts represent the very best of human effort. They may never see the cathedral. But it is a vision of the spire that drives them on.

This business we are in can be very painful. The work is risky. When the outcome eludes our expectations, our confidence and talent may be crippled. When we love, then lose the ones we care for, our souls are vulnerable to be crushed. This sort of masonry is dangerous. But if there were no one to quarry stones, no one to work and shape them, there would be no cathedrals. And we are in the business of building cathedrals.

*Chief, Department of Pediatrics and Pediatric Pulmonology, Tripler Army Medical Center, 1 Jarrett White Rd, Honolulu, HI 96859-5000. E-mail: charles.callahan@amedd.army.mil

The views and opinions expressed in this manuscript are those of the authors and do not reflect the official policy or position of the Department of the Army, the Department of Defense, or the US Government.
The Gathering of Physicians

By Matthew Zwerling, MD

What thoughts come to mind, what feelings arise when you wonder about the mystery of medicine, during those times when you are unable to explain something you have witnessed, or when struck by a seemingly magical insight or response to treatment? Have you ever spent an evening with a group of physician colleagues exploring concepts such as joy, compassion, trust, anger, forgiveness, or dreams? What would it be like to sit together informally, sharing thoughts and stories that connect you with the experience of being a physician, of being human?

A group of local doctors has been meeting once a month for the past few years to explore these and other questions, and to contemplate the meaning of medicine and service through the medium of story. Known as The Gathering of Physicians, the group is modeled after the Finding Meaning in Medicine groups started by Dr. Rachel Naomi Remen, author of the best-selling books *Kitchen Table Wisdom* and *My Grandfather’s Blessings*.

“There seems to be a deep river of meaning,” writes Dr. Remen, “that runs beneath the events of our daily lives … especially the lives of physicians. Through these groups we have found a very simple way of tapping into this river, and we are witnessing profound results. Most doctors have had rich and unusual experiences, but have never had the opportunity or the encouragement to reflect upon them or discuss them with medical colleagues. There are certain experiences that only another physician can fully understand. Having the opportunity to share unreservedly with colleagues is a remarkably fulfilling experience and often allows us to heal many of our professional wounds. It certainly has inspired those who have participated and enables many to recover a greater sense of meaning and satisfaction in this work.”

Dr. Andrew Wagner and I, having benefited both personally and professionally from regular attendance at Dr. Remen’s gatherings, believed a similar model would be valuable in Sonoma County. Once a healthy, vibrant, quality enterprise, our local medical community has undergone a painful fragmentation in recent years. Bitter rivalries have developed among physicians and between physicians and hospitals. There is disturbing competition for services (and survival). New physicians are reluctant to consider practicing here, both for financial reasons and because of the pervasive sense of unhappiness among local physicians.
practitioners. Joy and satisfaction are distant memories for many physicians.

Some choose rhetoric and legislative redress to fight the “saber-toothed tiger” of managed care, government regulations, and the like. Some have left our county for the presumed greener pastures of other communities or administrative work. Many hope for change, some just for survival. And some are choosing to reexamine their response to the external stressors and uncertainties physicians face, to search inwardly for ways to reconnect with the meaning of medicine.

*Signs of human community—its meaning and its beauty—can be found all around us, if only we look.*

—Anonymous

The monthly meetings of the Gathering of Physicians are organized as a conversation and discovery process, focusing on a specific topic chosen the previous month. Topics chosen over the past three years include boundaries, stewardship, privacy, ritual, renewal, and fear, as well as joy, compassion, trust, anger, forgiveness, and dreams. Participants are invited to bring a story from their personal or professional life, a piece of writing from world literature, a poem, a work of art, or an exercise, and to share this gift of experience as if sitting in a living room with a group of close friends.

Our conversation on privacy, for example, explored invasions of privacy through the Internet, with telemarketing, and in the hospital setting. One physician spoke of his ongoing discomfort with the lack of privacy when taking a history in a hospital room or in the ER. We explored the challenge of balancing privacy with expediency, and privacy with security. As we looked at the obligation of a parent to honor the privacy of a child, one physician was reminded of a recent experience when his teenager came home drunk one evening. The physician shared the concerns he and his wife had about the “rights” of parents to invade the private space of a child.

Today, like every other day, we wake up empty and frightened. Don’t open the door to the study and begin reading. Take down a musical instrument. Let the beauty we love be what we do. There are hundreds of ways to kneel and kiss the ground.

—Rumi

Physicians in the group bring poetry from Rumi, Hafiz, and Dickinson, while others bring music or musical instruments. The group often reads short stories, some written by local physicians, some by well-known writers such as Kahlil Gibran, Jack Kornfield, or Dr. Remen. Our personal, unwritten stories provide another rich source of shared experience. On one occasion, when the topic was trust, a physician spoke of the painful experience of a divorce, and its impact on personal and professional life. The individual had never shared this very personal story with other physicians, and stated that the group’s attentive listening felt extremely supportive.

At another gathering, three of us realized that we had each lost our mother within the past six months. We spent the evening sharing reflections on our mothers, our relationship with them, and the experience of the loss—even though neither loss nor death was the specific topic for the evening. Our conversation expanded and segued quite naturally, aided by the collegiality that had developed within the group. What is shared at the meetings is often quite moving, and it touches our hearts deeply.

A few simple rules govern the group’s interactions. Participants are asked to respect and maintain the confidentiality of the group if and when they consider sharing the experience with others. The intent of the gatherings is to be respectfully attentive to what others have brought, rather than to fix a problem, offer advice, or jump in to tell our own story. We are there to offer support, to share insights that arise, to reflect on what touched us. There is no requirement to speak, only to share the gift of one’s attention, to trust the wisdom that is being shared.

We are here to do,
And through doing to learn;
And through learning to know;
And through knowing to experience
wonder;
And through wonder to attain wisdom;
And through wisdom to find simplicity;
And through simplicity to give attention;
And through attention
To see what needs to be done.

—Ben Hei Hei, Jewish sage

Quiet reflection at The Gathering of Physicians allows for a greater awareness of the power and importance of silence, of listening. In his wonderful book The Healing Companion, Dr. Jeff Kane writes about the importance of listening: “The Chinese written character for listen is compounded of those for attention, ear, eye, and heart. You’ve already ‘listened’ to the illness story with your ears and eyes. To make sense of it, you’ll need to listen with your heart—that is, with your insides. ... Listening with your ‘heart,’ then, means staying tuned to precisely what you feel.” Physicians are typically not trained to listen with their heart, to elicit a personal story, to explore the meaning of an illness, or to value silence. Instead, much of our training focuses on the medical history, the scientific, objective data: “Just the facts, ma’am, just the facts!”

At one gathering, a physician shared a short story he wrote about his own internship experience. Visiting a home where an infant had just died, most likely from a crib death, the physician realized that he had “never witnessed a death outside the hospital,” nor had he “broken the news of death to a patient’s loved ones.” He also realized that he had not received even one lecture on how to deal with the interpersonal relationships surrounding death and dying. He knew immediately that he was in “uncharted waters of ways to kneel and kiss the ground.”

And through wonder to attain wisdom;
And through wisdom to find simplicity;
And through simplicity to give attention;
And through attention
To see what needs to be done.

To the study and begin reading. Take down a musical instrument. Let the beauty we love be what we do. There are hundreds of ways to kneel and kiss the ground.

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the value and power of sharing their own stories, feelings, or experiences as a way of humanizing the doctor-patient relationship. Many physicians deeply value and respect relationship skills in their personal lives, and some believe that the mutual sharing of stories can be therapeutically healing for both patient and physician. Barry Lopez, in Crow and Weasel, writes, “The stories people tell have a way of taking care of them. If stories come to you, care for them. And learn to give them away where they are needed. Sometimes a person needs a story more than food to stay alive. That is why we put these stories in each other’s memory. This is how people care for themselves.”

Burnout is defined here as a lack of harmony between our personal and professional values, between what is meaningful in our lives as human beings and as physicians. It is the antithesis of well-being and wholeness. By re-forming the community of medicine, the Gathering of Physicians honors the importance of wholeness and healing, and provides an opportunity for physicians to “care for themselves.” We have also created a safe, supportive space that serves to counter the sense of isolation and burnout felt by many physicians. The Gatherings of Physicians models a way of appreciating what gives meaning to the lives of our patients and, at the same time, reconnects us with the meaning of our work, of service, of healing, of our own wholeness.

The Gathering of Physicians is open to all Sonoma County physicians. We meet on the third Thursday of the month, from 7 to 9:30 p.m. Call 525-1311 for further information.
The art of medicine
The suffering of physicians

During the past 40 years, we have become all too familiar with the dehumanisation of modern medicine: new technologies have altered the relationship between doctor and patient; specialised physicians know more and more about less and less; doctors treat diseases rather than people; medical schools teach the science but ignore the art of medicine; medical technology has outpaced moral understanding; and hospitals have become cold, impersonal mazes. This critique of dehumanised medicine and its ethical quandaries helped give rise to the development of bioethics and the medical humanities. And reform-minded educators have pressed the case for respecting the patient as a person, and for taking care of the whole person through active listening, compassionate presence, and collaborative decision making.

But the patient is not the only “whole person” in the consulting room. Evidence in recent years suggests that physicians also suffer from the dehumanisation of modern medicine. There are many signs that being a physician today is not good for your health: rates of anxiety, depression, and suicide are higher among physicians than in the general population. Job stress among generalist physicians in the USA is directly linked to measures of poorer physical and mental health. In the USA, about 15% of physicians will be impaired at some point in their careers, which means that they will be unable to meet professional obligations, in some cases due to mental illness, drug dependency, or alcoholism. One index of these problems—burnout—has received a great deal of recent attention. Indeed, numerous studies in US health science centres have confirmed what everyone has known for years—namely, that rates of burnout among medical students, residents, and faculty are a cause for concern.

Burnout is not just an American problem. The Annual Meeting of the European Forum of Medical Associations and WHO, which is comprised of more than 40 European countries, met in Berlin in 2003 and called for more attention to physician burnout. In Australasia, emergency physicians and hospital consultants have been found to have high rates of burnout. Burnout among Japanese physicians has been called a “catastrophic collapse of morale”. Another study reports that cardiology residents in Argentina suffer from burnout. This list could go on. Burnout is usually identified by three major symptoms: emotional exhaustion, depersonalisation, and decreased sense of self-efficacy. But burnout, we believe, is also a euphemism for what many physicians experience as a crisis of meaning and identity. A deeper understanding of burnout, we suggest, begins by acknowledging its context: physicians in many developed countries live and work in a technocentric, dehumanised, and financially driven environment, often within a broken and unjust system of health care. Those who work in academic health centres face institutional strains caused by the marketplace restructuring of health care, a shrinking safety net, more indigent patients to care for, and increasing competition for research funding. Their counterparts in developing countries often work under conditions that are shaped by inadequate resources, a shortage of health workers, and weak health-care systems. In different settings worldwide, therefore, physicians may work under conditions that increasingly prevent them from living up to their highest ideals. This is the background for grasping the valuable definition of Christina Maslach and Michael Leiter: “Burnout is the index of dislocation between what people are and what they have to do. It represents an erosion in values, dignity, spirit, and will—and erosion of the human soul.”

One useful lens through which to view physician burnout is Theodor Adorno’s notion of “ethical violence”. In Problems of Moral Philosophy, Adorno called attention to a cruel aspect of collectively enforced morality. In his view, any set of ethical maxims or rules must be approvable by individuals “in a living way”. When an ethical norm “turns out, within existing social conditions, to be impossible to appropriate”, the result is ethical violence. Institutions that ignore existing social conditions and rigidly enforce moral rules are, according to this view, perpetrating violence on those expected to do the impossible. Of course, Adorno had political history in mind, but his analysis of ethical violence can help us understand the suffering of physicians. Medicine is filled with many people of good will, integrity, and commitment who strive to provide compassionate and
ethically sound care, teach and mentor students, maintain scientific standards of practice, keep current with the most recent literature in one’s field, and undertake biomedical research. These are all good and necessary activities. Yet current conditions can limit the ability of physicians to live up to these requirements and ideals, which in some individuals creates a cognitive dissonance that leads to cynicism, disillusionment, self-doubt, dis-ease, and a retreat from ideals. When institutions do not acknowledge the gap between ideals and the various limiting conditions of work, they unwittingly allow ethical violence to undermine health and wellbeing.

In this context, how can we humanise the experience of doctoring? One answer points to the need for structural and cultural change in large institutions where doctors work—for example, in hospitals, health science centres, or health maintenance organisations. The disillusionment of many physicians in many countries derives from the imbalance between the energy and focus devoted to strategic planning and generating a financial surplus and the attention given to the primary goals of professionalism and patients’ care. Another answer involves promoting activities that encourage self-care, reflection, and development. Academic and other health-care institutions and professional organisations need to provide opportunities that support and guide physicians in their search for meaning, wellbeing, and self-care. Physicians need compassionate and non-judgmental listeners. This is especially true, for example, among physicians who take care of seriously ill and dying patients. Our work in this area has shown that first-person narratives by such physicians can reveal some important themes that deserve increased attention: unmourned narratives by such physicians can reveal some important themes that deserve increased attention.

Unmourned losses can mount up when taking care of critically ill and dying patients. It is no secret that physicians tend to suppress their feelings to maintain their composure and ability to take care of the next patient. But the consequences of neither talking to anyone nor allowing oneself to feel the impact of these experiences often results in an accumulation of pent up emotion and unmourned grief. Similarly, the unrealistic expectations that physicians encounter can also be challenging. In Just Here Trying to Save a Few Lives emergency medicine physician Pamela Grim writes about informing a family of the death of their loved one: “This is the time when people hate you as a doctor. You have failed, flunked, dropped the ball. You should be sued—you will be sued. You are a quack…And a part of you believes all this because no matter how sure thing the death was, some part of you believes you really can perform miracles.”

Uncertainty in relating is another key issue. In 1979, Lawrence Grouse inaugurated the “A Piece of My Mind” column in JAMA and later wrote a piece titled “The Lie” for the column. He recounted the story of Annie who came into the emergency room having been kicked in the stomach by her horse. As Annie bled into her abdomen and went into shock, she asks Grouse “Will I live?” Grouse thought she was dying but assured her that she would live. When Grouse later told Annie that he had thought that she was, in fact, going to die, Annie felt betrayed and angry. Did Grouse do the right thing? This case is not simply about the ethics of disclosure—it is also about guilt, shame, regret, and the sheer uncertainty physicians face in such pressing circumstances.

The difficulty in having open conversations with critically ill patients is illustrated in the posthumous memoir of the physician Steven Hsi, Closing the Chart: A Dying Physician Examines Family, Faith, and Medicine. Despite the compassionate care he received, Hsi was most troubled by his physicians’ failure to ask the crucial questions: “What has this disease done to your life? What has it done to your family? What has it done to your work? What has it done to your spirit?” As suggested by Hsi, physicians faced with questions of unexplained suffering and death are loathe to ask existential questions that have no biomedical answer. Some physicians, as David Smith points out in Partnership with the Dying, may hold an unspeakable practical theodicy, a way of relieving the shame and guilt of failure by leaving matters ultimately to God or a higher power. But they tend to keep these thoughts to themselves.

There are no quick fixes for the suffering of physicians, just as there are no quick fixes for the suffering of patients. But we suggest that caring, compassion, and conversation are important in both contexts. Helping to recover meaning and to avoid burnout among vulnerable physicians involves respect for physicians’ stories, which in turn requires that physicians tell their stories. But to whom should physicians tell their stories? In some instances, physicians themselves need professional care. Alternatively, or in addition to obtaining therapy for themselves, doctors must seek—and institutions must provide—avenues for dialogue that allow renewal, self-care, mutual support, and reflection. Professional associations and institutions must create better working conditions and provide programmes that support stress-reduction, healthy lifestyle choices, personal reflection, and self-care. In turn, self-care must be seen not as an option but as an obligation. The obligation to care for the patient entails the obligation to care for the self, for when the health of the physician is compromised, is not the quality of patients’ care also compromised? We are just beginning to realise that humanising medicine depends in no small part on recovering the humanity of physicians.

*Thomas R Cole, Nathan Carlin*

The John P McGovern Center for Health, Humanities, and the Human Spirit, University of Texas-Houston Health Science Center Medical School, Houston, TX 77030, USA

Thomas.Cole@uth.tmc.edu

Further reading


COURAGE: A NEGLECTED VIRTUE IN THE PATIENT-PHYSICIAN RELATIONSHIP

EARL E. SHELP
Center for Ethics, Medicine, and Public Issues, Baylor College of Medicine, and Institute of Religion, Texas Medical Center, Houston, TX 77030, U.S.A.

Abstract—The contribution that the virtues can make to the moral life in general and to the moral community constituted in the patient-physician relationship more specifically is gaining increased scholarly attention. This paper explores the meaning and relevance of the virtue of courage for patients and physicians. Courage is presented as a virtue for physicians in addition to the excellences of competence and compassion and a virtue for patients in addition to the excellences of compliance and gratitude. In agreement with Alasdair Maclntyre, courage is held to be necessary, at times, to our expression of care and concern for one another. The patient-physician relationship is shown to be a context in which courage can be a relevant virtue.

Certain conditions are listed as necessary to courage: freedom, fear, risk, uncertainty, an endangered good and a morally worthy end. Equivalents to these necessary conditions are discussed and held to be present in patient-physician encounters. Physicians are pictured as a 'sustaining presence' who have duties toward patients of 'encouragement' that can be fulfilled in ways relative to the requirements of each circumstance. Patients are held to have a duty to learn about the nature of human existence and to develop the character necessary to its negotiation. Patients and physicians can be agents of courage who come together in a context of care and concern where certain goods are preserved even, at times, in the midst of loss. Thus, courage is presented as a relevant and important moral virtue for the patient-physician relationship in which those qualities that define who we are as a moral community are expressed and sustained.

INTRODUCTION

Having worked in a major medical center for several years, I have been privileged to observe first-hand the exchange between patients and physicians. During periods of clinical teaching and case consultation both the strengths and weaknesses of human existence have been revealed dramatically. In these settings I have observed behavior that, at times, seemed courageous or cowardly without being named as either. This troubled me.

I had not thought much about courage as a virtue or the forms of its expression prior to these clinical experiences. As a result of this exposure and my lack of understanding, I became concerned to differentiate courage and cowardice from their imitations and to consider what proper place courage has in the therapeutic relationship. What follows is an account of these and other variables, e.g. complaint or disease presented by the patient, specialty of the physician, setting (private office or public clinic), value systems of the parties, personalities of the parties, etc. Given these and other variables, it is probably foolish, if not impossible, to attempt to specify unconditional norms for the form and content of the therapeutic encounter. Such an effort would appear to disregard the unique needs, wants, desires, values and characters represented in each case perhaps to the detriment of the individuals involved. Further, an effort to impose rigid requirements on such an alliance would seem counter-productive in an area of human intercourse where the capability to respond in divergent ways to changing circumstances appears mandated and warranted if the desired ends, broadly speaking, of recovery or accommodation are to be achieved.

To contend that the patient-physician alliance properly can take different forms and that it is dynamic is not to say that it is exempt from moral, professional and legal standards of judgment. Rules of conduct from all three realms are held to apply to the patient-physician interaction but in such a way as to provide a framework or super-structure which permits discretion within their boundaries and, at times, perhaps exception. The individual and intimate nature of the exchange between patient and physician is accommodated by such an approach and explains,
in part, why certain traits or attributes are commonly emphasized not only as ideals to be approximated but also as standards of evaluation to be realized.

Two excellences or 'virtues' are popularly held as appropriate to and necessary for physicians: competence and compassion*. Similarly, two excellences or 'virtues' are popularly held, at least by physicians, as appropriate for patients: compliance and gratitude. Competence, compassion, compliance and gratitude are understood here as excellences attributed to persons in certain roles. As such, competence and compliance would seem not to have standing as 'moral excellences' or 'moral virtues' but compassion and gratitude might be given this moral status, i.e. 'moral virtues'. To cite these four features as excellences is not to exclude the relevance of others or to deny their relative importance. These four are mentioned not only because of their currency but because, in my opinion, they are subject to a much richer understanding and appreciation to health care contexts than is generally given. Among the excellences for physicians, probably none is mentioned by medical professionals and lay people more often than competence. Competence is understood as a capacity sufficient to meet requirements. Thus, competence for physicians seems, at least, to include two components or to take two forms. One component would include those capacities grounded in medical knowledge and its application: diagnosis and treatment. A second component could be characterized as non-medical though traditionally associated in an inseparable way with the physician's role: understanding, sympathy, comfort, patience, etc. Capacities in both areas would appear necessary for physicians if they are to respond in a sufficient manner to the types of requirements made of them by patients. Unfortunately, there is a tendency to limit competency as a standard of excellence to those activities of physicians considered more specifically medical: examination, evaluation and treatment.

A second premier excellence for physicians is compassion. Compassion is understood as a sympathy for the distress of another with a desire to help. Thus a compassionate physician is one who shows mercy to a person, usually in the role of a patient, who suffers some misfortune (injury, illness or distress). It is increasingly the case that the substance of the 'help' which expresses the compassion of the physician is the product of communication and negotiation between the physician and the patient. This means that compassion is being expressed more in terms of 'fellow-feeling' and less in terms of paternalistic benevolent conduct by physicians [cf. 1]. It is interesting that the prominence of compassion has not decreased significantly even though the curative powers of physicians have increased significantly over earlier generations. It is well known that people continue to turn to physicians when they are uncomfortable or distressed even though probably in a majority of instances the consultation is unnecessary or the physician is powerless to effect change [cf. 2, 3]. Is this due to a grand deception engaged in by physicians to dupe patients and to fill their pockets? I suspect that this is not the case. Rather, the continued consultation with physicians suggests something of the value placed on the sort of compassion expressed by physicians in response to a patient's worry and a sense on the part of patients that the physician genuinely wants to help. Further, it is probably compassion rather than greed that stops physicians from turning the worried-well away. Compassion is not a relic that remains from the period of medicine's impotence. It is a premier virtue that partially defines who a physician is and describes what a physician does. It is a central pillar upon which patient-physician relationships are built.

Turning to the excellences of patients, it is interesting to observe that physicians seem to classify patients as 'good patients' or 'bad patients' by the extent to which the patients comply with the requests and instructions of the physician and the degree to which the treatment objectives are realized. Compliance is the yielding by one person to the request, desire, or demand of another. In health care this has meant that patients would follow the instructions of their physicians believing that such compliance would maximize their potential for cure. The propriety of this sort of behavior assumes that the physician's counsel is medically accurate, that the anticipated results are desirable to both parties, and that the proposed action is morally and legally acceptable. Patient compliance is seen as exercising a desire to get well, an assumption of some degree of personal responsibility for one's health care, and a prerequisite for being excused from one's obligations. Such obedience on the parts of patients is consistent with the view of medicine that requires physicians to exercise some measure of authoritarianism, paternalism and domination as 'essential to good medical care' [4, p. 1507]. This posture and approach may, in fact, be entirely correct, given the facts of many clinical cases, especially if the physician acts in a truly beneficent manner which respects the autonomy of the patient [cf. 5]. However, some commentators have challenged the wisdom of unlimited patient compliance as counter-productive to the interests of patients [6] and a misunderstanding of the nature of medical authority [7]. Unreasoned compliance on the part of some patients might also evidence a vice similar to

*Franz Ingelfinger's provocative discussion of arrogance among physicians begins with an assumption that physicians are competent and compassionate [4, p. 1509]. I consider Ingelfinger's comments to be representative of the views of physicians in general and consonant with my experience. Competence, however, tends to be given more emphasis among my medical colleagues. And, its application tends more to be seen as more relevant to diagnosis and treatment than to understanding, sympathy, comfort, etc.

†There may be explanations for this, e.g. greater emphasis on knowledge and technique over character as a measurable quality and/or health care as a transaction between strangers rather than friends where more 'objective' criteria of evaluation can be relied upon.

‡The place of compassion in modern medical care merits a much more thorough investigation than can be provided here. Many questions deserve answers. For example, is compassion a matter of style among physicians? Can compassion be learned or is it innate?

§For a more complete discussion of the sick role, see Ref. [29].
slothfulness or indifference. Indeed, the potential exists for abuse or moral failure in any dependent relationship but this potential alone does not displace some degree of patient compliance as appropriate to the patient–physician interaction. Compliance is not necessarily a result of coercion on the part of physicians nor is the desire of physicians for compliance necessarily part of a medical deception that is self-serving. It is difficult to stipulate apart from a discussion of a particular case what degree of control and surrender is medically and morally warranted. It is important to note for present purposes that physicians tend to consider compliance as an excellence of patients that is of benefit to the patient and that helps to certify a patient as ‘good’, i.e., easy to manage, more enjoyable and more often than not, properly grateful, the second premier virtue of patients.

Gratitude is a thankful appreciation for gifts or benefits received. The place of gratitude in the contemporary patient–physician relationship is probably a preservation from a past era of health care in which the nature of exchange between patient and physician were substantially different. The days of free or reduced-fee medical care are basically past. Various social programs and the advent of third-party payment has removed gratitude as the price paid by patients for the humanitarian services of a physician. Increasingly the gift relationship in health care is yielding to a market relationship. Yet an exchange of benefits remains in these transactions which preserves the role of gratitude in them. The dominant view is that gratitude is an excellence more appropriate to patients than physicians. However, William F. May has challenged this view by arguing that physicians benefit in the therapeutic encounter in ways not measurable by money and for which they are in the debt of patients, e.g., for their formal and continued medical education and for service as experimental subjects. Gratitude, in most instances, is an excellence appropriate to patients and physicians. The nature of the exchange between the parties secures the place of gratitude in it.

Competence and compassion embodied in and expressed by physicians and compliance and gratitude embodied in and expressed by patients are only the excellences or virtues that are most commonly discussed. These brief comments can do nothing more than call attention to their place and function in the patient–physician relationship. Other traits or characteristics could be discussed. One wonders, for example, about the meaning and legitimate role of honesty (an on-going topic of debate), efficiency, sensitivity, strength and resolve in the patient–physician relationship. In addition, one wonders how the character of the patient–physician relationship might be altered if the traditional cardinal virtues were applied in a robust way.

The notion of virtue and place of virtues in the moral life have experienced a renaissance of interest evidenced by a growing body of recent literature. But only a portion of these studies have been applied to health care. The ultimate contribution that virtue theory may make to bioethics, the philosophy of medicine, and the delivery of health care remains to be seen. There can be little doubt that a virtue-based approach to these concerns will be different from a utilitarian or deontological one. A thorough study of the virtues in ethical theory would reveal that diverse understandings abound. A similar lack of consensus would be discovered by a review of medical literature representing different historical periods and regions. How the clinical encounter in general or any particular patient–physician relationship was perceived influenced the choice and understanding of the virtues viewed as relevant to it.

The suggestion that courage can have an appropriate expression in the patient–physician relationship may be controversial. Surely we would pause before esteeming as courageous the improperly paternalistic physician who administers a drug to a patient in disregard of the patient’s competent refusal. Similarly, we would not esteem as courageous the patient with cancer who knowingly takes placebos in order to prove their ineffectiveness against the patient’s disease. In order to reduce confusion and reasonably to be clear about the way in which courage is understood in this essay, the next section contains an analysis of courage as a moral virtue. Following this, a non-exhaustive exploration of the role of courage in the contemporary patient–physician relationship will be provided. I say non-exhaustive because I doubt that a complete study is possible or much more helpful. Similar analyses and applications of other traditional cardinal virtues could be undertaken, perhaps with great profit.

**COURAGE**

The words ‘excellence’ and ‘virtue’ have been used interchangeably prior to this point. No definition of these terms has been proposed. And, even now, many of the interesting and important topics in discussions of virtue and the virtues cannot be explored, e.g., source, unity, place in moral theory, correlate vices. A pursuit of these concerns would go far beyond the boundaries of the present discussion. Thus, I propose, without defense, as an operational understanding of virtues a combination of ideas from William Frankena and Alasdair MacIntyre. Accordingly, virtues are dispositions or traits that involve a tendency to act in certain kinds of ways in certain kinds of situations. They are not entirely innate and must be acquired, at least in part, by teaching and practice, or grace. The virtues sustain us in the relevant kind of quest for the good, contribute to a knowledge of the good and of ourselves [9, p. 63; 10, 35-43].
The notions that the virtues can be cultivated in some way and that they are related to the achievement or approximation of the good suggest something of their relevance to the relationship between patients and physicians and the environment of the relationship. Courage is one of the central virtues of the moral life. What its relevance is and how it can be expressed in medical encounters will be interpreted following a brief examination of its meaning.

**Definition**

To say that some action or that some person is courageous is to make both a descriptive and evaluative statement. And to attempt a definition satisfactory to everyone is not a simple task. Indeed, great minds have failed in the attempt (cf. Plato, Laches). The definition employed here contains elements touched upon by many commentators that are brought together in order to display certain necessary conditions for courage that differentiate the courageous from other forms of conduct. I propose the following: courage is the disposition to voluntarily act, perhaps fearfully, in a dangerous circumstance, where the relevant risks are reasonably appraised, in an effort to obtain or preserve some perceived good for one self or others recognizing that the desired perceived good may not be realized. Several elements of this definition require brief elaboration in order for the relevance of courage to the patient–physician relationship to be developed.

**Freedom and fear**

A basic element of courageous conduct is free choice on the part of an agent that counters the prohibitive influence of the emotion of fear. A courageous action is voluntary. It is a result of deliberation rather than ignorance of a circumstance. Courageous actions are chosen by the agent. They are not a result of accident. They are acts of decision which express a form of freedom rather than coercion or chance. The element of free choice in courageous conduct implies that the agent anticipates, to the extent possible, the potential consequences, accepts them, and assumes moral responsibility for them (cf. 11, pp. 246–247). The element of freedom together with an estimate of the worth of the anticipated ends (to be discussed below) partially explains why some conduct is honored as an act done courageously in contrast to being described only as a courageous act.

Speaking of courage in terms of conduct is not meant to imply that only overt forms of conduct can be seen as courageous. While an action may be more obviously courageous, an inaction may be no less real or laudatory. Consider the endurance of martyrs or the courageously held belief, opinion, or conviction which may place one in some danger. St Thomas Aquinas understood courage as enabling one to act or endure in accord with the will of God. The effect of courage is, according to St Thomas, to curb fear and moderate daring. He gave greater emphasis to the former effect over the latter. This implies that courage, in his view, and even though he gave place to both forms, engenders action more than restrains action (cf. Summa Theologica, II–II, q.123 in Ref. [12]). Josef Pieper, in the same tradition as St Thomas, emphasizes the opposite effect of courage. He views endurance rather than attack as more revelatory of courage (cf. [13, p. 130]). Yet, to rank one form or effect of courage over the other seems mistaken. Endurance may be indicated in one circumstance and attack may be indicated in another circumstance. Perhaps our tendency to view action rather than inaction as the paradigm of courage has been mistaken. We inadvertently may have tended to identify aggression alone with courage to our detriment. As John Howard Yoder reminds us, there can be an impotency of power and a power in impotency (14). Courage may entail endurance or it may entail action.

