AMERICAN OSLER SOCIETY

February 2017

Volume 17 - Issue 4

The Oslerian

President Joseph VanderVeer, Jr. 47th AOS President installed at the 2016 meeting at Minneapolis

A Message from the President

TWO FINAL HEROES: A MEDICAL HERITAGE

By Joseph VanderVeer, Jr.

The year was 1954. A young, handsome missionary was home on leave from Egypt with his gravid wife, who was to have medical consultation with Joseph B. VanderVeer, a cardiologist in Philadelphia. As he looked about the doctor's office, his gaze fell on a simple wooden sign in block letters that read DR VANDER VEER, centered amid the diplomas on the wall. He asked the doctor, "You don't happen to have any relatives in Iowa, do you?"

The man had brought his wife – in her fourth month of a pregnancy complicated by mitral stenosis – to see my Dad, a consultant who had a special interest in rheumatic heart disease in pregnancy. Yes, Dad answered, his father, Frank VanderVeer had been a GP in Iowa. The sign on the wall [Fig. 1] had been Frank's office "shingle."

Figure 1: Frank VanderVeer's Shingle

The husband related he became a missionary because of a fervent prayer by his mother when he was fourteen, in a coma from a head injury after falling off a hay wagon. In the prayer she promised God he'd become a missionary if he recovered. After Dr. Frank VanderVeer drilled a burr hole to release a blood clot in her son's head – done on their kitchen table in Cedar Falls, Iowa – he woke up and made a full recovery.

My grandfather, Frank VanderVeer, [Fig. 2] got his M.D. from Iowa in 1894, the year before Harvey Cushing got his from Harvard. Frank went on to be a rural general practitioner and Harvey, as we know, became the doyen of American neurosurgery. In my file I have a clipping from a 1947 article in the Cedar Falls *Daily Record* celebrating Frank Vander-Veer's 54 years in the practice of medicine, in which he delivered over two thousand babies, did a variety of surgical operations – appendectomies, hernia repairs, cholecystectomies – and at least three other documented emergency operations for head trauma. During World War I he served as a captain in the medical corps, head of the hospital at the Great Lakes Naval Training Station. The article said he was responsible for 3500 trainees and related he lost only two patients when the great pandemic of 1918 came through.

Figure 2. Frank L. VanderVeer, M.D. **(1869–1954)**

Granddad practiced until he was 79 and lived to be 85. I took the train out from Philadelphia to visit him and his wife Clara when I was twelve and he was 81. While I was there he brought out three things he wanted me to have: a mortar and pestle, a double barrel sixteen gage shotgun, and a slender surgical instrument of his own design. He said early in his practice he used the mortar and pestle to compound prescriptions for his patients. The shotgun had too great a kick for him now, and

Please turn to next page

President's Message (*Continued from page 1*)

he'd like to trade it to me for an over-and-under 410 /.22 combination shotgun/rifle he'd seen in a catalogue, that he could use to shoot the rabbits that were eating up his garden. I didn't own such a gun, and of the three gifts the only one I took home in my suitcase was the instrument, a slender stainless steel rod, 8" long, with a sharp, double-wire curlicue tip that he said he used to fish out peas, peanuts, and other spherical foreign bodies from children's noses and ears. For me, it came in handy twenty years later when I served in the Indian Health Service.

(One of my early cases was a six year old boy sent by the school nurse because of a horrible odor. She'd checked his mouth and teeth found nothing. When I saw him he indeed smelled awful. He had a plugged nostril, out of which, with the help of Granddad's instrument, I carefully teased a gooey, foul-smelling, impacted piece of Kleenex the size of a cigarette! To go at it with a hemostat would have just pushed it in further. Granddad's instrument did the trick.)

Frank VanderVeer was an avid gardener and had a big garden. Four years after my visit he didn't come in for lunch when Clara called. She found him slumped in the wheelbarrow, hoe in hand – just the way he would have chosen to die.

My father [Fig. 3] was a hardworking physician. Although our family schedule was arranged so we always had breakfast and supper together, we didn't see a lot of him when we were growing up. He left for the hospital to make rounds after our early breakfast and usually went back to see patients after supper in the evening. He never watched TV and I rarely saw him reading a book. We never played catch. Later I encountered a quote from Mark Twain that resonated with my teenage years:

"When I was a boy of 14, my father was so ignorant I could hardly stand to have the old man around. But when I got to be 21, I was astonished at how much he'd learned in 7 years."

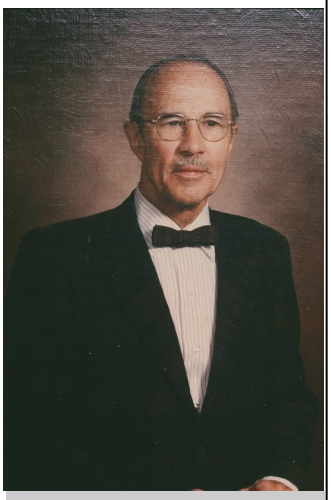


Figure 3. Joseph B. VanderVeer, M.D. (1905-1998)

What a contrast was the father of one of my girl friends who had taken early retirement and was always at home. Whereas my father spent four years in the Army Medical Corps in the South Pacific during WWII, this man made a fortune at home making brass propellers for liberty ships. He read widely, spoke fluent French and Italian, had many interests and was a brilliant conversationalist. He was sophisticated. Even after I stopped dating his daughter, I'd go visit him, and through him I became familiar with authors such as Stefan Zweig and Albert Camus. We spent many hours chatting and he wrote a letter that I'm convinced got me into college.

