AMERICAN OSLER SOCIETY

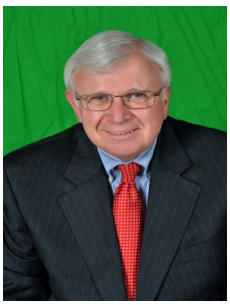
November 2021

Volume 22 - Issue 3

The Oslerian

A Message from the President

Robert Mennel



President
Robert Mennel
52nd AOS President
installed at the 2021 Zoom
Board of Directors
Meeting.

I am going to continue in this Oslerian Article my theme of writing about things that I have experienced in medicine during my medical life. The following may seem like an incomprehensible statement but to become a good doctor I believe that we should all experience illness and dealing with the health care industry through an illness in ourselves, a spouse, or one of our children. As physicians we are experiencing the medical encounter from the doctor's perspective and not the patient's viewpoint. They are quite different and if you have never been ill enough to experience a hospitalization or an invasive diagnostic test you are missing a piece of your medical education. I have had 4 major medical experiences in my life that have formulated my view of medicine. When I was 10 years old, I was confined to bed for 5 months with rheumatic fever. I was visited at home by Dr. Chandler who had little to offer me except for bed rest, auscultating my heart, kind concern, and reassurance for my parents. His care was greatly appreciated. The periodic visits to Dr. Corrigan, the Pediatric Cardiologist at Children's Hospital of Philadelphia, offered me the same plus an EKG and a CXR. These visits changed my life. The kindness shown to me and my family and the peace of mind that their reassurance brought to my family resulted in me becoming a doctor. My second experience that altered my thinking about medicine occurred as a resident at the University of Rochester. It was a practice of the department of medicine to send to their residents a copy of a patient's bill that they were caring for. The hospital charges for the tests and services that I had ordered on my patient surprised me and started me questioning medical practice costs. As a young resident, I knew that I would not be able to pay a bill if I had not had the insurance provided to me by the health care system. Fast forward 38 years to 2008, for the third event. My wife Kathie was diagnosed with an EGFR mutated lung cancer. Fortunately, her driver mutation for her lung cancer was sensitive to erlotinib. I am now an attending physician and relatively secure financially, or at least I thought I was. My insurance was billed approximately $10,000 per month or approximately $333 for the 1 erlotinib tablet per day that Kath required. To me it was worth every penny because she obtained a complete but temporary response. Kathie started her erlotinib in early November of 2008. She was due for her first CT scan after starting erlotinib to see if it was working on January 5, 2009. When we went for the scan that Monday morning, the young woman at the front desk of the radiology department in the hospital where I had been working for 30 years informed me that I would need to pay my new deductible of $1500 before Kath could receive her CT scan. I could afford to pay this, but I immediately thought of many of my patients that I knew could not get this necessary test. Kathie's illness has been very disturbing for me. Foremost because Kathie was a wonderful woman who eventually succumbed to her cancer. But secondly because my dealings with my healthcare system was not patient centered but business centered. It was a

Please turn to next page

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

cold encounter where we could have used more emotional warmth. The physicians were empathetic and caring but my health care system was cold and just business like. This encounter opened my eyes to the other side of medicine that my patients are exposed to. My fourth personal encounter and the last that I am going to present to you occurred in 2012. I developed atrial fibrillation. I decided to pursue an ablation. Let me say in advance that even with what I am about to recount to you, the outcome of the procedure for my well being was worth it if not worth every penny. I checked into the Heart Hospital at 9 AM on Friday, underwent my procedure and was discharged at 10:15 AM on Saturday, the following day. My bill for the procedure was $54,000. Every physician that I have asked to estimate what my bill was, including my cardiologist that performed my ablation, underestimated the cost by approximately $30,000 or more. We as physicians in general do not know what our patients are paying for our services.

I am a person who is not particularly adept in financial matters. I joined a large group so that I could practice medicine, taking care of people without being mired in the business concerns of a medical practice. However, having two parents who graduated from high school during the great depression, who wanted their two sons to have an education which was denied to them because their family could not afford college for them, I have gained an appreciation for money, and the relationship between financial security, peace of mind, and success. Looking at these four examples showed me that we have a major problem in medicine that may make our desired way of practicing medicine non sustainable. The purpose of the first example is to show that all of us who chose medicine, very likely did so for altruistic reasons influenced by the example of a caring physician. However, the last three examples show that our chosen field is rapidly being taken over by a concern for financial profit.

PAYORS

Insurance companies are a business, and they make their profit by the number of lives they can enroll, by discounts they can negotiate for various tests, by negotiated cost of care by specific physicians or health care systems, and by the amount of premiums they can retain. The problem that this poses for the patient is limited choices for care. For the physician this poses multiple problems. Perhaps you, as a physician, are not able to consult the physicians that you trust and are accustomed to work with. Frequently, a physician is forced to do a peer to peer because a proposed plan of care does not fit the strict rules that an insurance company has proposed even though the plan makes the most sense for the patient. There is no guarantee that your diagnostic or therapeutic plan will be approved, and you may be forced to use a therapy or diagnostic test that you do not think is in the patient's best interest. I have given examples of this in my last Oslerian article. One of the most cumbersome situations that I have been put in by insurance was for a 26-year-old with Familial Adenomatous Polyposis and intrabdominal Desmoid tumors. His insurance allowed him to see me as an outpatient but would not cover his admission to the hospital where I practiced. He had frequent bouts of sepsis and bowel obstruction. When he had to be hospitalized, I had to have one of my partners, who practiced at the hospital that his insurance company contracted with, care for him as an inpatient. He basically had 2 doctors.