Courage does not always take the same form in every context or role. The courage of a soldier may not take the same form as the courage of a lifeguard. We tend to think, though not exclusively, of a soldier showing courage by exposing himself or herself to danger in order to bring about some destruction of life or property. Alternatively, we tend to think, though not exclusively, of a lifeguard showing courage by taking risks in order to rescue the life of a floundering swimmer. Courageous acts need not have any single outward feature in common. Aristotle was correct: "...a courageous man feels and acts according to the merits of each case and as reason guides him (Nicomachean Ethics, 1115b 20-21)‡. What is courageous in one circumstance may be cowardice in another. Yet the essence of courage remains constant, independent of social setting or human personality. This essence is the mastery of fear for the preservation of a good against dangers. Its form is determined by the dangers faced, the values threatened and the resources available. The methods of responding to these dangers and threats will differ accordingly [15, p. 499]. As the good can take many forms, so can...
courage take many forms in its pursuit or preservation.

Fear can hinder one’s pursuit of the good. It can distort one’s perception and cause one to seek security rather than honor. The virtue of courage masters fear but the courageous person is not necessarily fearless or fearful. Commenting on Aristotle (Eu-
demian Ethics 1228 B), D. F. Pears, in an excellent analysis, notes that the courageous person may retain some general fear of wounds or death at a basic level but, all things considered, she or he takes the risk [16, p. 282]. Facing danger does not necessarily destroy the fear that accompanies the confrontation. Rather, the courageous person has a proper respect for danger. The fear that danger inspires does not over-
awe nor is it ignored. To be overcome by fear may result in the sacrifice of some good unnecessarily. To ignore fear might increase unnecessarily one’s chance of injury or loss [17, p. 163]. Thus, in some way and despite the fear inspired by danger, the courageous person acts or endures in order to pursue or preserve some good.

Risk

The words ‘danger’ and ‘risk’ appear in the definition above. The use of both terms is intentional. Each implies a chance of injury, damage, or loss. ‘Dangerous’ describes the nature of the circumstance relevant to courage. ‘Risk’ refers to vulnerability as the condition of the agent relevant to courage. Without vulnerability, without risk, courage has no place. But the nature of human existence is such that life is vulnerable at every point. This means that courage is relevant not only to those circumstances in which danger is clearly defined. Courage understood de-
scriptively and potentially evaluatively also is rele-
vant to all of life which is subject to those unpredict-
able events that are threatening, the most extreme of which can bring death.

As the ultimate risk, all courage has reference to death and its epiphanies. David Harned warns that our desire for security and fear are not the only obstacles to courage. Whatever obscures our vulner-
ability and mortality equally can undermine the foundations of courage [18, p. 140]. The fact that life ends provides every moment with some value. And it is paradoxical that in risking life it is found in all its fullness and meaning. The courage that is required to live, to risk is the same courage that is required to die, to risk no more. Courage is not reducible to calculating risks in a self-serving manner. It involves knowing what is good and evil, what is to be sought and what is to be sacrificed. More will be said below about risk, death, and courage as factors within the patient–physician relationship.

Worthy end

A disposition to take risks is a characteristic of courage. Courage demonstrates that one is prepared to risk some good in order to attain some end held

to be of equal or greater value. D. F. Pears has shown that many virtues, including courage, can serve two types of goals and involve a counter-goal. With regard to courage, the internal goal is acting cour-
ageously for its own sake and the external goal can be anything, e.g., victory in contest or health. Counter-goals like injury, loss, and death are avoided as the other goals are pursued. The counter-goals comprise, in part, the risks associated with the virtue [16, pp. 273-274]. Looking at courage in this way explains how an action may be described as cour-
ageous but not be valued as virtuous. The external goal of the conduct may not be noble. Hence, there is a reluctance to designate murder as a courageous deed even when the murderer takes great risks in executing the plot. The more noble the ends, the easier it is to use courage as a word of praise. A disposition to take risks may be expressed for morally good or morally evil ends. One can act from morally reprehensible motives and for morally repugnant ends and still show courage. The external goal must be morally worthy for a courageous act to be noble and the agent virtuous*.

An estimate of the worth of the desired ends also helps in differentiating courage from foolishness. Some external goals are not worth the risks. For example, it would be foolish for a millionaire to risk life to retrieve a one dollar bill being blown about by the wind of speeding automobiles on a crowded inter-
state highway. All things considered, the external goal seems incommensurate with the counter-goals or risks. Alternatively, it would seem courageous for a parent to risk life to retrieve a child from drowning in deep, turbulent water. All things considered, the external goal seems commensurate with the counter-
goals or risks. Despite the counter-goals, the internal and external goals of such conduct are subject to being judged as worth the risk associated with their achievement. But the good of others is not the only proper end of courage.

The worthy end of courage may provide some benefit to the agent. The agent may benefit in terms of preserving one’s integrity as well as attaining some end that is beneficial. Self-affirmation or the courage-
to-be is based on an affirmation of rational nature over against the irrational and accidental in life. To claim those moral values for oneself that positively define who one is as a person and who we are as a people is to affirm one’s essential being as a moral agent in the moral community. Thus, understood ontologically, joy is the emotional expression that accompanies the courageous affirmation of one’s own true being. Joy and sorrow can be present with courage. Sorrow for what is lost and joy for what is gained or preserved. Alasdair Maclntyre is correct that courage may be necessary to express care and concern for individuals, communities and causes [19, p. 102]. But it can also evidence care and concern for oneself. The good of others or oneself may merit the assumption of certain risks to attain or preserve those respective goods.

Uncertainty

There is no assurance that the good sought by courage will be realized. This element of uncertainty distinguishes courage from confidence. A courageous

*For views on this matter, see [12, II–II. 123.5], [49, 1115b 20] and [38, pp. 14–18].

*For a complete ontology of courage see Ref. [22].
person is confident that the desired ends are worth the potential costs but not all confidence is courageous (cf. Plato, *Protagoras* 350 d). The uncertainty of courage is not limited to the potential harms to the agent. It is attached as well to the results of the effort. The ends once realized may be discovered not to have been worthy of the borne risks. So, in an evaluative sense, the perceived value of the desired end is an unknown. One can never be sure in these circumstances that the desired goal is commensurate with the anticipated risk. But, it is the belief that the two are commensurable which prompts one to action. In acting, the agent evidences some commitment to moral ideals and values.

A scarcity of courage among people or within societies may indicate how little commitment there is to moral ideals or to the well-being of others. When we place little value on ourselves or others we are less likely to sacrifice or assume risks for their protection. When someone or something is valued highly enough we are more disposed to assume risks on behalf of that valued ideal or person. By acting courageously we profess that some other end is believed possible and preferable to the one which is anticipated to occur without the courageous act and that the alternate uncertain outcome is worth the perceived costs. Thus, it is the circumstance (dangerous, uncertain, worthy end, motive) that renders an act noble and not merely descriptively courageous. Courage, in the sense of virtuous, deals with how to live the noble life and to die the noble death. It deals with how to pursue and preserve, to the degree possible, the moral life and the moral community. Courage assists us in negotiating a reality that is dynamic, uncertain, and dangerous. To be courageous is to be freed from an all absorbing attachment to personal safety and position [20, p. 35].

**Summary**

I have suggested that courage is a moral virtue the expression of which benefits the agent or others and expresses one's solidarity with and concern for the goods of personal or social existence. That which is courageous can take many forms, i.e. it is relative to persons and contexts. 'Courageous' describes that sort of conduct that poses some risk to the agent in order to attain or preserve some perceived end for oneself or others. 'Courageous' also is a term of positive evaluation for that conduct that seeks a noble end and involves risks that most people would find difficult to assume. Given the nature of human existence as vulnerable and dangerous, courage is a virtue relevant to all of life, particularly those circumstances in which some good that is considered indispensable to the morally worthy life is in danger. I shall propose in the next section that the patient-physician relationship can constitute the sort of dangerous circumstance where courage is a relevant virtue.

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*Accommodation is understood as, among other things, providing meaning to meaninglessness, bringing order to chaos, and enabling one to live and die with what cannot be cured. A cure-accommodation pattern for the range of legitimate ends of the patient-physician encounter is suggestive but too simplistic.
Courage: a neglected virtue in the patient-physician relationship

We admire and support those who protect us from death and the negative effects of its epiphanies. To do so gives testimony to the value we place on life. Yet, try as we will, our vulnerability can be forgotten for only so long before we are reminded of how feeble our grip on life really is. The world about us can be hostile. The assaults upon life can be so great that there are times in which its loss is a gain. At times, death can be welcomed and those who seek it admired. Our evaluation of death is based upon the circumstances of the individual who experiences it. There are times in which it seems more noble to receive death than to labor against it.

Eric Cassell builds that part of the physician’s task is to teach people how to live as embodied and how to live with the body’s limitations [21, p. 182]. It is reasonable to suggest that these tasks include helping people to admit their vulnerability and mortality. This sort of recognition can provide a foundation for courage, for mastery of the fears in life that can rob it of its richness*. Physicians appear to have special opportunities to teach people that, as Paul Tillich said, “life is a series of surrenders, which require courage” [22, p. 74]. The surrender of the myth of omnipotence and immortality is perhaps the most difficult and requires the greatest courage. Doing so means that we are no longer ignorant of the potentially dangerous environment in which we live. Recognition of these potential dangers may generate fear that restrains courage. As Alasdair MacIntyre reminds us, to understand death as our end is a necessary part of courage. “...to be virtuous is not to avoid vulnerability and death, but rather to accord them their due” [10, p. 121].

Sickness and suffering

Our vulnerability and mortality tend to be more present to us when we are sick or suffer. Our sense of disintegration, of flagging omnipotence, and destructibility turns us to others whose represented powers may restore us to wholeness. Our loss of power in sickness is compensated by the powers of physicians to whom we turn for help. Our submission is a confession, perhaps painfully wrought, that we are not self-sufficient and omnipotent, that there are powers (benevolent and malevolent) greater than our own, that life is dangerous. The physician symbolizes relief and protection. The consultation and the subsequent process is a joint venture wherein resources are marshalled to defeat the threat, learn to live with the limitations it imposes, or to accept its realization. When patients are protected from the fact of their mortality their sense of omnipotence may be increased and the prospect for learning courage is lessened. Alternatively, patients who are not permitted an active part in the exchange may become more dependent than necessary and feel more important than they are. The patient may come to believe that he or she is unable to master anything, unable to wrest any form of victory from the midst of apparent defeat. This does not need to be the case in every situation. Periods of sickness can be seized as opportunities to learn about life, death and courage. One lesson is that courage may be required to surrender the good of life for the good of death. Thus, in a sense, sickness can provide a setting in which we learn about and develop the courage that is necessary to life.

The experience of sickness is not only one of physical pain or bodily weakness. It can also bring suffering. Eric Cassell suggests that the relief of suffering is one of the physician’s duties. Relief from suffering, which he defines as severe distress, is provided, according to Cassell, by imparting meaning to a situation where meaning is threatened [23].

How meaning is imparted is an open question. Perhaps performing well in this aspect of patient care requires of physicians and others greater energy and creativity than performing well in physical diagnosis and treatment. The presence of physicians to those who suffer can provide assurance to them that they are not excluded from the human community in which care and concern is mediated. In the experience of sickness and suffering the weak and strong are bound together in a therapeutic alliance. Rather than being abandoned the sufferer is a central concern. The one who suffers may be supported in his or her sickness as a means of affirming his or her place in the community. Alternately, his or her decision to endure no more may be respected and he or she may be assisted in dying as a means of affirming these cherished powers that gave life meaning but that now are gone*. The patient-physician relationship is a joint venture in pursuit of identifiable goods. It is a venture begun in a situation of threat and distress. It is a situation of uncertainty and potential danger.

Uncertainty

The patient-physician relationship is an alliance in uncertainty. The uncertainty is far-reaching involving all aspects of clinical medicine. Yet, physicians tend not to disclose their doubts to patients or colleagues, perhaps in order to prompt patient compliance and to maintain the esteem of one’s peers [cf. 24, p. 83]. This reluctance to expose one’s doubts is consistent with those images of physicians that symbolize strength, superiority or power: healer, teacher, protector, advocate, care-provider. These images suggest that the physician’s duties are defined in terms of and derived from his or her strength. But when the physician’s strength is useless his or her duties to patients do not cease.

A better image for physicians is that of a ‘sustaining presence’. This image allows for strength and

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*Our fears in life are often inspired by perceptions of our own death and our own dying. These fears can paralyze us or prompt us to action [cf. 50].

†Stanley Hauerwas also has written about suffering and medicine’s response to it [51, p. 52]. He considers it “...odd that in the name of eliminating suffering we eliminate the sufferer” [51, p. 229]. I agree that this approach is extreme but there can be circumstances in which it is a justifiable course. Philippa Foot also presents such a view [53]. Whether physicians have a duty or are permitted to eliminate the sufferer or assist the sufferer in eliminating himself or herself is an additional question. For a theological interpretation of suffering see Ref. [54] and for an exposition more biblically based see Ref. [55].

‡Hauerwas seemingly has failed to accept this point as valid.
weakness. It does not imply that the physician's duties are tied to strength alone. It suggests that embodied weakness can be present to weakness of body in a preserving and redeeming way. It calls attention to the value of fidelity in the presence of uncertainty and degeneration. An image of 'sustaining presence' can represent the physician's duties in cases where cure is possible and where it is not. It does not place total responsibility for patients upon physicians. It implies some degree of mutuality and cooperation. It does not suggest expectations of physicians that are impossible or unreasonable. It allows for fallibility and doubt.

Physicians can provide patients with few guarantees. They can covenant with patients to be present and to sustain them in the ways and degrees possible. Physicians can join patients in a pilgrimage into a dangerous unknown. Each assumes some risks through and some responsibility for the process and its conclusion. Their alliance is one of relative strength and weakness. Their task is to negotiate a reality that includes pain, sickness, suffering and death.

Tragedy

Medicine has been described as a tragic profession in which the limits of human existence are laid bare [25, p. 190]. Clifford Leech describes the principals in tragic literature as moving toward a growing awareness of the way things are in the human condition, a condition in which freedom and fate co-exist. The author of tragic literature is concerned to reveal three features of human existence: (1) that we discover our own mortality and recognize that by our choices we have had some role in bringing about our losses*; (2) that our actions can produce consequences opposite to what was meant or intended, and (3) that we understand that this is the way life is. We vicariously experience life and we learn about its necessities through tragic portrayals [26, pp. 36–65]. It may be for this reason that tragedy has survived as a literary and dramatic form. Tragedy does not entertain as much as it instructs and inspires. The tragic figure also can be a tragic hero. Some measure of victory is won even in the midst of loss [27, pp. 23–28]. The audience admires the greatness of spirit that the tragic hero embodies. Though yielding to necessity, limited victories are won. The hero's spirit and response to adversity may inspire awe, wonder, or admiration. Necessity and spirit win and lose in tragedy. We accept necessity (there is no alternative) but we are inspired by the human spirit which snatches some measure of victory out of natural defeat.

Patient-physician relationships are not portrayals on a stage or the printed page from which we can turn away. Within these relationships people in different roles come together to negotiate necessity and choice, freedom and fate. The experience is real and personal, not make-believe and vicarious. In this context the participants embrace life as it is and attempt to wrest whatever victory is possible, perhaps in the presence of the inevitable.

The unthinkable may become real. Death may come. Efforts to help may fail or even harm the intended beneficiary. Our finitude is reluctantly accepted. The patient-physician relationship can provide a context in which something of the nature of life is learned. Each participant learns that their respective powers are finite and that death, either then or at some future time, is our fate. The patient-physician relationship in this sense, becomes a vignette of life. In it, as in life, courage may be required to achieve victory even in defeat, to claim some good even at the loss of another good.

Patient-physician relationship as a context for courage

The patient-physician relationship is one in which the elements necessary for courage are present: freedom or choice, fear, risks, worthy goals and uncertainty. Yet courage is rarely mentioned as an appropriate virtue except in reference to a willingness to take risks† or to a patient's valiant effort to survive or overcome some disability. But courage can be applied more broadly than this for patients and physicians.

To use soldiers, which has been customary, as examples of courage no longer seems adequate. Modern warfare may not require courage on the part of combatants whose enemy is faceless and whose victims are known in numerical terms rather than personal ones. A more appropriate modern context for learning about courage can be the patient-physician relationship where the adversary (death, disease, distress) may be faceless but the victim is known and issues demands to be sustained and attended even when cure is impossible. In either case, courage may be required to negotiate a reality of disease, pain, suffering and tragedy. As a 'sustaining presence' a physician can teach patients 'the wisdom and authority of the body';. The security and comfort that is offered is not unlike that experienced between friends. To be a 'sustaining presence' implies that one wants to help, is loyal to the other party, and is honest about one's limitations.

Courage is required of those who choose a profession that embodies care and concern. And, 'encouragement' is properly one of their duties. Admissions of finitude and uncertainty may not come easy to those who desperately want to help others in distress. The honest disclosure of diagnosis, therapeutic options, and prognosis can itself be a process of 'encouragement' in which the parties discover the nature of the human condition, define what is important within life, recognize what dangers exist and decide what certain goods are worth. This process of disclosure can be a form of 'encouragement' that can enable patients to choose to retain or surrender autonomy. Nicolai Hartmann is correct that courage is particularly necessary where another's welfare, happiness, or destiny is at stake. In these instances, an agent places some personal good in jeopardy in the interest of another person. This "will-to-assume responsibility" for or with another may entail courage [11, p. 247].

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*It is increasingly clear that individual choices of lifestyle affect health status and mortality, see Refs [56, 57].
†Courage as a willingness to take risks on the part of physicians has been explored in Ref. [58].
‡I am indebted to Stanley Hauerwas for this phrase.
The capacity to be courageous in the therapeutic relationship is based on trust, truth and clear expectation [28, p. 36]*. Patients will be better equipped to affirm themselves despite their condition in a relationship with these characteristics. The ‘sustaining presence’ of physicians can powerfully state that the patient is affirmed by others and therefore worthy of self-affirmation. Out of this affirmation the patient may discover the capacities to be courageous. Physicians must not over-protect patients from the nature of human existence. Doing so may mean that patients never discover and learn the capacities to negotiate reality. As people must be given the opportunity to realize their creative potential, so must patients be given the opportunity to be courageous. Physicians, can enhance this prospect by being honest, loyal and helping. Otherwise these possibilities may go undeveloped and the goods associated with courage may be lost. Physicians, too, can learn of courage as they abide by patients when there is little or no more they can do. What Aristotle said of professional soldiers (in contrast to citizen soldiers) is true of physicians: “…The professionals go to face danger from the very outset in the belief that they are stronger, and once they realize that they are mistaken they run away, fearing death more than disgrace. But this sort of thing is not courage” (Nicomachean Ethics 1116 B 20-25). Physicians may be tempted to mirror this behavior in their own context. Such urges should be resisted.

Courage was seen in heroic societies as a quality of individuals necessary to sustain a family or community [10, p. 116]. The same is true in the patient–physician relationship. Courage understood in terms of power and loyalty can be a quality of physicians who sustain a relationship, practice, and tradition. This quality can be expressed in many forms from person to person, circumstance to circumstance. Sharing in another’s life does not consist in burdening the other with requirements. Rather, it consists in eliciting the recognition of personal values and capacities that may go unrealized otherwise. Eliciting courage is not the same as imposing values and norms. For physicians, it is assisting patients in not letting fear overtake them so that the opportunities present in sickness and dying are not lost to them and others. As ‘sustaining presence’ the physician shares responsibility for the process and the results. No one bears it alone. Learning to live includes learning even in dying.

Without courage the evils in the contexts of sickness and dying go unchallenged. Physicians ought not to tell patients how to live. Rather physicians ought to help patients develop the physical strength and the moral character with which to live. This may mean that some patients will struggle to live and others will accede to death. Either course holds potential for good and grief. Courageous living can bring joy and sorrow, even in the same moment. The patient–physician relationship can be a context for courage and encouragement within which the nature of the human condition is learned and the capacities necessary to its negotiation are developed.

**CONCLUSION**

I have suggested that courage is a virtue relevant to the patient–physician relationship in addition to the excellences of competence, compassion, compliance, and gratitude. The conditions appropriate to courage and its expression were seen as potentially present in this context in the forms of certain goods (e.g. cure or accommodation), vulnerability to danger and doubt. The nature of the patient–physician relationship was understood as a context in which the nature of the human condition can be learned and the character necessary to negotiate reality can be developed. I proposed that physicians, as a ‘sustaining presence’, have duties of ‘encouragement’ that can be fulfilled in ways relative to the requirements of each circumstance. Alternately, I proposed that patients have a duty to learn about human existence and the courage-to-be. Both patients and physicians are agents of courage who come together in relative strength and weakness to pursue or preserve the good life to the degree possible. As a context in which care and concern is expressed courage is a necessary virtue.

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*Wilkes is correct on this point but his supporting illustration confuses courage with faith and confidence. Wilkes is a psychiatrist who draws upon his Christian theological convictions. He cites the experience of the ancient Hebrews in becoming a community and confronting their oppressors as courageous. They were able to do so according to Wilkes because their covenant with Yahweh was based on trust, truth, and clear expectation. But confidence is not a sufficient condition of courage. Hebrew—Christian theology tend not to doubt the capacity of God to keep covenant. The risk of failure in the covenant is on the part of humanity.
Viewpoint: **Today’s Professionalism: Engaging the Mind but Not the Heart**

Jack Coulehan, MD

**Abstract**

Professionalism is au courant in medicine today, but the movement to teach and evaluate professionalism presents a conundrum to medical educators. Its intent is laudable: to produce humanistic and virtuous physicians who will be better able to cope with and overcome the dehumanizing features of the health care system in the United States. However, its impact on medical education is likely to be small and misleading because current professionalism curricula focus on lists of rules and behaviors. While such curricula usually refer to virtues and personal qualities, these are peripheral because their impacts cannot be specifically assessed.

The author argues that today’s culture of medicine is hostile to altruism, compassion, integrity, fidelity, self-effacement, and other traditional qualities. Hospital culture and the narratives that support it often embody a set of professional qualities that are diametrically opposed to virtues that are explicitly taught as constituting the “good” doctor. Young physicians experience internal conflict as they try to reconcile the explicit and covert curricula, and they often develop nonreflective professionalism. Additional courses on professionalism are unlikely to alter this process. Instead, the author proposes a more comprehensive approach to changing the culture of medical education to favor an approach he calls narrative-based professionalism and to address the tension between self-interest and altruism. This approach involves four specific catalysts: professionalism role-modeling, self-awareness, narrative competence, and community service.


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**H. L. Mencken** wrote, “There is always an easy solution to every human problem—neat, plausible, and wrong.”1, p. 442 This applies to today’s project to instill “professionalism” in medical education. I believe the movement to teach and evaluate professionalism in medical training is threatened with failure because the intervention is too simple, too neat, too flimsy, and doesn’t engage the problems it attempts to address. These problems, as I conceive them, are both internal and external to the profession. Internally, the medical community suffers from depleted moral imagination, while vast numbers of its individual practitioners suffer from existential conflict and timidity of response. Externally, the profession is beset on all sides by the disappointment, dissatisfaction, and misunderstanding of the people whom it is supposed to serve. So yes, professionalism in medicine does appear to be in bad shape; but no,

Professionalism—with a capital “P,” indicating the Simple Answer—will not revive it.

In this essay I present a series of reflections on today’s culture of medicine and medical education, with particular emphasis on the V-word: virtue. I want to address the issue that Larry Churchill raised more than 15 years ago, “How did we get to this point of not valuing a distinctive professional ethic? A profession without its own distinctive moral convictions has nothing to profess.”2–4 If indeed we as medical educators have nothing to profess, then an aggressive program to instill and promote a code of professional behavior in physicians-in-training will be artificial and bound to fail. In place of professionalism, I want to suggest a more comprehensive approach to a rebirth of medical morality for the 21st century.

**The Recent History of Professionalism**

By the early 1970s, biomedical ethics, which focuses mostly on patient rights and the structure and process of shared decision making, had replaced old-fashioned professional ethics in medical education. Many believed that professional ethics, based on virtue and duty, had confined itself to the special

Dr. Coulehan is professor, Division of Medicine in Society, Department of Preventive Medicine, Health Sciences Center, School of Medicine, Stony Brook University, Stony Brook, New York.

Correspondence should be addressed to Dr. Coulehan, HSC L3-086, Health Sciences Center, School of Medicine, Stony Brook University, Stony Brook, NY 11794-8036; telephone: (631) 444-9744; fax: (631) 444-8029; e-mail: jcoulehan@notes.cc.sunysb.edu.
require that educators measure the outcome of their efforts.12–17

Why have we resurrected this explicit focus on “a distinctive professional virtue”? Let me present my own view of the forces that medical educators have been obliged to respond to, in order to meet their goal of producing highly competent and ethical professionals. Over the past several decades, medicine in the United States has evolved into a vast, increasingly expensive technological profit center, in which self-interest is all too easily conflated with altruism. While medical treatment became more efficacious than ever before, it also became potentially more harmful to patients. As technology advanced, patients developed higher expectations of cure, but at the same time they became progressively less satisfied with the personal aspects of medical care. While specialists spent more time wielding the mighty machine, they spent less time listening to or connecting with their patients. Meanwhile, commercialism began to run rampant in medicine, including the rapid development of for-profit hospital systems and managed care organizations and the appearance of a vast array of opportunities for physicians to make money from commercial relationships, especially with pharmaceutical companies. Commercialism set the stage for increasing conflict between the interests of physicians and their patients. The costs of the system skyrocketed, but it nonetheless remained inequitable and inaccessible to significant segments of the population. The evolution of applied science was not accompanied by the evolution of a legal right to health care. Yet our lingering cultural belief in the full narrative tradition. To explain what I mean by this, let me describe briefly the texture of a medical trainee’s experience as it relates human values and professionalism.

Tacit versus Explicit Learning

Many observers have described a conflict between what we think we are teaching medical students and young physicians (the explicit, or formal, curriculum) and a second set of beliefs and values that they learn from other sources (the tacit, informal, or hidden curriculum).19–29 This conflict begins during students’ preclinical education and becomes more pronounced in the hospital and clinic. As students and house officers wend their way through years of training, they gradually adopt the medical culture and its value system as their own. An
important aspect of this socialization is the transfer, to trainees from their role models, of a set of beliefs and values regarding what it means to be a “good” physician.

The explicit component of professional development includes courses, classes, rounds, advice, or other teaching designed to instill professional values. Tacit learning, by contrast, includes the learning and socialization processes that instill professional values and identity without explicitly articulating those issues. This hidden curriculum continues throughout medical training. While the explicit curriculum focuses on empathy, communication, relief of suffering, trust, fidelity, and pursuing the patient’s best interest, in the hospital and clinic environment these values are largely pushed aside by the tacit learning of objectivity, detachment, self-interest, and distrust—of emotions, patients, insurance companies, administrators, and the state.

The Hospital Narratives

Culture consists of the matrix of stories, symbols, beliefs, attitudes, and patterns of behavior in which we find ourselves. With this in mind, I want to propose a mental experiment and ask the reader to immerse her- or himself in a contemporary teaching hospital. Once there, listen to the conversations among physicians and between physicians and other health professionals. Pay close attention to the texture of hospital practice, in particular to its oral culture, the stories that surround you. What sort of stories are they? How can they be categorized? Which of the narratives appear to be especially meaningful to their narrators and audiences? In what ways do they fit together? What do these stories teach about what it means to be a good physician? In other words, in what moral universe does clinical education take place?

The first surprising observation you may make is that the vitality of this universe is centered outside the patient room. The narrative world is most alive in the teaching hospital’s hallways and conference rooms and unit stations. Generally, you discover that physicians enter their patients’ rooms as infrequently as possible; and when they do enter, they listen to these patients as little as possible. Instead, they usually have an agenda in mind—a procedure to perform or a parameter to check. Their one-to-one interactions appear to play only a small role in shaping the “received wisdom” of hospital culture. In fact, procedures performed on patients are more frequently the starting place for the stories doctors tell one another than are their conversations with patients.

The second interesting feature is that stories permeating the hospital ethos don’t usually have patients as their active protagonists. Rather, patients serve as clever or frustrating or even stupid plot devices—presenting obstacles or challenges that may impair the story’s progress or, alternatively, pleasing foils or surprising twists that facilitate the story’s successful resolution. Nonetheless, the real protagonists or heroes of these stories are usually doctors, although in an increasing percentage of narratives the doctors may play second fiddle to cyborgs, i.e., machines of one sort or another that figure things out and set them straight.

With regard to villains, hospital narratives are considerably more varied. In some cases, the villain may be an impersonal negative force—a virus or accident, for example—which hardly qualifies as a villain at all. But in more complex cases, other health professionals may play the role of villains; for instance, the arrogant subspecialist, the power-hungry surgeon, the incompetent nurse, the stupid medical student, and so forth. Moreover, the patient’s own family may play a malevolent role, either as a result of being present (e.g., the hostile, questioning daughter) or being absent (e.g., the son who never shows up). Finally, patients themselves may take on the role of Bad Guys, with scripts that demonstrate ignorance, anger, and—above all—noncompliance. In addition, patients play another important role in hospital stories, as the butt of gallows humor.

From an emotional perspective, many hospital stories about patients feel rather flat, even though at the same time these stories are intellectually stimulating. Embedded within them are extraordinarily complex puzzles: diagnostic dilemmas and physiological conundrums. These quandaries share certain characteristics with crossword puzzles (find the correct word), jigsaw puzzles (fit the pieces together), and other games that require speed, endurance, and excellent hand-eye coordination. Nonetheless, the stories are two-dimensional because they contain little emotional resonance.

Yet the lack of emotional resonance in patient-and-doctor stories does not extend to interactions among students and hospital staff. Most of the feelings in medical culture that do get acknowledged are those of doctors or other health professionals, which tend to be expressed in negative attitudes and outbursts: “This place sucks!” “That gomer in 1215 is a real pain in the ass.” “I’m so pissed off at that resident I could scream.” Although expressions like these are permissible, the physician ethos in general disapproves of emotion and favors stoic acceptance. This, in fact, is one way that doctors demonstrate the superiority they feel over patients, who are often emotional and let subjective perspectives get the best of them.

Finally, as should be obvious, the virtues and values articulated in this thumbnail sketch of hospital culture bear little relationship to the traditional ethos and morality of medicine. If you accept this culture, you say self-interest whereas I say altruism. You say the patient is an object of interest; I say the patient is a subject of respect. You say the bottom line is to free up the bed; I say the goal is to promote healing.

This glimpse that I’m presenting of the world in which medical students and young physicians find themselves is a gross overgeneralization. First, it ignores the narratives of nursing, social work, chaplaincy, and many other professions. These professions, of course, overlap, reverberate with, and influence one another but—and this is quite remarkable—they seem to influence the culture of medicine very little. While physicians in the hospital are completely dependent on multiple other professionals and support personnel, the culture of medicine itself remains rather isolated and uninfluenced by them. Second, nowadays a substantial proportion of medical education takes place in clinic and office settings, where patient narratives may play a larger role in trainees’ overall experiences. Finally, I’ve overgeneralized about physicians.
medical professionalism. At an experiential level, medical students and house officers relieve or resolve their internal conflict by adopting one of three styles of professional identity.

- **A technical** professional identity, in which young physicians abandon traditional values and adopt a view of medical practice consistent with hospital culture. They become cynical about duty, fidelity, confidentiality, and integrity; and question their own motivation and that of others, thereby narrowing their sphere of responsibility to the technical arena.

- **A nonreflective** professional identity, in which physicians consciously adhere to traditional medical values while unconsciously basing their behavior, or some of it, on opposing values. In this type of self-delusion, a young physician believes that when she acts in accordance with hospital culture, she actually manifests the explicit values she learned in the classroom, although instead it is the hidden, negative values that are being expressed. For example, compassion is best manifested by detachment, and personal interaction is suspect because it lacks objectivity.

