The Story-Telling Dimension of the Physician-Patient Relationship

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Physicians and patients face the task of constructing narratives that provide meaning and purpose to their encounters. Typically patients tell stories about how illness has changed their lives. Physicians interpret these stories in order to determine the cause and treatment of the illness. Together physicians and patients create illness narratives that make sense of the symptoms and anticipate their cure. Critics of physician-patient communication observe that too frequently much of the patient's contribution to the story is either edited out or never heard. This is especially evident when physicians and patients discuss catastrophic news such as the diagnosis of a chronic or terminal illness. Two types of critiques attempt to explain the loss of the patient's voice in the medical encounter. I shall call the first the "holistic critique" and the second the "postmodern critique."

The holistic critique identifies the shortcomings of modern medicine's reductionistic approach to patients that neglect the psychosocial aspects of their personal stories. Personal stories in the medical context communicate accounts of patients' physical symptoms, their psychosocial contexts and the personal meanings of their illness. According to the holistic critique, medicine's exclusion of the psychosocial dimensions of patients results in an inadequate understanding of the non-biological factors that affect both health and illness.

The postmodern critique locates the loss of the patient's voice in modernity's penchant for illusions of mastery over contingency. In this view medicine gets its marching orders from modern culture, which requires medicine to create the illusion that all human frailties are potentially curable. Therefore medicine prefers to construct illness narratives that tell the story

of disease overcome and health restored. Patients whose stories cannot fit in the narrative movement from health lost to health restored find that they have no voice in the medical encounter. Both the holistic and the postmodern critiques call attention to the force of certain ideological commitments of medicine and culture that steer physician-patient communication away from the personal dimension of patients' stories towards stories about treatment and possible cure. Although they identify important factors that contribute to the loss of patients' voices and suggest helpful correctives, they miss the deeper existential and perhaps theological dimensions of the physician-patient encounter that challenge the project of modernity, mastery over the contingent.

In order to address the existential/theological dimension, I propose a third critique, the "critique of misplaced transcendence" that understands physician-patient encounters as a remnant of archaic healing rituals. According to Eliade, these rituals were primitive humanity's attempt to restore order to life after it had been disrupted by intrusions of the very thing that modernity wishes to control, chaos—the force that destroys human structure and order. The modern and ancient versions of the ritual differ in a crucial respect, which points to the importance of the critique of misplaced transcendence. The ancients knew that life was fundamentally irreparable. Once broken, life could only be recreated. The goal of the healing ritual was transformation. An encounter with chaos fundamentally changed people so there could be no repair, no restoration of what was lost. Hope was located in transformation or reorientation in contrast to modern medical rituals in which transformation has been replaced by rituals of repair and restoration.

Modern approaches to healing locate hope primarily, if not exclusively, in illusions of the human ability to control life's contingencies. Transcendence is misplaced in the sense that the healing ritual of modern medicine limits hope to an immanent finite hope that depends on medicine's ability to cure. When the patient presents with an incurable disease, maintaining hope for the patient, for the physician, and for medicine's credibility depends on narrating the

patient’s encounter with chaos as potentially repairable. Such reframing frequently presents obstacles to patients who need hope that does not depend on overcoming mortality.

The Holistic Critique

George Engle's work is perhaps the best know example of a holistic critique of medicine's penchant for excluding or marginalizing patients' personal stories. According to Engle, medicine is dominated by a biomedical paradigm designed to collect and interpret biological facts. Since the personal stories of patients primarily communicate their subjective responses to disease rather than empirical facts, the biomedical paradigm does not have the means for collecting or interpreting this type of data. As a result, the needs and limitations of the biomedical paradigm dominate the story making and telling that occurs in the medical encounter. Typically, physicians take control of the interview within the first eighteen seconds of the interview by asking a series of closed-ended questions that limit patients' responses to those that have a narrative fit with the kind of story that biomedicine is able tell about the patient.

Engle attributes medicine's almost exclusive reliance on the biomedical paradigm to its attempt to mimic the natural sciences. In a modern technological society, the caring professions derive their credibility from their claim to be “scientific.” Engle, a M.D. psychoanalyst, argues that paradigms for medical practice, based on the reductionistic model of the natural sciences are too limited to understand its subject—multidimensional human beings. He proposes a biopsychosocial paradigm as an alternative integrative paradigm that includes the biologic story without the reductionism of the biomedical paradigm. It recognizes and evaluates the contribution of non-biological factors to the health and illness of patients. Presumably this paradigm yields a more balanced interviewing style that invites and integrates the biologic and personal stories into a story that is more comprehensive and therefore more representative of the whole patient. In this way the patient's voice is heard and becomes a part of the stories of illness and treatment that the physician and patient jointly author.

