

Norman Quist, "Knowing Together: The Physician-Patient Encounter and Encountering Others: Imagining Relationships and Vulnerable Possibilities," *The Journal of Clinical Ethics* 33, no. 3 (Fall 2022): 249-56.

Perspective

Knowing Together: The Physician-Patient Encounter and Encountering Others: Imagining Relationships and Vulnerable Possibilities

Norman Quist

It should be our earnest endeavour to use words coinciding as closely as possible with what we feel, see, think, experience, imagine, and reason.

—Johann Wolfgang von Goethe, *Maxims and Reflections*

ABSTRACT

In this essay, by example of the physician-patient relationship and drawing on the work of D.W. Winnicott, I explore what may be possible together in relationships, and in the pursuit of health and flourishing, at understanding what we need, and getting ourselves and the other "right"—what we are afraid of and how we get each other wrong, and the distance or gap between "what has been" and "what might be." In pursuit of these questions, I consider what both physicians and patients might endeavor to do together to address this distance: to recognize and respond to each other, and to identify and address common needs and felt distances. And, how, along the way, we may be able to better identify and understand fundamental challenges to all relationships. Finally, I ask the reader to imagine a physician-patient encounter (and all relationships) as vulnerable possibilities. And I suggest a method for a way forward. While we may not always get what we want in a relationship, perhaps our earnest effort at knowing together will open a potential space for us to get what we

need. This is where I imagine that the physician-patient relationship begins: where all relationships begin.

In all relationships there is a distance between "what has been" and "what might be." What has happened and what may happen.¹ How our felt distance from each other matters to us depends upon our desire for the relationship—and the gap between how we imagine it, and what it has been. In relationships that matter the most to us, our intimate relationships, and relationship in which we are most vulnerable—relationships of concern and care, and our well-being—I imagine that our desire is to know and to be known. As Winnicott describes it, "Health here includes the idea of tingling life and the magic of intimacy."² In this relationship, as I imagine it, we desire (need) to be recognized and heard. And, as the relationship develops and matures, to be found by the other. Our flourishing, our becoming who we are, depends on this.

In this essay I focus on the physician-patient relationship and explore what may be possible together in the pursuit of health and flourish-

ing, and the distance or gap between what has been and what might be. In pursuit of this question, I consider what both physicians and patients might endeavor to do together to address this distance: to recognize and respond to each other, and to identify and address common needs and felt distances. And, along the way, we may be able to better identify and understand fundamental challenges to all relationships. Finally, I ask the reader to imagine a physician-patient encounter (and all relationships) as vulnerable possibilities. While we may not always get what we want in a relationship, perhaps our earnest effort at knowing together will open a potential space for us to get what we need.³ This is where I imagine that the physician-patient relationship begins: where all relationships begin.

The pediatrician and psychoanalyst D.W. Winnicott, reflecting in his later writings upon his early education as a physician, credits Thomas Horder as being a significant influence, teaching him to listen to the patient's own story and to take a careful history.⁴ Horder emphasized to the young Winnicott that "the doctor-patient relationship is the very soul of good doctoring."⁵ And at first impression this seems intuitively true. But no sooner have we recognized this than a question likely comes to mind: What kind of relationship is being imagined? And, what can be said about the distance between how we imagine it, and what it has been?

The physician-patient relationship begins in words—a question and a response: What brings you here today? Although this question initiates the encounter, there is already an unspoken but implicit expectation, an imagining, as the patient has sought out this physician for help—for care.⁶ Heard by the patient, the physician's question is an invitation, an opening to reveal why she has come, in her own words—spoken and heard. The physician's question is also an expression, a declaration, of recognition and concern. Question, response, and recognition. In this initial encounter, this being together, coming face to face, each anticipates, imagines (sometimes unconsciously), the possibility of a relationship. The patient may have also imagined who she hopes her physician will be, that is, qualities that might count for her as desirable, even imagined as ideal. Similarly, the physician, in her first words, imagines the patient; she also imagines using her skills and clinical judgment to address the patient's concerns and to provide care.⁷ This exchange of words fires the imagina-

tion of both patient and physician and brings to life, facilitates, the possibilities for a relationship. The openness and fluidity of this experience, its potential, was anticipated by Wittgenstein when he wrote, "Uttering a word is like striking a chord on the keyboard of the imagination."⁸

