received a firm scolding as I hid in the call room. "The first essential is to have your nerves well in hand," I could hear him saying. "Even with disaster ahead and ruin imminent, it is better to face them with a smile, and with the head erect, than to crouch at their approach."

Osler could be annoyingly condescending toward patients at times, but he also spoke of "the need of an infinite patience and of an ever-tender charity toward these fellow-creatures." He reminded me of "the likeness of their weaknesses to our own," something I tried to remember when I started my psychiatry residency and encountered so many patients, especially those who were anxious and depressed, who needed a bit of aequanimitas themselves.

Through the intervening years, I came across Osler's name in many contexts — in history of medicine lectures, reference books, the name of a hospital. Osler quotations prefaced articles like verses from scripture. It was akin to seeing the name of a colleague in print: Hey, I know him. I felt a bit of pride, a bit of resentment.

And somehow, so gradually that I hardly noticed it, I cultivated a degree of aequanimitas. Perhaps I should not have been surprised; after all, Osler said that "with practice and experience the majority of you may expect to attain [it] to a fair measure."

But sometimes I think Osler's notion of aequanimitas is flawed. Surely nothing short of pathological denial can give rise to the peacefully enlightened state he attributes to Antoninus Pius as he lay dying: "about to pass *flammantia moenia mundi* (the flaming rampart of the world)" with "the watchword, *Aequanimitas*" on his lips.

Still, I want to believe. Because there are days — when patients' conditions are deteriorating, family members are lining up to see me, computer printers are jamming — when it helps me to imagine myself rising above the troubled waters of the hospital "like a promontory of the sea." All about me, the swelling waves are stilled and quieted, and there I stand, with Uncle Will at my side, my hand outstretched in a benediction, my face glowing in a state of perfect aequanimitas.

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Learning to act like a doctor

> Imperturbability ... is the quality which is most appreciated by the laity though often misunderstood by them; and the physician who has the misfortune to be without it, who betrays indecision and worry, and who shows that he is flustered and flurried in ordinary emergencies, loses rapidly the confidence of his patients.
>
> Keen sensibility is doubtless a virtue of high order, when it does not interfere with steadiness of hand or coolness of nerve; but for the practitioner in his working-day world, a callousness which thinks only of the good to be effected, and goes ahead regardless of smaller considerations, is the preferable quality.
>
> — William Osler, *Aequanimitas*, 1889

As a student, I was given very little guidance in the management of my own emotions, or those of my patients. When I was a resident I had to tell a young wife that her husband had died from an embolus. She arrived unsuspecting on the ward, and I told her bluntly that, while we try in such cases to prevent sudden death, we are not always successful, and that with her husband we were not successful. She stared at me for a moment and then, bursting into tears, flung herself into my arms. I was inept and inexperienced, but I just held her until she stopped sobbing.

Recently, I learned that a friend of mine has inoperable cancer. He has been told he has less than a year to live. Breaking this unexpected news, his physician described the condition and its implications clearly and straightforwardly. What impressed my friend was the physician's imperturbability, especially as he himself was devastated and wept copiously in the doctor's office. The physician remained focused on the illness, apparently ignoring the effect the information was having on his patient. Later, my friend met with a radiotherapist who, although he was extremely busy, spent time discussing the treatment, its role in pain control, side effects, and my friend's feelings and fears. As they talked, he even put his arm around my friend's shoulder. My friend wonders why physicians are so afraid of showing their feelings. Close physical contact is an effective way of expressing compassion and is probably genuinely therapeutic as well.

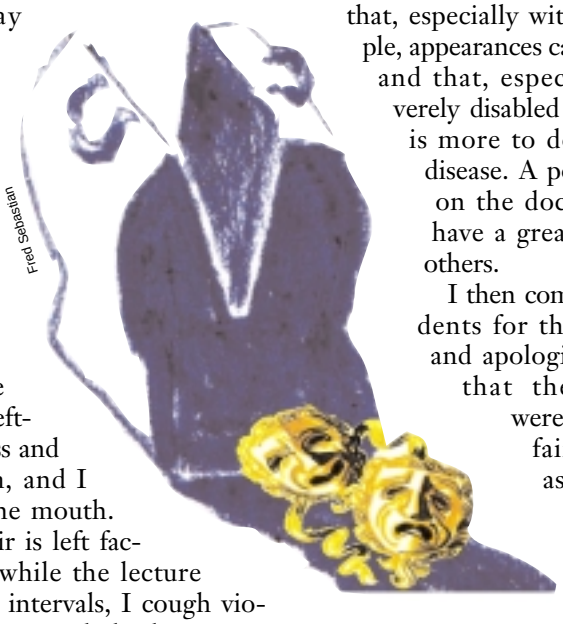
William Osler recommended that his students manifest a quality of imperturbability, which he called aequanimitas. This term conveys a sense of compassion, of sensibility to suffering, coupled with control in its expression. The first passage cited above implies that a person is by nature imperturbable or not. The second passage suggests that a student, however sensitive, can and should learn to act even callously if the patient's need calls for it. Can, and should, imperturbability be taught? Can a student who lacks a "keen sensibility" learn nonetheless to show compassion? One wonders if Osler's teachers taught him compassion and imperturbability, or if he was by nature endowed with them. How do we teach students to act the part of a compassionate physician, allowing the expression of feeling to the extent required for the patient's good? And when should physicians simply act like themselves?