- **A compassionate and responsive** professional identity, adopted by a third, substantial group of young physicians, who thereby overcome the conflict between tacit and explicit socialization.

Let me emphasize that these characterizations represent the physician’s internalization of what being a good doctor means and the manner in which he or she should behave. As such, they cut across my rule-based and narrative-based categories, which refer to the manner in which professionalism is conceptualized and taught by medical educators.

Williams and I claim that a large percentage of our graduates are best characterized as nonreflective professionals; that is, physicians who believe that they embody virtues like fidelity, self-effacement, integrity, compassion, and so forth, while acting in ways that not only conflict with these virtues, but also contribute to contemporary problems in health care such as rising costs, inadequate physician–patient communication, and widespread dissatisfaction. It is this group of physicians that most clearly exemplifies Albert Jonsen’s insight about the core dynamic of professionalism,

“...the central paradox in medicine is the tension between self-interest and altruism.”

A Flag in the Wind

Thomas Inui’s report, “A Flag in the Wind: Educating for Professionalism in Medicine,” which is based on his experience as scholar-in-residence at the AAMC, presents a systematic and comprehensive analysis of our continued failure to instill professional virtue in medical education. Because Inui’s eight conclusions parallel my argument, I want to summarize them here. First, “the major elements of what most of us in medicine mean by professionalism have been described well, not once but many times.” This is understandable because these elements are based upon “the attributes of a virtuous person,” about which there is widespread consensus. Next he observes, however, that the literature and rhetoric of medicine fail to grasp “the gap between these widely recognized manifestations of virtue in action and what we actually do” in medical education and practice.

Inui acknowledges that physicians “may be unconscious of some of this gap” but when they are conscious of it, they tend to be “silent or inarticulate about the dissonance.”

In his fifth conclusion, Inui draws attention to the discrepancy between “what they see us do” (the hidden curriculum) and “what they hear us say” (the formal curriculum). Under these circumstances, “students become cynical about the profession of medicine—indeed, they may see cynicism as intrinsic to medicine.” In this context, “additional courses on medical professionalism are unlikely to fundamentally alter this regrettable circumstance. Instead, we will actually have to change our behaviors, our institutions, and ourselves.” Finally, Inui indicates that the most difficult challenge of all is for students and educators to understand that medical education is “a special form of personal and professional formation” (emphasis added), rather than a species of technical learning.

Inui recognizes that the gap between belief and behavior that characterizes our teaching hospitals is partly unconscious. To the extent that this is true, these physicians manifest nonreflective professionalism; that is, in the formation of their professional identities, they have internalized the belief that certain nonvirtuous behaviors are virtuous, since they are “the way things are in medicine.” The term “nonreflective” implies that these physicians rarely, if ever, step back and consider the impact of their behavior on themselves and others, as human beings deserving of care and respect. Inui suggests that another part of the institutional gap between belief and practice is conscious and, therefore, hypocritical. Unfortunately, physicians with little interest in the narrative and value dimensions of medicine may at times be required to serve as teachers—and presumably role models—because of the infrastructure and demands of medical education. When these physicians impart their rote “wisdom,” they do so hypocritically. Trainees quickly detect this and respond with cynicism.

Narrative-Based Professionalism

To nurture the professional virtue, or narrative-based professionalism, that I am advocating, Inui observes that “we will actually have to change our behaviors, our institutions, and our selves.” In the educational culture that I’ve described, the prospects for such change seem bleak; yet I believe that cultural change is possible, given the right catalyst and sufficient receptivity in the medical community. I believe that receptivity among medical educators is growing, given their dissatisfaction with the processes and products of...
provide, throughout medical school and residency, a safe venue for students and residents to share their experiences and enhance their personal awareness. Doctors need to understand their own beliefs, feelings, attitudes, and response patterns. One of the earliest proponents of this view was the British psychiatrist Michael Balint, who encouraged physicians to meet regularly in small groups to discuss difficulties with patients and their personal reactions to practice.37 Physicians tend to view emotions as negative or disruptive, and often confuse intellectualizing their responses (naming an "affect") with genuine emotion.38 Physicians are particularly vulnerable to anxiety, loneliness, frustration, anger, depression, and helplessness when caring for chronically or terminally ill patients.39 They often try to cope with these emotions by suppressing or rationalizing them. The more effectively physicians reverse this process by developing self-awareness, the more likely they will have the resources to connect with, and respond to, their patients’ experiences.

In addition, the trainee’s moral development may be hindered by everyday learning situations. These include conflicts between the requirements of medical education and those of good patient care, assignments that entail responsibility exceeding the student’s capabilities, and personal involvement in substandard care. Once again, the opportunity to discuss, analyze, critique, and sometimes repair these situations allows students to find their own voice and may eventually empower them to develop that voice effectively.40–43

Narrative competence
Medical practice is structured around narrative—between physician and patient, teacher and student, and the like. However, as a result of the tension between explicit and tacit values, students learn to objectify their patients and devalue subjectivity. In part, they learn to conceptualize their patients in terms of flow sheets, rather than personal stories. At the same time, they internalize hospital narratives, which tend to be cynical, arrogant, egotistic, self-congratulatory, and highly rationalized, but nonetheless become influential in the formation of the trainee’s professional persona. Moreover, students immersed in these stories have little time to listen to, and may also lack the skill to understand and respond to, their patients’ stories, or to experience themselves as characters in the larger narrative of professionalism in medicine.

Accordingly, the third prerequisite for fostering narrative-based professionalism is the development of narrative competence. This can be understood as “the ability to acknowledge, absorb, interpret, and act on the stories and plights of others.”44 The narrative medicine movement provides a way of reframing the knowledge, skills, and attitudes of good doctoring under the aegis of language, symbol, story, and the cultural construction of illness.45–50 It draws upon the centrality of clinical empathy in establishing and maintaining therapeutic relationships, and also upon the broader, more imaginative empathy that allows observers to “connect with” the experience of persons not immediately known to them, such as the uninsured in Appalachia, HIV-infected children in South Africa, or refugees in Sudan.51–55

The trainee’s own life experience, molded by positive role-modeling and reflective practice, serves as the basic material from which narrative competence may develop. However, students may enhance their repertoires of life experience by exposure to the written, filmed, and oral narratives of real and fictional physicians; and they may increase awareness of their own developing professional identities by writing personal and professional narratives consistently and with discipline.56–61

Community service
Finally, in order to teach narrative-based professionalism, the medical curriculum must include socially relevant service-oriented learning. Interaction with patients in the hospital or office setting is insufficient to provide students and young physicians with narratives of interdisciplinary practice, biopsychosocial modeling, and social responsibility. The American Medical Association’s Code of Ethics specifies in section VII that “A physician shall recognize a responsibility to participate in activities contributing to an improved community.”62 In section III, the Code of Ethics indicates that “A physician shall . . . recognize a responsibility to seek changes in (legal) requirements which are contrary to the best interests of the patient.”62 These manifestations of
professional virtue need to be addressed in medical education.

Service learning may operate on many different geographic and social levels, from activities that take place locally to those on a national or international level. Moreover, the focus may include students contributing to clinical care (e.g., working at free clinics, doing clinical work in third-world countries), public health work (e.g., vaccinating migrant workers, assisting in “Stop Smoking” campaigns), health education (e.g., participating in HIV education in local high schools, speaking at church groups and community organizations), community service (e.g., volunteering in local agencies or with groups that provide direct assistance to third-world countries), and political action on health and welfare issues. Whatever the specific tasks involved, the minimal required “dose” of community service must be sufficiently large for students to view it as integral to the culture of medical education, rather than an unconnected add-on.

Conclusions
Professionalism is au courant in medicine today, but the movement to teach and evaluate professionalism presents medical educators with somewhat of a conundrum. Its intent is laudable: to produce humanistic and virtuous physicians who will be better able to cope with and overcome the dehumanizing features of the health care system in the United States. However, the impact of this movement on medical education is likely to be small and misleading unless it directly confronts the “central paradox in medicine,” which is the “tension between self-interest and altruism.”

In many ways, today’s culture of medicine tends to be hostile toward altruism, compassion, integrity, fidelity, self-effacement, and other traditional qualities. In fact, hospital culture, and the narratives that support it, implicitly identify a very different set of professional qualities as “good,” and sometimes these qualities are diametrically opposed to the virtues that we explicitly teach. Students and young physicians experience internal conflict as they try to reconcile the explicit and covert or hidden curricula, and in the process of their professional character formation they often develop nonreflective professionalism. Additional exercises in or courses on professionalism as it is currently taught are, in themselves, unlikely to alter this dynamic, even if they are supplemented by lists of competencies that trainees are required to demonstrate. This rule-based approach to professionalism does not alter the tension or conflict between tacit and explicit values.

Instead, I propose promoting narrative-based professionalism as a more comprehensive approach to changing the culture of medical education and addressing its central paradox. This involves immersing students and young physicians in a wide array of narratives, drawn from their own experiences as well as those of others, that display professional virtue. In essence, this approach would provide a counterculture of virtuous practice that may gradually displace the more negative elements of contemporary medical culture and allow students to bear witness to their profession, not just symbolically through oaths and White Coat ceremonies, but in the ways they conduct themselves in their day-to-day practice. Each component of this approach—professionalism role-modeling, self-awareness, narrative competence, and community service—overlaps with and reinforces the others. Moreover, each lends itself to longitudinal evaluative processes, such as the creation of narrative-based professionalism portfolios by students and residents.

Many of the elements for this development are already present, but in most medical schools dispersed too thinly and/or integrated too sparsely to produce a significant impact on the culture of medical education. I don’t know what critical mass might be required to initiate a chain reaction in medical education in favor of narrative-based professionalism. Presumably, however, it would not require that every faculty member and attending physician pass a litmus test for virtue and empathy. Nor would it mandate that commercialism disappear. The concept of a catalyst is important here because I believe that cultural change can take place if a relatively small number of well-placed faculty members, curricula, faculty development programs, and institutional supports are brought together with an aggressive treatment plan not only to alleviate the symptoms of an ailing professional culture, but also to set that culture on the road to recovery.

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bill, which would grant waivers from ACA requirements in 2014 if states can meet the ACA’s goals. The Vermont single-payer plan certainly can.

Perhaps we are at the dawn of systemic reform in U.S. health care. The Vermont single-payer plan will never be as efficient as Taiwan’s or Canada’s because it must work within the bounds of federal laws and programs and the realities of porous state borders. Nevertheless, it can produce substantial savings to fully fund universal coverage, reduce health care costs for most businesses and households over time, and reform a fragmented delivery system. Of course, someone will bear the burden — mostly the private insurance industry and high-wage businesses that don’t currently offer insurance. But if Vermont can navigate its political waters and successfully implement this plan, it will provide a model for other states and the country as a whole.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From the Department of Health Policy and Management, Harvard School of Public Health, Boston.

This article (10.1056/NEJMp1100972) was published on March 16, 2011, at NEJM.org.


I began to write, “I have seen a 24-hour-old child die. I saw that same child at 12 hours and had the audacity to tell her parents that she was beautiful and healthy. Apparently, at the sight of his child — blue, limp, quiet — her father vomited on the spot. I say ‘apparently’ because I was at home, sleeping under my own covers, when she coded.

“I have seen entirely too many people naked. I have seen 350 pounds of flesh, dead: dried red blood streaked across nude adipose, gauze, and useless EKG paper strips. I have met someone for the second time and seen them anesthetized, splayed, and filleted across an OR table within 10 minutes.

“I have seen, in the corner of my vision, an anesthesiologist present his middle finger to an anesthetized patient who was ‘taking too long to wake up.’ I have said nothing about that incident. I have delivered a baby. Alone. I have sawed off a man’s
leg and dropped it into a metal bucket. I have seen three patients die from cancer in one night. I have seen and never want to see again a medical code in a CT scanner. He was 7 years old. It was elective surgery.”

In a 2005 commencement address, the writer David Foster Wallace told the story of two young fish swimming along. An older fish swimming by greets them, “Morning, boys. How’s the water?” As the young fish swim on, one looks at the other and says, “What the hell is water?”

The third year of medical school is like being thrown head first into water. Although the impact is jarring, eventually the experience becomes natural. We become comfortable — legs-crossed, slouched-in-a-chair, coffee-in-hand kind of comfortable. Occasional moments, however, remind us that we are immersed in water. If we focus on them closely, we see that our lives are filled with these moments. The challenge is to collect them in a meaningful way — to spend time with them, wrestle with them, allow the discomfort they generate to sit inside us.

**Katharine Treadway:** Those of us who are fully acculturated into medicine can easily forget the power and turmoil of the third year and why it looms so large in physicians’ development. Studies have documented the high level of compassion with which students enter medical school and the sharp decline that occurs during the ensuing 4 years. Jack Coulehan captured this phenomenon poignantly when he asked, “How does professional socialization alter the student’s beliefs and value system so that a commitment to the well-being of others either withers or turns into something barely recognizable?”

Most of this decline occurs in the third year. It is ironic that precisely when students can finally begin doing the work they believe they came to medical school to do — taking care of patients — they begin to lose empathy.

The third year is generally the entry into the clinical experience, when medical students move from the classroom to the hospital. They perceive their task as learning how to apply to actual patient care the knowledge they’ve gained in the first 2 years. They do not understand the potential impact of the experiences and the environment in which their learning takes place. The “water” that surrounds them and of which, like the young fish, they may be largely unaware, is the hidden curriculum — all those behaviors and events that students observe and experience that may be at significant variance with what they’ve been taught. The impact of this hidden curriculum is profound.

It is powerful for three reasons. First, students are entering a foreign world where they face difficult, often overwhelming experiences. Second, the rules governing the responses to these experiences are unclear. It is not obvious to students that the beliefs and ideas with which they entered school still apply, so they take their cues from the behaviors they observe. Furthermore, since responses to these events are rarely discussed, students often erroneously ascribe a detachment and lack of caring to house staff and senior physicians. Third, these experiences have frequently gone unacknowledged and unexplored.

For the past few years, I have been a mentor to medical students during their clerkship year. As they have their first experiences with patients dying, they don’t know how they should respond, whether it’s OK to be upset. One student told me about his confusion when a patient he’d admitted to the hospital died and no one on his team even remarked on the death. It made him feel he wasn’t supposed to care. When, days later, his intern mentioned how bad she felt about losing the patient, he was relieved — it made him feel he was normal. His story revealed how vulnerable medical students are to the influence of behavior that contradicts their belief systems. At the beginning of medical school, most students would find it inconceivable that they might ever think it abnormal to care that a patient died. That the student even considered this possibility illustrates how fragile students’ ideas of physicianhood can be.
In a 1989 lecture on medical training, the medical sociologist Renee Fox remarked, “As they struggle, individually and collectively, to manage the primal feelings, the questions of meaning, and the emotional stress evoked by the human condition and uncertainty aspects of their training, medical students and housestaff develop certain ways of coping with them. They distance themselves from their own feelings and from their patients through intellectual engrossment in the biomedical challenges of diagnosis and treatment, and through participation in highly structured, in-group forms of medical humor. By and large, medical students and housestaff are left to grapple with these experiences and emotions on their own. . . . They are rarely accompanied, guided, or instructed in these intimate matters of doctorhood by mature teachers and role models. Generally their relations with clinical faculty and attending physicians are too sporadic and remote for that.”

How can we teach compassionate care as a learned skill in the same way that we teach the physical exam or the fundamentals of physiology? Clearly, the first step is to acknowledge that this is a skill to be taught. I believe that the question often posed — “Can you teach students to care?” — is the wrong question. In my experience, most students enter medical school caring deeply, and we actually teach them not to care — not intentionally, but by neglect, by our silence. We place them in profoundly disturbing circumstances and then offer no support or guidance about what to do with the feelings they have in abundance. So the issue is teaching students and residents the how of caring — helping them know what to do with their feelings and those of their patients.

Increasingly, medical schools are recognizing the need for more structured ways to teach students how to understand and cope with their third-year experiences. Many schools have launched formal curricula to guide students in self-reflection. Others have created longitudinal experiences in which senior physicians offer students closer guidance.

Four years ago, we changed the structure of the third year at Harvard Medical School. Instead of undertaking a series of isolated clerkships that were frequently offered at different hospitals, students now spend the entire year in one institution. Each major teaching hospital also has a longitudinal component that includes clinical case conferences conducted at a student level and a biweekly meeting to explore students’ experiences.

Neal Chatterjee: During my third year, I met with eight classmates for 2 hours every other week. What initially seemed an intrusion into our busy lives became an almost sacred space for recognition — both recognition that others felt similarly challenged, uncomfortable, and uncertain and recognition of moments that would otherwise have remained buried under Noon Conference attendance and potassium repletion. Most important was the shared nature of this collective self-examination, which helped buffer the inevitable discomfort and emotion that these moments generated.

Given the long hours, inescapant pages, and expanding responsibility of the clerkships, the transformation of the extraordinary to the mundane seems an inevitable consequence of medical training, a survival mechanism. The shared reflection and consideration we engaged in empowered us to take control of that transformation. While exploring some moments helped us to cherish their wonder and retain the humility they inspired, focusing on others helped us to strengthen our advocacy for patients.

During my intern year, this reflective power has stayed with me. An experience that might otherwise seem to be an errant thread is now held carefully and closely — and eventually woven into the fabric of my training.

Katharine Treadway and Neal Chatterjee: We believe that reflection that is integrated with clinical experience, not separate from it, is critical to students’ professional and emotional growth. The creation of a “safe space” for reflection and discussion can disempower the hidden curriculum by exposing it, allowing both positive and negative experiences to be used to reinforce values and behaviors conducive to the development of compassionate, emotionally engaged physicians. By being attentive to the complicated, challenging, and wondrous moments that define physicians’ lives, we can nurture this essential awareness. And we can begin by simply looking around us: this is water.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

From Massachusetts General Hospital and Harvard Medical School — both in Boston.
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Section Two

Beyond the Medical Literature
I want to thank the boy here for holding off long enough for me to make it to graduation today. In a week or two, you will have some serious competition, but so far, being asked to speak to you today has been one of the most moving moments I've ever experienced.

When you come to med school as a 30-year-old English teacher, med students are scary. In 19th century novels, at their worst, they're grave robbers, drunken louts, and even murderers. At their best, they're nihilistic philosophers, pedantic fops, and awkward dinner companions.

The last thing you expect is to find a group of people like this.

I don’t want to say that this place is like Lake Wobegone, where all the children are above average, though there are enough parents in the audience this afternoon that I’d probably get away with it, but we talk about outliers in medicine - standouts, cases on the ends of the spectrum - and this is a class of outliers. We have musicians and composers, puppeteers and pilots, a truly unhealthy number of triathletes and surfers -- and, as I discovered at our class play—not one, but two people who can twirl flaming batons. We have cartographers, photographers, writers, teachers, divers, gymnasts, chefs, and, at one point, even a teenager (who kindly pointed out to me that we were both born in the Chinese year of the rooster—since it’s a 12-year cycle). Being part of this group of people has been like nothing else in my life.

I've been waiting for four years to be found out and sent home, but today I think I can finally say, it's too late.

This is not to say that we aren't scary.

We have become the kind of people to whom it occurs that bilirubin-UDP-glucoronyl-transferase can be sung to the tune of Supercalifragilisticexpialidocious. We can no longer give directions to a restaurant without using the words proximal and distal, we’ve even lost the ability to use left and right without pausing first to see if we mean our own left. Worst of all, perhaps, we wear clogs in public, something I like to think we wouldn’t have done before.

We have changed.
And even to the extent that we have tried to stay the same, we have changed for others. My mother is the baby of eight siblings raised in rural Mississippi, and I'm her only child, so even though I haven't been back to Mississippi in years, the fact that I am in med school hasn't escaped notice, and one of my aunts called me last month to talk about my uncle.

When I was a kid, he drove an RC cola truck- Royal Crown cola for those of you born on the coasts - and during the summers I spent in Mississippi, when my two cousins and I would come back from the town swimming pool every day, he'd have put one RC Cola, one orange Nehi and one grape or strawberry Nehi in the freezer. We never saw him do it; we never beat him home, and the soda was never frozen somehow. And even though his two boys were a year older and a year younger than me and we competed over almost everything else, this was magic enough that we never fought over who got which. My uncle quit driving his truck 15 years ago when he went blind, from diabetes we've always thought. What my aunt called to tell me is that they now know he's had a growing tumor all this time.

This is a woman who used to tell me - you've got book smarts, Teri Ann, but you just got no common sense - so I think it's safe to say, she doesn't overestimate me. She didn't call me for book smarts, or medical advice - my uncle has been transferred to a big city hospital now and is under the care of expert neurosurgeons. She didn't even call to ask me to interpret or explain the information she'd been given. She just called to tell me the story.

I have 22 first cousins on my mother's side alone, and I'm not the one she'd call for anything else, but my aunt called to tell me this story because of what I've done here for the last four years - not because she thinks I have any more common sense now (I guess she doesn't overestimate this institution either), or even because she thinks I know enough to do anything, but because becoming a doctor, I'm learning, means above all, that people bring you their extraordinary moments.

We will hear many stories. We'll demand them: What happened? When? How? We will be readers of our patients' stories, and then, we will rewrite them as our own.

"This is a 55 year-old woman who presents with..." is our "Once upon a time..."— no less formulaic, and no less infinite in its narrative potential. But the stories we tell are not the same ones people bring. They are reaction, analysis, diagnosis, strategy— what we do when faced with a patient’s narrative.

The difference between a string of events, and the tale taken home at the end of the day is that we deem these events worthy of a second thought, a moment of reflection, worthy of the telling—we allow to this day’s work, the accumulation of meaning beyond habit.
The ability to take in someone’s story, to track and contextualize the meaning of a term—what does this patient mean when he says painful, when she says dizzy, when he says weak—this is only part of the job. We are readers when we try to understand what has happened to our patients. We are writers when we try to understand what has happened to ourselves.

Late in the Divine Comedy, Dante is asked to define faith, and he says:

Fede e' sostanza di cose sperate ed argomento delle non parventi.

Faith is the substance of things hoped for and evidence of those unseen.

Learning to doctor is something we have done within a network of expectations and support, of competition and friendship - a process of learning to think of ourselves relative to our teachers and our colleagues.

How many times have we paused – usually it is very early or very late - with needle or scalpel poised above a patient and looked briefly sideways – and with poorly concealed doubt - at the resident or attending standing beside us, and had them say, without urgency and without indulgence, “Go ahead.”

Perhaps they remember when they stood in our shoes, maybe they quietly celebrate not being there any more, or they silently run the possible complications of the procedure, but they don't look away and they don't smile.

(Remember, because this is important, that there was even a time when you paused with a pen because you were scared to write in a medical chart.)

And you move downward with the needle or the scalpel, not because you believe you can do this, but because the person standing next to you believes you can—and because this is enough.

How many times have you entered a room and said “Um, I’m the medical student on the team—would it be OK if I …" and had a patient say, with fatigue, with amusement, with indulgence… but calmly, “Go ahead.”

How many times have you looked at your classmates and …gone ahead because you thought, "well, they seem to think we can do this," not understanding at the time that the rest of us were also looking to you.

We act above our expectations for ourselves, because in the end, we are drawn into competence by the faith of those around us. This is the substance of things hoped for, as we search for evidence of things unseen.

The first time I walked into a patient’s room, traveling in a little pack of white coats
stiff enough to stand up on their own—my main concern, since I didn't know how to fix anything, was to stay out of the way. Unfortunately, I looked down (and this will surprise few of you who know me) and found toothpaste on my shirt, and just as the conversation turned to priapism, backed into a metal instrument tray. My classmates froze, the patient smiled, the attending winced, and at that moment, I decided I'd better redefine my goals. I was no good at staying out of the way.

If medicine is only a fight against disease, if medicine is a zero sum game, and our definition of success is to win, then we can, and eventually will lose.

But we can always get in the way.

We can stand between our patients and confusion, we can stand between our patients and insurance companies, we can stand between our patients and pain. We can mediate our patients' experience of disease - by placing ourselves, our words, our skills - the tools we came in with and those we have learned to use here - between them and what is hard.

We can define the task of medicine as we will - and commit to accompany a patient, as best we can, through the course of a medical experience. This may be across 25 years of struggle with chronic illness, or the arc of an emergency department visit. It may begin with a newborn checkup and end with a college physical. It may be the course of a surgery, a 45-minute hour, or the time it takes to suture a wound. But this is a guaranteed success task.

Before I close, I want to take a minute for Pat Patterson, whom we lost in October without really understanding why. For most of us, when we heard, it had been a while since the time when we saw Pat almost every day in the anatomy lab, and the news took us back.

What I remember most is that no matter what we asked him, Pat would laugh before he answered. I'd ask a question in my best serious student tone, and he'd drop his head and snicker, and then, raise his head and explain. Sometimes he'd start to smile or chuckle when I walked up, before I even said anything. I don't think I ever managed to impress Pat, though I certainly would have liked to, but I know I amused him. Contrary to the saying, Pat would laugh with you and even near you, but he was always also - just a little bit - laughing at you.

And so in that room on the 13th floor where we first wore scrubs, where we first handled a scalpel, where we laid hands on the first body in our care, and where we first got a glimmer of the ways people would give themselves to our learning, there was a teacher who made it almost impossible - though we certainly tried - to take ourselves too seriously. For this early lesson, we owe him our thanks, but also for the later one: that as we learn, among those we care for and also, those who care for us, there will always be those people and answers that remain outside our reach.
Here, now that we are at the end of the beginning, I think the most breathtaking thing about this training is that we get real patients so long before we feel like real doctors....

So in the coming months and years, when you're tired, when it's very early or very late, and you look sideways and find yourself alone with the needle or the scalpel or the pen...as you accumulate evidence of things unseen, remember also that there is already substance to the things you hope for.

Remember this story, these people who you began to learn to doctor with, and say quietly to yourself...

Go ahead. Get in the way.
Itzhak Perlman Improvises
by Jack Riemer

On Nov. 18, 1995, Itzhak Perlman, the violinist, came on stage to give a concert at Lincoln Center in New York City. If you have ever been to a Perlman concert, you know that getting on stage is no small achievement for him. He was stricken with polio as a child, and has braces on both legs and walks with the aid of two crutches.

To see him walk across the stage one step at a time, painfully and slowly, is a sight. He walks painfully, yet majestically, until he reaches his chair. Then he sits down, slowly, puts his crutches on the floor, undoes the clasps on his legs, tucks one foot back and extends the other foot forward. Then he bends down and picks up the violin, puts it under his chin, nods to the conductor and proceeds to play.

By now, the audience is used to this ritual. They sit quietly while he makes his way across the stage to his chair. They remain reverently silent while he undoes the clasps on his legs. They wait until he is ready to play. But this time, something went wrong. Just as he finished the first few bars, one of the strings on his violin broke. You could hear it snap - it went off like gunfire across the room. There was no mistaking what that sound meant. There was no mistaking what he had to do.

People who were there that night thought to themselves: "We figured that he would have to get up, put on the clasps again, pick up the crutches and limp his way off stage - to either find another violin or else find another string for this one...or wait for someone to bring him another." But he didn't. Instead, he waited a moment, closed his eyes and then signaled the conductor to begin again. The orchestra began, and he played from where he had left off. And he played with such passion and such power and such purity as they had never heard before. Of course, anyone knows that it is impossible to play a symphonic work with just three strings. I know that; you know that. But that night Itzhak Perlman refused to know that. You could see him modulating, changing, recomposing the piece in his head. At one point, it sounded like he was de-tuning the strings to get new sounds from them that they had never made before.

When he finished, there was an awesome silence in the room. And then people rose and cheered. There was an extraordinary outburst of applause from every corner of the auditorium. We were all on our feet, screaming and cheering, doing everything we could to show how much we appreciated what he had done.

He smiled, wiped the sweat from his brow, raised his bow to quiet us, and then he said, not boastfully, but in a quiet, pensive, reverent tone, "You know, sometimes it is the artist's task to find out how much music you can still make with what you have left." What a powerful line that is. It has stayed in my mind ever since I heard it. And who knows? Perhaps that is the way of life - not just for an artist but for all of us. Here is a man who has prepared all his life to make music on a violin with four strings, who all of a sudden, in the middle of a concert, finds himself with only three strings, and the music he made that night with just three strings was more beautiful, more sacred, more memorable, than any that he had ever made before, when he had four strings.

So, perhaps our task in this shaky, fast-changing, bewildering world in which we live, is to make music, at first with all that we have, and then, when that is no longer possible, to make music with what we have left.

From the Houston Chronicle, February 10, 2001
middle-aged black woman is leaning over, looking in. Lap rings at her car window makes her turn her head. A soft she is feeling lonely and helpless and unloved. Her flushed face as she struggles for breath between sobs. Her hand is resting on her hands, which are clutching the steering wheel at 8 o'clock. Tears stream down her forehead. Her body is shaking. A multi-story parking garage. Her body is shaking.

A young white woman is sitting in her little red car in the parking garage.

Dr. Martin Luther King

We are kin.

Chapter 2

Kindness

A Short Course In
When I began to think about writing this book, I knew...

"We are kin."

A SHORT COURSE IN KINDNESS
can give them the gift of comfort. I can recognize our encounters or any homeless person I encounter—but I know I cannot change the life of every homeless person. I know I cannot change the life of every homeless person. I had been in their unhoused bodies. How could I?

If I could think this way, would I ever walk past a homeless person with a mere opinion of embarrassment or right or wrong?

As these same stairs in the back of the house. We share the same stairs in the back of the house. I can still hear the same strains of conversation and same car. Our hearts beat in the same dance of conversation and same car. We are both to the same family; we practice the same craft. Our daughter, our daughter, our daughter. She is Kin. You can look at other people. —no matter their values. We can look at our children. —no matter our values. We can look at other people. —no matter their values. We can look at our children. —no matter our values. We can look at other people. —no matter their values. We can look at our children. —no matter our values.

When did we ever get the idea that we are different?

Everyone else. We all have families and lovers and babies, and babies. We all say. Everyone is just like me. I am just like you. We all were born with the same hot and cold, the same cool and dry. Everyone else. We all have families and lovers and babies, and babies. We all say. Everyone is just like me. I am just like you. We all were born with the same hot and cold, the same cool and dry.

The lesson, indeed, in those syndromes, is a simple one. To be happy. To be happy. To be happy. They want to be happy, and so do their children. They want to be happy, and so do their children. They want to be happy, and so do their children. They want to be happy, and so do their children. They want to be happy, and so do their children. They want to be happy, and so do their children.

There are whole countries living in their living rooms. There are whole countries living in their living rooms. There are whole countries living in their living rooms. There are whole countries living in their living rooms. There are whole countries living in their living rooms. There are whole countries living in their living rooms.

A SHORT COURSE IN KINDNESS
Some things never go out of style.

The Family of Man? It's still in print, forty-seven years later.

By the way, the book I discovered when I was five,

commend mine.

corate's membership in the family of man somewhat

do. I feel more like myself as I acknowledge my

some days I am too tired or busy — but when I

simply acceptance. I admit that I don't always succeed—

compassion, generosity, tolerance, understanding,

other. They are kind, they offer help, be it assistance,

I try to do that, because that's what kin do for each

 doesn't look away.

 can be the face, one of all the many faces that pass by.

give money if I am able or willing to. But most of all I
can say "Good luck" or "I bless you," if I am moved to. I can

mourn, laugh, hate, fear, breach, the capacity for pain. I can

invalidate or disregard. I can notice all we have in common:

shared humanity by looking into their eyes without
I think we have been sold a bill of goods about the importance of being nice — and in the process we have neglected the greater virtue: kindness. To me, nice doesn’t go very deep. It’s the manifest veneer on the surface. It’s smiling with one’s face but not one’s heart.

