

On Humility

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The new professionalism movement in medical education takes seriously the old medical virtues. Perhaps the most difficult virtue to understand and practice is humility, which seems out of place in a medical culture characterized by arrogance, assertiveness, and a sense of entitlement. Countercultural though it is, humility need not suggest weakness or lack of self-confidence. On the contrary, humility requires toughness and emotional resilience. Humility in

medicine manifests itself as unflinching self-awareness; empathic openness to others; and a keen appreciation of, and gratitude for, the privilege of caring for sick persons. Justified pride in medicine's accomplishments should neither rule out nor diminish our humility as healers.

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As a junior faculty member, I worked at a community health center in Terrace Village, Pittsburgh's largest public housing project. With its institutional buildings and drab, cracked streets, the place looked nothing like a village. The clinic, which sat beside a devastated playground, was one of the few places where people could safely socialize. Most of my patients were chronically ill and already under the care of 2 or more subspecialists at the nearby university hospital.

Not long after I began this job, a distinguished senior physician at the hospital telephoned me and asked if I needed some help. In fact, he offered to come over and see patients one afternoon each week. I was astounded: An almost legendary teacher and full professor offering to help the new kid on the block! What would he think of me? Moreover, what would he think of my patients?

My greatest fear was that the famous man would find patients at Terrace Village neither sick enough nor stimulating enough for his services. I couldn't have been more wrong. The professor made the necessary arrangements in his schedule and soon became an integral part of our clinic, warmly appreciated by patients and staff alike. He listened carefully to the elderly ladies, joked with the young men, and even made house calls. I was amazed that such a powerful physician could be so open, unpretentious, and even . . . humble.

My medical students consider this an inspiring story, but they get uncomfortable when I start talking about humility. In medicine, humility feels like a square peg in a round hole. Toughness, confidence, and assertiveness—yes. Drama, angst, and celebrity—yes. But prudence and humility—no, not exactly. We revere the concept of compassionate care but are skeptical about seeming to be weak; wishy-washy; or even deceptive, as in “false modesty.” Patients, too, may question the competence of physicians who too readily acknowledge their limitations.

This situation isn't new. In 1906, Sir William Osler warned medical students, “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 . . .” Today, I suspect that few students regard character formation as a part of their medical education at all, and even fewer consider humility an ingredient. To many of us, the word seems inconsistent with justifiable pride in our work.

I thought of my Terrace Village experience recently when rereading Dr. Franz Ingelfinger's 1980 essay “Arrogance” (1). Ingelfinger, speaking as a patient with cancer as well as a physician, wrote that what he most needed during the crisis of his illness was a confident, empathetic physician willing to guide him and “assume responsibility for [his] care.” I was surprised, though, when he used the term “beneficent arrogance” for this cluster of qualities, which he then contrasted with the “destructive arrogance” of “paternalism . . . accentuated by insolence, vanity, arbitrariness, or a lack of empathy.” I'm sure his labeling of confidence in practice as a form of arrogance was wrong. He mistakenly applied the word “arrogance” to positive qualities, such as steadiness, guidance, and fidelity.

I saw a prime example of genuine arrogance in the hospital last week. A Spanish translator was devastated when a physician pushed her aside as he entered 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, who had presumably signed a consent form, had no idea what was happening. Unfortunately, such obnoxious behavior is not rare. In addition to its damaging effect on patients, arrogant behavior by physicians can contribute to low hospital morale, excessive stress, and high staff turnover.

This incident is a striking manifestation of the deeper and more common problem of entitlement. My Terrace Village colleague had many accomplishments under his belt, yet he was unpretentious. I never saw him act rudely or throw his weight around, either at the hospital or the clinic.

Many aspects of medical education and practice foster a sense of personal entitlement that threatens, too often successfully, to strangle altruism. Students overcome innumerable intellectual, emotional, social, and economic hurdles to become physicians. In a culture that glorifies instant gratification, they delay their rewards for many years. They reach professional maturity in a hospital culture that undervalues introspection and vulnerability and is permeated by a “hidden curriculum” that teaches self-interested behavior under the cover of idealizing devotion to the patient's best interests. Medical education, which once promoted collegiality and shared values, tends now to foster egoism. “I paid my dues,” the saying goes, “so now I'm entitled.”

