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# The Doctor's Gaze | Dr. Bob Cutillo

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**The Veritas Forum**

How we care for our sick tells us much about who we are as a society. How should we view those who come to us for care? For Dr. Bob Cutillo, a physician at the Colorado Coalition for the Homeless, what we see depends on how we look. At a Veritas Forum from the Mayo Clinic, Dr. Cutillo draws on central themes from his book, Pursuing Health in an Anxious Age, and through examining ancient perspectives on patient care, including Dante, Nietzsche, and the Bible, argues that looking back may help us see the way forward.

## Transcript

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How should we view those who come to us for care? For Dr. Bob Cutillo, a physician at the Colorado Coalition for the Homeless, what we see depends on how we look. At a Veritas Forum from the Mayo Clinic, Dr. Cutillo draws on central themes from his book, Pursuing Health in an Anxious Age, and through examining ancient perspectives on patient care, including Dante, Nietzsche, and the Bible, he argues that looking back may help us see the way forward.

[Music] Good evening.

I'm honored to be your speaker tonight. It's the first time for me at the Mayo Clinic, and first time for me actually in the State of Minnesota, so I'll check that box. And I do want to thank also the Veritas Forum for sponsoring this event and for the local planning committee for making this possible.

And I hope tonight we're going to have a thoughtful discussion. And I've titled the Talk,

The Doctors Gaze, some ancient opinions on how we see our patients. And I'm going to start with a story, and this is when I was a first-year resident over 30 years ago.

Now for some, that may be ancient history, but I want to put an asterisk here. I'm not one of the ancient voices, okay? I'm going to give you some other voices that are going to be the ancient voices. So I was a first-year resident in Boston on the Internal Medicine Service, and we were on call one night, and the way that worked was we would go down to the emergency room, pick up our patient, bring them up to the floor, sometimes literally bring them to the floor, take our history and physical, write our orders, and go back down and repeat the cycle.

Get our patient, bring them up to the floor, do our history and physical, write our orders, go back down and get another patient. So most nights were busy. We would be up most of the night.

There occasionally would be nights we would have a quiet night, and we might actually find a hospital bed, and we'd lie down and make sure the nurse didn't take any vital signs. But most of the nights were busy, and so this particular night I had eight admissions, and so I was up for most of the night, but usually around three or four the admissions would stop, and that's when we would go back, and we would finish our nose. So I remember writing my physical on one of my patients, then I'm pleading the note at four o'clock in the morning, and I'm writing the history, and I'm going down to the genital exam, and I write down, testes descended, uncircumcised male, no masses, no lesions, no hernias, continue to write down to the end of the physical go to sign my note, and realize that I had done a very detailed male physical on my patient and gertrude.

So I learned a lot of things in that first year in medicine, but I knew that one was going to be a challenge all my life to see my patients as specific and distinct persons, as individuals who are in that hospital bed, but really they have a place in a world other than that hospital bed. They belong somewhere else. They're a part of something more, their family, their community, and it's in these places that they have specific roles to play.

So thus began for me a long curiosity to understand how our view of the patient is formed. What are the forces and factors that create the doctor's gaze? Now there are many you can make your own list. There's the basic ones like our family upbringing and our temperament.

There's some that are functioning in the most practical ways, the ones I've already alluded to, time and pressure. Those influence our view of the patient. They've always been there and they always will be there, and sometimes they're the most dominant because they're the most forceful.

Some of them are those large and unmanageable conditions or circumstances like the

economics of healthcare and healthcare policy and politics. But I think some of the most important ones are the ones that come to us through our culture. And I'm speaking about the immediate medical culture that we're all brought up in, but also the larger societal culture.

And it's important for us to look at them because first of all their influences we all share, and secondly their influences that often lie hidden below the surface. And because they're hidden they can be the most powerful because they're based in tasks and assumptions that we rarely mean. So one of my goals tonight is to name, inside of name some of them, to bring them out in the open with the hope that by seeing them more clearly it might allow us to see whether they fit, whether we like the proportions in which they fit so that they can form the kind of picture of the patient that we want to have.