The dictionary contains the distinction between being nice and being kind. Let’s distinguish the pleasant response, not the audience’s reaction. It’s the pleasant response, not the audience’s reaction. It’s the pleasant response, not the audience’s reaction.

Kindness is the greater virtue. A friend of mine recently told me about a scenario involving a hospital setting: The kindness of the nurses and physicians made the patients feel comfortable and cared for. The doctors and nurses were present and attentive, making the patients feel valued and respected.

What kindness is and isn’t.
It requires that we make a conscious choice to act, then communicate to one another, and a healthy sense of self. I think this is because kindness is essentially a creative and inspired act. It is born of empathy. I reason this is because kindness is essentially a creative and inspired act. It is born of empathy.

One woman who was asked this question said right after she did the 5K. "Yes, I’ve done this. Kind brings tears to my eyes. In the past year, the difference between being nice and being kind. The woman’s name is Deborah. She is the one who was asked this question and right after she did the 5K.

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How it is with kindness. Once we have learned how to
across it again — and again — almost right away. That's
where you get used to it and then come
unlike form it looks.

Kindness itself is the key — and in whatever
way, however it may be. I have already done something: I
opened my heart to be open for
my concept of kindness. I went forth looking for the
kindness act in the world. I have met many interesting
people who have helped me. I have met many more
who are overwhelmed by the energy to figure our
problems on our own. I am sure, but I won't see that. I won't
see you are good or I am sincere. What else have received
help.

I may think I am being kind because my inventions
been nice to her. I will feel I have done something to
let me know if there is anything I can do. I will have
tell her I know she's matt really loud right now and
prevent us from being kind to them. If I can't Debra and
I would really like to someone can actually

Kindness in being nice, when it's nice, is not going to
save the world. Kindness just might
important question for all us. Niceness is not going to

WHAT KINDNESS IS — AND WHY

A Short Course in Kindness
A SHORT COURSE IN KINDNESS

Kindness, like misery, loves company.

If you frame us all around the ears, our own capacity for being kind:

Kindness requires tough decisions. Kindness is not for wimps.

Sometimes kindness requires tough decisions. Kindness and kindness are not mutually

exclusive. Kind people can make tough decisions.

You have to be tough to make it through.

You have to be tough to make it through.
He suggested Darwin do a book on physics instead because they

hated becoming quite popular among London's city-dwellers.

warn criticise bully, and share us into not taking risks.

"We only do sorry." These voices have a million ways to
call, "You're going to fail." Or, "Most common of
troble, you've going to fail." "Of you're asking for

We all have voices inside that say, "You're asking for

self-worth, you will not hear the critics inside you."

"If you're not afraid of the voices inside you."

"If you're not afraid of the voices inside you."

How overwinding it feels us from more than just

Cold feet talk about how powerful this part is — and

take risks where we might get hurt. Writing

make sure we have the courage to be kind. The second
type of courage we need in order to be kind. The first

The courage to try to be our own compass is the first

know our hearts we done the right thing

Know of us can learn to ignore naysayers when we

Skepticism, you will discover that even the most

read it. Even Shakespeare got bad reviews.

Is what we want to do if we want to

shun. Change Darwin's own book him to opposite existing

meant, even kept about the way Carrie was looked

mocked, even depicted about the way Carrie was looked

addressed anything in this world has been criticized.

Second, remember that everyone who has ever

"Courage in the absence of fear is just not letting fear

WHERE COURAGE COMES IN

was depreciation. Like "scratching teeth." Keep you posted.

decided to rewrite this book — and will arrive to in the future, so

I am both very lucky and very unlucky. The New York Times will

admit they're there, as Mark Twain reminds us.

We all have them, and we can disarm them unless we

kindly. We start by acknowledging that these fears exist.

How do we make it our fears so we can act

other to disaster.

Unfortunately to walk. Two directions lead to safety, all the

moment I could do something "dumb", didn't like. When a

accept and approval, it was temporary. The next

no way to live. I was never truly happy. Even when I won

nuparit, of approval. Instead to live that way and it was

But I had to decide to do it anyway; I had to resolve

on it.

the things I said. Someone always laughs. You can

my spiritual beliefs. I knew some people would laugh at

personal things about my life and my beliefs, including

knew I had to speak from my heart to expose some very

If my book were to do any good in the world, I

commend (I do so say myself)," and it took

rejected and strengthened my sense of self. And it took

decided to write a book about it. This decision born

kindness. The process began when I saw — and felt — how

sequence of feelings, and choices that result in an act of

Take this book. It was born through the same
People walking with us, doing their best to meet life with
When we look behind us and see no followers, only
as possible. When will we know we have succeeded?

Kindness is a revelation that needs as many leaders
order to lead them by example.

Phrases like "When will we know we have succeeded?"
are repeated throughout the text. The text also mentions
a woman who is willing to risk her life to help others.
Reverend Bill and Other Healers

“Do not be afraid. Do not be satisfied with mediocrity. Put out into the deep and let down your net for a catch.” (Luke 5:4)

When I was first diagnosed with cancer, I read that people who decide to be proactive in their care eventually become their own medical directors. At the time, I felt so overwhelmed with the diagnosis and array of information and choices, I could not begin to imagine myself in that role. However, as I kept putting one foot in front of the other, opportunities presented themselves one after the other, and through some sort of intuitive and somewhat informed method, I found I had amassed with an incredible team of brilliant health care professionals, care givers and healers.

There are the healers who have not intentionally chosen to be in a profession of care but cannot help but generate the essence of it. One of these people who I have been fortunate enough to find on my path is Reverend Bill. Reverend Bill is a tall, lanky, middle-aged African American man with a kind face. His garb does not consist of long robes of silk and gold-embroidered fine fabric, and ornate head coverings. He wears a thick polyester uniform and hat of navy blue, with a nametag on his jacket. Okay, so he’s not officially a reverend – he’s a ferry worker – but I gave him the nickname after countless times walking by him as I disembarked the ferry. Bill’s job is to lower and lift the footbridge so that people can walk on and off the ferry. He then stands on the Seattle side to make sure all goes smoothly, the footbridge is secure, no one jumps over or trips and falls. He offers assistance and most likely does tons of other tasks for the ferry that I don’t see him doing in between ferry runs.

Above and beyond his duties at the footbridge, Bill offers a hearty “Good Morning!” to every person who disembarks. Now, I don’t mean a ‘g’morning’ under his breath sort of thing. With Bill towering over the crowd, he lifts his long arm, puts together his index and middle finger (kind of like the Pope – with all due respect – which is why I gave him the surname of reverend), and points to each person with a robust “Good Morning!” “Good morning, good morning, good morning!” over and over – this person, that person, the meticulously and expensively dressed older woman who is going shopping, the business man catching his plane, the mom with two small children and a baby in a stroller going to the zoo, the barista who works on the Seattle side, the construction worker, the tourists, and people like me, going to medical appointments up the hill, hundreds of people, “Good morning, good morning, good morning!” Every once in a while a person responds with a smile or, even better, a mutual “Good morning!” But most people shuffle off in their own world with weary frowns, perhaps too shy and embarrassed to respond, or not knowing how to respond, or thinking that Bill is a nut case.

My first radiation required thirty-eight treatments and I walked on and off the ferry every day, Monday through Friday for nearly six weeks. I looked forward to the burst of energy that Bill would be generating on the other side of the water amidst the predictability and regularity of the ferry workers, masses of people walking off and on, and the order of
events on the ferry. I began responding to Bill. Then I made a point of making sure I was on the right side while I exited with the herd of people so that Bill could hear and see me. After a while we began to make eye contact and when we did so, he would lightly bow to me and I would respond subtly with the same gesture. By the end of the treatment, he was aware of what I was going through and has always, since that time, asked how I am doing and how I am feeling.

It has been seven years since I first met Bill and I have walked on and off the ferry on his watch hundreds of times. We have gotten to know each other well. Bill no longer greets me with his human-made scepter. His long arms open wide, creating an inviting space into which I walk into a warm and compassionate embrace, briefly exchanging our news of the day. When I leave, we continue to delicately bow to each other, a sign, as in some cultures, to confirm that, “I recognize the soul within you.” I know that when I get to the other side for an appointment, infusion or invasive tests, “Reverend” Bill will be there with his own personal infusion of love and caring. I look forward to it as a brief but illuminating haven during my trek in and out of the city.

When I conjure up the image of Bill, reaching out with his long arms and pointing to people with his greeting, I can see filaments of light or streamers in bright colors propel out of his two fingers and descend upon each person walking over the footbridge. Sometimes I think he must be frustrated with most people “not getting it” but he perseveres nevertheless. I wonder how they cannot realize that, were they to acknowledge this kind gesture, they would be blessed. To be blessed, one needs only to receive one’s own epiphanies that come directly from God, or from others as a channel of God with a kind intention. How many times does an eagle fly over our heads, or double rainbow appear and we do not take a moment to be mindful of its miraculous being and appearance, to recognize that these are all gestures of beauty from God and we are blessed to see, hear and feel them?

Healers come in all kinds of forms and surround us daily. Our ability to recognize and receive the healing being offered will serve our own bodies and beings as well as the planet. Bill’s choice to use his own body, his gestures and towering height to reach people with his filaments of colorful light is a beautiful, self-made ritual in which everyone can participate. It is breathtaking to watch his gestures and accept his greetings. At the root of his actions, he is really saying, “Good...good...good morning, joy, love one another, love yourself, good.” No one told him to do it, he is not a politician or at a religious service and he asks for nothing in return. This is a message coming from a profound place within Bill’s soul and the sincerity of his heart, making him a true healer, and I, for one, am grateful to receive his generous blessing.
The Doctor's Dilemma
RETURNING SERVICE, GRACE, AND MEANING TO THE ART OF HEALING

Rachel Naomi Remen, M.D.
An interview with Peter Warshall

Rachel Naomi Remen is one of my closest friends. She is a life partner in our work at Commonweal, a small health and environmental research institute in West Marin. She serves as medical director of the Cancer Help Program, our week-long residential program for cancer patients, and director of the Institute for Health and Illness, our training program for physicians and health professionals who work with people with life-threatening illnesses.

From fifteen years of work together with people facing cancer, I have a deep sense of Rachel's life project. Rachel's special genius—no lesser word will do—is to uncover the great wisdom in life stories that point us toward the enlargement of the soul. Her unique gift for this work has its source in her triple identity as a person who has lived with a life-threatening illness for many years, a physician, and a healer steeped in the traditions of the healer's art. So Rachel lives and writes with uncommon access to that place within us where life and death meet, where all pretense dissolves, where a deeper knowing and caring can be found. —Michael J. Lerner

Rachel Naomi Remen: Every culture has its shadow, and represses the wholeness of its people in some way. It persuades us to diminish ourselves, by disapproving of certain parts of our wholeness. It is a very natural thing to give up wholeness for approval. We don't even realize we're doing this, though we do it all the time in a lot of relationships and within the culture. Until fairly recently, our culture edited people very severely—the heart, the soul, the intuition were not acceptable; all that was respected was the intellect, the facts.

Any medical culture intensifies the values of the larger culture it tries to serve. Medical culture intensifies the shadow of the culture as well. Possibly this is why medical people are looked up to in the culture, seen as successful people. In my experience, those who are perceived as successful usually bear the cultural wound most deeply.

Physicians have been wounded by their training. We are taught that objectivity is an invulnerable stance. But objectivity actually makes us vulnerable. From an objective stance, no one has access to his or her human strengths. You cannot cry or grieve or even pray. You don't even know that you're loved by the people you are serving. Objectivity makes physicians vulnerable to burnout. It prevents us from finding meaning. If the heart is a way of seeing, meaning is found when you see through the heart. The objective stance, distancing yourself, holding yourself apart, makes it impossible to find meaning. We find meaning only in the things we touch and that touch us deeply. Meaning is found only through genuine relationship.
The third-party payer system has created a crisis in medicine. It has invaded the integrity of the doctor/patient relationship. Ninety-five percent of California physicians really work for two people. They work for the organization that pays their salary, and they also work for the patient. What may be absolutely the best for the patient may not be economically the best for the organization. Your salary is paid by the organization. So there is this constant pull. There is now a certain lack of trust in these relationships. Malpractice suits started that—the doctor did not trust the patient. Now the patient does not trust the doctor, because he can never be sure whether what's being done is what's best for him or what best serves the company the doctor works for.

The third-party payer system has imposed a "business value system" on medicine. This can violate the deepest values of medical practitioners. Doctors are dropping out. Young, well-trained doctors are going elsewhere. It's not a question of money. It's about the violation of core individual values. It's about being asked on a daily basis to do your work at a level far below your capacity for excellence. It would be as if I said to you, "Now look, you're a good writer, a good editor. You've come here and talked with me for an hour. You could really have done it in fifteen minutes, and cut costs. And, you know, you're using so much audiotape. If you do it in fifteen minutes, you'll save tape. And you really don't need a pen—use a pencil." If you're a good editor, you can do something passable, even with all those constraints. But if you do this day in and day out, something dies within you.

Peter Warshall: My goddaughter is pregnant. She can have one obstetrician for the nine months, but suddenly, at the moment of birth, it's whoever is on call, any one of nine obstetricians on call.

RNR: Talk about violation of a relationship! And yet people accept this because they feel that this is how it's supposed to be.

In your father's generation [Peter's father was a pediatrician from 1945 to the late 1960s], doctors had the freedom to do things according to what was best. If they wished to spend more time with someone,

When relationship starts getting mandated, and you have only your eight or ten minutes for every person, no matter how frightened, how sick, or what their needs are...well, it violates the very reason you went into this work.

Many doctors have lost their sense of the meaning of their work, and they cannot go on.

they could. But when relationship starts getting mandated, and you have only your eight or ten minutes for every person, no matter how frightened, how sick, or what their needs are...well, it violates the very reason you went into this work. Many doctors have lost their sense of the meaning of their work, and they cannot go on.

There is a growing interest among medical educators and policy makers in helping physicians
preserve and recover the meaning of medicine. Freshmen medical students come into medical school on fire with a spirit of service—if you can preserve that, maybe doctors can last longer in these difficult times.

There’s a certain concern that medicine may be losing its soul. It’s an old soul. I happen to be of a Jewish background, and the only other thing I know that has this kind of lineage is Judaism. It goes back a long, long way. The doctors of generations ago would have been awed by our science and our tools, but they would have understood our commitment perfectly, because they shared it with us. It is an unbroken lineage.

PW: “Meaning” for doctors appears threatened by the technological—the techniques for long life, for fertility. Their tools change so rapidly.

RNR: And the tools are so seductive and so powerful.

PW: Are we messing with the natural law of things?

RNR: Of course we are. We messed with the natural law of things the minute a human first took an herb. The natural law of things has been altered very significantly for a long time. There are numerous ways of looking at this. Obviously, when we alter natural law, we do harm. We are not wise enough to recognize the interconnectedness of our actions. No human being could be wise enough.

Doctors feel burdened and overwhelmed by the decisions that are now expected of them. There are so many decisions we make now that used to be in the hands of fate. It used to be that somebody simply died. Now people have a cardiac arrest and they’re resuscitated. When do we resuscitate and when do we not? Or do we give a woman (who would otherwise not be pregnant) fertility drugs—and terminate the lives of three fetuses in her seven-fetus pregnancy? And which three? And how about euthanasia? I don’t believe that anyone wants to make these kinds of decisions. Anyone who’s ever had to put a dog or a cat to sleep—even when the dog or cat is old and suffering—knows how difficult it is. Imagine putting a human being to sleep. Could you do it? Yet these decisions sort of come with the turf. Nobody asked the doctor, “Do you want to make these decisions?” They’re being forced to make these decisions by the nature of the technology. It’s not a very comfortable place. I think most practitioners feel unprepared.

Technology has changed medical education into a “training.” It has been said that our technology is always fifty years ahead of our wisdom. And in that lag time, we may destroy ourselves. Do we act because we can or because we should? People are afraid, for instance, of genetically altered vegetables. But when in doubt, we generally go forward instead of waiting.

PW: The courts are being asked to judge. Like that recent decision about a woman who got divorced. She still wanted to use eggs fertilized by her former husband, and he said, “No, we’re now divorced.” But she said, “Well, you signed a legal document that we could do this.” The court ruled that he has that right to refuse, since it would be his child. It begins a strange techno-materialist decision-making, reminiscent of King Solomon.

RNR: We so easily outrun our headlights. We’re very technically capable, but we’re not very wise. In a recent situation, seven babies were born through “the miracle of science” and, at the age of two, two of them are obviously retarded. I have yet to see this actually written up in a newspaper. Reporters covering the second birthday simply said, “Oh, this one can’t sit up yet.” “This one has poor head support.”

PW: What can a culture do to change that kind of attitude? Most people I meet just accept that medical miracles are there for them. How do you work with medical students and doctors, given the dilemmas we’ve hashed over?

RNR: I work with doctors on two levels. I run a course called Continuing Medical Education (CME) at the Institute for the Study of Health and Illness at Commonweal. And I run a class called “The Healer’s Art” for freshmen medical students at the University of California, San Francisco. The physician graduates of the CME program teach with me in the medical school course. Both of these courses are about recovering, strengthening, and preserving the meaning in this work.

The medical school course is preventive, because meaning seems to function inversely as expertise. The freshman students are on fire with the meaning of their work; by the time they are seniors, this is gone. It’s as if they now know what they need to do, but have forgotten why they came. “The Healer’s Art” is an elective. An elective usually draws eight to twelve students, but we get somewhere between fifty and sixty every year. That means that almost one out of every two students in the school has chosen to take this course.

Among other things, we develop an atmosphere of safety between students, and between students and faculty. A harmless space between health professionals is rare. Doctors are competitive and isolated. It is rare to hear anyone admit vulnerability or pain. Creating harmless space, and having that experience of acceptance of other people, is, I think, the absolute model of the doctor/patient relationship. We start by helping them to be harmless with their colleagues. The first session, “Survival Skills for Medical Students,” starts with a simple exercise that enables students to recognize and reclaim a part of themselves that they fear may be changing in this process of becoming an expert. This is
everyone's hidden fear. Students are working fourteen-hour days, seven days a week. Nobody has any idea what is like beforehand. It's easy not to put parts of yourself that aren't immediately involved in the workday tasks.

We start by talking about the cultural shadow, explaining it. Just simply tell stories about it. We ask them to close their eyes and allow an image to come for the part of themselves that they are afraid may change in this process of becoming an expert. We give them big pieces of paper and little boxes of crayons that smell just like the ones in kindergarten. And they draw a picture of this part of themselves. Often the picture is a symbol, like a candle or a lighthouse. We ask them to name the quality at we...and we get words like compassion, fidelity, wisdom, trust of life, and the like. These are the parts that are threatened by the pressure of the training.

Cultural shadow is hard to heal. It's not like family shadow. Family shadow has more opportunity for healing, because when you become an adult you leave your family and you get validated by other people for things that were not validated by your family. Or you are accepted in ways that you never got accepted in your family. You have an opportunity to reclaim wholeness.

But cultural shadow is reinforced everywhere. There are no nonparticipants. So how do you heal the shadow of the medical culture? What occurred to me is that culture wounds, so culture can heal. You have to understand that nobody, absolutely no human being, can be harmless. In order to be a truly harmless person you would have to have a vision of the infinite, a chain of events that goes on forever, in order to know that any single action is truly a harmless action.

Doctors share their own struggles, their own doubts, their own dreams in the groups, and do the same exercises that the students do. In these small groups, the students share their pictures and discover that they are not alone: others who seemed confident and self-assured have the same inner concerns.

We talk about all sorts of ways to self-remember. We teach ways to feed the parts that matter. There's a special journal we teach them to keep. We teach about ritual, about prayer; we talk about imagery. We close the session with a five-minute meditation—but we can't call it that. We just spend five minutes in supportive community. If I am the doctor in the group, I ask the person on my left to say his name aloud. And in absolute silence, everybody thinks about what that person has shared here tonight, what his dream is for himself and his medicine. And everyone sends strength to that person in any way they care to. You might want to pray for him, if that's your way, or believe in him, or experience that his struggle is important. This is done in silence for about forty-five seconds. Then the next person to the left says her name and the group focuses its attention on her in just the same way, for forty-five seconds. Finally, the doctor says her name, and receives the support of the group as well. And for the first time, we come into right relationship with our fellow professionals.

Medical school is a marginalizing experience. So is medicine. In the next session, students often find that they are able to share things they may not be able to share elsewhere, because not only do they feel safe, they are with other people who can really understand these highly unusual experiences they're having, this highly unusual life they're leading.

We open the course with a drawing...
To serve is to make whole in some way. Service...it's more of a grace. It's very close to love, but a very pure kind of love. A befriending of the life in others, unconditionally.

And then, for about two hours, everyone reads aloud to each other.

This is a very powerful moment for everyone, including me. If you close your eyes while people are reading, you can’t tell who is a medical student, a surgeon, a minister, or a nurse. Somehow, through this simple exercise, we go past the divisiveness of our expertise, and inhabit the unity of our commitment. It always makes me wonder if there really isn’t only one role and one profession—and that is service. We each do this with our own skills or gifts or expertise, but it is the same work. We befriend life. We become a blessing.

One year, a young woman stood up after reading, looked around at her classmates, and said, “I had no idea that’s who you guys were. I thought I was here all alone.” Just as there is an isolation in the American culture, there is extreme isolation in the medical culture.

I run a drop-in evening group for doctors who, like myself, are recovering from their training. Sometimes I think that medicine is like a disease: you have to recover from it. “I’m a recovering doctor.” Each evening has a topic related to the practice of medicine...like compassion, or suffering, or listening. It’s a discovery model. As the “price of admission” to the evening, each person brings a story from his personal life, his professional life, from the world literature, or a poem, or an exercise to help people explore the evening’s topic more deeply.

During a session on listening, an oncologist brought a shopping bag with her. In the shopping bag were twelve stethoscopes she had liberated from Kaiser for the evening. She gave everyone a stethoscope and said, “Let’s listen to our own hearts for about eight or nine minutes.” So we started listening. We’re middle-aged, and for the first few minutes you could see that everyone was diagnosing himself. But eight minutes is a long time. And we all went beyond this and found something ineffable...an experience of profound mystery. There were two cardiologists in the room; both of them were blown away. So were we all. My experience was that I had never heard a heart before. I had auscultated thousands of hearts but I had never heard a heart before. It’s very, very moving. Talk about an experience of reverence and awe.

I think we have made a trade between mastery and mystery, between information and wisdom. Mystery used to occupy the same place in medicine that science does now, and I truly believe that it still does—except we often do not notice. We often tell ourselves stories to cover up the places where we encounter something that we cannot understand.

I sometimes think that medicine is a front-row seat on mystery. There is so much that happens that we can’t explain. A physician once told me the story of the time when he was 18 and his brother was dying of leukemia. About a day before his brother died, he was reading to him in his bedroom. His brother was lying in bed, eyes closed. He couldn’t tell if he was awake or not, but he did not know what else to do, so he kept going. As he was reading, he suddenly felt his brother’s hand on his arm. His brother’s eyes were open and he was looking at a blank wall. “Look, George, look,” his brother said. “There is someone there. Someone has come for me, George. Look. Can you see him?”

So George closed the book and looked at the blank wall and he couldn’t see a thing...“but I could feel it. There was something in the room with us. It was completely benign, totally good.” And he says that in this moment he knew that he was supposed to become a doctor. When his brother died, he went back to school and changed his major from engineering to medicine.

When I asked him to say more about it, he told me that he actually knew in that moment that he was a doctor and had always been a doctor. That he had been born with a doctor’s soul in him. Very mysterious! He says that it was like a moment of healing.
"coming to my true self. Whatever it was that came for my brother, it came for me too. Perhaps this was a rent of healing for him as well."

Once you get a group of doctors talking about mystery, it's often hard to get them to stop. So much of what we see just doesn't make sense. Sometimes it's a small thing, sometimes it's a large thing. But there's a lot that just does not fit into the box.

PW: In your book (My Grandfather's Blessings; see page 5), you say that service, in a sense, was letting the lives that touch yours, touch you. I kept on thinking, was "touch" there a metaphor?

RNR: The very oldest way of healing is touch, a connection between the hand and the heart. But we're trained to

You heal a dominant culture by forming a subculture of credible people, in the middle of it, who value something new, who reinforce and reward something that the dominant culture represses.

diagnose and cure, to connect the hand to the mind. In our CME workshop on healing, we may ask doctors to do hands-on healing with each other. At first it feels a little strange to lay your hands on someone and encourage the life in them. But many physicians say they felt as if something in them had always wanted to touch their patients in this way, and they couldn't think of a way to do it without being embarrassed. It's not just physical touch. It's more about the sense of belonging, of occupying a level playing field, a shared vulnerability and a shared strength. The experience I have, is, you greet the life in someone. You accept its present shape, accept it as it is. You recognize its holiness.

hands-on healing, you never see the person you were partnered with in the same way again.

PW: When you were talking about your sense of service, I thought of something. "Service" is a hard word, because another word like it in English is "servitude," and both come from the word for slave. In the Old Testament, you have three senses of service to the land: the manipulator (dominion over), the steward (caretaker), and the servant of the Earth. They keep fighting each other. Are we on a kind of quest for stewardship of the body?

RNR: A very strange idea floated through my head as you said that. I have no idea if the idea is valid or true, but what floated through was that service is much more about celebrating life than it is about dominating it. We don't dominate. We don't "steward." It's more like a celebration.

A long time ago, when I first got interested in this, I asked a number of people whose lives seemed to me to be lives of service to define it. Nobody could. People obviously were living it, but just couldn't talk coherently about it. It was ineffable, in some way. One of the people I asked was my colleague, Marion Weber, who is an artist. Marion is quite remarkable. She's a very, very wise woman. As we were driving somewhere I said to her, "I can't get clear on this article that I'm trying to write on service. No one even seems to be able to give me a decent definition for it." And she said, "Oh well, why make it so difficult? Service is Belonging." I think the dominion/stewardship/servitude construct has us standing next to something. It feels like a duality. Service doesn't have that distance. It's not a duality. To serve is to make whole in some way. Service...it's more of a grace. It's very close to love, but a very pure kind of love. A befriending of the life in others, unconditionally.

At some level, there's nothing personal in service. It's abstract. Just the same way that unconditional love is impersonal. It goes beyond any individual. So it's a response to the holiness that is at the foundation of all life. It's hard to put that into words. It's the sense that all that life is worthy. And it goes beyond your own prefer-ences in thinking about life, whom you like and whom you don't. Your own preferences are irrelevant. All life is holy. I think the Hippocratic oath is about a relationship between an individual life and life itself. A person and life itself.

Fixing, helping, and serving are three different ways of experiencing and perceiving. When you experience your work as service, the work itself sustains you. The work itself blesses you. Fixing and helping are ultimately draining; service is renewing. When I fix something, I get satisfaction, pride, all those ego things. When I serve, I get a sense of gratitude for the opportunity to do the work. I feel lucky. Perhaps fixing and helping are the work of the ego...and service is the work of the soul. \(\infty\)
On Being Sick and Being Cared For
By Pat Justis

I racked up 26 days of inpatient hospitalization in seven different stays at two different hospitals, one surgery, six endoscopies, two ultrasounds, three cat scans, 26 days of IV fluids, five weeks of total parental nutrition through a central line in my neck, five weeks of home health care, over 35 lab draws, conversations with 19 different doctors and five weeks of sick leave from work, all over the course of six months. I even crossed some sort of threshold with my insurance company who assigned me a case manager located in a distant city. To make my story almost absurd, in this same time period my spouse had a major back surgery and then a few months later a myocardial infarction. My mother had a total knee replacement. My view of health care was quite close up and personal.

Prior to this surreal episode I was a basically healthy 39-year-old woman devoted to taking good care of myself. Illness was a shocking event that threw me into a flurry of coping. I’d never anticipated a big illness at this age, my whole fantasy about my life was disrupted. But I was no stranger to hospitals, for the last seventeen years I had worked in a hospital, and in fact now held a job focused on quality improvement. At some point I became determined to use my experience as an education. I would glean what I could to make health care better for patients. I became a de facto mystery shopper.

I initially thought I would keep track of all the lapses, all the mistakes, and then tell a stinging tale that would shine a light on the dark places in health care and inspire change. I kept a running list of the problems I saw, they were visible, and for me pointed and poignant. Yet after the longest hardest stretch of illness, when I was truly depleted and hollow, something different was in my heart. I sat in my house freshly discharged from the hospital; nausea bringing me to a standstill and what I felt was the lingering glow of the compassion of strangers. In addition to the shock, sadness, anger, and fear that accompanied my illness, I was left with a strong sense of being held by kindness, of being gently carried. The mistakes happened, but what seems more important, more pressing, and perhaps more capable of inspiring change, is the story I have to tell about what went exceptionally well. The errors demand our attention but we must also magnify the strengths that exist.

A very tiny minority offered me neglectful or indifferent care. A surprising percentage of my care was offered in a true spirit of kindness. I will admit I was surprised. I had great respect for the physicians, nurses and many other disciplines that make health care live and breathe. After seventeen years of working in a hospital, I also knew the failures of the system. I knew some processes where outdated, full of complexity and waste, I knew that staff had to do more and more with less and less. The system was full of superhuman demands on its providers. Sometimes it all looked impossible. My friends and I would joke that it was not a good time to be sick.

I watched the payment system for health care swing from fee for service to discounts, networks, mergers, capitation and pre-authorization. I watched my colleagues work on
the phone for hours talking to faceless voices across the country, to convince someone far removed that being in the hospital was justified for a patient we all knew was terribly sick. The parasitic layers of insurance and managed care horrified us. I watched the first layoffs in a hundred-year history tear at the heart and soul of my organization. I watched leaders struggle to trim the budget without hurting patients, without hurting anyone. I watched an organization agonize over how to survive in the new “health care as competitive business” paradigm and still care for the poor, still reach out to the community. How could the organization not only survive but also continue to serve the needy? How could the people at the bedside tolerate rapid change and shrinking resources and stay kind? How could the organization nourish a culture of compassion in the middle of economic crises?

Whether healthcare flounders or prospers as a system, sick people still need the most basic human things from care providers. Patients are by definition vulnerable and should be protected from the swings of the system. Technical skills are critical, but largely invisible to the patients, and are assumed. Patients expect competence. Improvements to the technical side of care are important. We should move to stronger evidence based care. Medical errors must be reduced by redesigning our systems and processes. Organizations need to become more and more adept at learning, at inquiry and continuous improvement. In our quest to improve health care we must remember that relationships are still at the core. Before I became ill, I would have said that kindness was important, but my understanding would have been shallow. I had to live this experience to really know just how important compassion becomes when you are sick. The humanity care providers bring to the relationship with patients is the absolute foundation of both quality and healing. Frances Weld Peabody (1881–1927) said, “for the secret of the care of patients is in caring for the patient.” Rachel Naomi Remen, MD writes, “…the healing of suffering is compassion, not expertise.” As I remember the individuals who treated me most kindly, I remember how it felt to me, how it truly soothed me, it made my challenge tolerable and I strongly suspect it helped my body as well. Science is only beginning to understand how kindness affects cells.

