

PRESENCE IS THE PRACTICE: A REFLECTION ON EMBODIMENT, ILLNESS, AND THE CLINICAL ENCOUNTER

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KEYWORDS: Empathy; Medical education; Patient care; Narrative medicine

The year following my second cancer almost broke me in a way the cancer itself never had. During treatment, I had something to fight. My body was a combat zone, but I understood the terms. The days brought nausea and abnormal labs, surgeries, chemo, and radiation. My sternum was so destabilized after surgery that I learned to sleep sitting up, because lying flat made the two halves grind together. My hair fell out. I hardly recognized myself in the mirror, but I had a battle to win, a timeline, and a reason to get up.

The year after was much quieter and far more difficult. I came back to work, discharged from treatment but far from healed, and found that the world had not waited. My peers had built skills, relationships, and clinical instincts while I was away. I watched them, trying to close the distance. Some days, I felt like I was watching my own career through glass. My body, which had been the center of everything for so long, suddenly felt irrelevant. I fell into a deep depression, and I did not see a way out.

I could not have foreseen how my path back would appear. It arrived one midnight, in a hospital room, in the form of a patient I will call Carol.

I was a psychiatry resident on home call when the ER physician reached me around eleven on a Friday night. He had a patient who was belligerent, refusing admission, critically ill, and not listening to anyone. He needed me to come in and declare her "incompetent."

I pulled her chart before I walked in. Carol was in her fifties with a history of breast cancer, far enough in the past that she had stopped bracing for it. She had come in that morning for a routine CT scan for a nagging headache. She went home. Her oncologist called and told her to come to the ER immediately, without explanation, and to ask for him when she arrived.

She arrived at seven that evening. Her oncologist had already left for the night. An ER physician she had never met told her she had "too numerous to count" tumors in her brain, that the breast cancer had spread, and that she needed to be admitted tonight for steroids and radiation. He moved through the facts the way you move through a checklist when you are trying to get something done.

She heard the word tumors, and her brain shut down.

For the next four hours, person after person came into her room trying to convince her to stay. She refused them all. By the time I arrived, she had been sitting in that room for five hours and had not processed a single thing anyone had said to her. I walked in and found her pacing.

We could not have looked more different. Carol, a tall Black woman with a full head of dark hair, moved through the small room like someone trying to outrun what she had just heard. I was a short white woman, my fine brown hair undecided after chemo, wearing scrubs thrown on at eleven. She had four inches on me. I probably looked like I had just rolled out of bed, which I had.

None of that mattered. Or rather, all of it mattered, and none of it was the point.

I pulled up a chair and asked her to sit, and she did, and for a long moment neither of us said anything. I reached out and took her hand. Everything went still. Not quiet in the way a room goes quiet when someone stops talking, but still in the way that happens when something true is finally being acknowledged. Tears filled her eyes, and mine too. I was sitting with a woman who had just had her world taken apart, and my body knew exactly what that felt like, because mine had been taken apart too. The fear in that room was something I recognized from the inside, and sitting with her in it, holding her hand in both of mine, I felt the kind of stillness that arrives when you stop trying to fix something and simply agree to be present for it.

She said, finally, "I don't know what's going on."

I asked her to tell me what she had heard.

She said, "I heard 'too numerous to count tumors,' and then my brain shut down."

We backed up. I asked her to tell me about herself, her day, and what she was feeling. She did. We talked, sat in silence, and cried, and I held her hand. By the time I left, she understood what was happening in her brain, the purpose of the steroids, what radiation would feel like, and what the coming weeks would likely bring. She understood not because I explained things better than the physician before me, but because I waited until she was ready to receive it.

Then she told me the real reason she would not stay. Her cat was at home, and she had made no arrangements for its care.

I stepped out and called her neighbors until I found one who would go in that night. When I came back and told her the cat was covered, she exhaled for the first time all evening. I reached up and placed my hand on her shoulder, and I could immediately feel that she needed more than that. I pulled her into a hug. She was a head taller than me, and I had to reach up to hold on, and I did. She leaned into it. We stayed there for a moment, two women, holding each other in a hospital room at midnight, and something passed between us that I have never found the right word for. It felt more like recognition than comfort, though there was comfort in it too. It felt like two people who had both been through something terrible and had arrived, briefly, at the same place.

She stayed. She got her treatment.

I drove home through empty streets thinking about what had happened in that room, and what had made it possible.

The ER physician had done nothing wrong by clinical standards. He delivered accurate information and initiated appropriate care. Yet something fractured when he spoke, and Carol had remained in the fracture for five hours. Everyone who came in after tried to move her forward without first understanding where she was. They operated from their training, their urgency, and their discomfort with a patient who would not comply. None paused to ask what Carol's body was actually doing in that moment, what it had absorbed, and what it could not hold.