So one of the things I'm hoping to do tonight for you is to stop and look. Now for the sake of creating our conversation tonight, I'm going to set out sort of the architecture of my plan. I'm going to offer you four perspectives.

And I think, at least at the outset, all of them are valuable, but their value is heavily dependent upon their proportionality, their balance in the mix. And I'm going to suggest that you imagine these four perspectives on two levels. So you can imagine two of their perspectives on the first level and two on the second level, almost like a two-story house.

And I'm going to make the case that the first two on the first level, they come more naturally as products of Western society. They fit more with the cultural forces of modernity and late modernity, and therefore they more easily exert their influence on us. While the other two views are more quiet, they're more tenuous.

They might lie in undiscovered territory for some. But even if we have some familiarity with them, because they're more subtle and tenuous, they're easily overwhelmed by the power of the other views. So with that structure in mind, let me get right into the first perspective, what I've called the patient as vulnerable project.

And I want you to look at this comic strip with me. And you can see this very large man walking down the beach, and I'd probably say he has metabolic syndrome. It's my guess.

And we can only see the back of him, and he has this tiny little speedo on. And as the couple walks by, the husband says to the wife, "You're right, health care's a lot like speedo's. There's only so much you can cover." Now I know I'm hijacking this comic strip from the health care debates we had not too long ago, but I think besides it being a commentary on a health care policy, I think it also reminds us of something innate about the human condition.

That hope for health is a fragile pursuit, and deep down we know that despite our best

efforts, we remain exposed. We come into this profession at some level knowing that we and our future patients are vulnerable persons. And as health care professionals, that view is naturally reinforced along the way by the unique window we have on life.

We know that life can be tragic, and health can be extremely fragile because of the inside track we have on injury sickness and death. We know of those who have waited two or three years to have a baby to get pregnant only to have a fetal demise. We've had children who've had cancer, or perhaps a family member who dies of premature heart disease, or maybe a family is ripped apart by infidelity and in a sexually transmitted disease it brought into the family.

In one sense it's a privileged position, but it's also a hard one because we're practicing medicine as a tragic profession. We are acquainted with grief because there's so much sadness. But it's also a good fortune that we live in the age of unprecedented scientific accomplishments.

The scientific project of the last 100 plus years has given us enormous possibilities to fix what's broken. Now one of the good outcomes of this perspective I think is that it should motivate us to learn our craft well, become skilled in the practice of the profession to pursue excellence, because who we're helping learning to help is a vulnerable sick people. Now I admit it's not always easy to learn our craft well, there's so much to learn, and there's always more to learn.

I remember when I was a student at Columbia in New York City and I was in the midst of the basic sciences and studying some arcane equation or something that I couldn't see made any sense with anything. And I was very discouraged and first I just left the dorm and somehow I found myself in the hospital and I don't even remember how this happened, but I was sitting next to it down and I was talking to a patient from Harlem. A man my age who was very vulnerable to sickness because of his abnormal hemoglobin.

He had been admitted for sickle cell crisis. And so I spent better that part of an hour talking to him and learning about what we had in common and many things that we didn't have in common and how he dealt with life with his disease. And I can tell you for sure that when I went back to the dormitory I was much more motivated to learn about the hemoglobin molecule and hemoglobinopathies and how we could help them because I knew about him.

I think that as we remember why we are learning and who it is we are helping by our learning, it should motivate us to know the quality science that are undergirds diagnosis and treatment because it's our job to bring the best of biomedical science to each of our patients. Now as we know one of the necessities if we are to look well through this lens is some stepping back to develop what I call the clinical gaze. It's not my term but the clinical gaze.

Basically it's that where we learn to look at our patient as a set of working parts we know how the parts of the body work, how they malfunction and what we can do to repair that malfunction. Now part of the debt for that clinical gaze that's so valuable for us today we owe to the period of the Renaissance. So that period is roughly between 13 and 1600 because that's when the paradigm shift occurred from a medieval approach to the importance of basing our medicine in knowledge and observation.

