

Values in Health Care and Health Professions Education¹

T. W. Langfitt
*Chairman and Chief Executive Officer
The Glenmede Corporation*

The forces that have rocked the American health care system to its foundations in recent years have been building for a long time. The purpose of my comments today is to attempt to describe the origin of those forces and to suggest their meaning for a future health system, and for medical education. I will trace briefly the history of two movements and argue that they are converging to shape people's views of their personal health and what is needed to preserve it.

The first movement began about one hundred years ago with the professionalization of medicine around a model of scientific inquiry. Physicians gained new knowledge through scientific research that in turn was translated into diagnosis and therapy that steadily improved patient care. Over time, however, the physician and the patient grew apart. Physicians' knowledge in scientific medicine increased exponentially, accompanied by an armamentarium of technologically advanced machines and an increasingly arcane professional language. In recent times, physicians' orders have driven more than three-quarters of all health care costs, now more than one trillion dollars each year. Physicians determined what diagnostic tests were performed, when patients were admitted to the hospital, how long they stayed, and what was done for them. They prescribed pharmaceuticals and nearly all other health services. They set the fees for their services and the purchasers of those services paid the prices, mostly without comment. Physicians were in control.

Academic health centers emerged after World War II. Most of them began as a medical school and teaching hospital, then expanded over the decades to include additional hospitals, research institutes, and other health schools, creating gigantic, multi-purpose enterprises. In

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the largest and arguably most successful academic health centers, teaching, the time-honored primary mission of the medical school, receded into the background as research and patient care burgeoned. The academic health center became big business.

During this same time physicians, the schools that educated them, and the hospitals in which they did most of their work turned inward. Research and the practice of the medical and surgical specialties that were built upon the translation of research into patient care, created complex enterprises that became institutions unto themselves, increasingly removed from the patients and the communities in which they lived. Specialties divided into sub-specialties that performed wonders in the management of serious diseases but became increasingly isolated in their own worlds. In the process, the clinical departments distanced themselves from the parent institutions. Allegiance to one's specialty became more important than allegiance to one's medical school and university. Stature was measured more by success in professional societies and by lists of publications than by contributions to the institution. The attention of faculties was diverted from teaching to research and patient care. As long as medical care was almost entirely disease-oriented, diagnosis and treatment based on the biomedical science model were not only appropriate, they were (and continue to be) spectacularly successful.

But the education and training of physicians and the practice of medicine are now viewed by much of the public and policymakers to be out of step with the overall health needs of the people, because the public's perception of good health, and how to achieve and maintain it, has changed dramatically. In contrast, the physician workforce charged with serving those needs has changed very little. In other words, on the whole, the public holds a set of values about health care that has changed substantially, in large part because of the education of the public in preventive health, and, on the whole, physicians pursue the same values that created the scientific revolution in medicine.

Public values have changed because the people are better informed. Not only do they learn from the media, they are continually reminded by their personal lives and the experiences of their friends and families that a healthy intellectual and physical lifestyle can help save them from the ravages of smoking, substance abuse, poor diet, lack of exercise, and intellectual indolence. They are not surprised to learn that the care of individuals for their personal health has probably done as much to reduce the nation's burden from heart disease, cancer, and stroke as have the powers of curative medicine. Consequently, they have begun to distance themselves from scientific medicine. Part of this

movement is due to an understanding of health promotion and disease prevention that bypasses most traditional scientific medicine, and part of it can be attributed to a general skepticism about the power of science to understand the complexities of the human condition in the modern world. It is said that today there are more practitioners of alternative or non-traditional medicine in the country than there are primary care physicians.

This leads to examination of a second historical movement that at first glance might appear to have little relevance to understanding the future of the American health care system in general and the academic health center in particular. In fact, I will argue that the two movements are converging, and if the implications of that convergence can be fully realized, it will influence both the future health care system and the educational mission of the academic health center.