But despite my friendship and admiration for this older man, I began to notice some disturbing contrasts with my father. Dad didn't smoke and rarely drank; but I seldom saw this man without a cigarette or a cocktail in his hand. My father spent most of his time helping others; but this man was self-absorbed and not at all community-minded. Although he was highly intelligent, he was not well respected, whereas I continually ran into people who sang the praises of my father. In short, as I grew up and experienced the world, my esteem for my father grew; but for the other man, it faded. Later I encountered this in the Book of Proverbs: ***The righteous walk in integrity – happy are the children who follow them!*** [Proverbs 20:1]

My father Joseph was born in 1905. Like his father Frank, he also graduated from Iowa in Medicine. At the suggestion of Iowa Professor C.P. Howard – who had trained in Canada and was Osler's godson – Dad interned in Montreal and took a year of pathology at Montreal General Hospital. He took an internal medicine residency at Lakeside in Cleveland, then came to Philadelphia in 1932 as chief resident at Pennsylvania Hospital. After that, he served five years as a fellow under Dr. William Stroud, one of the first heart specialists in that city. Dad then set up his own practice. But after the attack on Pearl Harbor, he volunteered to serve in WWII.

He rose to the rank of Army colonel, head of the Pennsylvania Hospital Unit in the Pacific. He was gone 42 months. Mother later told me the story of his unit's arrival back in the States. I was seven, holding on to her skirt. After watching her in a long embrace with an olive-complexioned, mustachioed man, I tugged on her skirt. When she bent down, I whispered, "Is that man going to stay all night?"

Dad loved music. He played the violin and the banjo and led a dance band to pay his way through college and medical school. Music was his sole indulgence, and because Eugene Ormandy was one of his patients, we had season tickets to the Philadelphia Orchestra. As a boy, Dad heard Fritz Kreisler play, and a highlight of my youth was attending an Ormandy concert with Dad in which guest artist David Oistrakh played ***three*** violin concertos – during the Beethoven cadenza his bow broke and the concertmaster immediately stood and handed his over and the Russian kept right on furiously bowing. Dad said he was as good as Kreisler.

Iowa professor William B. Bean – a founder and first president of the AOS – was one of my father's friends. Dad sent me a copy of Bean's *Sir William Osler Aphorisms* when I was a medical student. When I became familiar with the Society, (after Dad's death in 1998) I was surprised that he'd not been a member, for

Continued on page 3

President's Message (*Continued from page 2*)

in his library he had several books by Osler. Dad did belong to the American Clinical and Climatological Association – a group similar to the AOS in some respects – and I attended two of their meetings with him; I concluded that as a busy cardiologist, he felt he did not have time for both.

Bernard Lown was another of Dad's friends. He sent Dad one of the first Cardioverters off the American Optical production line and I happened to be home from medical school the first time it was used in Philadelphia. The patient, a policeman with atrial fibrillation lay supine on the operating room table. He was 6'4"; Dad was 5'6". The only monitor was an old hot stylus EKG machine. When the patient was asleep and the anesthesiologist nodded to go ahead, Dad stretched to hold the paddles against the big chest as I pushed the button on the Cardioverter. The jolt knocked the stylus off the paper. It slowly returned to record the tracing as we watched and let out our breath: the irregular AF had become a regular sinus rhythm with an underlying Wolf-Parkinson-White abnormality. For me, it was as good as Ormandy and Oistrakh!

At Dad's retirement party I was asked to make a few remarks. In a short speech I called "Things My Father Taught Me," I told some of the things I'd learned from making rounds with him and attending his Thursday night Heart Clinics at Pennsylvania Hospital when I was home on vacation from college and medical school. They were tips like: Always sit down next to the bed on rounds; Take the pulse – don't be afraid to hold the patient's hand: A few minutes at the bedside will be much longer to the patient and will cost you little time; There are only twenty-four hours in a day – but never less; Treat every patient like a VIP; some patients will be VIPIs (very important persons, indeed). All these maxims were important influences as I matured in medicine. I concluded my talk by relating an experience from my youth that was almost as dramatic as what I witnessed later with the Cardioverter.

On a Saturday in the summer of my eleventh year Dad asked me if I wanted to go in town with him when he made rounds at Pennsylvania Hospital. It was a hot, muggy day and I welcomed the chance to read in the coolness of the 20°C atmosphere of the Basal Metabolism room in the Heart Station. He parked the car on the street across from the hospital entrance. As we parted he told me to meet him back in the car in an hour. He took in hand his ophthalmoscope, his stethoscope and heavy mercury sphygmomanometer, the latter a pop-open aluminum box containing two pounds of mercury. [Fig. 4] What unfolded an hour later was a succinct lesson for a young future physician. I later sought to apply its manifest virtues to managed care in my own medical practice.

An hour later I went back down to the car where I rolled down the window to watch the activity about the large stone archway – the ambulance entrance to the receiving ward (ED). Soon Dad appeared under the arch, and stepped up to the curb. Just then a woman screamed, **"Stop Thief!"**