Nowadays, we try to focus students' attention on effective and compassionate care. We try to show that pity alone, or a feeling of helplessness, is unjustified. At our school, healthy people are trained to act the part of a patient with a specific condition, thus allowing students to conduct an examination without exhausting a sick person. These portrayals are convincing because, apart from specific symptoms and signs, the "patient" gives a history from his or her own life. Because they are trained in a particular way, these actors are referred to as "standardized patients." Since my

retirement, I have acted both roles: that of teacher, and that of standardized patient.

Within a few weeks of starting their medical training, students are introduced to the basic concepts of geriatric medicine. The whole class is assembled for an introductory lecture on the prevalence of illness in the aging population and on issues of concern in this area of practice. These include the common prejudice that the illnesses of later life cannot be cured and that little can be done for severely disabled patients. The use of standardized patients is mentioned briefly.

After this introduction, the class is divided into small groups, who then pass from one "experience" to the next. These include interviewing a healthy elderly woman living alone, discussing medication problems with a pharmacist, trying to find one's way while wearing glasses with greased lenses, and interviewing a disabled old man. My part is to portray the old man.



During the introductory address, I am brought in, slumped in a wheelchair, wearing pyjamas and dragging one foot on the floor. I have left-sided weakness and parkinsonism, and I drool from the mouth. My wheelchair is left facing the wall while the lecture continues. At intervals, I cough violently and appear to choke, but no one pays any attention.

After the introduction, the groups interview me for about 10 minutes each. Although I appear so incompetent, I turn out to be a well-informed science teacher and a widower who lived alone before being brought to hospital because of frequent falls. I want to return home, but the hospital staff are arranging for me to go to a nursing home. I insist I should be allowed to go home. The attendant with me signals to the students that I am confused. When my wife is mentioned, I begin to sob.

Some of the students are speechless before this pitiful case. Their earnest faces peer at me; tears well in their eyes. Others, although visibly affected, continue the interview and focus on possible solutions, home care, safety devices, getting neighbours involved, and so on. Some students are so angry at the way I have been treated that they seek out the organizers of the session to express their feelings.

When every group has finished, I am wheeled into an adjacent washroom, where I quickly shave, put on a suit and tie and my steel-rimmed glasses and return to the class as a professor of medicine. There is great astonishment, as very few suspected I was a standardized patient. The purpose of the exercise it to emphasize that, especially with elderly people, appearances can be deceiving and that, especially with severely disabled patients, there is more to do than treat a disease. A positive attitude on the doctor's part can have a great influence on others.

I then commend the students for their sensitivity and apologize if they feel that their emotions were played on unfairly. However, as I explain, although pity is a natural reaction, it does not benefit the patient. Emotional involvement is desirable, but one must acquire imperturbability so that one can continue an interview and get the facts. An interview is not a conversation. But, beyond that, compassionate physicians will allow their sensibility to show, and will respond to the patient's emotional needs while also providing broad-based and effective care.

Colleagues in another faculty have questioned the ethics of involving students in an unexpected emotional scene. The objection is not that the standardized patient appeared so real that the students became emotionally involved, but that I then returned and showed them that I was "only" playing a role. The interview, they argue, had already taught the students that appearances can be deceiving, so my returning as professor of medicine only served to show that wilful deception is acceptable. We teach our students by what we do as well as by what we say.

But I believe that playing the role of patient enabled me to experience both the sensitivity of the students and their ability to control their feelings, and to encourage their compassion while promoting self-control. Returning in the role of teacher and physician shows that these, too, are roles that can be learned. In the physician's role, it is not deception to show genuine compassion while maintaining an imperturbable demeanour. Controlled emotions can provide the energy the physician needs to develop and implement a treatment plan, set an example for others, and overcome institutional apathy or disinterest.

Patients vary, of course, in the extent to which they welcome expressions of concern and close physical contact. Clearly, every patient is different, and the physician's role must be modified to meet the needs of each one. We must sensitize our students to the varied reactions of our patients, and teach them to respond in every case with sympathy, compassion, and a fair measure of aequanimitas.

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