In Shock: My Journey from Death to Recovery and the Redemptive Power of Hope (Awdish, 2017, pp. 222-225)

 “It looks like your breathing is getting better,” the ICU fellow reassured me. “And I think I can see the swelling starting to come down. The medicine is working. I want you to know, I’m not leaving. I’m going to be here all night. We won’t leave your side until you can breathe. You are safe.”

 He was part of a new generation of physicians that was being deliberately trained in empathy, trained to recognize the emotions in others and reflect them back. Though I knew I wasn’t entirely out of danger, I felt comforted by his words and by his reflection of the situation back to me. His messaging spoke to his assessment of my fear, his ability to empathize with me and his understanding of what I needed to feel secure.

 What was immediately stunning was the hard-won sense of trust his few sentences brought into that ICU room. I thought in those words there was more actual doctoring than in the prior twenty-four hours combined.

 It was so surreal that I had actually run the communication training program that he had taken during his orientation. I knew the steps that had been outlined to him. And yet, it felt completely genuine and effortless. I understood that his simple statement required a situational knowledge of how it must feel to be unable to breathe. It required an emotional humility to suspect I was fearful and would benefit from being reassured. It required that he allow himself to feel with me. It required a self-knowledge of what feelings he was bringing into the room so he didn’t dump in. I looked at the medical student and wondered if he recognized the skill involved. I wondered if after witnessing such an exchange he would be able to break it down into replicable chunks or whether to him it just looked like magic.

 Two weeks later, when I rejoined the team as the attending, I pulled [him] aside and acknowledged it might feel awkward for him to have me as his attending. “No, not at all,” he answered genuinely. “Just because you’re a doctor doesn’t mean you are different. We all will be patients at some point.” [She asked him what he remembered the fellow said.] “I think he just offered support, said things were getting better and he wouldn’t leave until you were safe. Something like that.”

 I thought about how often I listened to truly hear rather than thinking about advancing my agenda, or mentally rehearsing the next thing I wanted to say. How often does anyone listen generously, without ears pretuned to what they hope the answer will be? We hope the events of the day will allow each of us, physician and patient, to leave the hospital free of permanent scars.

 Our preformulated agenda is often nothing more than another mechanism of self-protection. We enter conversations with patients and families with each of our personal ghosts trailing behind us. We enter them not always aware of our capacity to bear more grief. We are not adept at gauging our resilience or counting the shadows in the room. I wondered if the new skills I was seeing in the fellow were indications of a shift. If training were changing, perhaps we would soften at the door of a patient’s room rather than steel ourselves. Perhaps we would stop believing we had to make impossible things look effortless. We could believe instead that we were there to truly listen.