Carol's experience could have unfolded differently. The outcome was not inevitable. It hinged on a series of small interventions that never happened. Had the ER physician paused to reflect before acting, called her oncologist and asked him to come in, or simply joined the conversation by phone, the trajectory might

have changed. Had he taken the time to sit with her, to clarify what she understood and what she feared, or simply shown her empathy, the situation might never have escalated to a competency evaluation. She might have received the care she needed far sooner, and with far less harm done along the way.

I had paused, not because I was a better clinician, but because I had been on her side of a conversation like that one. I knew what it felt like to hear a word that collapses everything else. My cancer had given me that. It had not made me softer or more sentimental. It had made me more precise, specifically about what presence requires and what its absence costs.

When Carol asked about my hair, I told her the truth. I told her I had just come through cancer too. That moment of shared humanity changed something between us. It gave her permission to be exactly where she was. The two of us, different in almost every visible way, both marked by illness, were trying to find solid ground. The asymmetry between us was real, and so was what dissolved it. She stopped being a patient who would not comply and became a woman who had not yet been heard. I stopped being the psychiatry resident sent in to declare her incompetent and became, for that hour, simply a person who understood something about what she was carrying.

If I were advising myself before my diagnosis, I would say this. Do not wait for your own crisis to teach you what a patient's crisis feels like from the inside. Build the skill at every stage of your career, not just once in medical school. Engage in education emphasizing narrative medicine and simulation training to develop more self-awareness. Find peers who have suffered critical illness and ask them about their journey. Engage in book or movie clubs to develop more empathy for the patient experience and connect more effectively with each patient you meet. This would not have replaced what I learned through my own illness, but it might have taught me to slow down, ask more questions, and listen more thoroughly.

The clinical encounter is always a meeting between two bodies. We do not often talk about it that way. We are trained to position ourselves as the ones who know, and our patients as the ones who receive. That framing flattens something important. Carol's body had been in that room for five hours, absorbing fear, refusing movement, holding on to the one thing she could still control. My body had spent a year learning, from the inside, what it means to lose that control. The encounter between us was not just physician and patient. It was two bodies that had both been broken open, meeting each other across a hospital room, and finding, in that meeting, something that made the next step possible for both of us.

When I drove home that night, something had shifted in me that therapy alone had not been able to touch. I had spent a year feeling like I was disappearing. My peers had moved past me while I was busy surviving, and I feared I would never fully close the gap. The depression I carried was not only about the illness itself.

It was about the fear that I had lost my place, that I would never again feel like a doctor who had something real to offer.

Carol gave me something back that night. The grief lingered as I drove home, and the gap between my peers and me remained. But for the first time in a year, I understood what my illness had actually given me, and that it mattered. I had been on the receiving end of the worst conversation a patient can have. I knew what it felt like to be the body in the bed, to have information land before you are ready, to need someone to slow down and stay. That knowledge was not incidental to my clinical work. It was at its center.

I left that hospital with something that, cautiously, felt like hope. Driving home, I came to believe that my experience was not a year of random, meaningless suffering. Instead it made me capable of something I could not have offered before: the ability to sit with another in their suffering and bring comfort. It also made me realize that I wanted to keep practicing medicine, and that wanting was something I had not felt in over a year. I was not behind my peers in any meaningful way. I could still learn the physiology of medicine that I had missed, but I had learned what it costs a patient when a physician cannot be present with them, because I had paid that cost myself. This was a lesson that I could not have learned from textbooks, and that I would use for the remainder of my career.

That recognition was the first real step out of the depression that had been swallowing me. Medication and therapy had both played their roles, but this was the moment I understood that my body's history, everything it had absorbed and survived and learned, was not a liability I was carrying into the clinical encounter. It was what made the clinical encounter possible. The illness had not derailed my career. It had deepened it in ways I was only beginning to understand.

Medical training teaches us to manage the body in front of us, but rarely to inhabit our own. We learn to override fatigue, suppress uncertainty, and distance ourselves from what we feel so that we can function in environments structured by hierarchy, time pressure, and loss. That distancing has a cost. It costs us the knowledge that arrives not as thought but as felt recognition, the kind that lets you walk into a room full of fear and know, without a checklist, exactly what to do. When we train clinicians to leave their bodies at the door, we are not making them more objective. We are making them less complete.

Carol is the reason I stopped asking, "Why me?" She is also the reason I believe that the most precise clinical instrument any of us carries is not what we learned in training. It is what we have lived. ■

Biographical Note

COL(ret) Jess Bunin, MD, MHPE is Co-Founder and Chief Architect of All Levels Leadership, Certified Executive Coach, and author of *Self-Awareness and Trust: Leading Healthcare Teams from the Inside Out*. A graduate of West Point and Tulane University School of Medicine, she completed her Internal Medicine and Psychiatry residency at Walter Reed Army Medical Center, served as a Psychiatrist at West Point and completed a Critical Care Medicine fellowship. She has since held leadership roles throughout the physician lifecycle to include Program Director and Associate Dean. She retired in 2023 after 23 years in the Military, deploying to Iraq as a Psychiatrist and Afghanistan as an Intensivist. She is passionate about developing future leaders through faculty development, coaching, and mentorship.