In the holistic critique, medicine essentially critiques itself for devaluing and ignoring the personal dimension of the patient. Some holistic critics consider medicine’s exclusion of the

psychosocial aspects of the patient's story to be unscientific in light of the fact that studies show that such non-biological factors make significant contributions to both illness and health. Others point to marketing problems, such as, poor levels of patient compliance, sagging levels of patient satisfaction, lawsuits, and doctor-shopping that result from insensitive and unbalanced interviews. The holistic critique is unable to question medicine's almost exclusive focus on cure as its paramount goal, nor does it consider how its ideology and practice are shaped by the needs of modernity. In fact, the holistic critique attempts to broaden medicine's understanding of science to include the patient's voice, in order not to exclude the psychosocial aspects of health and illness. A more integrative paradigm and better interviewing techniques are recommended for the purpose of making medicine even more effective in reaching its curative goals and promoting what the postmodern critique identifies as modernity's project of mastery and continual progress.

The Postmodern Critique

While the holistic critique argues for a more balanced and therefore more effective and humane approach to care that takes into account the personal dimension of patients, it never questions the curative goal of medicine or its assumptions about human nature—that it must be perfectible! The basic assumptions about the perfectibility of humanity are never questioned, nor are its practices of silencing the voice of those aspects of our humanness that challenge grandiose notions of perfectibility. A deeper analysis of typical physician-patient communication locates medicine's reliance on the reductionistic biomedical paradigm in the modernist strategy of creating the illusion of continual progress. Since faith in the notion of continual progress is difficult to maintain in the face of death and chronic illness, medicine is charged with reframing the limits of biological existence as unnecessary and curable disruptions in normal life. This critique finds that modernity, of which curative medicine is a part, distorts life and imposes additional unnecessary suffering on patients by distracting them from the limits of life with the promise of cure.

Arthur Frank's work with illness narratives in *The Wounded Storyteller* is a good example of the postmodern critique. Frank claims that the symptoms and the attending loss of function that come with serious illness interrupt the narrative continuity of the patient's life story and present him or her with the problem of restoring continuity. When faced with a grave or terminal illness, the narrative structure of the patient's life story prior to the illness is incapable of narrating the experience of illness. Loss of function, changes in physical appearance and an uncertain relationship to the future, change patients in such profound ways that they become unrecognizable to themselves in their own life stories. With no narrative available to structure and orient the interrupted life of the patient, he or she flounders as they are overwhelmed by the chaos of newly unstructured experience. Eventually most patients are able to construct a narrative that enables them to claim this chaos as their own and to make it a part of their personal experience. According to Frank, this occurs with the help of illness narratives that provide patients with narrative bridges that reestablish the narrative structure of experience by connecting the chaos of the present with a future that brings healing to the brokenness of life. Frank identifies three types of illness narratives, the restitution narrative, the chaos narrative, and the quest narrative that connect the broken present with future healing in distinctive ways.

Restitution narratives connect the present chaos of a life broken by illness with a future that holds the promise of health restored. The narrative structure consists of a four part movement of health enjoyed, health lost, receiving a remedy, and health restored. In this narrative illness is a temporary interruption in the continuity of life, an inconvenience that causes no fundamental changes in the patient's life story. Through this narrative patients find their hope in the promise of life restored to its pre-illness character. Life resumes as if nothing happened. Frank identifies restitution narratives as the dominant illness narrative in North America. Although restitution narratives can be fitting narratives for curable diseases, they can easily become narratives of collusion enabling physicians and patients to avoid facing life's limits.

