In the Tradition of William Osler

a new biohumanistic model of psychiatry

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ABSTRACT William Osler (1849–1919) is often considered the most influential physician in the emergence of science-based medicine. However, his approach to clinical medicine tends to be misunderstood, and its relevance to psychiatry has not been explored systematically. Osler's approach to the patient had four components: biological reductionism about disease, a scientific approach to clinical diagnosis, therapeutic conservatism, and a humanistic approach to the person. These concepts conflict with the pragmatic, eclectic, anti-reductionistic assumptions of contemporary psychiatry, as codified in its interpretation of a "biopsychosocial" model. This model leads to unscientific practice, with excessive use of medications given for symptoms, and inattention to identifying and treating diseases. This article suggests that implementing Osler's philosophy of medicine in psychiatry would greatly benefit the latter. It would inaugurate a new "biohumanistic" approach to psychiatry.

William Osler (1849–1919) was the best-known physician in the English-speaking world during his lifetime, and even in 2016 was voted "the

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most influential physician in history" in a poll of North American physicians, with Hippocrates as runner up (Rourke and Ellis 2016). However, his approach to the patient is often misunderstood. His emphasis on clinical bedside medicine and his emphasis on the humanities are sometimes seen as being in tension with modern technology (Barondess 2002).

The implications of Osler's approach to the patient and his philosophy of medicine for psychiatry have not been explored systematically. The only prior paper on this topic, from decades ago, emphasized the move in psychiatry towards a more scientific orientation, including biological work, which was seen as part of Osler's approach (McHugh 1987). This perspective is certainly correct, but it does not sufficiently bring out Osler's full philosophy of medical practice and how it can inform progress in psychiatry. Here, I will delineate how Osler's philosophy of medicine and his views of the psychiatry of his era might revolutionize the practice of psychiatry through a "biohumanistic" approach as opposed to the biopsychosocial approach now in vogue (see Table 1).

Osler's Philosophy of Medicine

Osler's philosophy of medicine was not, as many assume, simply about careful clinical diagnosis. It had four major components, some of which are not appreciated by those who are acquainted with Osler superficially. These were: biological reductionism about disease, a scientific approach to clinical diagnosis, therapeutic conservatism, and a humanistic approach to the person.

Biological reductionism undergirded Osler's approach to disease. Fundamentally, he was an anatomic pathologist in the tradition traceable to Giovanni Battista Morgagni (1682–1771), who believed that disease correlates with demonstrable abnormalities in tissues and organs. It was to this end that Osler conducted about one thousand autopsies in Montreal (1874–1884) and Philadelphia (1884–1889).

Table 1 *Osler's philosophy of medicine contrasted with modern psychiatry*

	Osler	*Modern psychiatry*
Philosophy of medicine	Disease-based, biologically reductionistic	Symptom-based, postmodernistically eclectic
Diagnosis	Clinical, solely based on scientific data	Clinical, based on professional preferences
Treatment	Drug-based, conservative	Drug-based, aggressive; or psychotherapy-based, aggressive
Humanism	Based on literature and poetry, focused on the uniqueness of the person	Based on psychological theory and/or social sciences.

This experience, combined with his broad knowledge of the medical literature, enabled him to write a definitive textbook, The Principles and Practice of Medicine (1892), which spread his fame throughout the English-speaking medical world.

Osler's scientific approach to clinical diagnosis reflected the tradition of Thomas Sydenham (1624–1689), in which syndrome recognition hinged on careful attention to symptoms and signs. Osler resisted "snap" diagnoses. Morbid anatomy and clinical diagnosis constituted a feedback loop, and the patient's history and the physical examination enabled him to suggest the underlying pathology. We must remember that few blood tests were available and that imaging procedures were rudimentary in Osler's time. Autopsies provided a corrective on the accuracy of clinical diagnosis, enabling him to apply the newfound knowledge to the next patient. Osler's fascination with the clinical correlates of postmortem findings helped him popularize the clinicopathologic method, the core of today's scientific medicine.

