

## An autobiography

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This issue marks the beginning of a series entitled "Contemporaries." Prominent physicians who have had a long association with The Cleveland Clinic Foundation will be asked to prepare brief autobiographies, emphasizing those accomplishments they believe were important as well as other significant events during their careers.

—Editor

*In it he was constantly making a hero of himself, exactly as I have done and am doing now, and he was constantly forgetting to put in episodes which placed him in an unheroic light. I knew of several incidents of his life which were distinctly and painfully unheroic but when I came across them in his autobiography, they had changed color. They had turned themselves inside out and were things to be intemperately proud of.*

Mark Twain

An honest autobiography is a biopsy of the author's memory usually done late in life when defeats have been suppressed, rationalized, or transmuted into triumphs. The biopsy, being self-inflicted, is not likely to be painful—at least not to the author. The time at which the autobiography is written has a large bearing on interpretation of events. At best, it reflects the distortions resulting from lapse of time and memory and the occurrence of subsequent events that have changed the writer. The author also suffers from



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peculiar inversions as well as distortions. If remembered at all, corporal and other punishments are seen to have contributed to noble characteristics when viewed from a temporal distance, but the same actions were most unpleasant and were usually considered unjust and evidence of the at

least temporarily ignoble character of the inflicter when the skin or heart still smarted. I prefer biographies because, if carefully researched and truthfully written, I tend to recognize friends when imperfections are described, but I do not see myself. An autobiography tends to depress me because I can never emulate the sterling qualities admitted by the author. An exception is the book that examines the world around the author rather than the author, but then this is not really an autobiography.

Most of us confess to our own modesty, but the mere intent to pen a reflection of one's life puts a strain on the reader to detect that amiable attribute. It is presumptuous to think that the reader is better served than the writer. Having proclaimed my reservations does not disqualify me from responding to a request for an abbreviated autobiography. A shortened version inhibits display of many admirable traits that could be shown in a less restrictive format; however, being in rather short supply of those traits, an abbreviated account seems appropriate to me. A shorter version is suitable to the required focus on a professional career also.

Autobiographers and other criminals often seek to explain the background of their exploits on the basis of family history. Both of my parents were of Scotch-Irish descent, an American designation that includes immigrants from Scotland and those Scots who had moved to or were banished to Northern Ireland in the 16th and 17th centuries. Settling in eastern Pennsylvania and later, after the American Revolution, in the western part of the state, most of the men in my family were farmers, although clergymen were well represented and there were a few physicians. My father was a Presbyterian minister, but both parents were raised on farms. I was born in Connellsville, Pennsylvania, in 1914—the last of five children, three of whom survived childhood. My growing years in a small town were uneventful. My father, a graduate of Washington and Jefferson College, was a scholar and a linguist, reading Greek and Hebrew daily. I do not recall that I impressed either parent with my scholastic achievements, but I received no reprimands either. My brother also graduated from Washington and Jefferson College and had finished the first year of medical school at the University of Pennsylvania when I completed high school. I also went to Washington and Jefferson. I hoped to become a biologist, but gradually shifted my

interest to medicine. About that time, a fraternity brother had written for an application to Harvard Medical School, but he decided that he would not be accepted, so he did not complete it. The form was on a table and I thought that it should not be wasted, so I applied. To my surprise, I was accepted. That summer I attended college to complete requirements for a degree, although this was not a Harvard requirement. I never inquired about the reason I was chosen, fearing that it might have been an error. The fear was groundless, for Harvard seldom admits mistakes.

My years in Boston were enjoyable. Although I had come from a small liberal arts college, the competition in medical school was not overwhelming. I found Professors Fuller Albright and Soma Weiss the most stimulating, and they probably influenced my choice of internal medicine as a specialty. Fortunately for me, most of my brightest classmates planned to be surgeons—specifically neurosurgeons.

In 1939, Pennsylvania almost required a rotating internship in the state for subsequent licensure, and I thought that I wanted to practice there. Most of the best internships were of two years' duration, but two full-time staff hospitals offered one-year appointments. I went to Geisinger Memorial Hospital in Danville, Pennsylvania. The excellent internist there, W. J. Stainsby, encouraged my interest in internal medicine. He was the first physician I had encountered who insisted on using generic names for drugs. The exception was Seconal—because he could not recall the generic term. My first resident in medicine was George E. Clark, Jr. George was an intelligent, calm, efficient, and tolerant physician, devoted to quality in patient care. Whatever he thought of me, he quickly dispelled any notion I might have had that medical excellence was best acquired on the eastern seaboard. He also solidified my interest in internal medicine.

A group of four or five interns and residents at Geisinger made a trip to the Cleveland Clinic for interviews and two of us were accepted as fellows. In addition to experience in patient care, I had acquired the instructor of nursing arts at Geisinger as my wife. A happy life and three children resulted. On starting in Cleveland in July 1940, I was glad to be reunited with my old resident, George Clark.

