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Timelessness in the Ever-Changing Medical Field

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Dean Minor, my distinguished colleagues on the faculty, friends and family, but most of all, students of the Class of 2014: What a pleasure and honor, and what a relief to actually be here, standing before you today. I say relief, because as you may have heard, this commencement season has been called Dis-invitation Season. Condoleezza Rice won't be speaking at Rutgers, Christine Lagarde, chief of the International Monetary Fund, won't speak at Smith, Robert J. Birgeneau, a former chancellor of the University of California, Berkeley, withdrew as speaker at Haverford College; the list goes on.

So this week, when I realized there would be no boycott at Stanford, I was happy. But of course, human nature being what it is, or maybe it is the fact that I'm here at Stanford, and we never settle for anything but the best, I began to wonder: Why wasn't I good enough to be boycotted? What's wrong with me that I had failed to offend enough people to engineer a boycott?

The truth is, I would have hated a boycott because this occasion, this day is particularly poignant for me, more so than for any other commencement speaker, speaking at any medical school this year, for two reasons:

First: because I have the privilege of speaking to and celebrating with my own students, welcoming them in a few minutes as my colleagues. That is such a privilege. It is the reason I think many of us have been at medical schools most of our careers.

Second: The medical school in question, which trained them and which employs me, is the finest medical establishment in the world, bar none. We are not at the Stanford of the East — we are at Stanford. (Maybe my saying that will result in a boycott somewhere else — so be it.)

During your time here, you, just like all of us when we were students, spent so many hours cramming knowledge and information into your brain. I have some disappointing news for you — all that stuff you memorized for Step 1 of your Boards? — Well, much, if not most of it, will no longer be true by the time you are giving a commencement speech.

"When you examine a patient, if you think about it, it is also a timeless ritual, a crossing of a threshold."

When I studied anatomy, our final exam after one and a half years of dissection of the body was a three-hour paper with five essay questions: one bone, one joint, one nerve, one vessel, one organ. We had pretty much memorized Gray's Anatomy in order to be able to answer those five questions. You had to gamble a little bit. For example, there are 200-plus joints in the body, but only about 20 that are exam-worthy. So, I gambled on the knee, prepared to write 2,200 words and draw two figures.

But the week before the exam, I had a dream about the temporomandibular joint and in the dream I heard the words, "the temporomandibular joint is a ginglymoarthrodial joint." This was clearly a message from the other world leaching from the examiner's brain entering the collective subconscious, and then filtering into my dream. I took this to be an important message, because I had no idea what the word "ginglymoarthroidal" meant and yet it had appeared in my dream. When I looked it up it meant this was a joint with both a hinging mechanism (ginglymus) and a sliding element (arthrodial). I told my best friend and swore him to secrecy, and of course in an hour my whole class had heard about my dream. I don't think there has been a point in time in the last century where more medical students memorized the details of the TM joint. Imagine my disappointment to break the seal on the exam question paper and find the joint they wanted was... the ankle! I remember the dirty looks I got from my classmates, and seeing so many of us discreetly start to roll our socks down and study our ankles and try to recall the deltoid ligament and what not.

The strange thing is that I can still in my sleep recite to you, "The temporomandibular joint is a ginglymoarthrodial joint formed by the anterior part of the mandibular fossa of the temporal bone and the articular tubercle above, and the condyle of the mandible below." The sound of Gray's Anatomy was like T.S. Elliot's, The Wasteland: "April is the cruelest month, breeding lilacs out of the dead land, mixing memory and desire." It has a musicality and a rhythm to it; Henry Gray was writing in iambic pentameter even if he did not know it. And as far as I know, the temporomandibular joint is still "a ginglymoarthrodial joint formed by the anterior part of the mandibular fossa of the temporal bone…."

But alas, if you extend what I learned beyond the core anatomy, beyond the core biochemistry, the crude physiology, the core knowledge of disease, much of what I learned was changed, refuted, or eclipsed with new understanding.

