Our Anabasis*

ALAN GREGG, M.D.**
Vice-President, Rockefeller Foundation, 
New York City

In addition to the liberty accorded the speakers at these dinners, a generous measure of reflectiveness must have been encouraged if one may judge from the records. So, I shall venture a theory or two, somewhat fortified by the conviction that you could supply a wealth of illustrative examples if the general pattern of my ideas makes sense. And I shall have, at least in point of reflectiveness, the benefit of your tradition, and even an aegis from the Greeks. For it was Plato who left us the wise and widely applicable comment that the “unexamined life is not worth living.”

Jumping—and I use the word advisedly—from Plato to James Thurber, I would quote the latter if only to forestall critics or perhaps to gain your clemency by pleading guilty. Thurber observes that “Speculation if confined to certainties is eased of its wonder and its warmth.” Parenthetically I cannot but think that the history of endocrinology might have been more sober and sequential if Thurber’s maxim had furnished the core of editorial critique in that field. . . . “Speculation if confined to certainties is eased of its wonder and its warmth.”

So let us start from the here and now, confining ourselves at least for a moment to the certainties of this meeting and this association. Let us begin by asking what keeps men together in contented and effective association? Curiously enough the analysis of this question seems to follow that strong sense of time which the Indo-European languages require their verbs to obey by means of making sharp distinctions between past, present and future. What keeps men together in happy and effective association? Clearly related to past, present and future, three things mainly keep men together: from the past it is shared experiences; in the present, beliefs generally agreed upon; and for the future, hopes and desires held in common. Of these three sources of gregarious reassurance and reward, I would think that shared experience is the most philosophical and profound; that facts and opinions presently agreed upon are the clearest and most manageable; and that identical hopes and desires are the least reliable and yet the most alluring. When someone speaks of the past we can close our eyes or stare in the fire. When he speaks of the present we look at his graphs and his evidence. But when he speaks of the future we want to look at him.

Now this evening I suggest that you close your eyes or stare in an imaginary fire. For I have no graphs for you to look at, no facts to prove, no hopes to cultivate nor preferences

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** Dr. Gregg is an alumnus member of Alpha Omega Alpha, elected by Harvard chapter in 1951.

to exploit. It is in your own recollections that I shall find, or fail of corroboration.

For my central theme concerns the profound power of experience in shaping us for the practice of medicine, the power of experience as contrasted with the mere acquisition of information. Surely we retain residues from the past more pervasive and long lived than memorized facts. Edouard Herriot said that what the French call "formation" is what remains after one has forgotten everything. We are only speaking of different aspects of this same idea of "formation" when we refer to a man's turn of mind, his ways of thinking, his approach, or his attitude. I repeat then that out of the three forces that bind men together in effective and rewarding association—namely common experiences, agreed upon facts and shared hopes—I shall deliberately choose to examine the role of what may be called shared experience. This I do because I have reasons for thinking it singularly neglected, ignored, perhaps misunderstood and yet for all that unquestionably interesting, delightfully varied and potentially valuable. Besides, you are presently spending these days on the facts that hold us together, and as for the future I would not wish to spoil tonight's good dinner by evoking the alarm reaction that follows most attempts at rhetorical persuasion.

