Opening Medical Education

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Time is said to season and mature. Yet, we are all victims of the limits of our own personal experiences. One can perhaps lessen these restrictions by wide-ranging reading and travel and by deliberately changing the nature of his experience and responsibility. However, the effective man finally defines the things he believes in and therefore his experience becomes his belief, and belief becomes his bias. In spite of the broadest of experience, of reading, of travel, an effective man is usually a biased man.

I agree at once therefore that these remarks have all the flaws of personal opinion and another man could have the same experience and find other answers.

A persistent involvement in medical organization, administration, practice, and teaching has left me convinced that changes in medical education and in the delivery of health care are happening because they are needed and not because of malignant or mischievous Federalism, or socialism, or unionism, or racism. Changes are needed.

Robert Marston, Director of the National Institutes of Health, gave the Shattuck Lecture in Boston in May 1968 and his words were, "Health and medical care are hot topics—not the cool subjects for reflection that we have known them to be. They are political topics. They are stage front, under the bright lights of national attention. This is a strange and unaccustomed and, in some ways, unfortunate place for a group of physicians . . . like us to find ourselves, but that is where we are."

We physicians must be involved. We will participate and lead, or not participate and be led.

I have convinced myself (my bias) that one effective means of improving the delivery of health services and at the same time, improving the educational experience of the premedical student, the physician, other health professionals, and of the public, is by an "opening up" of medical education.

Part of this belief has become reality through the Federal act, the Regional Medical Programs. An "open medical school" means more to me how-ever in what could be done by a coalition of a community's physicians and the regional medical school, working together to meet the community's total health needs, white, black, poor, rich, public, private, medical school, community hospital, general hospital.

To begin such an analysis, one does well to measure the role of medicine against the full life and times of our country. Medicine is important, but only as it relates to the total complications of a society which is dangerously shaken, and in which an element of near revolt is reality.

From whatever role one plays in our society, he cannot stand aside and ignore this present great engagement. A suburb cannot declare an "only white" policy, hotels cannot declare "only gentiles," the government cannot declare "no civil demonstrations," the university cannot declare "no communist speakers," the politician cannot ignore the anti-Vietnam voices and label them "unpatriotic," the parent cannot control the youth by "threat," the church cannot control the missing parish by the promise of "eternal hell," and the father cannot deny his daughter the company of a man of another color. We are all, in all of our public roles and in our private lives, participating in finding a new level of equality of man.

Much of this revolution has to do with food, housing, jobs, but even more it has to do with the nonmaterials sounded in the tingling quality of that sentence which justified the existence of a nation, "All men are created equal . . ."

All Men are Created Equal,
In Sickness or in Health?

Now, circumstances force our profession to become involved in these changes of contemporary life. In agreeing that "equality of man" is not a slogan but a guarantee of a basic right, and that in addition to food, warmth, and comfort a man deserves health, society has taken over the decision for us. We physicians and our organizations may insist upon the free enterprise nature of medicine, but instead we are advised that we are a service, and that money, color, or location will not determine the availability of care. Elected

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officials have interpreted this to be the will of the people, and legislation has provided methods of doing this, hopefully with the involvement of organized medicine. Medical school administrators, desperate for funds, already dependent upon federal research support, see new possibilities of support through "medical delivery" funding. The improbability of providing equal care to all and the improbability of finding sufficient primary physicians, make many of us shake our heads in rueful distrust. Many of us know that the promised land may not be reached, but an increasing number of us knows that the effort is going to be made and we are going to try to be useful in solving the issues between the "pie in the sky" group, on the one hand, and the advocates of "the good old days," on the other.

**Primary Physicians and Comprehensive Plans**

These actions involving the social system of medicine have occurred parallel to another significant movement within our profession. I am referring to the sharpened awareness of the importance of the final basic unit of any system of medicine, that is, the ultimate man who makes the face to face contact with the patient — the personal physician.

Large concepts involving masses of people and comprehensive care are evolving in this country. But no matter how large or how elegant or how mechanistic, there remains a final point when the patient and the physician close off the outside world and have a private physician-private patient relationship. One of the major reasons that the American physician and his organizations have long resisted outside interference with the practice of medicine has been their underlying basic understanding that the individual and the public welfare are best served by this final personal physician, primary physician role.

