

When Mike Rein asked me to give the “Last Lecture” in place of Dr. LaCombe two things occurred to me: 1) I could never give a talk to match Dr. LaCombe who is one of our best medical story-tellers and; 2) In other than a clinical setting I have always hesitated to offer advice to others on how to live their lives which is, in part, what last lectures are supposed to do.

So what I have decided to do here today is to talk about some aspects of medicine I think are important. Many of these thoughts were published in 2003 in what was formerly called the *ACP Observer* while I was President of the College. There will be a few bits of advice mixed in with these comments. But, before I start, perhaps it would be helpful to our exchange for you to know a little more about me beyond the introduction Dr. Jones just presented. In fact, I hope I don't tell you more about me than you might want to hear.

As I read biographical sketches and personal statements from applicants to our internal medicine training program, I am most impressed with the thoughtfulness and maturity they show at such an early stage of their medical career. As I look back I see in myself none of the seriousness of purpose or desire to be a physician that I see in these applicants. As I grew up I knew nothing about college or career planning.

Neither of my parents finished grade school. We ran a small grocery store in Roanoke and one day in the store, my father said to me: “Munsey, you don't want to run this store, be a dentist. The hours and the income are much better.” So, in August of 1947 following high school graduation in June, and knowing little about what to do, at age 16 I enrolled in the then tiny college in my hometown, Roanoke College. I joined the pre-med, pre-dental line to register. It was most fortunate for me to attend a very small college. In a different college environment I would probably have been totally lost and not made it. Nevertheless, I did and subsequently came to UVA for medical school. Life was very fortunate for me in that medicine turned out to be a great fit and, in retrospect, I can't visualize myself doing anything other than being a

physician—except perhaps being Howard Cosell or Bob Costas. I have really enjoyed my career which has included research, teaching, and what I will speak most about today, patient care.

In any event, we have reached the point of my last lecture. This is my opportunity to provide my last audience with words of wisdom – wisdom and experience gathered over 57 years in the field of medicine if I begin the count from September 1951 when I started medical school. Most of us in a teaching role – or even in life in general – come to realize that it is almost impossible to transfer wisdom gained from experience from one mind to another. It seems that humans must learn from making their own mistakes. In the book, The Prophet, by the great Lebanese writer Khalil Gibran, a teacher says to the Prophet:

“Speak to us of teaching”. And the prophet said: “No man can reveal to you aught but that which already lies half asleep in the dawning of your knowledge. If he is indeed wise he does not bid you enter the house of his wisdom, but rather leads you to the threshold of your own mind. For the vision of one man lends not his wings to another man.” Yet, as I will stress later, we know that role-modeling is very important in the training of medical students and residents. So something is transferable.

This morning, as I mentioned earlier, I am going to talk about a few aspects of medicine, the teaching of, and the practice of, based on my experiences. Bearing in mind the words of the Prophet, perhaps I can lead you into the thresholds of your mind where I believe you already have imprinted much of what I will say. If the words of this last lecture influence any of you to be better teachers, better learners, and most importantly better physicians, this last effort will have been worthwhile.

Upon completing residency in 1959, I spent six years with the U.S. Army Research and Development Command, doing research and seeing the world. I studied iron metabolism in Washington, tropical sprue in Puerto Rico and cholera in the Philippines. I wish that physicians, in fact all citizens, were required to do

national service as we were then. It provided a time to mature one's planning for a career in medicine and for gaining a broadening experience while serving our country. I recommend to you, particularly those in residency to look for such opportunities either in federal or state service or through other means. The federal and state governments should expand their programs using the National Health Service Corps as a model. These opportunities for service should be readily available, highly publicized and tied to debt reduction and provision of care to underserved areas. Practicing medicine while educating medical students and housestaff has been most gratifying work. It pushed me to study as my field advanced and changed. It kept me ethically and professionally alert so that I could serve as a model for the students and residents. And, it kept me engaged in—and optimistic about—life as I saw patients demonstrate hope, courage and endurance in the face of illness.

