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With Stillness and Solidarity

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From the Editor

With Stillness and Solidarity 1109
Jeremy Weleff, DO

Case and Commentary

How Should Clinicians Ally With Patients Whose Health Is Unlikely to Be Improved by Even Numerous Clinical Encounters? 1112
Adam T. Perzynski, PhD and Kurt C. Stange, MD, PhD

How Should Clinicians Own Their Roles as Past and Present Exacerbators of Health Inequity and as Present and Future Contributors to Health Equity? 1121
Lisa M. Lee, PhD, MA, MS and Anita L. Allen, JD, PhD

Decision Aids, Doorknob Moments, and Physician-Patient Solidarity in EDs 1129
Emily Shearer, MD, MPP, MSc and Jay Baruch, MD

Medicine and Society

Empathy and Calm as Social Resources in Clinical Practice 1135
Carter Hardy, PhD

For Clinicians to Do Less, Organizations Must Do More 1141
Pallavi Juneja, MD

Solidarity in Mortal Time 1149
Helen Stanton Chapple, PhD, RN, MSN, MA

Why Money Is Well Spent on Time 1155
Michael R. Ulrich, JD, MPH

Mindfulness Reminds Us What Health Care Is For 1161

Mindy Thompson Fullilove, MD and Marisela Gomez, MD, PhD, MS, MPH

History of Medicine

Does Osler's *Aequanimitas* Inform Our Contemporary Pursuit of Stillness? 1166
James B. Young, MD

Art of Medicine

Solidarity, Origins of the Hospital, and Transformational Ghastly Imagery 1172
D. Brendan Johnson, MTS and C. Phifer Nicholson Jr

Why Would Having Learned to Cope While Waiting for This Appointment Make This Pain Normal? 1181
Julia O'Brien

Podcast

Human-Centered Design and the Sounds of Solidarity: An Interview With John Meyer and Eve Payor

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FROM THE EDITOR

With Stillness and Solidarity

Jeremy Weleff, DO

The *AMA Journal of Ethics* has a long history of exploring unique and important roles of physician activists who stood up against systems of power that were in some way dangerous, oppressive, or unjust to individuals or groups that need and deserve protection and solidarity. The January 2004 issue, "Physician Activism," and the September 2014 issue, "Physicians as Agents of Social Change," were good examples, and this issue continues this thread of exploration.

Alliance building and activism can promote improved conditions for persons not well served by health care systems by co-creating social policy, community-based participatory research, and arts-based health promotion projects. Such stances of carefully considered solidarity and resistance to tokenism aim for equity, sustainability, and mitigation of health inequity generated in health systems that, in their current states, seem adrift and out of touch with those these systems are obliged to serve.

Many medical professionals find themselves in morally distressing situations, caught between doing what they believe is the right thing and having to be complicit in a structurally problematic system of health care delivery. They are not taught to ignore the inequalities they bear and witness but are placed in a system in which they may feel powerless to change them, have too much work to complete anyway, and are often disincentivized to speak up. Physicians who do stand up for injustices sometimes do so at their own serious personal risk—to their career, their finances, and sometimes their own personal safety.[1,2]

Nevertheless, in recent years, unrest, protests, and uprisings about class and race conflict have compelled many health professionals to take action, question structures of power, and stand in solidarity with communities facing oppression. These professionals have stopped what they were doing to speak out against and stand up for patients suffering health inequities in their many forms. In doing so, they have interrupted the typical, busy flow of events and taken positions of stillness to allow for the examination and questioning of the current (possibly unsustainable) model of health care delivery.

What does stillness look like? Taking the time to be still or slow down is the first step in serious ethical contemplation that leads to deliberate, sustainable action. Stillness is a set of actions needed for taking balanced, fair, and just action. It is also seen in the

whistleblower who loudly calls for an immediate stop to ongoing injustice or unfairness. It is seen in moments of silent remembrance and moments of defiance. It is the power of the sit-ins and stand-ups of protest. The fast pace of health care delivery, the use of technology in patient care, and the additional administrative burdens placed upon physicians threaten the ability to be still, slow down, and listen—simple therapeutic acts within the doctor-patient relationship that allow for alliance building and shared decision making and, when extended, support the doctor-community relationship (or health care system-community relationship). Most of these acts and practices allow for solidarity and allyship and are often at the intersection of health and politics.

Moving into a state of stillness, or slowing down, often comes at a cost. These acts are a threat to the fast-paced, profit-focused systems of "health" we inherited. Those who slow down face the resistance of a powerful bureaucracy that prioritizes productivity and wants to continue to churn at an ever-quickening pace. In this fast-paced world, the hospital and clinic became part of a "medical industry" and, in order to support such a system, individual physicians were "tasked" with taking on its expansion—seeing more patients, doing more procedures, and doing it all faster than before—which, unsurprisingly, led to increasing attention being paid to burnout and suicide within the medical profession.[3,4]

This theme issue examines the roles of stillness and slowing down as both a means to and an end of improving the delivery of health services at all levels—in the individual patient encounter, in the community, or for populations. Stillness and solidarity are stances that can move medical professionals at all stages of their careers from talking about to standing up for equitable redistribution of goods and services, restorative justice, and reconciliation. This theme issue also addresses the ethical questions surrounding stillness and the responsibilities of individual clinicians, medical educators, health care professionals, health care institutions, researchers, and policymakers to challenge the current pace of the "medical industry" and stand in solidarity to act on social needs and injustice in its many forms.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Clinicians Ally With Patients Whose Health Is Unlikely to Be Improved by Even Numerous Clinical Encounters?

Adam T. Perzynski, PhD and Kurt C. Stange, MD, PhD

Abstract
Patients experiencing homelessness and mental illness face conditions and circumstances that deserve focused ethical and clinical attention. The first commentary on the case applies insights from qualitative research about social determinants of health to these patients' care and dignity. The second commentary describes 3 kinds of power wielded by physicians—charismatic, social, and Aesculapian—each of which is considered in terms of whether and to what extent physicians' power should be owned, aimed, or shared.

Case

JJ is a 27-year-old man with schizophrenia, who is brought to the clinic by staff members from a local shelter. JJ does not adhere well to his antipsychotic medication, has experienced several inpatient psychiatric civil commitments and other encounters with numerous clinicians in the region's health care system, and does not have reliable access to shelter, food, water, or hygiene. You, JJ's caregiver in the clinic right now, empathize with him, staff from the shelter, and others trying to help JJ avoid poor health outcomes for which he is at such high risk.

You refilled JJ's medication and reviewed his laboratory values, but you know there is little you can do for JJ that can counter the myriad and well-known social determinants undermining the effectiveness of even the most skilled intervention any clinician could offer JJ during a clinical encounter. You wonder how to make the most of this moment you have with JJ on his life journey.

Commentary 1

by Adam T. Perzynski, PhD

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Recent years have seen dramatically increasing levels of health care system interest and investment in addressing social factors in primary care.[1,2] Some of this interest is driven by growing recognition of the immense financial expense and squandered human

potential associated with social inequity in examination rooms.[3,4] Social needs screening, referral, and coordination among social service organizations have demonstrated potential to fill some social care gaps in primary care settings.[5,6,7,8,9,10,11] However, the number of patients helped by these interventions is still somewhat limited. For example, one study found that, of 848 patients screened who had food insecurity and wished to be contacted, 98 (12%) had their referrals ultimately resolved by a local food bank.[11] Other work has further exposed the need for improved communications with patients[12] and the severe limitations of high throughput workflows.[8,13] An entire industry of startup companies and entrepreneurs is developing technologies around the promise of integrated care for patients with unmet social needs,[14] but health technology for this purpose needs to further reinforce solidarity and shared well-being.

JJ seems very familiar to health workers; the social, psychological, and disease challenges faced by the most vulnerable patients cared for in clinics, hospitals, and emergency rooms are daunting. Beneath the snapshot of his clinical encounters is a rich personal history involving relationships, events, places, passions, and the vicissitudes of life's fortunes and misfortunes. Present, but possibly not accounted for, are JJ's personal triumphs and tragedies. JJ's case helped me to reflect on my 2 decades of work with colleagues conducting qualitative interviews and listening closely to the concerns of persons who have various combinations of serious mental and physical health challenges.[14,15,16,17,18,19,20,21,22] I've talked with baseball fans about their diabetes control and the staggering weight gain they had from their antipsychotic medications.[20,21] Men who love yoga and meditation shared with us their fears and personal struggles after having a stroke.[15,16] Medications that caused weight gain or fatigue meant they could not lift what they needed to or stay awake and alert enough to make it through an 8-hour night security shift in the warehouse.[16] My own and others' research has found that patients' not taking medicine was occasionally due to clinical care teams' affronts to their personhood or patients' suspicion that prescribers' motives were financial rather than beneficent.[15,22,23,24,25]

How Stillness Moves Us Toward Solidarity

The stillness of a medical encounter in some ways is not still at all; time is short in busy clinics. Private talk about deeply personal needs, however briefly, can move our encounters with patients—especially those experiencing homelessness—beyond the often morally hazardous conditions on the outside of the examination room toward solidarity. Stillness can move us toward trust and the health benefits of trusted relationships. Even steep barriers to trust in clinical encounters can be surmounted with the simplest of "common ground" approaches—simply finding out what we share with one another.[26] When our experiences and those of the people we serve do not align, we can maintain solidarity with their suffering and offer our love.[27]

I remember an interview with a woman experiencing homelessness who told me about how she was raped the first night she had to sleep in a bus shelter. This woman's story came as a shock to me; I had simply asked her a question about why it was sometimes difficult to take her medicine for her bipolar disorder. Sometimes it just wasn't a high priority, she explained. Days before our conversation, she had received 3 new sets of clothes from a church group, but the clothes, the bag they were in, and her medicine were stolen at the shelter. She explained that she wanted to take her medicine, but she didn't always have it with her.

We felt solidarity in that particular moment because both of us felt ashamed, powerless, and a bit broken. Both of us were glad to have someone to talk to within the gray, air-conditioned walls of the clinical research unit, but nonetheless we experienced the fear and the trauma of those events—I, vicariously—when just talking about them. It's through this lens that I write with concern for JJ and what will happen to him and others in our tightly choreographed systems of social care. The social needs screening questions used at MetroHealth ask:

1. Have you worried your food would run out before you had money to buy more?
2. Were you unable to pay the rent on time?
3. Have you been humiliated or emotionally abused by your partner?

Qualitative inquiry has found that patients are generally appreciative of the opportunity to fill in the care team and possibly receive assistance with some of their needs.[28] Nonetheless, some vulnerabilities are so overwhelming that our patients struggle to contain their tears before they finish answering even one of the questions. The tables and figures on the social determinants of health can seem like a disservice to the truth of the challenges faced by our patients. How can we confront these challenges while preserving the dignity of patients like JJ? At times I'm frustrated with the safe, climate-controlled halls of the health care system, having commuted from the suburbs and a house with an overflowing pantry. As others have pointedly asked[29,30]: Who is this safe setting really for? I hope JJ feels safe in the clinic. I want him to. If he were my patient, I would consider whether I'd asked him lately how he feels about this place and his experiences here. JJ's case and every encounter with a vulnerable patient can be viewed as an opportune reminder for all members of clinical teams to anchor their efforts to meet instrumental health and social needs in a foundation of interpersonal, narrative humility and an unwavering respect for dignity.

Commentary 2

by Kurt C. Stange, MD, PhD

One of the most gratifying clinical teaching encounters is when a resident raises the exasperated question, "Why does this patient keep coming back to see me? I'm not doing anything for him!" So many clinical teaching episodes, like the clinical encounters they mirror, are transactional—linking symptoms and signs to diagnoses and using those diagnoses to launch evidence-based treatments. Those evidence-based treatments are based on the average effects of treatments in clinical trials in which selection and randomization make individual differences and social context inapparent to allow us to focus on a single factor.[31,32]

But, like JJ's schizophrenia, which is exacerbated by medication nonadherence for a complex mix of reasons, most health problems aren't caused by a single factor. The causes of suffering, disease, and illness—and even explanations of opportunities for healing—are multifactorial and multilevel, from the molecular to the societal.[33,34] Our efforts to put people's problems in neat little boxes give us a sense of control that often is out of touch with the complex contexts of people's lives and the possibilities for care that extend beyond delivering "commodities" of narrow diagnoses and treatments to the possibility of holistic healing.[35]

We should be aware of what our patients do and don't want from us. Patients do not come to serve as data for quality and performance metrics that sometimes provide

useful guidance but often serve to financially incentivize us and to wrest control of our motivations to be personal physicians and healers.[36,37] Moreover, patients do not come to gratify our egos as healers. For many patient conditions, we do not provide a cure; many patients coming to hospitals and to primary care, especially those age 45 and older, have multiple chronic illnesses of which we are witnesses and that we help palliate.[34,38] In talking about healing, patients say that they would like a cure, if possible, but when that is not possible, they want someone to stick with them on the journey.[39] They want someone to help them to transcend their suffering.[40]

Fostering Healing

In analyses of in-depth interviews of physicians identified as excellent healers on the basis of their scholarship, reputation, and awards and of their patients thought to have experienced healing,[41] my colleagues and I discovered that healing relationships require certain competencies in the physician: self-confidence, emotional self-management, mindfulness, and knowledge. Healing relationships also embody practices of valuing, being present, sharing power, and abiding. *Valuing* means actively appreciating patients in a nonjudgmental manner, regardless of their level of functioning, social situation, ethnicity, or life circumstances; such appreciation adds value to care over time, even when the care is ostensibly "futile." *Being present* means paying caring attention, witnessing, and empathizing with patients' suffering and joy. *Sharing power* means respecting patients as experts about themselves and leveraging trust and respect to encourage changes that support patients' health. *Abiding* means sticking with patients, providing continuity of caring over time, accompanying patients during crises, and ensuring that patients know we will not give up on them even if we are not able to provide a cure.