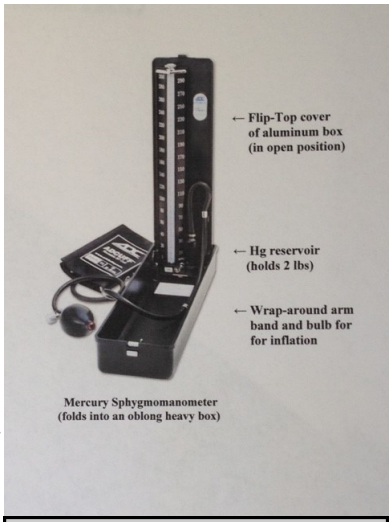


Figure 4. The Cardiologist's Weapon

Off to the right I saw a large man who had just snatched a woman's purse and was running down the sidewalk toward Dad, who was looking over toward me. He didn't turn to look at the man (First virtue, ***Discretion***). But as the fellow was about to pass behind him, Dad suddenly thrust his leg back. (Second virtue, ***Courage.***) The thief tripped and fell to the ground, and Dad hit him in the head with the sphygmomanometer, knocking him out cold and opening a gash in his scalp). Dad picked up the purse, handed it to the woman (Third virtue, ***Chivalry***), then grabbed the thief by his pants cuffs and dragged him through the arch into the emergency department. On the way home Dad said he told the ever-present policeman to arrest the man, and had the intern on duty sew the man up (demonstrating the virtues of ***Efficiency*** and ***Brevity***). I later realized there were no forms to fill out and no delays for authorization by managed care. I inherited that blood pressure machine and it still has a dent. It became prized part of my diagnostic equipment and of my Medical Heritage.

American Osler Society Convenes in the Deep South in Atlanta, GA

EMORY CONFERENCE CENTER HOTEL
April 9-12, 2017

Time to start planning and thinking ahead for the annual A.O.S. meeting at Emory University in Atlanta, **9-12 April 2017**. It is not too early to call and make reservation at hotel, register for meeting, and also pay annual dues if you have not yet done so.

For those driving or needing address for UBER, here is the venue address:

Emory Conference Center Hotel
1615 Clifton Rd, NE
Atlanta, GA 30329
404-712-6000

Atlanta Roads are unorganized and there is no grid. All roads lead to Emory so if you see a road sign that points to Emory but does not fit with your google maps directions, ignore the sign. Traffic is bad so try to avoid arriving at rush hour.

From the airport, for **domestic travelers** (Hartsfield-Jackson International Airport), it is about 17 miles to the hotel and 35 minutes. Cab rides will be about $50 - $55. UBER-X and LYFT have formal sanction to pick up passengers at the airport as of Jan 2017 so easy to get back and forth to the airport by UBER/LYFT, about $18 - $26, with about a $4 surcharge for UBER-X. Be aware that UBER-X is the only formal UBER option **from** the airport to hotel. You can ride the **MARTA Rapid Transit** from the airport for $2.50 plus $0.50 ticket fee - $3 no matter how you slice it. There is only one rail-line from the airport, easy to access from baggage claim area - just follow the ground transportation signs, and the rapid rail train runs straight north to the Lindbergh Station (25 minutes). The track splits north of the Lindbergh Station, so it does not matter which train you get on at the airport – if two trains are there, just get on the one that has the doors open. You then have to ride the Clifton Rd. bus (Route #6) so get a bus transfer when you exit the station. Yes, I know, a bit of a hassle but cheap. Bus ride from Lindbergh Station to Clifton Rd is about 15 minutes then about a 300 yard walk – the hotel is set back in the woods off of Clifton Rd. Even better, just **UBER or use cab from the Lindbergh Station (2424 Piedmont Ave, Atlanta, 30324**) to the hotel, about 4 miles, $8-10, and 12 minutes) plus avoid the 300 yard trek from Clifton Rd to the hotel lobby. Super Shuttle is a good option from the airport. (**SuperShuttle.com** or **atlairportshuttle.com** > about $35).

IMPORTANT IMPORTANT IMPORTANT International Attendees: Accessing the MARTA Rapid Transit from the **international terminal** is a major neurological inconvenience, also known as a headache. It involves a twelve minute bus ride from the international terminal to the Rental Car lot, going up four flights to a monorail taking you to the domestic terminal and then finding your way to the Airport MARTA Station. Takes about 45 minutes just to get to the MARTA Station and I do not recommend it. **Just do UBER-X, cab or Super Shuttle**. When returning to airport after conference, important to tell driver you are going to the **International Terminal**. Interstate access to the international terminal is via I-75, not I-85.

PLANNING FOR MEETING
APRIL 9-12, 2017

Sunday:

Sunday afternoon, April 9, 2017 is busy with options and you have to make choices. Plus come either Saturday April 8th or fly in early Sunday so that you may take full advantage of these opportunities.

- **Walking Tour:** I will give a walking tour of the Emory university campus. Meet in the hotel lobby at 11 AM. Budget about 60-70 minutes. Bring walking shoes.
- **Oakland Cemetery Tour**: Leave at 1:30 PM return about 4:00 PM. Tour guide is Martin Moran, MD. Google this and read about the historical cemetery. After the tour, have a snack and a drink at the adjacent pub, Six Feet Under, but you will have to UBER from there if you do not ride back on the bus – about six miles.
- **Civil War Tour**: For preview, go to Southern Spaces and click on "The Battle of Atlanta: History and Remembrance". http://southernspaces.org/2014/battle-atlanta-history-and-remembrance. Leave about 1:30 PM and return around 3:45PM. Tour guide is the well-known Civil War historian Dr. Daniel Pollock.

There will be a small charge for these two tours of $15 to offset bus charges.

- **Frank Neelon Annual Literary Gathering** will commence at 3:00 PM till 5:00 PM. Bring your Osler themed haiku. It is possible that I might have a haiku master there to critique your haiku efforts. Read up on haiku before attempting to create any of your own.
- **Past Presidents' Dinner Meeting (5:00 - 6:30 PM)**
- **AOS Board Meeting (7:00 – 9:00 PM)**

Monday:

On Monday, the Presidential Address will feature Joseph VanderVeer, Jr, MD. This will be in the Victory Bell Pavilion, a free-standing rustic venue overlooking the woods in a bucolic and serene setting. Budget 49 seconds to get there from the hotel lobby. Cash bar for reception but wine served with dinner.