Now one of the first publications that documented that change was the printing of the fasciculous medicine A in 1491. It was the first illustrated medical book, a book of only 29 pages. It would have been what Da Vinci would have used when he was as a dissection manual in his primary source of medical knowledge.

Six of the pages were occupied by illustrations of which this is one and as you look at the illustration you can see at one level there's the barber surgeon and he's dissecting the body and there's a demonstrator that's pointing out the structures and there's a heavily disinterested audience observing on that floor. But what I want you to notice is that the professor sitting up on the higher level in his magisterial throne in toning the Latin text, the text of scholars, not the text of the common people, never descending down to actually look at the patient but maintaining distance to teach objectively what they must be learned. Now as we've diligently pursued our knowledge of the body over the years since that time, the temptation to stand at a distance has only increased, especially as we depend more and more on our technology to see our patients.

Now this is not to demean or deny the value of technology. Every image created can become a helpful way to gain the objective view, each one augmenting our senses beyond their natural abilities. But as we increasingly depend on more and more powerful forms of technology through which we view the patient, it makes it increasingly difficult to return to the patient and get it all to make sense for them.

So maybe we've seen the bulging disc on the MRI or the torn meniscus on the MRI, but does it make anything to do with the patient's concerns? It requires us to have consciousness vigilance to remind ourselves that every technologically created image is an abstraction of the true patient, and by its power has the capacity to take us farther and farther away from them. Now what happens if we move back away from the patients in order to gain the objective view and end up staying back? Standing apart from the patient where risk of harboring two very unhelpful attitudes, the first one is about ourselves that we possess the power to fix all of our patients' problems, and we all know that that's an attitude that far too easily becomes grandiose and delusional. And the second one is in relation to the patient that we look at the patient paternalistically, and though that may be a benevolent attitude, it nevertheless is a controlling and superior one.

And that brings us to the second perspective, the patient as autonomous being. Now

that's a more recent development, and it's needed at least in part because of a response to the overindulgence of the first view. But even though it may be a reaction to the paternalism of that first view, it's very much in accord with the cultural view that has become the predominant understanding of self in our society.

What we might call, or what I'm going to call the Promethean view. Many of you have been at the Rockefeller Center in New York City. We used to go there at Christmas time and watch the skaters.

And if you go there, you see Prometheus lying on his side with a clump of fire in his hand. And as you may remember the story, Prometheus was a titan-god who deceived Zeus and stole fire from him, and gave it an all sorts of other divine gifts and knowledge to mortals. Now in a good sense, that's the Greek mythological explanation for how he came to have art and literacy and culture and all the technical developments of our society.

But there's also the underside of technology because it also made us believe that we have the power to control our own destiny. That we are not dependent, but independent creatures. And to use Charles Taylor, philosopher Charles Taylor's terms of self-authorization, we can order our world and flourish on our own terms.

Each of us our own master with freedom of choice, the prime value, meaning that we can have it the way we want it. Now the good side of this perspective, the patient's autonomous being, is that we learn to respect each one's autonomy in their particular situation. This is a needed corrective.

Here we are patient-centered, we believe these individuals have the right to understand what's happening to them. And then we also invite them to participate in their medical decisions that will affect their lives. But when this perspective is excessively exercised, it turns the medical covenant into a contract.

It creates a loss of trust in the doctor-patient relationship, or the practitioner-patient relationship, and the ordering of a healthcare along a habit your way menu-oriented approach. With expected outcomes and angry customers when the result is not obtained. Now in my own experience, nowadays far more than ever, patients come to me and tell me what they want.

It might come from the television, it might come from the internet, it might come from what someone else got when they went to their doctor. But the worst part of all this is not that they ask this of me, the worst part is that they expect that I can give it. And so changing that really interaction into a demand and expectation transaction gravely distorts the image.

