Address at AOA banquet. Friday, February 14, 2025.

When Dr. Pascuzzi suggested I might give the address on this occasion I was frankly astonished. What could an elderly journeyman physician who has lived on the very margins of academic medicine have to say to a gathering of the most accomplished of this year's medical students? I have come to believe that the most non-negotiable qualification of a teacher is credibility – and that that is true also for someone who gives a talk on this sort of occasion. As I contemplated this opportunity I was concerned that there were painfully few subjects in which I had sufficient credibility to qualify for the job. Certainly it wouldn't be to give advice regarding your professional lives over the next AI influenced decades. I am a recalcitrant albeit peaceful Luddite. What I thought I might be able to do is to give some historical perspective by pointing out a few ways in which life as an intern 60 (61) years ago was different from what you might expect four months from now.

In June of 1964 I set out from Seattle in a 1957 Oldsmobile to drive to Philadelphia where I would begin a rotating internship at Philadelphia General Hospital – a rotating internship because I wasn't confident about what exactly I wanted to do -- and I carried the conviction about the value of a broad education from my childhood as the son of a small college professor and my happily remembered days at an Indiana liberal arts college. Philadelphia because it wasn't Cook County (Chicago) or Bellevue (New York).

Philadelphia General Hospital was an old place – a linear series of connected buildings that stretched about a half mile along Curie Avenue. The east end of the hospital and the intern dorm - yes, there was a 3 story building that housed all 100 of our intern class - was across the street from the Arena where we could (and did) get in free in our work whites and watch epic battles between the likes of Bill Russell and Wilt Chamberlain

My first rotations were on in-patient medicine -- caring for patients in three long rooms with patient beds arranged with heads to the outside walls and curtains (sometimes) in between. Each bed had a table probably for placing patient meals but as you will see they had another important function.

Interns started all the IVs, mostly with indwelling needles. There were no angiocaths. There existed a device called an intracath in which a plastic tube was introduced into the vein through the lumen of a large (probably 16 gauge) needle. I had used a proprietary packaged version of those at the University Hospital in Seattle. But there was nothing so fancy at PGH. We had large reusable/resharpened needles through which we could slip a plastic tube which we fished out of a jar of alcohol and fastened to a blunt needle. It was a pretty dicey procedure and I quickly developed some facility in doing cutdowns. The bedside table was important because that was where we set the IV fluids (bottles) which we prepared ourselves – adding KCl, bicarb, vitamins, and usually a dollop of heparin in hopes of minimizing line clotting when the bottle ran dry. After a week or two I learned to number the bottles consecutively throughout the patient stay because the fluids often got far enough behind that I didn't know what day I was on.

One of the most vivid (I should say pungent) memories of those first few weeks was that of paraldehyde –if I got to the ward in the morning and could catch the sweet acrid odor of paraldehyde, there was a good chance the poor fellow with alcohol withdrawal I admitted the night before would be adequately sedated.

All five Philadelphia medical schools had services at PGH. My first rotation was with the Women's Medical College service. We had attending staff who were pleasant, often helpful, and available 3-4 times a week. My first resident was Geobel Marin, a delightful Columbian, who came by each morning with suggestions and consolation. Night call was every other day – we were largely on our own. There was a senior resident in the house; and he (and it was he) would often stop by during the evening to see how we were doing. I can remember some of their names and felt that they were earnest and well-informed – but not inclined or too busy to stick around and help with chores.

Intern work at PGH was physically demanding (mostly too little sleep) but exciting and immediately rewarding. Most lab work trickled back sporadically but some things like Gram stains, CBCs, and urinalyses which we could do ourselves were quickly available and salved the need for immediate satisfaction. The housestaff lab was several floors up. It was July and there was no air conditioning. I have happy recollections of doing gram stains, AFB stains, and CBCs - and the exhilaration of discovering something that I could run downstairs and address immediately for my patient.

If I needed an Xray quickly I could go to radiology and commandeer a portable machine and take it up to the ward to take my own picture. The elevators were creaky and prone to getting stuck – but it never happened to me.

Sometime later in the year while on the surgery service I did peritoneal dialysis solo using a gall bladder trocar and following printed directions laid out on the patient's chest. That episode was part of a bittersweet story which I remember tenderly but is too long for a digression now.

In August my dilatory practice of doing – or not doing – discharge summaries caught up with me and I had to spend several off-call evenings in the record room (also on a top floor) handwriting discharge summaries – The bad news, writer's cramp, fatigue -- the good news,

a forced exercise in editing and concision.

Sometime in the spring of 1965, in a series of communications with "selective service", I learned that my duty to begin active military service would begin a year thence – after what would be my first year of medicine residency at IU. The doctor draft was a somewhat complex process that involved a lottery.

The upshot was that I would depart on a governmental sponsored sojourn in Southeast Asia in June of 1966.

Indiana for me initially was Marion County General Hospital – and the first year that the municipal hospital was officially part of the IU residency programs in medicine and surgery. My first rotation was on Pulmonary which was based in the Flower Mission building just west of the main hospital. All the medicine residents rotated night call. A call to the ER could be pretty exciting particularly since it might mean managing pulmonary edema without loop diuretics (not available yet) –- rotating tourniquets, phlebotomy, marginally effective mercurial diuretics, and of course digitalis were the available tools. Hypertension control was relatively primitive – with reserpine, hydralazine, early thiazides – and in

emergencies sodium nitroprusside or Trimethophan, a ganglionic blocker which was treacherous at best, toxic at worst.

Many diagnostic modalities were yet to come – CT scans, echocardiograms, most ultrasounds – although neurosurgeons were bouncing echoes off the septum pellucidum to look for midline shift. Brain imaging was with plane angiography or pneumoencephalography (which I am told should be included in any anthology of torture devices).

Good antibiotics were available, some with significant toxicity -- chloramphenicol, aminoglycosides (streptomycin and Kanamycin only), and polymyxins --no cephalosporins, extended spectrum penicillins, or fluoroquinolones. (Methicillin was recently available)

So -- much was different from the experience you will have. But much was the same. The patients haven't changed (they were generally somewhat smaller). Then, as now, one learned more from his or her colleagues than from the staff. We weren't so siloed by disciplines then. Four years later when I was chief resident I had night supper most evenings with surgery chiefs. Among our colleagues there was a heavy preponderance of American born white males. Even eight years later in my wife's 1972 IU medical school class of 315, there were only 13 women. The enriching admixture of colleagues from the Asian subcontinent, the Middle East, and Latin America was still decades off.

Now if you will forgive me for doing something I long ago promised myself I would not do in old age – give unsolicited advice – Just a few little things – that won't be affected by any technological advance.

1) If you encounter one of the janitorial staff mopping the floor – ask his or her permission to proceed or for a suggestion for an alternate route to your destination.

2) If a young woman has to bring a small child with her to her appointment, address the child first and thank her for bringing her mommy to see you – and then tell the patient how beautiful her child is.
3) If a patient who regards you as his or her doctor dies, go to the funeral.
4) In general, but particularly if you have difficult or unpleasant issues to discuss, position yourself so that your eyes are below those of the patient. It can soften the fear or anger that the discussion provokes – I've been burned on this one more than once.
5) Be circumspect in anger. What you believe is righteous indignation, everyone else may regard as petulance.
6) Remember that at our most essential best we are servants. The founders of AOA realized this with the motto "worthy to serve the suffering".

I join your families, friends, and other faculty of IU School of Medicine in congratulating you on your hard work and accomplishments and wish you happiness and satisfaction in your work over the next 60 years