

Chapter 2

Being a Physician

Imagine that you were interviewing applicants for medical school—which I happen to do—and you were looking for the ideal future physician. What would you consider the most desired attributes? From the standpoint of a medical educator, I would want the applicant to be bright and inquisitive, an eager learner who will participate actively in class discussions and who will bring new ideas to the group. As a practicing physician, I want my future colleague to be reliable, well educated and trained, morally and ethically grounded, and imbued with the team spirit needed to make medical practice—whether group or solo—successful and satisfying for patients, staff, and colleagues.

What if you were the patient? As a sometime patient, I want my physician to be clinically competent, to be compulsive when it comes to following up on reports, to

Fig. 2.1 The stethoscope: one of the enduring symbols of medicine and the physician. This image found at: http://www.springerimages.com/Images/MedicineAndPublicHealth/1-10.1007_978-1-84882-515-4_21-0



be innovative in searching out new ways to approach old problems, and, perhaps most of all and even if it seems a little old-fashioned, to care for me as a person.

None of the attributes described above are mutually exclusive, and all are consistent with being an outstanding learner, colleague, and healer. Together, they describe qualities important in being a physician (see Fig. 2.1).

In this chapter, I will discuss the physician as a healer and as a person. Topics covered include the health of the physician as well as the health of the patient; service and giving back to the world; what makes a “complete” physician; and when to hang up the stethoscope and declare one’s career is over.

Protecting the Patient

The patient, who may mistrust his own parents, sons and relations, should repose an implicit faith in his own physician, and put his own life into his hands without the least apprehension of danger; hence a physician should protect his patient as his own begotten child.

Suśhruta (ca. sixth century BCE) [1]

An Indian sage Suśhruta, who probably lived a century or so before Hippocrates, helped develop the *Ayurveda* system of lifestyle and medicine. His works included—remarkably—descriptions of several hundred surgical techniques such as dilation of urethral strictures, hernia repair, and birth by caesarean section.

I find several intriguing aspects to the quote above. First, although Suśhruta and Hippocrates lived and practiced in the same general era, Hippocrates advocated natural healing methods and was not a strong proponent of operative intervention. Suśhruta, on the other hand, described surgery, and is quoted as telling, “Surgery is the first and the highest division of the healing art, pure in itself, perpetual in its applicability, a working product of heaven and sure of fame on earth” [2].

Second, it is perhaps no coincidence that, as a surgical “giant,” Suśhruta’s quotation above stresses protection of the patient. Keeping the patient from harm is just as pertinent now as it was in ancient India. Here are just some of the dangers:

- Errors of diagnosis: A pigmented skin lesion considered to be a simple mole turns out to be a melanoma. An infant with a fever attributed to a simple viral infection is found in the morning to have a stiff neck and ecchymotic rash. Errors of diagnosis are distressingly common and, according to Ely et al., can often be linked to the cognitive biases and perilous mental shortcuts of clinicians, who, in many cases, fail to consider the correct cause in the differential diagnosis [3].

- Inappropriate surgery: This is not about amputating the wrong leg, but about surgery that is not really needed. In the USA there are about 1 million hip and knee replacements annually, which is almost one in every 300 Americans. Yet there are no specific guidelines as to when major joint arthroplasty should be performed [4].
- Ridiculous recommendations by unqualified persons: A physician recently reported that a patient told of being advised by her yoga instructor to drink her own urine each morning because it would “cure everything” [5]. Today we read a lot about complementary and alternative medicine (CAM), and some of our best young medical practitioners have become passionate advocates, despite its mystical roots and paucity of rigorously vetted evidence.
- Abuse by insurance providers: This includes both private and government sponsored programs. What happens is a little like home insurance; you sign up optimistically expecting fair treatment and then when disaster occurs, you learn about the exclusions. Fighting insurance providers is tedious and time-consuming, which is what the other side wants, but it is the physician’s duty today to be the spokesperson for patients who don’t know the pathways to the goal of fair treatment.

I could name more dangers patients face, such as pharmaceutical errors and rushed hospital discharges. It seems to me that, more than ever, today’s patients need physicians to offer protection as part of their care.

1. Sharma PV. *Suśhruta-Samhitā* (Varanasi: Caukhambha Visvabharati). 2000; vol. 1.
2. Rajan S. Who is the father of surgery in India? Available at: <http://www.sukh-dukh.com/forums/showthread.php?t=79736>.
3. Ely JW et al. Checklists to reduce diagnostic errors. *Acad Med*. 2011;86:307.
4. Lawson EH et al. Appropriateness criteria to assess variations in surgical procedure use in the United States. *Arch Surg*. 2001;146:1433.

Courage in Times of Crisis

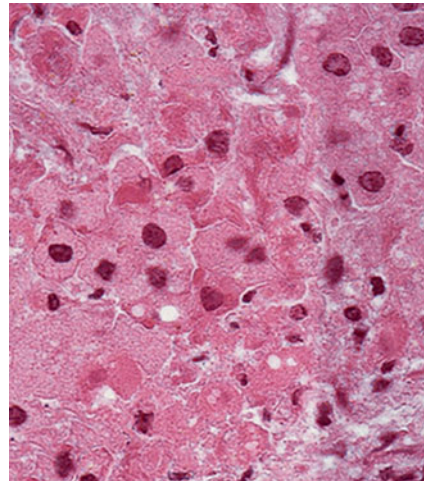
At the beginning (of the plague of Athens in the fifth century BCE) the doctors were quite incapable of treating the disease because of their ignorance of the right methods. In fact, mortality among the doctors was the highest of all, since they came more frequently in contact with the sick.

