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Narratives in Oncology

Emmanuel Levinas: A Doctrine for Doctors

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It happened in early July, a period known by insiders as "the worst time to get sick," acknowledging the cyclical changeover when freshly minted trainees begin their clinical education at urban teaching hospitals like ours. At this juncture, every intern literally starts a day after they graduate medical school, and every fellow is better characterized as a seasoned resident physician rather than a specialist. It is a phase shift that is clearly palpable. In this backdrop, I was a bit surprised when the young doctor nonchalantly presented the case to me, his first attending, during his first rotation in what amounts to an apprenticeship in radiation oncology.

"The patient is a 59-year-old homeless man with T2, non-small cell lung cancer. He was brought to the emergency department from the shelter due to shortness of breath. Work-up showed a mass on the chest x-ray, and fortunately the guy got lucky: the lesion is small and peripheral. Plus, there's no spread to the lymph nodes or distant sites."

The young doctor could sense that I needed to hear more and so he continued.

"No one is gonna give this guy clearance for surgery. Luckily, we can achieve tumor control rates that compete with resection by treating with SBRT combined with chemo."

As he presented, the first thought that occurred to me was, "Wow!" A part of me was amazed that a trainee could so readily reach a conclusion that was reasonable and evidence-based [1], while using an acronym for "stereotactic body radiation therapy" that was au courant. Working with such competence was sure to make my life easier during the upcoming 3-month rotation, particularly as I saw submission deadlines for two grant proposals on my personal horizon.

But the whole thing was also unsettling. Even though the "gods of guidelines" would have blessed the therapeutic recommendation, I needed more. I needed to meet "the guy." As we entered the large in-patient ward, it was easy to recognize him; he was disheveled, appearing just a few years older than me, wearing a tattered red sweatshirt which hung loose in many spots even though it was a size small. I introduced myself and invited the young doctor to do the same.

With great effort, we created a small space where we could be alone with him. Slowly, features could be observed. Cheek bones, that were far too prominent; long gray whiskers, not nearly in keeping with the neatly trimmed beards that adorn the pages of today's fashion magazines.

I made eye contact with him, but I could not be certain what I saw: was it self-pity? Coldness? Desperation? I simply wasn't sure. I paused to reflect.

The centrality of the face has been imparted to me by two dear colleagues (E.S., E.G.) with whom I have been privileged to study during the last 3 years. I worried that contemporary medicine focused too much on the molecular and the digital, surrendering the personal. Their prescription to me was profound: the writings of French philosopher Emmanuel Levinas [2]. Nearly 4 decades ago, as a young college student trying to acquire a rich foundation in the humanities, I had attempted to read Levinas but found his writing to be impenetrable. Notwithstanding, the experience and patience of my colleagues, coupled with their own curiosity to hear of the conflicts and drama surrounding cancer and those who treat it—let alone their inquisitiveness about life's end—ushered me in to a new system of thought.

Levinas, a great thinker who regarded philosophy as the wisdom of love rather than the love of wisdom, was obsessed with one's moral responsibility to "the other" (l'autre). His philosophy was predicated on the ethics of the other. Even so, Levinas recognized the challenge of reaching out to the other on a pragmatic level rather than lionizing the other in an abstract sense. He therefore advocated careful regard of the face as an entrée into the world of the other.

When one engages in face-to-face relationships, there is a genuine encounter reinforced by proximity and sameness, yet authenticated by the unlikeness. For Levinas, the other is revealed through "alterity," or the state of being different. It made sense when I recalled that personalized and precise medicine, after all, emphasizes that we have differences. The revelation of the face—each unique face—beckons us, even demands that we draw upon our ability to become concerned.

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Levinas was, by no means, making an amorphous pitch for empathy. He was explaining that the revelation of the face engenders connection between two individuals that can overcome any polarity that endeavors to separate them (e.g., healthy vs. ill, knowledgeable vs. ignorant). Accordingly, Levinas underscored that we must meet the other where he is…not where we might want him to be. Such a concept that embodies moral responsibility to the "other" can nourish the physician who struggles to muster compassion. For Levinas, the rules of the game were obvious: I owe the other everything, but this is not conditional upon what the other owes me.

What I have taken away from Levinas is the notion that there is a reality wherein once I, as physician, have met a patient at the level of the face, I feel the responsibility to him or her. I can no longer dodge or retreat from this obligation, precisely because the facial encounter is an ethical encounter. Physicians have a moral responsibility to probe the other and elicit those needs. Such exploration is enabled once we behold the face in earnest.

Meaningful channels of communication, perhaps including those enabled by facial connection, have been advocated by Verghese [3], who worried that the seductions of technology have conspired to breed the "iPatient." Verghese suggests that advances in medicine have had subtle but pernicious consequences—such as desensitization, and burnout—which must be actively combatted by health care providers.

I no longer perceive Levinas' ideas to be impenetrable; instead, they have become indispensable. Upon marshaling the courage to peer into the face of the other, the courage to get to know another person, the work of the oncologist can finally begin.

After a long reflection—a long silence—I reconnected with the patient. His eyes seemed to grow brighter with light pouring out of them. I felt like I knew him and, suddenly, I was ready to counsel him about stereotactic radiotherapy. But before that, I heard myself asking, "how are things going for you?"

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