His therapeutic conservatism arose from his concerns for accurate diagnosis combined with skepticism about drugs and other treatments. Here, he took as his model the "numerical method" devised in the 1930s by the Parisian physician Pierre Charles Alexandre Louis (1787–1872) and brought to the United States by Oliver Wendell Holmes (1809–1894) and others. Osler is sometimes called a "therapeutic nihilist," but he was willing to use modalities validated by the new statistical (or evidence-based) approach to therapy.

The role of Osler's humanism becomes more clear once the prior three features of biological reductionism, scientific clinical diagnosis, and therapeutic conservatism are appreciated. Osler's view was that every patient is a person, and thus each person needs to be appreciated as a human being; he made this general point in many oft-quoted ways in a series of celebrated lectures (Osler 1932). "The practice of medicine is an art, based on science," he said clearly (34). Medicine is not merely an art, for it has to have a scientific basis, otherwise it is prone to the many fads and varied opinions that have always been present in human speculation about health and illness. And it is not simply a science, like physics or chemistry, because it deals with fallible human beings (doctors) making judgments about the experiences of other fallible human beings (patients). Medicine is an art, based on science. Too often, in fields like psychiatry, clinicians emphasize the art or the science, or claim to support both but are not really clear about how they do so. Osler provided a structure for such clarity: patients may have diseases, understood reductionistically and biologically with careful clinical diagnosis and managed conservatively, but they also are persons and thus should be attended to as the unique individual human beings who they are. Many patients don't have diseases, but come to clinical attention for some kind of non-biological suffering, and they too need to be attended to as human beings who suffer for psychological or other reasons.

Osler famously turned to literature and poetry and the Bible as sources for understanding each patient as a human being. He wrote:

> On account of the intimate nature of his work, the medical man, perhaps more than any man, needs that higher education of which Plato speaks, "that education in virtue from youth upwards." . . . Start at once a bed-side library, and spend the last half hour of the day in communion with the saints of humanity. There are great lessons to be learned from Job and David, from Isaiah and St. Paul. Taught by Shakespeare you may take your intellectual and moral measure with singular precision. Learn to love Epictetus and Marcus Aurelius. . . . [Plato is] the master through whom alone we can think in certain levels. . . . Montaigne will teach you moderation in all things. (Osler 1932, 366–67)

Here is the relevance of the humanities half of the medical humanism of Osler. Yet this humanism lived in accord with his biological reductionism, not in opposition to it. This point is important, because many proponents of humanism, especially in psychiatry and psychology, are explicitly critical of biological approaches to mental illness (Frisch 2021; Kallivayalil 2020). Further, they take it for granted that reductionism is simple-minded and false, as well as inhumane.

In fact, it could be argued that it is inhumane to be anti-reductionistic when a mental illness is caused by a purely biological process, as in the case of schizophrenia and manic-depressive illness, which are completely genetic in etiology based on scientifically rigorous research such as twin studies (Bienvenu, Davydow, and Kendler 2011). Further, in manic-depressive illness, treatments exist, like lithium, that are highly effective in some people, resulting in almost complete eradication of any mood episodes and a normal life that can last decades in good responders (Goodwin and Jamison 2007). It would be inhumane to refuse to give lithium to such patients and instead give them a "humanistic" non-biological treatment, like "psychodynamic" psychotherapy or "existential-humanistic" psychotherapy. Such treatments by themselves, without effective medications like lithium, are ineffective in manic-depressive illness in general, dooming patients to repeated mood episodes in almost all cases (Picardi and Gaetano 2014). So a biologically reductionistic approach can be humanistic, and an apparently humanistic approach, inappropriately applied, can be anti-humanistic. Osler's biologically reductionistic humanism is not well understood among proponents of "humanism."

