

Dr. Vergheze, who directs the Center for Medical Humanities and Ethics, holds the Joaquin Cigarroa Jr. Chair and is the Marvin Forland Distinguished Professor of Medicine. In 2005, he was appointed Master of the American College of Physician and also elected to membership in the Association of American Physicians, a distinct honor since the group is almost uniformly basic research scientists and indicative of the fact that his writing and teaching related to internal medicine of the past 15 years have become mainstream.



Q&A

with **Dr. Abraham Vergheze**

Abraham Vergheze is guided by a philosophy that places great value on stories in teaching his students.

“Stories help you understand the past and they teach us valuable lessons. I believe that, as physicians, we become involved in the stories of our patient’s lives, sometimes as witnesses telling the story through a medical chart. At other times, we become players in the story. Many physicians, through books they have written, have told stories that have helped the rest of us and provided insights we may never have had without them.”

This philosophy is also embraced by Native American poet and writer, Leslie Marmon Silko, who has drawn on traditional stories and legends and her tribal ancestry in her widely published poetry, essays and fiction.

“The old stories still have, in their deepest level, a context that can give the individual a possibility to understand,” Silko said in an interview about her first novel, *Ceremony*. Without stories, “We have to suffer through and have to learn again.”

Q: Why have a course in humanities at a medical school?

I believe that including the humanities as an integral part of the medical curriculum is vital in helping students maintain empathy with their patients. Students come to medicine with a great capacity to imagine the suffering of others.

Then, as they enter their clinical years, students are taught to take the patient’s unique story of illness and translate it into the formal language entered into the chart. The student may hear a patient say, “the pain started at four in the morning and it immediately reminded me of my father because he died of cancer and it began with a similar pain. I called my sister in Washington and she was worried too and she suggested I take a hot bath...”

But what the student records in the chart is not the voice of the patient, but the voice of medicine, a formal language important for diagnosis and that sounds like this: “This 47-year-old white female developed the acute onset of left flank pain eight hours prior to admission...” This language is essential for diagnosis, but the danger is great that students may begin to think of their patients as simply the “diabetic foot in bed two,” the “myocardial infarction in bed three” or the “chronic renal failure in bed five.”

Through the humanities — literature, art, theater, and film — we can keep the students’ imagination of the suffering of others alive. Fiction is, as novelist Dorothy Allison said, “the great lie that tells us the truth about how the rest of the world lives.”

The voice of the patient is often beautifully captured in fiction and asks the reader or the listener to use what Joanne Trautman, a pioneer in the field of medical humanities, called “that



high faculty that involves thought and feeling in a visionary way, the faculty we call imagination...a sort of leap” to another human, to a patient, into ourselves, to those places where “our values and beliefs are made, stored and often unexamined,” as Delese Wear, who writes about human values in medicine, puts it.

Q: Keeping students’ imagination alive sounds like a good idea, but what advantage is there for a patient?

What we are preserving is the capacity to imagine the suffering of patients. One of the major causes of patient dissatisfaction with doctors is the failure to communicate caring, failure to truly place themselves in the patient’s shoes.

A Harvard Medical School survey of 2000 people last year showed that 12 percent had considered changing doctors because of bad communication. And a recent article in the *Journal of General Internal Medicine* asserted, “The quality of communication between physicians and patients is frequently identified as a critical factor in optimal medical care.”

Quite simply, having a doctor sensitive to and aware of a patient’s suffering makes for better medicine. As Dr. Francis Peabody said almost 80 years ago, “the secret of the care of the patient is caring for the patient.”

Q: Isn’t managed care to blame for a lot of poor doctor-patient interaction? Aren’t doctors’ hands tied by the constraints of these programs?

This could be true to some extent, as could the fact that medicine has become so technologically complex that it is rare for a single physician to provide care for a very ill patient. This makes it all the more critical for us to be empathetic and aware of suffering even when our interaction with patients is limited.

The organizational aspect of medicine, with its regulations, paperwork and need for time efficiencies, threatens and competes with the caring side of medicine. Our role is to keep the balance and emphasize the caring side of medicine.

Q: How can humanities courses play a role in helping medical students and, ultimately, their patients?

I have a deep personal belief that the humanities allow students to examine the changes they are undergoing, helping them explore their motivation and giving them a forum to express what they are feeling. The medical school experience is truly quite unique and it tends to transform the individual, not always for the better.

