EDITORIALS

Vision and Persistence: Changing the Education of Physicians is Possible

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J Gen Intern Med 27(8):890–1

DOI: 10.1007/s11606-012-2078-5

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More than 40 years ago, Margaret (Maggie) Mahoney*, who was at that time a staff member at the Carnegie Corporation, had a series of meetings with distinguished professors of medicine, including John Beck of McGill, Julie Krevans of Johns Hopkins, James Wyngaarden of Duke, Austin Weinberger of Case, Hal Holman of Stanford, and Oliver Cope of Harvard. The purpose of these meetings was to address fundamental issues regarding the training of the future physician leaders of the United States. In the early 1960s, the emphasis on basic science training for physicians was entering a period of heightened intensity. The future of medicine was seen as tied directly to success in the wet laboratory. However, at the same time these stalwarts of American medicine and a young program officer at the Carnegie Corporation were discussing the need to produce a different kind of physician leader. These leaders would be trained in an emerging set of skills, including health policy analysis and health services research. These leaders entertained concepts that clearly were not part of wet bench medicine—for example, perhaps the purpose of treating patients should be to improve their functional status or health status, and thus physicians needed to be leaders in measuring health status and function. Perhaps measuring and improving quality of care was important. Perhaps one should explore and develop a host of new statistical and epidemiologic techniques to assess how they might be used in clinical medicine.^{1,2,3}

The truly revolutionary aspect of these meetings was the desire to integrate population health and personal health. Before the meetings occurred, a physician interested in improving the health of a population or understanding something about how culture affected patient care and how that, in turn, affected health would normally depart for a school of public health after completing clinical training.⁴ At places like Hopkins, the street that separated the School of Public Health from the School of Medicine was as broad

as the DMZ separating North and South Korea. Everything one learned in clinical medicine, as well as the symbolic white coat and the stethoscope, was simply not acceptable in the School of Public Health.

These leaders had a different vision. They believed that physicians could work in both clinical medicine and population health. To make this vision a reality meant defining a new field. Margaret Mahoney convinced the Carnegie Corporation and the Commonwealth Foundation to fund what would become the Clinical Scholars Program, thereby changing the face of medicine forever. She subsequently moved with the program to the Robert Wood Johnson Foundation, where she was the visionary who persuaded the foundation and each of its presidents to sustain funding of the Robert Wood Johnson Clinical Scholars Program. It may be the longest ongoing training program ever funded by a foundation.

The Foundation's support has continued without interruptions to this day, and the more than 1200 physicians who have gone through the Clinical Scholars Program have become the leaders of American medicine. They have held positions in government ranging from Surgeon General to Assistant Secretary. Some head state health departments or lead organizations such as the Joint Commission on Accreditation of Healthcare Organizations. Many are in academic departments including deans of both schools of medicine and schools of public health. The scope of their presence and influence cannot be overestimated. Indeed, it is hard to imagine modern American medicine without the leaders produced by the Clinical Scholars Program.

Due to the efforts of this new kind of physician, fields were redefined and new fields, such as measuring health status and quality of care and understanding how healthcare policies affect patient outcomes, were opened up. But the vision also included having these physicians remain active clinicians, and graduates of these programs, who assumed jobs ranging from foundation presidents to assistant secretaries in HHS, still manage to provide patient care in free clinics or make hospital rounds. In essence, Maggie Mahoney and the leaders with whom she met and who shared her vision, changed the culture of medicine. The walls between schools of public health and medical schools were torn down. Population health and the delivery of clinical services were no longer incompatible. Methodologies

used in the social science became methodologies used in the clinical sciences. These new physician leaders who became accepted in both camps actually helped to merge the camps into one vision of health and health care for all.

But changing physician education requires more than a vision. For many of the past 40 years, Annie Lee Shuster, a program officer at The Robert Wood Johnson Foundation, used every skill in her armamentarium to convince the RWJ Foundation—its staff, its board, and its presidents as well as leaders of the Veterans Administration—to maintain the vitality of the Clinical Scholars Program. As a consequence, over those decades an extraordinarily diverse group of people has continued to allocate both financial and intellectual support for the Program. The results of this happy marriage of vision and persistence are many of the physician leaders of American medicine today.

Is there now an equally important change in physician education that needs to occur? The Internet and smart-phones have changed the way we purchase consumer goods; crowd sourcing has changed the way ideas are vetted; and people organize to improve our products and services and even bring down governments. Social media has changed the way we find mates, choose hotels, and decide whether to try that new, pricy, restaurant. Communication has become 24/7. However, to a large degree, medicine both does not take advantage of and has not kept up with this instant feedback, always connected world. Medical education still focuses on what a physician does in face-to-face contact with the patient. Office visits and hospital rounds still dominate the culture of American medicine. Indeed, physicians still ask if it is acceptable for patients to contact their physician by e-mail, if a physician who is covering for another physician should provide the same quality of care for patients who are not hers as she does for her own, or whether physicians have any responsibility for following up on patients after they are out of sight—e.g., after they have been discharged from a hospital or been seen in the outpatient setting.

Perhaps it is time to ask a different set of questions. Should main-stream medical care be expanded beyond bankers' hours, following the basic pattern of retail stores and internet sites? Should patients play a more prominent role in managing their health? For example, instead of requiring patients to ask for their x-ray or lab results, perhaps they should be responsible for maintaining these records, producing them as needed for care. Should patients have more control of their health care? For example, why can't they get their blood pressure checked by using a machine in any drug store and then refill their prescription without contacting any doctor? Should patients be able to have blood drawn and have the results sent directly to them so that they can monitor their own illness? In short, how do we transform the vision of medicine from one in which physicians control

the process, regulations dominate the playing field, and care is delivered at the convenience of health professionals to one in which patients are truly at the center?

Many small companies and physician entrepreneurs are tinkering with or investing seriously in producing a paradigm shift in the way care is delivered. In the new paradigm, the patient, not the physician, would be at the center of the universe. That shift would have enormous consequences, system-wide. For example, if the patient, not the doctor, were at the center of the universe, patients would not leave the hospital without an electronic copy of their records and all test results, written or printed in a manner they could understand and use to ensure that continuity of care became a reality. No patient who was discharged from the hospital and urgently needed physical therapy would need to wait days or weeks, watching themselves deteriorate, if they could arrange therapy immediately without waiting for somebody in authority to approve it.

The doctor of the future will need to partner with the patient in facilitating care and maintaining health. In this new world, a visit to a physician might be seen as a failure just as Internet providers believe that a visit to a store is a failure.⁵ Perhaps in 20 years, seeing a physician will represent a failure rather than a revenue-generating event. Wouldn't it be nice if the education of physicians were guided not by how many hours need to be spent in the hospital or in outpatient care, but rather by what physicians need to do to reduce dramatically these activities by helping people improve and maintain health?

The need to prepare doctors for this paradigm shift is urgent. Forty years ago, nobody thought the Clinical Scholars Program would succeed; paradigms, as Maggie Mahoney demonstrated, can be changed.

* Maggie Mahoney died on December 22, 2011.

Financial Disclosures: None reported.

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