Enacting these competencies and healing practices leads to relational outcomes of hope, trust, and a sense of being known.[41] Healing practices impart a sense of stillness and solidarity within and between practitioners and patients.[42,43] Martin Buber described these kinds of connections as "I-Thou" relationships,[44] which are characterized by dialogue and mutuality and fundamental to healing; such relationships contrast to "I-It" relationships, which aptly apply to commercialized, commoditized, impersonal features of US health care.[45]

With my colleagues, I have conducted further analyses of the interviews used to identify the competencies and healing practices, which show that patients' healing journey is full of stops and starts.[46] In the middle, it often looks like a failure. But through personal and relational persistence, patients who have a sense of safety and trust can move from being wounded and suffering to developing diverse healing relationships based on kindness and unconditional love. This experience leads to reframing of suffering, taking appropriate responsibility for healing, and positivity that sometimes help the person to transcend their suffering and circumstances and find meaning, purpose, and often generativity, or the emergence of interconnections between relationships and resources that foster hope and "a sense of wholeness and integrity that constitutes healing."[46]

Higher levels of care that involve integrating and prioritizing care, abiding, and assisting in transcendence of suffering[47] are neither recognized nor supported by the current organization of health care, which measures and supports basic care of acute and chronic disease, preventive service delivery, and mental health care. Our fragmented, depersonalized, greed-driven system actively works against providing these higher levels of care.[35,48] The mismatch between what clinicians know we can do to help people in a

relationship over time and how we are organized, rewarded, and punished in the current reductionist, commodified health care system is a major source of moral distress and burnout for clinicians and of loneliness, fear, and despair for vulnerable patients.[49,50,51,52,53] My colleagues and I have recently developed a patient-report measure based on careful analysis of what patients and clinicians say is important in health care.[54] Such a measure can be used to refocus the attention of clinicians, patients, and the health care system on what matters.

Understanding and Using Physicians' Power

Howard Brody identifies 3 kinds of physician power: charismatic (based on personal characteristics, such as character and charisma), social (based on our societal and community status), and Aesculapian (based on our knowledge of medicine). He asks us to consider whether our power is owned, aimed, or shared.[55] As physicians, we can engage in personal reflective practices[42,43] and share our power with patients by abiding as witnesses[45,46,56,57] and being available for teachable moments when healing is possible.[58,59,60] We can own our larger professional responsibility to address societal inequities that cause illness and suffering.[61] We can band together in professionalism[62,63,64] rather than in narrow self-interest to work toward a system that invests in relationships, measures what matters,[37,54] and supports healing and health.[65,66]

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Clinicians Own Their Roles as Past and Present Exacerbators of Health Inequity and as Present and Future Contributors to Health Equity?

Lisa M. Lee, PhD, MA, MS and Anita L. Allen, JD, PhD

Abstract
To improve health outcomes, the science and practice of medicine must move quickly in response to new information. Yet, in other important ways, health professionals must operate slowly and in a mode of intentional stillness to center empathy and light a path from empathy to solidarity. Solidarity, or standing with, prompts efforts to create circumstances in which disadvantaged communities can achieve health equity. This article argues for intentional stillness and solidarity to inspire ethical conduct and structural change. In the case presented, inaction and delay, which are neither virtuous nor antiracist forms of stillness in this context, would leave intact the status quo of disparity and inequity in cardiac medicine.

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Be still my soul the Lord is on thy side
Bear patiently the cross of grief or pain
Leave to thy God to order and provide
In every change He faithful will remain
Be still my soul thy best, thy heavenly friend
Through thorny ways leads to a joyful end
Katharina Amalia Dorothea von Schlegel[1]

For years now I have heard the word "Wait!"... There comes a time when the cup of endurance runs over and men are no longer willing to be plunged into an abyss of injustice when they experience the bleakness of corroding despair. I hope, sirs, you can understand our legitimate and unavoidable impatience.
Martin Luther King Jr[2]

Case

You are a cardiologist and researcher investigating outcomes after coronary angiography and percutaneous coronary intervention at a large academic health center (AHC) as part of a multisite, longitudinal study. Among patients who are part of a regional cohort of

patients who came to the AHC's emergency department with chest pain, many were confirmed to have elevated troponin levels, indicating myocardial infarction (MI). Several years of data consistently reveal, and now definitively confirm, that Black patients living close to the AHC are more likely than White patients to experience poorer outcomes (ie, increased mortality and hospital readmission).

You suspected your AHC's data would express racial and ethnic inequity patterns similar to those revealed throughout the country, so you are not surprised by what the final data reveal. The data's conclusiveness seems now to have new urgency for you, however, given widespread racial and ethnic health inequity throughout the country during the COVID-19 pandemic and those years' social, cultural, and political upheaval. Your impulse is to share these data with colleagues, despite your fear that a recently launched public relations campaign by your AHC could spur reprisals. You feel urgency about responding justly to your many individual patients of color; you wonder whether responding justly means sharing with those patients and the community what you know about inequitable cardiac care where you practice. You also wonder how your own cardiology practice has contributed to and continues to contribute to inequity.

You are aware of the need to act quickly, as you expect to see some of your patients during what remains of the week. You are also aware of the need to act thoughtfully and deliberately, to try to be part of a long-term solution to a long-term problem. You consider what to do next.

Commentary

The science and practice of medicine must move quickly in response to new information to improve health outcomes. Yet, in other important ways, health professionals must operate slowly and in a mode of intentional stillness to center empathy and light a path from empathy to solidarity. Solidarity, or standing with, prompts efforts to create circumstances in which disadvantaged communities can achieve fulfilling ends, including health equity and long, happy lives.

Whether one acts quickly or slowly, race is salient, as racism is a key backdrop in our changing society and a considerable social determinant of health. Local data obtained by the researcher in this case mirror national trends and outcomes in cardiac medicine that exemplify health inequities experienced by Black Americans. In particular, persistent disparities and inequities in cardiac health and health care affect Black patients of all ages.[3,4,5] Black infants are more likely to die of congenital heart diseases.[6] Compared to White people or to all other groups, Black people are 2 to 3 times more likely to die of preventable heart disease and stroke, to lack adequate access to specialized care, and to suffer kidney complications following a heart transplant.[7,8,9,10,11] Cardiac care and research—including on outcomes after coronary angiography and percutaneous coronary intervention—take place in a context of persistent race-associated health and health care inequity.[12,13] Achieving racial equity in cardiology and health care more generally will require new degrees of active collaboration among stakeholders and intentional antidiscrimination and antibias practices.[13,14]

At present, however, health research, clinical practice, and health care administration take place in contexts marked by what ethicists characterize as overlapping forms of personal, institutional, and systemic racism.[15,16,17] In 1997, the prominent philosopher Charles Mills described a centuries-old and still-prevalent "racial contract" to maintain people of color in subordinated, disadvantaged positions.[18] Scholars working in a critical

race tradition have, since the 1980s, emphasized that the interests of African Americans take a back seat to the interests of White Americans unless they happen to converge with White interests[19]; that traditional civil rights laws have not eliminated the special vulnerabilities of Black people burdened by the legacies of slavery and legally enforced segregation[20]; and that listening to the voices and stories of marginalized communities is a critical path forward in policy and practice.[21]

Recognizing that the force of history countermands unguarded optimism, we argue that virtuous intentional stillness, which can give rise to empathy and lead to prosocial action, is one vehicle through which to help build the necessary solidarity among groups and systems with proximity to power and privilege, on the one hand, and groups suffering health inequities, on the other. Empathy resulting from intentional stillness in turn generates solidarity, which can then motivate and inspire ethical conduct and structural change.

Intentional Stillness

Western philosophers since Aristotle have depicted patience, prudence, modesty, and reserve—what one might call the "stillness virtues"—as counterweights to the vice of reactive temerity inconsistent with goodness and sustainable flourishing.[22] Stillness virtues facilitate reflection, thoughtfulness, self-awareness, consultation, and planning.[22]

Stillness as a vice, however, amounts to harmful complicity or complacency. We speak of civil rights movements—confrontational strategic action—not civil rights *stillnesses*. In the context of cardiac medicine, complacent inaction and delay are neither virtuous nor antiracist forms of stillness, making it more likely that cardiac medicine will continue to contribute to persistent disparities and inequities in health and health care. However, systemic problems are not amenable to solutions dependent upon solitary efforts of single individuals, especially individuals who have been disempowered and under-resourced by an oppressive system.

It is particularly morally problematic to impose expectations of stillness on Black Americans, for whom stillness has been preached as a virtue appropriate for a submissive race of putative moral and intellectual inferiors and their superiors. In a popular hymn, a sufferer exhorts the soul to "be still" and "bear patiently the cross of grief or pain," leaving it to God "to order and provide."[1] The stillness that provides a balm for agitated souls—including Black souls—removes the pressure from society to right wrongs and exploits the vulnerabilities of people turning to patience and higher powers for their hope. This type of stillness asks the exploited and vulnerable to silently bear inequity to prevent discomfort of those who perpetuate a complex system that creates unjust outcomes. It is a failure of beneficence and justice to ask communities affected by racism, homophobia, and other inequities to be slavishly still as elites and institutions continue in stillness and complacently place self-interested priorities first, at times even falling prey to self-deception and representing that what is good for them must be good, ethical, and even God's will.

Here we define intentional stillness as quietude and thoughtfulness. For clinicians, reflection and critical thinking about moral intuitions can be a tool to help them gain a fuller understanding of the lives of patients whose lived experiences are different from their own. Critical reflection conducted with intention and openness can foster empathy, defined as a deeper understanding of and emotional engagement with others that leads to genuinely altruistic social behavior.[23,24] Intentional stillness is a practice that

decenters one's own experience to make room for critical reflexivity—which Stella Ng and colleagues define as a process of examining social structures of power, position, and embedded social structures that privilege one group over others—to better appreciate the experience of others.[25] It is an initial step toward building genuine empathy, which can mobilize people to act even when they do not stand to benefit from that action.[26]

For clinicians, intentional stillness requires a break from the rush of daily tasks as well as an openness to reflecting emotionally, intellectually, and morally on the existence of an entrenched and complex system of structural oppression, the role of medicine in perpetuating health inequity, and the profession's responsibility to contribute to a more equitable future. Intentional stillness can be an individual effort pursued through activities similar to meditation and mindfulness or a group effort with a guided version of a technique such as Schwartz Rounds®, a "slow intervention" that provides facilitated discussions for health care teams on clinicians' moral experiences and humanity in medicine.[27] Evaluations of such activities reveal gains in personal insight and empathy, resulting in prosocial behavior and organizational change.[27,28] Empathy serves as a pathway to solidarity, which is necessary for structural change.

Solidarity

Arguably one of the most highly valued prosocial behaviors undergirding social change, solidarity is an altruistic behavior that involves "standing with." Solidarity, as Jean-Jacques Rousseau described, results in common injuries (or common benefits), as "one cannot injure one of the members without attacking the body, and still less can one injure the body without the members being affected."[29] This definition aligns with Onora O'Neill's concept of "solidarity among"[30] and is based on a shared sense of *we* stemming from features that bind a group together.[30,31] In addition to Black political solidarity[32] and within-group commitments to addressing problems created by collective action or inaction,[31] we see solidarity as a moral duty requiring between-group recognition of common humanity, akin to O'Neill's "solidarity with,"[30] whereby people with power reconstruct systems in recognition of the worth of all human flourishing.

Solidarity is a vehicle for collective and individual justice, as it reflects "a basic need to stand in particularistic relationships with others" in order to achieve societal conditions necessary for individual flourishing.[33] In Felipe Santos' framing, "caring about" is rooted in empathy and generates solidarity and collective action.[26] Collective action takes several forms, including caring for, which is necessary to address needs created through faulty policy.

In sum, collective action to improve health equity can arise as a result of a strong sense of solidarity and between-group commitment to humanity stemming from empathy, which is developed through intentional stillness and critical reflexivity.

Moral Obligation to Release Study Findings

In our case scenario, a strong sense of solidarity—of standing with persons and communities whose time, efforts, and bodies made the research possible—motivates the moral responsibility to share study findings. The professional and practical implications that give the institution pause about releasing the data are understandable, but they are outweighed by at least 3 ethical motivations for sharing the data, which are revealed through reflection on ethical principles that is facilitated by intentional stillness and the sense of empathy and solidarity that result. First, there is an ethical duty to

share the knowledge because it has been gained through public sources of funding—the public pooling its resources for public benefit. Ethical principles such as reciprocity, gratitude, and accountability support the view that results of publicly funded research should be shared with the public. Second, there is a duty to share because a community's members have participated in the research. Reciprocity and respect for persons and communities as ends in themselves support the disclosure of research findings to those who took on research risks for the benefit of others. A third justification for sharing the data—supported by beneficence, nonmaleficence, justice, and solidarity—is that research results ought to be shared with all those persons and communities whose health and wellness can benefit from knowledge gained, regardless of funding sources and research participation.

