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Medical Virtue in Contemporary Practice: Has COVID-19 Reawakened Virtue in the Modern Medical Encounter?

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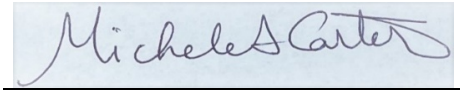

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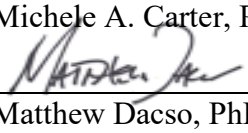

Matthew Dacso, PhD

Medical Virtue in Contemporary Practice
Has COVID-19 Reawakened Virtue in the Modern Medical Encounter?

by

Margarita Maria Ortiz, JD

Thesis

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To my loving, supportive family.

For the unconditional love, understanding, and patience.

My success is also yours.

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Medical Virtue in Contemporary Practice:
Has COVID-19 Reawakened Virtue in the Modern Medical Encounter?

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Crises like the COVID-19 pandemic further unsettle an already overburdened healthcare system, leading medical professionals to reevaluate priorities and redefine their professional identities. Focusing particularly on the meaning of *care* in the physician-patient relationship, this thesis develops an argument for the type of medical practice that incorporates Aristotelean ideals of virtue. The discussion shows that virtuous practice requires much more than following declarations of medical professionalism found in organizational charters—it requires a more humanistic approach suitable to address the complexity of the patient as person. Ultimately humanistic, this approach to caring is an engaged practice that involves empathy and attunement as the foundation of the healing presence and as a key to virtuous practice. An empathic attunement that witnesses and validates a particular patient's individual experience of illness and suffering leads the physician to engage in clinical discernment—a *being with* the patient that is a necessary element of the physician's clinical logic. Thus, supported by principles in the philosophy of medicine, and affirmed by physicians' personal narratives of illness and by reflections from pandemic medical professionals, I argue that virtue lies in the discernment, the prudential decision making. Physicians' personal experiences of illness, as well as the reflections of those practicing amidst the COVID-19 pandemic, provide examples of the reality of virtuous medical practice: that care is open and dynamic, changing with the tide of scientific progress and contextualized for each particular patient in this evolving world. In their remarkable experiences, physicians show that virtue lies in embracing the present, discerning the right and good thing to do, and ultimately in being present with their patients as they *care for* them.

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List of Abbreviations

UTMB	University of Texas Medical Branch
GSBS	Graduate School of Biomedical Sciences
COVID-19	SARS-CoV-2

Preface

Medicine has always been a vital part of my life. I grew up in a family of generations of physicians and now find myself living in a medical marriage, with a spouse who also is enamored of the enduring ideal of medical practice—being a caring doctor to many of the most vulnerable human beings. Immersed in a culture of caring while growing up and always driven by a love of humanity, my first professional endeavors explored the suffering and desperation of migrants with no other recourse than to emigrate to this country. This sharpened my knowledge of the intersections among health, medicine, and care, and it inevitably led me to explore the field of medical humanities. Interested in care and suffering, I wanted to explore why my grandfather, a rural town doctor, was such a vital part of the families he visited and served, and why it is so important for my forensic pathologist father to root out the cause of death for families seeking closure from the death of loved ones. Thus, this thesis is more than an academic project; it is a labor of love for a suffering humanity. It explores the virtue of caring and sets out to illuminate various responses to suffering. In particular, it examines what it means to care for others, especially those confronting challenges of an unprecedented, ever evolving pandemic.

Accepting that scientific progress and worldly events continuously redefine care in medicine, I explore the meaning of caring across different perspectives—what it means in professional declarations, in the lives of physicians and patients, and its implications amidst this COVID-19 pandemic. I discover that care in modern medical practice is open and dynamic; it is not tied to any scientific guide or controlled by prescription or proscription. Although the emergence of the coronavirus certainly disrupted established ways of caring and brought new challenges to scientists, doctors, and allied health professionals alike, the

pandemic also fostered new ways of caring and new ways of being. Medical professionals continue to rise to the task, responding with improvisations and innovations, continuously exploring ways to care for their patients, and upholding the virtues at the heart of the profession.

In the same improvisational way, I am challenged to write about the concept of care in the midst of a continuously evolving pandemic affecting people all over the world. As the coronavirus wavers in fluctuating patterns across the globe, I discover the unwavering resilience of humans helping humans, however they can—unscripted, adaptable, open to change. Rather than just redefining the concept of care, I find that many practitioners are seeking deeper dimensions of the caring experience. In story after story, doctors affirm caring as a unifying human endeavor and the ultimate comfort for their patients, as well as themselves. They show us that virtue in practice lies in learning to embrace the present, in adapting to the circumstances in which they are expected to care, and in discerning the right and good thing to do in caring for each particular patient.

We are all affected by this worldwide crisis. Care is at the forefront of everyone's lives, whether it is caring for self, for others, or for cherished ideals. Within this contemporary ambience, this thesis dives into the depths of care, describing what it means to care, and what drives doctors and other health professionals to care for a suffering other. The core of this thesis addresses what I propose is the vital question at the heart of medical practice: As a doctor, what is the right and good thing to do for a patient? How did my grandfather know how to respond? Why is my father called to do what he does? Investigating the call to care and inquiring how to respond to that call are fundamentally humanistic tasks. It asks, What does it take to *care* here and now, under these particular

circumstances? This question in turn begs another—whether —or rather, how—these current responses to the call to care during pandemic times can help prepare the future of medical practice.

Introduction

COVID-19: A Global Reality, A Force to Be Reckoned With

By February 2021, almost a year after the March 11, 2020 monumental declaration of a global COVID-19 pandemic by the World Health Organization, the United States had seen about 500,000 deaths.[1] That translates to an average of 1,370 deaths a day, or 57 deaths an hour, or one death "every minute of a miserable year."[2] The pandemic's death toll in one year was at more than the death toll of World War I, World War II, and the Vietnam War, combined.[3] Catching the world off-guard, destabilizing global society, and shocking medicine and science to uncertainty, the horror of its reality is lived by all of humanity—those who contract the virus, those who confront the virus in their work, and those who are imprisoned by the threat of the virus. And yet, figures, statistics, and even pictures can only capture the horrors in snapshots of split seconds of time. The impact of the coronavirus pandemic is best understood as it is told in the stories of those who describe its effect. Throughout this crisis, the world witnesses humanity as it collaborates to eradicate the virus and the disturbance it has caused to living.

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1 "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19 11-March 2020," last accessed March 14, 2021, https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020. As of February 20, 2021, the death toll was approximately 492,000. These numbers continue to rise. https://covid.cdc.gov/covid-data-tracker/#cases_casesper100klast7days. By the end of February, the number of infections stood at 30 million.

2 David Von Drehle, "What 500,000 Covid-19 Deaths Means," *Washington Post*, February 19, 2021, https://www.washingtonpost.com/opinions/what-500000-covid-19-deaths-means/2021/02/19/8492c9b0-72e1-11eb-b8a9-b9467510f0fe_story.html. These numbers continue to rise.

3 Julie Bosman, "US Virus Deaths Nearing 500,000 in Just One Year," *New York Times*, February 21,2021, https://www.nytimes.com/2021/02/21/insider/covid-500k-front-page.html?auth=link-dismiss-google1tap.

Stress, burnout, exhaustion, and the weight of professional accountability emerge as challenges for clinicians working in the frontlines of the crisis; clinicians learn how to manage trauma, embrace dynamic situations, and find ways to care at a time of supply shortage and ambiguous, uncertain science.[4] And though some are driven to the edge of their existence, an abundance of healthcare professionals remain unwavering in the hardships and excessive demands of the pandemic, redefining their roles and cultivating the endurance to witness, participate and share in the burden of suffering. Pioneers in redefining care and healing, these clinicians tread through grief to confront the challenges head on. Shaken in emotion, becoming a healing presence, clinicians at the forefront of the pandemic honor the necessity of human connection that is the center of the intimate clinician-patient relationship; in solidarity they share in the sense of loss and grief in their patients, in themselves, and in what *was.* Clinicians' experience of COVID effects a shift to a medical practice that is driven more by subjective values than by objective indicators, ultimately redefining the role of emotion in practicing sound and virtuous clinical judgment. In their resilience, these clinicians continue to honor their covenantal oaths in the service of humankind.

THE PRIMACY OF HUMAN CONNECTEDNESS

> It was 5:00pm in the intensive-care unit, and my team and I had just wrapped up our interview with elderly Ms. Armijo, who was in critical condition after emergency abdominal surgery. Exhausted after a long day, we headed for the door . . . From behind us, Ms. Armijo called, "You know, the thing I'm really worried about is being all alone."

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[4] Leah Ratner, Rachel Martin-Blais, Clare Warrell, and Nirmala P. Narla, "Reflections on Resilience During the COVID-19 Pandemic: Six Lessons From Working in Resource-Denied Settings," *American Journal of Tropical Medicine and Hygiene* 102, no. 6 (2020): 1178-80.

> . . . Frozen in midstride, I realized that we'd neglected one very important question: connectedness.[5]

Connectedness, this young doctor reflects, is life support; it could be and should be counted among "one of the patient's vital signs, as important, in its way, as any heart rhythm or puff of breath."[6] The COVID-19 crisis has juxtaposed human vulnerability against scientific prowess and has put medical practice on the spot to choose to recognize the primacy of human relationality.

Two predominant themes have emerged in the experience of the frontline healthcare workers: the importance of being a healing presence, and the transformative power of the COVID-19 experience that awakens that healing presence in those practicing in the frontlines of healthcare at the time of the pandemic. The authenticity of caring for patients receiving care during the COVID-19 pandemic shows the reciprocal healing effect of establishing a genuine human connection at a time when science cannot offer much hope. The way that caring manifests in the midst of events for which science has proven to be limited is emerging to be more healing than medical cures. In their illness narratives, physicians who have experienced critical illness testify that the connectedness and presence sensed from their treating clinicians during their illness trajectories were the most valuable influences in their care, thereby transforming the way they care for their patients. In their reflections they affirm that being with a patient is what matters in the end.

COVID-19 forces a recalibrated practice; it renews an exploration of shared meaning and directs the focus to the attunement between clinician and patient. Focused on

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[5] Anthony Feng, "Only Connect," *Pulse*, July 28, 2020, https://pulsevoices.org/index.php/stories/only-connect/print/.

[6] Anthony Feng, "Only Connect."

healing, clinicians reflect on the meaning of pandemic practice and good medical practice. In their practice, they determine that allowing themselves to be guided by focusing on their patients' values is to practice in a way that furthers the goal of acting for the good of the patient—or, in effect, healing for each patient. In this way, clinicians continue to surpass the challenges posed by the COVID-19 pandemic, each time with a renewed commitment to their service profession and their oaths of practice. Guided by *how to be* has proven to be far more healing than following streamlined professionalism declarations of *what to do*.

THE ROADMAP

This thesis explores the meaning of virtue in practice and evaluates the effect of the pandemic on medical professionals and on the practice of medicine. Its focus is bringing to light the imperative position that the relationship between the clinician and the patient holds as the moral basis of the clinical encounter. Focusing particularly on the meaning of *care* in the physician-patient relationship, this thesis develops an argument for the type of medical practice that incorporates Aristotelean ideals of virtue. The discussion shows that virtuous practice requires a prudential balancing of the multidimensional facets of the patient in his or her illness for the resulting clinical judgment to be prudential and wise. Immersed in the COVID battlefield, physicians see and embrace that prudential balance that leads to clinical wisdom as the pillar of the virtuous practice of medicine. This very humanistic approach to *caring* is an engaged practice that involves empathy and attunement as the foundation of the healing presence. Supported by physicians' personal narratives of illness, and affirmed by reflections from pandemic practice, the multidimensional nature of disease and the illness experience calls for the use of science

and humanism. In the humanistic profession that medicine is, caring for the patient in his or her wholeness is the (re)emerging protocol of the day.

Chapter 1, Medical Professionalism and Virtue, examines the role of professionalism in medical practice and discredits medical professionalism as the guiding light of a more humanistic practice. It establishes that while there exists a need for practice guidance, declarations of professionalism found in organizational charters (what I refer to as a *scripted* professionalism) are abstractions that fail to address the very essential humanistic aspect of medical practice. Eager to find the secret to the care of the patient, physicians' focus on caring for the patient is in deepening their relationships with them, such that with an illuminated understanding, they can make wise clinical judgments. At a time of crisis, to care for a patient means finding what matters, guided by a way to be, rather than a way to act.

Having dismissed the scripted professionalism charters as being ineffective guides for humanistic practice, in Chapter 2, Empathic Clinical Practice, I explain that emotion is a fundamental element of the multidimensional physician-patient relationship. If the physician-patient relationship is a connection for the exploration of suffering, then the physician, looking to act for the patient's good, must seek the necessary understanding to make wise clinical decisions. This type of clinical judgment required of the physician is a more engaged approach to the clinical encounter, an approach more appropriate to understand emotion and other variables affecting the patient's health. The chapter establishes that empathy is the emotion necessary for the therapeutic alliance between physician and patient. The use of empathic attunement is the road to integrating the connectedness of emotion into the clinical relationship.

Chapter 3, Physicians as Patients, presents as examples the reflections of physician-patients that speak to the important role that emotion and understanding play in caring for patient. This chapter evaluates the transformative effects of illness on the personal and professional lives of physicians who have also become patients and have lived through chronic or terminal illness. Selected for their intimate discussion of contemporary medical practice and the imperative plea for a more humanistic practice, their stories are contemporary testaments of the need to reawaken the healthcare industry to the true spirit of medical practice. Their lived experiences of illness shed new light on the meaning of the physician-patient relationship and on what matters most in caring for the patient. Being seen, being understood, and feeling their physicians' presence in their moment of illness were turning points in their healing journeys. Having deepened their understanding of the plight of the patient, they transform the way they see their patients and care for their patients. The chapter also features reflections from other patients supporting the physicians' experience. The reflections establish that *presence*, or *being present* with the patient, in one form or another, describes the experience of being cared for.

The experiences of medical professionals caring for patients during the COVID-19 pandemic affirm that what matters in the end is connection. Connecting to understand the patient and being a reassuring presence is sometimes the only thing that a physician or any of the other clinicians can do in caring for that patient. Thus, Chapter 4, Empathy and Attunement in Pandemic Times: Assaulted by a Global Pandemic, Reawakening of the Spirit of Practice, explores the way COVID-19 challenges clinicians to care for their patients. In their reflections, physicians and their fellow health professionals, facing almost-unbearable distress and suffering, reveal (and thus confirm) that which feels

revelatory for those physician-patients discussed in Chapter 3: that empathic practice is practice that affirms caring for the patient, and that in striving to act in the patient's good, it approaches the virtuous practice of medicine.

In closing, Chapter 5, Toward the Spirit of Medicine: Virtuous Practice in Contemporary Times, proposes that the virtuous practice of medicine requires the medical sensibility that allows the physician to bear witness to the multidimensional experience of illness of the patient and have a deepened understanding of the right and good thing to do for that patient. I question, whether, in the end with the pandemic trailing behind us, COVID-19 did indeed force a recalibrated practice.

Chapter 1 Medical Professionalism and Virtue

THE SECRET IN MEDICAL PRACTICE

The secret to the care of the patient is in caring for the patient.[7]

In his memorable 1926 lecture "The Care of the Patient," Dr. Francis W. Peabody emphasizes the wholeness of the human person. He stresses that the effect of emotion in the patient is as central to the diagnosis of the disease as are the organic symptoms. Observant to the excitement of scientific progress taking place since the turn of the twentieth century, Peabody urges future doctors to consider the role of other nonscientific variables in the patient. Peabody stresses the immeasurable value of considering the patient's life with the same scientific precision as he gives to medical cues; he urges that the patient's life is as crucial to determining the patient's good as is the medical diagnosis.

Peabody's impending death from terminal leiomyosarcoma of the stomach undoubtedly influenced his beliefs regarding the practice of medicine. But having noticed the popularity of the new science, he foresaw a foundational change in the focus of medical practice. The trend focusing on the objectivity in modern scientific medicine, with its ability to quantify and diagnose disease, was beginning to transform medicine into a technical practice. Peabody feared this emerging trend would be the "new medicine" that would eventually replace the multidimensional ethic of care that focused on thinking about the patient's wholeness; he feared that rather than using their intellectual processes in the investigation of their patients' illness, physicians would become enamored by the promise

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[7] Francis W. Peabody, "The Care of the Patient," *Journal of the American Medical Association* 88, no. 12 (March 19, 1927): 877-82.

and possibilities of the emerging quantifiable science, using it to replace rather than enhance the care of the patient.

In its effect, the COVID-19 pandemic has brought to light the importance of that ethic of care Peabody favored, especially when science could not (yet) help. Almost a century later, COVID-19 puts Peabody's reflections to the test: does caring for the patient mean more than what Peabody suggests? It is clear that COVID-19 has effected a refocus on the plight of the patient and the effort of their physicians; it has forced an exploration of the shared humanity between doctor and patient and the meaning of care. Redefining their roles, the patient is re-emerging as a person, and the health professional as liaison in the journey.

The predominant question becomes, What does it mean to care for the patient in pandemic times? Established practices have fallen short of resourceful at a time when the science is not certain and scripted care does not work. Through this pandemic it has been evident that physicians rediscover that the practice of medicine is as unscripted as their patients are, and that the only guiding light is to act in a way that looks to the good of each patient. No universal code or magic formula exists, only connectedness to the patient and purpose. Reignited in the search for the secret to the care of each patient, physicians rediscover virtue amidst chaos.

MEDICINE UNSCRIPTED: WHY NOT A SCRIPTED PROFESSIONALISM?

The resource for pandemic workers did not come in the form of a scripted professionalism; physician charters and other professional codes did not provide guidance. Rules imposed by medical professionalism are not a virtuous practice "to do" list. Virtuous practice must be based on a robust intention in the fidelity to a certain ideal in medicine—

always to seek excellence in working for the good of the patient. And since the good of the patient is defined relative to that patient, no universal to do list can exist. Virtue is a state of character; it is in choosing to do right, that virtue exists. So, it is an issue of character formation based on intention to pursue the good, or the ultimate end of something. It is precisely because intentionality is involved that medical practice implicates morality. The medical professionalism of the day is not geared towards character formation by intention.[8] Instead, under the auspices of guiding physicians to act in a predetermined professional way, medical professionalism prescribes a standard of conduct for physicians based on predetermined shared core values and predetermined professional behavior. Hoping to form habitual what they practice in what they practice, they are not choosing to do good but acting in a way that they are told is good.

The increasing scientific progress and the ethical quandaries resulting from progress and innovation trigger an emphasis on bioethics to consider the propriety, the limits, and the implications of scientific advancements. Thus, in light of this quickly developing science, the emergence of managed care, and other market forces distracting from the care of the patient, the healthcare industry launched a professionalism movement. This movement that began in the mid-1990s addressed concerns of physician involvements in commercial and political activities that affected the way they were motivated to practice and the type of practice of medicine they pursued. Decisions became loaded with implications and full of conflicts of interest, each creating moral queries:

> Several decades ago . . . clinical medicine [posed] but three questions: What is wrong with the patient? What can I do for the patient? What will be the

8 Aristotle, "Nicomachean Ethics Book II: The Works of Aristotle Volume II," in *Great Books of the Western World, Volume 9,* ed. Mortimer J Adler, trans. W.D. Ross (Chicago: Encyclopedia Britannica,1952), 351. I use the Aristotelean definition of virtue throughout this work.

> outcome? Today we might pose several more: What will it cost? What are the options? Which among the options is the most ethical (and also the most appropriate from the legal perspective), providing the best balance among the often-competing principles of beneficence, nonmaleficence, justice, and autonomy?[9]

Medical organizations implemented efforts to address current disruptions of conflicts of interests in medical practice.[10] This effort culminated in 2002, with the endorsement of the American Board of Internal Medicine's (ABIM's) *Physician Charter*.[11] The concept of medical professionalism has been ambiguously discussed and given different definitions in institutional codes, professional association charters, medical school charters, and medical school curricula, but the ABIM *Physician Charter* lays out the most widely recognized medical professionalism standards, modeled after the iconic American Medical Association's (AMA) *Code of Medical Ethics* first appearing in 1847.[12] Aiming to stabilize, protect, and regulate the medical profession from volatile economic

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9 Charles S. Bryan, et al., *Medical Ethics and Professionalism: A Synopsis for Students, Residents, and Practicing Physicians* (Columbia, SC: RL Bryan, Company, 2005), 4.

10 Levinson S. Wendy, Shiphra Ginsburg, Frederic W. Hafferty, and Catherine R. Lucey, "Chapter 4," in *Understanding Medical Professionalism*, Kindle ed. (NY: McGraw-Hill Education, 2014).

11 American Board of Internal Medicine, "The Physician Charter," last accessed March 14, 2021, https://abimfoundation.org/what-we-do/physician-charter. The *Physician Charter* resulted from the combined efforts of the American Society of Internal Medicine (ACP-ASIM), the American Board of Internal Medicine and the European Federation of Internal medicine under the "Medical Professionalism Project."

12 American Medical Association, "Code of Medical Ethics," last accessed March 14, 2021, https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-overview. It represented an amalgam of the basic Hippocratic ideals, that is, "stoic notions of duty and virtue," Jewish and Christian teachings, and gentlemanly behavior, as noted by Edmund D. Pellegrino and David C. Thomasma in *The Virtues in Medical Practice*, (New York: Oxford University Press, 1993), 185. The AMA Code of Medical Ethics was "the world's first national code of professional ethics." In the *History of the Code*, a small brochure produced by the AMA's Council on Ethical and Judicial Affairs, the AMA lists the code, answers questions and in its brief history states that the code "continues to be the embodiment of self-regulation necessary for the practice of good medicine."

and political forces, as well as increase the public trust in the professionals subject to it, the *Physician Charter* creates a type of contract between the medical profession and the society it serves, overseeing that physicians and healthcare systems "remain committed to patient welfare and to the basic tenets of social justice." [13] In moral unity under this social contract, each physician in practice submits to these shared standards of education and training, committing to live a professional life guided by the proclaimed three fundamental principles and the ten enumerated professional responsibilities.[14] The guiding principles of the *Physician Charter* capture the ethical concepts expected of those in the profession. In only doing so, then a *Physician Charter* like ABIM's represents an ethical threshold— an objective, uniform, ethical standard—by which to identify the core values of medical practice. How professionalism is to be interpreted and implemented remains a separate endeavor, ultimately creating inconsistency in the application of its tenets that could result in the unreliability of its teachings. It raises enough ambiguity to doubt the efficacy of such declarations. It fails as a guide for the humanistic practice necessary for our times.

A Critical Analysis of Professionalism: What Is Its Effect and What Does It Represent?

The implications of medical professionalism —whether it augments or diminishes the moral dimension of the medical profession— are hotly debated. If medical professionalism can indeed "be defined in concrete behaviors" and should be "understood

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[13] American Board of Internal Medicine, "The Physician Charter;" Medical Professionalism Project, "Medical Professionalism in the New Millennium: A Physician's Charter," *Lancet* 359 (February 9, 2002): 520-22.

[14] American Board of Internal Medicine, "The Physician Charter," American Board of Internal Medicine; "Medical Professionalism in the New Millennium: A Physician's Charter," Medical Professionalism Project, 520-22.

as a lived approach to the practice of medicine,"[15] two principal questions stand out: Does having a professionalism standard promote a minimalistic ethic for the practice of medicine? Could following listed professional responsibilities for what is permissible and impermissible in medical practice lead to virtuous practice? In other words, is the intention of "being professional" enough to establish virtue? On this, the professionals in the field disagree.

