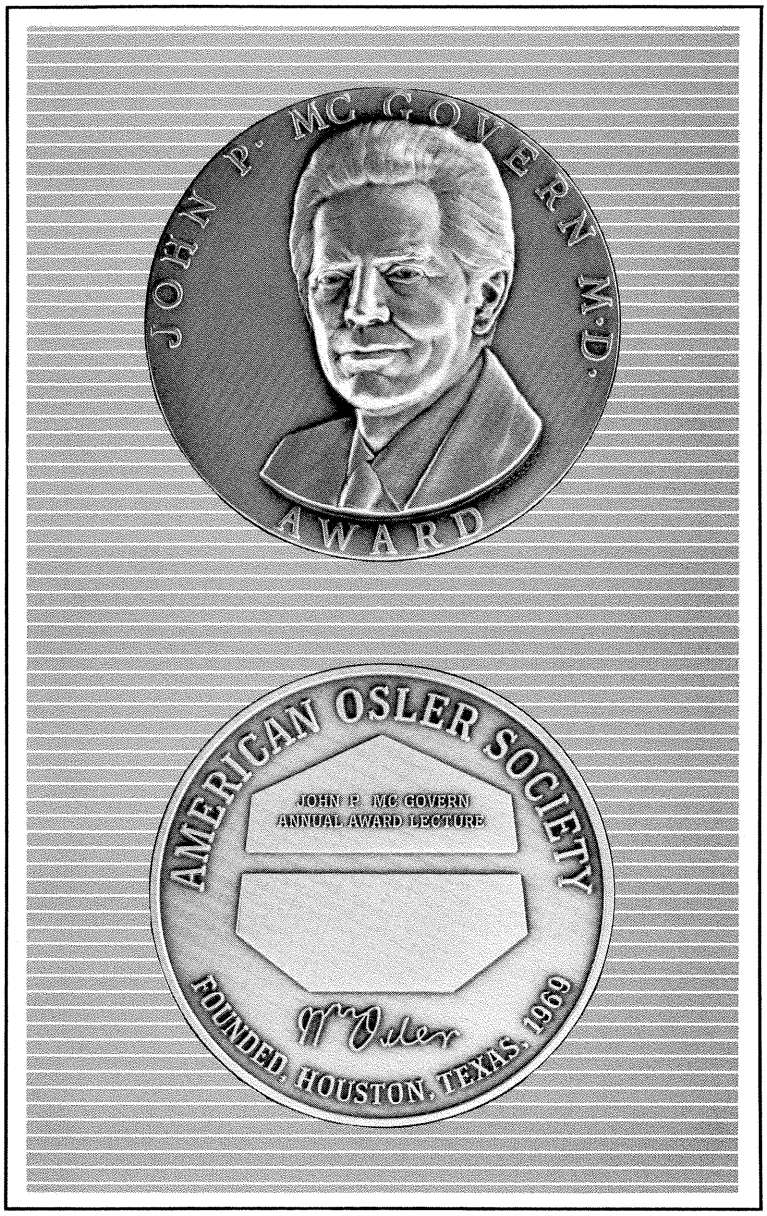
"TO HUMANE MEDICINE: BACK DOOR OR FRONT DOOR?"

EDWARD J. HUTH, M.D., F.A.C.P., F.R.C.P.



American Osler Society, Inc.
John P. McGovern Award Lectureship

American Osler Society, Inc.

JOHN P. MCGOVERN AWARD LECTURESHIPS

1. "Our Lords, The Sick" presented by Albert R. Jonsen, Ph.D., April 12, 1986, in San Francisco, California.
2. "To Humane Medicine: Back Door or Front Door?" presented by Edward J. Huth, M.D., April 29, 1987, in Philadelphia, Pennsylvania.

Cover — Obverse and reverse sides of John P. McGovern Award Lectureship commemorative medal which is presented to each annual lecturer.

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EDWARD J. HUTH, M.D., F.A.C.P., F.R.C.P.
Editor
Annals of Internal Medicine
American College of Physicians
Philadelphia, Pennsylvania

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JOHN P. MCGOVERN AWARD LECTURESHIP

Through the generosity of the John P. McGovern Foundation to the American Osler Society, a John P. McGovern Award Lectureship was established in 1986. This lectureship makes possible an annual presentation of a paper dedicated to the general areas of Sir William Osler's interests in the interface between the humanities and the sciences — in particular, medicine, literature, philosophy, and history. The lectureship is awarded to a leader of wide reputation who is selected by a special committee of the Society and is especially significant in that it also stands as a commemoration of Doctor McGovern's own longstanding interest in and contributions to Osleriana.

