The most powerful prescription

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Humanism, as defined by the American Humanist Association, is "a progressive philosophy of life… affirming our ability and responsibility to lead lives of personal fulfillment that aspire to the greater good."[1] In the context of end-of-life medical care, it serves as a non-dogmatic set of values that guides physicians in promoting individual well-being by meeting patient needs in the present moment. It is recognized as an essential component of palliative medical care and emphasizes eliminating religious practices that dehumanize, or detract from, goals and human concerns that are present, tangible, and observable.[2] Prioritizing the evolving needs of patients as they develop allows physicians to embrace humanity, have emotional "presence," and preserve human identity during end-of-life care to the fullest extent. This is an obligation due to every patient by virtue of their own inherent human dignity and therefore transcends the bounds of any single specialty.

While the epistemological definition of humanism considers it to be "nontheistic,"[1] this does not preclude religious patients from receiving care grounded in humanism; the provision of structured spiritual care at the end of life has been shown to improve quality-of-care outcomes and is currently recommended in clinical guidelines.[3–9] A humanistic physician, however, would seek to ensure that religion serves human ends rather than dictate them.[2]

Further, humanism holds that only through curiosity, inquiry, and use of intellect can someone accrue accurate knowledge.[2] In the context of clinical practice, this means a physician must actively seek to understand the

unique narrative and spiritual history that informs their patient's goals, how they define dignity, and how they cope with decline at the end of life. This inquiry-based understanding facilitates a patient-centered approach to care that enables a physician to address their patient's specific and evolving needs. Simply put, knowing the patient is an indispensable component of providing humanistic care.

Accordingly, humanism is not an abstract philosophical stance, but a specialized clinical discipline in end-of-life care that requires attentiveness to the beliefs that mold a patient's goals and their personal understanding of the terminal nature of the human condition. During my second-year obstetrics and gynecologic clerkship rotation, I witnessed a physician, equipped with this deep, personal understanding of her patient, facilitate an end-of-life discussion. In doing so, she skillfully offered an undoubtable sense of fidelity, solidarity, and reassurance, shaping the patient's experience as well as my own understanding of intentional humanism and humanity in end-of-life care.

This story is about a patient named Anne.

Anne was a woman from North Dakota whom I came to know as someone who carried herself with unconquerable optimism and brightness. Weeks before I met her, she began receiving treatment for end stage ovarian cancer. Despite a bare head, cachectic figure, nasogastric tube, and prognosis of terminal cancer, she was either smiling or peacefully sleeping every time I visited her.

Weeks prior to making my acquaintance, Dr. B., the attending on service, Anne, and her family had already undergone multiple discussions about goals of care and the things in life that mattered to her most. Anne had previously made clear to Dr. B. that she did not want to die in an intensive care unit with a tube in her throat. She did not want to be bedridden with broken ribs from chest compressions or to rely on a machine to breathe for her. What she wanted was to maximize the possibility of successful chemotherapy treatment, to be lucid enough to speak with her children when they visited, and, if possible, to return home to North Dakota before the end of her life.

However, during my short tenure on the gynecologic oncology service, and before the proposed treatment plan could be brought to fruition, Anne developed a small bowel obstruction and had been many days without food, now reliant on IV nutrition. Her body was beginning to show the signs of her long battle, and it became clear that a crucial conversation about the goals of her care in this new circumstance was imminent. One afternoon, Dr. B. met with Anne and her husband John. Dr. B. entered the room with calm purpose, pulled a chair to Anne's bedside, and sat at eye level with a hand on the bed; signaling with her posture alone that this conversation would be had with respect, presence, and compassion. She allowed for a moment of quiet and stillness, one that often precedes difficult moments like these. As she began discussing Anne's prognosis, her voice softened. Dr. B. explained, with careful but honest clarity, that Anne's illness was progressing, and she likely had weeks to a short number of months left to live. Anne began crying, but Dr. B. did not look away. After a moment, she asked if Anne was surprised; Anne looked at her lap and whispered, "no." Dr. B. reached for Anne's hand and, with resolution, gently stated, "however you choose to move forward and whatever the outcome, I am still your doctor. I will be here for you, and I will do everything I can to make sure you are cared for and comfortable every step of the way."

That single promise transformed the room. Amidst the reality of a terminal prognosis, Dr. B. offered Anne agency and reassurance that she would not face the end of her life alone. Her words were not just a clinical commitment, but an act of preserving Anne's human dignity, a reflection of her unwavering belief in patient-centered care that honors the person beyond their disease. Still Anne's doctor, Dr. B. now donned a role like Charon, the mythic Greek ferryman, guiding her last days with quiet devotion to her final wishes. Despite the realization that her life was coming to an end, this brought Anne something—something she desperately needed in that moment and something that I still can't fully name—momentarily bringing her back to the warm, familiar smile everyone came to know so well.

