The Charles S. Bryan Lecture in the Humanities

OSLER THEN AND NOW: ARE THE HUMANITIES STILL THE HORMONES?

Charles S. Bryan, M.D., MACP

South Carolina Chapter
American College of Physicians

Charleston, South Carolina

October 21, 2017

Thank you for the enormous honor of this lectureship. I hope future lectures in this series will provide abundant food for thought and self-renewal. Rather than give a straight humanities lecture, I've chosen to address a problem in medical education: Are the humanities relevant in today's medical practice and, if so, how?

The text to which I keep returning is a one-page essay on "The History of Medical Teaching" by the French medical historian Danielle Gourevitch. It was published in a supplement issue of *The Lancet* entitled "The Lancet 2000" designed to greet the new millennium [1].

Gourevitch writes that a century earlier—that is, around the year 1900—physicians were "at the top of the aristocracy of knowledge." They were usually among the most learned men (and occasionally, women) in their communities. Doctors, at least the better doctors, were broadly knowledgeable in the sciences and the humanities. People looked to doctors for wisdom, for help in tough situations freighted with uncertainty about the outcomes.

Professor Gourevitch takes as the avatar of this construct, the epitome of the broadly-knowledgeable early-twentieth-century physician steeped in the humanities and sciences, Sir William Osler (1849–1919). She calls Osler "the last maître à penser for a noble-minded general medicine."

Gourevitch's concluding paragraph is chilling. She writes: "Today's technical and dehumanized medicine has no past, has no cultural language, has no philosophy, does not even have any books. . . . The year 2000 will witness the triumph of medicine, but also the substitution of doctors by health technicians. I do not believe in the pretense of teaching literature to first-year medical students, which is done only for political correctness. . . . Doctors should intellectually chase nascent science; alas messages of seminars generally have no other aim than cost containment in health care. Under these circumstances, one wonders whether doctors really need an academic training [1]."

Mark these key words: "Science," "technology," "technician," "humanities," "humanism," "caring."

Here is the outline. First, we will frame the issue: Do the humanities matter? Second, an argument in the affirmative: the humanities still matter. Third, an argument in the negative: the humanities no longer matter. Finally, I'll offer twelve suggestions for your consideration.

FRAMING THE ISSUE: DO THE HUMANITIES STILL MATTER?

The growing literature on the medical humanities—of, as some now prefer to say, the health care humanities [2]—often conflates "the humanities" with "humanism." They are not the same thing. Let us review some definitions from the *Oxford English Dictionary*:

- **Humanities**: Learning or literature concerned with human culture
- **Humanism:** The quality of being human; devotion to human interests or welfare
- **Humane:** Characterized by sympathy with or consideration for others; compassionate; benevolent
- **Humaneness:** Humane quality or condition; compassionateness
- **Humanize:** Make human; give a human character to
- **Humanitarian:** A person concerned with human welfare

Most arguments for the medical humanities include the word "empathy." The arguments run to the effect that exposure to the humanities insulate medical students, residents, and practicing physicians against (in Professor Gourevitch's words) "today's technical and dehumanized medicine."

The terms "medical humanities," "humanism," and "empathy" are a bit controversial. We'll focus mainly on history, literature, the visual arts, and bioethics—the most common components of medical humanities programs, but certain others may be just as important. We'll make "empathy" more or less synonymous with caring over and above the basic level of "beneficence" (that is, "doing good"). (For example, sewing up a laceration satisfies the requirement for beneficence, but "empathy" insists on concern for the person who has suffered the laceration.)

Many and perhaps most North American medical schools now have humanities programs, and some of these programs are highly visible. There is a *Journal of Medical Humanities*, many journals of ethics and bioethics, and a *Journal of Medical Humanities and Bioethic*s. These programs unquestionably produce great discussions and high-quality scholarship, but do they make much of a difference in practice?

This question has become a hot topic in medical education, since humanities programs must justify their budgets and time in the curriculum. The big question, to reiterate: Do the humanities promote empathy?

The need is obvious. Medicine desensitizes to the suffering of others. From a review of 18 studies (eleven involving medical students and seven involving residents) it was concluded that empathy—the ability to really care about patients—declines during medical school and residency. Declining empathy compromises professionalism and health care quality [3]. Neuroimaging studies indicate that medical school, residency, and practice down-regulate perception of other people's pain, which is the emotion-sharing component of empathy [4]. Hence, in Professor Gourevitch's words, "today's technical and dehumanized medicine."