Tuesday:

The Tuesday Evening Banquet will be housed in the Rollins School of Public Health on the 8th floor overlooking downtown Atlanta. This will be a buffet style old-fashioned barbecue but with vegetarian options available. In a break from tradition, there will be a speaker. Eric Solberg, MD, Vice-President, Academic and Research Affairs, from the University of Texas, Health Science Center at Houston will entertain us. A.O.S. members and guests will be treated to a passionate and dynamic account of the history of the tobacco industry and the campaign to eradicate smoking. Dr. Solberg and his partner in the anti-smoking effort, Dr. Alan Blum, have amassed a collection estimated to contain nearly 200,000 artifacts chronicling the very genome of the cigarette industry. Did you know one of the first lectures on the deleterious effects of smoking was delivered around 1604? This is a do-not-miss event and I encourage spouses, medical students and graduate students to attend. We hope to have on display thirty or so artifacts from this collection.

DINING: Those seeking fine dining should plan ahead and make reservations. Nearby quality restaurants include **Floataway** (1123 Zonolite Rd. Atlanta, 30306 > 404-892-1414), **General**

Continued on page 5

Muir (Avenue Place, Atlanta, 30329 > 657-927-9131), which is 3 minutes walking distance, great for coffee and breakfast too, plus incredibly silky calorie-enriched cheesecake. For those seeking somewhat more adventuresome dining, try the **Double Zero** (1577 North Decatur Rd, Atlanta, 30307 > 404-991-3666) in the Emory Village. The hotel has a pub with superb outside sitting space. Check with the hotel concierge, as frequently they will be happy to take you and pick you up in the hotel's courtesy van. There are a number of other dining opportunities at **Emory Point**, a three to four minute stroll from the hotel.

Nearby Museums: The **David Sencer CDC Museum** (1600 Clifton Rd, Atlanta, 30333 > 404 -639-0830 > www.cdc.gov/museum/) is within walking distance, located across the street from the hotel - about a 7 minute walk. Quite intriguing, informative, and interesting and free but not open on weekends. On the Emory campus, **the Michael C. Carlos Museum**, a world class museum with Egyptian, Roman, Mesopotamian collections. Admission $8. Open Saturdays 10:00 – 5:00 PM & Sundays 12:00 – 5:00 PM. 571 South Kilgo Circle, Atlanta, 30322 > 494-727-4282. About a 14 minute walk from hotel. Exercise enthusiasts and nature lovers bring your shoes. Two large parks **(Hahn Woods & Lullwater Park)** with extensive walking trails free of cars, each a short walk from the hotel.

American Osler Society Committee Membership 2016-2017

COMMITTEE	CURRENT CHAIR	CURRENT MEMBERS	NEW CHAIR	ROTATES OFF	NEW MEMBERS
Bean Award	S. Podolsky	J. Duffin, J. Erlen, J. Murray	No change	None	None
McGovern Award*	H. Swick	P.Miller, S. Moss	P. Mueller	S. Moss	None
Lifetime Achievement Award	B. Fye	R. Kahn, P. Kligfield	No change	R. Kahn	S. Moss, C. Pierach
Nominating*	H. Swick	P. Miller, S. Moss	P. Mueller	S. Moss	None
Finance	M. Molina	D. Bindschadler, B. Cooper, M. Stone	No change	None	None
Membership†	L. Drevlow	J. Richardson, V. McAlister, E. Matteson, S. Peitzman	C. Partin	L. Drevlow	None
Publications	M. Jones	C. Lyons, W. Roberts, J. Greene, H. Travers	No change	None	M. Malloy
Annual Meeting – Program Committee#	J. VanderVeer	L. Drevlow, W. Evans, G. Frierson, R. Mennel, C. McAlister	L. Drevlow	W. Evnas, G. Frierson, R. Mennel, C. McAlister, J. VanderVeer	J. Bailey, C. Partin, S. Peitzman, H. Travers, M Wardlow
Annual Meeting – Local Arrangements Committee	D. Pierach, L. Drevlow	C. Boes (Executive Cmt. Liaison)	C. Partin	C. Pierach, L.Drevlow	B. Silverman, W. Jarrett

OSLER FOR WHITE COAT POCKETS

A *Vade Mecum*

Listed below is the Preface and excerpts from the "Pocket Manual" (Vade Mecum) written by Joe VanderVeer and Charles Bryan for medical students.

Preface

Almost fifty years ago Drs. John P. McGovern and H. Grant Taylor, attending the annual meeting of the Association of American Medical Colleges (AAMC), heard medical students express dissatisfaction with their education which they frequently described as "dehumanizing." The students, they concluded, seemed to be expressing needs that Sir William Osler (1849-1919) addressed during his lifetime. He was the most celebrated physician in the English-speaking world at the turn of the twentieth century Two years later McGovern and Taylor helped organize a symposium to mark the 50th anniversary of the death of Osler, which was published under the title *Humanism in Medicine*. It was the last major gathering of people who had known Osler personally.

