Can Osler teach us about 21st-century medical ethics?

Mark W. Millard, MD

In medicine, we are voyeurs. We are present at the most intimate and personal of our patients' experiences. We are there at birth; we pronounce their passing; we listen to the tales of humanity, of griefs and triumphs, of what takes place behind closed doors. We are trusted, we are confided in, we have become very much as secular confessors and can listen, if we choose to take the time, to the nuts and bolts that make each one of us unique, as a story spills out over a series of encounters.

But while our white coats lend an aura of priestly authority, our texts are imperfect and require revision every 5 years or else are out of date; we cannot quote with authority as one might from the Old Testament, or Koran, or the Bhagavad Gita. Medical truth appears almost evanescent and transient, a linguistic oxymoron, much unlike the Forms that flickered on the walls of Plato's cave.

Our patients turn to us for wisdom, for counsel, for help, for cure and restoration of health in the setting of disease. Sometimes, the questions are easy: frankly metastatic cancer, unknown primary, is easy to treat, or perhaps more accurately easy *not* to treat. Straightforward extrinsic asthma likewise is usually a "slam dunk." But other questions nag at our consciences because we might not really know the right answer, and our patients get very uncomfortable when we admit our human frailty and the imperfection of our knowledge. And then our feelings and our loyalty to colleagues and to political, religious, or ethical beliefs may influence our opinions on topics that we never discussed in medical school or learned about in residency or fellowship training.

Understanding the facts of a case, and searching for an answer, either with UpToDate or Hippocrates or just Googling for help, often helps to answer medical issues of a content nature: a diagnosis, a treatment, a prognosis. But the dilemmas of life are not often so content driven. When I speak with my colleagues and friends of the struggles they face, it isn't about treating coronary artery disease or diabetes. When I polled for the real issues that seemed to defy the latest edition of Harrison's textbook, these were at the top of the list:

- When family members aren't on the same page as the treating team in the setting of irreversible illness
- When a mistake is made and the patient is unaware
- When consultants disagree over treatment and lobby the patient to accept their own version of the truth
- When insurance changes limit access and continuity of care, or denial of service can only be avoided through a convoluted documentation process that takes more time to master without recompense than the service itself

Medscape, the Internet health care professional section of *WebMD,* published a survey of physicians about the most common ethical dilemmas (1). This survey listed additional items physicians struggle with:

- Reporting an incompetent or impaired colleague
- Owning up after making a medical error
- Physician-patient confidentiality when one partner of a couple is HIV positive and the other doesn't know
- Prolonging futile care for a dying patient
- Denying care to a nonpaying patient
- Whether to honor a family's request not to tell a patient that he or she has a terminal disease
- Exaggerating a patient's condition to get insurance coverage
- Writing a prescription for a family member or friend

Ethical principles allow us to derive moral instructions to address specific dilemmas we face, and a useful construct to evaluate controversial issues is that of Beauchamp and Childress (2), who created a hierarchy of four principles:

- Patient autonomy, the right to refuse treatment
- Beneficence, the adjuration to "do good"
- Nonmaleficence, the instruction to "do no harm"
- Justice, both "doing the right thing" and ensuring "distributive" fairness

This hierarchy, which is often employed by ethics consultants in the hospital addressing the specifics of any circumstance, reflects contemporary emphasis upon the individual's freedom to *refuse* treatment options——which is not to be confused with the right to *demand* specific treatments that might be untherapeutic or potentially harmful. Autonomy may also be construed as the right to "know," because

From the Baylor Foster Lung Center, Baylor University Medical Center at Dallas.

Presented at internal medicine grand rounds, Baylor University Medical Center at Dallas, April 26, 2011.

Corresponding author: Mark W. Millard, MD, Baylor Foster Lung Center, 4004 Worth Street, 3rd floor, Dallas, Texas 75246 (e-mail: Mark.Millard@BaylorHealth.edu).

Figure 1. Sir William Osler. From Images from the History of Medicine, National Library of Medicine.

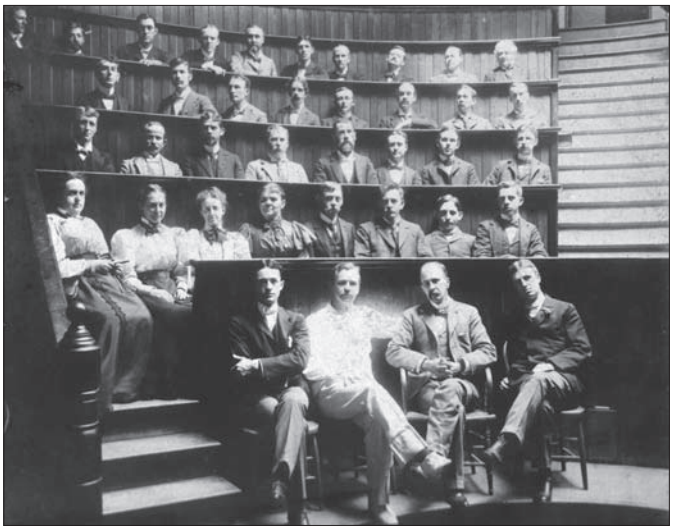

Figure 2. The graduating class of the Johns Hopkins Medical School, with Drs. Harvey Cushing, Howard Kelly, William Osler, and William S. Thayer seated in front, ca. 1900. From Images from the History of Medicine, National Library of Medicine.

appropriate decision-making or more classically "informed consent" requires the full disclosure of risks and benefits. This rank order of ethical principles differs from that in previous eras, when a paternalistic beneficence trumped all other values. Reordering such adjurations may lead to significant differences in any particular decision in the setting of a moral dilemma, and that fact must be considered when we look back into our heritage for answers to our current problems. Solomon may have written that "there is nothing new under the sun," but the reflection of light upon the landscape of choices varies with the era and time as much as anything else. In truth, the very concept of "good" can become redefined based on changes in societal values. For example, at various times in history, the goodness of racial purity was held paramount, which led to 20th-century atrocities against European Jews at the hands of fair-skinned, blue-eyed Germans and the segregation of races in the USA following the Emancipation Proclamation.