Now what I've already suggested is that these first two views, the patient as autonomous

being the second view, and the patient as vulnerable project, the first view, are heavily dependent on our modern and late modern mindset. And therefore they're more natural for us to assume because they mimic that mindset. So at this point what I want to do is call in one of my ancient voices in order to consolidate these first two perspectives.

And I can think of no better person to call in as a consult than that surprising specialist of modern culture. Some of you may recognize him, but this is Frederick Nietzsche. Now in many ways there's no greater profit of our current culture than Nietzsche.

Though writing over 150 years ago he understood with unusual prescience what would be some of the most powerful influences in our world today. Some of you may know him well, he was uneventfully born in a small rural or German parsinage in 1844. He became the most brilliant philosopher of his time.

He was precocious, he was prolific, he was a genius to the point of becoming a megalomaniacal in his last years. But whatever view of his overall philosophy when you read Nietzsche, one of the things you can't help but his mire is his intellectual honesty. And that honesty led him over the course of the development of his philosophy to accept his mistakes and make significant changes over the course of his career.

Yet there were several elements of his philosophy that were there from the beginning and only strengthened with time, two of which I think applies specifically to our discussion tonight. The first one was his awareness that life is tragic and suffering is an intransient component of reality. In fact that became one of the major critiques of the philosophy of his time that it denied the reality of suffering in the world.

And he claimed that modern modernity's optimism is a superficial whitewash in its attempts to paint out the picture of suffering. So his first important work was called the birth of tragedy. And in that he argued that it was the Greek tragedies of old that best defined life correctly.

That life is a struggle and that what we need is to be heroic if we're going to survive and overcome. The second element that he had from the beginning became very strong as his philosophy devous is what he called the pathos of distance. That in order to live in a world of suffering, one had to maintain distance.

So suffering or the German word lied was very real but mid-lide which is suffering with or translated as pity was a destructive emotion. It's something that makes us weak and ineffective. Mid-lide would paralyze the helpful hand.

Empathy would destroy us, he said. We'd be so overwhelmed to think of all the pain in Africa that it would, as he said, in quotes, unhinged the wings of the soul. It's something he repeated over and over in his mature works and in fact ultimately incarnated in his own life as he became more and more separate from others and increasingly isolated

and lonely as he aged.

But he felt that was the cost he had to pay as the herald of a new age. Now for those of you who know Nietzsche in the end Nietzsche's conclusion was power. That that would define and direct the new age.

Whereas he summarized it in his final years there is the will to power and nothing else. The goal was to seek mastery, first over self and for those who had the power to overcome self they would be the super race of the new age or what he called Superman who would then exert their power for the good of culture and society. Now I don't know if I've been clear to this point but what I'm suggesting is that it is inherent in our perspective of the patient thus far, the two views that I've given you is this mindset of control.

That's one of the commonalities that links them. So if we go from the first perspective where increasingly the doctor is in control that gives way to the second perspective the patient is in control. But either way whether the doctor or the patient is in control we forget what we one time understood that we're inherently vulnerable.

That our existence is fragile, finite and fleeting and in fact neither of us are in control. Now at this point I could give many illustrations of how easy it is to forget the inherent vulnerability of our existence. But what I'm asking you to consider is that the cultural forces of control and self-authorization make it exceedingly difficult to remember this basic truth about ourselves.

Now in our context remembering has a twofold value for our current task because first of all it makes us aware that the first level, the two perspectives that I've given you thus far on the first level they can be good in their proper measure. But it also shows that they're insufficient for our noble task and thus it prompts us to want to look further into our own ways. So using my analogy of the two level house it invites us to explore what's on the second floor.

Now I might argue that in some sense we don't know how to get to the second floor it's almost like we're on the first floor and we don't know where the stairs are. Or maybe we know where the stairs are but they're creaking in their old and we're afraid they're going to crack if we go up. But I think for the sake of enriching our understanding of the patient let's take the risk and go up to the second floor.

As I go up and enter on the first room of the second floor I'm going to give you our third image. The patient is sacred traveler. And for that I'm going to have you illustrate that with this old fresco.