Paul Krugman, a Nobel Laureate in Economics, said "Left to their own devices, Private Health Insurance Companies do not work" I think he is correct. I believe that Private Health Insurance Companies have an irreconcilable Conflict of Interest between providing the best care for the patient or the highest reward for their stockholders. It is not a popular idea in our country, but perhaps it is time for universal healthcare. The US is one of the few developed countries with a multitude of health insurers.

PHARMA

My field, oncology, is the poster child for a multitude of very expensive drugs. The example of my wife's cost for erlotinib is a prime example. However, if you would like to read a very good article on the pricing of orphan drugs, I would recommend an article by Aidan Hollis PhD from the Department of Economics at the University of Calgary (Healthcare Policy 15:70-80, 2019). In this article he looked at the pricing of Kalydeco and Orkambi. These two drugs are for the treatment of Cystic Fibrosis. They are considered orphan drugs because they treat a small % of the CF population. It is estimated that 25,000 patients globally could benefit from these drugs. These drugs when they came on the market were priced at $300,000 per year and they must be taken for the rest of the patient's life. Arguments for the staggering prices for these drugs usually follow this reasoning. They are beneficial for the patient and improve their quality of life. There is a small market, and they must be expensive to recover their investment. These drugs are expensive to develop, and the high price encourages further investment in innovation. Large profits encourage companies to seek cures for rare diseases which these companies would otherwise have little reason to study under the standard rules for drug pricing. These high prices must be borne by the insurance companies and generally they are paid because these drugs are effective. This dilutes the financial pool, which pays for the care for other patients. Patients who are not insured and have one of these diseases have a difficult time getting the best treatment. This demonstrates a major problem in our healthcare system. Vertex the company that owns these two drugs is a little disingenuous when it argues for these unreasonably high prices. First, much of the cost of developing this drug was subsidized by the Cystic Fibrosis Foundation Therapeutics who incidentally also benefits from the high pricing of this drug. Dr. Hollis estimated that the revenues from Kalydeco and Orkambi was $33 billion with a profit of $18.6 billion. The conclusion was that "Vertex's financials show that high prices were not justified by costs or the need to support innovation. In-

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stead, the prices seem more designed to reward stockholders." In 2015 the former CEO of Vertex sold options in Vertex stock under an approved trading program and made approximately $1 million each week for a total of $50 million. This example deals with only two drugs. In 2020, there were 20 new drugs approved by the FDA for Oncology. These drugs have real value for treating patients. However, many of these are extremely expensive. It is embarrassing to ask our patients to use these drugs at the prices being asked when such avarice seems to be running rampant within the industry. I don't know of a solution for this, but it is certainly a very large problem that may make medicine as we know it an unsustainable practice.

HOSPITALS

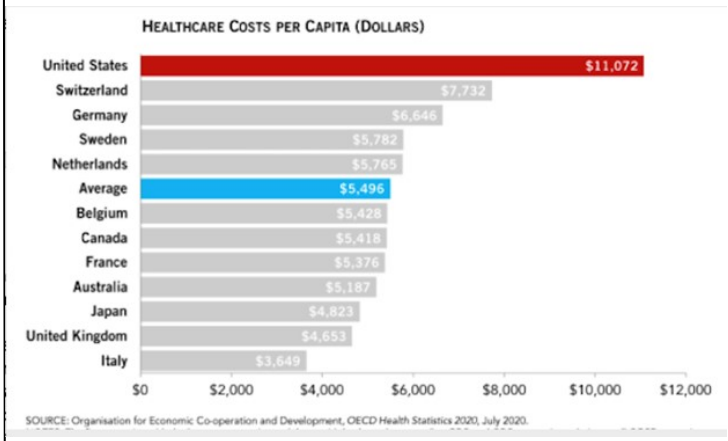
The other player in this field are the hospitals. My bill of $54,000 for a 25-hour admission is a prime example of this. I can give many examples of unreasonable charges. However, having sat through hours of board meetings for our hospital, I can see the reason for some of these over charges. This helps explain them but does not justify them. The hospitals have been forced to act with less and less compensation for their services. Lucrative surgical procedures have been removed from the hospital to surgery centers run by physician groups. Necessary services such as dietitians, physical therapists, social workers, and chaplains, are needed but not adequately reimbursed. Also, the two topics that we have just discussed namely expensive drugs and third-party payers take their profit from the hospital's income as well. This leads to a difficult problem. The DRGs of the 80s were an attempt by the government to restrict payments to multiple parties and eliminate fee for service. Value based care more recently was an attempt by the government to reapportion and restrict payment. This explanation is not an attempt to justify the excessive charges that come from hospitals but an attempt to explain them. It is obviously one problem which leads to the unbridled cost of our medical care.

I think that the US has excellent medical care, but it is limited to the people that can afford to pay for it. We pay the most per capita for healthcare of any developed country. This is approximately $11,000 per person. (Figure 1) This adds up to 18% of our GDP. However, we have the worst outcomes for any developed country. Our outcomes are so poor because so many of our people do not have access to good medical care. The access to medical care may be lacking because the emphasis is shifting away from what is best for the patient to what is most profitable for many of our supporting industries.