Greek general and historian Thucydides (c. 460–395 BCE) [1]

One of the quiet little secrets of medicine is that doctors and others who provide direct patient care are exposed to a lot of very sick persons, some with infections that defy antibiotics and some patients with mental derangements that make them dangerous to themselves and others, including those who provide health care.

In 1883 Dr. F.R. Hudson was shot and seriously wounded by a man whose wife he declined to visit [2]. In 2013 in Beijing, a doctor was stabbed to death by a patient displeased with the outcome of surgery on his nose [3]. Attacks on physicians are

Fig. 2.2 Ebola virus: Hepatocellular necrosis and typical intracytoplasmic viral inclusions are seen in liver of a patient with Ebola virus hemorrhagic fever. <http://www.springerimages.com/Images/MedicineAndPublicHealth/2-AID08E3-10-048A>



not uncommon and are among the hazards that attend the practice of medicine. But more to the point are the infectious diseases that we can treat but cannot cure.

O’Flaherty, in 1991, wrote of the physician’s duty to treat the patient with communicable disease. In the setting of some physicians refusing to treat AIDS patients, she wrote: “Physicians today, inexperienced at weighing personal risk against professional responsibility, are examining the extent of their occupational obligation” [4].

Over the past two decades, we have become more comfortable treating patients with AIDS. We better understand its modes of transmission, we have refined our methods of avoiding contagion, and the drugs are superior. But what of future plagues?

Consider the Ebola and Marburg viruses, and other causes of viral hemorrhagic fever for which there is no immunity, no reliable prophylaxis, and no sure cure (see Fig. 2.2). When these highly contagious infections hitchhike to our world aboard a sick airline passenger or are introduced by a terrorist, how many among us will follow the example of Benjamin Rush M.D. who, during the 1793 yellow fever epidemic in Philadelphia, wrote to his wife: “I had resolved to perish with my fellow citizens rather than dishonor my profession or religion by abandoning the city” [5].

Who would enter the medical profession if the risk to the practitioner’s life were high? Happily, this is not the case today. We continue to find innovative ways to protect physicians, staff, and their families from infectious diseases, and, unless some catastrophic, communicable plague emerges, health care professionals are in less danger from their patients than from lifestyle choices we make for ourselves each day, as discussed in the next section.

1. Thucydides: History of the Peloponnesian War, Warner R, trans. Middlesex, England: Penguin Books; 1954,151.
2. News Note: The Journal;1883;1:281.
3. Chinese doctor stabbed to death in latest hospital attack. Available at: <http://news.yahoo.com/chinese-doctor-stabbed-death-latest-hospital-attack-084856196.html>.
4. O’Flaherty JO. The AIDS patient: a historical perspective on the physician’s obligation to treat. The Pharos. 1991;54;13.
5. Butterfield LH, ed. Letters of Benjamin Rush, vol. 2: 1793–1813. Princeton: Princeton University Press;1951,734.

About the Health of the Physician

The physician will hardly be thought very careful of the health of others who neglects his own.

Roman physician and philosopher Claudius Galen (ca. 130–200) [1]

He was known as Galen of Permegeon, a city in what is now Turkey, where he was born. He was a leading physician of ancient Rome, with a special interest in anatomy, perhaps based on his experience treating the wounds of gladiators and his dissection of animals. He systematized the medical knowledge of his day in hundreds of written works, and his influence lasted for 1,500 years (see Fig. 2.3).

However, Galen was wrong on several important points. As examples, he believed that arterial blood and venous blood were contained in separate systems, and that humans have two-chamber hearts and five-lobed livers. His work has been described, perhaps not totally fairly, as “a weird hodgepodge of nonsense, Aristotelian philosophy, Hippocratic dogma, and shrewd clinical and experimental observations” [2].

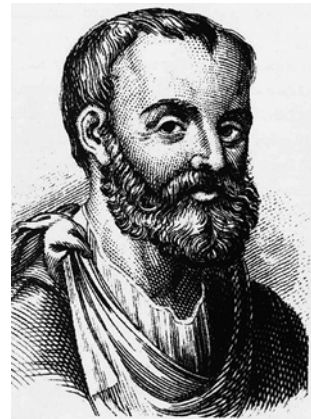


Fig. 2.3 Galen of Permegeon.
http://www.springerimages.com/Images/MedicineAndPublicHealth/5-10.1186_1748-7161-4-6-10

But Galen was correct when it came to physicians preserving their own health. The admonition goes beyond avoiding contagious diseases. Today the greater threats to physicians are depression, substance abuse, premature diseases of aging, and suicide.

Gerber writes: “A troubled physician and physician’s family is one result of working hard for others and ignoring one’s own needs” [3]. The overburdened physician, often depressed, may be tempted to self-treat with alcohol or drugs.

Gastfriend reports a 10–15 % prevalence of substance abuse disorders among physicians; that this prevalence mirrors that in the general population should give us scant comfort [4].

With practice pressures, long work hours, and often sleep deprivation not unlike the experience of residents in training, physician well-being can yield to career exhaustion, and studies show that, at any time, approximately one in three physicians is experiencing burnout [5].

To combat these problems, the Mayo Clinic has pioneered the “Physician Well-Being Program” to promote physician well-being through research, education, and the development of wellness promotion programs that foster physician satisfaction and performance” [6]. But substantive change can only follow a fundamental philosophical change in physician thinking.

We clinicians must come to believe that only when we are emotionally and physically healthy—and rested—can we provide optimum care. Anything less, neglecting our own health, is in fact being careless with the health of others.

