

Teaching Old Docs New Tricks: Changes in Medicine Mean Changes in Medical Education

In 1910, Abraham Flexner issued the Flexner Report, a devastating analysis of the state of medical education at the time. Abraham Flexner was an educator, not a physician; but he had studied the educational models of John Dewey, and he had a keen eye for what we would today call outcomes assessment. He immersed himself in the study of medical education that included a whirlwind tour of medical schools in the United States and Canada.

Flexner said that medical schools at the time, many of which were proprietary, for-profit ventures, were marked by “low admissions standards, poor laboratory facilities, and minimal exposure to clinical material” and that they were “producing a surplus of poorly trained physicians.” Even though his recommendations may have relied too heavily on the highly scientific German model of education which failed to link research with patient care,¹ his report was hugely influential. It resulted in the closure of almost a third of existing medical schools, radical reform of the rest, and the end of for-profit proprietary medical schools.

Today there is no single person who is changing the face of medical education, and we are not suffering from lack of quality or consistency in training. Still, we face challenges as daunting as those Flexner faced a century ago. These challenges will require changes as radical as those he proposed.

For example, we are still working to close the gap between science and patient care that plagued medicine after Flexner. Daniel Sulmasy has pointed out that there is still a tendency to see the patient as an object of scientific investigation and to neglect spirituality and the transcendent. He proposes a new kind of clinic that will remedy this problem. Patient care also suffers from poor communication between caregivers and patients. Doctors don’t always listen,

and patients don’t always understand. The problem is exacerbated by the sheer number of care providers. Primary care physicians, advance practice and nurse practitioners, hospitalists, specialists and new disciplines like hospice and palliative care make the need for excellent communication and continuity of care even more urgent than they were in the past.

Another challenge is the shift from volume-based, pay-for-service system to a value-based system that stresses quality over quantity. Matt O’Connor has noted, “We care about the people and our goal is to keep them out of our clinics and hospitals – which means that we need to create the programs to do that.”²

Big data has provided the information that led to the transformation from a volume-based, individual approach to a value-based approach that is based on prevention, health and community need. In his well-known article “Hot Spotters,” Atul Gawande describes the case of Jeffrey Brenner, a family physician in Camden, New Jersey. After an encounter with a gunshot victim, Brenner started thinking about the link between hospital use and various social factors, including crime. He adopted the police department’s “Compstat” model, which used data to focus police resources on high-crime neighborhoods. He made his own crime maps and correlated them with reams of admissions data from three local hospitals.

“I’d just sit there and play with the data for hours,” he says. The more he played the more he found. For instance, he ran the data on the locations where ambulances picked up patients with fall injuries, and discovered that a single building in central Camden sent more people to the hospital with serious falls—57 elderly in two years—than any other in the city, resulting in almost three million dollars in health-care

bills. “It was just this amazing window into the health-care delivery system,” he says.

Brenner took what he learned from police reform and tried a Compstat approach to the city’s health-care performance—a Healthstat, so to speak. He made block-by-block maps of the city, color-coded them by the hospital costs of its residents, and looked for the hot spots. The two most expensive city blocks were in north Camden. One had a large nursing home called Abigail House and one had a low-income housing tower called Northgate II. Brenner found that between January 2002 and June 2008 some 900 people in the two buildings accounted for more than \$200 million in health care bills. One patient had 324 admissions in five years. The most expensive patient cost insurers \$3.5 million.”³

He eventually learned that just one percent of Camden’s population accounted for nearly a third of the city’s health care costs. That population was where the focus should be. This kind of discovery would not have been possible without the vast data Brenner had access to. As other studies have shown, the problem was not what the hospitals were doing wrong. Rather, poverty, crime, poor education and lack of social support were causing readmissions. His understanding of health care – focused on diversity and disparity and cause and *effect within communities* – is as dramatic as the change that took place in medicine after the discovery of bacteria or the mapping of the human genome. We have long understood the importance of disease vectors in public health, but this new population health model is far more nuanced. In the 1980s, a shift occurred from infectious to chronic health. As a result, public health has focused much more heavily on the social determinants and their environment – where people live, learn, work, pay and pray affect community health. This is where health care is not taking account of the vast knowledge of public health in addressing these community factors. It sees the community itself as a factor in causing disease and inhibiting health. This paradigm goes far beyond Flexner’s view of scientific observation of a patient.⁴

This new model has two important implications. First, we need to think of groups or cohorts of patients. Scott Wallace, an associate professor at Dell Medical School says physicians will have to think differently: “What does it mean to think about a segment of patients? How do you define and identify groups with shared needs?”⁵

This new perspective means that care providers no longer will have the luxury of looking at this patient only (as virtuous as that may be). Their vision must now be more circumspect, so that they see the patient-in-his-or-her-socioeconomic-context rather than just an isolated specimen. This will require new professional habits or virtues,⁶ broader vision and a different kind of diagnostic sensitivity.