Osler's View of Psychiatry

Osler was the first Chair of Medicine at John Hopkins, from 1889 to 1905 (Bryan 2020). He left three years before the arrival of the first professor of psychiatry, Adolf Meyer, who would go on for four decades in that role and would train many highly prominent leaders of 20th-century American psychiatry. Meyer's personal influence was huge, and his approach to psychiatry, which he called

"psychobiology," would form the core basis for the basic concepts of American psychiatry. It remains so to this day, with the "biopsychosocial model" of medicine and psychiatry being highly indebted to Meyer (Ghaemi 2010).

Meyer's thinking differed from Osler, though. Meyer was highly influenced by the pragmatism school of American philosophy. Before coming to Johns Hopkins, Meyer had engaged in weekly lunches in New York with the key living philosopher of American pragmatism, John Dewey. While Meyer was Swiss and had trained in the classic European tradition of psychiatry, he created a hybrid that was more American than European, more pragmatic than classical, and more practical than scientific (Ghaemi 2010). In contrast, Osler, of Canadian origin, was molded by the European tradition and had moved to Oxford before Meyer arrived in Baltimore. In short, although Osler impacted American psychiatry at Johns Hopkins, the influence of that psychiatric school did not follow Osler's own philosophy of medicine.

In his own practice, Osler was of course famous for his bedside manner. Although a close disciple reports never hearing talk of "psychotherapy," Osler's last 1912 revision of his classic medical textbook changed the title of a section called "Faith Healing" to "Psychotherapy" (Bliss 2007). Psychotherapy had begun to be seen as a treatment in the last decade of Osler's life, when he was at Oxford. Osler knew Sigmund Freud personally from Freud's earlier years of neurological research; they had corresponded about cerebral palsy. Osler's extensive medical library included Freud's first book, the 1900 classic *Interpretation of Dreams,* but no other later works. Apparently, Osler recorded his own dreams after reading the book (Bliss 2007). Osler is reported to be somewhat skeptical about Freud's theories about the sexual origins of hysteria, but such ambivalence was common in that era. Still, it is notable that Osler was open-minded enough to refer at least one patient to Freud in 1911 (Bryan 2020). The clinical details and outcomes of that case appear to be unknown.

Among leaders in the field, Osler was closest to Silas Weir Mitchell (Cushing 1940), who is thought of mainly as a neurologist, but who created the concept of "neurasthenia" and his treatment of the "rest cure," both highly popular perspectives before the rise of Freud.

Osler never wrote or taught about the details of psychiatric diagnosis. His classic 1912 medical textbook had a penultimate section on "Diseases of the Nervous System," which included a section on "General and Functional Diseases" (Osler 1912). There Osler wrote about epilepsy, migraine, choreas, neuralgias, "occupational neuroses," "hysteria," "neurasthenia," and "traumatic neuroses." The 10 pages on hysteria are rather detailed and include a neutral discussion of Freud's theory of sexual origin; the recommended treatment is "psychotherapy," which includes hypnosis, suggestion, and reeducation methods, followed by a full-page of description of Freud's theory of unconscious causation and dream interpretation. Osler describes Freudian ideas without any interpretation, or any stated

preference for or against them. In the course of describing the psychotherapies, Osler shows his awareness of the importance of the human relationship: referring to the various methods, including adding massage or hydrotherapy, he comments that they depend "upon the tact, patience, and above all, the personality of the physician; the man counts more than the method" (1105). Some psychotherapy studies indeed find that the "therapeutic alliance," the relationship between the clinician and the patient, is the strongest predictor of treatment response, as opposed to the specific type of therapy employed (Fluckiger et al. 2018).

Osler does not discuss dementia praecox (schizophrenia) or manic-depressive insanity, which had been defined by Emil Kraepelin about a decade earlier (Kraepelin 1921). Osler's library did not include the works of Kraepelin or other classic 19th-century thinkers in psychiatric diagnosis, like the French school of Philippe Pinel. However, Osler studied earlier works on melancholy, such as the classic work of Robert Burton (Bliss 2007). That literature was more humanistic than clinical.

