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

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 will be a bit of pride, a bit of resentment. 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.”

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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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retirement, I have acted both roles: that of teacher, and that of standard-
ized patient.

Within a few weeks of starting their medical training, students are intro-
duced to the basic concepts of geriatric medicine. The whole class is
assembled for an introductory lecture on the prevalence of illness in the ag-
ing population and on issues of con-
cern 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
in the room, where I quickly shave, put on a
suit and tie and my steel-rimmed
glasses and return to the class as a pro-
fessor of medicine. There is great as-
tonishment, as very few suspected I
was a standardized patient. The pur-
purpose of the exercise it to emphasize
that, especially with elderly peo-
ples, appearances can be deceiving
and that, especially with se-
verely 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 stu-
dents for their sensitivity
and apologize if they feel
that their emotions
were played on un-
fairly. However,
as I explain, al-
though pity is
a natural
reaction, it
does not
benefit the
patient. Emotional involvement is de-
sirable, but one must acquire im-
perturbability so that one can continue an
interview and get the facts. An in-
terview is not a conversation. But, be-
yond 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 stu-
dents 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” play-
ning 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 decep-
tion is acceptable. We teach our stu-
dents 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. Return-
ing in the role of teacher and physi-
cian shows that these, too, are roles
that can be learned. In the physician’s
role, it is not deception to show gen-
uine compassion while maintaining an
imperturbable demeanour. Controlled
emotions can provide the energy the
physician needs to develop and imple-
ment a treatment plan, set an example
for others, and overcome institutional
apathy or disinterest.

Patients vary, of course, in the ex-
tent to which they welcome expres-
sions of concern and close physical
contact. Clearly, every patient is dif-
f erent, 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 equanimitas.

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