Faculty Profile: Abraham Verghese

Paula Bailey interviews Abraham Verghese, MD, MACP, Professor and Senior Associate Chair for the Theory and Practice of Medicine. Prior to coming to Stanford, he was the Director of The Center for Medical Humanities and Ethics at the University of Texas Health Science Center at San Antonio, where he held the Joaquin Cigarroa Jr. Chair in Medicine and was the Marvin Forland Distinguished Professor of Ethics. His books, *My Own Country* and *The Tennis Partner* are taught in many medical schools as part of the humanities curriculum. His writing has appeared in *The New Yorker, Sports Illustrated, The Atlantic, Esquire, Granta, The New York Times Magazine, The Wall Street Journal* and elsewhere.

Dr. Verghese, a belated welcome! How are you enjoying your time at Stanford?

I'm loving it! It's been a wonderful transition. Great weather and I think for the first time in my medical career, I'm doing exactly what I wanted to do. I think a job is always a combination of doing the things you love to do, and some things that you like to do less. I've found just the right mix—most of what I'm doing, I like.

Tell us about your vision for teaching medical students and physicians, and that probably gets to what you love to do, right?

Yes. I've learned by coming full circle that the most important way we have to influence medical students and residents is really at the bedside, one by one. There really is no short-cut; there is no classroom lecture that can substitute. This place has such a wonderful reputation for research, and we want to try and make sure that it also has an equivalent reputation for the clinical training of our students and our residents. My chair, Ralph Horwitz, shares my view that the clinical encounter at the bedside is terribly important. In other words, you can have all the theoretical knowledge in the world, and if your interaction with the patient is somehow clumsy and not done well, the relationship won't even begin.

We in western medicine have spent a lot of time on patient communication. Everybody is really sophisticated these days about cultural differences, and making eye contact, and reading nuances in the voice, but the physical exam has been sort of glossed over. The examination of the body is an art that has faded as technology has become ascendant; people have less faith in their ability to examine the patient. My bias is that if you examine the patient well, you not only convey a certain skill and competence to them, but you also earn the right to make decisions with them about their health care. I learned these lessons the hard way from my patients with chronic fatigue. I learned to give them one hour to just tell me their story (and bill for a new patient visit), and then have them come back for the second visit to do the physical, because I could not do them at the same time. They had too much to say.

On the second visit, I would do the most thorough exam I could think of doing. Invariably the patient would say, "I've never been examined like this before." I would see these very voluble patients quiet down. Then, when I would tell them the same things they had heard at the Mayo, or wherever else they'd been, I always felt that if they accepted it from me, it was because I'd earned the right to have their trust because of this thing that transpires in the physical. So I'm very interested in that. We are trying to put together the first Stanford conference on bedside medicine a year from now. The first day will be easy. It will focus, for example, on how well does feeling the spleen work, how accurate is that, and how well does looking for thyroid over-activity work, etc., but the second day is going to be all about what does touching the patient mean to the patient? What does it convey about empathy, about skill? What mythical, or mythological, or archetypal role are we playing when we go through this extraordinary act, where one individual gives permission to another to touch them? It's a tremendous privilege. That's a long-winded way of saying this is the aspect of medicine where I'm really hoping I'll make a difference. I have

Faculty Profile (continued)

had the help of Drs. LaVera Crawley, David Magnus, Audrey Shafer and Clarence Braddock in this venture, and I am most grateful.