Each moment was intentional, skillful, and thoughtfully directed. When Dr. B. asked if Anne was surprised to hear her prognosis, the question wasn't truly for her, it was for her husband. It was Dr. B.'s way of helping John accept the reality ahead, to help him acknowledge the long, hard fight she had endured, and that it was okay to start letting go; and she knew he would only truly hear this through his wife's own words.

The importance of elevating humanity in these moments cannot be overstated or forgotten. Being present at the end of someone's life is allowing oneself to be a human companion, feeling and expressing sadness

alongside them to communicate empathy and connection. By knowing and remaining closely attuned to her patient, Dr. B. grounded her practice in humanism, offering genuine emotional presence that enabled her to respond to the specific and evolving needs of her patient. With her words, silence, demeanor, and action, Dr. B. proved to a dying patient that she was with her as both a clinician and fellow human being. Doing so, she demonstrated that the most powerful medicine that can be offered is sometimes not found in a prescription or procedure, but in our presence, honesty, and humanity.

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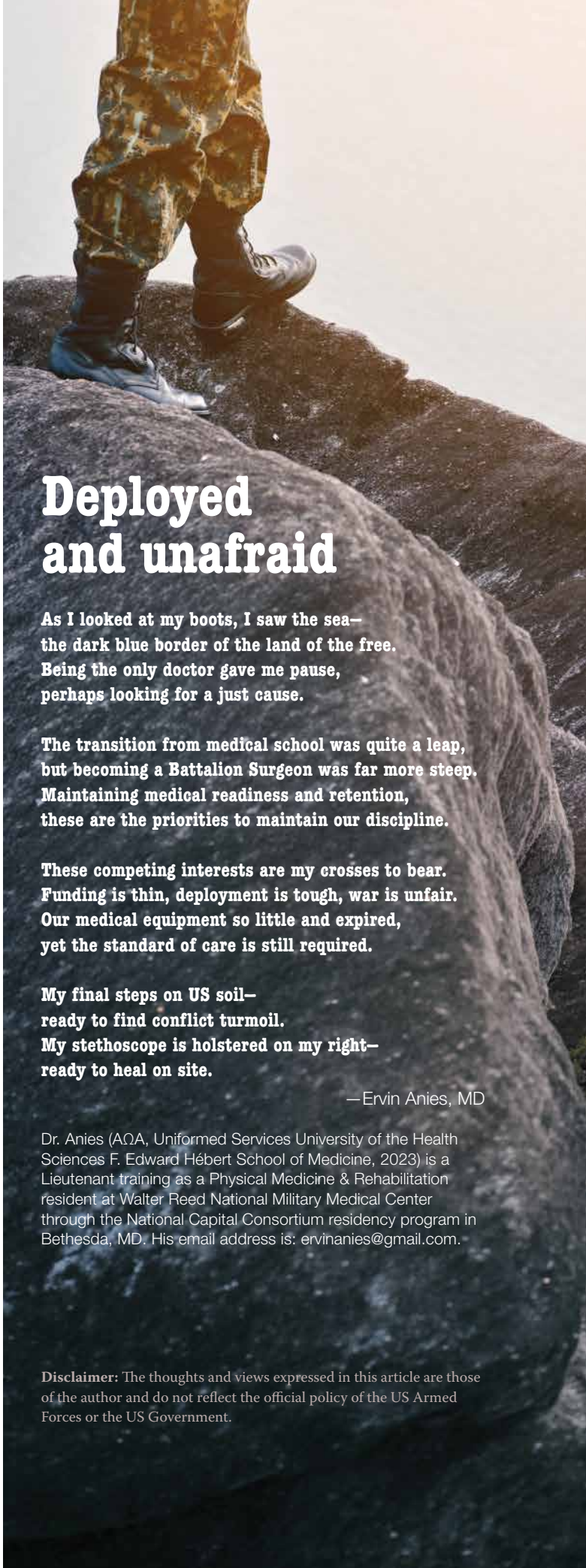

Deployed and unafraid

As I looked at my boots, I saw the sea—
the dark blue border of the land of the free.
Being the only doctor gave me pause,
perhaps looking for a just cause.

The transition from medical school was quite a leap,
but becoming a Battalion Surgeon was far more steep.
Maintaining medical readiness and retention,
these are the priorities to maintain our discipline.

These competing interests are my crosses to bear.
Funding is thin, deployment is tough, war is unfair.
Our medical equipment so little and expired,
yet the standard of care is still required.

My final steps on US soil—
ready to find conflict turmoil.
My stethoscope is holstered on my right—
ready to heal on site.

—Ervin Anies, MD

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