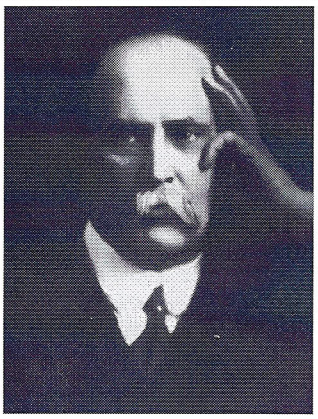


AMERICAN OSLER SOCIETY

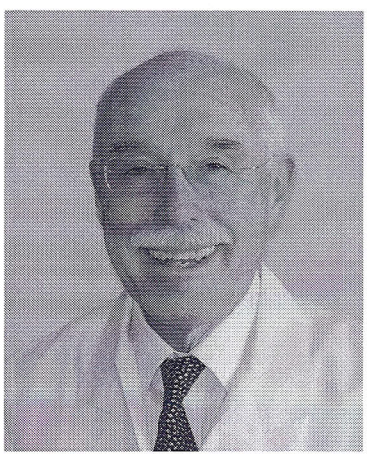
February 2008
Volume 8, Issue 4

The Oslerian

A Message from the President

Internal Medicine as a Vocation

Inside this issue:



Frank A. Neelon

Greetings, Fellow Oslerians

In 1897, William Osler addressed the New York Academy of Medicine on the subject of "Internal Medicine as a Vocation"[1] In his speech Osler defined internal medicine as "that which remains [of general practice] after the separation of surgery, midwifery , and gynaecology." Already Osler must have been leery of the pitfalls of specialization, because he says that such internal medicine practitioners could not "be called specialists, but bear without reproach the good old name physician," and further pointed out that "the student of internal medicine cannot be a specialist."

No doubt Osler envisioned the internist as a counselor in difficult or doubtful cases, a diagnostician and ally of the general practitioner and surgeon, but there is no hint that he anticipated the role that would evolve for general physicians" (internists, pediatricians and family doctors) in the late 20th century United States. That's not surprising since the notion of a primary care doctor who provides first-contact and ongoing care for patients with chronic diseases—indeed, the very idea of chronic disease (let alone its chemical treatment)—was not visible on the radar screen of medicine in 1897. Nevertheless, as the means of detecting and measuring the disturbed physiological processes that we call chronic diseases became available, doctors were recruited to care for those patients. When specialization made the idea of true general practice no longer tenable, general internal medicine and pediatric and family medicine doctors (and later physician's assistants and nurse practitioners) were enlisted to care for patients with the heart disease, cancers, stroke, chronic obstructive pulmonary diseases, and diabetes that account for two-thirds of all deaths in the United States. I suspect that Osler would have been happy with such a general role for internists, just as he applauded the life and work of 19th century general practitioners. He might even embrace the idea of a "primary care home"[2]—a practice location where patients start and continue their queries about health and symptoms, where the clinicians know and value their patients as human entities and see them more than once in a lifetime; a place where, as Robert Frost said, "when you have to go there,/ They have to take you in."

The Generalist as Endangered Species

Valuable as primary care doctors are, their ranks are shrinking rapidly,[3] and the projected futures of internal medicine look mainly glum.[4] The reasons for this dour outlook seem two-fold: the lure of specialization that Osler warned against, which pulls candidates away from primary care, and a decreased influx of new generalists from the medical schools.[3] Now, the road to proficiency in internal medicine has never been easy. At a time when post-graduate medical training barely existed, Osler recommended that the nascent internist devote the first ten years after medical school to eking out a living through general practice or autopsy work or service in a dispensary and use the few dollars accrued to finance his self-education through brief stints in the clinics and laboratories of Europe. Since candidates would have no free money, Osler interdicted all romantic entanglements ("put [your] emotions on ice; there must be no 'Amaryllis in the shade,' and ... beware the tangles of 'Naera's hair'").[1] Not only were marriage and family not possible but, as the allusions to Milton's Amaryllis and Naera imply, Osler forbade even dalliances, which might distract the candidate from his goal. Those ten years of penury would be followed by ten more years of

(Continued on page 2)

President's Message (continued)

subsistence living, after which the now mature generalist would be poised for marriage and family and the rewards of consultative life.