Over the last 10 years we in internal medicine have become more concerned about the declining numbers of medical students choosing a career in our discipline. In 2003, the College began a multifaceted effort to revitalize internal medicine. However, if we are to attract more top-notch medical students to careers in internal medicine, we who are internal medicine's role models, in both academic and private practice, must show that we are excited about, proud of and professionally fulfilled by our work. Students need to see first-hand how we savor and meet the intellectual challenges of diagnosis, how we value keen powers of observation and judgment, how we feel called to give compassionate and skillful care to patients.

In view of the changing training environment brought about by a number of factors including: the increased acuity of illness in hospitalized patients, the shortened length of stay and very importantly, the work hours rules, leaders of training programs in internal medicine must re-dedicate themselves to adapt to these changes and to find better ways to teach patient-focused, targeted investigation based on thorough knowledge of pathophysiology, as well as on an attentive history and physical examination. This approach is key not only for enhancing interest in internal medicine, but also for achieving the best care for patients, for

making optimal yet judicious use of resources and, not insignificantly, for honing the internist's specific clinical acumen and judgment over time.

Students must also see their teachers as agents of their own professional destiny, striving to change those things that now hamper our work and dampen our spirit. They must see us succeed in improving the practice environment by working to reduce or streamline bureaucratic demands on our time and attention, and by advocating for and achieving more equitable physician reimbursement. And they must see us developing models of practice that are efficient, effective, professionally and personally satisfying, and meet the challenges of inevitable change. I hope you recognize that these points are major thrusts of current ACP practice and advocacy efforts. As physicians, we have an integral role in the process of political changes. With health care so thoroughly dependent on government actions, it is unrealistic to think of medicine apart from politics, always above the fray.

Immense changes have occurred in medicine in the nearly 53 years since I finished medical school. The training environment in the mid-1950s was so different from today, both in the level of supervision and the inpatient population that we treated. I recall with twinges of both fear and exhilaration having near-complete autonomy over patient care as a house officer at New York Hospital. As an example of a change in patient management, at that time, we kept myocardial infarction patients in the hospital on complete bed rest for three to four weeks. As a trainee, I had ample opportunity to learn clinical medicine at these patients' bedsides as they spent weeks recuperating. We residents got to know our patients well (and they, us). Through the days and nights we spent with them, we learned something of the art of practice.

Since then, that art has changed dramatically. On the plus side, to use the cardiac example again, we have substantially improved outcomes for MI patients. We now have greater understanding of cardiovascular

disease and its prevention, as well as a large range of medical and surgical treatment options. We discharge MI patients in days instead of weeks.

Perhaps the most vivid way for me to mark—and celebrate—the substantial progress we have made in diagnosis and therapy this last half-century is to recall one of my patients during residency who had fatal thrombotic thrombocytopenic purpura. Nancy was just 42 years old and previously had been healthy. Her illness began with subtle neurological changes that progressed relentlessly after admission, along with purpura and intestinal bleeding. No effective treatment was known and she died after three days in the hospital. Today, a patient like Nancy would almost certainly be treated with plasmapheresis with great success.

As I look back on my career so far, I find it ironic that while we have witnessed such amazing progress in medicine, we seem to experience so little satisfaction and joy as a result of that progress. Stunning advances in science and clinical practice have made it possible for us to help more patients and effect more cures than we ever dreamed in the early days of my practice. One would expect physicians to be ecstatic with the new medicine. On one level, of course, we are. We sometimes even take for granted our present astonishing clinical prowess.