Osler's last visit to Baltimore in 1913 was on the occasion of the opening of the Henry Phipps Psychiatric Clinic there, the first American psychiatric inpatient unit in an academic general hospital. He spoke little of psychiatry proper, but emphasized two points in his address. He was jubilant to see all of medicine, even psychiatry, becoming more scientific: he reveled in his generation's participation in "a new birth of science . . . remodeled hospitals, a new outlook for humanity" (Bryan 2020, 745–46). One may infer that he hoped psychiatry too would become more scientific, just as medicine in general. And yet, at the same time, he noted that mental illnesses were very common and apparently increasing. He took the long view: from the standpoint of human nature, we were little different in the 20th century from ancient Greece and Rome. We were still in the childhood of civilization, and despite the advances of science, most people hardly understood it, and still relied on beliefs that were prescientific. Such beliefs originally involved magic and superstition, and over centuries had been overlayed with religious apparel: "In the childhood of the world, we cannot expect people yet to put aside childish things."

A year later, Osler's concern would ring true, as the advances of science were put to brutal use in the deadliest war in human history to date. The Great War was the last great event in Osler's life, a tragedy that included the loss of his only child and perhaps also the loss of his intellectual optimism about the progress of humanity: "We were foolish enough to think that where Christianity had failed Science might succeed," he said during a wartime talk (Bliss 2007, 418). The inference for Osler's view of psychiatry may be that he wished to see psychiatry becoming more scientific in its diagnoses and treatments, but he was concerned that most human beings would remain unscientific in their understanding of their psychological states of mind.

Osler's Relevance to Modern Psychiatry

Once Osler's philosophy of medicine is appreciated, it can be understood why he stood in an ambivalent relationship to the psychiatry of his day, and why his relevance to modern psychiatry is revolutionary in nature.

In Osler's era, a scientific approach to clinical diagnosis had only just begun in the work of Kraepelin, and it was immediately superseded soon after Osler's death in 1920 by the rise of Freudian ideology. Psychological speculation replaced clinical observation, the antithesis of where modern scientific medicine was going under Osler's inspiration. Statistical testing of treatment was rejected by Freudian psychiatry in the mid-20th century, another deviation from Osler's approach. And treatment at that time was hardly conservative: everyone got psychoanalysis for whatever they had. The biological approach to psychiatry was not better: therapeutic activism reigned there too, with the widespread use of frontal lobotomy midcentury, followed by excessive use of electroconvulsive treatment (ECT). One of Osler's last students, Wilder Penfield, who would later become a famed neurosurgeon, famously said to the main advocate of frontal lobotomy, neurologist Walter Freeman, "Walter, don't you realize you're doing a very dangerous thing?" (Lewis 1981, 213) The old biological therapeutic extremism has been followed in the last few decades with a similarly activistic rise in the use of psychiatric drugs (Shorter 2021).

Psychopharmacology in current psychiatry is practiced in a manner completely opposed to the Hippocratic origins of Osler's approach: drugs are given for symptoms, not diseases—a direct contradiction of Hippocrates and Osler (Ghaemi 2008, 2022). It may be asked how current extensive use of psychiatric drugs can be seen as harmful, especially in contrast with prior interventions like lobotomy. Psychiatric drugs obviously have harms, like all drugs. In the tradition of Oliver Wendell Holmes (1883), derived from Hippocrates, long-term symptomatic use of drugs tends to produce more harm than good, and long-term harms often are additive, while short-term symptomatic benefits often decline with time (with tolerance, withdrawal syndromes, or mild but limited benefit). For example, serotonin reuptake inhibitors (SRIs), widely prescribed and commonly assumed to be benign, clearly cause a serious withdrawal syndrome in long-term use, associated with suicidality (Khan et al. 2023). Most psychiatric drugs are studied short-term, meaning for months, but not much long-term, with the longest randomized trials of SRIs being only one to two years in duration. Hence long-term harms are mostly unstudied and certainly cannot be presumed to be absent.