In a physician-patient relationship, as in all relationships, the words we first use with each other matter in a unique and interesting way. We use words together—in response to the other. We make an impression. Our words signal our receptivity of, and attitude toward, the other; they may also signal our defense. Simply put: In real time, each considers the unspoken question: Am I being understood? We listen and observe. We rely on a theory of mind and imagine, looking for clues and confirmation, what the other might be thinking. Paradoxically, sometimes, in hearing our own words, what we find ourselves saying, we may seem to be strangers to ourselves. The act of speaking one's words, and hearing them as they are spoken, can be generative, but it also introduces risk, as we try to get our words and the other right—and participants simultaneously defend against, or parry, their desires, vulnerability, and anxiety. After all, we can't simply say what first comes to mind.⁹

*Everything has already been said;
but since nobody ever listens,
we must always start over again.*

—Andre Gide, *Le Traité du Narcisse*

Successfully communicating with another is no easy affair—it is always aspirational. Our efforts are sometimes frustrated and incomplete, and we often are at a loss to say why. But this is not news. Sometimes it may be, as Gide noted, that "no one was listening." Understanding why "no one was listening" would seem to be of the utmost urgency, for meaningful conversations at least. Was there something about the words we used? Perhaps it was a matter of recognition, and our response to the other.

Were we listening?

Thankfully, in many of our everyday interactions, communicating does not become an issue for us. We get what we want—thus, we assume that we have been understood. We also

rely on shared social conventions. We understand that, when a colleague asks us how we are doing, we are not expected to recite our existential concerns. We have developed workarounds, so that everyday interactions with others can smoothly move along and we can get ordinary things done. Every conversation need not be “meaningful.” We have also learned to deflect uncomfortable questions. When our interlocutors seem to have forgotten the rules of the game, we might reply, “This is not the time to discuss that” (whatever “that” is). At other times, as the familiar lament expresses, “We don’t know what to say.” We can’t seem to grab hold of the words we want. Words that capture how we think and feel—our sense of things. And then there are times when we seem to know exactly what we want, when we seem to have the right words, but we are unwilling to risk saying them—we substitute other words instead.¹⁰

Successfully communicating in relationships that are most important to us requires a sharper set of skills and attention. Among other reasons, in these interactions we likely find ourselves in the hold of heightened feelings of vulnerability and dependency (perhaps unconsciously). We have a history with the other that matters to us. In these relationships, when communication does not go as expected, when it breaks down, we may similarly struggle with the impulse to resist and defend, but with elevated intensity as there is more at risk, as we may hold these relationships as fundamental in how we identify ourselves—to who we are as a physician, patient, partner, and friend. Here, it is no exaggeration to suggest that communicating well or poorly, our success or failure at understanding and being understood, makes every difference in our lives. A relationship cannot stand if we do not feel heard and understood, recognized as who we are.

An example of a breakdown in communication in a clinical setting is relayed by Sanders and colleagues, who write that “Patients frequently report that their physicians are not listening or, at least, that they do not feel heard.”¹¹ This is a powerful claim. Following these authors, it seems that patients do not feel recognized. As they emphasize, “These are trying times for the patient-physician relationship.” They comment on the consequences for practice: “The benefits of good communication and a strong patient-physician connection cannot be overstated. Evidence and experience show that

this connection improves diagnosis, adherence to prescribed regimes, and even some outcomes.”¹²