McGovern became the driving force behind the founding of the American Osler Society (AOS) in 1970, which evolved into an international organization to perpetuate Osler's life and ideals. (In this volume Appendix A is a brief life of Osler and Appendix B gives information about the Society.) The authors of this pocket manual (called a *Vade Mecum* from the Latin, meaning *Go with Me*) are members of the AOS. Joe VanderVeer, Jr., a surgeon, taught at the University of Oregon in Portland, OR, and at the University of Arizona in Phoenix. Charles S. Bryan, an internist specializing in infectious disease, was professor of medicine at the University of South Carolina

Osler once said he'd like his epitaph to be "I taught students in the wards," and indeed, his forte was bedside teaching. Nowadays one rarely encounters bedside teaching, and much has changed since Osler's day. But we believe his ideals and aphorisms are still inspiring, for he was the epitome of the humanist physician. They form the basis for this *Vade Mecum*, in which we share many of his counsels as well as some of our own. It is meant to supplement efforts now being explored by medical educators and by outside organizations, notably the Arnold P. Gold Foundation, to promote humanism in medical practice. We believe that the character of the physician still matters in an age during which health care is increasingly seen as a commodity to be bought and sold like any other. Several of our chapters discuss character and virtue ethics.

Efforts to encapsulate the best of Osler's wisdom and aphoristic advice began with Osler himself, who in 1904 published *Aequanimitas With other Addresses to Medical Students, Nurses and Practitioners of Medicine.* Consisting of 18 addresses delivered between 1899 and 1903. *Aequanimitas* solidified Osler's reputation as an inspirational figure just as his 1892 textbook *The Principles and Practice of Medicine* had established his reputation as the foremost generalist-physician in the English-speaking world. We cite many of Osler's writings in this book (most are in boldface type) and for simplicity in the footnotes, his essays and addresses are named by title only, with complete information given in the bibliography. Other referenced authors are cited in footnotes by name and year of their publication, with the complete citation given in the bibliography. That extensive list of references also includes a number of other collections of Osler's essays and addresses since *Aequanimitas* was brought out.

We recognize all too well that today's students and residents, immersed as they are in digital technology, may lack the time and inclination to delve into the humanities to the extent that members of previous generations of physicians were encouraged to do. Perhaps this small volume, kept in white coat pockets as a *Vade Mecum,* will be of help, and we hope to receive feedback and comments from our readers.

We thank our colleagues and friends who have made helpful comments.

THE QUEST

In his forward to the 2015 *New York Times Book of Medicine* physician-writer Abraham Verghese wrote:

The AIDS epidemic changed my career and my life. Among the many things I learned was that when one could not cure, one could heal. By that I mean that even in this fatal illness, one could help the patient and the family come to terms with the disease, one could relieve pain and suffering; I learned that healing occurred by one's presence, by caring, by being there for the patient through thick and thin. It was something the horse-and-buggy doctor of a century before understood; even in those pre-antibiotic and pre vaccine days when scarlet fever and typhoid and

tuberculosis were untreatable scourges, the doctor still had much to offer.

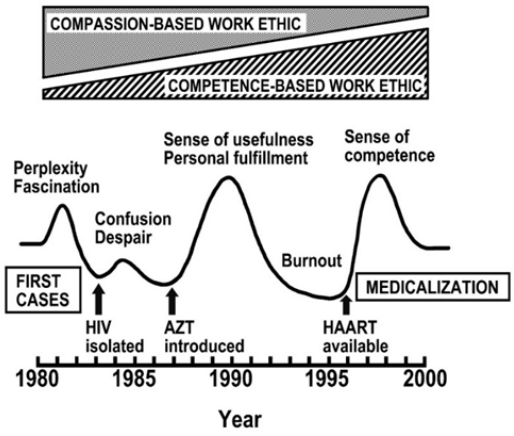
The physician of today has a great deal more to offer than in the pre-antibiotic and pre-vaccine days. Osler's era was like that, but the humanistic spirit that motivated Osler still is relevant today. New diseases like AIDS or SARS or Ebola bring new challenges, but beyond the technology and the new therapeutic agents, the relationship of patient to physician remains as the basis for healing. As students and residents in training to be outstanding physicians, you are on a Quest for wisdom, knowledge and skills that will make you extraordinary doctors.

In an 1892 address at the University of Minnesota, Osler congratulated the students on choosing medicine as a career:

"*Students of Medicine, Apprentices of the Guild, with whom are the promises, and in whom centre our hopes—let me congratulate you on the choice of calling which offers a combination of intellectual and moral interests found in no other profession, and are not met with at all in the common pursuits of life—a combination which, in the words of Sir James Paget, "offers the most complete and constant union of those three qualities which have the greatest charm for pure and active minds—novelty, utility, and charity."*

Novelty, utility and charity are three facets of the challenge of medicine, of the Quest that you have embarked upon. One of the authors of this *vade mecum* (CSB) experienced that challenge in mid-career much as Dr. Abraham Verghese did. The **novelty** was facing a totally new and frightening disease; **utility** was involved in seeking a treatment, hopefully a cure for the disease, once it had been identified; and **charity** was to characterize the care given to his patients. Here is his account.

As an infectious disease specialist, the HIV/AIDS epidemic gave me the opportunity to live through what amounted to a truncated history of medicine between 1981, when "AIDS" first came to the world's attention, and 1996, when high-active antiretroviral therapy (HAART) became widely available. In retrospect, it was an attenuated, emotional roller coaster as shown below.



The wavy line indicates the emotional well-being of infectious diseases specialists during this period. In the beginning, the medical work ethic was primarily "compassion-based" because doctors lacked drugs and other technologies to do much for their patients. After HAART, the disease became "medicalized" and the work-ethic became primarily "competence-based." (See chapter COMPETENCE AND CARING)

Beginning in 1981 the early cases left us fascinated but troubled and perplexed. What was it? What could we do for it? It was a grim novelty. We felt as though we'd been thrown back into medieval times—people were dying of a strange disease of which we knew little and for which we could do essentially nothing. As it became clear that we had on our hands a major epidemic, we became depressed. We became, perhaps for the first time, real *doctors* who made house calls, immersed ourselves in knotty social prob-lems, and responded to the public demand for answers.