For example, the highest suicide rates in all the professions are among doctors, lawyers and dentists and the rate is about twenty-fold higher than that of the general population. For women physicians it’s even higher than male physicians — at about 41 per 100,000 population vs. 12 per 100,000 for total female population, according to the American Medical Association.

The phenomenon of suicide, as well as the incidence of drug addiction among physicians, reflects the tremendous stresses individual doctors are subjected to and the changes students undergo during medical training.

Q: Why is there so much distress in what should be a rewarding profession?

We can only speculate. We theorize that when students enter their clinical years and witness the kind of carnage one sees in a general hospital, there are not many avenues for them to talk about what they feel.

In fact, until recently, the macho culture of hospital training programs actively discouraged students from revealing they were affected by anything they saw. The result is physicians often numb themselves against what they see. In the process, they also numb themselves to their own emotional distress. When they become sick, they deny their “patienthood” and focus on a symptom and self-medicate. This was one of the topics I dealt with in my book, *The Tennis Partner*. I saw this situation first-hand — it happened to a friend.

Q: Is use of humanities a trend in medical education?

While many medical schools have had ethics programs in place for some time, it’s heartening to see a growing and serious focus on making the humanities an integral part of the curriculum also. The emphasis on humanities is, I think, a unique feature of our Center. When we teach ethics, we try to do so in the context of narrative and stories rather than teaching it in a didactic fashion.

I should emphasize that humanities and ethics curricula can only go so far. Too often students hear two messages: one, a formal curriculum that emphasizes compassion and caring, and then they see the “hidden curriculum” reflected perhaps in the manner in which doctors behave poorly toward each other, toward nurses and toward their patients. In short, the best means of teaching students ethics and humanities is by exposing them to the caring physicians on our faculty who live this example.

Dean Wartman, for example, sees patients in our downtown clinic every week. President Cigarroa takes weekend transplant calls and still performs transplants. It is inspiring for the



students to see their commitment to service. We have to practice what we preach.

Q: You often talk about the link between physicians and storytellers. Why?

As physicians, we become involved in the stories of our patients' lives, sometimes as witnesses telling the story through a medical chart. At other times, we become players in the story.

Many physicians, through books they have written, have told stories that have helped the rest of us and provided insights we may never have had without them. I think of Somerset Maugham, Conan Doyle, Ethan Canin...

One very fine example is John Berger's, *A Fortunate Man*, where he follows an English country doctor and sees him change from his almost transactional mode of dealing with medical emergencies and serious illness to engaging himself with his patients over the years and inevitably becoming part of their stories.

Q: You've talked about the use of literature, but how else are the humanities utilized?

The range is great, as the humanities creatively use the performing and visual arts and literature to address such varied topics as death and dying, pain, aging, diverse cultures, patient narratives, spirituality and medical ethics. Tess Jones excels in using these other media to bring understanding in these difficult areas.

For example, the film and the play, *Wit*, is an important way to convey end-of-life issues. Beyond the curricula, electives expand the basic offering, enabling students to pick courses and research topics that suit their particular specialty or interest.

Q: What immediate results will be apparent in medical treatment, if any?

We speculate that a broadly educated physician is a better physician and we would like to prove it. Our task is not so much to inculcate empathy, humanity and ethical conduct in the student, but simply to keep alive their innate humanity, integrity and empathy.

There is no doubt that literature, the performing and visual arts, film and poetry, all allow us to better understand the human experience. For a doctor, this means he or she will be able to understand and empathize more deeply with a patient's life and suffering.

Q: Were you trained in this way?

Not formally, no. The good news is that most of us, though we are radically changed by training, eventually return to the former versions of ourselves — return to our “pre-cynical” phase, if you will.

I have a personal and deep interest in writing and literature, and many of the arts. It has been a great advantage to me as a physician, and in the last few years, it has been gratifying to see medical schools reach out to the humanities.

And I believe strongly that study of the humanities provides a more resilient background for handling the many conflicting viewpoints in medical care in the United States. It's important, too, in helping increase sensitivity in a time when average life expectancy has increased significantly even in the past 10 years, and when advances in medicine can sustain life far beyond the level envisioned in the past.

Personally, I was inspired by Somerset Maugham's novel, *Of Human Bondage*, to become a doctor. I think, as students read patients' stories about grief or pain, as they read about the frustrations of aging or disease, or as they read doctors' accounts of errors they have made or of their own suffering, they can only develop a keener understanding both of their profession and their own impact on the people they will treat and care for.