Is this thing we call shared experience so powerful? I think it is. What is it, after all, that binds us not only to the friends we still miss this evening, Bill Palmer and Francis Peabody and Warfield Longcope, but to Osler and Frank Billings, J. B. Herrick, Fred Shattuck, Freidrich Müller, James McKenzie, Thomas Lewis and Fernand Widal, and in another chapter even to Sydenham, to Harvey and Maimonides and Galen. It can hardly be the mere facts and opinions we share with these men that puts us in their brotherhood, but rather the experiences we have known as did they, simply because we all became doctors. The bonds of common experience require no verification and no renewal. It is not the areas of merely intellectual agreement that bind us to our colleagues of the past but the frustrations and predicaments both we and they have lived through, of ignorance and powerlessness, or sometimes a happier circumstance—the kinship of lucky survivors. We have thus something in common with the doctors of every age and every country, with the mediocre, obscure and forgotten as well as the great and distinguished and famous. It is what our patients have made of us quite as much as what we have made of them, that forges for doctors a common bond. We all have played the same role to the rest of mankind. We had to meet their expectations, and had each our bit of that community of experience that all doctors share—and only doctors. For in the last analysis human societies make their healers, and the healers then make the doctrine. And eventually if the makers of doctrine happen to espouse the scientific method a feed-back phenomenon begins: the doctrine because it is true begins to make true healers of the healers, and the healers, using the truth, begin to remake the society that made them. But until science has provided us with the complete explanation and control of every phenomenon that confronts us as doctors we shall have to accept, with a degree of modesty to match our ignorance, the traditional professional role that society has given us—its pleasures, its frustrations, its humor and its anguish, its rewards and its burdens.
Since what we all have lived through simply as doctors seems to be so important, I have been looking during the past few years for some account or listing of the generic experiences of young men and women on their way into the profession of medicine. Would there not be food for thought in such a record? I've searched steadily and in more than one country for a doctor's autobiography or biography that records the events that impressed him in his student days, together with a thoughtful discussion of the interpretations he placed upon those events: something of the order of "The Education of Henry Adams" but relating to the nature of becoming a doctor. I know such an account would interest me. It might even be useful to younger students for comparison, for reassurance or freeing their thoughts about what they could be and do—and when. But thus far my search has been in vain—neither biographies nor autobiographies nor any considered essays upon the generic experiences that make a doctor out of a green beginner—none of these have I found.

Perhaps I should be consoled by reflecting that had I found a plenty I would have had to look further for a subject for this evening's talk. For tonight I should like to present to you, with due apologies for being in so speculative a mood, a rather simple array, or first approximation, of the formative experiences on the way to becoming a doctor. These experiences may come before the medical school or even after it, and for this reason I call them "formative" and "on the way to becoming a doctor." The time at my disposal precludes extended discussion or the luxury of giving more than one example of each meaningful type of event. Obviously the way you take an episode decides the meaning it will have for you. And that interpretation usually derives from your own previous but sometimes only faintly analogous experiences.

Rather than the first person of the autobiographer or the third person of the case history I have used the second person singular as appropriate for conveying the kind of thoughts and feelings so many of us have had, whether we began our careers in Buenos Aires or Bangalore, Vancouver or Visagapatam, Helsinki or Hong Kong, Capetown or Chicago, London or Los Angeles, Bucharest or Boston, Keio or Karachi, Dunedin or Edinburgh, Utah or Uppsala, Moscow or Melbourne. For the sake of clarity I repeat that I do not refer to the extensive body of verifiable facts or presently shared opinions in medicine throughout the modern world. Nor am I competent either to assert or to deny that the followers of Aryuvedic medicine or the healers of other cults with which we are not really familiar, share all or none of the pattern characteristic of modern medicine throughout much of the world. But one may be sure of one thing, however—that the events significant to beginners in medicine do not always come in the same order and still more important that the meaning or significance of a given event or even type of event will vary and vary almost incredibly, depending on the order and nature of all that has preceded it.

But still if a recognizable assortment of experiences characterizes the entrance to medicine whether or not they follow any pattern of sequence, then I would say that in sharp contrast to their apparent universality these typical experiences have received astonishingly little attention, deliberate or inadvertent.

Except for those examples of young men going into medicine to
please or to obey their parents, the earliest event of major importance on the way into Medicine relates to the choice of medicine as a career. An experienced schoolmaster of my acquaintance told me that boys decide in favor of medicine both earlier and with fewer subsequent changes of mind than they bring to the choice of any other calling.

