Presidential Address

The vital role in medicine of COMMITMENT TO THE PATIENT

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For the past year I have considered in detail what subject would be of most importance to you, our new Initiates into Fellowship, on this significant occasion as you enter one of the most exciting and important decades of your entire surgical lifetime. The subject I have chosen is "The Vital Role in Medicine of Commitment to the Patient."

At the outset, I want to emphasize that I certainly do not have easy solutions to the serious, complex problems facing surgery today. However, I would like to share with you concepts and principles that have served me well in a surgical career that began over four decades ago. I am confident that with the abilities all of you have already demonstrated, the current problems are all solvable.

I also want to emphasize strongly that I am astonished at the "gloom and doom" expressed by some physicians about the future of medicine. My attitude is exactly the opposite: I remain as enthusiastic and excited about the pleasures and opportunities of surgery and medicine as in my early house officer days. My attitude is a blend of confident optimism with pragmatic realism. Certainly, my more than 20 years as chairman of surgery at New York University and Bellevue Hospital have provided me with broad experience in dealing with many facets of the practice of surgery and with human behavior. I have acquired a separate, broad experience in dealing with the many varieties of human behavior through the professional liability issue. My interest in this subject began acutely over two decades ago after receiving my first subpoena. Having successfully completed more than five jury trials as a defendant, I now have an intimate knowledge of the problem that I could not have gained otherwise. My enthusiasm and optimism remain unchanged.

The fact that major changes are occurring in medicine is obvious. The occurrence of major changes, per se, is obviously not a cause for gloom and pessimism because change is almost always occurring. A familiar comment is that the one thing that is certain in life is that change is inevitable. The 1982 book by Peters and Waterman on excellence dealt primarily with the capacity of prominent business corporations to successfully adapt to changes over decades.[1] Repeating what I said earlier, I have great confidence not only in the ability of surgeons to adapt, but also in their continuing leadership role in medicine.

Basic facts about the College

The foundation of the College in 1913 was a landmark in American medicine, the significance of which could not possibly have been fully appreciated, even by its founders. It was the first surgical organization to not only set standards for surgical competence, termed a benchmark by Charles Drake in his Presidential Address in 1984,[2] but also to assess the moral character of the surgeon, separate from his technical proficiency. As emphasized by Frederick Coller in his Presidential Address in 1950, which was entitled "For the Benefit of Patients," the founding principles were "to establish and maintain an association of surgeons, not for pecuniary profit but for the benefit of humanity by advancing the science of surgery and the ethical and competent practice of its art."[3,4]

The need for an organization with standards, a benchmark, is well reflected in the first major project the College undertook—setting standards for hospital accreditation. After initial planning, the first survey was made in 1918 with astonishing results: only 13 percent of 700 hospitals even met a minimal standard. Fearing a grave public reaction to the deplorable state of many hospitals, the reports, although printed, were never distributed; a survey the following year found major improvements. This pioneering work by the College was the forerunner of today's Joint Commission on Accreditation of Healthcare Organizations.

Major achievements over the first few decades were discussed in 1960 in the excellent book *Fellowship of Surgeons* by Loyal Davis.[5] These accomplishments include the development of graduate training programs, the annual Clinical Congress, and major activities in trauma and cancer. The remarkable growth of the college during the past few decades has been summarized by George W. Stephenson, MD, FACS, in his book, *The American College of Surgeons at 75* (ACS, 1990). The predominant theme from the founding charter throughout has been echoed again and again: "For the good of the surgical patient."

Four aspects of surgery

There are four major distinct activities in surgery: the surgical operation, scientific investigation, teaching, and the personal bond that develops between the surgeon and his or her patient. Which of the four is enjoyed the most varies with the individual instincts of each surgeon.[6] I personally enjoy all of them and

consider surgery the most exciting of professions.

The surgical operation is the central core on which the specialty is based and from which it derives its name. Clearly, one of the major fascinations of surgery is working with one's hands and brain, much like the performance of a symphony by the musician, or the painting of a picture by the artist. I know this field well, for I have always referred to myself as a "cutting surgeon." Obviously, however, the operation, though central, is only one important part of surgery.

The second area, the science of surgery, is the discovery of new knowledge by application of the scientific method, either in the laboratory or with clinical investigation. This area needs no explanation of its basic importance, for these studies create the knowledge on which our profession is based. This basic spirit of the excitement of intellectual inquiry is, of course, the foundation for all of science.

The third area, teaching, is a treasured ethic that epitomizes the medical profession—teaching one another, especially the next generation. The fourth area is the subject of my address: the personal bond between the patient and his or her surgeon, a strong sense of commitment that overrides all other considerations.

This topic, commitment to the patient, was chosen primarily because of its major importance to the future of medicine. It is my personal longstanding belief that this central ethic, "Do what's best for the patient," is the true essence of medicine, the vital spirit itself.

Why is humanism so important?

Medicine is the profession that studies and treats disease in a human being. The treatment of disease is scientific; the treatment of the human being has been termed "humanism," often called the art of medicine. Humanism is a word with several meanings, for it encompasses a broad range of human activities, including philanthropy and public service. In medicine, the important parts with each patient are *commitment to the patient* and *compassion*.