1. Claudii Galeni Pergameni. *Of protecting health*, book 5.
2. Inglis B. *A history of medicine*. New York: World Publishers; 1965, page 39.
3. Gerber LA. *Married to their careers: career and family dilemma in doctors’ lives*. New York: Tavistock; 1983, page 81.
4. Gastfriend DR. Physician substance abuse and recovery: what does it mean for physicians—and everyone else? *JAMA*. 2005;293:1513.
5. Shanafelt TD. Enhancing meaning in work: a prescription for preventing physician burnout and promoting patient-centered care. *JAMA*. 2009;302:1338.
6. Physician Well-being Program, Mayo Clinic: Available at: <http://mayoresearch.mayo.edu/mayo/research/physicianwellbeing/>.

Ceasing Doctoring at the Right Time

I have entered my eighty-fifth year; and when I retired a few years ago from the practice of physic, I trust it was not a wish to be idle, which no man capable of being usefully employed has a right to be; but because I was willing to give over before my presence of thought, judgment and recollection was so impaired that I could not do justice to my patients. It is more desirable for a man to do this a little too soon, than a little too late; for the chief danger is on the side of not doing it soon enough.

English physician William Heberden (1710–1801) [1]

For many reasons, physicians are retiring earlier today, according to hospital executives, physician recruiters, and researchers in the field [2]. Among the reasons cited by physicians, the commercialization of medicine tends to lead the list. But when should you and I hang up our stethoscopes and actually retire?



Fig. 2.4 William Heberden.
http://www.springerimages.com/Images/MedicineAndPublicHealth/1-10.1007_978-1-84882-342-6_1-2

According to Heberden, one of leading physician scholars of his day, for whom the knobby distal interphalangeal joint manifestations of arthritis are named (see Chap. 5), a wise clinician retires before becoming a danger to patients (see Fig. 2.4). In sports parlance this might be considered retiring at the top of your game.

In my early years of practice I encountered a beloved, quite elderly physician who was still seeing his long-time patients, even though his clinical skills and judgment had retreated to a danger zone. The physician leader at the local hospital, upon being advised of the problem by colleagues, had a serious chat with his aged colleague, who soon afterwards began his well-deserved retirement.

One valuable option in physician retirement today is the “bridge job” [3]. The previously held belief that the practice of medicine is “all or nothing” need not be true today. Whatever one’s practice style—entrepreneur, employee, or academic—the ability to identify medically related activities that allow phased retirement can be the key to contentment once full-speed practice is in the rear-view mirror. Bridge job possibilities include administration, insurance medicine, or volunteer care of the homeless.

As an academic physician, I “stepped down” as department chairman at age 62, and I continued to see patients for the next 8 years and spent my nonclinical time teaching, writing, and mentoring young faculty. Like any responsible faculty dinosaur, I progressively reduced my weekly work hours, until I finally “retired” at age 76; but I still volunteer as an interviewer for applicants to the local medical school and I write books like this.

I believe that I did not retire to be idle, and that my “bridge jobs” were and are useful to society. Yet I ceased active patient care before, in Heberden’s words, “my presence of thought, judgment and recollection was so impaired that I could not do justice to my patients” and before a major medical misadventure occurred.

1. Heberden W. Letter. Quoted in: Scarlet EP. Fair flower of Harvard. *Arch Int Med*. 1965;116:611.
2. Bahrami B et al. Is there any difference in the retirement intentions of female and male physicians? *Clute Institute J Bus Econ Res*. 2004;2:45.
3. Kim S et al. Working in retirement: the antecedents of bridge employment and its consequences for quality of life in retirement. *Acad Management J*. 2000;43:1195.

The Self-Complacency of the Young Physician

The first acts of a graduate are apt to be his precedents through the coming years, for there is no era in life in which his self-complacency is so exalted as the time which passes between receiving his diploma with its blue ribbon, and receiving cape and gloves to wear at the funeral of his first patient.

American physician and educator Daniel Drake (1785–1852) [1]

Daniel Drake was a towering figure among American physicians. He received the first medical diploma in Cincinnati in 1805, the first awarded west of the Appalachian Mountains. Drake was instrumental in establishing the Medical College of Ohio and he served as its first president and, later, led the Ohio State Medical Society. He also, in 1827, founded the *Western Journal of the Medical and Physical Sciences*, which he continued to edit until 1848 [2] (see Fig. 2.5).



Fig. 2.5 Daniel Drake (Public domain). http://commons.wikimedia.org/wiki/File:Daniel_Drake002.png

Could it be that the “self-complacency,” perhaps the self-confidence, described by Drake characterizes the frontier medicine of his day. Courage was often needed when resources were in short supply. Remember that we would not see ether anesthesia until 1846, Lister’s antisepsis would come two decades later, and the first targeted antimicrobial, Ehrlich’s arsenic-based anti-syphilitic drug Salvarsan, would eventually follow in 1910.

As a young physician practicing in Ohio in the early nineteenth century, Drake seems to have been a risk-taker, living by the Thomas Aquinas adage; “If the highest aim of a captain would be to preserve his ship, he would keep it in port forever.” Aquinas would probably applaud the physician who takes reasonable risks in the best interests of his patients—the heroic surgery or the trial of an untested drug when all else has failed.