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You must have been about 11 years old when it happened. You had a very sore throat and after a night when the lamp never went out and your mother was at your side whenever you called for her, you awakened to see her anxiously scanning your face and heard her ask your father to call Dr. Lawrence. You used to see Dr. Lawrence go up Cascade Avenue in his new horseless carriage followed by his man driving the other older horseless carriage in case the new one broke down or blew out a pneumatic tire. When Dr. Lawrence came into your room he put his lighted cigar very carefully on the marble top of the dressing table. Your mother didn’t seem to mind that at all. He smelled awfully strongly of tobacco when he leaned down and put his ear right on your bare chest. Then he asked your mother to get a pitcher of fresh water, turned to you and said, “Now watch!” He took a bottle out of his medicine bag, uncorked it deftly with one hand and shook some shiny brown crystals into the water which immediately turned a wonderful purple. “Let him” (he didn’t say ‘make him’) “let him gargle with this every two hours,” and then turning to you, “but don’t swallow it! Two pounds of this powder would turn all Prospect Lake purple! By the way did you hear the sicklebill curlews night before last? Asleep? Well I was coming home from the Malones at 3 o’clock in the morning,” and turning to your mother he added, “8½ pound boy . . . and the curlews’ eerie crying was beautiful.” Then he turned to your Mother and said, “Mrs. Bacon, you haven’t a thing to worry about. I’ll be back day after tomorrow and sooner if you want.” Your mother suddenly looked very relieved and just after Dr. Lawrence had left you heard her say to your father, “Doctor Lawrence is so faithful!” That was her highest praise, as any one could guess from her way of saying it.

Four days later sitting in the swing in the bright September sun an idea suddenly swept you through and through—“when I grow up I want to be a doctor.” You rather thought that with anything as big as that you ought to tell God about it immediately—and not just casually standing up, either. But if you knelt down then and there somebody might see you and ask why—and you couldn’t tell. So you ran upstairs to the only room in the house that could be locked—the bathroom—and there you knelt down under three towels, an empty hot water bottle and your father’s back-scratcher, and took the Almighty in on a decision that you never doubted nor regretted from that day to this.

After that day there came—some years later—a wonderful experience encouraging your hope or confirming your resolve to become a doctor. One Saturday afternoon you were down town shopping. You met your English teacher right in front of Eldon’s book store. He had always seemed busy too busy to talk to any of his students with any appearance of leisure. So you were surprised when he said with the air of an equal rather than a teacher, “Say, Raymond, have you a few
minutes free?” Such a dignifying form for the question! On promptly saying yes, you were led the length of the book store back to a browsing room you had never seen before. Your English teacher reached down a volume of Wordsworth and read you the Ode to Tintern Abbey. That was all he did, but you walked home on air. It wasn’t the beauty of the Ode that stirred you; you were moved beyond words and just because—for the first time in your life—you were treated as a grown-up presumably possessing freedom and tastes of your own. Then why not go to the university of your dreams instead of the nearby college? Right there in that book store you turned the corner.

Perhaps one further event reinforced the nascent conviction that you really were grown up and free to choose your own career. In Junior year in college you wanted to take an advanced course in Psychology without having taken the preliminary course. For this you had to get special permission. You explained that you were interested in Psychology, had read a good deal, and that your roommate who took the preliminary course the year before had mentioned nothing of it that was unfamiliar to you. Almost miraculously you were admitted to advanced standing on the basis of interest and independent reading instead of the usual requirement of “credit hours”: that was a bracing and beautifully maturing thing to have happened—even though it came before the medical school. What it really suggested to you—though you may not have formulated it at the time—was simply that one can learn without having a teacher—an axiom that only the best teachers apparently can afford to identify themselves with at all generously.

These two types of experience are characteristic for the years before entering the medical school: the choice of medicine as a career and some form of reassurance that this choice has been better than a hope—responsible personal decision rather than a dream. Nowadays in the United States such reassurance must frequently come only on the day the college student gets the letter of acceptance from a medical school admissions committee. Elsewhere in the world it is the students who decide whether or not they will enter the medical faculties since the only requirement is satisfactory graduation from secondary school.

Have you ever wondered how long in your dealings with patients it took you to get over the fact that your first patient was a cadaver? It is commonly known that medical students dissect the bodies of the dead: it is less commonly realized that these same dead do a good deal of cutting, probing and pulling at the minds of their youthful dissectors—if we may call assumptions and values by the name of ‘mind.’ What most of us sought that first day among the naked, stark dead in the dissecting room was detachment—detachment enough to stand and view the machinery devoid of spirit, detachment and time enough to compose life with stinking death. You had never seen a dead person nor a naked woman but your first task was to bathe and shave her—without her permission. She was the recipient of your services—and nothing more. The Patient as a Person—the Cadaver as a Patient—the Person as a Cadaver—take your choice.