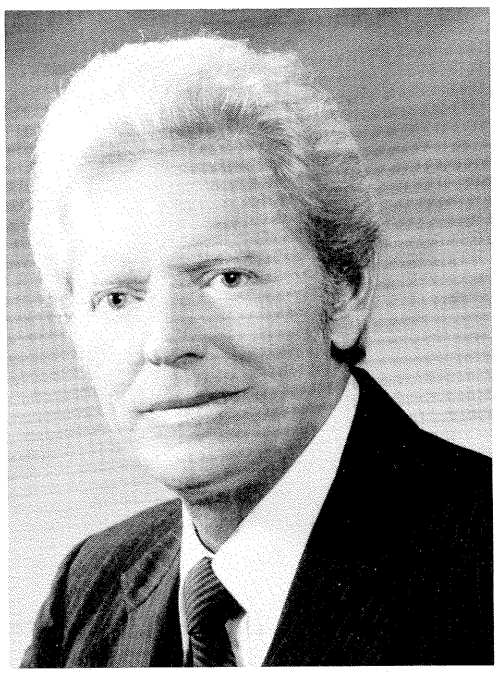
Doctor John McGovern earned his undergraduate and M.D. degrees from Duke University. He subsequently took postgraduate training there and at Yale University School of Medicine. His varied graduate medical education experiences also include training at Guy's Hospital in London; L'Hopital des Enfants Malades in Paris; Children's Hospital in the District of Columbia; and the Boston Children's Hospital. Early academic appointments were at George Washington University and as a John and Mary R. Markle Scholar in Medical Science at Tulane University. In 1956, Doctor McGovern moved to Houston, Texas where he founded the McGovern Allergy Clinic, which has grown to become the largest of its kind in the United States.

Rich in associations, accomplishments and friends, Doctor McGovern has earned a very remarkable vita. He remains founder/consultant of the clinic which bears his name. He is a member of numerous honorary and professional societies; is past president of many professional organizations including the American College of Allergists and the American Osler Society; has 22 honorary degrees; and is the author or coauthor of over 200 books and articles. Among many accolades, Doctor McGovern has been honored with the Clemens von Pirquet Lecture and Award; the William A. Howe Award; the Distinguished Service Award, American School Health Association; the Distinguished Achievement Award, Pi Kappa Alpha; and elected as an Honorary Fellow of The Royal College of Physicians, London, England. His record of service includes a Presidential appointment to the board of regents of the National Library of Medicine, which he chaired in 1973-74. Doctor McGovern is held in high regard by his associates, colleagues and friends.

The Award Lectureship serves as an appropriate vehicle for public acknowledgement of Doctor McGovern's American Osler Society related activities and generosity. In addition, it recognizes his commitment to perpetuating the counsels and ideals of Sir William Osler. Subscribing to these, Doctor McGovern has enthusiastically practiced the axiom and

example of Osler "We are here to add what we can *to,* not get what we can *from,* life."

J.D.K.



JOHN P. MCGOVERN, M.D.

EDWARD J. HUTH, M.D., F.A.C.P., F.R.C.P.

Speaker for the second American Osler Society—John P. McGovern Award Lectureship was Edward J. Huth, M.D. Editor, **Annals of Internal Medicine,** American College of Physicians, Philadelphia, Pennsylvania. He is a well-known leader, practitioner, teacher, writer and editor in the field of medicine.

A native of Philadelphia, Doctor Huth received a B.A. degree from Wesleyan University where his heavy engagement with courses in critical literary analysis and creative writing foreshadowed the evolving of his medical career into the editorship of **Annals of Internal Medicine.** After receiving the M.D. degree from the University of Pennsylvania, he trained in internal medicine at Penn's University Hospital. In the years before his entering editorial work for the **Annals** he collaborated with J. Russell Elkinton at the University in clinical investigation of potassium deficiency, mechanisms for renal acidification, and the genetics of, and functional disorders in, renal tubular acidosis. His academic posts have included professorial appointments at the University of Pennsylvania (School of Medicine, School of Veterinary Medicine) and Medical College of Pennsylvania.

