Ideal and Reality:
Problems and Perspectives of Medical Practice and Patient Care
in Contemporary Health Care Systems

An Honors Thesis
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<tr>
<td>AMA</td>
<td>American Medical Association</td>
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<td>CDG</td>
<td>Curriculum Development Group</td>
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<td>HMO</td>
<td>Health Maintenance Organization</td>
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<td>IPA</td>
<td>Independent Practice Association</td>
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<td>MCAT</td>
<td>Medical Colleges Admissions Test</td>
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<td>MDA</td>
<td>Medical Doctor Advisor</td>
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<td>OTA</td>
<td>Office of Technology Assessment</td>
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<td>PCC</td>
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<td>Preferred Provider Organization</td>
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Introduction

The current focus on health care reform in the United States has illuminated and reemphasized the inconsistencies and inadequacies of the medical system. Thanks to exhaustive investigations and endless debates, specialists, politicians, hospital and medical school administrators, insurance executives and medical practitioners have identified the problems that denote the discrepancies between the first-rate research and treatment available at many medical centers and the less than universal coverage for the population.

In many respects, the topic of this essay that intends to explore the problems of medical practice is one of ideal and reality. Americans are generally aware of the rigor of medical education in this country. The selectivity of medical schools makes acceptance quite an accomplishment. The highly concentrated medical school curriculum and the tremendous workload in residency all contribute to the intensity and difficulty of a medical education. Successful completion of such programs requires a sincere motivation that may result from numerous personal and professional aims. Nevertheless, the goals of medical research and education inevitably center on one single concern: treatment of the sick. Many aspects of the American health care system deserve praise. But studies demonstrate that often the practicing physician does not enjoy the praise of those he is there to help. The realities of practice conflict, therefore, with the ideals of aims, aspirations and training. At the center of the current discussions, then, lie the concerns and frustrations of the public and of medical professionals including educators and researchers, and, of course, doctors themselves.

Any attempt to analyze fully the exasperation of all those involved in American health care delivery would be overly ambitious. Therefore, this report restricts its focus to the area
of discontent expressed by patients with respect to their physicians. More specifically, this study aims to accomplish three basic tasks. The first is to expose and determine specific areas of patient discontent. This information is gathered from accounts and case studies assembled in publications and medical literature. The second task seeks to investigate and validate the complaints through discussion with physicians. Interviews with three selected practitioners enable a further understanding of medical practice and help establish a basis for confronting and determining the origins of patient dissatisfaction. The interview results then introduce the final task which aims to further investigate the cause of the discontent. Documented studies, reports and criticism concerning the ideals and limitations of medical practice and training are used to substantiate the ideas introduced and discussed in the interviews.

Any study is hardly conclusive, and this essay will perhaps corroborate and elaborate upon some of the findings reported in secondary sources. Moreover, these three interviews may provide us with additional insights into the complexities of a difficult but immensely important question. Like all studies which intend to contribute to our understanding of various issues, this report may also stimulate additional questions and excite other avenues for investigation into questions of considerable interest to human health and welfare.
Chapter One: The Ideals and Reality of Medical Practice

Historically, the physician has occupied a unique role in society. Making house calls during off hours and being available to help those in need, sometimes in measures drastic enough to be considered lifesaving, has made the doctor no ordinary professional but an integral part of every community. Certainly, modernization and the urban environment have contributed to the vast changes in the way doctors practice and are regarded by the public. However, many of the ideals of the medical profession have remained unchanged.

A. The Ideal Physician

Medical educators and patients both agree that good physicians should be "competent, caring, communicative, committed to enhancing the health of the patient, capable of handling pressure well and facing calamitous situations in the lives of others with great equilibrium; not authoritative, fighters against disease, and excellent technicians and teachers" (Hendrie and Lloyd 84). Many of these ideals have existed for millennia. The Hippocratic Oath, composed in the third century BC, continues to serve as one of the fundamental guidelines for the correct, ethical practice of medicine.

Dr. Chase Kimball, professor of psychiatry at the University of Chicago, specifies and elaborates the requirements of a good physician. First and foremost, he must be aware of "[his motivations], abilities and competence" (318) How capable is he in performing necessary tasks? The doctor must confront his abilities and the limitations of his profession. Humility is often a virtue in the practice of medicine, for it reminds the physician that his skills and influence do not extend indefinitely. Patients depend upon doctors for accurate assessments of their medical condition, not unrealistic diagnoses blurred by overconfidence.
Next, the physician must be able to get to know as much about "his patient as a person as he would about the complaint" (Kimball 318). The individual suffering from illness or impairment is no less important than the condition itself. A compassionate, patient-centered approach to care facilitates and enhances treatment.

The physician should recognize his multiple roles and responsibilities. Apart from the traditional provider of medical care, doctors serve as teachers, explaining to patients the nature of their disorders or conditions and the implications for treatment and care. The doctor also counsels patients, who are often faced with difficult and important decisions. Other responsibilities include maintaining patient confidentiality and providing continuous care.

Dr. Kimball's detailed account of the qualities essential to good doctor-patient relationships provides a useful set of criteria. However, it should not serve as the exclusive means of gauging a doctor's abilities and performance. Patients, who are the ultimate recipients of medical care, the benefactors of medical wonders, and the potential victims of poor health services, must themselves determine what constitutes the practice of good medicine. Marketing researcher Lynn Cunningham conducted patient interviews and detailed some of the most positive remarks made about physicians. These accounts most notably emphasize the personal qualities of the physician: "my doctor is always there when I need her," "she takes a special interest in me and knows me personally," "my doctor holds my hand" (19-20). Similar comments concerned the doctor's expenditure of time with patients, communication and patience. Although it is expected that the physician provide personalized attention and warmth, patients seem to acknowledge, in particular, the significance of this criterion in their expectations of satisfactory health care.
B. The Dilemma: Realities of Health Care Delivery

The physician in the past was ignorant, empirical, wonderfully generous, and beloved by his patients; the physician of the present is less ignorant, less empirical, and all too often considerably less generous and not at all beloved. (Vevier 55)

Health care delivery in the United States has been identified as an area of growing concern. As a result, the inadequate and sometimes brutal reality of health care is emerging. The public's attention is drawn more and more towards the limitations and shortcoming of the American health care system, and less to the marvels of modern medicine. Public dissatisfaction targets the insufficient and poor quality of medical coverage and also addresses the sub-standard performance of American physicians. How ironic this seems in light of claims that "some of the world's best medicine is practiced in the United States" and that "American physicians are the product of the world's best medical-training programs," (Nash 119). Where, then, is medicine in this country going wrong?

Statistical information sometimes provides unclear findings regarding public satisfaction with physicians. But one consistent aspect of these surveys reveals the reason behind patient dissatisfaction. It is important to note that, generally, the source of discontent is not associated with physicians' abilities to wield the tools of healing and care. Quite the contrary is true. In one survey conducted with 1,000 families, the physician as medical technician received high approval ratings, coinciding with the view that American physicians are learned and well trained (Hendrie and Lloyd 56). This, of course, does not suggest that medical procedures are always flawlessly achieved. The numerous news media reports concerning poor clinical practices, bad judgment and overall incompetence suggest the opposite. Other surveys revealed that patients tend to overrate the quality of their care, and sometimes fail to perceive their doctors' shortcomings (Spiegel and Backhaut 111). Poor medical care, then, is quite common and widespread despite the public's lack of awareness.
However, factors other than the technical capabilities of doctors are needed to explain the existence of patient dissatisfaction.

Earlier, we noted that patients have a high regard for friendly, compassionate, personalized attention in their medical care. It should therefore follow that deficiencies in these qualities create discontent. Indeed, this has been shown repeatedly and consistently. In the same survey cited above, of the 1000 families interviewed, 64 percent were "dissatisfied with their doctor-patient relationship (Hendrie and Lloyd, 56). In another case, numerous complaints were filed with the Board of Medical Examiners against a certain ophthalmologist. Although the dissatisfied patients made no mention of his skill or technical competence, he was repeatedly referred to as "arrogant, uncaring, not very nice, and more concerned about money than about his patients" (Cunningham 63).

C. Communication Breakdowns

Poor communication was cited as one of the major causes of patients' frustrations. Patients surveyed were disturbed that their doctor failed to listen to their symptoms and explanations, and that he was not providing enough information or speaking in coherent and intelligible terms. As one patient explained: "I think that I'm entitled to at least a laymen's explanation of what is happening. But when I ask my physician for clarification you'd think I'm questioning his mother's virtue" (Spiegel and Backhaut 118).

Good communication establishes a fundamental understanding between doctor and patient and is therefore crucial to effective diagnosis and therapy. Studies have illustrated that patients who have interactive relationships with their physicians, more easily understand their situation, and are, in turn, more compliant in their treatment. (Odegaard 117; White 227). During the interview, it is the physician's responsibility to pose relevant questions which will guide the discussion towards the problem. He can then assesses the situation based on the acquired information, and formulate a series of possible diagnoses. Finally, the doctor must
convey his findings in a manner that neither overwhelms the patient with technical terms nor provides insufficient information, leaving the patient confused or ignorant of his situation (White 160).

Although good communication is essential to good patient care, a surprising number of physicians inadequately perform this task. Failing to listen to patients is the first problem. One study revealed that 56 percent of patients felt that their doctors were not properly listening to their complaints (Hendrie and Lloyd 54). Another survey found that, on average, doctors would frequently interrupt their patients during the interview (Odegaard 102). This sends two unfortunate messages: "leave the talking to me" and "stop telling me what's wrong and just answer the questions" (White 31).

Poor communication is not merely offensive to patients; it eliminates the relevance of doctor-patient care in the therapeutic process. One physician estimated that doctors can make an accurate diagnosis 75-90 percent of the time by simply questioning patients and listening to their complaints (Kassler 1). Moreover, when the patient is able to explain the problem from his own viewpoint, he may offer additional information vital to the diagnosis. One doctor wrote that "the idea of what is being expressed, the underlying theme of the communication and its context are equally important and may be more significant than the factual content" (Hendrie and Lloyd 54). Numerous cases substantiate this claim. One such example involves a woman who sought medical attention for chronic headaches, heart palpitations and high blood pressure. She underwent a series of clinical tests and interviews which did not reveal the cause of her symptoms. During a later discussion, once the patient had become more assured of her physician, she was able to reveal the true cause of the problem. Her husband apparently had been engaged in an affair, which had adversely affected her psychological and physical well-being (Nash 28). This case clearly demonstrates the effectiveness of open dialogues between doctor and patient.