History can inform us, then, of a traditional perspective against which we can compare our current views, for better or for worse. In fact, the majority of our current dilemmas are but reflections through the darkened glass of time of previous struggled-with issues that are now reprised in our own time. As such, it is instructive to look backwards at those who were clear masters in their own days and articulated choices and a perspective that history judges as authentic. Such a master was William Osler *(Figure 1).*

OSLER

Born the son of Anglican missionaries in Ontario, William Osler grew up to become the greatest advocate of the practice of medicine we recognize today, who took the startling advances in the knowledge of disease pathophysiology of the late 19th and early 20th centuries and used that foundation as the basis for diagnostic and treatment strategies. A keen observer of human behavior, a master of patient examination, an ardent reader of the developing medical literature, and a prodigious writer, Osler was claimed by physicians of three different countries as one of their own. His textbook, *The Principles and Practice of Medicine,* went through 16 editions, was translated into at least six languages, and was the last major single-authored textbook of medicine to be widely circulated.

Graduating from McGill in 1872, he joined its faculty after 2 years of postgraduate education in Europe, was lured to the University of Pennsylvania with the promise of a significant improvement in economic status and work in a larger clinical facility, and relocated 5 years later to Baltimore as the chief of medicine at the newly created Johns Hopkins Medical School *(Figure 2).* By the time he left Hopkins in 1905 to "retire" as Regius Professor of Medicine at Oxford, he was revered by medical students and residents as a master teacher, and his reputation had grown larger than life. His last 15 years at Oxford only further burnished Osler's contributions as a clinician, teacher, and writer.

OSLER AND MEDICAL ETHICS

One hundred years later, what can William Osler teach us about medical ethics? There exist no audio or video recordings of the man. What do exist are 1600+ articles he published, texts of speeches, and student notes of his rounds. Osler did not write or teach in a cultural or historical vacuum, and his views of contemporary issues generally reflected the Victorian and Edwardian milieu of his time, although his classical grounding and ecumenical reading allowed him, in general, a more moderate and tolerant view. Indeed, he never appeared sympathetic to the German heresy of racial purity but was silent on issues of racial segregation on the wards at Johns Hopkins. He believed women were created to be nurses yet gradually warmed to the idea of women as physicians and, observing their success in Europe, wrote that he longed for the appearance of an American medical *Trotula* (an 11th-century luminary Italian female physician) to justify full acceptance. Finally, with the economic incentive to admit women as medical students to Johns Hopkins, Osler advocated for a

nondiscriminatory policy. A kind paternalism infused his works, and some of his choices would make many of us feel rather awkward in the 21st century, especially in the setting of "full disclosure." He suffered from a lack of available and proven therapeutic interventions, but as his clinical experience broadened, he came to restrict treatments to a very few almost homeopathic remedies (such as cool baths for typhoid fever). Despite his skepticism towards the legion of patented medicines available, Osler appeared to only reluctantly abandon blood-letting as a valid therapeutic intervention, although by the end of his career, he limited its usefulness to cases of severe pneumonia. But even with these caveats, he spoke eloquently, although sometimes in a rather frustratingly pedantic style, of a way of practice and perspective about medicine from which much can be learned.

Time has buried the practical applications he might have advocated for most of the illnesses he encountered, but the writings of Osler that persist articulate a way of dealing with diseases, with patients, and with life itself. Albert Jonsen, in *The New Medicine and the Old Ethics,* noted that "Sir William represents the ethos of medicine" (3). Copies of his most popular essay, *Aequanimitas* (literally, equanimity), were given to thousands of graduating medical students as a roadmap for surviving the ardors of medicine. Richard Golden wrote in a 1999 *JAMA* article celebrating Osler's 150th year, "[His] humanism, which permeated all of his activities, was the *sine qua non* of his particular claim to posterity" (4). It may be instructive to look at Osler's perspective on the practice of medicine and dealing with both peers and patients before turning to specific writings germane to the contemporary issues noted earlier.

The practice of medicine and peer-to-peer relationships

William Osler was not a general practitioner, although he developed an encyclopedic expertise in pediatrics, hematology, neurology, cardiology, infectious diseases, and all of general medicine. He also enjoyed a thriving consultative practice that complemented his clinical responsibilities as a teacher and writer and provided significant income. He addressed the general medical community much more than the specialist in his writings and remained very sensitive to the temptations and rewards of medicine practiced at the turn of the 20th century. Even so, he considered all physicians his brothers and members of the "guild." In one address he spoke of the conflicts of interest that physicians face:

> My message is chiefly to you, Students of Medicine, since with the ideals entertained now your future is indissolubly bound. The choice lies open, the paths are plain before you. Always seek your own interests, make of a high and sacred calling a sordid business, regard your fellow creatures as so many tools of the trade, and, if your heart's desire is for riches, they may be yours; you will have bartered away the birthright of a noble heritage, traduced the physician's well-deserved title of "Friend of Man", and falsified the best traditions of an ancient and honorable Guild (5).