The quest narrative, differs from restitution narratives which sustain hope by encouraging patients and physicians to interpret incurable conditions as it they were treatable illnesses. Quest

narratives embrace mortality as a natural limit of the human condition and narrate the end-of-life as something to be lived, shared, and valued. Quest narratives tell a story about discovery, self-transformation, and of gifting others with lessons learned along the way. According to Frank, the quest narrative, unlike the restitution narrative, empowers patients to tell their own stories and thereby become meaning makers in the face of chaos

Frank refers to the chaos narrative as the "anti-narrative" meaning it gives expression to what cannot be narrated. It is a broken narrative that provides a means for expressing the fragmenting loss of self and future. When overwhelmed by the changes that come with serious illness, the patient's sense of the flow of linear time is interrupted and the sufferer enters a period of wandering as if in a wilderness with no familiar landmarks or maps. Although it is not a narrative in the usual sense, it is a form of speech available to those who are experiencing the unmaking of their life story. Only by loosening the restrictions of logic, grammar and syntax and admitting metaphor and hyperbole does the chaos narrative become capable of giving voice to the overwhelmed. By challenging the conventional narrative structures of the stories of human witnesses and social institutions, themselves not in chaos, the chaos narrative gives voice to the suffering patient.

It is not easy to hear the voice of a patient in chaos because it brings to light a hidden chaotic dimension of being that threatens all narratives and cultural projects. The first impulse the physician is often to protect the experience of his or her own continuity by silencing the patient's voice. The medical interview accomplishes this by interrupting the patient's chaos narrative through the imposition of a narrative of restitution that suggests that what has been lost can be restored. If successful, the voice of chaos gives way to a narrative that suggests a cure. When they reframe the limits of finitude as unnecessary and correctable anomalies, restitution narratives serve modernity's need to deny human frailty and preserve scientific myths of continuity and progress. The physician-patient encounter reveals an adversarial character when viewed as a struggle between patients, as representatives of chaos, and physicians, as

representatives of modernity, who are unwittingly using the narrative in a deception to transform signs of finitude into symptoms of a potentially curable disease.

The Critique of Misplaced Transcendence

Physician-patient relationships must bear many difficult things. Undoubtedly one of the most difficult situations that physicians and patients face together is life's ending. The bad news must be given and decisions must be made about end-of-life care. Deciding when to stop curative treatments and shift to palliative care is one of the most difficult choices that physicians and patients face and they must face it together. The decision to withhold or withdraw curative treatment announces both that life for this patient is coming to an end and that medicine has failed in its task to master contingency. As a result this decision is often postponed, in the service of preserving the hope of both patient and physician. This delay is often harmful to the patient because it postpones hospice admission and perpetuates futile treatments that are often painful and costly. Hope becomes the central concern for both patient and physician. Patients need it in order to carry on and physicians feel they must provide it, both out of a concern for the welfare of their patient and as a culturally determined response designed to disguise the limits of medicine.

The meaning of hope, however, varies significantly for the participants in this dialogue depending on the narrative context through which hope is constructed. For example, when religious narratives are the dominant cultural narratives, death and dying can be narrated as events in a life drama or meta-narrative consisting of a cycle of stories that hold together the paradigmatic life experiences of orientation, disorientation, and reorientation in a hopeful tension. The Psalms provide a clear example of this cycle of narratives. When the status quo (orientation) is disturbed, sufferers express their loss through lamentation. The lament expresses the loss of everything dear; the sense of self, loved ones, possessions, and a future. It is similar to Frank's chaos narrative in that they both express loss and disorientation, but they differ in a crucial aspect; the chaos narrative expresses the loss and disorientation of an individual, while the lament expresses not only the individual's experience, it also gives voice to the dying in

which all finitude participates. Whereas modern chaos narratives tend to threaten the larger community and isolate the sufferer, the lamentation gives voice to individual suffering while connecting the sufferer and the community to a common experience of discontinuity shared by all mortals. Through this connection the community helps the suffering to essentially die to what is passing away. By accepting and working through the loss, both the individual and the community prepare themselves for accepting a reorientation to life, enabling suffers to accept the irrevocable changes that are occurring and to discover a new way of being that affirms life even in the midst of radical change.

These reorienting narratives point to hope that lies in the future. The past in which sufferers found their previous orientation is passing away. By acknowledging that there is no way to control this passing, the lamentation helps the suffering die to the past in order to accept the future. There is no hope in trying to preserve or regain one's previous existence. The reorientation of hope to the future sharply contrasts with the hope offered in restitution narratives. As its name implies, restitutive hope lies in possessing the power to restore what was lost. Transcendence is misplaced in the medical interview in the sense that hope it offers depends on the power to preserve the finite. Hope is reduced to treatment regimens and the possibility of cure (restoration of health). Since there is no place for chaos and inevitable loss in restitution narratives, these narratives must exclude the voices of chaos and reframe life's finite limits as potentially curable.