Physicians' incapacity to communicate information to their patients constitutes another part of this problem. On one hand, patient frustration results from the inability to understand
the physician's use of technical language and jargon. On the other hand, some doctors do not sufficiently inform patients or fail to disclose important implications of the diagnosis and treatment. These problems are often attributed to the physician's insensitivity or disinterest. But often the very opposite is true. Some physicians provide inadequately detailed or overly technical descriptions and explanations so as to avoid confronting their strong feelings toward the patient's pain and discomfort (Reiser and Rosen 75). For the afflicted individual who wants to understand the nature of the diagnosis and its therapy, this ambiguity or indirectness can be troubling. But to the doctor, labeling disease as something other than the cause of suffering is a means of distancing himself from the unpleasantness of his profession.

Very often, the manner in which doctors talk about their patients is also indicative of their view that they alone "command" the treatment (Reiser and Rosen 76). Doctor's "order" tests and "perform" various operations; and, although the patient has to endure the often unpleasant or painful procedure, his participation in his own care is often not acknowledged. This outlook essentially eliminates the patient from the picture, and renders his perspective and concerns unnecessary.

D. Understanding the Patient

In all its forms, inadequate communication results in dissatisfaction among patients. However, a doctor possessing this essential skill is not guaranteed to provide the desired care. The doctor must effectively go further than listening to and discussing patient concerns: He must fully relate to and understand what the patient is experiencing.

As one doctor explained:

people who are troubled, who are in pain, who are disabled want to see someone, to
talk to someone to share their trouble with someone. As much as a cure they want sympathy, reassurance, encouragement. They want explanations: why did this happen? how long will it last? They want justifications: should I stay at home from work? Above all they want someone who cares" (Spiegel and Backhaut 101).

In their book, *Medicine as a Human Experience*, Doctors Reiser and Rosen offer another perspective. They liken the interaction between doctor and patient to the mother's nurturing care of her child (20). This analogy draws upon the fact that, like a helpless baby, the patient feels vulnerable, nervous and concerned. To ensure her child's comfort and security, the mother's own manner must be fluid and soothing. Similarly, the physician must consider the patient's fear and malaise and respond with warmth and ease. In so doing, he creates a relaxed and caring atmosphere ideal for compassionate treatment.

Yet the importance of a compassionate approach goes beyond making the patient more comfortable; it is essential to accurate diagnoses and, in turn, the proper delivery of care. Earlier, we noted that the patient's description of his condition can often provide more information than the results of tests and procedures. Similarly, only when a doctor shares his patients perspective will he fully understand what is wrong. Sometimes, when the patient is reluctant to explain his true concerns, a doctor must play detective and intuitively derive the causes of the condition. For example, a patient may complain about one problem and jokingly describe an altogether unrelated event or concern. Likewise, the patient's body language or tone of voice may reveal a certain discomfort. A persevering and conscientious doctor would consider the problem not only by what it presents on the surface, but by further examining the underlying implications. Is the joke or nervous movement a hidden message as to the real cause of the problem? (Reiser and Rosen 97). To recognize and intercept such hidden messages, a physician must, first of all, be attuned to the patient's point of view. He is then much more capable of determining the problem and, in turn, providing the required care.
Treating chronic or terminal conditions also requires an extensive understanding of the patient's perspective. According to Dr. Elizabeth Kübler-Ross, all dying patients go through a series of predictable and repetitive stages, namely, denial, anger, bargaining and depression, before finally accepting the certainty of death (Howell and Schroeder 208). It is therefore crucial that a doctor fully understand the "five stages of dying" in order to fully support and assist the dying patient.

In the first stage of the dying process, the patient experiences denial, and has difficulty confronting the inevitability of his condition. A doctor, aware of these feelings, will respect the patient's need to deny, not by providing a false hope — quite on the contrary, most patients prefer to know the truth — but rather by showing his sympathy and support. This approach also applies to the "bargaining stage" during which patients make an offering of good will (changing ones lifestyle for the better, for example) in the hope that such efforts will yield a recovery. The compassionate, understanding doctor will not diffuse these efforts, but rather encourage the patient's determination to be healthier. On the other hand, were the physician not aware of his patient's struggle to achieve order in an otherwise hopeless situation, he may not be prepared to support the patient's efforts. This is particularly true of the anger stage which perhaps presents the physician with his most formidable challenge. Frustrated and infuriated, the patient vents his anger by blaming those around him. The patient wishes to be heard, his claims understood, and not merely acknowledged through a passive agreement. Once the physician listens the patient and exposes the cause of his anger, he can offer comfort and relief. Throughout the dynamic process of dying, it is most crucial that the doctor maintain a close and regular contact with the patient. The doctor's support also extends to the patient's family which experiences a similar series of emotional stages. An understanding physician will meet regularly with members of the patient's family and accommodate their needs to express their feelings.

Medical educators have explained that doctors need only extend their involvement in patient care to the point where it facilitates and enhances treatment. If carried too far, the
physician's professional and personal contributions can be counterproductive. "The physician must exhibit both compassion and detachment — a combination difficult enough to achieve which causes many to pursue one to the exclusion of the other" (Vevier 84). Indeed, as we have seen, inadequate attention to compassionate care is often counterbalanced by excessive detachment.

E. Consequences of Patient Dissatisfaction

Society has clearly defined its expectations of capable and compassionate physicians for the practice of good medicine. But doctors have strayed from these ideals; and as a result, the desired personal care and attention is being inadequately provided. This outcome of this rift between ideal and reality is often grim and unfortunate. The media consistently report on the increasing numbers of malpractice suits filed against doctors. These are frequently the products of serious and unforgivable errors on the part of physicians, but they are also provoked and sometimes even caused by the problems of poor personalized care. In interviews conducted with patients intent on suing their physician, poor communication was frequently and explicitly cited as one of the reasons for the determined legal course of action. In addition, patients who contact attorneys often note that "no one listened to them, no one cared, or that when staff members talked to them, eye contact was lacking" (Cunningham, 69).

Additional examples further demonstrate the intimate relationship between poor communication or the lack of compassionate care and retaliatory legal action. One case involved a Spanish-speaking woman who did not understand the risks of reconstructive breast surgery. She experienced complications and sued her surgeon, believing that she was improperly informed of the procedure (Cunningham 62). Under these circumstances, the physician may not have been at fault because of the language barrier. However, this example
reemphasizes the need for doctors to establish good communication with patients and to inform them properly of the treatment in question.

Perhaps the most compelling scenario is one in which litigation was never pursued. This case involved an elderly woman who was misdiagnosed, and her stomach cancer went untreated, resulting in the woman's death. When the woman's children were asked whether they would pursue legal action against the physician, they answered:

"How can we sue someone who tried everything he knew to find out what was wrong? This man cared for our mother—we knew it. He spent time with her and informed her and us of every alternative and every diagnostic procedure. He even turned the bed around in the hospital room so she could have sunlight without glare. That's someone who cares. We couldn't sue him" (Howell and Schroeder 53).

This case illustrates that a physician's good intentions and sincere efforts generally have significant bearing upon his patients' impressions of his competence and ability to provide care.

F. The Next Step...

In this chapter we identified the discrepancies between the ideal of medical practice and the inadequate care of patients. These observations invite numerous questions. First, why are doctors not able or willing to treat patient's compassionately and humanely? Furthermore, what are the fundamental causes of the observed inadequacies in compassionate care? Are there flaws in medical training and practice which can help explain this dilemma?
To pursue these issues we will consider the views of three practitioners. Their ideas will help provide a starting point for investigating the factors associated with the clear and present inadequacies of patient care.
Chapter Two: Empirical Evidence — Three Interviews

This section will investigate the inadequacies of patient care, identified in the first chapter. It attempts to gain insight into the causes of this problem by consulting three medical practitioners.

A. Introduction

The Physicians

The three doctors have each been selected to contribute their insight and ideas on specific aspects of medical training and practice, as well as their personal ideals and outlooks. Questions, then, focuses on each physician's areas of expertise and personal experiences.

The first physician, Dr. Davis,1 recently entered the medical profession. He is therefore most qualified to provide a relatively accurate account of his medical education, including important experiences and their subsequent effects on his personal and professional development.

The second, Dr. Randall,1 is an experienced physician who was at one time dissatisfied with the medical profession. Some questions address his medical education, as well as the evolution of his ideals both before and during his practice. Additional questions focus on the specific causes of discontent in practice, and how the problems were resolved.

The third interviewee, Dr. Stein,1 was an accomplished physician who chose to abandon his area of practice and to seek an alternate specialty. Questions directed to him

1Pseudonyms have been used in order to maintain the confidentiality of the interviews
address training and development, and stress the relationship between his two areas of specialty, including the events and conditions that influenced the change of practice.

The Questions

The interview questions are divided into two broad areas: (1) personal outlooks and choices, and (2) experiences encountered during education and training. The personal questions concern the reasons for each practitioner's choice of medicine, including reasons for pursuing the medical career and other influences that motivated this decision. Other questions deal with ideals of practice before and after completion of medical school, and with the discrepancies between the doctors' expectations of medicine and the realities of practice. The responses determine additional questions that explored the specific concerns related to dissatisfaction or unrealized expectations.

The other area of questioning addresses medical education. This is divided into the following subcategory: content of curriculum, medical school environment and instruction. The questions focus on the coursework emphasized during medical training and its subsequent application, the importance of the science and non-science courses offered in medical school, and feelings concerning medical school reforms.

The medical school environment and its effects on students is also explored. These questions relate to the rigors of the medical curriculum and their effects on the development of personal views and ideals. Other questions concerned studies in the "clinical" stage of medical training, and their contribution to the development of good bedside manner and communication skills.

Finally, medical instructors and their influence on the each physician's personal and professional development, are discussed.

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2 A complete list of the interview questions is provided in the Appendix.
B. Interview One: Dr. Davis, Internist

Dr. Davis is an internist who has been practicing since 1991. His medical training is unique; for, instead of completing his preclinical studies in a United States based institution, he studied his first two years at the American University, located on the Caribbean island of Montserrat. He later completed his clinical studies, the latter two years of most medical programs, at Louisville, Kentucky, and served his residency at Ball Memorial Hospital in Muncie, Indiana.

