This is an abridged version of an invited lecture given to the Harvard Medical School graduating Class of 2014 on May 28, 2014. The lecture was established by the Harvard Medical School Class of 1958 to honor Dr. Hermann L. Blumgart.

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REFLECTIONS ON 59 YEARS OF DOCTORING

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I was invited to give this lecture because I have just retired from the practice of medicine at the Massachusetts General Hospital (MGH) after 59 years. I have been asked to share with you some of the values that have guided me on my long medical odyssey.

There are four immutable principles that form the bedrock of my philosophy with respect to my caring for patients. These are as follows:

1. The patient always comes first. A corollary to this is that in any given circumstance and at any given time, weigh all the information and always try to do that which is best for the patient.
2. Apply the golden rule to medicine, enunciated so beautifully by Dr. Robert F. Loeb, the legendary chief of medicine at Columbia Presbyterian Hospital: "Do unto others as you would have done to you if you were that patient in that bed at that time."
3. I have always tried to be not only a *caregiver* to my patients but also a *friend*.
4. Abide by the immortal words of Dr. Francis Weld Peabody, a Harvard Medical School graduate who gave a lecture to Harvard medical students in 1926 that was published in the Journal of the American Medical Association in 1927—the same year Dr. Peabody died quite prematurely.[1] He concluded his classic lecture with these transcendent words that should be emblazoned in every caregiver's mind: "One of the central qualities for clinicians is an interest in humanity, for the secret of the care of the patient is in caring for the patient." And I really care about my patients.

But Dr. Peabody said so much more in that talk: "The practice of medicine in its broadest sense includes the whole relationship of the physician with his patients. It is an art based to an increasing extent on the medical sciences, but comprising much that is still outside the realm of science," and "The significance of the intimate personal relationship between physician and patient cannot be too strongly emphasized." True in 1926 and even more true 88 years later.

The Virtues of Humanism

So, how do we go about truly caring for our patients? It starts with the noble virtues of compassion, kindness, sensitivity, and understanding. Respect for your patients is crucial. Try to listen carefully and sympathetically to what they are telling you. And always pay particular attention to details. Sometimes, the answer is in the small stuff.

Another way I have tried to respect my patients is to respect their time by keeping my appointments running on schedule. Your time is precious, but so is that of your patients. Remember, time that is wasted can never be lived again.

I encourage you to examine your patients. These days, many physicians rely on their non-M.D. assistants to examine the patient and perform no examination themselves. Nothing connects you *physically* more closely to the patient than a *physical* examination. Even though my interest is in the cardiovascular system, I can't tell you how many important incidental findings I have detected over the years on physical examination—things like skin cancers, pathological lymph nodes, enlarged organs and masses, breast cancers, aortic aneurysms, and many more.

As I have said, I try to cultivate friendships with my patients. I give them a warm greeting and a warm farewell. With patients whom I have come to know very well, you'd be amazed how much a gentle hug can convey your affection and depth of your care. I try to know as much as I can about my patients—their jobs, families, interests, and concerns. In each encounter, I make a point of discussing some important aspect of their lives other than their medical problems. To me, there's not a person on earth who doesn't have an interesting life story to tell.

It's almost impossible to communicate with patients too much. In today's world, communication is facilitated through the use of IT. But I can assure you that patients still appreciate hearing from their doctor. I never allow a patient to get test results only from the information systems; I always send them a note discussing the pertinent aspects of the results. You'll probably do it by email, and that's ok. If there is a potentially serious finding, I urgently call the patient myself to discuss the finding and how we should proceed.

Educating patients about their illnesses and medications is not only a necessity but also may help facilitate their care. The more informed patients are about their condition, the more intelligently they can care for themselves. Meticulous informed consent by the physician, particularly if it involves high-risk procedures, is crucial. I address all questions and concerns a patient may have. Remember that even if the risk of death from a given procedure is

only 2%, for any individual patient undergoing that procedure, it is either 2% or 100%.

Therapeutic decisions often include options, sometimes as many as three or four. I outline all options to the patient, detailing the risks and benefits of each, but I never ask, "What do you want us to do?" I decide what option I think is best and so advise the patient. Sometimes the patient will choose a different option, and that is certainly the patient's prerogative.

I need hardly say that it is important to be scrupulously honest and dependable with your patients. If you tell them that you are going to do something, like call them in the next 2 days, then do it. If a terrible mistake in management has occurred, tell the patient the truth. Even our presidents have never learned that an attempt at a cover-up is always worse than the truth, no matter how bad the truth may be.