Medical professionalism can be perceived as an effort to standardize medical care into discrete duties, leaving out much of what medical practice traditionally embraces. Under this perspective, the practices scrutinized under the listed professionalism standards amount to promoting idealistic practice disregarding intention—a skeletal "basic professionalism."[16] Without intention, it is a sham professionalism.

Contextualizing the professionalism movement within the greater history of medicine, it appears to have been a social and cultural shift in the ethic of care from an ethic that embraced the relational dimension of medicine and focused on healing, to one focusing on market politics—economy, efficiency, and pragmatism—the political agenda of the1980s and 1990s.[17] The creation of healthcare as an industry meant that regulatory practices had to be adopted to control market forces. The only way for the industry to guarantee expectations was to adopt standards aimed at earning the public trust, which actually promoted healthcare as a commodity subject to marketplace ideals of organization,

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15 Wendy et al., "Chapter 4," in *Understanding Medical Professionalism*.

16 Herbert M. Swick, Charles S. Bryan, and Lawrence D. Longo, "Beyond the Physician Charter: Reflections on Medical Professionalism," *Perspectives in Biology and Medicine* 49, no. 2 (Spring 2006): 6.

17 Tom Koch, "Professionalism: An Archaeology," *HEC Forum* 31 (March 14, 2019): 219. Koch explains that political climate as one that pursued economic efficiency ideals that were also present during the 1970s emergence of bioethical notions of pragmatism and societal justice.

standardization, and contracts. Under this reality, the professionalism model represents a business education model of professional identity formation and a form of "medical socialization and supervision in which acceptance of and conformity to an economically-focused, bureaucratic social agenda dominates."[18] In this way, the use of professionalism as a regulatory tool means that it fails as a moral tool. As a regulatory tool, it becomes devoid of the moral center of the profession, failing to promote reflection or personal moral growth. As an unreflective practice, it has been compared to a union-like approach of commitment—an "unquestioned loyalty to other members of the same profession" far-removed from virtue and the humanistic way in which the term was used in relation to the medicine as a profession.[19]

Teaching medical professionalism as a moral guide and as a professional identity formation rubric is problematic. Teaching a true medical professionalism to medical students is a challenge because most approaches to teaching professionalism take the form of teaching behavior in terms of competencies—almost a "teaching to the test" method—thereby ignoring the formation of character and intuition learned best from role models. Thus, to medical educators, teaching professionalism as presented in the curricula presents a conundrum knowing that character formation takes time and role modeling. But subject to a time crunch and as it is evaluated and understood, professionalism teaching in schools

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[18] Koch, "Professionalism: An Archaeology," 221.

[19] Edmund D. Pellegrino, " Professionalism, Profession and the Virtues of the Good Physician," *Mount Sinai Journal of Medicine* 69, no. 6 (November 2002): 378-85. Pellegrino explains that the earliest evidence linking "profession" with "medicine" is in the writings of Scribonius in 47 A.D., who referred to medicine as the "profession of medicine." The context of Scribonius' use of the term "profession of medicine" was humanistic, defining "the profession of medicine" as one of "commitment to compassion or clemency in the relief of suffering," more akin to the virtue ethics ideals embedded in Hippocratic ideals. Pellegrino also clearly defines *profession* as a public declaration and public commitment.

boils down to teaching familiarity with medical competencies in order to evaluate the student to have "met" those required professionalism standards. Additionally, these competencies are perceived as "mere academic abstractions" that seem unworkable to teach.[20] They are words and ideas not tied to any concepts for practical application.[21] Whether the professionalism standards or competencies include "virtues" by name is inconsequential to virtuous practice because they are not being used to shape character, only taught to show that the desired qualities have been considered in the student's education. The listing of a competency is ineffective without a guide to implementation. Thus, while "[professionalism's] intent is laudable: to produce humanistic and virtuous physicians who will be able to cope and overcome the dehumanizing features of the healthcare system . . . virtues are habits of the heart, not pockets of knowledge about the heart."[22] To implement a true professionalism, that professionalism must be focused on character, it must engage emotion and reflection, and it must ultimately be done in the pursuit of the practice of medicine in the most excellent way possible to pursue the good of the patient: the virtue method. A true professionalism would have to be a "professionalism that engages the heart, as well as the mind."[23] A true professionalism

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[20] Jack Coulehan, "Today's Professionalism: Engaging in the Mind but Not the Heart," in *Humanitas: Readings in the Development of the Medical Humanities*, ed. Brian Dolan (San Francisco, CA: University of California Medical Humanities Press, 2015), 241.

[21] Delese Wear and Mark G. Kuczewski, "The Professionalism Movement: Can We Pause?" *American Journal of Bioethics* 4, no. 2 (Spring 2004): 1-10.

[22] Coulehan, "Today's Professionalism: Engaging the Mind but Not the Heart," 250, 236.

[23] Coulehan, "Today's Professionalism," 237. Coulehan suggests four touchstone components of professionalism essential for character formation, in sum, "positive role modeling, frequent opportunities for personal reflection, development of narrative competence, and inclusion of service learning (community service)," 248-50.

would be one that promotes excellence in practice rather than fulfilling standardized requirements.

Yet the attempt to use medical professionalism as a starting guide provides an opportunity to accept and deal with the influence of the different forces affecting the practice of medicine. As such, it is representing a call to action in evaluating where the profession is headed and beginning to think about effective ways of professional identity formation that combat negative influences. But can professionalism become a "cornerstone" if implemented using a virtue-based approach? [24] A virtue-based approach to medical professionalism would hold on to the idea of having a social contract between the profession and the public, but this time it would promote a return to virtuous practice by proposing that the fundamental principles be based on the commitment to *core health values*. Core elements that embrace a moral commitment to the ethic of medical service to society, and the public profession of those core health care values would embrace a value-driven practice.[25] Such a value-based approach provides a guide that effects a moral commitment to society.[26] But problems remain with such an approach; it only works idealistically. While a value-based medical professionalism approach would appear to pursue the spirit of medicine, it retains unworkable ambiguity in establishing core health values and runs into difficulties in practical application. This puts into question the idea that a professionalism driven practice is the solution to the lingering issues and conflicts in contemporary medical practice. The problem is the delivery of professional formation;

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[24] Matthew K. Wynia, Stephen R. Latham, Audiey C. Kao, and Linda Emanuel, "Medical Professionalism in Society," *New England Journal of Medicine* 341, no. 21 (November 1999): 1612-16.

[25] Wynia, et al., "Medical Professionalism in Society," 1613-14.

[26] Wynia, et al., "Medical Professionalism in Society," 1614.

its form is ineffective. The point is this: the form of a professional formation program in the form of declarations (whether of competencies or core health values) does not provide effective professional formation, even if the declarations are virtue based, because it lacks clarity and ignores the individualism of doctors and patients.

The disagreement of medical professionalism as a useful device for professional identity is in that it disregards the true intent of the practice of medicine and its effectiveness as the moral tool it purports to be. In practice, it appears shallow, limited, and impractical in its application because it is clouded with interpretative difficulties. Even in an aspirational role, it fails to be an all-inclusive ideal of the ethical and moral aspects of the practice of medicine. A charter like ABIM's *Physician Charter* is not representative of the core values of the practice of medicine, and its tenets are broad concepts that require working definitions. The ambiguity leads to inconsistent application because of definitional inconsistencies that seem subject to interpretation. Thus, in practical application, it is unworkable.

Scripted medical professionalism as guidance for physicians who intend to embody their roles as healers—ones that pursue medicine with intentionality of pursuing the good of the patient—is a starting point because it calls to mind the important role of professional formation. However, as it stands now it is not solid moral practice. As it stands today, it is an incomplete guide to professional formation; medical practice as science *and art* requires much more than a promise to the public of a commitment to mastery of skills and medical competence. An attempt to use professionalism as a substitute for the intellectual processes involved in practicing medicine is a reductionist attempt to medical practice, and at the same time "an attempt to render professionalism quantifiable, [using] skills and practices

as surrogates for virtue."[27] In the learned profession of medicine, medical, scientific competence is necessary but with the physician-patient relationship at its moral center, the driving force in practice should not only concern itself with regulated performance but in moral responsibility it must also concern itself with the cultivation of the physician's character.[28]

THE INTERSECTION OF MEDICAL PROFESSIONALISM AND VIRTUE: CAN VIRTUE SAVE MEDICAL PROFESSIONALISM?

Competence and caring are the heart of the medical profession. But in contemporary life, medical professionals feel vulnerable to the different forces pulling them in different directions, so life begs for a compass-like professionalism, a "how to" guide to navigate real-life obstacles, helping to ease the moral distress of contemporary decision-making. In *How Virtue Ethics Informs Medical Professionalism*, the authors identify that the problem is that *professionalism* is ill-defined because it should be beacon and map—purposeful as an aspiration and strategic as a map.[29] They conclude that a professional ethic is a critical element of a profession driven by intentionality. Virtue ethics has much to offer a working professionalism because "virtue ethics unites the ideals of professional behavior with the animating passion to pursue them," specifically in its task of uniting intentionality of practice with behavioral traits that actively pursue that intention.[30] Under Aristotelean virtue, the search for virtue in medical practice is a search

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[27] Coulehan, "Today's Professionalism," 241.

[28] Character will include the physicians' motivations and intentions in the practice of medicine. Discussing clinical phronesis, in *The Virtues in Medical Practice*, Pellegrino and Thomasma explain this relationship among virtue, motivation, and intentionality.

[29] Susan D. McCammon and Howard Brody, "How Virtue Ethics Informs Medical Professionalism," *HEC Forum* 24 (November 9, 2012): 257-72.

[30] McCammon and Brody, "How Virtue Ethics Informs Medical Professionalism," 270.

for a physician's *is* and *why*—that is, the physician's intentions and motivations. Motivated by practicing as excellently as possible in the pursuit of a practice focused on healing, a physician approaches virtuous practice. Therefore, implementing a search for this relativistic mean—the Aristotelean mean that lies between extremes of particular behavior—requires reflective practice and a "willingness to explore all ways one may set out to act virtuously."[31] The search for virtue is not a clear, objectively determined road but a search for the right way to be. Virtue proponents thus argue that focusing on virtue clarifies abstract concepts, allowing for physicians to develop and find their balance, finding what virtue means and what virtue looks like in their personal medical practice. Virtue requires deliberate choice. This method reinforces the idea that a medical professionalism standard must necessarily be a beacon. Medical professionalism as in place today in documents like the *Physician Charter* is off-center and must be redirected on setting the intention of the practice. The intentionality approach of professional formation is the implementation of professionalism principles focusing on the goals of the practice of medicine as a service profession focused on the good of the patient, remembering that, "principles and duties enable physicians to do good, but virtues enable them to be good, to make the difference that can make a competent professional, a noble one."[32]

FROM AN ETHICS OF DISTRUST AND FORCED EFFICIENCY TO COVENANTAL TRUST IN OATHS

> Principles and duties are the letter of medical ethics. It remains to virtue to live according to the spirit of medical ethics, which has been, and should remain focused on the good of the sick person.[33]

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31 McCammon and Brody, "How Virtue Ethics Informs Medical Professionalism," 261.

32 Pellegrino and Thomasma, *The Virtues in Medical Practice*, 173.

33 Pellegrino and Thomasma, *The Virtues in Medical Practice*, 173.

It is not a surprise that the established medical professionalism does not improve quality of care. The way it is treated, today's medical professionalism is not a beacon to higher ideals of practice but more akin to an effort to force efficiency to create a public trust in the profession. It is objective and it is precisely in its objectivism that medical professionalism dismisses the importance of character and connection so necessary in the physician-patient relationship. By establishing minimal expectations of competency, it fails to address the cultivation of relationships and the humanistic, relational aspect of a healing medical practice. The way the charter states its principles and commitments in the imperative *must* and *should* (what I believe to be a masked imperative) conveys a mistrust in the skills of the people of this learned profession and conveys a minimal ethic of attending to patients.[34] Its legalistic tone presumes misbehavior and conveys punitive consequences to physicians failing to meet it, or by those who by some unidentified standard are deemed to be acting unprofessionally. Listing professionalism as a skill set ignores that the power of medicine is in the depth of the therapeutic alliance between the physician and patient that is the moral core of the profession that gives it its purpose and meaning. Ultimately lacking foundational communication or connection or relationality, how can medical professionalism define the practice of medicine as a service to humanity?

With the bioethics movement informing medical professionalism, professionalism's focus is an attempt at setting standards in a way that seeks definitiveness by defining the proper way to do things. This obscures a more virtue-driven approach that

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[34] For example, under the charter's fundamental principles, "*physicians must* . . . have respect for patient's autonomy . . . " and under commitments, "*physicians must* . . . ensure that patients are completely and honestly informed . . . *should never* exploit patients . . . must actively participate in the development of better measures . . . should be committed to working with other physicians . . . *have a duty to* uphold scientific standards . . ." Medical Professionalism Project, "Medical Professionalism In the New Millennium: A Physician's Charter," 520-22.

describes a way to be. Thus, a professionalism based on virtue ethics would insist on character building that would inform what to do. The focus must be on building character in order to know what the right and good thing to do because it is the right thing to do. It is not enough to act from duty or economic pressures or punitive consequences. The virtuous physician acts in a way that best fulfills the ultimate goal of medicine; "it is not sufficient to follow rules irrespective of internal attitudes, feelings, [and] reason" because motivation has a big role to play in the foundation of professional identity formation.[35] Good action alone does not encourage a virtuous approach to each clinical encounter; the "virtuous physician will intend means that will be most perfectly in the best interests of the sick person . . . [this] excellence in medical intent requires the possession of virtues that will enable the good intention" to be carried out by the physicians.[36]

Therefore, a standardized medical professionalism is not virtue. Listing basic competencies in a duty-based approach, it does not consider the roles of motivation, emotion, or even reason and does not guide the professional to fulfill the listed competencies. As a guiding document to humanistic practice it fails; its competencies merely identify basic professional skills necessary in medical practice. It does not embody the whole of medicine as a human endeavor. Considering virtuous practice as a golden mean (as Aristotle suggests)—perhaps in two continuums, the scientific and the humanistic—this duty-based professionalism focuses only on what to do, and not at all on connection, motivation, and emotion. Clinical judgment must consider a patient's

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[35] P. Gardiner, "A Virtue Ethics Approach to Moral Dilemmas in Medicine," *Journal of Medical Ethics* 29 (September 2003): 297-302.

[36] Pellegrino and Thomasma, *The Virtues in Medical Practice*, 168. For the discussion on intentionality and motivation, see 165-68.

multidimensional existence, and guidance for professionals must reflect that. What this means for professionalism is that its task is identifying and labeling those things that aim at forming a professional identity that promotes the right balance of skill competencies and humanistic considerations. Reinstating trust in a profession will require much more than imposing a set of rules on what to do that identify the profession to be an enterprise rather than a vocation.

IF NOT MEDICAL PROFESSIONALISM, THEN WHAT? A SEARCH FOR THE SPIRIT OF MEDICINE IN PRACTICE

Rana Awdish, a critical care physician who became an ICU patient herself, advocates for purposeful practice. She finds professionalism tactics ineffective to motivate medical practice focused on the good of the patient. Through her advocacy she insists on the need to move away from institutional and professional standardization. In one of multiple publications, Dr. Awdish and Dr. Leonard Berry join forces:

> Medicine is constantly evolving as new ways to treat, heal, and even cure, emerge. We must continually reflect on the changes, and correct the course as needed. This work cannot occur in a vacuum of forced efficiency. Physicians, patients and administrators all must maintain and build on what is sacred and soulful in clinical practice. We must listen generously so that we nurture authentic bidirectional relationships that give clinicians and patients a sense of mutual purpose that no best-practice guideline or algorithm could ever hope to achieve.[37]

Medical practice cannot be encapsulated in any particular model of healthcare delivery, and thus cannot be scripted. Professionalism as listed in charters perpetuates a business model of the profession, complete with legalistic notions of contract and

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[37] Rana Awdish and Leonard Berry, "Making Time to Really Listen to Your Patients," *Harvard Business Review* (October 9, 2017), last accessed March 14, 2021, https://hbr.org/2017/10/making-time-to-really-listen-to-your-patients.

enumerated lists of expectations and unlisted yet punishable "unprofessional" offenses. True professionalism is manifested in the relational aspect of the therapeutic alliance between doctor and patient pushing to the best of their abilities to fulfill the ends of medicine.

In contrast to a scripted medical professionalism, the Hippocratic tradition of oath recitation is "among the earliest phases of a sophisticated moral cognizance" of the practice of medicine.[38] The tradition of taking oaths in medical school recognizes the power of the structural asymmetry in the relationship that binds a doctor and a vulnerable patient in the clinical encounter. Recitation of the oath invokes trust in the physician's commitment to morality in the practice of medicine because the physician declares out loud the intention of the practice and makes a promise. To join in the healing tradition, medical students reciting the oath traditionally call upon the mythic gods of Apollo and Aesculapius to impose a sense of duty and courage and to guard them from moral temptations in the practice of their *techne* and in their commitment to care for both body and soul of their patients.[39] Practice guided by an oath to care for body and soul of patients is practice with the intentionality to pursue the spirit of caring that approaches virtuous practice.

The Arnold P. Gold Foundation, a foundation dedicated to advocating humanism in medicine and the human connection in healthcare through educational initiatives and other programs, validates the use of the oath recitation. The Gold Foundation endorses the White Coat Ceremony as a way to instill in the young medical students who will become

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[38] Richard M. Zaner, "Power and Hope in the Clinical Encounter: A Meditation on Vulnerability," *Medicine, Health Care and Philosophy* 3 (2000): 265-75.

[39] Zaner, "Power and Hope in the Clinical Encounter: A Meditation on Vulnerability," 265-75.

professionals a sense of purpose in medicine's humanistic origin "before they are influenced by others who may not be good role models."[40] Taking an oath reinforces, reminds, and commits the one who professes the oath to the humanistic foundation of the profession.

The physician-philosopher Edmund Pellegrino considers an oath to be an act of profession that is integral to establishing "a binding commitment to place one's special knowledge and skill at the service of the sick . . . [through which] one enters a moral community whose defining purpose is to respond to and advance the welfare of patients."[41] Pellegrino explains that each patient encounter is an extension of that oath as another act of profession inviting trust, "promising that the doctor can be trusted and incurs the moral obligations of that promise."[42] Promoting an ethics of trust, taking the oath acknowledges the relational aspect of medicine and the healing relationship between doctor and patient as the moral center of the medical profession. Although oaths have evolved according to the shifting cultural values of the time, their focus is on the doctor-patient relationship that is central to the cherished Hippocratic Oath and its corresponding corpus of texts. Taking the oath goes beyond the mastery of professional competencies, embracing the purpose, humility of spirit, and reverence for humanity and the profession: "it serves as a powerful reminder and declaration that we [in the medical profession] are all part of something infinitely larger, older, and more important than a particular specialty or institution."[43]

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[40] Arnold P. Gold Foundation, "A Community of Caring," last accessed March 14, 2021, https://www.gold-foundation.org/about-us/.

[41] Edmund D. Pellegrino, "Professionalism, Profession and the Virtues of the Good Physician," *Mount Sinai Journal of Medicine* 69, no. 6 (November 2002): 2.

[42] Pellegrino, "Professionalism, Profession and the Virtues of the Good Physician," 2.

[43] Howard Markel, "'I Swear by Apollo'—On Taking the Hippocratic Oath," *New England Journal of Medicine* 350, no. 20 (May 13, 2004): 2029.

Focusing on the relationship at the center of the medical encounter means much more than meeting a set of declared competencies identified in a charter as professional competencies to be mastered. The physician-patient relationship, in its purpose, is the basis of the moral framework for medical practice and must be the focus of practice.

A focus on the healing relationship at the center of the profession reinforces an ethic of virtue in practice. For physicians, through realizing that the relationship in medicine is a healing relationship that is covenantal and trusting in nature, it is a call to character in each medical encounter. In the context of the relationship with all its contemporary limitations and under the professed oath, a physician must decide the right and good thing to do for the patient and in general, for medicine as a profession: "the good physician will be one who exhibits those character traits which most effectively achieve and indeed are indispensable for attainment of the ends of medicine."[44] A more virtuous professionalism is a balance based on a mindset of vocation, not contractual negotiation; the profession must be governed by tenets that embody "fidelity to medicine's ideals."[45]

In times of crisis, an ethic of professionalism unifies, but it is unlikely to be found in prescriptive and proscriptive charters of professional behaviors. A time of crisis does call upon unifying action, but the call will be based on the ineffable: that sense of moral duty, a return to the spirit of the calling, the sacred healing tradition that medicine represents, the unifying force of a shared experience in humanity. It will be a way of being,

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[44] Pellegrino, "Professionalism, Profession and the Virtues of the Good Physician," 4.

[45] Rita Charon, "Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust," in *Humanitas: Readings in the Development of the Medical Humanities*, ed. Brian Dolan (San Francisco: University of California Medical Humanities Press, 2015), 218.

a witnessing, an outstretched hand—not for learning what to do, but what, as a matter of character is learning how to be.

Chapter 2 Empathic Clinical Practice

ENGAGING WITH A SUFFERING HUMANITY: EMPATHIC CLINICAL PRACTICE

> The belief that medicine involves the application of impersonal facts to an objective problem that can be seen separately from the person who has it is the cardinal and emblematic error of twentieth century medicine.[46]

Individual, personalized care in contemporary medicine is an enigmatic concept; the role of emotion, whether empathy, compassion, or any other, is far from settled in clinical practice. Stereotypical judgments abound that the use of empathic emotions in clinical practice distracts from skillful practice and decision making. Yet for the clinician, in his role as scientist in a humanist profession, arriving at clear diagnoses and promoting the patient's best interests will require a grasp of the patient's life beyond consideration of mere clinical indicators alone; "empathic understanding is basic to expert practice for both doctors and nurses" because as "a form of personal relatedness that involves more than cold intelligence" it is "something more than mere observation"—it represents "understanding people in their own individuality."[47] For the physician, connecting in an emotional dimension is necessary for gaining an understanding of the patient in his world, what the patient loses in illness, and for acting in a way that best restores or heals that patient.

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46 Eric Cassell, *Doctoring*: *The Nature of Primary Care Medicine* (NY: Oxford University Press, 1997), 46.

47 Jeanne Levasseur and David R. Vance, "Doctors, Nurses and Empathy," in *Empathy and the Practice of Medicine*, eds. Howard Spiro, Mary G. McCrea Curnen, Enid Peschel, and Deborah St. James (NY: Yale University Press, 1993), 79-80.

THE CLINICAL ENCOUNTER REQUIRES EMOTION

At the basis of the clinical encounter is an interpersonal relationship which will work to integrate the interests and values between the physician and the patient seeking that physician's help. The clinical encounter creates *a space* wherein now together in this relationship that connects them, physician and patient engage in the patient's story so that "a decision and action be taken which will be for the good of the patient, both technically and morally."[48] It is how the connection happens and what develops from its maturation that determines the resulting type of care the patient receives. It is in this space of the clinical encounter that the physician-patient relationship blossoms or wilts.

