



Louise Stone
Jill Gordon

A is for aphorism

‘Wherever the art of medicine is loved
there is also a love of humanity’

Keywords

aphorisms; proverbs, medicine; art; humanity

He was an amazing diagnostician. He could listen to the history and then with this long, pointy, bony finger he'd say, "So, what do you think was significant in that bit of the history? What did you feel there as you examined the abdomen? Did you look at this here? Have you seen these?" But he was a very warm person too – just so caring.

Years after the experience, this senior doctor remembered with fondness and laughter a clinical teacher from her junior years. She described someone who seemed to exemplify the Hippocratic aphorism 'wherever the art of medicine is loved there is also a love of humanity'. But is there any evidence that those doctors who love the art of medicine also love humanity, or is the art of medicine just 'romantic rhetoric – a nod in the direction of humanitarianism'?¹

The American cartoonist Charles M Schulz had a way of nailing this kind of problem. In a 1959 *Peanuts* cartoon, Lucy laughs at Linus when he tells her he wants to be a doctor. She responds by shouting at him: "You could never be a doctor! You know why? Because you don't love mankind, that's why!" Linus thinks for a moment, before shouting back: "I love mankind... it's people I can't stand!!" His response captures a feeling familiar to us all. It's so easy to love in the abstract, so difficult to love in the particular.

Arthur Frank, in his book 'The Wounded Storyteller', describes stories that our Western

culture tends to use around illness.² One of these stories he calls the chaos narrative. 'Chaos' describes a situation where there is layer on layer on layer of problems 'that go down to the bottomless depths'. Solving one problem uncovers another and another and another. Patients in chaos manage their lives one overwhelming day at a time. General practitioners who help these patients to navigate their difficult life course say it is like gardening in a swamp: it is challenging, messy and has the potential for great despair.³

Our aphorism links the art of medicine with a love of humanity. For the sake of the discussion, we should assume the love of humanity involves a love of individuals, so that we are willing to trudge through the swamp in order to help them manage their lives one difficult day at a time. Loving humanity involves choosing to value each person who presents as a patient.

But what exactly is the art of medicine? In 1979, Avedis Donabedian wrote extensively, if indirectly, about the 'art' of medicine. He believed that quality of care is based on creating the right structures, implementing the right processes and identifying the right outcomes. He describes quality care as a blend of technical and interpersonal skills that together create the art of medicine.⁴ His article is clear, but dry. We come much closer to the force that motivated his impressive career when we consider the words he spoke in an interview towards the end of his life:

"Systems awareness and systems design are important for health professionals but are not enough. They are enabling mechanisms only. It is the ethical dimension of individuals that is essential to a system's success. Ultimately, the secret of quality is love... If you have love, you can then work backward to monitor and improve the system."

A true artist requires talent but also commitment to the mastery of his or her craft. Each artist must love their art enough to master their craft. Therefore, the

art of medicine involves learned skills; it involves the capacity to synthesise complex webs of data: cognitive understanding, emotional perception and professional intuition. Medical care involves practical wisdom: the ability to take evidence and synthesise and particularise it to get the best outcome for this patient at this time, taking into account all the contextual richness of his or her life. The art of medicine, and the people whom medicine serves, are inextricably related.

It is therefore difficult, perhaps impossible, to conceive of the art of medicine without recognising the importance of human understanding and an ethical commitment to care. Bruce Newton, a neurobiology researcher, has made some suggestions about why this might be the case. He asserts that quality care requires doctors to have the capacity for emotional empathy (the ability to feel with another's experience) and cognitive empathy (the ability to think oneself into another's experience).⁵ Newton cites a series of research studies that mapped levels of moral reasoning versus expressed empathy over childhood, adolescence and young adulthood.^{6,7} It seems that empathic responses even in pre-school years correlate highly with altruistic behaviour in adulthood. Interestingly, there is also evidence that while empathy erodes in the medical student and early clinical years,⁵ it does so more rapidly for those choosing specialties that are less person centred, such as radiology and pathology. So when the opportunity to practice the healer's art is lost, the love of humanity can diminish.