Second, it requires a new public ethic, a new kind of virtue, that enables all of us to deal with illness as the social reality it is. As Michael Rozier points out in his excellent article, we must imagine “structures of virtue” that will compensate for the bad habits that lead to hypertension, diabetes, obesity, respiratory problems and other chronic illnesses.⁷ These new virtue structures are analogous to structural or social sin (conditions or structures which foster injustice, prejudice and violence), except they will be oriented to moral goodness. They will provide organizational incentives that “nudge”⁸ people and communities into a different view of themselves and the world around them, and lead them to make better choices as a result. It is not just about changing bad individual habits but creating environments that support healthy choices. For example, access to grocery stores, and places for children to play safely are key to healthy eating and physical activity.⁹ Our responsibility as people of faith is to create environments that will help all people achieve better health outcomes and human flourishing.

This is an important insight because in the Catholic tradition, morality is based not just on obedience to laws (which comes as a surprise to many!), but rather on clear vision of the goal or purpose for which God has created us and an internal drive toward that goal.

St. Thomas Aquinas and others described this goal as happiness – the experience and joy that come from living life as God intended. This happiness is not superficial and transitory, but the deepest satisfaction of a life well lived. Virtues are not just individual acts of obedience, but the habitual skills or qualities of character that enable us to easily and happily choose things that contribute to happiness. Virtues are not just *knowing about* moral goodness or health, but *having* them as internal principles of life. These structures of virtue should eventually lead to a kind of civic virtue that moves from “me” to “us,” and from disease intervention to disease prevention. They ask us to consider how our environments, policies, and law create opportunities to choose behaviors that promote health.

This paradigm shift is a challenge for ethicists who, as Rozier and others have noted, tend to see their work primarily in terms of individual patients and on discrete moral choices: “What is the answer to this case?” Sometimes this approach devolves even further into crisis management where ethicists are called as first responders to resolve the problem, but are not inclined to go upstream to see if the problem could have been averted in the first place. Many systems are aware of the need for change and are beginning to assess how their ethicists and ethics committees approach their work.¹⁰

Meeting these challenges in the United States will not be easy. Unlike other countries¹¹ that have a more social and egalitarian understanding of health and health care that is rooted in a notion of the common good, the prevailing ethos in the United States is highly individualistic and market-based. What is more, American individualism fosters a deep suspicion of institutions – starting with government but also extending to health care -- which will make it difficult to sell any idea of structures of virtue.¹² Many will consider such a concept to be one more example of inappropriate government involvement in private life. (Recall what happened when the Affordable Care Act tried to include a provision for paying

physicians for consultations about end-of-life care. It was branded as a “death panel” and disappeared).

Population health, public virtue and public health itself are firmly rooted in Catholic notions of justice and the common good. Health is first an individual pursuit, yet it is also a community pursuit because our communities shape us and also provide the resources we need to stay healthy. Reversing long-held understandings of health as private and individual will not be easy, but doing so is an essential part of the transformative mission of Catholic health care.

C.E.B.

¹ See Thomas P. Duffy, MD., “The Flexner Report – 100 Years Later,” *Yale Journal of Biology and Medicine* 84/3 (2011): 269-76. Duffy refers to this as the “hyper-rational system of German science [which] created an imbalance in the art and science of medicine.”

² “MDs of the Future: Medical Schools Are Preparing Physicians to Enter a Value-Based World,” *Hospitals and Health Networks* (September 2017)29-32, at 29. O’Connor is quoting Clay Johnston, M.D., the new dean of UT Dell Medical School. This effort is being led by established medical schools such as A.T. Still University School of Osteopathic Medicine in Arizona and New York University School of Medicine, but principles are being adopted by new medical schools across the country including the University of Nevada at Las Vegas.

³ Atul Gawande, “The Hot Spotters: Can We Lower Medical Costs by Giving the Neediest Patients Better Care?” *The New Yorker* (January 24, 2011):

⁴ For an example of public health in action, see the Harlem Children’s Zone, <https://hcz.org/about-us/history>

⁵ O’Connor, p. 30. See also Meredith Minkner, ed., *Community Organizing and Community Building* (Rutgers, 2011) Chapter 8, “Community Health Assessments or Healthy Community Assessments: Whose Community? Whose Health? Whose Assessment?”

⁶ I thought I was very clever to draw this virtue analogy, but I discovered, happily, that many others have already thought of it. One of the best articles is by my colleague Michael Rozier, S.J. “Structures of Virtue as a Framework for Public Health Ethics” appeared in *Public Health Ethics*, Volume 9/1 (April 2016): 37–45. See also Tiffany Cloutier et al., “Living Virtues of Public Health”

and Henry Fineberg et al., “Seven Deadly Sins and Living Virtues of Public Health” *Academy Health*, February 15, 2012.

⁷The Robert Wood Johnson Foundation has a funding initiative called the Culture of Health. A summary of findings is available at <https://www.rwjf.org/en/libraary/research/2016/10/defining-and-measuring-a-culture-of-health>.

