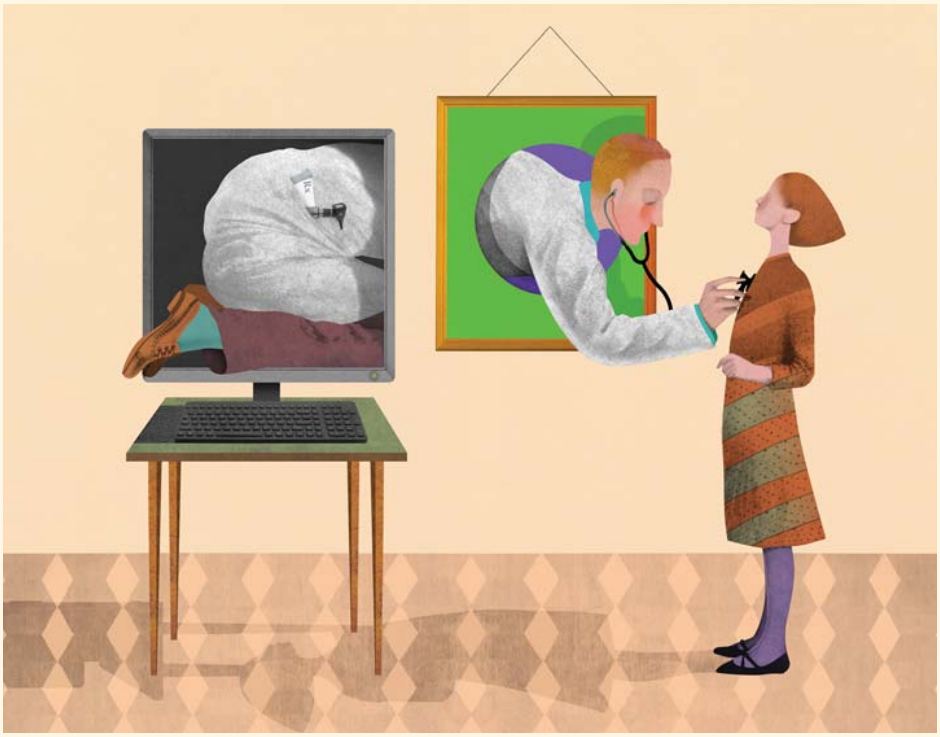

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The Importance Of Being

Good patient care is found not on a computer screen but in being truly present with patients.

BY ABRAHAM VERGHESE

Recently a colleague asked if I would address a small, informal quarterly gathering of hospitalists. We settled on a date, and when she asked me for a title for my remarks, I offered: "Presence."

From the pause on the other end of the line, it was clear she seemed to think there was more to follow—a subtitle perhaps, without which the word seemed to dangle.

"Just 'presence'?"

(I'd been doodling on the paper in front of me, trying it out.)

"Yes," I said. "Presence, period."

On the paper, the period seemed critical. (I'm reminded of the precocious boy-narrator in an Isaac Babel story who says, "No iron can pierce the human heart as icily as a well-placed period.") My period asked me, the reader, to stay with the word—to be present. No subtitle. Just: Presence.

The idea of "presence" had its origins for me in a parking lot not far from my office at Stanford University and near one of my favorite spots on campus, the Rodin Sculpture Garden. In walking past Auguste Rodin's *Gates of Hell*, a massive pair of bronze doors inspired by Dante's *Inferno*, I'm consciously or subconsciously reminded to seize the day. In the past year, I'd watched construction on a unique building in the same vicinity. The signage said it was to be the home for the modern art collection of one family, the Andersons, who were giving the collection to Stanford. From a distance, it looked like a cake box sitting on a narrower and well-lit square pedestal.

It occurred to me that the intent of the university and of the Andersons might be that the collection should not only enhance our lives as viewers but specifically enhance our lives as *educators*, even in fields far removed from art history. Fields such as my own of internal medicine and infectious diseases. In clinical teaching, I've tried when I can to link art and medicine using such iconic paintings as Luke Fildes's *The Doctor*. But with modern art, with the abstract, it feels challenging to make such a connection. In truth, modern art has always felt a little intimidating to me.

One afternoon shortly after the museum opened, on my way back to my car, I impulsively decided to walk in. It was spring. I felt brave. I imagined the punchline: "Physician walks into Modern Art Museum!" After all, this isn't a place where we routinely find ourselves, or if we do, it's not related to work. Personally, I felt my visit *was* related to work and not just by proximity to my place of work: I was here in the true spirit of an educator (so I told myself) trying to climb out of what novelist Walker Percy called the ruts of specialization, the narrow chutes of professional work and our specialized language that can leave us wearing blinders to other forms of knowledge and inquiry.