Given the rigors of abnegation prescribed by Osler, it is perhaps a wonder that internal medicine survived at all. I suppose that codifying the training to formal residency programs lasting three or four years helped make training more attractive, as did paying house officers modest but certainly not inconsiderable wages. Still, a number of factors work against sustaining the ranks of doctors devoted to general medicine, *per se*. Osler's warnings about the "drift into specialism" have come to pass. In part, this reflects the attraction of higher income available to the cardiologist or gastroenterologist—no small matter at a time when the average indebtedness of graduating medical students is $130,000 and specialization offers the chance to double or triple one's yearly income. In part, too, it reflects the shallow portrait of the doctor as a "knowledge automaton"[5] or "talking book" that is often promulgated (perhaps unwittingly) during medical school. Since students despair of ever knowing everything about everything, they constrict the horizon of what is to be known by specializing. I think that students are mistaken in their appreciation of what doctoring is about, but gaining that perspective takes years beyond the decision to specialize or not. Osler says that the "physician develops more slowly than the surgeon, and success comes later"[1]; we might say the same of residents who are, alas, forced to choose at a young age between specialization or generalism. There is no getting around the fact that such life decisions are and must be made on the short side of experience and wisdom.

The Tyranny of Time Pressure

Even more worrisome than the pull out of generalism into specialization is the lack of attraction of primary care itself. There are now approximately 900,000 licensed medical doctors in the United States, and the number has been growing linearly for the past 4 decades.[6] Over that same time span, the percentage of medical practitioners who devote themselves to primary care has fallen, again almost linearly, from 40% to 34%. Is that an acceptable proportion? This raises the question of how many primary care doctors this country needs, and that is not an easy number on which to get consensus, so let me share a little thought-experiment of my own. Truls Østbye, Kimberly Yarnall and their colleagues at Duke[7,8] have estimated the amount of time it would take a primary care practitioner to fulfill just the current guidelines for preventive health and chronic disease management. They made their calculations based on each doctor having a panel of 2500 primary care patients whose age, gender and disease distributions mirror the US population. Their very conservative estimate is that a primary care doctor needs 1.04 hours per patient per year just to carry out these non-urgent (and often not symptom-driven) tasks. Each doctor would thus need 2600 hours per year just for all the authoritatively mandated preventive and protocol-driven tasks for an average-sized panel of 2500 patients, but each doctor has only about 2000 office-based hours each year for patient care. How do they squeeze 2600 out of 2000? Obviously they don't—they either have phantom patients (technically part of the panel, but who never come to the doctor) or they gloss over many of the recommendations.

I think that our medical students have sensed the time dilemma confronting primary care[9] and have voted with their feet for seemingly more luxuriant pastures. Could we rectify this situation? Could we find ways to lessen the time burden? Let's assume that primary care doctors should spend half their time (~1000 hours/doctor/year) on preventive and protocol-driven tasks; this means each doctor has "room for" a panel of 1000 patients and each of these patients has, on average, two hours with the doctor/year. Of course some would require much less and some more, but that seems a reasonable allocation for ensuring that both routine and urgent problems are covered.

How Many Doctors Do We Need?

Do we have enough primary care doctors? Well, my calculations suggest that 300,000 primary care doctors could care for every one of the ~300,000,000 men, women and children in the US. Right now the US has approximately 920,000 doctors, of whom about 280,000 are engaged in primary care.[6] So at present we are about 20,000 primary care doctors short, but if present trends continue, by the year 2010, the population of the US will have increased to 310,000,000 and we may have as many as 285,000 primary care doctors. In just 2 years the deficit will increase from 20,000 to 25,000! These demographic trends have most observers very worried.[10,11]

The forthcoming presidential election may well lead to changes in US medical care. The dialogue that is ongoing[12] raises many questions about the nature and the financing of our health care system. Among those questions are the following: Can we continue by asking doctors to work harder and faster than they legitimately can?[9] At present, the US has one primary care doctor for every 1150 citizens, but there is wide geographic variation in that number from 1 per 800 in Massachusetts to 1 per 1500 in Mississippi.[13] Can we continue to largely exclude our more than 40 million residents with no health insurance? Can we—and do we want to—fill the breach in primary care with physician's assistants and nurse practitioners?[14]

Recovering Osler's Paradigm

Perhaps the most important question is, can we resurrect Osler's vision[1] of medical practice as a sacred calling, a vocation, whose rewards of personal and professional satisfaction will more than compensate for the long and arduous road toward that goal? I think maybe we can, but it will take concerted professional and political action. In the spirit of dialogue, I submit the following immodest proposals that medicine might adopt:

1. **Lessen the indebtedness of graduating medical students** by underwriting their tuition or, better, by minimizing tuition itself. How could we do this? I will give one example. From my observation, the so-called basic sciences of medicine are taught not as scientific endeavor but as catechism, while the principles that scientific inquiry might teach—curiosity, skepticism, doggedness, learning-by-doing, for example—have been replaced by temporary indoctrination with facts derived from scientific discovery. Given the availability of modern communications, it should be possible to inculcate science-derived information by

distance learning. That means that a single (small and well-paid) teaching faculty could, via electronic and computer connections, serve the whole country with resulting savings in student tuition. Furthermore, that course could be taught as history rather than the indoctrination of facts and thereby demonstrate how scientific inquiry and discovery has unraveled our understanding of how the body works and doesn't work. Regional or medical school sections would still provide the personal guidance and the remnant of practical learning, such as anatomical dissection, that is deemed necessary.

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2. Make the practice of primary care attractive once more by lessening the time burden on practitioners, by buttressing the idea of the medical home, where patients are truly known and valued and to which they turn when they think they are in trouble. Certainly there are information systems available or possible to develop that will help the doctor in this daily task. We need to fund the sustenance of doctoring as well as the "wars" we wage on various diseases.[15]

3. Provide primary care doctors a reasonable income. How much doctors should earn each year is open to debate. At the present time US primary care doctors make about $150,000 year.[16] At that rate, it would take about $45,000,000,000/year to pay for the 300,000 primary care doctors I think we need. Forty-five billion dollars may seem a lot, but it represents only 2.25% of the current $2,000,000,000,000 that the US spends each year on health care. In fact, we could increase compensation to $200,000 per year (to care for 1000 patients per year) and still come in at 3% of the total expenditure. A very good, if not lavish, yearly income, coupled with a job description that seems doable, will attract doctors.

4. Enlarge the perspective of the doctor's job. These days, evidence-based medicine is the rage, and who could object to the use of evidence, even though much of what is being passed off as *medicine* is merely evidence-based *treatment?* But I submit that the doctor's job is much more than mere treatment. Perhaps including the patient's narrative in the body of evidence will help.[17] Perhaps a wider acquaintance of succeeding generations of students with the purposes of the internal medicine and other primary care disciplines risk death by marginalization. But I think Osler was right. I think that we need to encourage the idea that the unspecialized care of patients is a high calling, unparalleled in its opportunity for self-sustenance, for self-education, for self-fulfillment. Only if we do this will we prevent a vocation from becoming avocation.

Francis A. Neelon

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References

1. Osler W. Internal medicine as a vocation, *in Aequanimitas with Other Addresses.* Third edition, Philadelphia: P Blakiston's Son & Co; 1932.
2. Grumbach K, Bodenheimer T. A primary care home for Americans. *JAMA* 2002; 288: 889-93.
3. Rich EC, Maio A. Late to the feast: primary care and US health policy. *Am J Med* 2007; 120: 553-9.
4. Hemmer PA, Costa ST, DeMarco DM, et al. Predicting, preparing for, and creating the future: what will happen to internal medicine? *Am J Med* 2007; 120: 1091-6.
5. Larson EB. Physicians should be civic professionals, no just knowledge workers. *Am J Med* 2007; 120: 1005-9.
6. American Medical Association. Physicians in the United States and possessions by selected characteristics. (Accessed February 14, 2008 at http://www.ama-assn.org/ama/pub/category/2688.html).
7. Østbye T, Yarnall KSH, Krause KM, et al. Is there time for management of patients with chronic diseases in primary care? *Ann Fam Med* 2005; 3: 209-14.
8. Yarnall KSH, Pollak KI, Østbye T, Krause KM, Michener JL. Primary care: is there enough time for prevention? *Am J Pub Health* 2003;93:635-41.
9. Morrison I, Smith R. Hamster health care. *BMJ* 2000; 321: 1542-2.
10. Sandy LG, Schroeder SA. Primary care in a new era: disillusion and dissolution? *Ann Intern Med* 2003; 138: 262-7.
11. Salsberg E, Grover A. Physician workforce shortages: implications and issues for academic health centers and policymakers. *Acad Med* 2006; 81: 782-7.
12. Relman A. *A Second Opinion. Rescuing America's Healthcare: A Plan for Universal Coverage Serving Patients Over Profit.* New York: Public Affairs; 2007.
13. Association of American Medical Colleges. *2007 State Physician Workforce Data Book* (accessed 14 February 2008 at *http://www.aamc.org/workforce/statedatabookjan2008.pdf*).
14. Mundinger MO, Kane RL, Lenz ER, et al. Primary care outcomes in patients treated by nurse practitioners or physicians. *JAMA* 2000; 283: 59-68.
15. Showstack J, Lurie N, Larson EB, Rothman AA, Hassmiller S. Primary care: the next renaissance. *Ann Intern Med* 2003; 138: 268-72.
16. Physicians search. Physician's compensation survey. (accessed February 14, 2008 at *http://www.physianssearch.com/physician/salary2.html*).
17. Charon R, Wyer P. Narrative evidence based medicine. *Lancet* 2008; 371: 296-7.