Because physicians and their patients are inevitably connected, the role of physicians is always in relationship to their patients. Having professed to help the patient that comes seeking help, the physician aims to determine the best course of action that will effect and promote that patient's good. As the patient's good is the moral goal of medicine, the physician is morally obligated to seek the patient's good competently. Together with the patient, the role of the physician is to fulfill his or her professed obligation to care and to guide the patient to healing and wholeness.[49]

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48 Edmund D. Pellegrino, "Medicine Today: Its Identity, Its Role, and the Role of Physicians," in *The Philosophy of Medicine Reborn: A Pellegrino Reader,* eds. H. Tristram Engelhardt, Jr., and Fabrice Jotterand (IN: University of Notre Dame Press, 2011), 150. Pellegrino perceives the good of the patient at the ultimate goal of medicine. He defines in "more clinical terms, a right and good healing and helping act." (151)

Pellegrino, "Moral Choice, the Good of the Patient, and the Patient's Good," in *The Philosophy of Medicine Reborn: A Pellegrino Reader*, eds. Tristram Engelhardt, Jr., and Fabrice Jotterand (IN: University of Notre Dame Press, 2011), 163-86.

49 Thomas R. Egnew, "The Meaning of Healing: Transcending Suffering," *Annals of Family Medicine* 3, no. 3 (May/June 2005): 255-62. In "The Meaning of Healing," seeking a definition of "healing" in medicine, Thomas R. Egnew interviews Cassell, Kubler-Ross, Saunders, Inui and other pioneers in the field. Reconciling their responses, Egnew concludes that healing is "related to developing a sense of personal wholeness," involving "physical, mental, emotional, social and spiritual aspects of the human experience," and that "wholeness of

The physician's and patient's expectations define the purpose and goals of the clinical encounter. While public dissatisfaction with the contemporary medical practice spans over wide issues of education, training, motivation, professionalism, and ethics, a major cause of tension in contemporary medicine is the disagreement on what the goals of medicine are or should be, and how this applies to each clinical encounter. The dissonance in the goals for the clinical encounter is "the difference between what patients want from their physicians and, in contrast, how the physician perceives the encounter."[50] The fundamental issue is the clash of expectations regarding physicianhood, the purpose of the clinical encounter, and the goals of the clinical encounter. [51]

Modern day clinical encounters are abbreviated versions of the medical encounters of the past, reflecting contemporary trends of medical practice: they are brief, limited in scope and context, and generally, they are between strangers in a type of fee-for-service exchange. [52] In the current practice model that incorporates contractual consumerism, the interaction between physician and patient is also challenged by corporate expectations of efficiency, and physicians' defensive practice in awareness of legal action. These additional stressors cloud the intended purpose of medical practice, resulting in the shift of focus in the clinical encounter and doctor-patient relationship. Shaped by marketplace

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personhood" is linked with characteristics of personal relationships. As an operational definition, Egnew determines "healing is the personal experience of the transcendence of suffering" (258).

50 Shimon M. Glick, "The Empathic Physician: Nature and Nurture," in *Empathy and the Practice of Medicine: Beyond Pills and the Scalpel*, eds. Howard Spiro, Mary G. McCrea Curnen, Enid Peschel, and Deborah St. James (NY: Yale University Press, 1993), 89.

51 Cassell, *Doctoring*, 108. In *Doctoring*, Cassell defines a *physicianhood*, that is, the professional role of a doctor. Cassell writes that "physicianhood is a role, a set of performances, duties, obligations, entitlements and limitations connected to a function or status…it is a special role that makes possible the special, almost magical connection that constitutes the doctor-patient relationship."

52 This is due to the effect of the compartmentalization of general medicine into specialties.

ideas, medical practice is part of the health care industry that enforces a shift from an ethic of healing to a fee-for-service business exchange for curative expertise. The importance of emotion is underplayed in the climate of modern medical practice, which holds the physician as a businessman and the healthcare model as fundamentally based on self-interest and for-profit strategies. This, the moral malaise of the profession, redefines the physician's role to include that of "a businessman, an entrepreneur, a proletarian, a gatekeeper, and a bureaucrat."[53] The reality of medical practice now involves a lot of interface with computers, very limited interaction between patients and their physicians, and hardly any human touch.[54] Now with more informed patients that self-diagnose with Dr. Google, mistrust of the physicians' expertise or an attempt to seek a predetermined service ("Doctor, I need you to give me a prescription for an antibiotic") a transactional approach to the clinical encounter is not uncommon.[55]

The clinical encounter, however, is much more than a diagnosis check or a service request for a quick fix. The basis of the clinical encounter is that it is a space for the development of the physician-patient relationship. This space is a space for connection between the physician and the patient that becomes a shared exploration of suffering focused on the patient's good—*that* patient's good. Thus, the purpose of the relationship is to find *that* patient's good. Within this relationship, suffering and scientific medicine

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[53] Edmund D. Pellegrino, "Character, Virtue, and Self- Interest in the Ethics of the Professions," in *The Philosophy of Medicine Reborn,* eds. Tristram Engelhardt, Jr., and Fabrice Jotterand (IN: Notre Dame Press, 2011), 231, 245. The "moral malaise of the profession," is a phrase frequently found in Edmund D. Pellegrino's writings.

[54] Even as far back as 1995, as Eric Cassell published *Doctoring,* he discusses the beginning of these listed problems, which have now overwhelmed practice.

[55] "Dr. Google" I refer to patient's web searches for self-diagnosing using search engines, including the referenced universal search engine here of *Google*. https://www.google.com/.

intersect and emotion is necessary to engage in that purpose. The way in which a physician engages with the patient determines the type and quality of the medical care that the patient receives. Emotion is thus an essential part of the clinical logic in the physician's clinical method.[56] In this type of therapeutic alliance the physician connects to the patient through the use of emotion to understand that patient's concerns, stressing the feeling of being heard, accepted, and seen as another human in suffering. In this way, the physician and patient engage in a "close, caring interpersonal relationship" that is transformative and redefines the physician's role—a "metamorphosis … from doctor to healer…from doer to helper…an accompanier in the healing journey."[57]

SOUND CLINICAL JUDGMENT REQUIRES CONNECTEDNESS

The connection between physician and patient must involve emotion. Emotion exists in the clinical encounter because physicians are in relationship with their patients. Multidimensional, "all relationships exist at all levels of the human condition: physical, emotional (feeling), social, cognitive (intellectual) and spiritual."[58] The involvement of emotion often takes the form of emotional resonance. In the medical encounter, emotional resonance is manifested in a natural response to witnessing the suffering of another—the patient to the doctor, the doctor to the patient. As a basis for the relationship emotion

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56 Cassell, *Doctoring*, 52. Explained by physician/ philosopher Eric Cassell, "clinical logic is the logic of a chain of questions and answers following from the nature of illness as a process," a way to carry out the engagement between patient and doctor. In particular, he discusses the inclusion of emotion, like empathy, as part of clinical logic.

The *clinical method* is a method of engagement that promotes "clinical wisdom," or clinical *phronesis*, that takes the way in which medicine uses observation to observe the person of the patient. (85)

57 Thomas R. Egnew, "Suffering, Meaning, and Healing: Challenges of Contemporary Medicine," *Annals of Family Medicine* 7, no. 2 (March/ April 2009): 170-74, 172.

58 Cassell, *Doctoring*, 182.

informs the intuitive understanding of how to engage with the patient. Engaging with the patient will mean *being present* with that patient moment to moment, mindful of the patient's story. Being with the patient involves using emotion to connect, and in *engaged curiosity* becoming a facilitator of the story.[59] In this way, the physician shows unconditional presence while pursuing the clinical task to guide, formulate, and implement goals of care.[60] Strategically, emotional detachment fails in practice; so much of what is necessary to understand and act depends on using or tapping into emotion. Practice without emotion is ineffective toward acting for the good of the patient and would fail as virtuous practice or even as competent practice: "detached concern leads to errors in medicine …these errors result in distortions of the medical worldview for both patient and physician."[61] This fiction of strategic professional detachment is one of the "prevalent reasons for contemporary medicine's quality-of-care crisis."[62]

It follows that in the challenge to become physician-healers pursuing the good of the patient, knowing how to connect and engage with patients is part of a physician's clinical wisdom, if not the key to virtuous practice. Yet skepticism persists. Some believe that the use of emotion and empathic practice diminishes the patient's perception of the physician. Because "the patient regards the physician as an authority and wants the

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59 Abraham Verghese, "The Physician as Storyteller," in *Humanitas: Readings in the Development of* the *Medical Humanities*, ed. Brian Dolan (San Francisco: University of California Medical Humanities Press, 2015), 224-35. This idea of engaged curiosity is part of Jodi Halpern's theory.

60 Brad Stuart, Tracey Danaher, Rana Awdish, and Leonard Berry, "Finding Hope and Healing When Cure Is Not Possible," *Mayo Clinic Proceedings* 94, no. 4 (April 2019): 677-85.

61 J.A. Marcum, "Emotionally Detached Concern or Empathic Care," in *Humanizing Modern Medicine: An Introductory Philosophy of Medicine* (Springer Science + Business Media, B.V., 2008), 266.

62 Marcum, "Emotionally Detached Concern or Empathic Care," 266.

opinions and the decisions of a scholarly, experienced expert," the use or show of emotion is discouraged.[63] They argue that emotional influence has a negative effect on decision-making and clinical judgment because it "will undermine the ability to function as wise, understanding doctors, who give of themselves in guiding patients through life's concerns and illness."[64] But this argument defies logic because the complete emotional suppression for which it argues eliminates the basis for concern for patients.[65] And what then would motivate a physician's practice if not the intention of striving for some goal? Emotional detachment discards motivation to practice. Without motivation to practice the task of medicine cannot be reached. To be the wise, understanding doctor a patient expects requires a focus on human suffering that elicits an emotional, empathic understanding of that patient's distress and illness. The clinical understanding of a patient will deepen from the empathic connection that informs the doctor's clinical decision-making. As a form of gathering information, empathic observation is required by the scientific method. Skillfully empathically attuned to the patient, the physician will function as the wise, understanding

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63 Richard Landau, "…And the Least of These is Empathy," in *Empathy and the Practice of Medicine: Beyond Pills and the Scalpel,* eds. Howard Spiro, Mary G. McCrea Curnen, Enid Peschel, and Deborah St. James (NY: Yale University Press, 1993),108.

64 Richard Landau, "…And the Least of These is Empathy," 108. Landau points out that neither Osler nor Peabody, two pioneers in medical education, mention the word "empathy." In his *Aequanimitas* address Osler warns against "showing indecision and worry" which Landau interprets as the use of emotion and Peabody in "The Care of the Patient" discusses the art and care of the patient but does not specifically include emotion or empathy in the practice of the art. He further argues that the gathering of information of which Peabody talks is really for a "scientific evaluation" of patient.

65 Jodi Halpern, "From Idealized Clinical Empathy to Empathic Communication in Medical Care," *Journal of Medicine and Philosophy* 17 (2014): 301. In a discussing Oslerian detached concern, Halpern attributes the "concern" to duty that highlights the power differential between physician and patient— " 'detached concern' was an idealized, white-coated concern, in which by refraining from emotional contamination, physicians would gain therapeutic power." But detachment led down dangerous pathways to the 1960s era of dehumanizing medical research that led to the bioethics movement, 301-02.

doctor the patient needs: "the bond permits effective tuning or shaping of physicians' technical medical actions to the patient."[66] The use of emotion in seeking understanding by observation in this type of empathic engagement is a "basic form of thinking;" it triggers intuition—that "process by which the mind directly grasps forms of things, recognizes the similarity of some percept to a known form, relationship and meaning"—to understand.[67] Intuition reveals "such kind of truths the mind perceives at first sight" that inform understanding.[68] Scientific *and* emotional dimensions of understanding complement each other to represent objective *and* subjective understandings that illuminate the physician's critical, clinical thinking that are part of his or her intellectual processes. Those things that cannot be objectively perceived can be extracted from the patient's story because that patient's story is a view of his or her multiple dimensions of personhood. Pursuing an emotional connection with the patient allows the physician to see the patient in his illness when "listening deeply...[and] becoming an empathic witness to patient's suffering."[69]

CONNECTION AS "BEST PRACTICE:" USING EMPATHY TO CONNECT

At the center of the physician-patient relationship is communication. Empirical studies determine that communication within the clinical encounter is an important component of patient-centered care because it affects health outcomes. Thus, it is an important physician competency. "Best practices" for physician communication include fostering the relationship, gathering and providing information, making decisions,

66 Cassell, *Doctoring*, 187.

67 Cassell, *Doctoring*, 121.

68 Cassell, *Doctoring*, 121. Cassell quotes John Locke in the final fragment of this passage.

69 Cassell, *Doctoring*, 119-120.

responding to emotions and enabling disease and treatment related behavior.[70] Physicians stress the importance of the relationship and seeing the patient as person through language, engagement, rapport, showing genuine interest, seeking to understand, listening actively, expressing empathy and sympathy, providing reassurance, and assessing patients' psychological distress.[71] What these best practices reflect is an emphasis on deepening the relationship between the physician and the patient. Particularly, fostering the relationship and responding to emotions will require that the physician and patient transcend the strictly clinical agenda to connect on an emotional level, effecting a perspective shift from sole concentration on organic disease to considering the effects of illness on the patient. Within this task of diagnostic listening the physician taps into his own emotion as method of attunement to the patient— "[enlisting] the listener's interior resources—memories, associations, curiosities, creativity, interpretive powers, allusions to other stories…to identify meaning."[72] The identified best practices include emotion as an important component in communication, thereby making empathy—the response to patient emotions— part of what should be the clinical standard of care.

In physician-patient communication, empathy is the bridge between the physician and the patient. Empathy is also the bridge that links the physician's objective and subjective understanding of the patient. The patient, in turn, reciprocates. Its effect is to

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[70] Ann King and Ruth B. Hoppe, "'Best Practice' for Patient-Centered Communication: A Narrative Review," *Journal of Graduate Medical Education* (September 2013): 385-93.

[71] King and Hoppe, "'Best Practice' for Patient-Centered Communication: A Narrative Review," 390. Table 3 lists roles and responsibilities as well as skills that represent "best practices" in the medical interview.

[72] Rita Charon, "Narrative Medicine: A Model for Empathy, Reflection, Profession and Trust," in *Humanitas: Readings in the Development of the Medical Humanities,* ed. Brian Dolan (San Francisco: University of California Medical Humanities Press, 2015), 213.

deepen the connection between them. Translated literally from the Greek, empathy more accurately means a *feeling into*, which closely identifies empathy with an understanding. Therefore, the word connotes meanings of getting to know something or getting a grasp of something. Though definitions of empathy vary in scope, they define empathy to be multidimensional, having both affective and cognitive components.[73] Empathy in medical practice describes a "a form of personal relatedness" that reflects "an understanding based on a reasonably complete knowledge of *who* the patient is." [74] In another's words, "the ability to respond to the feelings and reasons for the feelings the patient is experiencing in a manner that communicates an understanding of the patient." [75] Or, more simply, empathy is attuning to the patient at his or her emotional level. Empathic practice is therefore resonance with the patient's emotional *state* (not with the patient's emotion) which serves to provide context for the determination of appropriate care. Strategically, it can be perceived to be a way "to gather affective information about a patient which has a significant impact on a patient's illness experience."[76] In his famous 1926 lecture *The Care of the Patient*, Peabody explains that empathic knowledge forms part of the "impressionistic painting of the patient surrounded by his home, his work, his friends, his

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[73]Lou Agosta, "A Rumor of Empathy," *Medicine, Health Care and Philosophy* 17 (2014): 281-92. Existentially defined, empathy is a multidimensional process that contributes to authentic human relationships. In this publication, Lou Agosta evaluates empathy within a Heideggerian lens, in reference to *Dasein* perspective that begins with the idea of human encounters as exchanges between "beings-in-the world."

[74] Jeanne Levasseur and David R. Vance, "Doctors, Nurses and Empathy," in *Empathy and the Practice of Medicine: Beyond Pills and the Scalpel*, eds. Howard Spiro, Mary G. McCrea Curnen, Enid Peschel, and Deborah St. James, 79-83.

[75] Marcum, "Emotionally Detached Concern or Empathic Care," 267. Marcum discusses the work of researchers on the variety of definitions of empathy and classifications.

[76] Marcum, "Emotionally Detached Concern or Empathic Care," 269. Marcum cites the ideas of and the words of Jodi Halpern.

joys, sorrows, hopes and fears" that forms the clinical picture of the patient.[77] In contrast to emotions that are reactive and incite action, the use of empathy to clinically engage with the patient involves curiosity driven by a desire to understand that patient's experience. In the physician-patient relationship, empathy does not involve sharing in the motives of the person whose feelings are exposed but only provides a very personal understanding, a feeling into the effect of their patients' emotional state on their conditions.[78]

In clinical settings empathy fosters the genuine attention necessary for skillful listening. As engaged, empathic curiosity it is not a completely affective resonance with the patient.[79] Because it aims at understanding, its focus is cognitive. Empathy cannot be exercised like Oslerian imperturbability or detached concern because "empathy is an experiential way of grasping another's emotional states . . . a 'perceptual' activity that operates alongside logical inquiry."[80] The practice of empathic listening gives meaning to intuitive perception because "so long as physicians continue to exercise their skills of objective reasoning to investigate their *empathic intuitions*, empathy should enhance

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77 Francis W. Peabody, "The Care of the Patient," *Journal of the American Medical Association* 88, no.12 (March 19, 1927): 878.

78 Jodi Halpern, "Using Resonance Emotions," in *Empathy and the Practice of Medicine: Beyond Pills and the Scalpel*, eds. Howard Spiro, Mary G. McCrea Curnen, Enid Peschel, and Deborah St. James, 160.

79 Halpern, "From Idealized Clinical Empathy to Empathic Communication in Medical Care," 301-311.

80 Jodi Halpern, "What is Clinical Empathy?" *Journal of General Internal Medicine* 18 (August 2003): 671.

Landau, "And the Least of These is Empathy," 106-07. Arguing against the involvement of empathy in clinical encounters, Landau supports Osler's "detached equanimity," and quotes Osler's1932 address *Aequanimitas* to define it: "Imperturbability means coolness and presence of mind under all circumstances, calmness amid storm, clearness of judgment in moment of grave peril, immobility, impassiveness…a judicious measure of obtuseness as will enable you to meet the exigencies of practice with firmness and courage, without, at the same time, hardening the human heart by which we live."

medical diagnosis rather than detract from it."[81] It enhances medical diagnoses by providing context that is crucial to determining appropriate care. Context is necessary to the care for the patient because it helps determine the actions that will achieve the good of the patient. Caring for patients has always been the charge of medical practice but contemporary times of fast scientific and technological progress, and the increasing non-clinical responsibilities of physicians, have shifted the meaning of care from a culture of caring to a culture of cure. Prior to the nineteenth century, "caring was all that was available for physicians; medical knowledge and practice prior to the 19th century promoted caring relationships between patients and physicians."[82]

> Our task is to reclaim the validity of empathy as intersubjective knowledge . . . this practice involves a 'reflexive interpretation' in which there is a 'a constant oscillation back and forth between observation of the patient, and of ourselves, allying imagination, emotion, memory and cognition in the service of informed understanding . . .
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> The 'empathic physician' is neither objective or subjective, neither detached nor identified, but *dialogically linked to the patient in a continuing cycle of reflexive interpretation that integrates the objective and the subjective*. [83] (emphasis added).

A context-driven, empathic practice manifests engagement and connection in different ways but all result in a dynamic interaction between the physician and the patient ("dialogically linked"); the physician's intuition senses what resonates from the interaction with the patient, engages it, and pursues it. "Empathy is no mere skill or mental state . . . it is a myriad of ways in which one person can engage with another. It includes verbal and

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81 Halpern, "What is Clinical Empathy?" 671.

82 Marcum, "Emotionally Detached Concern or Empathic Care," 271.

83 Marcum, "Emotionally Detached Concern or Empathic Care," 270. Citing these words from *More*, Marcum argues that empathy completes the clinical picture because it complements the physician's clinical, objective knowledge to "yield a complete or holistic picture of the patient."

non-verbal communication, physical touch, sustained presence, and sometimes personal familiarity."[84] Under the pressure of the external forces that haunt medical practice—overwhelming workload, time pressure, and profit vigilance—empathic practice takes many forms.

Engaging in the process of clinical understanding is as important as the resultant physical action because it communicates a presence of mind and body. Clinical detachment, adherence to routine interactions, or impersonal responses are not dynamic engagements with the individual patient and therefore dismissing the value of connection, fail in the task of medicine as unsupportive of the patient. Failing to act empathically is mindless practice and could effect a type of patient abandonment, amounting to a reckless disrespect of another's experience of illness. Failure to understand the patient's values can lead to non-supportive practice and clinical detachment; saying to a patient "it's up to you" communicates a lack of understanding of patients' needs and fails to show a willingness to engage in the task of the clinical encounter. Attunement to the patient is needed to understand the patient and determine how to act (or how not to act) for his or her good because it orients the physician on how to use the tools that scientific medicine provides to fulfill the humanistic task of medical practice.

Embracing a balanced approach, mindfulness is a guide to empathic practice. Mindfulness acknowledges a shared presence through which the physician sees the patient as another human.[85] Research shows that because human beings are relational beings,

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84 Georgina Campelia and Tyler Tate, "Empathetic Practice: The Struggle and Virtue of Empathizing with a Patient's Suffering," *Hastings Center Report* 49, no. 2 (2019): 20.

85 Ronald Epstein, *Attending*: *Medicine, Mindfulness and Humanity* (NY: Simon & Schuster, 2017), 77.

cooperation and collaboration require an understanding of the others' experiences.[86] The use of mindfulness in a clinical encounter between the physician and the patient is practicing *being present* with another. This *shared presence* leads to understanding and trust that are fundamental for the physician-patient relationship to flourish. Being present is a type of awareness that is a settling into the moment, a type of heightened awareness. In settling into the moment, a physician gives genuine, nonjudgmental attention to the other. The result is that physicians become aware of the complexity of the patients' issues and engage in seeking to understand the patient's experience. Thus being present—in awareness—is essential in the clinical encounter because it "enables true caring for the patient or the capacity to be with the patient's situation." [87] The physician becomes fully informed of the patient's physical and emotional dimensions, and as fully informed, engages in the intellectual processes that result in clinical judgment.[88]

An essential element of mindful practice is keeping a *beginner's mind*.[89] Yet, the reality of keeping a beginner's mind with each patient is not an easy task because expertise and past experience taint the processing of information. Inattentional deafness or inattentional blindness, phenomena that naturally occur when preconceived notions of illness gathered from expertise and experience with other patients, influence doctors' attention and behavior. [90] Though expertise and past experience are useful tools for the

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86 Epstein, *Attending,* 77.

87 Julia Connelly, "Narrative Possibilities: Using Mindfulness in Clinical Practice," *Perspectives in Biology and Medicine* 48, no. 1 (Winter 2005): 87.