You would be amazed at the power of a simple unexpected phone call from a doctor to a patient. After my patients are discharged from the hospital, I try very hard to call them at home within 2 to 3 days to see how they are doing. It's surprising how many patients have important questions about their discharge instructions and medications. And patients never forget those calls.

Many years ago, I was rounding late at night. I finished visiting with my patient, and as I was leaving the room, I heard this forlorn voice from his roommate say, "Gee, I wish you were my doctor." When I asked him why, he said he hadn't seen his doctor for 2 days. I cannot emphasize strongly enough that the most important part of a hospitalized patient's day is when their doctor comes by, not the nurse practitioner, the physician's assistant, the resident, or the fellow. They want to see *their* doctor.

When you get to know your patients, you can get some sense of what I call their "disease tolerance." You will care for alarmists and you will care for stoics. Some patients never call unless there is a real problem. These patients get my immediate attention. This relates to denial, which is a two-edged sword. It enables patients to coexist with often serious and debilitating illnesses, but when extreme, it can also be very destructive. Many patients have died unnecessarily because of excessive denial.

Challenges in Patient Care

Sometimes in the course of doctoring, uncomfortable situations may arise. One predicament that is frustrating to both the doctor and patient is when we are unable to arrive at a definitive diagnosis despite an exhaustive workup. Medicine is far from an exact science; it seems that we don't know what is going on with our patients just about as often as we do know. One helpful approach to this unsettling situation is to emphasize to the patient that it is equally as important to know what diseases that patient *does not* have. I am delighted when I can tell patients that they don't have cancer or some other serious disease based on the information we have. Much of the time, whatever the patient has either resolves without a diagnosis, or a definitive diagnosis eventually becomes clear. The management of these patients reminds me of a quote by 18th century Frenchman Giles Menage, who said, "Medicine may be defined as the art or the science of keeping a patient quiet with frivolous reasons for his illness and amusing him with remedies good and bad until nature either cures him or kills him."

Equally frustrating are those patients in whom the diagnosis is known but the patient fails to respond to treatment. This dilemma demands patience from both the doctor and the patient. In particular, patience is crucial if an invasive or surgical option is under consideration. Don't pressure yourself into doing something that can make a difficult situation even worse. I do not send a patient for an invasive procedure until I believe it is absolutely necessary and unless I am convinced it will benefit the patient. Timing is critical in this setting. Dr. Benjamin Rush, the most renowned American physician of the 18th century and, incidentally, a signer of the Constitution, put it well: "Solomon places all wisdom in the management of human affairs, in finding out the proper times for performing certain actions. Skill in medicine consists in an eminent degree in timing remedies."

What about the "difficult" patient? They come in many different forms. You will be treating patients with bona fide psychiatric illnesses, the most common of which are anxiety, obsessive-compulsive disorder, and depression, which is very frequent. In particular, I urge you to learn to recognize depression, which is actually pretty easy to spot. It diminishes the quality of so many lives—somewhere between 10 and 20% of our population—and is a treatable as well as a potentially lethal disease.

Remember that there are always two components to a patient's illness: the illness itself, and the reaction to the illness. Sometimes the reaction is more debilitating than the disease. The physician must recognize and treat both of these components.

Some patients are just plain angry, unpleasant, and hard to like. In most such patients I try to understand not so much what they are saying but why they are saying it. Sometimes you find that their anger is related to a bad situation at home or somewhere else in their lives. And some patients are just plain angry. In patients with chronic complaints and little therapeutic success, try to determine early on whether or not there is an element of secondary gain to the patient's illness. There is no more legitimate shelter from the daunting storms of life than sickness, and some people enter those shelters with no intention whatsoever of ever leaving them. Don't knock yourself out trying to heal a patient who has no intention or desire to get better. As the Roman philosopher Seneca said, "It is part of the cure to want to be cured." I usually make minor adjustments in their program, carry them along from visit to visit, and let somebody else—such as a psychiatrist or psychologist—try to extract them from their morass.

When I alter a patient's therapy, I often tell them that only one of three things can happen: they are going to feel better, worse, or the same. If the patient feels better, that's fine. If worse, I want to hear from them. And if the same, we'll go along until the next visit. I caution you to be careful of changing the medical program of a patient who feels well. If indeed the patient feels well, you can only make that person feel worse with a change in therapy. Always try to use medications that have the greatest therapeutic effect with the fewest side effects. Side effects are the most frequent reason that patients discontinue their medications.

