Medical and Clinical Spectrum

Research Article

Trust Before Knowing, Humility After: A Hasidic Framework for Diagnostic Error, Burnout, and Therapeutic Restraint

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Received: 2026 Oct 20

Accepted: 2026 Oct 24

Published: 2026 Oct 29

Citation: Julian Ungar-Sargon. Trust Before Knowing, Humility After: A Hasidic Framework for Diagnostic Error, Burnout, and Therapeutic Restraint. *Med Clin Spectr*. 2026; 1(1), 01-06.

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Abstract

A single typed page from a manuscript argues that knowledge is safe only when it is enclosed by two forms of trust: a faith that precedes knowing and a deeper faith that follows it. Written as a Hasidic homily on the Noah narrative, the discourse describes the epistemic and moral structure of the clinical encounter with unusual precision. Drawing on fifty years of neurological practice, I read it alongside the literature on diagnostic error, physician burnout, defensive medicine, dementia care, prognostic communication, and therapeutic restraint. I argue that its three-part structure (trust before knowledge, rigorous knowledge, humility after knowledge) gives clinicians a vocabulary for failures our technical language can name but not repair premature closure, depersonalization, defensive practice, reductionism, and the inability to stop. I close with concrete implications for clinical teaching and answer three objections, including the charge that religious language has no place in clinical reasoning.

Keywords: Clinical Epistemology; Diagnostic Error; Premature Closure; Physician Burnout; Depersonalization; Prognostic Communication; Therapeutic Restraint; Dementia; Medical Humanities; Hasidism; Humility

1. Introduction

The physician most dangerous to patients is rarely the one who knows too little. More often it is the one who knows a great deal and has forgotten what his knowledge stands on and what it must bow to. I reached this conclusion over five decades of neurological practice. I found its clearest statement not in the medical literature but in a homily by a Hasidic master in Milwaukee.

Medicine already has precise names for the failures I mean. The diagnostic error literature speaks of premature closure and anchoring [1–3]. The burnout literature speaks of depersonalization [4,5]. Health policy speaks of defensive medicine and low-value care [6,7]. Palliative care speaks of the difficulty of stopping [8]. These terms name what goes wrong. They say less about the dispositions whose absence they reveal, and less still about how those dispositions are formed.

The discourse examined here supplies that missing account. Its central claim is that knowledge must be enclosed on both sides by trust. There is a trust before knowing, which keeps knowledge from being manufactured. There is a deeper trust after knowing, which keeps knowledge from becoming possession. I do not ask the reader to share the theology in which this claim is expressed. I ask only that we notice how accurately it describes the anatomy of clinical judgment, and what it suggests we do differently.

The essay proceeds in three steps. Section 2 presents the source briefly. Sections 3 to 9 apply its structure to clinical practice, one failure at a time. Sections 10 to 12 draw out implications for teaching, answer objections, and conclude. A working translation of the discourse appears in the Appendix.

2. The source

Reb Yitzchok Yoel Rabinowitz of Linitz–Kontikoziva (1840–1885) belonged to the Chernobyl Hasidic dynasty. He left short discourses (ma'amarim) on the weekly Torah readings. The one examined here survives as a single typed page headed *Ma'amar 7, Parashat Noach.* I work from a photograph of that page; a working translation is given in the Appendix.

The discourse takes as its occasion Genesis 6:9: "Noah was a righteous man, whole in his generations; with God did Noah walk." The Aramaic translation of Onkelos renders the last phrase "in the fear of God." From these words the Rebbe builds a compact theory of knowledge in five moves.

1. Two faiths. *Da'at*, knowledge or understanding, must be enclosed by *emunah*, faith or trust, on both sides. The faith after knowledge he calls ha-yadua asher lo noda, "the known that is not known." It is not ignorance. It is what knowledge discovers at its own limit. A medieval dictum puts it starkly: the purpose of knowledge is that we do not know.