88 Chapter 5 of this thesis builds on this point in discussing prudential judgment and its role in clinical phronesis.

89 A concept that Dr. Epstein retained from his Zen practices and applies to his medical practice.

90 Epstein, *Attending*, 17, 52-3. Dr. Epstein argues that "expertise leads doctors to assume that they know things that they cannot." He gives examples using the inaccuracies in the

cognitive processing of information in medical discernment, they may actually roadblock the affective understanding of the patient's experience. Thus, using a tool like keeping a beginner's mind "uncouples expertise from one's present experience."[91] A beginner's mind takes a conscious effort; it is "cultivated . . . [an] intentional setting aside of the knowledge and preconceived notions that one has gained from books, journals, teachers, and past experiences to see the situation with new eyes."[92] A beginner's mind means putting aside expert knowledge in lieu of a more intuitive approach to understanding, and later being able to reach for that stored knowledge when needed. In this way, a beginner's mind sparks the physician's intuition to know how to engage with the patient: "intuition can then inform [the physician's] understanding, taking into account prior ideas, successes, and failures," thus informing clinical judgment.[93]

CLINICAL EMPATHY IN ACTION

With empathy as the connective emotion, attunement as a practice that helps to achieve that connection, and empathic, mindful practice as the result, it is difficult to declare a normative standard, or enumerated categorical rules that teach "how to" practice. But guided by the idea of mindfulness, working to understand the patient as a multidimensional person is mindful practice that fulfills two goals of clinical empathy: (1) to understand the patient's experience sufficiently to be effective in treating his or her

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doctor's assessment of pain level (vs. what patients describe) to prescribe medication and how this, if not listening, can lead to inadequate care (more objectively, inadequate, or unnecessarily excessive) medication. He concludes that research studies show that as time passes, physicians "often get worse at understanding patients' subjective experience of illness….expertise blinds them and their empathy declines."

91 Epstein, *Attending*, 53.

92 Epstein, *Attending*, 53.

93 Epstein, *Attending*, 54.

illness, and (2) to communicate successfully so as to build a good therapeutic alliance necessary for treatment.[94] The affective use of empathy to tune in to the factors affecting the patient's condition, trigger the use of expert knowledge and are the key to the therapeutic alliance necessary to restore the patient to wholeness.

Observational studies of physician-patient interaction show that response to patients' emotional cues improves diagnoses, increases the effectiveness of medical care, empowers patients, and plays a direct role in healing.[95] Guided by being there, being interested, and being reflective about the patient's experience, physicians are informed responders, not to be guided by emotion alone or by science alone, but by mindfulness with genuine motivation to care, to understand, and to act in a way that supports the dynamic connection in the physician-patient relationship. "The focus is on how the bilateral empathic communication operates in medical care," and what conditions or actions encourage that communication.[96] The focus is not on the imposition of obligations to either or both parties. The relationship is dialogical and dynamic: "what is practical, and often appropriate, is limited or partial engagement;"[97] or sometimes what is practical is more cognitive than affective, or more affective than cognitive. Despite the variance in dynamic, clinical engagement clearly requires skillful empathic listening and response, which

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94 Halpern, "From Idealized Clinical Empathy to Empathic Communication in Medical Care," 302.

95 Halpern, "From Idealized Clinical Empathy to Empathic Communication in Medical Care," 303.

96 Halpern, "From Idealized Clinical Empathy to Empathic Communication in Medical Care," 304.

97 Halpern, "From Idealized Clinical Empathy to Empathic Communication in Medical Care," 304.

manifests differently in different contexts. Actively listening and knowing how to respond to verbal and non-verbal cues helps physicians to engage with patients.

Considering that through engaged curiosity, a physician reaches toward the goals of clinical empathy, as part of mindful practice engaged curiosity is method of clinical empathy in practice—a process through which "the clinician's cognitive aim of understanding the patient's individual perspective is supported by affectively engaged communication."[98] Clinical empathy in practice is a skill grounded in curiosity by attuned listening, and it can be cultivated. It is an undertaking of the practice of presence, and its practice rewards both the patients and the physicians who care for them. [99]

Seeking to identify empathy in action, a qualitative study of physician-patient interactions resulted in the identification of different models of empathic communication in the clinical encounter.[100] The study identifies empathic skills and verbal and non-verbal empathic opportunities that cue the use of an empathic response. In a categorical way, through the evaluation of recorded interactions, researchers analyzed the verbal and non-verbal cues to show how a physician could identify opportunities for empathy. In attempting to describe empathic communication, their research acknowledges the contextual nature of empathic practice and stress the importance of empathic connections in the dynamic between physicians and patients. The researchers conclude that the preferred model of practice in medical school favors diagnostic practice over empathic

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98 Halpern, "From Idealized Clinical Empathy to Empathic Communication in Medical Care," 302.

99 Epstein, *Attending*, 67.

100 Anthony L. Suchman, Kathryn Markakis, Howard B. Beckman, and Richard Frankel, "A Model of Empathic Communication in the Medical Interview," *JAMA* 277, no. 8 (February 26, 1997): 678-82.

practice. Because of that training, the physicians interviewed are most comfortable not acting on "empathic opportunities." Researchers observed that for these physicians caring for a patient, they were more comfortable with a more scientific care of the patient—a "diagnostic exploration of symptoms"—with which they had the most familiarity.[101] Thus, the gap is created by a clash of expectations: that while physicians do take care of their patients, their patients feel unseen, unheard, and unacknowledged. Herein lies what Cassell found to be the paradox in medicine: "the physicians care, but their medicine is uncaring."[102]

VIRTUE IN PRACTICE AND BEING PRESENT

> Virtue is found not in the mirroring of emotional experience but in *how* the process of empathically attuning deepens relationships, recognizes, and respects the patient's emotional experience.[103]

Empathic attunement is fundamentally based on the primary goal of medicine: caring for the patient. As part of virtuous practice, empathic attunement pursues the human flourishing of both the doctor and the patient: the patient's care is optimized, and the physician finds "the greatest satisfaction of the practice of medicine."[104] The question remains: How do empathy and attunement contribute to virtuous practice? Empathy and attunement play a supporting role in the exercise of clinical wisdom. This supporting role is clear in the practice of *presence*.

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101 Suchman et al, "A Model of Empathic Communication in the Medical Interview," 682.

102 Cassell, *Doctoring*, 178.

103 Campelia and Tate, "Empathetic Practice: The Struggle and Virtue of Empathizing with a Patient's Suffering," 21.

104 Peabody, "The Care of the Patient," 877-82.

The practice of presence is a not just a physical undertaking; it refers to being cognitively consciously aware of the experience. As a skill to be honed, it requires deliberate action in attending to the communication needed in a relationship that requires empathic witnessing to flourish. Whatever the source of the empathy, its practice is a deliberate "willingness to suspend disbelief, to use the imagination, and to enter into the world of another" so as to help the relationship and the parties to the relationship—both physician and patient—flourish.[105] In the middle of the continuum between vicarious feeling and distanced perspective taking rationality, is the practice of empathic attunement.[106] Empathic practice used in diagnostic listening requires the balanced approach required of virtue; "it requires training, knowledge, deliberate effort" to develop skills of empathic attunement.[107] A practice of empathy that approaches virtue requires an internalization of those principles and skills that deepen the relationship between physician and patient, such that they flow naturally to the intent of practice—seeking to fulfill the good of the patient: "to be fully virtuous is to be effortlessly responsive to the requirements of the situation one is in."[108] To become effortless in its practice is to constantly do it, to habitually practice those acts that one knows are good, such that the task flows naturally to become part of one's way of being and acting. To have the ability to respond in empathic

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105 Helle Mathiasen and Joseph S. Alpert, "Lessons in Empathy: Literature, Art, and Medicine," in *Empathy and the Practice of Medicine: Beyond Pills and the Scalpel*, 135-46. The Authors distinguish between empirical empathy—empathy derived from experiencing the same phenomenon, from "natural" empathy. When discussing it as a skill in practice, however, the source of empathy is inconsequential; the point is in what empathy represents, which is a suspension in disbelief to share an experience of the other.

106 Campelia and Tate, "Empathetic Practice," 18.

107 Campelia and Tate, "Empathetic Practice," 21.

108 Richard Reilly, "Virtues and Moral Aspiration," in *Ethics of Compassion: Bridging Ethical Theory and Religious Moral Discourse* (MD: Lexington Books, 2008), 73.

attunement in each clinical encounter is an indispensable part of virtuous practice of medicine.

Using empathy and attunement as related in the practice of empathic attunement is both skill and art to aspire to do excellently. The contextual uniqueness of each patient situation requires that the way of engaging with or being with the patient has to become part of the physician's character by becoming effortless—becoming part of the way that the physician is with his or her patients. According to Aristotle, virtue is learned; virtues are states of character that one acquires through conscious, habitual effort to aspire to do something excellently.[109] Training in attunement must be intentional training in *being* and *feeling* through finding ways of connecting that tap into patients' perspectives and identify their values. But to do so excellently the practice must cease to be practice and become part of the physician's clinical manner and part of his expertise; "the development of clinical expertise is rooted in such cumulative, concrete experience necessary for competence grown into expertise."[110] Such is the case for empathic attunement as skill, art and ultimately, virtue.

Guidance exists to support the development of empathic practice. Cultivating empathic curiosity is foundational to the process of attunement. Clinicians have been tasked to practice skillful empathic listening. In empathic listening, the empathic physician engages the patient in a way that "involves knowing when to give gentle guidance, when to speak and when not to say a word, when to intervene (and to what degree), and when to

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109 Aristotle, "Nicomachean Ethics, Volume II: Book II," in *Great Books of the Western World Volume 9*, ed. Mortimer J. Adler, trans. W.D. Ross (Chicago: Encyclopedia Britannica, 1952).

110 Levasseur and Vance, "Doctors, Nurses and Empathy," 83.

get out of the way."[111] While connection is imperative for a successful physician-patient relationship, it is not simply accomplished. Some patients welcome empathic attempts and others reject them.[112] And while no formula exists, methods suggest an emphasis on active listening and a type of attention that seeks to connect with the patient's manner of being. Thus, as a practical matter, suggested behaviors abound. Some suggest simply to repeat the patient's words, not interpret them; attending to verbal and body language, sitting down and keeping eye contact; in instances of conflict, not becoming defensive but navigating through it; and allowing open-ended communication.[113] Others advise minding gestures, pauses, vocal tone, and interpersonal distance;[114] reflecting, not reacting, and settling into the moment.[115] To help patient's tell their stories, showing genuine curiosity, allowing the patient to frame the interview, keeping a positively encouraging atmosphere, being non-judgmental, and allowing positive silences.[116] Simply suggested, allowing the telling of the

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[111] Rana Awdish and Leonard Berry, "Finding Hope and Healing When Cure Is Not Possible," *Mayo Clinic Proceedings* 94, no. 4 (April 2019): 684.

[112] Campelia and Tate, "Empathetic Practice," 19-23. Campelia and Tate contrast two different styles of patient. A mother that welcomes the connection and works with the physician to connect and a teenager that has much more complex feelings that rejects attempts to connect and turns away connection. The authors conclude that this latter case requires a quite different method of attuning, describing that a game of video games, space. They argue that empathic attunement requires a respect for patients and their emotional lives (19), and that people define the mode of caring that they need (23).

[113] Halpern, "From Idealized Clinical Empathy to Empathic Communication in Medical Care," 308. Both Jodi Halpern (here) and Danielle Ofri in the documentary film *Why Doctors Write* that providing an open-ended period did not significantly extend the clinical encounter. Halpern attests here that it takes *90 seconds* to let a patient speak without interruption and Ofri timed the most extensive open-ended period to be between 4 and 5 minutes.

Danielle Ofri, "Why Doctors Write," documentary film (NY: Ken Browne Productions, 2020).

[114] Jodi Halpern, "Empathy and Patient-Physician Conflicts," *Society of General Internal Medicine* 22 (February 2007): 696-700.

[115] Connelly, "Narrative Possibilities: Using Mindfulness in Clinical Practice," 84-94.

[116] Jodi Halpern, "Gathering the Patient's Story," *The Permanente Journal* 16, no. 1 (Winter 2012): 52-4.

patient's story, facilitating it if needed, and actively listening to it. The overarching theme in these practices is simply finding a way of being that fosters connection with the patient and the understanding of the patient, because acting for the patient's good requires listening closely and attuning to what the patient expresses as his or her own good.[117] These practices encourage an awareness of the effect of the psychological and social dimension of a patient's life. Understanding the patient, the disease, and the trajectory of his or her illness, requires the consideration of individuality; it requires the mature realization that human life is unique, that emotion is integral to flourishing, and that skill and art cannot be unwound in medicine. What is clear is this: context is everything and in an exercise of judgment, empathic practice is part of the necessary clinical practical wisdom of doctors in whom patients wish to trust.

> Science and technical ability alone will not help here because moral questions, issues of value, are present that cannot be resolved scientifically. The practice of medicine, in general, is a moral technical endeavor precisely because doctors' actions are directed at the good of the person, not just the person's disease. . . . It is what makes clinical practice different from medical science. Learning how to act in the best short-and-long term interests of the patient –developing clinical wisdom—is what distinguishes clinicians. . . .
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> Twenty-five hundred years ago, Aristotle, who was the son of a physician, called the capacity to make these kinds of decisions *practical wisdom:* bringing general knowledge to bear on a particular human problem through reasoned deliberation in order to act for the good of someone.[118]

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117 Edmund D. Pellegrino, "Moral Choice, the Good of the Patient, and the Patient's Good," in *The Philosophy of Medicine Reborn: A Pellegrino Reader*, eds. Tristram H. Engelhardt, and Fabrice Jotterand, 163-86. Pellegrino identifies 4 components of the patient's good: the ultimate good, the biomedical good, the patient's perception of his own good and the good of the patient as a human person. He urges the physician to think of the primary of the patient's interests and concern himself with "the person who is to live the life illness imposes, not what we think." (171)

118 Cassell, *Doctoring*, 100-01. In a more extended discussion, Cassell discusses the types of knowledge from patients that are needed to inform clinical wisdom that considers questions of value: meaning, emotions, aesthetics, and intuitions. Then conscious reasoning in reflection.

Thus, while it is clear that medicine needs both emotion and reason, clinical wisdom requires the delicate balance of both. Ultimately in pursuit of the *good of the patient*, humanistic concern and clinical competence are inseparable in the virtuous practice of medicine; the virtuous practice of medicine necessarily requires a "hypertrophied conscience" for the ethical excellence that virtue requires.[119]

> Humanistic or humane medicine . . . does not abandon the scientific cure; rather, it strives to obtain that cure within a *caring* ethos.[120] (emphasis added)

What is very clear is that:

> Medical practice is not an either-or-situation. There are no dichotomies: clinicians need science *and* emotion, reason *and* intuition, technology *and* narratives, equanimity, *and* empathy.[121]

EMOTION, BURNOUT, AND COMPASSION

The involvement of emotion necessarily brings with it the possibility of physician burnout. It is true that the clinical encounter begins a healing process in which the physician and patient connect from their separate worlds into the shared space that the physician-patient relationship is, and in which both find meaning.[122] But in a world where the demands of practice can be dehumanizing for physicians facing pressures from external stressors, practicing amidst this anxiety can trigger a crisis of meaning for physicians. Yet

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119 Shimon M. Glick, "The Empathic Physician," in *Empathy and the Practice of Medicine: Beyond Pills and the Scalpel*, 85-101.

120 Marcum, "Emotionally Detached Concern of Empathic Care," 276.

121 Howard Spiro, "Empathy: An Introduction," In *Empathy and the Practice of Medicine: Beyond Pills and the Scalpel*, 2.

122 Eric Cassell, "The Meaning of Healing: Transcending Suffering," *Annals of Family Medicine* 3, no. 3 (May/ June 2005): 259 Figure 1.

because the physician-patient relationship is reciprocal, the connection arising from the exercise of empathic practice with the patient and for the benefit of the patient, can also work to restore the sense of meaning for the physician. The shared sense of connectedness can reignite a physician's existential meaning by reestablishing a lost sense of purpose.

Each encounter with a patient is an opportunity to make a meaningful difference. Physicians testify to this effect that, "during moments of empathic connection, the real meaning of medical practice is suddenly illuminated in terms of hidden personal meanings."[123] Clearly, the relationship advances the human flourishing of the patient. But the physician, too, benefits from the clinical encounter because each encounter is a reminder of purposeful practice and it restores the sense of meaning in practicing medicine. In the face of burnout, turning away from emotion is detrimental; a physician keeping clinical distance, acting in a detached way would hinder the goal of the medical encounter for the patient and for himself or herself: detached behavior "disables the very modes of care, respect and connection that are critical to human flourishing and intrinsic to the practice of medicine as a moral art."[124]

Instead, in the face of burnout, clinicians need the connection that the physician-patient relationship offers. This connection in humanity—particularly in the vulnerability they share—is their saving grace. Their relationship becomes a "bridge and leveler" that as patients feel understood and supported by their physicians, they reciprocate the connection and they too, seek to understand, respect, trust, and support their physicians.[125] Observational studies show that empathic distress results in burnout, but not all empathic

123 Halpern, "What is Clinical Empathy?" 673.
124 Campelia and Tate, "Empathetic Practice," 23.
125 Campelia and Tate, "Empathetic Practice," 23.

practices have the same result; burnout depends on the type of empathy involved. What this means is that the lack of connection, or the wrong type of connection in the relationship obscures purpose, causing the distress from which burnout results. As relational beings, humans need connection, meaning, and a sense of purpose. Empathic practice can help restore the sense of loss. But it must be the right type of empathy.

Empathy exists at different levels. An existing anti-empathy movement makes clear that to use empathy as a moral guide, it must be exercised properly. Empathic distress studies discussing burnout clearly find that empathic distress results from the exercise of empathy where feelings are shared, rather than understood. The findings of this empathic distress study support the use of empathy in a relationship such as the physician-patient relationship, but also show that empathy inappropriately exercised does trigger harmful burnout: "there is an underlying vulnerability [for the empathizer] . . . [that] leads to an overly personal distress that interferes with [the empathizer's] life" that in the long run is more harmful than good.[126] These findings show that empathy used solely as emotional resonance, that type of empathic feeling that shares the feelings of another, results in negative health outcomes. This is contrasted with experiencing a compassionate response—a *feeling for* someone in suffering after understanding. Compassion—this *feeling for* someone— can result from the proper exercise of empathy, but it is the result of, not the foundation of, an empathic practice that seeks to feel into the situation of another. The experience of compassion after a proper exercise of empathy actually

126 Paul Bloom, *Against Empathy: The Case for Rational Compassion* (NY: Harper Collins, 2016), 137. Bloom uses Simon Baron-Cohen's observational research to make this point.

promotes resilience and professionalism and thus provides better coping skills for stress.[127] Burnout is inevitable in such an intense profession, but as these researchers conclude, the compassionate effect of proper empathic practice may actually ease the risk of burnout. [128] Thus naturally, compassion flows from empathic practice. Compassion is the response from deepened understanding. In this way, compassion— *feeling for* the sufferer—is an "extension of emotional empathy by means of cognitive processes."[129]

Burnout is real, but research does not refute the value of empathic practice in clinical relationships. Engaging with the patient with empathy is not necessarily the road to burnout. The use of empathy in the physician-patient relationship is more aligned with maintaining curiosity, presence, and witnessing of the feelings of the other, than with sharing those feelings.[130] It is an understanding that feelings exist and manifest in illness, thereby affecting the patient's experience of illness. Thus, empathic practice is not the type of empathy sharing in sentiment— "I feel what you feel"—but an elevated dimension of *being with* aimed at engagement for understanding.

Patients feel that what they need from their physicians is a "reasonable amount of empathy" in a relationship that also embraces professionalism, compassion, honesty, and respect.[131] Patients continue to believe that empathy is an essential part of the physician-patient relationship; with empathy, patients feel heard and understood. Discussing the effect of empathic practice, a patient offers her perspective on the issue, describing her

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127 Here Bloom uses Tania Singer's research. Bloom, *Against Empathy*, 138.

128 Bloom, *Against Empathy*, 138.

129 Bloom, *Against Empathy*, 141.

130 Congruent with Jodi Halpern's research, as discussed *supra*.

131 Bloom, *Against Empathy*, 145. Bloom, discussing Christine Montross (a surgeon) and novelist Leslie Jamison .

physician's intuitive grasp of the anxiety and fear tormenting her. The patient explains that his reaction of calmness amidst the chaos came from a deepened understanding of her condition: "without empathy, this doctor wouldn't have been able to offer the care I ended up appreciating. He needed to inhabit my feelings long enough to offer an alternative to them and to help dissolve them by offering information, guidance and reassurance."[132] For doctors, it is a practice that is "both heartbreaking and also beautiful."[133]

EMPATHY ENABLES CLINICAL WISDOM

> And now here is my secret, a very simple secret:
> It is only with the heart that once can see rightly; what is essential is invisible to the eye.
> -Antoine de Saint-Exupéry, *The Little Prince*

Relatedness is the source of meaning in all relationships. A relationship uniquely formed, created between two beings is what motivates action because it is the *connectedness* with one another what gives each involved the sense of accountability and moral responsibility to one another, it is what is essential and invisible to the eye. In the passage referenced above, a fox convinces a boy to tame him, because taming him would connect them and give some meaning to their encounters. Such connection is also sought after in the physician-patient relationship. In this relationship that connects physician and

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[132] Bloom, *Against Empathy*, 147-50. As directly quoted from Leslie Jamison by Bloom. In the same discussion, Bloom explains Adam Smith's philosophy of bidirectional empathizing—that is, that the patient feels an empathetic response in support of his or her physician. The point is not relevant to our discussion to our point here, but it would be important in discussing physician moral distress and burnout. (150)

[133] Richard Shiffman, "Learning to Listen to Patient's Stories," *New York Times*, February 26, 2021, https://www.nytimes.com/2021/02/25/well/live/narrative-medicine.html?surface=home-discovery-vi-prg&fellback=false&req_id=886733588&algo=identity&variant=no-exp&imp_id=697738392&action=click&module=Science%20%20Technology&pgtype=Homepage.

patient, it is the connectedness that is most valuable because it determines how the two relate, thereby determining the care of the patient.

Empathy and the connectedness resulting from it is part of the medical sensibility required in clinical practice. Physicians must use emotion to attune to their patient's lives to best understand their patients and to determine how to fulfill their role for that patient. Seeking the good of the patient in their role as physicians, their use of empathy represents much more than an empathic feeling for their condition; the use of empathy becomes an act of care. Acknowledging a patient's emotions validates that patient's experience of illness. It is a strong act of connection in a relationship that is already asymmetrical to validate the feelings of the more vulnerable one to it; a meaningful recognition by someone, perceived as an expert, who genuinely acknowledges that that the patient's crisis is real and that that state of crisis requires the attention of the physician.

Empathy in practice provides a many-fold advantage: the use of empathy helps physicians attune to the patient, connect with the patient, and inform the physician's sound clinical judgment. Empathy is an indispensable element of the practice of medicine that contributes to the exercise of clinical practical wisdom. Reflective physicians, some immersed in both roles as patient and doctor, identify empathic practice to mean one thing: *presence*.

Chapter 3 Physicians as Patients

Reflection for Our Times

Modern society is immersed in a hyperculture that demands instantaneous transmission of information and promotes an age of distraction and multitasking. Pursuing humanistic medicine in this climate is not easy; the technological age dismisses the value of reflection in healthcare and the impact of the interpersonal relationship between doctor and patient that is embodied in the clinical encounter.[134] The benefits of resting in reflection are undermined by a society that pushes to use every bit of time for something that yields something tangible; the benefits are often ignored because reflective practices take time and focus.[135] Yet reflection is a sensibility necessary for the clinical practice of medicine because it is through this understanding of both disease and the psychology of the patient that physicians are able to reflect on the right and good thing for each particular patient; laboratory test results or electronic medical record notes alone do not give a complete picture of the patient. Only through reflective thinking—the *intellectual processes* Peabody considers indispensable in the care of the patient— can physicians exercise clinical judgment that reflects clinical wisdom.[136]

In contrast, unreflective multitasking diverts attention away from the patient, focusing instead on data collection and other compliance concerns. The emphasis on the required administrative tasks depreciates the transformative effect of the interpersonal

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134 Stephen Bertman, "Pursuing Humanistic Medicine in a Technological Age," *Journal of Patient Experience* 4, no. 2 (2017): 57-60.