More clearly than ever before that first day, emotions involved your olfactory sense and vice versa. When you went to the wash room
to get your hands clean enough to
light a cigarette you found two
classmates there vomiting. When
another student came in, he sniffed
conspicuously and turning upon the
nauseated neophytes exclaimed, "I
was getting along all right until you
did this; damn it, you've spoiled my
day!" Yes, we sought detachment
desperately, by fair means or foul,
in the bravado of indecent jokes and
in deliberately exaggerated realism.
There was even some flavor of re-
|lief, escape and detachment in con-
centrating our attention on the feats
of memory expected of us—the new
names of every bone and muscle,—
the power of being able to name
everything, the relief of a Latin
incantation. H. L. Mencken noted
once that love involves the inhibi-
tion of disgust. On this basis Anat-
omy as the gateway to medicine may
have some value as a test of the be-
ginner's enthusiasm and sincerity.

Another memory recalls a dif-
ferent imprint from the anatomy
course. One day one of your class-
mates found in his cadaver the
rather uncommon anomaly of an
accessory pectoral muscle. The emo-
tion this discovery produced in all
of your fellow students deserves atten-
tion: it was one of relief—a sud-
dden vacation, as it were, from the
rigid and tiring uniformity of the
human machine. Little did you real-
ze during that stern schooling in
uniformities that within three years
your clinical teachers would be snarl-
ing at you, "But don't you know
that human beings are different?"
Nor did it occur to you that Em-
|bryology with its bewilderingly swift
sequences of becoming, rather than
permanently fixed states of being,
offered a better paradigm of the life
sciences than its revered elder
brother Gross Anatomy.

Of human dissection as an experi-
ence many interpretations may be
made in private and many opinions
held in public. But few would deny
the power of its imprint on young
people, regardless of whether you
choose to accent its stark realism, or
its unending mystery, or its blunt
evidence of uniformity, or its power
in presenting that great leveller of
all manner of men, Death. No mod-
ern profession seems to require at
entrance an experience so close to
the initiatory rites of primitive
tribes in point of mystery and strain.
One begins medicine, as one begins
a prizefight, by shaking hands with
the Adversary: it is a good tradition
but not necessarily easy, so some
dodging and fast footwork is to be
excused in the first round.

I would record a query as to one
consequence of introducing the stu-
dent to the morphological sciences
first and foremost, when he is in his
most receptive phase. This query
may well take the form of the record
on an event which for the sake of
variety I'll put in its original form
of a personal record in quotation
marks. The story reveals the radical
change of ways of thinking that
come when narrative, time sequen-
ces, and history-taking suddenly ap-
ppear to the student to have as much
importance as the sedulously culti-
vated skills of measurement and
description.

"A team of five students was to
watch by means of the fluoroscope
the effect of fright on peristalsis in
the cat. We were the last group in
the class to perform this experiment:
we had heard of the vivid results
obtained by other groups. It hap-
pened by chance that in our team I
assigned the task of recording the
experiment. When I suggested that
we record the sex of our cat and
where it had come from—was it an alley cat, or a hapless domestic pet?—the suggestion was usually ignored as a piece of sentimentality. The instructor observed dryly that we were 'doing an experiment, not writing a novel.' The cat was therefore weighed and its weight recorded. But on exposure to a barking fox terrier our kindly tabby seemed but little disturbed nor was her peristalsis appreciably affected, though the recorded consensus of our team was that there was 'some inhibition of normal peristalsis.' But off the record we ruefully admitted that our experiment had 'failed.' I was delighted at the experimental result but outraged at the interpretations put upon it. Not until long afterwards did I learn that the cats in which Walter Cannon first observed the effect of fright on peristalsis were wild alley cats but that when he first undertook to demonstrate the phenomenon to his chief Professor Henry P. Bowditch, Cannon had the misfortune to use an even-tempered domestic tabby who had led a hitherto placid and amiable life with dogs and children, so no inhibition of peristalsis was observable in that animal. Experiments don't fail: the failures are in narrating, observing, recording and interpreting. I think it was an important experience to have my blind conviction of the importance of narrative vindicated. The time factor is so important. Time alone can change many an apparently static pattern. Time provides the ultimate terminus to many an otherwise apparent finality."