Medical faculties have, not all but in a majority sense, denied this need for primary physicians and have almost denied the full social significance of a medical school.

A school of language, of music, of science can have (but may not have, of course) a neutral existence within the community, yet still be a satisfactory member of both community and college. A medical school may also aim for the neutral role by confining its activities to medical student education and to its own internal hospital functions and research programs. However, the nature of a medical school makes possible for it to have a different relationship to its community than any other school within the university. If careful effort and thought are devoted to the premedical years, to the intern and resident program of the regional hospitals, to the auxiliary health personnel, and beyond this, to the continuing education of the physicians in private practice, the school could serve as a catalyst — bringing life to a regional medical concept, with values beyond the numerical addition of a medical school to the community.

The walls of a medical school need not exist in a restrictive sense. Encouraging capable practicing physicians to be teachers, fostering education programs within community hospitals, and participating in and contributing leadership (but not implied dominance) to comprehensive health programs are natural extensions of a medical school's influence. The organizational stimulus for such work could best come from the medical school, and perhaps here is an instrument which could break down apparent barriers between private practice, on the one hand, and medical education, on the other. In a similar manner, the medical school could extend its responsibility backward and have concern for the premedical education years.

**The Return of Proprietary Medicine?**

Although a different kind of proprietary medical school was the proper target of the Flexner Report and although medical schools became associated with universities and acquired "full-time" staffs subsequent to that report, the circle has now almost completed itself, and once again medical schools appear to be (in certain respects) in danger of being "proprietary." The word is used here in the sense that, although the medical school is now university-based and the staff indeed has become "full-time," in many schools this has meant the exclusion of the private practitioner, thus the full-time staff has become proprietary of the right to teach.

The influence of the basic scientist upon the curriculum appears to have increased in this era of munificent grants. The university clinician, aware of the source of grant money, is more often in the laboratory than on the ward. The end result of this proprietary circle suggests that the medical student has a decreased exposure to the teaching of clinical medicine (which, in theory, is the major reason medical schools are operated). On the one hand, the clinicians of the community are often excluded, and, on the other hand, the clinicians of the medical school faculty exclude themselves as teachers. Laboratory research is an essential and proper university function and stimu-
lates both faculty and student. However, it seems to be almost unpopular to suggest that research is not necessarily teaching.

Should not a medical school broaden its responsibility to include the region it serves? Should we separate the educational and research duties at the medical school from the community and regional needs? Has the increasing growth of full-time staffs isolated the student body from the clinician-teacher of the community? Has research displaced teaching?

The social scene, both medical and public, changes. The assumption that the medical students and medical education exist in a separated period of time and are the responsibility of one specific group, and that the care of the sick is the responsibility of a different group may well be interfering with the health welfare of the public. Proprietary medicine, overly possessive of the right to teach or the right to treat, perhaps is recurring in a new guise.

My criticism is of the structure of the practice of medicine which interferes with the concept that a physician is a scholar and teacher. The arbitrary cut-off which stops him from continuing throughout his lifetime to be all three — physician, scholar, teacher — serves to lessen the man, his ability, and his role in our society. Could not the criticisms of the modern physician, a recurrent theme of our press, to a great extent be neutralized if organized medicine did not put forth arguments in the economic area, or in defense of “free enterprise,” but instead presented to the public a massive demonstration that medicine was adapting its social structure to the changed needs of society? Leadership for this must come from coordination of professional societies and medical schools. It could not happen without the cooperation of the regional physician organizations, regional hospitals, and regional undergraduate universities.

Effective coordination of students, house staff, and practitioners could bring adequate care programs to those areas now labeled depressed, or ghetto, or isolated. The physicians of a community will either provide care for all citizens of the area or some outside agency will. Coordination does not mean that the medical school becomes a dominant partner and defines the local rules. Broad local committee structure with appropriate civic representation could coordinate physical facility construction, specialized diagnostic and therapeutic centers, and the use of public money for health care. Community hospitals, medical schools, public health organizations, and physicians would all participate in planning and implementation. Leadership for the use of Federal funds must come from the region and from the men who practice; there must be regional leadership and physician leadership. Again, one says lead or be led.