My primary care physician, Sarah Lux, MD, her practice partner Susan Links, MD and my gastroenterologist Kathy Wagner, MD were throughout this siege a model of how to deliver compassionate care. I have thought a great deal about what they and the other exceptional care providers I met have in common, and it is my intention to try and put into words the very specific behaviors and attitudes that make up compassionate care from my patient perspective. Describing kindness is risky, it can slide into triteness, but I refuse to define it by contrasting it with acts of indifference or neglect. True kindness is much more than a lack of meanness, just as wellness is much more than a lack of illness. The best care is high art, based on an awareness that the patient is a person with a life much larger than the illness, and an appreciation for how horrid illness can be. The best care flows out of true empathy.

Illness does two basic things that create a craving for kindness. First, illness is lonely. No one feels exactly like you do, pain adds to a sense of being uniquely forsaken, and the world seems as though it goes on without you. (It does.) You are set apart, essentially
defective, often for hours, in a room by yourself, in your darkest hour, in a bad nightgown. There are buttons to control television and lights, and it often seems those are the only real things you can control. Everything else is gone. The button for help, the “call light” is an odd thing to use. You have to make a decision that your request for help is worthy, then push the button and wait, and then talk to a disembodied voice, sometimes about fairly intimate details, all while knowing it is possible for anyone in proximity of the nursing desk to hear you. This creates a craving for tenderness.

If you feel well enough to enjoy visitors, the loneliness still hums in their presence. You are still apart, still the one in the nighty, the one in the bed. You will stay here when they leave. They wear clothes, drive cars and sleep in their own beds. These seem like tremendous privileges. Visitors and staff take these perks for granted. The patient is trapped.

The second key aspect of the craving for kindness: illness makes you vulnerable. All the power you normally feel, while clothed in your own home is far removed when you are horizontal and hooked up to an IV. Some patients are well insulated by their defenses but I strongly suspect they still carry a wish to be treated gently, softly, warmly, kindly. I talked to a young woman I know with a rare and complicated disease that often rules her life. She has difficulty manufacturing red blood cells and has frequent transfusions. She and I had a shared confession, when we felt our worst, and we lay in hospital sheets, our skin felt incompetent to protect us from the world. The word vulnerable barely got at how unzipped we felt, how unmercifully exposed. And we both had the same craving, we both hungrily watched for the smallest acts of kindness. Both of us are well loved by a legion of family and friends, our craving did not come out of some lack, some chronic neediness. The illness process itself creates a certain open rawness, a sense of being broken, as wish for comfort. The loneliness and vulnerability of illness are soothed when care providers see you as a whole person, express empathy about the process of illness, proactively work to relieve pain and suffering, and demonstrate kindness with simple acts.

A Person with a Life

Once a person has removed all jewelry and personal clothing, checked all valuables at the door, and climbed into generic jammies, they are mostly anonymous. Interests, talents, competencies, relationships, challenges; they all become vague, less visible. A sick person in the hospital is removed not only from the concrete context of their life, but from the feeling of it as well. The hospital is a version of the twilight zone; an odd unnerving disconnected place. An inpatient is robbed of almost all familiarity, all power. When health care providers ask about who you really are, or in any way show awareness of you, the person, aside from illness, it is a tremendous relief. One nurse, noticing my magazine, engaged me in a conversation about photography that changed how I felt for the rest of the evening. I reclaimed my sense of myself as an artist, as a maker of images. The next day I found myself hoping she would be there again. It was not that she spent a great deal of time, she could not. She reminded me that I was more than a patient and that illness was a process not an identity.
I am the mother of two small boys, ages 2 and 7. Illness is completely and utterly at odds with mothering small children. Perhaps the hardest part of being ill was being knocked out of mothering, too sick to care for my kids. Twenty-six nights in the hospital was 26 nights that I did not bathe my children, read them bedtime stories or kiss their small buttery-skinned cheeks goodnight. I’d never been away like this and it ripped my heart out. The care providers who recognized that I was a parent and who talked with me about what and who the illness was impacting, showed me particular compassion. Illness touches all of who you are. Illness touches all the people who love you. Illness is a thief.

A rather obvious implication of being seen as a full person is the recognition that you have a need to make choices, and to have access to the information you need to make informed choices. It is wonderful to be considered competent and responsible, a bona fide adult. The truly kind care provider acts just like Dr. Lux, Dr. Links and Dr. Wagner, who behaved like allies, like knowledgeable partners. They told me the truth, outlined options and then we made decisions jointly. I once read a dictionary definition of paternalistic that said it meant “to give care without responsibility.” A different dictionary said paternalistic was to “use authority to supply needs or regulate conduct.” Compassionate care providers responded to my needs without diminishing my own authority or responsibility. They were not threatened by the prospect of me regulating my own conduct.

**Illness is horrid**

Seeing illness day after day puts care providers at risk for seeing sickness as ordinary and commonplace. For the person in the bed, unless terribly chronic, hospitalization is a wild event, a disruption of massive proportion. Life is quite simply, on its ear, thrown in the wind, knocked over, stormy and uncertain. Sickness hurts. Pain, nausea, fatigue, drugs, it all tears the fabric. Conversation is difficult through pain, nearly impossible in nausea. Noises hurt like jabs and cranked up my nausea. The man next door with an aquarium-like cough haunted me. Every time the paging system blurted into the room to locate a nurse it was visceral and disturbing. There were days when the ringing of the phone sparked a strong pain in my gut. A hospital is a weird and difficult place to live. Illness takes up space, it crowds out possibilities. When health care providers notice the nasty traits of illness, name them, and offer empathy, it is a tremendous salve. I felt wonderfully supported when a covering physician said my ill pancreas was like an angry grizzly in a small dark room. I thought, “Yes!! He gets it—he knows.” His words made me less alone, less crazy. I was grateful to have someone to laugh with over the absurdity of being served blue Jell-O and watery broth for breakfast. I was thankful for those who knew that fresh ice chips can be a woman’s best friend, and for the people who understood that washing your hair is sometimes momentous. The small things are not small. When the monsters are named, they are less fierce.
Together Against the Pain

During one hospitalization, a night nurse came on and observed that my pain had bounced up and down all day. He proposed a new plan, discussed it with me, consulted with a physician, educated me as he implemented the new plan, and then tucked me in for a night of much needed relief from pain. He treated me like a partner, then became active in his pursuit of my comfort. I will always be grateful. Asking for pain medications is difficult and messy. Like most patients I was aware of the need to be prudent in my use, and felt also good character demanded that I be as stoic as possible. There was an awkward sense of incompetence and weird hint of begging surrounding pain medications. I was keenly aware that narcotic pain medicines are like a rip tide ready to knock me off balance and spin me out to sea. Yet I hurt and my wish for relief at times was intense and overrode all other considerations. Pain bites. Pain is ultimately a private matter and despite neat tricks like reporting pain on a scale of 1–10, the precise level of pain and more importantly, the level of suffering, is known exclusively by the patient. The kindest nurses treated pain as our common foe, they considered me to be knowledgeable about my pain, they educated me, and conspired with me about how to use the medications most effectively.

Kind Acts

Kind acts are often simple. I was astonished to discover how passive I became when ill, how limp and motionless. I was out of character. Illness made it hard to self-evaluate, hard to generate options, hard to ask for what I needed. Once I lay on a gurney unattended, waiting for someone to return and wheel me into my endoscopy. A man with some job unconnected to me walked by, paused and asked “Are you cold? I can get you a warm blanket.” I was cold, and tense and unaware of my coldness. I accepted the blanket, and not only my body but my soul was warmed. I felt cared for.

Here is the naked truth about the spirit of kindness in simple acts. My urine was collected, measured and documented, standard hospital procedure. The math of what goes in and what comes out is important. Every time someone came in, donned gloves, measured my urine and rinsed out the collection container I was hypervigilant. I watched their face and body intently, on guard for any evidence of revulsion; any sign that the handling of my body fluids was repugnant. It is tremendously vulnerable to watch a stranger deal with your urine. I knew my pee was unpleasant and my wish for kindness and respect stung with surprising intensity. As I watched I discovered it is entirely possible to measure and empty urine with a certain understated reverence. I was totally grateful to those who quietly showed me respect, who somehow dignified the ceremonial processing of the piss by being conscious of me. Kind acts often flowed from a place beyond words. We can sense almost animal-like, what is in the hearts of those around us. Illness seemed to amplify this sniffing out of intentions. I sometimes think I became a little more like my god, attending only to the most important signals. The best providers were also like my dog, they too observed intently.
The world of medicine is now full of very impressive machines and gadgets. They light up, beep and ask for countless adjustments, resets, fine tunes. My IV pumps were a constant source of sirens and bells that needed response. For a while I had two clanging pumps on two poles. The best care providers looked me in the eye. They fiddled with the equipment as needed, but they saw me and they heard me. Humans first, machines second. Technology is an integral part of expertise, but only people can offer compassion. It is impossible to offer compassion without attention, without deliberate focus. Compassion comes from first things first.

Sometimes the answer to how to improve healthcare looks deceptively simple. All health care providers need to remember is what it feels like to be sick, then listen and talk to patients as people, respond from a warm and empathetic heart. But some of the healers are wounded, some of the healers are angry with the system, some are sad because they feel lost from what motivated them in the beginning. How does a hospital create a sense of heart and soul for a staff that feels overburdened and perhaps undervalued? What about the caregivers locked into a view that things are “screwed up” and somebody “at the top” should be blamed? You can teach concrete skills, like how to listen well, but the true spirit of kindness must flow from the caregiver’s heart. You cannot command people to care. Can you expect people to take responsibility for their own attitude and ability to be loving? Maybe. Kindness needs to be internally motivated, not mandated and regulated. Perhaps the behavioral manifestation of compassion can be made explicit and then accountabilities defined. The hiring process can focus on relationship skills; training and coaching can target acts of compassion. Technical competence delivered in a cold or heartless spirit is not longer acceptable. Two things must happen at the same time. The care providers at the bedside must be well loved by the organization so they in turn can be loving. There must also be a fanatical insistence on compassionate care linked to very proactive and firm accountability. Leaders can work on treating staff just as they wish staff to treat patients. Leaders must have a fire in their belly for patients, and must model key relationship skills. Donald Berwick, the president of the Institute for Healthcare Improvement reminds us that “interaction is care.”

In my own experience as a clinician I learned that I could be replenished by forgetting myself, by truly serving patients. I learned that by doing the equivalent of washing feet, I could find my best self. The pressure, the hypnotic trance of tasks, the struggle to “get it all done” must shift to an awareness that it is the relationship we offer each other that are the center of care. If care providers listen deeply and deliberately to patients, the stories themselves will be transformative. If care providers see the whole person, and see the impact of illness on that particular life, then kindness can flow. The frustrating processes need to change, errors must be reduced. The organizational climate can always be improved, but it is only through a true focus on patients that caregivers can be rejuvenated, only by working from a place of compassion, can health care providers reclaim the birthright of their professions. The examples are there. Watch, listen; study those gifted healers among you whom gently, sweetly, care for people who happen to be sick.
Emotional Literacy: A Field Report

As I was completing a year as a Fetzer senior advisor, scouting the research, theory, and applications of what can be called "emotional literacy," a tragic incident occurred that brought home to me the urgency of the topic.

A sophomore at Thomas Jefferson High School in Brooklyn, 15-year-old Khalil Sumpter, was scared that two fellow students were going to beat him up. Ian Moore, a senior, and Tyrone Sinkler, a junior, had a falling out with Khalil over a small dispute, which had escalated to their picking on him and making threats.

So, Khalil brought a .38 caliber pistol to school one morning and, 15 feet from a school guard, shot Ian and Tyrone to death at point-blank range in the school’s hallway. The shooting, horrifying as it was, is no longer uncommon in America's inner-city schools. But this shooting became front-page news because the shooting took place just a half hour before New York's then Mayor Dinkins had been scheduled to visit Thomas Jefferson High School.

Because of the shooting's high profile, I was asked to write an article for the New York Times on the psychological lessons of the incident. In the article, I pointed out that the incident, chilling as it is, can be read as a sign that America's children are desperately in need of lessons in how to handle their emotions and settle disagreements, in caring, and just plain getting along. The signs of the deficiency can be seen in violent incidents like these, growing ever more common in schools. But they can also be read in statistics, showing sharp rises in the number of teenage suicides, homicides, drug abuse, and pregnancies in the last decade.

In short, while the lagging test scores of American school children in math and reading have troubled educators, a new kind of deficit, in many ways more alarming, is becoming all too apparent: emotional literacy. As one Brooklyn school teacher told me, "We care more about how well school children can read and write than whether they'll be alive next week."

In the article, I described a handful of pioneering courses in emotional literacy, courses that teach children how to manage their feelings and how to get along with each other. Within days, the teachers of these courses were flooded with calls and letters from across the country from educators who wanted to help start such courses at their own school. As I write this some four months later, I still get calls and letters from educators who want to know how they can reach those who teach the emotional literacy courses. The queries to the teachers themselves now number in the thousands.
There is a disabling bias... that acknowledges too narrow a band of mental skills; as a result, we fail to cultivate the intelligent management of emotion.

Over the decade I’ve been covering human behavior at the New York Times, rarely, if ever, have I had such an outburst of interest in an article. Why this one, of the hundreds I’ve written?

The Intelligent Management of Emotion

Let me offer you some of my reflections. As a psychologist, I’ve been struck by a deep and disabling bias in contemporary society, one that can be traced from the highest levels of intellectual abstraction—among philosophers of mind—down through our social institutions, especially medicine and education, into the mud of the muddles it makes of our professional and personal lives. That bias is in acknowledging too narrow a band of mental skills; as a result, we fail to cultivate the intelligent management of emotion.

It seems to me we are naive about what it means to be smart, focusing on academic abilities to the detriment of emotional skills. Of course, academic abilities such as math and verbal reasoning are essential tools. But in navigating our lives, it is our fears and envies, our rages and depressions, our worries and anxieties that steer us day-to-day. Even the most academically brilliant among us are vulnerable to being undone by unruly emotions.

In short, our culture encourages us to be emotional illiterates, living at the mercy of emotional storms. The price we pay for emotional illiteracy is in failed marriages and troubled families, in stunted social and work lives, in deteriorating physical health and mental anguish and, as a society, in tragedies such as the killings at Thomas Jefferson High School.

Our social nets for the emotionally illiterate are prisons, safe houses for abused wives and families, mental hospitals, and the therapist's office. Our reliance as a society on these as the answer to deficiencies in emotional intelligence is akin to offering emergency rooms for the sick without also teaching people the basics of self-care, nutrition, hygiene, or health science.

The best medicine is preventative: we need to teach our children the essential skills of emotional literacy, to give as important a place in the schools to inculcating emotional intelligence as we do to math and reading.

A New Way of Thinking About Being Smart

But just what do we mean by "emotional literacy"? One way to answer that can be found in recent advances in cognitive psychology and brain research that are leading to a rethinking of the very concept of intelligence itself.

One of psychology’s secrets is the pathetic inability of intelligence scores, despite their popular mystique, to predict who will succeed in life. While IQ tests remain excellent predictors of how well one will do in school, they have little or nothing to do with who will eventually earn the most money or prestige or have the most satisfying personal life. A high IQ is no guarantee of prosperity, prestige, or happiness.

One problem is that IQ tests, which focus mainly on aptitudes in verbal and mathematical skills, fail to assess how people differ in the intelligence with which they handle their emotions. But that skill is crucial to understanding why one person thrives in life while another of equal intellect dead-ends: emotional aptitude is a meta-ability, determining how well we can use whatever other mental skills we have.

Emotional intelligence and academic IQ are independent faculties. Psychologist Seymour Epstein at the University of Massachusetts has found that among people bright enough to be in college, IQ is utterly irrelevant to such indicators of life success as salaries and promotions, happiness with friendships, and family and romantic relationships. He found that people with high IQs in the conventional sense were often poor pilots of their lives. Given people of equal intellectual gifts, those with high emotional intelligence fare far better.

His data show that people who are emotionally adept—who know and manage their own emotions well and who read and deal effectively with other people's feelings—are at an
advantage in any given field and are more likely to be content with their lives. People adept in emotional intelligence, for example, can pick up the unspoken interpersonal rules that govern success in a corporate or professional career or master the habits of mind—such as self-discipline and delayed gratification—that foster their own productivity.

By contrast at the low end of the spectrum, the mind of the sex offender offers an example of emotional retardation. Criminologists are finding that a common psychological fault line is evident in rapists, child molesters, and perpetrators of family violence alike: they are incapable of empathy, one of the fundamentals of emotional intelligence. This inability to feel their victims' pain allows them to tell themselves lies that encourage their crime. For rapists, the lies include, "Women really want to be raped"; for molesters, "It's just another form of affection"; for abusive parents, "This is just good discipline."

Effective treatment for such people is, in effect, an emotional re-education. It begins with helping them feel empathy for their victims, and it includes helping them expand their own constricted range of emotion beyond hurt and rage.

Such an education, of course, should not come after the fact but well before, as a preventive measure. Educating our children in emotional literacy would acknowledge what research like Epstein's is revealing—that, in essence, we have two minds, an emotional faculty that makes our moment-to-moment decisions day-to-day, and a rational one that knows things like reading and math and comes up with explanations or alibis for what the emotional mind has decided.

We need a new way of thinking about what it means to be smart, one that recognizes that the ability to manage our emotions is the fundamental mental skill.

The rational mind is measured by IQ, but the emotional mind determines our successes and failures, disappointments and satisfactions. We need a new way of thinking about what it means to be smart, one that recognizes that the ability to manage our emotions is the fundamental mental skill.

The Ingredients of Emotional Intelligence

Intelligence, conventional wisdom has it, entails a cold, hard-nosed processing of information. It is hyperrational, rather like Mr. Spock of "Star Trek," the archetype of a dry view of fact unmuddied by feeling. Emotions have no place in intelligence; they are, by definition, irrational.

This model of intelligence has been promoted by cognitive scientists who have been seduced by the computer as the operative model of mind, forgetting that, in reality, the brain's wetware is awash in a messly puddle of neurochemicals. The brain is nothing like the sanitized silicone that cognitive science has taken as its guiding metaphor. As a result, our predominant models of how the mind processes information lack any indication that rationality can be swamped by feeling.

But in order to persist in this view, cognitive scientists themselves have had to ignore the relevance for their models of mind of their own personal hopes and fears, their marital squabbles and professional jealousies—the wash of feeling that gives life its flavor and its urgencies and which in every moment biases exactly how well or poorly information is processed.

This lopsided scientific vision of mental life is under critical examination by a revisionist school of thought in cognitive science which has begun to consider "hot cognition," the skew that unruly feelings put into the flow of information in the mind, and "maladaptive schemas," the distorted models of ourselves and our world that cause life's emotional shipwrecks.

A small group of psychologists have begun to explore the rudiments of emotional intelligence, recognizing the sense in which it is the master aptitude, either interfering with or facilitating other mental abilities. This group of thinkers has come to realize the key place emotions play in the intellect.

One of the first was Harvard University's Howard Gardner, whose model of intelligence, as put forward in Frames of the Mind, breaks through the conventional thinking embodied in IQ tests to include
There is, as yet, no consensus among researchers about the basic elements of emotional intelligence. A range of talents. His model of seven key intelligences includes the two main categories of emotional intelligence: the intrapersonal, knowing one's own feelings, and the interpersonal, knowing the feelings of others.

Other psychologists are pursuing research and one or another of these two sides of emotional intelligence. Psychologist John Mayer at the University of New Hampshire is analyzing the keystone of emotional intelligence, awareness of our own moods from moment to moment. John Kihlstrom at the University of Arizona is one of a group of social psychologists who have concentrated on what they call "social intelligence, skill at reading and handling the feelings of others.

Miron Zuckerman at Rochester University and Bella DePaulo at the University of Virginia, former students of Robert Rosenthal at Harvard University, and Paul Ekman at the University of California at San Francisco, have done extensive research on the ability to read and send nonverbal signals, a key faculty in social intelligence. Peter Salovey at Yale University has begun to tie all these abilities together in a unified theory of the specific psychological skills that make for emotional intelligence.

In short, psychology has been flirting with the notion of emotional intelligence but in bits and pieces. There is, as yet, no consensus among researchers about the basic elements of emotional intelligence. What is needed is an integrated working definition of emotional intelligence and its key components. This working definition should both focus and foster research that, in turn, brings greater precision to the concept as well as guides practical applications, particularly in education.

The Neurophysiology of Emotional Intelligence

Think back to the last time you "lost it," blowing up at someone — your spouse or child or perhaps the driver of another car — over a provocation that, with some reflection and hindsight, later made you feel the outburst was uncalled for. That explosion was an emotional hijacking.

New studies of brain function suggest that at those moments the amygdala — a structure in the limbic system, our "emotional brain" — has reacted to the situation crucial moments before the cortex — the "thinking brain" — has had a chance even to glimpse what is happening. Joseph LeDoux, a neuropsychologist at the Center for Neural Science at New York University, has discovered that the amygdala is the central repository for emotional memories, especially those strong impressions of rage and fear from earliest life.

LeDoux has shown that the architecture of the brain gives the amygdala a privileged position: all sensory inputs travel there in a single synapse, while the cortex is several more synapses down the neural line. That means a difference of as much as a twenty-fifth of a second, a vast advantage in brain time which is reckoned in thousandths of a second. The amygdala can react in a delirium of rage or fear before the cortex knows what is going on.

Small wonder we are so often bewildered by our emotional outbursts. The amygdala is fully mature in life's earliest years, long before higher brain centers like the cortex. This may explain the lifelong power of emotional experiences in early childhood: the amygdala remembers and springs into action in those situations in adult life that trigger emotional memories. It also may explain why these emotional reactions can be so confusing. Many of these early emotional memories are from a time in life when we did not have words adequate for comprehending our emotions.

Indeed, the structural relationship between the amygdala and cortex offers a crucial insight into emotional life: the connections from cortex to amygdala are only inhibitory. While the amygdala can hijack the brain, the cortex can only put the brakes on. That means, in essence, that we cannot decide when we have our emotional outbursts, but we can control how long they last. A quicker recovery time may well be one mark of emotional intelligence.

LeDoux's model of the amygdala's role in emotional outbursts is, for the moment, largely speculative — though it already offers a useful heuristic
for understanding emotional life. It exemplifies a range of work by brain researchers who are actively investigating the neural underpinnings of emotions. No theory of emotional intelligence would be complete without integrating such work.

Brain research would offer a model of emotional intelligence, a set of first principles. Another rich source of such insights might be recent work on the neurobiology of temperament, innate emotional tendencies that seem to be genetically fixed. For example, Harvard University's Jerome Kagan has shown that from birth, about 15 percent of children are "behaviorally inhibited." They are overly sensitive, clinging, and timid and tend to grow up to be painfully shy.

And yet not all such delicate infants grow up hanging back from life. The difference is in how they are treated by their parents and how they learn to handle their natural timidity. Kagan has found that those parents who engineer gradual emboldening experiences for their children offer a lifelong corrective to their fearfulness.

Another such neurobiological dynamic underlying the tendency to depression is a disparity in activity between left and right frontal lobes. In most people a center for negative emotions is located in the right frontal lobe. Richard Davidson, a psychologist at the University of Wisconsin, has found that some people have an innate overactivity in this brain center. Such people are by temperament dour and irritable, given to melancholies and anger. By contrast, those with relatively more activation on the left frontal lobe tend toward cheeriness.

Still another brain-based emotional style centers on the intensity with which people feel their passions. Ed Diener, at the State University of New York at Stony Brook, finds that for some, the least provocation unleashes emotional storms, while those at the other extreme barely experience any feeling even under the most dire circumstances. At the ultimate, this includes criminal psychopaths who feel nothing while committing grisly crimes.

These and other brain-based propensities are the hard-wired infrastructure of our emotional lives. They offer a merging model of emotional intelligence an understanding of the innate patterns of emotional life, of what can be changed and what must be lived with.

How Emotions Matter for Health

How we handle our emotions can have consequences for our physical well-being. Over and above the disease process itself, emotions can sometimes make the difference between life and death. Consider these recent scientific findings:

- Among several hundred medical students at the University of North Carolina who were rated for hostility levels while in their early twenties, those with the greatest chronic anger were 7 times more likely than their peers to be dead 25 years later.

- Of 100 patients preparing to go through bone marrow transplants at the University of Minnesota, an extremely high-risk procedure, 12 of the 13 most depressed were dead within a year. But of 87 who were not depressed, 34 were still alive at the end of the year.

- In a Harvard study, 122 men who had their first heart attack were evaluated for optimism. Eight years later, of the 25 most pessimistic men, 21 had died; of the 25 most hopeful, just 6 died.

Hostility. Depression. Pessimism. Evidence is building that suggests such emotions can make the body more readily succumb to disease. These three studies linking emotional states and disease are supported by more than a hundred others. Howard Friedman at the University of California combined these studies into a meta-analysis showing that such affective emotions double a person's susceptibility to disease of every kind. Friedman found that disturbing emotions, if prolonged and habitual, are as strong a medical risk factor as smoking.

On the positive side, the intelligent management of dif-
Given the growing evidence for a link between emotions and health, an educational program in emotional literacy would be preventive mind-body medicine.

Difficult emotions seem to help the body fight disease. For example, Dr. David Spiegel stunned the medical community in 1991 when he reported that women with advanced breast cancer who went to once-a-week support groups in addition to their medical treatment had lived twice as long as other women with comparable cancer and medical care. No medical treatment at that point in the progression of the cancer could have helped as much.

The women in these groups learned how to better handle the flood tides of anger, sadness, fear, and grief that typically overwhelm and exhaust people with such a deadly disease. One woman, for example, came in enraged, saying, “Men are bastards.” What she really meant, she came to realize in talking with her group, was that she wanted her husband to be more caring while she underwent chemotherapy. With that realization, she was able to ask for and get the care she really wanted. That is emotional intelligence in action.

The impact of emotions on health, for better and for worse, has long been discounted by physicians whose medical training, until recently, taught them that the brain and the immune system were completely separate organs. That medical canon is no longer true. The new science of psychoneuroimmunology is showing that there are biochemical connections between the brain—especially the emotional centers—and the immune system, offering a pathway for emotional states to affect health.

Nowhere is there yet an effort to inculcate in children the kinds of emotional skills that would help them manage their emotional life in a healthy way. Given the growing evidence for a link between emotions and health, an educational program in emotional literacy would be preventive mind-body medicine.

A Curriculum in Emotional Literacy

Only a handful of pioneering schools have already begun to teach courses in emotional literacy. Such courses are, as yet, rare despite high interest in them among educators.

One historical root of these courses can be traced to a movement of the 1960s and 1970s, “affective education,” which utilized lively experiences to make conceptual points in the study of human behavior. This began with the Tavistock groups, which taught principles of group dynamics by putting people through an encounter group experience. An offshoot of the encounter group movement of the time, affective education used such experiences to teach organizational dynamics, motivate entrepreneurs, and the like. Oddly, the approach was not then used directly to teach a better understanding of emotional life.

One of the leaders of the affective education movement was Harvard University psychologist Al Alschuler, who went on to teach the approach at the University of Massachusetts School of Education. One of his students was Karen Stone-McCown, one of the founders of the Nueva School in Hillsborough, just south of San Francisco. Stone-McCown was among the first to realize that the principles of affective education were best suited for teaching about affect itself. “Self-science,” as she called it, has been woven into the kindergarten through middle school course work at the Nueva School for close to 20 years.

About as fully integrated is the Mysteries Program, an emotional literacy curriculum started in the mid-1980s at the Crossroads School in Santa Monica. As at the Nueva School, students at Crossroads study emotional literacy along with math and reading right from the first year of school. These two programs are perhaps the oldest continuously used curricula in emotional literacy.

Others have hit on parallel curricula in emotional literacy to combat emotional turmoil in children’s lives. A group at the Princeton Theological Seminary, for instance, developed a Sunday school curriculum in handling emotions as a response to domestic violence. Since its start in 1988, more than 1,000 clergy have been trained in using the curriculum. It deals with topics such as love, suffering, anger, and forgiveness—all targeted to
the emotional atmosphere of a troubled home and all as apropos for the religious context as the educational.

In the New Haven public schools, Yale University psychologist Roger Weissberg has created a kindergarten through high school program that teaches such skills as self-management, personal problem solving, and communication. To cover all grades, Dr. Weissberg has created a pastiche of course borrowings, e.g., a drug education program from Minnesota for the first four years, then a violence prevention program from Seattle for grades four and five, and a San Francisco program in conflict resolution for grade ten.

The New York City Public Schools have led the way in introducing at least part of the emotional literacy curriculum, focusing on conflict resolution—a response to the rising level of school violence. Educators for Social Responsibility, the courses, known as "Resolving Conflict Creatively," are available in more than a hundred New York City public schools (a small number given the size of the New York school system).

This conflict resolution program focuses on how to settle the kind of family, neighborhood, or school yard arguments that can escalate into incidents like the shooting of Ian Moore and Tyrone Sinker. Sadly, the Brooklyn high school where the two students died was on the verge of starting a Resolving Conflict Creatively course—a first planning meeting had been scheduled for the day after the shooting.

Resolving Conflict Creatively teaches lessons on listening and dealing with anger, on cooperation and handling conflicts. In lessons on conflict, for example, students discuss times arguments were settled peacefully and are taught ways to engineer a compromise.

Although the courses do not change children overnight, as children advance through the curriculum from grade to grade, they do change the tone of a school and the outlook—and emotional intelligence—of the girls and boys who take them. The concrete changes are fewer-fights, put-downs, and name-calling in schools where the courses are taught, more caring and cooperation among students, and a more peaceful classroom atmosphere. Not the least of the effects is that teachers say they find positive effects in themselves, including being better able to deal with anger—their own and their students'—and to listen.

Dr. Deborah Prothrow-Stith, a psychiatrist at the Harvard School of Public Health, is surveying close to 40 different conflict resolution courses like this, including one she designed, to distill the key elements.

Toward a Model Emotional Literacy Curriculum

Such a focus on conflict resolution, urgent as it is, represents only a small part of a full course in emotional intelligence. Single-problem courses do not cover the full range of emotional skills that a preventive mental health program should. For example, the conflict resolution skills speak to one of the most distressing symptoms of emotional deficit but ignore the emotional skills that might head off teen suicides, pregnancies, or drug abuse or promote intergroup understanding.

The following would be included among the topics in a more complete emotional literacy curriculum:

▼ Self-awareness.
Building a vocabulary for feelings; knowing the relationship between thoughts, feelings, and reactions; knowing if thought or feeling is ruling an action.

▼ Decision making.
Examining actions and knowing their consequences; a self-reflective view of what goes into decisions; applying this to issues such as sex and drugs.

▼ Managing feelings.
Monitoring “self-talk” to catch negative messages such as internal put-downs; realizing what is behind a feeling (e.g., the hurt that underlies anger).

▼ Self-concept.
Establishing a firm sense of identity and feeling esteem and acceptance of oneself.

▼ Handling stress.
Learning the value of exercise, guided imagery, and relaxation methods.

▼ Communications.
Sending “I” messages instead of blame; being a good listener.
\section*{Group dynamics.}
Cooperation; knowing when and how to lead, when to follow.

\section*{Conflict resolution.}
How to fight fair with other kids, with parents, and with teachers; the win-win model for negotiating compromise.

Such model curricula exist only outside the mainstream of public school systems in a handful of private schools that teach their students emotional literacy in an ongoing lesson plan. There is, in theory, no reason why such a curriculum could not be taught in every school in the nation. It exists already in many but only in bits and pieces, usually as part of courses in health, personal development, sex and drug education, and the like—but not as a fully developed, step-by-step curriculum.