Other risks that may exist but are widely ignored include observational evidence that SRIs may be associated with carcinogenicity in humans (Cosgrove et al. 2011); there are clear animal data that many SRIs are biologically carcinogenic at clinically relevant doses (Amerio et al. 2015). Assumptions that these agents are safe based on lack of obvious associations in clinical practice should be tempered by the experience with estrogen hormone replacement, as long-term

observational beliefs about safety were shown to be false in a large randomized trial proving carcinogenicity (Vandenbroucke 2009).

Other known SRI harms could be added: osteoperosis and increase fall risks in older persons, decreased clotting with bleeding risks, cardiac arrhythmia, and worsening of sleep architecture (Chen et al. 2023; Holshoe 2009; Laporte et al. 2017; Sterke et al. 2012; Zhou et al. 2018). These harms do not include the highly prevalent known side effect of sexual impairment, and other standard problems such as drug interactions.

Another brief example involves amphetamines, widely used for purported attention deficit disorder in children and adults, and widely claimed to be "safe." These agents clearly are neurotoxic in numerous replicated animal studies, causing neuronal atrophy and cell death (Vergne et al. 2011). Adequate human studies have not assessed this neuronal risk, with no randomized trials assessing this harm. Amphetamines also increase the risk of cardiac arrhythmias, with one report finding a doubled risk of sudden death in middle-aged adults (Schelleman et al. 2012).

Both SRIs and amphetamines have symptomatic benefits only and have not been shown to have disease-modifying effects on an underlying disease (Ghaemi 2022). If this is correct, then the long-term use of these drugs symptomatically, as is current psychiatric practice, goes completely against Osler's philosophy of medicine, and, by extension, the Hippocratic tradition.

Of course attention can be given to the role of the pharmaceutical industry in encouraging and promoting overuse of medications (Shorter 2021). But the pharmaceutical industry does not exist in a vacuum. The pillars of mainstream psychiatry—the "biopsychosocial" approach and the DSM system—also enable misuse and overuse of medications because of their basic conceptual assumptions.

In short, as most of medicine has become more and more Oslerian—in other words, scientifically based with a grounding of clinical diagnosis in biological pathology—psychiatry has gone in the opposite direction. First it was overtly anti-biological in its adherence to Freudian ideology. Then it pretended to be scientific by using drugs and referring to biology, but it did so in a symptom-based manner, not with careful detection of diseases of the body (Shorter 1997).

Readers might wonder whether in recent decades psychiatry has become more scientific, given its use of an operationalized diagnostic system with specific criteria for almost 400 "disorders," the *Diagnostic and Statistical Manual* (DSM), now in its fifth edition (DSM-5) (APA 2013). As described elsewhere, the rise of the DSM system in the 1970s, heralded by the radical changes of the third edition (DSM-III), was not based primarily on scientific research (Decker 2013). Most DSM-III definitions were based on clinical opinion, without any empirical scientific research to support the validity of the diagnoses given. The leaders of DSM-III admitted this point, arguing that they were establishing "reliability," or agreed-upon definitions, like a dictionary. They did not claim "validity," the correctness of those definitions. They held that future research could change the

diagnoses and lead to greater validity, but the vast majority of definitions in DSM-5, four decades after DSM-III, are the same (Ghaemi 2014a). Little progress has been made in validity because the DSM revision process has become explicitly a "social construction," where definitions are given that are professionally preferred, for economic, legal, or other reasons (Ghaemi 2014b). Some DSM leaders have admitted that research data are not the sole or main source of decision-making for DSM diagnoses, and the National Institute of Mental Health (NIMH) has stated that DSM diagnoses are not sound for scientific research (Ghaemi 2018).

In short, modern psychiatry completely depends on a diagnostic system that is not primarily research based, and not scientifically proven. This approach to clinical diagnosis is the exact opposite of Osler's emphasis on a scientific clinical diagnostic structure. And another important difference between medicine and psychiatry is the role of the pathological autopsy. Brain abnormalities have not been found to correlate well with clinical diagnoses, whether before DSM-III or since, and laboratory tests have been notoriously unsuccessful as well (Shorter and Fink 2010).