In 1971 Doctor Huth succeeded Doctor Elkinton as Editor of **Annals of Internal Medicine** and broadened his dedication to many aspects of medical writing and publishing through serving as chairman of the

committee that prepared the 4th edition of the style manual published by the Council of Biology Editors, as a member of the Board of Regents of the National Library of Medicine, and as a founder of the International Committee of Medical Journal Editors (the "Vancouver group"). His other national activities related to the intellectual and ethical foundations of medical writing and to publication style have included participation in activities of the American Medical Writers Association, the Council of Biology Editors, the American National Standards Institute, and UNESCO. These activities provided the basis for his two books, **How to Write and Publish Papers in the Medical Sciences** and **Medical Style and Format: An International Manual for Authors, Editors, and Publishers.**

Doctor Huth is a Fellow of the American College of Physicians and a Fellow of the Royal College of Physicians of London.

"To Humane Medicine: Back Door or Front Door"

by

Edward J. Huth, M.D., F.A.C.P., F.R.C.P.

Not being a member of your society, I cannot even guess what inner needs bring each of you to your meetings. If your needs are to come together once a year at the shrine of Saint William and worshipfully fondle the biographic equivalents of shreds of his shirts, hairclippings, or other relics of fact, I shall disappoint you. I know little about Osler, but I do know more than some of our contemporary students. About 15 years ago at the height of problems with thefts of books from medical school libraries, the librarian at Penn posted a sign one day at the checkout desk: "Osler did not steal library books." The sign had not been up 10 minutes when a student stopped by and asked, "Who is Osler?"

Indeed, who is Osler as he lives in our history and, particularly, how is his life relevant to teaching and practicing humane medicine? One of your most eminent members, George Harrell, has given some answers in his paper[1] on Osler's practice:

> The small amount of time he spent with his own hospitalized private patients is commented on repeatedly over the years, especially for patients without advanced organic disease. On other patients with interesting disease problems, he would make repeated visits for teaching.
>
> He spent a short time with private patients[,] coming in and out of the room quickly so that patients frequently complained that they did not have time to talk to him or to retaliate to his remarks.

But in contrast,

> He had an unusual facility to make all patients feel that he was interested in them as persons, whether they were on the public wards or on the private pavilion.

The apparent paradox may be accounted for by another of Harrell's assessments:

> He stressed meticulous clinical observation with emphasis on diagnosis and pathogenesis of disease. Laboratory findings were a strong point in the teaching, but definitely were secondary to observation.

"Observation" is the keyword. We are pleased as patients when our needs are truly seen, and Osler's patients may have felt themselves truly seen

as persons from his closely inquiring into the details of their illness and thoroughly examining their bodies.

Why should we be concerned today about humane medicine? Is this a more worthy topic today than it would have been in Osler's day? Is medicine less "humane" than it was then? What is "humane" medicine?

All around us are evidences that our society has lost some confidence in medicine as a public service.[2-4] That loss could be due to many different causes and some may be well beyond our control. One expert on effects of the public media has pointed out[3] that television often portrays physicians so idealistically that real physicians fail against the image. Certainly in some surveys of public opinion[4] patients have complained of how they are seen and cared for. Ironically some of this dissatisfaction may stem from the efficiency with which we reach highly accurate diagnoses by rushing the patient off for one of the new almost incredible imaging procedures rather than taking a detailed history at length. This apparent decline in confidence in our capacity for humane care is seen by some keen observers who are not of, but are close to, our profession. A good example is Charles Odegaard, a humanist who has come to know us[5] from his seat in such bodies as the Millis Commission and the Board of Directors of the Clinical Scholars Program run by the Robert Wood Johnson Foundation. Some groups within the profession imply by their actions that they too perceive a decline in confidence in our humaneness; note the great response of the American Board of Internal Medicine represented by its several reports on "humanistic qualities in the internist."[6-7]

If the apparent decline in confidence in medicine is due to a feeling by today's patients, unlike Osler's patients, that we do not see them as persons, perhaps we can find remedies for that defect. I am not sure that we can. Impersonality runs through much of our huge and complex society; I am struck with how often voices in our public media refer to men and women as "people," not as persons. In our increasingly crowded world too many of us do not see the difference between *populus* and *persona.*

How does the patient want to be seen?

Patients are men and women. Patients, like the rest of us, have a view of themselves and of the world around them that has been shaped by their lives as infants and children. The most ancient memory we carry is being cared for in the mother-child dyad. That memory is a frame through which much of our view of others around us must pass; Dinnerstein, a psychologist who has dissected the problem of dependency[8] more thoroughly than anyone else I know of, puts it thus:

> Few of us ever outgrow the yearning to be guided as we were when we were children, to be told what to do, for our own good, by someone powerful who knows better and will protect us. Few of us even wholeheartedly try to outgrow it.