From a large literature let's pick out the case of one medical student, disguised as "Andrea Ricchione," from a 2001 article entitled "Vanquishing virtue: The Effect of Medical Education," by Jack Coulehan and Peter Williams [5]. Andrea entered medical school with empathy in abundance. She'd graduated from a prestigious liberal arts college, had spent a year as a teacher with a volunteer organization in inner-city Baltimore, was well-informed about ethical and social issues in medicine, and during her interview before the Admissions Committee told stories about interactions with specific patients while volunteering in an emergency department. A couple of months before

Andrea graduated the professors invited her to write about her medical school experience. She wrote that "medical school is an utter drain. . . People are rude, the hours are long," and so forth. She ultimately concluded that "the most important thing I could do for my patients, for my fellow human beings, for the future of medicine, as well as for me, was to assure myself some peaceful time." She added her belief "that habits formed now will rarely be overcome in the future."

We'll come back to Andrea Ricchione. Returning to William Osler, and recalling Professor Gourevitch's opinion that he was "the last maître à penser for a noble-minded general medicine," can he help us out today?

Were Osler to reappear magically in any hospital he'd find it almost unrecognizable. Our style of practice differs from Osler's as much as his did from Thomas Sydenham (1624–1689) or Herman Boerhaave (1668–1738). Also, Osler never claimed to be a visionary.

Still, Osler's legacy is a useful anchoring point for discussing the relevance of the humanities for at least three reasons.

• A recent Medscape® poll of U.S. physicians [6], Osler was voted the most influential physician in history." To whom else can we turn?

• More than anyone else in history (with the arguable exception of Hippocrates, of whom we know very little with certainty), Osler imported to physicians, at least throughout the English-speaking world, a sense of cohesiveness, a sense of belonging to (in his words) "a remarkable world-unit in the progressive evolution of which there is a fuller hope for humanity than in any other direction [7]."

• Finally there was his eloquent restatement of the Hippocratic ideal of "where there is love of humanity, there also is love for the art [of medicine]," the ideal we all parroted before an Admissions Committee when we gave some permutation of "I like science and I want to help people." He gave this statement in his last major address, "The Old Humanities and the New Science," his presidential address in 1919 to the Classical Association of Great Britain. He spoke of "love of humanity associated with the love of his craft!—*philanthropia* and *philotechnia*—the joy of working joined in each one to a true love of his brother. Memorable sentence indeed! In which for the first time was coined the magic word philanthropy, and conveying the subtle suggestion that perhaps in this combination the longings of humanity may find their solution and Wisdom—philosophia—at last be justified of her children [8]."

Competence and caring—these are the twin pillars of medicine, articulated by successive generations of clinical teachers, and an ideal to which most medical educators still pay lip service. Science is value-neutral; we turn to the humanities for guidance. Osler in 1919 took his metaphor from endocrinology, from the newly-discovered hormone, thyroxine. He said that the humanities "do for society at large what the thyroid gland does for the individual. The humanities are the hormones. . ."

Forty years after Osler's lecture on "The Old Humanities and the New Science," in 1959, the British novelist and physical chemist C. P. Snow said much the same thing in *The Two Cultures and the Scientific Revolution* (1959), which was assigned summer reading before my freshman year of college.

Educators who have quoted from Osler's 1919 lecture include Al Jonsen, a pioneer of medical ethics, and Edward W. Hook, long-time chair of the Department of Medicine at the University of Virginia. For Hook, injecting humanities into medical education consisted treatment of a deficiency disorder [9].

Perhaps the most important end-point of higher education is the ability to stage debates within our own minds, to ask ourselves tough questions and argue from different positions. The purpose

of my lecture is to share with you my own internal debate on the role of the humanities in medical practice. Are the humanities still the necessary hormones?

ARGUMENT IN THE AFFIRMATIVE: THE HUMANITIES STILL MATTER

Nine years ago, in August 2008, I gave my farewell lecture to first-year students at the University of South Carolina School of Medicine after a 31-year career as a charter faculty member. It was scheduled as the students' introductory lecture on professionalism, and I was supposed to supply three multiple-choice questions for their examination.