Victor Montori, in *Why We Revolt*, makes a compelling and sometimes poetic argument for a reevaluation of the physician-patient relationship.¹³ Montori writes: “In the depth of our encounter, we must think through, work through, feel through, and talk through my problems as a patient” (chap. 6). “This exchange, described as a conversational dance and called shared decision-making,” Montori writes, “remains—unfortunately—rare” (ibid.). “Shared decision-making helps to avoid the tyranny of evidence—of doing what the study found was best, regardless of who the patient is. . . .” (chap. 12). Montori describes this environment poignantly: “As a patient, I should feel that what matters most to my clinician is going on right now. . . . This time together needs to be slowed down and understood” (chap. 6). Applying Montori’s recommendation, the process of examination and treatment is something that the physician does *with* the patient rather than *to* the patient, explaining, when possible, what is happening, or about to happen, and why. In this manner the physician invites, or opens the possibility for a patient’s questions. Health and well-being are goals that physicians and patients pursue together. Or, as I have been suggesting, worked through and felt through as (two people) patient and physician, face to face. In other words, a relationship that grounds authentic shared decision making—elucidating a patient’s values, following question, response, and recognition—requires a facilitating environment.

It is well known that the institutionalization of medicine has introduced important and vexing organizational and systemic ethics challenges. Although appointment times are shorter, making the time physicians spend with each patient a critical ethical concern, it is still possible for physicians to commit to creating a facilitating environment for shared decision making in the time that is available. However, physicians will need to be vigilant and may have to push institutional boundaries. But Montori is right. An empathic relationship—working through together—is essential in identifying, understanding, and responding to the patient’s values, for shared decision making. This is but one feature of Montori’s call for a revolt in the practice of medicine—but, arguably, the most important—and one for which a response is

within the reach of all physicians.¹⁴ As we learned from the research work of Schneider, years ago, physicians may be mistaken about what it is the patients want.¹⁵ But none of what I have been suggesting requires physicians to impose their view of a relationship upon any patient. But I am suggesting that physicians signal or model their availability to each patient, and to some patients this may come as a surprise: patients may wonder how to respond.¹⁶

In the physician-patient encounter, as I have described it, there is a frame. The physician speaks first and guides the encounter with a question, recognizing the patient: question, response, recognition. The physician endeavors to create a facilitating environment. But, in practice, even the most attentive and attuned clinicians, committed to a facilitating environment for shared decision making, when operating within a similar frame or structure, patient after patient, will need to be vigilant to the habituation of their “clinical response.” One way to counter this may be for clinicians to make a deliberate effort to begin again—with each patient: listening anew to each patient’s own story as if for the first time.¹⁷

WHAT MIGHT BE

One way to support a communicative and facilitating environment—an essential component for all relationships—returning the epigraphs of Goethe and Wittgenstein—may be for clinicians (and for all of us) to pay particular attention to how they (we) use words, and how they encourage patients (others) to use words. In this context, what might it mean or reveal if we—both clinicians and patients—were to make it “our earnest endeavor to use words coinciding as closely as possible with what we feel, see, think, experience, imagine, and reason”? How might this imaginative effort, this commitment, facilitate our knowing, together: our effort to get the other—and ourselves—right? How might we begin?

It is clear that Goethe’s advice, and our “what might be” suggestion, are highly aspirational, that we “endeavor to use words coinciding as closely as possible with what we feel, see, think, experience, imagine, and reason.” But within Goethe’s epigraph is a method: that our effort must first of all be “earnest.” Applying this method to the clinical encounter, it seems reasonable to further imagine that the earnest ef-

fort demonstrated by clinicians will resonate with patients, thereby increasing their feelings of safety and relationality. By engaging others with our words and our world, allowing/inviting others to hear us in a particular way—to get us right—we are also modeling a way of being with them: our earnestness!¹⁸ And if we further imagine how this kind of conversation unfolds, it need be no surprise that our earnestness “feels true” or authentic to the other. In its totality, it’s possible that the experience for both patient and physician may be transformative, changing us, and changing how we experience the world—and what we can say about it, and about ourselves. In this facilitating environment, feeling recognized, patients and clinicians—all of us—have an opportunity to find other words, words that come closer to “saying” what we mean. And would not all of this be an immediate benefit to the relationship?

