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"A Gentle and Humane Temper"

humility in medicine

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ABSTRACT Humility is the medical virtue most difficult to understand and practice. This is especially true in contemporary medicine, which has developed a culture more characterized by arrogance and entitlement than by self-effacement and moderation. In such a culture, humility suggests weakness, indecisiveness, or even deception, as in false modesty. Nonetheless, an operational definition of medical humility includes four distinct but closely related personal characteristics that are central to good doctoring: unpretentious openness, honest self-disclosure, avoidance of arrogance, and modulation of self-interest. Humility, like other virtues, is best taught by means of narrative and role modeling. We may rightly be proud of contemporary medical advances, while at the same time experiencing gratitude and humility as healers.

In his story entitled "Toenails," the surgeon Richard Selzer (1982) warns readers that total immersion in medicine is wrongheaded. Rather, to ensure their own health, doctors should discover other passions that permit them periodically to disconnect from medical practice. Selzer's surgeon character devotes his Wednesday afternoons to the public library, where he joins "a subculture of elderly men and women who gather . . . to read or sleep beneath the world's newspapers" (p. 69). Among these often eccentric personages is Neckerchief, an arthritic man in his 80s who suffers from severe foot pain. His toenails, never

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trimmed because of his inability to reach them, have grown so long that they curve beneath his toes and dig into the skin when he walks. When the surgeon learns of Neckerchief's problem, he rushes back to his office, picks up a pair of heavy-duty nail clippers, and returns to the library where, with Neckerchief perched on a toilet in the men's room, he trims the man's nails. This results in immediate pain relief. Subsequently, the surgeon brings his nail clipper to the library every Wednesday and often performs the same service for other homeless eccentrics, like Stovepipe and Mrs. Fringes.

When I present this touching story to medical students, they respond immediately to its humor and compassion. They consider the surgeon a role model of unpretentiousness. They enjoy the way he punctures the balloon of medical arrogance. But even though we discuss the story in the context of professional virtue, they're very reluctant to apply the word *humility* to his character or behavior.

This is not surprising. Nowadays, humility is hardly a valued ideal. The words "good physician" call up an image of confidence, technical skill, and assertiveness, a cluster of characteristics that seems inconsistent with humility. Medicine's popular image features drama, angst, and celebrity, rather than prudence. Although compassionate care remains an avowed goal of medicine, the virtues associated with compassion (e.g., prudence and humility) are less popular. In today's medical culture, *humility* appears weak, wishy-washy, counterproductive, or even deceptive (as in the case of "false modesty"). Moreover, patients themselves are likely to question the competence of doctors who too quickly acknowledge their own limitations.

Medical humility was already a hard sell in 1906, when William Osler tried to whip up enthusiasm for humility in a lecture to University of Minnesota medical students, with these prescient words: "In these days of aggressive self-assertion, when the stress of competition is so keen and the desire to make the most of oneself so universal, it may seem a little old-fashioned to preach the necessity of humility, but I insist . . . that a due humility should take the place of honor on your list [of virtues]" (p. 121). I suspect that Osler's students, like those of today, were not especially attracted to humility, although in their culture the word *virtue* would not have seemed as strange and affected as it does today. Few students in 2011 conceive of their education in terms of character formation at all, let alone see humility as part of it. Does anyone still believe that virtue is its own reward?

When Osler said that humility should take "the place of honor" among medical virtues, what did he mean? What, specifically, does *humility* mean when applied to medical practice? Standard definitions provide little help. The *Oxford English Dictionary* defines *humility* as "the quality of being humble" or "an act of self-abasement," while the adjective *humble*, in turn, means "having or showing a low opinion of one's own importance." Wikipedia offers the following: *humility* is "the quality of being modest, reverential, even politely submissive, and never being arrogant, contemptuous, rude." Such definitions are neither endearing, nor very helpful. In this article I want to rehabilitate *humility* by exploring what it

might mean in the context of medical professionalism—in other words, to operationalize the concept.

I must begin by acknowledging that a given attitude or behavior pattern may be molded by more than a single virtue. Thus, my students are correct in saying that the surgeon in "Toenails" exemplifies compassion. My contention is that his behavior also demonstrates humility. One can be humble without being compassionate and vice versa, but in many contexts these and other virtues overlap. My goal here is to investigate the observable characteristics that constitute the "meat" of humility as a virtue in medicine. If professionalism is a core competency in medical education, and if demonstrating medical virtue is an essential part of professionalism, and if humility is an acknowledged medical virtue, then what might it look like in practice? To that end I consider four distinct but closely related personal attributes: (1) unpretentious openness, (2) avoidance of arrogance, (3) honest self-disclosure, and (4) modulation of self-interest.