In Osler's time, revolutionary understandings of the root causes of so many diseases were occurring at a most dizzying pace. The discovery of Koch's bacillus, tuberculosis, was probably sentinel, as well as the experiments of Pasteur, which disproved the popular theory of spontaneous generation. Osler, nevertheless, appealed to the ancients in spelling out his theory of practicing the highest standard of medicine:

> To you the silent workers of the ranks, in villages and country districts, in the slums of our large cities, in the mining camps and factory towns, in the homes of the rich, and in the hovels of the poor, to you is given the harder task of illustrating with your lives the Hippocratic standards of Learning, of Sagacity, of Humanity, and of Probity. Of learning, that you may apply in your practice the best that is known in our art, and that with the increase in your knowledge, there may be an increase in that priceless endowment of sagacity, so that to all, everywhere, skilled succor may come in the hour of need. Of humanity, that will show in your daily life tenderness and consideration to the weak, infinite pity to the suffering, and broad charity to all. Of a probity, that will make you under all circumstances true to yourselves, true to your high calling, and true to your fellow man (6).

Without this kind of motivation, to Osler, the end result would be a gradual staleness of intellectual curiosity to the point that "the new, even when true, startles, too often repels" (7). He recognized "two great types of practitioners—the routinist and the rationalist," and "into the clutches of the demon routine the majority of us ultimately come" (7). Unless the postgraduate education derived from several venues was continually practiced, the physician risked premature senility: "The greatest enemy to the scientific practice of medicine is the practice of the routine" (7).

There were "rules of the game" that also applied to etiquette between physicians. Osler commended mutual respect, unity, and friendship among guild members. His words spoke to the need for intellectual honesty but also kindness towards fellow practitioners. Even so, when he came face to face with those whose words and actions violated these strongly held tenets, Osler could become a bit testy himself. Cushing, in his mammoth biography, recorded this anecdote:

> For an episode occurred there during one of the sessions, which concerned the "General Secretary" who made clear what were his feelings regarding the proper relations of one physician to another. The official report of the meeting states that a certain Dr. D__ read a paper on "the Conduct of Medical Men towards each Other and towards each other's Patients" in which he scoffed at the custom requiring a new-comer to call on those already settled in the place; claimed it was perfectly justifiable to report one's cases of operation and extraordinary cases in the papers, and went to say "take all the cases you can get, and keep them if you can without reference to the previous attendant." There were few occasions, when Osler became, for righteous reasons, greatly worked up, and this was one of them. It is said that on the conclusion of this amazing paper, he arose and to the consternation of his fellows, waved a copy of the Code of Ethics in the reader's face and publicly denounced him (8).

His more recent biographer, Michael Bliss, noted that while Osler well recognized second-rate practice, in both the academic

as well as clinical realm, his approach was usually that of gentle criticism:

> Osler almost never gossiped about weak medical brethren, as students or practitioners. His dislike of malicious personal gossip was pronounced. If you began to criticize someone in his presence, he would immediately change the subject. He had strong dislikes, to be sure, and on at least two occasions spoke out openly in medical meetings against second-raters being allowed to stay on in first-rate positions. Privately he knew there were a lot of "damned fools". . . in the medical profession, but publicly the worst the world contained was "sons of Belial." To talk behind a person's back seemed to Osler both professionally and personally unethical (9).

Because of this perspective, perhaps, Osler was considered a peacemaker in his profession and, as Golden noted,

> spread the doctrines of "unity, peace and concord" among his colleagues by means of a personality that brooked no prejudice or intolerance, brought together clannish schools, societies and factions and eliminated hostility through his special charm, friendship and the appeal of his magnetic leadership (4).

In our current times, when we struggle with peer review and so-called health care "reform," it is instructive to recall Osler's contributions.

Physician-patient relations

Joseph Pratt, who chronicled 1 year of Osler's bedside teaching at Hopkins, summarized the way his mentor practiced: "He acted on his belief that . . . 'we are here not to get all we can out of life for ourselves, but to try to make the lives of others happier'" (10). Osler manifested a personal compassion without inappropriate emotional engagement that allowed him to discuss in a dispassionate fashion the features of a disease to his students while at the same time warmly comforting the subject of his lecture "with remarks and explanations to the patient so that he would not be mystified or frightened" (11). Another anecdote reflects Osler's doctrine of equanimity, which allowed him to visit the bedside of a gravely ill patient but walk away whistling. When asked about this unusual behavior, Osler quipped, "I whistle that I may not weep" (4).

As committed as he was to a scientific way of practice, Osler never forgot that real, live human beings got sick *(Figure 3).* He counseled medical students to "care more particularly for the individual patient than for the special features of the disease" (12).

In his early years, Osler practiced a kind of beneficent paternalism that might have also been influenced in part by the Victorian/Edwardian reluctance to discuss sexual issues. Sexually transmitted diseases, as we call them nowadays, were no stranger to history, and in fact, syphilis was a common diagnosis on the wards and in the clinics at Montreal General Hospital in 1882 when the "baby professor," as Bliss called him, was first teaching. With its myriad protean manifestations and curses afflicting its victims, syphilis challenged its observers for recognition.

