# LEST WE FORGET: THE ART OF MEDICINE

By Kurt J. Isselbacher

I believe it is a valid assumption that most students applying to medical schools wish to become physicians because they look forward to caring for the sick with empathy and compassion and to be of benefit to mankind. In their altruism, they view their future role as healers who endeavor to provide comfort and support to those in need.

Unfortunately, in the last three or four decades and perhaps even earlier, those goals and aspirations seem to diminish and even disappear as students traverse their medical education and training. And as they emerge as bona fide physicians and finish their residencies, it is often hard to detect signs of their original altruism.

What accounts for this remarkable change from their original aspirational goals? What has happened to the motivation to become a compassionate healer? Although the individual physician may not be aware of this transformation, regrettably the change has become real and lamentable. In that context we have witnessed a gradual shift from medicine as a profession and calling to more of a business with doctors labeled "providers" and patients frequently referred to as "clients" or "consumers".

The practice of medicine goes back to the 5th century BC and to Hippocrates, considered to be the father of western medicine. In those times and for centuries thereafter, it was the art of medicine, not science that "cured" patients. In fact, it is noteworthy that the "Hippocratic Oath" being sworn to by physicians states that there is "art to medicine …and that warmth, sympathy and understanding may outweigh the surgeon's knife or the chemist's drug". [1]

In that context we should recall that patients have benefited by the ministrations of priests, rabbis or other faith healers as well as by

[1] Luis Lasagna, (1964), "Hippocratic Oath – Modern version", PBS Broadcast: pbs.org. wgbh.nova/doctors/oath_modern.html.

shamans, sorcerers and witch doctors. What is their secret? It is the power and aura of authoritative figures and the effect of their positive pronouncements. As long as patients place their trust in them, their proclamations provide comfort and sometimes even a cure.

Today is no different. Patients seek reassurance, support and guidance from their physicians, irrespective of the nature of the disease or its prognosis. Without it patients will feel adrift, as if at sea without a navigation system.

The art of medicine and its practice is developed by those who have an intrinsic desire and commitment to the healing process. It is a skill obtained by observation, apprenticeship and training. It is sharpened, fine-tuned and nurtured by experience. For the art of medicine to be applied effectively and with salutary results requires the establishment of a fundamental rapport between doctor and patient. It must be a relationship built on trust, confidence and mutual respect; whether this is possible often becomes evident at the first encounter. The physician must convey that personal distractions have been put aside and all attention and focus is on the patient's medical problems. How is this achieved?

An effective and thorough probing of a patient's physical as well as emotional issues requires time. Yet this is the very ingredient that is currently being shortchanged. Our medical system greatly undervalues the time devoted by the primary care physician (PCP) in evaluating the patient's illness, yet it compensates well financially for procedures and tests because they can be quantified. As a consequence, and as a means of responding to this inequity, the PCP on his or her own or at the request of the employer will see more patients per unit of time and hence has less time for any given patient. The result leads to dissatisfaction for both patient and physician.

Time is also critical for being able to listen effectively to the patient. It is a truism in medicine that listening to the patient may provide the diagnosis. Listening involves not only a thoughtful assessment of the patient's spontaneous comments but it also requires a careful questioning and probing of the symptomology. It should be a process

devoid of prejudgment and one that inspires confidence. In so doing the physician conveys concern and empathy.

The physical examination should be careful and complete with care and concern for the patient's modesty. However, in today's medical economic climate and with its commensurate time pressures, the physician will tend to curtail this examination, elect not to pursue his own inquiry in depth and frequently opt to refer the patient to a specialist, perhaps even before the underlying illness is adequately explored. At the same time laboratory tests and imaging studies will be ordered in an effort to expedite the diagnostic process and to compensate in part for a hurried history and suboptimal physical examination.

Yet a thorough physical examination is as valuable today as it was in the past. We know that the physician may observe subtle and even crucial findings often not revealed by a barrage of tests. Consider the importance of finding evidence of spider angiomata suggesting cirrhosis, palpating the "water-hammer" pulse of aortic regurgitation or finding abnormal proprioception in a patient with macrocytic anemia.

It is also important to emphasize that when tests or procedures appear to yield unusual or surprising results, the physician needs to consider whether these may represent artifacts or possible errors in interpretation before the findings are accepted as valid.

After analyzing the clinical data, perhaps the most critical aspect of the doctor-patient relationship depends on how the physician's diagnosis and treatment plan is communicated. The impact on the patient surely will be based not only on what he or she is told but on how the information is presented. Consider, for example, that the initial results suggest that the patient has breast cancer. A blunt and direct approach stating that "I believe you have breast cancer" will sound like a death knell to most women, no matter how stoic they are. It is better to consider phrases such as "there is something on your mammogram that suggests cancer, but we can't be certain until we obtain more information". The difference is slight but real. I am always amazed

how some physicians elect to transmit 'bad news' in a very insensitive manner. There is every reason for us to soften the blow when we express negative findings for the first time. We need to let the possibility of an adverse outcome or bad news first 'sink in' or be 'incorporated' into the patients psyche and then let the patient ask us for more details.

The totality of bad news can wait; it doesn't have to be delivered as a blunt instrument; and when it is presented, room should be left for hope and some potential for a positive outcome.

In the past, there were some who chided physicians for being negligent in 'truth telling'. It was suggested that we will be remiss in our duty as physicians if we hold back critical data or do not 'tell all'. However, I believe we should not impose information on a patient but rather provide it when asked and then to impart the data as sensitively as possible.

Finally, one of the most important aspects of patient care involves nonverbal communication, especially the laying on of hands. Touch is considered one of the most fundamental means of contact with our environment.[2] It is vital in childhood development as it provides feelings of safety and security; it serves many similar and other functions in nonhuman primates. We see evidence of its power in Michelangelo's Sistine Chapel portrayal of God's finger reaching out to give life to Adam.

We regularly witness the display of high-fives and hugs as ways to show support as well as sharing joy in achievement. So also in the practice of medicine, touch is a potent tool to be used and fine-tuned with experience. The physician's gentle touch on an arm or the squeezing of a shoulder conveys a message of support, compassion and sharing. Such simple tangible acts tell the patient, "I care".

Knowledge of the scientific basis of medicine is essential for arriving

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[2] M. J. Hertenstein, R. Holmes, M. McCullough and D. Keltner, "The communication of emotion via touch", *Emotion* 9 (2009): 566.

at the correct diagnosis and prescribing objective treatment. However, the ability to convey compassion, empathy and inspire trust is critical for the healing process. In fact, the healing process is incomplete without the application of the art of medicine.



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