Osler, our example of the ultimate physician offering the best medical care, charged handsomely for his time. He also gave uncompensated time to many who needed it. Osler in his later years, was financially very secure, but I doubt that he could comprehend the financial burden of non-physician institutions on today's medicine. We have ourselves to blame for this change in medicine's course. All of us in medicine are or have been very busy caring for patients. We have not had the time or in many instances the desire or where with all to be involved in the politics of medicine. This has made it easier for third parties such as payors and pharma to inculcate their financial agenda into the role of medicine. Don't get me wrong. We must be financially viable, or we will not be able to accomplish our goal of the best care for everyone. Let's be honest, medicine is a three trillion-dollar business. This will attract people into our space whose major goal is profit from our patients. We must not allow medicine's goal to change from the best care for everyone to profit for shareholders.

I would like to end on a quote from Michael Bliss' book, "William Osler A Life in Medicine" (p 280) which was attributed to Dorothy Reed when she had moved to a residency in New York. Evidently her new chief badgered her about what made Hopkins so special. Her reply was "well, sir, (she finally burst out) it is hard to point out the essential differences, but you may understand when I say that in six years in Baltimore, I never heard money mentioned in regard to the practice of medicine. Here, when my attending or a visiting professor is taken around the hospital, the conversation always reverts to the almighty dollar, how much a man received for an operation, or how much less or more was being made this year or last." We in the Osler Society have been concerned with the fact that new physicians are spending more time with the technology of medicine and less time with talking to and examining the patient. I agree with this concern completely. However, perhaps we should be more concerned with the much greater forces that are converting medicine's focus to profit rather than our patient's well-being.

Figure 1.



Welcome to Galveston
AOS 2022 Annual Meeting
An Historical Perspective

As Dr. Richardson related to you in the August edition of the *Oslerian Newsletter* Galveston was devastated by the Great Storm on September 8th, 1900. More than 6,000 people died and over 3,000 buildings were destroyed. A number of books have been written about the storm, but none are more poignant than *Isaac's Storm* (1999) written by Erik Larson. Isaac Cline had been assigned to open the Texas Section of the new U. S. Weather Bureau in Galveston in November 1893. In 1900, "Isaac was only twenty-nine," but, "considered himself a weather sage." In 1891, "He wrote an article in response to a tropical storm that ten days earlier had come ashore near Matagorda about 120 miles southwest of Galveston...Hubris infused the text just as it infused the age." Isaac stated, "The coast of Texas is according to the general laws of the motion of the atmosphere exempt from West India hurricanes." "He argued that if anything the coast (of Texas) was much less susceptible to hostile weather. No greater damage may be expected here from meteorological disturbances than in any other portions of the country. In fact, he wrote, the liability of loss was much lower."

In 1886 a hurricane hit a town called Indionola on Matagorda Bay that caused such destruction and so many deaths that the survivors abandoned the town. "Galveston's leading men seemed to grasp the significance of the Indionola storm" and "could see that Galveston was even more vulnerable to destruction than Indianola….and resolved to build a seawall." "If Galveston had any lingering anxiety about its failure to erect a seawall, Isaac's 1891 article would have eased them. It was here that he belittled hurricane fears as the artifacts of an absurd delusion." "It would be impossible, he wrote, to create a storm wave which could materially injure the city."

So much for Isaac's delusion. The Island was devastated and was years in recovering. Building of the original Seawall began in 1902 and was not completed until 1904. It consisted of a 3 mile section of concrete that stood 17 feet above sea level extending from 6th Street to 34th street. The city also raised the grade of the Island from 8 feet starting at Avenue A to 10 feet at Broadway and 12 feet at Avenue P which was continued to the new

Raising the grade of the Island 1904-1910

Seawall. Using manual screw jacks workers lifted two thousand buildings including a cathedral and filled the underlying area with 11

Raising the grade under St. Patrick's Cathedral

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million pounds of sand. That task was not completed until 1910.

Since the 1900 Storm the Island and Seawall have been tested on a number of occasions. Most recently with Hurricane Ike in 2008. Ike's occurrence on September 13th was eerily close to the anniversary of the 1900 Storm and it devastated the Island with flood waters that surged in from the Bay side of the Island. The Medical Branch was significantly effected with flood waters entering the first floor of the main hospital. Fortunately the hospital had been evacuated, but the damage was done requiring a 6-8 week period before the hospital was opened again for mainly maternity and newborn services. Full recovery was several years in the making.

Hurricane Ike pounding the Seawall in 2008

Living on an Island has its challenges, but also its charm. We look forward to your arrival in April and hope you will find enjoyment in the Island culture.

By Michael Malloy

COMMITTEE	CHAIR	CURRENT MEMBERS
Bean Award	J. Harris	K. Bettermann, M. Flannery, R. Wadhwa, G. Sarka
McGovern Award*	M. Jones	C. Partin, M. Molina
Lifetime Achievement Award	D. Canale	J. Alperin, L. Drevlow, P. Miller, R. Nesbit
Nominating*	M. Jones	C. Partin, M. Molina
Finance	M. Molina	F. Bernadett, B. Cooper, A. Nadall, M. Stone, J. VanderVeer
History and Archives	H. Swick	M. Hague-Yearl, R. Del Maestro, R. Stone, D. Kratz
Membership†	R. Del Maestro	R. Fraser, P. Mueller, S. Patel, K Ray, M. Trotter
Media and Technology	P. Travers	G. Frank, E. Hines, G. Huston, J. Klaas, M. Malloy, C. Sobol
Annual Meeting - Program Committee#	C. Boes	W. Jarrett, R. Kyle, V. McAlister, M. Moran
Annual Meeting - Local Arrangements Committee	J. Richardson, B. Thompson	J. Alperin, D. Burkholder (Executive Committee liaison), M. Malloy

*Chaired by the most recent living Past President and comprised of the 3 most recent living Past Presidents
†Chaired by the Second Vice President
#Chaired by the First Vice-President

A Calling Only Matters If You Answer

In talking with Charley Bryan a few months ago about the case for a Young Oslerian group, he mentioned that so many Oslerians arrive too late to our Society, and say with regret, "I wish I'd joined sooner."