Figure 3. Osler at a patient's bedside. From Images from the History of Medicine, National Library of Medicine.

Osler was about to discuss a case of a child with congenital syphilis, but before he greeted the child's mother, he cautioned his listeners about the social implications of the disease, in a way that probably wouldn't happen in our current culture of "full disclosure."

> Gentlemen,—in the out-door department and on the surgical side you have many opportunities of seeing acquired syphilis in its recent forms. . . . First a word of caution. Do not use the term syphilis before your patients, particularly in the case just to be brought in of a mother and her child. Many a poor woman has lived in blissful ignorance of the precise nature of her child's affliction until an incautious word has suggested to her the cause, and then, for her, "farewell the tranquil mind." We shall use the old term lues (13).

There was also a downstream benefit of the desire to help, which on one occasion might be considered self-serving, such as in the case when he offered his cloak to an elderly alcoholic man out in the cold. Osler is quoted as saying that while he couldn't keep the gentleman from drinking himself to death, he could prevent the man's freezing from cold. That Osler also secured permission from the man to perform an autopsy and retrieve the man's cirrhotic liver, and his cloak as well, is not widely reported (14).

More disquieting to us today, but more likely reflecting the altered ranking of values that placed autonomy below beneficence and perhaps below even "justice," is the assertion that Osler encouraged, if not participated in, what would be euphemistically called "covert autopsies" for the sake of obtaining pathological materials (15). Anecdotal and student reminisces may cloud the truth, but the question must be raised as to whether Osler's quest for advancing knowledge breached patient/family consent. The potential benefit of furthering knowledge of disease processes and having pathological confirmation of clinical diagnoses may have trumped concerns over autonomy at that time in Osler's mind.

While beneficence and nonmaleficence provided strong motivation for Osler, he nevertheless regarded patient sensitivities as a primary concern. On the wards and in clinics, open discussions of clinical presentations were often made with less regard for patient sensitivities or privacy, but Osler managed that delicate balance well. Indeed, the concern of balancing privacy while not interfering with teaching rounds represents a continuing dilemma to this day. Early on in his career, Osler expressed the same sort of concern for a patient's sensitivities while in Europe and attending a presentation in an amphitheater of a German medical school:

> It was fortunate the poor patient was deaf, as the questions of prognosis and treatment were discussed thoroughly. Amputation of the leg was then performed, as the disease had progressed too far for resection. We could not but feel, however, that it was hard to keep the poor man waiting on the table. Certainly, the ward would have been the most appropriate place for instruction (16).

The wards and clinics were different, however, than the private consultative practice, and Dr. Osler enjoyed a thriving if not lucrative practice in Philadelphia, Baltimore, and later Oxford. There is no record of students and residents accompanying Osler while he visited his private patients. And, too, the errors of youth often involve passion, which becomes tempered in later years. Osler's involvement in autopsy pathology became severely curtailed during his Hopkins years. And was it a change of heart with time over full disclosure in the setting of tuberculosis, a less "sensitive" subject matter, or perhaps the understanding that isolation from the public could reduce its contagium that later led to his adjuration for full disclosure: "No greater mistake is possible in the treatment of tuberculosis than to keep from the patient in its early stages the full knowledge of its existence" (17).

Even paternalism had its limits in Osler's mind. Withholding information for the sake of protecting an innocent perspective on life may be one thing, but risking the life of a trusting soul in the setting of scientific experimentation was entirely different and violated the principles of both autonomy and nonmaleficence. The development of Koch's postulates brought a new methodology to the world of medicine. Perhaps Osler was thinking of the self-inoculation experiments of John Hunter with syphilis to link the primary chancre with the secondary disease, but his words in a talk given later in life prophesied the retrospective condemnation of the much-later Tuskegee experiments.

> The limits of justifiable experimentation upon our fellow creatures are well and clearly defined. . . . For man absolute safety and full consent are the conditions which make such tests allowable. We have no right to use patients entrusted to our care for purposes of experimentation unless direct benefit to the individual is likely to follow. Once this limit is transgressed, the sacred cord which binds physician and patient snaps instantly. Risk to the individual may be taken with his consent and full knowledge of the circumstances (18).

There is much, then, to be learned from this master clinician, teacher, and author about the practice of medicine and of dealing with our colleagues and our patients. But does Osler speak to us about specific dilemmas we face today, beyond grand statements and overarching principles?

Medical mistakes

Medical mistakes happen. Sometimes they are trivial and have no real impact, and we are all aware of circumstances when we are responsible for fatal errors. Osler spoke freely of his mistakes, both in diagnosis and therapy. By the late 19th century, medical malpractice was not an infrequent cause of litigation in the USA, so any admission of error could well lead one to court. Despite his free admissions of error, there is no record that I know of that Dr. Osler was ever sued. His writings plead for intellectual honesty in the hope that with experience, knowledge would transform into wisdom. In a farewell address to American and Canadian students, Osler counseled:

> Begin early to make a threefold category—clear cases, doubtful cases, mistakes. And learn to play the game fair, no self-deception, no shrinking from the truth; mercy and consideration for the other man, but none for yourself, upon whom you have to keep an incessant watch (19).

