



# The Compleat Physician

With an innovative new course, “Patients, Doctors, and Communities,” the Albert Einstein College of Medicine has combined a wealth of material about communication, ethics, humanism, professionalism, population health, and prevention into the third-year clerkships—rounding out the skills needed for effective clinical practice in the 21<sup>st</sup> century.

More than a few patients have a story about a physician who is tactless, brusque, insensitive, uncommunicative, or just plain unprofessional. My own tale involves a prominent orthopedic surgeon in Manhattan whose office wouldn’t or couldn’t tell me when he might get around to reading my X-rays and MRIs. After two weeks and several fruitless phone calls, I followed up with a fax. No response. Then, in an end-run around his staff, I sent the surgeon an email. Finally, he called back, mainly to scold me for my impertinence and impatience, letting me know, rather bluntly, that he had sicker and more important patients to tend to. When we finally got around to discussing my case, it was clear that he had listened to little of what I had said during my exam. In effect, he had reduced me to a “shoulder injury” that possibly needed surgery and that would be squeezed into his busy O.R. schedule at his convenience.

Apparently, he skipped class the day they taught communication skills in medical school. More likely, his alma mater didn’t teach any formal classes related to humanism or professionalism in medicine back in the day. For generations, medical educators assumed that the skills of doctoring were simply too amorphous to be teachable, or that students would absorb these abilities through osmosis. Well, some did and some didn’t.

Today, humanism and professionalism is taught in medical schools all over the country. Yet, many would argue that educators are still doing too little to make practitioners more caring and communicative. They’re certainly not doing enough to counterbalance the pressures that chip away at these desirable traits, such as the bottom-line business mentality that permeates the health-care system and the prevailing house staff culture that effectively teaches fledgling physicians to reduce their workload and discharge patients as soon as possible, above all else.

“Professional behavior has diminished,” says Albert S. Kuperman, Ph.D., associate dean for educational affairs and witness to five decades of medical practice. “A lot of it has to do with communication skills. Communication encompasses and embraces many aspects of medical education—it is not just history taking, or finding out what is wrong and then expressing what needs to be done to fix it. It is dealing with the patient’s cultural, spiritual and religious beliefs, with the patient’s lifestyle and socioeconomic status, with quality of life issues, with the fact that the patient may already be practicing some form of alternative or complementary medicine. Many physicians ignore all

this. They just take the history, usually too fast, and then give their recommendations, usually too fast.”

Physicians tend to pay even less attention to health promotion and disease prevention, or to population health, Dr. Kuperman adds. “It’s a disgrace. You never even think about going to your physician for advice about health maintenance or nutrition, for example. These are important issues that need to be addressed in medical education.”

## THE EINSTEIN SOLUTION

Einstein was among the first medical schools to weave clinical content, including the skills of doctoring, into the pre-clinical half of the curriculum, beginning in the early 1970s. These innovations set the stage for Introduction to Clinical Medicine (ICM), a two-year-long program that features intensive training in communication skills, plus workshops on ethics, culture and spirituality, complementary and alternative medicine, violence, public health, and other topics. A mainstay of the preclinical years since 1988, ICM is taught in parallel with courses in the biomedical sciences, achieving a rough balance between the arts and the sciences of medicine.

Whether any of these early lessons in the healing arts are reinforced in the clinical years is left to chance, however. “It’s random,” admits Dr. Kuperman. “It depends on the clinical sites, the patients, the physicians, which differ from student to student. We hope that at the end of full clerkship year, they get it all. But they don’t get it all.”