"There but for the Grace of God goeth I," I thought. And it was true. Had Richie Kahn not been at Pen Bay Medical Center and had I not been by lottery assigned there for my third year of medical school, it might have been decades before I found the AOS. That would have been years adrift where my love of history and my thrill of the human experience in the almost mystic encounter we have with patients would have found safe harbor, reaffirmed in the friendships and fellowship of the AOS. "And why would it have taken me so long?" I thought. Not an easy question. I'm clever enough to canvas societies and institutions. I've found grants before. I've applied to scholarships, schools, programs, fellowships—why should it be that so many people like me arrive late to the party?

Again, Charley had a good analogy. "It's like the sea turtles in Carolina. Thousands of little turtles come up from the sand. Many are gobbled up on their march to the sea. Many more of the ones that do make it to the water get eaten by ocean predators, or starve, or get tangled in nets. A small portion live a hidden life that landlubbers know nothing about until they arrive again on their ancestral shores as adults to lay their eggs." It's a potent conceit. I have a number of friends whose love of history rivals mine, and yet when push came to shove, the academic channel of biomedical science in pursuit of promotion was a path of least resistance. Rather than sit around a table and talk cases and curiosities, or marvel at a personal moment in medicine that made one feel how truly sacramental healing and healers can be—the accolades and approbations were more easily found on the road to reductionism. On the other hand, for those for whom an academic itch did not need to be scratched, the financial rewards of a busy practice precluded the time to meet or read—and so the burgeoning spirit of humanism went unnurtured. There are too many seagulls and squid and sinking-lines for the trainee-turtle to evade. And so, it is not surprising that a small population find their way back—after professorships are promoted or practices are profitable, returning at long-lost to the shores of virtue and wonder on our little island of service to both soul and sinew.

What the American Osler Society was trying to find was a Sargasso of sorts, a safe sea-within-a-sea to provide shelter and protection and nourishment for those turtles to not just survive, but thrive, before their long journey back. That's at least how I would think about this Young Oslerian proposition.

Young physicians (and I include medical students under that because the practice of medicine demands we remain forever training and learning, Osler being our super-senior resident) don't join the AOS earlier because they are either introduced to it late or unable to partake in its offerings because of the barrier of busyness. Even if the best resident keeps daytight compartments, the deck is only a few fingerbreadths above the wave—we just can't take the extra weight of making it long distances or days at a time for the jubilee of the annual meeting.

A Calling only matters if you answer. I had been called to Medicine. Now the AOS was calling me to help support the doctoring-spirit of Medicine—the promotion of the Oslerian virtue and genius that leavens our profession. My answer to the proposal of a Young Oslerian group is the following:

> In order to develop a supportive network for the promotion of humanism and the humanities as it relates to medicine—the format and platform needs to be readily accessible. This may start simply as a corner of the newsletter and a corner of the website. Such spaces allow room for sharing experiences, ideas, questions, scholarly work—and in time features such as a blog could allow for interaction in response/reply to posts. Eventually, participating Young Oslerians might wish to offer virtual presentations in the form of webinars or podcasts, and the AOS website would be a well-suited space to showcase these efforts. Other Young Oslerians might feel inspired to take their appreciation for the humanism in medicine and work in their own institutions toward curricular or extra-curricular development—and whether its building coursework around Vade Mecum for White Coat Pockets or a book club on Osler's biography, AOS could help support those efforts by providing subsidy for those activities. Indeed, a mission like seeing the Vade Mecum integrated in local medical professionalism or developing physician courses might be a rallying or unifying effort for Young Oslerians farflung across the country. And while physical

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barriers of being able to fly across country or even out of country (in the case of Montreal and London) for annual societies may restrict, Young Oslerians could meet quarterly or twice a year within their regions for food and fellowship—celebrations that could be supported in part by the AOS. And for those who can make it to the annual meeting, setting some time apart to recognize these Young Oslerians in the programming would be appreciative and reaffirming.

The first step to all of this is to identify potential members. Recent William Bean awardees have been notified and placed on an e-mail distribution list. Student members of AOS have been also placed on this list. Every Oslerian is a representative of the society, and if you've had a meaningful interaction with a student, resident, fellow, or junior faculty member—invite them to consider joining the group. If your medical institution has a history special interest group, share notification of this effort with them. Many schools offer some form of humanistic curriculum—those advisors might also know of students who would be particularly suited for the group. Make the call, someone will answer.

As for me, my intent is to practice what I've preached by submitting regularly to the AOS newsletter or finding fellow Young Oslerians who will contribute. That's a start to a conversation, and I anticipate carrying it on to fruition will slowly but surely result in the kinds of activities I described above.