This is a fresco that is from around 1440. And it detects a scene on the pilgrims hall on the ground floor of the hospital of Santa Maria de la Scala and Sienna. A crush from the

Sienna Cathedral.

It's one of Europe's first hospitals was actually one of the largest and most famous in medieval Italy. And this is a famous place in the middle of the Italy. And this fresco still hangs there in that pilgrims hall.

And it functioned at that time primarily as a shelter and as an infirmary for the countless pilgrims who came through Sienna. The interesting thing is there were a lot of pilgrims that came through Sienna because it was on the road to Rome. So in the scene we see the doctor kneeling before the patient surrounded by some consulting physicians.

And the physician that's kneeling is looking at the face of the patient and he's wiping the foot with a towel. I think you could perhaps remember this particular position compared to the fasciculous medicine if you wanted to make a comparison. But notice the focused look of the physician as he gazes at the patient and try to imagine what he's seeing.

Consider what a sensei experience it is. It's he seeing, he's touching, and he's probably also smelling if you look at the wound on the right thigh there. So he's have a very concrete experience with the patient.

But also in the way he's looking at him so intently there's something holy about his attitude as well as he gives this care in this church based infirmary. Because he's looking at the person as someone special, someone with a God given dignity because they're made in the image of God. And in that sacred view also a person that has a destiny.

It's very easy for this physician to know this person is on a journey after all they're a pilgrim on their way to Rome. But the person is also recognizing the patient as being on a spiritual pilgrimage that he's come from God, that he's on a journey and that it's a journey home back to the God who created him for a purpose. Now if you think about that kind of view it has great value for us because when we look at a person this way it gives us great resolve to defend patient dignity beyond any prejudice of society, irrespective of gender, race or national origin, and regardless of any physical or mental ability.

But it actually goes beyond any human value of judgment, even our own sense of the value of the person because it even supersedes our own limited view of ourselves because none of us fully grasp how much worth we have in the eyes of God or how much purpose God has created us to have in the life he's given us. Now in the second room on this second floor I have my last image for you. And it's the patient as fellow pilgrim.

And for that I'm going to illustrate it with this painting from the early 1800s and the painting is called the pilgrimage to Canterbury. And many of you would be familiar with the Canterbury Tales by Geoffrey Chaucer, he wrote it in the, it's really his greatest work, and he wrote it in the late 14th century. And if you remember the story there's a host

who's the innkeeper, there's Chaucer, and there's 29 pilgrims, 39 pilgrims at all, and in fact if you went in there and counted them they're all there.

Now if you remember the story what the plan was is that each pilgrim would tell a tale on the way to Canterbury and each pilgrim would tell a tale on the way back. And remember told the best tale we get a free dinner at the inn. It turns out that Chaucer died before he could finish all the tales.

But in the tale that he did tell he provides a very interesting picture of humanity that seems less available to us now than then, but I think it might be essential to read it. I think it might be essential to recover. Because if you look carefully at the pilgrims, they're a motley crew representing all the divisions of society at that time.

There's a working class miller, there's a mercantile merchant, there's a noble knight of military prowess, there's an intellectual priors, there's a socialist and a conservative, there's a corrupt church officials and a carpenter and a cook. They're all on the journey together and what Chaucer shows is that despite the wide differences in the stations of life represented by each pilgrim, any one of which are capable of destroying the fellowship, they stay together and share the journey because they're all going to the same place. They're all going to the shrine of St. Thomas Beckett and Canterbury Cathedral to thank him for his help throughout the year, especially for the times when they were sick.

So it's because of the definite and common goal of the journey, that's what's crucial for keeping the pilgrims on the same pilgrimage and turning a crowd of incongruous people into one company. Now that image of humanity, I would suggest as an enticing one. Because it offers us the idea that what we have in common is more important than what makes us different.

