

# Medical Education Update

## Medical Education: the 21st Century

Welcome to the new century. No, I'm not disoriented by being 10 years late in my awakening. I'm referring to the dawn of the new century of medical education.

It was 100 years ago that Abraham Flexner, working for the Carnegie Foundation for the Advancement of Teaching, published *Medical Education in the United States and Canada*. This seminal work, known more informally as the Flexner Report, fundamentally changed the American medical education system.

Medical education of 1909 was in shambles. Medical schools ranged from those of high quality university programs to proprietary, for-profit, doctor-owned schools with no set educational criteria or methods. Prior to 1909, the American Medical Association (AMA) and its leadership recognized substandard educational systems and had already formulated proposed changes. Not wanting to condemn their own members, the AMA enlisted the Carnegie Foundation to conduct a survey of all schools and to make independent recommendations (even if they happened to mirror what had already been formulated to some degree by the AMA and the American Association of Medical Colleges).

In stepped Flexner. From 1909 to 1910, he and the president of the AMA visited all 155 medical schools in the United States. He completed and published his report in 1910. It was sensational (in more ways than one) blasting the inferior medical schools. The muckraking press picked up the story and brought it to the public's attention. By 1928, the United States was down to 78 medical schools through either closures or mergers.

The Flexnerian Revolution led to the implementation of admissions criteria, rigorous basic science training in the early years and bedside, mentored clinical training in the later years. If this sounds familiar, it is because the system has remained virtually unchanged for the past 100 years.

Except for an occasional new medical school (the University of Washington School of Medicine enrolled its first class of 50 students in 1947), the overall medical student numbers stood relatively stable until the 1960-70s when there was significant expansion. In 1965, graduate medical education (GME) or residency training also expanded because Medicare and Medicaid funded differential reimbursements to those hospitals that had residency programs.

In 2000, medical schools again began to implement their second major expansion in numbers because of

predicted, marked shortfall in physician supply by 2025. As a beneficiary of expansions occurring in many medical schools, WSU Spokane enrolled its first class of 20 University of Washington first-year WWAMI medical students in 2008. Our second class is now halfway through its academic year.

And here we are now in 2010. Once again the Carnegie Foundation is issuing another report. Scheduled for publication in June 2010 is a book entitled *Educating Physicians: A Call for Reform of Medical School and Residency*. In its transformational recommendations, this book may well do for the 21st century what Flexner's report did for the 20th century. If you want to read a preview, the authors of the report have published a short summary article: *Irby DM et al. Calls for reform of medical education by the Carnegie Foundation for the Advancement of Teaching: 1910 and 2010. Acad. Med 2010 Feb;85(2):220-227*. One of the recommendations will be to "locate clinical education in settings where quality patient care is delivered and not just in university teaching hospitals."

In this issue of the newsletter, you will read articles reflecting on medical education taking place here in Spokane, a location that qualifies as a "not just a university teaching hospital" site. Dan Meza, a current 1st-year UW medical student in WWAMI WSU Spokane, writes a moving (and humorous) tribute to the remarkable mentoring he has received from Spokane physicians. Katie Mackay, a 2nd-year UW medical student who last year did her first year in WWAMI WSU Spokane, writes a thoughtful and thankful article detailing the influence of her experiences here as well as an innovative notion to include medical students in the mix when developing a medical home. Dr. Matt Layton, Director of the UW-Spokane Psychiatry Residency Program, writes of the pleasure of giving back to medicine what has been given to him by participating in teaching across the spectrum for medical education -- from medical students to residents. Dr. Randy Poncher, a practicing pediatrician and a clinical faculty member, writes of the value, joy and pride of being part of a medical student's training.

Get ready for medical education in the 21st century.

Will there be changes? Certainly.

Will there be obstacles? Definitely.

Will there be solutions? Eventually.

Will you be part of the process? Hopefully.

*George Novan, MD*

*Associate Director, WWAMI Medical Education Program  
WSU Spokane*

*Faculty, Internal Medicine Residency Spokane*

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## Medical Education Update, cont'd

### A tribute to remarkable mentoring received in Spokane

Urachus. As a first year medical student it is amazing how one short word, especially when unfamiliar, can be completely mortifying. My clinical preceptor had been waiting all week to share her interesting finding with me and her expectant look told me that it was my turn to wax eloquent about a condition related to this word. I didn't know the answer. And although there was no grade or patient's wellbeing at stake in this optional clinical experience, I wanted very badly to rise to the occasion. Why? Because of my experience with Spokane physicians.