As often as not, students leave these lessons in the classroom. “The clerkships are viewed as a different world,” says Dr. Kuperman, “In the third year, students are seeing

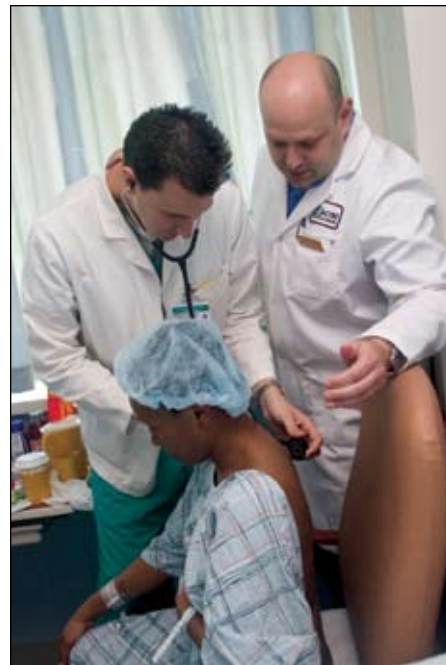
# Einstein was among the first medical schools to weave clinical content, including the skills of doctoring, into the pre-clinical half of the curriculum...

patients, thinking, 'Now, I'm doing *real* doctoring.' If anything, they should be enlarging and enriching the foundations of the doctor-patient relationship, not forgetting about them."

In 2004, at Dr. Kuperman's behest, the Division of Education established three new committees that were asked to enhance the teaching of communication, ethics, humanism, professionalism, population health, and prevention throughout the curriculum.

The committees concluded that "the material has to be taught in clinical context, that is, in the third and fourth years," says Paul Marantz, M.D., M.P.H., associate dean for clinical research education. In addition, committee members felt these teachings should be integrated across courses and disciplines, rather than bundled into one or two stand-alone courses.

"We then began to clamor for some time in the curriculum that we could 'own,'" says Dr. Marantz. "The reality is, if responsibility for teaching the material were left to the various clerkships, it was not going to hap-



pen, certainly not at the level we had envisioned. It could have created a major political battle. Much to my relief, it really didn't. The clerkship directors had to give up about every third Friday afternoon over the course of the year, a good chunk of time. I think people realized this was the right thing to do. Reform of this sort was talked about ten years ago but ran into a brick wall. So, times have changed."

After two years of deliberation, the curriculum reform team, guided by Drs. Marantz and Steven C. Martin, associate professor of medicine and of epidemiology and population health, unveiled "Patients, Doctors, and Communities," or PDC, a series of 20 Friday afternoon sessions stretching from the closing months of year two to the end of year three. During each session, students meet in small groups with a single faculty preceptor to discuss such topics as the use of medical

interpreters, end of life issues, medical errors, and promoting behavioral change in patients. Before class, students are asked to prepare by identifying a patient or clinical situation from their own clerkship experience that relates to the topic at hand. The sessions include a mix of personal and group reflection, didactic instruction, and skill practice, often ending with a reflective writing exercise.

To make the most of these sessions, the PDC team recruited 20 senior faculty from across the clinical spectrum, including generalists as well as subspecialists—a veritable who's who of the Einstein faculty.

PDC was launched in June of last year, starting with the Class of 2008.

## FOR AND AGAINST

"There are reasonable arguments against this change," admits Dr. Marantz, who was PDC course director for its first year. "First of all, we are an evidence-based culture, and we lack the evidence that the doctors we are turning out really are that bad. For all the complaining of patients that doctors don't listen, the literature suggests that patients malign doctors in general but like their own doctor. A lot of what is causing dissatisfaction among patients, one could argue, is more systemic than it is personal."

A stronger argument, in his view, is that the skills and attitudes that constitute the compleat doctor aren't teachable. "Can you create a *mensch*"—a good, caring, sensitive human being—"if the person isn't already one when they get to medical school?" Dr. Marantz asks. "This is what you learn from your mother. We can't fix this at the stage of medical school. It's a reasonable argument, but it is not a good enough argument for us not to try."