Dr. Davis traces the origin of his interest in medicine to his youth. He recalled his fascination with injuries and treating cuts and minor wounds when his peers evaded any such contact. He also expressed a love of the sciences. But despite these interests, Dr. Davis explained that he chose not to enter medical training immediately after college as do most students. Rather, he worked on graduate studies and served as an orderly in a hospital for a number of years. To this experience he attributes his unbiased respect toward the "medical team" which, as he pointed out, consists of nurses, functionaries and personnel other than physicians, all of whom contribute significantly to the overall success of patient care. He also explained that he suffered a severe injury soon after beginning his practice in 1991 which enabled him to see "the other side" of medical care.

Dr. Davis noted that his expectations of the medical profession before starting his training were far from the reality that he later encountered. He had "an idealistic mindframe of the doctor being an important person in the community. Now he is just a member of the community rather than the center of it." Moreover, "pressure from insurance companies and always justifying why you are doing this or that, was a lot more than I ever thought it would be." In addition, Dr. Davis explained that the threat of malpractice forces doctors to rely far too much on unneeded testing. Ultimately, this excessive caution strains the relationship with patients. Frequently, doctors avoid interacting with "risky patients," such as those seeking a third or fourth opinion, and instead refer them to specialists.
In contrast to these less appealing aspects, Dr. Davis expressed his delight at seeing patients and their families satisfied and grateful for his treatment and care. "Most rewarding is when a patient pats you on the back and tells you that they are here today because of what you did," he said. In addition, he explained that unlike many of the specialized disciplines, primary care often offers the benefit of greater freedom to control one's work schedule. This factor enabled him to spend more time with his family by reducing the number of patients that he consulted. Dr. Davis explained that financial rewards are not his first priority, and that he is satisfied with his level of financial comfort. And as far as coping with the darker reality of medical practice, he explained, "I look at the good and try to negate the bad."

Dr. Davis voiced his disapproval of the concentration on the sciences during the whole spectrum of the medical education. During the pre-medical studies in college, the overburdening demands of the science courses is, in his view, a weeding-out process. "More should be used in the humanities and [other areas] to get a well rounded person instead of just somebody doing whatever it takes to get the grades." Once in medical school, again, "it's all science." He noted that there is little emphasis placed on any other areas, including the social sciences, which are, in his opinion, particularly important within the primary care setting. He explained that these courses contribute considerably to establishing a good rapport with patients. Communicating well with patients requires a knowledge of the social influences of disease, as well as an awareness of the key words and questions which will encourage a patient to reveal important background information. Thus, often the lack of emphasis on psychology and sociology in medicine contributes to poor clinical practices. Some of the younger medical students are too "analytical and clinical and forget about the person. They really do not have a caring for the rest of the person" and for the family and spouse of the patient, "but only for what is hurting. It needs to be personalized a little bit more. A lot of U.S. graduates are cold and just want the answers and to get on with it."

During medical training, the professors who influenced him most, explained Dr. Davis, were those who cared for and attended to patients' needs. He explained that these were the "doctors who would hold the patient's hand" or "sit down in the patient's room"
rather than standing at the bedside or at the door to the room." Patients often complained that
doctors would ask them questions but were not concerned with the responses. He also
noticed a lower quality of patient care at the teaching hospitals. Doctors would sometimes
behave unprofessionally, performing lower standard surgical operations. He explained that in
a traditional hospital, a surgical incision is made using a standard technique yielding an
optimally precise result. However, at teaching hospitals, often such procedures were
performed haphazardly and with little consideration to accuracy and quality.

Dr. Davis's personal and family experiences facilitated and enhanced his ability to cope
with terminal diseases and death. To protect yourself emotionally, "you convince yourself
that you did everything you could. There has to be the realization that you cannot do
everything for everyone, and sometimes you are limited by the severity of the condition."
Davis also expressed his belief that patients have the right to know the nature and
implications of a terminal illness. Such information enables them and their families to make
the necessary plans and to prepare themselves to go through the stages of Kübler-Ross's
death and dying. "You also try to maintain a good rapport with the family and help them as
much as possible."

Dr. Davis brought up an additional aspect of terminal illnesses. When death is
imminent, he confronts patients and discusses their feelings about their illness and the kinds
of measures they would like to take. Depending upon the patient's needs and desires, he
suggests the optimal course of treatment: either a "heroic" life prolonging treatment or
programs such as hospice1. This leaves the decision-making to the patient and his family.

As far as student-instructor relations were concerned, Dr. Davis felt he had been
treated fairly during his medical education. During residency he resented the older physicians
berating modern trainees, whom, they claimed, were blessed with an abundance of
technology that was not available during their own training. He saw this view as simplistic
and reactionary since new technologies necessitate greater learning and impose new
responsibilities. But for the most part, the atmosphere was warm and compatible. "The

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1 The hospice system is briefly described in chapter five
nurses helped a whole lot. My fellow residents helped a whole lot. And the teaching faculty was very understanding. When we would make rounds the next day after being on call and we were up all night, they would understand. I couldn't carry on a complete sentence sometimes. My train of thought would just be lost."

Dr. Davis did express his disapproval of the overload in residency which creates a poor learning environment. The system used in some New York hospitals, where residents are required to work fewer hours per rotation, is more educational, he thinks, since it forces one to acknowledge his capacity to learn and to recognize his limitations.

The continuing education of the physician was, for Dr. Davis, an aspect of the practice that is, to an extent, burdensing. Having limited time to devote to patients, as well as personal needs discourages learning and restricts one's capacity to remain current of new technologies and techniques.
C. Interview Two: Dr. Randall, Family Practitioner

Dr. Randall is a family physician who has been in practice for 26 years. He completed his training at the Indiana University Medical Center where he also served a one year internship. Dr. Randall recently chose to sell the private office he established soon after finishing his medical training. The harsh realities of modern practice required him to devote a great deal of effort to managing a business in addition to practicing medicine. "In the past you could get yourself some equipment and hang out your sign and you were in business. But it's not like that anymore." Randall explained how government agencies dictate limitations and make demands, and that the insurance companies are interposed between patient and doctor. These factors coupled with spiraling overhead costs, have contributed to the increasing difficulty and complication of managing a private practice. This has made it almost impossible for a solo practitioner to survive, and as a result, in recent years the number of private practices has diminished. Dr. Randall continues to practice in his original office; but, instead of being the manager, he works through the local hospital which handles the paperwork and enables him to devote himself entirely to patient care. Although his own position has shifted, he pointed out that the clinic is unchanged as far as the patients are concerned.

Beyond the economic and financial difficulties of the medical system which Dr. Randall considers the prime problem area, he has been more or less satisfied with his practice. "Most rewarding is being able to see patients and provide care which dramatically improves how these people function and feel." Becoming well acquainted with people and sometimes taking care of three and four generations within the same family, he explained, is the greatest appeal of family practice and of primary care in general.

As with any aspiring physician, Dr. Randall went into medical school with certain expectations of the medical profession. His early attractions to the medical field were based

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1 The residency for family practice has since been extended to three years.
on his interest in the sciences and his ability to help people, as well as the financial rewards of the profession. To a large extent, the ideals were "tempered and grounded," but his basic philosophy of contributing to the well-being of people has largely remained unchanged.

Dr. Randall explained that the scientifically based pre-clinical curriculum, which accounts for the first two years of most medical programs in the United States, was intensive and largely unappealing. But while he conceded that science per se is not used on a daily basis, a solid scientific background is fundamental for understanding and appreciating the medical profession. For this reason, the large majority of his classmates were very motivated and attached to the sciences. He did point out that although unusual, "there was the occasional music major. Anyone can do it regardless of the background if they have the intellect."

Studies in the social sciences were not emphasized during the pre-clinical years, nor in the clinical setting. Dr. Randall explained that during the first two years of medical school, instructors were often research scientists, concerned more with the study of "squid nerves" and the like than with people. Consequently, they often lacked a good understanding of social science and its role in medical care. "You sort of developed your skills in these areas," he noted. He did feel, though, that these studies are important and should be addressed since the doctor encounters many psychologically influenced disorders and sicknesses. But at the same time, it is difficult to incorporate these studies within the curriculum, and often they are not discussed to any great extent. Much of the knowledge of psychological and sociological bases for illness is acquired during the residency and also throughout professional practice.

Practical experience also enhances understanding in confronting terminal patients and death. Learning to cope comes with experience. "You just have to deal with each case on an individual basis. You let the patient set the pace. Some want to talk [about the implications of a specific terminal or chronic situation], while others do not. Some handle it well, some do not." As far as dealing with death, since there was no formal training in medical school, "you
learned to accept it and to move on." He pointed out that, predictably, a doctor suffers more with patients to whom he is more attached. "But you do not dwell upon it and let it become too much of an emotional thing."

Empathy and communication were other areas not formally addressed during Dr. Randall's medical training. "They teach you to do a history and a physical," but little more is required. Although he did not believe that the lack of formal education in these areas resulted in a lower quality of medical care, "you have to sharpen your skills. Practice helps to some extent — I communicate much better now than when I first started." In Dr. Randall's experience, students were expected to develop any non-scientific understanding on their own. This included mastering knowledge of the humanities, which are reserved for the undergraduate studies. The vast amounts of information packed into the curriculum cannot allow for subjects which, in his judgment, "are limited," since they "do not impact your practice specifically."

Dr. Randall explained that the lifestyle in medical school, especially during the first two years, was rigorous and harsh. But most of what he considered the "personality molding experience," that is, the part of training that enhances a physician's resilience and stamina, occurred during clinical training. In the junior (third) year of medical school, when the student begins working within the clinical setting, he comes into contact with all levels of medical workers, and occupies the lowest rung in the medical ladder. Students do "scout work" or odd jobs such as taking patient histories, making elementary examinations and performing basic tests. Because of their low rank, students tend to be disregarded, and their needs are often overlooked. Nonetheless, he believes that these tasks and experiences are required in medical training. They build character and other positive qualities necessary for the practice of medicine.

Teaching hospitals generally attract a "clientele" from the lowest socio-economic strata. However, in spite of this situation, Dr. Randall claimed that good health care was provided within these settings. The instruction during the clerkships was largely assumed by junior residents who were one step away from entering professional practice. Senior physicians
contributed little formal instruction after the preclinical studies.