Are we not really teaching that aspect of it now?
We teach medical students all these aspects of the physical exam in the first two years. Then when they arrive on the wards in their third year, carrying their reflex hammers and opthalmascopes, and flashlights, and stethoscopes, they quickly find that very few people carry anything but the stethoscope, and that the stethoscope is really more of a mating symbol, I call it, than it is a diagnostic instrument. They realize that the ebb and flow on the wards really revolves around getting tests done and getting data from the computer. The computerized medical record, along with burgeoning technology, has seriously threatened the patient/physician interaction in the hospital. I would contend, and I will keep saying this til the day it stops being true, that the patient in the bed has now become an icon for the real patient, who is in the computer. The patient in the bed simply exists to signify that there is a file in the computer. Now, of course, I'm being facetious. We clearly pay attention to the person in the bed, but what I mean to say is that looking at the body, orienting oneself from the body has become almost passé. The body is viewed as incidental, in many cases for good reason, because a mammogram or CT scan can perhaps see much more clearly than the human hand. Never-the-less, there are things that only the human hand can find, like whether it's painful in a particular spot. That's not something that any machine can tell you. There isn't any machine in the world that can do a knee reflex and convey the information of a tendon reflex. There are elements of this exam that are so important, and in this era of biomarkers and other sexy tests, we have forgotten the value of the good physical.

Do you think people want to feel that you have really seen them, rather than that you have just read about them somewhere else?
Yes, I think people want to feel you've really seen them, but I think it's more than that. My bias is that if you do the bedside stuff well, if you really have confidence in your exam, it leads you to order tests judiciously, based on good hunches, and then I think you are more cost efficient, and you are about a half a day to a day ahead of people who have to wait for all the test results to fall out of the sky to get a clue as to what is going on. By the way, I don't think one needs to prove this. Every time I say this, I hear, "Can you prove it?" We don't need proof that it's easier to drive a car by looking out of the window than by following the arrow on the GPS without looking out of the window. I don't think I want to do a trial to prove that being a skilled physician at the bedside has some advantages. There are so many anecdotes I can think of—we all have them—where an exam of the patient completely changed the course of everything, or where failure to recognize a finding on the exam proved costly. Not doing a careful history and physical exposes patients to so much unnecessary testing, so much unnecessary "stuff."

You mentioned that you are planning a conference. Who will attend?
The conference is a terribly important way for us to, as I see it, define what is a new field. At first I think it will be mostly for all of us nationally and internationally who are interested and have been focused on this field of bedside medicine. The great thing about being at Stanford is that the institution provides a wonderful platform here from which to speak in a way that people pay attention. I'm really hoping to use that. A recent dinner meeting involved faculty from SCBE and also people from Comparative Literature, Romance Languages, Sociology, and Anthropology, because I really think this field of "what does it really mean to touch the patient" is in need of a better definition. It needs to be defined; we need to learn what measures we can use to describe and study this field. The conference is about defining that field, staking a claim to this and saying it has a function and a purpose.

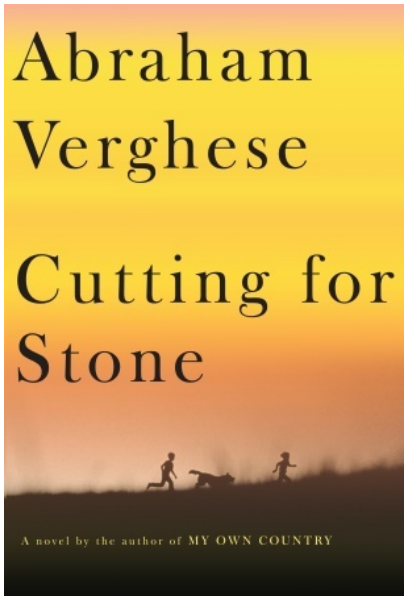
Do you have other plans for reaching past the impersonal reliance on technology in the practice of medicine and accessing the art of the healer?
My chair's belief, which I share, is that we need to allow students to see the magic, the excitement, the great intellectual challenge of being in internal medicine, and that somehow, nationwide, we are failing to do that. When I came into internal medicine, what attracted me was the 'sleuth' quality of being a physician. I think many medical students come to medical school imagining that's what it will be like—they will have this knowledge, learn a special skill, and pretty soon they can divine things at the bedside. It's ironic that they wind up at the end of their training, often having less faith in their skills to divine anything, and too much faith in tests. That's our doing, our fault. The other thing I would like us to have done here at Stanford, a measure of our success, is to have attracted more students to internal medicine. I'm very gratified that this year we have twenty-one students going into medicine, out of a class of eighty-something. Last year, it was just nine. I don't think I can take credit for that. I do think Dr. Horwitz' arrival, and a new energy and a new bustle among the faculty and residents have

Faculty Profile (continued)

contributed to this; we have always had great clinical talent here, but the willingness of the department to get behind that talent, showcase it, and give it adequate resources has made all the difference.