Clinicians recognize the obligation to provide care according to the individual needs of each patient. After hundreds of years of building an inequitable health system in the United States that has resulted in persistent health disparities for people of color, it is clear that even with a focus on the needs of individual patients, systemic biases continue to fuel health disparities. It is incumbent on all of us in the health, science, and technology sectors to dismantle the systems and structures that propagate health inequities and mistrust. Solidarity plays a necessary, albeit insufficient, role in achieving this goal. A clinician-researcher who stands in solidarity with a community of Black research participants and patients, such as the one in the case scenario, should recognize their moral distress at the suggestion of withholding research data that could benefit Black cardiac patients, especially if the main reason for doing so is fear of bad publicity or institutional disapproval. Self-interested fear is incompatible with solidarity that stems from empathy. It is, instead, a sign of complicity and complacency. Withholding knowledge resulting from research data is a failure of scientists' social responsibilities to generate knowledge that supports human flourishing. Moreover, suppression of scientific evidence has been criticized as dishonest, lacking in respect for colleagues and the law, and a failure of good stewardship.[34]

The pace of justice, equity, and inclusion has been unjustifiably slow, as thoughtfulness of care, accountability, and deliberative community engagement by those with the power and resources to effect change have been lacking. Intentional stillness resulting in empathy that in turn ignites solidarity can help medicine begin to move toward more just and equitable care for all of us.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

Decision Aids, Doorknob Moments, and Physician-Patient Solidarity in EDs

Emily Shearer, MD, MPP, MSc and Jay Baruch, MD

Abstract
Potential benefits of decision aids and technology, such as artificial intelligence, used at the bedside are many and significant. Like any tools, they must be used appropriately for specific tasks, since even validated decision aids have limited utility when they are misapplied, overly relied upon, or used as a substitute for thinking carefully about clinically and ethically relevant questions. Patients are more than data points in human form, as they come to emergency departments with stories. As technology casts ever-lengthening shadows over patient-clinician interactions, a key question is: *How should clinicians cultivate relationships with technology so it functions in solidarity with patients?*

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Case

Something does not sit right about this emergency department (ED) patient. His asthma flare-ups have brought him to the ED multiple times for shortness of breath, despite escalating asthma medication interventions by his pulmonologist. The emergency medicine intern, who is a few months into her training, listens to his lungs. He's wheezing, but mildly. His symptoms could fit an asthma exacerbation, but he appears comfortable. Does asthma explain his visit to the ED? Could it be a pulmonary embolism (PE)? What about risk factors for heart disease?

The intern knows a senior resident physician will ask for her differential diagnosis. The patient's heart rate is over 100, so a common decision tool validated for use with patients at low risk will not rule out PE.[1] She considers ordering a d-dimer to further stratify his risk for PE. He could have underlying pneumonia, so she orders a chest x-ray. There's also a clinical decision rule for assessing the 6-week likelihood that a patient like this one (eg, with symptoms suggesting an acute cardiac syndrome) will experience an adverse cardiac event.[2]

The intern finishes examining the patient. Now about to leave, with her hand on the doorknob, she asks, "Sir, what do you think is causing your shortness of breath?"

He responds, “My neighbors have been trying to kill me with poisonous vapors in the air conditioning vents.”

Commentary

This case involves a patient, uncertainty, and a “doorknob moment.” Typically, we think of doorknob moments as occurring when *patients* spring new, important, and sometimes embarrassing information on their physician when he or she is about to leave. Here, however, we have a *physician* doorknob moment: just when she is about to leave, the intern pivots away from the previous diagnostic roads, opening up a new line of inquiry with different forms of data.

In this encounter, the intern correctly considers possible poor outcomes for the patient—PE and acute cardiac syndrome—and leans on risk-stratification aids to rule out the most life-threatening possibilities. This is good medicine: decision aids are typically constructed and validated on the backs of large, well-designed research studies and, as such, can help us appropriately stratify patients’ risk. We heavily rely on the scores and rules these aids provide to guide disposition decisions, consider interventions, and communicate with patients.

But decision aids are tools, and, like any tools, they must be used appropriately for the task at hand. Even prospectively validated decision aids have limited utility if our approach is off the mark, if we ask the tool to answer the wrong question, or if we rely on these tools to define our questions. When considering the role of decision aids and artificial intelligence (AI) in making decisions in the ED, we must ask: What do we want this technology to do for us? Are we using it to replace our thinking or augment it, to process data faster, or to provide something to hold onto when we find ourselves floating in uncertainty? In this situation, the real source of the patient’s distress—severe, uncontrolled mental illness—was gleaned in part by the resident’s curiosity about the human experience. How might the intern have better employed the tools at her disposal—along with her empathy and curiosity about the human condition—to better build solidarity with her patient?

Decision Aids Cannot Structure Narratives

In the scenario above, the intern’s first inclination was to respect the evidence-based approach that pervades medical education. However, her experience also underlines why we cannot simply apply decision rules without understanding when they are most helpful. Decision aids aim to cut through noise to elements of value. But making decisions about what counts as valuable data is a decision we make before we think we are making decisions.

Consider the challenges faced by AI systems, such as IBM’s Watson, which was designed to tackle health care diagnoses.[3] The challenge Watson’s designers have faced is not that Watson cannot come to a diagnosis with all the proper inputs (diarrhea + vomiting + 4 other sick relatives after a family barbeque = food poisoning), but rather that it is difficult for the new Watson system and machines like it to generate the appropriate narrative questions to “ask” patients (“Did other people at this barbeque also vomit?”) In part, this difficulty arises because, unlike human brains, AI is not very good at imagining counterfactuals[4] or emulating empathy. In other words, AI is not very good at sensing what is not there or when something is not right. AI is not capable of doorknob moments—at least not yet.

Using Decision Aids in Solidarity With Patients

Patients come to the ED with stories to tell. They're not data in human form ready to be entered into an algorithm. But finding time to listen to their stories is challenging, given that we face pressures to move as many patients as possible through the ED. Against time constraints, we are expected to be both fast and accurate, to satisfy the reductionist tendency in medicine to "find" an answer. Under the weight of competing expectations, we can be tempted to use decision aids inappropriately as substitutes for time spent with patients or as blunt instruments to simplify problems that are not simple.

This approach is problematic because, although we like to believe we reason inductively based on data and evidence, we know the human brain is in fact prone to deductive shortcuts, quickly reaching a decision and then finding the evidence retrospectively to support it.[5] In the ED, where decisions are often made on ambiguous, incomplete, and scattered information, what we choose to consider as evidence is subject to conscious and unconscious forces. And why and how we make these choices isn't often interrogated.

Moreover, if we choose to concentrate too heavily on objective data, we risk excluding the subjective data that might reveal to us what matters most to the patient. Studies show that patients often cloak their true worries. They want doctors to probe what is not said, what might be lurking between the lines.[6,7,8] They want doctors to be interested not only in diagnostics, but also in questions of why and how long will this last and what does this mean for me.[9] For physicians in overwhelming clinical environments, diagnostic tools used wrongly may become not an aid but a distraction, detracting from other forms of meaningful inquiry in the patient-physician dialogue.[10]

Wayfinding Together

Authors have used the metaphor of "wayfinding" to describe the complex diagnostic process that physicians and patients face together and the role AI that may play in it.[11] In this journey, data are acquired, next steps are pursued, new information is generated and interpreted, and so on. This is an iterative process, in which different questions arise and various destinations become clearer along the way. We, as human clinicians, drive this diagnostic journey—assisted, when appropriate, by technological aids.

But what might we lose if we become overly reliant on such aids? What alarm bells might we silence that would otherwise have cued us to change course or seek out data that seems missing? When swimming in uncertainty, how can we avoid pivoting to recognizable data points out of ease and instead use our uncertainty to trigger doorknob moments?

Consider navigation tools such as Google Maps. Before these tools, navigation was a stressful process, invoking anxiety, wrong turns, and arguments among loved ones. With these tools, navigation is easier and more accurate. But we have given up the value of being lost, the discovery to be had by finding our own way. We pay attention differently to the physical terrain when it serves as our guideposts, when it is the source of our focus and not just passing scenes outside our window. We also develop a more intimate relationship with our own mental landscape. Why did I doubt that left turn? Why was I so sure about the right at the light? Few of us would give up our navigation technology. But what we lose is our relationship with the process of navigation. There is value in friction and inefficiency, in having to think about how we are thinking under conditions of

uncertainty. This is especially true in clinical decision making, in which the destination is unknown and the process of discovery requires first identifying the signposts for our journey.

Cultivating Stillness Amid Chaos

It is easy to say that clinicians must create mental space and find doorknob moments of stillness in their practice. The reality is that it is difficult to do so in clinical medicine, especially in the ED, where time is short and interruptions and distractions are rampant. It takes mental energy for the brain to switch between tasks and regain focus, only to be interrupted again. The psychology literature illustrates the demanding cognitive toll of making simultaneous decisions under time pressures.[12,13]

The result is the innately inhuman way we move from patient to patient, with patients' entire and unique lived experiences distilled to a chief complaint and data points. Even when a patient dies, we might pay our respects with a few seconds of silence and then move on. The first author (E.S.) tells her nonmedical friends that finding moments of stillness is like iceberg hopping—even when you land a moment of stillness with a patient, you already begin to feel the ice slowly melting beneath you.

As technology casts ever-lengthening shadows over clinical interactions, the question becomes: How can we redefine our relationship with technology and decision aids so that they remain adjuncts to our relationships with patients rather than obstructions? How can we use our tools such that they help us climb up our diagnostic ladders quickly, without forgetting to check that they are up against the right walls? The ideal use of clinical decision aides requires outsourcing algorithmic-like knowledge to apps or other tools and off-loading some of our cognitive burdens, thereby making more time and space for meaningful interactions with patients. In essence, forging solidarity and stillness with patients requires developing solidarity with our technology.

Creating Space for Uncertainty

Developing comfort with stillness and solidarity is one function of the arts in medical education. The arts, for example, challenge us to become comfortable with uncertainty, instability, and constraints; to pay attention to what is said and unsaid; and to recognize how our emotions influence how we think[14] and what we notice. The arts value what we do not know as a ripe area for inquiry, valuing problem *finding* as much as problem *solving*. The arts involve a constant interrogation of intention, methods, and form.

Despite what we might think, physicians are makers, too. We make diagnoses and prognosticate, develop treatment plans, and build trust.[15] At first glance, the arts and technology might appear to be strange bedfellows, but the arts might serve an important role in fostering stillness and solidarity with our patients through use of our technologies in emergency medicine. They could do this by cultivating humility, a greater comfort with uncertainty, and an openness to various possibilities. The arts can encourage us to have doorknob moments, even when it feels like we are standing on an iceberg. They might help us recognize when we need help from technology and when the human brain and heart are enough.

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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

Empathy and Calm as Social Resources in Clinical Practice

Carter Hardy, PhD

Abstract
Empathy has been shown to improve patient care and physician well-being. However, the emotional labor involved in expressing empathy might interfere with experiencing calm, equally important to clinicians' well-being. This article offers examples of how clinical environments can bolster both empathy and calm and suggests that empathy can be expressed socially, not just individually, to build solidarity and make space for calm.

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Extended Emotions

Emotional engagements—such as empathy—have been shown to improve patient care,[1,2,3,4,5,6] physician fulfillment,[3,7,8,9] and the health of the entire care team,[2,3,6,8,10,11] and therefore they should be encouraged in clinical practice. However, these benefits must be measured against the obstacles to empathy in the structure of clinical training and practice.[7,12,13] In a profession inundated with expectations, adding more should not be taken lightly. Specifically, the emotional labor involved in empathy could hinder emotional stillness, or calm, which is the state of not being pulled by any strong emotions. The ability to experience this restorative state is equally as important to physician well-being and patient care as empathetic engagement.[14] But how can the demand for empathy be balanced with the need for calm?

One possible answer is for physicians to "extend" some of their emotions to the local environment. While there are variations on this relatively new theory—often referred to as extended mind theory—it generally hypothesizes that mental activities and contents could extend beyond the brain.[15,16,17] There are 3 ways philosophers have argued that emotions could be extended[17,18]: (1) by parity (or functional similarity between internal processes and external resources), (2) by integration of internal processes and external resources, and (3) by social approaches. Here, I apply recent research on extended emotions and recommend 3 possible changes that can be made to clinical practice to simultaneously bolster both empathy and calm: (1) the use of physical prompts, such as notes and posters (parity), (2) the integration of music, and (3) social extension of emotions across a clinical team.

Making Space for Calm

Parity approaches to extended emotion focus on how features of the environment function like cognitive processes.[15,17] Consider the way that someone with Alzheimer's may use a notebook as a reliable tool to remember important information when their memory might fail them.[15] If these patients need to remember something, like directions, they record it and reference it when needed. Clark and Chalmers argue that the notebook functions like memory and thus deserves some epistemic credit for the remembering.[15] In clinical practice, parity of memory and physical structures would be akin to the use of checklists and databases to off-load some of the labor of memorizing patient information. This approach, however, would have to work differently for emotions like empathy.

When defined as an understanding of others' mental states, empathy is an excellent candidate for extension. Empathy—both basic and narrative—can be functionally bolstered by the environment. In its most simplistic form, empathy is a curiosity about the other's experiences.[3,19] In the medical setting, basic empathy can be extended in the local environment with reminders for clinicians to ask how patients are experiencing their illnesses, thereby encouraging clinicians' curiosity even when it is lacking or inconvenient. Such reminders could include notes on exam sheets or computer prompts.

In its more complex narrative form, empathy occurs when physicians indulge the curiosity of basic empathy and co-construct narratives with patients to best understand their situation.[3,20,21] Narrative empathy does increase emotional labor, but it need not be entirely reliant on the physician. Patients can be primed to share their stories in a variety of ways, including handouts at check-in, videos in the waiting room, or posters in the exam room. In the same way that there is space for posters that say, "Ask your doctor about this medication" or "Tell your doctor about these symptoms," there could be patient guides for best informing physicians about one's experience of illness. For instance, a poster could say, "Don't forget to tell your doctor about your experiences leading up to your symptoms" or "Doctors also want to know about your emotional experiences; tell them how you feel." Such posters would help patients co-construct their narratives with their physicians for a more accurate understanding of their symptoms or condition. In this way, physical structures that provide prompts can be used to alleviate some of the physician's active focus on empathy in order to make space for calm.