The biblical narratives, such as the psalms of celebration and God's response to Job's challenge, that reorient the sufferer are similar to Frank's quest narrative in that they find hope in the anticipation that a blessing or gift will be discovered. This blessing gives life new meaning and purpose to life that is independent of restoration. The new orientation comes as gift and surprise. It is not the next stage; there is no bridge from here to there; it seems to appear to those who can wait. The lamentation and Frank's chaos narrative provide the path to hope that does not require the denial of finitude. Depending on the community's level of acceptance of contingency, laments and chaos narratives can move the suffer/patient in one of two directions.

They can either connect suffers with a community of witnesses who can share the wait for a path to hope. Or they can isolate the suffer from a community so threatened by contingency that the relationship between the community and the patient/sufferer depends on him or her giving up their lament for the language of survival, the restitution narrative.

Although the postmodern critique of physician-patient communication provides a useful way of understanding how larger cultural interests shape the stories that physicians and patients construct, it fails to place this interest in denying or controlling chaos in its larger historical and existential context. The critique of misplaced transcendence identifies significant parallels between archaic healing rituals through which the afflicted and the comforter struggle to come to terms with a life undone by life's fundamental contingency and the medical encounter which discusses catastrophic news and considers treatment plans. By reframing such physician-patient encounters as ritual, the tension between universal themes of chaos, creation, and recreation become visible. These themes correspond to the basic cycle of human experience from orientation, to disorientation and reorientation.

Conflict between the voices of chaos and restitution--Illustrated

The following verbatim illustrates conflict that arises when a patient's need to express her experience of chaos conflicts with her physician's need to restructure her suffering into something that he can treat. He tries to comfort his patient by redefining HIV/AIDS as a potentially curable disease. If he is successful in calming her distress by persuading her to invest in learning about the disease and the promising research that is being done; her distinctive voice will be silenced and as a result loose her connection to hope beyond cure.

Timothy E. Quill, MD writes in an article published in the Archives of Internal Medicine, that he was aware of a sense of dread as he prepared to tell one his patients that she has AIDS. His dread stemmed from a sense that this news would "shake the foundations of her faith and her sense of who she was." The patient is a woman who contracted AIDS from her ex-husband. She has tree children and is described as a devout Christian. When she agrees to be tested for HIV

her physician asks what she would do if her test were positive, she replied, "I don't know, but I don't think God would do this to me."

> PATIENT: Is it AIDS?
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> DR. QUILL: I'm afraid it is.
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> PATIENT: Oh no, Dr. Quill. Oh my God!
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> DR. QUILL: I was shocked too.
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>> PATIENT: Oh God. Oh Lord has mercy. Oh God, don't tell me that. Oh Lord has mercy. Oh my God. Oh my God, no, Dr. Quill. Oh God. Oh no. Please don't do it again. Please don't tell me that. Oh my God. Oh my children. Oh Lord have mercy. Oh God, why did He do this to me? Why did He do this to me? Why did He do this to me, Dr. Quill? Oh Lord have mercy. Oh my God, Jesus.

The patient receives the news that she is HIV positive (she does not distinguish HIV for AIDS) and instantly experiences the unmaking of her world. To express her overwhelming experience of threat and loss she uses a chaos narrative. It is not easy to follow the narrative flow. Her speech jumps around from an address to God, to a magical wish that this catastrophe could be taken from her, illustrated in her vivid testimony to the magical power of words. She says to the physician, "Please don't do it again" The physician's words assault her. If he could only take back his words or never repeat them maybe she could regain her life. Then she feels the impending separation from her children (and all that she loves) and like Job she asks God to give an account of God's unfair attack, and asks for mercy.

The normal narrative flow is disrupted as her world comes apart. She becomes the conduit through which chaos enters the ideological world of medicine and the personal world of her physician. The physician is the first witness, the first representative of the culture to hear her lament.

> DR. QUILL: You're still alright at this point, okay.

PATIENT: You don't know how long I've had it, Dr. Quill?

DR. QUILL: I don't know.

PATIENT: I can't sit. [She walks around room]

DR. QUILL: It's okay.