Medicine originated with the fundamental human instinct to help a fellow human being in distress, the sympathy of man for man. This is the message in the parable of the Good Samaritan. The Latin word for this basic human instinct is *caritas*, which is variously interpreted as caring, charity, or simply unselfish love. The central importance of humanism is best understood by the fact that *the high status of medicine for centuries was based almost totally on humanism*. Only in the last half of this century has it been possible to treat effectively a large number of diseases.[7]

It was also recognized empirically long ago that illness produces an abnormally sensitive emotional state (especially anxiety and fear) in almost everyone. Thus, the bulk of medical treatment for decades was treating the spirit of the patient, often termed the Samaritan function, rather than the disease. Osler fully understood this fact, well recognizing that most treatments used in his time were simply placebos. Because of his refusal to use many popular nostrums, he was often labeled as a therapeutic nihilist. The long-recognized importance of the study of the humanities in the classics is also based on this fact, for a broad understanding of man enhances the capacity of a physician for understanding and sympathy.[8,9,10]

Treating the emotional state of the patient while treating his or her disease is not difficult. It seems deceptively easy, so simple it is often ignored as being superficial and unimportant. It requires some time at the bedside, listening sympathetically to the patient, talking with him, and examining him (the laying on of hands). The manner in which this is done is most crucial. The key features include *a cheerful optimism with kindness, engendering faith and hope, minimizing pain and fear*. This, of course, is the "bedside manner."

With the fortunate rapid scientific advances in the 20th century, it was realized almost instinctively that there was an innate danger that excessive concentration on the scientific treatment of disease would minimize humanism. Peabody, a scientist of the first rank in the 1920s, established the world famous Thorndike Laboratories at the Boston City Hospital. At the same time, he strongly warned of the danger of neglecting the emotional needs of the ill patient in his classic 1927 paper, "The Care of the Patient."[11] In 1950, Coller in his Presidential Address similarly emphasized the crucial importance of maintaining humanism as a central core of medicine. Over eight other Presidential Addresses on this occasion have echoed this same theme.

Today—in 1990—the vast majority of medicine is based on science, treating the disease that is present; humanism, although of lesser magnitude, remains crucial. It is similar to the fourth wheel on an automobile, only one of four, but without which the car

will not move. To elaborate further, the practice of medicine, which is predominantly humanism with little science, has some resemblance to faith healing; at the opposite extreme, scientific medicine with little or no humanism is impersonal and cold. The importance of maintaining this crucial blend of science and humanism was eloquently expressed by Dunphy in a classic address in 1976.[12] (Dunphy was President of the College in 1963 and a beloved surgical statesman to all of us who knew him.)

Hence, to emphasize once again, the central core of the entire ethic of medicine is the commitment of the physician to his patient. This ethical bond is for the benefit of the patient, not for the physician, and not for the public. This is the vital heart of medicine, what makes it a profession rather than a business or a trade.

Personal experience

Speaking from personal experience, several major events in my surgical career began with a decision to "do what seems best for the patient." Such decisions were at times personally uncomfortable, even hazardous. This instinctive interest in patients must have been a natural one, similar to that of most students choosing medicine as a career. It was not due to a classical education, for my childhood education in the rural Texas Panhandle was excellent but certainly not classical. It was not due to a strong medical environment, for I never knew my grandfather, a horse and buggy doctor in eastern Texas around the year 1910. My only hospital experience before entering medical school was a childhood appendectomy; my surgical interest first began during my third year surgical clerkship at Vanderbilt University.

However, in 1952, during the Korean War, I had the good fortune to make one of my best contributions to surgical science by demonstrating the feasibility of repairing arterial injuries in battle casualties, even though I had not yet completed my surgical residency. The circumstances were unusual ones. Official military orders, which had been developed during World War II, were that all vascular injuries, without exception, were to be ligated. In Korea, helicopter evacuation made prompt surgical care much more feasible, but the order was inflexible. Your speaker, Lt. J.G. Spencer, perhaps with some youthful temerity, felt that repair would be much preferred to the existing 50 percent amputation rate. After some encouragement from colleagues, none of whom had any authority, we were able to launch a successful vascular repair program. I ruefully remarked at the time, "This had better work, for otherwise we will all be court-martialed!"

Years later, in New York City, my interest in professional liability was rudely started with my first subpoena. At that time, I had never seen the inside of a courtroom. I quickly became seriously concerned, not only as an individual but as a participant in the basic social process itself. It was my first experience with a process that makes a patient an adversary of the physician—a situation that is exactly contrary to the basic ethical goals of medicine. This concern subsequently led to my work with professional liability in the American College of Surgeons over the past 15 years. The major goal has always been to get a better insurance program for an ill patient, one that would benefit him far more than would suing his physician.

In recent years, the concept of regulation of house staff hours has arisen. Being convinced that such regulations could easily harm patients, I have strongly supported the firm, uncompromising opposition of the College to any fixed regulation of hours. Regulating hours automatically introduces a time-clock mentality—and means that at the end of a specified period of time, the physician abandons the patient. Commit-

ment to an ill patient, regardless of time or circumstances, is our central ethic. Indeed, many patients in years past owed their lives to this dedication. Such commitment undoubtedly causes fatigue, which is uncomfortable and undesirable for several reasons, but fatigue must be accepted if it is necessary to care for the patient. Certainly, an irrational fetish should not be made of fatigue, per se; an equal certainty is that changes need to be made in residency training to minimize the work load of house officers. The solution, however, is not time-clock regulation, abandoning the patient, but developing adequate paramedical personnel to assist in the patient's care.