I started out by giving them the three questions and the answers. I told them that rather than talk about professionalism I was going to tell them about "Some of my Teachers."

I told that in the sciences my teachers included James Watson in biology (co-discoverer of the structure of DNA), Louis Fieser in biochemistry (inventor of napalm and author of the standard textbook in that field), Albert Lehninger in biochemistry (who demonstrated the electron transport chain and clarified ATP production in mitochondria), David Bodian in anatomy (who clarified the pathogenesis of polio, and whose work, along with that of John Enders, enabled development of a polio vaccine), and Vernon Mountcastle in physiology (who discovered the columnar organization of cells in the cerebral cortex, the turning point in understanding the sensory function of the brain).

The students gasped. I continued "For those of you who didn't have famous teachers in the basic sciences, let me tell you something: You didn't miss a thing." I told them it probably didn't matter who you have for a survey course in the sciences as long as they can teach. I told them that on the other hand teachers in the humanities made a huge impact in my life.

For philosophy I had Rogers Albritton, one of the great philosophical minds of the twentieth century, who introduced me to the giants of Western thought starting with Plato. For history of the American South I had Paul Buck, recipient of the Pulitzer Prize, and I later had the extreme privilege of doing a senior thesis in history under David Herbert Donald, recipient of two Pulitzer Prizes. For sociology I had David Riesman, a public intellectual best known for *The Lonely Crowd: A Study of the Changing American Character* (1950). Perhaps the most influential course I took was in the philosophy of religion under the great theologian Paul Tillich, from whom I gleaned the insight that has perhaps guided me more than anything else: that faith and belief are not the same thing. "Truth" in this transitory life is at best an approximation. "Faith"—the confident trust that gives us a rationale for everything we do—holds "belief" and "doubt" in dynamic tension. Thus, to use a quotation from my term paper for Tillich's course: "Faith is not belief in spite of evidence, but life in scorn of consequence—a courageous trust in the great purpose of all things and pressing forward to finish the work which is in sight, whatever the price may be" [10].

By way of confession, I was extremely fortunate to be accepted into a medical school after two years of college—that is, into a five-year program at Johns Hopkins—for had I stayed in college surely a counselor would have noted that what really turned me on was writing term papers in the humanities. I would probably have wound up a disgruntled associate professor of history at a liberal arts college you've never heard of. At Hopkins I sought out the great medical historian Owsei Temkin, who obtained NIH funding for me to do a summer project in the history of medicine. He suggested looking at the decline of bloodletting during the nineteenth-century; between 1800 and 1850, bloodletting went out of fashion, but doctors were at a loss to explain why they no longer bled. One quotation from the paper I wrote on the subject stands out, a statement by the Philadelphia surgeon Samuel D. Gross: "The fate of blood-letting. . . shows what little faith there is to be

placed in human judgment, and how sadly we are influenced by authority and fashion in a matter pertaining to the dearest interests of society" [11].

This idea—the idea that the prevailing style of medical practice doesn't necessarily equate to what's best for patients—proved helpful in clinical decision-making for HIV-infected patients in the years between 1987 (when AZT became available) and 1996 (when highly-active antiretroviral therapy became available). National experts were recommending that AZT for everyone diagnosed with HIV. I reasoned, by analogy with other infectious diseases and from knowledge of medical history, that the experts might not be right. AZT might do more harm than good in patients who were doing well (who had high CD4 counts) by causing the virus to become drug-resistant. Several of my patients are, I think, alive today because of this conservative strategy [12].

But apart from this one specific example, I find it difficult to say that the humanities improved my patient outcomes. This has been the case even though I've had the good fortune to have occasional manuscripts published in peer-reviewed journals not just in medical history, but also in the classics, in literature, in philosophy, in ethics, in art, and even in theology. (I hasten to add that none of these papers was ground-breaking, indeed most were rather trivial.)

On a personal level, though, the humanities have been enormously helpful. These include poetry.