PATIENT: Why did he do this to me? What have I done to him? Why does he do this to me? Why? Why? Why? Oh Lord. What am I going to do with all of my children? I won't be able to see my grandchildren. I just had another grandbaby. I won't ever be able to see . . I won't live to see the baby. I won't be able to get up off my chair. Oh, Dr. Quill, I don't know what to do. Oh God, I don't know what to do. My son-in-law is not going to let the kids come over.

DR. QUILL: First thing we have to do is learn as much as we can about it, because right now you are okay.

Putting this bad news in a rational framework is the first step in using the restitution narrative to restructure the patient’s experience of chaos. He is essentially saying that HIV is not strange or mysterious, we know alot about it. It has a specific and concrete cause that has been identified, it has a typical course with which we are familiar and so on. The implication is that like other diseases we know its cause and therefore we can do something about it.

PATIENT: I don't even have a future. Everything I know is that your gonna die anytime. What is there to do? What if I'm a walking time bomb? People will be scared to even touch me or say anything to me.

The patient feels cut off from her future as she considers the possibility that she could die at anytime. In Baumen’s words she feels that does not share a common future with the living and that they will protect their sense of having intact futures by shunning her. She is a walking challenge to the modernist notion of continual progress expects to be shunned.

DR. QUILL: No, that's not so.

PATIENT: Yes they will, 'cause I feel that way about people. You don't know what to say to them and what to do. Oh God.

She is not persuaded by direct reassurance that her life has not radically changed. She is aware that because the "language of survival" has lost its relevance for her, those who are still invested in the language of survival will have nothing to say to her. She is aware from her own experience how threatening the chaos of another can be. Here we can see the beginning of the struggle between the chaos narrative and the introduction of the restitution narrative. The patient resists having her voice silenced through the reframing that restitution narratives offer.

DR. QUILL: What we have to do is to learn some things about it . . . even though it's scary it may not be as scary as you think. Okay?

PATIENT: Oh my God. Oh my God. I hate him. I hate him. I hate the ground he walks on. I hate him, Dr. Quill. I hate him. He gave this to me. I hate him. He took my life away from me. I have been robbed. I feel as if I have been robbed of a future. I don't have nothing.

Again the patient expresses her sense that her world has been unmade, reduced to nothing and again her physician attempts to silence her chaos narrative by asserting the narrative structure of the restitution narrative. By learning about the illness, she will realize that there are things that can be done, presumably tests, treatments, and waiting for the development of new treatments. Her physician assures her that once she begins to narrative her experience in terms of what can be done she will lose her fear. Meaning that the as fear of having HIV gives way to an investment in treatment the experience of chaos will pass and it won't be so scary.

DR QUILL: There is a future for you.

PATIENT: They don't even have a cure for me.

Her physician attempts to reconnect her with her future. She equates having a future with being cured. It is clear from the following statement of Dr. Quill's that he is also equating "a future" with a cure.

DR. QUILL: There's a lot of work going on right now, and you can have the infection for a long time before you get sick. There is a lot of research going on.

PATIENT: I read about it. I have a friend with it. I went over to the university . . . Since you told him

he

had AIDS, he has been at my house and I feel so sorry for him I was being nice to him. Oh my God, my God. It just doesn't pay to be nice. It doesn't. What do you get out of it?

Here she expresses her sense of the unfairness of life. Being nice did not protect her from HIV. On yet another level she is coming to terms with the power of contingency to overcome all illusions of protection, not only medical but also theological illusions that the righteous (nice) enjoy God's protection (see Job).

DR. QUILL: Neither you nor he knew that there was a risk back then.

PATIENT: Another cross to bear.

DR. QUILL: You never did anything wrong.

PATIENT: What am I going to tell my children when they are old enough to tell them?

DR. QUILL: Before you tell them anything, you are going to learn a lot about this.

PATIENT: I can't go home. I can't even stay here. I'm so scared. Oh my God. I knew that you were going to tell me this. I always liked you. I didn't want you to tell me this. Oh God. I don't know if I can deal with this. I don't know, Dr. Quill, if I can deal with this.

Dr. QUILL: You've worked through this before. It's going to be hard, but it may not be as bad as you

think. Okay? I think what you have to do . . .

Here the physician attempts to help his patient restore a sense of continuity by comparing her diagnosis to something that to which she has successfully adapted, the working through her ex-husband's HIV diagnosis.

