



**Address to the McMaster Osler Club  
And the First Year Students of the Medical Class of 2010**

*November 22, 2007, John Cunningham, class of 1972*

I want to thank the Osler Club for inviting me to speak to you here tonight. I also want to welcome the class of 2010, both to the McMaster community and to the medical profession. I hope you are finding, as I did, that being in medical school and being at McMaster is one of the most exciting and exhilarating events of your lives. One day you are an outsider to medicine looking in with a mixture of awe and confusion, and then suddenly you are here, with the insiders taking you under their wing and guiding you toward an understanding of the art and the science of patient care. A warm welcome also to my colleagues, friends and fellow alumni of McMaster's medical school.

For the first-year students, you have by now succeeded in the first problem of problem-based learning, and that is, finding the tutorial room. You may also know something of the reputation of the McMaster medical school, but many of you will not be aware of the journey of discovery that created this school forty years ago. I was asked to address you, not perhaps because I am the one with the whitest hair, but amazingly enough to me, I am one of the few people still around from those first days. I was in the first class of the new school when it started in 1969, and in that year I was like you, and excited to be at the beginning of this amazing career in this amazing medical school.

It is perhaps difficult now to understand what medical education was like in the first half of the last century. In 1910 Flexner surveyed the medical colleges of North America and he issued a report calling for the education of medical students to be grounded in the study of basic sciences—a dramatic departure from the apprentice-based training of physicians of the 19<sup>th</sup> century. In the decades that followed the universities adopted this recommendation, and spurred on by rapid advances in biomedical science by the mid-fifties the scientific underpinnings to clinical care were the cornerstone of medical education. The educational structure was referred to as the 2 plus 2 model; two years of basic science and 2 years of clinical work on the wards of the teaching hospitals. Medical students like you came to the university alive with energy and enthusiasm for their new profession and were subjected to 2 years of mind numbing lectures on biochemistry, physiology, pharmacology, microbiology, and hundreds of hours of dissection in the anatomy lab learning the minutiae of muscle insertions and bone tuberosities. The students' goal became, not health care, but survival: memorize enough to pass the all-important end-of-term exams and avoid being thrown out of medical school. Not an inspiring beginning to a career of caring for the sick.



The 1960s were a remarkable time of change, a society that now seems in some ways more tolerant and flexible than our own. It was a time of post-war boom and, if not affluence, certainly the feeling that things that had been impossible during the years of the Second World War were now economically and psychologically possible. But it was also the time of a new war, the Vietnam War, and this engendered a spirit of revolt against established authority. In Ontario the economic boom and the baby boom created the conditions for medical school expansion and McMaster, which had been founded in 1887 and had moved to Hamilton in 1930, was chosen as the site for a new medical school. The University president, Harry Thode, wanted the new medical school to be unique, special and first class. Bypassing the senior generation of medical academics, he engaged the 35-year-old cardiologist, John Evans as Dean. John Evans brought with him Bill Spaulding as Associate Dean and Fraser Mustard as Chair of Pathology. All three had trained at University of Toronto and as a result of their own experience with the 2 plus 2 model, they were committed to creating a new paradigm in medical education.

The central dichotomy here is being aware of the difference between teaching and learning. Mark Twain said: "Everything has been thought of before. The hard thing is to think of it again."

The teachers of the '60s were not the first to understand that the goal of a medical school is not teaching medicine, but facilitating the learning of medicine. Human experience goes through cycles. Previous generations have understood that teaching does not guarantee learning. Can anyone guess who said the following lines?

"People have now-a-days got a strange opinion that everything should be taught by lectures. Now I can not see that lectures can do so much good as reading books from which the lectures are taken."

The year was 1766 and that was Dr. Samuel Johnson (not a physician but a lexicographer, an occupation in which he defined himself as "a harmless drudge").

In the first half of the twentieth century, teaching, through lectures, was once again predominant. Perhaps it was because of the simple idea articulated by one of my colleagues from different school: "We give them 200 hours of lectures on the topic. Then they have no excuse for not knowing it."

Or perhaps it was a consequence of what my 87-year-old father said to me the other day when we discussed the issue. He said "teaching is easily measured, learning is not." Quite true.