In medical school, I was struggling with anatomy. I was questioning whether it was really necessary to memorize the origin, insertion, and innervation of every muscle. Then I stumbled upon a quirky poem in *Punch* magazine in 1960 by one Richard Percival Lister (1914–2014), described as a writer, poet, artist, and metallurgist, entitled "The Judgment" (1960) and reading in entirety:

> I dreamed the angels came to me by night.
> They stood about my bed, severe of mien,
> And asked one Question, 'What is enstatite?'
>
> 'It is an orthorhombic pyroxene,'
> I said, and as I spoke I heard the jangle
> Of planets crashing down the cosmic seas.
>
> I added hastily: 'Its cleavage angle
> Is eighty-seven (more or less) degrees.
> If it were fifty-six, not eighty-seven,
>
> We should, quite clearly, have an amphibole.'
> At this they swept me singing, up to Heaven
> Where angel hands received my battered soul.

From this poem I gleaned the idea that we should strive toward being the best in the world at whatever we allow fellow humans to pay us to do. Competence is the prime requisite for the physician *qua* physician (that is, acting in the capacity of a physician, not as a concerned layperson). I once wrote that "in a sense, beneficent competence is compassion, whereas compassion without competence is fraud." The protagonist of Lister's poem might have screwed up in other aspects of his life but, by golly, he knew his minerals—and that's what he allowed his fellow humans to pay him to do. After my first wife told the preacher who'd married us that "he loves medicine more than he loves

me"—that is, I spent too much of my limited time at home reading journals and so forth—I found comfort in "The Choice" (1933) by William Butler Yeats:

> The intellect of man is forced to choose
> Perfection of the life, or of the work,
> And if it take the second must refuse
> A heavenly mansion, raging in the dark.
> When all that story's finished, what's the news?
> In luck or out the toil has left its mark:
> That old perplexity an empty purse,
> Or the day's vanity, the night's remorse.

Okay, so I overinvested in my career (as the counselor put it), but wasn't this perhaps for the greater good, and shouldn't I forgive myself? As Yeats put it, "it's an old perplexity." I asked the preacher which he loved more, his wife or the church, and he had no answer.

And at this moment of my life—Donna and I have just celebrated our thirty-fifth anniversary, and I've just announced my plans to retire on my forthcoming seventy-sixth birthday, I find comfort in the opening lines of "Ash Wednesday" (1933) by T. S. Eliot:

> Because I do not hope to turn again
> Because I do not hope
> Because I do not hope to turn
> Desiring this man's gift and that man's scope
> I no longer strive to strive towards such things
> (Why should the agèd eagle stretch its wings?)
> Why should I mourn
> The vanished power of the usual reign?

In the medical school library, I look at what the students are memorizing and tell them, "I'm glad it's you, not me!"

Having looked at history and literature, let's turn to the visual arts. Several months ago, on our trip to London, I booked for the first night a hotel near the Tate Gallery specifically so I could contemplate *The Doctor* (1891), by Luke Fildes, for at least an hour. The term "empathy," which only entered the English language in 1909, comes from a German word that was coined in 1863 in the context of art appreciation. As *Einfühlung* in German, empathy denoted the ability to examine a work of art and appreciate how the artist must have felt during its creation. As it turns out, Sir Henry Tate commissioned Fildes to paint a subject of the artist's choosing, and Fildes—who was deeply affected by the attentiveness of a physician named Gustavus Murray during the fatal illness of the artist's son (presumably, an acute infection such as scarlet fever). I've long been taken the doctor's body language in this painting as an example of how we should all position ourselves at the bedside (sit down; maintain a spine angle of less than ninety degrees, do not cross your arms or legs, and focus on the patient). I studied the painting for more than an hour and began to notice small details for the first time, such as how the angle of the green lamp shade parallels the angle of the doctor's arm. Body language. Empathy.

We'll mention ethics only briefly. Although I was nominally in charge of an ethics program,

Detail from *The Doctor* (1891) by Sir Luke Files (see text).

W
wrote most of a synoptic manual on ethics for medical students, and organized small-group discussions, I'm not sure that ethics makes us more empathic. That's not its main purpose; ethics matters because of the importance of moral reasoning to today's practice.

In summary, I've personally found the humanities foundational to the practice of medicine, and I've lived by the credo of "the twin pillars"—the humanities and the sciences. I've followed Osler's advice to medical students to "start at once a bedside library, and spend the last half-hour of the day in communion with the saints of humanity."

But can this advice be generalized? Do the humanities matter for medical practice to the extent that they should be included in the curriculum?