Countercultural though it is, humility need not suggest weakness or self-abnegation. Quite the contrary, humility requires toughness and emotional resilience. In medicine, humility manifests as 3 qualities: unflinching self-awareness; empathetic openness to others; and a keen appreciation of, and gratitude for, the privilege of caring for sick persons. None of these is easy.

My helper at Terrace Village was a role model in reflective practice. He taught me to step back and consider how my own feelings and behavior affected patient care situations and to understand how empathy requires hard work. Neither today's fast-paced medical training nor contemporary culture fosters this type of self-awareness. The idea that an experience can be educational even though it doesn't transmit facts or convey a technical skill surprises many of us.

Each year, I meet with a group of first-year medical students for a series of sessions on self-awareness, professional values, and personal growth. In every group, a couple of students express skepticism about these sessions. "The discussions are interesting," they explain, "but right now we're under so much academic pressure that we can't enjoy them. It's not like we learn anything in small group. After all, these issues have no right or wrong answers." The concept that education consists of a stack of right answers doesn't take us very far toward self-discovery. Fortunately, most students get hooked into the group dynamic and, by the end of the year, are highly engaged.

Responsiveness to others works at 2 levels. At the interpersonal level, responsiveness means attempting to understand our patients as accurately as possible or, in other words, using doctoring skills to enhance empathy and build a trusting relationship. At the moral level, responsiveness requires that we sometimes make tough choices about how and where we invest our energy. My colleague surely had "better" things to do on Wednesday afternoons. I'm sure he had numerous reasons for donating his time, among them enjoyment of primary care practice. Altruism and compassion were also in the mix. But humility played a big role. Without the wisdom of humility, altruistic behavior can lead to self-delusion, compassion can become an obsession, and both may generate a damaging sense of hubris. Witness the prevalence of obsession, detachment, depression, and burnout among physicians.

In cautioning against arrogance, Ingelfinger observed that medical knowledge is always tentative and incomplete (1). He noted, for example, that in 1980 the cause of peptic ulcer disease remained unknown, despite decades of investigation. Only a couple of years later, Marshall and Warren discovered *Helicobacter pylori*, which eventually led to our current understanding that peptic ulcer disease results primarily from chronic *H. pylori* infection. Physicians are justifiably proud of the many important medical advances that benefit humankind, but undoubtedly, future research will show that many current beliefs and practices are mistaken and probably harmful to patients.

Although the imperfect state of the art is sobering, it is not a convincing basis for deep humility in physicians. A more solid foundation is simple awareness of the hope and trust that sick people put in us and the responsibility that it entails. The most refreshing thing about first-year medical students is their wonder, enthusiasm, and gratitude for the opportunity to become physicians. It would be difficult to maintain such an acute sense of humility during one's professional life and still function effectively. But the basic situation remains: the mystery of healing, the trust and gratitude of patients. These are humbling experiences.

I once had a patient who developed eosinophilic pneumonia and pericarditis that proved to be the Churg–Strauss syndrome. She had a complicated disease course involving several hospitalizations and multiple subspecialists. Her eventual recovery was remarkable. From a technical point of view, my role was peripheral; however, from my patient's perspective, I was the physician who "pulled [her] through." When I moved to another city shortly thereafter, every December I received from her a large Virginia ham packed in dry ice, along with a note expressing her thanks. Year after year, our family marked the beginning of the Christmas season from the day that Mrs. Conway's ham arrived at our door. Then, one December, no package appeared. We learned that Mrs. Conway had died. How could I fail to be humble in the face of Mrs. Conway's gratitude?

Under the aegis of a new professionalism, old virtues are making a comeback in medical education. Competency-based curricula require that students demonstrate such qualities, as integrity, altruism, and compassion in behavioral terms. Whether this educational refocusing on professional identity will effectively create a generation of more reflective physicians remains uncertain. Virtue can undoubtedly be learned, but the circumstances under which it can be meaningfully taught are controversial. The characteristic qualities of humility—honest self-awareness, reflective openness to others, and a deep appreciation of the gift of healing—are important features of doctoring that are nourished by role modeling in an appropriate environment. We are right to be proud of the amazing power of medical technology, but justified pride in medicine's accomplishments should neither rule out nor diminish our humility as healers. An ounce of humility is worth more than a ton of arrogance.

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Reference

1. Ingelfinger FJ. Arrogance. *N Engl J Med*. 1980;303:1507-11. [PMID: 7432420]