My colleague, Bob Bomengen, M.D., a solo physician practicing in an Oregon frontier community, was faced with a 14-year-old boy accidentally shot in the abdomen, with the aorta damaged. “Dr. Bob” opened the abdomen and, with his hand, prevented aortic hemorrhage until the rescue helicopter could arrive from 175 miles away. The boy survived [3]. Another family physician colleague, early in his practice, suddenly faced with a patient with acute subarachnoid hemorrhage, used the instruments available in his office to drill a hole in the patient’s skull; the patient lived, presumably owing to the emergency surgery. What courage—self-confidence—these acts must have taken?

And then comes the first preventable death, a sobering event for a young doctor doing his best for his or her patients. Most physicians can recall this first patient death decades later. Today, with postgraduate training programs of 3 to even 8 years, most young physicians experience their first patient death during training. The wise physician learns from the experience and goes on, but a little more cautiously than before.

1. Drake D. Editorial. *West J Med Surg*. 1844;354:2.
2. Daniel Drake: In: *Appleton’s cyclopedia of American biography*. New York: Appleton; 1887, p. 223.
3. *Reader’s Digest*. May, 2005.

The Physician as Advocate

Only those who regard healing as the ultimate goal of their efforts can, therefore, be designated as physicians.

German pathologist Rudolph Virchow (1821–1902) [1]

Since early times, the holy grail of early “medicine men” (and women), and later, physicians, of diagnosis and therapy has been healing. Sometimes it is actual cure; at other times, support while nature heals; and all too often, the healing power of caring when the end of the therapeutic trail has been reached. And at times, part of healing is speaking out for the patient.



Fig. 2.6 Rudolph Virchow.
http://www.springerimages.com/Images/MedicineAndPublicHealth/1-10.1007_s00268-004-2056-0-0

Virchow was a leading scientist of his day (see Fig. 2.6). But his legitimacy to speak of healing comes from his promotion of medicine's role in social reform: "Medicine, as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution: the politician, the practical anthropologist, must find the means for their actual solution... The physicians are the natural attorneys of the poor, and social problems fall to a large extent within their jurisdiction" [2].

To Virchow's thinking, part of doctoring is advocacy, helping the patient and family cope with the problems we all recognize and, today, the labyrinthine health care bureaucracy we all face. This is our work: to diagnose, to treat as best we can, and to advocate for our patient when needed. These three phases are all part of healing. The latter—the advocacy championed by Virchow—may seem the least gratifying of the three activities, but sometimes can be the most effective.

Today, there is a growing sense that physician advocacy is fundamental to medical professionalism. Yet, as Earnest et al. state: "Despite widespread acceptance of advocacy as a professional obligation, the concept remains problematic with the profession of medicine because it remains undefined in content, scope, and practice" [3]. One impediment is that patient advocacy activities, such as writing letters to insurance companies when vital medication or surgery recommendations are denied, are unlikely to be "reimbursable" events. When the health care system eventually defines the physician's role to include addressing social problems that affect health and compensates fairly for this type of activity, the lives of both patients and physicians will be better. And advocacy will be formally recognized as an important role of healers.

1. Virchow R. *Disease, life and man: selected essays* by Rudolph Virchow. Trans. by L. J. Rather. Stanford, CA: Stanford University Press; 1958.
2. Brown T et al. Rudolph Carl Virchow. *Am J Public Health*. 2006;96:2104.
3. Earnest MA, et al. Physician advocacy: what is it and how do we do it? *Acad Med*. 2010;85:63.

Being a Pioneer

It is not easy to be a pioneer—but oh, it is fascinating! I would not trade one moment, even the worst moment, for all the riches in the world.

American physician Elizabeth Blackwell (1821–1910) [1]

Elizabeth Blackwell, the first woman to receive an M.D. degree in the USA, was certainly a pioneer. Born in England, Blackwell moved with her family to the USA at age 11. Her decision to pursue a medical career, like the decisions of many aspiring physicians today, was influenced by the painful death of a friend who, we think, suffered from uterine cancer [1, 2] (see Fig. 2.7).

After one rejection after another from leading medical schools of the day Blackwell was finally accepted by Geneva Medical College, now State of New York Upstate Medical University in Syracuse, New York. Even here, her application prompted such indecision among the administrators that her fate was put to a vote of the 150 male students. If even one voted “nay,” she would be rejected. But, according to legend, the young men, considering the matter to be comical, voted



Fig. 2.7 Elizabeth Blackwell
(Public domain). http://commons.wikimedia.org/wiki/Elizabeth_Blackwell#mediaviewer/File:Elizabeth_Blackwell.jpg

unanimously for her acceptance [3]. In 1849, Elizabeth Blackwell received her medical degree.

Blackwell continued her studies in France, and her career included time in England, where she became the first woman on the United Kingdom Medical Register. In 1851, she returned to the USA where her work included clinical practice, lectures, writing, and social activism [4].

Distinguished as her career was, Blackwell's chief contribution to medicine was serving as a trailblazer for generations of young women who would follow her into medical careers. These included her own sister, Emily Blackwell, who was the third American woman to earn an M.D. degree. Other American beneficiaries of her pioneering efforts include such illustrious names as:

- Annie Lowrie Alexander (1864–1929)—first licensed female physician in a southern US state [5].
- Florence Rena Sabin (1871–1953)—first woman physician elected to the US National Academy of Sciences, discussed later in Chap. 8.
- Marie Equi (1872–1952)—a leader in the fight for women's access to birth control.
- Virginia Apgar (1909–1974)—the “mother” of neonatology and the APGAR score.
- Nancy Dickey (1950–)—first female president of the American Medical Association.

There are thousands more, thanks to the bravery and determination of Elizabeth Blackwell and those who followed her path. Today women constitute almost half of all US medical students.