ARGUMENT IN THE NEGATIVE: THE HUMANITIES DON'T MATTER

A few studies suggest that in the short term humanities programs in medical schools protect students from objectification of patients as they pass from the pre-clinical years (or "pre-cynical years") to the clinical years ("cynical years") of their educations. However, no well-done studies substantiate a sustained effect, and the literature is replete with critiques of methodology [13–20].

Let us re-visit the case of Andrea Ricchione, the humanistic student who found medical school "an utter drain." Let us assume that repeated doses of the humanities throughout her medical curriculum steeled her against the cynicism she encountered on the wards, when residents referred to students as "hits," "gomers," or "frequent fliers," when residents and attendings under pressure from hospital administrators focused mainly on length-of-stay, when ward rounds centered mainly around computer-generated information.

From medical school Andrea will enter residency. Will the humanities help her now? From residency she will enter practice, more likely than not as a salaried employee. She will be graded on productivity, using metrics that place little emphasis on empathy and caring beyond the minimum level of politeness required of any provider-client transaction. She'll be asked to do more and more in less and less time. Will the humanities help her now?

My friend the medical historian Kenneth Ludmerer in the last book of his trilogy on medical education in the U.S. flattered me by quoting me as having written of how difficult it is "to honor professionalism in an environment that doesn't value professionalism" [21]. One might say the same thing about empathy—it's difficult to be really caring in an environment that doesn't really value caring. Jerome Groopman and Pamela Hartzband, writing recently on "Putting Profits Ahead of Patients," assert that "Research in cognitive psychology indicates that repeatedly cueing the physician to view patient care as a market exchange risks promoting selfish behavior and eroding essential aspects of our profession that contribute to high-quality health care, including pride in work, sense of duty, altruism, and collegiality [22]." I've recently become aware of something called "geographic rounds": on a hospitalist service, bunching one's patients on the same ward takes priority over continuity of care.

Should Andrea Ricchione and others like her study humanities in their spare time, or would they do well to study something else of their liking?

Faith Fitzgerald, the charismatic internist and medical educator, wrote a classic essay for the *Annals of Internal Medicine* entitled simply, "Curiosity [23]." She asks three questions. Do required courses in the humanities—literature, drama, sociology, music, and art, for example—take away time the students could use better in other activities? Is there hard evidence that being well-versed in the humanities makes a person more humane? And as a corollary to the second question, does single-minded pursuit of the sciences make students' "inhumane"?

Fitzgerald, who'd been dean of students at the University of California at Davis, reviewed with her colleagues more than ten years' worth of subjective descriptions of third- and fourth-year medical students by clerkship preceptors. They gave "nice" points for descriptors such as "caring," "warm," "concerned," and "good with patients and families." They subtracted points for descriptors such as "callous," "abrupt," and "arrogant." They then went back and reviewed the number of units the students had taken in the humanities before medical school, and the number of units they had spent in the sciences.

Surprise, surprise! Students who had taken the most units in the sciences racked up more "nice" points than those who had taken more units in the humanities!

Fitzgerald concludes that the most important requisite for a doctor may be *curiosity*. One must be curious about science, and curious about people. She suggests that curiosity "converts strangers (the objects of analysis) into people we can empathize with." Curiosity causes us to find out about our patients as human beings, to explore their cultural, social, occupational, and spiritual backgrounds, for example. Curiosity causes us to imagine how our patients might feel, that is, to have empathy (from its Latin roots, "in-feeling"). Therefore, "Both the science and the art of medicine are advanced by curiosity."

I have a third concern, a concern that challenges the "two cultures" paradigm—the "sciences and humanities" paradigm, the paradigm of Osler and C. P. Snow, in which I've spent most of my adult life. Recently, Harvard psychologist Jerome Kagan suggests a "three cultures" model: the *natural sciences*, the s*ocial sciences*, and the humanities [24].