In his Lectures on Angina Pectoris and Allied States from 1897, Osler described the diagnostic and prognostic errors he made in the setting of chest pain. He did not appear to be afraid to admit his errors, nor the impact that his mistakes had upon his patients.

> One must be a professional Ulysses in craft and wisdom not sometimes to err in estimating the nature of an attack of severe heart pain. There is no group of cases so calculated to keep one in a condition of wholesome humility. When you jostle against a hale vigorous specimen of humanity, who claps you on the back and says, "the deuce take you doctors! I have scarcely got over my fright," you would like to forget that five years before you had almost signed his death warrant in a very positive diagnosis of angina pectoris vera. On the other hand, Mr. X. has left you with the full assurance that his cardiac pains are due to overwork or tobacco, and you have comforted his wife and lifted a weight of sorrow from both by your favorable prognosis. With what sort of appetite can you eat your breakfast when, a week later, you read in the morning paper the announcement of his sudden death in the railway station? (20)

During his Philadelphia years, Osler split his time between the autopsy room and the hospital. It was inevitable to

discover errors quickly and acknowledge them because different actions could potentially alter the prognosis. In one case reported by Michael Bliss in his biography of Osler, a pleural effusion, thought to be small, was noted by the doctor upon a cursory examination. When the patient suddenly died the next day, Osler was surprised to discover a chest full of fluid, a fatal outcome that might have been avoided with aspiration. He impressed his students with his honesty and candor about his mistakes (21).

So, it seems out of character when history also discovered an event that suggested not telling "the whole truth" was ever a part of Osler's practice, especially when it came to a medical error. Michael Bliss told the story:

> A close friend remembered an occasion when a distinguished older surgeon asked Osler to examine a young adult's hand that he had amputated above the wrist for a supposedly malignant cancer. Osler realized the diagnosis was wrong. Rather than show up the old man, he submitted no report, forgoing a fee. When Osler told his friend about the case, years later, he said, "No one but you and me ever knew of the unfortunate circumstance and we have both forgotten it" (22).

Here we see the collision of competing loyalties, and Osler was early on in his career, having just established himself in Montreal. Clearly, respect and concern for the profession of medicine trumped the responsibility for full disclosure in this circumstance. The very fact that this kind of event is so rare in the long career of Osler bespeaks the man's dogged insistence on practicing what Sokol has called "virtue ethics" (23).

The impaired physician

How far could collegial respect go when that principle collides with issues of impairment or risk to a patient? While Osler was certainly capable of speaking out publicly against "a second-class general practitioner" who was being considered for membership in the then prestigious Association of American Physicians (24), he also held his own counsel in the setting of more conflicting issues. He was willing to dismiss inadequate or disinterested medical students, as he did with a young female whose name was Gertrude Stein, but on the other hand may have been willing to protect his better-established colleagues. For example, Osler may have been the only one who suspected William Halsted's continuing addiction to morphine. Halsted, then chief of surgery at Johns Hopkins, had been almost destroyed professionally by earlier addictions to cocaine and morphine, and his initial selection as the first chief of surgery at Hopkins was made only after assurances that he had conquered these inner demons. Such might not have been the case, but Osler never exposed his colleague. Years later, after he had died, Osler's recollection of Halsted's continuing addiction was published:

> About six months after the full position had been given I saw him in a severe chill, and this was the first intimation I had that he was still taking morphia. Subsequently I had many talks about it and gained his full confidence. He had never been able to reduce the amount to less than three grains daily; on this he could do his work comfortably and maintain his excellent physical vigor—(for he was a very muscular fellow). I do not think that any one suspected him—not even Welch [chief of pathology] (25).

Loyalty to the guild was a reflection of Osler's sense of history and reverence for the traditions of the past. That tradition's central focus was a paternalistic beneficence, for the sake of the patient.

When physicians disagree

But what about when guild members disagreed and the patient was caught in the middle of two conflicting opinions? How would Sir William handle that dilemma? These observations were first published in the *Johns Hopkins Alumni Magazine* by a friend and mother of one of his patients shortly after his death and speak of a way of conflict resolution.

> Three times in my life I have seen him, when in consultation, smash the attending physician's diagnosis and turn the entire sick-room the other way about; but he left the room with his arm about the corrected physician's neck, and they seemed to be having a delightful time. The reason for this was perfectly evident; every physician felt himself safe in Sir William's hands; he knew that he could, by no possibility, have a better friend in the profession; that if, with the tip of his finger, Sir William gaily knocked down his house of cards, he would see to it that the foundation was left solid (26).

Osler spoke personally about conflicts between physicians and intellectual honesty in many of his writings. He noted with regret when speaking to the New Haven medical community that "the quarrels of doctors make a pretty chapter in the history of medicine" (27) and actually suggested that within that fraternity, cases should be discussed and adjudicated:

> The well conducted medical society should represent a clearing house, in which every physician . . . would receive his intellectual rating, and in which he could find out his professional assets and liabilities (27).

How much does this sound like "peer review"? Rather than lobby with a patient for approval, direct and honest communication between physicians provided the means for resolution. For Osler, it was the physician's responsibility to manage a case, and upon calling in a consultant for a second opinion, the point wasn't to give the patient more information to make a reasonable decision, as we might consider today, but rather for the managing physician to choose the right course. Patients might obtain "book learning" just as medical students, but there was no substitution for experience and wisdom to choose the correct course—something patients could never possess. In fact, for Osler, patients could not even be trusted to provide an accurate reflection of another physician's actions or opinions.