Michael P. H. Stanley, MD
William Bean Award recipient, 2018

A Call to Action For The Young Oslerians

Dear Young Oslerians,

RE: Development of a "Young Oslerians" group that will be self-governing, under the sponsorship of the American Osler Society—Invitation to be a charter member, and call for volunteers interested in a leadership role

We are issuing this call to all students, residents, fellows, and young physicians who have participated in American Osler Society (AOS) activities, or are interested in the promotion of humanism and the humanities as related to medicine.

NEEDS STATEMENT

Through the years, many students and, to a lesser extent, residents and young physicians have attended AOS meetings and presented papers. Unfortunately, the exigencies of residency training, establishing a career, and fulfilling other obligations (such as parenting) usually prelude participation in a voluntary organization such as the AOS until one's forties, fifties, or even sixties.

We therefore perceive the need for an Internet-based network of young persons who could stay in touch through the years until such time as they are able to participate actively in the AOS.

MISSION STATEMENT AND ACTIVITIES

These should be developed by the charter members of the "Young Oslerians" group, but here are some suggestions:

The mission statement might include the phrases "supportive network" and "promotion of humanism and the humanities (such as history, biography, literature, poetry, philosophy, ethics, and even art and music) as these may relate to medicine.

Potential activities might include sharing life experiences, disseminating creative works (for example, essays, articles, or poetry), collaborating on projects (including, possibly, publishable research), being responsible for a section of the current *Oslerian Newsletter*, and conducting regular (annual, semi-annual, or quarterly) Zoom sessions.

A major benefit would be establishing friendships with like-minded medical humanists. Most members of the AOS consider it one of the most rewarding experiences of their careers, and the regret is often expressed that "I wish I'd joined sooner."

ROLE OF THE AOS AS A SPONSORING ORGANIZATION

The AOS will provide faculty support as needed and requested, and will also respond to financial requests to meet specific needs. Such needs might range from reimbursements for updating **periodically members' e-mail addresses to the costs of formatting and publishing material (or even an**

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online journal).
Otherwise—and we emphasize this strongly—this will be *your* organization, to do as you like with it!

Action Item:

If you are interested in becoming a Charter Member please email the *Sponsors* (Charles Bryan and Mike Malloy) with the following response:
(1) Yes, I would like to become a charter member of the "Young Oslerians" group.
(2) Yes, I have the time to volunteer to be a member of the initial leadership group. Or
No, I do not have time currently to be a member of the leadership group.
(3) Current stage of career:
Medical Student (MS 1-4)
Postgraduate Year (PGY 1-8)
Physician-in-practice (PIP 1-?)
(4) Current institution or practice location
(5) Email address
(6) Phone number

With very best regards,

Charles S. Bryan, M.D.
(cboslerian@gmail.com)
Michael H. Malloy, M.D.
(mmalloy@utmb.edu)
(*Sponsors*)

To Be a Great Agent of Change, Just Be a Good Doctor

The humble enzyme is an agent of change facilitating interactions, lowering activation energies, and accelerating transformations of one thing into another. It accomplishes all this one reaction at a time. While these catalysts are not themselves changed by the changes they bring about, we humans are. Our actions change our being. Medical students are eager to attend conferences, panels, and workshops on how to become "agents of change" before they've even become doctors—many without first asking: what would it mean to be an agent of change?

"When desiring to change, we wish to bring about something better…but thought of better or worse implies thought of the good."[1] Medicine is a moral science. Doctors are agents of change inherently because their every action changes a patient's and population's life. Our actions affect not just healthcare but are geared to the mesh of society's philosophical and political progress, too. Since our perceived reason for change is change not just for the better, but ultimately for the Good, being an agent of change is a disposition towards identifying what is Good and working to fulfill its potential. That duty is a province of morality and not a school of management. To be an agent of change for the good of others, first foster a sense of goodness in your own life.

Trainees should find mentors with habits to emulate and read lives they themselves would want to live in order to calibrate a barometer of the Good. I think about William Osler, who dovetailed an affable, virtuous disposition with Medicine. In his lifetime headlines might not have called him a social reformer, diplomat, or influencer, though his colleagues understood him as such. To be a *great* agent of change, just be a *good* doctor. If trainees pay close enough attention to their barometer, one day some everyday event will catch their notice as pushing them away from, rather than pulling them towards, becoming good doctors. Maybe there's no call room for the night-float resident or a patient that keeps canceling because she has no transportation, but whatever it is, it stands in the trainee's way of being a good doctor. You think to yourself, "Somebody should do something!" That somebody's you, Dr. Changemaker.

Michael P.H. Stanley, MD
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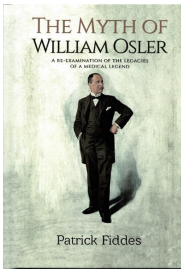

***The Myth of William Osler: A Re-Examination of the Legacies of a Medical Legend*, by Patrick Fiddes. London: Austin Macauley Publishers Ltd.; 2021.**

Journal of an Oslerian

The Useful Myth of William Osler

In 1914 Dr. Edmond Souchon (1841–1924) of New Orleans sent a form letter to prominent physicians asking them to name their most original contributions (1). Osler replied:

> I do not think I have ever done anything that has not been done by someone previously, often very much better. One picks up a brick or two and carries it to the common edifice, but I have only been a hod carrier and do not come into class with the great architects of the whole building, or even with the designers and decorators of the halls and rooms (2).

Patrick Fiddes uses this passage in *The Myth of William Osler*, adding that "while Osler may have been only a 'hod carrier,' he

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was an exceptional one." Fiddes praises Osler for "his character, his humanism, and his teaching." His purpose, however, was to write the first intellectual biography of Osler from a critical perspective and to demonstrate how the myth became disproportionate to the man.