The building was suffused with natural light. There were no corridors, no rooms that led into rooms, no sense of a labyrinth. Instead it was open—the cake box sans cake. I could and did stroll around the whole thing in fifteen minutes. It was much less intimidating than, say, the Louvre, where a tourist popping in for a few hours (after standing in line for a long time) can come away overwhelmed, feeling the mind has been shrunk instead of expanded. And yet the compact space (by museum standards) held a who's who of modern art: Jackson Pollock, Mark Rothko, Willem

Illustration by Brett Ryder

de Kooning, Wayne Thiebaud, and many more. Iconic names. I had a vague *cognitive* knowledge of that kind of art but no experience. Just as I might know who RuPaul is, or 50 Cent or Amy Winehouse—but don't ask me to hum a tune.

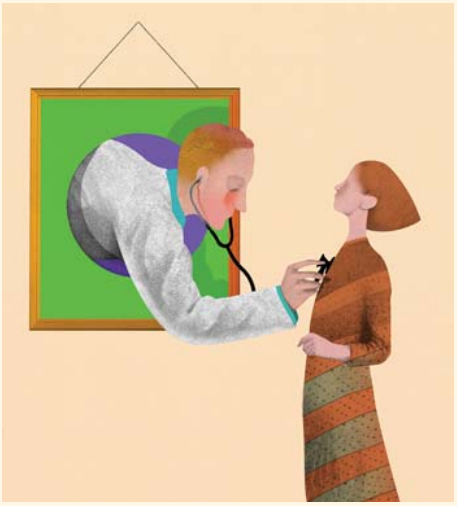
I was pleased with myself after my visit. Whatever fears I had (about being grilled about my knowledge by docents, or scrutinized by security guards, or finding the art to be opaque and mysterious) were unfounded. The place was inviting and friendly.

From then on, I made it a practice to stop in.

It was in the repeated visits that I began to recognize and relate to certain paintings and sculptures. If I imagined myself to be a crude but sentient probe being sent into orbit around an unknown planet, then in my loop, my antenna received different and discrete stimuli. I was surprised to find I didn't really care for "funk" art. Even though funk art is "figurative"—featuring recognizable things such as fish and words—I wasn't drawn to it. Not yet anyway. My reaction was the opposite: to hurry past.

But I found myself seeking out the bench in front of Pollock's *Lucifer* and Rothko's *Pink and White over Red*. The scientist in me recognizes my bias here: These are well-known artists, their works the jewels of the collection, and the benches strategically placed. Still, I believe it was more than that: I was also responding to the inherent appeal of these paintings, even though the words to explain why didn't come easily.

On Thursdays I have the great privilege of making afternoon rounds with the three chief residents in internal medicine at Stanford Hospital. They often have a patient in mind for the four of us to see. These sessions are about reading the patient's body as a text, about bettering our skills at mining the body for all it is saying. But we make all sorts of diversions, and one afternoon, in lieu of the bedside, I took them to the Anderson Collection. I made no claim to knowledge or purpose. I wasn't the tour guide—I just walked them through a space that was new to them. In doing so, I thought of a connection to our clinical work: I drew an analogy to the phenomenon of "transference" and "countertransference" in patient care. In



psychiatry, for example, patients can develop feelings for the therapist; this "transference" is often useful for patient and therapist to dissect. "Countertransference" refers to the feelings the therapist develops for the patient, feelings that range from anger to attraction. Such feelings are normal and important to recognize in oneself, primarily so as not to act on them. Walking among these paintings and observing our responses—both positive and negative—was a means of being self-aware and attentive to a variety of countertransference.

After nearly a dozen visits, alone and with others, even though I wasn't consciously trying to relate the art to the pedagogy of medicine, I began to make connections. My tool is the medical gaze, the desire to look for pathology and connection, and it would seem there was no opportunity for that within a pigmented square of uniform color or a rectangle of haphazard paint splashes. But in me a profound and inward sort of observation was taking form.