135 Bertman, "Pursuing Humanistic Medicine in a Technological Age," 59.

136 Reflecting judgment is basic to the virtue of prudence. Chapter 5 of this thesis discusses the relationship between prudence, clinical judgment, and clinical wisdom. In Chapter 2 of this thesis, Peabody references this concept as *intellectual processes* in the medical encounter.

experience between doctor and the patient.[137] Precisely because of this "assembly line" or "fast-food approach" to medicine, the value of connection and relationships should be emphasized, given the limited time doctors are given to interact face-to-face with their patients.[138]

For most physicians, empathic understanding can only be an intellectual understanding of the illness experience. But there is a difference between the intellectual understanding and the experiential understanding of phenomena. Physicians that life has destined to play both roles of physician and patient agree that the lived experience of illness is revelatory and transformative. Their reflections agree with Danish existentialist philosopher Søren Kierkegaard's connection between reflection and understanding:

> Life must be understood backwards. …. life can never be really understood in time because at no particular moment can I find the necessary resting place from which to understand it.[139]

To physician-patients it becomes evident that their existential understanding of illness and suffering deepened because of having lived through illness and suffering themselves. It is true that their reflections are lessons to themselves and admonishments to their medical colleagues, but they are also much more than that: they are epiphanies that transformed their professional lives. These physician-patients understand that the imperative task of medical practice is to prioritize the understanding of the patient and the

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137 Bertman, "Pursuing Humanistic Medicine in a Technological Age," 58.

138 Schiffman, "Learning to Listen to Patients' Stories," *New York Times*, February 26, 2021.

139 Kierkegaard, Notebook IV A 164; 1843 (D) in *A Kierkegaard Reader*, eds. Roger Poole and Henrik Stangerup (London: Fourth Estate, 1989), 18. In Sarah Bakewell, "The Dancing Philosopher," *The Existentialist Café*: *Freedom, Being, And Apricot Cocktails* (New York: Other Press, 2016), 259.

patient's needs. In reflection of their experiences and their roles as physicians, they discover the meaning of caring in relationships as what matters most in the end.

ON THE OTHER SIDE OF THE STETHOSCOPE: FROM CASES TO LIVED EXPERIENCE[140]

Research from the Association of American Medical Colleges shows that the transformative effect of physicians' experience of illness on their post-illness practice is positive. Through their lived experiences of illness "physicians learn the importance of empathy and language and gain an appreciation for trauma of illness," ultimately reworking "a new dynamic with patients."[141] Post experience, physicians find a new appreciation of the hardships and struggles of illness that their patients face and gain an understanding of the existing barriers of patients seeking medical attention and care.[142]

With a team of highly trained physicians working over her, at the threshold of death—and even momentarily over it—Rana Awdish feels unheard, unseen, and materialized.[143] As a highly trained critical care physician she finds herself in a familiar environment, but as a patient she is in an unfamiliar place. Seven months pregnant she survives multisystem organ failure that leads to months of lingering trauma complications and unsteady recovery. Tracing the "abject vulnerability of being a patient" in her

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140 The credit for this section subtitle is to the Medical College of Wisconsin, "On the Other Side of the Stethoscope: When Doctors Become Patients," *Medical College of Wisconsin Online Magazine*, April 9, 2018, https://www.mcw.edu/mcwknowledge/mcw-stories/on-the-other-side-of-the-stethoscope-when-doctors-become-patients.

141 Lindsay Kalter, "Trading Places: When Doctors Become Patients," *AAMC Online News* (February 4, 2019), https://www.aamc.org/news-insights/trading-places-when-doctors-become-patients.

142 In particular, patients' struggles with access to care and quality of care limitations.

143 Rana Awdish, *In Shock: My Journey from Death to Recovery and the Redemptive Power of Hope* (New York: Picador, 2017). Additional references will be cited in the text as *In Shock*, followed by the page number.

continuous writing and patient advocacy, Awdish stresses that even in a technically perfect world, words matter; that language and communication have the power to both connect and push away. [144] She testifies that "as a patient, I was privy to failures that I'd been blind as a clinician…I recognized myself in every failure...my experience changed me…I wanted the value of empathetic, coordinated care to spread through our system."[145] Awdish has been advocating for this very cause since. In the shortcomings she perceives as a patient, Awdish recognizes herself in those medical professionals that she encounters and criticizes, doing what she had so often done. She now understands that up to that point, her relationships with patients have been largely based on the story that she has "subconsciously constructed" for that patient, now recognizing this as the type of behavior that "in many ways inflicted more suffering" than the physical pain already present.[146] She vividly remembers particular moments of suffering and helpless vulnerability. She remembers the excruciating pain and the attending residents' resistance to her words in responses filled with disbelief and mistrust: "Are you sure your pain is an eight? I just gave you morphine an hour ago."[147] (*In Shock*, 132-33)The uninformed insinuation of a narcotic addiction created overwhelming helplessness in her.[148] (*In Shock*, 132-33) Just one of the

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144 Kalter, "Trading Places: When Doctors Become Patients," 2.

145 Rana Awdish, "A View from the Edge—Creating a Culture of Caring," *New England Journal of Medicine* 376, no. 1 (January 5, 2017): 7-9.

146 Awdish, "A View from the Edge," 7.

147 Awdish, "A View From the Edge—Creating a Culture of Caring," 8. Awdish describes the conversation as hostile and accusatory, condescending with both the nurse who "harrumphed her way to the phone and sent her accusatory remarks to the on-call team, audibly," to the resident who only talked to her "a few steps from the doorframe." Awdish was put on a defensive position, not knowing how to make her case or "explain something away I hadn't done [take narcotics at home]."

148 Awdish comments that the residents and nurses that came to see her "had only the barest of knowledge about me when they were called by the nurse. My age, medical record number, room number, the surgeon who operated on me and the type of surgery would have been on a printout in one of their pockets, but little else."

many care blunders she discusses, Awdish hopes that in openly sharing her story, she communicates to "system leaders and every employee that everything matters, always. Every person, every time."[149] From the newest of the transporters to the highest of physicians and administrators, behavior attitudes either communicate care or dehumanize.

Epiphanic, Awdish's story shows her new understanding that empathic connection is manifested in every aspect of the delivery of care. Experiencing the failures of the system reshape her; realizing her shortcomings helps her to reset and mold her future self.[150] Most importantly, her reflections reveal that medicine is much more than following a medical protocol; everything matters, everything means something. Awdish is confident that the system has the opportunity to work with physicians and all other caretakers to alleviate suffering. In looking back to live forward, Awdish determines that what matters in the end is caring, and that caring for another means engaging in "compassionate, coordinated care."[151] Her transformation from clinical detachment to compassionate understanding she describes as "abandoning my armor at the bottom of the sea when I had to learn to breathe underwater."[152] (*In Shock*, 164).

Awdish concludes that part of caring for patients is recognizing their suffering through *being present*. In this sense, a physician's practice of presence means being physically present with a heightened awareness of the moment, ready to engage the patient. The practice of presence in the clinical encounter results in moments that embrace—"a

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149 Awdish, "A View From the Edge—Creating a Culture of Caring," 8.

150 Awdish, "A View From the Edge—Creating a Culture of Caring," 8.

151 Awdish, "A View From the Edge—Creating a Culture of Caring," 9.

152 The metaphor refers to the armor of Oslerian clinical detachment—distance and coolness for clear judgment, and she earlier discussed the change from "valuing efficiency to cultivating a relationship." (*In Shock*, 51)

sacredness," and as such are particularly "intense, and intimate and perfect, "and transformative because "everything about life [is] wrapped up in those moments . . . love and respect and humanity and science." (*In Shock*, 230-31). To Awdish, presence embraces the idea of a balanced approach to being a certain way during a clinical encounter; rejecting dichotomies, she defines presence to embrace love *and* respect, and humanity *and* science. Awdish realizes that a physician's greatest gift is not "healing" in the curative sense but the "ability to be absolutely present with suffering"—to allow the moment to transform physician and patient. (*In Shock*, 231-32) She describes the redemptive power of presence in terms of meaning:

> As physicians we often feel we aren't enough . . . we frame our losses and successes in terms of the disease . . . If we instead had faith in the meaning of our presence, we could turn and stand at the end of the chasm and face it together. We could acknowledge its vastness and darkness. We could speak openly about our fears. We could offer insights of what we'd witnessed when others face this same darkness, our orientation would change. We could look in the same direction. We could have faith that our presence was meaningful, that in many ways it was everything. (*In Shock*, 231-32)

Awdish determines that being present also means honoring all aspects of knowledge, "not just medical knowledge, but all the body's knowledge and the truths that can only be delivered through the patient's perspective, and our communal knowledge of suffering and identity." (*In Shock*, 248) These bits of information Awdish describes as "sparks" that unite to connect and illuminate "the whole." (*In Shock*, 248) To describe *care* Awdish reminisces about a hospital transporter that made her feel seen and heard. During her darkest days at the hospital after the loss of her child, she describes this hospital transporter in contrast to the other caretakers and medical professionals involved in her care. She describes him as being able to see her pain and acting as an advocate for her—by warning care providers not to ask her about the baby they assumed still lived, whose

memory would rekindle feelings of loss.[153] (*In Shock*, 88) Awdish feels understood and valued as that transporter acts with care to relieve her burden of anxiety and grief.

In the same manner, the late physician Paul Kalanithi writes about his transformative experience of illness. A neurosurgeon trained in literature and philosophy, Kalanithi deeply reflects on meaning and purpose.[154] In his memoir *When Breath Becomes Air*, Kalanithi embarks on an existential exploration of his dual role as physician and patient.[155] He is troubled by contemporary medical politics prioritizing the scientific over the humanistic— "how little do doctors understand the hells through which we put patients." (*Kalanithi*, 102) Kalanithi realizes that in his young practice, immersed in the rigor of the hospital demands, he too, like most residents "was not *with* the patients in their pivotal moments, [he] was merely *at* those pivotal moments" having become "inured to [the suffering]." (*Kalanithi*, 81) Upon closer confrontation with his own mortality, Kalanithi's practice changes; his conduct changes during his doctor-patient encounters— what had become routine and mundane and an exercise in "failed empathy" becomes an engaged interaction supporting the humanistic relationship to care for the patient. (*Kalanithi*, 85) Kalanithi's highest ideal becomes to support his patients through illness by offering guidance: "guiding a patient and family to an understanding of death or illness." (*Kalanithi*, 86) Through guidance, he uses his understanding to support the patient. To him,

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153 She writes that after this first warning, "it seemed every transporter now knew the expectation was to protect me from well-meaning questions while I was off the floor. In an eight-hundred-bed hospital, the expectation was to form a protective enclosure around a patient." Such a small act of kindness is *care*.

154 Paul Kalanithi, *When Breath Becomes Air* (NY: Random House, 2016), 42-3. Paul Kalanithi explains that his drive to study medicine was in pursuit to "keep following the question of what makes human life meaningful, even in the face of death and decay" through the "direct experience of life and death questions."

155 Paul Kalanithi, *When Breath Becomes Air* (NY: Random House, 2016). Additional References will be cited in the text as *Kalanithi*, followed by the page number.

guidance is a manner of being with someone, being present in his or her moment of need. Thus, even the mundane task of asking for informed consent becomes "an opportunity to forge a covenant with a suffering compatriot," not "a juridical exercise in naming all the risks." (*Kalanithi*, 88) Kalanithi understands that it is this act of being with the patient—in the form of offering guidance and support—that is at the heart of caring.

Kalanithi guides because he understands the experience of illness and suffering, in all its physical pain, emotional pain, and uncertainty. He experiences the fear and anxiety of his patients. Kalanithi discusses one such instance, during which, realizing the overwhelming fear and anxiety of a patient in having to choose (or decline) to undergo a procedure, he could detect his patient's confusion and sensed the superficial, hasty refusal of surgery. (*Kalanithi*, 90) Kalanithi acts with an intuitive grasp of emotions, supporting the patient's thought process, noticing that "as [he]talked, [he] could see the enormousness of the choice she faced dwindle into a difficult but understandable decision. I had met her in a space where she was a person, instead of a problem to be solved." (*Kalanithi*, 90) In this way, he cares for this patient—engaged and present in awareness of her need, he is empathic, understanding how to proceed. Meeting patients in the space of shared humanity means realizing that, whatever the situation is, when it comes to illness, "nobody has it coming" and will need the support and guidance from one who understands the task of medical practice. (*Kalanithi*, 86)

Kalanithi understands that in medicine, the moral requirement for technical excellence is foundational to the forging of the human relationships that make the experience of doctoring the most humanistic of practices; "good intentions were not enough, not when so much depended on skills." (*Kalanithi*, 105) With excellent technical

skills, physicians focus must shift to address the patient's existential dimension. Like his patients, jointly with his physician, Kalanithi explores his values to find the treatment that best suits him. After months away for interventions and recovery treatments for his cancer, Kalanithi cannot stay away from the profession which gives his life meaning and gives him a sense of identity—returning to his patients and to the operating room is his life's desire. (*Kalanithi*, 149) Kalanithi returns to his work, having experienced the uncertainties, anxieties, and other emotional fluctuations of being a patient with terminal cancer, Kalanithi more easily understands his patients' needs and how dynamic care must be to adjust to those changing values and needs:

> The tricky part of illness is that, as you go through it, your values are constantly changing. You figure out what matters to you, and then you keep figuring it out . . . death may be a one-time event but living with terminal illness is a process. (*Kalanithi*, 160-61)

He understands the supporting role of the doctor and the effect of presence, awareness and caring for the patient.

> If I did not know what I wanted, I had learned something, something not found in Hippocrates, Maimonides, or Osler: the physician's duty is not to stave off death or return patients to their old lives, but to take into our arms a patient and family whose lives have disintegrated and work until they can stand back up and face, and make sense of, their own existence.
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> Once an acute crisis has been resolved . . .the patient and family go on living—and things are never quite the same . . . Emma [Kalanithi's oncologist] had not given me back my old identity. She'd protected my ability to forge a new one. (*Kalanithi*, 166)

Intellectual understanding is an attempt to at least recognize the plight of the patient in his illness, but what these physician-patients offer is experiential insight. They testify to the transformative power of experience. They advocate for respect for the patient's

narrative and for the doctor's imperative moral duty of bearing witness to the existential crisis they witness. Scientific theory is not enough to understand or explain the necessity of emotional connection or even multidimensional understanding, but for those doctors fortunate enough not to have to live through illness, these physicians' experiences are testimony, plea, and admonishment of the crisis of medicine, what patients seek, and ultimately what matters most in the end. These physicians reveal that in the end, what matters is the understanding that the relational dimension of medicine; the unending pursuit of understanding and grasping the fullness of the human experience of illness. In the end, what matters most is to meet the patient with courage to care for him or her as person in body and spirit, not just to respond to the diseased body. Awdish and Kalanithi discover that by just being there, aware, understanding, supporting, and guiding, they care for the patient the way they would have wanted to have been cared for.

In *The Soul of Medicine: Tales from the Bedside*, physicians describe experiences in their practice "that changed the life of each [the doctor and the patient] forever." [156] (*Soul*, 206) In these tales, physicians reminisce on events that illuminate their understanding of medicine and their role in the lives of their suffering patients. Written in the collective style of Chaucer's *The Canterbury Tales*, Nuland collects these stories to expose a medley of lessons that get at the heart of doctoring as a humanistic practice. These stories show that at the heart of medicine is a call to *judgment*: "judgment will always be

156 Sherwin B. Nuland, *The Soul of Medicine: Tales from the Bedside* (NY: Kaplan Publishing, 2010). Additional references will be cited in the text as *Soul*, followed by the page number.

the most difficult aspect of the art of medicine" and choosing well its most rewarding. [157] (*Soul*, 207)

In *The Dermatologist's Tale*, a doctor walks with the patient in a journey of discovery and describes the call to action in medicine as a willingness to pursue "finding the needle in the haystack within another haystack." (*Soul*, 31-3) In this story, the dermatologist meets a frustrated patient that not knowing the source nor the therapy for contact dermatitis, "tearfully expressed grave doubts that [he] could help her." (*Soul*, 33) Together, they discover the root-cause of her physical distress as exposure to particular chemical reactants in the skin products— "a (seemingly) simple story with a (seemingly) simple solution." (*Soul*, 33) For this patient, the dermatologist's work—as mundane as it may have been to search through product ingredients—was a practical, non-medical investigation (and resolution) of the source of her distress. In contrast, the many other physicians the patient has seen stopped the investigative process at the pronouncement of a diagnosis, dismissing the disturbance the uncomfortable diagnosis caused in her daily living. This dermatologist understands that regardless of the diagnosis, what this patient needs most is an investigative effort and a solution. By engaging with the patient, the dermatologist can help. In caring for this patient, the dermatologist understands that she does not need a diagnosis, she needs a solution.

Similarly, in *The Gastroenterologist's Tale*, the gastroenterologist learns that tapping into the emotions in the patient's life is the way to understand the patient's symptoms and suffering. (*Soul*, 35-9) Here, the gastroenterologist and his resident learn

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[157] Nuland restates this Hippocratic observation and notes that it is the ultimate mainstay of diagnosis.

that caring for a patient means meeting the patient where he is. Regarding himself as a healer of people, he works to resolve each patient's "packet of riddles." He stresses the influence of the connection between the patient's life story and his illness because acknowledging where the patient comes from helps solve the riddle. (*Soul*, 37) In his tale, the attending physician and his resident examine a patient's osteoarthritis of the hips and knee and engaging in his history discover that his condition is related to his past imprisonment at the Auschwitz concentration camp. The doctors witness the patient's breakdown as he relives his past, and almost intuitively realize that to care for this patient at this time, is to embrace and reassure him that those days are over. A non-scientific solution, these doctors understand that caring for patients takes an appreciation of "the individuality of people and the necessity to cast rules aside when they seem to make little sense for the person at a given moment in his or her life and yours." (*Soul*, 37) Their powerful lesson is a lesson in the non-routine nature of care; to care for individual patients means to acknowledge what is most needed at that moment of the patient's life.

Being present means taking responsibility for the moment at hand and the resulting judgments and actions. *The Anesthesiologist's Tale* speaks to perception and responsibility. (*Soul*, 73-85) This anesthesiologist realizes that the ultimate truth about obligations in medicine is that responsibility for a patient's wellbeing belongs to all healers involved in that patient's care, and that being with a patient as anesthesiologist means taking responsibility for that patient's life as much as any other healer present in that room. In a close call where the surgeon's signs of mental instability are apparent prior to surgery, the anesthesiologist realizes that in the operating room, working together for a patient means that healing is not a question of authority or medical hierarchy because all healing

responsibility is focused on the patient's good. This anesthesiologist feels responsible for ignoring her intuition to stop a surgeon who seemed "out of sorts" just prior to a procedure in which they would collaborate. Although the patient ultimately survives, she realizes that her role includes responsibility for the patient's life in all aspects of care, including protecting him from behaviors that put his life at risk or situations incongruent with the patient's good. (*Soul*, 75)

Patients are doctors' best teachers. The relationships doctors have with their patients teach them to think and act like humanistic scientists—to engage with each individual patient in a humanistic manner and with his understanding and the intuitive grasp of the situation, to determine how to care.

> There is a paradox here at the heart of medicine because a doctor, like a writer, must have a voice of his own, something that conveys the timbre, the rhythm, the diction, and the music of his humanity that compensates us for all the speechless machines . . . whether he wants to or not, the doctor is a storyteller, and he can turn our lives into good or bad stories, regardless of the diagnosis.[158]

The transformative experiences of physicians in patient care bring them closer to practicing in a way that connects them to their patients and to their sense of purpose in medicine.

After experiencing the physical manifestations of depression for the first time, psychiatrist Robert Klitzman writes in his book *When Doctors Become Patients*, that by having to live through the physical and emotional dimensions of the mental illness he "fully appreciated what patients undergo, and how hard it is to put depression into words."[159]

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158 Anatole Broyard, *Intoxicated By My Illness* (New York: Fawcett Columbine, 1992), 53.

159 Robert Klitzman, *When Doctors Become Patients* (NY: Oxford University Press, 2008), 3. Additional references will be cited in the text as *Klitzman*, followed by the page number.

Motivated by his personal experience of patienthood, he studies the experiences of physicians who have crossed the boundaries between doctor and patient. Having been on both sides of the stethoscope, Klitzman explains that these physician-patients possess "unique double lenses . . . dual, contrasting sets of experiences as both physicians and patients" that transform their "understandings of themselves, their roles, and their interactions with patients and colleagues." (*Klitzman*, 4-6). These doctors, forced into the role of patient, find what matters in the care of the patient; they find that having lived the experiences of their patients deepens their understanding of the uncertainty, anxiety, and despair that patients feel. In this way, they find value in this connection to the patient because really knowing how it feels to be a patient helps them to care for one. Ultimately, as Awdish and Kalanithi agree, Klitzman concludes that generally, "the experience of becoming seriously ill finally compels them to change their thinking, and see themselves in their work more broadly, and from a different vantage point." (*Klitzman*, 12) Rather than use existing narratives, Klitzman interviews seventy physicians at length, debriefing his observations and conclusions thematically. Klitzman classifies the physicians' transformation into three broad categories of deepened physician understanding: becoming a patient, being a doctor after being a patient, and interacting with patients.

In "Us versus Them," Klitzman notes that most physicians become aware of the barriers patients face and triggers them to reassess their roles in how they approach the physician-patient relationship. (*Klitzman*, 257-72) Klitzman notes that doctors move more toward an attitude of becoming "allies" with their patients, an attitude of "we're all in this together." These doctors know they must incorporate both empathy and connectivity, but they struggle with the dynamic. Others notice the need to rectify the injustices of

socioeconomics. The doctors learn to go out of their way to find their own ways to "listen to people's hearts," thereby "[fulfilling the patients'] vision of being taken care of." (*Klitzman*, 262)

Physicians who become patients also reassesses the boundaries of the more practical struggles of the clinical relationship, including balanced decision making. They struggle to discover a universal standard of what it means to "share" in decision-making. Absent a fair formulaic approach for balance in decision making, physicians "adjust their styles to meet the needs and challenges of particular patients" and "intricate patient preferences." (*Klitzman*, 269, 271) Ultimately, they discover that there is nothing routine about medical care and that "success" in medical care depends on their engagement and connection with their patients.