Historical considerations

From the times of antiquity and the Hippocratic oath to the present, the central, dominant importance of commitment to the patient has been emphasized repeatedly in all ethical codes. The Hippocratic Oath states, "That I will exercise my arts solely for the cure of my patients..."; the Code of Maimonides in the 12th century said, "I have been sanctioned to care for the life and health of man"; and the Declaration of Geneva, 1948, stated, "The health of my patient will be my first consideration." Anglo-American medical ethics were summarized almost two centuries ago in 1803 by Percival in his book, *Medical Ethics*, and formed a strong component of the first American Medical Association (AMA) Code of Ethics, which was developed in 1847.[13] This altruistic dedication to the sick, even when contrary to self-interest, was the basic reason that western society nearly a thousand years ago granted the medical profession the unique privileges of self-government and self-control of its educational process.[2]

In the past century, the basic importance of this bond between the physician and the patient has been emphasized repeatedly. Many of the contributions of Osler, the leading medical figure of his generation, were humanitarian, for the majority of nonsurgical diseases could not be effectively treated. In the classic Flexner report in 1910, the projected goal in medical education was the training of scientifically-based humanistic physicians. Three years later, in 1913, the founding charter of the American College of Surgeons stated, "To establish and maintain an association of surgeons, not for pecuniary profit but for the benefit of humanity by advancing the science of surgery and the ethical and competent practice of its art..."[4]

Subsequently, in 1927, the paper by Peabody, "The Care of the Patient," became a classic because it eloquently expressed the prime importance of the personal bond between the patient and his physician.[11] Since 1930, this prime importance of commitment, overriding all other considerations, has been a dominant theme in at least nine separate Presidential Addresses.

Hence, to summarize, both in recent decades and past centuries, the vital importance of the commitment of the physician to his patient has been repeatedly emphasized. Yet now, in 1990, there are clear signs that powerful forces are attacking this classic ethical bond, which is the vital heart of medicine.

Several physicians have recently warned that weakening this central medical ethic of commitment is occurring, and could become a major destructive force for the entire profession. The most alarming of these signs is an increasingly critical public opinion that the primary motivation of the physician is often for commercial reasons, not primarily for the benefit of the patient. It should be emphasized that this is a public perception; the degree to which it is true cannot be precisely measured.

In 1985, Lundberg soberly warned of the trends that were discerned through two public opinion polls conducted by the American Medical Association in 1981 and 1984. [15] Sixty-eight percent of the public felt that the high cost of medical care was the principal problem, and 86 percent believed that physicians could help solve the problem; only 20 percent believed that physicians were actually doing so. Only 27 percent felt that physician fees were reasonable, which was a decline from 42 percent in 1982. Perhaps the most alarming opinion was that in both surveys more than 60 percent of those surveyed felt that physicians were too interested in simply making money.

The following year, 1986, Eisenberg, at Harvard, was alarmed by the miserable role model that physicians often provided to third-year medical students during their first exposure to clinical medicine. She wrote eloquently about the irrationality of the "gloom and doom" malaise resulting from socioeconomic factors such as increasing government regulations, malpractice crises, and DRGs.[16] She strongly emphasized that the two basic pleasures of medicine are the treatment of the ill patient and the intellectual challenge of solving clinical problems, not the income earned. Quite perceptively, she pointed out that poor patients are far more threatened by financial restrictions than is the physician, because their health—and even their

lives—are in jeopardy—not simply their incomes. The role of the physician with regard to these socioeconomic problems should be to serve as an advocate for proper health care for his patients, not simply to be self-serving. "Medical education does not exist to provide doctors with an opportunity to earn a living but to improve the health of the public," she said.[16]

In 1987, Relman, editor of the *New England Journal of Medicine*, strongly warned of the intrinsic conflict that exists between the financial imperatives of business and the altruistic ideals of medicine.[17] His examples included the development of investor-owned health care corporations, open market competition for patients, and "gatekeepers" whose income may be related to the withholding of medical services. Such a market-based, profit-oriented approach could easily become a disaster for the poor. He warned about the potential grave consequences if there were an increasing loss of public confidence in the medical profession's commitment to the welfare of patients.

In a similar vein, only a few months ago Pellegrino clearly stated that a choice must be made between two opposing ethical codes—one based on the primacy of our ethical obligations to the sick, the other on the primacy of self-interest in the marketplace.[13] In considering this basic conflict, he clearly delineated the unique characteristics of medicine that make it a "moral community," not a business. A central factor is the disabling effect of anxiety when illness occurs, making the sick patient uniquely vulnerable to exploitation. The medical ethic is exactly contrary to the business ethic, which states that vulnerability invites a "hostile takeover." An additional fact is that medical knowledge is intended for one purpose—the care of the sick—and is obtained only through the socially-sanctioned privilege of a medical education. It cannot be purchased on the market. Hence, by definition the medical profession has a stewardship entrusted to it for the care of the sick.