Nonetheless, modern psychiatry could be said to be in the position of modern medicine when Osler entered the profession in the mid-19th century (Havens et al. 2001), and that situation is exactly the scenario where Osler's methods could prove useful. It all begins and ends with honest clinical diagnosis based purely on our best clinical observations. Such diagnosis cannot include economic considerations, like what definitions would lead to more or less insurance reimbursement, as has been the case in DSM discussions of depression (Ghaemi 2013); it cannot include legal considerations, like which definitions would lead to more or fewer lawsuits, as in DSM discussions of trauma (Decker 2013); and it cannot include which diagnoses are more popular among clinicians, as has been the case with DSM debates about personality disorders (Zachar, Regier, and Kendler 2019).

In sum, psychiatry needs to replace DSM with a new Oslerian textbook of diagnosis, purely based on clinical science. At the same time, therapeutic conservatism should reign, with many drugs given much less frequently and for shorter durations, when used for symptoms or for diagnoses whose validity is poorly proven. In contrast, certain drugs, like lithium, should be used more frequently and for longer duration, given their proven efficacy for manic-depressive illness, meaning both bipolar illness and unipolar depression (Barroilhet and Ghaemi 2020).

These judgments are strictly Oslerian. They are based on asking two central questions: how well established are the diagnoses based on clinical research, and how well established are the treatments based on statistical proof of efficacy? Nothing else matters: not whether the diagnoses are in DSM, nor whether they are popular with clinicians or patients, nor whether the treatments are popular with clinicians or patients.

Another aspect in which modern psychiatry differs from Osler is in psychiatry's advocacy of the "biopsychosocial" (BPS) model. This theory is derived from

Adolf Meyer's "psychobiology," and in its main version, it holds that all illness is partly biological, partly psychological, and partly social. It directly and clearly rejects biological reductionism, and thus contradicts Osler's basic philosophy of disease. It can be shown that the biopsychosocial model, so defined, is false scientifically, since many illnesses are purely biological in causation. This claim of scientific falsehood is not made dismissively or loosely. Many proponents of the BPS model, including G. L. Engel in his oft-cited 1977 paper on the topic, claim that "all" or "almost all" illnesses, medical or psychiatric, are multifactorial in etiology, meaning they have biological, psychological, and social causes in equal measure, or in various combinations. Engel applied this concept to his field of gastrointestinal expertise, especially for ulcerative colitis. Others routinely claim it for standard psychiatric clinical pictures, like "depression" or "anxiety" or their DSM equivalent rephrasing, terms which are equivalent to "fever" in medicine and thus sufficiently vague and general to support such multifactorial etiology (Gabbard and Kay 2001; Kendler 2012; Uher and Zwicker 2017). The claim of multifactorial etiology is obviously false in medicine, and less obviously false in psychiatry too.

In medicine, one can pick any autosomal genetic disease as a counterexample, like trisomy 21, which is 100% biologically caused. It is important to distinguish claims about etiology versus pathogenesis or treatment, given that the three are commonly conflated. It may be said that one could take "a more holistic approach": trisomy 21 could have psychological and social aspects that need to be addressed if we were to see patients as individual human beings. But this claim has nothing to do with etiology; it is about pathogenesis and treatment. One of the hallmarks of the vagueness of the BPS model is that it flips from one aspect to another to defend itself. On the issue of etiology alone, the claims about multifactorial nature of "all" medical illnesses is disproven empirically, and thus scientifically false.

In psychiatry, the claim also is false, despite prominent and repeated support for the multifactorial model. Genetic twin studies show that schizophrenia and bipolar illness are almost completely genetic, with no notable environmental causation (Bienvenu, Davydow, and Kendler 2011). There is no "psychosocial" aspect to their etiology, although such factors can influence their later clinical features or interventions.

I have critiqued the BPS model in detail elsewhere (Ghaemi 2010). My key claim here is that a central feature of the BPS model is its eclectic and postmodernist basic conceptual assumptions. The advocates of the BPS model tend to view psychiatric conditions as social constructions, which are relativistic, not as natural disease-entities. Further, the BPS model presented as a general theory does not provide research based or conceptually coherent guidance on when and where each of its three components are more or less relevant, nor does it define whether such relevance applies to disease causation, pathogenesis, or treatment.