Each of these three cultures has its unique vocabulary, focus, chief sources of evidence, extent to which the variables under study can be controlled, and sphere of ethical influence. Each has its criteria for what constitutes a thing of beauty. In the natural sciences, a thing of beauty is a conclusion that involves the most fundamental material components of nature (think the double-helix model of DNA, for example). For the social sciences, a thing of beauty is a conclusion that supports a broad theoretical view of human behavior. But for the humanities, a thing of beauty is a semanti-

TABLE . THE THREE CULTURES (after Kagan)			
AREA	**NATURAL SCIENCES**	**SOCIAL SCIENCES**	**HUMANITIES**
Primary focus	Understanding and explaining natural phenomena	Understanding human behavior and psychological states	Understanding the meaning humans impose on experience as a function of time/place and life history
Chief sources of evidence	Observations of material entities	Behaviors, verbal statements, and (less often) biological measures	Written texts and human behaviors
Extent of control of conditions	Rigorous control is strongly desired.	Control of contexts is often difficult	Minimum control of conditions of observations
Primary vocabulary	Semantic and mathematical concepts	Constructs referring to psychological features, states, and behaviors of individuals or groups	Concepts regarding to human behavior, with serious contextual restrictions on inferences
Influence of history	**Minimal**	**Modest**	**Major**
Ethical influence	**Minimal**	**Major**	**Major**
Criteria for beauty	Conclusions that involve the most fundamental components of nature	Conclusions that support a broad theoretical view of human behavior	Semantically-coherent arguments describes in elegant prose

cally-coherent argument described in elegant prose.

My chief problem with the humanities is that the professors and other experts use their "elegant prose" to construct such "semantically-coherent arguments" that, when you look more closely, often hinge on the slippery meanins of words. And their arguments can be combative. Professors of the humanities, at least in my experience, are no kinder, no more caring, than the rest of us, and their verbal combats do not always foster cooperation and good will. I've heard of more than one department of medical history, for example, in which world-famous professors hate each other. In such instances, "the humanities" clearly don't equate to "humanism" expressed as kindness, as unconditional positive regard for our fellow humans.

Margaret Edson, in her play *Wit* (2001), makes this point through the character of Vivian Bearing, an English professor with stage IV ovarian cancer. Bearing is upset by the impersonal style of her health care providers. Then she recalls how she, too, was harsh and uncaring toward the dumb jock in her class.

For physicians, I would argue that the social sciences may be at least as important as the humanities.

William Osler's case for the medical humanities had more to do with what they could do for medical students and doctors, for oneworldview and wisdom, than it did for the promotion of empathy in medical practice. (Actually, he never used the word "empathy," which was not in vogue during his lifetime.)

In his essay on "The Medical Clinic: A Retrospect and Forecast," Osler had this to say: "A man's attitude towards his fellow creatures is largely temperamental. If naturally devoid of the milk of human kindness, to assume a kindly interest in the sick is impossible." Put differently, our capacities to care may be to a large extent determined in early childhood, and has probably become more-or-less set before we enter medical school.

In his essay on "The Leaven of Science," given at the opening of the Wistar Institute in Philadelphia, Osler had this to say: "Biology touches the problems of life at every point, and may claim, as

no other science, completeness of view and a comprehensiveness which pertains to it alone. . . . The study of biology trains the mind in accurate methods of observation methods of reasoning, and gives to a man clearer points of view, and an attitude of mind more serviceable in the working-day world than given by other sciences, or even by the humanities." Does this not reinforce what Professor Gourevitch said, that "doctors should chase nascent science" rather than make pretense of the humanities.

TWELVE SUGGESTIONS

Let me again express gratitude for this lectureship and my hope that future lectures in this series will be entertaining, stimulating, and thought-provoking. Allow me to paraphrase what I told the first-year medical students in my 2008 lecture: "To those of you who haven't immersed yourselves in the humanities, you may not have missed a thing vis-à-vis your ability to empathize with your patients."

Here's my main conclusion: Like our medical student, Andrea Ricchione, we are well-advised to do whatever we can to insulate ourselves from the numbing effects of today's business-oriented style of medical practice. Here are twelve suggestions:

1. Start a commonplace book—a journal or scrapbook of quotations, ideas, and tidbits of information that strike you as edifying, inspiring, and/or enriching. Here's one of my favorite entries, from the physician-writer Oliver Wendell Holmes, Sr.: "We reach the creator chiefly through his creatures."
2. Search for the transcendent—develop your sense of awe and wonder. You may find it in the humanities, to be sure, but you may also find it in your place of worship, in music, in art, or in nature. Reserve a cabin on the Merced River in Yosemite, for example.
3. Be humble about what you think you know. I was fortunate to know Dr. Shigeaki Hinohara, probably the most celebrated physician in Japan, who died earlier this year at the age of a hundred and five. One of his anchor-points were these lines from Robert Browning's"Abt Vogler": On the earth, the broken arcs; in the heaven a perfect round." Whatever we think we know on earth is at least to some extent limited.
4. Understand your caring style and your capacity to care. It helps to know your profile from the Myers-Briggs Personality Inventory. Some prefer to care almost exclusively through appropriate use of technology. Others prefer to care more about the unfolding drama patients' lives. One of the great things about medicine is that there's room for all types.
5. Discover and cherish the wisdom of the ages. Be familiar, for example, with the wisdom literature of the Old Testament (or Hebrew Bible): Psalms, Proverbs, Ecclesiastes, and other books. Read *The Meditations of Marcus Aurelius*. Learn the first paragraph of the *Enchiridion*, by Epictetus. Obtain a copy of *The Oracle* (also known as *The Art of Worldly Wisdom*), by the seventeenth-century Jesuit Baltasar Gracián, and open it to a random page when you're in a bind.
6. Visit the art museums when you go the "Big Towns." Find a painting or two that really makes you think. When you're in Washington, D.C., for example, visit the American Wing of the National Gallery and study the four panels of *The Voyage of Life* (1842) by Thomas Cole. I've done this at least once a decade since I was twenty.
7. Listen to music according to your tastes. I'm not sure it really matters what you listen to, as long as you internalize Johann Pachelbel's Canon in D Major.

8. Read good stuff in bed. Don't watch the late-night shows. Don't read whodunits. Read something that informs you about the human condition. This was of course Osler's advice to medical students: "Start at once a bed-side library and spend the last half-hour of the day in communion with the saints of humanity."

9. Be an informed citizen. Liberals and conservatives are both right, and what we need in this country is intelligent compromise.

10. Humanize every patient, except perhaps in emergencies. For more than three decades, and with dubious success, I tried to teach medical students that in the opening paragraph of every H & P they should try to make the patient before them seem like the most interesting human being in South Carolina, a person that everyone should feel honored and privileged to take care of.

11. Practice frequent small acts of kindness. Let other drivers go ahead of you. Open doors. Speak to patients' family members in the elevators. A student said that William Osler's unwritten motto was "to do the kind thing and do it first." Listen carefully to the following, entitled "What I Learned from My Mother" (1992), by Julia Kassdorf, and see if you can pick out a phrase taken directly from the Hippocratic Oath:

> I learned from my mother how to love
> the living, to have plenty of vases on hand
> in case you have to rush to the hospital
> with peonies cut from the lawn, black ants
> still stuck to the buds. I learned to save jars
> large enough to hold fruit salad for a whole
> grieving household, to cube home-canned pears
> and peaches, to slice through maroon grape skins
> and flick out the sexual seeds with a knife point.
> I learned to attend viewings even if I didn't know
> the deceased, to press the moist hands
> of the living, to look in their eyes and offer
> sympathy, as though I understood loss even then.
> I learned that whatever we say means nothing,
> what anyone will remember is that we came.
> I learned to believe I had the power to ease
> awful pains materially like an angel.
> Like a doctor, I learned to create
> from another's suffering my own usefulness, and once
> you know how to do this, you can never refuse.
> To every house you enter, you must offer
> healing: a chocolate cake you baked yourself,
> the blessing of your voice, your chaste touch.

12. **Write down somewhere your unifying principles**, the principles you're unwilling to compromise, and review these from time to time. Foremost should be love for fellow humans. William Osler's favorite poem seems to have been "Abou Ben Adhem." Memorize it:

Abou Ben Adhem (may his tribe increase!)
Awoke one night from a deep dream of peace,
And saw, within the moonlight in his room,
Making it rich, and like a lily in bloom,
An angel writing in a book of gold:—
Exceeding peace had made Ben Adhem bold,
And to the presence in the room he said,
"What writest thou?"—The vision raised its head,
And with a look made of all sweet accord,
Answered, "The names of those who love the Lord."
"And is mine one?" said Abou. "Nay, not so,"
Replied the angel. Abou spoke more low,
But cheerily still; and said, "I pray thee, then,
Write me as one that loves his fellow men."