Yet, the violence in America’s schools has created a crisis that calls out for emergency instruction in emotional skills like communication, cooperation, and conflict resolution. And the mounting rates of teen suicide, drug abuse, and pregnancy all speak to the need for self-confidence, clear thinking, and knowing how to handle distressing feelings. Until those skills are fostered and until the climate of violence in the school yard and fear in the classroom subside, other education will inevitably falter.

Even so, for now the emotional literacy movement is largely at the fringes of education’s mainstream, available mainly in progressive private schools and in a scattering of troubled inner-city schools. As every educator knows, any reform in school curriculum incurs, at best, glacial resistance. If emotional literacy courses are to become a standard part of our children’s schooling, a well-organized effort will be needed. But, judging from this year of scouting and from the response by educators to word of courses in emotional literacy, my sense is that a national movement may be waiting in the wings.
We seem to live most of the time in big buildings of who we are in the world and how we are doing, but it is so entirely blown to bits when we’re faced with really huge loss.

By Anne Lamott
LAST YEAR IN MAY MY YOUNG SON, SAM, AND I went to Club Med in Ixtapa, Mexico. I had, at the time, a best friend of twenty-five years, with whom I spoke two and three times a day on the phone, who'd had metastatic breast cancer for two years. I also had a lover with whom I spoke two and three times a day, whom I loved and who loved me. Now I can report that sometimes grief looks like a silent phone. But I went away in May because I needed to be alone with Sam, and I went to Club Med because it is such an easy way for a person with kids to travel. It turned out that I am one of those people about whom others say derisively, "Oh, she's the kind of traveler who loves Club Med," as if we are also the people who prefer Chuck E. Cheese parlors, and instant coffee, and Barney. But I did love it.

Then in early November the big eraser came down and got Pammy, who died, and the lover, with whom I parted, mutually, and the grief was huge, monolithic. There was acute grief, and there was also a heightening of the subtle, ever-present grief we all walk around with because we've all lost so much: time, lovers, family, childhoods, dreams. The difference was that for
the first time in my life, I got to go ahead and really grieve. All those years a lot of us fell for the great palace lie that grief should be gotten over as quickly as possible, and as privately, that after a while it's gratuitous suffering, verging on hysteria, Charlotte Brontë with PMS; but what I've discovered is that the lifelong fear of grief keeps us in a barren, isolated place. And that grief may in fact be the way home.

I have come to believe that it is grieving alone that heals grief. The passage of time will lessen the acuteness, but time alone will not heal it. We are a city in grief; we are a world in grief, and it is at once intolerable and a great opportunity. I think it is only by experiencing it, that ocean of sorrow, in a naked and immediate way, feeling its huge mystery, that we come to be healed, come to experience life with a real sense of presence, and spaciousness, and peace.

I began to learn this in February of this year in, of all places, Ixtapa. Sam and I went back to the same club three months after Pammy's death, partly for reasons of punctuation. Many, many things had changed. First of all, Sam was still joyful and together with people he knew, but no longer the social butterfly he was last year, when I could leave him happily all day in the club's amazing child-care program. This time he was clingy, heavily Oedipal. I began to call myself Jocasta; he began to call me darling. Second of all, this time we were there with hundreds of sober alcoholics and their families, in a package put together by Sober Vacations International. SVI, a Los Angeles-based travel agency, arranges charters for large groups of people in recovery—ski weeks, for instance, and tropical vacations. It sounded, and in fact turned out to be, a great way for a sober old alkie like me to travel: Last year at Club Med I eventually felt a little worn down by all the drinking that goes on, all that ice-cold beer, all the boozy blender drinks, the toothpicks with little plastic panties. I wasn't ever actually tempted in any serious way, although there were a number of times when I saw myself, in my mind's eye, stretched out on the beach, slamming down a few social gin rickeys. But I just got tired of it, actively tired of being one of the few sober people around.

This year I was also going to have at least one great friend to play with. Last year I swam and ate alone most of the time, walking into the dining area three times a day feeling shy and odd and cringe-y, with my arms stiffly at my sides, like Pee-Wee Herman. But Sober Vacations invites great speakers along, and one of this year's was a close friend of mine named Tom, an extremely funny and mentally ill Jesuit and alcoholic, who drank like a rat for years, smoked a little non-habit-forming marijuana on a daily basis all that time, and also did a little bit of amy1 nitrate, although he adds that that was just to get to know people.

His best friend, Pat, was along, too. Sam and I had breakfast with both of them at the airport the morning we left. Pat is a very pretty woman in her late forties who claims to be a hundred pounds overweight. She and Tom adore each other. He is her AA sponsor. "Pat has a lot of problems," he told us over breakfast. "This is true," said Pat.

"She was sober for four years," he continued, "until her husband got brain cancer. Then for a few years she had a little social Tylenol with codeine every day, and the merest slug of NyQuil every night for a cold that just wouldn't go away.... And then she got sober again."

We got on the plane soon after and flew to Club Med, Ixtapa, and it's all so beautiful and gracious that it's like some sick joke—adobe haciendas, cobblestone paths, a long white beach, palm trees and bougainvilleas, lavish and lush landscaping, warm ocean water, open-air dining areas overlooking the sea, Fellini's Satyricon meals. And competent young people everywhere you look, who have been hired to take care of you and your child, to see to your every need. I mean, call me crazy, but I like that in a place.

GRIEF, AS SOMEONE ONCE WROTE, IS A LAZY Susan. One day it is heavy and underwater, and the next day the lazy Susan spins and then stops at loud and ragerful, and the next it is wounded keening, and the next day numbness, silence. I had been hoarse for the first six weeks after the losses in November, from shouting in the car and crying, and I had blisters on the palm of one hand from my rage, from hitting the bed with my tennis racket, bellowing in pain and anger. But on Sunday, our first morning in Mexico, the lazy Susan stopped at a feeling of homesickness, like after my parents sold the house where I grew up.

I woke before Sam and lay in my bed in the cool, white adobe room—delicate peach and blue bedspreads, delicate peach and blue curtains—filled with memories of my first day here last year, of calling Pammy and my lover that first morning, how they both gasped with pleasure to hear my voice. I lay there this time thinking that I had made a dreadful mistake to return, that I was not ready to laugh or play, and I wondered whether or not God had yet another rabbit He or She could pull out of the hat. And then my Oedipal little son woke up and hopped over to my bed. He patted my face for a while and said, tenderly, "You're a beautiful girl."

We went for breakfast in the open-air dining area, sat with Pat and Tom, and we all ate our body weights in waffles and bacon, and chocolate croissant and fresh fruit. You can eat as healthy or as not as you wish. Sam, who often barely eats and is thought by some to be photosynthesizing, watched nervously. He knew I was going to drop him off at the Petit Club, which is for the two- and three-year-olds. As I mentioned, last year he didn't mind. We'd walk from our room to the Club, holding hands, and he'd cry out joyfully, "Hi, Sky, my name is Sam. I yike you," because he doesn't say L's. "Hi, Yeaf," he'd say happily to the leaves, "my name is Sam. I yike you."

It seems very long ago. Now he looks at me all the time like a mournful fiancé and says, "I want to kiss you on the yips."

Grief ends up somehow being about illumination: So often
we get stuck in these big constructs, thinking that if this happens, then that, and as soon as this, then that, and if only this, then I could really start blah-blah-blah. We seem to live most of the time in these big buildings of who we are in the world, and how we are doing, but it is so entirely blown to bits when we’re faced with really huge loss. And then later, in the poignancy of the little things that you begin to notice again, comes a sense of what is true and meaningful, and you get in a deep cellular way that it is only the moment that saves you from drowning.

This year after breakfast every morning, Sam and I went for a walk on the beach, at one end of which are tidepools, filled with tiny fish and crabs and shells. And after we played there for a while, we’d walk toward the Petit Club, on the other side of the giant swimming pool, and I would look at Sam’s small, concerned face and see that the jungle drums were beating inside him, and my heart would be heavy on his behalf, for all his losses so far, and to come. But bearably heavy—which is to say, I’d drop him off anyway.

And then every single morning Pat and I met in the shade of a palm tree by the volleyball net on the beach. We lay in chaise longues, slathered on our many unguents, and gossiped. Oh, God, it was heaven, to have a girlfriend to goof off with, who was not about to die. Being with Pammy those last few months was the best and most beautiful and painful thing in my life, because there is consecration in taking care of the mortally ill, and you’re dealing with spirit, spirit that is intangible but that you’re able to take care of, through the body. It’s incredible, priceless, excruciating, rich beyond words, but—and I feel a little disloyal saying this—this other stuff is a bit more relaxing.

So we would lie in the shade, or bob in the waves, and talk. We talked a lot about her husband and my daddy, who both died of brain cancer, and how only days after their deaths we were able to put on our makeup again, floss our teeth, and get on with everyday living. Wouldn’t it be better to rend our clothes and keen and burn the person’s hogan? Wouldn’t it be healthy to show or carry the marks of sorrow, and let the world know that something bad has happened, to say, This hurts so badly, and everyone should see? Wouldn’t it be better on everyone’s behalf to take some time? Because if you move away from the dead too fast, well, there goes the person. Doesn’t it make sense for a family to dance in grief on the grave, to say, It looks like we are up here, and you are down there, but your family is here, the continuity, the immortality, and so in some funny way we are up here, and you are up here, too?

Sometimes on the beach I’d cry a little, and Pat would be silent for a while, and then she’d point out a gorgeous bronze teenager in a fabulous bikini and say heartily, “That’s a cute suit. That looks nice. Maybe we should get one. I wonder if they have it in a 20.”

IT IS ODD AND SCARY AT TIMES TO BE SO QUIET, NOT TO HAVE A LOT OF WORK-RELATED TRAUMA AND DRAMA GOING ON, BECAUSE THE PAIN RISES. THERE ARE OLD, OLD FEELINGS OF SORROW AND LOSS THAT I THOUGHT I HAD NICELY BOXED UP, TIED UP WITH A BIG RED BOW, STUCK AWAY ON A SHELF SOMEWHERE. EVERYONE WANTS ME TO GET BACK TO WORK. GRIEF IN THIS CULTURE OFTEN LOOKS LIKE WORKAHOLISM; TO SOME EXTENT, IT’S SELF-MEDICATION. I WAS NEVER BEFORE AWARE OF HOW MUCH UNCOMFORT I WAS STUFFING, HOW STONED I STAYED ON WORK AND ACHIEVEMENT. I THOUGHT IT ALL JUST SPOKE OF A HEALTHY WORK ETHIC. I DON’T BUY THIS ANYMORE. FOR ME, TOO MUCH OF IT IS A DRUG, WITH RUSHES, TRANCES, GRANDIOSITY, WITHDRAWAL, AND TIME RACING BY, UNLIVED.

About a month before Pammy died, we went shopping. I wanted a dress to wear to a nightclub that night, and I found a beautiful lavender mini, very retro and forties, but shorter than I am used to. So I tried it on. It looked good, but I felt a little self-conscious, and I asked Pammy, “Do you think this makes me look bigger?” She looked at me and sighed, this thirty-seven-year-old woman with a two-year-old child, and said, “Annie, you just don’t have that kind of time.”

All I am saying is that I hope I move toward the quiet and slow.

THESE NOW-SOBER PEOPLE HERE have survived some terrible things: People do not come into AA after successful dinner parties. (Not everyone here got sober in AA, by the way, but many of them seem to have, and all of the speakers did.) For instance, I know an incredibly popular and successful man who, when he was still drinking, poured booze down a tracheotomy shunt in his neck, another man who fed his newborn baby heroin to keep it from dying of withdrawal or from broadcasting that its parents were still shooting up. One of the best mothers I know, who is now a much-loved grandmother, got into such hopeless and paranoid despair when she was drinking that she took her little children out on a
motorboat underneath the Golden Gate Bridge and planned to give them fruit drinks laced with Valium to knock them out before she threw them overboard. Some of my happiest friends used to try to kill themselves on a fairly regular basis; some of the most interesting, serene people in my galaxy used to repeatedly do time in the bughouse. Some have gone through the twenty-eight-day, spin-dry, rehab programs; others detoxed in AA meetings, but they all felt formerly doomed. Even the ones who looked fine were doomed, even the world-famous football player who is here this week as a speaker, and here they are, some sober for months, some for many years, vacationing together. So when you see them all holding hands in prayer at the end of a meeting, you actually get to see, for once, a collective phoenix that rose from the ashes.

Tom and his AA sponsor, Father Terry, gave a lecture on God one afternoon. SVI set up optional lectures and meetings you could go to all day. Most of the lectures were brilliant, and funny. It was a little like going to get some daily, psychic chemotherapy. Terry talked about the God of childhood, who loves and guides you and, if you are bad, will roast you; God as a high-school principal in a gray suit, who could never remember your name, but was always leafing unhappily through your files. This is the childhood God of every Catholic I’ve ever known. It seems almost a miracle to me that not all of them ended up alkies, drinking warm gin from the cat’s dish.

“Oh, it does to all of us, too,” Tom said later. “A total miracle.”

Then Tom spoke about how he sometimes saw God as a huge underachiever who needs constant encouragement. “This is one of the tiny pitfalls of creating God in your own image,” he said. “Namely that God turns out to be so small that He or She is probably not capable of all that much. And how do you know if you’ve done this? I think you can safely assume you’ve created God in your own image when it turns out that God hates all the same people as you.”

He talked about the longing for intense spiritual experience, for peace, for relief from the bondage of self. But there’s a real difference, he said, between a spiritual experience and, say, a hallucination. “For instance,” he said, “when I was drinking, I longed for the experience of going into a church and having the statue of Mary wave back at me. And sometimes it did—just quick little waves, and then she’d sit down. But you can tell you’ve had a genuine spiritual experience when you feel a deep sense of liberation afterward. We feel it in our chest, our lungs, our soul.”

I was beginning to feel this occasionally, although sometimes I just felt out of control. For example, I had brought my tennis racket along, but didn’t end up playing at all. I only used it a few times to beat the bed in the afternoons while raging and crying in silence. These episodes were usually after a fairly long period of prayer and meditation, when I felt like I was becoming so serene and holy that I was probably going to end up being the Dalai Lama’s fiancée. And then the rage and craziness would hit. The depth of the feeling continues to surprise and threaten me, but it doesn’t wash me away, like I’ve spent my life thinking it would. Instead, it’s like an inside shower, washing away the calcification of nearly forty years’ worth of unrievied grief, unangered rage, uncried tears. Jung said, some time after his beloved wife died, “It cost me a great deal to regain my footing. Now I am free to become who I truly am.” It is costing me a great deal, too, and I hope I remain willing to pay.

I thought of this a lot in the weeks after the big eraser came down. I also kept hearing what the Buddhists would say—if you want, you will suffer; if you love, you will grieve. I kept thinking, so why bother? And I don’t know. If Sam asks me someday, I will have to say, I don’t know. That I only know to bother.

Every afternoon when I picked Sam up at the Petit Club, you’d have thought he’d spent the day in a workshop on surviving the loss of your mother. Then all of a sudden I’d appear, Lazarus-like, to take him home. His joy was huge. We always stopped to watch the iguanas who gathered on the grass near the lagoon by our room; the giant adults very Jurassic Park, the babies from Dr. Seuss. They are one of the best things about being here, because, as Tom pointed out, they are little sight gags, right there on the lawn, so wonderfully ridiculous and unmediated that it’s like some sort of communion between you and them and something ancient. They are so immediate and unabashed that they couldn’t help but make you feel somewhat buoyant again; as did, one afternoon, watching someone on the beach chase his hat, which the breeze kept blowing a little farther away, the hat playing with the person like you’d play with a baby. I have never been so aware of the amazing contrast that goes on between the hugeness of ongoing loss and the tiny tendrils that draw us back into life.

We spent a lot of time in our room, our wonderful cool room where the quiet air conditioner was always on. This is such a quiet place that I kept starting to cry, and then I’d fall asleep. Sometimes grief looks like narcolepsy.

Here is what a friend named Dale told me: If you have the courage to really feel the loss, and losses, the wound is deep but heals cleanly. There will always be a scar, but the healing will have taken place. And the self, no longer not trying to feel the pain, relaxes.

One afternoon in our room I had been crying a little bit, while Sam dozed in his own bed, surrounded by plastic animals. Then I fell deeply asleep. I woke much later to find Sam standing by my bed, tugging at my sleeve, looking at me earnestly with his huge googly extraterrestrial eyes. He cleared his throat and then said something I guess he must have seen on TV: He said, “Excuse me, mister.” I cannot express how painful and sweet and almost lonely the feelings in my chest were. Whitman wrote, in Song of Myself, “Sometimes touching another person is more than I can bear.”

Even as the week wore on, (continued on page 96)
Long Way Home
Continued from page 66

every time I dropped Sam off in the morning, he’d cling to me like a baby possum and weep. Last year, on the last day, Sam was given a Petit Club diploma naming him Mr. Congeniality. This time I found myself marvelling, What award will they give him this year? The Mr. Edmund Muskie on the train when the press was mean to his wife award? The Tammy Faye Bakker award? And then I'd beat myself up for a minute and consider rushing to the emergency ward at the big hospital in Zihuatanejo to get my tubes tied, lest I risk inflicting life and myself on any more children. And then I'd take a long, deep breath and go look for Pat and Tom.

THERE WAS A MAN HERE THIS TIME WITH JUST ONE leg. I'd seen his prosthetic leg lying around by the pool a few times before I actually saw him, and when I did, he was climbing up the trapeze ladder. (The resort offers circus classes for children and trapeze lessons for everyone, every afternoon.) He was wearing shorts, and his stump was visible an inch or two below the hemline, and I've got to say that it certainly kicks the shit out of feeling self-conscious in shorts because of your cellullite or stretch marks.

I watched him climb, reach the platform, put on his safety harness, and then swing out over the safety net, his one leg hooked over the bar of the trapeze, swinging back and forth, and finally letting go. A teacher on the other trapeze swung toward him, and they caught each other's hands and held on, and they swung back and forth for a while. Then he dropped on his back to the safety net and raised his fist in victory. "Yes!" he shouted, "Yes," and lay there on the safety net for a long time, looking up at the sky.

I went up to him at lunch the next day and said, "You were great on the trapeze. Are you going to do it again?" and I hoped he would so I could do some serious writing about spirit and guts and triumph. And he said, "Oh, honey, I got much bigger mountains to climb."

The next day I saw his plastic leg lying on a beach towel at the far end of the beach where the windsurfing lessons take place. Oh, dear, I thought. The shoelace of the expensive sneaker on the foot of the plastic leg was untied. I went and tied it, then sat down in the sand. There were a dozen fishing boats out on the bay, white pelicans in the air. I couldn’t see the man with one leg anywhere. I wanted to talk to him. A few months before Pammy died, our friend Dale read us a line by the great Persian mystical poet Rumi: "Where there is ruin, there is hope for a treasure." We talked at the time of a sunken ship on the bottom of the ocean, full of jewels and gold; the sacred we can feel in devastation, the incredible sense of immediacy and presence we had felt some days toward the end, cruising malls and parks, Pammy in her wheelchair, looking like a cross between the Queen Mum and an Easy Rider, lashing me to go faster, relishing the feel of the wind in her wig.

GRIEF SUCKS, BUT THE AVOIDANCE OF GRIEF robs us of life, of the now, of a sense of living spirit. It keeps us from that e. e. cummings place, of "Now the ears of my ears awake and now the eyes of my eyes are open. It's much harder than we think, though. It's not just feeling this ocean of sadness, of losing those we love. It's asking yourself, How alive am I willing to be right now? My answer, until Pammy got so sick, was, Can we talk about this tomorrow?"

PAT HAD GONE SNORKELING ALMOST EVERY afternoon and loved it, although it was impossible for her to climb back into the boat unaided. On the day before we left, I decided to give it a try. The snorkel boat left at three every day and took ten or fifteen people out to a cove about twenty minutes away. Over lunch, though, I started to chicken out, until Pat said I had to go, that we couldn't be friends if I didn't. "Then tell me what you love most about it," I said. She thought for a moment, and then got a faraway, sensuous look on her face, was all but licking her lips as she slowly replied, "I like picking out the guys who are going to help push my big, wet, slippery body back up onto the boat."

Tom and I ended up going together. The boat took a bunch of us across the bay to a little cove near a beach with grass huts and umbrellas on the white sands, the loveliest cactuses on low, ancient neighboring hills framing it all. We donned our gear and jumped in.

The water is not crystal clear like it is in the Bahamas, and there are not a million brilliantly colored fish to watch, but all I can say is that if there is a heaven, and there very well may be one, it might be a little like snorkeling: dreamy, soft, bright.

I floated off by myself. At first my breath underwater sounded labored and congested, unearthly, like Dave the Spaceman's when he's in the pod outside the Mother Ship in 2001. And then, in the silence, it felt for a while as if I were breathing along with everything in the world. It is such a nice break from real life not to have to weigh anything; so much of the time life is sort of heavy and cumbersome. Beautiful green plants swayed in the current; funny little fish floated past. I was very much in my body, for once, breathing slowly, then floating into daydreams of Pammy and her wonderful two-year-old daughter. Near the end Pammy said, "All I have to do to get really depressed is to think about Rebecca, and all I have to do to get really joyful is to think about Rebecca." Floating, slow and present, I was somewhat surprised to discover that the inside of my mask was quite wet with tears. I could have used a windshield wiper. Sometimes grief looks like snorkeling, weightless and silent and slow, but then again, so does life. I felt very lonely for a moment. I don't think I would feel so lonely if I didn't still feel the big pieces of Pammy still in me. Still, of course, I want those pieces in me for the rest of my life, whatever the price. I floated along, still crying a little, but not feeling nearly so adrift. I watched the small fish swim in and out of the feathery green sea plants and thought about beautiful, wild, happy Rebecca. Tom came paddling over just then, and for a long time we lay there bobbing on the water's surface, faces down, barely moving our fins, lost in our own worlds, side by side, and I began to feel that something which had dropped was rising on its own.
I will not die an unlived life.
I will not live in fear of falling or catching fire.
I choose to inhabit my days, to allow my living
to open me, to make me less afraid, more
accessible, to loosen my heart until it becomes
a wing, a torch, a promise.
I choose to risk my significance, to live so that
that which came to me as seed, goes to the next as
blossom. And that which came to me as blossom
goes on as fruit.

— Dawna Markova
After the Blue

for Mrs. P
By Bryce Kellams, M.D. '97

The abruptness of the change
like the soft bed of blackness
after a violent dream
how the clamor of needles and machines
the pounding and beeping
of electricity dancing with drugs
people circling and shouting
to claim a leg or tube or vein
how this well-intentioned assault
is all at once stopped.

The room empties like a sigh
blowing out each monitor
leaving the last nurse
to undo what has been done,
to slowly unveil the human
who lies there
in the peaceful pause
at the end of the breath.

There is now only this
simple pronouncement to make
to lay a hand on the chest
a silent table
warm as bread
the muscles smooth
mouth slightly open,
yet eyes wide and fixed
at a great distance
as if in the moment of passing
awestruck by something
which we in our focus
had simply failed to notice.
Shroud

A word. With little power
A word only: clichéd in silence
and unknown in fact to all
but orderlies and undertakers.
The days of royal linen gone,
Supply Rooms carry plastic squares.
Where is the celebration
of the life and body?

I'll come one day to wear
your mourning and my shroud,
but if you've loved me,
search the shelves at home.
You'll find a faded sheet
I've washed a hundred times
where we made love and slept,
the afghan knitted as a gift,
the old green spread that carried me
through college and the beach.
Bring something large enough
not for my body only;
more goes with me on this trip.
Wrap me in memory,
in remnants of life together,
not in that sterile white
made in the thousands for the everyman.
Let me be someone,
even in death;
send with me fragments
of people I have loved,
for I shall love them still.

—Ellen Mauck Lessy
At death’s door, some people mysteriously take a turn for the better. What does the body know that medicine can’t explain?

By Stephen S. Hall

Stanley Gerbach* staggered into the Veterans Administration Medical Center in West Haven, Connecticut, one day in January 1967, desperately ill with a raging fever of about 104 degrees. He was a quiet, balding man of 52 years, a jewelry repairman, married with one child, and, as he would soon learn, dying of a terrible disease.

His West Haven doctors poked him and prodded him and ran all the usual tests. They quickly discovered that his blood count was perilously low, and when they slipped a needle into his pelvic bone, they found that the body’s blood-making apparatus, the marrow, was overrun with rogue cancer cells known as blasts. The attending physician on the case was Rose Papac, and as she reviewed all the test results, everything added up to a diagnosis of a quick and deadly cancer of the blood known as acute myelomonocytic leukemia. Papac, trained as a hematologist and oncologist, knew only too well that Stanley Gerbach’s chances of survival were nil.

“Without response to treatment, three months was the median survival rate,” Papac recalled recently, sitting in her office at the Yale University School of Medicine, where she is a professor of oncology. “With a complete response to treatment, the prognosis would be about one year.”

Papac decided to try to buy Gerbach a little time with chemotherapy. So the following day, the West Haven doctors started him on two drugs considered the treatment of choice in those days,

Illustrations by Janet Woolley

*The patients’ names have been changed.
6-mercaptopurine and prednisone—now known to be, at best, minimally effective in slowing the disease.

The orders were for 50 milligrams "q.i.d." (meaning quater in die, or four times a day), and no one was terribly surprised when Gerbach’s condition failed to improve the following week. Indeed, his disease was progressing exactly as predicted—rapidly and lethally. But then there occurred a serendipitous (and perhaps even irrelevant) turn of events.

“When a new intern took over the case ten days later, he read the treatment orders as ‘q.d.,’ or once a day, instead of four times a day,” says Papac, recalling how, his doctors unaware, Gerbach ended up with one-fourth the recommended dose.

“But then his blood counts came up to normal, and he was less anemic, and we became aware that he was getting better.”

Over the next two weeks, his fever broke and color returned to his face. The most startling transformation, however, could be glimpsed only with a microscope: All those abnormal cells choking Stanley Gerbach’s bone marrow had simply vanished. “A once-in-a-lifetime experience,” Papac says, remembering the sight.

Two months later, having received a quarter of the normal dose of an almost useless medication for an incurable disease, Stanley Gerbach walked out of the VA hospital and embarked on the second part of his life. “He has never relapsed,” Papac says. Twenty-five years later, Stanley Gerbach is alive and well and still exchanging Christmas cards with Rose Papac every year.

Such rare and improbable medical reversals go by the name of spontaneous regression or spontaneous remission. They are medical flukes, unpredictable and inexplicable, bright isolated shafts of sunlight cutting across the grim, gray statistical tables of survival rates. To many doctors, they are distracting and bothersome aberrations; says one prominent oncologist, “I think you’d have a better chance of getting struck by lightning than of having a spontaneous remission of cancer.” To others, they are “whispers of nature,” infrequent but tantalizing clues about the ways the human body can rally itself to fend off mortal disease. If only we had the ears to discern these whispers, goes the argument, we might discover revolutionary new approaches to medical treatment and healing.

But at this juncture in the popular retelling of cases, the plot typically takes one of two turns, both of them dead ends.

Many physicians simply dismiss the original diagnosis as flawed; it wasn’t a case of spontaneous remission, they conclude, the doctors just blew the diagnosis. In the other direction lies the “cancer quacks,” as Rose Papac calls them, those who precipitously attribute these miraculous cures to herbal remedies or vitamin therapy or, all too often, a superhumanly “positive” mental attitude displayed by the patient. To talk seriously about spontaneous regression, Papac says, is to walk “a thin line between doubt and quackery.” Which is precisely what Papac did when she gave a Grand Rounds talk on the subject at the Yale School of Medicine a couple of years ago.

Asked to prepare the talk in 1989, in part to refute some of the more preposterous claims, Papac sorted through three decades of her clinical practice and realized she had encountered at least eight, and possibly ten, cases of spontaneous remission. The most remarkable, in her opinion, was the story of Stanley Gerbach. His case not only embodied all the medical mystery that bedevils spontaneous remission, it gives little comfort to either the medical profession’s reflexive skepticism or the charlatans’ facile explanations.

“Lots of people doubted it and said, ‘You must have misdiagnosed the case in the first place,'” Papac recalls with a smile. “But when they saw our evidence, they agreed that the diagnosis of leukemia was correct.”

And how would Papac characterize Gerbach’s attitude? Was he upbeat? Was he combative and feisty? Did he, in the words of best-selling mind-body guru Bernie Siegel, see his disease not as “a sentence but a new beginning?”

“I wouldn’t rank his attitude as the most positive of any we’ve seen,” she says after a pause, choosing her words carefully. “He was a very frightened person, very fearful. He was paralyzed by the thought that death was imminent.”

Miss X, as she was called in the literature, suffered no less a diagnosis than Stanley Gerbach. A woman of 31, she lived in Baltimore, and her medical problems began, she believed, following a tumble off a bicycle. She visited her physician, complaining of a lump and pain in her right breast. Several weeks later, the cancer-ridden breast as well as the nearby lymph nodes were removed by surgeons at Johns Hopkins Hospital. Miss X remained healthy for approximately one year. Then her condition began to deteriorate.

She started to lose vision in her right eye, a problem caused by a second tumor apparently spread by the original. She lost more and more weight. A lump developed in the other breast, and then a new tumor poked up like a bony outgrowth from her sternum. Bedridden with pain, barely able to breathe, Miss X had little to look forward to beyond her six daily grains of morphine.

“I saw her twice, and in May her condition seemed really desperate,” her physician later recalled, “I left for England shortly afterwards, and, of course, did not expect to find her alive on my return.” But during the summer and fall of 1899, Miss X steadily improved. The pains subsided, the awkward tumor rising out of her breastbone just as mysteriously melted away, and by October of 1900, Miss X had recovered enough to drive the one and a half miles to the train station to meet her very surprised physician. “She had improved,” Sir William Osler observed, “in every way.”

Just as Osler has been credited with ushering in the modern era of American medicine, his account of Miss X is among the first 20th century descriptions of what in fact is a very ancient phenomenon. As he noted in a 1901 article, these cases are “among the most remarkable which we witness in the practice of medicine, and illustrate the uncertainty of prognosis, and the truth of the statement that no condition, however desperate, is quite hopeless.” Spontaneous remissions have occurred—“without any obvious reason,” in Osler’s perplexed, faintly protestant phrase—for centuries.

One of the earliest recorded anecdotes dates back 700 years, to a time when a reformed politician and anti-papist in central Italy named Peregrine Lazziosi became a Servite monk and priest, traveled far and wide doing good works, and ultimately developed a debilitating and unsightly cancer in his foot. Facing amputation of his foot, the monk prayed during the night before the operation and dreamed that the tumor disappeared. He awoke to find it gone and lived to the age of 80, dying in 1345. His miraculous recovery earned him canonization as St. Peregrine, and he became known as the patron saint of those with cancer and malignant diseases.

William Boyd, a prominent Canadian pathologist, later suggested that cancerous
factor in each person, and those are the kinds of things that could lead to a cure of cancer. So the idea of the conference was to find out if these whispers of nature had a common denominator, some lead that we could follow up with further study.” Thus, on May 9 and 10, 1974, modern medicine flirted, for the first and only time, with spontaneous regression as a phenomenon worthy of organized scrutiny.

But no light bulbs went off, no common denominator emerged to link the intriguing reports. Some participants believed, as Cole did, that the immune system was the key. Gustav J.V. Nossal of Melbourne, Australia, told his colleagues, “I’m going to put my money on the immune system. We’ve got a hobbyhorse—let’s trash it for what it’s worth.” But to many it’s been like beating a dead horse, because spontaneous remissions have yielded precious few clues since then.