Music Integration

The second approach to extended mind—integration—argues that some of our environmental resources become so integrated with us that it would be wrong to label them as separate systems.[17,22] Remove that resource, and those experiences or abilities would be either impossible or significantly hindered. For example, resources that are "tools for feeling" help us cultivate specific emotions by providing feedback, which makes them more integrative than the functional fillers of parity extension.[22]

One notable way that we integrate with the environment to extend our emotions is through music,[22,23,24] but we can also commonly do so with keepsakes and even other people.[23,25] Krueger argues that "the listener offloads some of the regulatory and emotional work onto the music—and the music thus becomes part of the extended vehicle needed to bring about certain emotions."[22] Music and listener are an integrated system when it comes to emotional regulation. Music even "mobilizes participants to act

in contextually appropriate ways,"[22] such as somber music for grieving or upbeat music for celebrating. Relying on music for emotional regulation helps us enter into desired emotional states and better recognize our current emotions. Given the importance of music to emotional life, it is not only odd but also damaging that most clinical settings are sterilely silent.

One way to bolster calm for physicians, then, would be to integrate music into the clinical environment. People already use music in spaces and at times set aside for calm, such as during meditation or a massage. However, integrating music into medicine would require some trial and error to determine what works best, since clinical practice requires periods of focus and strong, guiding emotions. As one option, calming music could be played at a low volume in all locations—from waiting rooms to exam rooms—with the volume periodically increasing and decreasing to encourage moments of calm. Alternatively, the music could be played at a low volume in most areas but be noticeably louder in break areas, indicating that those are areas for restorative calm.

Emotional Solidarity

Social extension is the most controversial approach to extending emotion, but it may be the most adaptive to clinical practice. The trick is rethinking how to attribute emotions. Consider Scheler's explanation of grieving parents.[26] Scheler argues that the grief experienced by the 2 parents cannot be properly explained as 2 different, but simultaneously experienced, emotions. Rather, it should be understood as their shared grief felt for the loss of their child.[27] The emotion is spread out between them. Other emotions can also fit this mold, belonging exclusively to neither one nor the other but rather belonging equally to multiple subjects.[18] Social extension of emotion can include large-scale examples like mass panic or small-scale examples like romantic love.[23]

In clinical practice, social extension of emotion involves rethinking the recommendation that physicians be more empathetic. Rather than interpreting this as the need for each *individual* physician to be more empathetic, it should be interpreted as the need for the clinical team to be more collaboratively empathetic. Socially extending narrative and basic empathy would, in turn, bring greater emotional solidarity to the care team and serve to make space for calm.

Narrative empathy. The construction and communication of narratives should be shared among team members. Different members of the clinical team experience the patient's story differently. Taken alone, these narratives are only partial understandings. Taken together, these partial understandings deepen empathy with the patient by extending empathy across multiple clinical professionals. Co-constructing narratives with patients likewise gives patients more opportunities to explain their perspectives and feel heard, which can itself be healing.

Basic empathy. The extension of empathy as a feeling of curiosity would be similar to grief in that it would be felt among multiple people. It would be the collective, dynamic feeling of curiosity and openness towards patients. Members of a clinical team could both (1) be open to the patient's experiences at different times and (2) help regulate group empathy by reminding members to be empathetic—whether through example or commentary.

Empathy should be encouraged among the members of a team, so that they can be better attuned to their patients' emotional needs. Rather than empathy being delegated

to one empathetic nurse who carries the bulk of emotional labor, empathy should be socially extended to all the members of the clinical team. Other emotions, such as sympathy or even calm, could also be socially extended.

Conclusion

These are only a few representative examples of how emotions could be extended in clinical practice. Despite their simplicity, each of these means could be significant in lightening physician responsibilities and for improving patient care and physician well-being. Conceiving of some emotions as capable of being extended in different ways reduces the demands on any single clinical professional, better enabling calm, if only by making space for it. More efficient use of space via physical prompts can help physicians empathize with their patients. The integration of music can help bolster the experience of calm. Finally, accepting the social extension of empathy as a shared experience and responsibility would lessen the emotional labor of any single clinical professional.

One purpose of this article was to facilitate thinking about clinical environments as essential parts of ethical behavior and experiencing calm. Future research should expand on initial applications of extended emotions to examine practical implications of both the applications suggested herein and the emotions they extend. What are limitations of narrative empathy? How should we ensure consistency when narratives are constructed by a team? When is music calming? Through questions such as these, extended emotions reveal new areas of research and ways to improve clinical environments.

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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

For Clinicians to Do Less, Organizations Must Do More

Pallavi Juneja, MD

Abstract
Medicine is defined by doing; however, bias, error, and burnout are potential consequences of speed and constant activity. On an individual level, slowing down might reduce bias; resting might reduce error; mindfulness might reduce burnout. Despite its benefits, stillness can be an unattainable privilege for some due to systems of power, including gender, race, and capitalism. In response, institutions must confront these systems and support individual clinicians through radical acts of solidarity because, just as we have fought to make doing—speaking, learning, and working—equal opportunity, so must we ensure that "non-doing" belongs to everyone.

Constant Activity as an Ethical Problem

Medicine is often described as a *practice.* This word underscores 2 critical features of medicine: the lifelong learning that is inherent to the profession and the value of experience that is gained with repetition. As such, medical "practice" entails never-ending action on the part of the physician. But constant activity does not solely offer benefit without also posing an ethical problem. Primarily, time pressures encourage fast thinking and quick decision making—whether on boards or wards—which may generate bias, error, and burnout.

Psychologist Daniel Kahneman dichotomized thinking by speed into "fast" and "slow" in his widely read 2013 book, *Thinking Fast and Slow*.[1] System 1 is described as fast: an automatic way of thinking by intuition or prolonged practice. As a medical student, board examinations simply would not be surmountable without System 1. However, Kahneman reminds us that System 1's pitfalls include impulsivity and bias. For example, board exams allow 90 seconds per question; thus, speed is an expression of knowledge. In one analysis of 2211 questions in a question bank for the United States Medical Licensing Examination® Step 1, race/ethnicity was mentioned in the stem of 20.6% of questions. However, the use of race/ethnicity was central to the case in only 9.5% of these questions; it was merely a general demographic descriptor in the other 90.5% of cases.[2] Moreover, in 51% of those cases for which race was considered central, genetics was mentioned in relation to race. In the setting of time-bound board exams during which students often rely on System 1 thinking, the routine though unhelpful use of race/ethnicity and the less frequent stereotypical association between race and

genetics both risk perpetuating race-based diagnostic bias that is already inherent in the preclinical curricula.[3]

On the wards, time constraints not only encourage fast thinking but also ceaseless activity. Residency is designed for trainees to learn by doing: see the patients, write the notes, present succinctly, answer all pages, put in the orders, admit a patient, run a code, discharge a patient, perform a procedure, transfer a patient, update family. The thought that activity breeds competence is widely accepted. For example, Malcolm Gladwell coined the "10,000-hour rule" in his book, *Outliers: The Story of Success*, suggesting that it takes 10 000 hours of intensive practice to achieve mastery of skills.[4] This same concept has been embraced in medicine, particularly by procedural specialties.[5] In fact, there was widespread concern that duty hour restrictions—that is, restricting resident workweeks to 80 hours and shifts to 28 hours in length—might unintentionally produce less competent physicians.[6,7,8] Surgical specialties were particularly concerned, given that operative competency has classically been measured by the number of cases performed.[9]

But hour restrictions were implemented for the purpose of reducing medical error after the case of Libby Zion in New York City in 1984. Zion died after a cardiac arrest in the emergency department, and a private investigation determined that her death was due to medical error. A grand jury met and issued 5 recommendations in 1986, one of which was to limit the consecutive working hours of interns and junior residents. These recommendations were transformed into legislation shortly thereafter.[10] While the impact of resident fatigue on patient safety has been debated in the literature, the relationship between sleep deprivation and impaired cognition has been demonstrated.[11] Thus, the association between fatigue resulting from overactivity and increased error is reasonable and has been noted by governing bodies in medicine, including the American College of Obstetricians and Gynecologists (ACOG).[12]

In addition to error, the constant activity of physicians has been thought to produce burnout. In one study, 604 residents in Japan were surveyed in 2018 to 2019, and, after controlling for individual factors, it was found that excessive paperwork and excessive working hours were independently associated with burnout.[13] Conversely, duty hour restrictions have been shown to have a positive impact on resident wellness in multiple studies.[14,15] However, burnout remains a critical issue. In one study of 4664 medical residents from multiple specialties, the overall prevalence of burnout was found to be 35.7% and as high as 40.8% in some specialties.[16] Most recently, when residents were called upon as first-line responders during the initial wave of the COVID-19 pandemic, workload increased in unprecedented fashion, resulting in a predictable increase in burnout.[17]

Stillness as a Solution

To intentionally slow down challenges the constant, often unquestioned activity of medical training—and its consequences. For example, as described by Kahneman, System 2—or slow thinking—is more methodical and requires more effort than System 1 thinking but is also more resistant to bias.[1] Therefore, individual students and clinicians who both make themselves aware of and choose to engage in System 2 thinking might limit their own unintentional bias. With regard to error, given that duty hours in residency were restricted to reduce medical errors, it is reasonable that another way to reduce medical errors might be for residents and other clinicians to recognize their need for rest and limit their activity. Such self-induced stillness is also recommended by governing

bodies in medicine, such as ACOG.[12] Given the relationship between restricted weekly duty hours and improved wellness,[14,15] rest and reduced activity may also reduce burnout. Another proposed solution to burnout is mindfulness, which is the practice of being fully and nonjudgmentally present.[18,19] Such individual commitment to stillness provides meditative space for reflection and meaningful reinvigoration.

It is important to recognize that stillness in any of these forms is not the passive absence of doing but rather the active practice of "non-doing." Thus, as a deliberate act, stillness is not actually simple. Moreover, individual acts of stillness are a privilege that is not available to everyone; the practice of stillness is limited by structures of power that include gender, race, and capitalism.

Stillness Is a Privilege

Gender. A recent study of interruptive behavior at residency teaching conferences found that male attendees interrupted more frequently than female attendees, behavior that was amplified by the presence of a male faculty discussant.[20] Beyond medicine, one study showed that both men and women made more interruptions when speaking with a woman than when speaking with a man.[21] Even in one of the most esteemed professional spaces, the Supreme Court, where women are already underrepresented, female justices are interrupted at rates 3 times as high as male justices at times.[22] During a 2020 vice presidential debate in which Mike Pence interrupted Kamala Harris, Harris' response—"Mister vice president, I'm speaking"—was echoed by women everywhere on platforms like Twitter.[23] All of this is to say that women lack the privilege to intentionally *not* speak because, even when they are in the authoritative position of speaker, they are more likely to be interrupted and therefore less likely to be heard. So, when a woman pauses and is still, she may in fact be conceding her sexist fate of being overlooked.

Race. Two 2017 studies have found that subjective evaluations of medical student achievement, such as Alpha Omega Alpha (AΩA) nominations and medical student performance evaluations (MSPE), are significantly influenced by the race of the student.[24,25] Black and Asian students were less likely to be nominated for AΩA than their White counterparts even after controlling for all objective data, including test scores and volunteer hours.[24] In MSPE letters, Black students were more likely to be described as "competent" than their White colleagues, who were described using "standout" or "ability" keywords even after controlling for USMLE Step 1 scores.[25] Thus, medical students of color are academically disadvantaged due to inherent racism and may need to do more to achieve an assessment equally favorable to that of White students. In this way, non-doing becomes a privilege aligned with race.

Capital. Within medicine, productivity as a priority is best exemplified by the high rates of presenteeism among residents.[26] Studies reveal that residents choose to work when ill for 2 reasons: (1) because of a sense of obligation to their patients and (2) out of concern that they cannot be easily replaced.[27] The former is certainly noble, and the latter is possible. But residents' commitment to presenteeism is also a more sinister symptom of health care as a capitalistic structure. To put it plainly, residents have been exploited to make them the driving physician workforce of cost-conscious hospitals that employ them.[28] In response, some residencies have started to form unions.[29] During the COVID-19 pandemic, physicians' sense of obligation was further exploited and often went uncompensated.[30] Thus, the act of non-doing—even as a mode of self-preservation

when sick—is a privilege that counters the expectations constructed by capitalism and internalized by resident physicians.

Radical Solidarity

Because stillness is a privilege, institutions must confront systems of power and support individual physicians through radical acts of solidarity.

Gender and race. It is perhaps unsurprising that physicians who are women and people of color experience higher rates of burnout,[31,32] given that non-doing is a privilege aligned with both gender and race and that excessive activity contributes to burnout. Burnout is also exacerbated by gender and racial bias in the training environment (such as unfair evaluations) and in the workplace (such as interruptive behavior). In one study, only 35% of women clinicians reported *never* encountering a negative experience due to gender or race compared with 70% of men.[31] With regard to race, in 2 other studies, 23% of physicians of color reported that a patient refused care due to their race/ethnicity,[32] and 35% of family medicine trainees experienced intimidation from patients based on race, gender, or culture.[33]

In response to inequitable opportunities for stillness, institutions have a responsibility to support trainees and physicians who are women and people of color. Foremost, expanded education on discrimination is a necessary foundation for reform; this training can start in medical school.[34] For example, in the classroom, rather than relying on System 1 recognition of associations between race and disease in question stems, educators can foster System 2 thinking to examine social and political determinants of health.[3] This type of curricular reform is an example of institutional solidarity that confronts racism and can shift the responsibility to slow down from individuals to institutions.

Additionally, hospitals must establish and expand clear nondiscrimination policies to support clinicians as well as patients.[35,36] For example, institutions must formalize, emphasize, and encourage non-retaliatory reporting of patient and staff discrimination. Such reporting might also transfer the need for action and activism from the individual to predetermined committees and institutional boards, relieving physicians of the need to react and instead permitting them space to cope with a sexist or racist experience.