The physician cannot be a double agent, serving both the patient and the marketplace. Like Eisenberg, Pellegrino emphasized that our goal with problems with excessive regulations, economic priorities, and malpractice, should focus not on what these problems do to us, which is essentially self-serving, but on what they do to our ability to care for our patients. By so doing, we remain faithful to the central aim of medicine: the care and cure of the sick. Public sentiment would then be allied with medicine, and would not be critical.[13]

In summary, these thoughts all warn of a common public opinion that patients trust their physicians technically and personally but not economically. Physicians are increasingly being regarded as highly successful businessmen who function based on the business ethic rather than on the professional ethic. The harshest judgement comes from some medical economists who bluntly state that the ethical ideals of the Hippocratic Oath are outmoded and mythical. They say that the physician is simply an entrepreneur who provides a commodity, and the patient is a consumer. The doctor-patient relationship is a commercial transaction that should be regulated by the rules of the marketplace and business world. In this regard, normal business activities such as aggressive advertising, paying in advance, and undertaking profit-making enterprises that are unrelated to direct provision of physician services are all clearly legal and good business practice. But, are they ethical? Are they primarily in the spirit of what is best for the patient?

Coinciding with this public skepticism, a "gloom and doom" malaise has arisen among some physicians about the future of medicine with the strong socioeconomic forces changing it. The frequency of this gloom and doom malaise is unknown; it may represent only a minority, but widely publicized, opinion. An alarming fact, however, is the recent sharp decrease in applications to medical school, from 42,000 to 29,000 over a period of 12 years.[18] During this time, the number of male applicants has decreased sharply, about 50 percent. This, perhaps, is the most alarming fact of all, representing a major decrease in interest in medicine as a vocation.

I personally agree with Eisenberg that the gloom and doom malaise is simply irrational, and that it does not recognize the basic fact that the intrinsic heart and pleasure of medicine is the treatment of the ill patient, not the income earned. Both the public skepticism of medicine and the gloom and doom malaise are probably related to the same basic cause—failure to make the care of the patient the priority consideration in our thoughts, our words, and our actions.

Medical negativism

Why has this medical "negativism" occurred? It seems paradoxical that in comparing the century of medicine from 1890 to 1990, the stature of medicine seemed considerably greater in the times of Osler

than it does at present. At that time, little more than providing comfort and reassurance could be done for many serious diseases. Osler clearly understood this limitation, but he also realized that illness produces an abnormally sensitive emotional state in almost everyone, especially anxiety and fear. He concentrated primarily on treating the "spirit of the patient." He was often considered a therapeutic nihilist because he rarely used the vast majority of medicines available, recognizing that they were simply placebos

with admixtures of alcohol and opium. Now, a century later, after numerous major scientific advances, the treatment of disease is infinitely better, but the prestige of medicine has decreased, apparently because of a decreased recognition of the basic importance of humanism. As stated earlier, the central importance of humanism is clearly evident from the fact that for centuries the distinguished status of medicine was based almost totally on humanism.

This strong instinctive interest of the public in humanism, care for the fellow man, is clearly reflected in our major social and legal documents. A landmark concept in our Declaration of Independence is that "all men are created equal." The Golden Rule has been a central ethic for human behavior in western society for centuries. The household familiarity of the biblical parable of the Good Samaritan clearly expresses the ideal commonly projected by man.

These facts all support the concept that much of our current problem is due to a perceived lack of humanism by physicians in treating their patients. It is clearly not due to a lack of science, for scientific progress in the past 60 years has been incredible. *Hence, more science, per se, will not solve the problem.*

Currently, strong socioeconomic forces automatically decrease humanism, unless the physician perceives the dangers and acts accordingly. Two major factors can be easily defined: the cost of medical care, and scientific progress with increasing technology and multiple specialists. A third major factor, and the most crucial one, is lack of physician understanding of the central importance of commitment to the patient.

1. *Economic factors*. The striking increase in the cost of medical care is obviously the major national consideration and has led to major problems in many areas. Despite numerous modifications, the goal of providing high-quality care at an affordable price remains an elusive, unsolved one. In the past decade, a competitive market approach has been encouraged, resulting in enhanced competition with advertising and growth of both health maintenance organizations and for-profit hospital corporations. While the cost of medical care remains unsolved, a serious myth has been perpetuated that this is primarily the fault of medicine, reflected in the public opinion poll described by Lundberg.[15]

Careful analyses, however, show multiple causes beyond the control of medicine. These include the aging of the population; generous social programs such as Medicare for everyone; complex technological advances such as CT scanners, organ transplantations, and joint replacements; and intensive care units for the seriously ill. An economist has critically pointed out that 18 percent of total medical costs for an entire lifetime is expended during the last few months of life. Unfortunately, only in retrospect does it become clear that these expensive months were indeed the "last ones!" Only a fraction of those costs are under the control of the physician.

He or she is particularly restricted with the malpractice climate; attempts to restrict costs by limiting diagnostic studies or medical care frequently raise the threat of a malpractice suit. I do not know any way in which the true cost of defensive medicine can be measured, but it is surely huge. I seriously doubt that such costs can be meaningfully reduced until there

are fundamental changes in the basic professional liability system. No matter what rhetoric is used about "appropriate diagnostic studies," if a patient has an "adverse event" and files suit, a paid "expert witness" can almost always be found who will testify under oath that not performing some specific, expensive test was malpractice because it would have prevented the complication. This problem will surely become worse rather than better as more expensive diagnostic technologies, such as magnetic resonance imaging, are developed.