Physician Self-Renewal

If one is to speak of “opening” medical education and thereby involving the majority of physicians in personal medical teaching, it is apparent that major new efforts must be made to augment the educational opportunities of the physicians themselves. Sabbatical leaves from practice must be available and this will require regional plans for coverage of a practice, sources of sabbatical leave income, and designated postgraduate medical centers with special “self-renewal” educational programs for the practicing physician. The already planned National Biomedical Communication Network, utilizing satellite transmitted television, plus computer-stored information will be a major educational and clinical aid to the physician.

Although the man in private practice enthusiastically has participated in the postwar expansion of postgraduate courses, these episodic, short-term courses do not accomplish the advantages of a long-term exemption from the burdens of private practice. Although the confinement of private practice partially could be overcome by the regional teaching role described, a periodic, lengthy sabbatical leave may be necessary to allow the physician to maintain his standards of knowledge and his feeling of self-confidence (especially important as he takes a major role in teaching), and to provide a necessary pause for contemplation. The harassed life of successful private practice can become almost a prison. No other profession offers as many hours of service, requires so many hours of study, and demands so much giving of self. A sabbatical leave, available regularly throughout the man’s active career, could answer his needs and serve further to keep the physician, the student, and the school within the continuum.

The Disadvantages

Who or what could suffer from such an extended medical education program? First, it is certainly not the patient. The extension of authentic premedical, medical student, and house officer programs into the community hospitals and health centers should only benefit the patient.

Research in methods of delivering medical care, in techniques of teaching the layman about health, in evaluation of performance are all neglected fields for investigation and are natural areas for community research.

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OPENING MEDICAL EDUCATION

Would the physician suffer? There is already general agreement that the formal medical school years can offer but a framework for a physician's education. The phrase "not four years but 40" dramatized this, and the increasing acceptance of responsibility by the medical schools for programs of continuing education has resulted in a wealth of short-term, once-over-lightly refresher courses. This sense of responsibility came to some schools early, while the faculties of others have rejected this role, with pleadings of "too busy" and criticisms of "too commercial" and "a poor means of teaching." However, the enthusiasm of the man in practice and his willingness to leave his practice and return to the campus, paying out money and losing income, has made apparent that the consumer considered this an effective means of learning, even when the faculty was critical of this technique as teaching.

In addition to the willingness of physicians to be students, there is among them a latent, immense reservoir of teaching ability and administrative capacity. Such administrative and teaching capacity could be given its full head, within the continuum that is medical education. The energies, drive, ambition, and desire for identity which are within most physicians find other means of expression. Why not let these energies creatively be used to the advantage of the whole?

THE SUMMING UP

As an organized portion of society, medicine is justified in presenting its concepts and reasons for certain beliefs relative to what is in the public good. To do this effectively, it must, however, be certain that its organizational structure is not interfering with its own potential.

The medical school could add to its accepted administrative functions broad means of aiding community hospitals and health centers in the establishment of adequate educational programs. This could be done in numerous ways, and that which is effective and possible in one setting may be unworkable in another. Major experiments in health services are needed: automated laboratories, comprehensive health centers, prepayment insurance programs, variations of group practice, the role of professional aides, community resources planning, increased enrollment of Afro-American, Oriental-American, Spanish-American, and American Indian students. Such research is just as legitimate and as needed as the classic and honored laboratory research. Such research is human, not test tube; it requires involvement of the medical school in the community, not in a meddling sense and not restricted to the back benches of welfare and dole. The community's physicians, the civic leaders and the medical school must recognize the phenomenal demands for health care, the accelerated cost of care, the short supply of health professionals, the polluted environment, are all facts which make it certain that medicine is a primary political, social, and economic issue in this country. Let us declare ourselves in and let us recognize that change is upon us.

The two great areas of medical talent, private practice and medical school, must come together and work together.

"Health" consumes a very large fraction of this country's budget. Perhaps $50,000,000,000 is spent this year in the health field. However, there is a limit to the amount of money, to the numbers of professionals, to the quantity of research, to the number of beds, to the number of renal dialysis patients, to the number of transplants, etc., that even this rich nation can afford. Even as benevolent a consideration as "good health for all" has realistic limits. This is a hard truth for an American to accept. We are activists and have considered any problem as but a challenge with a solution. In our enthusiasm we sometimes suggest that with enough money and enough research, disease will be eliminated and the unspoken implication is that death will be eliminated in that golden future realm.