WHAT DOES IT MEAN TO BE PRESENT? FROM INTERESTING CASE TO SUFFERING HUMAN

"Presence, period."[160] And connection. "The dystopia prevalent in American Healthcare within the experience of patients and physicians alike is the sense of losing contact."[161] Someone present (aware and in the moment) feels less pressure to do and instead can *just be*. Listening and engaging are forms of presence. Being present is meeting someone where "they" are, as shaped by their past, and living in their present. But there is a greater challenge: "physicians often enter the lives of patients on their absolute worse days," and being present will require a great deal of trust in the young (and sometimes brief) clinical relationship. (*In Shock*, 136) In *The Importance of Being*, Dr. Abraham

160 Abraham Verghese, "The Importance of Being," *Health Affairs* 35, no. 10 (October 2016): 1924.

161 Verghese, "The Importance of Being," 1925-26.

Verghese expresses being present as having a blank canvas—the concept of a beginner's mind—not bringing into the relationship any labels, including those of stereotypes, diagnoses and past medical history. To Verghese, a "new patient" cannot even be one that the physician has already met in the computer (such he calls the *iPatient*) because "having read all the labels *before* seeing them in the flesh…is as far from the blank canvas as one can get."[162] Being present also does not mean "being busy with them in a medical way" but to just *be*: "sometimes words and speech are just a way of forgetting our being or that of the person we are dealing with." [163,] (*Being*, 1926) Sometimes, the best thing to do is nothing or to say nothing, and with the patient, be witnesses to the disease, the illness, and its effects. As a clinical teacher, Verghese wants his students to *see*—"a kind of seeing that is more important"—the recognition of the individual with the disease, one "whose care is entrusted to [the physician]." (*Being*, 1927)

In rounds with her residents and fellows, Dr. Awdish describes ways of *being with* patients as she remembers from experience in her care. She emphasizes finding the context of each patient's illness by listening to and engaging in their stories. She encourages the practice of "humility in listening" that "requires that [physicians] abandon assumptions to make room for truth. A truth that could be messier, but that will allow to see the patient in the context of their values and their life." (*In Shock*, 51-2) Listening to an uninterrupted narrative, asking questions that reflect the patient's values, is empathic practice that Awdish confirms has "the potential to heal everyone involved." (*In Shock*, 53) She

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162 Verghese, "The Importance of Being," 1926. Additional references will be cited in the text as *Being*, followed by the page number. The concept of a *beginner's mind* is explained in Chapter 2 of this work.

163 To "words and speech" I might add *action,* too.

describes instilling a sense of respect and reverence to all stages of life, revealing having to redirect residents' attitudes, especially as she notices the disrespect and irreverence to the unconscious patient on which they are working. (*In Shock*, 125) Dr. Awdish demonstrates presence even to those who expect it least or not at all, as she does when talking to unconscious patients.[164] (*In Shock*, 124) Awdish embraces the vulnerability of the patient and the impact of words. Being present, she shows that it also means easing a patient's burden, and seemingly impossible tasks like communicating with a patient attached to a ventilator or calling family at the patient's request. (*In Shock*, 125) To Awdish, being present is helping patients and their families through the darkness and burden of illness, honoring all aspects of knowledge.

Kalanithi closely echoes Awdish's beliefs. Kalanithi believes that *being with* patients is honoring human relationality. He lives true to this, recognizing the struggles of his patients and meeting them where they were, in the space of shared humanity. (*Kalanithi*, 90, 96) For Kalanithi, presence is doing what the moment calls for to care for the patient: listening, engaging, becoming a liaison, guiding, providing encouragement. To Kalanithi, uninformed, unreflective action, prejudices, and assumptions from physicians are behaviors that do not support a patient. Rather than promoting connectedness and *being with* the patient, these behaviors constitute inaction that amounts to abandoning the patient. Making this point, Kalanithi describes the loneliness and helplessness (a not *being with*) and abandonment by a resident refusing to wake his attending for medication correction in his care. (*Kalanithi*, 185-88) Ignoring his concern and desperate plea for help, the resident

164 Dr. Awdish makes a note that she does this because she believes they can hear, as she remembers she could.

reacts defensively to Kalanithi's request, becoming argumentative and authoritative, and in effect devaluing Kalanithi's physical and emotional states. Seemingly only concerned about his reputation as a good resident, he pushes the burden to Kalanithi, asking—"do you really want me to wake someone up for this?" Kalanithi reflects on his defeat: "and there it was. Meeting his obligation to me meant adding one more thing to his to-do list: an embarrassing phone call with his boss, revealing his error . . . if he could just push it off for a few more hours, I would become somebody else's problem." Ignoring his pain, ignoring his fear, and in distrust, the resident sees Kalanithi as a problem, abandoning him in his pain, and directly in opposition of being with his patient.

Like Kalanithi, Atul Gawande's father, also a surgeon, becomes a terminal cancer patient that living through patienthood easily senses the type of doctor that he does not want to care for him. Guiding his father through medical care during his last months opens Gawande's eyes to the importance of the dynamic between the patient and the doctor. In *Being Mortal: Medicine and What Matters in the End*, Gawande echoes Kalanithi, Awdish, and other patients' concerns, bringing to light the overwhelming burdens on the patient.[165] In Gawande's observations, his father seeks a physician that is not only a technical expert, but one that understand his needs. He writes of one, that after growing exasperated from his father's questions, shows himself as "authoritative, self-certain, and busy with things to do." (*Gawande*, 197) Increasingly frustrated, in a show of power the physician warns his father about the danger of his tumor and in hostility shifts the total burden: "the decision for my father was whether he wanted to do something about it. If he did, the neurosurgeon

165 Atul Gawande, *Being Mortal: Medicine and What Matters In the End* (NY: Picador, 2017). Additional references will be cited in the text as *Gawande*, followed by the page number.

was willing to help. If he didn't, that was his choice." (*Gawande*, 197) In contrast, another neurosurgeon—showing "no less confidence"—allows his father's questions and acknowledging the struggle in this type of medical decision, supports him. Gawande's father feels comfort in hearing from his neurosurgeon admit that "he might feel the same way himself" in having to choose. (*Gawande*, 198) Gawande notes the physical cues: really looking at him, at eye level, physically turning away from the computer to face his patient, Gawande's father senses his doctor's understanding of him. Gawande contrasts the styles and notes that the difference is not in expertise—both were excellent at their craft—but in the willingness to engage with their patients to establish a trusting relationship. The latter neurosurgeon respects and engages his father, interested in his father's values, making "an effort to understand what father cared about most." (*Gawande*, 199) Ultimately, both patient and doctor are willing to face the uncertain future together, in a relationship of trust:

> They knew what was coming, but they also knew what mattered to him and left well enough alone. This was, I remember thinking, just the way I ought to make decisions with my own patients—the way we all ought to in medicine. (*Gawande*, 199)

In the end, they decide for the type of medical care that allows for "living for the best possible day, today." (*Gawande*, 229) Gawande humbly sees, through his father's struggles, that "we've been wrong about what our job is in medicine…we think our job is to ensure health and survival" but what matters most is "larger than that; it is to enable well-being. And well-being is about the reasons one wishes to be alive." (*Gawande*, 259) This is precisely the understanding the physician seeks in being present and engaging with his or her patient.

Not all humanistic physicians have been physically afflicted by illness. Other physicians are transformed by their experiences caring for patients of crises past. The HIV crisis taught physicians like Abraham Verghese the importance of *being*. Immersed in the crisis, Verghese feels the need "to be medically busy" even at a time when no effective HIV treatment exists. *(Being*, 1926) Intuitively, though, he does what he knows to do: convey to his suffering HIV patients that he will not abandon them. He figures that when scientific knowledge limits medicine, humans can continue to doctor. Present in his patients' illness, Verghese does not do away with the ritual of laying hands and caring. Although he cannot do much to medically care, he offers his continued presence.

It is precisely this presence to which literary critic and writer Anatole Broyard refers in his illness memoir of patienthood, *Intoxicated By My Illness*.[166] Chronicling his experience of illness with terminal metastatic prostate cancer, Broyard eloquently voices on what he (a patient) seeks from his doctors: more than love, patients seek *empathetic witnessing*—"an appreciative critical grasp of their situation." (*Broyard*, 44) He wishes the doctor "would just *brood* on my situation for perhaps five minutes and he would give me his whole mind once, be *bonded* with me for a brief space, survey my soul as well as my flesh to get to my illness, for each man is ill in his own way." (*Broyard*, 44) He explains that the doctor "doesn't have to lie to the sick or give him false assurances: *he himself*, *his presence*, and *his will to reach the patient* are the assurance the sick man needs . . . the doctor must usher the patient . . . into whatever physical and mental purgatory awaits him." (*Broyard*, 55) (emphasis added) As he imagines his ideal physician, Broyard describes his

166 Anatole Broyard, *Intoxicated By My Illness* (NY: Fawcett Columbine, 1992). Additional references will be cited in the text as *Broyard*, followed by the page number.

ideal doctor as one "entering my condition" and "holding me by the hand," understanding that this illness is "the crisis of my life." (*Broyard*, 43)

Through their experiences, these physicians and patients describe witnessing illness as a genuine attempt to understand with steadiness, guidance, and personalization.

DOCTOR AND PATIENT AND THE PERSISTENCE OF SUFFERING

After suffering from a virally induced heart attack that was later diagnosed to be caused by cancer, sociologist and expert in the ethics of care, Arthur W. Frank, speaks to the transformative power of the illness experience and how the transformation is actually reciprocal. Discussing the physician's role as storyteller, in *Why Doctors' Stories Matter*, Dr. Frank notes that the alienation and frustration of patients feeling unheard in the clinical encounter results from physicians not engaging in their part of the storytelling.[167] He observes that doctors, like patients, must live with the persistence of suffering and are transformed by witnessing the suffering.[168]

Broyard, too, notes that the connection between physician and doctor is reciprocal when both parties accept that the fact of illness is a *crisis*. He observes that in the emergency room he receives the attentive treatment he seeks; "the nurses and doctors perceived illness as an emergency, an emotional crisis," and emergency care a "continual improvisation." (*Broyard*, 56) Broyard observes that this crisis response is rewarding to both the physicians and the patients:

> In learning to talk to his patients, the doctor may talk himself back into loving his work. He has little to lose and everything to gain by letting the sick man into his heart. If he does, they can share, as few others can, the

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167 Arthur W. Frank, "Why Doctors Stories Matter," *Canadian Family Physician* 56 (January 2010): 51-4.

168 Frank, "Why Doctor's Stories Matter," 52.

> wonder, the terror, and exaltation of being on the edge of being, between the unnatural and the supernatural. (*Broyard*, 57)

And indeed, Gawande testifies,

> I never expected that among the most meaningful experiences I'd have as a doctor—and, really, as a human being—would come from helping others deal with what medicine cannot do as well as what it can. But it's proved true whether it's a patient . . . or someone I loved as much as my father. (*Gawande*, 260)

It is evident that the struggle is as rewarding as it is difficult. Of physician-patients he interviews, Klitzman observes that "these doctors didn't always become saints; they encountered conflicting impulses and frustrations. Day-to-day, optimal empathy [is] hard to sustain." (*Klitzman*, 308) They, however, become enlightened of the biological, social, and psychological dimensions of patients. Continuing to struggle, in their integrated roles they enlighten many to go beyond making sense of the patient experience into the existential dimension where they co-exist in a shared humanity. Klitzman notes that because of their experiences as patients, the doctors "internalized the white coats they wore." (*Klitzman*, 298) Transcending their socially constructed roles, they doctor beyond education and academic degrees. (*Klitzman*, 298)

BEING PRESENT AS ENGAGED PRACTICE, AS VIRTUOUS PRACTICE

Presence—"a one-word rallying cry for patients and physicians, the common ground we share, the one thing we should not compromise" is the heart of connectedness. (*Being*, 1927) It is the path to informed clinical judgments. Presence is the kind of physician response that will embody virtue in practice.

After having lived through critical illness, physicians show extraordinary transformations that link their personal and professional identities. In effect, their

transformations by illness forge their new identities—a shift in character—a new manner of being in their person and their practice. From their existential crises in illness arise insight and wisdom, that become embedded in the way they want to be and how they want to care for patients in their practice. Transforming the way they care, they metamorphosize, blossoming into a stabilizing force of presence for their patients, embodying virtue in contemporary practice.

These physicians demonstrate that for the physician seeking to understand the patient's crisis, the practice of empathic attunement connects the physician to the patient by tapping into emotion. Connecting—engaging—witnessing—are acts of presence; seeking understanding by engaging in heightened awareness is a way to be present. Thus, responding to patients' suffering through the practice of empathic attunement is to be present with patients in their experience of illness. To the physicians, it is the key to a purposeful practice of medicine. Physicians' ability to see their patients and understand their suffering is necessary to the reflective balancing called for in exercising clinical judgment. It reflects the kind of prudential wisdom required to determine the right and good thing to do for a patient. Aristotle calls for this ability in order to exercise practical wisdom—what he calls *phronesis*. This *clinical phronesis* is virtue in practice; it is reasonable, prudential action in light of an understanding of the patient and is thus indispensable to the virtuous practice of medicine.

Chapter 4 Empathy and Attunement in Pandemic Times: Assaulted by a Global Pandemic, A Reawakening of the Spirit of Practice

KEEPING ON: SEEKING TO 'JUST BE'

> They continue working through a sense of duty and professional honesty, because it is the only thing that they can do…because there is no other way...united by that good will and sense of honor.[169]

Like the transformative experiences of illness of the physicians and patients as featured in Chapter 3, COVID-19 has proven to be such an event of illness that transforms how medical professionals understand their roles in medical practice. Whether at the bedside or an office visit, the COVID-19 pandemic has redefined the way in which physicians practice medicine, approach caring, and define healing. As humanity collaborates to control the spread of the virus, physicians have found new ways of connecting with their patients and attending to their needs, even when human-to-human encounters prove to be a practical impossibility. Now practicing under more moral distress than ever, more physicians chronicle the impact of being amidst the crisis and the way in which their experience has forever changed their perspectives in medicine. In short, they have refocused the way in which they practice medicine and find meaning in their practice. Powerless over the virus and caught in a web of contemporary medical politics and practice, they ultimately discover that the practice of medicine is more relational than scientific and that the value of caring is in *being present*—bearing witness to someone

169 Roger Ruiz Moral, "Applause: Reflections On *The Plague* and Being a Doctor in a Pandemic," *Hektoen International: A Journal of the Medical Humanities* 12, no. 3 (Summer 2020). https://hekint.org/2020/05/06/applause-reflections-on-the-plague-and-being-a-doctor-in-a-pandemic/.

else's suffering.[170] Clinicians' published reflections show the rediscovery of meaningful practice and virtue in practice during this global pandemic of unprecedented magnitude.

A year after the World Health Organization declared a SARS-CoV-2 pandemic, the United States has seen an unimaginable 30 million infections that have (so far) crossed an unimaginable threshold of half a million deaths.[171] COVID-19, a tidal wave washing over clinicians—an image of flooding, immersion, darkness, and uncertainty—appeared on the cover of a *Scientific American* piece titled "Psychological Trauma Is the Next Crisis for Coronavirus Health Care Workers."[172] It is a haunting image joining the daunting statistics and images emerging daily in news stories. Overwhelming questions arise. Seeking what has resulted and how clinicians have been able to handle the surge in medical demand and uncertainty about the devastating pathogen, periodicals lend space, dedicate columns, and devote opinion editorials to their reflective voices. Reflections of the lessons from the pandemic by those immersed in it are revelatory: the pandemic has redefined *caring* and *healing* and has reinstated the workers' sense of duty as vocational. Under all layers of personal protective equipment (PPE), with very limited contact, working with imperfect information, and with little certainty of medical cures, what emerged is grander than a cure: at a time of burnout, the public witnesses the transformation of medical practice from its

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170 Margarita Ortiz, "The Clinician Chronicles: Lessons from the Bedside," *2020 Annual Combined Retreat and Symposium*: *Innovations in Education, Research and Clinical Care During the COVID Crisis; Lessons Learned*. Academy of Master Teachers; Academy of Master Clinicians; Academy of Research Mentors, University of Texas Medical Branch, October 29, 2020.

171 Centers for Disease Control, COVID Data Tracker, last accessed March 11, 2021, https://covid.cdc.gov/covid-data-tracker/#datatracker-home.

172 Jillian Mock, "Psychological Trauma Is the Next Crisis for Coronavirus Health Workers," *Scientific American* (June 1, 2020): 1-9. https://www.scientificamerican.com/article/psychological-trauma-is-the-next-crisis-for-coronavirus-health-workers1/ This article was originally published with the title "Frontline Trauma" in *Scientific American* 322, no. 6 (June 2020): 36-7.

scientific curative glory to its more fundamental role as a vocation in the service of humanity. The response to the COVID-19 pandemic represents a recognition that while modern medicine cannot always save our mortal bodies, our humanity can heal. From this pandemic continues to emerge a medical practice with a renovated focus on human connection and the strength of solidarity of a unified humanity. Clinicians consistently keep the faith by "keeping on." Finding ways to care for patients under such uncertain terms, they practice good medicine by returning to its basis: connecting with one another and caring for one another. "Our health professionals are seeing incredibly sick people in what is really a tidal wave washing over them, and they are *leaning into* that work because it's what we do," because it is the "frightening reality of what care looks like" in a world encased in "the anxiety, the fear, the overwhelming responsibility, and the ethical burden of hard decisions."[173] And still, clinicians in these pandemic times are compelled to continue plowing through the grief, illuminated by a renewed sense of purpose in bearing witness and being part of a vulnerable humanity. They see, understand, and share in the burden of illness with their patients.

ASSAULTED BY A GLOBAL PANDEMIC

In an in-depth exploration of the experience of healthcare workers working through the COVID-19 pandemic, researchers identify four main themes and subthemes that best characterize and track the changes for pandemic health professionals, dividing them into: (1) working in the pandemic era, (2) changes in personal life and enhanced negative affect,

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[173]Mock, "Psychological trauma Is the Next Crisis for Coronavirus Health Workers," 3; Kasey Grewe, "Headlines Don't Capture the Horror We Saw: I Chronicled what COVID-19 Did to a Hospital. America Must Not Let Down Its Guard," *Atlantic*, December 6, 2020, last accessed March 17, 2021, https://www.theatlantic.com/ideas/archive/2020/12/new-york-doctors-know-how-bad-pandemic-can-get/617302/.

(3) gaining experience, normalization and adaptation to the pandemic, and (4) mental health considerations.[174] Looking to evaluate the effects of pandemic work experience, researchers track participants' emotional phases when taking care of patients and handling other pandemic-related changes. In the study, the participants reveal their mental health and moral distress. Researchers conclude that the COVID-19 pandemic represents a stressful time for clinicians—working in ambiguity and in the uncertainty of loose scientific information, increasing doubt on the professional and personal control dimensions of the virus, and losing confidence in their expertise and skills.[175] Yet at this time of feeling an overwhelming sense of helplessness and exhaustion "in spite of all this hardship, their professional duty to 'raising the line,' a commitment to their medical oath, the notion of self-sacrifice and religious considerations compelled them to carry on."[176] The researchers' findings align with a similar qualitative study which found that "though there were negative emotions working during the pandemic, some growth was evident in terms of affection and gratefulness, development of professional responsibility, and self-reflection."[177] A Chinese study also showed similar results in that "intensive work drained healthcare providers physically and emotionally," but unwavering to the hardships, medical professionals "demonstrated resilience and a spirit of professional dedication to

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174 Mehrdad Eftekhar Ardebili, Morteza Naserbakht, Colleen Bernstein, Farshid Alazmani-Noodeh, Hamideh Hakimi, and Hadi Ranjbar, "Healthcare Providers Experience of Working During the COVID-19 Pandemic: A Qualitative Study," *American Journal of Infection Control* (Article in Press 2020): 1-8, https://www.ajicjournal.org/action/showPdf?pii=S0196-6553%2820%2930896-8.

175 Eftekhar Ardebili et al., "Healthcare Providers Experience of Working During the COVID-19 Pandemic," 2-3.

176 Eftekhar Ardebili et al., "Healthcare Providers Experience of Working During the COVID-19 Pandemic," 4.

177 Eftekhar Ardebili et al., "Healthcare Providers Experience of Working During the COVID-19 Pandemic," 8.

overcome difficulties."[178] Rocked by the virus, health professionals in these three studies consistently remain undeterred by the excessive demands imposed by pandemic practice, remaining faithful to the spirit of their profession. Despite the heavy workload, feelings of helplessness and sense of providing futile care, these physicians and nurses, guided by their sense of conscientiousness, reaffirm their loyalty to the medical oath to care for the sick through the challenges posed by the pandemic.[179]

Characterized as "an abyss . . . darkness . . . [and] working against logic," the pandemic has proven to be a time where rules are continuously reshuffled. The uncertainty of the virus' behavioral profile forces a continuous "recalibrated practice."[180] The COVID-19 pandemic terrorizes the globe and places clinicians at the front lines to struggle in a "torn reality," living a crisis between and within their personal and professional identities.[181] Suffering and isolated, clinicians and patients seek connection in "fighting dual epidemics: the coronavirus and loneliness."[182] They bear witness to suffering, and distressed in their realization that "watching someone suffer alone is its own form of

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178 Eftekhar Ardebili et al., "Healthcare Providers Experience of Working During the COVID-19 Pandemic," 8.

179 Eftekhar Ardebili et al., "Healthcare Providers Experience of Working During the COVID-19 Pandemic," 4.

180 Selected words from reflections in the following: Danielle Ofri, "A Bellevue Doctor's Pandemic Diary," *New Yorker,* October 1, 2020; "In Harm's Way," *New York Times*; "Voices of the Pandemic," *Washington Post*.

181 Moral, "Applause: Reflections on The Plague and Being a Doctor in a Pandemic," https://hekint.org/2020/05/06/applause-reflections-on-the-plague-and-being-a-doctor-in-a-pandemic/.

182 Dhruv Khullar, "'A Disembodied Voice': The Loneliness and Solidarity of Treating the Coronavirus in New York," *New Yorker*, April 8, 2020, https://www.newyorker.com/science/medical-dispatch/a-disembodied-voice-the-loneliness-and-solidarity-of-treating-the-coronavirus-in-new-york?itm_content=footer-recirc.

punishment," they are shaken to the core to care.[183] The moral trauma of the pandemic puts the role of emotion in clinical practice at the forefront of the crisis.

EMOTION: THE PATH TO BEING PRESENT

Facing immeasurable uncertainty and bearing "the moral burden of the care decision," many hospital workers at Montefiore Medical Center in the New York's lower income Bronx borough question their professional role in the pandemic: "What are we doing here? We are not going to be able to help this person…[and how does that affect] the person next door that maybe we could [do] more for?"[184] They react not only in reference to their COVID patients but also to other patients that feel the brunt of the pandemic in limited access to medical care and medical resources. Keeping on, doing what they do, these clinicians respond by providing care and support however they can, "breaking down emotional barriers they normally maintain . . . in its way, [providing] the moral response the situation demanded—doing whatever it took to offer the dying some measure of human connection."[185]

Emotion is a necessary part of medical practice, especially in a reciprocal way, during this pandemic. Through the unprecedented intensity of the coronavirus pressures, doctors live through an emotional evolution.[186] While most do not question their

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183 Khullar, "'A Disembodied Voice,'" April 8, 2020.