2. *Scientific factors*. The basic danger that scientific progress would automatically obscure the importance of humanism was prophesied by Peabody in his classic paper over 60 years ago, when he warned that medical students were being taught "a great deal about the mechanism of disease but very little about the practice of medicine" or, to put it more bluntly, they are too "scientific" or do not know how to take care of patients.[11] Peabody's perception is remarkable, for he fully recognized the basic importance of scientific investigation. He established the famous Thorndike Laboratories at Boston City Hospital in the 1920s, from which numerous major advances emerged for years after his premature death in 1927.

This problem has occurred because the vast increase in scientific knowledge has naturally produced multiple specialists and complex technology, automatically hindering the development of a strong physician-patient relationship. A frequent patient complaint is, "I saw many doctors, had a lot of tests, and got lots of bills, but no one really knew me (or cared?)."

3. *Lack of physician understanding of the central importance of commitment to the patient*. It seems very clear that many physicians do not understand the central importance of the ethical bond between a patient and his or her physician. It is not recognized because it is not effectively taught either in medical school or in residency training and rarely discussed thereafter. If the subject was not strongly emphasized in training, a natural assumption is that it is not very important.

This basic ignorance is made even worse by shocking statements by some individuals that the basic principles in the Hippocratic Oath, emphasizing that responsibility to the patient overrides all other considerations, is out-of-date and outmoded. The compassionate bedside manner is considered an unimportant ornament, a historic, idealistic example for someone like a missionary to follow but not for the practicing physician to employ. Such statements are a classic example of the combination of ignorance and arrogance in trying to dismiss the lessons of more than 2,000 years of medical history that have passed since the time of Hippocrates.

Quite the contrary is true. This ethical commitment is the vital difference between the profession of medicine and a business. This commitment to the patient is the reason society long ago placed the profession of medicine in a special category, recognizing that the basic mission was altruistic for the benefit of the sick, not primarily for the benefit of the physician. In this economic age, doing what is best for the patient may require hard, tough decisions. Such decisions may be contrary to economic guidelines, regulations, or even the rules of the corporation where a physician is employed. Pellegrino has analyzed this basic conflict well in a recent book.[19]

These basic ethical codes are not well taught either in medical school or subsequent medical training principally because no one knows how to teach them effectively. Certainly, the responsibility cannot be delegated to a medical ethicist or to a committee. Burgeoning scientific knowledge has increasingly crowded the curriculum in all medical schools with sharp debates about what should be omitted. This overwhelming predominance of science in the curriculum automatically minimizes the role of humanism, implying that if it is not taught it must not be very important. Most students enter medicine because their humanitarian instinct is stronger than their business instinct; but, unfortunately, something in medical education and subsequent experiences seems to diminish, rather than enhance, this important basic feeling.

If a physician does not recognize the prime importance of this ethical bond, his behavior can readily be interpreted by the public as being primarily self-serving. I strongly believe that much of the loss of prestige of the medical profession is due to this one fact. This is crucial, for the problem is easily solvable by each of you with your patients, both by what you do and what you say. As previously stated by both Eisenberg and Pellegrino, the physician's irritation with the multiple bureaucratic influences that restrict his practice of medicine is natural and soundly based.[13,16] The physician's irritation, however, should be expressed as to how this detracts from the care of his patients, not what these do to him personally. Enlisting the help of the patients—rather than simply

refusing to treat certain patients, such as indigent patients who have inadequate reimbursement from Medicaid—is essential to enlist public support. Caring for such patients clearly demonstrates to the public that the central ethic of medicine is commitment to the care of the sick.

As described in the preceding section on the importance of humanism, the core elements of the physician-patient relationship are very simple. They require some time at the bedside, listening sympathetically to the patient, and talking with him in an appropriate manner. This "bedside manner" is the difference between a mechanic and a respected physician.

Most of the essential features of the basic physician-patient relationship are intertwined with "compassion." This is discussed in the next section.

Compassion

Compassion is a state of mind, a feeling of concern, sympathy, and respect. To the ill patient, it is far more profound than the trite statement, "I'm sorry you're sick." It reflects the basic humanitarian instinct of the physician, a concern for sickness in a fellow man. The "state of mind" is crucial, for "how one thinks is how he behaves."

This simple statement, "how he behaves," is the crux of the issue, the behavior of a physician with his or her patient. A distressingly frequent criticism of physicians by their patients is lack of compassion, indicating that, consciously or subconsciously, it is often fumbled.

As emphasized earlier, the importance of physician behavior is based on the fact that illness creates an abnormally sensitive emotional state in the patient. This clear recognition by Osler was a major reason for his almost legendary reputation as a physician. Not recognizing and treating this part of a patient's disease is a fundamental error, similar to ignoring a fever or a severe anemia. The basic elements are simple, but require some time with the patient, listening sympathetically, talking with him, and examining him. The manner in which this is done is crucial. The key features include an appropriate cheerful optimism with kindness, engendering faith and hope, minimizing pain and fear.

The unique privilege of the intimate one-to-one physician-patient relationship should be emphasized. It is a special stewardship of medicine, embodied in our classic ethical codes. Usually the patient's family and close friends are the only other individuals in his life that have the same degree of intimacy. This privilege, granted a physician by society along with the MD degree, should be cherished and treated with care and respect.

