Love in Clinical Practice

Abstract: This essay is a brief exploration of the role of love in today's clinical practice. It addresses the barriers to physician's love of his patient, and the potentials for of overcoming these barriers through awareness, openness, and risk-taking. This task is set forth for its own sake—love and well being of the patient, and not to reach any other end in the process.

Included is a brief review literature on the topic with helpful advice from some of today's authors, some of the thinkers of the century just gone by, and some timeless sources.

Introduction

What is the place of love in today's clinical practice in the US? Can love be placed into the context of practice, or can one practice medicine in the context of love? Newly installed AMA President J. Edward Hill, M.D., compared the environment of today's medicine to the swamps of his native Mississippi, "Hill encouraged physicians to use their "professional, ethical, social, even spiritual" compass to guide their steps through the muck to 'safe, high ground'. He said that this compass will direct us—physicians home, to the soul of medicine. Healing the sick, comforting those beyond treatment, preventing harm, making life better for others, connecting to a higher cause and, most of all, caring. Caring for and about people—and populations." [14]

Can today's physicians love their patients and what stands in the way? I sought the answers to these and other related questions from the time

before I entered medical school. Medical school failed to supply satisfactory answers, as did residency training and my medical practice. Hence I decided to embark on the exploration of this topic on my own.

My medical school experiences are still quite fresh in my memory, accompanied, I must admit, by disappointment. There, as part of the class on physical diagnosis, we were taught about the attitude a physician should assume toward a patient. We were specifically and openly instructed that it does not matter whether the doctor really cares for his patient. It was only important to know how to create the impression of caring. We were then given a set of simple techniques, so we would know how to fake it well. Yet even at that time I observed that some physicians had more than a fake concern for their patients.

The same professor taught us that most of the job a physician does nowadays can be performed by a computer. The one exception was interpreting patients' complaints. Patients, being highly varied, had infinite ways of describing their complaints and this would be impossible for a computer to interpret reliably, at least for the computer with contemporary capabilities. Yet it seemed that observing and interpreting was not all that a physician could offer; that there was also room for direct action, and the kind of action that could not be substituted by a computer. In addition observation did not need to be limited to interpretation of physical findings in order to make a diagnosis, but could also be attuned to other aspects that unify the patient and his physician and could perhaps potentiate actions of healing.

The practice after residency seemed to streamline a physician into a soldier of the pharmaceutical industry and a manager of 'clinical productivity.' Yet

even now, from time to time, I am fortunate to observe in some my colleagues and experience within myself that warm and infinite light that can only be called Love.

Definitions

Before proceeding further, I would like to go over some of the definitions[4] of love. Greeks used five different words to describe various forms of loving relationships: *philia*, *eros*, *agape*, *storge* and *xenia*. In most dictionaries, *agape* is described as fatherly love of God for mankind and reciprocal love of mankind toward God. It is also described as brotherly love, and descending love—love that was given to man by the divine. Seguin[1] gives the following explanation: “Agape is a reflection of the love of God. Paul expresses it strongly pointing out the fact that God is Love, and therefore, any kind of love the Christian may feel toward his fellow is only a part of the love that God has given to him. It is, then, a *descending* love which is always heavenly.”

Philia is a dispassionate virtuous love toward friends and community. This type of love, as developed by Aristotle[2], was based on goodness, pleasantness, and usefulness. Both parties benefit from philia relationship.

Eros refers to passionate love with sexual desire and longing. Plato[3] sees eros as a stepping stone on the way toward the love of absolute beauty. For that reason this type of love is sometimes called ascendant. The ascent is toward a higher (and perhaps absolute) kind of love termed *platonic eros* or *platonic love*.

Storge is a natural love of parents for their offspring. This type of love usually involves the elements of authority, possession, guidance, and

identification[1] (of parent with their child and vise versa).

Xenia was a relationship of hospitality love. It was a ritualized relationship between a host and a guest, where a host provided food and shelter, expecting only gratitude in return.

In this article, when I speak of love of a physician toward his patient I mean a very specific type of love. While the scope of this article doesn't permit a more exhaustive exploration of the nature of love, in my research I stumbled upon a tangible description of a loving feeling that a physician may experience toward his patient. I call it tangible because many descriptions coming from poetry, which is better suited for this subject, seem too much out of reach for the minds that are used to thinking in terms of natural science. The description comes from a psychiatrist C.A. Seguin[1]. Here is his progression of thought as he explores a psychotherapeutic relationship that leads him to formulating his own type of love that he calls *psychotherapeutic eros*.