When I entered my first year as a medical student in the WWAMI Spokane program I had thought that my identity was already well established. I was a teacher of at-risk youth, with beliefs informed by the urban/immigrant neighborhood in which I had grown up, accustomed to the big cities and frenetic pace of the East Coast. In five short months this has changed. I now find that I am deeply committed to a group of peers, physician guides and a community of patients, all rooted here in Spokane. I have discovered in our small WWAMI cohort a sense of both diversity and intimacy, and within the broader medical community of Spokane, I have come to know physicians with remarkable technical and analytical abilities who possess an equally remarkable devotion to caring for people. The above interaction with my preceptor is a reflection of the investment that the Spokane medical community has made in me, and of my growing desire to offer something in return.

But how had this happened? It began on the court—the basketball court. Of course this is a bit of hyperbole, but it illustrates a broader point. Growing up, basketball had often been a way of assigning a hierarchy among peers. In our neighborhood when tensions rose, they were expressed on the basketball court in altercations that sometimes led to the loss of life and limb; I learned to avoid basketball. When I played with my Spokane classmates, however, I found a sensitivity and understanding of my hesitation, a willingness to help me learn, and a true sense of camaraderie. I also discovered that the best player in our class was a young woman who was equally well versed in developmental anatomy. I had entered into a new society and it was topped by a woman who could both play basketball and identify the median umbilical ligament.

I soon realized that remarkable qualities such as those are shared by all of the 20 member medical school and 8 dental student Spokane class. Those students have supported under-served care in Latin America, done clinical and basic research here and abroad, competed in collegiate athletics (including golf), founded successful businesses, climbed mountains, taught children,

translated Slavic literature and more. Still, they aspire to continue helping other people by organizing medical education for school kids, a Saturday clinic for indigent patients (we need preceptors), a screening clinic for STDs and forums encouraging disadvantaged students to enter the medical profession (among others).

This desire to do more has been fueled by the support of a remarkable group of physicians (and 3<sup>rd</sup> and 4<sup>th</sup> year medical students) who have given us (even lowly M1s) an opportunity to observe and contribute. Can you imagine an M1 being allowed to participate in neurosurgery? Or delivering babies? Or offering a differential diagnosis in grand rounds with M3s and M4s? I've found my glamour, too. I've had the estimable opportunity to talk one-on-one with my preceptor (Dr. William Sayres) about the evolution of medical care in the United States. I've assisted in the physical exam. I've seen the first intimations of trust emerging from a resistant patient due to a preceptor's careful listening.

So it was those examples that I channeled as I sat down recently to see an infant with a runny nose and cough who was experiencing pain while nursing. I got the history from Mom. "Yes, it seemed to start yesterday. I brought him in as soon as possible. I've been working double shifts. I don't think any of the other kids at the shelter have had any symptoms." Mom held the baby close, protective even in the doctor's office. My preceptor, Dr. Janet Walker, came in and I repeated my findings, the physical exam was performed and the diagnosis was made. Then the very careful, attentive mother turned to me, "Would you hold my baby?" she asked me, "I need to go to the bathroom and it is hard to do while watching him." I am not accustomed to holding babies and I have certainly never held a baby who is potentially contagious, but how could I decline to help someone who was placing such confidence in me? "Of course I would." I replied. The mother left the room and I turned to my preceptor who said, "I'll stay with you." While we waited we talked about our own children and family, best clinical practices and the developing immune system. She could have sent in a nurse or a medical assistant and launched back into her busy schedule—but she didn't.

Shortly thereafter, the mother returned and thanked us. We disinfected ourselves and as we stepped out of the room my preceptor turned to me and said, "Good job." This time it was two short words that now inspired me with a sense of determination, a commitment to helping others, and an awareness of my part in a Spokane medical community already hard at work. I envisioned myself caring for patients, providing well-reasoned diagnoses, prescribing meds and opening my own clinic. Then I thought again, I had just offered to hold a contagious baby during my clinical rounds. I haven't even had microbiology let alone three and a-half years of medical school plus residency--nor have any of my peers. Maybe I still need some help.