Quite apart from the pace at which knowledge will change, you will also be leaving medical school during the greatest transformation of health-care delivery ever known to this nation. Recently, I hesitate to tell you, I almost lost my hospital privileges because I did not finish my ICD 10 training — or was it ICD-11? It was ICD something, I am pretty sure of that. You can tell I am not a numbers person — that is why I went to medical school. For those of you who are not familiar with the term, ICD is an international classification of disease. The training was to inculcate me in the fact that we now have 71,924 procedure codes and 69,823 diagnosis codes — I wrote that down in my diary that night. I am still struggling to understand how knowing these codes will make one iota of difference in the care of a patient other than making it more cumbersome.

Take ICD code Y92022 — it allows you to say that the cause of the patient's external injury was a bathroom in a mobile home. When I saw that code I was reminded that years ago I made a house call in Tennessee to a patient in a trailer and I noticed when I went to wash my hands in the bathroom of the mobile home there was a huge brick

resting on the toilet lid. As I was pondering this, my patient called through the door that the toilet works fine and I was to feel free to take the brick off the lid.

Later, when I emerged and asked about the brick, my patient told me that giant sewer rats were in the habit of coming up through cracks in the septic tank. The brick was to keep them from entering the trailer. I tell you, the quality of my sleep was affected for many days thinking of how much I had put at risk that day by answering nature's call. Am I reassured all these many years later to know that there are 10 codes for mobile-home-related injuries, and that ICD code Y92022 exists just to anticipate the kind of injury I avoided? Not at all. These are some of the challenges you will face in the fast-changing health-care environment.

And then there is the electronic medical record; as important as it is, it has also become a monster of epic proportions. A paper about to be published by my colleagues in medicine, Jeff Chi et al., suggests that as students in your medicine clerkship, you wind up spending as much as six hours a day in front of the computer. Residents spent at times even more than that. That just astonishes and worries me. And you are not doing it by choice, but because that has become the nature of our work. And I hope as talented as you are, one of you will patent a way for us to keep the best of what is good about the EMR, and toss the rest of it. I hope you will find ways for us to spend more time with the patient, and with each other, in true dialogue and fellowship. The EMR with its drop-down boxes, its ready-made templates, and the way it can populate pages at a stroke of a button, would suggest that every patient, even ones missing limbs and unconscious, have bilateral normal reflexes, normal gait, normal cranial nerves. I like fiction, I read fiction, I even write fiction for God's sake, but I don't think fiction has a place in the medical record. You will need courage and determination to push back when things detrimental to your time with and your care of your patients are being thrust at you. Electronic medical records don't take care of patients: you and our amazing colleagues in nursing and the other health-care professions care for patients. People take care of other people.

Well if so much is changing in knowledge, in health-care delivery, what then is timeless? What is it that has not changed for me? That's what I would like to close with: the two things that will not change for you.

First, what doesn't change is the heritage we carry. I was in Ireland recently at a ceremony of the Royal College of Surgeons of Ireland, and along with the mace carried by the college porter, was a red-striped pole, the barbers pole, which as you know harks back to the era of the barber surgeon. But our lineage, your lineage, goes back before that to 2600 B.C. — Imhotep the priest-physician, Hippocrates of Cos around 420 B.C., then Galen about 200 A.D., and 1030 A.D. Avicenna, and in the 16th century, Paracelsus, my favorite, an outrageous character who of course burnt the books of Avicenna, Galen, and Hippocrates. His full name was Philippus Aureolus Theophrastus Bombastus von Hohenheim — the word bombastic in the English language comes from him.

He is the only physician whose words I have framed in my bedroom. They say, "This is my vow: to love the sick, each and all of them, more than if my own body were at stake." And the lineage goes on from Paracelsus to Vesalius, Harvey, Lister, Pasteur, and of course you are so fortunate at Stanford to see this history as you stroll down our Discovery Walk where on those beautiful panels you can see both Stanford history and scientific history, the two being quite inseparable, charted together. I mention this history because I hope that as of today, whenever you enter a room, you will be conscious of that legacy, of this unbroken chain extending back centuries, how in standing before a patient, you stand as the latest incarnation of this lineage and you have behind you generations of physicians, standing with you in the room, from Paracelsus, Osler, Curie, Shumway.

And I hope that sense of history will make you conscious that when you are there with the patient, you are also participating in a timeless ritual. Rituals, like this one today, with all its ceremony and tradition are about transformation, about crossing a threshold — indeed the ritual of our graduation ceremony is self-evident.