Turning this argument on its head, Dr. Marantz continues, "It has been humbling to realize that it is less about

making students better people and more about not making them worse. A driving force behind all this is the recognition of the toxic effects of the clinical teaching environment. We all know the ways in which our professional ideals were chipped away during our third year. We've all lived through the adversarial relationship between the doctor and patient that is a part of the house staff culture. The goal of a busy house officer is to get patients out as quickly as possible, reduce his or her workload as much as possible, and buff up the chart—which is resident-speak for 'cover your behind.'"

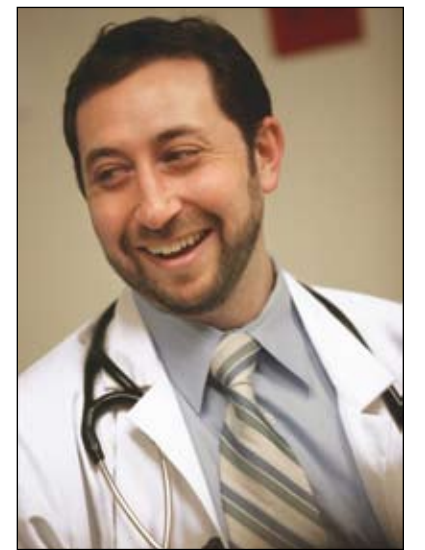
Regulators have cut down on marathon shifts for interns and residents in recent years, easing these pressures somewhat. "But you still have the same basic set of motivations," contends Dr. Marantz. "And you've added to the mix this rather unprofessional concept of the doctor watching the clock. In my day, if the patient was sick, you stayed until the patient wasn't sick. There is a very different professional inculcation going on if you say to that intern or resident that among your top priorities is leaving on time. And then they go out into practice, where making money is a major motivation. All these incentives are opposed to the basic concept of medical professionalism, which is that you have to put the patient first."

Still, there are skeptics who doubt the value of PDC and like-minded curriculum reforms. Dr. Marantz comes home to one every night. "I'm married to a doctor who thinks that trying to teach this stuff is ridiculous," he says. "She's a doctor in practice, I'm not. So, she doesn't want an egg-head like me to tell her, 'You weren't trained properly in terms of doctoring skills.' She says, and she is quite right,



"I know how to take care of patients. I don't need somebody to teach me how to be a warm and caring doctor.' She's learned a lot being a practitioner. You do grow in that role."

Finally, what will happen when these medical *mensch*s hit the real world of clinical practice, which provides little time (or reimbursement) for this ideal kind of doctoring? "They are still going out into a dysfunctional system," Dr. Marantz acknowledges. "That is part of our agenda, to teach about health-care systems and health policy, and to see if we can begin to train the doctors who are going to change the system for the better."



## COMPLAINTS AND PLAUDITS

As for students, the reaction to PDC is mixed. The last thing the Class of 2008 wanted to hear was that a whole new course was being added to the clerkship year, which, after internship, is probably the hardest 12 months in a physician's career.

Not surprisingly, the most common complaint is that PDC is too demanding. "We worked them too hard in the beginning," Dr. Marantz admits. "It was a mistake, and we've changed the assignments."

More than a few students have complained that the lessons have little value and occasionally cover old ground. "I'm puzzled that they are not as accepting," says Dr. Kuperman. "As students becomes more experienced, and see patients in the real world of the clinical environment, you would think they

would be more desirous than ever of enhancing and enriching their skills."

"There is nothing like a requirement to kill a good idea," he adds with a hearty laugh. "Seriously, the turnout for extracurricular enrichment activities, such as the student-run course on social medicine, is amazing. Unfortunately, you have to have some requirements. I think our students do understand that the entire curriculum cannot be elective, that you can't say, 'I'm interested in the kidney, but the hell with the heart.' I don't think you would want a doctor like that."

Mimi McEvoy, MA, CPNP, co-director of ICM and assistant professor of pediatrics, is not that surprised by the student feedback. "We are attempting to change the culture of medical education. As educators, we believe

(Continued on page 42)