Doubtless the discovery of the importance of the time factor in medicine may be so gradual as hardly to be called an "experience." But a well developed sense of time, narrative and sequence adds as much and as new a form of understanding living tissue as a moving picture projector brings to a series of separate frames. This narrative sense informs and infuses Sir James Mackenzie's wonderful example and later Sir Thomas Lewis' insistence on studying the natural history of disease. It makes possible the idea of process and dynamics in the interpretation of disease. Consequently when the novice on his way into medicine has an experience that discovers to him the importance of narrative, it is a cardinal event even though its full meaning may not be felt at the time.

As you got well into the medical school there came slowly or perhaps in some sudden revelation an almost overwhelming sense of how much you ought to know to practice medicine. As an alternative to the cheap cynicism or truculent self-assurance so often summoned to meet such worries I venture to record what Soma Weiss told me was his experience.

"I was inscribed as a first year student at the University of Budapest. We counted ourselves very fortunate to have the great Professor Eotvos as our Professor in Physics. He did not appear on time at his first lecture. This seemed to increase our interest in what he would prove to be like. Suddenly the side door to the platform swung open and a huge white-bearded man strode in carrying two large books. He must have been six feet two or three and in every way he met or surpassed my expectations. He slammed the two books on the lectern and then looked out over some three hundred of us students and in a deep booming voice he cried, 'I know nothing!' We students were dumbfounded at such a fantastic statement. With some reason we could have said that
—but not Professor Eötvös. He repeated it—"I know nothing!"—and then dramatically pointing to the books he shouted with a peculiar precision and emphasis, "But gentlemen, I have learned how to find out anything I want to know!" He stopped, and looked out over the class as though to let that idea sink in.

"Now I do not believe I have ever felt such a glorious sense of relief, of spiritual freedom, elation, almost ecstasy, in all my life before or since. I see why now, but I didn't then. The swiftly increasing sense of how much I would have to know in order to practice medicine had up till that moment all but overwhelmed me. And here was no less an authority than the great Professor Eötvös saying that finding out how to learn was what he relied on—not on knowing everything... or even anything. To me such a simple incisive attitude toward the vast accumulations of medical knowledge came as an astounding relief."

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Together with learning, as Soma Weiss did, what attitude to take toward the size of his task, you wanted to know a dependable answer to the perennial question "How am I doing?" With your conscience reinforcing the pressure of the competition all around you, solicitude as to the quality of your performance must have tempted you to leave all such decisions as to your competence to the wisdom of your teachers. From that immaturity of evasion solution progress was slow. Finally it came in this wise.

During your internship you had as visiting men two physicians of very different character, tastes and interests. You had soon learned to write two different styles of history of a patient, one that Dr. A. would find satisfactory and another for Dr. B.; quite a different selection and presentation of facts. But you could not control the situation: Dr. A. would find the histories written for Dr. B. very poor—and vice versa. And you got bored with such pica-pau maneuvering. It seemed not much better than intellectual prostitution. So you got up courage to ask the Resident if he could give you any tips on writing good histories. The Resident was Bill Palmer. He gave you the perfect answer. He said, "I don't know any devices"—and then after a pause he added, "I think if you wrote a history that satisfied you it would be a good history."

Now you had learned to take a history for Dr. A. or Dr. B. in about 45 minutes and do the rewrite in a half hour. But the next afternoon, fired by the idea of having only yourself to please, you spent two hours and a quarter getting the history and an hour and a half writing it out. And then two miracles—or near miracles—took place. First you could hardly wait to get to the library. On the other cases you'd gone to the library from a sense of duty. But this time it was from spontaneous eagerness and interest. The patient had migraine—about which much indeed had been written, but you suddenly realized and for the first time, that the time to use the library is after you've begun to work and not as a substitute for work. The other miracle was that both Dr. A. and Dr. B. took up that case and both asked who had written such a good history. Of course you stepped manfully forward and took the responsibility, thinking the while, "You haven't the faintest inkling of what this means to me!" Nor had they. For in realizing that you have only yourself to please, in short, in integrity, lies the answer to that
The ever-returning question, "Quis custodes ipsos custodi?" Who is to supervise the supervisors?