Let's switch gears now to your new book, coming out in January, 2009, Cutting for Stone. Tell us about it, particularly that interesting title!

The title is actually from a line in the Hippocratic Oath, "thou shall not cut for stone," which is a reference to bladder stones. These were epidemic in the dark ages, and there were these charlatans who went from city to city to cut out bladder stones and relieve suffering, however the danger was people would die of infection the next day. My novel has nothing to do with that. It's really all about a protagonist whose name is Stone. It's very much a medical saga. It begins with a nun giving birth to twins in an operating room in a mission hospital in Africa. One of the twins becomes the narrator for the story. It's really about the very things we just talked about—how medicine can save you, but it can also destroy you, it can swallow you up, it can cater to your pride, it can humble you. All my pet peeves about medicine, along with all my joy in medicine, are embodied in this story.



Have you been successful in carving out 40 percent of your time for writing, away from the Department of Medicine? I understand you have an office in a secret location for that very purpose, which should make it easier!

It's actually been pretty successful. I've been fairly religious about blocking out that time and treating it as though I'm at a clinic with patients waiting and I have to be there, or I have to be at my lab for a lab meeting. It's funny how when I must turn down an evening invitation because I have to write, I get a lot of flack from not only family, but others who say, "Big deal! He has to stay home to write!" Yet, if I were a neurosurgeon and if I said, "I'm sorry, I can't come to your dinner because I have to go and relieve a subdural bleed!" that would be perfectly understandable, because that's important! I realized that the only way to make one's writing have value, is to treat it with value. I block out time on my calendar now. I'm not claiming I write from the minute I get there until the time I leave, but it certainly is the place where I try and avoid regular email, and really try and focus on my creative projects. It's consisted to a great degree recently of wrapping up the novel, because it's still in the galleys and second-pass stages. It's also consisted of writing a few editorials about the very thing we are talking about, bedside medicine.

Something just occurred to me. Can you schedule creativity? Do you just go into that office and go into that mode?

Yes and no. For me, at least, and I think this is true of most people, if you want to write, you need to apply your butt to that chair, you know? I don't think it works for everybody to be like Frost walking in the woods or Thoreau walking around a lake. The act of creative writing is utterly mysterious, but it does require that you begin, that you are there. It does require that you start to write, that you try and beat your head against this topic you are working on, and then things mysteriously can open up—the muse, if you will. It sounds clichéd, but I do think that in the process of doing it, you tap into thoughts that you didn't have, were you not sitting there writing. At least for me, I write in order to understand what I'm thinking. So yes, you can schedule the time you'll devote to it. I have a few things I'm working on, and every time I go to that office, I pick them up and start again. You make your progress, you put things away for a while and look at them again. I'm not turning out a column for a paper, so the product is not always that visible immediately.

Is there anything else you would like to talk about?

Let me add one more thing. When we put together this dinner to look at bedside medicine and get all these views from our colleagues outside medicine who are on the Stanford campus, I later heard from some of these individuals after the dinner. An English professor wrote to me and said, "In twenty years on campus I've never had such a wonderful discussion and never seen such a coming together of people from different disciplines." One thing I'd like to put together is a quarterly dinner, where we pick a topic and invite fifteen people from all across campus. To me, the real strength of being in a university should be that we use these connections with people from other disciplines. It keeps your creative juices flowing, and every now and then, serendipity will allow that interaction to produce something valuable!