After the completion of medical school, an individual possesses a vast storehouse of information. During practice, some of this knowledge is exchanged for practical understanding. "There are certain things you can learn to understand about patient care which come only through experience." Dr. Randall described this process as a means of achieving an equilibrium between the knowledge physicians gain in medical school and skills and understanding they develop throughout their practice. Keeping up with emerging information is very difficult for two reasons. First, it is well known that the medical profession is highly demanding and time-consuming. This leaves little room to stay abreast of the emerging medical discoveries and advancements. In addition, the ever expanding knowledge and understanding of medicine has made it difficult for practitioners to stay abreast of new advancements within their field. This is particularly challenging for specialists who practice within a highly specific area of medicine and who require knowledge of new technologies and recent advances in medical treatment.

Finally, Dr. Randall explained that the financial benefits of the medical profession influenced his choice of career. "Would I have gone through what I went through for thirty thousand a year? Don't believe so." He explained that during that time "there was not really any better way to make money" without an already established wealth. Business requires both experience and money, and many people from a middle-class background "went in to better their lot." However, he did not feel that physicians who were attracted to medicine's financial rewards deliver a lower standard of care. "The quality does not go down as you make more money. Certain super-specialists who will not hold your hand do a great job. The patient does not care [as long as the] result is good." Dr. Randall pointed out that more emphasis is required on the doctor-patient relationship in the primary care areas. But ultimately, the success, and therefore the wealth of the physician, are determined by his or her competence and capability to provide optimal results.
Currently practicing in geriatric psychiatry, Dr. Stein chose to switch to this area of medicine after more than a decade of practice in internal medicine. A graduate of the Indiana University School of Medicine, Dr. Stein is completing his residency in the Larue Carter Psychiatric unit at the medical center. Dr. Stein's interest in geriatric psychiatry has been long lived and gradually cultivated over the years. "It was a question of timing. I knew that is what I wanted to do, the question was when to make the switch." He referred to an aphorism: "all internists will be geriatric doctors because their patients get older," and he explained that to an extent this is true. With age, people become more vulnerable to the effects of diseases and disorders. "There are a lot of mood disorders, thought disorders, depression, and a vast array of physical disorders. There are also the degenerative disorders such as Alzheimer's and Parkinson's disease, as well as chronic infectious and non-infectious diseases. All this creates a great challenge." He also explained that his chosen field would provide him with options for research or academic work and teaching.

Dr. Stein cited other factors which motivated this change of practice. His private practice was demanding: the long hours took their toll, and the lack of control imposed by government intervention was, to a certain extent, restrictive. "The business aspect of medical practice is not formally discussed in medical school, and most doctors do not want to spend their time managing a business." Selling his practice to a hospital was not an option that appealed to him. Changing specialties offered the best solution in every respect. Dr. Stein justified his decision to undergo, once again, a thoroughly demanding residency by explaining that this would enable him to consecrate his future efforts to practicing in the area of his greatest interest. "I asked myself, what do you want to be doing in the next twenty years?"

Dr. Stein traced his interest in the medical field to its challenges. "There was always the fascination of the treatment of disease. Some element of prestige, some element of being able to achieve something on a 'higher plane.'" He explained that doctors are often idealists
who believe that "they can save the world." "There certainly are a lot of positive things which
go along with being able to help people. But along the way you come to a realization that you
do not cure most people, but help them cope and make small gains where they can." This is
especially important in treating chronic illnesses, which do not simply go away. "As time
goes on, nobody escapes death, and that is something that a lot of us have to deal with. We
spend a lot of energy and a lot of time, invest a lot of ourselves at taking care of these
patients, and we become attached to them. And as we get older the number of problems and
drug interactions and complications increase." Dr. Stein explained the frustrations caused by
the limitations of caring for certain patients. "It has been termed 'feeling impotent' to treat
these patients. There is a lot that can be done for some patients and less for others. You learn
to say 'well, we made some small gains, this is not a curable process.'"

In Dr. Stein's experience, the medical school curriculum was heavily oriented on the
sciences. "By and large there are certain really important things which are beaten into you
head," he explained. Yet he estimated that probably about 50 percent of the material learned
in medical school "was not terribly useful." The relevance of the medical curriculum depends
upon one's area of specialty. For instance, for those involved in drug research, physiology
and pharmacology are areas of considerable importance. On the other hand, primary-care
physicians depend less upon their knowledge of these areas. Medical school training is
designed to provide a broad base of knowledge which helps students choose their field of
expertise.

The social sciences, he noted, were sparsely addressed. Some emphasis was placed on
behavior and sexuality during the second-year courses, and a standard psychiatric rotation
during the fourth-year clerkships, but little formal training in the behavioral sciences was
offered beyond these introductions. Dr. Stein expressed his belief that these areas are
important in looking beyond the scope of visible conditions. In certain people who come
back regularly, "a lot of what the doctor can see, if there is time, are problems with mood
disorders and depression, or problems with relationships within the family." For instance,
patients who seek medical attention for headaches, often receive CT scans and sometimes even neurology evaluations. The diagnosis is then given as organic headache syndrome caused by muscle tension or other minor physiological disorders. Yet often, these headaches are more closely associated with emotional disturbances. "I found that an empathic approach, which takes a lot of time in the office will usually yield an initial problem: a headache or backache, followed by a nice little dissertation of what is really going on. That’s the underlying issue."

Dr. Stein regarded good communication as a vital part of successful diagnosis. However, he acknowledged that during his medical training, this aspect of practice was only touched upon in the psychiatry rotations during the clinical (practical) studies of the fourth year. Dr. Stein quoted a study which revealed that on average, doctors claimed to spend between three and ten minutes per patient. "Once you get beyond 'what is the headache like, what is the blood pressure like, what is the blood sugar and cholesterol and how are the kids,' time is up." These time constraints do not allow much opportunity to see the patient in his social state and to consider possible findings with the biological problem.

Empathy and compassion were also sparsely addressed during training. Dr. Stein noted that there "was some loose sort of attention to compassion and empathy." For example, in an anatomy course the instructor mentioned the importance of respecting the cadavers, since this respect should carry over into clinical practice. "But there was no formal training relating to compassionate care, nor how to interpret your own feelings when you are dealing with these folks." The instructing physicians varied in their approach towards patients. Some were compassionate whereas others had a more "cavalier" style. These aggressive doctors sometimes antagonized patients with their blunt and unsympathetic techniques, although this was not their intention.

Dr. Stein explained that the medical school environment was inflexibility and unable to meet special demands of students. He spoke about a friend who, during the second year, was having some trouble academically because he wished to spend more time at home with his
wife and young children. He explained to the dean of students that he felt confident of achieving good results in school, but that he also had personal needs. He was shocked to find that the medical administrators were completely uncompromising, and they informed him that the medical training had to take priority. Within a month he had abandoned his studies. Dr. Stein explained that this rigidity may not be designed expressly or intentionally, but it is nonetheless inherent within the system.

During the third year, students take their place in the hierarchy of medical practice. Since they occupy the bottom rung, students often feel despondent. At certain times clinical work is done with difficult and even aggressive teachers, often exacerbating the unpleasantness of the experience. Other clinical work is completed under the guidance of more cooperative and empathetic doctors; in general, the situation improves with time. This is particularly true for interns who are often depressed during the first six months, but gradually adapt to their working climate. Dr. Stein pointed out that, despite their low status within the “medical caste system,” third-year students are often relieved when they arrive at this point in their studies, which for them represents the long awaited opportunity to work in the clinical environment after years of tedious preclinical preparation.

Dr. Stein explained that the medical curriculum contains many mechanisms which enhance the desire to remain current after the completion of the training process. Competition is also a motivating factor. The drive to remain aware of advancements in the profession, Dr. Stein explained, is apparent in a selected few who are determined to keep learning, and, in essence, to be the most qualified for scarce and lucrative positions. Burnout, he noted, often affects many of these practitioners.
E. Conclusions

As we noted earlier, the three doctors interviewed had varied experiences, both personal and professional. Each was asked questions directly or indirectly linked to problem-areas within the medical system in the United States.

The physicians each offered a slightly different perspective on medical training. All three found the preclinical studies unappealing to a large extent, although they reported that the worst personal treatment occurred during clinical work and residency. Although each doctor felt that instructors were generally fair towards students, Dr. Stein commented on varying circumstances and difficulties with which students had to cope. Moreover, two of the three physicians had a low regard for the quality of patient care they observed during clinical training. Dr. Davis was unimpressed by the lack of professionalism at the teaching hospitals and the lack of warmth shown to patients within this setting. Dr. Stein also suggested that certain physician's practices were not well regarded by patients.

The doctors had differing opinions regarding the medical school curriculum. Dr. Randall felt that a solid scientific background was important to the practice of medicine. He therefore supported the purely scientific studies of the first two years of medical school, believing that they were necessary for success in future practice. Dr. Davis felt that there was too much focus on the sciences during the entire process of medical education, and Dr. Stein understood the rationale behind the tremendous concentration on the sciences, though he found much of it unnecessary. On the other hand, the doctors all felt that behavioral science courses were important for creating a good understanding of patients and for recognizing one's own feelings. It is implied that such course-work ultimately enhances certain aspects of clinical applications, although the doctors did not explicitly state that better communication or greater empathy results.

The area of continuing education and staying current of relevant scientific and medical discoveries was not discussed in detail by any of the physicians. Dr. Randall expressed his
approval of the Continuing Medical Education (CME) programs, but claimed to have difficulty in keeping up with the information explosion of the recent years. Dr. Davis indicated that this was not among his priorities, and Dr. Stein suggested that staying ahead of the field is the primary motivation for continuous learning, and is mostly focused upon by competitive and ambitious physicians. This information corresponds to other accounts which suggest that doctors are not staying abreast of continuing discoveries and developments in medicine. However, Dr. Stein's unique case suggests that doctors should be evaluated on an individual basis since their personal interests and motivations are the factors most influential to the continuing study of medicine.

There were other aspects of medical training and practice discussed by the physicians. These were mostly related to the physician's background and personal interests. The most uplifting and gratifying part of practice was associated with the physicians' roles as benefactors and their abilities to contribute to their patients' well being. Dr. Stein also cited professional challenges as contributors to personal satisfaction.

Finally, the three doctors commented on the business aspect of medicine as one particular area of their practice that they dislike. Interestingly, Doctors Reedy and Spangler, who were at one time dissatisfied with their practices, and Dr. Davis, who had never considered abandoning his trade, pointed to the same general area of discontent. Problems with insurance companies and with government regulations were identified as the major causes of this dissatisfaction.