When Healing Fails

Caring for dying patients demands the full measure of all the noble virtues I have mentioned in dealing with patients and their families: compassion, concern, sensitivity, and understanding. I have never been comfortable having patients die under my care, especially if death was sudden and unexpected. When a patient dies, there is a small measure of consolation if you can honestly say to the family that everything was done that could possibly have been done to save that patient's life.

I find it agonizing to deal with families in these circumstances. Yet it is our job to bring them a measure of solace and comfort. Whenever one of my patients dies, I unfailingly send a note of condolences to the family and attend as many wakes and funerals as I can. Failures are inevitable. And you will find, as I have,

that you remember your failures much more vividly than your successes. I recall with anguish three women, ages 21, 35, and 42, who had mitral valve prolapse and ventricular irritability. All were completely asymptomatic and fully active. All died suddenly, unexpectedly, and tragically, before we had defibrillators.

There was an interesting editorial in the March 4, 2014, issue of *Circulation* by Dr. Joseph Loscalzo, Chief of Medicine at the Brigham and Women's Hospital, entitled, "A Celebration of Failure".[2] While we are a society that places the highest premium on success, he points out that failures are inevitable, an important part of life, and precede practically every great advance. He concludes that "we cannot avoid failure, and if we view it through the constructive lens of self–improvement, the only mistake we can make is the one from which we learn nothing." The philanthropist Paul Tudor Jones has said, "Failure is the fire that forges the steel."

End-of-life issues are always emotionally challenging. We physicians should try to make sure that our patients have living wills that spell out their end-of-life wishes. Even with these directives, the situation may be ambiguous, and many patients do not have these important documents. Most people make it clear that they don't want to continue to live if they are suffering greatly with no chance of improvement or a cure. Also, people usually express a desire not to go on if they have severe, irreversible loss of mental faculties. But it is never easy for anyone to make these life-ending decisions. Hospitals have resources that can be of great help in guiding end-of-life care, such as optimal care and palliative care committees. Hospice care at the end of life is fantastic. My personal modus operandi in ambiguous end-of-life situations is to stand back, look at the whole picture, try to decide which decision is best for the patient, and act accordingly in advising the patient and particularly the family on a course of action.

Another question we get asked is "Doc, how long do I have to live?" This is a question that I answer very carefully and even ambiguously. I try not to give the patient a definite time-frame because you can be sure that patient is going to start looking with dread at the calendar. And we are often so wrong. I usually speak in generalizations, such as "People with your condition can live for months or years," or "the average length of life for people who have what you have is 10 to 12 months, but many patients go on much longer." I try to include a touch of optimism. And there are so many advances that can offer hope to seriously ill patients. There are many examples of patients with "incurable" diseases who have lived long enough for a cure to come along.

Do No Harm: How Not to Treat Patients

There are some human qualities that I believe have no place in our interactions with patients. These include anger, arrogance, insensitivity, and sarcasm—anything that demeans patients or makes them feel any more vulnerable or uncomfortable than they already are, simply from the visit itself or the problems they face. Have I ever been angry with a patient? Of course, although I have a very high threshold for anger and try very hard not to convey these feelings to the patient. One thing that really raises a doctor's dander is when a patient fails to follow our instructions. Patients usually try as best they can to follow our recommendations, but I have had numerous instances in which patients failed to follow my advice. Remember that we as doctors are *advisors*, not *enforcers*. And patients are free to do whatever they choose with our advice.

Arrogance is for me one of the most unpleasant of all negative human traits. For whatever reason, there is a rather high prevalence of arrogance among doctors that seems to increase the further doctors distance themselves from the idealism of medical school. Beware of arrogance; it demeans people, including the person who is being arrogant.

It has been said that humility is the highest form of conceit. I don't agree. I consider it a virtue. I have never forgotten where I come from. The most important event that ever happened to me was the decision of my mother and father to immigrate to the United States from a small, impoverished town in central Italy in the early 1920s. Everything else in my life has followed.

The media now barrage the public with all sorts of medical information as well as a great deal of misinformation. Patients, in turn, besiege us with what they see and hear. Much of the current advertising on television is for prescription medications. Commercials invariably advise the public to "ask your doctor" about taking the medication after they recite all the terrible things that can happen if you take the medication. Some patients come in armed with all sorts of medically related articles. Sometimes it's annoying, sometimes I actually learn something, but always I try to be patient.