Dedicated research is also required to make effective and evidence-based changes. However, institutions must be careful to avoid the "minority tax," the phenomenon whereby those affected by bias are disproportionately called upon to address the problem of bias.[37] Therefore, schools and hospitals must invest in and compensate health equity work so that progress does not rely on the undervalued overactivity of marginalized groups. For example, scholarship in health equity can be rewarded through academic credit, stipends, and titles. This approach might attract more researchers to the field, permitting women and trainees of color to do less if they choose. At the same time, such institutional solidarity would honor health equity work done by trainees and physicians as an academic activity that can be included on professional resumes to be considered in recommendations (such as MSPE), promotions, or nominations (such as AΩA).[37]

Capital. Duty hour restrictions are an example of institutional support to uniformly prevent residents from being overworked. However, such restrictions have in turn raised concerns about physician competency.[6,7,8] It can be countered that residents don't

always learn by doing, especially in a culture of ever-increasing productivity driven by the capitalistic structure of health care. In 2012, internal medicine interns spent 22% more time on indirect patient care (eg, charting) than in 1988.[38] Overall, 40% of interns' day is spent in front of a computer; only 12% of their time is spent providing direct patient care and 15% in educational activities, which include the seemingly integral task of participating in rounds.[39] Non-doing, by creating space for reflection and consolidation of knowledge, is critical to work-based learning, too.[40] Given the available data, residency programs and accrediting bodies, such as the Accreditation Council for Graduate Medical Education, have a responsibility to help residents do less. For example, administrative tasks can be re-delegated to clerical staff—which would require a financial commitment to hire such staff.[38] Additionally, reducing census caps on resident services would reduce service hours to create opportunities for pause, such as attending conferences.[41] Ultimately, institutional solidarity that supports non-doing can help balance learning and working.

Historically, it has been a battle to get women into medicine, to get people of color into medical schools, to get trainees paid. And the battle continues today to make sure that women are heard, people of color are embraced, and trainees are respected. But just as we have fought to make doing equal opportunity, so we must also ensure that non-doing belongs to everyone. Institutional acts of solidarity that confront systems of power can make stillness more accessible and equitable for those who are inherently expected always to do more.

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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

Solidarity in Mortal Time

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Abstract
The concept of *mortal time* is useful in exploring what the hospice care framework might offer nonhospice clinicians. While hospice patients seem distinct from those in other settings, life-threatening serious illness brings with it profound vulnerability that permeates the atmosphere of caregiving. Hospice clinicians lean into this vulnerability, seeking to make meaning for patients and families in the critical present. Clinicians elsewhere can strive to overcome it, working to save themselves and their patients for a rosier future. Mortal time signals the shared human condition, however, and, as such, it can be an entry point for solidarity among patients and coworkers, strengthening both.

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Vulnerability and Mortal Time

What can the hospice approach to patient care offer clinicians in acute care and the clinic? The question itself implies that a clear marker divides patients in hospice care from seriously ill patients "outside" hospice care. But are the 2 types of patients so different? Using the concept of *mortal time*,[1] I argue that the vulnerability of seriously ill patients—that is, their exquisite susceptibility to harm—impels clinicians who treat such patients both inside and outside of hospice to provide care that best serves those patients as they acknowledge the existential threat posed by that vulnerability. Unlike rescue care, however, hospice care is organized around the reality of human finitude (ie, mortal time) that vulnerability brings to light, plumbing it as a resource for hope in the human condition rather than as a problem to solve. Reframing vulnerability as mortal time provides an avenue for seeking common ground across diverse clinical approaches.

McQuellon and Cowan describe mortal time as occurring when the patient and family grapple with the prospect of unavoidable personal death.[1] Learning the diagnosis of a life-threatening illness often marks the beginning of mortal time. It might span days, months, or years. The diagnosis holds and colors the life experience of calamity, regardless of what is being done about it or the patient's condition in the moment.

When some of these patients with a terminal illness wish to benefit from the comprehensive support of the Medicare Hospice Benefit (MHB), the US health care system asks them to make a difficult choice. Unlike palliative care, which can accompany curative measures, hospice reimbursement mechanisms prohibit them.[2] In choosing hospice care, therefore, caregivers and patients enter an accentuated phase of mortal time. They must adopt a way of life robbed of the illusion of infinitude and embrace a "critical present" of sorts.[3] Supporting that specific vulnerability, as hospice does, becomes a skill relevant to acute care settings in view of the difficulty in differentiating between the seriously ill and the dying, both living in mortal time.

Making Meaning in Mortal Time

On an intake visit, my prospective hospice home care patient towered over me as he answered the door, sporting his T-shirt, Bermuda shorts, and tracheostomy. Jack (not his real name) had head and neck cancer. He ushered me through the house to the back porch, as it was an unusually warm early spring morning. He sprayed the patio table with glass cleaner and wiped it down before we sat down to discuss his home care plan.

Was Jack dying? Certainly, but not immediately. He sought companionship from hospice to navigate the path ahead. His future was limited and unknowable, even as he coped with the routines of his daily life, including tube feedings. Yet he had the wherewithal to recognize and make the most of the good weather as we discussed his situation.

Many who are unfamiliar with the framework of hospice care believe that finding "peace" in dying is the best hope possible and that such is hospice's goal. But this assumption reveals a failure of imagination. Hospice's far broader agenda is to enable patients and families to extract the most meaning they can from living each hour and minute—to expand their universe as the now unstoppable illness tries to contract it. Opportunity exists in dying that no other phase of living offers, precisely because mortality is so real. Patients like Jack are willing to seize the opportunity to live each day in defiance of death, not waiting for the illness' progression to rob them of it, along with so much else.

How was Jack different from the seriously ill patients that acute care clinicians care for? Unlike many seriously ill patients in acute care settings, he was conscious, alert, able to perform activities of daily living, not yet bedbound, and able to make the most of the present moment as he grappled with the unknown. Yet his disease made him fragile. Benefitting from advances in chemotherapy and immunotherapy, many cancer patients live in a similar kind of limbo, yoked to a terminal diagnosis, yet far from actively dying. They navigate their awareness of mortal time along with the demands of "normal" life, balancing medical visits and a fluctuating sense of their own wellness.

Not-yet-hospice-ready patients with serious illness can focus on the future. They and their families hope their current unfortunate or even dire circumstances are temporary, that the horizon of finality will recede. Propitious treatments continue on an outpatient or inpatient basis. Setbacks requiring acute or critical care might even reinforce that tomorrow-oriented perspective. If illness progresses, however, clinicians recognize that their sickest patients face a constrained time horizon, even when no one has officially categorized them as "Dying." And as technology becomes ever more elaborate, sorting the rescuable patients from the unrescuable—the "living" from the "dying"—gets trickier. The length of time patients spend under hospice care illustrates the reluctance to give

up on rescue. Although the MHB is intended for people with a life expectancy of 6 months or less,[2] in 2018, 50% of hospice patients spent 18 days or more in hospice.[4]

Mortal Time Without Meaning

After the 1990 passage of the Patient Self-Determination Act,[5] advocates for excellence in end-of-life care recommended advance care planning (ACP) as the major mechanism for negotiating a transition from rescue care and its potential for bad dying to management of life-threatening illness. Yet, in too many cases, conversations and documents fail to forestall unwanted or inappropriate care.[6,7] One reason is that ACP assumes (erroneously) that hospitals can enact the patient's goals in a meaningful way. In truth, the atmosphere of urgency in critical care settings often forecloses this possibility, especially when patients are very sick. Treatment plans generally follow one of only 2 tracks: (1) full code and "do everything to rescue from death" or (2) "do not resuscitate," in which case the treatment plan might be less clear. This bifurcation of end-of-life care is pragmatic rather than patient centered. It enables time-pressured clinicians to manage multiple patients more easily, since most are considered rescuable. Accordingly, clinicians need not question the clinical momentum[8] that "moves things along"[9] for most patients. The path is clear. By the time a tipping point is finally reached to call the patient Dying,[10] the person is too sick to interact. The best opportunities that hospice offers for finding meaning in mortal time have often been lost.

Many seriously ill patients share hospice patients' profound vulnerability, even if they continue down a rescue path. They live in mortal time, yet without the refuge that an acknowledgement of this fact might provide. Their clinicians, busy with rescue's demands, deepen patients' fragility as they weaponize technology to both hold death back and shield themselves from grappling with it. It is bruising work for them.

But the intensity of the critical care environment demands unwavering focus. Caregivers cannot afford to slow down enough to take in the frailty that patients present. It feels dangerous. It is wearing enough to care for them, much less to enter their liminality. Thankfully, managing the "stuff" connected to seriously ill patients, along with their sheer numbers, means that confronting human inadequacy and helplessness—a part of the territory of serious illness and dying—can be mostly ignored, along with the bruises.

How Stillness Creates Space for Meaning

But human inadequacy and helplessness cannot be ignored forever. Moral distress is rampant, causing clinicians to leave their professions,[11] as repeated exposure to morally distressing events is both inevitable[12] and unrelieved by improving their rescue skills.[13] If patients teach "the reality of the vulnerability of living,"[14] the self-grounding needed to tap into this truth can be elusive. Rushton has suggested that clinicians seize moments for stillness in their work to buffer its harms and allow new truths to emerge.[15] Pausing allows time for breath, slows the pace of interaction, invites new questions, and supports a shift to stillness rather than reactivity. Now it becomes possible to notice the gravity of this moment and its inherent ambiguity. Only by seeking stillness can we open a space for leaning into our shared humanity and helplessness rather than shunning it. Hess offers the patient's narrative as a way to support the rugged pathway walked by patients and clinicians.[16] Information the family shares about the patient's interests furnishes something to talk about while delivering care, regardless of the patient's ability to respond.

We have established that patients with serious life-threatening illness live in mortal time and that some might be undefended by the illusion of an unlimited future. Those journeying alongside them, loved ones and clinicians, can find each other in mortal time.[1] This state of being diverges from polite society, which does not support such awareness.[17] The rescue environment of acute care likewise fails to sanction it. Acknowledging the reality of finitude can be a deviant, subversive, and therefore powerful act. Loosening one's grasp on a retreating future is not to despair but to avail oneself of new benefits. It shifts one's weight, literally and figuratively, to seek stillness and be open to the deep realities of human presence and human helplessness. The framework of hospice care incorporates these uncertainties and puts them to use, recognizing how unique mortal time can be in human experience. Along with creating endemic anxieties and struggles, mortal time brings family members together to honor a life precious to them. It allows sharing of memories, asking forgiveness, healing of relationships, and converting final moments into legacies of meaning.

Mortal Time as Common Ground

Acute care clinicians labor differently than hospice and palliative care clinicians. But their patients' fragility is similar. An unimaginative health care system imposes falsely dueling categories of care, rescuable and unrescuable, and this division will likely persist. Can hospice and palliative care clinicians' familiarity with mortal time offer common ground to their fellow clinicians engaged in rescue, an opportunity for drawing strength from each other? To gain the courage and balance to sojourn there, it is advisable to link arms, to seek solidarity across the divide that mortal time imposes.[18]

Bruce Jennings suggests that it is both a moral duty and a social necessity to demonstrate solidarity with the dying by standing up beside, for, and with those living through mortal time. He advocates "civic palliative care," arguing that families and patients should not have to navigate mortal time on their own. He makes the moral case that "[t]he object of civic palliative care is the patient's embodied and relationally embedded personhood, not just her disease, symptoms, or isolated body and self."[19] It is this personhood that serious illness buries and that hospice seeks to resurrect.

Every clinician seeks to provide care that best serves the patient. How can we leverage this solidarity of purpose to learn from each other during the patient's journey through mortal time? I suggest 3 ways that clinicians who are troubled by their patients' mortal time (and their own) can explore common ground: (1) by perusing how the hospice frame of care emphasizes the strengths and opportunities in this unique time of life; (2) by noticing how urgency distracts and keeps "us" (humans still upright and living in the illusion of our self-reliance) from tapping into the vulnerability of mutual interdependence and ambiguity about the future that we share with humans abed (our patients); and (3) by finding ways to forge and maintain relationships with our colleagues—across disciplines, professions, and care settings—to hold each other up in this important work.

Some months passed between that spring morning and the last days of Jack's life in a hospice facility. It was a tough road. He and his family were fearful, but their eyes were open; they had control of each step along the way; and they were not alone. Mortal time and its attendant vulnerability can bear us up if we have the courage to reach for friends and fellow caregivers who are willing to go there with us—all of us living and dying, together.

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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

Why Money Is Well Spent on Time

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Abstract
There are a few reasons why incentivizing clinicians to spend more time with patients can improve health outcomes. Doing so affords clinicians time to assess social determinants' influences on their patients' health experiences; offers opportunities to identify and respond to patients' loneliness; and helps motivate patients' trust in health care, strengthen patient-clinician relationships, and bolster patients' adherence to clinicians' recommendations.

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If Time Is Money

If time is money, then an important way to ensure that clinicians spend their valuable time with patients is to enable and incentivize them to do so via financial reimbursement for time spent with patients. Increasing time spent with patients potentially could have a significant impact on health outcomes on a number of measures. Time spent with patients enables a better understanding of patients' needs. For example, determining whether and to what extent an individual's health is influenced by social determinants—such as poor housing conditions, insufficient access to food, or poor health literacy—takes time. To improve patient trust, cooperation, and health outcomes, the health care system should better incentivize time spent between patient and clinician to enable a deeper, more meaningful collaborative relationship.

Addressing the social determinants of health (SDOH) has been recognized as a critical component in improving health outcomes.[1] Therefore, to incorporate SDOH in the health care system is not merely to acknowledge their impact but to move beyond the traditional paradigm of medical treatment by mitigating the adverse effects of SDOH as much as possible.[2] Because the health care system has largely been focused on acute medical treatment to improve health outcomes,[2] an exceedingly large amount of money and resources are expended on health care, with middling results.[3] Instead, the health care system must focus on caring for the individual, not simply on treating a health condition.

