

Reflections

Reflections on being a doctor

John G. Merselis, Jr., MD (ΑΩΑ, Johns Hopkins School of Medicine, 1957)

I believe there is something special about being a doctor. The practice of medicine has been described as a calling, a way of life, and a sacred trust. It is all of these, and more.

I remember as a young child delaying bedtime in order to see my dad when he came home from evening office hours, or waiting in the car while he made a house call. Sometimes, on a Saturday morning I sat in the doctors' lounge at Orange Memorial Hospital while he visited patients. I remember conversations with hospital-based physicians, Dr. Abel (pathology) and Dr. Seward (radiology) who were focused on the care and well-being of patients.

Medical internship, residency, and fellowship reinforced the concept of caring and the responsibility that goes with it. So, too, did my clinical experience in Africa and Haiti.

Medicine is about personal engagement and interaction that is focused on health, comfort, and well-being in an intimate, interpersonal relationship that is unique to our profession. It is a privilege to serve the needs of others.

We define ourselves in myriad ways. There are the obvious markers of race, gender, age, religion, family and socio-economic status, but these are, at best, generalities, and shallow, inadequate measures of our unique personal qualities. We learn by engaging with others, listening attentively, and realizing that everyone has something to offer; everyone has a personal story to tell. My actions, achievements, shortcomings, and outright failures as husband and father, friend and neighbor, entrepreneur and volunteer, and as a practicing physician and medical colleague, have become essential measures of who I am. We are what we do.

Avedis Donabedian, a professor of medical care organization at The University of Michigan, offers this perspective:

Health care is a sacred mission...a moral enterprise and a scientific enterprise but not fundamentally a commercial one. We are not selling a product....Doctors and nurses are stewards of something precious.¹

Medicine is truly a way of life; an entree into the minds and bodies of other human beings; an intimate interpersonal relationship that helps enable healing and the well-being of others. It is a unique partnership unlike any other.

Sir William Osler wrote, "The practice of medicine is an

art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head."²

In the unceasing and often turbulent contemporary debate about health, there are calls for new programs designed to offer evidence-based medicine and patient-centered care, as if these honorable concepts have somehow just been discovered rather than have been evolving over time and reflecting the most fundamental values and deepest commitments of the medical profession. These terms have become the jargon of marketing and public-relations experts, and politicians who have inserted themselves into the complex interactions and relationships of our profession. I fear that in today's world, medical traditions and professionalism are on a collision course with corporate endeavors and national politics—driven by social economics. Access, quality, and price are the expressed concerns.

As we continue to move from a framework of personal opinion and authoritative judgment to ever-greater fact-based decision-making, the debate needs to focus on the quality and availability of information that can be used to make informed decisions, the ways by which we measure results (outcomes), and on the methods by which knowledge can be most effectively shared and applied to provide informed, compassionate, and comprehensive personal care for each individual.

New technologies provide more reliable information and ever-better data. It is essential that we seek new ways to carry out our mission, but perhaps some of today's urgent pleas for change reflect not only a desire for betterment of the science, but also recognition of a profound need to return to fundamental values established by the healing art of an earlier time.

We are reminded by Dr. Francis Peabody (ΑΩΑ, Harvard Medical School, 1906) that "One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient."³ Again, no one has said it better than Osler, "The old art cannot possibly be replaced by, but must be incorporated in, the new science."⁴

Nostalgia can never become a substitute for progress, but retrospection allows us to reflect on, and preserve, the important traditions that support and sustain our essential human values. The marriage of art and science is challenging, but it affords each a unique opportunity to flourish and to enhance the value of the other. We ignore this truism to the detriment of the profession, and at the peril of those we serve. It remains the responsibility of

physicians to ensure the triad of availability, accountability, and affordability in order to serve the needs of humanity.

As I started to experience formal academic and clinical studies at Johns Hopkins, I noted that my dad spent a good deal of time in conversation with his patients. He was a good listener.

I received the finest pre-med and medical education, taking required courses in biology, chemistry, and physics. Perhaps it would have been of greater benefit to have focused more on the humanities. These subjects have enduring value. Is it not true that the flying buttresses of the Chartres Cathedral are as much a reflection of ingenuity as the unwinding of the double helix of DNA? Or, that the genius of Mozart's *40th Symphony* rivals that of the computer software programmer?

In medical school we concentrated on contemporary discoveries in physiology, anatomy, and the traditional clinical disciplines. With hindsight I wish that I had been offered courses in medical economics, health care delivery systems designed to meet global needs, and academic studies in the history and evolution of medicine.

In the clinical years we focused on understanding the nature of disease, its causes, patho-physiology, clinical manifestations, and on accurate diagnosis and rational treatment. Great emphasis was placed on taking the medical history directly from the patient in comprehensive detail. It was important to note word choice and body language. The physical examination was carried out in meticulous detail—inspection, palpation, percussion, and auscultation. There was no listening to the chest through a buttoned shirt, no shortcuts in examining the abdomen, no skimping on the neurologic exam. Focus was on the patient, and on the disease. It was about getting it right, about winning, and losing, the battle against illness.