1. Baker R. The first woman doctor: the story of Elizabeth Blackwell, MD. New York: J Messner; 1944.
2. Roth N. The personalities of two pioneer medical women: Elizabeth Blackwell and Elizabeth Garrett Anderson. *Bull NY Acad Med.* 1971;47:67.
3. Curtis RH. Great lives: medicine. New York: Atheneum; 1993.
4. Sahli NA. Elizabeth Blackwell, MD (1821–1910). New York: Arno Press; 1982.
5. Cohn S. More than petticoats: remarkable North Carolina women. Guilford CT: Globe Pequot; 2012; p. 82.

Standing Above the Common Herd

There are men and classes of men that stand above the common herd: the soldier, the sailor, and the shepherd not infrequently; the artist rarely; rarer still, the clergyman; the physician almost as a rule. He is the flower (such as it is) of our civilization; and when that stage of man is done with, and only to be marveled at in history, he will be thought to have shared as little as any in the defects of the period, and most notably exhibited the virtues of the race. Generosity he has, such as is possible to those who practice an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and what are more important, Herculean cheerfulness and courage. So that he brings air and cheer into the sick room, and often enough, though not so often as he wishes, brings healing.

Scottish author Robert Louis Stevenson (1850–1894) [1]

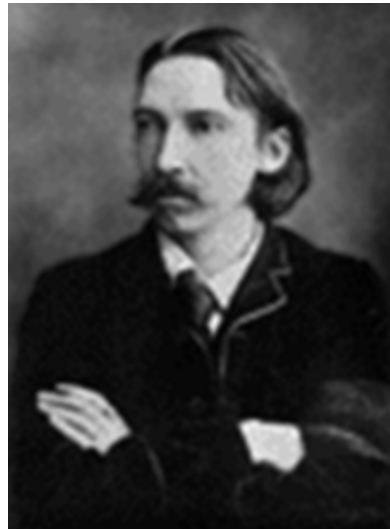


Fig. 2.8 Robert Lewis Stevenson. <http://www.springerimages.com/search.aspx?caption=Robert%20Louis%20Stevenson%20>

Stevenson, although not a physician, experienced several serious illnesses during his life and thus spent his share of time in the presence of healers. He was both a grateful and articulate patient. The now-famous tribute to physicians quoted above was published, curiously, in the Dedication of a book of children's poems [1]. Being both patient and poet, he offered a special perspective on the characteristics of physicians he had known and their virtues, including a comparison to persons in other life roles. I note with amusement that, when it comes to those who "stand above common herd," Stevenson not unexpectedly places physicians at the top of his list. But along the way, he ranks soldiers, sailors, and shepherds above artists, and all of these above the clergy (see Fig. 2.8).

Despite the skills, professionalism, and altruism of most physicians today, medical doctors no longer seem to "stand above the herd," at least when it comes to public confidence in professional honesty and ethics. In a Gallup Survey using honesty and ethical standards as criteria, medical doctors ranked a modest fifth, trailing nurses, military officers, pharmacists, and grade school teachers. Physicians continue to be ranked above, actually two levels above, the clergy. The bottom of the list? Members of congress, car salespeople, and lobbyists [2].

Interestingly, our US cultural priorities may be revealed in a study from the University of Wisconsin ranking occupational prestige—the relative social class of those in various jobs. In this survey, physicians were listed number one, ahead of attorneys, computer scientists, college professors, and physicists [3]. It makes me wonder if prestige is still equated with honesty and high moral standards, or is it viewed as indicating financial success?

1. Stevenson RL. Dedication. *Underwoods: a child's garden of verses*. New York: Peter Fenelon Collier & Son: 1887.
2. Gallup Honesty and Ethics Survey: 2010. Available at: <http://www.gallup.com/poll/145043/Nurses-Top-Honesty-Ethics-List-11-Year.aspx>.
3. Hauser RM, et al. Socioeconomic indexes for occupations: a review, update, and critique. Madison, Wisconsin: Center for Demography and Ecology, University of Wisconsin; 1996.

Hobby-horses, Tyrants, and Mighty Purposes

A man like me cannot live without a hobby-horse, a consuming passion—in Schiller’s words a tyrant. I have found my tyrant, and in his service I know no limits. My tyrant is psychology. It has always been my distant, beckoning goal and now since I have hit upon the neuroses, it has become so much the nearer.

Austrian neurologist Sigmund Freud (1856–1939)

We health professionals know about Freud, recognized as the “father of psychoanalysis” (see Fig. 2.9). Less well known to doctors is the man whom Freud cites, German playwright Friedrich Schiller (1759–1805). Freud’s allusion to his work, and specifically to the word “tyrant” sent me on a quest for context—the literary work Freud was citing in the quote above. I believe my search was successful. Here is what I found: Describing Schiller’s play, *Fiesco: or the Genoese Conspiracy*, Thomas writes: “No one can mistake the autobiographic note in the speech of Bourgognino which closes the first act: ‘I have long felt in my breast something that would not be satisfied. Now of a sudden I know what it was. (*Springing up heroically*) I have a tyrant’” [2].