In Memoriam

Earl F. Nation (1910-2008)

Earl F. Nation, charter member, ninth president, and active participant in all aspects of the American Osler Society, died at his home in Pasadena, California, on New Years Day, 2008, twelve days shy of his ninety-eighth birthday. He had been active and well until December 27, having recently had his driver's license renewed and having registered for the 2008 annual meeting, when he awakened with a loud mechanical noise over his left ear that proved, on CT scan, to reflect a cerebrovascular accident involving the left temporal lobe. An MRI scan demonstrated a large lesion consistent with astrocytoma. He returned home for several quiet and largely asymptomatic days but lacked his usual energy. After watching the Rose Bowl parade on New Year's Day, he took a nap, then developed distress. His last words, spoken to his sons Bob and Bill, were "I love you all. Don't call the paramedics."

A memorial service will be held for Earl in Pasadena on March 2, 2008, and we anticipate that the biographical sketch prepared for that occasion will be reprinted in sufficient quantity for distribution to all AOS members. In brief, he was born in Zephyr, Texas, graduated from high school and college in San Diego (the latter at San Diego State College, where in 2005 he was honored as a Distinguished Graduate), received his medical degree from Case Western Reserve, and did a urological residency at Los Angeles County Hospital. It was there that he contracted tuberculosis,

Earl Nation on May 3, 2007, just before leaving Montreal after the annual meeting of the American Osler Society.

leading to a 24 month hospitalization during which he read Harvey Cushing's *Life of Sir William Osler*. Recovered, he enjoyed a long and distinguished career practicing urology in Pasadena and, later, a long and distinguished career as a medical historian. The American Osler Society was but one of the numerous organizations that benefited from Earl's energy, enthusiasm, and largesse. His contributions to the AOS were legion, but perhaps none of more lasting value than his compilation of the secondary literature that led to the two volumes of *An Annotated Checklist of Osleriana*. Earl was predeceased in 1997 by his wife of 61 years, Evelyn. His longtime secretary, Carolyn Guiditta, remained his faithful and devoted friend until the very end.

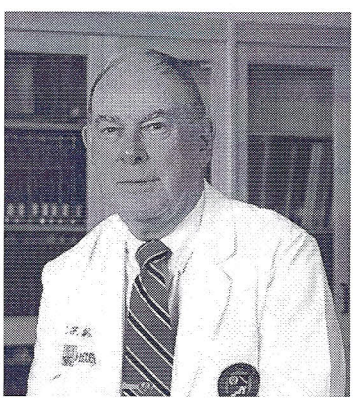
—CSB

In Memoriam

Charles F. Wooley (1929-2008)

Charles F. Wooley, longtime member and twenty-sixth president of the American Osler Society, died at his home in Columbus, Ohio, on February 15, 2008, of presumed pulmonary embolism following otherwise successful hip replacement surgery. He had been in good health and planned to present a paper entitled "Anglo-American Cardiology: Osler, Lewis, Libman, Cohn, et al., and the Mount Sinai Connection" at the 2008 AOS meeting in Boston. The covering letter to his abstract submission read: "Conflict?—No! Enthusiasm—Yes? Only request—First morning session."