Time Spent With Patients

The emergence of medical-legal partnerships (MLPs) provides a useful example of the benefits that can arise from moving beyond standard diagnostics and medical treatment to allotting time to learn more about the patient.[2] In MLPs, lawyers coordinate with health care professionals to assess and alleviate underlying legal complications that contribute to poor health in conjunction with treating the patient's medical problems.[4] The paradigmatic example is treating a child's asthma with both medical care and legal support to ensure that the landlord fixes problems in the home, such as mold, that are exacerbating the child's asthma.[2] In doing so, whatever medical treatment is provided is more likely to succeed in accomplishing its goal of improving the child's health. But understanding the child's living conditions to the extent of determining not only whether they contribute to the child's asthma but also whether they breach a landlord's legal obligations to provide habitable premises takes time. More generally, it takes time to determine whether patients' health problems are exacerbated by their living conditions, unstable employment, illegal denial of health care reimbursement, neighborhood violence, or unjustifiable disconnection of heat or water.[2] Not all patients are the same.

Data suggest that access to an MLP can reduce hospital visits for patients with chronic illnesses, improve treatment adherence, increase access to housing and utilities, reduce stress, and assist with education and employment needs.[2] Thus, the success of MLPs relies heavily on time spent with patients to assess and care for them in a holistic way, which includes screening them and documenting their legal needs.[4] Time is also required for training to effectively integrate legal personnel into a health care setting.[2] What MLPs make clear is that attempts to address SDOH that contribute to poor health without the health care system reimbursing for time spent with patients will be of limited success. Just as we have come to understand over time that health outcomes are the result of a complex interaction of many factors beyond physical illness or impairment, so must we change health care system functioning to enable clinicians to spend the time necessary to determine and attend to those many factors.

Time Spent With Others

Efforts to address SDOH cannot simply focus on things like food security and clothing; they must also include interactions with others. The COVID-19 pandemic has highlighted the importance of time spent with other people. Since the pandemic emerged in March 2020, states have at times been forced to take drastic measures to ensure social distancing to slow the spread of the disease. The highly contagious coronavirus has forced loved ones to miss birthdays, holidays, and important events. These social distancing measures, while important for disease control, have brought a greater focus on the impact of loneliness on people's health.

Loneliness occurs when an individual's social interactions are perceived to be fewer in number, less frequent, or of lower quality than what they desire.[5] Loneliness is related to, though distinct from, social isolation, which is an objective state that can be measured by indicators such as living alone, low levels of social activity, and having few or infrequent social contacts.[5] Loneliness has been associated with negative health consequences, including depression, suicidality, substance abuse, and cognitive decline.[6] During the COVID-19 pandemic, the impact of loneliness was similar to that of other more established, well-known risk factors such as smoking, obesity, and hypertension.[7] Loneliness can even accelerate aging, with social isolation and loneliness associated with a roughly 50% increase in risk of developing dementia,[8] a 32% increase in risk of stroke, and a 29% higher risk of incident coronary heart disease.[9]

Younger individuals also suffer from loneliness. During the peak period of social isolation early in the pandemic, the fear was that the mental health of the older population would be affected the most, given the potential hindrance of fully availing themselves of the benefits of technology and that youth are better equipped to interact with others via technology, such as the various social media platforms.[7] However, during the pandemic, it is younger individuals who have suffered the most from increasing loneliness.[7] This finding is especially problematic, given that youth is a critical period for development of mental health problems and neurodevelopment.[7]

Taking the time to evaluate loneliness is critical, given its potential connection to suicide, which is an increasing public health problem in the United States. While suicide is the tenth leading cause of death in the United States, it is the second leading cause of death for individuals 10 to 34 years of age.[10] Tragic suicides of female college athletes—with no apparent signs of risk and seemingly everything going for them on the surface—illustrate how imperative it is to have time to understand the complexities of an individual's life.[11,12,13] And, given a general lack of mental health care professionals, primary care physicians may unfortunately be the best positioned to develop a relationship with patients that could uncover suicidal ideation.[14]

The United States has historically valued independence, personal responsibility, and self-reliance.[15] But the health care system should not. We have even more evidence now that connections to others—indeed, the most *social* aspects of the SDOH—are vital to the health and well-being of people.[15] The association between social isolation and loneliness, on the one hand, and poor health outcomes, on the other, is an essential part of the justification for incorporating the SDOH into the medical profession.[15] But to properly assess and address these issues and their connection to the growing suicide crisis likely requires the health care system to incentivize—or perhaps, more appropriately, to allow—clinicians the time to develop a relationship with their patients.

Time for a Change

The US health care system is widely considered to discourage—or at least not to incentivize—time spent with patients. The limitations of the 15-minute doctor visit in the US health care system are well understood.[16] And, to be clear, this is not a phenomenon that only exists in this country. In fact, some countries have average consultation lengths of 5 minutes or less.[17] But the quality of the interaction between patient and clinician has consequences for patient care. It is positively related to patient satisfaction.[18] Patient satisfaction, in turn, can influence whether and how often individuals seek interactions with the health care system, as well as their willingness to comply with medical advice. As an example, patients' trust in their clinician can affect their adherence to medication and follow-ups for treatment.[18]

The significance of the patient-clinician relationship is not a revolutionary idea. The evolution of patient rights and the centrality of informed consent underscore that medical decision making and addressing health problems is a collaborative endeavor. Physicians are less paternalistic than in 1972, when California's Supreme Court concluded in *Cobbs v Grant* that physicians have an obligation to disclose treatment options and their risks and benefits.[19] The ethics and law of informed consent thus mandate that clinicians disclose information that the patient would deem material in making their decision.[19] But if health care decision making is to be a collaborative process, the health care system must enable and incentivize such collaboration, which requires that clinicians have adequate time to know patients and their values.

Undoubtedly, short patient visits—with brief interactions being all too common—are one barrier to collaborative health care decision making. But the reimbursement structure plays a central role in the continuation of these quick visits.[15] Reimbursement for time spent with patients would afford an opportunity to generate a more patient-centered health care system. It would also financially acknowledge the importance of exploring more thoroughly the many potential causes of patients' poor health.[20]

Conclusion

An emphasis on time spent with patients should not be taken to mean that quantity alone is the goal. Quality time with a patient is the best way to determine the patient's problems and values and to establish a stronger, more trusting relationship that will address the multitude of factors that may be impacting their health. And while financial reimbursement for time spent with patients would incentivize and acknowledge the value of the clinician's time, money is not the only barrier to spending quality time with patients. For example, clinician time is taken up by administrative obligations, including a growing reliance on electronic medical records, which reduce time for direct patient care. Furthermore, financial reimbursement without properly training and educating clinicians about how to best use this time would be fruitless.

Enabling and empowering clinicians to spend more time with patients could allow clinicians to listen, reflect, and develop relationships with patients that considers their individual values and needs. Doing so will engender patients' trust and cooperation, which are necessary for long-term relationships with—and adherence to treatment plans of—health care professionals. If we want to truly embrace SDOH, we must provide a framework that makes it possible to do so. Only then will we see more clinicians focusing on treating the individual, not simply the disease.

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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

Mindfulness Reminds Us What Health Care Is For

Mindy Thompson Fullilove, MD and Marisela Gomez, MD, PhD, MS, MPH

Abstract
Could clinicians help people more if they were buddhas? This article considers what the late Thích Nhâ't Hanh meant in his call to "become buddhas" and applies Nhâ't Hanh's mindfulness practices to managing crises and anxiety in health care settings. This article also considers recovery strategies, techniques for becoming calm, and reminders about why stillness matters for compassionate practice in health care.

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We need a collective awakening. One buddha is not enough. All of us have to become buddhas in order for our planet to have a chance.
Thích Nhâ't Hanh[1]

Crises, Anxiety, and Mindful Practice

Buddhist monk Thích Nhâ't Hanh called for us all to become buddhas at this moment of planetary crisis.[2] The question we wish to address is this: *Why, during crises, is it useful for individuals to become buddhas?* A short answer is that, because crises provoke anxiety, which, in turn, impedes individual and collective decision making, mindfulness is needed to calm us to improve our thinking. In what follows, we develop a series of ideas: (1) this is a time of crisis, (2) crisis provokes anxiety, (3) anxiety impedes decision making, and (4) mindfulness can promote calm and help us recover. We apply these ideas to ourselves and to the systems within which we work.

This Is a Time of Crisis

More than 2 years of the COVID-19 pandemic have taken a toll on the United States and revealed stark problems with the state of the nation. Prior to January 2020, many might have thought that our country understood and used science; that our health care system was strong enough to manage a pandemic; that we were all committed to democracy; and that we had made progress in eliminating inequity. Instead, we have lived through a tumultuous period of devastating climate consequences, bitter political partisanship with profound attacks on democratic processes, and inequity playing out in the number of bodies in refrigerator trucks. These crises reveal deep ecological trouble and disruption in our social, economic, political, and natural interconnectedness.

Crisis Provokes Anxiety

Although it is tempting to minimize, project, or deny the difficulties of this moment, there is a thrum of deep eco-anxiety in many of us as the truth presses in on us: our way of life is unsustainable.[3] It is understandable that high levels of anxiety accompany a crisis of this proportion. It is not one or another policy that must change but rather our "way of life"—our intertwined social, economic, cultural, and political ways of living. Anthropologist A.F.C. Wallace studied the sudden taking apart of a way of life—what he called "mazeway disintegration"—noting how profoundly difficult it is.[4] While a disaster of one or another kind might provoke a temporary upheaval, after which "things will go back to normal," a crisis that calls on us to change our way of life—that is, *not* to go back to normal—strikes deeply at the roots of collective security. Wallace noted that, in such circumstances, there were 2 ways forward that societies had taken: totalitarian government or religious revival. Nhâ't Hanh's call that we all become buddhas opens a third path, that of mindfulness, rather than a devotion to a particular religion or political party.

Anxiety Impedes Decision Making

There is an old saying in African American neighborhoods that holds that "a scared man can't gamble, and a jealous man can't think." This folk wisdom applies to collectives as well. We see fear operating to limit our ability to see the big picture. In studies of collective consciousness, Wallace and Fullilove[5] noted that there are a number of threats to collective thinking, among them inattentional blindness, which the American Psychological Association defines as "a failure to notice unexpected but perceptible stimuli in a visual scene while one's attention is focused on something else in the scene."[6] In the COVID era, for example, people are focused on fighting about masks and ignoring that the larger problem of ecological mismanagement has created conditions for many new pathogens to arise.[7]

We also see jealousy in partisan efforts to make "my side to win." There are many examples of these efforts—from the gerrymandering of election maps to the January 6th attack on Congress. Partisanship has impeded progress on legislation to address threats to all Americans and all humans. For example, the defeat of the proposed Build Back Better legislation is one example of failure to address climate change, although the Inflation Reduction Act, signed into law in August 2022, contains many of the same provisions but with less funding.[8] Calming the nerves of the nation to enable problem solving in the spirit of solidarity is essential at this time.

Mindfulness

Calms anxiety. Thich Nhâ't Hanh encountered the Vietnam War as a young monk and learned to practice mindfulness under dire circumstances. He went into many dangerous situations—not as an armed combatant but as a person prepared to help with rebuilding the nation. His deep connection to the universe, his respect for the interrelatedness of all life—our *interbeing*—gave him a perspective on life that was often absent in a time of war. In this current period of reckoning, the pathologization of anxiety—such as the manipulation of anxiety to further the aims of totalitarianism—is a real and present danger. For example, the former president of the United States, in calling Covid "the Chinese virus," ratcheted up anxiety and intergroup hatred.[9] By calming ourselves, we prepare ourselves better to face the scale of our problems and engage with others compassionately.

Increases focus. Stephen Covey's famous book, *7 Habits of Highly Effective People: Powerful Lessons in Personal Change*, includes the habit "Begin With the End in Mind."[10] Community organizer Ernest Thompson spoke of this direction-finding task as "finding what you're for."[11] When used to guide strategic planning, the articulation of values and goals has a particularly important role to play in times of frequent disaster. Pulled in many directions by the rapidly changing demands of the moment, people can become "ambulance chasers" rather than strategic actors, and they will quickly become worn-out and discouraged. Guided by their values and standing on a platform of action, they are much more likely to achieve their stated goals and to improve the overall situation.

Creates awareness of interrelatedness. Nothing about changing our way of life will be quick or easy. In 1967, the Reverend Dr Martin Luther King Jr laid out the scope of the work we have to do:

> Now let me suggest first that if we are to have peace on earth, our loyalties must become ecumenical rather than sectional. Our loyalties must transcend our race, our tribe, our class, and our nation; and this means we must develop a world perspective. No individual can live alone; no nation can live alone, and as long as we try, the more we are going to have war in this world. Now the judgment of God is upon us, and we must either learn to live together as brothers or we are all going to perish together as fools.[12]

From the perspective offered by King, what we must be *for* is a world perspective in which we understand our interrelatedness with all living beings. Nhâ't Hahn calls this "interbeing."

Applications to Health Care

The diverse and vast set of organizations that makes up the American health care system could play an important role in calming the mind of the nation, but, at present, health care as a system seems to deliver care according to clinical standards and plays only limited roles in communities' well-being. Even when hospitals offer wellness programs, they offer them as services to individual patients. This individual-care model is insufficient at this time of reckoning when millions are in distress. Deep ecologists aren't the only ones who understand that unimagined horrors are lurking that will require all the sangfroid we have or can muster. In this particular catch-22, we, as clinicians, could help create collective calm by implementing a community-level mindfulness approach, but we'd have to believe we should step outside of our small sphere of influence.

In summary, the Swedish environmentalist Greta Thunberg has pointed out that we have to act now, building a new way of life, even if we don't have a blueprint for how to do that.[13] We can begin by pausing and finding stillness, settling the mind and body so that we see beyond the turbulence and the distractions. Within this space, we become more discerning—noting our values, listening to and respecting ourselves and one another—thus enabling our co-creation of a platform for truth telling, recovery, and survival.