What Freud and Schiller describe as a “hobby-horse” or “tyrant,” I think of as a mission, an aim, or a purpose that gets you out of bed in the morning and gives life extra meaning. Here, from the Preface to the drama *Man and Superman* by Irish playwright George Bernard Shaw (1856–1950), is one of my favorite inspirational quotes: “This is the true joy in life, the being used for a purpose recognized by

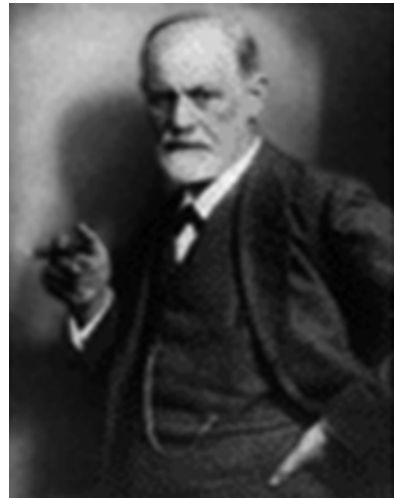


Fig. 2.9 Sigmund Freud.
http://www.springerimages.com/Images/MedicineAndPublicHealth/1-10.1007_978-1-4614-0170-4_1-24

Fig. 2.10 Sir Winston Churchill. <http://www.springerimages.com/search.aspx?caption=winstonchurchill>



yourself as a mighty one; the being thoroughly worn out before you are thrown on the scrapheap; the being a force of Nature instead of a feverish, selfish, little clod of ailments and grievances complaining that the world will not devote itself to making you happy” [3].

While writing a book like “Medicine’s Giants,” I sometimes think of another writer, Sir Winston Churchill, who used the word *tyrant*: “Writing a book is an adventure. To begin with it is a toy and an amusement. Then it becomes a mistress, then it becomes a master, then it becomes a tyrant. The last phase is that just as you are about to be reconciled to your servitude, you kill the monster and fling him to the public” [4] (see Fig. 2.10).

How many of us have “hobby-horses?” For most physicians so afflicted, of course, the “consuming passion” is medicine, especially the doctor’s specialty. I wonder how many of these “hobby-horses” evolve into “masters,” even “tyrants,” that dominate the lives of unsuspecting physicians. How many feel the passion, and master it? Or, is this sort of passion seldom seen in young physicians today?

1. Freud S. Letter to William Fless, 1895, Quoted in: J History of Behav Sci. 1967;3–4:159.
2. Thomas C. The life and works of Friedrich Schiller. Middlesex, England: Echo Library; 2006, page 57.
3. Shaw GB. Preface: Man and Superman, a drama. 1903.
4. Winston Churchill quotes. Available at: <http://www.goodreads.com/quotes/37949-writing-a-book-is-an-adventure-to-begin-with-it>.

Service in Medicine

You ask me to give you a motto. Here it is: Service. Let this word accompany you as you seek your way and your duty in the world. May it be recalled to your minds if ever you are tempted to forget it or to set it aside. Never have this word on your lips, but keep it in your hearts. And may it be a confidant that will teach you not only to do good but to do it simply and humbly. It will not always be a comfortable companion but it will always be a faithful one. And it will be able to lead you to happiness no matter what the experiences of your lives are.

Physician and theologian Albert Schweitzer (1875–1965) [1]

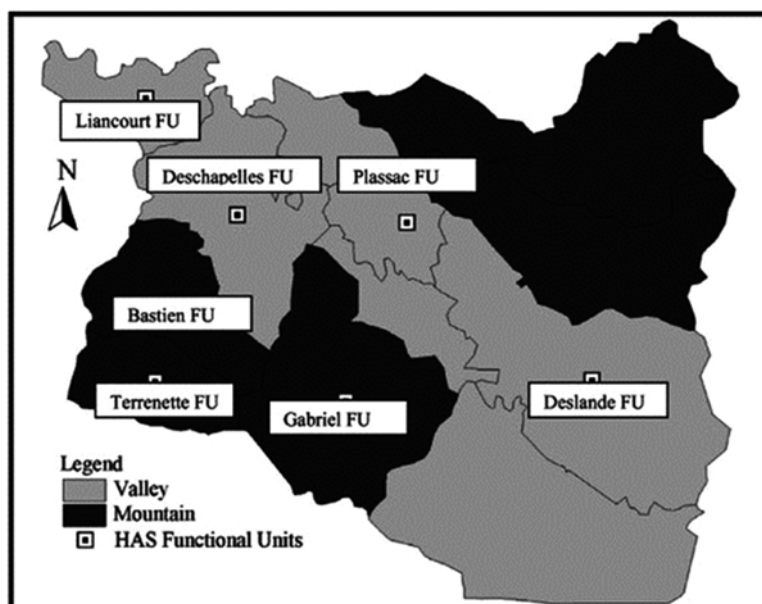


Fig. 2.11 Map of the Functional Units (FU) where the Hôpital Albert Schweitzer (HAS) operates its programs in Haiti. http://www.springerimages.com/Images/MedicineAndPublicHealth/5-10.1186_1475-9276-6-7-1

Best known for his service as a medical missionary, Schweitzer founded a hospital at Lambaréné, Gabon in 1913. The advice cited was directed to a group of nursing students, but it should resonate with all healers. Certainly the spirit of service was, as described in the previous section, Schweitzer's "mighty purpose."

There is also a Hospital Albert Schweitzer at Deschapelles in Haiti, founded by Larry and Gwen Mellon in 1956 as a tribute to Schweitzer. The hospital is the hub of an integrated health system serving the inhabitants of central Haiti (see Fig. 2.11).

Aside from the laudatory altruism advocated by Schweitzer, there is a moral justification for our obligation to serve others. Despite the mountains of debt many young physicians incur during education and training, none of us got where we are alone. Our parents contributed mightily to our success, as did our teachers through all levels of education. Physicians in many specialties, nurses, technicians, and other health professionals shared their wisdom, their clinical pearls, and their diagnostic maneuvers—all in an effort to make each of us the best healer possible.