But much of the joy we should experience has been dampened by practice hassles. These hassles largely stem from our country's failure to develop a coherent medical care system that keeps pace with changes in medicine and society. Our current fragmented “non-system” makes it hard to be a doctor today, especially the kind we all vowed to be. Whenever I talk with internists, I hear a similar lament: “I feel excitement and satisfaction when I am in the examining room with my patients, but these feelings are sobered when I then have to deal with the complexities of compliance, coding and insurance.” The sad reality is that for American internists, these hindrances steal time we could spend with patients and cause tremendous

professional dissatisfaction. The College has worked very hard for a number of years to alleviate the causes of our dissatisfaction but progress is slow.

Now, I want to turn to that aspect of medicine about which I feel most strongly—the compassionate care of patients. It distresses me terribly when I hear of uncaring physicians as I did just last week from my cousin who was referred to a gynecologist in New York City. She described being treated in a cold, condescending and dismissive manner. She was very upset when she called me to relate her experience. I really wonder why such people like her gynecologist choose medicine as a career.

Medical educators have been concerned about medical students and residents becoming less empathetic as they progress through medical school and residency training. The most recent report showing these troublesome findings was published in this month's issue of Academic Medicine. Most schools of medicine have been reviewing their curricula and their learning environment to try to enhance the development of compassion in their trainees. As a result, medical education has started to focus more attention on "humanism in medicine" and on "medical humanities".

One wonders at times whether compassion can be taught but clearly it is important to try. Of course, involving students with the humanities to stimulate sensitivity to the human condition should begin before medical school. Many of us believe that premedical students should have a curriculum focused more on humanities than science. Across the country Schools of Medicine are trying to provide an environment which stresses professionalism and caring and concern for others. As a result of this effort, it is certainly evident to me that medical students are treated differently now than in the past.

When I entered medical school in 1951, the Dean may have said hello before we were handed a box of bones and told that an exam on those bones would given in one week – hardly a way to stimulate

humanistic feelings and professionalism. Now at the University of Virginia and many other schools of medicine, when our new medical students arrive, we have a convocation highlighted by an inspirational talk focused on humanism and compassion. In addition, in the first week, we have what is called a white coat ceremony at which the Dean presents every new student a white coat to symbolize their entry into the profession of medicine and what this means. Among the other aspects of professionalism it is pointed out that the core of professional behavior is ALTRUISM: one is expected to place the interest of those served above self interest. This approach is a good start but more is necessary.

The medical schools faculty physicians caring for patients in teaching settings must be role models for the medical students by practicing in a compassionate fashion every day. This is a heavy responsibility for physicians who teach students because with the daily demands of practice, research and teaching, it is sometimes easy to lose sight of our primary purpose as physicians: providing compassionate care to our patients.

Sometimes we need to remind ourselves that being a good doctor is not simply a matter of maintaining knowledge and technical skills. We must also nourish and exercise those humanistic qualities that our patients and their families most want and need in their physician: kindness, personal warmth, and compassion.

Allow me now to share with you some personal experiences from my own practice. After many years of practice, and teaching, and enjoying good health, I gained much more insight into patients' feelings when within the recent past, I had two febrile illnesses. The first was pneumonia and the most recent, despite immunization, was influenza. During each of these illnesses, I had a high fever and felt terrible. Some might call what I experienced "toxic delirium," but during the first fever bout, my mind revolved continuously through my file of patients. Faces flew by. In sharpest focus were those who had died. I was overwhelmed

with admiration for these brave patients. How many of them had presented an optimistic, even smiling persona during our short time together in the office or hospital only subsequently to endure fear and uncertainty during long, often lonely nights! In my feverish discomfort, I wondered how they had summoned the inner strength to deal with greater suffering and far more serious illnesses than my limited one. In fact, I became so overwhelmed by this feeling that during the fever bout I asked my wife to take notes on my ramblings. It was a surprise to me when I read her words following my recovery. The notes rang true with the feelings I had experienced.

In more than thirty-five years of practice, I have cared for patients with serious hematologic disorders; my patients often required toxic chemotherapy and many had a far-from-certain outcome. In my feverish state, I kept wondering how my patients dealt with the terrifying uncertainty that is often at the heart of their illness, and I wondered too whether I had done enough to ease their discomfort and help them maintain hope. These illnesses and the insights I gained provoked me as a doctor to “suffer with” my patients more than I ever had before.