Importantly, in this facilitating environment, physician and patient are committed to the relationship as it changes—as equals. This is arguably the ideal ground for shared decision making. Winnicott captures this dynamic, the mutuality of the doctor-patient (therapeutic) relationship, or “care-cure,” as he imagines it, when he writes: “we find that when we are face to face with a man, woman or child in our specialty, we are reduced to two human beings of equal status. Hierarchies drop away.”¹⁹ Reflecting upon Winnicott’s observation, we are once again reminded of our relationality, as equals.²⁰ But what does this mean in terms of question, response, and recognition? And how does it translate to each patient in the clinic? Put another way, there is a distance between reading of our mutuality, imagining a common humanity between physician and patient, even when this seems intuitively true, and what might be done, what it might require to actualize this in practice: what happens with each patient in the clinic. When Winnicott imagines that “hierarchies drop away,” for example, he is likely thinking first of relationships within a psychoanalytic encounter—the therapeutic relationship between the two people in the room. Two different rooms—clinic and consulting. But how are these engagements analogous? In each instance the physician (as Winnicott was also a physician) is challenged to recognize and respond to a patient who is suffering—and the engagement is constructed by questions and words that “strike a chord on the keyboard of the imagina-

tion,” and response and recognition, all grounded (dependent) on the earnestness of each participant. There need be no hierarchy here, rather a knowing together.

For the physician in the clinic to do this over and over again with each patient demands a great deal. Among the many differences, the 15-minute clinic encounter is far from the “psycho-analytic hour.” Yet in this time the physician in the clinic can still practice and model earnestness, a knowing together, and the method of question, response, and recognition: “to use words coinciding as closely as possible with what we feel, see, think, experience, imagine, and reason.” We might even imagine that this approach could help bridge the gap that some physicians report, lamenting the commodification of transactional medicine, and make the practice of medicine more meaningful and rewarding for the physician—a revitalization of the spirit and practice of the fundamental physician and patient relationship.

Throughout this essay I have suggested that our health and flourishing is entwined with our effectively communicating our wants and needs in relationships (as patients, clinicians, partners, and friends). I have suggested that feeling heard, and listening and speaking earnestly to the other, and in a particular way, may be transformative. And, hopefully, by sketching a facilitating environment and suggesting a method, to have shown a way forward for each of us to better understand and get what we need (and to better understand and respond to the needs of the other). At its best, a knowing together.

EPILOGUE

*Yet why not say what happened?
/Pray for the grace of accuracy. . . .
—Robert Lowell, Epilogue*

Iris Murdoch famously remarked that it was revealing to ask of a philosopher: What is he afraid of?²¹ And, although Murdoch was speaking to and about philosophers, this is a question for us all. She observes, “It is frequently difficult in philosophy to tell whether one is saying something reasonably public and objective, or whether one is merely erecting a barrier, special to one’s own temperament, against one’s

own personal fears.”²² It is axiomatic that we are all challenged to understand, to get right, what it is that others are saying—what they mean. But we are similarly challenged to get ourselves right: can we mean what we say? What do we fear? We are, after all, seeking to understand the struggles of another—and our own.

In conversations, in our use of words and descriptions, we are often implicitly assuming that the other will use our words, our description. (If they would only do this then the problem would be resolved.) And our disposition here is understandable, we privilege our view of things, and this seems to work for us—or, that’s how we see it. If challenged, we may resist and defend. But, as Lowell reminds us, saying what happened is not easy, we have to “pray for the grace of accuracy.” And an appeal to grace may be ever more appropriate when we are recommending, especially to those who are suffering or most vulnerable, a way of life—a certain way of health and flourishing. (Ironically, it is in recognizing, and then working through these struggles, that the full force of—and uncertainty about—the autonomy of another may be most vexing to us.) It seems to me, however, that this is the time in our conversation when we want to clear the way, as we can, together, for the other to identify and explore their wants, needs, and desires—their projects and way of life. To talk earnestly and safely about these things, and, at best, to close the gap or the felt distance between us. With this as our aim, and recalling Wittgenstein’s claim that “*The limits of my language mean the limits of my world,*”²³ what might be if we, in earnest, “*endeavour to use words coinciding as closely as possible with what we feel, see, think, experience, imagine, and reason*”? Committed to begin again, as if for the first time: question, response, and recognition.²⁴ What are we afraid of?

