Master Clinician Faces Potential Extinction

Fear that the master clinician is disappearing in the United States is expressed in a commentary by Geoffrey McLennan, M.B.B.S., Ph.D., a University of Iowa, College of Medicine pulmonology professor. A list of the qualities of the master clinician is provided that includes being:

- Personable, adaptable, perceptive, and analytical.
- Creative, ethical, and intuitive.
- Informed and able to integrate complex information.
- Empathetic, caring, holistic, and with good communication and clinical skills.

There is concern about the master clinician losing clinical history and examination skills and increasingly relying on technology. In addition, there is concern about the growth in the number of students and the reduced length of the hospital stay making it more difficult for students and residents to have adequate patient exposure. It is suggested that the plea for the master clinician is not to preserve the past. Rather that the array of clinical and other skills that define the master clinician serve as a strong foundation upon which alternative strategies such as technology are used.

(McLennan G. "Is the master clinician dead?" Academic Medicine. 2001; 76: 617-619.)

Allopathic Medical School Central Application System Crashes

A new online application system created by the Association of American Medical Colleges (AAMC) designed to allow students to apply to medical schools has developed major glitches. Scheduled to begin June 1 when applications to allopathic medical schools typically are able to be submitted, the process was delayed to June 21 because of inadequate servers, software problems, and a power failure at the system headquarters in Washington. Even after the delay there were long waiting times, crashes, and software difficulties.

As a result, the Association of Medical College Application Service (AMCAS) has received about half as many applicants as it did last year at this time when disks and paper applications were being used. One of the medical schools using the system, Yale University, reported delays that resulted in the need of 8-10 minutes to download a single screen.

Reports from applicants indicated that it took up to 80 hours to fill in the online application during its first 10 days of operation. AMCAS has no backup ready if the system fails, reported Robert L. Beran, vice president for student affairs and education services for the AAMC. If the system is not functioning by the end of July, it will have to shift to paper, he added.

(McGrane S. "Glitches stymie medical school applicants." N.Y. Times. 2000; July 5: D3.)
Financial Distress of Teaching Hospitals

There have not been so many university teaching hospitals in financial distress since the Great Depression. The University of Pennsylvania, as a result of losing $300 million in two years, is discussing the sale of its teaching hospital and clinics to a for-profit chain. Both Tulane and George Washington University have already done so. Similarly, the University of California–San Diego Medical Center was almost bankrupt in the mid-1990’s and had to be bailed out by state funds. After having merged, the primary teaching hospitals of Stanford and the University of California–San Francisco are losing tens of millions of dollars annually. In order to cut costs and improve bargaining power with managed care organizations, rivals Massachusetts General Hospital (MGH) and Brigham and Women’s Hospital (BWH) formed Partners HealthCare System. Boston’s Beth Israel Hospital and Deaconess Medical Center became Caregroup System. In New York City, New York University Hospital and Mt. Sinai merged as did New York-Cornell and Columbia Presbyterian. Of these, only the merger of MGH and BWH has been successful. It is likely that as a result of the financial difficulties facing academic health centers, there will be fewer larger academic health centers.

(Blumenthal D. “Unhealthy hospitals-addressing the trauma in academic medicine.” Harvard Magazine. 2001; March-April: 29-31.)

Complementary and Alternative Medicine in Health Professional Education

A conference held by the Josiah Macy Jr. Foundation indicated that there are more visits in a single week to practitioners of complementary and alternative medicine (CAM) than to primary care physicians. Patients share very little information about these visits with their physicians, who are unaware of the risks or benefits of CAM services. In addition, physicians also are not familiar with theories and practices of CAM. The conference was held with representatives of several medical schools, the American Board of Internal Medicine, National Board of Medical Examiners, Association of American Medical Colleges, and the MacArthur Foundation. Recommendations included:

• Integrate into curricula of health professional schools an awareness and knowledge of CAM and its risks and benefits.
• Engage in collaborative research on the safety, efficacy, and mechanisms of CAM.
• Collect data on use of CAM therapies.
• Professional and educational associations should make available evidence-based CAM information and CME as well as provide information to the public.
• Requirements of licensing and credential bodies should include information about the safety and efficacy of CAM.