2. Two fears. The first faith yields a lower fear (yirah tata'ah), fear of consequence. The second yields a higher fear (yirah ila'ah), reverence before what cannot be grasped.

3. A sin of sequence. Adam's primordial error was not wanting to know but reaching for the Tree of Knowledge before the Tree of Life, knowledge with nothing beneath it.

4. An antagonist. Amalek, the nation that attacked Israel in the wilderness, is read through Rashi's gloss on Deuteronomy 25:18, "who cooled you on the way." Amalek does not destroy belief. He cools it, and he strikes just after revelation.

5. A structure. The ark's three storeys (Gen. 6:16), the festival sequence of Passover, Pentecost and Tabernacles, and the doubled name "Noah, Noah" read as two Sabbaths of rest, all encode the same order: faith, knowledge, faith.

The Rebbe seals the argument with *gematria*, the traditional reading of the numerical values of Hebrew letters.

In the discourse, "faith" does not mean assent to doctrine. It means a stance of trust and reverence toward a reality that can be approached but never exhausted. Every clinician meets such a reality daily, in the form of another person.

3. The three storeys of the clinical encounter

Every clinical encounter, done well, has the three storeys of Noah's ark. Most clinical failures I have witnessed, my own among them, were failures to build one of them.

	Lower storey: faith before	Middle storey: knowledge	Upper storey: faith after
Clinical task	History; listening	Examination, localization, investigation, diagnosis	Prognosis, treatment choice, accompaniment
Virtue	Disciplined trust in the patient's account	Rigor	Humility; reverence for the person
Characteristic failure	Manufactured knowledge: leading questions, templates, interruption	Evasion: withholding a diagnosis in the name of humility	Closure and possession: the diagnosis taken for the person
Fear	Lower fear: of error and consequence		Higher fear: reverence
Rest	Watchful waiting		Therapeutic restraint

The lower storey: before I know

A patient enters and I do not yet understand what is wrong. What is required first is not knowledge but disciplined trust. I must trust that the patient's account means something, and that it is true in its own way even where it is inaccurate, contradictory, or shaped by fear. The evidence supports the old clinical intuition. Hampton and colleagues found that the history alone led to the final diagnosis in 66 of 80 medical outpatients [9], and Peterson and colleagues later reported a similar proportion [10]. The history is not a preliminary to diagnosis. In most cases it is the diagnosis, offered by someone who does not know he is offering it.

The Rebbe says that faith before knowledge guards experience from being manufactured. Clinically, this warns against knowledge produced by technique rather than received through listening. Beckman and Frankel found that physicians interrupted patients' opening statements after a mean of 18 seconds [11]; Marvel and colleagues, fifteen years later, after 23 seconds [12]. The leading question, the templated review of systems, and the checkboxes of the electronic record shape the answer before it is given. The patient learns quickly which story the physician is prepared to hear and tells that one. The trust of the lower storey is the willingness to hear a story I did not anticipate.

The middle storey: knowledge

Neurology possesses one of the most beautiful forms of knowing in medicine: localization. We ask first where the lesion is, and only then what it is. There is a moment, familiar to every neurologist, when scattered signs converge. An ipsilateral Horner syndrome crossed sensory loss,

hoarseness, and a tendency to fall toward one side stop being a list. They become a place, the lateral medulla, and the lesion declares itself.

The Rebbe places this moment at Pentecost, the festival of revelation, and I will not disparage it. It is what the patient came for. A physician who withholds a diagnosis in the name of humility has not reached the higher faith. He has refused to climb to the middle storey. The discourse is not anti-intellectual, and neither is good medicine. Knowledge must be pursued fully and rigorously.

The upper storey: after I know

The diagnosis is made amyotrophic lateral sclerosis, glioblastoma, Alzheimer disease. Here the discourse makes its most important demand. Having known, I must let my knowing bow.