> It is the confounded tales of patients that so often set us by the ears, but if a man makes it a rule never under any circumstances to believe a story told by a patient to the detriment of

> a fellow practitioner—even if he knows it to be true!—. . . he will have the satisfaction of knowing that he has closed the ears of his soul to 99 lies, and to have missed the 100th truth will not hurt him. Most of the quarrels of doctors are about non-essential, miserable trifles and annoyances—the pinpricks of practice (27).

When caregivers, patients, and their families disagree

In our current era, the principles of autonomy, beneficence, and nonmaleficence routinely collide over issues pertaining to end-of-life care, and disagreements arise between patients, families, and the health care team over the degree of aggressiveness of care with decisions to resuscitate, to provide life-sustaining mechanical ventilation, or to provide artificial hydration and nutrition. In Osler's era, the prevention of infectious diseases through hygiene, clean drinking water, vaccination, and to a degree, isolation was possible, but many diseases, once established, pursued their own natural courses. A cure for pneumonia was something hoped for, but not present when Osler taught at the bedside. "Pneumonia is the most acute disease nowadays. We cannot cure it" (28).

In the absence of cure, therefore, Osler placed emphasis upon not "hurting" with untherapeutic treatments and focused on providing comfort. He would tolerate homeopathic remedies and "the blind faith that some have in medicine" (29), recognizing the human desire for hope. Morphine, however, gave the greatest of comfort in many circumstances, and Osler believed that when cure was unlikely, rest, even if drug induced, was preferable to suffering.

Bliss described an episode where Osler was called to the bedside of a dying young physician who had refused morphine, hoping that Dr. Osler could provide a cure.

> Dr. Osler came, a gentle, tender presence, . . . and talked to him like a sorrowing tender Mother for her little boy, and then he put his arm around him and said, "Now Swan I want you to let this good woman here give you some morphia tonight so that you may relax and sleep, for that is what you need; and I want you to do this for me, your old Professor and friend." The verdict had been given, and from the hand he had counted on to save! [Osler continued] ". . .If Miss M. will fix her hypo, you will take it while I am here, and then tomorrow I will find a stronger Swan; and we will talk everything over." Dr. Swan agreed, he had refused always and everyone to take morphia, the only thing to relax and enable him to lie down (30).

Full disclosure was yet to rise to the top of the hierarchy of medical practice, delayed by the paternalistic beneficence of the era. This reduced conflicts over management decisions and allowed for the natural history of illness, which could not yet be altered, to proceed. Osler believed that there were ways to communicate "in the right way to an intelligent man" that an illness was fatal, but also believed that it was "really not often necessary, since Nature usually does it quietly and in good time" (31). While he lived within an era of limited therapeutic options, it is unlikely that he would ever have been an advocate of heroic therapies with little chance to succeed, nor would he have permitted intervention in the setting of futility.

Euthanasia and assisted suicide

The kindness and compassion that have always been associated with Osler make it difficult to believe that his very name was transformed into a verb associated with euthanasia: to *oslerize*. Such a malapropism arose from popular misunderstanding, fanned by a scandal-hungry press, after a farewell address entitled "The Fixed Period," given at Johns Hopkins in 1905, at which Osler commented upon the "energy of youth and the uselessness of old age" (32). At the age himself of 56, he bemoaned the intellectual feebleness of those over 60 and made a facetious reference to a novel by Trollope that proposed forced retirement at age 60 and "a year of contemplation before a peaceful departure by chloroform." The next day, headlines across the Northeast read "Osler endorses euthanasia"—something that he himself denied. Yet the damage was done and even impacted a project at Johns Hopkins to name a building after him, as funds pledged suddenly evaporated. To make matters worse, a new verb then appeared in the lexicon of life: "to oslerize" became associated with euthanasia. Two years later, in the preface to the second edition of *Aequanimitas*, he acknowledged the furor, writing:

> To one who had all his life been devoted to old men, it was not a little distressing to be placarded in a world-wide way as their sworn enemy, and to every man over sixty whose spirit I may have thus unwittingly bruised, I tender my heartfelt regrets (33).

But would Osler countenance euthanasia or assisted suicide? His biographer, Michael Bliss, equivocated on that question but noted that there is no record of Osler suggesting such. Osler's "endorsement" of palliative care dates back to the 1880s when he read Munk's *Euthanasia; or, Medical Treatment in Aid of an Easy Death,* published in 1887, which advocated the judicious use of opium which "induces sleep, indirectly, and in the kindest way, through the relief of pain" (34). Osler deplored suicide as "so often a cowardly and selfish act" but recognized circumstances where it could not be "condemned" (35).

It was never for Osler to condemn, or at least except in the most extraordinary of circumstances. Yet given his reverence for the tradition of history, he would not have been likely to move beyond advocating active palliation of discomfort. In his 1917 Sillman Lecture at Yale, he recited the Oath of Hippocrates *(Table),* which specifically prohibits active euthanasia. He would not turn his back on the wisdom of the ages, both Greek wisdom and the wisdom from his religious upbringing as the son of Anglican missionaries sent to minister to the wild Canadian frontier where he was born. Palliation and comfort care, yes; euthanasia or assisted suicide, unlikely.