The medical school equivalent of undergraduate Phi Beta Kappa is Alpha Omega Alpha (AOA), the professional organization that "recognizes and advocates for excellence in scholarship and the highest ideals in the profession of medicine." Only students in the top 25 % of a medical class can be considered for membership; not all are selected. The AOA motto, since the time of founder William W. Root, M.D. in 1902, is: "Be worthy to serve the suffering" [2]. But one need not be in the top quartile of a medical school class to aspire to this message. Every healer, whatever his or her class rank, should "be worthy to serve the suffering."

The latest initiative to recognize medical service to humanity is the Gold Humanism Honor Society (GHHS), established in 1988 by the Arnold P. Gold Foundation to foster humanism and professionalism in medicine. The GHHS "honors medical students, residents, role-model physician teachers and other exemplars recognized for 'demonstrated excellence in clinical care, leadership, compassion and dedication to service'" [3].

1. Schweitzer A. From a letter to his students, 1953. Quoted in: *Ann Intern Med.* 1997;127:853.
2. Alpha Omega Alpha. Available at: <http://www.alphaomegalpha.org>.
3. The Arnold P. Gold Foundation. Available at: <http://humanism-in-medicine.org/about-us/>

The Compleat Physician

The Compleat Physician is one who is capable in all three dimensions: he is a competent practitioner; he is compassionate; and he is an educated man. To use the classical terminology, he combines *techné* with *philanthropia* and *paideia*. Few men can perform with perfection, even adequately, at all levels. We must repress the tendency to apotheosize our profession by expecting all physicians to excel in all three.

American educator and author Edmund D. Pellegrino (1920–2013) [1]

Pellegrino was one of modern America's leading medical philosophers, ethicists, and humanists. He served as president of The Catholic University of America and as Chairman of the President's Council on Bioethics. He was a prolific author of scholarly articles and books, and founder of the Edmund D. Pellegrino Center for Clinical Bioethics at Georgetown University.



Fig. 2.12 (a) Kos, the island of Hippocrates. (b) Stamp with the likeness of Hippocrates, issued on the occasion of the unification of the island with the Greek motherland (1948). http://www.springerimages.com/Images/MedicineAndPublicHealth/1-10.1007_s11789-010-0014-y-2

Here I choose to focus on the third of the dimensions described by Pellegrino: *paideia*, being an educated human being. Fortunately, American physicians enter medical school only after some degree of liberal arts education, perhaps introducing them to literature, music, and visual arts, as they hurry toward acceptance in medical school. I point this out because, in many countries, medical school begins immediately following secondary education, and thus the graduating physician is quite focused on doctoring, without the leavening of a broad-based education.

Osler considered it important that young physicians continue to read widely outside medicine. His book, *Aequanimitas*, ends with a curiously unnumbered page with the heading: “Bed-side Library for Medical Students.” Among Osler’s recommendations are the Old and New Testament, Shakespeare, Marcus Aurelius, Cervantes’ *Don Quixote*, and Emerson [2].

But what about after medical school and residency? Medical practice is demanding and time-consuming. And, of course, so is family life, especially if there are young children. And television and the computer are highly seductive. The early practice years are the time to establish what—I hope—will become lifelong habits of reading for pleasure, of attending cultural events, and of travel to the sites, such as Greece and Rome, where history occurred. Read some of Osler’s recommendations. Go visit the Greek island of Kos and walk the ground where Hippocrates walked (see Fig. 2.12).

After a few years in small town practice, a member of the town board came to my office. He strongly encouraged me to become a member of a committee reporting to the town board. When I hesitated—after all, I was still building a busy practice—he pointed out, “Dr. Taylor, don’t you realize? You are perhaps the most educated person in town. We need you to serve.” Of course, with that comment, I felt I must join the committee.

That conversation also highlighted my—the physician’s—duty to give back to the community, discussed next.

1. Pellegrino ED. Humanism and the physician. Knoxville TN: U Tenn Press;1979, p. 157.
2. Osler W. *Aequanimitas* with other addresses. Ed. 3. Philadelphia: Blakiston; 1932.

Giving Back to the World

There can be fewer luckier people in the world than the surgeons of India who have the opportunity to treat not only the rich but also the poor and destitute.

Roman Catholic nun Mother Teresa (1910–1997) [1]

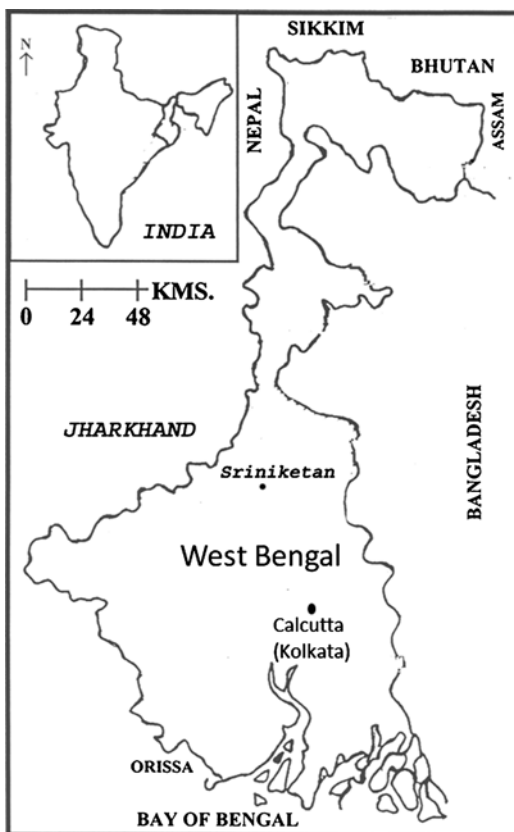


Fig. 2.13 The location of Calcutta in West Bengal, India. http://www.springerimages.com/Images/Environment/1-10.1007_s10661-012-2744-4-0

Sometimes called *Blessed Teresa of Calcutta* and best known for her work in the slums in the capital city of the Indian state of West Bengal, Mother Teresa was the founder of the Missionaries of Charity, which administers schools, orphanages, shelters, and hospices for the sick and needy. She received the 1979 Nobel Peace prize and was beatified in 2003. Her “mighty purpose” was service to the poor, sick, and disabled (see Fig. 2.13).