How Long Do College Professors Work?

The century-old trend toward increasingly earlier retirement among American workers ended in the 1980’s, a direction that is mirrored in academia that appears to encourage longer careers.

Some universities are phasing out older professors by slowly reducing their workload. However, universities also have the opportunity to utilize older people in creative ways, such as relying more on part-time workers than they did in the past.

It is debated as to whether the causes of longer careers may be due to lifestyle options or a reduction in economic security. F. William Sunderman, M.D., the 102-year-old director of the Institute for Clinical and Laboratory Science at Philadelphia’s Pennsylvania Hospital, is a great believer in continuous work and indicates that he will never retire.

Some predict an emerging continuum of learning and work with interspersed periods of leisure.

(Bunk S. “How long will you work?” The Scientist. 2001; April 30: 31-32.)
Interdisciplinary Education in Geriatrics and Gerontology

Education that seeks to bring more than one discipline into collaborative endeavors organized around a common goal is considered to be multidisciplinary. Interdisciplinary education requires that multiple disciplines interact with each other transcending their disciplinary boundaries in hope that synergism results. It is based on the assumption that problems are major and complex enough that no one health professional discipline possesses all the skills and knowledge needed to address a problem. Furthermore, a team of professionals from a variety of disciplines will enhance the ability to solve the problem. One cannot obtain interdisciplinary involvement without there being a mix of both students and faculty from different disciplines. Interdisciplinary education and training provides opportunities for students to be exposed to more than one disciplinary perspective.

Among the barriers to interdisciplinary education are:
* Tradition
* Lack of incentives
* Perceived status differences
* Competition for funds
* Differences in education among disciplines
* Scheduling differences among disciplines
* Lack of student interest in interdisciplinary studies
* Lack of faculty experience in interdisciplinary education

(Skinner JH. "Transitioning from multidisciplinary to interdisciplinary education in gerontology and geriatrics." Gerontology & Geriatrics Education. 2001; 21(3): 73-85.)

Regional Demand for Specialists and Generalists and Medical School Graduates

There have been reports of an oversupply of medical specialists and even some that indicate there also are too many generalists. The University of Washington School of Medicine performed a survey of all its 3,824 affiliated residency program graduates and had almost 2,000 respondents.

It appeared that there was a strong demand in the northwest for both specialists and generalists. It was concluded that the use of national averages to make conclusions about the regional demand for physicians needs to be revisited.


Educating Doctors in Prevention

In the fragmented U.S. health care system, medical specialists are providing some preventive care and counseling. This appears to be true for primary care physicians as well. However, considering the potential of preventive measures on health status, such measures provided in the U.S. in 1997 were probably too little and too late.

At modest cost, and with little time, opportunities for improvement of community health can be obtained by providing more preventive services. Research has shown that preventive care adds only one to two minutes to a routine primary care visit. This is particularly relevant to primary care physicians because of their practice scope. Reorienting the values imparted on medical students can help improve the current situation.

(Dovey S, Green L, Freyer GE. "Educating doctors to provide counseling and preventive care: Turning 20th century professional values head over heels." Education for Health. 2000; 13 (3): 307-316.)
While physicians know they need to keep up with developments in biomedical science to acquire new information and skills, they also must keep pace with the organization and financing of health services. Continuing medical education (CME) and training programs, as well as those at the medical school and residency level, must revise their curricula so that skills are obtained to manage high-quality and cost-effective care for patients. There are a number of barriers to change, including:

- Competition with other topics for time.
- Lack of departmental ownership of new topics.
- Lack of instructional material on new topics.
- Faculty inexperience, knowledge gaps, and negative attitudes on new topics.
- Little teaching experience in new sites where partnerships are appropriate.

Strategies that can be employed include:

- Integrating new material and topics into existing courses rather than a new course.
- Involving the highest level of leadership promoting new topics and providing direction.
- Drawing from newly available instructional material and Web-based programs.
- Strengthening faculty knowledge/ability to teach new topics (faculty development).
- Stimulating collaboration with new sites (e.g., community practices, health plans).


The Medical Education Digest also is available for viewing on the Internet at http://medicine.nova.edu/ostmed/admin/facdev.