Now if we quickly bring that idea forward to our own world as healthcare workers, we can immediately see that one of the things that we have in common and we share with our patients is our common vulnerability to sickness, suffering and death. Now admittedly there are times when that perspective is more easy to entertain than others. For example, when you need a patient who's your age and has a condition that you could have, a recent patient of mine was my age and they were had colon cancer, and maybe wonder about my own risk of colon cancer.

Perhaps it's a patient that is having a miscarriage and you had one or your wife had one or someone close to you had one. Perhaps you're treating a patient with lupus and your sister has lupus. It's at these times that we entertain more this perspective of commonality.

There are other times that it's more like we're forced to consider this perspective. Like when we face a global epidemic, when we face contagious diseases like Ebola, or some

other global infectious disease, that challenges some of our most basic assumptions about separation and safety. How do we react in those situations? Do we recognize our shared vulnerability and act accordingly or do we try to increase the separation? In the Ebola outbreak that I talk about in the book, both of those were at work.

What I want to say about this attitude is it's more than just a but for the grace of God go I kind of perspective. It has a separation kind of concept to it. It's more but it's more by the grace of God we go together.

With this view we're invited to consider that we're only as healthy as our neighbor. That isolated health, that isolated individual cannot be healthy or to use Wendell Berry's term, the community, a place in all its creatures is a small unit of health. Many of us have little trouble recognizing that isolation and loneliness is one of the greatest risks to our patients' health.

The question is do we recognize that isolation and loneliness is one of the greatest risks to our own health? Now let's not be naive. The second floor is not an easy place to get to. For some we don't even know it's there.

But there's a whole array of forces lined up against it. Most obvious are the personal ones. I mean let's be honest there's a basic natural human hesitation to get close to difficult things.

Life in the trenches is messy. We prefer the clean, partitioned and separate spaces of our technoscientific understanding of the world. But there's all kind of cultural forces also that keep us on the first floor.

The medical ones that tell us to maintain the professional patient distance reminding us we are different. But there's also the larger cultural ideas that we are not creatures of destiny or we're certainly not creatures that share a destiny if there is one. And anyway there's this deep chasm of a secular, secular, secular divide that we must not cross.

But the honest truth is that it's neither safe or healthy for us or our patients to remain apart. And fortunately in my experience is sometimes the patients that take down the wall. I had recently, this would be say six months ago, I had a patient who I met in the homeless clinic where I work.

And shortly into the history he basically blurts out that he's tried to commit suicide six times. And when he said that and then there was a pause, first of all I was shocked and somewhat overwhelmed by that thought. And then I was not able to find words to step into that space.

And then fortunately he stepped into the space and he said, you know every time I've tried something's happened that's thwarted me. God must have a reason why I'm still here. And in that statement he invited me into a space that typically the secular, secular,

secular divide keeps me away from.

And yet I can see that the patients maybe want it much more than we do.

[Music] Now I've left the hardest task for the end. It still remains.

How do we integrate all this? So for that I'm going to bring in my cleanup hitter, my last ancient voice. And this is an ancient voice that I call up because I think he has the ability to knit all these perspectives together into one view. And it's the Italian poet of the late 13th and 14th century, Dante Eligari.

The reason why I think he has so much to offer is because of his brilliance as a poet. But also because he was uniquely placed on the cusp of the Renaissance as a dawned. So he was able to look back and look forward.

He was able to look back and see the good of what had been. But he also had the ability to look forward and was excited about what was coming. So Dante was one of those people who true to the Renaissance spirit had a high opinion of reason and its ability to understand the world.

He was excited about the knowledge being gained through the early scientific investigations of his time. And he basically was believing that the world would be a better place through scientific investigation. He also likewise understood the importance of personal choice and the need of the individual to exercise their freedom.

Yet for Dante the value of science and the importance of individual autonomy made sense to him only within the framework of a sacred view of humanity. So he said, "Man, big M, man, have freedom." And that's one of the most important things about us, what distinguishes us from other creatures. And he also knew that it would only make sense if man was seen as a part of the bigger story.

And so he writes one of the biggest stories in all of Western literature, the epic adventure called the Divine Comedy. If you've never read it, someday I think you should. But in it, he takes us on a metaphorical journey through the afterlife.