I know the disease, but I do not know this man's illness. I know the median survival, but not his days. I know the natural history, but not what he will make of it: whom he will forgive, what he will finally say to his daughter, what he will discover he can bear. Cassell argued that suffering is experienced by persons, not bodies, and that a medicine which treats the disease while ignoring the person can relieve the one and deepen the other [13]. The Rebbe's phrase gives Cassell's insight its shape. The person before me is ha-yadua asher lo noda, known and not known. My diagnosis is true, and it does not exhaust him.

The Rebbe links this upper storey to Tabernacles, when one dwells in a hut whose roof must by law let the stars show through. That is the posture I ask of physicians after diagnosis: to remain with the patient under a covering that gives real shelter and makes no pretense of enclosing the sky.

4. Premature closure: Adam's sin of sequence

Premature closure is knowledge reached for before the patient's story has been lived through. The discourse calls this Adam's sin. Adam did not err by wanting to know. He erred by reaching for the Tree of Knowledge before the Tree of Life. Knowledge with nothing beneath it, the Rebbe warns, has nowhere to go but toward mastery.

The diagnostic error literature describes the same error in cognitive terms. Premature closure means accepting a diagnosis before it has been verified and ceasing to consider alternatives once a plausible explanation appears. In Graber and colleagues' analysis of 100 diagnostic errors in internal medicine, it was the single most common cognitive contributor [1]. Croskerry catalogued its relatives: anchoring, confirmation bias, and "search satisficing," which stops looking once something has been found [2]. The National Academies concluded that most people would experience at least one diagnostic error in their lifetime [3].

The discourse adds a moral account of a cognitive phenomenon. Premature closure is a heuristic misfiring under time pressure, but it is also knowledge that has outrun the trust that should have preceded it. The anchored physician stops listening because he believes he no longer needs to. The debiasing strategies we teach, such as forced consideration of alternatives and the diagnostic time-out, are attempts to rebuild the lower storey after the fact. They work better when the storey was built in the first place.

A subtler form of the same sin is now common: the scan ordered before the hands have touched the patient. Imaging is knowledge, often superb knowledge, and I would not practice without it. But the examination is a walking-with, and the scan does not walk. When imaging precedes history and examination, it produces knowledge without context. Incidental findings are common on brain MRI in the general population [14], and each demands further knowledge, until the patient becomes the site of an investigation rather than the subject of an encounter. A generation that learns the brain first from images risks putting the Tree of Knowledge before the Tree of Life. This is a warning about sequence, not an argument against technology. The MRI belongs on the middle storey. It cannot serve as the ground floor.

5. Depersonalization and the cooling of competence

Depersonalization is not ignorance. It is certainty that has gone cold. The discourse names this cooling Amalek, and two details of its reading are clinically exact.

First, Amalek attacks on the way, in the middle of the journey. He does not attack medical students. The student and the young resident are still warm with fear and wonder. The danger comes in the second decade, when the physician has seen five hundred patients with Parkinson disease and the five hundred and first becomes "another Parkinson's." Second, Amalek attacks right after the miracle. Medicine has its miracles. A thrombectomy can reverse a dense hemiplegia within hours. A child with refractory epilepsy can reach a first seizure-free year. A myasthenic crisis can lift. Amalek comes then, in the shrug that follows: "Yes, that works."

Maslach's account of burnout has three dimensions: emotional exhaustion, reduced personal accomplishment, and depersonalization, the tendency to experience patients as objects, cases, or burdens [4]. I know of no better clinical translation of Rashi's "cooled." In a national survey, 45.8% of American physicians reported at least one symptom of burnout [5]. The depersonalized physician often knows a great deal. What he has lost are the two faiths around his knowing: the trust with which he once approached a stranger, and the reverence that should follow even a correct diagnosis.

The Rebbe calls Amalek "head and root of heresy," and his idea of heresy is instructive. Heresy here is not a set of wrong propositions. It is a temperature: the "yes, I know all that" that settles over a person once he has understood. The institutional pressures we rightly blame for burnout, among them documentation burden, productivity metrics, and loss of autonomy, are real. But they exploit a vulnerability that the discourse locates in knowledge itself. Competence left standing alone tends to cool.