Pollock's piece, *Lucifer*, had a manic energy, a seduction—not unlike some hypomanic people I know. (We all know them; they seem more prevalent than they really are, such is their energy.) The force was confined to an elongated rectangle against a white wall. I could imagine the frenzy of an artist standing over the canvas—no easel here—throwing paint at it, using different colors, using anything *but* a brush (turkey basters, syringes). At times I felt I was looking into a mind—*his*, or maybe mine—and seeing the neurofibrillary tangle. It was not the mind depicted in the static histology slides of medical school; it was dynamic and alive, like watching thoughts emerge from a substrate of neurons, or a dream evolving. Yet there was order in the midst of that anarchy. From a distance, the random splashes of color looked mostly black and green, and only when you got close could you see thin streaks of vibrant yellow and blue and red, which were nonetheless necessary for the energy perceived from afar. My response to *Lucifer* was far from constant; it seemed to have a connection with how *my* day had gone.

As my visits accrued, I felt much like someone returning to a city over a long time span. Each visit I noticed that I had changed, and what I observed was changing, too.

At first I had studiously avoided reading anything about the art. The rationale was this: In bedside physical exam rounds with my medical students on Wednesdays and chief residents on Thursdays, I ask that if at all possible, the physician or the student who knows the patient, and is bringing us to visit, *not* tell us anything medical about the patient—especially the diagnosis. This isn't so we can be clever and deduce this on our own but rather to ensure that on these rounds (which are not about management, but observation) we are not biased by a label. We can read the body as a sacred text being opened for the first time. Labels such as "cirrhosis" or "endocarditis" can blind us to what else is on display. Similarly, with the paintings, I had wanted to experience them without bias. Now that they were becoming familiar, I read about whatever work caught my fancy.

In 1956 Pollock wrote of his work:

"When I am in my painting, I'm not aware of what I'm doing. It is only after a sort of 'get acquainted' period that I see what I have been about. I have no fears about making changes, destroying the image, etc., because the painting has a life of its own. I try to let it come through. *It is only when I lose contact with the painting that the result is a mess.* Otherwise there is pure harmony, an easy give and take, and the painting comes out well."

The italics are mine. That line resonated with me because it paralleled the dystopia that is prevalent in American health care. It's the thing that is drag-

ging down the experience of patients and physicians alike: the sense of *losing contact*. More specifically, it's the sense that the intermediary of the electronic medical record (EMR) and fulfilling every "Lean" mandate has made us lose contact with our work. The result is a mess, with great unhappiness in the ranks.

Rothko's *Pink and White over Red* is a square of a beautiful and vibrant red with a long, horizontal pink rectangular slit at the top, like the slot in the door of a speakeasy as depicted in a noir film—the opening through which the bouncer checks you out. It's the sort of painting that when I was young and ignorant I might have been tempted to dismiss. ("Big deal, I could've done that." The older me might have replied, "Yes, but you would never have thought of it.") But having learned to sit with the painting, to be present, I viewed it differently. It seemed to represent my interior space, what I see on the back of my eyelids when I close my eyes, the image still etched with the glow of the window through which I was gazing. It is soothing. It is the womb. It is emotion. It is pre-consciousness.

In the most cursory reading of Rothko, I came across this:

"If you are only moved by color relationships, then you miss the point. I'm interested in expressing the big emotions—tragedy, ecstasy, doom."

And:

"Art is an adventure into an unknown world, which can be explored only by those willing to take the risks."

Forgive me if I felt he was speaking to me personally, rewarding me for being brave enough to drop in from the parking lot and engage with his work. There was also pointed instruction here. If we were to substitute the word *medicine* for *art*, his aphorism would read:

"Medicine is an adventure into an unknown world, which can be explored only by those willing to take the risks."

Being with patients, being *present* and willing to engage directly in the manner they most want is a form of risk. The representation of the patient in the EMR (the iPatient, as I call it) is necessary. But being with the iPatient too long is a guaranteed way of *not* being present with the actual patient. It can even begin to feel safer and simpler to be present with one of the many "enchanted objects" around us—computer screens, tablets, and smartphones—than with human beings. Perhaps this is what I most want to teach at the bedside: not the causes of low sodium or the latest sepsis protocol. Or not *just* that (and besides, odds are you can find that online in a flash). I want to teach the art of being present. That, as Rothko says, is an adventure into a risky, unknown world.

I want to teach the art of being present. That, as Rothko says, is an adventure into a risky, unknown world.

I look back and think of patients long gone, particularly patients in the early AIDS era, who were young men for the most part at a time when I too was a young man. Was I present? They were full of the ripening of life, full of desire and longing and ambition, at a time when I too was full of those things. I wanted to "do" for them, to fix what ailed them. I wanted to be busy with them in a medical way, even though in those days we had no effective HIV medications and there was nothing we could do to change the course. I would examine them, because that was what I knew to do, and that ritual, with its laying on of hands, conveyed an important message to the patient that they would not be abandoned. The absence of any treatment also taught us physicians powerful lessons. I learned from my physician assistant, Della, a warm and caring woman who felt less of the pressure to *do*, and instead could just *be*. I remember her cajoling me to make more home visits. Once as we walked in to see a patient who was hours from exiting the world, I said, "What are we going to do here, Della?" She said: "We are going to be with him."