In 1983 isolation of the causative virus (now known as HIV) gave us the hope that help was on the way, but the patients kept coming and coming, dying and dying, and we became increasingly confused and despondent. The 1987 demonstration that the new drug AZT (now known as zidovudine) pro-longed life excited us, like everyone else. But the epidemic still spread and its implications caused great public anxiety. Infectious diseases specialists were suddenly in great demand. Most of us became minor celebrities in our hometowns.

But the promise of AZT proved illusory—it bought patients about six months before the virus became resistant to it. More and more patients came and died. Many and perhaps most of us suffered from burnout. The intense research work—the utility—began to bear fruit. In late 1995 HAART became available. Suddenly the disease was eminently treatable. Provided they understood the disease and took their drugs faithfully, most people infected with HIV could lead near-normal lives. The disease had become "medicalized." Within the span of just 15 years, we'd gone from practicing "medieval medicine" to diagnos-

OSLERIAN VIEWS

ing and successfully managing the disease by using the most powerful tools of molecular biology!

In the beginning, we (that is, infectious diseases specialists) had little or no "competence" to offer, so we focused on caring at its highest levels including "compassion" in the sense of becoming fellow sufferers. We gave freely of our time. To various degrees we made significant sacrifices, and sometimes took personal risks, to care for sufferers from this devastating disease. The care ethic was primarily "compassion-based."

Later, the availability of HAART along with molecular tools for diagnosing and staging the disease made the care ethic primarily "competence-based." Patients no longer needed house calls. They no longer need long emotional support sessions, at least not from doctors. The focus of our anxieties began to shift. At first, we worried whether we were giving our patients enough emotional support. On a Sunday afternoon, for example, should we indulge in watching the second half of a pro football game, or go out for nine holes of golf—or should we drive 30 miles into the country to see one of our dying patients whom we'd probably never see again. But later, and continuing into the present, our main concern centered on doing the best possible job at managing the various drugs and keeping watch for potential toxicities.

We do not wish on any of the readers of this *vade mecum* something as terrible as the HIV/AIDS epidemic. It's far better to absorb these take-home points just by reading about them. Still, we predict for all of you a life of "novelty, utility, and charity" beyond your wildest expectations, for they apply to many other fields of medicine. We suspect that both individually and collectively you'll be up to the challenge of the Quest as you continue to absorb skills and knowledge and learn to apply them with wisdom and compassion.

The Medical Humanities Section is meant to highlight activities in programs for the medical humanities, history, and art across the U.S. and internationally. Articles describing activities and opportunities in this area are requested, as well as essays, prose and poetry highlighting the humanities.

COMPETENCE AND CARING: THE TWIN PILLARS OF MEDICINE

Competence and caring are the pillars of medicine on which all else rests. William Osler sometimes dubbed these the "head and heart": "As the practice of medicine is not a business and can never be one, the education of the heart—the moral side of the man—must keep pace with the education of the head. Our fellow creatures cannot be dealt with as man deals in corn and coal; 'the human heart by which we live' must control our professional relationships." Medical educators and the general public have expressed concern that the U.S. healthcare system seemingly undermines in physicians qualities like empathy and altruism. We believe the rising importance of shared decision making will revive enthusiasm for knowing patients "through and through."

When anthropologist Margaret Mead, was asked to name the first sign of civilization, she reportedly replied "a healed femur bone of a human being." Someone cared enough to stay with the wounded person and perhaps splint the limb, even though such attention went against the survival-of-the-fittest mentality of prehistoric peoples. Osler expressed a similar opinion: *"Medicine arose out of the primal sympathy of man with man; out of the desire to help those in sorrow, need and sickness . . . the instinct of self-preservation, the longing to relieve a loved one, and above all, the maternal passion . . . gradually softened the hard race of man."*

But which matters more: competence or caring? Both are necessary, but our short answer is: Beneficent competence **is** caring, but "caring" without competence is fraud. A sick person can get caring from family, friends or even strangers, but a sick person engages a doctor who has special competence and training. As bioethicists Edmund Pellegrino and David Thomasma put it, *"Nothing is more inconsistent with compassion than the well-meaning, empathetic but incompetent clinician."* Osler said similarly, *"In a well-arranged community a citizen should feel that he can at any time command the services of [a person] who has received a fair training in the science and art of medicine, into whose hands he may commit with safety the lives of those near and dear to him*."

The definition of "competence" is straightforward: the power, ability, or capacity to perform a task or function. The definition of "caring" can be surprisingly problematic. "Caring" is often used as general term, as in the familiar statement by Harvard physician-educator Francis Weld Peabody: "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." But at what level should caring take place?

It is possible to parse "caring" into several terms, based on their Greek or Latin roots, which in ascending order of difficulty are: beneficence, empathy, sympathy, and compassion (Table 1).