The power of pure reason conjoined with the scientific method emerged from the Enlightenment that commenced in the seventeenth century, and inspired modernity. The architects of the Enlightenment believed that the world was neither random nor guided by divine providence. It is rational and knowable, they said; through science mankind would not only come to know the physical world, but would develop the powers to shape it. Down through the centuries the genius of Darwin, Einstein, and Freud, among many, gave truth to the Enlightenment philosophy, and science and reason triumphed—or so it seemed.

A long time ago Hegel said that the Enlightenment had betrayed mankind. What did he mean? For our purposes, I believe he meant that science and pure reason were making promises they could not keep. The leaders of the Enlightenment were unbridled optimists. They believed the world was perfectible, that a utopia was realizable, because human beliefs and human behavior were ultimately knowable in scientific terms. With knowledge gained through scientific inquiry humankind would be shaped toward that perfect society.

The events of the twentieth century deeply undermined, if they did not totally destroy, this optimistic view of an ultimately satisfactory world order. They were two devastating world wars, the Holocaust, the threat of nuclear annihilation, the blow to American esteem of a morally indefensible war that failed, the revolution in social mores, and now, at the end of the century, a deep sense of rootlessness and anxiety about the future. On average, people in America have far more physical comforts, and they are much better educated and informed, than their forebears at the beginning of the century. But these averages hide large and growing disparities across economic, racial, and ethnic divides. One of the most disturbing societal trends is a steady decline in social

associations and social trust. People do not trust each other and their institutions as they used to do. Robert Putnam, in a book entitled *Bowling Alone*, has documented decreases in social memberships of all kinds, from bowling leagues, to Rotary and Lions Clubs, to Parent-Teacher Associations. Along with redefinition of the family, and a general loosening of family ties, individualism is replacing the communitarianism that was such a distinguishing feature of this nation in its formative years. Unbridled individualism and the growing political power of special interest groups now confound the democratic process.

What does all of this have to do with the future of the health care system and the academic health center within it? Why do I contend that interaction of these powerful societal forces is likely to shape the health care system and deeply influence the mission of the academic health centers in the future? There are two answers, I believe, and they follow in sequence.

Citizens of the future will be much better educated in matters that interest them. The large majority of them are interested in their personal health and the health of their families. Health information will be available to them at their fingertips and in understandable formats. Consequently, they will want to develop relationships with their physicians that are based on mutual understanding and respect, and they will also expect high-quality contemporary medical care. They will become adversarial if they believe they are not being understood and their needs are not being met. They will trust physicians and the health care system even less than they do now. For the present, physicians have lost their dominant position within the health care system to the economic forces of managed care. But they will regain control of the system from managed-care organizations, and justly so, if they understand how to relate to the individual needs of their patients. The fundamental relationship within health care is, and likely will be for as far as we can see into the future, that intensely personal interaction between the doctor and the patient.

I believe the implications of this line of reasoning for the education of physicians are substantial. It appears that most young people arrive at medical school with a strong desire to learn the practice of medicine so they can minister to patients to improve their health and well-being. The students also know that, at least until now, it has been a secure profession that pays well, and that is a significant attraction for most of them. Their altruistic motives have not been well served by medical education. In the early years they spend most of their time in the basic sciences, where the professors commonly teach them what they want to teach them, not necessarily what they need to know as a

foundation for the practice of contemporary medicine. In their clinical years, they rotate through specialty and sub-specialty services, mostly on the floors of tertiary-care hospitals where they experience crisis-oriented, disease-related, organ-specific, episodic medicine. They have many elective opportunities, which they take mainly in the sub-specialties, including several rotations in their specialty of interest in other departments across the country. The purpose is to improve their chances of winning a position in a residency training program of their choice.

A large majority of these young people who enter medical school with an unformed vision of the practice of medicine as a worthwhile societal good end up in the practice of a specialty, with their interests focused on how they can benefit patients through the medium of their powerful but highly concentrated skills. If their skills and the patients' needs don't match, their interest in the patients and their problems is limited. Until recent times, many patients have had few places to turn for an understanding of their whole needs. Leaders in many medical schools now recognize the limitations of the traditional educational model, and are modifying it in the directions required better to meet the needs of the public. A few medical schools are in the process of radically transforming their curricula in the appropriate directions.