The Torah says the war with Amalek continues "from generation to generation" (Ex. 17:16). The defense against

cooling must be handed down, and in medicine that is the work of teaching. When I teach residents to localize, I teach knowledge. When I make them sit down, hear the whole history without interruption, and return the next morning only to ask how the patient slept, I am trying to teach the two faiths on either side of it. These lessons travel through what Hafferty and Franks called the hidden curriculum: values transmitted by example rather than syllabus [15]. The war with Amalek is fought there, generation by generation, or it is lost there.

6. Two fears: defensive medicine and reverence

Defensive medicine is the lower fear operating without the higher. Onkelos insists that Noah walked with God "in fear," and the discourse derives two fears from the two faiths. Fear, it suggests, is the form intimacy takes when it is real.

The lower fear in clinical life is fear of consequence: of missing the subarachnoid hemorrhage behind a "migraine," of the lawsuit, the licensing board, the morning conference. It is not contemptible. It keeps us checking, and many patients owe their lives to it. But it is fear of what might happen to me. Left to itself it produces tests ordered to protect the physician rather than to inform a decision. In Studdert and colleagues' survey of high-risk specialists in Pennsylvania, 93% reported practicing defensive medicine [6].

The higher fear is reverence before the person. For a neurologist it takes a particular form, because I examine the organ of knowing itself. I test orientation, memory, language, praxis, and judgment, the faculties by which a human being knows. That brings a temptation peculiar to my specialty. Because I can localize memory, I may conclude that I have localized the person. Because I can describe the neural correlates of decision, I may conclude that I have explained the one who decides. Reductionism, the conflation of mechanism with person, is the Amalek of neurology: finite understanding made absolute, practiced on the instrument of understanding itself.

Here the discourse's central reversal applies. We expect knowledge to dissolve fear. In the Rebbe's account, knowledge deepens fear and changes its object. The person of the second faith is not less afraid than the person of the first. He is afraid of something larger, and therefore freed from many smaller fears. I have found this true. The more precisely I understand the brain, the more I tremble before the one who uses it, the one who looks back at me from the bed and is at that moment trying to read my face.

The higher fear is also the better protection against error. A physician who stands in reverence before the patient listens more carefully, examines more thoroughly, and doubts his conclusions more honestly than one driven by fear of litigation alone. The higher fear does not abolish the lower. It contains it and gives it a worthier object.

7. When the patient's knowledge fails

When the middle storey collapses in the patient, the upper storey becomes the work of those around him. My specialty shows this collapse more often than any other.

In advanced dementia, knowledge departs in stages: names, then faces, then the thread of a sentence, then the sentence itself. Yet I have watched repeatedly what remains. A melody survives when language has gone. Jacobsen and colleagues found that brain regions encoding long-known music are relatively spared in Alzheimer disease [16]. A blessing learned in childhood remains, along with the hand rising toward a doorpost, the quieting at a familiar voice, and the trust extended to whoever holds one's hand gently. Something of the enclosure outlasts what it enclosed.

Mr. R., an 86-year-old retired tailor with Alzheimer disease, had been without meaningful speech for more than a year when his family asked me to see him for nighttime agitation in his nursing home. He no longer recognized his daughter. He had been started on an antipsychotic, and he was sleeping more but eating less. On examination he was inattentive and could not follow commands. Then his daughter, sitting beside him, began to hum the melody he had sung at his own Sabbath table for sixty years. He took up the tune. He could not supply a word of it, but he held the melody to its end, and his hand, which had been plucking at the sheet, came to rest on hers. As he was wheeled from the room, he reached toward the doorpost.