These three interviews offer insightful and useful ideas on both medical training and practice. The description of experiences and opinions obtained in medical school revealed that the effectiveness and completeness of medical training are in some respects questionable. Could it therefore be that the observed inadequacies of medical practice are somehow associated with shortcomings in the education of physicians? Although such an assumption follows logical reasoning, this relationship is not explicit. Therefore, ascertaining the relevance of medical education to the problems described earlier requires a more extensive
investigation into physician training. Medical education and training will be further explored in the following chapter.
Chapter Three: Medical Education: Ideal, Reality, Innovation

The need and desire for quality health care necessitate an efficient mechanism for shaping promising, respectable individuals into competent physicians. Ideally, medical institutions acknowledge this need and translate it into a comprehensive and effective curriculum. For the most part, medical institutions throughout the United States follow a similar, standard training format. They first seek to familiarize students with "the language of medicine," and the proper use of scientific instruments and techniques in problems solving. Next, medical faculty teach students analytical and reasoning skills which are critical for the often fragmented and incomplete information present during practice. Medical educators also teach proper communication skills, which although basic, are essential for the practice of good medicine. In addition, medical institutions recognize and "hope to expand on the individual physician's capacities for constructive empathy, helping others by the use of his or her own compassion." Finally, medical schools attempt to encourage a learning that continues beyond and after medical training. (Vevier 36-37)

A. The Curriculum Breakdown

Meeting these diverse requirements calls upon medical institutions to present an equally comprehensive and flexible curriculum. In an attempt to balance scientific skills and clinical competence, medical schools have traditionally relied upon Abraham Flexner's four-year model described in 1910 in his well known and highly regarded Medical Education in the United States and Canada. This central doctrine for medical education breaks down the
curriculum into the so-called didactic studies of the first and part of the second years, and the clinical studies, comprising the bulk of the following two years. (28-91)

The curriculum outlined below was taken from the University of Illinois College of Medicine, although it accurately represents the traditional program offered at most allopathic medical schools throughout the United States (Grady 3-4). During the first year, the aspiring physician follows an intensive curriculum in the "basic sciences" (e.g. microbiology, genetics, gross anatomy, immunology, etc.). The students' only exposure to the actual practice of medicine during the first year often comes through contacts with Medical Doctor Advisors (MDA). Knowledge of the sciences and laboratory skills are evaluated through comprehensive examinations administered biannually. These written and practical tests represent the only forms of evaluation students receive during the first year of studies.

Ideally, this first year serves as the students' initial contact with their future profession. The emphasis on purely scientific study is justified by the need to establish a basis for future practice.

By contrast to the almost exclusively didactic study of year one, the second year introduces medical students to the clinical format in which they will practice as physicians. The studies are often broken down so that one part of the day is devoted to lectures and laboratories, while the remainder is spent with patients. This clinical work focuses on fundamental skills such as writing patient reports and patient histories, and performing physical examinations and basic tests. During the second year, student evaluations include standard tests, as well as practical assessments conducted within the clinical setting. At the end of the second year, students are required to take test one of the National Board of Medical Examiners.

The third and fourth years of medical school are generally less structured than the first two. During these years, students are required to complete sixty weeks of clerkships within the clinical setting, each of which varies in length from four to twelve weeks. Clerks are directed and supervised by senior physicians, but they perform their duties on an independent
basis, contrary to the didactic "spoon-fed" nature of their early years at medical school. Students are certified after successfully completing the second part of the National Board of Medical Examiners.

After graduating from medical school, the newly titled interns or first year residents apply for year-long internships. These internships have been labeled the single most important part of a physician's training since they often serve as good indicators of the individual's capabilities and competence as a deliverer of medical care (Nash 113). Following the internship, doctors usually elect specialties requiring several additional years of residency, the specific length of which depends upon the desired field of practice.

The standard curriculum influenced by Flexner is at the very basis of medical education in the United States. Before Flexner, the American Medical Association (AMA) and other similar societies sought to regulate medical practitioners and training facilities. But since the government did not officially acknowledge the rights of states to license physicians until the late nineteenth century, numerous institutions, each embracing varied philosophies and approaches, were able to prosper. In 1908 Flexner launched a thorough examination of the medical schools throughout the United States and Canada. His investigation exposed sometimes startling deficiencies in medical training. In his Report to the Carnegie Foundation for the Advancement of Teaching, Flexner strongly criticized the quality of medical training. He noted the inadequate facilities, the often erratic teaching methods of amateur professors and the low caliber students. The impact of the Report was felt throughout the United States and resulted in the closing of half of all existing medical schools (Kaufman 170). The Report also promoted standardization of a curriculum that formerly lacked both cohesiveness and predictability. In effect, this limited medical practice to the systematic and scientifically based allopathic approach to medical care. Allopathy is the modern method of treatment in which physicians actively intervene through surgical techniques or drug therapies to counteract the effects of illness or other pathological conditions (Bauer 39).
There is no disputing the fact that Flexner’s contributions thrust American medicine towards greater organization and modernization. However, his reports also became the targets of considerable controversy. Many critics claimed that Flexner’s reforms greatly limited the diversity of the medicine practiced. New, higher standards in education created greater tuition costs, which restricted medicine to upper-income white men (Kaufman 171). Over the course of this century, changes have enabled greater opportunities for all men and women interested in pursuing the medical career. But other problems inherent in a system established nine decades ago continue to burden modern medical education. These will be further explored and discussed throughout this study.

B. The Question of Compassion

To be a good doctor, a truly complete one, a physician must understand molecules and cells, organelles and organs, but he must also understand the complex, ineffable miracle we call the person. (Rieser and Rosen 34)

The medical school curriculum outlined above presents the continuum of the traditional process of education: the initial acquisition of facts and information and their subsequent application. But while this serves as the future doctor’s fundamental source of knowledge, medical education involves far more than the assimilation of facts. What distinguishes medicine from other scientific disciplines is, of course, the human factor. Somehow, medical students must gather the knowledge and understanding necessary for proper diagnosis and treatment within a context that considers the patient’s emotional needs and concerns.

Medical schools expect their students to possess an inherent empathy and understanding of the ill and handicap (Vevier 88). The duty of medical educators is to guide future physicians and help them develop a responsiveness to patients’ needs. To achieve this understanding, students must be made aware of the individual that exists beyond the scope of
a scientific examination. In essence, this understanding involves the concepts of "the lived body" or "the lifeworld" (Odegaard 128). Both of these ideas refer to basic human experiences. "It is the realm of everyday interaction and practical projects. Here we do not conceive the world through scientific ideas, rather we perceive it through our senses and engage in it through bodily activity" (129). Understanding the significance of this shared experience, one that exists beyond the boundaries of science, helps the student become attuned to the needs of the patient. This, in turn, enables (at least in theory) the delivery of compassionate health care.

However, the question extends to practice where it must address an area of health care delivery that depends more on feeling and understanding through experience than on thought and analysis. There is unfortunately no direct methods of teaching humanity and compassion. Yet medical educators generally agree that prospective physicians may develop and cultivate these qualities within a learning environment that unites sciences and humanities.

Student observations of the interactions between patients and senior physicians serve as one of the primary means for "teaching" compassionate behavior. This approach assumes that once students are sufficiently exposed to the clinical setting, they will relate to patients in the same humane manner displayed by their teachers (Vevier 91). Senior physicians are able to monitor the progress of their "trainees," and observe students' interactions with patients. Student doctors are then evaluated on the basis of their technical competence and accuracy, and on their "bedside manner." Such assessments provide a means for medical educators to identify any weakness in their student's practices, which can, in turn, assist future doctors in improving their methods of interacting with patients.

Student-faculty interactions also exercise influence on the development of humane physicians. It has been suggested that aspiring doctors often respond to patients in much the same way as they, themselves, are treated by senior physicians (Hendrie and Lloyd 84). Therefore, conditioning doctors to be humane requires a faculty sensitive to the needs of the students. The importance of these interactions is further emphasized by the fact that, ideally,
doctors serve as teachers to their patients, helping them learn about and understand the implications of a given medical condition.

Instilling an awareness of patient needs can also be accomplished in the classroom. Courses in the social and behavioral sciences, such as psychology and sociology, are often taught as part of the preclinical curriculum. Such courses serve multiple roles. First, they help enhance students’ awareness of the social and psychological bases for disease (Hendrie and Lloyd 76). In the previous chapter, we noted the importance of understanding the non-scientific causes of disease to accurate diagnosis and treatment. These courses also enable students to understand and thereby relate to individuals of varying backgrounds, customs and beliefs (White 39). Second, the social sciences offer a different perspective on medical practice. Unlike the “hard” sciences (biology, chemistry, physics), these disciplines deal with more abstract, less easily defined issues and ideas. They therefore expand the student's understanding of medicine to encompass the less tangible and concrete (White 228). Finally, possessing an understanding in psychology enables physicians to recognize and thereby to address their own feelings toward patients and the clinical environment (Odegaard 22). As we shall later see, confronting one's feelings is important for coping with the difficulties experienced in the medical profession.

C. The Problem Areas: Medical Education's Darker Side

As we have seen, the traditional process of medical education involves the training of selected individuals to become competent physicians, qualified in treating the sick accurately and humanely. Yet, a vast rift separates the public's ideals of health care and the less than favorable evaluations that these services have received. Could it therefore be that the public's discontent reflects inadequacies in medical education? Despite the intensity of the medical program, are medical schools failing to provide students with the desirable and necessary guidance and instruction?
Medical school administrators and other experts have, for the most part, directed their criticism to three broad areas of medical education programs. First, they claim that the organization of the medical school curriculum itself contributes to physician inadequacy. In short, the basis for the system of medical education does not work. Second, they suggest that the coursework and curricular content are insufficient for the complete education of competent and empathic doctors. Finally, they blame outmoded methods of instruction and the mixed interests of the medical school faculty for the limited effectiveness of medical training.

D. A Flawed Learning Atmosphere

The structure of medical school is such that students are forced to consecrate all their time and energy to their studies. The tremendous intensity of the coursework typical in medical school creates serious constraints. Many have characterized medical preparation as excessively rigid and unsympathetic to individual needs (Hendrie and Lloyd 98). This obligation to devote one's almost entire attention to study places severe strains on relationships with family and friends. Such limitations on social life often leads to isolation, even from fellow students. In addition to the oppressive workload, academic competition is widespread and often fierce. The good will inherent in medical students is therefore put to a grueling test (Vevier 19).