That may be changing. There is a latter-day version of Everson and Cole’s report on the way, a new and even more ambitious survey of spontaneous remission cases that benefited from computerized searches of the literature. The Sausalito, California–based Institute of Noetic Sciences recently completed an annotated bibliography of more than a thousand instances of spontaneous regression reported in medical journals, most cases dating from the past 40 years. The survey includes not only cancer, but a broad range of diseases from tuberculosis and heart ailments to warts.

“I feel we are missing a major chapter in medical research,” says Brendan O’Regan, who heads the institute’s project, “and that there should be a field of spontaneous remission research. I think these people are a gold mine. These are nature’s successes, nature’s success against cancer. Why aren’t we studying them?”

O’Regan suggests that at the very least physicians should routinely save the blood serum of these unusual patients, and donate such material to a national “Remission Registry” where currently unknown immunologic factors might be identified.

It’s interesting that the institute, which is known for the research it has sponsored on the connection between the mind and the body, does not necessarily attribute remissions to that interesting intersection. In fact, neither do any of the researchers who have dabbled in spontaneous regression, except in an indirect way. As Rose Papac has put it, “metabolic aspects of emotional reactions could influence growth of tumors.” Says O’Regan, “I have no doubt that when this bibliography comes out, people will be hanging out shingles saying ‘Spontaneous Remissions and Mind-Body Workshop.’ I already see that Bernie Siegel has mentioned our project in his last book. I think it’s going to be a fact of life, but we can’t control that. People will want to say, ‘This is proof that the mind can cure cancer,’ and I say, ‘We cannot say that.’”

The inability to say much of anything, in fact, is the most conspicuous product of the field. A most revealing anecdote, moving in its helplessness, came during the 1974 Hopkins conference from Alfred S. Ketcham, chief of surgery at the National Cancer Institute. Ketcham told how his father had recently been diagnosed with cancer, how he’d undergone surgery for removal of a cancerous kidney, and how he’d looked up at his son from his bed and demanded, “How come you didn’t use spontaneous regression on me?” As Ketcham told his colleagues that day in 1974, “We’d all like to use it if we could.”

How often does spontaneous remission occur? One speaker at the Hopkins conference asserted that only one case involving lung cancer had been reported among the 750,000 Americans who died of that disease between 1950 and 1974. An early ballpark figure suggested once in every 80,000 or so cases of all types of cancer, although Warren Cole concluded that it occurs “much more frequently” than that. Certain cancers are known to have higher rates of spontaneous regression: kidney cancer, neuroblastoma (a childhood tumor), malignant melanoma, choriodiscinoma (a reproductive system cancer), and certain types of lymphoma. (Conversely, some cancers rarely reverse themselves—lung cancer, for one, and tumors of the stomach, intestine, and pancreas.)

But the true rate of spontaneous remission may never be known. Just as researchers such as Cole and Boyd began looking at the phenomenon in the 1950s, doctors embraced antibiotics and chemotherapy with great fervor, and pharmaceutical companies became powerful economic engines promoting their use. Whatever clues spontaneous remission might have suggested got swamped in the wave of drugs, even though studies have shown that the incremental improvement in survival rates for certain cancers since the 1950s is due more to early detection than to treatment. Physicians such as Rose Papac believe the aggressive use of radiation and chemotherapy may have drowned out the whispers of nature.

“It really concerns me that everyone feels impelled to treat immediately when they see these diseases,” says Papac. “In the past, before the aggressive use of chemotherapy became the norm, there used to be an opportunity to follow people along who clearly had incurable disease. The idea was that you would simply relieve the symptoms as they occurred, and a lot of patients got along pretty well for quite some time. Now that approach is almost never accepted. It is a tenet that people with disease must be treated. Doc-

APRIL 1992 HIPPOCRATES 43
masses that similarly regress without adequate explanation be called “St. Peregrine’s Tumors.”

But by what mysterious mechanism does spontaneous remission occur? As Boyd wrote in the 1950s, “A moment’s thought is sufficient to convince us that in biology, as in other fields of science, nothing is really spontaneous, for every event must have a cause.” But the cause, the biology of spontaneous remission, eludes researchers. Without it, spontaneous remission might just as well be called St. Peregrine’s Curse.

Among those who have tried to solve the puzzle were two surgeons at the University of Illinois College of Medicine in Chicago, Tilden Everson and Warren Cole. In the mid-1950s, Everson and Cole began a landmark analysis of reports of spontaneous remission of cancer, which they defined as “a partial or complete disappearance of a malignant tumor in the absence of treatment that ordinarily is considered capable of producing regression.” The two surgeons excluded lymphomas and leukemias (cancers of the immune system and blood), as well as the skin cancers known as squamous cell carcinomas, because all three forms of cancer vary greatly in growth rates. Even so, Everson and Cole compiled a total of 176 instances of spontaneous remission of cancer and published the results in a famous 1966 monograph.

One of the most remarkable cases was that of a 30-year-old woman diagnosed with malignant melanoma, a particularly aggressive form of skin cancer that nonetheless seems associated with instances of spontaneous remission. When doctors attempted to remove a grape-sized nodule from the woman’s shoulder, it ruptured and had to be taken out in pieces, with the likelihood that some malignant material escaped removal. Even so, not only did the wound heal, but all metastatic spread of her cancer disappeared. Four years later, a 28-year-old male melanoma patient was purposely given a transfusion of this woman’s blood. Although the man suffered from widely disseminated cancer in his head, thigh, buttocks, and armpit lymph nodes, within six weeks all the metastatic tumors disappeared.

Like Osler and everyone since him, Everson and Cole were at a loss to explain how these mysterious events occurred. They did note that such cases have always been marked by intriguing, ambiguous, and often contradictory factors that hint at biological mechanisms, not miracles. Cole, a former president of both the American Cancer Society and the American College of Surgeons whose every phrase and sentence betrayed a reluctance to speculate, believed that regression most likely occurs because the patient somehow marshals a heightened immunologic response to malignancy.

For instance, the disappearance of tumors has often been accompanied by a concurrent bacterial or viral infection and fever, a link that prompted William Coley, a surgeon at Memorial Hospital in New York around the turn of the century, to experimentally induce bacterial infections in cancer patients; those experiments continue to this day, with mixed results. In the early experiments, vaccines that were made up of killed bacteria, which became known as “Coley’s toxins,” caused some tumors to shrink or disappear. Suspecting that the vaccines triggered some natural anticancer agent, researchers sought and ultimately discovered tumor necrosis factor. Isolated in the early 1970s, the powerful tumor-killing molecule is produced as part of the body’s immune and inflammatory response, and is now being tested against cancer.

In many other cases, tumors seem to melt away following biopsy procedures or similar surgical insults, possibly by prompting a local immune response. In one study published in 1980, seven of 44 non-Hodgkin’s lymphoma patients had a temporary spontaneous remission, and all seven had previously undergone surgical biopsies of a lymph node. Indeed, among Everson and Cole’s 176 cases, biopsy or surgery was most often the event that preceded the remission.

Some remissions appear to be triggered by hormonal changes, such as a case reported in 1989 of a pregnant 28-year-old woman whose acute leukemia spontaneously regressed following childbirth, only to recur three months later. And as it becomes more evident that susceptibility to some cancers is inherited, it seems that individual genetic makeup—for instance, a person’s metabolism and immune system, which are controlled by the genes—may also play a role in spontaneous regression.

Tantalizing clues have sometimes led researchers in promising directions. Steven A. Rosenberg, a surgeon and researcher at the National Cancer Institute who operated on Ronald Reagan’s cancerous colon in 1985, has encountered three cases of spontaneous regression during his career, including a patient who was sent home to die with stomach cancer in 1956. While treating the man in 1968, Rosenberg reviewed his history and noticed that the man had developed a severe infection following surgery, and that the shrinking tumor had been infiltrated with immune cells. Since then, he and his colleagues have experimented with a treatment in which immune cells that specifically attack cancer are removed from the patient’s tumor, revved up with immune-boosting chemicals such as interleukin-2, and then reinfused into the patient’s bloodstream. In a recent twist, the team has also inserted the gene for tumor necrosis factor into the immune cells in an attempt to heighten the anticancer effect even more.

Not many physicians, however, believe the clues of spontaneous regression are worth pursuing. And everyone agrees that it is a notoriously intractable problem to research. Nearly two decades ago, hopes of finding underlying mechanisms prompted Edward Lewison, who was at the time chief of the Breast Clinic at Johns Hopkins Hospital, to organize a historic meeting. It was Lewison who coined the term “whispers of nature”; then, as now, Lewison firmly believed that cases of spontaneous remission represent rare but critically important hints about the way the body resists disease.

“There is something in human beings that controls cancer, no question in my mind about it,” Lewison says. “Some cancers of the breast grow very rapidly, and some grow extremely slowly. That in itself is an indication of a growth-regulating
grade lymphoma. Willem was referred immediately to the University Hospital in Groningen.

When Willem showed up there in July of 1984, the swollen lymph node measured about the size of an apricot. His doctor, Liedeke Postma, and Sibrand Poppema, the pathologist on the case, quickly attempted to confirm the diagnosis by performing another biopsy. But as they waited several days for the results of the test (it would again find a high-grade lymphoma, an unusually aggressive cancer of the immune system), Willem’s disease took a turn more appropriate to science fiction than medical fact.

“The amazing thing,” recalls Poppema, the unexpected remission, Willem was in perfect health with no trace of disease; his doctors reported the case in the journal Cancer in 1988. Postma still thinks the original diagnosis might have been wrong (“You must,” she says, “recognize that possibility”), but Poppema insists otherwise. “I’m very convinced,” he says, “that this is a genuine case of spontaneous regression.”

The irony of their “treatment” has not been lost on Willem Blau’s doctors, however. “If we had not waited, we would have begun chemotherapy,” Poppema says. “And, of course, it would have been another remarkable example of response to treatment.”

In an age of death-fearing patients, aggressively distraught relatives, and eager malpractice lawyers, patients who remain untouched by treatment are nearly as rare as cases of spontaneous remission. And yet Willem Blau’s case reiterates one of the most remarkable, and controversial, outgrowths of spontaneous regression in the last two decades: An acceptable (though controversial) form of treatment for two types of cancer has become... no treatment at all. One is the childhood cancer neuroblastoma, the other a group of immune-system malignancies known collectively as low-grade non-Hodgkin’s lymphomas.

Neuroblastoma is a devastating cancer that develops in the neural tissue of fetuses and often causes abdominal tumors in infants, with 380 new cases each year. It has long been known that on occasion these tumors mysteriously disappear. C. Everett Koop, later surgeon general of the United States, acknowledged in a 1955 paper that neuroblastomas sometimes inexplicably regress after simple biopsies, writing, “This has been observed by us also, and we have no explanation for it.” Audrey Evans, a physician at Children’s Hospital in Philadelphia, has seen hundreds of cases of neuroblastoma. Happily, she has also seen dozens of spontaneous remissions. Now, she says, these regressions can be reliably predicted in many patients.

Neuroblastoma tends to take two forms, Evans explains: a “good,” relatively benign form (where the chance of recurrence is less than 20 percent) and a “bad,” more aggressive form (where recurrence strikes more than 90 percent of patients). Evans and her coworkers have devised a system for distinguishing between the two forms using the child’s age, the stage of the disease, and the level of a blood component called serum ferritin.

For example, even with advanced disease, a child younger than three months who has a normal ferritin level would have a good prognosis. Their predictive method has become so accurate that they simply do not treat children with the “good” form with anything more than surgery, sometimes even those with abdomens so terribly distended that the tumors account for 25 percent of body weight. No chemotherapy, no radiation, nothing.

“For a long time nobody had a spontaneous regression because neuroblastoma was so bad that nobody went without treatment,” Evans says. “I’m sure there are far more cases of spontaneous regression than we see. We have a significant number of children that we treat with surgery alone. We may only get ninety-five percent of it. We don’t do anything further, and the disease doesn’t come back.”

The question, of course, is why. The answer, alas, remains St. Peregrine’s Curse—as yet, no one can explain the biological process at work, though Evans notes that in “bad” forms of neuroblastoma, chromosomal abnormalities are much greater in number than in the good form, and genetics may hold the key.

Another group of cancers that has a conspicuously high rate of spontaneous remission is the slow-growing non-Hodgkin’s lymphomas, affecting about 37,000 new patients every year. Curiosity about them prompted an unusual and controversial study begun in 1963. Doctors at Stanford University School of Medicine decided to explore an alternative to chemotherapy by following a group of patients with slow-growing lymphomas and, with their consent, initially not treating them. In a 1984 article in the New England Journal of Medicine, Stanford researchers Sandra Horning and Saul Rosenberg concluded that as a group the patients whose treatment was deferred for years fared as well as patients who immediately received expensive and unpleasant chemotherapy—they died at the same rate and got worse at the same rate.

Significantly, 19 of the 83 Stanford patients—fully 23 percent—experienced spontaneous regression of their disease lasting anywhere from four months to more than six years. Buried toward the end of Horning and Rosenberg’s article is a startling sentence. “Another advantage in deferring treatment,” they wrote, “is that it may allow spontaneous regression of disease.” That may mark the first time

now at the Cross Cancer Institute in Edmonton, Alberta, “is that the tumor did not grow. It should have been growing quite rapidly. After a couple of days, it was clear that it was getting smaller. When you see it getting smaller instead of larger, that's very... unusual.”

This novel development posed an equally novel medical dilemma: Should they blast away at this shrinking tumor with standard chemotherapy? Or should they do something heretical: Simply wait a few days and do nothing? “There was a lot of discussion, of course,” Postma says. “To decide to do nothing—that's not an easy decision.”

“We said to each other, ‘Let's take a risk and wait on starting treatment to see what happens,’” Poppema remembers. “As long as it got smaller, we felt we could wait. And the more we waited, the smaller it got. It continued to get smaller and smaller until it disappeared completely.”

When last checked, seven years after...
that spontaneous remission has been described, in a major medical journal, as a desirable and attainable goal of medical treatment. If the whispers of nature are loud enough to be heard in Palo Alto, why not elsewhere?

Today, Harold Whitely believes the operation he underwent in 1966 saved his life. What actually happened is that his surgeon performed a biopsy and promptly declared him incurable. So whatever majestic and occult process of healing began to unfold inside Harold Whitely was strictly his doing, although he doesn’t quite understand that either.

At the time, Whitely was 55 and living in Monroeville, Pennsylvania, just east of Pittsburgh, where he worked as a body-shop mechanic in an automotive dealership. In September of 1966, during a regular checkup, he mentioned a recent bout of breathing difficulties, which prompted a referral to West Pennsylvania Hospital in Pittsburgh for further tests. His physician there, Alexander Lowy, Jr., discovered an enlarged lymph node just above Whitely’s right collarbone. And when he looked at X-rays of Whitely’s chest, he detected a shadowy spot about the size of a quarter on the right lung, typical of a tumor. Lowy decided Whitely needed a biopsy.

Under local anesthesia, surgeons removed a small portion of his swollen lymph node, and the tiny bit of excised tissue went up to the pathology department. The report whirled back down like a bombshell. “They just took one look at the slide and said, ‘Oat cell carcinoma,’” recalls Lowy, referring to a fast-growing type of lung cancer (now called small-cell carcinoma) that got its original name because the cells resemble scattered oats. “Oat cell carcinoma is like a death certificate,” he says. “It was just a matter of time. In cases like this, the patient will last one to two years at most.”

Lowy broke the news gently, perhaps too gently; Whitely was told that he had a tumor, and if it caused problems such as pain, the discomfort could be relieved.

“In an indirect way, they kind of kept it from me,” Whitely concedes now. “They didn’t tell me it was as serious as it was. They just didn’t tell me. And maybe that was just as well.” Unbeknownst to Whitely, his hospital discharge report read, “It was felt that this patient’s symptoms were minimal at this time, but since he was completely inoperable and incurable, nothing would be gained by giving him treatment.” When Whitely walked the doors of West Pennsylvania Hospital in the fall of 1966, statistics suggested that the rampaging cancer would claim him within 24 months.

Which is why Lowy thought he was seeing an apparition when Harold Whitely shuffled into his office in 1971, complaining of a sore shoulder. “I was just a ghost walking in, as far as they were concerned,” Whitely says.

The radiology department at West Penn reviewed Whitely’s old X-rays. The film of September 22, 1966, showed a “definite mass” in the lungs; a film taken six months later, on March 16, 1967, showed nothing at all. If medical technicians used exclamation points in their reports, there would be a few in the 1971 memo from a flabbergasted radiologist at West Penn, who wrote, “Mass is not present... absolutely not present.” The 1971 radiologist, of course, intimated that the 1966 pathologists had blown the diagnosis. But the 1971 pathology department reviewed the biopsy slides and unanimously confirmed the oat cell diagnosis. Indeed, Lowy and colleagues have trotted out the slides at medical meetings, sent copies to cancer experts, and published images in the medical literature, and no one yet has disputed their conclusion.

No one, that is, except Harold Whitely. Oh, he’s landed back in the hospital a few times for unrelated ailments, but he’s a self-described ornery old man who now lives in Florida, mows his lawn, tinkers around his house repairing gadgets, and doesn’t quite understand the fuss surrounding his case. “I just thought it was one of them things,” he says. He didn’t even realize there was anything unusual about it until Lowy sent him a copy of the article he published about it in the journal Cancer in 1986.

“I’m one of these persons, if someone has to do something to me, I just say, ‘Do it,’” Whitely says in his homey Western Pennsylvania accent. “I believe if you’re going to make it, you make it. If not, you won’t. You really don’t have any choice.”

Alexander Lowy, Jr., too, is philosophical, but in a different way. “Why is this man not dead?” he asks. “We didn’t treat him. He’s really the only lung cancer patient that has been going for, well, forever. It’s about twenty-five years now. I’m still looking for someone to tell me why. Why? This wasn’t supposed to happen.”

Lowy’s reaction bespeaks astonishment, incredulity, disbelief—the standard descriptive glow surrounding the miracle of spontaneous regression. But as St. Persegrine’s poet laureate, William Boyd, wrote optimistically in the 1950s, “Perhaps it is time that we stopped using such expressions when we hear of a case of spontaneous regression of cancer... When the clinician—and the experimentalist concentrate on immunity rather than on mortality statistics and methods of carcinogenesis, we may begin to think of the prevention, the control, and the cure of cancer.”

A generation later, the astonishment still has not been retired in favor of testable hypotheses, and the field of spontaneous remission, such as it exists, remains defined by anecdote and speculation. It adds one more dollop of irony that we as a society have become so quick to ascribe cure to medical intervention that even those who experience spontaneous remission invariably give credit where credit is not always due. “Of course Doctor Lowy should have some of the credit,” Harold Whitely says these days. “But it was really that doctor that operated on me. It was his doing that it turned out the way it did.”

Next December, 26 years after concocting a mysterious and marvelous cure somewhere in the laboratory of his ingenuous self-healing cells, the “incurable and inoperable” Harold Whitely inexplicably turns 81 years of age.

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Stephen S. Hall is a contributing editor and author of Mapping the Next Millennium: The Discovery of New Geographies, published in February by Random House.
Passed on  
Croaked  
Kicked the bucket  
Gone to heaven  
Gone home  
Expired  
Breathed his/her last  
Succumbed  
Left us  
Went to his/her eternal reward  
Lost  
Met his/her Maker  
Wasted  
Checked out  
Eternal rest  
Laid to rest  
Pushing up daisies  
Called home  
Was a goner  
Came to an end  
Bit the dust  
Annihilated  
Liquidated  
Terminated  
Gave up the ghost  
Left this world  
Rubbed out  
Snuffed  
Six feet under  
Consumed  
Found everlasting peace  
Went to a new life  
In the great beyond  
No longer with us  
Erased  
Crossed over  
Cancelled  
Made the change  
Got mertelized  
On the other side  
God took him/her  
Asleep in Christ  
Departed  
Transcended  
Bought the farm  
With the angels  
Feeling no pain  
Lost the race  
His/her time was up  
Cashed in  
Crossed over Jordan  
Perished  
Lost it  
Was done in  
Translated into glory  
Returned to dust  
Withered away  
In the arms of the Father  
Gave it up  
It was curtains  
The long sleep/The big sleep  
On the heavenly shores  
Out of his/her misery  
Ended it all  
Angels carried him/her away  
Resting in peace  
Changed his/her form  
Dropped the body  
Rode into the sunset  
Bradyed  
Eliminated  
Taken Out  
Made the transition  
Gone to Jesus
One autumn day in 1964, Elisabeth Kübler-Ross, a Swiss-born psychiatrist, was working in her garden and fretting about a lecture she had to give. Earlier that week, a mentor of hers, who taught psychiatry at the University of Colorado School of Medicine, had asked her to speak to a large group of medical students on a topic of her choice.

Kübler-Ross was nervous about public speaking, and couldn’t think of a subject that would hold the students’ attention. But, as she raked fallen leaves, her thoughts turned to death: Many of her plants, she reflected, would probably die in the coming frost. Her own father had died in the fall, three years earlier, at home in Switzerland, peaceful and aware of what was taking place. Kübler-Ross had found her topic. She would talk about how American doctors—who, in her experience, were skittish around seriously ill patients—should approach death and dying.

Kübler-Ross prepared a two-part lecture. The first part looked at how various cultures approach death. For the second, she brought a dying patient to class to talk with the students. Asking around at the hospital, she found Linda, a sixteen-year-old girl with incurable leukemia. Linda’s mother had just taken out an ad in a local newspaper asking readers to send Linda get-well and sweet-sixteen cards. Linda was disgusted by the pretense that her health would improve. She agreed to visit the class, where she spoke openly about how she felt. The students, Kübler-Ross observed, were rapt but nervous. They avoided dealing with the source of their discomfort—the shock of seeing an articulate, lovely young woman on the verge of death—by asking an abundance of clinical questions about her symptoms.
Soon afterward, as her biographer, Derek Gill, relates, Kübler-Ross took a job as an assistant professor of psychiatry at the University of Chicago. Four students from the Chicago Theological Seminary learned that she was interested in terminal illness and asked if she might help them study dying people’s needs. Kübler-Ross agreed to try. At Chicago’s Billings Hospital, she began a series of seminars, interviewing patients about what it felt like to die. The interviews took place in front of a one-way mirror, with students observing on the other side. This way, Kübler-Ross gave the patients some privacy while accommodating the growing number of students who wanted to watch.

Many of Kübler-Ross’s peers at the hospital felt that the seminars were exploitative and cruel, ghoulishly forcing patients to contemplate their own deaths. At the time, doctors believed that people didn’t want or need to know how ill they were. They couched the truth in euphemisms, or told the bad news only to the family. Kübler-Ross saw this indirection as a form of cowardice that ran counter to the basic humanity a doctor owed his patients. Too many doctors bridled at even admitting that a patient was “terminal.” Death, she felt, had been exiled from medicine.

Kübler-Ross began to work on a book outlining what she learned in her work with the dying. It came out in 1969, and, shortly afterward, Life published an article about one of her seminars. (“A gasp of shock jumped through the watchers,” the Life reporter wrote. “Eva’s bearing and beauty flew against the truth that the young woman was terribly ill.”) Kübler-Ross received stacks of mail from readers thanking her for starting a conversation about death. Angered by the article and its focus on death, the hospital administrators did not renew her contract. But it didn’t matter. Her book, “On Death and Dying,” became a best-seller. Soon, Kübler-Ross was lecturing at hospitals and universities across the country.

Her argument was that patients often knew that they were dying, and preferred to have others acknowledge their situation: “The patient is in the process of losing everything and everybody he loves. If he is allowed to express his sorrow he will find a final acceptance much easier.” And she posited that the dying underwent five stages: denial, anger, bargaining, depression, and acceptance.

The “stage theory,” as it came to be known, quickly created a paradigm for how Americans die. It eventually created a paradigm, too, for how Americans grieve: Kübler-Ross suggested that families went through the same stages as the patients. Decades later, she produced a follow-up to “On Death and Dying” called “On Grief and Grieving” (2005), explaining in detail how the stages apply to mourning. Today, Kübler-Ross’s theory is taken as the definitive account of how we grieve. It pervades pop culture—the opening episodes of this season’s “Grey’s Anatomy” were structured around the five stages—and it shapes our interactions with the bereaved. After my mother died, on Christmas of 2008, near-strangers urged me to learn about “the stages” I would be moving through.

Perhaps the stage theory of grief caught on so quickly because it made loss sound controllable.
The trouble is that it turns out largely to be a fiction, based more on anecdotal observation than empirical evidence. Though Kübler-Ross captured the range of emotions that mourners experience, new research suggests that grief and mourning don’t follow a checklist; they’re complicated and untidy processes, less like a progression of stages and more like an ongoing process—sometimes one that never fully ends. Perhaps the most enduring psychiatric idea about grief, for instance, is the idea that people need to “let go” in order to move on; yet studies have shown that some mourners hold on to a relationship with the deceased with no notable ill effects. (In China, mourners regularly speak to dead ancestors, and one study has shown that the bereaved there suffer less long-term distress than bereaved Americans do.) At the end of her life, Kübler-Ross herself recognized how far astray our understanding of grief had gone. In “On Grief and Grieving,” she insisted that the stages were “never meant to help tuck messy emotions into neat packages.” If her injunction went unheeded, perhaps it is because the messiness of grief is what makes us uncomfortable.

Anyone who has experienced grief can testify that it is more complex than mere despondency. “No one ever told me that grief felt so like fear,” C. S. Lewis wrote in “A Grief Observed,” his slim account of the months after the death of his wife, from cancer. Scientists have found that grief, like fear, is a stress reaction, attended by deep physiological changes. Levels of stress hormones like cortisol increase. Sleep patterns are disrupted. The immune system is weakened. Mourners may experience loss of appetite, palpitations, even hallucinations. They sometimes imagine that the deceased has appeared to them, in the form of a bird, say, or a cat. It is not unusual for a mourner to talk out loud—to cry out—to a lost one, in an elevator, or while walking the dog.

The first systematic survey of grief was conducted by Erich Lindemann, a psychiatrist at Harvard, who studied a hundred and one bereaved patients at the Harvard Medical School, including relatives of soldiers and survivors of the infamous Cocoanut Grove fire of 1942. (Nearly five hundred people died in that incident, trapped in a Boston night club by a revolving front door and side exits welded shut to prevent customers from ducking out without settling their bills.) Lindemann’s sample contained a high percentage of people who had lost someone in a traumatic way, but his main conclusions have been borne out by other researchers. So-called “normal” grief is marked by recurring floods of “somatic distress” lasting twenty minutes to an hour, comprising symptoms of breathlessness, weakness, and “tension or mental pain,” in Lindemann’s words. “There is restlessness, inability to sit still, moving about in an aimless fashion, continually searching for something to do.” Often, bereaved people feel hostile toward friends or doctors and isolate themselves. Typically, they are preoccupied by images of the dead.

Lindemann’s work was exceptional in its detailed analysis of the experience of the grieving. Yet his conception of grief was, if anything, more rigid than Kübler-Ross’s: he believed that most
people needed only four to six weeks, and eight to ten sessions with a psychiatrist, to get over a loss. Psychiatrists today, following Lindemann’s lead, distinguish between “normal” grief and “complicated” or “prolonged” grief. But Holly Prigerson, an associate professor of psychiatry at Harvard, and Paul Maciejewski, a lecturer in psychiatry at Brigham and Women’s Hospital, in Boston, have found that even “normal” grief often endures for at least two years rather than weeks, peaking within six months and then dissipating. Additional studies suggest that grief comes in waves, welling up and dominating your emotional life, then subsiding, only to recur. As George A. Bonanno, a clinical psychologist at Columbia University, writes in “The Other Side of Sadness: What the New Science of Bereavement Tells Us About Life After Loss” (Basic; $25.95), “When we look more closely at the emotional experiences of bereaved people over time, the level of fluctuation is nothing short of spectacular.” This oscillation, he theorizes, offers relief from the stress grief creates. “Sorrow . . . turns out to be not a state but a process,” C. S. Lewis wrote in 1961. “It needs not a map but a history.”

To say that grief recurs is not to say that it necessarily cripples. Bonanno argues that we imagine grief to be more debilitating than it usually is. Despite the slew of self-help books that speak of the “overwhelming” nature of loss, we are designed to grieve, and a good number of us are what he calls “resilient” mourners. For such people, he thinks, our touchy-feely therapeutic culture has overestimated the need for “grief work.” Bonanno tells the story of Julia Martinez, a college student whose father died in a bicycling accident. In the days after his death, she withdrew from her mother and had trouble sleeping. But soon she emerged. She went back to school, where, even if sometimes she felt “sad and confused,” she didn’t really want to talk to her friends about the death. Within a few months, she was thriving. Her mother, though, insisted that she was repressing her grief and needed to see a counsellor, which Julia did, hating every minute of it.

Bonanno wants to make sure that we don’t punish this resilient group inadvertently. Sometimes the bereaved feel as much relief as sorrow, he points out, especially when a long illness was involved, and a death opens up new possibilities for the survivor. Perhaps, he suggests, some mourners do not need to grieve as keenly as others, even for those they most love.

Yet Bonanno’s claims about resilience can have an overly insistent tone, and he himself turns out to be a rather imperfect model of it. He thrived after his own father died, but, as he relates in his book’s autobiographical passages, he became preoccupied, many years later, with performing an Eastern mourning ritual for him. The apostle of resilience is still in the grip of loss: it’s hard to avoid a sense of discordance. All of which forces the question that’s at the heart of all thinking about grief: Why do people need to grieve in the first place?

To the humanist, the answer to that question is likely to be something like: Because we miss the one we love, and because a death brings up metaphysical questions about existence for which we have few self-evident answers. But hardheaded clinicians want to know exactly what grieving accomplishes. In “Mourning and Melancholia” (1917), Freud suggested that mourners had to
reclaim energy that they had invested in the deceased loved one. Relationships take up energy; letting go of them, psychiatrists theorize, entails mental work. When you lose someone you were close to, you have to reassess your picture of the world and your place in it. The more your identity was wrapped up with the deceased, the more difficult the loss. If you are close to your father but have only a glancing relationship with your mother, your mother’s death may not be terribly disruptive; by the same token, a fraught relationship can lead to an acute grief reaction.

In the nineteen-seventies, Colin Murray Parkes, a British psychiatrist and a pioneer in bereavement research, argued that the dominant element of grief was a restless “searching.” The heightened physical arousal, anger, and sadness of grief resemble the anxiety that children suffer when they’re separated from their mothers. Parkes, drawing on work by John Bowlby, an early theorist of how human beings form attachments, noted that in both cases—acute grief and children’s separation anxiety—we feel alarm because we no longer have a support system we relied on. Parkes speculated that we continue to “search” illogically (and in great distress) for a loved one after a death. After failing again and again to find the lost person, we slowly create a new “assumptive world,” in the therapist’s jargon, the old one having been invalidated by death. Searching, or yearning, crops up in nearly all the contemporary investigations of grief. A 2007 study by Paul Maciejewski found that the feeling that predominated in the bereaved subjects was not depression or disbelief or anger but yearning. Nor does belief in heavenly reunion protect you from grief. As Bonanno says, “We want to know what has become of our loved ones.”

When my mother died, Christmas a year ago, I wondered what I was supposed to do in the days afterward—and many friends, especially those who had not yet suffered an analogous loss, seemed equally confused. Some sent flowers but did not call for weeks. Others sent well-meaning e-mails a week or so later, saying they hoped I was well or asking me to let them know “if there is anything I can do to help.” One friend launched into fifteen minutes of small talk before asking how I was, as if we had to warm up before diving into the churning waters of grief. Without rituals to follow (or to invite my friends to follow), I felt abandoned, adrift. One night I watched an episode of “24” which established the strong character of the female President with the following exchange about the death of her son:

AIDE: You haven’t let your loss interfere with your job. Your husband’s a strong man, but he doesn’t have your resilience.