For generations the academic leadership of the nation's medical schools, and their admissions committees, have struggled to define the personal attributes and the skills that are most desirable for the practice of medicine. Some schools have been dedicated to the education of future academic leaders. Consequently, their criteria for admission have been different from those of schools whose primary mission is the education of practitioners. In both kinds of schools the contest between selection based on pure intelligence and commitment to the scientific model, and selection based on the human qualities that we want so much to identify with a practicing physician, has caused that profile of the ideal medical student to vacillate across a rather wide spectrum. One of the harbingers of the coming age has been a general movement toward a more "humanistic" profile of the ideal medical student.

Now comes recognition of the new settings in which physicians will function. Most of them will practice in HMOs and other types of managed-care arrangements where they will be accountable for understanding both the costs and the benefits of the ministrations to their patients. They will be required to know the fundamentals of health promotion and health economics, sound business practice, and organizational development in addition to a set of competencies built on scientific medicine, and they will need to possess the personal qualities

and skills that will allow them to relate effectively to increasingly intelligent and demanding patients. What a tall order to fill!

I believe academic health centers have two main options to respond to the growing gap between contemporary medical education and training and the health needs of the public. The first option is for a school to persist in its current mission in the belief that the biomedical sciences and medical specialization will continue to be the most important driving forces in the practice of medicine; that people will learn to manage their own preventive health strategies and will turn to traditional medicine when they are sick; or that physicians will treat serious diseases, and nurses, physician assistants, pharmacists, public health professionals, and practitioners of alternative medicine will serve most of the primary health needs of the public. An academic health center taking this position, and it likely will be an institution with a long commitment to research and specialty medicine, may change its curriculum only at the margins. The question it must address is whether it or any academic health center can take the risk of flying in the face of the changing demands both of prospective students and of the consumers of health care.

I predict that the large majority of medical schools will not take that risk, and not only because they do not want to court failure. They will come to believe that their best course is a balance between teaching students contemporary scientific medicine—an objective that must never be compromised, but must be achieved in new ways—and at the same time bringing into the curriculum many new topics that are integrated into new curricular tracks that prepare the students to practice patient-sensitive medicine in settings constrained by economic forces. This new set of objectives cannot be accomplished by tinkering around the edges of the present curriculum. It requires re-creation of the curriculum, and that, in turn, requires enthusiastic participation by the large majority of the faculty. In the process, medical education will be re-energized. The current model is worn out from decades of use. The faculty should now gather around a new conception of the role of the physician in society, and work together to teach students to approach that new goal. If all of this is pursued by medical schools and their parent academic health centers—and I wish to emphasize that much of what I have described is applicable to the other health profession schools—all health professionals will be able to relate more effectively to patients whose view of themselves and their world has been transformed in the latter part of the twentieth century.

There is one more risk of great importance. The medical profession may take on more than it can manage. It may make promises it

cannot keep. In years past, leaders of American medicine warned against what they called “the medicalization of social problems.” They defined the role of medicine in society to be the diagnosis and treatment of physical and mental diseases. They believed that the medical profession was not equipped to deal with social issues that lay beyond the boundaries of the biomedical model. They argued that any such movement would distract the research and clinical enterprises from their primary mission, which was challenge enough.

I believe that was wise counsel for the time. One can argue that devotion to this mission accounts for the extraordinary success of modern medicine, a success that might have been compromised if medicine had taken on a broader mission. The question for us now is whether changes in societal expectations, and the shift toward a model of good health interleaved with the biomedical model of disease, allows medicine another choice. This is a debate that has not truly begun, because medicine has not yet made that choice. Nor, I should say, is it clear who will supply the resources for an expanded mission.