As we think about Mother Mary Teresa a few pages after a message from Dr. Albert Schweitzer, it is hard not to see the parallels in their lives. Although their lifetimes overlapped by 32 years, I find no evidence that they ever met. Yet both championed selfless care of the most needy; both achieved international recognition for their work; both received the Nobel Peace Prize (Schweitzer, 1952; Mother Teresa, 1979); both directly changed many lives for the better and inspired countless others to do the same.

Writing about “giving back to the world” in a recent issue of the *Journal of the American Medical Association*, Pescovitz invokes a metaphor that involves the Jordan River that feeds both the Sea of Galilee and the Dead Sea. The Sea of Galilee gives back the water to the Jordan River, which then flows south to the Dead Sea, where the current ceases. Fish and vegetation thrive in the Sea of Galilee while the waters of the Dead Sea are devoid of life—dead. The author summarizes: “In life, we all should be like the Sea of Galilee. We should give back to the world that gives us so much” [2].

What does this have to do with medicine today? Despite murmurings that today’s medical students lack altruism, Streed describes a survey of 900 medical students at ten US medical schools, finding that 86 % believed in the concept of health care for all, and that two thirds would donate future time and income to support that care [3]. The surge of interest among medical students to help in disasters such as the Haitian earthquake or Hurricane Katrina may be an indication of a rising commitment to “give back.”

1. Mother Teresa: Speech to the International College of Surgeons, Calcutta, 1998: Quoted in: McDonald P. The Oxford dictionary of medical quotations. New York: Oxford University Press; 2004, page 71.
2. Pescovitz OH. Swimming in the Sea of Galilee. JAMA. 2013;309:885.
3. Streed C. Where does our altruism go? Available at: <http://boards.medscape.com/forums?128@921.yHFbaguebo@.2a382796!comment=1>.

The Intimate Chambers of Our Patients' Lives

As physicians, we are invited into the most intimate chambers of our patients' lives. We should acknowledge that unfettered trust with dignity, deference, and respect. For a physician, caring for patients is not only a duty; it is a privilege. Alleviating pain and restoring health for another human being induce an exhilaration few others experience in their careers.

American heart surgeon Michael E. DeBakey (1908–2008) [1]

Michael DeBakey was a remarkable man, and not only because he lived just a few months short of 100 years. During a 75-year career in medicine, he operated on more than 50,000 persons; he invented the roller pump that was a key feature of the early heart-lung machines; and he was the first to use a successful external heart pump in a patient. In 2005 he suffered an aortic dissection, and his life was saved as



Fig. 2.14 Michael E. DeBakey. <http://www.springerimages.com/search.aspx?caption=MICHAELDEBAKEY>

his team performed a *DeBakey Procedure*, a technique that DeBakey had developed [2] (see Fig. 2.14).

Despite DeBakey's larger-than-life accomplishments and his innovative thinking, he was—after all—a high-volume, operating-room-dwelling, cardiac surgeon. Thus I find it refreshingly curious that the phrase “we are invited into the most intimate chambers of our patients' lives” comes from a surgeon. I do not refer to the use of the word “chambers,” as in heart chambers; this is a word heart surgeons use often. No, I am intrigued that this internationally renowned surgeon was sensitive to the personal vulnerability of his patients. This is an attribute stereotypically associated with family physicians, pediatricians, nurses, maybe psychiatrists, not necessarily surgeons.

As a medical school professor privileged to teach medical students throughout all 4 years of the curriculum, I encourage incoming doctors-to-be, garbed self-consciously in their new white coats, as follows: Not long ago you were college students, or perhaps working to earn some tuition money. Today you are *student doctors*. You will encounter patients in the office and hospital, often alone without a mentor to guide you. These patients will tell you secrets they would not tell their mothers. They will show you their bodies. They will let you touch them and sometimes invade various orifices. They will tell you what really worries them, which will sometimes come as a surprise. They deserve your respect, and the best you have to offer.

My wish is that all young doctors will finish their careers with honor and dignity, and with respect for their patients, as DeBakey did. If this happens, then the next generation of new physicians will inherit the sense of patient trust that we veteran healers did, as their first patients invite them into the intimate chambers of their lives.

1. Personal essay by Michael E. DeBakey, MD. In: Manning PR, DeBakey L. *Medicine: preserving the passion*, ed. 2. New York: Springer; 2004, p. 39.
2. DeBakey ME et al. Surgical considerations in the treatment of aneurysms of the thoraco-abdominal aorta. *Ann Surg*. 1965;162:650.

<http://www.springer.com/978-1-4939-1334-3>

On the Shoulders of Medicine's Giants

What Today's Clinicians Can Learn from Yesterday's
Wisdom

Taylor, R.B.

2015, XIV, 251 p. 100 illus., 48 illus. in color., Hardcover

ISBN: 978-1-4939-1334-3