> …sympathy and love stand more nearly related to the feelings he [psychotherapist] may experience. Let us look at them closer.
>
> As I have said, there is no sympathy without love, but this statement needs qualifications. There may be cases in which the love is not directed to the very person we sympathize with, as when we love children or artists in general, and sympathize with *this* child or *that* artist, not loving them as persons. In that case we would be able to feel compassion for them, but that feeling, not accompanied by love, changes completely its significance. If I feel compassion for a person without loving him, I am really bringing out, as a proper

answer, shame, hurt pride, feelings of abasement. Compassion can only be accepted as a sign of love.

Therefore, we may take as a conclusion that the only justified affect the psychotherapist can feel toward his patient is love.

But, there are, of course, several forms of love. We have to go back now to the previous analysis and to accept that the psychotherapeutic love is not the one from lover to lover, neither those from friend to friend, father to son, teacher to pupil or pastor to follower. Which one is it then?

I postulate now that it is a different, new and not assimilable kind of love, a love that shares some of the characteristics of the others, but that distinguishes itself from them very distinctly. I, therefore, propose for it the name of "psychotherapeutic Eros". I am using the Greek word because it may help us to understand the real implications of the concept, to avoid confusion with sexual love and bring out its relation to Plato's ideas, since it would be something similar, but different, from the platonic "pedagogic Eros".

Much work will have to be done to rightly define and delimit the concept of psychotherapeutic Eros, and I may try to do it in the future. For now, I shall point out some of the features that seem to be important.

Some of them are negative, as we saw before. Psychotherapeutic love has to be free from: (a) authority, and tendency to possession; (b) identification; (c) dogma; (d) imposition of values, rules or knowledge; (e) sexual attraction.

The author then goes on to emphasize the importance of his first negative principle—to be free from authority:

> If he is a good therapist, he will make out of this disparate relationship, one of mutual understanding on the same human level. For that he will have to love in the sense I have emphasized before: relating himself to the real values of his patient and giving himself to the intentional movement of bringing out the highest in him.

While some discussion can arise as to whether a definition for a psychotherapeutic relationship can be applied to general medical practice, I believe the answer is yes. In fact I think this kind of interaction will benefit any helping relationship. What stands in the way of doctor's love for his patients?

Today's Challenges

Fear of litigation is one of the greatest challenges to the open and loving doctor-patient relationship. One can observe it in the medical literature, which reduces love of a physician for his patient to a strategy for avoiding a lawsuit. Below is what one can see in an article by an orthopedic surgeon. The title of the article is *Malpractice: Love thy Patient*[5]. The word love does not appear anywhere else in the test. In the abstract one finds, "The Hippocratic oath commands doctors to be the patient's supreme advocate. Coupling this command with a well-trained physician is the sine qua non of orthopaedic risk management." In the body of the article the author proposes techniques for improving the relationship with patients:

"… through good self-discipline, doctors can learn to be adept at leaving the aggravations in the hallway before entering a patient's hospital or office

examination room…

… Listening with undivided attention and good eye contact conveys a sense of real concern…

… Communication consists of good listening skills and appropriate questions, and other avenues of information exchange, such as web sites, videos, pamphlets, and office brochures…"

Yet none of these techniques can help one in the search for a truly loving relationship toward a patient. This is because these tricks of the trade were born out of fear, and designed for 'risk management'.

Financial pressure is another important barrier to love. This was recognized and described by another orthopedic surgeon who says, "My message to you today is simple. We need to fall in love again—fall in love again with our patients and with our reasons for choosing to be physicians. Managed care is still in front of us, and we have not yet overcome all of the hurdles. But for the last several years, managed care has been our focus and our patients have taken a back seat. It is time we move from the plan to the patient… We are not entrepreneurs, not insurance brokers, not managed-care gurus, and not the landlords of outpatient surgery centers. We are physicians treating the patient first. We must fall in love again with the concept of who we are and what we do best—treat patients who have musculoskeletal problem."[6] I cannot fully describe a breath of fresh air that I experienced after reading his words. Until then, I had not met a physician who would agree with me that medicine is not and cannot be business. "Medicine is business" is a dictum I have heard repeatedly throughout medical school and residency training. The author of this article continues,

“We've become the drive-through fast-care center. While the members of the public demand speed and impersonalization in many aspects of life, they want personalized medical treatment and a personal relationship with their physicians. Because of the increased financial burden of managed care, we have been forced to sacrifice quality of care for quantity of care.”

