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Sir William Osler: Would He Have Made His Relative Value Units (RVUs)?

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For 40 years, the 2-volume set rested, unread, on my bookshelf. Recently, coincident with the 100th year of his death, I opened *The Life of Sir William Osler*, Harvey Cushing's biography of the "father of modern medicine." The book divides Osler's life into 4 periods: the Canadian period (1849–1884), which included his upbringing, his medical education, and his first faculty position at McGill University; the Philadelphia period (1884–1889) as Professor of Clinical Medicine at the University of Pennsylvania; the Baltimore period (1889–1905) as Physician-in-Chief of the new Johns Hopkins Hospital; and the Oxford period (1905–1919) as the Regius Chair of Medicine. Cushing's book not only allowed me to understand Osler's life but also delivers a lesson to all of us who struggle to assign value to what we do as clinicians and educators.

The Philadelphia period offers a particularly telling message for today's clinician-educators. Arriving in the city in October 1884, Osler rapidly immersed himself in medical education, patient care, and scholarly activity. He described his time there as among his most productive periods. The publications he wrote during his less than 5 years in Philadelphia take up more space in his bibliography than those he wrote during his 16 years in Baltimore or his 15 years at Oxford (1). In Philadelphia, he wrote his seminal works on chorea, bicuspid aortic valve, endocarditis, and malaria and attained much of the clinical insight that led to his landmark text, *The Principles and Practice of Medicine*. Philadelphia is also where he cofounded the Association of American Physicians, which still exists as one of the most important honorary societies focused on the advancement of science in medicine.

However, if one were to use today's metrics to assign value to Sir William's work as a clinician-educator in 1884 to 1889, would he have been labeled a success? Cushing's detailed reporting of Osler's life inspired me to quantify Osler's clinical work effort by 2019 standards. In doing so, I found that he was an underachiever. The father of modern medicine would not have made his relative value units (RVUs)!

Dr. William Pepper, Chair of Medicine, recruited Osler to the University of Pennsylvania. In my search of the Osler online archives at McGill and Johns Hopkins as well as the "Osler box" in the University of Pennsylvania Archives, I could not find a job description, contract, or any other documentation that the university could have used to benchmark Osler's productivity. Either this documentation has been lost, or its absence is an example of how different our era is from Osler's.

Cushing writes that Osler and Pepper shared supervision of the Hospital of the University of Pennsylvania's 2 large wards but that "Osler had the wards almost to himself" because Pepper had other time-consuming responsibilities (2). Osler spent most of the mornings on inpatient rounds, likely sharing responsibility for patient care with the 4 other "assistant physicians" listed on the hospital staff roster. With 367 patients admitted to the inpatient medical service in 1887 and an average length of stay of 25.6 days, it is difficult to imagine that Osler's inpatient clinical RVUs would have justified his "value" using 2019 standards (3). It is impossible to guess what Osler's outpatient revenues would have been in Philadelphia. Although many of his contemporaries were active in private practice, Cushing writes that Osler had a strong "disinclination for a general practice" and limited his nonhospital clinical work to consultation. Further, he seemed not to attribute importance to billing; his ledger from February to May 1885 lists only 2 consultations for which he billed the patient. Cushing's view of the time was, "The consultations had been few indeed—not that he much minded."

Almost every afternoon, Osler would leave the university hospital by the back entrance and enter "Old Blockley," Philadelphia's almshouse and hospital for indigent people. He would teach on the wards, and it was there that he did most of the 162 autopsies performed during his 4 years and 8 months in Philadelphia. Linking clinical presentation to autopsy findings for his students, he perfected his role as the master clinician-educator. Spending hours on each dissection, "if he found something especially interesting he would send out a runner to get all of the boys and show what a wonderful thing he had found and how interesting and instructive it was" (2). But Osler would have earned no clinical RVUs for his autopsy efforts. Autopsies are not a billable service, and only recently has there been any attempt to assign RVUs to them (4).

In Philadelphia, Osler was an active, contributing member of multiple medical societies and clubs. They were the backbone of physician collegiality, cooperation, communication, and education. He also served as an editor of *Medical News*, for which he wrote 30 editorials and 9 book reviews in 1885 alone. None of these valuable activities would have generated a single clinical RVU in 2019.

Ninety-nine years after Osler left Philadelphia, the U.S. health care system devised the resource-based relative value scale (5). Although its intent was to aid in the distribution of Medicare reimbursement, it paved the way for today's clinical RVU model, which is widely used to value physicians' work on the basis of delivery

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of reimbursable services. Clearly, the "business" of medicine of the 1880s was not what it is today. For example, the clinical revenues of the Hospital of the University of Pennsylvania in 1887 were $38 964. However, the important issue is how business has intruded on the values of the medical profession.

In 1889, when Pepper heard that Osler was being recruited by Johns Hopkins, he exclaimed, "We are about to lose Osler, and what in the world shall we do?" Today's chairs of medicine might focus more on the RVU performance of faculty they are at risk for losing rather than on their other value to the institution. Tenets of our profession that are part of Osler's enduring legacy have assumed lower priority. Now, 100 years since Sir William died, it is time we step back and refocus on what the real values of the master clinician-educator should be: teaching, mentoring, collegiality, research, and care of the patient. If not, I fear that someone a century from now will look back on our era and ask, "Why did they allow it to happen?"

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