NOTES

I am grateful to Jodi Halpern, Randy Howe, and Leslie LeBlanc for reading this essay and for their thoughtful comments. I benefited from them all. Still, they ought not be held responsible for the words that made it onto the page.

The sources of the epigraphs in the text are as follows.

J.W. von Goethe, *Maxims and Reflections*, 2nd. ed., trans. T.B. Saunders (London, U.K.: MacMillan, 1908), 317.

A. Gide, "Toutes choses sont dites déjà; mais comme personne n'écoute, il faut toujours recommencer," *Le Traité du Narcisse* (Paris, France: Librairie de l'Art Indépendant, 1891), translated as "Narcissus," in *The Return of the Prodigal*, trans. D. Bussy (London, U.K.: Secker & Warburg, 1953).

R. Lowell, "Epilogue," in *Day by Day* (New York, N.Y.: Ferrar, Straus, and Girox, 1977).

1. These lines are inspired by Aristotle's description of the difference between the historian and the poet. "From what we have said it will be seen that the poet's function is to describe, not the thing that has happened, but the kind of thing that might happen, i.e. what is possible as being probable or necessary. The distinction between the historian and the poet . . . consists really in this, that the one describes the thing that has been, and the other a kind of thing that might be. Hence poetry is something more philosophic and of graver import than history, since its statements are rather of the nature of universals, whereas those of history are singulars." Aristotle, "Poetics," *The Complete Works of Aristotle*, ed. J. Barnes, trans. I. Bywater, vol. 2 (Princeton University Press, 1984), 91451b1-7.

2. D.W. Winnicott, "The Concept of a Healthy Individual," in *Home Is Where We Start From* (New York, N.Y.: Norton, 1986), 31. Knowing and being known, and being found, as I use them here, have limits; they are broadly adapted from Winnicott. An engagement with them rewards the effort, but is beyond the scope of this essay.

In Winnicott's description of communication (object-relating) there is a tension (dilemma) in the self that is both communicating and non-communicating: "the individual's use and enjoyment of modes of communication, and the individual's non-communicating self, or the personal core of the self that is a true isolate" (p. 182). "Here is a picture of a child establishing a private self that is not communicating, and at the same time wanting to communicate and to be found. It is a sophisticated game of hide-and-seek in which it is a joy to be hidden but disaster not to be found" (p. 186). See D.W. Winnicott, "Communicating and Not Communicating Leading to a Study of Certain Opposites," in *The Maturation Process and the Facilitating Environment: Studies in the Theory of Emotional Development* (Madison, Wisc.: International Universities Press, 1965), 179.

3. The concept of potential/transitional space is multidimensional and a central feature in D.W. Winnicott's work—a space that lies between fantasy and reality. Winnicott writes: "The potential space between baby and mother, between child and family, between individual and society or the world, depends on experience which leads to trust. It can be looked upon as sacred to the individual in that it is here that the individual experiences creative living" (p. 103). A further elaboration of its scope and operation can be found in Winnicott's *Playing and Reality*.

Adapted for my purposes, the "potential space" may come into being in the individual's experience of the environment—in our relating to others (as mother/child; therapist/patient), when there is human reliability over time that leads to trust. This allows for "the creative playing that arises naturally out of the relaxed state. . . ." (p. 109). As I suggest, in the potential space an open, safe, and creative conversation becomes possible, one that is responsive to need and where anything might be imagined, spoken, and heard—together. D.W. Winnicott, *Playing and Reality* (London, U.K.: Tavistock, 1971).

4. Clare Winnicott noted, "In later life, Winnicott said that psychoanalysis was an extension of the discipline of history-taking that he had absorbed from Horder." This quote and the quotation in the text above are from C. Winnicott, "D.W.W.: A Reflection," in D.W. Winnicott, *Psychoanalytic Explanations* (Oxfordshire, U.K.: Routledge, 1978), 12. This is quoted in K. Robinson, "From Pediatrics to Psychoanalysis, 1911-1938," in A.T. Kabesh, *Twelve Essays on Winnicott* (Oxford, U.K.: Oxford University Press, 2019), 27.