The knowledge in that room was no longer his. His diagnosis was settled, and so was its course. What remained to be decided belonged to the upper storey, and others had to hold it for him. We tapered the antipsychotic. The staff learned the melody and hummed it at bedtime, and his nights grew quieter. When his intake fell further and a feeding tube was proposed, his daughter recalled that he had once said he did not want to be kept alive by machines, and she declined it. That was substituted judgment in the strict sense. It was also something more: a daughter's trust, extended on behalf of a father who could no longer extend it himself. He died some months later in the home, with the melody being sung at his bedside.

I do not want to sentimentalize this. The trust of a patient with severe dementia is not the second faith the Rebbe describes, which is an achievement of knowledge that has learned to bow. It is closer to the first faith returned without its sequel. The upper storey then belongs to others: the family, the nurse, the aide, the physician. They must supply on the patient's behalf the faith after knowledge that he can no longer hold. A righteous person's doubled faith, I have come to believe, can be lent.

Our ethics already gestures toward this. When a patient lacks capacity, we ask surrogates to exercise substituted judgment, deciding as the patient would have decided [17]. Substituted judgment is faith after knowledge held on another's behalf. It asks the surrogate to honor a person whose present knowing has failed but whose life still makes claims on us.

The Talmud states the obligation in an image I keep before me be careful with an elder who has forgotten his learning through no fault of his own, for both the whole tablets and the broken tablets were placed in the Ark (Berachot 8b). The patient who has lost his knowledge is a broken tablet in the ark. He is not a ruin to be managed. He is a fragment to be

kept, and the clinician is among those charged with keeping him.

8. Watchful waiting and therapeutic restraint

Medicine has two kinds of rest, and the second is far harder than the first. The name Noah means rest, and the discourse reads its doubling in Genesis 6:9 as two Sabbaths, recalling the Talmudic teaching that if Israel kept two Sabbaths, they would be redeemed at once (Shabbat 118b).

The lower Sabbath is the rest of one who does not yet know. Clinically it is watchful waiting: declining the test that only my anxiety demands and allowing a symptom to declare itself over time. It requires trust that time is also a diagnostic instrument, and that not every uncertainty must be resolved today. The Choosing Wisely campaign, which asks specialty societies to name tests and treatments that are often unnecessary, is an institutional attempt to recover the lower Sabbath [7].

The upper Sabbath is the rest of one who knows and lays down his tools. It is the decision not to escalate, the deprescribing of medications whose benefit has lapsed, the turn toward palliation, the willingness to stop. This is the restraint of someone who could act. The discourse treats such restraint not as defeat but as a higher service: authority deliberately restrained is a different act from the absence of authority. The evidence is consistent with this. In Temel and colleagues' trial in metastatic non-small-cell lung cancer, early palliative care improved quality of life and reduced aggressive end-of-life care, and median survival was longer, not shorter [8].

The upper Sabbath is the hardest thing I have had to learn. After fifty years I usually know exactly what else could be done. Choosing rest instead, as reverence rather than resignation, demands a trust my knowledge cannot supply. At the bedside it rarely looks dramatic. Most often it looks like a quiet conversation about what the patient wants, followed by the discipline of honoring the answer.

9. Speaking the known that is not known

Prognostic communication is the upper storey made into speech. The task is to tell a patient what is known without pretending to know what is not.

Clinicians fail in two directions, and the discourse anticipates both. The first is false certainty: the median survival delivered as a sentence; the natural history recited as fate. This is knowledge standing alone, having forgotten its limit. The second is evasion: withholding prognosis in the name of hope, or out of the physician's own discomfort. This is a refusal to climb to the middle storey, a counterfeit of humility.

The palliative care approach summarized as "hope for the best, prepare for the worst" is in effect a grammar of the second faith [18]. It asks the clinician to state clearly what is known while also naming what is not: the range of outcomes, the individuality of the course, the things that matter which no statistic predicts. Simpkin and Schwartzstein have argued that tolerating uncertainty, rather than eliminating it, should become a core clinical competence [19]. The discourse explains why this is not a concession. Uncertainty acknowledged after rigorous knowing is not a gap in knowledge. It is knowledge that has reached its edge honestly.