PATIENT: I got my church, Dr. Quill. I can't let them see me like that. I can't do it. I would rather . . . because I can't let our church see me like this. They mean a lot to me. Oh, Dr. Quill, and my daughter. Oh, I won't see my daughter and my baby.

DR. QUILL: You are still the same person. Okay?

The patient begins to count her losses, church community, close relationships with her daughter and granddaughter. Her physician has the sense that his patient feels as though she has lost her life and reminds her that she is still the same person, which presumably means that she has the same history, same future, and the same web or relationships that she had prior to her diagnosis. She is not comforted

PATIENT: Why is He doing this to me?

The patient expresses her sense of God's betrayal. She has been a nice church going person who has done nothing so wrong so as to deserve such a severe fate.

DR. QUILL: I don't know. You are still the same person. What we have to do is eventually learn as much as you can about this. The odds are that you are going to stay healthy for a long time. Okay? You are still very healthy right now.

The physician backs away from the question of theodicy and asserts the continuity of her life and seems to assert this continuity with "learning as much as you can about this." Again we see intimations of the restitution narrative that are not missed by the patient. Knowledge about the disease is associated with the possibility of treatment and cure. His patient asks him directly if he is saying that a cure is possible.

> PATIENT: What you telling me? I still have a chance to beat it? Can I beat it?
>
> DR. QUILL: I think that is possible.

Now the restitution narrative is fully present, being the same person and having hope for a future lies in the possibility of cure, "I think that it is possible"

> PATIENT: How can you be sure when you don't even know what the cure is for it?

The patient is skeptical about the offer of a restitution narrative and questions her physician's use of it.

> DR. QUILL: A couple of things, okay? We don't think you've had this very long; a couple of years at the most. Alright. A lot of people believe that the virus can stay around for many years before it produces many problems. Sometimes 6 or 8 years. There is a lot of research going on now to try to find ways to treat it.

The physician's response doesn't directly address her question about how he can be certain that she can place her hope in a cure. He essentially says that there may be enough time for medicine to find a cure before she dies from AIDS.

> PATIENT: Oh, God, Lord Jesus.

She is not yet reassured.

DR. QUILL: You may have a lot of time before we have to deal with this. I think the first thing we have to do is probably get some further blood tests. We should repeat it to be 100%, 1000% sure, even though they have repeated it once. I think that's wise to do because the only way that you could have gotten it is from your husband. I think we ought to repeat it even though we know that it is probably true.

PATIENT: I don't know if I can live with myself . . . in my bed right now. I don't like him, Dr. Quill. I don't even want to stand by him. I won't even stay with him. I don't . Why must I pay for his sins? Why? My children.

DR. QUILL: It's very scary. Also, there are a lot of things we can do.

PATIENT: Oh Lord have mercy. Then I have the pituitary thing.

DR. QUILL: Like your pituitary tumor, it has been there for years. It doesn't . . .

PATIENT: It's not the same.

DR. QUILL: No, it's not the same thing. If the tumor gets worse, we know what the treatment is.

PATIENT: It's not the same. It can't be cured. You talking about something they never came up with , never came up with a cure for. I've got nothing. All they can do is just treat whatever comes along like a cold, or pneumonia, stuff like that - that's all.

The patient resists her physician's attempt to impose a restitution narrative on her personal chaos. She remains within the chaos narrative and retains her voice. When her physician attempts to collapse the distinctions between the "pituitary thing," which can be treated, and HIV, she protests.

DR. QUILL: That's right. But right now there are millions and millions of dollars being poured into research and that's what we have to hope for.

Once again hope is identified with cure and the reference to the millions and millions of dollars suggests to his patient that finding a cure is very likely. The reference to the “vast” resources of medical research helps the patient to buy into the restitution narrative.

PATIENT: It doesn't make me feel good.

DR. QUILL: I wish I had something more clear to tell you, but I think there are a lot of folks who are in the same shoes that you're in and they are all hoping. They are figuring out ways to cope. That's what we have to figure out.

PATIENT: Dr. Quill, will you still be my doctor?

DR. QUILL: Absolutely, I will.

PATIENT: You promise?

DR. QUILL: Absolutely. We'll meet very regularly so we know what's going on.

PATIENT: Okay, alright. I'm so scared. I don't want to die. I don't want to die, Dr. Quill, not yet. I know I got to die, but I don't want to die.

DR. QUILL: We've got to think about a couple of things . . .

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