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JULIA MAROUS STRAUT

In a busy hospital corridor, the father of a young girl with cancer asks his daughter's physician to tell him more about her condition. The doctor responds with data on the girl's blood tests and drug regimen. This is not the information the father is searching for, however. What this man really wants, though it may not be apparent even to him, is to sit down and discuss his own sense of guilt and complicity in his daughter's illness. Doctors have told him his daughter is dying. He needs an answer to a question that will take some courage to articulate: *Is there anything I could have done differently that would have saved her?*

During my years at the National Cancer Institute, I became aware of such scenarios playing themselves out again and again. Sometimes physicians, typically newly arrived oncology fellows, would sense a parent's need to talk but would not allow themselves to engage in "real life" discussions. They were uncomfortable taking on such counseling, or claimed it would eat into their time. Other oncology fellows grappled with displaced anger, frustration consequent to an inability to fulfill a "hero-rescuer" role, and the like. My colleagues and I soon recognized that unless these issues were brought to light, the clinical setting would become a tangle of mis- and missed communications.

What patients and their families go through as they deal with life-threatening illness offers a magnification of what others may experience. A patient might think, for example, that a pain in her chest means she is having a heart attack when really she is experiencing indigestion. Our students must learn to, as appropriate, calm suspicion and anxiety about dreaded illnesses. And in cases of life-threatening conditions, they must confront the stark reality of unfairness, recognizing that the world is sometimes unreasonable and unresponsive despite our very best efforts and wishes. No matter how much we may want to tell that father his little girl will be okay, we can't, and we need to recognize the scope of that hurt in the family and often the community.

Even in the most tragic of circumstances, the doctor-patient relationship can be uniquely rewarding to both. It is unlikely to be so, however, if physicians do not understand the many social and psychological dynamics at work in their interactions with their patients and patients' families. The late Dr. Leo Criep, a prominent allergist/immunologist and Pitt professor, was well aware of the complexities of this relationship. Dr. Criep passionately asserted that during this age of tremendous biomedical research promise, scientific acumen was no substitute for compassion, insight, and understanding. In his honor, his family has worked with the School of Medicine to establish what is believed to be the nation's first endowed chair focused on the dynamics and philosophy of patient care. After an extensive national search, Robert M. Arnold, professor of medicine, has been chosen to serve as the chair's first incumbent (see p. 36). Like Dr. Criep, Dr. Arnold is a clinician, scientist, and teacher; and like Dr. Criep, he is committed to creating the best possible environment for meaningful communications and interactions between doctors and their patients. I've asked him to bring his leadership, creativity, and vision to the school's extensive efforts to promote humanism in medical education and clinical research.



Arthur S. Levine, MD
Senior Vice Chancellor for the Health Sciences
Dean, School of Medicine