184 Jordan Kisner, "What the Chaos in Hospitals is Doing to Doctors," *Atlantic* (January/ February 2021), https://www.theatlantic.com/magazine/archive/2021/01/covid-ethics-committee/617261/?utm_medium=social&utm_campaign=the-atlantic&utm_term=2021-01-05T19%3A04%3A46&utm_source=twitter&utm_content=edit-promo

185 Kisner, "What the Chaos in Hospitals is Doing to Doctors."

186 Dhruv Khullar, "The Emotional Evolution of Coronavirus Doctors and Patients," *New Yorker*, July 7, 2020, 1-7, https://www.newyorker.com/science/medical-dispatch/what-fighting-the-coronavirus-feels-like.

commitment to doctoring, they quite humanly experience varying degrees of emotion in caring for their patients. Dr. Kochav, a hospitalist working in the coronavirus wards and Intensive Care Units (ICUs), describes this emotional trajectory, which he confirms also "mirrored from what [he] had heard from other doctors."[187] He explains the evolution in three phases: feeling excitement and fear, a gradual hardening of heart, and finally a recharged return to caring for another human.[188] The excitement of "learning on the fly" in the face of the mysterious and unrelenting nature of the virus, and the fear of losing patients and loved ones, carries him through the journey.[189]

COVID showed itself to the world as a reminder of things yet to be known, and as a challenge to discern and react. But in response, humanity showed COVID that it, too, is a force of nature to be reckoned with. This virus overwhelms hospitalist Dr. Kochav (and the world) but his response to it, too, is overwhelming. It is true that in his emotional journey, Dr. Kochav's initial realization of his powerlessness over it turned into a desensitization and detachment, and a disconnected, mechanical treatment of patients. But through the darkness, he emerges with resilience, realizing that he must feel connected: caring for people again takes seeing them once more as human beings—seeing pictures at barbeques, of family, of their personal lives—glimpsing at their lives apart from their ICU, COVID identities. This contextual knowledge is a type of emotional intelligence informing care decisions, and it provides a connection to his patient. In contextualizing the non-clinical life of the patient, the analysis of care for that patient changes. A critical care nurse

187 Khullar, "The Emotional Evolution of Coronavirus Doctors and Patients," 3.
188 Khullar, "The Emotional Evolution of Coronavirus Doctors and Patients," 3.
189 Khullar, "The Emotional Evolution of Coronavirus Doctors and Patients," 3.

in Dallas, TX describes the effect of the emotion tied to the care she provides to each patient. In explaining the reorganization of care sparked by the COVID crisis, she says:

> We prioritize video chats and allow families to grieve…they remind me that this statistic is a human who at some point had a first kiss, learned to drive, loved a child.[190]

A critical care doctor in Louisville, KY echoes her sentiment, reflecting that:

> Each COVID patient I have taken care of has a unique and heartbreaking story. They are allowed no visits, and we are wearing so many layers of PPE that even our emotions are masked.[191]

These clinicians reflect a desire to be connected, to treat the person; not only a body inhabited by COVID-19, but also mind and spirit. Being empathically attuned in care situations means recognizing the role of emotion for both caregiver and patient as vital to patient care. For Dr. Khullar, involving emotion means accessing a connection with his patients that allows for providing non-mechanical care. In fact, Dr. Khullar is affected more personally after he and his wife survive COVID-19 infections. During his experience he lives what he feared, embodying the experience he so often witnessed in his COVID-19 patients.[192] With this deepened understanding, he now connects more deeply with his patients; sharing in the fear and threat of the virus, understanding more deeply—intellectually, physically, and emotionally—their physical and emotional needs.

Fellow physician Dr. Bhattacharya recalls his own evolution as a doctor, from practicing in a conservative, self-protective way of avoiding becoming "emotionally distraught," to understanding that "a good doctor is characterized first by the ability to feel

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190 "In Harm's Way," *New York Times*, July 8, 2020, featured reflection by Mary Catherine Kecksein, Critical Care Nurse in Dallas, TX.

191 "In Harm's Way," *New York Times*, June 11, 2020, featured reflection by Sonia Compton, Critical Care Doctor in Louisville, KY.

192 Khullar, "The Emotional Evolution of Coronavirus Doctors and Patients," 3.

others' pain."[193] Dr. Bhattacharya attributes much of his understanding to having to confront suffering after "having watched people suffer and [feeling] helpless because there's nothing [doctors] could do."[194] That "the fight against COVID-19 is not a momentary disruption but a new way of life" holds true to the way that these experiences have shaped physicians' practice to give emotion and empathy a larger and central role.[195] Especially in situations where "no game-changing treatments for the disease" exist, physicians can only *just be*, focused on the present moment, taking one breath at a time.[196]

To *just be* in the moment is the way to "bearing witness to the here and now…allowing [yourself] to be in the middle of the story." [197] Full of ambiguity and uncertainty, the pandemic gives its survivors—patients and health professionals alike—a chance to reevaluate personal morality and reprioritize values. Illuminated by their past and current grief, clinicians rediscover the vulnerability of the human condition and the restorative power of the human connection.

STRIKING A BALANCE BETWEEN EMPATHY AND REASON

In their pandemic practice, physicians' minds struggle to determine rightful care for their patients; they face a neurological opposition between their empathetic and

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193 Khullar, "The Emotional Evolution of Coronavirus Doctors and Patients," 5.

194 Khullar, "The Emotional Evolution of Coronavirus Doctors and Patients," 5.

195 Khullar, "The Emotional Evolution of Coronavirus Doctors and Patients," 2.

196 Charlotte Alter, "'We Won't Let Him Die In Our Ambulance:' A Day With a Paramedic Facing the Coronavirus Pandemic," *Time*, April 20, 2020, https://time.com/collection/coronavirus-heroes/5815747/coronavirus-paramedic-experience/.

197 Rebekah Taussig, "A Partner With Cancer, a New Baby and a Pandemic: How I Learned to Live in a Tangle of Joy and Pain," *Time*, January 5, 2021. In this piece, a disabled teacher examines her life situation and the role of the pandemic and the value of bearing witness to reality by allowing yourself to be in your role in the middle of the story.

analytical thinking.[198] Describing the tension in the exercise of both embracing and constraining empathy, writing in his usual *New Yorker* column *Medical Dispatch*, Dr. Khullar explains the existing dichotomy in medical practice. He explains that as a practical matter "a temporary blunting of emotion is what allows us to insert a catheter into a patient's neck or a tube down a patient's throat; if we feel too much, we can't think and act, while if we feel too little we don't care."[199] This makes sense. Doctors must be able to act, to make care decisions. But, engaging the patient's perspective, which means engaging empathy, is necessary in considering medical action. The role of that patient's perspective is the key to figuring out what will maximize the clinician's understanding of the patient and the patient's situation, thereby maximizing the goals set for that clinician-patient relationship and the goals of care. Dr. Khullar admits that in times of emotional weakness, he experiences a temporary slipping away from this perspective, which results in "detached decisions about intubation after intubation."[200] He realizes that being part of the patient's moment, aware of the circumstances of this patient, brings him back to reality, reigniting his sense of purpose. He describes detachment dissipate when just as he is slipping into it he is "jolted awake—by a young mother, who is talking to her toddlers over FaceTime, through labored breaths, for perhaps the final time."[201] The moment is a reminder of patients' heavy burden; their sense of terror, isolation, and the feeling of a "perfunctory existence" in helplessness and hopelessness.[202] Ultimately, the jolt into the present moment immerses him in his and his patient's reality, reigniting within him the spark of meaningful

198 Khullar, "The Emotional Evolution of Coronavirus Doctors and Patients," 5.
199 Khullar, "The Emotional Evolution of Coronavirus Doctors and Patients," 5.
200 Khullar, 5.
201 Khullar, 5.
202 Khullar, 3-5.

practice in what he continuously confronts. This difficulty in accepting the role of emotion, especially the balance between it and reason is not unique to Dr. Khullar. Many like him experience it, and it is well articulated by Dr. Valerie Briones-Pryor:

> I try my best to be connected. It's an honor to be with someone in those last moments . . .
>
> This pandemic has taken me through the stages of grief . . . the problem with acceptance is that you start to get numb . . . at some point, you almost have to depersonalize it, and that doesn't feel right, either.[203]

Deeply intertwined with the existential, the pandemic has been an exercise in humility to the human race, especially in how to handle the physical and emotional vulnerability that are very much part of human existence. The pandemic has been and continues to be a unifying force within the medical profession, and between it and the people it serves.

Fundamentally, it is the value of solidarity that underlies the response to the existential crisis clinicians experience. Witnessing brutal tragedy and a slow, deepening personal exhaustion from this new normal, clinicians are under intense moral distress. Emotions are an inevitable part of the human experience, and thus an indispensable part of the clinical and relational equation. In a time of heightened emotions—this "sea of pandemic emotions"—maintaining perspective in personal and professional endeavors, as well as between the personal and professional identities, is protective of the connections between the clinician and the clinician's personal life, the clinician and his professional

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[203] Eli Saslow, "I Needed Something Good to Happen," *Washington* Post, December 19, 2020, https://www.washingtonpost.com/nation/2020/12/19/doctor-coronavirus-vaccine-hope/?arc404=true.

life, and the clinician in his professional life with the patient.[204] Addressing the tension between embracing and constraining empathy for her patients, pediatrician Rebekah Diamond examines the relationship of emotions between her professional role as a doctor and her personal life as a parent. She describes her privileged position as a physician and compares it to the suffering of her patients. She struggles with the contrast in thinking that although her role as a pediatrician gives the appearance of less intense suffering, she experiences just as much grief as she sees and senses in her suffering patients. She figures that the grief she feels results from all that witnesses *and* shares with the experiences of her patients and their families—she lives in pandemic times, has a family, and shares the fear and anxieties that her patients and their families have. She is part of the same suffering humanity. It is unavoidable for her not to be cognizant of these personal feelings of grief in her daily practice. She explains that emotion is deeply involved in her empathic clinical practice, especially as it resonates with her personal life. She argues that physicians like herself must be allowed to, on their level of life and regardless of privilege, simply feel, and like her patients, just be a human amidst a pandemic—as fearful, as anxious, and as overwhelmed as her patients and their families. In this way, she and other physicians and patients live in solidarity undergoing the same type of existential crises as their fellow humans, equally as vulnerable to the multidimensional attacks of the virus, and as connected as ever. This deepened understanding helps her to care for her patients. Defeating a COVID existential crisis of doctors and patients will take deep understanding of one another (in both personal and professional roles) as fellow suffering humans: putting

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[204] Rebekah Diamond, "As a Doctor and Mother, I'm Balancing Privilege and Pain Through This pandemic," *Washington Post*, September 14, 2020, https://www.washingtonpost.com/lifestyle/2020/09/14/pediatrician-mom-covid-guilt-gratitude/.

aside inequalities and standing in solidarity with patients and their families, they are witnesses to one another, focusing not on the contrasts but on the similarities. Resembling a picture of empathy and attunement in pandemic times, emotions are reciprocal between clinicians and patients.

From the beginning of the COVID-19 pandemic several journalistic outlets gather and continually publish clinician reflections, which often reflect moral transformations now manifested in their clinical practice. The *New York Times*, *The Washington Post*, and *The New Yorker* are among publications with dedicated COVID sections focused on providing multidimensional perspectives of the crisis. Immersed in the grief caused by this "tragedy of unique cruelty," spreading "a horrifying feeling of vulnerability," from these accounts it is clear that from the COVID-19 crisis clinicians emerge illuminated. [205] Rather than feeling limited by their "humanity," they are instead "finding its depths."[206] Motivated and guided by the hope of overcoming COVID-19, clinicians trudge on in uncertainty, responding to the need with the affirmation of their presence in the medical moment that each instance of a patient's care represents.

HUMANISM IN MEDICINE: THE EVOLUTION OF CARE AND THE SHIFT IN CARE DECISIONS DURING THE PANDEMIC

> The burden of COVID-19 extends far beyond the physiologic manifestations. While the social and psychological scars that this pandemic will leave on all of us remain to be seen, the decreased compassion and humanism experienced by our patients is unquestionable. Yet, even while avoiding direct physical contact, wearing PPE, limiting in-person communication, and demanding social isolation, opportunity still exists to

205 "In Harm's Way," *New York Times*, April 17, 2020, featured reflection by Manuel Penton III, a Pediatric Infectious Disease Fellow, Brooklyn NY.

206 "In Harm's Way," *New York Times*, April 17, 2020, featured reflection by Manuel Penton III, a Pediatric Infectious Disease Fellow, Brooklyn NY.

> express the empathy that led us to the practice of medicine far before the age of COVID-19.[207]

The "pervasive uncertainty" of COVID-19, its politization, the unreliable published guidelines, and the unsteady clinical leadership to command it, define the early days of the pandemic. Clinicians were forced to look for answers from one another. In camaraderie and with feelings of inadequacy, clinicians continue to search for methods and guidance in clinical decision making.[208] Unclear standards for COVID-19 care, coupled with the unsettling behavioral profile of the virus, result in care decisions that reflect care providers' perseverance to do what they certainly know how to do: focus on connection. Still analytic but scientifically limited, care decisions reflect a more engaged, empathic clinical practice as clinicians devise new ways to communicate the healing touch, or a sense of companionship through the illness. Navigating in the darkness, learning on the go, and without answers or a sense of where the pandemic is headed, clinicians needing to act redefine how they care for patients and for each other. Their practice reestablishes

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[207] Jonathan D. Sonis, Maura Kennedy, Emily L. Aaronson, Joshua J. Baugh, Ali S. Raja, Bryan J. Yun, and Benjamin A. White, "Humanism in the Age of COVID-19: Renewing Focus on Communication and Compassion," *Western Journal of Emergency Medicine* 21, no. 3 (May 2020): 499.

[208] Robert P. Baird, "How Doctors On the Front Lines Are Confronting the Uncertainties of COVID-19," *New Yorker*, April 5, 2020, https://www.newyorker.com/science/medical-dispatch/how-doctors-on-the-front-lines-are-confronting-the-uncertainties-of-covid-19.

One such expression of uncertainty came from clinician Jennifer Gillen, a Medical-Surgical Nurse in Richmond, Texas "we were in the dark. We were learning as we went. It seemed like every shift we were changing something. It was terrifying because we just didn't have answers." As published in "In Harm's Way," *New York Times*, July 11, 2020. Workers expressed their reliance on compassion, empathy and spirituality: "out twice a day prayer over the hospital intercom broadcasts hourly now. For those of whatever faith and those who claim no faith, we all wanted to believe." Anna Fong (ER Physician), "In Harm's Way," *New York Times*, July 5, 2020.

connection as the essential component of care necessary to overcome barriers imposed by the pandemic:

> For me, connecting with my patients is essential. I need to see them as people. But there were all these barriers between us: the mask, the curtain, the limitation on how many times I could go into his room. Everything felt different. . . . Medicine is partly science and partly art. You usually have some sense of where you are going. But not with COVID-19. Nothing seems guaranteed.[209]

They are forced to find new ways to connect:

> Nursing has changed. While we fight the virus, I no longer know if my patient is a veteran, or what they do for a living, or anything about their family . . . they don't see my smile or my concern for them through my mask, shield, glasses, hat, gown, and gloves. We all look alike to our own patients. Not only are they alone, but now it is difficult to reassure them even with a soft touch.[210]

Dying from COVID-19, a popular New York Emergency Department doctor writes to his peers in support of their practice to boost morale, reminding them that amidst all the chaos and frustration they did have the power to care for their patients, writing: "in this exceptionally challenging time, with a limited number of tools to fight the virus….we do have other tools at our disposal: decency, empathy, and compassion."[211] These tools, so valuable in COVID-19 practice—decency, empathy, and compassion—are the fundamental basis of medical practice.

As the pandemic adds barriers to caring for patients, families of the sick also fare terribly; the pandemic strips the intimacy and sacredness of the death experience, their last

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209 "In Harm's Way," *New York Times*, June 22, 2020, featured reflection of Intensivist Absar Mirza from Alpharetta, Georgia.

210 "In Harm's Way," *New York Times*, April 18, 2020, featured reflection of ICU nurse Rita MacDonald from Royal Oak, Michigan.

211 "In Harm's Way," *New York Times*, March 30, 2020, featured reflection of Emergency Department doctor, Frank Gabrin, in his obituary.

touch and final goodbyes conducted "via iPad in a Ziploc bag, surrounded by faceless staff in head-to-toe PPE."[212] Comparing pre-COVID-19 and COVID-19 ICU work days, internal medicine resident Vanessa Van Doren reflects on the added intensity of an already intense ICU practice brought by the pandemic.[213] The beside becomes meaningless without knowing the patient; "when our patients are dying, as so many of them are now beyond the reach of our current medical knowledge, we cannot bring their family in to see and understand the depth of their loved one's illness…" and though "these conversations are much more likely to happen over a call room phone than at the bedside, we have to try [to ask, 'tell me about him.']"[214] In Van Doren's pre-COVID ICU experience, stories gave patients their non-ICU identities: "through the stories, the voiceless, nearly-motionless . . . took on new life. [A] fading body was replaced by a rich, complex picture painted by the person who loved him most."[215] Van Doren explains that conversations like these deepen the connection with the patient and the patient's family; they confirm that the person laying in the bed held life with meaning and the right choice in the moment is to "just be with him."[216] Van Doren's experience through COVID care changes the way she understands practicing medicine. She realizes that in the end, when nothing else can be done, when all meaning appears gone, she can just *be* with her patient— bearing witness to a life that is, that has been, and an absence that will not go unnoticed.

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212 Vanessa Van Doren, "The Right Choice," *Intima* (Fall 2020), https://www.theintima.org/the-right-choice-vanessa-van-doren.

213 Van Doren, "The Right Choice."

214 Van Doren, "The Right Choice."

215 Van Doren, "The Right Choice."

216 Van Doren, "The Right Choice."

The COVID-19 pandemic cast a shadow of fear over the healing touch of the physician. Yet because "compassionate touch plays such an incredible role in defining who we are as human beings," pediatrician Dr. Kajsa Vlasic contemplates the impact of its absence in the care she provides to her young patients now and the effect of its absence in their future development. [217] Minimizing touch and limiting exposure time with patients, especially her young patients, undoubtedly jeopardizes the healing process, as patients struggle with a shaken sense of the safety and security of this place that is supposed to be a healing place. Discussing concerns about pandemic effects like this one, critical care physician Rana Awdish addresses the moral impact of the pandemic on physicians resulting from interruptions in medical care and changed rituals in pandemic practice.[218] Awdish's essay, *The Shape of the Shore*, gives a brief glimpse into the reality of pandemic physician distress. In it, Awdish describes the distress caused by the horrors and tough decisions that ICU physicians and other hospital workers experience during the COVID-19 pandemic. Awdish describes distressing changes in rituals—from having to text family members the pictures of their dead, to having to shock dead bodies long enough to allow the team to "gown up."[219] Her concern arises from respect for the patient and her role as care provider—someone supposed to be "caring for" the patient. More specifically, changes resulting from the COVID-19 crisis, like the almost-anonymity of the patient and exclusion of the family from the ICU, make the care physicians provide "feel somehow

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[217] Kajsa Vlasic, "I Miss Touching My Patients," *Intima* (Fall 2020), https://www.theintima.org/i-miss-touching-my-patients-kajsa-vlasic.

[218] Rana Awdish, "The Shape of the Shore," *Intima* (Fall 2020), https://www.theintima.org/the-shape-of-the-shore-rana-awdish.

[219] Awdish, "The Shape of the Shore."

invisible and hollow."[220] She describes the angst she feels about the changes in moments of care, perceiving those changes to be something that "feels very harmful" and which leave her feeling "inhuman."[221] Until the acceptance of her role as a physician having to adjust to the challenges posed by the pandemic, she experiences a decline in her professional morale. This decline in professional morale blinds her and her colleagues from seeing the good that they do—the humanity they bring into the *impossible circumstance* in which they all partake. Awdish ends her reflection with a metaphor of being immersed in the waves far from the safety of the shore, but that together with her colleagues, in "using [their] imperfect strengths to bring each other above the surface," they saved each other in choosing to care amidst the challenges; by choosing to be present for their patients, they stay afloat at a time when everyone seems to be struggling for air.[222]

Family physician Anthony Feng writes of connectedness as playing a primary role in care and healing. Believing has finished checking on a patient, out the door his patient's comments jolt him awake:

> It was 5:00pm in the intensive-care unit, and my team and I had just wrapped up our interview with elderly Ms. Armijo, who was in critical condition after emergency abdominal surgery. Exhausted after a long day, we headed for the door…from behind us, Ms. Armijo called, "You know, the thing I'm really worried about is being all alone."
>
> Frozen in midstride, I realized that we'd neglected one very important question: connectedness. . . .
>
> I listened . . . it was a direct, visceral reminder: asking about her connectedness to her family was as crucial as probing into her abdominal pain or lab results.[223]

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220 Awdish, "The Shape of the Shore."

221 Awdish, "The Shape of the Shore."

222 Awdish, "The Shape of the Shore."

223 Anthony Feng, "Only Connect," *Pulse*, July 28, 2020, https://pulsevoices.org/index.php/stories/only-connect/print/.

Feng realizes that connectedness is life support, and it is two-fold: in his role as physician he must connect to his patient and to the patient's world, but in turn, the patient reciprocates the connection, connecting with him. He reflects that *connectedness* is "one of the patient's vital signs—as important, in its own way, as any heart rhythm or puff of breath."[224] Although Feng refers to connectedness of the patient to her family, to be able to understand the very need for her connection with her family, Feng must first attune to the loneliness of the hospital experience. What this patient needs is a little extra effort from her doctor—the right questions and the retrieval of a missing cell phone that is sorely missed. Dr. Feng feels "grateful to [the patient] for the reminder that you cannot experience full health or healing if you feel disconnected from those you love," and of course, from those that care for you.[225]

Caring is foundational to the institution of the medical practice of science. Physicians practice scientifically precisely because they care for the wellbeing of their patients. Caring happens because of some connection. In 1926 Francis W. Peabody axiomatically proclaimed this principal dogma of connectedness and caring in medical practice, in the famous address delivered to the Harvard Medical School class. In *The Care of the Patient*, Peabody reveals, in an ironic type of way, that the *secret* to the care of the patient is *in caring* for that patient.[226] More precisely, he tells them that the secret to the care of the patient is in wholesomely caring for that patient in all dimensions of existence.

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[224] Anthony Feng, "Only Connect."

[225] Feng, "Only Connect."

[226] Francis W. Peabody, "The Care of the Patient," *Journal of the American Medical Association* 88, no.12 (March 19, 1927): 877-82.

Advising against the total reliance in the new, technologically focused science, Dr. Peabody encourages them to use new scientific technology as one of the many tools of the doctor, reminding them of the value of the traditional practice—a practice that is more relational than scientific, more personal and thoughtful than protocol-driven or routine. A traditional practice that "promoted caring relationships between patients and physicians," where:

> Each person was unique, each person's temperament would play a key role not only in making the diagnosis but also in guiding the hand of the physician in recommending appropriate therapy.'[227]

By the twentieth century, clinical medicine had far progressed, and though "caring had been a critical element in medical practice," the ethic of care was being replaced by an ethic of cure. [228] Thus, Peabody reminds them—perhaps warning them—that care is caring for more than only treating organic disease, commanding them to notice that the disease affects the whole being (and each patient) in a distinct way. Explaining the connection between the disease and the patient his message affirms that "the essence of the practice of medicine is that it is an intensely personal matter."[229]

> Medicine is not a trade to be learned but a profession to be entered…all that medical school can hope to do is to supply the foundations on which to build. . . . an art, based to an increasing extent on the medical sciences, but comprising much that still remains outside the realm of any science. The art of medicine and the science of medicine are not antagonistic but supplementary to each other.[230]

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227 J.A. Marcum, "Emotionally Detached Concern or Empathy," in *Humanizing Modern Medicine*: *An Introductory Philosophy of Medicine* (NY: Springer Science + Business Media B.V., 2008), 271. Here, he quotes Joel Howell discussing the ethic care prior to the nineteenth century.