“Suffering with the patient” is the classic definition of compassion in medicine. It is an imaginative leap into another's shoes, a move enabling us to appreciate firsthand something of what it feels like and means to be that particular patient. Those of us who attended the 1999 Virginia ACP Chapter meeting heard a poignant testimonial to the power of a compassionate act to make a difference for a patient. In a stunning presentation, Steve Schalchlin, an accomplished pianist and entertainer afflicted with HIV/AIDS, told us how several years earlier he had reached the limit of his ability to tolerate not only his illness but also the toxic treatments for his many opportunistic infections. Late one night, when his will to live was at its lowest, a young nurse came into his hospital room. She sat with him, took his hand and quietly said, “You know, you're our favorite patient on this floor.” That kind, compassionate act, Mr. Schalchlin told us, rekindled his spirit and sparked his will to live.

As Mr. Schalchlin's experience suggests, compassion in the patient-physician relationship can influence outcomes and change a patient's ability to confront an illness. Teresa Gilewski, MD, wrote in the Dec. 26, 2001, *Journal of the American Medical Association* about compassion's subtle yet forceful therapeutic power. She pointed out that it is easy for physicians to focus on the power of medical science and technology—and forget about the potentially profound influence of compassion. Yet even momentary expressions of compassion by a physician can be deeply meaningful and potentially healing to a patient.

Dr. Gilewski wrote eloquently of a cancer survivor who recalled with special gratitude a young house officer who would take just “a few extra minutes” at the end of a busy day to sit and talk with him, sometimes about his therapy but often about nothing at all medical. Years after his grave illness and life-threatening treatment, the patient remained “touched by moments of compassion that enveloped him with a comfort from knowing that others wanted to alleviate some of his suffering.”

Experiencing compassion also affects the doctor. Even in situations where we can make little apparent medical difference, offering a patient our compassionate presence means that we learn something of who this other person is, and of what it means to be human. “In some of those ‘extra moments’ spent with patients,” Dr. Gilewski wrote, “I’ve heard about unfulfilled dreams, fears and relationships. Sometimes I forget how much I’ve learned about life from these people.” By taking the time and interest to “suffer with” a patient, she continued, “the patient-physician relationship is temporarily suspended and transcends to one of human being to human being.”

When I was practicing, it was reassuring to recall that many patients and the families of deceased patients had told me that our relationship—and their perception that I truly cared about them—had helped them bear not only difficult treatments, but also the deeper anguish that a grave illness can bring. That I had

somehow shared in their suffering and allowed their suffering to touch me mattered to them deeply.

We need frequently to remind ourselves how important compassion can be in helping patients cope with illness and find healing. Compassion can easily be made part of our daily practice: As Dr. Gilewski wrote, “The opportunity for compassion presents itself every day in every outpatient clinic, in every patient room and in every hospital hallway.”

In addition to excellent clinical skills, listening, touching, and displaying genuine warmth and sensitivity to the needs of our patients and their families are the hallmarks of the compassionate physician. We must make compassion a core element of our everyday clinical competency. Only by doing so will we be the physicians our patients want and need. We must also make sure that medical students and residents experience physicians who exhibit compassion in patient care. By observing compassion at work, this next generation of physicians will learn its artful practice.

All of you have heard the quotation I am about to present, but for me, they remain the last word on compassion in patient care. They are the simple closing statement of Francis Weld Peabody, MD, in his 1927 Harvard Medical School address: “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.”

I hope that this review of my experiences and feelings have, in the words of the Prophet “led you to the threshold of your own mind” and that entering this threshold will stimulate you to be excellent role models to foster the development of skillful and caring physicians.

Thank you for this opportunity to present my “Last Lecture”.