A native of New Jersey, Charlie graduated from Providence College and the New York Medical College, then did his internship, residency, and cardiology fellowship at Ohio State University, where he would spend the remainder of his career. As an active and prolific investigator, he was honored with a Career Research Development Award from the National Institutes of Health. His research included pioneering observations on the use of diagnostic ultrasound and the use of genetic markers to identify specific types of heart disease. He directed the Cardiology Catheterization Laboratory at Ohio State from 1962 to 1971, an era that saw the rise of open heart surgery as we know it today. He was also involved in the early use of cardiac pacemakers and electrophysiology. As a teacher, Charlie received numerous awards for excellence from medical students and house officers. Especially since



Charles Wooley at the Ohio State University Medical Center, where he made his mark as clinician, teacher, researcher, and historian

retiring from full-time faculty status in 1992, he made numerous contributions to the history of medicine and especially of cardiology. His presentations, published articles, and books were noted for their clarity and especially for their splendid illustrations. During his AOS presidency, he prepared a brochure for planned endowment giving. An obituary recognized such Oslerian attributes as "a keen sense of personal and social responsibility," "the highest ethical standards," and his serving as a "willing, patient, and Socratic mentor."

Charlie is survived by his wife of 53 years, Mary Lucia, a daughter, three sons, five grandsons, five granddaughters, and a sister.

—CSB

Income, Expenses, and Liquid Asset Balances, 2001-2007

	2001	2002	2003	2004	2005	2006	2007
START BALANCE, 1 JANUARY	**439,237.65**	**447,236.97**	**377,566.91**	**477,546.88**	**522,103.45**	**524,372.87**	**543,221.51**
Income							
Dues and initiation fees	9,900.00	14,865.00	14,535.28	15,661.92	10,723.44	15,531.31	16,449.92
Meeting income	33,575.00	39,060.85	49,547.88	48,098.31	28,091.00	31,633.83	55,261.60
Latchkeys, ties, T-shirts	1,329.00	805.00	1,303.55	960.00	603.00	475.00	771.00
Book sales and royalties	85.00	5,831.50	15,247.45	4,732.12	2,908.36	2,091.00	2,186.90
Educational Endowment Fund	20,855.00	540.00	1,320.00	1,895.00	1,075.00	1,170.00	1,065.00
Friends of 13 Norham Gardens	355.00	185.00	345.00	680.00	425.00	230.00	505.00
Friends of Osler Library	460.00	160.00	195.00	1,065.00	700.00	255.00	855.00
McGovern lectureship/contributions	36,849.20	10,000.00		12,500.00	12,500.00		5,640.00
Miscellaneous income			750.00	15,273.90	243.71		
Appreciation of equities	-22,233.11	-48,670.55	91,610.34	34,966.62	28,405.24	51,463.64	25,689.55
Total Income	**81,175.09**	**22,776.80**	**174,854.50**	**135,832.87**	**85,674.75**	**102,849.78**	**108,423.97**
Expenses							
Administrative assistant	6,000.00	4,500.00	4,500.00	9,500.00	8,000.00	8,000.00	6,000.00
Supplies and postage	293.85	1,247.87	4,514.71	1,651.86	1,259.00	1,119.35	3,078.26
Printing	1,677.64	1,566.28	1,038.01	1,030.05	1231.22	1,105.71	1,328.63
Latchkeys and other merchandise							
Persisting Osler I, II, and III	882.00	3789.58					
Meeting expenses	37,134.72	30,835.87	43,510.82	45,566.15	35,139.02	51,401.41	50,441.84
McGovern Lectureship Account	6,162.21	4,830.00	3,740.00	2,780.27	8,797.79	8,079.45	5,209.94
Wm. B. Bean Educational Endowment	4,388.00	3,309.05	2,738.07	139.99	4,500.00	5,736.42	4,322.73
Deposits for future meetings	1,271.18	19,457.03		500.00	718.75		3,800.00
Friends of Osler Library	610.00			505.00		950.00	
Friends of 13 Norham Gardens	480.00			380.00		625.00	
Subventions for books	4,199.20	17,000.00	7,294.71	16,530.12	12,026.88		20,851.79
Web site	1,195.00	600.00		500.00	500.00		
Refunds	790.00	1,630.00	45.00	2,345.00	1,960.00	1,610.00	440.00
Money management fees	3,460.02	1,661.18	3,107.87	6,201.25	3,874.47	4,119.84	4300.43
Miscellaneous expenses	4,631.95	2,020.00	4,385.34	5,016.25	5,398.20	1253.96	1,278.95
Total disbursements	**73,175.77**	**92,446.86**	**74,874.53**	**91,276.30**	**83,405.33**	**84,001.14**	**101,052.57**
END BALANCE, DECEMBER 31	**447,236.97**	**377,566.91**	**477,546.88**	**522,103.45**	**524,372.87**	**543,221.51**	**550,592.91**