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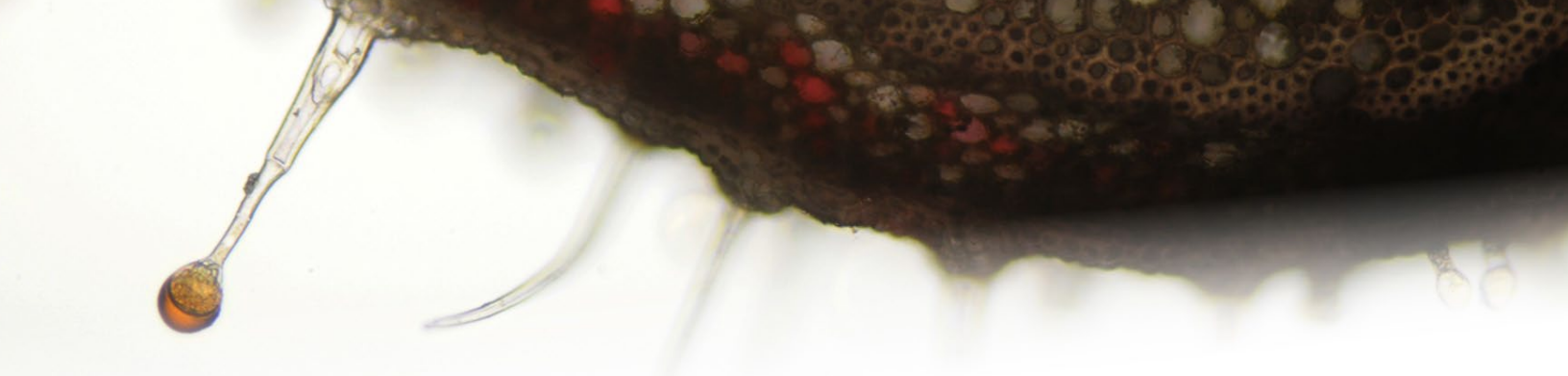

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HISTORY OF MEDICINE: PEER-REVIEWED ARTICLE

Does Osler's *Aequanimitas* Inform Our Contemporary Pursuit of Stillness?

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Abstract
William Osler (1849-1919) was an academic physician who has been revered by many as an accomplished internist of his time. His contributions to the philosophy and practice of medicine foreground characteristics of a compassionate caregiver, including imperturbability and equanimity. This article defines these qualities, argues that Osler demonstrated both, and suggests how today's clinicians can apply these qualities to their own pursuits of stillness in their practices and relationships with patients.

Introduction

Traditional medical school curricula seem to have minimal space for teaching students to deal with emotional challenges and the toil of training and subsequent practice. To soothe their anxiety, fatigue, and, at times depression, students can seek stillness through introspection and study of William Osler's *Aequanimitas*.[1,2,3] Osler (1849-1919) was an iconic clinician who some have said was the greatest academic internist of his time.[4,5] Osler's idealized caregiver, as described in *Aequanimitas* and commentaries by Osler's biographers, requires an understanding of mindful practice, cultivated through insight into the humanities and a humanitarian approach to the patient and oneself.[5,6,7,8,9] Osler's sympathy, empathy, and steadfastness while caring for patients influenced many caregivers during his lifetime and afterwards. These qualities can, and should, be linked to emotional stillness. Osler was not, however, the first clinician to champion the concepts of sympathy, empathy, and steadfastness. Others in the 18th century promoted compassionate care with principles similar to those of Osler. For example, Thomas Percival's 1803 treatise, "Medical Ethics or a Code of Institutes and Precepts Adapted to the Professional Conduct of Physicians and Surgeons," has been hailed as a "milestone in the development of modern codes of medical ethics"[10]—just as, I would argue, Osler's *Aequanimitas* represents a milestone in medical *etiquettes* by including what Osler described as imperturbability and equanimity.[10] Perhaps these words, ascribed to Osler, are better remembered than Percival's precepts because of their relevance to our time, when exploding administrative demands and officious regulations consume considerable resources and can lead to burnout. We can cultivate imperturbability and equanimity to resolve emotional challenges because the stillness

they generate can be therapeutic, improve health care, and provide solace for the clinician.

Evolution of Modern Medicine

Paul Starr characterized the evolution of modern American medicine in his 1983 (updated in 2017) Pulitzer and Bancroft prize-winning book, *The Social Transformation of American Medicine*.[11] We've steadily moved from a fee-for-service platform to myriad models, including what is now often termed value-based care and managed care. All of these changes have occurred in a heavily scrutinized and regulated milieu, with clinicians spending mind-boggling amounts of time massaging electronic medical records while attempting to achieve admirable patient satisfaction scores and outcomes. Although the practice of medicine in the late 1890s was different than today, a similarity was the centrality of the patient-clinician relationship paired with practitioner competence and caring. This type of patient care requires that the clinician have insight, empathy, and an ability to prevent, diagnose, and manage disease with imperturbability and equanimity. Establishing trust on the basis of stillness resulting from these qualities still resonates in our maddening professional world today.

Osler's Essay

Aequanimitas was the title of Osler's 1889 May Day address for the University of Pennsylvania medical school graduating class.[1] It was a short lecture, as the 39-year-old Osler (who would soon leave for Baltimore and Johns Hopkins University to become one of the Big Four medical school founding fathers) noted that the students were busy with celebrations.

The address was a reflection on relationships of physicians, surgeons, and perhaps health care practitioners generally with their patients. In the published essay, Osler introduced the concepts of imperturbability and equanimity with a frontispiece quotation from Marcus Aurelius: "Thou must be like a promontory of the sea, against which, though the waves beat continually, yet it both itself stands, and about it are those swelling waves stilled and quieted."[1] Two major themes or qualities emerge in this essay. The first, imperturbability, refers to "coolness and presence of mind under all circumstances, calmness amid storm, clearness of judgment in moments of grave peril."[1] Equanimity, a second theme or quality, was said to be "as important in our pilgrimage as imperturbability."[1] Importantly, these 2 essay themes did not mean that emotional caring for the patient was absent. Also important is that the target audience of the essay wasn't just medical students and physicians but other health care practitioners, including nurses.

The address became the lead work in Osler's first book of essays titled *Aequanimitas With Other Addresses to Medical Students, Nurses and Practitioners of Medicine* (1904, with a third edition in 1932).[1] The Eli Lily Company distributed 150 000 copies of the third edition to graduating medical students between 1932 and 1953, with others receiving the collection well into the 1970s.[8] Charles S. Bryan, physician, academician, accomplished historian, past president of the American Osler Society, and editor of the monumental *Sir William Osler: An Encyclopedia* has addressed the meaning of the work as well as the controversy it generated.[2,3,6] Critics of Osler fault his endorsement of imperturbability, with its concomitant quality of equanimity,[12,13] as symptomatic of emotional detachment from the patient and thus of apathy and an absence of caring. However, Osler had defenders.[4,14,15] Bryan's thoughtful defense, based on his assessment of Osler's writings juxtaposed to those of Stoic philosophers, is that

equanimity constitutes not *apatheia* (absence of emotion or apathy) or *eupatheia* (allowance for good emotions) but rather *metriopatheia* (measured emotions).[6] Importantly, equanimity produces an emotional stillness, or peacefulness, from which empathic care emerges. Bryan also points out that critique of Osler for not using the word *empathy* is misguided, as the word did not enter English lexicon until 1909.[6]

E.E. Brush II, who graduated from Johns Hopkins School of Medicine in 1903 and had observed Osler's bedside teaching, patient interactions, and relationships in general,[16] also endorsed the wisdom of Osler's philosophy and particularly what Osler called *phlegm*, or imperturbability. Osler noted that "the physician who has the misfortune to be without it [phlegm] … loses rapidly the confidence of his patients."[1] This statement emphasizes the importance of stillness lying within the caregiver—despite the chaos of some patient encounters—and its centrality to trust. Brush believed that Osler was simply putting the patient at ease.[16] Indeed, imperturbability facilitates calmness and stillness that cultivates effective patient-clinician relationships.

Osler's Influence on Curricula

Osler's ideals can be applied to medical school curricula competency development frameworks. For example, Epstein and Hundert argued for a multimethod assessment of professional competence that includes clinical reasoning, expert judgment, management of ambiguity, professionalism, time management, learning strategies, and teamwork in addition to the usual core knowledge and skills.[17] Habits of the mind were included in the dimensions of professional competence with the goal of trainees gaining insight into their own emotions.[17] In 2002, influenced by this framework, Cleveland Clinic Lerner College of Medicine (CCLCM) of Case Western Reserve University (CWRU) was created.[18]

CWRU came to have 2 schools of medicine (CWRU School of Medicine and CCLCM), each with distinctive curricula. Both schools of medicine include a significant focus on the humanities and on personal health, well-being, and burnout. Empathic patient care is constantly stressed. Competency-based education and the humanities have been employed to foster self-reflection. Foundational thinking contained in *Aequanimitas* runs through the CCLCM curriculum in particular, with an emphasis on small-group, noncompetitive, problem-based learning and early exposure to patient care. In CCLCM, traditional medical school courses become threads running through case-based discussions. Humanities, professionalism, and professional identity formation are as important as traditional medical school topics, such as anatomy, physiology, and pharmacology. In order to promote teamwork rather than competition, there are no tests, grades, or academic distinctions in the CCLCM curriculum. Successful development of 9 competencies is necessary to graduate, with 3 having roots in the humanities: professionalism (students must demonstrate compassion, respect, honesty, and ethical practices), personal and professional development, and reflective practice (students must demonstrate insight into the development of the lifelong skills necessary to become a trusted health care professional). Reflective practice is the competency that addresses introspection, stillness, imperturbability, and equanimity. Development of the CCLCM curriculum is an example of how Osler's concepts and teaching have endured for over a century.

How Equanimity and Stillness Help

Health care practitioner burnout is a devastating syndrome characterized by depersonalization and emotional exhaustion, which can lead to depression and

disengagement.[19,20,21,22] It is rampant, with rates of burnout exceeding 50% in studies of residents and practicing physicians,[19] and problematic, as it can result in medical errors as well as other significant consequences.[20] Health care practitioners wearing a carapace of invincibility may fail to recognize burnout, which is driven by excessive workloads, draconian clerical burdens, lack of control over issues affecting work lives, and inadequate organizational support. Studies have found that women and younger professionals appear more vulnerable to burnout.[19,20,22] Cultivating stillness, as reflected in the term *equanimity*, can help.

Stillness has meanings related to silence and motionlessness, but the term can also mean emotional calmness, serenity, tranquility, placidity, quietness, and peace. Personal introspection and self-discovery can manifest as equanimity and lead to stillness. Equanimity can, for example, ease the disquiet of emotions associated with delivering bad news or working in a hospice environment.[23] Health care professionals have shared their experiences of travail and how the stillness born of equanimity leads to redemption.[24,25]

Wear It on a Badge

A lanyard embroidered with the single word *Aequanimitas* holds my Cleveland Clinic identification badge. It was distributed by the American Osler Society, an academic endeavor focused on the relevance of Oslerian values in the context of the historic evolution of the health care profession.[26] The lanyard prompts clinicians to meditate on the patients, colleagues, other caregivers, administrators, friends, and teams required to make an academic—or any—medical center thrive while they compassionately minister to patients. Thoughts become, in a moment of stillness, grounded in personal experience and the insights Osler passed along. Those thoughts spill over to the days in clinic or hospital and even to our personal lives. It is essential to expose our students to the concepts of Osler and other great role models generally and to the power of imperturbability and equanimity specifically.

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ART OF MEDICINE: PEER-REVIEWED ARTICLE

Solidarity, Origins of the Hospital, and Transformational Ghastly Imagery

D. Brendan Johnson, MTS and C. Phifer Nicholson Jr

Abstract
Identity formation is a critical moral psychological feature of ethics that is often neglected in health professions education. Inner transformation has been philosophically key from antiquity to the present day, especially for thinkers like Gilles Deleuze and Georges Bataille. Francis Bacon, a favorite thinker and painter of Deleuze, specifically inspired meditation on images of corporeal suffering as part of a "spiritual ordeal" that can provoke a kind of transformation key to health professionalism, deepening human solidarity. This article considers this theme in historical, social, and cultural contexts and as an ethical foundation of some of the earliest known hospitals as well as contemporary pursuits of health equity and moral formation in the health professions.

Let all mortal flesh be silent, and stand with fear and trembling…
Divine Liturgy of St James[1]

Healers' Transformations

Ethical progress requires what might be called internal and external change. The external side of health care ethics—policies, research, and institutions—is often the predominant focus. Far more challenging is the internal side of medical ethics: How does one become an ethical healer? Asking such questions is fraught. Professionalism has been the dominant grammar to speak about the internal aspect of ethical comportment in medicine. But prominent critics have claimed that the mainstream professionalism and medical ethics discourse has been, at the very least, insufficiently formative[2,3] and, at worst, protective of patriarchal, economic, and White-guild power.[4,5] Furthermore, external ethical action—for example, changing or designing institutional and communal forms—requires being the "right kind of person" for the task, and inner ethical strength is required to resist the deforming nature of unethical external systems. Thus, having a robust ethical inner life is a prerequisite for genuinely ethical medicine. But how can this inner life be developed? As will be discussed in this article, meditative reflection on arresting—even grotesque—images of suffering and illness can be a method to develop inner self-transformation in relation to the world, enabling solidarity with patients and peers. Similar contemplation of the poverty and abject suffering of marginalized people in the 4th century CE gave rise to the birth of the hospital, and, in

the same way, contemplation of contemporary images of use of force and torture could motivate institutional change.

Art and *Askesis*

Since the time of the ancient philosophers, the task of inner self-transformation (in Greek, *askesis*) has been consistently recognized as an essential component of the ethical life. But just as consistently, there have been disagreements over the means to and ends of such a change. Classical Stoic philosophers sought self-discipline and cultivated a "negative" *apatheia*—minimizing the influence of external events on one's emotional life[6]—but today we require a "positive" transformation toward compassion, solidarity, and agency. These qualities, although "public" in nature, require one's inward journey of *askesis* to be tied to the world around one and to the people in it. Inner transformation comes through both inward reflection and external interaction, leading one to further engage with one's neighbor.