The economics of practice

In Osler's day, health insurance remained to be invented, and there was nothing to insulate the financial obligation that

Table. The Oath of Hippocrates*

I swear by Apollo the physician and AEsculapius and Health (Hygieia) and All-Heal (Panacea) and all the gods and goddesses, that, according to my ability and judgment, I will keep this oath and this stipulation—to reckon him who taught me this art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of my art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others. I will follow that system of regimen which, according to my ability and judgement, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous.

I will give no deadly medicine to anyone if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion.

With purity and with holiness I will pass my life and practice my art. (I will not cut persons labouring under the stone, but will leave this to be done by men who are practitioners of this work.)

Into whatsoever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption, and, further, from the abduction of females or males, of freemen and slaves. Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.

While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times! But should I trespass and violate this Oath, may the reverse be my lot! (Adams, II, 779, cf. Littre, IV, 628.)

*From Osler W. *The Evolution of Modern Medicine: A Series of Lectures Delivered at Yale University on the Silliman Foundation in April, 1913.* Ebook available at http://www.gutenberg.org/files/1566/1566-h/1566-h.htm.

patients incurred towards their caregivers. Many hospitals retained charity wards, financed by donations and municipal funding, but medical practice was entirely "fee for service." Osler himself built a successful consultation practice starting in Montreal, which grew lucrative in Philadelphia and even more so in Baltimore. By the time he was in his mid 50s, the demands of both the academic (teaching and textbook writing) as well as private-practice worlds were such that, upon learning that her husband had been offered a position at Oxford, Grace Osler leveled with her husband: "Better to leave Baltimore in a ship than a pine box" (36). Even in Oxford, however, he would continue a restricted fee-for-service practice and later advocated, albeit unsuccessfully, for the continuation of direct patient care income for clinical faculty at Johns Hopkins as a means of encouraging teaching and engaged clinical care, troubled by his perception that fully funded faculty tended to withdraw from the wards into their research labs. Knowing the rigors of private practice, Osler pitied the "40-visit-a-day" practitioner (37). And too, while seeing patients in the ward, Osler's practice was not to bill for hospital services rendered, while his medical colleagues, and especially the surgical faculty, did. Osler's charges for outpatient services were not based on a sliding scale related to the perceived income of his patient either, but he nevertheless defended the practice when some of his patients complained about surgical fees (38).

Even 100 years ago, there were rumblings as to the economics of health care and the best way for it to be financed. For Osler, governmental responsibility pertained to the prevention of infectious diseases through sanitation and clean water supplies. By the second decade of the 20th century, discussions in England and Canada raised the specter of a nationalized health service, something that the then resident of Oxford opposed.

> I really do not think that . . . Canada would ever be likely to have a complete . . . control of the profession. I do not believe it would be good for the profession or good for the public. I think the profession must stand on the individual work of the Doctors (39).

Truly, for Osler, "the laborer was worth the hire" but fee-for-service practice did not automatically bring a collection agency into the picture for unpaid bills. Osler wrote about "good debts" and recognized that "in every department of the profession the amount of unremunerative work is, and ever must be, enormous" (40). Economic enhancement was not the purpose of medicine, he lectured, saying at one point, "No one should approach the temple of science with the soul of a moneychanger" (4).

CONCLUSION

The French have a saying, *plus ca change, plus c'est la meme chose*—the more things change, the more things stay the same. While we may be led to believe by popular culture that we live in the brave new world of the postmodern 21st century, the fact is our hopes and dreams, our vices and virtues, are all replaying themes of humanity. Looking at the past informs us of our current status and helps us establish roadmaps to follow into the wilderness of life. We need not be slaves to the choices and dictums of others, but being cognizant of their wisdom and their lessons learned, perhaps we might not repeat the errors of their ways. Osler wrote much on the new era of what he called "scientific medicine," which he distinguished from both homeopathy and allopathy; he lectured on philosophy and the importance of history to inform the choices of his time. As Bliss noted, Osler didn't talk much about ethics because he and his close colleagues *didn't need to;* they intuitively understood their calling and their limits.

William Osler was not just a great man of his times but speaks to us today in the dilemmas that we face about a way of practice and life. Despite having no modern diagnostics and relying only upon his eyes, his stethoscope, and a microscope, his approach to diagnosis and of dealing with patients remains fresh and energizing to anyone who would open his volumes and read his writings. Living within the transition years that gave way to a new order of the ethical hierarchy, he certainly reflects more the paternalism of the day, but there is no one who has undergone the scrutiny of years without blemish as has Sir William. Osler keenly recognized that much of the practical aspects of what he taught would be overthrown within a decade, but the way he practiced and lived and the practice

of "virtue ethics" remains undiminished. To understand what Osler has to say to us today, 100 years later, is to listen to his own "way of life":

> I have three personal ideals. One, to do the day's work well and not to bother about tomorrow. . . . The second has been to act the Golden Rule, as far as in my lay, towards my professional brethren and towards the patients committed to my care . . . and the 3rd has been to cultivate such a measure of equanimity as would enable me to bear success with humility, the affection of my friends without pride, and to be ready when the day of sorrow and grief came to meet it with the courage befitting a man (41).

Osler wrote his own epitaph, "that I taught medical students in the ward" (42). He can still teach us today.