Managing Expectations

By now you are thinking, "This old guy is one of the last dinosaurs from the Jurassic Age of Medicine." And you are probably right. The way I have practiced medicine has been labor-intensive and time-consuming. A doctor is in a sense a bigamist, married to both our spouses and our profession. And the profession can be a demanding task-master. At the peak of my career, my average work day was around 15 to 16 hours. Fortunately, my wife of 59 years and my four daughters have been great and rarely complained about my being an absentee husband and father. I suspect very few of you will follow in these footsteps, nor necessarily should you. But that was simply my personal commitment to the practice of medicine.

Today the advent of IT and financial pressures have revolutionized the way in which medicine is practiced. Computers, iPhones, and iPads have been an annoying burden to me that places a bigger and bigger emotional wedge between me and my patients. But they are part of your DNA, and also part of the DNA of many of your patients, especially those who are your cohorts or younger. This revolution will continue. You will have fully electronic records, robots that make rounds on your patients and communicate with you at home, patients monitored in the ambulatory setting with physiologic apps to help anticipate changes in their condition, and who knows what else. Any information you need is at your fingertips. But technology is not warm and fuzzy. It cannot comfort a wife whose husband has just passed away. It must be tempered with a large measure of humanism.

You will live in a world of medical assistants, nurse practitioners, physician assistants, and others yet to come. Financial pressures will allow you 30 minutes with a new patient and 15 with a returning patient. No matter how you cut it, you will have less time with your patients than I did, at least in the clinic. But my message to you is loud and clear: *Make whatever time you spend with your patients count and as humanistic as possible.*

Influencing Others

It is likely that all of you will teach in one form or another. I have always felt that we have an obligation to teach. In fact, the word "doctor" is derived from the Latin word for "teacher"—it has been a large part of my life and is the reason I chose to stay in academic medicine. Teaching and mentoring are labors of love. I have often said that there are only two

rewards for teaching: getting your name on a plaque on a wall and gratitude from those you teach. When I joined the staff of MGH in 1962, teaching was expected of you. Being appointed an attending physician on a medical service was an honor. There was no financial remuneration. All of that is changing now. Many academic hospitals have some full-time teachers in the clinical sciences who are paid a salary for their teaching responsibilities. And attending physicians on medical services and in the various subspecialties are accorded some remuneration for their supervision of patients being managed by residents and fellows in training. You can build a career as a clinical teacher.

Hand in hand with teaching goes mentoring. I recall Dr. A. Clifford Barger, a professor of physiology and the most popular professor in my first 2 years of medical school. He was remarkable for his ability to know something about everyone in our class. In his long tenure at Harvard, he mentored hundreds of students and influenced the direction of their careers, including mine. Each year Harvard Medical School gives several mentoring awards to faculty members in Dr. Barger's memory. Indeed, it is remarkable how you can influence students at all levels—medical students, nurses, house officers, fellows—sometimes without even knowing it. I was amazed and deeply touched when, upon announcing my retirement, I got letters and emails from people all over thanking me for influencing them in the choice of a career or in some other way. Some of them I could not honestly remember because the teaching encounter was so casual and brief.

The Final Touches

Never forget how privileged you are to be in your chosen profession of medicine. You will go to work every day with no other purpose than to relieve pain and suffering and to heal the sick. I cannot think of a higher calling. Though depersonalizing external forces make it increasingly difficult to enjoy this noble calling, we should never forget that the beauty and essence of medicine still lies in the highly personal and precious interactions between ourselves and the patients we serve. Cherish your patients. And as Dr. Peabody urges us, truly care for them. Remember that there are thousands of doctors out there, and your patients have chosen you as the custodian of their most precious assets—their health, well-being, and even their lives. This is a great honor, but it is also a huge responsibility.

I congratulate all of you on this landmark occasion. After long years of preparation, you are now ready to take your place in the world as bona fide M.D.s. And you will be entering medicine at a time that is both exciting and challenging.

Follow your dreams. May they all come true. And I hope that 59 years from now, you can look back on your life in medicine with the same sense of satisfaction and fulfillment that I feel right now. Practicing and teaching medicine have been sheer joy for me, and I hope they will be for you as well.

References

1. Peabody, FW. The Care of the Patient. JAMA. 1927; 88:877-82.
2. Loscalzo J. A Celebration of Failure. Circulation. 2014; 129:953-55.