5. The remark was made by Thomas Horder, who was "one of the most respected doctors of his day, who influenced him [Winnicott] profoundly." M. Horder, *The Little Genius: A Memoir of the First Lord Horder* (London, U.K.: Gerald Duckworth, 1966), 56.

6. This point, of a beginning of a relationship, recognizes but brackets the conscious and unconscious readings of what can be called, broadly, "first impressions," components of an immediate inclination or "feeling" about someone. These include mood, body language, and dress. Unconscious bias may also be a factor. All of these cues may be in play prior to any words being spoken (and tone of voice matters). We also get people wrong, as Roth, in *American Pastoral*, sarcastically describes it:

You get them wrong before you meet them: you get them wrong while you're with them and then you get home to tell somebody else about the meeting and you get them all wrong again. Since the same generally goes for them with you, the whole thing is really a dazzling illusion empty of all perception, an astonishing farce of misperception. And yet what are we to do about this terribly significant business of other people, which gets bled of the significance we think it has and takes on a significance that is ludicrous, so ill equipped are we all to envision one another's interior workings and invisible aims? . . . The fact remains that getting people right is not what living is all about anyway. It's getting them wrong that is living, getting them wrong and wrong and wrong and then, on careful reconsideration, getting them wrong again. That's how we know we are alive: we're wrong.

P. Roth, *American Pastoral* (New York, N.Y.: Vintage, 1997), 35.

As I hope that this article demonstrates, while I agree with Roth about the tendency to get people wrong, I disagree with his broader cynicism: the possibility for us to get them, and they us, right—and how to try, in earnest, to do this. And, how this process may be transformative for both participants, allowing each to see their world and the world of the other in new ways—to achieve higher levels of self-understanding, integration, and relationality.

7. Following Aristotle, “it is not the function of medicine simply to make a man quite healthy, but to put him as far as may be on the road to health; it is possible to give excellent treatment even to those who can never enjoy sound health.” Aristotle, “Rhetoric,” in *The Complete Works of Aristotle*, ed. J. Barnes, trans. W.R. Roberts, vol. 2 (Princeton University Press, 1984), 1355b11.

8. L. Wittgenstein, *Philosophical Investigations*, 3rd ed., trans. G.E.M. Anscombe (New York, N.Y.: Macmillan, 1968), §6; §67, p. 32e. It must be noted that Freud too is taken by the potential of words. He writes, “In psychoanalysis nothing occurs but the interchange of words between the patient and the physician. Words were originally magic and the word retains much of its old magical power even today. With words one man can make another blessed or drive him to despair.” S. Freud, *A General Introduction to Psychoanalysis*, trans. G.S. Hall (Hertfordshire, U.K.: Wordsworth Edition Ltd., 2010).

9. Here I emphasize, as most readers will immediately recognize, that our comments and conversations with others are self-censored. I suggest that they may also have unconscious components. And, I nod to Sigmund Freud and the challenge of free association—a “method according to which voice must be given to all thoughts without exception which enter the mind. . . .”—that the analysand cannot say, following this method, whatever thoughts or feelings first come to mind without inhibition—without halting, without censoring. J. Laplanche and J.-B. Pontalis, *The Language of Psychoanalysis* (New York, N.Y.: Norton, 1973), 169.

10. *Ibid.*

11. L. Sanders, A.H. Fortin, 6th, and G.D. Schiff, “Connecting with Patients—The Missing Links,” *Journal of the American Medical Association* 323, no. 1 (7 January 2020): 33-4, doi: 10.1001/jama.2019.20153. Sanders and colleagues are commenting on a study by D.M. Zulman et al., “Practices to Foster Physician Presence and Connection with Patients in the Clinical Encounter,” *Journal of the American Medical Association* 323, no. 1 (7 January 2020): 70-81, doi: 10.1001/jama.2019.19003. This is an excellent commentary on the challenges for the patient-physician relationship, especially as it requires institutional change.