Acknowledgments

I want to personally thank Dr. Marvin Stone, for his many helpful suggestions at the start of my journey to study the ethical dimensions of Dr. Osler's life and teachings, and Dr. Michael Emmett, chief of medicine at Baylor University Medical Center at Dallas for his decades-long demonstration that Oslerian practice is still alive and well, 100 years later. My gratefulness is also extended to Cynthia Orticio for her editorial skill in working with this manuscript.

1. Medscape. *Physicians' top 20 ethical dilemmas.* Available at http://www.medscape.com/features/slideshow/public/ethical-dilemmas.
2. Beauchamp TL, Childress JE. *Principles of Biomedical Ethics,* 5th ed. Oxford, UK: Oxford University Press, 2001.
3. Jonsen A. *The New Medicine and the Old Ethics.* Cambridge, MA: Harvard University Press, 1990:67.
4. Golden RL. William Osler at 150: an overview of a life. *JAMA* 1999;282(23): 2252–2258.
5. Osler W. Teacher and student (1892). In *Aequanimitas with Other Addresses to Medical Students, Nurses and Practitioners of Medicine.* Philadelphia: P. Blakiston's Son & Co., 1904: 42.
6. Osler W. The master word in medicine. In *Aequanimitas with Other Addresses to Medical Students, Nurses and Practitioners of Medicine.* Philadelphia: P. Blakiston's Son & Co., 1904: 388.
7. Cushing H. *The Life of Sir William Osler,* vol. 1. Hamburg, Germany: Severis, 2010 (originally published 1940): 529.
8. Cushing, vol. 1, p. 205.
9. Bliss M. *William Osler: A Life in Medicine.* Oxford, UK: Oxford University Press, 1999: 229.
10. Pratt J. *A Year with Osler 1896–1897.* Baltimore: Johns Hopkins Press, 1941: vi.
11. Christian H. Osler: Recollections of an undergraduate medical student at Johns Hopkins. *Arch Intern Med* 1949;84:77–83.
12. Osler W. Aequanimitas. In *Aequanimitas with Other Addresses to Medical Students, Nurses and Practitioners of Medicine.* Philadelphia: P. Blakiston's Son & Co., 1904.
13. Bliss, p. 104.
14. Bliss, p. 114.
15. Wright JR Jr. Sins of our fathers: two of the Four Doctors and their roles in the development of techniques to permit covert autopsies. *Arch Pathol Lab Med* 2009;133(12):1969–1974.
16. Osler W. Letters to my house physicians (1890). In McGovern JP, Roland CG, eds. *The Collected Essays of Sir William Osler*. Birmingham, AL: Classics of Medicine Library, 1985.
17. Quoted in Cushing, vol. 1, p. 685.
18. Osler W. The evolution of the idea of experiment in medicine. In *Transactions of the Congress of American Physicians and Surgeons, Seventh Triennial Session.* New Haven, CT: Congress of American Physicians and Surgeons, 1907: 1–8.
19. Osler W. The student life. A farewell address to Canadian and American medical students. *The Medical News* 1905(September 30);87(14):625–633.
20. Osler W. *Lectures on Angina Pectoris and Allied States.* New York: D. Appleton and Company, 1897. Available at http://mcgovern.library.tmc.edu/data/www/html/people/osler/AP/P000a.htm.
21. Bliss, p. 139.
22. Bliss, p. 87.
23. Sokol DK. William Osler and the jubjub of ethics; or how to teach medical ethics in the 21st century. *J R Soc Med* 2007;100(12):544–546.
24. Pratt, p. vii.
25. Osler W, Bates DG, Bensley EH. The inner history of the Johns Hopkins Hospital. *Johns Hopkins Med J* 1969;125(4):184–194.
26. Reid A. A giver of life. In *Johns Hopkins Alumni Magazine*, *vol. IX, November 1920–June 1921.* Baltimore: Waverly Press, 1923: 313.
27. Osler W. On the educational value of the medical society. *Boston Med Surg J* 1903;148:275–279.
28. Pratt, p. 184.
29. Osler W. The treatment of disease. *Can Lancet* 1909;42:899–912.
30. Bliss, p. 266.
31. Bliss, p. 265.
32. Davidow Hirshbein L. William Osler and the fixed period: conflicting medical and popular ideas about old age. *Arch Intern Med* 2001;161(17):2074–2078.
33. Quoted in Cushing, vol. 1, p. 670.
34. Munk W. *Euthanasia; or, Medical Treatment in Aid of an Easy Death.* London: Longmans, Green and Co, 1887: 73.
35. Bliss, p. 328.
36. Lewis J. *Something Hidden: A Biography of Wilder Penfield.* Halifax, Nova Scotia: Goodread Biography, 1983: 53.
37. Cushing, vol. 1, p. 602.
38. Bliss, p. 277ff.
39. Quoted in Bliss, p. 451.
40. Osler W. Remarks on organization in the profession: made at the opening of the new building of the Nottingham Medical Society. *BMJ* 1911;1:237–239.
41. Osler W. L'Envoi (1905). In *Aequanimitas, with Other Addresses to Medical Students, Nurses and Practitioners of Medicine,* 2nd ed. with three additional addresses. London: H. K. Lewis, 1910: 473.
42. Osler W. The fixed period [lecture delivered at Johns Hopkins, February 22, 1905]. In *Aequanimitas with Other Addresses to Medical Students, Nurses and Practitioners of Medicine,* 2nd ed. with three additional addresses. Philadelphia: P. Blakiston's Son & Co., 1910: 391–411.