The importance of compassion was eloquently described by Peabody in his classic 1927 publication, *The Care of the Patient*.[11] To quote, "The treatment of a disease may be entirely impersonal; the care of a patient must be completely personal. The significance of the intimate personal relationship between physician and patient cannot be too strongly emphasized..." The final sentence in this classic paper was often quoted by Dunphy: "One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is caring for the patient."[12]

This basic importance of compassion is based on an interaction between two fundamental human instincts. First, it has been long recognized that illness invariably evokes some degree of anxiety, the physiological equivalent of "an alarm reaction." The second basic instinct is not commonly recognized. If the anxious, frightened patient senses that his physician is sympathetic and understanding, his anxiety is decreased. However, if the patient senses that the physician is indifferent and uncaring, anxiety is increased and a second instinctive emotion, *anger*, often evolves. Simply put, the anxious patient feels angry that he or she has been rejected with indifference by the physician to whom he turned for sympathy and understanding. *I cannot emphasize too strongly* that this fundamental reaction is the kernel from which many adversarial physician-patient relationships develop. It should be emphasized that this is a subconscious perception by the patient. Often a physician may quite innocently be simply unaware of it, and puzzle to himself, "Why is he so ungrateful and angry?"

Four basic concepts

For many years in frequent lectures with third-year medical students I have emphasized four attitudes upon which genuine compassion is based:

1. Envision each patient as "a member of your family," and treat him as you would want one of your family treated. This, of course, is a simplistic expression of the Golden Rule.

2. An important corollary of this concept is that all patients are treated with dignity or respect, regard-

less of their background, or economic or social status. A physician is not a social judge but someone who treats illness in human beings.

3. Be "gently honest." Both words, *gently* and *honest*, are crucial. Honesty may be summarized briefly with the succinct admonition, "Never lie to a patient." Dunphy eloquently emphasized this point in 1978.[20] What a patient is told is a matter of individual judgement, but be certain that what is said is correct. A crucial part of the bond between a physician and a patient is complete trust in the physician's honesty and sincerity.

The word "gently" describes the tone and manner with which truth is conveyed. Truth can be expressed gently, thoughtfully, and sympathetically, or bluntly, harshly, and impersonally. This is the art of medicine, implied in the concept "a member of your family."

For example, a laparotomy has found an inoperable neoplasm with peritoneal metastases. How to tell the patient and the family? On the one hand, a cold, blunt approach is to tell the patient that he has widespread cancer for which nothing can be done surgically; chemotherapy and radiotherapy can be considered but usually do not work, so life expectancy is only a few months. The exact opposite is to tell the patient gently and sympathetically that this is a malignancy that has spread to different organs and cannot be treated surgically. Two possibilities are the use of radiation and chemotherapy. One cannot offer much encouragement with these modalities but one can always try and hope for the unusual exception, perhaps a miracle.

Both statements are "honest," for spontaneous, unexplained remissions of malignancies, although rare, do occur. The crucial importance of the latter approach is that a slim ray of hope has been left, and the physician has not abandoned the patient.

4. Consider which of three goals is possible with treatment: cure the disease, comfort if a cure is not possible, or help the patient die with as much comfort and dignity as possible.

Why is compassion fumbled? With the fundamental importance of compassion and the simplicity of the concept, it is somewhat astonishing that it is so commonly fumbled. The reasons seem to be at least threefold. *First* is the belief that a physician must be "professional," formal and detached, considering the problem, not the individual. This detached, somewhat aloof impersonal manner is based partly on the belief that authority is enhanced by an element of impersonal aloofness, even mystery, somewhat akin to the ancient "witch doctor." In modern times, however, the patient is often simply infuriated, not impressed.

A *second* cause is a traditional teaching in medicine of not visibly displaying any emotion, maintaining a "stiff upper lip." The "Aequinimitas" Valedictory Address by Osler at the University of Pennsylvania in 1889, delivered when Osler was 40 years of age, emphasized equinimitas and imperturbability.[21] This classic address was delivered at a time in medicine when cure was seldom possible. Osler's goal was to emphasize maintaining a calm, somewhat optimistic attitude even in discouraging circumstances.

I am reasonably certain that Osler was widely misunderstood. This was a short statement, addressing a graduating class of students, at a time when the majority of Osler's clinical experience was ahead of him. Certainly, Osler was the most compassionate of physicians, keenly aware of individual patients and their problems. This is well reflected throughout his life, starting with his childhood on the Canadian frontier where his father was a rural minister. The numerous contributions Osler made to humanism were well summarized in the centennial Shattuck lecture by Brownell Wheeler earlier this year.[22]

In our present age, a century after Osler's address, avoiding any display of emotion—"staying cool"—is common behavior. With an ill patient, however, a cool imperturbable demeanor by his physician is usually interpreted by the patient as indifference.

Quite the contrary to appearing indifferent and imperturbable, a compassionate physician uses both his "head and his heart." I have often emphasized to students, "Be glad you can cry with a patient." To show an emotion of grief, concern, and pity for a patient who has a tragic illness, such as a mother whose eight-year-old child has just become blind from a head injury, is a sign that the physician is a human being, not an indifferent machine. The emotional expression of grief, such as tears or audibly crying, is powerful and healthy. What is the point of attempting to maintain a "stone face," not displaying even the trace of a tear, in the face of overwhelming tragedy?

A common erroneous concept is that a display of emotion can interfere with thinking. Quite the contrary is often true, for strong disciplined emotion is a spur to thinking, widely recognized in creative

thinking and writing. It harnesses powerful subconscious intellectual forces that are crucial to concept formation and deductive reasoning. With discipline, one can cry and think at the same time!