An alternative biohumanistic model, as advocated below, would provide such coherent guidance based on research. For instance, since schizophrenia and manic-depressive illness are completely genetic in etiology, the biohumanistic model would reject any claim to try to provide psychological or social theories for their causation, such as the classic postmodernist claim, exemplified by Foucault and his followers, that psychosis is a social construction based on ideas that Enlightenment society rejects as irrational (Foucault 1965; Laing 1967). It would apply also to demonstrably false claims about family structures causing these illness—for example, blaming the parents—which is still quite common in child psychiatry (Kelleher and Hoagwood 2015; Larson and Corrigan 2008). The BPS model has no way to reject such false claims due to its absolute rejection of biological reductionism.

More specific debate on the BPS model would require a separate lengthy discussion, but the main point to be made here is that it is not definitively proven as sound scientifically or conceptually, and there are many reasons to question it. This point is important in relation to the question of humanism, since many advocates of the BPS approach in the mental health professions appear to think that it is necessary and sufficient for the goal of being humanistic with patients (Gabbard and Kay 2001). As discussed below, these advocates show an absence of understanding that being humanistic is not the same thing as advocating certain psychological or social theories about mental illness.

This matter can be clarified by discussing Osler's medical humanism. The modern psychiatric literature infrequently refers to the humanities, such as literature and poetry. Most apparently humanistic discussions involve theorization in psychology or the social sciences, such as post-Freudian theories about adult development or family dynamics, or social epidemiological theories about the impact of poverty or social isolation on mental illness (Compton and Shim 2015; Erikson 1950; Phillips 1989). While this nonbiological work is important, it is not the humanities. It is not about the struggles of each individual human being to find meaning in life, to face adversity and disease, to experience uncertainty and loss, to face mortality. Patients come to psychiatric clinicians and they may receive drugs, or "psychodynamic" psychotherapy, or cognitive-behavioral therapy, but they often leave those treatments not having been seen as a single human being with wants and fears and losses. There is a tradition in psychiatry and psychology that seeks to meet that need, the "existential-humanistic" approach (van Deurzen et al. 2019). However, most "existential-humanistic" psychologists and psychiatrists are explicitly anti-biological: they fully reject biological reductionism of any kind and tend to oppose even milder biological attitudes in relation to mental states. They are humanistic at the expense of biology, while many other psychiatrists are biological or even psychological without being humanistic. Neither live up to the standards of Osler's vision of medical humanism.

A solution would be to inaugurate a new "biohumanistic" approach to psychiatry, applying Osler's medical humanism, based on biological reductionism which contrasts with the BPS model, to psychiatric conditions (Ghaemi 2010). Some of those conditions, like schizophrenia and manic-depressive illness, would be seen to be biological diseases of the brain, and would be diagnosed and treated with drugs based on clinical and statistical research. Other psychiatric conditions, just as with many medical presentations of suffering, would be found not to be based on a biological disease of the brain or body. Some could be a result of psychological trauma alone, others could have social roots such as childhood abuse or poverty, and still others could be common existential crises, such as adolescence and the mid-life crisis. In those cases, the various psychotherapies, rather than drugs, would be central treatments, at least in the clinical setting. Obviously social interventions also would be warranted, especially for prevention or in the case social determinants of health like poverty and sexual trauma (Marmot and Bell 2016; Marmot and Wilkinson 2006). In all cases, whether biological diseases were present or not, all patients would be seen as individual human beings, appreciated in their uniqueness.

This would be modern psychiatry in the spirit of William Osler. It would be a revolution in the profession. And it would finally bring psychiatry back in line with the evolution of modern scientific medicine, a goal often claimed but not achieved, partly because the psychiatric profession has not comprehended the nature of modern scientific medicine. A study of the tradition of Osler can provide that understanding.

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