Unpretentious Openness

The first and most obvious feature of humility as a professional virtue is acceptance of one's limitations or, as Thomas Aquinas (2007) put it, having "knowledge of one's own deficiency" (p. 277). Realistic self-assessment allows for "openness to new ideas, contradictory information, and advice" (Tangney 2000). In an essay published in *Mayo Clinic Proceedings*, Li (1999) characterized the humble physician as being "able to appreciate the mysteries of disease and the marvels of healing" (p. 529). Humility acknowledges ambiguities, mysteries, and surprises. It's an interior response to the insight that medicine is "totally awesome," as my children used to say. This is what I mean by unpretentious openness.

Last summer the nursing staff on an oncology unit at our hospital was dumbfounded when a newly minted intern sat down with the husband of a terminal cancer patient. He had stepped into the room and asked the husband if he would like a cup of coffee, indicating that he was on his way to get a cup himself. After bringing the coffees, the intern sat quietly for 45 minutes, listening to the man talk about his wife and their life together. The intern sat mostly in silence, communicating his interest nonverbally. This episode was so astounding to the nurses because they considered the behavior out of character for a physician, especially for a harried house officer. If truth be told, such a conversation would also have been out of character for a nurse on that unit, because the nurses' schedules are so rigidly regimented.

Why is such an incident unusual? Surely, most physicians-in-training experience empathy and compassion for their terminal cancer patients. It is perfectly true that the intense demands of their jobs may not normally permit them to spend substantial time with individual patients and their families. Yet how many residents are responsive to the possibility of doing so, if and when an appropriate occasion arises? I consider this vignette as suggesting humility because it illustrates

the intern's unpretentious openness to an opportunity, whether planned or unplanned. He could have finished his charting, had lunch, or taken a break to read the latest specialty journal, but instead he chose to sit quietly with his patient and her husband.

To function within your own capabilities, you first have to be aware of what they are, to assess your personal strengths and weaknesses realistically, as well as your medical knowledge and abilities. Thus, the starting point for humility is self-awareness, an attribute that today's fast-paced medical training and our culture in general do not foster. In fact, introspection is highly disvalued in the hidden curriculum that permeates medical education (Coulehan 2005; Coulehan and Williams 2001; Hafferty and Franks 1994; Hunnert 1996). At best, self-awareness, like the art of medicine, bedside manner, clinical judgment, and professional virtue, tends to be damned with faint praise: a desirable attribute that ought to develop as the young physician gains experience and maturity, but not a topic that should be addressed in the curriculum. While medical educators question whether such qualities can be *taught*, they assume that young doctors will *learn* them as a result of clinical experience. The concept that teaching is restricted to processes that transmit facts or convey technical skills is prevalent in medicine. This is strange, because medicine traditionally relied on good role modeling as a prime source of clinical and moral education. Role modeling is teaching, and trainees learn to be good doctors from their role models.

As part of a course called Foundations of Medical Practice, I facilitate a group of 10 or 12 first-year medical students in a sequence of sessions on self-awareness, personal growth, and professional values. (Coulehan 2010). Each group includes one or more students who are initially skeptical about the objectives of this sequence. "The discussions are interesting," they'll explain, "but right now we're under so much academic pressure that we can't enjoy them. We have anatomy and physiology exams to study for. It's not like we learn anything in small group. After all, these issues have no right or wrong answers." Such students usually offer unhelpful suggestions—for example, the course should be optional or offered later in their curriculum. They believe that the meat and potatoes of education consists of learning facts and technical skills; engagement with interpersonal, moral, and emotional issues is dessert, nice but not necessary. Fortunately, most of the skeptics are co-opted into the group process by their peers and, by the end of the course, are willing to buy into medical education as, at least in part, a process of character formation and self-discovery.

