Last Song — Sharing Humanity while Maintaining Boundaries

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"You must sing for me," she said. "I'm dying, after all."

Ms. N. was sitting on her vast white sofa, frail among the cushions, enveloped in a pink dressing gown that paled next to the fuchsia of her lipstick. She was partially silhouetted by the late November sun from the wall of windows behind her. In her right hand, she held a flute of champagne, and she closed her eyes as she sipped from it. Her malignant bowel obstruction made swallowing impossible, however, so she spat the champagne into a glass bowl beside her.

I smiled and looked at the floor, trying to will the request away. We had met earlier in the week during my first visit as her home palliative care physician, and I was getting used to the brusque cadence of her Eastern European accent, just as she was no doubt getting used to my questions about her pain and nausea. Today, however, the tables had turned abruptly: in a conversation about her extensive record collection, my other career as an opera singer had surfaced. This aspect of my life became the focus of her line of questions.

"I'm not sure that singing is such a good idea," I said, trying to reorient the spotlight. This visit wasn't about me, after all; it was about her. I was keen to occupy as little space as possible.

"But you must," she insisted.

I had never sung for a patient before, and the thought of it was odd and uncomfortable. In asking me to sing, she was asking me to cross a boundary — that invisible line in medicine that marks the edges of professional behavior appropriate to our clinical roles.[1] We learn in medical school to maintain a distance between ourselves and our patients. We hide any parts of our personal histories that risk distracting from the patient's narrative. First and foremost, we represent the profession of medicine. Our individuality takes a back seat.[2,3]

Indeed, there is a kind of safety in the distance created by the well-defined roles of patient and physician. Boundary crossings create uncertainty — we move away from a clearly demarcated clinical relationship to something much more nebulous and potentially destabilizing for both parties.[3] We also risk shifting the focus from the patient to the physician; a physician's disclosure of personal information to a patient is often more disruptive than beneficial.[4] Finally, personal relationships may cloud both our judgment and that of our patients. But at the same time, patients want physicians who aren't robots, who are friendly and relatable. Is there a safe way to show patients that we are human while also remaining professional?

Ms. N.'s request raised questions for me. Would singing be too weird? If I sang today, would I be expected to sing for her every time I visited? Most important, would she see me as less of a doctor — less professional, less trustworthy? After all, who wants an opera singer adjusting their morphine?

Her quiet imperiousness prevailed. After a few moments of polite standoff, it became clear that — boundaries be damned — singing for her was the path of least resistance. I sat down at the polished mahogany piano in the center of the room. The bench creaked as I shifted my weight. She transferred to her wheelchair and came closer to the piano. My weekly singing lesson was later that day, so I had music with me.

I opened my book to the final song of Benjamin Britten's cycle *Seven Sonnets of Michelangelo*. I stretched a deep breath into my back and started playing the opening chords. I played haltingly at first, my fingers straining for the right notes. The piano was imperfect, frail, with an out-of-tune key here and there, but the sound had character and depth. I listened critically as I sang the first notes. Was I singing flat? Why was that note so shaky? But when I glanced over at Ms. N. — relaxed face, eyes closed, the premonition of a smile — I realized that she probably didn't care about the imperfections of my voice, or that I was not creating a great work of art. I started to sing more freely, enjoying the melodic arcs. As the piece ended, the closing piano chords ascended higher, softer, and died off into nothing.

She was quiet for few seconds, and then thanked me, her eyes still closed. As I tied my shoes at the front door, I promised to return the next day to check on her pain.

As a physician in the first few years of my practice, I find that

my personal and professional selves are still jostling with one another; they seek an elusive smoothness in their waltz, still sometimes forgetting the steps and tripping each other up.

Ms. N.'s request for me to sing might, on its surface, seem to have demanded an inappropriate blurring of these two selves. But when I recall those moments I spent with her, I realize that I didn't feel invaded. She wasn't prying into my personal life — she wasn't asking about my love life or my religion or casting me in the role of surrogate grandson, as some patients have uncomfortably done. Instead she was asking me to share something deeper that resonated with our mutual humanity — music.

Perhaps paradoxically, that deepness felt much safer than discussing the details of my life. I would rather, for example, talk about the spine tingle I get when listening to a Bach aria (or even how I cry every time I watch *The Lord of the Rings*) than demur politely when patients ask me if I'm single so they can set me up with their granddaughters (presuming that I'm straight). Connections forged with other people over shared experiences of the arts — movies, visual art, books, pop music, opera, theater, magazines — transcend these personal details and tap into something universal. They bypass areas of potential tension that might subtract from a therapeutic relationship and locate a more profound plane of connection, perhaps less personal but more human.

Since that day with Ms. N., I have found other ways of sharing arts with patients that don't require a vocal warm-up and a grand piano. Recently, for example, I spotted on a patient's bedside table a novel that I'd also read; we talked about the characters and the writing style, and we laughed when we discovered that neither of us had particularly enjoyed it. Now I always try to ask what's playing in patients' earbuds, or what they're binge watching, or what art galleries they visit.

Ms. N. died a few days after I sang for her. In this line of work, there will continue to be times when a patient like her, having given an intimate glimpse into her life to this stranger at her bedside, will reach out and want to know who I am. I hope that even when I'm tired or in a rush or feeling protective of the boundaries around my personal life, I will still be able to honor this request for reciprocity and find another way to show them that I'm human. And if they ask, I hope I'll agree to sing.

Identifying details have been changed to protect the patient's privacy.

Disclosure forms provided by the author are available at NEJM.org.

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