Why does such a heavy load burden students during the preclinical studies? One explanation considers the fact that Flexner introduced his model for medical education at a time when much of what is known today was still undiscovered (Hendrie and Lloyd 97). For this reason, the medical curriculum during the early part of the century was far less densely packed with information than its modern counterpart. However, the time allotted for studies has not taken into consideration the wealth of "new" scientific information acquired over the past eighty years. In other words, medical studies now cover infinitely more material in the
same time period as before, resulting in the observed overload, which the founder of modern medicine in the United States had never intended.

Many critics also consider the atmosphere present during residency as antithetical. Residency is the ultimate "hands-on" experience, where medical school graduates practice treating patients within the clinical setting, alongside senior physicians. But unlike established physicians, residents must contend with an enormous and sometimes overwhelming workload. Eighty-hour work-weeks are not uncommon. And residents often practice in highly stressful and often unrewarding settings, treating terminally ill patients or those with complicated conditions (White 55). Many residents lose what limited social life they experienced in medical school, and their entire world, both vocational and social, exists exclusively within the confines of their designated hospital wards. Depression is widespread — in one study, almost a third of the interns and residents questioned claimed to suffer from depression and distress, and as many as 18 percent "had suicidal thoughts and a plan for committing suicide" (Hendrie and Lloyd 104). This environment is clearly not conducive to proper physician development, and it breeds cynicism and resentment of patients. Moreover, these studies have demonstrated that over the course of medical training, students' attitudes become increasingly negative at the cost of diminishing humanitarian ideals.

E. Science Overkill

The heavy emphasis on "hard" science in the medical school curriculum itself is considered a problem area. Students frequently complain about the apparent irrelevance of the preclinical studies in the basic sciences to their future in medicine (Hendrie and Lloyd 99). They often regard these studies as an obligatory rather than integral part of their quest for professional certification. Frustration often results from the apparent need to overcome another obstacle.
Dr. Carleton Chapman, former Dean of the Dartmouth Medical School, sees medical training as a sort of "curricular Darwinism, [where] the fittest are those who are most adept at rote memory" (Vevier 53). He and other critics of the preclinical curriculum underscore the futility of forcing students to acquire basic scientific knowledge before giving them the opportunity to explore and experience the clinical setting. Certainly, medical and scientific knowledge is essential to the practice, but does this imply that it must be learned in its entirety before practical work can begin?

Students' frustrations with their curriculum is not the only problem. A number of experts in the medical field, including medical school faculty and administrators are questioning the role of the sciences during the first two years of medical school. Some believe that the intensive and typically didactic "force-feeding" of the preclinical curriculum compels thoughtful, interested students to compromise their intellectual development, and become dependent upon having the facts passively presented to them (Vevier 38).

Moreover, examinations, such as the National Board of Examiners tests one and two, require students to assimilate and reproduce massive quantities of information. Such concentration on facts and figures may actually distract future physicians from understanding their intended roles in practice (Hunt and Sobal 323). After all, "it is not the function of the physicians to know; it is his function to acquire background knowledge relevant to the problems of the patient and to act in diagnosis, prognosis and therapy (Odegaard 108).

The effects of science-overload are dramatic. In one study, third-year medical students watched a recording of simulated patient interviews and were then encouraged to pose questions or make observations regarding what they witnessed. The result: "A full 90 percent of the questions...asked [by students] concerned measurements and biological information. Two thirds of all the students never asked a single question about the patient's personal or emotional history" (Nash, 134). In another case, a student participating in a
discussion on "The Dying Patient," asked: "How can you expect us to think about death and dying when we have an exam tomorrow?" (Hunt and Sobal 323).

Interns, too, seem to focus their efforts almost entirely upon their technical and scientific knowledge. Residents, eager to prove their specialized skills or fearful of misdiagnosing, often order a vast array of superfluous tests. As a result, they "learn a great deal about a disease while they learn very little indeed about the patient" (Nash 115). How can it be that medical school graduates and practicing residents possess such a limited understanding of their roles as doctors? Undoubtedly, the basic sciences play an important part in the field of medicine. But is it desirable for medical programs to create the image that science takes precedence?

Flexner did not think so. His stress on science did not apply exclusively to knowledge but also to the systematic scientific methodology (Cassell 10). His fundamental concern was to develop an organized method of teaching doctors. Furthermore, he recognized the dilemmas of limiting ones focus to science:

Now science, while widening our vision, increasing our satisfactions and solving our problems, brings with it dangers peculiarly its own. We can become so infatuated with progress in knowledge and control, that we lose our perspective, lose our historic sense, lose a philosophical outlook, loose sight of relative cultural values... (Vevier 80)

Coupled with the overwhelming emphasis on the sciences lies the problem of inadequate attention to the behavioral studies. As we have already seen, psychology and sociology play an important role in helping future physicians develop their sensitivity and understanding of patients. But often these disciplines are not properly taught or their importance is dwarfed with respect to the "hard" sciences (Hendrie and Lloyd 76). In other

1 Presumably, this title refers to the name of the seminar since the author provided no additional explanation.
instances, students fail to understand the practical importance of their social and behavioral
science courses. To avoid this confusion, educators suggest that these disciplines be
combined with the general scientific studies. For example, courses in pediatrics and family
medicine could readily incorporate concepts and ideas relating to sociology and psychology
(Hunt and Sobal 321).

Misunderstandings of the social implications of patient care also occur within the
clinical environment. These often result from mixed messages conveyed by senior faculty at
the teaching hospitals. For instance, a psychiatric specialist providing instruction to students
is likely to stress communication and its importance in diagnosis and treatment. On the other
hand, in another clerkship, students may be instructed by an orthopedic surgeon whose
approach is centered more on extracting scientific data during rounds (Rieser and Rosen 99).
As a result, students would tend to refer to each method of patient care based upon the setting
in which it was taught.

The emphasis on science for admission into medical school creates another problem. In
order to qualify for most programs, prospective medical students must demonstrate their
proficiency in the "hard" sciences. Students are required to elect basic science courses as
college undergraduates and must score competitively on the Medical Colleges Admissions
Test (MCAT), which examines scientific knowledge and understanding and verbal and
written skills (Zabela et al. 27). Medical admissions personnel encourage students to be well-
rounded in other, non-scientific areas. But the admissions process scarcely considers factors
such as human understanding and compassion. Assessing an individual's characteristics and
capacity for compassion and human empathy is complicated and subjective and highly
impractical (Vevier 96). Although medical admissions committees prefer applicants with
some background in the humanities, specific knowledge and proficiency are still the
preferred means of evaluating a candidate's qualifications.

The need for effective and reliable individuals to fill the duties of physicians, as well as
those capable of enduring the rigors of medical school, encourages a certain emotional and
psychological profile among medical students. Psychological studies have described medical students as being:

obsessive, compulsive, orderly, highly organized, responding to the dictates of their own conscience. Their modes of functioning are rather basic attributes of what are called a healthy obsessive compulsive character. That is, productivity, achievement, isolation, denial and repression serve to protect the student from disturbing intrapsychic and interpersonal conflicts. They tend to strive for mastery, control and thoroughness along with safety and self-restraint. They put intellectual matters above emotions, security above pleasure, service to others above self-service, exactitude above fantasy. ... Faculty members describe the typical medical student as a hard worker, extremely conscientious, a little shy and retiring, who doesn't let go of his feelings, and is somewhat hard to draw out. They suppress their aggressive and sexual impulses in the interest of satisfying conscience and need for security. (LaDou and Likens 17)

The fact that these qualities are often present in medical students hints at the means whereby future doctors are expected to cope with the medical environment. Critics have suggested that medical schools prefer students with "a stiff upper lip" (Howell and Schroeder 75). They point to the fact that schools often fail to recognize their students' feelings, and therefore do not provide adequate counseling facilities to help them cope with their poignant emotions. This contributes to the discontentment in medical school that we observed earlier. However, problems are not only apparent in training. As we shall see in the following chapter, emotionally repressed students often have serious difficulties in practice.
F. Shortcomings of Instruction in Medical Schools

The instruction provided in medical institutions has also been the target of considerable criticism. As we have already noted, student-faculty interactions help to stimulate and enhance compassionate care. Surprising, therefore, is the number of incidents in which students have been verbally abused and humiliated by senior physicians (Hendrie and Lloyd 100). These assaults often breed anger and resentment among students and result in a poor morale and a lower self-esteem. Patients are the ultimate victims, since their psychological well being reflects the mood present in the clinical environment.

The expansion of medical schools also has taken its toll on the quality of education. The incremental growth of the class size over the years has resulted in less frequent and personal contacts between professors and students. In addition, the growing responsibilities of senior physicians to research and patient care have left less time for students. As Dr. David Rogers, Professor of Medicine at Cornell University, explains,

Gone are the leisurely laboratory sessions where students and faculty became acquainted with each other in a problem solving mode. Gone are the informal after-hours get-togethers with faculty who knew students and vice verse...Gone are the genuine, go at your own pace problem-solving sessions in which students learned to think deductively and gain experience in logical decision-making. (Vevier 38)

No concrete evidence suggests that these trends are responsible for problems in health-care delivery. Yet the quality of medical education is largely determined by the contributions of faculty to student achievement and development.

Recognition for achievement in research is essential to the success and status of a medical institution which derives much of its funding from public and private grants.
Therefore, the medical faculty's publication and research largely determine salary and promotions, while teaching and clinical work are often secondary in emphasis (Hunt and Sobal 324). Not surprisingly, "medical schools are dominated by professors who are often much more interested in research and the subtleties of diagnosis than in actual patient care. Unfortunately, some tend to view a patient as little more than a convenient receptacle within which to study a fascinating disease" (Nash 13). In another survey, students reported that during their clinical rotations, the senior physicians only visited with patients 20 to 30 percent of the time (White 59). This unhealthy learning environment only further de-emphasizes the importance of treating patients, while stressing scientific achievement.

Finally, poor teaching techniques are to blame for the unencouraging state of medical instruction. Medical educators continue to depend heavily upon lecture as the primary means of information delivery during the preclinical studies. Many medical programs regularly require students to sit through several consecutive hours of descriptive lectures. Yet studies have indicated the limitations of didactic lecturing. One report suggests that students forget four fifths of the information acquired through lectures within eight weeks (Foley and Smilansky 1).

The descriptions and detailed accounts of problems associated with the medical training process clearly indicate the need to reconsider the medical school curriculum. The next two sections briefly examine some of the alternatives to the traditional model for medical education.