The angel wrote, and vanished. The next night
It came again with a great wakening light,
And showed the names whom love of God had blest,
And lo! Ben Adhem's name led all the rest.

REFERENCES

1. Gourevitch D. The history of medical teaching. *Lancet* 1999; 354 (supplement 2000); SIV.
2. Jones T, Blackie M, Garden R, et al. The almost right word: The move from medical to health humanities. *Acad Med* 2017; 92: 932–5.
3. Neumann M, Edelhäuser F, Tauschel D, Fisher MR, Wirtz M, Woopen C, Haramati A, Scheffer C. Empathy decline and its reasons: A systematic review of studies with medical students and residents. *Acad Med* 2011; 86: 996–1009.
4. Decety J, Yang C, Cheng Y. Physicians down-regulate their pain response. An event-related brain potential study. *Neuroimage* 2010; 50: 1676–82.
5. Coulehan J, Williams PC. Vanquishing virtue: The impact of medical education. *Acad Med* 2001; 76:598–605.
6. Rourke S, Ellis G. The most influential physicians in history, part 4. The top ten. http://www.medscape.com/features/slideshow/influential-physicians-part 4, accessed 6 January 2017.
7. Osler W. Unity, peace and concord. In Osler W. *Aequanimitas, With other Addresses to Medical Students, Nurses and Practitioners of Medicine*. Third edition, New York: The Blakiston Company; 1932: 425–43.
8. Osler W. *The Old Humanities and the New Science.* Boston: Houghton Mifflin Company; 1920.
9. Hook EW. The Jeremiah Metzger Lecture. Humanities in medicine: treatment of a deficiency disorder. *Trans Am Clin Climatol Assoc* 1997; 108: 203–21.
10. Lake K. *Landmarks In the History of Early Christianity*. London: Macmillan and Co.; 1920: 96.
11. Bryan LS Jr [Bryan CS]. Bloodletting in American medicine, 1830–1892. *Bull Hist Med* 1964; 38: 516–29.
12. Bryan CS. Coping with the HIV/AIDS epidemic. In: Duffin J, ed. *Clio in the Clinic: History in*

Medical Practice. New York: Oxford University Press; 2005: 73–86.
13. Buck E, Holden M, Szauter K. A methodological review of the assessment of humanism in medical students. *Acad Med* 2015; 90: S14–S23.
14. Dennhardt S, Apramian T, Lingard L, et al. Rethinking research in the medical humanities: a scoping review and narrative synthesis of quantitative outcome studies. *Med Educ* 2016; 50: 285–99.
15. Doukas DJ, McCullough LB, Wear S, et al. Medical education in medical ethics and humanities as the foundation for developing medical professionalism. *Acad Med* 2012; 87: 334–41.
16. Doukas DJ, Kirch DG, Brigham TP, et al. Transforming educational accountability to medical ethics and humanities education toward professionalism. *Acad Med* 2015; 90: 738–43.
17. Graham J, Benson LM, Swanson J, et al. Medical humanities coursework is associated with greater measured empathy in medical students. *Am J Med* 2016; 129: 1334–7.
18. Polanski IJ, Fangerau H. Toward "harder" medical humanities: Moving beyond the "two cultures" dichotomy. *Acad Med* 2012; 87: 121–6.
19. Shapiro J, Coulehan J, Wear D, et al. Medical humanities and their discontents: definitions, critiques, and implications. *Acad Med* 2009; 84: 192–8.
20. Tseng F-Y, Shieh J-Y, Kao T-W, et al. Developing and evaluating medical humanities problem-based learning classes facilitated by the teaching assistants majored in the liberal arts. *Medicine* (Baltimore) 2016; 95: e2765.
21. Ludmerer KM. *Let Me Heal: The Opportunity to Preserve Excellence in American Medicine*. New York: Oxford University Press; 2015: 257.
22. Groopman J, Hartzband P. Putting profits ahead of patients. *New York Review of Books*; 13 July 2017: 47–50;
23. Fitzgerald FT. Curiosity. *Ann Intern Med* 1999; 130: 70–2.
24. Kagan J. *The Three Cultures: Natural Sciences, Social Sciences, and the Humanities in the 21st Century*. New York: Cambridge University Press; 2009.