⁸Rozier refers to the “nudge” theories of Thaler and Kass; Malcolm Gladwell’s “tipping point” theory may also be pertinent, in the sense that there is a point at which group opinion shifts toward a different kind of behavior.

⁹See Ellen Barnidge, PhD, MPH; Sandra Stenmark, MD; Hilary Seligman, MD, MAS, “Clinic-to-Community Models to Address Food Insecurity,” *JAMA Pediatrics*, (2017): 171(6): 507-508 doi:10.1001/jamapediatrics.2017.0067

¹⁰See two perspectives on this assessment Becket Gremmels of CHRISTUS and Alan Sanders of Trinity elsewhere in this issue.

¹¹N Ikegami and J C Campbell, “Health care reform in Japan: the virtues of muddling through” *Health Affairs*, 18, no.3 (1999):56-75

¹²See Hugh Hecl, *On Thinking Institutionally*, especially chapter 1, “Our Modern Impasse,” for a description of the decline of confidence in our institutions (Boulder: Paradigm Publishers, 2008).

Tomorrow's Ethicists and Providers: Observations From the Field on Undergraduate Attitudes Toward Ethics

With the help of a group of young ethicists, CHA has been exploring the shortage of ethicists and the lack of awareness that prevent many students from exploring a career in health care ethics or mission leadership. As part of that inquiry, we thought it would be helpful to share some observations gleaned from teaching 60 undergraduates in the fall of 2017.

My 60 students included 51 freshmen, all learning to be health care providers. The course provides an overview of major ethical topics in the clinical world and is required for all students in a health-related degree program. It is probably the only time many of them will have a chance to discuss the ethical dimension of their future careers. For many, it was the first time they had questioned their own beliefs about ethics and morality. I understand that 60 people is not a substantial "n" in which to draw meaningful data. However, I do believe that we can gather some insight into the way this generation views morality and how they connect, or do not connect, ethics with a job in health care.

1) Autonomy Rules

When we discussed decision making, advance care planning, and physician-assisted suicide, students expressed a strong desire to defend autonomy. They saw the idea of choice as a right and felt that we should be able to choose to have or to deny any treatment, including physician-assisted suicide. PAS is seen as an option required on any end-of-life list. They have absorbed the libertarian arguments connected with the marketing of "death with dignity" and having control. Many unfortunately did not recognize the negative impact PAS could have on society or the way it limits autonomous choice. Their attitudes suggest that we (i.e., Catholic health care)

need to do a much better job presenting our position on PAS.

2) More Advance Care Planning

With autonomy, students noticed the need for more discussion regarding care planning. I believe that this stems from the desire to defend a person's ability to make decisions for themselves. Most hinted at the hope that such discussions will make traumatic events easier by providing clarity for the surrogate decision maker. Paradoxically, however, they wanted advance directive documents to have more power. When choosing to undergo or withhold a treatment, they tended to think a written document should take precedence over a surrogate.

3) Relativism is Strong

This should not come as a surprise. Students identify ethics and morality as very personal. "I have my ethics. You have yours. We should respect that." Ethics is not grounded in principles, or in objective rules. This idea of relativism extends to the role of the physician and care team. Students want their physicians to be value neutral. They wanted the doctor to share medical knowledge and to provide the relevant treatment options, but they did not want the doctor to express personal preferences or offer opinions regarding the morality for any choice. This is the right of the patient. They saw that the role of the ethicist or ethics committee is not to establish boundaries or make recommendations, but merely to help to clarify values and negotiate a compromise.

4) Finally, Some Good News

Most students were unaware of the ERDs, but were pleasantly surprised by them. Starting from a position of autonomy and personal choice, some students acknowledged their initial bias against the church “dictating treatment.” However, after reading the document, they recognized the ways the church upholds human dignity and the many facets of a person’s identity. Some students began to see an alternative to relativism, and said they respected Catholic health care in naming their values and beliefs. More importantly, they respect the institution for adhering to those statements. One named this as “authenticity.”

further their own ethical training and reflection. We may even entice one or two to pursue formal ethics education. We all know the benefits that proper ethics education can have on health providers. So why not work together to tackle this very issue?

N.B.H.

My experience in the classroom may not be particularly encouraging, and it probably reflects societal attitudes. They are starting points, maybe even guideposts on our way to form future health providers. These observations provide a better understanding of our audience. As we consider who will replace us as ethicists, physicians and nurses, these observations provide Catholic ethicists with opportunities to engage with the upcoming leaders in health care. The students were very absorbed in the topic. Many even discussed joining in the health care ethics minor. Unfortunately, the current structure for educating future health leaders limits these conversations.

We at CHA and our members are in a position to provide opportunities for engagement with these students. You, our readers, may look at ways to bring local students into the conversation. Do you have an internship? Are you willing to host students for an afternoon or day? Could your ethics committee include positions for students? Do you network with local universities and medical education centers offering your expertise for talks, course design, and even instructing? By working with these students, we not only educate them, we give them the chance to