ON THE BRAIN

Somebody to Love

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In the middle of a long, busy stretch attending general medicine wards, the fog of fatigue settled in more each day as the capacity for transformation seemed to dim. My team of trainees gave the details of our new intensive care unit transfer's month-long hospital stay: perforated bowel, septic shock, abdominal abscess, respiratory failure. Recovery would be slow at best, and the patient was likely to linger in the hospital for some time yet.

He was relatively young, in his 50s. I asked what his life had been like before this hospitalization. What did he do for a living? No one knew—that was not part of the sign-out—so the clinical story from the past month had to serve to describe him, at least for the moment.

I saw him later that day. He had a fresh tracheostomy and was still on the ventilator. He tried to mouth words, but I couldn't make out much. With determination, he clumsily grasped a marker in his edematous hand and scrawled on unlined paper fixed to a clipboard. Squeezing his message around others he had written earlier, black marker leaking through from the papers behind like an odd little memoir, he wrote, "WATER! I need WATER!!!"

I sighed as I ungowned. After all that effort trying to eke out meaning from our restricted interaction, his foremost concern didn't seem very urgent against the backdrop of his acute conditions: he was thirsty.

By that point, he had so many specialists managing his care—surgery for his postoperative care, infectious diseases for his antibiotics, interventional radiology for his abdominal drain, pulmonary for his respiratory failure—that there wasn't much left for our team to do. So we set about seeing if we could get him cleared to drink water.

When I went to see him the next day, I cringed a little at the thought that I might end up staying as long again when, with a long list of patients, I really didn't have time. During our visit, a visitor came and greeted him from the doorway. My patient waved them in, and the visitor sat quietly in a chair in the corner as we finished up. As I was leaving, I asked the visitor if they were family, and they said, "He's my pastor."

My patient had big, expressive eyes and an open demeanor. When not writing, he usually had his hands clasped neatly over his chest like he was waiting patiently for something. His salt- and pepper-colored stubble evoked wisdom. Members of his family were usually there, and a steady rotation of visitors took turns sitting in quiet vigil near a windowsill filled with offerings of balloons and flowers. What, I wondered, does it mean to be unable to speak when, as a pastor, speech is so integral to your identity?

For several days, we clunked along. Communication remained difficult. He mainly wrote short phrases with simple but pressing concerns, like "Butt sore," letting me know he needed to be repositioned. The inflated cuff on his tracheostomy tube should have precluded speech, but he could sometimes croak out a few breathy words, overriding the forces attempting to silence him.

His medical conditions were improving, albeit at a glacial rate. We celebrated together when the speech therapist cleared him to drink water and again later when we could remove his nasogastric tube. I helped him take sips of water.

Toward the end of my service, I developed a vague awareness of something diminishing in me: the part that works hard to find meaning and connection in my work. After 15 years in practice, I now know that this is what burnout means for me. As the familiar numbness took hold, my work felt reduced to a list of uninteresting tasks. I felt increasingly low, aware that, in my disengagement, I was no longer doing my best work.

I was in this state on one of my last days with my patient when, at the end of an otherwise routine visit, he took my hand in his, looked at me seriously, and mouthed, "I love you." I wasn't sure I understood, so I asked him to repeat. He took a measured breath before again mouthing, "I love you," this time with more emphasis.

"I love you, too," I heard myself blurting out. And while stunned at my own response, I also felt the profound truth of these words. He gave an affirmatory nod, and I left the room with a sense of something having awoken inside me, bubbling up from where I had buried it long ago.

Did he somehow sense my increasing weariness during our visits? When you are robbed of speech, do your powers of observation soar? Or was it because it was Sunday, and he was reclaiming his identity as a healer himself?

I believe he was referring to *agape* love, a concept from Christian theology. According to this concept, agape is a selfless love of others associated with charitable acts, including caring for the ill.[1] And although I'm not sure if I believe in God, I do believe in love, which often provides answers where medical science falls short. Indeed, former US Surgeon General Vivek Murthy, MD, described love as "the world's oldest medicine."[2]

Admitting to my patient that I loved him felt exhilarating but also like a free fall, exposing my own vulnerability. But by allowing myself to receive and respond fully to his affection, he was able to reclaim some of his most treasured identity despite being incapacitated by illness. The result was a powerful circle of healing: I helped him, he helped me, and then I helped him again by allowing him to help me. Caring became mutually beneficial, and we both came out of this conversation restored to what mattered most.[3]

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Clinicians who, like me, struggle with burnout can find healing in the loving connections we form with our patients and health care community. But love doesn't always feel welcome in medicine. A culture demanding perfectionism doesn't hold space for the vulnerability that love requires, and a health care system that prioritizes efficiency doesn't always allow the time needed to cultivate loving relationships.[4,5]

When I went to medical school, the idea that I could love patients in an agape sense was enmeshed with my dream of becoming a physician. I realize now that I have long carried this with me with such a degree of embarrassment that I have hidden it even from myself.

However, if we are not continually reiterating the centrality of loving relationships in medicine, our work can feel transactional and task oriented, like a long list of mundane chores: put in an order, look up a dose, write a note. Its busyness can feel like the central purpose and become detached from its greater meanings and motivations. Yet it is also through these small, everyday tasks that our loving bonds are forged.

I am grateful to my patient for helping me recognize my need to ground my work in love. In the hospital where I work, I've since noticed that although suffering is all around me, so is love. If I'm intentional about it, I can find love nearly everywhere: a teenage girl in the elevator holding a container of food to bring to someone, a huddled group of security guards laughing together, a man pushing an elderly woman's wheelchair down the hall, a tech giggling as we notice I'm muttering to myself, the tearful hug of a patient's wife.

Embracing our vulnerability and explicitly acting in love can feel like an act of rebellion against a health care system that often feels dehumanizing to clinicians and patients. But through small, consistent, loving actions aimed at fostering connection, we can regain our humanity while better preserving that of our patients.

Now, when I work at the hospital, I'm always trying to find somebody to love.

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