228 Marcum, "Emotionally Detached Concern of Empathy," 271.

229 Peabody, "The Care of the Patient," 877.

230 Peabody, "The Care of the Patient," 877.

Today, working through unsettled COVID-19 scientific certainty, a compassionate practice based on much more than scientific knowledge constitutes the practice of good medicine. To Peabody, the physician in his role as a professional ideally has the scientific foundation to deal with what is variable—the patient, the disease, the environment. COVID-19 is one such variable and doctors practicing during the pandemic live up to the task in doing what they can do in their moments with patients. The pandemic has stirred medical practice. Author Martha Hamilton writes of her personal, recent non-COVID hospitalization: "through it all…it began to hit me how much I had enjoyed my days in the hospital for the amount of human interaction it brought and the number or smart, caring nurses and doctors and other hospital workers…whom I had met and who helped me through it."[231] Hamilton describes the people and the way they care for her as the "constant cast of competent, confidence-inspiring caretakers," that turn what was to her an uncertain, "frightening emergency hospital visit into an unexpected source of joy."[232]

In a short, artfully sketched but strongly messaged five-minute video, New York Presbyterian's Director of Global Health in Emergency Medicine Craig Spencer presents an eye-opening account of pandemic physician moral distress.[233] Dr. Spencer starkly reminds the viewer that all humans, not only medical professionals, have a responsibility

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231 Martha Hamilton, "During My Recent Birthday, I Had to Go to the Hospital. The Medical Staff and Technicians Made It Kind of Nice," *Washington Post*, January 9, 2021, https://www.washingtonpost.com/health/pandemic-caring-doctors-nurses-memorable-birthday/2021/01/08/a37a3b64-4fa6-11eb-bda4-615aaefd0555_story.html

232 Martha Hamilton, "During My Recent Birthday, I Had to Go To the Hospital. The Medical Staff and Technicians Made it Kind of Nice."

233 Craig Spencer, "A Day In the ER Battling COVID," last accessed March 14, 2021, https://www.youtube.com/watch?v=IdeHSkDCm58&feature=youtu.be

to respond to the pandemic, acknowledging that "we're are all being asked to do things we've never done before."[234] In his plea to invoke responsible pandemic behavior, he chronicles the daily living of an ER doctor during pandemic times, highlighting the unsettling reality of the virus and the toll it takes on patients, doctors and other caregivers. Deeper in those reflections, he emphasizes that "caring for the patient" means caring to connect to their families and to their emotions; physically connecting, doctors and other caregivers hold the hand of the patient whom they cannot save and witness the grief of the families in seeing their loved ones die. In a similar way, acknowledging the connection between patient and family, clinicians dealing with the impending COVID-19 death of retired nurse Iris Meda find a way to allow her daughter to hold her mother until her death.[235] Extraordinary scenes like these affirm that distressed caregivers, patients, and families, in finding ways for physical and emotional support and connection, reinforce empathic practice as the emerging protocol.

The care of the patient that Peabody suggests is the care that the COVID-19 pandemic once again brings forth as care that reflects the ends of medicine: care that aligns with the good of the patient. Peabody essentially describes attunement to the patient as the secret to caring for the patient and as the type of approach that considers the existential dimensions of illness existing in concert with the disease of the body. Being attuned to the patient's experience of illness requires the physician to be *present* in the patient's moment and experience of illness. The pandemic proves that at times when science fails to lead, humanity persists in the

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234 Spencer, "A Day In the ER Battling COVID."

235 Lawrence Wright, "The Plague Year," *New Yorker*, January 2021, https://www.newyorker.com/magazine/2021/01/04/the-plague-year.

challenge, connected and adaptable—taking the lead by reacting with the appropriate moral response.

The practice of good medicine is relative to the patient. It is one where the focus and interest of the physician is in the human that is the patient: a relative balance of science, emotion, and reason into discernment. It is time, as Peabody would demand, to exercise medical practical wisdom.

EMPATHY AND ATTUNEMENT IN PANDEMIC TIMES

> We will remember these days . . . Some day we will remember that during a pandemic there was still kindness and compassion . . . we will remember that what we do still matters.[236]

Seeking to *just be* resonates through the reflections of practitioners in pandemic times, allowing themselves to grieve, experience, and react. To *just be* allows them to adapt to the situation: to step in with the times and to use the embodied experience that together with their expert knowledge, consistently continue to do what they know how to do. The extraordinary reflections of the care they provide reflect their attunement and empathy. The practice of medicine during the COVID-19 pandemic proves that even at a time of uncertainty, by just being present, connecting, and caring for the sick with "decency, empathy and compassion, 'still matters.'"[237] As the "necessary next normal" begins, the "kindness, caring, compassion and courage" embodied by medical professionals is

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[236] David Hilden, "We Will Remember The Days," in *A COVID-19, Diary From a Pandemic: Humanities and Medicine*, September 17, 2020, https://myhealthymatters.org/a-doctors-diary-from-a-pandemic-we-will-remember-these-days/.

[237] Hilden, "We Will Remember These Days."

foundational to the ethic of care they are reinstating for post-pandemic medical practice.[238]

For clinicians, particularly doctors and nurses, the COVID-19 pandemic represents a moment to rest in being.

> There comes a time when there is nothing more that healthcare providers can do for a patient despite our best intentions and advanced technology, but to be present, to bear witness, to share the pain, suffering and loss with our patients and their families.[239]

To *rest in being* is resting in a non-judgmental space where we acknowledge the value of our experience. That although "everything matters . . . we are not alone as we feel;" "folded into this moment together . . . tomorrow [we will] rise just like today."[240] In solidarity, humanity will overcome the COVID-19 pandemic and its onset of crisis after crisis, and after all is done, having the courage to continue moving toward a more engaged clinical practice.

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238 *Hippocrates Café: Reflections on the Pandemic* (St Paul: PBS, 2020), https://www.pbs.org/video/hippocrates-cafe-reflections-on-the-pandemic-37970/.

239 *Hippocrates Café: Reflections on the Pandemic,* Minute 46:27.

240 Julia Bloom and Cabin of Love, "Simply Exploding," In *Hippocrates Café: Reflections On the Pandemic* (St. Paul: PBS, 2020), Minute 21:19.

Chapter 5 Toward the Spirit of Medicine: Virtuous Practice in Contemporary Times

Clinical Judgment and Virtue

The predominant themes of pandemic practice—the importance of being a healing presence, and the transformative power of the illness experience that awakens that healing presence—have everything to do with virtue in practice. The virtuous physician, or what the virtuous practice of medicine means, while they are abstractions that cannot be captured by checklists or competency achievements, they center around character and the use of prudential judgment in clinical practice. But the question is, what does it mean to be a physician living with those abstractions? An engaged clinical approach that fulfills the ends of medicine aims to achieve the right and good thing to do in the practice of medicine for the patient being attended. By including in the clinical logic a multidimensional understanding of the patient, an engaged clinical approach leads the physician to wise clinical decision making, and thus toward a more virtuous practice. As a practical matter, this mindful approach leads physicians to live through the abstractions of charter declarations or listed competencies. This engaged clinical approach considers the complex balance between the scientific and human dimensions of medicine by engaging the physician in a prudential judgment of what he or she knows how to do with the understanding that he or she has of the patient. While empathic attunement in this engaged approach is not itself virtue, it supports virtue in that it informs the exercise of prudence by providing the avenue for connection and understanding of the patient and the patient's

medical circumstance. The practice of empathic attunement is thus an opportunity for a move towards a more virtuous practice of medicine.

Central to clinical judgment is prudence. Prudence, as explained by physician-philosopher Edmund Pellegrino, is virtuous. Prudence is used in discernment of the moral thing to do—the right and good thing to do—within the context of scientific knowledge and patient understanding.[241] Pellegrino bases his definition of prudence on the Aristotelean concept of virtue, which identifies virtue as a relative concept. To Aristotle, virtue is the mean between extremes, a mean that represents a practical balance in the continuum of opposing actions. Using this, Pellegrino reasons that medicine is not only an intellectual enterprise, but that it is also a moral enterprise. Because it is a moral enterprise, clinical judgment must reflect practical wisdom to be considered virtuous. Being practical itself is being wise because it itself implies balance in the intellectual processes that go into consideration in choosing how to respond or act. Using intellectual and moral considerations, prudential medical decision making is wise, and is thus an exercise in practical wisdom. Not a moral formula or a method but a way to evaluate a "complex situation fraught with uncertainties," prudential judgment is guided by sensitivity to the moral aspect of care, which in turns sets the intention of the "healing" sought in that medical encounter.[242]

In this way, prudential discernment considers context and the complexities of life and humanity, navigating through "the maelstrom of anxiety, uncertainty, and urgency characteristic of the medical encounter…to tell us how to resolve our understanding…of

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241 Edmund D. Pellegrino and David C. Thomasma, "Phronesis," in *The Virtues in Medical Practice* (New York: Oxford University Press, 1993), 84-91.

242 Pellegrino and Thomasma, "Phronesis," 85-6.

the competing values, principles or virtues."[243] Motivated by prudence, a physician's clinical judgment furthers the ends of medicine by supporting its ultimate end of achieving "the health of individuals and society," and "its more proximate end," the determination of "the right and good healing action for a specific patient."[244] Prudence is a character trait that promotes sensible decision making, and intended to help the physician exercise good clinical judgment, it is a character trait that meets Aristotle's definition of virtue. Thus, pursuing this excellence in clinical decision making, as motivated by the pursuit of the patient's good, approaches virtue in practice.[245] Clinical judgment based on prudential discernment reflects action based on a deeper understanding of the task of medicine and what it means to practice *good medicine* for the patient, regardless of contemporary challenges like those posed by the pandemic.

THE GUIDING LIGHT IN PANDEMIC CLINICAL PRACTICE: PRUDENCE IN ACTION

The practice of medicine during the pandemic relies heavily on physicians' best judgment in considering how to practice medicine given the unprecedented nature, uncertain science, and the manifested impacts of COVID-19. Prudence guides physicians in exercising their "deliberative capacity to reason well;"[246] in making decisions, clinicians consider what they know, what they know how to do, and how they could act in the best "healing" way possible for each patient. Care decisions during the pandemic are guided by the available scientific knowledge, the clinicians' medical knowledge, and their understanding of their patients. By *being present* in each patient's moment, physicians are

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243 Pellegrino and Thomasma, "Phronesis," 89.
244 Pellegrino and Thomasma, "Phronesis," 85.
245 Pellegrino and Thomasma, "Phronesis," 85.
246 Pellegrino and Thomasma, "Phronesis," 90.

sensibly humanistic and prudential scientists. Seeking understanding, they empathically attune to each patient, connecting to each, and ultimately acting with a prudential understanding of science, moral insight, and that "intuitive grasp of what [is] right and good [in the situation]."[247]

Immersed in this pandemic, *adaptability* has anchored virtuous medical practice in contemporary times. Learning to embrace the present, adapt, and innovate, physicians attempt to find that Aristotelean golden mean, a reasonable position between extremes that defeats the urge to either completely clinically detach and dehumanize, or becoming overcome in emotion that over-empathizes. Virtuous practice lies in the discernment, in the finding of the balance (the *golden mean*) relative to the circumstances. Thus, virtue lies in the clinical logic that guides the physician's prudential decision making, whatever the circumstance. Even if the profession accepts the status quo as a new normal and acts to establish protocols and routines that peril to lose the importance of connectedness, a physician's virtuous practice defeats attempts at this standardization of care.

PANDEMIC PRACTICE IS CONTEMPORARY PRACTICE: FINDING VIRTUE IN CONTEMPORARY MEDICINE

Prior to the pandemic and partly because of the globalization of the problem, modern medicine had not yet faced the degree of uncertainty in the health care questions that became twisted in the sphere of the progressive scientific climate and party politics.[248] COVID-19 poses new risks, reshuffling of priorities, and deepening unanswered questions. Non-COVID related disease management forces a new distressing calculus on physicians.

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247 Pellegrino and Thomasma, "Phronesis," 89.

248 Here I am referring to already looming questions of the moral propriety of certain scientific pursuits and other moral, ethical ongoing debates.

While causing distressing symptoms of moral distress for physicians, existing challenges like minimized visits, rushed medical decisions, cancellations of elective procedures, declining clinical trials, and fear among patients waiting to present to the hospitals with life threatening conditions, these challenges actually promote a more engaged, personalized clinical practice during the pandemic.[249] While issues remain in whether physicians should be worried about exposure risk in their practice, or where to draw the line between urgent and non-urgent cases for hospital admission, physicians come together to figure out solutions: "right now, 'the sum total of what we hear from colleagues at other institutions is the best data we have.'"[250] In the end, an ethic of *caring for* rather than only *taking care of* the patient emerges: "the need for vigilance about viral transmission need not detract from an equally important message: Covid or no Covid, we are still here to *care for* you."[251] (emphasis added) The distinction between *taking care of*—an attitude implicitly reinforcing a an emotionally detached concern,—and *caring for* a patient—a more present, humanistic empathic care—is a distinction made by bioethicist and author of *The Encyclopedia on Bioethics* Warren Reich.[252] The distinction is crucial to the understanding of clinical practice that emerges from the lived experience of the clinicians

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249 Lisa Rosenbaum, "The Untold Toll—The Pandemic's Effects on Patients without COVID-19," *New England Journal of Medicine* 328, no. 24 (June 11, 2020): 2368-71.

250 Lisa Rosenbaum, "The Untold Toll—The Pandemic's Effects on Patients without COVID-19," 2370. The author explains that the risk-benefit analysis is unworkable under such uncertainty and as examples uses the following questions: "Should hospitals schedule LVAD placements when ICU and ventilator capacity may soon be exceeded? Is a patient with severe aortic stenosis more likely to die from his underlying valvular disease or from a vale-replacement hospitalization that leaves him with coronavirus infection? How many times can you expose a cath-lab team to patients with Covid-19 associated myocarditis, which can mimic an acute coronary syndrome, before so many staff members are infected that no one remains to treat patients with real myocardial infarction?"

251 Lisa Rosenbaum, "The Untold Toll—The Pandemic's Effects on Patients without COVID-19," 2371.

252 Warren Reich, *The Encyclopedia on Bioethics* (NY: Free Press, 1978).

practicing medicine in the midst of this COVID-19 global pandemic. Reich suggests that while "taking care of the sick person emphasizes the delivery of technical care …*caring for* or *caring about* the sick person suggests a virtue of devotion and concern for the other as a person." [253] The pandemic has recovered the necessary emphasis of *connection* in medical practice.

As the pandemic brings about an emphasis on connection as a solution to the conundrums imposed by it, innovative methods to connect arise throughout medical practice, not only COVID-19 practice. The rise of telemedicine, attributed to necessitated practice modifications, results in more effective personalized attention, with accessibility to communication and facilitated communication with family and patients.[254] Physicians can now meet their patients with the "quality of care that is empathetic rather than for the bells and whistles (ineffective treatments, unnecessary testing), a hint at the silver lining of the pandemic for patients needing access to care, and continuity of care.[255] Thus, communication with patients and patients' families has become possible through tele media. Ideally, the incorporation of empathic, engaged practice, though challenged by

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253 J.A. Marcum, "Emotionally Detached Concern or Empathic Care," in *Humanizing Modern Medicine: An Introductory Philosophy of Medicine*, 259. It is worthy to note that this concept of devotion really reinforces the practice of medicine as vocational, which in turn, supports oath taking to guide identity formation.

Further explained, "Taking care of" can be boiled down to the legalistic 'due care," while "caring for…includes an empathic or emotional engagement."

254 Physicians without the traditional office distractions—interruptions, door openings, computers, etc.

255 Ezekiel J. Emanuel and Amol S. Navathe, "Will 2020 Be the Year That Medicine Was Saved? The Coronavirus is Forcing Reforms That Could Change America's Health Care System Forever if Congress Requires It," *New York Times*, April 14, 2020; Sara Heath, "How Will COVID-19 Change Patient Experience, Healthcare Delivery?" *Patient Engagement HIT*, May 18, 2020, *https://patientengagementhit.com/news/how-will-covid-19-change-patient-experience-healthcare-delivery#:~:text=COVID%2D19%20has%20sparked%20a,trends%20Press%20Ganey%20has%20discovered.*

geographical distance, would necessarily adjust to fit the medium. Additionally, the focus on connection is evident in the gathering of teams of doctors, nurses and medical students that become *Family Liaisons* or *Family Engagement Navigators* for hospitalized patients.[256] Alongside an emphasis on connection, this adaptability is a major theme even in non-COVID pandemic practice. Doctors even offer *curbside visits* to meet the need for care of some patients.[257] Hospitals and physicians meet the unparalleled intensity of the pandemic clinical crisis with the same intensity in innovation and redesign of healthcare provision. One Boston primary care physician put it this way:

> Organizations are working on what it means to do a good job, what it means to give patients peace of mind, when realistically, they can't. And that required a chance in how clinicians delivered services. Healthcare is reframing what it means to take good care of people. . . . Care is getting better because of [the effect of the pandemic] and it's because we have been thinking about nothing except meeting people's need. It is becoming clear this is how healthcare should have always been practiced.[258]

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256 Kasey Grewe, "Headlines Don't Capture the Horror We Saw," *Atlantic*, December 6, 2020, https://www.theatlantic.com/ideas/archive/2020/12/new-york-doctors-know-how-bad-pandemic-can-get/617302/.

Stephanie Parks Taylor, Robert T. Short, Anthony M. Asher, Rashmi Muthukkumar, and Pranavi Sanka. "Family Engagement Navigators: A Novel Program to Facilitate Family-Centered Care in the Intensive Care Unit During COVID-19," *NEJM Catalyst* (September 18, 2020), https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0396.

257 A. Pawlowski, "Older Patients Are Putting Off Routine Care: How to Help Them Get to a Doctor: Tips to Avoid Becoming 'Medically Isolated' During the Outbreak," *Today.com*, April 1, 2020, https://www.today.com/health/coronavirus-telemedicine-doctors-help-older-americans-keep-medical-appointments-t177332.

258 Sara Heath, "How Will COVID-19 Change Patient Experience, Healthcare Delivery?" *Patient Engagement HIT*, May 18, 2020, https://patientengagementhit.com/news/how-will-covid-19-change-patient-experience-healthcare-delivery#:~:text=COVID%2D19%20has%20sparked%20a,trends%20Press%20Ganey%20has%20discovered.

FOLLOWING THE YELLOW BRICK ROAD: JOINING THE JOURNEY

The changes resulting from the pandemic are not limited to improvements to the healthcare delivery system or clinical practices. The long-term effects of pandemic transformation have yet to be measured. One effect is certain: the medical profession is in a place of admiration in its service of humanity. As of January 2021, medical school applications had surged by over 25% and doctors and nurses have been pinned as the heroes of our time.[259] By December 2020, Stanford University reported a 50% jump in applications.[260] What is evident is that the pandemic inspires confidence in joining the cause—the fight against disease. This fight against disease is not just against COVID-19 but also the disease of *societal injustice* perpetuated by gaps in healthcare. Through the pandemic, the nation continues to struggle with and grieve the societal injustices embedded in the current model of health care delivery: accessibility gaps and social determinants of health. The nation notices how these injustices manifest in the higher mortality rates and how they continue to impose a death sentence upon those in those groups. The American Academy of Medical Colleges notes that:

> Applicants are motivated to get out there and fix societal problems. They're saying, "I need to do something to make this country more equitable, and I think the best way for me to do that is through medicine."[261]

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259 Stacy Weiner, "Applications to Medical School Are At An All-Time High: What Does This Mean For Applicants and Their Schools?" October 22, 2020, https://www.aamc.org/news-insights/applications-medical-school-are-all-time-high-what-does-mean-applicants-and-schools; Jon Marcus, " 'Fauci Effect' Drives Record Number of Medical School Applications," *npr.org*, December 7, 2020, https://www.npr.org/2020/12/07/942170588/fauci-effect-drives-record-number-of-medical-school-applications.

260 Jon Marcus, "'Fauci Effect' Drives Record Number of Medical School Applications," *npr.org*, December 7, 2020, https://www.npr.org/2020/12/07/942170588/fauci-effect-drives-record-number-of-medical-school-applications.

261 Stacy Weiner, "Applications to Medical School Are At An All-Time High." *aamc,org* (October 22, 2020), https://www.aamc.org/news-insights/applications-medical-school-are-all-time-high-what-does-mean-applicants-and-schools.

The nationally celebrated Dr. Anthony Fauci agrees that the pandemic represents a call to action for young applicants, much like the war efforts of the past.[262] Having struggled for truth-telling during a presidential administration that much of the time attempted to abscond with it, Fauci is a figure of scientific trust, responsibility, and integrity in medicine. This 'Fauci Effect' honors the responsibility and roles one takes to help a cause. Honored, Dr. Fauci explains that this 'Fauci Effect' is:

> The effect of the physician who is trying to and hopefully succeeding in having an important impact on an individual's health, as well as on global health . . . a responsibility not only to yourself, but as an integral part of society.[263]

Time and training will develop young professionals' intentionality of practice and determine whether their "desire to serve their fellow humans with empathy, compassion, and altruism" survives the confrontation with "a [medical training] culture that sometimes seems to value detachment, self-interest, and objectivity."[264]

THE FUTURE OF PRACTICE: HAS THE PANDEMIC FORCED A RECALIBRATED FOCUS?

Contemporary medical practice is nestled in a distressed medical system entangled in moral pluralism, and multiple notions of patient-care models and clinical approaches to professional duties and care. Yet the pandemic brings the medical profession back to the

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262 Dr. Anthony S. Fauci is a physician, scientist, director of the National Institute of Allergy and Infectious Diseases (NIAID) and medical advisor to the President of the United States, https://www.niaid.nih.gov/about/anthony-s-fauci-md-bio.

263 Jon Marcus, "'Fauci Effect' Drives Record Number of Medical School Applications," *npr.org*, December 7, 2020, https://www.npr.org/2020/12/07/942170588/fauci-effect-drives-record-number-of-medical-school-applications.

264 Bryan et al, "Medical Ethics and Professionalism: A Synopsis for Students, Residents and Practicing Physicians," 19.

core of caring. Redefining how to care, daily the world witnesses clinicians acting in solidarity, doing their part, as vulnerable as their patients to the relentless effects of the COVID-19 virus and pandemic. Clinicians move to fulfill their oath to care, and in considering the complexity of life and in their patients' moment of illness, they welcome, hold, and care for their patients. But most importantly, together with their patients they bear witness to suffering and stand in solidarity with them against the COVID-19 virus. Showing relationality, clinicians attune to their patients' world seeking to understand how to care for each. In tune with their patients and the mission of medical practice, together they seek healing. In their resilience, clinicians show the world what it means to care for others, themselves, and their society. They show the practice of *good medicine* in a way that defies scientific medicine and understanding.

Life and medical practice are dynamic. When discerning how to act and when to act, and in considering the limits of medical science and the fragility of human condition, sometimes professing to heal means to just to show up and be in the moment. The most healing action from the doctor may be to honor the sense of loss and grief of the suffering other, filling the moment with presence. Thus illuminated and driven by the pandemic's multidimensional grief, there remains ingrained in blood, sweat, and tears that maxim of a century ago that *the secret to the care of the patient is in caring for the patient*. As the true healing practice of medicine, caring is the practice of good medicine; it is the embodiment of medical virtue in contemporary times restoring the loss meaning in the medical encounter.

It is clear that the COVID crisis awakens the call to care for health professionals. But as health professionals continue to rise to the challenges of medical practice in

responding to their call to care, society and the profession settle into a new normal and only time will tell whether this emerging protocol is here to stay. As the first year of COVID-19 life becomes part of our past it is worthwhile to consider what can be expected from a post-COVID-19 future, after living through the emotions, discomfort, challenges to practice, and the call to care—with all issues and emotions that have been exposed because of it.

It is certainly true that this year of loss and disruption unmasks questions of the adequacy of certain medical practices, but this year has also brought out the best in the medical professionals caring for those in need. An emerging protocol based on the more humanistic relational practice sustained these professionals at a time when the brilliance of science was caught off guard. As a humanistic medicine became the cornerstone of pandemic practice, one question remains: has COVID, indeed, saved the soul of medicine and rescued the spirit of practice?

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Vita

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