This author proposes certain measures for remedying the current situation. He advises to improve communication, to shift medical education from medical economics to evidence-based learning, and be open to alternative modalities. He still, in my opinion, falls into a trap of only cosmetic improvement measures, “We need to convince ourselves and our colleagues that proper communication can bring about (1) increased patient satisfaction and thus an increase in physician satisfaction, (2) better patient compliance and support of the physician, (3) greater practice efficiency, and (4) fewer malpractice suits.” He then speaks of surveys and other techniques of improving communication. Yet his reasons for doing all that include reducing malpractice suits, improving efficacy (perhaps a nicer way of saying ‘clinical productivity’), and improving ‘compliance’. None of these can be a motive for true love. In addition, the way of love may not always be accompanied by the patient and physician satisfaction, yet it must remain unshaken by any such dissatisfactions.

Rationing of medical resources was recognized by this writer as another impediment to love. “For those of us who take direct care of patients, priorities and rationing—at their deepest level—create what is ultimately a problem of love and the heart… In the United States we call love for patients fidelity and seeking fairness for the population stewardship. Since priority setting and rationing inevitably deprive identifiable people of

potential benefits, the question for practicing clinicians is whether they can embrace fidelity and stewardship at the same time in their dealings with patients."[7] In my experience, in the US rationing can only be, and has only been meaningfully controlled by the insurance, leaving the physician (luckily) on the sideline of most such decisions. The conflict between fidelity toward a patient, stewardship toward a population, fear of litigation, and financial pressure would inexorably lead the vast majority of physicians to offering to every patient everything that is available. This unfortunately is now going on with respect to patients with 'good' health insurance, producing unnecessary suffering and expense[16].

Whether or not the idea of rationing, by itself, poses a conflict to love is also questionable. If one considers how really modest our arsenal is, how little we can do for the current onslaught of the chronic illness, one is much less likely to see a threat from rationing. I would be hard pressed to find a singe case from my practice of the past two years (and I serve mainly medicaid patients, who are the most rationed) where rationing made a decisive difference for patient's survival or quality of life.

In addition, if we can accept the limitations of medicine, we can surely accept the existence of financial limits. There is no need for a physician to identify with financial institutions or patients' financial situation. In fact, financial limits on the care that we provide have nothing to do with the degree of caring we could offer.

Fear that a love toward the patient will degenerate into a sexual or other kind of inappropriate involvement is a factor expressed in an article written by a psychiatrist. This article was addressed to the non-psychiatrist physicians to help them with managing relationships with their

by patients. Initially he acknowledges and describes the kind of love that is not only appropriate but also integral for treatment. “Bonds may form whenever patients and physicians interact. This bond is characterized by a particular form of love akin to the Greek agape, or brotherly love. The love that forms is an integral part of the patient-physician relationship. This love is not characterized by romantic feelings, but rather denotes a platonic relationship and one in which intimacy is used to benefit the patient.”[8] In his article, however, he does not expand on the topic of love, but instead speaks of the boundaries as means of protecting both patient and physician. “Mutually understood boundaries provide protection for the patients in the relationship by allowing certain limits on physical space and contact and emotional involvement. Physicians also may have a number of psychological vulnerabilities. Caring for patients may foster strong emotions in physicians; boundaries protect the physician from overextending in this regard.”

While it is true that caring for patients may provoke strong emotions in both physicians and patients, there may be ways of dealing with such emotions that are different from simply setting up boundaries. While boundaries can be healthy, there can be different types of boundaries. Boundaries that exist within the context of love function very differently from those existing for the sake of mutual preservation. The former type of boundaries can be compared with the ones that a loving parent sets up for his child; the latter kind is set up between two hostile states. Setting up boundaries is a passive and fearful strategy. Perhaps love, being by nature active, perceptive, uniting, fearless, and responsible, can offer another way of overcoming the pitfalls that this author is concerned about. A loving

relationship is characterized by harmony, not boundaries. One who is not attuned to love will perceive only boundaries, but for the one who loves, there is nothing but harmonious freedom. It is similar to a beautiful piece of music that is characterized by harmony of tonality and rhythm, rather than their boundaries, with each note having its proper place and fulfilling its ultimate freedom by becoming one with the whole—a symphony.