Times have changed medical education profoundly. From 1940 to 1943, formal training on

the medical service was confined to one weekly session, presided over by Dr. Russell L. Haden, although there was an evening lecture each week for the fellows in all specialties. Dr. Haden was chairman of the Medical Division and his weekly clinical meetings were a joy. Staff and fellows alike were expected to be in their seats at 8:00 A.M. Two patients were presented; often one was Haden's own patient. The fellow was expected to give a complete presentation without notes, omitting all trivia and including all essentials. Usually Haden questioned the patient personally, and it was a revelation to see how proud the patient seemed to be that he had been selected for study. Haden was soft-spoken and kind to the patient. He demanded and received respect and devotion from his trainees. Although he was a hematologist, he had an enormous practice in internal medicine and could make intelligent comments on practically any problem. Haden was the finest diagnostician I ever encountered, as well as an enthusiastic, optimistic therapist. He constantly reminded his trainees of little mistakes that they had made in the past, but did not mention the big errors because he knew that these had already registered. Subtle signs of curable diseases could not be missed, such as the appearance of myxedema or the smooth clean tongue of untreated pernicious anemia. All of us noted whether the patient appeared to be myxedematous when we opened one of Haden's examining-room doors.

A. Carleton Ernstene was the first cardiologist at the Clinic. He was a handsome, rather quiet, well-spoken man of almost incredible order and was a model of logical thought. He took me on his service for about a year before he entered the United States Navy in World War II. Daily discussions with him were a fine educational experience.

A third member of the staff who influenced me particularly was Dr. E. W. Netherton, the dermatologist. Most of the medical fellows spent three months on his service and were turned into competent clinical dermatologists in that short period—a remarkable transformation. Netherton was a modest, dignified gentleman who had a passion for meticulous observation and detailed notes, the latter a rarity for extremely busy clinicians. Some of these attitudes rubbed off on the fellows, and all finished his service with the knowledge that dermatology is a science and Netherton was a benign master of it.

In 1943, I entered the United States Army Air Force and was stationed as an internist at hospitals in Georgia, Florida, and Texas. In Texas, I had the opportunity to see a great deal of acute rheumatic fever for the first time. I was certified by the American Board of Internal Medicine while still in the service in 1946, being in the last group to take the essay type of examination. It may be that my handwriting was instrumental in changing the nature of the examination subsequently. George Clark, my old friend, was discharged from the Air Force long before I was and settled in Austin to practice. He advised me to spend some time with Dr. Frank N. Wilson, the electrocardiographer at the University of Michigan. It was excellent advice and I observed in Wilson's laboratory for six weeks. Wilson was a modest and truly great man and was a model for writing a single word in place of ten.

In November 1946, I returned to the Cleveland Clinic on the assistant staff in Cardiology. I was supposed to head the Section of Electrocardiography and see patients half time, which meant four new patients and three consultations daily plus seeing former patients and hospital patients. In a few weeks, we had Wilson's central terminal switch constructed for our electrocardiographs, and we were, perhaps, the largest institution in the world using the central terminal leads.

My first published paper was about electrocardiographic changes induced by exercise.<sup>1</sup> Soon after I recognized the electrocardiographic alteration caused by hypokalemia. Through the years, some original electrocardiographic observations were reported by Drs. Gordon R. Cumming, Fernando A. Tapia, and Athan J. Georgopoulos. Papers dealing with various clinical subjects were interspersed, but no profound observations were made. We did describe a peculiar condition known as micturition syncope.<sup>2</sup> In 1957, we reported elective cardiac arrest by use of a potassium solution during open heart operation, but this was really the result of original thinking by W. J. Kolff. In October 1958, F. Mason Sones first performed selective coronary arteriography, and a new era in cardiology was begun. Soon Sones and E. K. Shirey were obtaining many arteriograms, and it was obvious that correlation of clinical and arteriographic findings should be made. Sones resisted premature reports, fearing that in early experience with coronary arteriography important lesions may have been missed.

Finally, he agreed that correlations should be done but stipulated that I should do them, excluding Shirey and himself from participation. His reason was that he regarded me as a skeptic, and Shirey and he would be biased toward positive correlations. A series of papers relating clinical and arteriographic findings followed. None of this work would have been possible without Sones' enthusiastic support and the availability of his data. We talked over the possibility of doing natural history studies of coronary disease and the need for them was emphasized after Rene Favaloro, our surgical associate, developed the coronary bypass operation in 1967. The difficulty was that we did not have time to organize and implement such studies. One day Sones told me that he had just met a young Dutch cardiologist during a European trip, and he thought that he was our man for these natural history investigations. He said that Albert V.G. Brusckhe would be my responsibility and I was to supervise him. I had some misgivings but I agreed, and as usual, Sones had chosen wisely. Albert Brusckhe was a brilliant, energetic, personable, well-trained cardiologist who required little help and no supervision, which I did well. In 15 months, he compiled the data for and wrote three monumental manuscripts about natural history with Sones and myself as co-authors. Other papers have followed these, mainly in association with and often written by Drs. Welch, Lim, Heupler, Kramer, Underwood, Sheldon, Siegel, Cosgrove, and Loop. Most of these papers related to the natural or unnatural history of coronary disease. One described the ergonovine test for the variant form of angina pectoris, which was based on a 1972 idea that coronary spasm was the probable cause of pain induced by ergotomaine-type drugs.<sup>3</sup>

My clinical duties were unchanged for 20 years, but in 1966, I was made head of the Department of Clinical Cardiology and F. Mason Sones was head of the Department of Pediatric Cardiology and the Cardiac Laboratory. Although these departments were separate and Sones and I had quite different personalities, we meshed beautifully personally and professionally. We retired as department heads about the same time and remained close until Sones' death in 1985.