Beneficence ("doing good") is caring at its most basic level. As such, it is now recognized as one of the four cornerstones of medical ethics (along with nonmaleficence [do not harm], justice, and autonomy) put

OSLERIAN VIEWS & MEDICAL HUMANITIES

forth by Beauchamp and Childress. In 1902, Osler reminded members of the Canadian Medical Association that **"the profession of medicine is distinguished from all others by its *singular beneficence.* It alone does the work of charity in a Jovian and God-like way."**

To be continued.
To

Table 1. CARING: A HIERARCHY OF TERMS

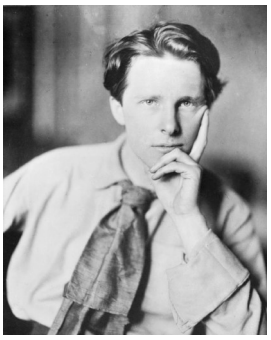
TERM	ROOT	ESSENCE
Beneficence	Latin, *benefi-centia*, "active kindness"	Doing good for someone else
Empathy	Greek, *en* ("in") plus *pathos* ("feeling")	Understanding (intellectually) how someone else feels
Sympathy	Greek, *sympa-theia*, "like-feeling"	Experiencing feelings similar to someone else's
Compassion	Latin, *com* ("with") plus *pati* ("to suffer")	Becoming a fellow sufferer with someone else

POETRY CORNER

The Soldier
By
Rupert Brooks

If I should die, think only this of me:
That there's some corner of a foreign field
That is forever England. There shall be
In that rich earth a richer dust concealed;
A dust whom England bore, shaped, made aware,
Gave, once, her flowers to love, her ways to roam,
A body of England's, breathing English air,
Washed by the rivers, blest by the suns of home.
And think, this heart, all evil shed away,
A pulse in the eternal mind, no less
Gives somewhere back the thoughts by England given;
Her sights and sounds; dreams happy as her day;
And laughter, learnt of friends; and gentleness,
In hearts at peace, under an English heaven.

Rupert Brooke 1887-1915



Continuing with Rupert Brooke from the November issue of the "Oslerian" and moving to his WWI poetry. Born 8 years before Revere Osler in Rugby, Warwickshire, England, he received a scholarship to King's College, Cambridge and was a member of the Georgian and Dymock Poets. Known for his boyish good looks, Virginia Woolf boasted she had gone skinny-dipping with him on a visit to Cambridge. Commissioned into the Royal Navy in 1917 he contracted septicemia from an infected mosquito bite and died while on a ship anchored in a bay off the Greek island of Skyros while awaiting the invasion at Gallipoli. He is one of 16 World War I poets commemorated in Poets' Corner in Westminster Abbey.

OPINION

Medical Student Top Concerns: Today vs Forty Years Ago

Articles expressing opinions on contemporary issues related to the medical humanities, ethics, and practice of medicine will be presented in this section following review and approval of the Board of Directors.

Joe VanderVeer asked me to survey some medical students here at UTMB to determine what medical students were concerned about in 2016. I did so, asking one male and one female student from each of our four classes of students to list their top three concerns for their future careers. Listed below are their responses by year of student and sex.

First Year Male:

1.) Residency preparedness- Due to the highly competitive residency programs, I worry about what I need to do to be a contender. Whether it be expanding my resume through research or clinical work, I wonder what else I should focus on in school, other than test scores, to give me the best chance at a good residency.

2.) Future of healthcare- With the rapidly changing healthcare setting, both in medical advancement and forms of payment, I worry what the future will look like. I believe that medicine will move to a more socialized approach and wonder about how that will impact me. I think that with this move, there will be increased patient load, additional frustrating red tape, and less than ideal compensation when compared to past compensation. However, I overall believe that basic healthcare is right in this country.

3.) Paying for school- Seeing the rising costs of many things, especially education, I wonder how long this debt will be a factor in my life. I understand that I will earn enough money to eventually pay off this debt I have taken on, however I am concerned about how long this will be a distraction in my life.

First Year Female:

1.) Getting a good score on my step 1 test so that I can get into a good residency in my field of interest

2.) Physician burn out: I do not want to be a burnt out physician. I want to be the best physician for my patients

3.) Getting into residency: I am concerned that I won't have enough stuff on my resume to get into residency.

Second Year Male:

1.) Not matching into the specialty of my choice.

2.) Experiencing burnout from working/studying long hours.

3.) Realizing later on that I did not choose the right specialty for me.

Second Year Female:

1.) Insecurity regarding residency matching. There seems to be a growing competitiveness of residency programs partially due to increased gap between positions available and numbers of applicants for most residency programs. A huge concern as a medical student now is the preparation for future positions and I am worried about not being accepted into my top choices regarding specialty, location, etc.

2.) Concerns regarding adequacy of information to apply to patient care. I realize that in the future we will likely be more prepared to deal with a great manner of patient scenarios, yet I worry that our curriculum is not comprehensive. My personal fear is that medical students are not taught enough about public health, including the Affordable Care Act and preventative medicine. I fear that my colleagues and I will be ill-prepared to advise patients and provide the best care possible in terms of topics such as cancer screening covered by their insurance, billing information, medication coverage etc. These fears stem from anecdotal evidence of current physicians not having this information readily available and obscurity from other sources of information.

3.) Concerns about discontentment with chosen field. With the broad array of specialties which I may go into, there is a fear that I may choose a field that leaves me dissatisfied with my career. Becoming a physician is such a long road that it feels as if choosing a residency and field is set in stone.

Third Year Male:

1.) Increasing legal regulation of care - for example being prohibited from discussing my faith with patients in situations I feel it is appropriate and necessary or being required to provide abortion referral when it is not medically indicated in my opinion

2.) Not being able to provide my patients the care they need from the potential of decreasing numbers of providers accepting federally funded insurance. I am concerned I won't be able to refer patients to needed care in the future.

3.) Increasing medical expenditures for unnecessary care: i.e. continued dollars spent at end of life when this may in actuality prolong suffering and unduly increase the burden on the health system.

Third Year Female:

1.) Limited Residency Positions (concerning the increasing number of graduating medical students, but limited number of residency positions).

2.) Job security (concerning increasing number of Mid-level providers doing similar jobs for less pay).