Mechanization of medicine pervades all medical specialties and is another major disruptive force of a good doctor-patient relationship. By mechanization I mean its machine-like quality, ergo the term mechanical. Most of today's practice in any specialty is focused on placing the patient in the right place along a predetermined algorithm, without putting much importance on the patient's non-physical attributes. This approach is rooted in the philosophy underlying our medical practice and is beyond the scope of this article. Among psychiatrists mechanization is seen in their change of title from psychoanalyst to psychopharmacologist. Among surgeons it is seen in the creation of high volume surgi-centers. Among medical generalists it is seen in the degeneration of a physician evaluation into a physician triage. Yet all of us are in position to practice a loving relationship toward our patients in our everyday practice, provided we can open ourselves up to what is already there—the vast sea of important non-physical information. Without a frank discussion and patient consent a surgeon would not be able to operate on a patient (except for the cases of true emergencies) any more than a medical doctor give a medication and expect a patient to use it. While this point is usually ignored, it is this meeting of the minds, more than any physical condition that makes any kind of therapy possible.

Today's Explorers of Love

I was glad to discover a modern medical philosopher and ethicist who was willing to explore love. In this article the author advances the idea that following the traditional principles of beneficence, autonomy, and justice needs not the only approach to medical ethics[11]. He proposes what he calls the ethics of caring as an alternative that can stand alone or enhance application of the above principles. He quotes the findings of Carol Gilligan, who observed in her studies that "women solve ethical dilemmas by seeking ways to maintain relationships rather than by making more detached judgments about what would be most fair to each party." The author suggests that both men and women may adopt either a principled or a caring approach.

He explores the topic to a certain extent touching on both philosophical and ethical issues. "The ethics of caring assumes that connection to others is central to what it means to be human; that relationships, rather than alienation, give meaning to our existence." The author defines caring as being receptive and responsible. He then extends caring to love. "The ethics of caring requires that we feel as well as reason. Our natural impulse to care comes from compassion and human love." He reiterates that caring can guide our actions and our application of principles of beneficence, autonomy, and justice. Indeed I agree completely—trying to apply those principles without caring is similar to playing Russian roulette. The author very perceptively describes the process of numbing that young physicians undergo during their training. Young physicians suppress their feelings to be able to cope with their training and work in the medical ward culture which does not value empathy. "I have observed that this assimilation

threatens the students' moral sensitivity, moral commitment, and even moral character—all aspects of their ability to care—more than it threatens their ability to reason about ethical issues.” This is quite true. There are very few examples that I could recall where expanding one’s outlook to caring and love was not seen as a threat to the efficiency of mechanical reasoning. Yet true love takes only the time it takes one to know what’s in one’s heart.

This author of this article also described the immediate value of doctor’s loving disposition, “…the attitudes with which those doctors deliver care—their attentiveness, kindness, and compassion—are in many cases as therapeutically important as the curative treatments. I am thinking especially of dying patients, but it is also true for many chronically ill persons, where caring is the heart of the matter. More than the framework within which we apply principles such as beneficence and respecting autonomy, the ethics of caring is itself a moral action that benefits the patient.” I would agree with describing one aspect of love as a moral action, but it is also a lot more than that.

The author finally gives truly practical advice, a place to start for all of us right now, “I doubt we will ever approach an ideal caring atmosphere for patients unless we extend our caring to our students, residents, peers, and ourselves. Harsh treatment of other caregivers is unlikely to coexist with warmth and support for patients.”

I discovered another brief article whose author rightfully questions our medical education and proposes a novel solution[12]. He quotes a common patient complaint, “I think that doctors should understand that the patient is a person… I felt that no one had the time or the will to sit and listen to me".

Any US practitioner will agree that this complaint is the most typical and descriptive of a conflict we face. To acquiesce and give the patient more time and take time away from other patients? Giving up ‘clinical productivity’ is not seen as a viable option for most physicians. Without love, I believe, there is no way of resolving this conflict.