Avoidance of Arrogance

A second feature of humility as a professional virtue derives naturally from the first: avoidance or suppression of arrogance. Many believe that arrogance is more pervasive in and characteristic of today's medical persona than openness or modesty. A number of factors in ourselves, our profession, and society contribute to

the belief that physicians are entitled to special handling. Not long ago a Spanish translator in my hospital was devastated when a physician pushed her aside as he rushed into a non-English-speaking patient's room. "I don't have time to spend talking," he growled. "I need to do this procedure right now." And he did, while the frightened patient had no idea what was happening (Coulehan 2010). The process of informed consent was a sham. Unfortunately, such rude and assertive behavior is not uncommon. And in addition to its damaging effect on patients, arrogant behavior by doctors may be responsible for low hospital morale, high levels of stress, and high staff turnover (Berger 2002; Tarkin 2008).

John Gregory (1772) wrote: "Experience demonstrates that a gentle and humane temper, so far from being inconsistent with vigor of mind, is its usual attendant; and that rough and blustering manners generally accompany a weak understanding and a mean soul" (p. 182). However, many aspects of medical education foster a strong sense of entitlement that encourages "rough and blustering manners." Students overcome innumerable intellectual, emotional, social, and economic hurdles in order to become physicians. In a culture that glorifies instant gratification, they delay personal and financial reward for many years in order to achieve their objectives. They also accumulate massive debts from student loans. They reach professional maturity in a hospital culture that disvalues introspection and vulnerability (Coulehan 2010). Entitlement is also promoted by a "hidden curriculum," which teaches young physicians that self-interest is the *real* name of the game (Coulehan 2005; Coulehan and Williams 2001; Hafferty and Franks 1994; Hunnert 1996). The difficult process of becoming a doctor, which once engendered interdependence, collegiality, and shared values among physicians, tends now to be interpreted more solipsistically, as a series of challenges to be met and overcome on one's own. One's ultimate success is a solitary accomplishment.

The House of God, Samuel Shem's (2003) ironic saga of internship, is almost an urtext for this culture of entitlement. Shem's story purports to tell how dysfunctional medical training squeezes the natural humanity and compassion out of young doctors. In fact, however, a close reading reveals that most of its characters come off as poster boys or girls for self-justifying exceptionalism (Coulehan 2008). Nothing in the book suggests that these doctors ever connected with, or advocated for, their patients to begin with. Yes, they may have been victims of unfeeling senior physicians, but they were, at the same time, victimizers of their patients and the hospital staff.

As Patrick Duff (2004) observed: "Humility should be at the top of the list of desirable professional attributes. . . . [However,] medical students and physicians are very accomplished and highly successful individuals. At times, their sustained pattern of success can lead to an inappropriate sense of entitlement and arrogance. From the perspective of patients and coworkers, nothing is more immediately recognizable, more unsettling, and more offensive than hubris" (p. 1362). I'm not sure that *hubris* is precisely the right word here, since it suggests the pres-

ence of an unavoidable fatal flaw. Physician arrogance is a flaw all right, but it is avoidable and usually isn't fatal—except sometimes for patients.

Honest Self-Disclosure

A third feature associated with humility is honesty, especially about mistakes. In his *Lectures on the Duties and Qualifications of a Physician* (1772), the great Scottish physician John Gregory wrote: "I may reckon among the moral duties incumbent on a physician that candor, which makes him open to conviction, and ready to acknowledge and rectify his mistakes. . . . True knowledge and clear discernment . . . are inconsistent with self-conceit" (p. 189). The duty to acknowledge medical error, at least to colleagues, is not controversial in theory, but in practice physicians tend to restrict or compartmentalize the concept of truthfulness. They blame American litigiousness for their reluctance to be truthful, although, historically, physician truthfulness about prognosis and error has usually been considered harmful to the patient and, therefore, not ethically warranted (Lazare 2004; Oken 1961). In other words, physicians made a virtue of manipulating the truth before malpractice considerations reared their ugly head.

Just how candid should the doctor be? Is it sufficient to present a "softened" story, or to withhold some of the gory details? Moreover, is disclosure sufficient, or should physicians apologize for their mistakes? In his memoir *Healing the Wounds* (1985), David Hilfiker describes his years as a family physician in rural Minnesota. He tells the story of a woman whose unintended abortion resulted from his failure to obtain a pelvic sonogram that was clearly indicated. His patient experienced symptoms and signs of pregnancy, but repeated pregnancy tests were negative. Rather than sending her to another town for a sonogram, Hilfiker diagnosed a missed abortion with retained fetus, based on the clinical findings and negative tests. While doing the D & C, he discovered that the fetus had been alive before the procedure. "During the days, and weeks, and months after I aborted Barb's baby," he writes, "my guilt and anger grew. . . . There was no way I could justify what I had done" (p. 380). Hilfiker apologized for his mistake to the patient and her husband, but this didn't diminish his own anguish: "I decided that it was my responsibility to deal with my guilt alone" (p. 380).