The *third* major reason for the fumbling of compassion is simply that it is not taught, both from not understanding its basic importance and because there is no known effective method for teaching it in the classroom or lecture hall. It is most effectively taught by directly observing a physician talking to his or her patient. With the burgeoning growth of science steadily crowding the curriculum in medical schools, effectively teaching compassion is difficult, and perhaps impossible. For the majority of physicians, it must be self-taught.

Guidelines for learning compassion. Compassion must be essentially "self-taught," adapting to one's own personality. Otherwise, it is obviously artificial, an adornment, not an expression of sincere feeling. With a moderate amount of conscious effort, compassion is readily achievable—for kindness to a fellow man is a normal human instinct. The basic four principles have been emphasized earlier: treat a patient as a member of your family; treat all with dignity and respect; be gently honest; and project the goal of cure, comfort, or help die with comfort and dignity. Two additional guidelines have been found helpful in innumerable conversations with patients over past decades.

First, be certain the patient is comfortable in your presence and is asking questions. A frequent criticism of physicians is that they have poor communications with their patients; a patient can't get answers. A detached "businesslike approach," working rapidly with a rigid time schedule, almost precludes good communication. Effective listening—listening carefully and sympathetically (empathic listening)—in itself may often be strongly beneficial. Edwards has eloquently described this process from personal conversations while visiting dying patients in their homes.[23]

Second, pay attention to the countenance of the patient, because it often reflects the quality of the physician-patient relationship. Because of anxiety, a patient usually wants to see his or her physician. If seeing his physician relieves the patient's anxiety in some way, the patient often will smile when the physician leaves him. He is simply "glad he's seen his doctor."

The dying patient

One of the most important parts of the bond between a physician and his patient, when death is inevitable, is to help him die with as much comfort as possible. This important ethical responsibility has been badly distorted, even vulgarized, in recent years with jargon terms such as "No Code." "No Code" unwittingly conveys a degree of indifference and lack of caring that is almost repugnant. "No CPR" is certainly indicated for many terminal patients, but surely should not be interpreted to mean "don't call me."

For decades medicine could often do little more than comfort. Thomas clearly described this fact in his recent autobiography *The Youngest Science.* Death was common, a familiar experience for the physician. It often occurred in the patient's home with the physician playing an important role. Now, the numerous miraculous developments in medicine, principally in the past 50 to 60 years, have made death uncommon except in the elderly or those who have progressive chronic diseases. This lack of familiarity with death has undoubtedly contributed to a serious misunderstanding of the important role of the physician.

There are two important principles that should guide the conduct of the physician. *First,* virtually no one is comfortable in the presence of impending death. Death is contrary to basic human instincts; to the physician it often represents a failure of therapy. A natural impulse, therefore, is to shun the dying patient, finding some pretext to stay away from him, much as if he had an infectious disease like tuberculosis or leprosy. This occurs very often. Interviews with patients who have inoperable malignancies have again and again found that patients are aware of impending death, are not afraid of it, but that they deeply resent being virtually "abandoned" by their physicians.

A physician can discipline his natural instincts by understanding that helping a patient die and comforting the family is one of the crucial characteristics of the compassionate physician—that is, simply helping someone die with dignity and respect. The timeless

biblical verse from *Ecclesiastes*, Chapter 3, Verse 2, eloquently expresses the fact that death is a natural process that comes to everyone: "There is a time to be born and a time to die; a time to plant and a time to pluck up that which is planted."

The *second* important principle concerns what the physician should do. The natural questions with a dying patient are, "What can I say?" or "What can I do?" Obviously, very little can be said, but the key principle is very simple: "*be there*"—perhaps not for long but as frequently as possible. These concepts were eloquently expressed in a panel discussion on the care of the dying patient at the Clinical Congress of the College in 1974.[24]

The greatest need of dying patients is that they not be feared, rejected, and abandoned by the living just because they are dying. Edwards recently described periodic visits with dying patients with "empathic listening," simply listening intensely and sympathetically.[23] Kübler-Ross has written extensively about dying patients. She describes five progressive stages: denial and isolation, anger, bargaining, depression, and acceptance.[25] Visiting with the patient and listening carefully helps both him and his family accept the inevitability of impending death. This crucial role of the physician was eloquently expressed by Dunphy in 1976 in his "Annual Discourse—On Caring for the Patient with Cancer."[12]

The importance of the physician's "being there" is based on the fundamental human instinct that "man does not want to die alone," but surrounded by family and close friends. This basic instinct of not dying alone is expressed with timeless eloquence in the biblical verse from the *Book of Psalms*, Chapter 23, Verse 4: "Yea, though I walk through the valley of the shadow of death, I will fear no evil: for Thou art with me; Thy rod and Thy staff they comfort me."