In any event, in the '60s learning was rediscovered. By this I mean the importance of the student engaging with and learning the material him or herself, rather than the teacher lecturing on the topic. John Evans and his colleagues understood this distinction. They wanted students to learn and they reasoned that to get students to engage with the material they had to be motivated to learn, and they understood that motivation would be enhanced if the material was interesting. They wanted medical students to struggle with clinical problems, not after two years of basic science study, but from day one. They reasoned that learning the basic sciences in the clinical context would make the topics not only more relevant but also more memorable. They rejected passive lecture based learning in favour of interactive learning in small groups. From their ideas came the central tenets of McMaster's medical school teaching philosophy—small group, self-directed, problem-based learning. And so came into being that amazing medical school of my youth, a medical school with no lectures, no labs, and no exams.

How could such a plan be ratified by a University senate? I think it's fair to say it couldn't happen today. It was possible in the '60s because all kinds of ideas were being looked at freshly, through new eyes and with a new willingness to move beyond the traditional confines of what had been done before, to move into a new future. Suffice it to say the senate did approve the curriculum and the new experiment in medical education was launched.

The early days at McMaster Medicine were heady times. There was so much energy and enthusiasm amongst the faculty, so much commitment to the creation of a new concept of medical education, one devoid of the jumping of meaningless hoops of formal accomplishment in favour of a process of largely self-directed discovery with faculty acting as the guides. The vision of Dante led by Virgil through Purgatory comes to mind as opposed to the Dickensian image of 19th century rote learning. It was a heady brew that left us all a little intoxicated with enthusiasm.

It's hard for me to think of that time without remembering some of the fun and iconoclasm that went with it. Jim Anderson, the first Chair in Anatomy was our earliest mentor and he was more like Puck from a Midsummer Night's Dream than Virgil with his endless absurd puns and non-sequiturs. His overriding characteristic was a desire to have fun, something he usually accomplished by making himself the butt of the joke. For more than 30 years I have repeated a saying I got from him. Whenever one of us finally understood what he was getting at, he would say, "small town boy comes out of anaesthetic".

Dave Sackett, the Chair of Epidemiology, was Jim's match in verbal repartee and after these many years, I recall his remark that the only murmurs the students in our class had ever heard were coming out of the back seat of a car. Perhaps



more relevant to you was his oft repeated mantra, “You become what you pretend to be”, and indeed as you proceed through medical school you will model and you will become the physicians you want to be. As a sociologic study of McMaster medical students described it, you will put on the “cloak of competence”.

In those days, even the Dean served as a small group tutor, and I remember Dr. Evans, the cardiologist, in the true McMaster spirit of integrating the psychosocial with the physical aspects of medicine, joking with us about his supposed researches in the field of veterinary psychology. Little did he know that 40 years later such ideas would be taken eminently seriously. Perhaps it was another example of his being a man ahead of his time.

Dr. Moran Campbell was chairman of the department of medicine. He was a respiratory physiologist with an international reputation, and a product of the rigorous British medical educational and exam system, which considered it normal for senior house officers completing their training to fail their qualifying examinations at least once or twice. It took me 20 years to call Dr Campbell by his first name, so perhaps you can imagine my shock when I discovered that my classmates in the first term were happily calling the Professor of Medicine by his Christian name as if they had gone to school with him. But Moran took it in his stride. Perhaps he thought this was just the normal behaviour of students in North American medical schools (but somehow I doubt it was the practice in Toronto). In tutorials he was a wonder of informality and directness, sitting on the edge of a table in shorts and an open shirt discussing physiology and medicine with chalk and blackboard.

In the days of the 2 plus 2 curriculum there was no such thing as early clinical exposure. McMaster was unique in offering the remarkable opportunity of seeing patients from day 1. I still remember going on hospital rounds and working in the office with Dr Rudnick, my family physician preceptor. It was a powerful formative experience. Nearly two generations of physicians have been trained at McMaster and most of those graduates still value that early exposure to real patients with real problems. It helped them to understand why they were here studying medicine.

So, what does it mean to be a health care professional? In the simplest of terms it's about helping people who are sick. Aging, injury and illness are depressing and demoralizing. Have you ever been ill? Or seen a loved one ill? It can be overwhelming. A physician has the privileged opportunity to contribute to making people better, not all people, but some.