There is much to admire about this book, and also its author. I came to regard Patrick Fiddes as a kindred spirit. We are now on a first-name basis. We are both retired internists whose careers entailed felicitous blends of patient care, teaching, research, and thinking about the nature of medicine including its ethical dimensions. Our eighth decades found the two of us mining the Osler literature on opposite sides of the equator. We sought to recognize not only Osler's accomplishments but also the chinks in his armor. Our motives were different and complementary.

My purpose was to consolidate the vast Oslerian corpus into an encyclopedia, and to this end I recruited 177 contributors from four continents (3). I was keenly aware that critics might view it as just one more stone on the rock pile of Osler hagiography, recalling that a reviewer called my 1997 book on Osler exemplary of "a body of serious hagiography larger than that of any other physician except, possibly, St. Luke" (4). I therefore tabulated everything that might be considered "negative" about Osler from a twenty-first-century perspective. I identified 30 such criticisms, to which I have since added ten more. Most are minor. A friend, quoting *Hamlet*, quipped: "The lady doth protest too much, methinks."

Patrick's purpose was to satisfy requirements for a Ph.D. at Monash University, Melbourne, Australia. He needed to acquire broad competence in the humanities, especially philosophy and history, and to write a doctoral thesis. After more than 33 years as a rural consultant physician (that is, an internist) in a rural base hospital in Victoria, Australia, Patrick became head of general medicine and director of physician training at Peninsula Health in Melbourne, where he subsequently became director of undergraduate clinical education for Monash University students. Curricular concerns enhanced a previous interest in medical history and ethics. He began to dialogue with Paul A. Komesaroff (b. 1954), an internationally prominent endocrinologist, philosopher, and ethicist at Monash, prompting Patrick's decision to become a full-time graduate student.

It thus came to pass that I celebrated my 78th birthday by completing the encyclopedia, while Patrick celebrated his 78th birthday by donning a doctoral robe after passing oral examinations and defending a thesis on *William Osler's Life in Medical Education*.

Patrick informs me he chose to focus on "the Osler myth" after hearing again and again that Osler was "the father of bedside teaching." Those of us who have participated in Osler societies or clubs know quite well that he was not "the father of bedside teaching" nor "the father of modern medicine" nor even "the father of internal medicine." Osler was none of these things any more than Henry Ford was "the inventor of the automobile." And he was not necessarily "the greatest physician in history," although nobody can say who was. Osler hyperbole occurs largely outside the small circles of "Oslerians" who have studied him in depth. We honor him but do not idolize him. We are often amused when the less initiated cite "Osler quotations" for which there is little or no documentation (5).

Elsewhere, I have suggested that Osler became emblematic of "the heroic age of medicine"—the period between roughly 1820 and 1920 when medical teaching, practice, and research came to be defined much as we know these today—because like other "outliers" (as characterized by Malcolm Gladwell) he came from an advantaged background, enjoyed a series of lucky breaks, and, most importantly, worked not only harder but *much harder* than his peers. He was also uncommonly charismatic and kind. I analyzed the reminiscences of 205 of Osler's contemporaries and concluded that he endeared himself to others primarily through his vitality and kindness (6). Osler may not have been the "quintessential physician," as Richard L. Golden wrote (7), but he was certainly the quintessential encourager. He helped others feel better about themselves and in so doing inspired their best work.

As an intellectual biography, *The Myth of William Osler* succeeds in many respects. Fiddes accurately situates Osler's character in "his faith, his Britishness, his Hellenism, and a life lived in accordance with Saint Matthew's 'Golden Rule.'" Through exposure to Father W.A. Johnson, the youthful Osler "unconsciously experienced the educational philosophy that Jean-Jacques Rousseau had proposed in his highly influential book *Emile*: the natural intellect of a child exposed to the challenges of nature, his environment and the people around him." Fiddes is perhaps less interested in what Osler gleaned from his methodical reading life—Osler stressed "the silent influence of character on character" by daily communication with "the saints of humanity"—but this would be an almost insurmountable task. Fiddes correctly points out that Osler's bias against early subspecialization may have had unintended consequences for the field of internal medicine.

My salient new insight from Patrick's book is Osler's relative inattention to medical history-taking. Several times each year I receive a request from someone, somewhere, for documentation of where Osler wrote or said: "Listen to the patient, he is telling you the diagnosis." My standard answer: The only documentation appears to be the obverse of a medal designed in 1968 by Dr. Masakazu Abe, professor of medicine at the Jikei Medical College in Tokyo (8). Osler on ward rounds focused on physical findings. He did not like to probe patients with open-ended questions, at least on teaching rounds. Fiddes dwells on Osler's failure to appreciate what Rufus of Ephesus (c. 70–110 C.E.) had to say about medical history-taking in his short treatise, *Medical Questions*. Apparently none of Osler's contemporaries did, either. Unfortunately, the skimpiness of Osler's patient records denies us the ability to fathom the depth of his history-taking with private patients.

The Myth of William Osler takes a sharp turn at Chapter 5 when Fiddes starts faulting Osler for not making a serious study of philosophers other than Plato. As an undergraduate browsing the bookshelves of his Toronto mentor, James Bovell (1817–1880), Osler showed little interest in the likes of Locke, Berkeley, Kant, Hegel, Spinoza, and Descartes. He skipped over "the more philosophical fields of metaphysics and logic," overlooked the "ethics and truth telling of Hooker, Cabot and Gisborne," and sidestepped "Hume's philosophies of sympathies and empathy … Kant's deontology the consequentialism of Bentham and Mills in maximizing happiness, and … the eudaemonic virtue ethic of Aristotle."