But the desires go beyond being guided, being told what to do. Consider these questions.

Do you understand me?
Will you help me?
Will you stick with me?
Will you always care for me?
Will you take advantage of me?
Will you always do the right thing for me?

These are questions all children would probably put to their mothers if they could fully phrase their feelings. And the questions emerge in later dyads; these questions are likely to be put, or implied, to a prospective wife or husband. In fact these questions are borrowed and slightly adapted from a paper published recently in the **Canadian Medical Association Journal,**[9] "Our patients' seven unspoken questions." I cannot argue here that these are indeed questions patients have in their minds when they see us, but I point out that some of them are clearly reflected in one classic document that defines, among other matters, what we owe patients in our contracts with them, The Hippocratic Oath.

Among these questions, one, the first, seems to me to be the main question to be asked in assessing whether a physician's care is humane or not. (The term *humane* is not really a satisfactory adjective for the kind of medicine I think we have in mind with "humane medicine." The phrase suggests a possible alternative, *inhumane,* and there is much care that while not humane in the sense of the phrase is certainly not inhumane — unfeeling, brusque, impersonal, or cursory, perhaps, but not inhumane. "Humanistic medicine" is not right either; it implies to me a kind of care embroidered with threads of consciously acquired culture rather than the careful care given by one very human physician to a very human patient.)

"Do you understand me?" This is the patient's first assessment of the physician. The question runs far beyond such simpler questions as "Did you listen to my complaint and do you know what my symptoms are?" It implies a long string of other questions that may not be directly linked to the questions weighed by the physician as he thinks about what disease or disorder or injury the patient brings to the encounter. "Has the physician sized up the relative importance to me of my symptoms? Has the physician accurately gauged the strength of my anxiety, my depression, my confusion, my longing? Does the physician know the limits to the care I can get at home? Does the physician know the limits of my financial resources?" And the questions can run further. I do not mean to imply that most patients always have all of these questions at the front of their minds; they probably do not.

The patient's second question, "will you help me," necessarily implies that the patient expects the help to be tendered by the physician will be

properly shaped by the understanding acquired by the physician in accord with the patient's first expectation. Care that satisfies the patient as far as circumstances permit in response to these two questions may be what we call *humane medicine.*

How can we educate and train physicians likely to practice medicine that is "humane" thus defined?

One method is implied by what I presume is a motive behind the annual meetings of your society: if one is educated in the shadow of a model physician, one may move in his steps, the modelling effect. The humane clinical teacher sets out by example a pattern for how to behave humanely. The key term here is *pattern.* But in a particular clinical encounter how does the physician conduct himself if the pattern does not include a picture of a problem? The modelling process is defective when it does not convey operating principles that become working tools for the follower. Indeed, the modeller may have simply worked with a genetically determined package of traits and not on principles. The follower fails when he or she was not born with these traits; perhaps Osler was such a "modeller" and touched followers with his traits while not conveying to them explicit principles for conduct with patients. We can yearn to be like him but if we are not made of the same biological stuff, we may not become even third-rate imitators. This view certainly betrays my conviction that most of our behavior is likely to be genetically determined, a view that is unpopular with educators. Our phenotypes may be shaped in part by education, and one of my later proposals rests on this premise, but the genotype is probably more critical. This view does raise the question of whether we might select medical students for the right behavioral genotypes, certainly a heretical question.

A second kind of proposal for training the humane physician comes from persons thoroughly educated in one of the disciplines known some years back as "the humane letters": the literatures of English, of the other modern languages, and of Latin and Greek. The proposition in general is that medical students or physicians-in-training can be led to be more sensitive to the human condition, and hence to the plight and needs of the patient through the reading, analysis, and discussion of literature, both prose and poetry. I can not recapitulate the argument for this proposal here; it has been well developed by numerous spokesmen. Perhaps the most developed and persuasive argument is that by Eric Cassell[10] in **The Place of the Humanities in Medicine.** In brief the argument is that literature shows us the human plight, that medical students can be led to see that plight through literature, and that such knowledge tells us in advance what we will find in patients. Can literature really change us that deeply? I am skeptical. My skepticism comes, I know, from my own experiences. I feel that in the arts one is ready to really see or to really

hear or one is not. I remember clearly the first symphonic concert I heard, when I was a freshman in high school. I heard for the first time, among other works I still remember, the Beethoven Fifth Symphony. No one had told me what to hear and how to hear it but that first hearing was like a light's being turned on in a dark room. Nothing I could have been told could have prepared me for the effect; something already in me prepared me to hear. Is anyone moved by literature who has not already been moved by experience? Or who does not already have some innate capacity to be deeply touched by the particular way words not usually charged with deep feeling are put together so as to give them meaning beyond what they usually carry? Consider the famous poem by Emily Dickinson, number 650 in the collection by T. H. Johnson.[11]