The interesting point this author brings up is his questioning of our educational methods and, even more importantly, he suggests that the key may be not in learning techniques but in learning hoe to like people more. “Might knowledge of consultation techniques alone—many borrowed from those used by door-to-door salesmen—be inadequate to enable doctors to talk to people and manage their distresses? Most will admit that some patients are more easily helped than others. It may be these patients are technically better at being patients--they use more easily-read body language, perhaps—or might the doctor simply like them better? Should this be the case, doctors might profitably learn how to like people more, rather than learn techniques for coping with them.”

The author then expands that what he really means is love, specifically agape, or brotherly love which, as he rightfully says, receives no attention in medical textbooks. He too gives specific accounts of love’s value, “…yet accounts of its [love’s] power recur through thousands of years of myth and history. A doctor schooled in the application of brotherly love should seldom provoke the complaint "no one had the time or will to sit and listen", or "he says there's nothing more to be done"—there is always something that can be done, right up to the last kindnesses at the end of life. Similarly, "I'm afraid there's no chance" announces the exhaustion of technique, yet is unnecessary in brotherly love. Chance of recovery may appear improbable indeed, yet countless stories, songs, and poems testify to the power of love

to shift the balance of probability. None makes such claims for mannered pretence."

How can this be taught? The author proposes a study whereby students will be randomly exposed to selected literary works and assessed by role playing.

Teaching love is a challenge indeed. I don't think one can learn love through reading, any more than one can learn swordplay or a play of a musical instrument by observing. Nor can assessment by role-playing really be accurate. Even the best actors have trouble playing the intricacies of human relationships. Perhaps one way of having at least a brief exposure to such training could be an apprenticeship type of relationship. An apprenticeship with a physician who is in full disposal of his intellectual, social, moral, physical, and loving potential, and who is in action—in direct patient care making real moment-to-moment decisions.

While the precision, insight, and practicality of advice on the topic of love offered by the last two authors are rare in the current medical literature, we find much more liberal exploration of the topic if we look only half of century back. Below I revive two of the masters of the recent past to help me in this search.

Masters of the Recent Past

Surprisingly, I found Freud's writings to be of great value, not those dealing with his theory, but those that describe the technique of psychoanalysis. Freud acknowledges from the outset that the management of transference-love is the most significant difficulty encountered by a psychoanalist[9]. He says that transference-love in the psycho-analytic treatment is an "inescapable fate" of the patient. "This phenomenon, which occurs without

fail and which is, as we know, one of the foundations of the psycho-analytic theory, may be evaluated from two points of view, that of the doctor who is carrying out the analysis and that of the patient who is in need of it." What is most interesting, is that in discussing the condition of the patient Freud advise the analysts not to try to disarm patient's love by going into two extremes of either denying its reality and intellectualizing about it, or allowing oneself to be reduced to the level of the lover. He invokes neutrality in this sense only—to be neutral toward reduction to physicality, or pseudo-elevation to intellectual rejection of the patient's feelings. Instead he recommends to allow the patient continue loving, permitting love to be the engine of analysis that takes the patient to a freer mode of existence.

Contrary to today's usual thinking, Freud did not consider transference-love unreal, but only different from the usual love in a sense that it was provoked by the therapeutic situation. While he believes that resistance to the psychoanalytic process exaggerates this love, such exaggerating does not invalidate patient's love-feelings. "Nevertheless the resistance did not, after all, *create* this love; it finds it ready to hand, makes use of it and aggravates its manifestations. Nor is the genuineness of the phenomenon disproved by the resistance… Transference-love has perhaps a degree less of freedom than the love which appears on ordinary life and is called normal; it displays its dependence on the infantile pattern more clearly and is less adaptable and capable of modification; but that is all, and not what is essential."

Freud also describes the role of the analyst during a psychotherapeutic journey. The analyst must relinquish all possibilities of personal gains in order to lead the patient to a true transformation. "She has to learn from

him to overcome the pleasure principle, to give up a satisfaction which lies to hand but is socially not acceptable, in favor of a more distant one, which is perhaps altogether uncertain, but which is both psychologically and socially unimpeachable. To achieve this overcoming, she has to be led through the primal period of her mental development and on that path she has to acquire the extra piece of mental freedom which distinguishes conscious mental activity—in the systematic sense—from unconscious." I think these words of Freud offer a valuable insight on a role a physician may play in patient's life and vise versa. One doesn't need, and according to Freud, should not try to make love disappear, but rather to permit it to take the patient (and the doctor) to another level. Remembering our role and our responsibility may help us stay on course. But there is something else about Freud that I believe was responsible for his ability to make such leaps on a regular basis.