And when he does that, he does some very important things to help us understand life as a journey. Perhaps the most stunning is that he puts himself in the middle of the action. So listen to how he begins this monumental work.

He says midway along the journey of our life, I woke to find myself in a dark wood for I had wandered off the straight path. So from the very first lines of this massive and monumental poem of over 14,000 lines and 100 cantos, Dante the poet shows us that he's writing about Dante the pilgrim. And Dante the pilgrim is set out on a journey.

He's a man with a destiny, but he's lost his way. The other, then also what he makes

clear as you read it, is that he makes it clear that he must make the journey himself. No one can make it for him.

He has to exercise his autonomy, has to exercise his freedom, he has to make his own choices. But he's also someone who needs a lot of help to find his way. And so throughout his journey, he's aided by the help of others.

The most important are his guides, Virgil, the writer of the Aeneid, and later Beatrice. But all the way he meets and talks to countless others, some teaching by their negative example, some teaching by their positive example. And when he ascends the Mount of Purgatory, the terraces are filled with fellow pilgrims, each struggling with different problems, but all believing they're on the way.

And as they go, they know that both need help and need to give help to others if they're to make it. Now if any of you take this journey with Dante, you'll have a thrilling adventure. As you follow him down into the depths of hell and up into the heights of heaven.

And everywhere you go, you're going to see the consequences of choice. But underlying all the individual stories and all the very specific places that people end up because of their choices, Dante throughout is posing that the most crucial decision you must make, the most basic choice of all is how you see the world. Is the world ordered by love? Or is the world ordered by power? And he says you have to decide that.

Now I've tried to argue in our discussion this evening that if I stay on the first level of our house, we're in great danger of defining the world by power. We believe we can control circumstances. We seek mastery.

We look at health as a possession that we can manage and manipulate, because we live in a world ordered by us and for our own self. Each one autonomously pursuing and exerting their own powers and individuals, and if Nietzsche would have his way, exerting their power over others. But on the second level, we recognize mystery and uncertainty.

We seek relationship and we look at health as a gift. We receive inertia for our own sake, but also for the sake of others, because we live in a world ordered by love, and love seeks not just that I arrive or you arrive, but that way you all arrive. Now let me conclude with one last picture, and to help you imagine maybe where you belong in all this.

And the picture I'm showing you is it's called the storm on the Sea of Galilee. This is a Rembrandt painting from 1633, and it used to hang in the Gardner Museum in Boston until it was stolen with 12 other works in 1990. This is the only seascape that Rembrandt ever painted.

And in it, he depicts a familiar scene for those of you who know the Bible. It's the scene from the life of Jesus. You can find it in Mark chapter 4. It's also in other two gospels,

Matthew 8 and Luke 8. But packed into four or five verses is this dramatic scene of a furious storm crashing waves, terrified disciples afraid they're going to drown.

And this curious element of Jesus asleep in the stern and needing to be awoken so he can save them. Now in recording the event in this painting, Rembrandt does a very interesting thing. Many of you know that there should be 13 people in the boat.

There should be Jesus in his 12 apostles. But if you look very, very closely, you'll see there's 14 people. Because Rembrandt did hear what he did in many of his paintings.

You put himself in the painting. And by putting himself in the painting, what he's saying is, if you truly want to understand the story, you need to put yourself in it. You need to get in the boat and not stand apart at a distance.

Now, our last slide, if you go to the Gardner Museum today, you're going to be surprised to find an empty frame hanging on the wall where once held by the storm on the Sea of Galilee, hanging there in homage to the missing work and representing hope that it'll one day be returned. But I like to use it as an invitation for you to fill in the frame for yourselves. Don't let anyone rob you of the opportunity to paint your own picture of how you see your patients.

Don't let it be limited by the fixed images of our culture, but make it a picture that incorporates all the perspectives of the patient. And be sure to put yourself in the picture. Thank you.

[applause]

[music]