So what? From the article Fiddes wrote with Komesaroff (9), which is much more critical of Osler than Patrick's new book, I suspected they wrote as though the late Robert M. Veatch (1939–2020) was looking over their shoulders. Veatch observed that Osler did not study the more modern philoso

Continued on page 10

MEDICAL HUMANITIES

phers such as those of the Scottish Enlightenment. Yet Veatch acknowledged Osler as "the most philosophically sophisticated physician" of his era (10). I would argue that this constitutes high praise indeed, especially since Osler had but a single year of higher education in the liberal arts. Veatch aimed to defend a thesis (the absence of serious dialogue between physicians and moral philosophers for more than 150 years), not criticize Osler. Why dwell on Osler's failure to plow through heavy philosophy?

I would argue that it would have been highly irresponsible of Osler to burn the midnight oil trying to fathom Adam Smith, David Hume, and Kierkegaard (for example) after committing himself to keeping the standard textbook of medicine up to date. It behooves us to be the best we can be at whatever it is that we allow other people to pay us to do. Anything else is superfluous. Osler saw what reading philosophy and theology did to Bovell, who ultimately left medicine for the clergy. Curiously, Patrick gives only passing notice to Oslers friend and patient, the psychologist-philosopher of William James (1842–1910), whose pragmatism resonated with Osler's approach to life and his thoughts about the nature of "truth." In January 1909, Osler while in Paris went out of his way to attend a lecture by the French philosopher Henri-Louis Bergson (1859–1941); Osler reported to a colleague that Bergson "paid a remarkable tribute to William James whom he called the most distinguished & stimulating of living thinkers in Philosophy."

Fiddes suggests that Osler's habit-based way of life ultimately became his Achilles heel, leading him toward intellectual ossification. Toward the end of his Baltimore period (1889–1905), Osler realized he was in a rut, mainly because of demands on his time, which may explain in part why he used Anthony Trollope's phrase "the fixed period" during his unfortunate farewell address at Johns Hopkins. Osler's "fixed idea" that most ground-breaking, paradigm-shifting contributions to the world's body of knowledge are made before the age of 40 resonates with a recent distinction between "fluid intelligence" and "crystallized intelligence." The former begins to decline after age 20 but the latter persists into late adulthood. Osler's intellectual horizons broadened during his Oxford period (1905–1919). The last years of his life found him dialoging with public intellectuals such as Sir Frederic Kenyon and Gilbert Murray as they sought to recalibrate the balance between the sciences and the humanities in British higher education. They welcomed him as a peer and colleague who had something to say.

H. Brownell Wheeler wrote in the *New England Journal of Medicine*: "It may be less important who Osler was than who we need him to be. Osler the myth may be more relevant than Osler the man" (11). The myth of William Osler remains, I suggest, useful in at least three ways.

First, as I wrote in *Osler: Inspirations from a Great Physician*, Osler exemplifies the monomyth of the universal hero, the story line common to the great hero-myths and fairy tales, the story line of such recent contributions to popular culture as *The Lion King* and the Harry Potter novels. A seemingly ordinary person is called to adventure, finds helpers and mentors, confronts dragons, and, prevailing, returns to the world with a restorative elixir. I previously suggested that Osler's restorative elixir was the reconciliation, for his generation, of the perceived tension between "the old humanities and the new science," which as we all know he took as the title for his last public address. I view Osler as an avatar of personal effectiveness.

Second, and as a corollary, Osler's gift for bringing out the best in others made him a *field influencer*—a person who palpably influences the direction of an occupation, academic discipline, or school of thought. For example, Osler's approach to medical history was perhaps superficial by today's standards, but Osler influenced the discipline, notably by spearheading formation of the History of Medicine Section of the Royal Society of Medicine. That led to a friendship with Charles Joseph Singer (1876–1960), whereupon Osler recruited Singer to Oxford to pioneer the history of medicine as an academic discipline. Osler did not stop there; he put the young George Sarton (1884–1946) in touch with Singer, which proved a boon to the emerging history of science (pioneered by Sarton) and even to the broader history of ideas. Richard C. Cabot of Boston wrote immediately after Osler's death: "I doubt if any single man has ever so deeply influenced any other profession.… An influence such as his never dies out, but it is implanted in the lives of those who lived and followed him and through them extends from generation to generation." Results of a poll of North American physicians in 2016 affirmed Cabot's prophesy: Osler was voted "the most influential physician in history."

Third, and most important, Osler more than anyone in history with the arguable exception of Hippocrates (a shadowy figure about whom we know little with certainty) fostered the myth of the medical profession as a great worldwide community where "distinctions of race, nationality, colour, and creed are unknown" and offering "a fuller hope for humanity than in any other direction." Osler's occasional endorsement of medicine as an apostolic succession of cultivated individuals tracing to Hippocrates is of course highly naïve, but the idea that like-minded individuals might make a difference in these troubled times remains attractive. Scott Podolsky and I concluded our recent essay: "A 21st-century Osler might be sufficiently enlightened to replace 'the profession of medicine' with 'the global community of healthcare workers" as a sizable share of humanity committed to the scientific method and to the proposition that in humanized science rests the fullest hope for preserving higher life forms on a fragile planet" (13). Yuval Noah Harari pointed out in his best-seller, *Sapiens*, that about 70,000 years ago our species developed the capacity for mythic language, and it is largely through subscribing to common myths that large numbers of strangers can cooperate successfully (14). I keep returning to Osler's statement in his last address that "there must be a very different civilization or there will be no civilization at all." Sage advice for the Anthropocene!