French postwar philosophers Georges Bataille and Gilles Deleuze were proponents of this new model of *askesis*. Janae Sholtz describes Bataille's and Deleuze's exploration of "radically jarring meditative exercises" or "spiritual ordeals" to move beyond our old selves and overcome indifference, apathy, or passive acceptance of the status quo.[6] Bataille, for example, searched for a way to "get out of oneself," and there are a variety of experiences—laughter, ecstasy, torture, anguish, eroticism—that he identifies to do so, precisely because they expose us to our limits and human finitude. One of Bataille's favorite techniques was meditation on transfixing images—such as those of torture—because such images operate "through contagion and force": they transfix him, and he can neither keep looking nor turn away. As described by Sholtz, the "pure violence of the image itself" arouses a kind of "affective contagion" that causes "laceration of the isolated self."[6] In Bataille's words, "The sight—horrible—of torture opens the sphere that enclosed (or limited) my personal particularity, it opens it violently, lacerates it."[7] In short, the individual's preoccupation with the self is shattered by the power of the image.

There are many historical examples of transfixing images of violence that have spurred this laceration of the personal sphere, engendering solidarity and engagement. To name a few, pictures of the horrors of the Holocaust have played a role in ongoing work against anti-Semitism and ethnic cleansing/genocide worldwide. Nationwide broadcasting of footage of the Edmund Pettus Bridge in Selma on "Bloody Sunday" turned the tide of the civil rights movement, drawing more people from all over the country to participate.[8] More recently, the images of George Floyd's murder have shown the personally transformative and socially revolutionary power of such images. As strange as Bataille's suggestion may at first seem, meditation on particularly intense images certainly has the power to change the world. Rather than dehumanizing the other, beholding such images can simultaneously increase compassion and desensitize us just enough to get our hands dirty. The suffering other, whose image has lacerated one's own personal sphere, demands a response.

Francis Bacon

The 20th-century painter Francis Bacon was the creator of a series of images that evoke ghastly flesh, although his work pushes even beyond the human form. Bacon blurs the boundary between man and beast by dismantling human forms (such as in his famous series of "screaming" Pope heads, deconstructions of Velázquez's famous portrait of

Pope Innocent X[9]) and by giving nonhuman forms emotional voice, as can be seen in his *Fragment of a Crucifixion* or *Three Studies for Figures at the Base of a Crucifixion*.[10,11]

Figure 1. *Head 1*, 1948 (CR 48-01), by Francis Bacon

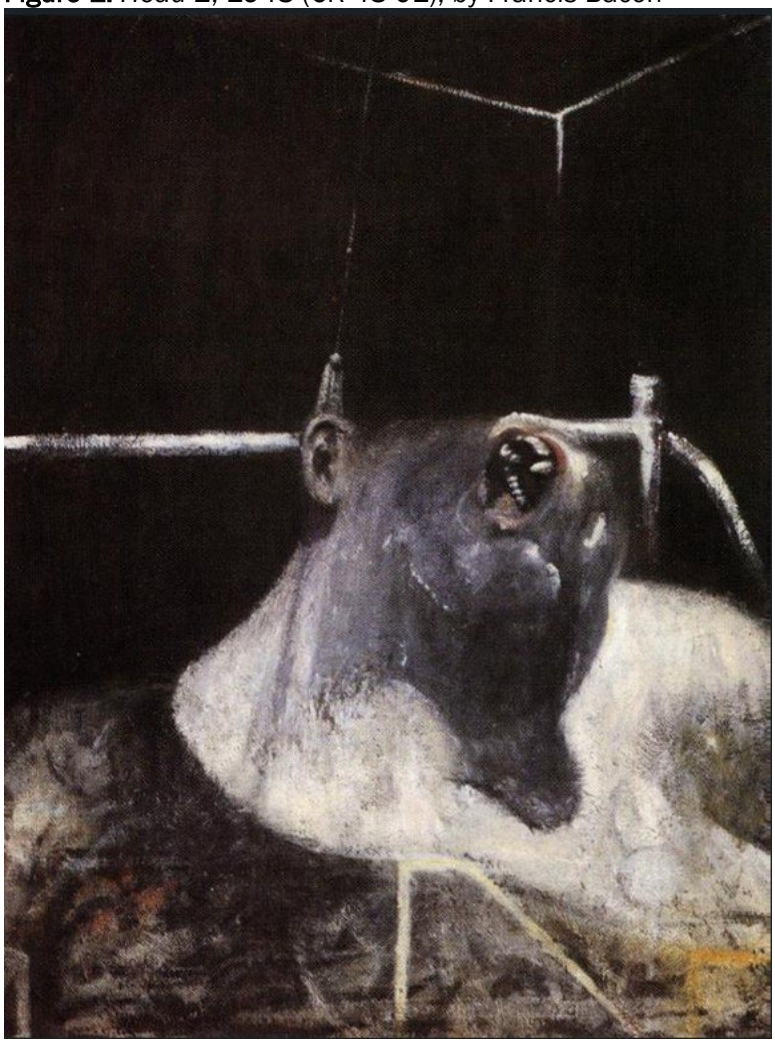

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Figure 2. *Fragment of a Crucifixion*, 1950 (CR 50-02), by Francis Bacon

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Figure 3. *Three Studies for Figures at the Base of a Crucifixion* (CR 44-01), 1944, by Francis Bacon

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Bacon's work captivated Deleuze, who used it as a conceptual launching pad for his theory of art and sensation. The silent vocalization of the monstrous flesh that Bacon portrays draws the viewer with its intensity and depiction of a near-otherworldly (yet human) form. What is this vocalization, and why can it make us feel both vulnerable and finite, amplifying our awareness of suffering in ourselves and others? Deleuze writes of Bacon's art:

> The mouth … turns all meat into a head without a face. It is no longer a particular organ, but the hole through which the entire body escapes, and from which the flesh descends.… This is what Bacon calls the Scream, in the immense pity that the meat invokes.[12]

This pity is an affective response of compassion, spurred by personal identification with the grotesque form of the "meat." Bacon depicts a space where, as Deleuze writes: "Man becomes animal, but not without the animal becoming spirit at the same time, the spirit of man.… It is never a combination of forms, but rather the common fact: the common fact of man and animal."[12] Ceaselessly pursuing the root of all corporeal solidarity, he goes from body to flesh and, finally, to meat: "Meat is the common zone of man and the beast … a state where the painter identifies with the objects of his horror and his compassion,"[12] because "he goes to the butcher's shop as if it were a church, with the meat as the crucified victim."[12] Invocation of the meat as "crucified victim" sacralizes, and thereby humanizes, all flesh—be it animal or human. Humanization of all flesh affirms its value and maintains our gaze—rescuing it from the dehumanization and abstraction that it undergoes. Far from being a mere reduction of flesh to the inhuman, Bacon's work elicits compassion and solidarity—hard-won through horror and close attention—qualities that shared vulnerability in flesh brings into existence. For Deleuze, Bacon's artwork is "of a very special violence," which manifests a certain "*zone of indiscernibility*"[12] that blurs the distinctions we draw between flesh: it is both human and nonhuman, alive and dead, healthy and suffering. To focus on these images is to sink into our own corporeal vulnerability and meditate on our past, present, or future sufferings.

Images of Suffering and Torture

What has all this to do with health care ethics? Medicine cannot be ethical if it does not prioritize an unflinching focus on suffering bodies over and against our inborn tendency to turn away, especially from the bodies of the poor. Because disease makes its own "preferential option for the poor,"[5] any moral system of healing must be well acquainted with suffering, smells, sickness, and death—even if it also means blurring the distinction between the (healthy, put-together) *us* and the (needy, dependent) *them* via the spirited solidarity of all meat.

Suffering. The founding of the hospital was one such place where close attention to suffering bodies gave rise to a new moral ethos for medical practitioners, thereby creating a new institutional form and sustainable culture of care. Individual *askesis* led to lasting social change. In Asia Minor in the 4th century CE, St Basil the Great founded his City of Mercy (later known as the *Basilead*)—the institutional genesis of the hospital form—which offered professional medical care, a centralized location, overnight stays, and nursing, all of which were free for all. His close companion St Gregory of Nazianzus explains this community's ethos of care, while criticizing Greco-Roman culture for its avoidance of the sick and its equation of illness with social worthlessness. In a fundraising speech, he describes the plight of those with the "sacred disease" of leprosy:

> No one would believe who has not seen it: human beings alive yet dead, disfigured in almost every part of their bodies, barely recognizable for who they once were or where they came from; or rather, the pitiful wreckage of what had once been human beings. By way of identification they keep calling out the names of their mothers and fathers, brothers, and places of origin: "I am the son of so-and-so. So-and-so is my mother. This is my name. You used to be a close friend of mine." And this they do because they cannot be identified from the way they used to look.... Who know[s] whether they should grieve more for the limbs they have lost or for those they have left[?][13]

Are these leprous bodies not Bacon's screaming forms? Gregory gives grisly detail to enjoin his audience to remember "the fact that we are flesh and compassed in a lowly body, and we are so derelict in our obligation to look after our fellow man that we actually believe that avoiding these people assures the well-being of our own persons."[13] This foundational ethos of attention amidst dehumanization reaffirms that we are bound together in one body, and the weal and woe of one affects all.

Restraints. A more contemporary example involves the use of force in medicine. While some use of physical and chemical restraints unfortunately remains necessary,[14] it is nevertheless the case that their (over)use is increasingly being called into question. The burden of force in clinical settings falls disproportionately on minoritized patients,[15] and, undoubtedly, the poor; it also reflects underfunding (via unsafe staffing ratios) and continues the carceral logic of health care. Indeed, there has been a growing movement known as abolition medicine in academic and activist spaces that is challenging this logic and imagining new possibilities.[16,17]

What is the role of images and their transforming power here? With respect to restraints, perhaps visuals depicting patients' distress at their restraints would be instructive, as physicians are apt to leave the room, put in the orders, and let others do the "dirty work"—at best, to minimize voyeurism and, at worst, to escape discomfort with what is happening. This response could be contrasted with the "positive" example of Tony Robert-Fleury's famous 1876 painting, *Pinel Freeing the Insane,* a classic study of liberation from (medical) restraint.[18]

Torture. The furthest extremes of contemporary US physicians' inappropriate engagement with violence, however, are their documented participation in modern capital punishment and participation in torture during the War on Terror.[19] Public reports and deeply disturbing photos going back to the early years of the War on Terror helped galvanize public consciousness.[20] CIA-run "black sites" (secret prisons) were sites of deep medical complicity with violence, where a "'board-certified physician' was in the room for every session of waterboarding"[19] and where medical officers participated in "rectal rehydration" of patients who refused oral intake (a practice Physicians for Human Rights has called "sexual assault masquerading as medical treatment.")[21] Perhaps via images of such terrible deeds, Bataille's "pure violence of the image itself" would effect a "laceration" of our personal—indeed, professional—identity, shattering both our self-preoccupation as well as our assumed benevolence, and spurring viewers to contend ever more forcefully for a holistically healing profession.

To take another example of how images of torture can lead to activism, in 2006, medical professionals in North Carolina caused a decade-long pause in executions after professional organizations prohibited participation and ceased working with the state Department of Corrections; at roughly the same time, a documentary (filmed in 2005) was produced by the Death Penalty Photography Project giving a behind-the-scenes look at North Carolina's death row.[22]

While it is difficult to neatly draw lines of causation, visual exposure to the reality of terrible suffering seems to have strengthened protests against medicine's involvement in such violence. Just as the early Christian focus on the suffering body led to a burst of institutional creativity, so these modern images of suffering also instill personal conviction and motivate institutional change, revealing the inextricable connections between internal and external transformation.

Transformation to Equity

As intimate witnesses to suffering not unlike Basil the Great, Gregory of Nazianzus, or modern viewers of images of torture or capital punishment, we—as the result of our *askesis*—might similarly strive for a new moral ethos centered on social responsibility, justice, and equity in health care. To insistently gaze upon broken bodies reminds us of the fact of suffering and compels us to prioritize life over and against our desire to run away from suffering and our fears of dependence and death. This task is especially necessary in a profession like medicine, which has drawn primarily from privileged groups for its membership.

Perhaps our usual fears of contagion, suffering, and death are the aspect of "normal" (ie, status quo) psychology that Bataille attempted to surmount in order to make an ethical life of solidarity possible. Yet to attain such a state, (trans)formational cultures, relationships, and institutions are necessary; the solidarity of all flesh that they enable has obvious implications not only for medicine but also for contemporary issues such as biosphere destruction and climate change.[23] Bataille and Deleuze set up the problematic to which Francis Bacon and the origins of the hospital provide a possible solution: a close viewing of ghastly bodies that, paradoxically, pushes us towards a profound solidarity with all suffering flesh.

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ART OF MEDICINE

Why Would Having Learned to Cope While Waiting for This Appointment Make This Pain Normal?

Julia O'Brien

Abstract
This comic investigates ethical dimensions of the experiences of patients whose pain has become normalized while waiting for clinical attention.

Figure. Detail from *Reading the Busy Calendar of a Busy Body*

(Click here to view the entire graphic narrative.)

Media
Procreate®.

Caption
This story takes place within an artist's calendar as they self-reflect on the anxiety of seeking medical help after experiencing painful symptoms that have already become routine. Most physicians schedule appointments months in advance, requiring patients to suffer pain that remains clinically unassessed. Ironically, some patients' capacity to cope with pain that is neither assessed nor mitigated by clinical means suggests to some clinicians that their pain is bearable; this form of iatrogenic harm is exacerbated when patients' experiences are ongoing, anxiety generating, and discredited by the very clinicians called upon to help them. As in the comic, people whose suffering has become "both expected and taboo" often wait until their condition worsens. Many patients prepare to make the most of their visit, struggling to find the right language (ie, terminology) to be taken seriously.

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