3.) Contracts and loan repayment, (when and how do we learn the business side of medicine).

Fourth Year Male:

1.) Finding a medical specialty that they love.

2.) Matching into a residency they want.

3.) Changing health care policies and how it will effect their future career.

Fourth Year Female:

1.) Getting burned out/frustrated with the intricacies of practice (fighting with insurance companies, high patient load, etc).

2.) Concerns about debt and paying back loans.

3.) Further legislation from the government that limits our practice.

So there you have it. If I were to summarize, I think the top themes particularly in the first two years seem are about concerns for getting into the residency program of their choice; experiencing burnout; and beginning to be concerned about the cost of medical school. By the third and fourth year concern about acquired debt becomes a recurring theme as well as negotiating the landscape of understanding the financial aspects of the health care system and how changing policies will affect their practice.

Are these themes so different from what

LETTERS –OBITUARIES-NOTICES

may have concerned medical students 30 to 40 years ago? From my own experience I would say "yes" and "no". I must admit to some uncertainty about what direction my career and residency would take initially, but I think I felt more freedom and less pressure to make a decision on the direction I would take before my 3rd or 4th year of medical school. Also, the issue of "burnout" never occurred to me, although I must admit to considering dropping out after my first semester, but was not aware of or able to attach a name to the reason I might have considered dropping out. And the issue of debt accumulation was not a big deal. I was very fortunate in that between family support, some job related income and minimal scholarship funding I got through medical school with only $5,000 worth of debt. By today's standards that is nothing. Finally, concern about the structure of the health policy financing that was in place was not on my radar screen, mainly because we got so little information about the environment that we were graduating into. I think today, we do a little better job of informing the students of some of the issues they will encounter upon graduation, but as you can see by some of their remarks they now have enough information to be concerned about how unsettled the future is for health care financing.

Letters to the Editor will be accepted that address issues presented in previous publications of the *Oslerian,* or that are related to contemporary issues in the medical humanities, ethics or practice of medicine. Publication is subject to approval by the Board of Directors.

I would like to close with some questions that hopefully will encourage some discussion and responses from our members.

1. Do you perceive different concerns among the medical students with whom you come in contact?
2. Do you think the concerns reflected by the students' responses here are valid?
3. Do you perceive concerns within the next 20 years that these students have not anticipated?

Please send your responses to mmalloy@utmb.edu and let's see if we can get some discussion going.

AOS Treasurer's Note

We have closed out our books for 2016, and have had a reasonably good year compared to 2015. Our expenses exceeded our income by about $7,000, and that is an improvement from last year.

You might be interested in the distribution of our expenses for 2016. Our largest expense was our annual meeting (about $50,000) followed by our administrative expenses ($20,000). With the distribution of the Oslerian by email, we have cut our printing and postage costs in half (now $2500). The website and Ask Osleriana had expenditures of about $4500 this past year. Expenditures for the Bean Awards totaled $6000. All in all, our 2016 expenditures amounted to about $100,000 compared to income of $93,000.

Our investment portfolio showed good growth in 2016, earning about $25,000. However, yearly money management fees associated with the Fidelity account were $4600. Other money management fees associated with processing credit card payments were $1500. Although it is very convenient to pay dues and the like by credit card, the processing fees are about 4%.

That brings me to our 2017 dues. Payments have been brisk in the past few weeks, and currently only 38 individuals still owe dues. However, 7 of those 38 are behind in their dues payments and have not paid dues for 2 or more years. Recall that we agreed to leave our dues at $150 per year. That, of course, will only work if everyone pays their dues in a complete and timely fashion. For those of your who have not yet paid your dues for 2017, I would urge you to do so very soon.

I will provide a very detailed report at our 2017 meeting. In the interim, if you have questions, please email me: jrich@utmb.edu

Best Regards,
Joan Richardson

AMERICAN OSLER SOCIETY

Call for Art for 2017 Annual

Aequanimitas

The* AMERICAN OSLER SOCIETY *exists to bring together members of the medical and allied professions, who by common inspiration are dedicated to memorialize and perpetuate the just and charitable life, the intellectual resourcefulness, and the ethical example of Sir William Osler, who lived from 1849 to 1919. Its* OSLERIAN *is published quarterly.

We're on the Web!
√ us out at: www.americanosler.org

Looking Ahead to Atlanta

Meeting in Atlanta, GA. April 9th-12th, 2017

William Osler once said that ***"no man is really happy or safe without a hobby."*** *He also counseled doctors to* ***"have a hobby and ride it hard."*** *Many Oslerians do indeed have artistic hobbies, and in Atlanta will have a chance to show their stuff. Again this year at the Annual Meeting, Herbert Swick has organized an Art Exhibit where we can share our creations. Please use the form below to contact him to arrange to show your work when we meet in Atlanta , GA.*

2017 AOS Art Exhibit Application Form

Name: _____

Address: _____

_____

Phone: _____

Email: _____

Type of work: (please check)
☐ painting/drawing (medium: _____)
☐ photography
☐ sculpture (material: _____)
☐ other art form (please specify): _____)
Title of work: _____
Size: _____ (Dimensions in cm)
Brief description of work (optional): _____

_____
Special exhibition needs, if any **

Deadline for applications is March 15, 2017.

Please submit applications to: Herbert Swick, 4 Brookside Way, Missoula, MT 59802 or by e-mail to hmlswick@msn.com. Please direct any questions to him at that address, or call him at 406-542-6560.** It may be possible to accommodate special needs, depending upon the nature of the request and the exhibit space.

AOS Members — *Please forward to the editor information worth sharing with one another as well as "Opinions and Letters".* - MHM