12. *Ibid.*; see note 9 above.

13. V. Montori, *Why We Revolt: A Patient Revolution for Careful and Kind Care* (New York, NY: Rosetta Books, 29 September 2020), kindle. Montori,

a physician practicing at the Mayo Clinic in Rochester, Minnesota, is well known for his advocacy for a “revolt” in medicine: “We want, and must fight for, careful patient care.” Montori goes further, arguing that “the conditions in which the physician-patient relationship must ‘operate’ are hostile. Not because of the choices clinicians get to make in deciding whether or not to engage earnestly with their patients, but by the fact that those choices are aggressively curtailed or simply not available anymore. This is why I think the unhurried conversation is the most important innovation in healthcare.” Author’s personal communication with Victor Montori, 8 August 2022.

Montori’s charge puts us in the thick of questions of institutional or systems ethics. And, it invites a further question: what can/ought physicians do? Engaging these questions is beyond the scope of my effort here, but this is essential. This said, the allocation of time within the physician-patient encounter is a primary ethical concern. I was introduced to Montori’s work several months ago, after hearing an interview he gave on patient-centered care, and thereafter had the pleasure of corresponding with him about our shared concerns—a striking family resemblance.

14. It is a goal for the physician to understand and model the structural elements of what I have called, after Winnicott, a facilitating environment: that the patient feels recognized and heard, and invited into a shared decision-making dyad that grounds the practice of medicine itself: physician and patient.

15. C.E. Schneider, *The Practice of Autonomy: Patients, Doctors, and Medical Decisions* (Oxford, U.K.: Oxford University Press, 1998).

16. A central feature of a physician’s endeavor, and a reason commonly offered by trainees when asked why they chose—or were called—to medicine, is that they want to help others. Kierkegaard, certainly an unexpected clinical companion, provides a compelling reflection on “helping”—“In order to truly help someone else,” he writes, “I must understand more than he—but certainly first and foremost understand what he understands. If I do not do that, then my greatest understanding does not help him at all. . . . But all true helping begins with a humbling. The helper must first humble himself under the person he wants to help and thereby understand that to help is not to dominate but to serve, that to help is . . . to be . . . the most patient, that to help is a willingness for the time being to put up with being in the wrong and not understanding what the other understands.” S. Kierkegaard, *The Point of View* (Princeton, N.J.: Princeton University Press, 1998), 45.

17. Attending to our habits of listening to others is a challenge for us all, but especially so when we have established relationships with them. In a sense, we know them too well. There may be a tendency for us to anticipate, to think ahead, sometimes subconsciously, to what we expect the other person is going to say, as in: “I knew you (they) were going to say

that.” In these instances, we are not actively listening—and certainly not “as if for the first time.” The patient’s perception of the lack of active listening in the accounts reported by Sanders (see note 11 above) may similarly be attributed to physicians “listening” by habit, and not “as if for the first time.”

Identifying and understanding how structural changes in the practice of medicine bind or constrain physicians professionally and personally, and the practice of medicine generally, and what options or responses or models for delivery of care are feasible, and at what cost or burden, must be the subject of another article. Clearly the availability of boutique medical practices has been one response. At an institutional or systemic level, the challenges are well explored in the literature. These and similar questions are brought forward in Montori’s book, *Why We Revolt*, see note 13 above.

18. We use/choose words intentionally, with focused attention and commitment, with an introspective attitude and mood—in earnest. And then, as possible, finding the words, as best we can, to say to the other what we mean (to get our meanings and ourselves—and our world—reflectively, right).