G. Tradition versus Innovation.

The premise that students and residents are human and should be treated as such is valid and must be taken into account if the medical curriculum is to improve. We have seen that the unrealistic and oppressive workload found in medical school is antithetical to the appropriate development of qualified physicians. Didactic studies with enormous emphasis
on science, and deficiencies in, or improper implementation of, the behavioral disciplines, aggravate the problem. One possibility is to restructure the medical program so that it becomes more open and enables student self-expansion. Such a curriculum would consider students' human needs and provide opportunities to explore personal feelings and ideals. Ultimately, this requires a less densely packed curriculum and more independent study opportunities (Vevier 20).

An additional argument exists for incorporating courses in ethics and the humanities into the curriculum. Similar to the behavioral sciences, these areas address less concrete and precise questions and require a different approach to problem solving. These disciplines thereby enhance students' analytical skills which make up an important part of clinical practice. Others have also suggested introducing courses in history, philosophy and literature, within a framework that is relevant to medicine (Cassell 21, 24, 29). One professor wrote: "literature can enable a student to see the patient from different perspectives; literature can promote vicariousness; literature just might encourage a more empathic response to patients" (Wear 36). Some physicians, including Dr. Randall, argue that adding such courses to the traditional medical curriculum will only exacerbate the time-strain on students. However, if integrated effectively within the existing agenda, such disciplines will embrace one of Flexner's most central themes: "the physician is an educated man" (26).

Finally, critics suggest that medical institutions must recognize that overextending their faculty is counterproductive to their goal of producing competent physicians. Just as it is antithetical to overburden students with information, overloading professors with duties in patient care and research detracts from the quality of education (Vevier 42). Mass instruction and the diminishing contacts between student and teacher must be confronted directly and treated seriously. This entails reconsidering faculty responsibilities and emphasizing direct interactions between students and instructors.
I. Recent Innovations

A number of medical schools have addressed the problems of low morale and insecurity, and the high levels of stress that affect their students. These institutions have introduced orientation programs that assist students in managing their stressful environment while encouraging greater motivation for learning (Hendrie and Lloyd 138). A number of schools, including the Universities of Maryland and Nevada, have also implemented "academic support services." These programs use the Meyers-Briggs Personality Type Inventory which assesses specific strengths based on certain personal characteristics, and suggests methods for optimal study and time-management. Yet, in schools adopting these specialized student services, the curriculum itself has remained largely unaltered. On the other hand, reforms in the University of Michigan, McMaster University in Ontario, and the University of New Mexico, and others, have targeted the very foundation of the traditional "Flexner" curriculum.

McMaster University has been among the forerunners of innovation, setting the trend for schools throughout the world with its problem-based curriculum (Hendrie and Lloyd 142). Unlike the "lock-step" two-year preclinical program followed by clinical clerkships, described earlier, students at McMaster train within the clinical setting from the beginning of their studies. Learning is not achieved through teaching in a formal setting, but rather in small groups organized by tutors who stimulate and direct student development. These problem-based programs are designed to build students' critical thinking and to encourage the application of scientific methods to problem analysis. Unlike the didactic, preclinical curriculum, at no time is information supplied gratuitously to students in the problem-based format.

At Michigan State University Medical School, a similar, problem-based program has been added to the traditional track. The two educationally diverse approaches create a means for comparing the achievements of graduating students. The innovative "track II" also gives
students opportunities to pursue their studies within the clinical setting. In addition, it encourages their feedback and participation in revising and enhancing their own training environment. Students form diagnostic groups to identify difficulties in learning, and curriculum development groups (CDG's) made up of faculty and students consider the specific problems and explore ways of revising the curriculum (Davis, 300). Standardized testing of students' knowledge and clinical abilities reflect similar achievements for the two tracks. But the major differences become evident after graduation: More students coming from these innovative programs elect specialties in primary care disciplines such as family medicine and pediatrics than their traditional-track counterparts (Hendrie and Lloyd 143).

Such evidence demonstrates the usefulness of the problem-based curriculum in promoting primary care. At the University of New Mexico, the primary care curriculum (PCC) was implemented to make use of these findings. New Mexico's chiefly rural demographic distribution necessitated more primary-care practitioners. To accommodate this need, the University of New Mexico created an alternative curriculum in which students would spend four months caring for patients in rural areas of the state after the end of their first academic year. During the second year, students would train in small groups, with the remaining two years identical to those of the original track. (Hendrie and Lloyd 144)

The results of the radical changes in medical education in these institutions and others have been encouraging. Graduates of innovative programs have proved to be competitive with their traditional track colleagues. Moreover, students participating in the New Mexico and McMaster programs were reportedly more satisfied with their studies and experienced less stress within their educational environment (Hendrie and Lloyd 144). As we have noted, raising morale is a tested way to combat the cynicism and resentment instilled in many future physicians by the sometimes negative learning atmospheres of traditional programs.
I. Conclusions

In this section we considered medical training and its aims and aspirations. We noted that the medical school environment, the process of selection and the content of curriculum all reflect upon the understanding of patients and the skills necessary to facilitate the practice of good medicine. However, criticism has exposed the shortcomings of traditional medical programs and revealed their inability to cultivate and enhance the delivery of compassionate care. Attempts at exploring new strategies for educating physicians further emphasize these shortcomings in medical training. Presumably, the observed deficiencies in education result in the dissatisfaction of patients, as noted in the first chapter.

However, the immediate relationship between education and practice is, in itself, incomplete. That is, the training of doctors does not only guide their performance as caregivers, but also has significant bearing upon their ability to cope with the difficulties they experience. This indirect relationship, then, addresses the role of education on patient dissatisfaction in conjunction with physicians' problems. These ideas will be further addressed in the following chapter on physician stress.
Chapter Four: Physician Discontent

The results of the physician interviews, detailed in Chapter Two, inspired further study and investigation into medical education. In this section, we shift our focus to the second major problem-area identified by the three physicians: the business of medical practice. The results of the interviews concur with numerous reports revealing that bureaucracy in all its forms and the business aspects of medicine are a major source of discontent among practicing physicians. The modern private practice resembles other free enterprises and is, likewise, filled with obstacles, uncertainty and risk. These difficulties and constraints thus compound and aggravate the already stressful medical environment.

A. Stress and the Doctor's Office

Physicians have traditionally preferred practicing from a private office. Private practice offers autonomy and freedom to the physician, and enables the continuity of care which enhances and promotes personalized treatment. However, as Doctors Randall and Stein explained, the benefits of owning a modern private practice come at considerable costs. Operating a private office is becoming increasingly difficult in light of the growing role of insurance companies and the increasing amounts of complicated paperwork. The physician's struggle to manage his practice begins with his often limited business understanding. Medical schools rarely, if ever, address this business aspect of medicine; and despite years of intensive training, doctors walk into practice "as helpless as newborn babes..." (LaDou and Likens 34).
Operating a private practice entails many of the same responsibilities as managing any other small business. The doctor must hire employees and determining their salaries and benefits. Insurance companies and government intervention have contributed to the increasing complexity of billing and reimbursement. Little wonder that many private physicians employ personnel to handle this enormously time-consuming paperwork (Hoffmeir 73). Newly established practices also have the added difficulties of attracting patients. Often, this can only be accomplished once the physician has gained the recognition and trust of his community, a process that may take a number of years. In some competitive urban areas, doctors requiring a more aggressive approach to attracting patients may turn to costly multimedia advertisement campaigns. Although not highly regarded by the American Medical Association, these publicity campaigns have continued to grow in popularity (Hoffmeir 15). Finally, cost is a major problem for the private practitioner. The expense of malpractice insurance and the rising prices of office space and equipment all create serious financial burdens.

With the hassle of establishing and maintaining a private practice, not surprisingly, the number of newly established doctor's offices is declining. One source claimed that solo practice may soon disappear altogether (Hoffmeir 72). Young physicians are turning to other modes of practice which do not impose the time investment and expense of private practice. One option is to form a coalition with other doctors in "shared expense" practices. In these, several doctors divide their operating costs, although their practices remain otherwise independent of one another. In other cases, physicians opt to work for established physicians, or form partnerships and group practices with other doctors. In either of these practices, some of the autonomy of the independent physician is exchanged for lower expenses, as well as the advantage of having other doctors present for consultation. Finally, some physicians turn to so called "Health Maintenance Organizations" or HMO's for employment. HMO's can be described as hybrids, uniting health care providers with insurance groups. Theoretically, HMO's are designed to reduce the wasteful and needless
medical intervention that often accompanies the unregulated, fee-for-service medical practice. Because HMO's bill participating patients for a predetermined fee rather than at the actual cost of medical care, it is to their advantage to limit the medical and surgical procedures that they provide to their patients.

There are numerous types of HMO's, each offering certain benefits and disadvantages to participating physicians. Some doctors join the so called open-panel HMO's or Independent Practice Associations (IPA's) which contract private physicians and either pay them a salary or take a percentage of their consultation fees (these are similar to another type of contractual organization known as Preferred Provider Organizations [PPO's]). Physicians participating in IPA's benefit from a secure patient base, and are usually able to maintain the traditional continuity of care and closeness with patients. However, these organizations also impose certain constraints. Because IPA's only reimburse patients for consultations with physicians employed within the organization, primary care physicians are forced to limit their referrals to these specialists. Moreover, numerous physicians join provider organizations only reluctantly and out of fear of losing their patient base. Feelings of entrapment may turn to resentment that may affect the quality of patient care. (Hoffmeir 75-77)

Many young physicians with little practical experience and huge tuition debts choose to work in another type of HMO known as closed-panel HMO's. These self-sustained HMO's are particularly attractive to the young physician because, unlike private practice or organized partnerships, no initial financial investment is necessary. These groups offer a salary and often numerous benefits. However, these advantages comes, once again, at the price of autonomy. As one physician working in an HMO explained, "I have to see a patient every ten minutes. If a patient needs dialysis, I never see him again. I don't have any real relationship with my patients" (Hoffmeir 10). In addition to limiting consultations, these organizations seek to reduce diagnostic procedure by implementing a complex system of billing that adds to the difficulty of ordering tests. Although critics have suggested that these cost-capping
measures adversely affect patient care, this has not been conclusively determined (Hoffmeier 82).