Pain — has an element of blank —
It cannot recollect
When it begun — or if there were
A time when it was not —

It has no future — but itself —
Its infinite contain
Its past — enlightened to perceive
New Periods — of pain.

Perhaps no other writer has described pain more powerfully or precisely, but how many students in their 20s will grasp all that that poem says and implies? It presents its own obstacles to comprehension, its quirks in grammar, its quirks in punctuation. Grasping all of its essence calls for both a grasp of the devices represented by its grammatical quirks and the reader's having lived through some pain of duration or some years of caring for persons in relentless and unrelievable emotional or physical pain. Probably the more important point is that literature usually tells you its message but patients often cannot convey what physicians need to know if they would know the whole person of the patient.

What might be a third means of training "humane" physicians?

I go back to a phrase in Harrell's account of Osler in his practice: "meticulous clinical observation." I emphasize "meticulous" and "observation." These terms carry the essence of the old saw: "To be a good doctor you don't have to be smart but you have to be thorough." But Osler is probably not a paradigm for what many of today's patients would regard as the thorough physician, the physician who sees all of the patient's needs, and I emphasize "all needs." His shortcoming by today's standards is clear enough in Harrell's telling us of patients who complained that he spent too little time with them; this is still a frequent complaint of patients. "Seeing the whole patient" implies knowing the patient's values, yearnings, weaknesses, resources — the whole range of what makes up one's person.

Do we train our medical students adequately in how to see fully the person who is the patient, not only the "medical" facts but the whole fabric into which the "facts" are set? Seeing the whole person is an awesome skill; indeed, no one ever sees the *whole* person, not even by the end of a lifetime together the intensely devoted spouse. But to me this is the essence of "humane" medicine, and I do not see that this proposition informs today the design of the medical curriculum in even the best of our medical schools, except perhaps the present experimental curriculum at Harvard. The training that would be needed would have to run far beyond the usual present curricular content on history-taking.

Sometimes the problem of educating physicians to see the whole person has been dodged by claiming that one cannot teach the "art" in the "art and science of medicine." I have come to dislike thoroughly that phrase, "art and science." "Art" implies an inborn skill, an intangible skill that cannot be dissected into what makes it up. The "art" of medicine is a skill I believe can be analyzed, defined, and taught. To the extent that the skill can be observed closely, detailed as to its components, defined for its execution, and systematically applied, it is science and not "art."

Nevertheless how to train the medical student to "see the whole person" is an awesome problem. The problem is in part due to the age of the student. What medical students know themselves well enough at their age to be able to see the whole person in someone else? McWhinney has quoted in one of his recent papers a passage[12] that nicely sums up the problem:

> Mature awareness is possible only when I have digested and compensated for the biases and prejudices that are the residue of my personal history. Awareness of what presents itself to me involves a double movement of attention, silencing the familiar and welcoming the strange. Each time I approach a strange object, person or event, I have a tendency to let my present needs, past experience or expectations for the future determine what I will see. If I am to appreciate the uniqueness of any datum, I must be sufficiently aware of my preconceived ideas and characteristic emotional distortions to bracket them long enough to welcome strangeness and novelty into my perceptual world. This discipline of bracketing, compensating, or silencing requires sophisticated self-knowledge and courageous honesty.

How many medical students enter medical school equipped with this maturity?

Is one solution to preparing practitioners with the needed emotional foundations for a full and clear view of patients' needs some better method with which we select students for admission? I cannot review here the premises with which we decide who gets into medical school. Are motives for

entering medicine good predictors of who will be humane physicians? The literature on motives and their value for selection is scanty. The overt motives for entering medicine have been described in some formal studies of which that by Rogoff[13] may still be the most complete. But we know little of underlying emotional motives. They probably little resemble the usually stated motives and may have far more to do with what kind of physician one becomes. Lawrence Kubie, a one time psychiatrist at Yale and a sharp observer of the emotional structure of physicians in academic medicine, commented thus.[14]

> When a youth decides to become a doctor, a lawyer, a businessman, or an artist, the decision is not made... out of a deep introspective knowledge of himself and of how he would fit into the lifework he has chosen.