I stumbled on this piece of information in the writings of Dr. Medard Boss, who was not only a great Swiss psychiatrist but also had the good fortune to be analyzed by Freud himself. Here is what he writes in regard to Freud's advice to analysts to be impenetrable to the patient like a mirror, "…Those, however, who personally experienced the mirror cold "Freud" know beyond doubt that he was opaque only to his own imagination and that to his patients and disciples his unusual kindness, warmth, and humanness shone through even from a distance."[10] Therefore I think that Freud's own loving nature was the key to his success.

Medard Boss, who is my personal hero, was a psychiatrist who recognized that all medical and psychological interventions were inevitably rooted in philosophy. He was an existentialist, follower of Martin Heidegger, and

founder of his own method of psychotherapy called daseinsanalysis, radically different from Freud's psychoanalytic approach. He offers a very useful insight on the issue of love and a doctor-patient interaction.

Here is how he describes a physician's transformation as he progressed in the analysis of a patient.[13] "It was not only the patient's attitude toward the therapist that went through such important transformation, however; his stance toward her had also changed markedly during the first few months of treatment. His initial resistance to the idea of taking on still another difficult case, his revulsion toward her initial behavior, at once arrogant and artificial—all of these gave way to a lively interest and enduring benevolence. He began to sense in her a wealth of buried human gifts, especially a great capacity for love." This sensing of the other person's potential is the decisive factor in developing love for the person. "As a result, the therapist was able to enter a selfless relationship to her that recognized her as and gave her the respect due another human being-in-the-world, the relationship akin to that of a good gardener caring for his plants."

In fact, as the author says, all love appears when being together with a person reveals possibilities of relating to the world not recognized or appropriated before. Here is how this sounds in the language of an existentionalyst, "all genuine love of one person for another is based on the possibility, which the loved one offers to the lover for a fuller unfolding of his own being by being-in-the-world with him."[10]

This author gives numerous descriptions of a loving doctor-patient relationship, refining the various aspects of it. "From the analyst for the practice of psychoanalysis demands above all selfless care and cherishing

of the patient…He must accept the other fully the way he is, with all his physical and mental beauties, as well as blemishes. All the patient's possibilities must be given a chance to emerge. He must become free, regardless of the personal ideas, wishes, or judgments of the analyst."[10]

The author is also quite precise in his description of characteristics that an analyst must develop, "adequate human relation between the analyst and his patient…presupposes in turn that analyst himself has matured into the freedom of selfless concern for his patients…It means that the analyst has all his own sensual and egotistical tendencies at his free disposal and can keep them from interfering secretly or openly with his genuine concern and selfless love for the patient… [therapeutic relationship] must be an otherwise never-practiced selflessness, self-restraint, and reverence before the patient's existence and uniqueness. These qualities must not be shaken or perturbed by cooperative, indifferent, or hostile behavior on the part of the patient.[10]

I have nothing to add to the words of this master of love.

What to Do Now

I was glad to hear the new president of the AMA appeal to the profession to consider caring to be of primal importance. Dr Hill calls us to return to the 'safe, high ground', to the soul of medicine. Perhaps there is hope. I think we can reach this 'safe, high ground' by plunging deeply into the nature of love and making our seat firmly in the midst of it. This journey, as it seems to me, involves continuous risk-taking by a physician for the patient's benefit. For the one who loves can no longer hide behind the walls of the guidelines for legal protection; he cannot please his colleagues by following the community standard nor can he be assured of his financial assets.

Instead, he must start afresh in each situation and let his heart speak the truth of the moment while it unfolds.

In practical terms we could all start with following the advice of Dr Branch, “I doubt we will ever approach an ideal caring atmosphere for patients unless we extend our caring to our students, residents, peers, and ourselves. Harsh treatment of other caregivers is unlikely to coexist with warmth and support for patients.”[11]

I would like to end this article with the description of love offered by St. Paul. Seven years ago I chose this passage to be read during my wedding ceremony.

“Love is patient and kind; it is not jealous or conceited or proud; love is not ill-mannered or selfish or irritable; love does not keep a record of wrongs; love is not happy with evil, but is happy with the truth.

Love never gives up; and its faith, hope, and patience never fail. Love is eternal.[15]

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