We live in an age of euphemisms. So the Unemployment Insurance of my youth has become Employment Insurance. The Workers Compensation Board has



become the Workers Safety and Insurance Board. And looking after people who are sick has become health care. Now I have nothing against the idea of trying to keep people healthy, but the reality is that in spite of all efforts, everyone is going to get sick. And it will be your opportunity to help some of the people in your community to recover sufficiently to carry on satisfying and productive lives. Does that give job satisfaction? You bet it does. Your hard work today is going to put you in the personally rewarding position of making some people better in the future. I have always admired St Joseph's Hospital here in Hamilton for its uncompromising motto. "It is an honour to serve the sick".

And what does it mean to be a McMaster medical student? I want to focus on two aspects. The first is your need to take responsibility for your own education—this is the strength of the McMaster program and the legacy of the founders—take the responsibility to learn for yourselves. Don't wait for someone else to tell you what to do or what to think. Don't wait for someone else to solve the problem—do it yourself. If there are days when you wonder, is this the way to run a medical school? Is this the way to get a medical education? Remember that it works. Nearly 40 years have elapsed since the first class. It worked then. It works now. The McMaster MD Program has remained true to its founding principles. It is still committed to self-directed learning in non-competitive small groups, collaborating together with real patient problems. This model of education works. Believe it, engage in it and don't spend much time worrying about the system. Trust in tutorial education, that foray into the power of the small group to lift the consciousness of the whole group. Believe in the power of your own commitment to your education, secure in the knowledge that you will succeed. And be aware that in the end, problem-based learning has not been proven to produce a superior physician, but it has been shown that those who embrace problem-based learning have more fun, and increased pleasure and satisfaction translates into increased commitment to the goal.

I love quotations that carry the wisdom of the past forward to our time. This is one I love to quote to my children and perhaps you will find it relevant to your own struggles to educate yourself. Once again from Samuel Johnson:

"If the profession you have chosen has some unexpected inconveniences, console yourself by reflecting that no profession is without them; and that all the importunities and perplexities of business are softness and luxury, compared with the incessant cravings of vacancy, and the unsatisfactory expedients of idleness."

The second issue on the topic of what it means to be a McMaster medical student was brought alive for me several weeks ago in a speech given by a senior American medical school dean. He said: "There is no one in the health care system who is more altruistic than our students *on day one*."



It started me thinking. My first question was, so what is altruism? Because if it means always acting in a selfless fashion, then clearly it is not a sustainable philosophy on which to base a lifetime of behaviour, probably not even in the church, but certainly not for a professional career. To my relief I found that the Oxford English dictionary defines altruism as ‘regard for others as a principle of action’. Note, it does not say anything about sacrificing yourself for the good of others. Each one of us has our own very legitimate needs and these are not to be put aside by putting on the cloak of the profession, but within your professional capacity acting with regard to others is a principle of action that does fit the long-standing values of the profession. Physicians have long considered that the good of their patients is a guiding principle of action.

So what happens after day one of medical school? How do you hang on to that idealism, that altruism, in the face of the daily round of personal and professional responsibilities? Well, I’ll tell you, it’s not easy. Life exacts a toll. But if there is any secret it is contained in doctor to patient, human to human interaction. It has been said that “the secret of patient care, is caring for the patient”. It a good line, and it’s true. But it is couched in abstract terms. Over my lifetime I have found the way to keep in touch with the power of this idea is to personalize it. I ask myself, “What would I do if this were my mother, or my father?” “What would I do if this were my child?” “Would I be in such a hurry to get this patient out the door if this were my grandparent?” “Would I be more sympathetic if I were the patient and not the doctor?” I believe that to maintain the highest values of the profession, the altruism of the profession, you have to keep in touch with your basic human values by engaging your own personal feelings and emotions. The goal is not to depersonalize interactions with patients, but to keep your own vulnerable and caring personality in the forefront of the doctor/patient encounter.

I was at the Physician Assistant education conference in Tucson recently and in her address to the assembled clinician educators the president of the organization said: “It’s a real gift to be a part of this community!”

I can only echo that sentiment, and I extend to each one of you my hearty welcome to the profession of looking after the sick. I know you will find, as I have, that “it’s a real gift to be a part of this community!”