When I speak of opening medical education, I speak also of the laymen. I, in part, am suggesting that one of the major ways to improve the effective use of health dollars and manpower is to educate the public as to the reality of disease versus normal psychosomatic responses to the daily stress of living. One major way to decrease the demand on the physicians is to educate the healthy public away from hypochondrias. Equally, both the public and the profession need to learn the limits and value of preventive "check-ups." I don't deny the important role of certain periodic examinations; however, one wonders how many man hours of expert physician time are now consumed by totally healthy people who simply have sufficient money to buy a doctor's time?

We physicians must educate ourselves as to specific things only we can do... and enthusiastically delegate those roles that don't need our particular skills.

From a completely different perspective, do we not need to educate ourselves as to the inherent power of our profession? I refer of course to our privileged role of access to all levels of society, of the largest significance of being the "healer" in a
sickened society. In every community, can not this special profession, with all of its awareness of the gamut of human emotions, with the unusual knowledge of the inner fears and hopes of our fellow men which is the physician’s privilege, can we not do more? In this paper I have spoken of an “opening” of medical education and have dwelled at length on the classic concepts of medical education and the need to involve all physicians. However, in these final remarks, I have suggested that there are much larger, much deeper, more provocative areas in which the public and ourselves must admit we are uneducated or miseducated.

I do not suggest that we can, with my comments or with any other, enter a great new bright arena. However, there is an excitement all about us which is making us participants in questions of ethics, of right and wrong, of justness, and of equality of man.

Do we lead, or are we led?

REFERENCES

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From the Speeches and Writings of George C. Griffith

Categories of Education

Education in all of its categories—medical school, graduate school, internship, residency, and postgraduate training, and on every level, is in a state of unrest—of fomentation—even, of revolution. The reasons are ethereal. Undoubtedly, most of the upheaval stems from the breath-taking explosion of knowledge which envelops us in logarithmic progression.

Medicine is enmeshed in this excitement. There is dissatisfaction with medical school curriculum—unhappiness about its length as well as its content. Administrators of medical schools are attempting to shorten college medical curriculum from eight years to five. By attending college and medical school for four quarters of each year, the student can receive a baccalaureate degree in two and one-quarter years after graduating from high school; and a degree of Doctor of Medicine two and three-quarter years later. Thus, both degrees are earned in five years instead of the customary eight. All of this would be accomplished through concentrated effort, and the elimination of duplication in courses.

The mere possession of a Doctor of Medicine degree is not a license to practice. It is a beginning. Minimum graduate training consists of from one to five years of intensive training before the American physician is ready to attend the sick, to prescribe treatment, or, literally, to hold the fate of a patient in his hands. Graduate training is not to be taken lightly. It is almost the equivalent of medical school training, and undoubtedly it is more important, for it translates basic education—facts or theories—into the practice of medicine.


A Constricted Heart

While I was in medical school, teachings about the heart stated, “never touch the heart or it will stop and the patient will die.” In 1869, Lower, of England, wrote that dropsy may result from venous obstruction; by 1842, Chevers, of France, was well aware of the constrictive effects of pericarditis; and, in 1898, Delorme, also of France, suggested the surgical removal of the pericardium. But it remained for our own Paul Dudley White to suggest that a Miss C. S. O., age 18, would be benefited by the removal of a constricting pericardium. In 1931 it was my good fortune to observe and assist in the treatment of this young lady, utilizing all of the methods then available to relieve the pleural effusion, the ascites, and the edema of the legs. Having just recently returned from training in thoracic surgery, Edward Churchill successfully removed the pericardium over the anterior surface of the heart.

This young lady made a full and complete recovery with astonishing speed. Now, may I skip to 1968 and tell you that on Wednesday, April 3 of this year, Dr. White presented her and two of her children at the annual meeting of the American College of Physicians.

In the year following the case of Miss C. S. O., Mr. J. K. walked into my clinic in Philadelphia. Miss Stratton, my secretary then and now, rushed in to exclaim, “J. K. has a constrictive pericarditis . . . I know because the veins flap as you described them in Catherine.” He did, in fact. James was completely cured by successful surgery performed by William Bates; he has lived to become a veteran of World War II, is the father of six children, and a farmer in Pennsylvania.

—Griffith, George C.: (from a speech before the Los Angeles County Heart Association, May 9, 1968).