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In Spokane I have been introduced to a fascinating new field and a great new set of friends and classmates. I have had a remarkable set of mentors. I realize I still have a long way to go and recognize that I will do it with the help of a formidable body of colleagues, some of whom contribute great experience and others who share great enthusiasm. And on that note, although it is a lot to ask, but I just can't resist, would you be available to precept next Saturday?

*Daniel Meza  
UW School of Medicine  
M1 Medical Student  
Spokane WWAMI Program*

### My Medical Home

It makes sense to train physicians for the types of environments in which they'll practice. The University of Washington puts this theory into practice by sending medical students to locations that range from the Harborview ED to small rural Alaskan towns accessible only by plane. Fortunately, this sentiment has led to recent expansion of the medical program in Spokane where students have access to new facilities, enthusiastic faculty and a dedicated team of physicians and administrators facilitating the first year of medical education. My experience in Spokane as a 1<sup>st</sup> year medical student, and continuing in Seattle as a 2<sup>nd</sup> year student, encouraged me to consider the impact the learning environment has on medical education and future career plans.

As discussion continues in the medical community about creating patient-centered medical homes (with the goal of more continuous, accessible and coordinated care), I've been giving some thought to the concept of a medical home from the perspective of the provider (me!). Ideally, medical homes should create a more fulfilling interface for both provider and patient, and as a physician in training I'm curious about how I might someday fit within a medical home. What does it mean to have a medical home as a provider? What qualities make a medical practice engaging and fulfilling and where are physicians most likely to find those qualities? Just as the definition of an ideal medical home may differ from patient to patient, physicians likely have varying ideas of what makes the perfect "provider-centered" home. At the very least, I humbly suggest provider-centered medical homes might include the following characteristics:

- Adequate resources to serve the patient population
- A range of physician experience –from students to highly trained and practiced physicians
- Opportunities for continued medical learning
- A strong community of allied health professionals that enthusiastically collaborate
- Additionally, I claim that Spokane has all of these qualities and more!

As a "west-sider" transplant, I'm poised to recognize the benefits of medical education in Spokane, especially in comparison to Seattle training sites. The *personal/lifestyle* benefits of getting a medical education in Spokane include the following: affordable housing, a wealth of outdoor activities near Spokane, relative paucity of city traffic, a growing downtown with many local shops and restaurants, etc. Better still, Spokane offers the following *professional* benefits in regards to medical education: a large full-service medical community, hands-on experience, the opportunity to network with an incredible community of physicians who are supportive of developing physicians and free hospital parking (among many others)!

In addition, I believe the process of finding a provider-centered medical home starts early in the process of becoming a physician. I've heard physicians say that students often choose their specialty based on *how* they see themselves fitting with the vibe of different specialties, and I think this is true of *where* students choose to practice as well. A single dynamic physician can attract a student to a particular medical field. Likewise, one influential physician (or group of physicians) can entice a student to want to practice in a particular city or region. In this regard, continued efforts toward ensuring that medical students can train in Spokane and the Inland Northwest are essential!

I eagerly look forward to being a part of the continued expansion of medical education in Washington State. I've been fortunate enough to find a medical home in Spokane, and can't wait for the day when I can practice medicine as a physician in the community and watch other students find their medical home here as well.

*Katherine Mackay  
UW School of Medicine  
M2 Medical Student*

### The pleasure of giving back to medicine

"A pleasure to have on my service...bright, enthusiastic and professional." "Very intelligent, works well independently." "Displayed compassion and empathy with patients." These are real-world examples of comments made by attending physicians on medical student evaluations. The kicker? Both of those students grew up in Spokane! And those talented, smart and highly motivated young adults who are becoming physicians want to come home to train and practice.

It is a joy to work with those amazing people who come from diverse backgrounds, have a wide array of interests and life experiences and are eager to learn medicine. I am truly fortunate to be in the position of teaching first-, third- and fourth-year medical students, as well as

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advanced resident physicians in their third and fourth years. Yes, there are challenges at times, but in my opinion the rewards far outweigh any downside to teaching. Our vertical medical education model of medical student, intern, resident, and attending physician makes "giving back" an intrinsic part of the process. The phrase "see one, do one, teach one" still rings in my ears twenty years after earning my medical degree. The point of this article is not only to tell you how much I enjoy teaching, or just to praise those high quality medical students who grew up here, but also to ask you as physicians in the Spokane region and the surrounding community for your help.