Since my early days in medicine, I have had an interest in medical history, but it was almost time for retirement before I became serious in pursuit of the subject. Most of my writing has concerned

late 18th century British developments in heart disease. If one confines interest to a narrow segment, it is not difficult to be an authority.

Although interest does not necessarily imply expertise, three areas of clinical medicine especially challenged me. The first was taking a medical history. This requires patience, precision, and careful observation of the response to a minimal number of questions. The patient must be allowed to tell the story, interrupted only by gentle prodding intended to return him or her from diversions from the main theme. The urge to "help" the patient with the history is irresistible to some. I considered it the ultimate recognition when Sones would ask me occasionally to take a history from one of his patients. The second interest was in auscultation of the heart—like history taking, a form of listening. Once expert auscultation was the mark of a cardiologist and, even now, accurate observation of sounds and murmurs will save the patient time and money and the physician embarrassment. The third area of interest was objective reading of the electrocardiogram. Frank N. Wilson taught that the electrocardiogram was a laboratory test and should be read as such. He always had clinical information available when he read an electrocardiogram, but he never looked at or asked for it until he had written his interpretation, which he never changed subsequently. Not only does such a reading promote accurate observation, but also one avoids overinterpretation—the most common error.

In teaching, I tried to emphasize these three areas of interest and also evaluation of published papers. Undergraduate medical education insists so strongly on the acquisition of "facts" that critical analysis of reading is not stressed. Acceptance of the written word, particularly when it appears in a prestigious journal or under the name of a famous physician, is widespread among young physicians. Trust must be developed in accurate firsthand observation, and all published material should be viewed with skepticism. To be intelligently skeptical, one must read carefully and fairly.

Although someone must take responsibility for medical organizations, I was always willing to allow someone else to volunteer or be conscripted. I was reasonably active in the affairs of the Heart Association, but inactive in most other organizations of which I was a member.

I did make a few creditable contributions in

Clinic committees. One of these was my assistance in the maintenance of peace between Sones, Efler, and Kolff in the early days of open heart surgery. The second was the selection of Dr. William S. Kiser as nominee for Vice Chairman of the Board of Governors by a committee of which I was chairman. After a short time, Dr. Kiser moved up to Chairman.

Also, when I was on the Board of Governors, the Watergate debacle was first publicized. I was the only member of the Board who thought that the President was doomed. I cannot honestly say that this insight had any effect on the history of the Clinic, and there were many occasions in which I was a minority of one in Board decisions and probably wrong. As I remember it, Congress never asked that the Watergate question be put to a vote by the Board.

Official retirement came in 1979. It was my good fortune to be offered office space by Drs. Sheldon and Loop, successively. The location has enabled me to keep in daily contact with cardiologists and cardiovascular surgeons. It has facilitated some clinical investigative studies under the watchful eye of Dr. George W. Williams and his associates in Biostatistics. However, my output has not been proportional to available time.

American medicine offers many types of medical practice. One of these lies in a multispecialty clinic such as the Cleveland Clinic. This type of practice need not be a cold relationship between patient and physician and, indeed, should never be. Most of us consider each patient as one of his own, and call for help from colleagues if and when necessary. If the patient believes that he or she is being treated as a problem rather than as an individual, we have not performed as intended. When the system operates properly, both the patient and physician should be satisfied. The administration of a large institution should be as inconspicuous as possible. Great satisfaction

comes from feeling that there are no intermediaries between the patient and the physician. A large specialty clinic offers a choice of readily available expert consultants—a source of satisfaction to the patient and physician.

An autobiographer generally tells a story that is intended to be instructive or entertaining to the reader, even if not true. It is difficult to avoid stating some guiding principle, although the principle was not always clear during the heat of the battle. Danger accompanies such a statement because the reader is likely to reflect that, given adherence to that principle and either the sterling background of the author or his or her heroic victory over a modest background, more should have been accomplished in a long life. Therefore, I shall try to avoid “lessons” from my life. With a Presbyterian foundation, I have no difficulty with the concepts of guilt and duty, but that acknowledgment of the concepts has led to their implementation toward being a worthy servant of the patient, I do not claim. Even those closest to me cannot say it—only those whom I have tried to serve. Of this I am certain: few physicians do as much for the patient and for medicine as their allotted talents would allow—certainly not I.

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## References

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