I recently visited the Università degli Studi di Padova, home to one of the first medical schools in Europe. Just outside the lecture halls where Galileo spoke of re-centering the solar system, hang wooden and stone placards given to the first physicians to graduate from the institution. With the abbreviations Phil et Med Doct, the university bestowed its graduates with both a degree in medicine and one in philosophy. Historically, ours is a profession of looking inward, into our patients and into ourselves.

While we are still familiar with the practice of questioning our methods and diagnoses, we may have become more reluctant to travel inward and challenge ourselves. This loss of introspection comes at a great expense not only to our personal well-being, but also to our ability to interact with and understand our relationships with patients and colleagues in health care. I believe that practitioners who are willing to travel, to explore unfamiliar territory in physical as well as emotional and moral space, are better prepared to understand and help our patients as they traverse the bounds of sickness and health; we are better prepared when we learn to map the healing process.

The ultimate goal of any traveling is the gathering of data for comparisons. Like a blue sea against a green palm, or an amber sunset against a volcanic horizon, colors and concepts seem brighter and more distinct when they are set against a backdrop of their opposites. In the art world, these opposites are appropriately called “complements.” Witnessing these comparisons in the physical world helps us define our geographical location.

In the introspective world, we compare not colors and shapes, but morals and opinions to define our “metaphysical” location in relation to the rest of the philosophical possibilities. This is the place we refer to when we tell our colleagues “where we stand” on controversial issues like abortion or physician-assisted suicide. Unlike the blues and reds, whose differences are familiar and comfortable, moral differences are more difficult to describe. Though often associated with specific religions, families or other cultural predilections, morals are specific to each individual. Morality is that country populated by our beliefs. In it lie our own regions of good and of evil, right and wrong, and for each of us, these regions have different landscapes and borders.

Moral regions and boundaries are not destinations advertised by freeway exit signs; they are areas whose borders are vaguely drawn from above and—like most border-crossings—indistinguishable by foot. In order to define moral boundaries, to be sure of our own beliefs, we must be aware of change, of difference and of conflict. We must pay attention to signs and be willing to recognize alternative perspectives in order to see those differing opinions as complementary—data that allow us—and challenge us—to more clearly define our viewpoint.

Implicit in that challenge to define these perspectives is the duty to question them. It is this practice that I find particularly appropriate for us students and practitioners of health care professions, for whom it is important not only to know our moral grounds, but also to be in the habit of recognizing and questioning them in the face of others. Our patients will have their own goods and evils, their own morals, their own backgrounds, and their own ways of looking at the world and their health. Therefore, we owe it to our patients to practice our own moral cartography and outline our perspectives in the face of others.

Practicing medicine requires attention to and respect for these personal maps. When taking a history, we are trained to recognize changes, aberrations, influences—significant data—and why we think they’re there. To treat the whole person, this history includes not only past medical history, but also social influences, economic influences. We ask ourselves where our patients have come from, and where will they go from here. Each piece of their history is a coordinate that assists us in the map-making process.

It is rare, if not impossible, to perfectly triangulate our patients’ origins and destinations because each traveler practices his own cartography, the bulk of which occurs after the journey is complete. Our patients have just as much difficulty describing where they’re “coming from.” Imagine drawing a map to a watering hole only after bushwhacking for two hours to get there. Moral cartography involves
A lot of bushwhacking.

As a result, like most travelers, many patients are weary. Their journey through sickness and health, diagnoses and symptoms, has given them new data about themselves. They will not likely return to the same “home,” same path, same routine they knew before the journey of their disease. The way we treat that patient should change to meet their evolving needs, as we aim to assist their navigation of new terrains.

This dynamic practice of acquiring new information and challenging the old—which most call learning—is common in clinical medicine. To be most effective, this intentional and willed learning must apply equally to the philosophy of medicine. Practitioners willing to try a new treatment must also be willing to travel moral grounds—willing to get outside our comfort zones, willing to explore new borders, and willing to change to better serve our patients.

The distances we travel do not need to be far. We do not all need to swim in the Mediterranean to know that seas are salty, just as we do not all need to visit Padova to be inspired by the philosophy of medicine. However, we—not simply as medical professionals, but as humans—should be willing to explore wherever it is that we are now: our goods, our evils, our morals. Then we will not simply be great travelers, and great cartographers, but great learners and great physicians.

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