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Sooner or later—it may have been an experience unuttered but borne in shy loneliness—came your realization that medicine is not omnipotent. Consequently the question posed itself whether some patients were worth working so hard on—frogs, babies for example, or aged, defenseless, friendless derelicts with pneumonia, or admirable persons with incomparable cancer and in unremitting pain, or hemiplegics with broken necks, and the long array of "incurables" on the Island? Do you remember that day you compared notes with your brother? He was in the third year of a civil engineering course and you were interning at the City Hospital. He told you he had spent the whole afternoon writing the specifications for a bridge to carry up to 20 ton loads with a specified factor of safety—three, thirty foot spans. He said he could specify anything he wanted in point of material with known and provable tensile strength, expansion coefficients, shear, etc. And the result was to be a bridge not seriously short of perfection. His afternoon had been one of imaginary but untrammelled creation.

It came upon you like a tidal wave that you had spent that same afternoon working over an elderly taxi driver who complained of headaches and spots before his eyes, headaches of eight months' duration and neglect, who, at the best, would return to a fifth-rate rooming house with December weather for his convalescence. In short, that for the bridge you were building you had the equivalent of rusty girders, old timber of uncertain strength, doubtful cement and used brick. Your job was not to create perfection. It was to do the best under the circumstances. You could not ask for, or expect, the ideal in material to work with, nor perfection in the finished product. You used to think doctors cured people. Not any more! Your job was to make do with what confronted you. Make Do. M.D. Quaint idea! M.D. stands for Make Do. Work for the handicapped... who is handicapped, your patients or you? Both. Helping the survival of the unfit... with more to come.

What in the world was the solution? Where to find a formula for head and heart too? Hold on! How was it that you had found it so natural to compare treating a chronic nephritic with building a bridge? Were you thinking of a patient as a piece of machinery comparable to a structure like a bridge because your first patient had been a cadaver and your entrance to medicine by way of chemistry and physics? What of compassion? Doesn't the mere fact that there is such a thing as compassion make it seem shallow to compare treating patients with building bridges, ideal specifications, perfect materials, etc. etc. Had you planned to live from the practice of medicine, or to live in the practice of medicine?

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Despite the readjustment that began to take place between the detachment of the nascent scientist and the none too mature compassion of the beginner in therapy, by the time you got to work on the district in obstetrics you were getting a bit discouraged with the patchwork—as it seemed—the patchwork and inadequacy of the acute hospital with its re-entrant cases coming back again from the stews and sties that had made a mockery of convalescence. And the places actually denominated "Homes for Incur-
ables.” Then at last with your first three obstetric cases, the path turned and you saw the practice of medicine as you had wanted it to be. Your first patient was a girl of 17 and from Monday night at 9 till 5 o’clock Wednesday morning you stayed by —her first baby and professionally speaking your first too. Everything, according to your report, had been “normal.” At last a husky baby, faint smiles and the long sleep of carefree exhaustion. The next was a perfectly charming negress who like so many of her race possessed the ultimate in tact, good manners and warm kindliness. There too it was the first baby and the husband as beautifully grateful to his wife and as laughingly delighted by his young son as anyone you could have imagined. And the third a stout Irishwoman of huge frame and hearty manner, mildly disgusted with her husband’s complete alcoholic eclipse, but with more of the evidences of angry resentment at her pain than dismay or feeling deserted. Her brisk performance and perfect delight at learning it was a boy—a fact you celebrated together with a bit of whiskey she’d hidden from her husband expressly for celebrating in case it was a boy. These experiences were sound, refreshing and what you had hoped the practice of medicine would be like: life-giving, based on knowledge of the machinery but transcending it and giving a sense of completed accomplishment leading somewhere, even if you got a deal more credit than you deserved.