PRESIDENT (sternly): It’s not a matter of resilience. There’s not a day that goes by . . . when I don’t think about my son. But I’m about to take this nation to war. Grief is a luxury I can’t afford right now.

This model represents an American fantasy of muscling through pain by throwing ourselves into work; it is akin to the dream that if only we show ourselves to be creatures of will (staying in shape, eating organic) we will stave off illness forever. The avoidance of death, Kübler-Ross was right to note, is at the heart of this ethic. We have a knack for gliding over grief even in literary works where it might seem to be central, such as “Hamlet” and “The Catcher in the Rye.” Their
protagonists may be in mourning, but we tend to focus instead on their existential ennui, as if the two things were unrelated. Bonanno says that when he was mourning his father he had to remind himself that “just about any topic pertaining to a dead person . . . still made people in the West uncomfortable.”

Uncomfortable and sometimes—the Johns Hopkins psychologist Kay Redfield Jamison, an expert on bipolar disorder, suggests—impatient. In her new memoir, “Nothing Was the Same” (Knopf; $25), about the death of her husband, Jamison describes an exchange, three months after his death, with a colleague who asked her to peer-review an article. Finding it difficult to switch from contemplative sadness to hardheaded rationalism, Jamison snapped, “My husband just died.” To which her colleague responded, “It’s been three months.” There’s a temporal divide between the mourner and everyone else. If you’re in mourning—especially after a relationship that spanned decades—three months may seem like nothing. Three months, to go by Prigerson’s and Maciejewski’s research, might well find you approaching the height of sorrow. If you’re not the bereaved, though, grief that lasts longer than a few weeks may look like self-indulgence.

Even Bonanno, trying to offer a neutral clinical description of grief, betrays how deeply he has bought into the muscle-through-it idea when he describes a patient who let sad feelings “bubble up” only when she could “afford to.” Many mourners experience grief as a kind of isolation—one that is exacerbated by the fact that one’s peers, neighbors, and co-workers may not really want to know how you are. We’ve adopted a sort of “ask, don’t tell” policy. The question “How are you?” is an expression of concern, but mourners quickly figure out that it shouldn’t be mistaken for an actual inquiry. Meanwhile, the American Psychiatric Association is considering adding “complicated grief” to the fifth edition of its DSM (the Diagnostic and Statistical Manual of Mental Disorders). Certainly, some mourners need more than the loving support of friends and family. But making a disease of grief may be another sign of a huge, and potentially pernicious, shift that took place in the West over the past century—what we might call the privatization of grief.

Until the twentieth century, private grief and public mourning were allied in most cultures. In many places, it used to be that if your husband died the village came to your door, bearing fresh-baked rolls or soup. As Darian Leader, a British psychoanalyst, argues in “The New Black: Mourning, Melancholia, and Depression” (Graywolf; $16), mourning “requires other people.” To lose someone was once to be swept into a flurry of rituals. In many nations—among them China and Greece—death was met with wailing and lamentation among family and neighbors. Some kind of viewing followed the cleaning of the body—what was known as a wake in Ireland, an “encoffining” in China. Many cultures have special mourning clothes: in ancient Rome, mourners wore dark togas, and the practice of wearing dark (or sometimes white) clothes was common in Continental Europe in the Middle Ages and the Renaissance. During the Victorian era in England
and the United States, family members followed an elaborate mourning ritual, restricting their social lives and adhering to a dress code. They started in “full mourning” (for women, this was stiff black crêpe) and gradually moved to “half mourning” (when gray and lavender were permitted). Among Hindus, friends visit the house of the bereaved for twelve days and chant hymns to urge the soul on to the next world. In the Jewish shivah, a mourner sat on a low chair and chose whether to acknowledge visitors; those mourning their parents may recite the Kaddish for eleven months, supported by a minyan of fellow-worshippers. Even at the turn of the twentieth century, “the death of a man still solemnly altered the space and time of a social group that could be extended to include the entire community,” notes Philippe Ariès, the author of the magisterial “The Hour of Our Death” (1977), a history of Western attitudes toward dying.

Then mourning rituals in the West began to disappear, for reasons that are not entirely evident. The British anthropologist Geoffrey Gorer, the author of “Death, Grief, and Mourning” (1965), conjectures that the First World War was one cause in Britain: communities were so overwhelmed by the sheer numbers of dead that they dropped the practice of mourning for the individual. Certainly, there does seem to be an intuitive economy of grief: during war, plague, and disaster, elaborate mourning is often simplified or dispensed with, as we now see in Haiti. But many more Americans died during the Civil War than during the First World War; it seems, then, that broader changes in the culture hastened the shift.

Even before the war, according to Emily Post, mourning clothes were already becoming optional for any but the closest of kin. More people, including women, began working outside the home; in the absence of caretakers, death increasingly took place in the protective, and isolating, swaddling of the hospital. With the rise of psychoanalysis came a shift in attention from the communal to the individual experience. Only two years after Émile Durkheim wrote about mourning as an essential social process, Freud’s “Mourning and Melancholia” defined it as something fundamentally private and individual. In a stroke, the work of mourning had become internalized. As Ariès says, within a few generations grief had undergone a fundamental change: death and mourning had been largely removed from the public realm. In 1973, Ernest Becker argued, in “The Denial of Death,” that avoidance of death is built into the human mind; instead of confronting our own mortality, we create symbolic “hero-systems,” conceptualizing an immortal self that, through imagination, allows us to transcend our physical transience. (“In the early morning on the lake sitting in the stern of the boat with his father rowing, he felt quite sure that he would never die,” the young Nick Adams thinks in the last line of Ernest Hemingway’s “Indian Camp.”) Gorer himself had diagnosed an over-all silencing of the mourner: “Today it would seem to be believed, quite sincerely, that sensible, rational men and women can keep their mourning under complete control by strength of will and character, so that it need be given no public expression, and indulged, if at all, in private, as furtively as . . . masturbation.” Ariès added that this silence was “not due to the frivolity of survivors, but to a merciless coercion applied by
society."

In the wake of the AIDS crisis and then 9/11, the conversation about death in the United States has grown more open. Yet we still think of mourning as something to be done privately. There might not be a “right” way to grieve, but some of the work Bonanno describes raises the question of whether certain norms are healthier than others. In Western countries with fewer mourning rituals, the bereaved report a higher level of somatic ailments in the year following a death.

Today, Leader points out, our only public mourning takes the form of grief at the death of celebrities and statesmen. Some commentators in Britain sneered at the “crocodile tears” of the masses over the death of Diana. On the contrary, Leader says, this grief is the same as the old public grief in which groups got together to experience in unity their individual losses. As a saying from China’s lower Yangtze Valley (where professional mourning was once common) put it, “We use the occasions of other people’s funerals to release personal sorrows.” When we watch the televised funerals of Michael Jackson or Ted Kennedy, Leader suggests, we are engaging in a practice that goes back to soldiers in the Iliad mourning with Achilles for the fallen Patroclus. Our version is more mediated. Still, in the Internet age, some mourners have returned grief to a social space, creating online grieving communities, establishing virtual cemeteries, commemorative pages, and chat rooms where loss can be described and shared.

In “On Death and Dying,” Elisabeth Kübler-Ross, too, emphasized community by insisting on the importance of talking to the dying. Against the shibboleth that we die alone, Kübler-Ross thought that we should die with company. “On Death and Dying” shaped our grieving styles by helping establish the hospice movement and by an updated notion of the “good death,” in which the dying person is not only medically treated but emotionally supported.

Yet the end of Kübler-Ross’s own life was a lonely one. Like many pioneers, she was driven by messianic convictions that sometimes distanced her from her friends and family. Named “Woman of the Decade” by Ladies’ Home Journal in the nineteen-seventies, she separated from her husband and left him with the children, bought a house in Escondido, California, called it Shanti Nilaya (Final Home of Peace), and, in 1977, established it as a “growth and healing center” for the dying. She became a devoted exponent of reincarnation, arguing that death was a transition to a better stage, akin to breaking out of a cocoon. (As a volunteer in Europe after the war, she had been moved by the sight of butterflies carved into the walls of the children’s barracks at Majdanek, a concentration camp.)

Then, in 1995, Kübler-Ross suffered a stroke that left her paralyzed on one side. By 1997, living a severely circumscribed life in Arizona, she had grown depressed. “For 15 hours a day, I sit in this same chair, totally dependent on someone else coming in here to make me a cup of tea,” she told a reporter from the San Francisco Chronicle. She became known as “the death-and-dying lady who can’t seem to manage her own death.” Her isolation was chronicled in the documentary
“Facing Death” (2003). It showed a solitary Kübler-Ross in her cluttered home. “I always leave the television on,” she says. “That way something is always moving.” An English muffin hardens next to her on a plate. She says that she got in the habit of saving food in case she is hungry later in the day. Her son Kenneth lives nearby and stops in “from time to time.” Yet she seems as hauntingly alone as the patients she interviewed some thirty years earlier.

It has become a truism of the hospice movement that people resist death if they have something left they need to say. After the documentary, Kübler-Ross emerged from her anomic to revisit what she had written about grief. Realizing that the stage theory had grown into a restrictive prescription for grief, she collaborated with David Kessler, a hospice expert, to write “On Grief and Grieving.” Near the end of a chapter about her own grief—which arrived late in life, following the death of her ex-husband—she noted, “I now know that the purpose of my life is more than these stages. I have been married, had kids, then grandkids, written books, and traveled. I have loved and lost, and I am so much more than five stages. And so are you.”

“On Grief and Grieving” was a personal triumph of sorts for the ailing Kübler-Ross. Yet her crusade to open up a conversation about death and grief was ultimately distorted by her own evasions: the woman who wanted us to confront death unflinchingly came to insist that it was really an opportunity for personal growth among the survivors, as if it were a Learning Annex class. As she put it in an essay for an anthology, “Death: The Final Stage of Growth” (1997), “Confrontation with death and dying can enrich one’s life and help one to become a more human and humane person.” This approach—suffused with an American “we can do it better” spirit—made grief the province of self-help rather than of the community. In the end, Kübler-Ross could perhaps have done more to help her own family grieve after her death. Like many Americans, she planned her funeral, and insisted it be a “celebration” rather than an occasion for mourning. Dozens of “E.T.” balloons were released into the air, symbolizing “unconditional love.” Perhaps we were to picture her bicycling through the sky toward home.

Behind the balloons the painful fact of mourning remains: even a good death is seldom good for the survivors. The matter-of-fact mordancy of Emily Dickinson, the supreme poet of grief, may provide more balm to the mourner than the glad tidings of those who talk about how death can enrich us. In her poem “I Measure Every Grief I Meet,” the speaker’s curiosity about other people’s grief is a way of conveying how heavy her own is:

I wonder if it weighs like Mine—
Or has an Easier size.

I wonder if They bore it long—
Or did it just begin—
I could not tell the Date of Mine—
It feels so old a pain—

I wonder if it hurts to live—
And if They have to try—
And whether—could They choose between—
It would not be—to die.

PHOTOGRAPH: JENNY LYNN

Subscribe now to get more of *The New Yorker*'s signature mix of politics, culture, and the arts.
Who Will Heal The Healers?
As a girl Pamela Wible had recurring dreams in which she'd find dying people, bandage them, take them home, and nurse them back to health. She knew even then that she wanted to be a doctor. Wible became a family physician, believing it would allow her to serve not just her patients but also their families and communities. At the age of thirty-six, however, after working in six different clinics in ten years, Wible was ready to quit. Rushing through thirty office visits a day, she wasn't meeting her patients' needs — or her own — and she grew so depressed she stopped working.

Wible's depression lasted six weeks before she was, as she recalls it, “jolted out of bed” with a vision of how healthcare could be. Within weeks she led a series of healthcare forums in Eugene, Oregon, where she lives. The ideas gathered at the forums became her business plan, and within months she'd launched a clinic designed entirely by her community.

At her two-room office in the basement of a wellness center, Wible is not just the doctor but also the receptionist, the nurse, the bookkeeper, the insurance biller, and the janitor. Yet she works only part time, sees patients for up to an hour apiece in a living-room-like setting, and makes house calls. She is relaxed and quick to laugh. She even finds time to travel the country and encourage other doctors to leave what she calls “assembly-line medicine” and to create clinics in collaboration with their communities.

Wible's not alone in her dissatisfaction. A recent Physicians' Foundation study of twelve thousand U.S. primary-care physicians found that 78 percent of them believed medicine was either “less rewarding” or “no longer rewarding,” and 76 percent said they were either “overextended and overworked” or “at full capacity.” Another study shows that physicians can experience “empathy burnout” after seeing just ten patients in a day; most doctors see three times that many.

Wible was born in Philadelphia, Pennsylvania, to a lesbian psychiatrist and a Jewish medical examiner. Her parents' marriage didn't last, and she spent part of her childhood in Philadelphia with her father and part with her mother and her mother's partner in rural Texas. She says living with two lesbians “on the buckle of the Bible Belt” forced her to develop a sense of humor. With her father Wible spent much of her time in the morgue. She also accompanied him to his part-time jobs at a jail and a methadone clinic, where he introduced her as a "doctor-in-training."

Wible attended Wellesley, a liberal-arts college for women, and went on to medical school at the University of Texas at Galveston, where she protested the vivisection of dogs, believing that the same lessons could be taught in humane ways. She started petitions, but few students signed, because, they told her, they feared they would be "blacklisted." She was eventually granted exemption from the vivisection labs. Wible describes this as the first of many times in her life that she would stand up to authorities, express her beliefs, and persevere.

Wible is as optimistic about changing the face of healthcare in the United States as she is angry about the current system, calling it "predatory" and "submerged in a putrid stew of greed, bureaucracy, and unethical leadership." She's currently writing a book with the working title Doctoring for Democracy.

I met Wible two years ago, when I was looking for a new family physician. At the end of my first hour-long appointment, she pointed out that the plastic sippy cup I'd brought for my toddler contained harmful chemicals. I was both shocked and thrilled at the level of attention and care. During my husband's first appointment — for a cold he couldn't shake — Wible took stock of his diet and recommended more fruits and vegetables, especially leafy greens like kale. He was skeptical at first but now makes kale smoothies most mornings and hasn't been sick in more than a year.

Wible told me how, after Hurricane Katrina in 2005, she flew to Houston, Texas, of her own accord, despite official warnings that physicians should not "self-deploy." Before she went, she had been working on a presentation about community-designed ideal medical practices, and the irony of the situation hit her: "Here I was writing about how to transform our healthcare system. Meanwhile I was waiting for official instructions to tell me the right thing to do. Don't we all know the right thing to do?"

Entering the Astrodome, Wible and a colleague were greeted by a tired young physician who asked them to take charge of the medical clinic. Wible didn't feel equipped but worked the night shift for a week. Her resting heart rate increased fifteen beats per minute and didn't return to normal for weeks afterward. She believes this is how most doctors are living: in a constant state of stress. A month after she returned to Eugene, Wible received official word that she was free to volunteer.

Passaro: Before you started your own practice, you worked at what you call "assembly-line" clinics. What was that like?

Wible: I didn't have time to connect with my patients. They had to fight through the phone system to get an appointment, and when they finally got in to see me three weeks later, they had maybe fifteen minutes to get all their questions answered. Sometimes we would rush through one or two main concerns, but there were still five more we didn't have time to discuss. They would speak fast to get all their issues on the table. I didn't feel that I could ask questions about patients' lives unless they were the last patient of the day and I stayed late, or maybe if they came around noon and I was willing to skip lunch. I rarely took bathroom breaks, just so I could spend more time with them. That was the price I paid to develop real relationships with my patients.
They spent a lot of money on special software for these slick programs were to pay the overhead. There was no time to slow down, no time for your patients. The pressure to see as many patients as possible is driven by high overhead. In one job my overhead was 74 percent. So if I rushed thirty patients through in a day, twenty-two of them were to pay the overhead. There was no time to slow down, no time to think, no time to care.

**Passaro:** It must have been dispiriting to have so little time for your patients.

**Wible:** I think so. Nothing against men: it's just that Western medicine was designed by men, and men are more willing to turn healthcare into a competitive sport of who can see the most patients per day. But we all had to play that game; the rules were drilled into us to the point that, if I had a no-show, I'd worry, *Oh, no, I'm down one.* One employer gave us monthly color-coded charts that compared us to our peers in terms of speed and number of patients seen. They spent a lot of money on special software for these slick report cards. It took me hours to figure out how to read them. Ultimately the message was “You're a shitty doctor.” That's the kind of intimidation used to control physicians.

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**Passaro:** Does the “assembly line” affect women more acutely than men?

**Wible:** I think so. Nothing against men: it's just that Western medicine was designed by men, and men are more willing to turn healthcare into a competitive sport of who can see the most patients per day. But we all had to play that game; the rules were drilled into us to the point that, if I had a no-show, I’d worry, *Oh, no, I’m down one.* One employer gave us monthly color-coded charts that compared us to our peers in terms of speed and number of patients seen. They spent a lot of money on special software for these slick report cards. It took me hours to figure out how to read them. Ultimately the message was “You’re a shitty doctor.” That's the kind of intimidation used to control physicians.

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**Passaro:** It must have been dispiriting to have so little time for your patients.

**Wible:** I was physically, mentally, and emotionally exhausted. When I was out in the world at a grocery store, for example, I sometimes saw someone I thought might be a patient, but I wasn’t sure, because I hadn’t had time to get to know them during the office visit. So I used to hide behind my grocery cart to avoid them. I felt bad that I couldn’t even remember my patients’ names.

**Passaro:** How is it different for you today?

**Wible:** Now my practice is relationship based. I’m never thinking, *How many patients did I see today?* Just the other day I was in the grocery store, and there was one of my patients in front of me in line and another behind me. Plus the cashier was a patient too! We were all so happy to see each other. We embraced, and I snooped in their carts to see what they were buying. That’s what it’s like when you’re a community doctor. I ride my bike to work, and people wave to me. I feel as if I’m in a Norman Rockwell painting from the 1950s. [Laughs.]

Practicing medicine looks so complicated. It doesn’t have to be. Providing care is actually simple.

**Passaro:** What do you offer now in your practice that you didn’t before?

**Wible:** The most important therapy I deliver is a human relationship. I’m not doing anything controversial or woo.

In medical school we received only two hours of nutrition education. I pretty much had to discover, through my own research in the medical library, how diet can heal or prevent diabetes, hypertension, and high cholesterol. A plant-based diet is essential to human health. It’s disgraceful that many people in this country don’t have access to fresh fruits and vegetables, only junk at convenience stores. Some poor neighborhoods don’t even have grocery stores. We do this to people, and then we’re angry when they develop diabetes. When I cared for Katrina refugees, everyone over thirty was on insulin.

**Passaro:** Can you offer an example of how you approach certain health problems now versus how you did when you were in the factory system?

**Wible:** One little girl came into my office because she was urinating frequently at night. This had started when she’d moved in with her dad and stepmom. In a standard clinic, if a patient has urinary frequency, you automatically start with a urinalysis. But because I could take time to talk with her, I realized that her anxiety about living with a new mother was causing her symptoms. I told her to tell the adults when she wasn’t comfortable about something. I allowed her to access her feelings and speak her truth. Days later her symptoms disappeared. I didn’t even have to touch her.

I’ve recently begun to teach my patients how to examine their partners’ bodies. A lot of women are afraid to examine their own breasts, so I instruct them and their partners on how to do it. I’ve taught them how to examine ovaries and how to screen for melanoma, which is most likely to start on the back. It’s hard to examine your own back, so it’s often the partner who discovers a suspicious mole.

**Passaro:** What advice do you have for patients who don’t have the luxury of hour-long doctor visits? How can they foster better communication with their doctors?

**Wible:** They should probably follow the advice of an elderly woman I know. She went to her doctor for one of those fast visits. When the doctor rushed in, she asked, “How much time do we have?” He said ten minutes. She said, “Well, I want...
you to take off your coat and hang it up, and I want you to lean forward and look me in the eye and really listen to what I’m saying before you answer my questions.” You have to get physicians out of their robotic, technical mode and into a state of being fully present, which I think most doctors are still capable of attaining.

Passaro: Why has medicine changed so much since the days of house calls and family doctors?

Wible: In the last fifty years all these third parties have inserted themselves into the sacred patient-physician relationship: insurance companies, pharmaceutical companies, government regulators, technology — “advancements” that we don’t want and that might not even be good for us. Many of the tests we can order now only make people more anxious than they were before. How is that helpful? We get a lot of information that we don’t need, but we’re not even gathering information about lifestyle and nutrition. We don’t ask basic questions like “How’s your life going?”

Passaro: How did the medical profession get away from individual practice?

Wible: I trace the industrialization of medicine back to two programs: employer-sponsored healthcare, which started just after World War II; and Medicare, which started in 1965. Before those programs, doctor-patient relationships were more transparent and more personal.

Then major employers started going with complex insurance programs, such as health-maintenance organizations [HMOs] and preferred-provider organizations [PPOs]. The physician was put in a position of either signing on to work in a big group or else losing any patients who worked for, say, Ford Motor Company. The preferred-provider system was also sold to doctors with a promise of more money for less work, because of less overhead. Doctors wouldn’t have to worry about staff and business and paperwork. There were slick brochures and free trips to Hawaii when you signed up. You can see how doctors got seduced.

There’s an element of prestige when one belongs to a big group and can say, “I’m a preferred provider.” We doctors basically want the American dream like everyone else. After all the effort and expense of our education, we generally feel we deserve some comfort in life. So when these third parties promised us the world, it was pretty easy for us to fall for it. But then some administrator on the fourth floor turned up the speed on the assembly line, and before we knew it, we were churning patients through and skipping bathroom breaks.

And with the big providers came an increasing complexity that, it seems to me, was created by bureaucrats to justify their own existence. At a certain point you had more complexity and headache than service being rendered.

Now, instead of walking or biking to see your neighborhood doctor, you have to drive across town to a big clinic, park in a parking garage, and sit in a cafeteria-sized waiting room. This isn’t what people want. People want home visits. They want it to be the way it used to be. And there’s no reason why we can’t have that now.

Passaro: Are there not any advantages to group practices?

Wible: There is less need for the physician to deal with business and administrative tasks. Plus co-workers become sort of a family. You can easily consult with colleagues: if I saw a rash on a patient and wasn’t sure what it was, I could talk to the dermatologist down the hall.

You get retirement benefits and group health insurance. And when I was one of twenty family-practice doctors in a group, I was on call only once every twenty days. Of course, on that day I was slammed because I was responsible for all twenty doctors’ patients. But for the other nineteen days I didn’t have to think about it.

Passaro: What inspired the design of your current practice?

Wible: My original vision was that citizens would come together and articulate what they desired in healthcare. I wanted to facilitate the design of a dream clinic. I woke up with this idea on December 7, 2004, and held my first community forum on January 20, 2005. About thirty people showed up. I did eight community forums in all and got about a hundred pages of written testimony, which became my business plan. Eugene is a pretty creative town, and those pages were overflowing with wonderful ideas. We were open for business by April 1, just a few months later.

Passaro: What are some of the changes people wanted most?

Wible: People said that they wanted to be heard and to be treated as a person, not as a commodity. Simplification was another theme: people wanted to eliminate the medical assistant who weighs and measures and takes notes that the physician doesn’t read, anyway. Many people wanted to make sure that nobody would be turned away for lack of money. They wanted their doctor to be willing to barter, which I am.

Passaro: What are some items you’ve accepted in trade from patients?

Wible: Dog care, carpentry, gardening, massages, cleaning services. Local artisans have donated the use of a kiln and glass-fusion classes. I donate many of these traded items to other patients in need. Then there’s the delicious homemade bread and homegrown produce. I will work for food.

_I couldn’t sustain my enthusiasm on the assembly line; it was such a dehumanizing experience. I was tired of interrupting crying people to say, “Sorry, we’re out of time.”_ 

(end of excerpt)
The Practice of Law: Your Job, Your Career, or Your Calling?

After seven years as a hospice volunteer and four years as an integral coach to the legal community, I have witnessed tremendous suffering—remarkably, more among those “living” in our legal communities than those dying in our public hospitals. What is it about our work that brings about such outcomes?

In 2002, a middle-aged partner of a prominent San Francisco law firm was exiting the UCSF Cancer Center after a quarterly check-up. It had been 10 years since his original prognosis when he was told that he might only have two years left to live. As he reached the street door of the center, which also gave access to the adjacent hospital, he ran into a founding partner of his firm, a man 15 years his senior whose cancer was metastatic and highly advanced. They had seen one another at the office that morning, but this would be the last time that they would meet. The senior partner died three days later. The surviving partner then vowed that his last day in life would not be in the office, unless his work became his calling.

It is said that one’s work is either a job, a career, or a calling. A job is something that you do for money and little more. A career is a ladder that you climb for status, power, and money. It is externally referenced, and success is based upon meeting the expectations of others, not your own self-fulfillment. A calling may include status, power, or money, but it is self-referencing. It is a professional life lived in congruence with your passions.

Passions are rarely confined to the professional domain. If your professional life is your calling, it is because you are in pursuit of your life’s purpose, which extends well beyond your work existence. Consider Martin Luther King. Do you think he ever considered his work as a “job”? Were his sacrifices, as a civil rights leader, part of a “career”? Is there any doubt that his work as a preacher, as a civil rights leader, as a community member were not coherently joined, sustained, and invigorated by his “calling” to change racial relations in this country, once and for all?

The example of King shines a light on what is at the heart of a fulfilled life—your relationship to your own mortality. You know that your death is inevitable and that your life span is decreasing continuously. You know that your life expectancy is uncertain and that death will come whether or not you are prepared. You also know that when death comes all of the status, power, and money that you have accumulated cannot help you. So what really matters? What do you believe you are here to do? What is your purpose? What gives your life meaning?

One of the difficulties of our modern life and upbringing is that we rarely are invited to consider these fundamental issues. As you proceed through primary and secondary school, acquiring skills and making a record adequate to allow you to compete for space in a university of your choice, little time is given over to introspection. Perhaps in college you are able to study philosophy or psychology, but then the quest for graduate school entry leaves little room for actual contemplation of the great ideas of human existence offered in your undergraduate years. In law school, the functional equivalent of boot camp for lawyers, there is the constant pressure and competition for top grades and then the anticipation, and preparation for, the dreaded bar exam, all serving as a constant source of distraction. Having run that tortuous gauntlet, you may have been offered a job—not necessarily the one you sought, but a job nonetheless. When, in that hectic period, do most people make the time to inquire into life’s meaning?

But, ask yourself now: How do you approach this finite existence called “life”? Is it a container to be filled? Or is it, by the nature of its inevitable closure, a gift to be savored? If the former, you will find plenty to keep you busy. You will find a mate, procreate, raise your progeny, acquire things, pursue status, compete, and conquer. If the latter, you will find yourself slowing down and heightening your awareness of all that is around you. You will observe life in all its particulars, opening up your awareness to all that it offers, expanding your curiosity of what more you want to experience, learn, explore, and discover. You will build and sustain meaningful relationships.

Imagine that you are 95 years old. Your life has gone exactly as you had wished. You are fulfilled, happy, and at peace. As you look back from that place, imagine what your life would have to have been to deliver you there. How important were your contributions to your community? How significant were your relationships with family and friends? Did you leave time to follow your passions? If so, what were they? Did they include travel, music, art, further education, public service, or charitable works? Is the life that you are leading fulfilling, happy, and at peace? As you look back, what more did you want to experience, learn, explore, and discover? You will build and sustain meaningful relationships.

Recognize that the answer lies in pursuing a path. Outcomes flow from the journey itself, not from reaching the destination. Awareness is fundamental. Can’t you find a precious few moments each day for quiet introspection? It may be meditation, a yoga practice, prayer, or playing music. The object is to create space for silence, to allow you to drop deeper into...
yourself, to allow the myriad of thoughts racing through your mind to be observed but not acted upon. They are, after all, only thoughts. As you learn to create space in your mind you will find that your awareness grows. With your growing awareness you can open your curiosity and find new perspectives that shift your beliefs and judgments about how life should be. You become aware of your inherent goodness and generosity. You learn the significance of human relationships.

From this awareness, you acquire an initial inkling of what your purpose in life might be. It doesn’t come all at once. As you proceed further down the path of awareness, your purpose evolves and becomes more elaborate. As your purpose takes shape, something extraordinary happens. You find an ability to identify goals and set priorities which support your purpose. Other to-dos, largely creatures of your habitual thinking imbedded from your culture and upbringing, can fall by the wayside, since they are not truly yours.

As you pursue your goals by following your priorities, you find relationships that sustain and nurture you. Your life becomes balanced because there is an alignment between who you are and what you do. You will find yourself in the company of those who naturally support you because you are following your passions and are generous, open, and forthcoming. This all takes time. It doesn’t happen at once. In fact, it can’t, because you are continuously evolving, discovering, and modifying your life to fit the ever-changing circumstances of the world in which you live. But this time is neither futile nor frustrating, because you are pursuing your path and not that of someone else.

So how does all of this fit into where you find yourself now? First, you cannot begin to consider what to change until you know where you might be going. Take time to be with yourself. That time exists in your life, right now—even if you think otherwise. As you begin to pay attention to the subject of purpose, you will find it beginning to emerge from what you are reading, or listening to, from conversation, and from inspiration.

Second, what parts of your current life support what you anticipate your purpose might be? Observe yourself, keep a journal. Try to expand those elements of what you do to see if more is truly better. Third, study your relationships. Spend time with people who inspire, support, and nurture you. Avoid those who are toxic to you. You know who they are. Fourth, take care of your body. Take up a slow movement practice such as yoga or Qi Gong to learn where and how you carry stress in your body so that you may find ways to discharge it. It will make for better health and mental clarity. Fifth, listen—truly listen—to others. While giving others the gift of your attention, you allow them to go deeper into their own thoughts and allow yourself to become acquainted with the sources of your reactions. You will learn that there are minds that operate quite differently from your own. You will create a capacity for understanding those differences and develop tools for reconciling them, always of help in effective lawyering.

All along you are building capacity to attain that fulfilled, happy, peaceful life you seek. You will make choices that feed your passions. You will build relationships that nurture you as you increase your capacity to nurture others. You will bring your life into balance. And, if you find that your current work is not allowing you to follow your path, you may elect to change your workplace, your specialty, or even your career. Remember, if it isn’t your “calling” then it’s just work. You deserve much more, as does the world from you.

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Section Three

Reading List
THE HEALER'S ART
Winter Quarter, 2013

Suggested Reading List


Hesse, Hermann, “Siddhartha.” *Shambhala*, 2005


Merton, Thomas, *The Seven Storey Mountain.* Harcourt Brace, 1999


Remen, RN. “The power of words: How labels we give patients can limit their lives.” Western Journal of Medicine, 2001. 175:353.


Salzberg, Sharon, A Heart as Wide as the World. Shambhala: Boston, 1997


DETOXIFYING DEATH CURRICULUM

SUGGESTED READING LIST


Hine, Virginia, *Last Letter to the Pebble People*.


*Kupferman, Jeanette,* *When the Crying’s Done.* U.K.: Robson Books.


LeShan, Lawrence, Ph.D. *You Can Fight for Your Life.* M. Evans Co., 1977.


*St. Christopher’s Hospice. Someone Special Has Died.* St. Christopher’s Hospice, 51-59 Lawrie Park Road, London SE26 6DZ.


* Books on grief.