As the German philosopher Martin Heidegger said, sometimes words and speech (and action, I might add) are just a way of forgetting our being or that of the person we are dealing with. I don't think I got it then. I get it now.

Recently, while on rounds with my students, we visited with a patient whose mother was in the room. They were both so gracious, and as ill as he was, he was generous in allowing us to examine him, to focus on aspects of his illness that had little to do with management but were purely to educate the students. Once we were in the hallway, I asked the students if they had noticed anything special about the mother. They had not. And yet the mother had vitiligo, a condition that strips the skin of pigment, a patchy process at first that eventually results in no pigment anywhere for most people with the disease. While it had no bearing on the son's condition, it was a striking observation because the son had darker skin and the mother was almost white. Had we entered as true beginners without homing in on the label "patient," they might have seen it too.

That sense of starting with a blank slate is a feeling I relish. It has become harder to come by. Increasingly, students have a "flipped" patient experience, where a "new" patient is someone they have already met in the computer, having read all their labels *before* seeing them in the flesh. It is as far from the blank canvas as one can get.

My colleague Alexander Nemerov, an art historian and Stanford professor, recently gave the "First Lecture" at the university—an occasion when all thousand-plus Stanford freshmen gather in Memorial Auditorium on their first academic day to hear from a chosen faculty member. In his lecture, Nemerov spoke of Helen Keller, who at nineteen months experienced a febrile illness and subsequently lost sight, hearing, and therefore speech. She was in darkness until a remarkable teacher, Anne Sullivan, came into her world.

Nemerov described his visit to the Keller home in Alabama, and to the now-famous water pump on the property, as if visiting a shrine. There, after months of struggling to teach Keller language through signing, Sullivan had held the young girl's hand under the flowing liquid of a hand pump and repeatedly signed out the word "water" in her palm. Suddenly, she broke through. The child understood, as Nemerov says, that the "word and the world could almost magically be the same thing."

I resonated with the image of Keller at the pump. It seems to me that our efforts as teachers are encapsulated in that mo-

ment: Our job is to allow the student to "see" in this way, to open up their world.

What is it I want my students to see? I want them to see the signs of disease, the phenotypic manifestations of disease that get buried by the hype around genotype. I want them to see that the outline of a cigarette packet in the shirt pocket of a male patient tells us much more about the patient's risk of sudden death than anything in his genome. So much of diagnosis is to be found in the history and the physical, which in turn guides us to order tests more judiciously. Those visits to the bedside with my students every Wednesday and Thursday—guiding hands to feel spleens and eyes to observe neck veins—are like putting their palms under the water pump, allowing them to feel and connect.

Beyond that, there is another kind of seeing that is even more important. Disease is easier to recognize than the individual with the disease, but recognition of the individual whose care is entrusted to us is vital to both parties. There are some simple rules: First, we must go to the bedside, for that is where the patient is. It's a vital and simple step, but harder than it looks. It simply isn't possible for the patient to feel recognized and cared for when they feel unattended; the fact that their data is getting a lot of attention in a room full of computer monitors where doctors sit does not satisfy. The gravitational forces of the hospital are always pulling us away from the patient to a screen, and it is not our doing. We are chained to the medical record, and every added keystroke adds another link in the chain. We must be unchained.

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Second, when we go to the patient, it follows that we must *listen*, and we must examine with skill. The patient's disease is not located on an image in the computer, nor on a histology slide, nor in numbers of body chemicals—it is located in or on their body. To touch the place that hurts, to examine the body, is to affirm the locus of their illness.

Third, one must revisit and revisit, as few things are completely revealed at the first encounter.

The crisis in health care—spiraling costs; inequities of care; the abysmal incentives for primary care; the paucity of geriatric care when our population is aging; physician depression, dissatisfaction, and attrition—offer no easy solutions. There are a few things that are timeless in medicine, unchanged since antiquity, which we can keep front and center as we bring about reform. One is the simple truth that patients want us to be more present. We as physicians want to be more present with the patient, as well, because without that contact, our professional life loses much of its meaning.

It is a one-word rallying cry for patients and physicians, the common ground we share, the one thing we should not compromise, the starting place to begin reform, the single word to put on the placard as we rally for the cause.

Presence.

Period. ■

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