Many students, residents, and faculty with whom I have had the tremendous pleasure of working with over the past ten years know that major expansion of medical education in Spokane at both undergraduate and graduate levels is not a matter of if, but when. And we know very well that we will need your support for this concept (which thankfully has already been made clear), but we will also need your commitment to teach these delightful students and residents. We will need to pull together as an interdisciplinary medical community to realize this goal, and to work through the inevitable growing pains that accompany any endeavor worth doing, such as even going to medical school in the first place.

What a pleasure to know that even as we debate the future of healthcare and face difficult economic times, many of the best and brightest from right here in Spokane want to be doctors, and they want to come back home. You can be a part of that by giving back to them your knowledge, wisdom and experience. Thank you!

*Matt Layton, MD  
Program Director, UW  
Psychiatry Residency Program, Spokane*

### The value, joy and pride of being part of a medical student's training

I am honored to have been asked to share with you some thoughts about teaching medical students and residents. I have been teaching for almost 38 years both here in Spokane and in Chicago and have relished every minute of those years. I knew that I was getting old when about 15 years ago one of my former medical students told me that her mother had been a medical student of mine. They both ended up going into Pediatric practice together and I heard that the mother has recently retired.

The definition of Doctor is Teacher. Thousands of years before medical schools, textbooks and the Internet the only way medical knowledge was passed on from generation to generation was for physicians to teach

students, and for those students to become physicians and pass on their knowledge to their students. I believe that this "antiquated" system is still the most efficient, thorough, and enjoyable way for students to learn medicine. Textbooks teach from diagnosis to symptoms while we teach the real way our patients present--from symptoms to diagnosis--and remember that we teach our students much more than the facts that the textbooks teach. Through our words, but more importantly through our deeds, we teach our students how to care for patients.

We teach them:


- how to speak to each member of the family in the patient's exam room and treat them with dignity as our guests,
- how important it is to wash our hands in front of families before starting our physical exams,
- how we often need to stay late to care for an ill child,
- how we often need to call for urgent lab results before the lab slips come back to us or before the results are emailed to us,
- how we sometimes need to walk up thirty-four flights of stairs in an inner city housing project to obtain consent for a lumbar puncture for an infant with newly developing signs of meningitis,
- how we sometimes need to call after hours to inform a family of a normal lab result that they have been worrying about, or
- how we sometimes need to go to a family's home because an abnormal x-ray result requires that a child needs to be admitted to the hospital and the family doesn't have a telephone because they can't afford one.

Always take your students with you when you visit that home or walkup those thirty-four flights of stairs. Remember the best "social history" is the old fashioned house call where you and your students can actually see how your patients live. Always allow your students to go into the patient's room before you do. Let them do their own histories, perform their own physical examinations, come up with a differential diagnosis and a most likely final diagnosis and describe a treatment and follow-

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up plan. Only then examine the patient with them present and refine the patient-care plan together. Students can, and often do, contribute greatly to patient care. They often know a lot about clinical medicine and their knowledge of basic sciences is usually more extensive and up-to-date than ours. Their questions often force us to look at issues from new perspectives that we have never thought of before. One caveat—if you don't know the answer to a student's question never give the student a guessed answer or an answer you are unsure of; admit you don't know the answer and look it up together--both of you will learn something in the process. Lastly, when your students' rotations are over, take them out for a nice lunch. This is a tradition we have in Chicago that I wish would be adopted here in Spokane.

A fair question you might ask me is, "What is in it for me?" To that I would answer that spending time teaching the most valuable members of our society, our future

physicians, is not only intellectually rewarding, but is a lot of fun. You can see them grow in confidence and ability almost daily. And when I get to see one of my former students who has gone into practice become a competent and happy clinician or get to go to a lecture given by one of my former students who has gone into academic medicine, I can almost feel myself swelling with pride. To those who are already teaching I would say, "Keep up the good work." And to those who have never taught, I would say, "Give it a try." I'm sure the huge majority of you will thoroughly enjoy it.

Sincerely and From the Heart,

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