In his classic book, *Being Mortal*, Dr. Atul Gawande describes the process:

The simple view is that medicine exists to fight death and disease, and that is, of course, its most basic task. Death is the enemy. But the enemy has superior forces. Eventually it wins. And in a war that you cannot win, you don't want a general who fights to the point of total annihilation. You don't want Custer. You want Robert E. Lee, someone who knows how to fight for territory that can be won and how to surrender when it can't, someone who understands that the damage is greatest if all you do is battle to the bitter end.⁵

In my student years we did not acknowledge the inevitability of death, or study the process of dying. It is possible

to comprehend and accept that death can provide the ultimate relief from intractable suffering. Gawande puts it this way:

The only way death is not meaningless is to see yourself as part of something greater; a family, a community, a society. If you don't, mortality is only a horror. If you do, it is not.⁵ As our time winds down, we all seek comfort in simple pleasures—companionship, everyday routines, the taste of good food, the warmth of sunshine on our faces.⁵

Why do we remember some of our patients so clearly many years later? Perhaps it is because the relationship between physician and patient is so deeply personal. We knew them as unique individuals, friends, neighbors, members of a shared community. Perhaps it is because we gathered information from them through direct conversation and query. There was a process of relationship-building that constructed this physician-patient partnership, creating a bond that could be sustained through the most difficult times.

We invested the time needed to learn the lessons of caring—lessons about afflictions and adversity, life and living, death and dying, and compassion, empathy, and trust.

The intimate interaction between doctor and patient, a relationship that embodies mutual respect and trust, appears to have diminished. Perhaps that is due to administrative and corporate practices involving insurance and quality assessment mandates, and changes in the economic structure of reimbursement for health care services. Perhaps it is because of increased sub-specialization that often results in several physicians with different disciplines participating in the complex care of one patient.

We are caught up in a contentious political and economic debate over how health care services should be provided and paid for. Are they a right or a privilege? What about those who cannot afford essential services? Doctors have an obligation to actively engage in this discussion. Our elected officials and corporate executives should carefully read and closely follow the Hippocratic oath: "*Primum non nocere*. First do no harm." This is our challenge—and remains our responsibility.

In spite of all the changes in the socio-economics of today's society, the basic principles of the doctor-patient relationship have remained essentially unchanged. We want the best of diagnostic and therapeutic technologies, but beyond that we want someone to accompany us through the uncertainties of illness and on the final journey to the end of life. Someone who is experienced,

informed, open-minded, and continuing to learn. We want compassion and camaraderie, comfort, and a measure of control. We want a physician who is committed, capable, and empathetic, using the science of medicine to provide the art of caring. We want a physician who “exercises the heart as well as the head.” We want a doctor who finds joy as well as satisfaction in the practice of medicine. We want a doctor who is sustained by passion and purpose. We want someone who cares.

References:

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Acute abdominal pain

James J. Chandler, MD, FACS (AQA, University of Michigan, 1956).

In 1963, fielding a call from an Oregon physician and having an available bed, I accepted a nine-year-old boy with abdominal pain. He was a beautiful, bright child wincing in pain whenever he moved. He was apologetic about reacting to his discomfort.

He began having pain in the center of his abdomen a few hours earlier, with slight nausea. This became worse and more on the right side. His temperature was normal, and white blood cell count elevated. He was another patient referred who required careful evaluation of his history, all other factors and especially the physical examination of his abdomen.

Authors Dunphy (AQA, Harvard Medical School, 1933) and Botsford wrote, *Physical examination of the surgical patient*, published in 1953, considered by many to be the best textbook on the physical examination of the abdomen. My mentor and the Chairman of Oregon’s Department of Surgery was Professor J. Englebert Dunphy. We were in awe of this unforgettable teacher who was an excellent operating surgeon, and one of the world’s acknowledged surgical leaders. We all watched Dr. Dunphy as he

demonstrated examination techniques. His approach, the way he spoke, moved his hands, used his fingers, and his percussion of the abdomen regions were etched in our minds. We read, and re-read, Dr. Dunphy’s writings.

I spoke softly to my young patient as I leaned over to get down to his level. I said, “Do you have a dog?” This opened the door. I began questioning him about the onset of his symptoms and sequence of events. I spoke with his parents about others in the family, his schoolmates, and his parents’ impression of his illness. I examined his upper body, then focused on his abdomen.

I asked the boy to try to suck in his stomach, then “blow out your belly like a cat’s back.” He had trouble doing that. Probing a little more deeply, using tapping percussion technique, I found more tenderness in the center of the right side of his abdomen. I told him and his parents that I thought he probably had appendicitis but I wasn’t certain, that he should be observed and re-examined overnight. They agreed with this plan, as later did the staff surgeon.

Enter the intern!

Bruce graduated from Baylor Medical School about a month earlier. Bright, hard-working, eager, and young, he was well-groomed, polite, and knew everything he should about all the patients under his care. In short, he was a senior resident’s delight.

Bruce approached me an hour or more after we decided what to do about my young patient. He agreed with my findings, and the plan for observation. However, he said he thought we should check the patient for porphyria. I thought, “Oh, my God! What a pain! This is a rare disease we read about and never see.”

I told Bruce that I was certain the patient had appendicitis, but there was no reason I could think of that he shouldn’t be screened for porphyria. I put Bruce in charge of the project.

Bruce asked the boy to urinate in a basin and then put the basin in that Oregon August morning bright full sunlight. Hours later the patient’s urine had turned red! He had acute intermittent porphyria, and escaped a surgical scalpel.

I do not know what field of medicine Bruce pursued, or how his career progressed after his pediatric surgery rotation, I only know I shall be forever in his debt, and an admirer.