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You had been dismayed and outraged when a youthful classmate on his obstetric service renewed his Crede’s silver nitrate solution carelessly ordering 25% instead of one-tenth that strength . . . and so blinded a baby for life. But your exasperation was short lived. At Charity Hospital outpatient there seemed to collect all the sick stevedores in the city. One day when you were in charge of the male outpatient a gaunt negro of fifty came in saying he couldn’t swallow “so good.” You sometimes used to think the negroes never complained of anything and it would have been well had you been on guard that day against underestimating his distress. His story and emaciation suggested a possible carcinoma of the stomach. So you arranged for a test meal the next morning. When you were passing the stomach tube, in his convulsive retching his aneurysm burst and he died as only such patients die. How do we reconcile ourselves to those deaths for which in our innermost beings we must take the full and bitter blame? It is in such situations that caution and competence, humility, intellectual honesty and integrity prove their worth. It is in such circumstances that the avoidance of blame, the evasion of responsibility or just plain inadequacy of education and training increase the already intolerable tragedy by denying it, or failing even to recognize it. And they say that medical education is so expensive! It is unsatisfactory medical education that is expensive—and so expensive.

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One kind of experience may perhaps best be mentioned without an example drawn from life. It is not an inevitable experience but it may occur and when it does the effect is hard to forget. By so much as one’s relations with his chief have been intimate and admiring, the day of utter disillusionment, if it ever comes, is a lonely sort of date, deserving no anniversary—a day hard
to get through without either anger or self-pity. Our major disappointments in people come oftenest when they are under temptations we have not imagined or pressures we do not know. On their side they may be at the time too preoccupied to notice our disillusionment. In any event there is for the witness a speechless finality about a fallen idol and a loneliness that leads more often than not to autumnal maturity and complete independence.

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It was in the days when Fowler’s solution was widely used as a “tonic.” At supper you had gotten into an argument with another intern on what was meant by the word “tonic.” You’d gone to the extreme of saying that you’d expect more results if Fowler’s solution were given in much larger doses. Your adversary taunted you with “teaspoonfuls instead of drops?” and you had retorted “No! of course not!” though at that instant it flashed through your mind that you had advised that very morning an out-patient to begin a course of Fowler’s solution—and had you said teaspoonfuls or drops? Well—to shorten the story—you got that patient’s address from the record room, took a street car as soon as you could to a street in North Philadelphia, found your patient and his wife and the bottle with the dosage in drops all safe enough. But will you ever forget those three hours of anxiety and shame that prepared you as nothing else could for your patient’s parting remark as you started back for the hospital, “Doc, I would take anything you was to put in a bottle for me just exactly like you told me. Ain’t you the doctor?” And all the way back to the hospital, the while reorganizing your whole existence, you could only repeat “Ain’t I?”

The events and interpretations I have selected do not represent all of the generic experiences characteristic of the doctor’s anabasis or way up into medicine. I well know that any one of you could supply from a mere month’s clinical work more vivid examples of each type of experience than I have presented. As I explained at the outset it is from your own recollections that I shall find or fail of corroboration. These stories are offered as examples, not proofs,—examples to contrast in their concreteness with the abstract ideas that form the real substance of this talk.

My essential thesis has been that what binds our profession together throughout the world is not so much the facts we agree upon or the knowledge we share, as the experiences we have all gone through, and the way we understand them and fit them to the pattern of our values. Our fellow-feeling rests as much on the similarity of our relationships with patients as on the identity of our formulated knowledge or beliefs. And even more certain, the continuity of our professional heritage from the past cannot have come from the changelessness of either theory, practice, belief or admitted fact. All these have changed too much for that to be possible. Our professional history hangs together because the cardinal experiences of the doctor with death, birth, responsibility and confidence, fear and courage, ignorance and learning, power and powerlessness, have remained so little changed through the centuries, and even through the last few decades.

And now I beg you to let me rest my case by naming these cardinal experiences once again: Choosing to be a Doctor, Experiencing Mean-
while Great Encouragement, Facing Death and the Machinery, Realizing the Meaning of Narrative, Finding Out What to Learn and How, Finding Compassion as the Answer to Detachment, Witnessing Birth and Assisting Happiness, Taking Responsibility for Death, Seeing Your Idol Fall, and, then as at once the greatest danger and the greatest reward in medicine—and so the deepest bond between us all—the First Time a Patient Trusts You—with his life.