Commitment to the patient

The primary importance of the bond between the patient and his physician is the care of the patient. Two major benefits, however, also frequently come to the physician. A strong sense of commitment harnesses intellectual energies that otherwise remain dormant and greatly increases the capacity for conceptual thinking. Being totally familiar with the pertinent data, analyzing it again and again, often leads to an idea that may successfully change the course of therapy. This is creative thinking, or deductive reasoning. A physician studies a patient with a complex, unsolved problem in the same manner that a writer develops a novel or an artist creates a painting on canvas.[26]

Separately, the physician derives a strong sense of pleasure and achievement by tenaciously analyzing and solving a complex problem. This is "simply helping a sick person get well." A few years ago I responded to a request by our graduating students to write something for their *Year Book* with the following statement: "The nuclear fuel of medicine is the personal pleasure the physician feels when he has cured or comforted an ill patient." Over 60 years ago, Peabody, in his timeless classic, expressed the identical thought: "Time, sympathy, and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine.[11]

Medical history abounds with examples of physicians who, upon the death of a patient for whom no successful surgical treatment was available, found impetus to develop a major scientific achievement in subsequent years that benefitted countless patients. Death in one patient was the spur that motivated John Gibbon to ultimately develop a heart-lung machine after more than 25 years of intermittent, frustrating laboratory investigation.[27] Similarly, John Kirklin was motivated after the operative death of a patient and began a laboratory investigation that within a few years produced the Mayo-Gibbon pump oxygenator in 1955, a keystone in the launching of modern day open heart surgery. This strong intellectual spur to creative investigation stemming from experiences with one patient was the subject of a major address in 1983.[27] The strength of this motivation, which originated from the commitment of the physician to his patient, is well illustrated by the fact that the investigators usually continued without encouragement, and often with ridicule or even pungent criticism. The ancient Greeks recognized the major importance of inspiration in motivation. Their word for this "divine madness" was *entheos*, the forerunner of *enthusiasm*.

Responsibility of leadership

As new members of the College of Surgeons, you have a major leadership responsibility in American surgery. Your capacity to be leaders has already been demonstrated through the years of sustained hard work that led to your election to this College. As you build

your surgical careers, you will find that the decade ahead will be one of the most exciting and important times of your entire surgical lifetime. One of you in this audience tonight will probably be standing here on this rostrum about 25 years from now giving a Presidential Address.

Surgeons are natural leaders, both by temperament and by experience, accustomed to making prompt, complex decisions with emergency problems, often with limited data. This ability for decision-making, within a finite period of time, often while under stress, is the hallmark of the surgeon.

The story of Walter Wiley, a surgeon in New York City in the late 1860s, is a remarkable example of what one surgeon can do. Not long after the Civil War, a committee was formed at Bellevue Hospital to decide whether nurses should have some type of basic education before caring for patients. Astonishingly enough, no school of nursing existed in the United States, and for several weeks opinions in the committee were divided between whether educating a nurse was a good idea or not! Finally, Walter Wiley, a junior faculty member in surgery, asked the committee's permission to go to England, at his own expense, to see the work of Florence Nightingale. The results of his trip were spectacular: His visit quickly led to the foundation of the Bellevue School of Nursing, the first such institution in the entire United States.

As you tackle the tough problems that currently abound in medicine, remember this quote from Leon Uris: "A strong measure of self-confidence, even bordering on arrogance, is important. Be confident that with persistence and hard work you can solve the problem, even though you have never done it before, and nothing in your background suggests you ever could do it!"[28]

I want to emphasize four different problems that urgently need action. *First* and foremost is the vital importance of commitment to the patient, the central theme of this address. The solution to this problem is simple and straightforward, available to each of you with your individual patients. If you understand its importance and act accordingly, teaching it to your juniors, major improvements will occur almost immediately.

Failure to maintain this strong physician-patient relationship has led to incredible events in some socialistic governments. In certain large hospitals in northern Europe, surgeons work rigidly by the clock, with another "team" completing an operative procedure if the time allotted to the first team has passed. Another "team" subsequently cares for the patient in the intensive care unit; so the initial operating surgeon may never see the patient again. This assembly-line structure, resembling an automobile manufacturing plant, is undoubtedly financially efficient but surely almost completely eliminates any physician-patient relationship. The physician works for the state, and the patient is dependent on the state for his health care, not the physician.

Second, enlist the help of your patients and the public to help solve our major national problems in medicine, the cost of medical care and the care of the poor. We have remained silent too long. We need to speak up and be recognized publicly as ardent spokesmen for the best medical care for our patients. The problems should not simply be "passed on" to the government.

This has happened in socialistic countries. The inevitable economic result is rationing of medical facilities. Tertiary hospitals with modern technology are usually rare in such countries, with long waiting lists for complicated, expensive operations. Intensive care units are similarly rationed. As mentioned previously, nearly 20 percent of the total medical experiences of a lifetime will occur in the last six months of life. Only in retrospect, however, does one know that his was truly the "last six months!" When a patient dies be-

cause of inability to get into an intensive care unit, money is automatically "saved." Why are few voices of protest heard? "Dead patients can't speak!"

A *third* area that needs to be challenged concerns the frequently heard negative myths such as "bad doctors" or "unnecessary surgery." The myth of "bad doctors" was discussed in an article in the June 1990 issue of the *Bulletin*, pointing out that there never has been any meaningful data supporting this harmful myth that has dominated the professional liability arena for over a decade. Similarly, the myth of "unnecessary surgery" needs to be challenged publicly. We should demand to see the reliability of the data on which these criticisms are based.

Finally, teaching is both a basic responsibility and a pleasure in medicine, providing a strong role model for the next generation through both our words and our deeds.

There has been both too much gloom and doom talk and too much silence by the majority. The profession of surgery is the most exciting of all professions, combining in one profession the creative use of the hands and the brain in the surgical operation, exploring unsolved problems in the laboratory or with clinical research, forging a close humanitarian bond while relieving sickness in a fellow man, and teaching the future physicians of tomorrow. Ω

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