Some of the evidence for a primacy of deep-seated, emotional motives for entering medicine comes from biographical data. One good example comes from the life of Willa Cather, the great American novelist in the literature of the American Midwest. In a recently published biography of Cather, Sharon O'Brien[15] closely describes Cather's strong desire in adolescence to become "William Cather" and to study medicine. Her desire appears to have stemmed from her seeing her mother, and hence women in general including herself, as weak. She saw her mother roused from what was probably a neurotic asthenia[16] by a competent, forceful male practitioner who became for a while her ideal. Medicine as a vocation could give her the strength she craved in the face of seeing women, and particularly herself, as weak. But could Cather, if she had entered medicine with such a motive, have tolerated the "weakness," the dependency of patients, which she would have despised in herself?

I must concede we have little evidence that unconscious motives which lead physicians to enter medicine limit their capacities to see the "whole person" and deal adequately with the patient's dependencies. But physicians do grow up with the same dependency needs and defenses against them as other persons. We are not exempt from the human condition. If we have those needs and cannot consciously tolerate them as adults, can we tolerate them in our patients so that we can adequately serve them in accord with their needs? If we do not have a deep awareness of "the biases and prejudices that are the residue" of our personal histories, can we see patients clearly?

We can not realistically expect medical schools to identify in their applicants the emotional matrixes out of which came decisions to enter medicine. Even if they could, would they be able to predict what emotional matrixes in students at entry would best enable them much later in practice to adequately care for others? What medical schools could do, however,

would be to train students from the very first week of school in close observation of patients, in seeing patients entire—social, cultural, economic, emotional. But such training would have to include training them to observe themselves, to see how and when their own weaknesses cripple their capacity to truly see patients and to shape care accordingly.

The problem of educating to be able to "see the whole person" and then be able to provide care fully informed by what they see and know, including what they know about themselves, has not been ignored. The Society for Research and Education in Primary Care Internal Medicine has a group of members intensely devoted to "the medical interview and related skills" and their views, recommendations, and persuasions are carried regularly in a newsletter, **Medical Encounter.** A few medical schools have programs for the development of these skills at the residency level. But very few medical schools in the United States or Canada begin training their students at the very beginning of their education in the skills of seeing the "whole person" and translating that view into what the patient needs as circumstances and resources permit. And I do not know that any schools systematically train students through their four years in self-observation.

If this judgment as to what medical schools should do to prepare their students to become truly humane physicians is correct, could our schools revise their curricula to do what is needed? I doubt it. The political problems in attempts at thorough and rational revision are enormous. We all know the special pleading and self-serving arguments that arise from basic-science departments if it is proposed that medical schools exist first and mainly to train practitioners to care for the ill and the injured. Even if this premise is accepted there are the wasteful territorial claims to curriculum from narrow clinical specialists that crowd out possibilities for greater curricular concentration on skills that are vital to good care in any specialty. The problem of getting out of present orthodoxies in curriculum is nicely illustrated by the widely-known and cited GPEP report.[17] Assembled from the views of a large number of medical academicians, the report does specify some details for clinical training in skills relevant to truly knowing patients and their families but holds to the conventional wisdom that this is mainly the business of the "clinical years." Unsurprisingly it ignores completely the critical need for physicians' self-knowledge in the patient-physician dyad.

The one influential group that seems to have wrestled more effectively so far with the essence of needs in training the humane physician is a subcommittee of the American Board of Internal Medicine. Its report[7] should be read closely be all medical educators. Unfortunately the Board's influence on training is mainly in residency programs and is unlikely to touch curricular committees largely representing constituencies other than

internal medicine.

Perhaps some day in the distant future universities will come to see that their medical schools themselves have become medical-science universities and that the one-time central purpose of schools of medicine is buried under tons of research enterprises that bring in money and earn distinction but, despite their distant relevance to care of the ill, contribute next to nothing to the central purpose. When the day of that insight arrives, some medical educators may have the sense to reinvent the college of medicine, move the peripheral enterprises to some other locus, and make sure that its dimensions and units are such that it will devote itself efficiently and rationally to preparing physicians for the proper care of the ill. This hope is, I admit, utopian.

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