When you examine a patient, if you think about it, it is also a timeless ritual, a crossing of a threshold. You are often in a ceremonial white gown, the patient is in a paper gown, the room is decorated with furniture unlike any room in your house or theirs, and in your hand like some shaman you carry stethoscopes and lights and tongue blades and reflex hammers. You stand there not as yourself, but as the doctor, the latest in that lineage harking back, as we said, centuries. Your presence, your garb, and the setting are all leading the patients to expect a ritual. They are most aware of it, and incredibly, as part of that ritual, they have given you the privilege of touching their body, something that in any other walk of life out of a special context would be considered assault, but they allow it of you. If you listen well and examine them with some skill, (and by the way,

the exam will include bedside ultrasound and EKG with your iPhone) you are going to first of all avoid the embarrassment of missing obvious things. But then, perhaps more importantly, the ritual properly performed earns you a bond, a connection. It is no accident that if you read letters from patients complaining about their care, about their hospitalizations, it often uses language such as "he or she never touched me" or "he or she never laid a finger on me." The ritual is timeless and it matters. Celebrate the ritual. With every year of practice, be better at it than you were the previous year. Develop the skill just as you develop your knowledge.

The second thing I want to mention that is timeless, is what we can learn from our patients. I don't mean learn medically (which is obvious and something we will all do). I mean what we can learn personally about how to conduct ourselves in this world, but you have to be listening.

"You have to be listening. I have learned much from my patients, innumerable such lessons."

I have learnt much from my patients, innumerable such lessons. I will share just one, which has helped me cope. In the days before we had the drugs we have now for HIV, I had a patient who was a hemophiliac. By the time I met him, he was in his 30s, a college teacher in a small town in rural Virginia. He walked with a stiff gait, his arms swinging at an odd angle at his side, the result of many episodes of bleeding into his joints when he was a child, bleeding that would require hospitalization and plasma infusions in the days before Factor 8 concentrate.

As a child he had more hospital admissions than kids his age had ice cream. And the great tragedy for so many of those children was that they survived their childhood only to find by the mid-1980s they had been infected with HIV that had tainted the blood products they so often received.

He was, I will never forget, uncommonly brave. A lifetime of dealing with hospitals and doctors seemed to have made him stoic, and he dealt with AIDS matter-of-factly. If he despaired, cursed God, took it out on his family, I never saw it or heard of it. Once, toward the end of his life, I put him in hospital — he hated to be admitted. And when I went to see him, for the first time in my knowing him, he seemed to be depressed, to have lost hope. I had no treatment that would reverse things. We had nothing to offer him that night, no way to minister to him. In fact, he was ministering to me, he was instructing me.

He told me the story that as a little boy, he would sometimes wake up in the night with pain in a joint. He knew from his experience that he was bleeding into the joint, but he also knew that his parents so badly needed their sleep — they were each working two jobs, working weekends, driving an ancient car, and choosing to have just one child because of the financial pressures put on them by his illness. If he woke them about his pain that night, they would dutifully get up and sit with him, put on icepacks, be sleepless with him, take him in the morning to the hospital, and stay a with him another night in the hospital after working a full day. For that reason, he tried his best not to wake them, to wait till morning so they could get some sleep.

And his way of toughing it out was to put a record on his toy record player, a hymn called Joy Comes in the Morning. He would play that again and again until dawn broke. Joy Comes in the Morning. That was his way of coping, his mantra for carrying on. He is long dead, but in my toughest times, that is what I fall back on: my memory of him, his courage, his stoicism, and telling myself to hang in there, because Joy Comes in the Morning.

Graduates of the Class of 2014, may you celebrate the rituals of medicine, recognizing their importance to both you and the patient.

May you find courage to face your own personal trials by learning from your patients' courage.

May you minister to your patients even as they minister to you.

When there is nothing more medically you can do for patients, remember it is just the beginning of everything you can do for your patients; you can still give them the best of you, which is your presence at their bedside.

You can heal even when you cannot cure by that simple human act of being at the bedside — your presence. May you discover as generations before you have, the great happiness and satisfaction inherent in the practice of medicine, despite everything. When you come on rounds to see your patients, may your presence bring joy in the morning. It has been a privilege to watch you on your journey. Good luck and god speed.