Patients sense the difference immediately. A prognosis delivered from the middle storey alone sounds like a verdict. The same prognosis delivered from the upper storey sounds like the truth told by someone who will remain with them.

10. Implications for teaching and practice

The three-storey structure can be taught, observed, and assessed. It does not require new curricula so much as a shared vocabulary for practices good teachers already model. I suggest six.

1. **Protect the opening narrative.** Let the patient finish the opening statement before the first focused question. Teach residents to notice when they interrupt, and to name what they expected to hear.
2. **Examine before you image.** Except in time-critical settings such as acute stroke, ask the trainee to state a localization and a differential before reviewing imaging. The point is sequence, not austerity.
3. **Hold a closing time-out.** Before committing to a diagnosis, ask two questions: "What else could this be?" (the lower storey rebuilt) and "What does this diagnosis not tell me about this person?" (the upper storey built).
4. **Return without a task.** Build into rounds at least one visits whose only purpose is to ask how the patient is. It cannot be billed. It is the single most effective antidote to depersonalization I know.
5. **Name restraint as competence.** In case conferences, present decisions not to escalate with the same seriousness as interventions, including the reasoning and the conversation that led to them.
6. **Remember persons, not only diseases.** Case reports remember a disease. Reflective writing, of the kind narrative medicine has championed [20], lets trainees remember a person: approached in trust, known, and released into what could not be known.

None of these practices depends on the Rebbe's theology. Each depends on his structure. Each also gives faculty something observable to assess in the hidden curriculum, where, as Section 5 argued, the defense against cooling is won or lost.

11. Objections

The structure is pessimistic. It promises no arrival: every gain of knowledge must be surrendered again to trust, and the war with Amalek never ends. Applied to medicine, this might seem to counsel perpetual self-doubt. But the discourse does not distrust knowledge. It distrusts knowledge's tendency to congratulate itself. Its realism concerns the aftermath: the cold that follows the fire, the shrug that follows the miracle. Medicine needs this realism. Our successes are the moments of greatest danger to our humanity, and a professional culture that celebrates mastery without attending to what mastery does to the master will keep producing depersonalized physicians.

Humility can excuse indecision. A physician paralyzed by the limits of his knowledge serves no one. The discourse agrees. The higher faith is available only after knowledge. It is no substitute for diagnosis, for decisive treatment, or for the courage to commit to a plan under uncertainty. The neurologist who cannot localize because "the brain is a mystery" has not reached the upper storey. He has never built the second.

Religious language does not belong in clinical reasoning. I do not ask any reader to adopt the Rebbe's theology. I ask only that we notice the accuracy of his structure. Trust before knowledge, rigorous knowledge, and humility after knowledge describe good clinical practice in any tradition or none. The religious vocabulary has one advantage over our technical one. "Premature closure" and "depersonalization" name failures. The discourse names the virtues whose absence those failures reveal and insists that the virtues can be cultivated.

12. Conclusion: how a physician remembers

The discourse begins and ends with the proverb "the memory of the righteous is a blessing" (Prov. 10:7). Its final equation makes that memory a structure: faith, knowledge, faith. To remember a righteous person is to remember a life whose knowing was held from below and from above.

Physicians are keepers of memory too. We remember patients for years, sometimes for a lifetime. A case report remembers a disease: presentation, findings, outcome. A physician should remember a person, and that memory can follow the shape of the encounter. I approached him in trust before I understood. I came to know him, and to know what was wrong. Then I released him into what I could not know: his course, his meaning, his end.

The Rebbe wrote for Hasidim, not physicians. Yet his single page describes the moral form of clinical work more precisely than most of what I was taught in medical school. The good physician is not the one with the greatest store of knowledge. He is the one whose knowledge is enclosed, entered with trust and left with reverence. He builds three storeys and he rests twice. And when his knowledge has done everything, it can, it bows.

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