AMERICAN OSLER SOCIETY

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Aequanimitas

The Oslerian *is published approximately four times a year by the American Osler Society, Inc., a non-profit organization. Members of the American Osler Society are encouraged to send news items of interest, including but by no means limited to their personal activities and accomplishments and accompanied by photographs or other illustrations. For distribution of reprints and other materials of possible interest to AOS members, please send 180 copies. Your ideas for* ***The Oslerian*** *are of course most welcome! Direct all correspondence by mail, fax, or e-mail to the Secretary-Treasurer.*

Secretary-Treasurer's Report

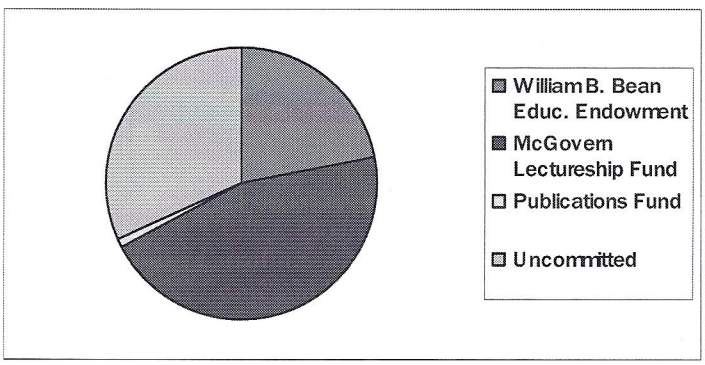
Shown on the previous page is a breakdown of AOS income and expenses for the calendar year 2007.

1. The year-end balance of our liquid assets again stands at an all-time high ($550,592.91). This is the case largely because the value of our equities (managed by Fidelity Investments, with diligent supervision by Paul Dyment and other members of the Finance Committee) appreciated for the fifth straight year.
2. The John P. McGovern Foundation donated $5,000.00 for the purpose of starting a publications fund.
3. Distribution of our year-end balance is as follows: $249,012.85 in the McGovern Lectureship Fund, $121,521.58 in the William B. Bean Educational Endowment Fund, $5,000.00 in the new Publications Fund, and $174,968.48 in uncommitted assets. This distribution is shown in the figure, below.
4. The purchase value of our year-end inventories is $12,959.90, consisting of the following: four copies of *The Persisting Osler III,* one latch key (which is not for sale; it will be kept as a template for possible re-manufacture), 42 four-in-hand ties (25 gray, 17 red), 42 bow ties (27 gray, 15 red), 188 posters, 31 T-shirts, 50 McGovern medals, and 46 lifetime achievement medals.
5. Meeting expenses shown on the previous page include a payment ($623.30) for the 2006 meeting in Halifax, Nova Scotia, and $1,786.50 for continuing medical education (CME).
6. Unusual expenses during 2007 included $20,851.79 for subvention of a supplement issue of *The Journal of Medical Biography* and $2,307.24 for purchase of 30 new president's plaques.
7. Miscellaneous expenses shown on the previous page consisted of $1,175.00 for review of financial records and preparation of a tax return, $18.95 banking fees, and $85.00 dues to the American Association for the History of Medicine as a constituent society.
8. A more detailed report will be presented to the Board of Governors and will be summarized at the Annual Meeting in Boston, May 2008.

Respectfully submitted

Charles S. Bryan

Secretary-Treasurer



Dates for Future Meetings

1. The **2008 meeting** will take place in Boston, Massachusetts, 4-7 May. John Noble chairs the Local Arrangements Committee. Those who have not made their reservations should contact Sanchia Mitchell (803 540 1000 or *smitche@gw.mp.sc.edu* and should make hotel reservations directly with the Holiday Inn Beacon Hill (617 239 2401).
2. The **2009 meeting** will take place in Cleveland, Ohio, 20-23 April, in tandem with the AAHM meeting. James Young will chair the Local Arrangements Committee.
3. The **2010 meeting** will take place in Rochester Minnesota, 25-28 April, in tandem with the AAHM meeting. Bruce Fye and Paul Mueller will co-chair the Local Arrangements Committee.