Patrick Fiddes has written an important book. It should be read as the doctoral thesis it was, keeping in mind that doctoral students in the humanities must stake out positions and defend them at all costs. This observation is not meant to be a criticism; in a similar vein, *Sir William Osler: An Encyclopedia* could be viewed as the labor of a self-confessed workaholic. One of Osler's sharpest recent critics observed that he can still be read to advantage (15), and in this regard Patrick is perhaps his own best example.

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THE POETRY CORNER

I See You

By Jacob Harper

I see you. Please trust me. And I'm reaching out.
Converted, convicted, forever devout.

Are my words getting through? Right now, I can't
tell.
Do you hear? Do you feel? Trapped inside that Hell?

Can you sense all the love that fills up this room?
Or is it just void, condemned to your doom?

"We have tried everything," we said to your mother,
Who quietly wept as she clung to your brother.
"You've still got options! Just go try another."
Her cries full of fear and enough love to smother.
And over the room, her screams seem to hover.
Unaware of what insurance will and won't cover.

I've seen it before, that look in her eye
When we realize the truth, but choose to deny
An the breakdown in logic, it makes us all cry
As we finally see that our loved one will die
And we feel like there's no way we'll ever survive
As they start CPR and attempt to revive.

It's the same look they give me, when I break the
news
That the x-rays came back with six tumors in view
And the light in their eyes, in those baby blues
Goes out in an instant. I burnt out the fuse.
I give them their timeline. "What do you want to do?"
They're fighting a battle they're destined to lose.

They give me that look when they've got months to
live
But those little pink lines means they're having a kid.

All their life plans just got turned on their head
The best news of their life is horrific instead
And the husband drifts off to the dreams that he had
None of which starred him as a single dad

But the heartbroken look that these people give me
Is sometimes offset by another I see
It's the look that I get when I tell them with glee
That the medicine worked. They're now cancer free

Or the joy in their eyes when I give them the test
Expecting the worst, hoping for the best

And a miracle happens, the results come back clean
That's a joy you can't picture, it has to be seen
In a world so ugly, so hateful and mean
That moment's so pure, unjaded, pristine

And now, with all that, it's just you and me
When your mom comes tomorrow, what look will I
see?

Will it be the look that drives me to tears
The one from my night mares. The one that I fear?
Or will you get a miracle, and turn this around?
One foot in this hospital, one foot on the ground?

As I sit beside you, in the dead of the night
I scramble, I grasp, for any source of light

For the first time in years, my head bows to pray
Begging we both can get through this day

Open your eyes, wake up and be free
You know that I see you. Do you see me?

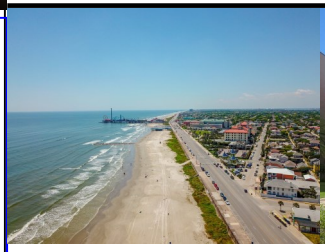
Jake is a first year medical student at UTMB who submitted this poem as an entry for a Medallion Award. He is from Salt Lake City, Utah. He completed his undergrad at the University of Utah in writing and rhetoric. He and his wife desperately miss the mountains and skiing, but Texas has treated them well and made them feel right at home.

AMERICAN OSLER SOCIETY

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. The* OSLERIAN *is published quarterly.

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

Looking Forward to Galveston, TX



Save the dates of April 10-13, 2022 for the AOS meeting in Galveston, Texas. The planning committee has selected an enticing venue at the San Luis Hotel along the Seawall and put together inviting extracurricular and banquet experiences. More information will be forthcoming.

Call for Abstracts for 2022 Annual Meeting in Galveston, TX, April 10-13, 2022

Abstracts should be sent by e-mail to: aosrenee@gmail.com and must be **received** by **15 November 2021.** Abstracts submitted by e-mail will be acknowledged. The abstract should be no longer than one page. It should begin with the complete title, the names of all co-authors, and the corresponding author's mailing address, telephone number, FAX, and e-mail address. This should be followed by a two to three sentence biographical sketch indicating how the author would like to be introduced. (This will probably be your entire introduction. Don't be modest!) The text should provide sufficient information for the Program Committee to determine its merits and possible interest to the membership. The problem should be defined and the conclusions should be stated. Phrases such as "will be presented" should be avoided or kept to a minimum. Only one abstract per person will be accepted.

Three learning objectives should be given after the abstract. Each learning objective should begin with an active verb indicating what attendees should be able to do after the presentation (for example, "list," "explain," "discuss," "examine," "evaluate," "define," "contrast," or "outline"; avoid noncommittal verbs such as "know," "learn," and "appreciate"). The learning objectives are required for Continuing Medical Education credit.

A cover letter should state: Whether any of the authors have a potential conflict-of-interest such as direct financial involvement in the topic being discussed, and whether there will be any mention of off-label use of drugs or other products during the presentation.

Each presenter will have a 20-minute time slot, which will be strictly enforced. Presenters should rehearse and time their papers to 15 minutes, in order to permit brief discussions and to be fair to the other speakers. Although 20 minutes might seem quite short for a paper in the humanities, our experience with this format has been overwhelmingly favorable.

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