Hilfiker subsequently shared this guilt with thousands of readers. He later moved to Washington, DC, and practiced in an inner-city health center, an experience he recounts in *Not All of Us Are Saints* (1994). Hilfiker's confessional approach, as he struggles to justify his and his family's privileged status in the midst of a dysfunctional and poverty-stricken community, is a moving example of humility. Later still, in *Urban Injustice: How Ghettos Happen* (2003), Hilfiker takes a step beyond personal reflection to social and economic criticism. His narratives allow us to explore the rugged terrain of honest acknowledgment and apology. Interestingly, these stories, while engaging, tend to make the reader uncomfortable. Such stark honesty about one's doubts, values, limitations, and mistakes is

difficult to confront. We would rather manage disclosure of mistakes by modulating the responsibility (everyone has bad days, my hours are too long, other people's mistakes led to my mistake, etc.). We would rather accept our privileged status in life without delving too deeply into the heart of fairness. However, for Hilfiker confession is an essential component in the process of personal healing. And on a more day-to-day level, it is clear that a simple apology results in measurable benefits for both patient and doctor: "An effective apology is one of the most profound healing processes between individuals, groups, or nations" (Lazare 2006, p. 1403).

Modulation of Self-Interest

A final feature of humility is the ability to maintain inner balance and to modulate self-interest. Pellegrino and Thomasma (1993) approach humility, which they call "self-effacement," by focusing on the relative roles of altruism and egoism in medicine. According to Jonsen (1992), the tension between self-interest and altruism create a paradox at the core of medicine. Self-effacement is the virtue that modulates or suppresses the tendency for one's self-interest to interfere with serving the patient's interests—in other words, humility facilitates altruism. Pellegrino and Thomasma argue that self-effacement functions like yeast, allowing other virtues to "rise" and express themselves. The good doctor embodies compassion, respect, and fidelity precisely because she is sufficiently reflective and motivated to down-regulate her personal interests (e.g., convenience, peer approval, pleasure, financial gain, power, or prestige) when it is in her patients' best interests to do so.

This notion of discovering a morally appropriate balance of interests reflects Aristotle's concept of the Golden Mean. It acknowledges the moral claims of both parties. Obviously, physicians have duties to themselves and their families, as well as to patients. The idea of total self-effacement evokes the myth of a practitioner who devotes his entire life and energy to helping others, in essence, emptying himself out. Since this is an unattainable ideal for most doctors, it presents an easy target for critics who believe that serious consideration of virtue in medicine is unrealistic, nostalgic, and self-deluding. However, humility framed as a search for the Golden Mean focuses on the practical task of maximizing altruistic behavior, while at the same time acknowledging one's personal needs and limits. This kind of balancing or reflective equilibrium harks back to self-awareness. Good physicians have a duty to put the interests of their patients ahead of self-interests, insofar as a reflective acceptance of their personal limitations will allow.

Virtue as Narrative

The virtue tradition holds that there are deeply held values and qualities internal to the goals of the profession, a commitment to moral behavior grounded in "that which I hold most sacred" (to quote a contemporary version of the Hippocratic Oath). In practice, this traditional view is a kind of meta-narrative or narrative ideal that has developed over 2,500 years as a summation of, and reflection upon, stories of actual and fictional physicians practicing in different times and cultures. While the values and qualities can be defined abstractly, such definitions are not compelling; they don't *show* us the way. It is easy enough to say (as does the *Oxford English Dictionary*) that *compassion* is "participation in another's suffering; fellow feeling, sympathy." However, only a concrete example will help open our eyes to the personal meaning of compassion. When a lawyer asked Jesus of Nazareth what "to love your neighbor" means, Jesus responded with the story of the Good Samaritan, rather than with a general statement, like "you should do what you can to help everyone who needs help."