19. D.W. Winnicott, “Cure,” in *Home Is Where We Start From: Essays by a Psychoanalyst* (New York, N.Y.: Norton, 1986), 115. Winnicott takes “care-cure” as an extension of holding. On hierarchies, Winnicott continues, “I may be a doctor, a nurse, a social worker, a residential houseparent—or, for that matter, I may be a psychoanalyst or a parson. It makes no difference. What is significant is the interpersonal relationship in all its rich and complex human colours. There is a place for hierarchies in the social structure, but not in the clinical confrontation” (page 115). Winnicott writes, “a sign of health in the mind is the ability of one individual to enter imaginatively and yet accurately into the thoughts and feelings and hope and fears of another person; also to allow the other person to do the same to us” (page 117).

20. Extending Winnicott’s observation on our relationality, that “we are reduced to two human beings of equal status,” the reader might contemplate, and perhaps embrace, this reduction in full appreciation of the “human condition.” Perhaps calling to mind the lessons of the Greek tragedies, or after being reminded of the sharp and insightful observation of Terence: “I am a man. And nothing human is alien to me.” Or, grappling with Freud’s observation: “Human megalomania will have suffered its third and most wounding blow from the psychological research of the present time which seeks to prove to the ego that it is not even master in its own house, but must content itself with scanty information of what is going on unconsciously in its mind.” Linking these observations, as we strive for a relationship with another, to get ourselves and them right, and “what might be,” it’s clear that we, as “rational animals,” have work to do. We begin with humility. Winnicott, “Cure,” *ibid.*, p. 116. Terence, *The Self Tormentor*, trans. A.J.

Brothers (Warminster, U.K.: Aris & Phillips, 1988). S. Freud, “Fixation upon Traumas: The Unconscious,” in *A General Introduction to Psycho-Analysis: A Course of Twenty-Eight Lectures Delivered at the University of Vienna*, trans J. Riviere (New York, N.Y. Liveright Publishing, 1935), SE, XVI, 284-5, from Lecture XVIII.

21. I. Murdoch, “On God and Good,” *The Sovereignty of Good* (New York, N.Y.: Schocken Books, 1971), 72. In the spirit of Lowell and saying what happened, there is in Winnicott a note on “the role of one who cares. . . .” “We are dead-honest, truthful, saying we do not know when we do not know. An ill person cannot stand our fear of the truth. If we fear the truth, let us take up another profession, not that of doctor.” Winnicott, “Cure,” see note 19 above, p. 116. On my reading, in being “dead-honest, truthful, saying we do not know when we do not know,” the physician models a shared decision making that is simultaneously honest, vulnerable, and self-reflective. This frame supports, and by modeling shows, what authentic decision making looks like (and feels like)—in a conversation about these things. The aim, of course, is increasing patients’ autonomy and authentic decision making.

22. *Ibid.*

23. L. Wittgenstein, *Tractatus Logico-Philosophicus*, ed. D.F. Pears and B.F. McGinness, trans. D.F. Pears and B.F. McGinness, with an introduction by B. Russell (New York, N.Y.: Routledge and Kegan Paul, 1972), §5.6.

24. A philosophical aside: Although the title of this essay highlights knowing together in the physician-patient relationship—and in all relationships—it is also a reflection about words: using words to communicate with others (and in our inner dialogue) about our world and theirs, and meaning, in all relationships: what we each find meaningful, and why. Perhaps to wonder about these things. How to live. Our flourishing, and even our health. In other words, to create an opening for a dialogue that is philosophical. And that takes us to Socrates, who, in “Republic” remarks that “the only proper judge of the two men [is] the one who is able in thought to enter with understanding into the very soul and temper of a man, and who is not like a child viewing him from outside. . . .” Although Socrates is speaking here about one who can judge the difference between two men, the tyrant and the ruler (and tell us of the consequences if one or the other will govern the city), our interest is in Socrates’s identification of the ability: one “who is able in thought to enter with understanding into the very souls and temper of a man.” This is the man Socrates is looking for; the man with this ability (and a particular kind of experience), that Socrates suggests we listen to. Arguably, this is the person we are all looking for—perhaps to become. Plato, “Republic,” in *The Collected Dialogues of Plato*, ed. E. Hamilton and H. Cairns, trans. P. Shorey (Princeton, N.J.: Princeton University Press, 1961), 577.