Newton also discusses how empathy needs to be regulated in specific circumstances. For instance, a surgeon may need to cause pain and suffering, switching off their emotional reactions in order to 'get the job done' for the patient's long-term benefit. Doctors may also need to override other negative feelings, such as prejudice or dislike, which can sour the therapeutic relationship. Most doctors have days when they struggle with the burden of patient suffering, trying to provide humane and sensitive care without becoming overwhelmed, burnt out or callous. Newton calls this 'role-playing empathy'. It is difficult work, requiring commitment as well as skill.

Donabedian knew that positive therapeutic relationships and patient-centred care are

associated with better patient outcomes.⁸ Greenhalgh and Heath^{9,10} provide a neat summary of the qualitative and quantitative evidence around the therapeutic relationship: trying to define what is 'good' about this aspect of quality care. They conclude that the relationship is difficult to measure, but we must accept there is a balance between not measuring this aspect of quality at all and distorting the picture by capturing only part of its essence. In the end, they encourage clinicians to choose to deepen their art by undertaking a therapeutic relationship audit. This involves asking such questions as 'are my therapeutic relationships as good as they possibly could be?'; 'What attempts have I made to reflect on or improve the humanistic or relational aspects of my job?' These are active choices: the 'loving' of the art.

The art of medicine includes attending to feelings, extending our cognitive models of the way people think and behave, and incorporating patient preferences. It sometimes involves the difficult moral choice to detach from or engage with suffering. The principle of distributive justice requires the fair allocation of not only physical but emotional resources, in order to provide 'the greatest good for the greatest number'. The most difficult task for the physician is how much to 'harden their hearts' to achieve the best outcome for each patient and all the patients that follow. To continue to serve humanity, physicians must be detached enough to 'do what has to be done' while still demonstrating the unconditional positive regard patients need to endure their suffering. This means choosing to provide quality, person-centred care, no matter what you feel at the time.⁵

Perhaps it is in choosing and reflecting on this balance of calculated and sensitive care, the active loving of the art of medicine, that we achieve the most humane outcomes for our communities.

Authors

Louise Stone MBBS, BA, MPH, DipRACOG, FRACGP, FACRRM, is a PhD candidate, Centre for Values, Ethics and the Law in Medicine, University of Sydney, NSW. dr.louise.stone@gpet.com.au

Jill Gordon MBBS, MA, MPsyMed, PhD, FRACGP, FASPM, is Associate Professor and Research Associate, Centre for Values, Ethics and the Law in Medicine, University of Sydney, NSW

Competing interests: None.

Provenance and peer review: Commissioned; not peer reviewed.

References

1. Saunders J. The practice of clinical medicine as an art and as a science. *Med Humanit* 2000;26:18–22.
2. Frank A. *The Wounded Storyteller: body, illness and ethics*. Chicago: University of Chicago Press, 1997.
3. Stone L. On botany and gardening: diagnosis and uncertainty in the GP consultation *Aust Fam Physician* 2012;41: 795–98.
4. Donabedian A. The quality of medical care: a concept in search of a definition. *J Fam Pract* 1979;9:277–84.
5. Newton BW. Walking a fine line: is it possible to remain an empathic physician and have a hardened heart? *Front Hum Neurosci* 2013;7:233.
6. Eisenberg N, Fabes RA. Empathy: Conceptualization, measurement, and relation to prosocial behavior. *Motiv Emot* 1990;14:131–49.
7. Eisenberg N, Fabes RA. Prosocial behavior and empathy: A multimethod developmental perspective. In: Clark MS, editor. *Prosocial behavior. Review of personality and social psychology*. Thousand Oaks, CA, US: Sage Publications, Inc, 1991;327.
8. Stewart M. Reflections on the doctor–patient relationship: from evidence and experience. *Br J Gen Pract* 2005;55:793.
9. Greenhalgh T, Heath I. Measuring quality in the therapeutic relationship - Part 1: objective approaches. *Qual Saf Health Care* 2010;19: 475–78.
10. Greenhalgh T, Heath I. Measuring quality in the therapeutic relationship – Part 2: subjective approaches. *Qual Saf Health Care* 2010;19:479–83.

correspondence afp@racgp.org.au