In a sense, the names of medical virtues—words like *integrity*, *compassion*, *altruism*, *courage*, *fidelity*, and *humility*—represent post-hoc categories by which we interpret hundreds and thousands of healing narratives: myths, parables, narrative poems, epics, sacred writings, and especially the lives of real doctors confronting conflict and quandary in their professional lives. By allowing these stories to influence our character formation, we learn what virtue means. Thus, the narratives medical trainees create in response to the behavior of role model physician-teachers are the most important component, building upon the more general narratives of virtue internalized during childhood and adolescence. Likewise, stories of doctors like Albert Schweitzer, David Hilfiker, Paul Farmer, William Osler, Cicely Saunders, Catherine Caldicott, Perri Klass, Danielle Ofri, and Thomas Starzl teach us more about virtuous traits than we could ever learn by definitions, rules, guidelines, or algorithms for virtuous behavior. The same is true of fictional physicians, as in stories by Anton Chekhov, Mikhail Bulgakov, William Carlos Williams, Richard Selzer, Susan Mates, and others (Monroe and Coulehan 2002).

Under the aegis of the new professionalism, explicit attention to virtue has made a dramatic comeback in medical education (Coulehan 2005; Hafferty and Levinson 2008; Kinghorn, McEvoy, and Balboni 2007). In my school, like many others, the competency-based curriculum requires that students demonstrate, and be evaluated on, behavioral manifestations of integrity, altruism, respect, and compassion. Whether or not the current educational focus on professionalism achieves its ultimate objectives, the trend reveals a conscious movement toward reengagement with traditional values. However, the question remains: "Does the emperor of the new professionalism have any clothes?" (Kinghorn, McEvoy, and Balboni 2007). I believe for the clothes to be real, medical trainees must internalize professionalism as "a bundle of contemporary narratives, either observed

directly through role model physicians and other health professionals, or indirectly through stories and film. In other words, to learn professionalism is to enter into a certain kind of narrative and make it one's own" (Coulehan 2005, p. 897). I've suggested the term "narrative-based professionalism" to refer to this tradition, in contrast to "rule-based professionalism," which emphasizes objectives, competencies, and measurable behaviors that dissect and reconstruct the concept of professionalism, but do not focus on its narrative ethos (Coulehan 2005).

Students will remember a story like Selzer's "Toenails" long after they've forgotten the list of medical virtues given in Pellegrino and Thomasma's book. Moreover, when Selzer's character comments, "I never go to the library on Wednesday afternoon without my nail clippers in my briefcase" (p. 69), it means something to them as aspiring physicians. They can relate to his simple, unpretentious attitude, even if they violently resist calling it "humility." As Selzer's surgeon comments further, "You just never know" (p. 69).

Conclusion

In this essay I've highlighted the virtue of humility because it is perhaps the most difficult for contemporary physicians to grapple with. What does it mean in practice? The injunction "Be compassionate" evokes a reasonably clear image of what is required. However, the injunction "Be humble" sends a mixed message. Our narratives about compassion are fully positive, but narratives about humility leave us with questions. Doesn't humility compromise medical effectiveness? Shouldn't we make a virtue of reducing our limitations, rather than acknowledging them? How can humility be tracked or measured?

My hypothesis is that physicians who cultivate unpretentious openness, honest self-disclosure, and modulation of self-interest, and who avoid arrogance, have demonstrated humility. I recognize the substantial overlap that exists among these categories, but they are not identical and considering them separately has heuristic value.

These days hospitals compete relentlessly for market share, trumpeting their leading-edge facilities and outstanding medical staffs. Their advertisements scream: our doctors are the best in the nation! We have the world's finest cancer specialists! We're ranked #1 in heart surgery! Some institutions also include a softer pitch by trumpeting their staff's compassion, fidelity, and personalized care. However, one professional virtue plays absolutely no role in today's medical market place: humility. Imagine, if you will, a full-page spread in the *New York Times* headlined with these words: OUR DOCTORS RANK AMONG THE MOST HUMBLE IN THE UNITED STATES. WE ADMIT OUR MISTAKES. WE READILY ACKNOWLEDGE OUR LIMITATIONS!

How many patients would such a pitch attract? Not a single one, I suspect, except perhaps the occasional ethics professor. In fact, most readers would burst

into laughter before switching their allegiance to the competition. And no wonder. We rightfully seek excellence, integrity, and compassion in our physicians. We want good results. We want to feel cared for. In the marketplace humility seems counterproductive.

One thing is certain: to morally invigorate our profession for the 21st century, the movement toward explicit emphasis on behavioral competencies—interpersonal competence, cultural competence, narrative competence, and so forth—will need to be supplemented by emphasis as well on developing self-awareness, understanding the limitations of competence, and allowing due consideration for human vulnerability. In the new professionalism, unpretentious openness, honest self-disclosure, avoidance of arrogance, and modulation of self-interest must be included as integral parts of the picture. And, taken together, they constitute humility.

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