B. Financial Stress

Debt and financial concerns affect physicians in private and organized practices. The high cost of tuition alone usually leaves the medical graduate in considerable debt. According to one report, on average, medical school graduates owe in excess of $55,000 (Zabela et al. 51). Coping with such financial deficits requires careful planning and sound advice. But often the only solution is to treat more patients. Debt and compensation seem to be a recurring theme for doctors who feel trapped by their professional duties. Debt can also be the product of physicians' poor personal money management. While this problem is, of course, not reserved to doctors, it perhaps derives from inherent misinterpretations or incorrect expectations acquired during training. Medical school is so demanding and rigorous that motivation to endure the difficulties can often only come from setting one's sight upon the prize. For many students this prize is, at least in part, the financial comfort they anticipate upon successful completion of their training. But once their goal has been reached, the sad realities become brutally apparent. The existing debts and unexpected costs seem overwhelming, and the physician can only hope to attain his expected lifestyle by working even harder. Sometimes, even this is insufficient; and the doctor can either react by employing better cost management or by going further into debt, which is the reality of an estimated 10 to 20 percent of physicians (LaDou and Likens 34). In other cases, desires for the lavish lifestyle, when unrealized, create disenchantment and depression. The young doctor who convinced himself of the rewards he stood to gain is likely to question the worth of his aspirations and endeavors.
C. The Burdens of Competition

Competition, although not explicitly identified by the physicians interviewed, is another factor that accounts for considerable stress in the medical profession. We already noted that medical schools, like other institutions which limit enrollment, generally select students who are most competitive in their achievements. Competition for scholastic success persists during medical training, and continues after graduation, when students battle for the most lucrative and prestigious internships. This competitiveness in the medical school environment often paves the way for competition in practice. In one sense, competition in the tradition of capitalism encourages a higher quality of excellence that benefits the patient. However, the competitive environment can also cause serious problems. The number of practitioners, especially in areas where the concentration of doctors is already dense, continues to grow. One study estimated that the number of doctors increased 43 percent between 1978 and 1990, despite a national growth in population of only 15 percent (Nash 149). Another report suggests that since 1990, the number of physicians in practice and in training has largely exceeded the needs of the public (Vevier 21). The exponential increase in practitioners has embittered the struggle to attract a "clientele." Doctors sometimes resort to attacking the reputations of their rivals, a measure that counteracts the benefits of physician unity (Howell and Schroeder 55). It has also been shown that such competition negatively affects self-esteem, leading some practitioners to harbor sentiments of inadequacy and concern about their success in practice. Doctors may also find themselves alienated, and unable to turn to fellow physicians for consultation or criticism. "In short, [unhealthy competition] detracts from the enjoyment of the practice of medicine" (Howell and Schroeder 55).
D. Malpractice and Defensive Medicine

The imminent threat of malpractice is another serious cause of physician stress and discontentment. The incremental rise in malpractice suits is best reflected by the exponentially increasing cost of malpractice insurance. According to one study, certain high-risk clinics may pay as much as $165,000 in annual insurance premiums (U.S. Congress 29). Although the extravagant costs of insurance places severe constraints on practicing physicians, the effects of malpractice litigation are sometime much more poignant and devastating. Whether or not a lawsuit is justified (not surprisingly an overwhelming majority of physicians who have been the target of litigation feel that the suit was unjustified), its effect on the physician, both financial and emotional, is often serious. Since malpractice insurance usually covers patients' claims and settlements, financial costs reflect time losses from practice as the result of legal obligations. During a trial, a physician will likely lose several working days, equivalent to up to $5,500 (U.S. Congress 28). But the more severe damage is often emotional. Physicians who have been the subjects of litigation claimed to experience "short-term losses in self-esteem" and often "symptoms of clinical depression, anger, fatigue and irritability" (U.S. Congress 29). In addition, because legal procedures often take years to resolve, concern and anxiety can persist long after the suit has been filed.

The popularity of legal action has brought about a form of self-protective practice known as "defensive medicine" which often negatively affects the patient-doctor relationship. According to an Office of Technology Assessment (OTA) report commissioned by Congress, "defensive medicine occurs when doctors order tests, procedures, or visits, or avoid high-risk patients or procedures, primarily to reduce their exposure to malpractice liability" (21). Dr. Davis explained that often doctors who have previously been sued may become reclusive or overly wary of patients. Preoccupied with their own concerns, these physician may not devote their full attention to the needs of patients. Thus begins an insidious cycle in which patients of fearful doctors feel neglected and are, in turn, more likely to file suit.
Some argue that the nature of malpractice litigation serves as a mechanism for controlling the quality of medical practice. However, a report on the "rate of negligent injury" observed at several New York State hospitals showed no significant correlation between the number of malpractice claims filed and the occurrence of "medical negligence" (U.S. Congress 24). Moreover, the OTA study explained that doctors wishing to minimize the potential for negative results may perform additional, physically straining tests which in themselves may adversely affect patients.

E. Emotional Distress

Along with the burdens of bureaucracy and the business environment, doctors must contend with other forms of stress. Their profession compels them to witness the horrors of human suffering and death. This aspect of medical practice is as inevitable as it is unfortunate. Doctors are particularly vulnerable to the effects of emotional strain because they tend to be high-achievers accustomed to unlimited success (Nash 130). Failure inevitably occurs, for patients die despite the intervention of even the most complete and technologically advanced methods of treatment. Therefore, coping with the emotional stress requires experience and some habituation and, most importantly, an effective means of confronting and resolving the trying experiences.

Various stress management and coping techniques can be learned during training or early in practice. But for these to be effective, doctors must have positive attitudes regarding psychotherapy, and they must be willing to confront their problems (Howell and Schroeder 77). Yet, as we have seen in Chapter Three, medical education does not endorse this approach, and even seems to suggest the very opposite. In training, students are, in essence, encouraged to endure emotionally difficult situations, rather than confronting and resolving them. Unsurprisingly, the adverse effect of this approach carries over into medical practice, where the problems of denying deeply felt emotions finally emerge. The fact that many
doctors do not seek to understand the patient’s perspective is often a direct result of their effort to evade a painful reality. This emotional escape affects the doctor’s behavior, and ultimately, patient care.

One analyst outlined a number of "maladaptive" behavioral patterns used by some doctors as a means of coping with their emotional struggles (Howell and Schroeder 88). In each case, the physician develops a protective device to shield himself from having to confront disturbing issues. The "defensive doctor" has never confronted or understood the realities of his profession. His inability to cope with difficult situations leads to feelings of inadequacy and failure. Frequently, this physician expresses his frustration by blaming others, including patients. "The laughing doctor" represents another behavioral type. He is jovial and outwardly content, but in reality he merely uses humor to block out the unpleasantness. The "angry doctor," on the other hand, makes no attempt to hide his resentment of medical practice, lashing out at patients and staff. Other types include "the autocratic doctor" who seeks absolute control of his practice, and the super-physician who is only satisfied when he feels that his patients need his services.

F. Physician Burnout

Whether stress is a result of a physician’s inability to confront his feelings, or the frustrations that emanate from the professional struggles, the most extreme cases often result in physician burnout. The French psychiatrist Charcot stated that American physicians "go to extremes, they make their work a matter of pride, nothing distracts them and after a certain time they fall prey to neurasthenia (nervous exhaustion)" (Payer 132). This statement, made in 1887, demonstrates that physician burnout is not a new phenomenon. Signs of burnout include boredom and lack of reward from practice. A doctor may feel entrapped, and he may seek excitement and distractions by turning to extramarital affairs or by investing in expensive hobbies (Nash 131). In many cases, such doctors lose their sensitivity to people
and disengage themselves from interactions with their families and friends. Not surprisingly, many separations in marriages and divorces result. Inability to deal with patients also leads to a professional divorce, in which physicians completely abandon their practice and instead pursue administrative work or research (Nash 130).

Other signs of burnout are more blunt and troubling. It has been reported that on average, doctors are three times more likely to commit suicide than the general population (LaDou and Likens 21). Alcoholism far surpasses the national average. One report from 1984 showed that each year 600 doctors become alcoholics, in addition to the estimated 10,000 to 20,000 who are already alcoholics¹ (Nash, 131). Doctors are also reported to have thirty to one hundred times the drug abuse levels of the general population, an added hazard in a profession where dangerous substances are easily accessible (LaDou and Likens 21).

The problems of burnout and emotional impairment detailed above have consistently failed to gain recognition. The support network which exists among physicians is partly to blame. Doctors often are opposed to exposing their colleagues, since accounts of emotional trouble may have severe repercussions on a physician's career (Nash 132). In addition, many physicians harbor the belief that revealing these problems to the public will further tarnish the reputation of the health care system. But most surprisingly, few reports which have come to the attention of state medical boards have resulted in significant action. Indeed, the whole spectrum of stress-related problems in the medical profession has gone largely uninvestigated. The reasons for this are not clear, but critics suggest that medical regulators, like medical educators, choose to resolve these problems by ignoring them.

What is bad for the doctor, one must assume, will also adversely affect the patient. As we have previously seen, the patient is particularly vulnerable and insecure; and ease and comfort are important in facilitating effective treatment. When the doctor is preoccupied with his own problems, or even resentful of his situation and angry with patients, there can

¹ The author explained that it is difficult to determine conclusively the exact number, which may be as high as double the reported figures.
effectively be no possibilities for meaningful exchanges between doctors and patients. This brings us full circle to the problems of patient dissatisfaction that we observed in the first chapter.

G. Conclusions

Physicians naturally experience the adversities and conflicts of medical practice. Furthermore, often doctors have certain interests that extend beyond treating the sick, such as self-preservation or financial reward, for example. This perspective offers a new means for understanding the problems of patient dissatisfaction. In the second chapter, we considered the deficiencies in medical education and training which leave many doctors ignorant of, or inadequately prepared to meet the needs of their patients. By contrast, here we explore the interests, conflicts and conditions within practice that ultimately limit the doctor's ability to provide the desired patient care. That is, the physician is aware of the importance of compassionate medical treatment, but for the reasons identified above, he becomes incapable of providing it. We should note that although medical education may not be the cause of physician stress, it is associated with the difficulties of dealing with these conflicts. Therefore, problems which arise during medical training and those evident in practice are interrelated, and together account for the observed dilemmas in patient care.

Through this analysis we have identified and explained the factor responsible for the problems of patient care. However, this discussion fails to determine the basis of these dilemmas and why the institution of medicine exists in its present organization. Where is the root of the problem that results in the deficiencies in training and in practice? To answer these questions, we should extend our scope beyond the medical framework, and consider the ideals ingrained within American culture and society. The final chapter will address this aspect of culture and its relationship to medical practice.
Chapter Five: Cultural Influences on Medical Practice

In this study, I have attempted to elucidate the problems that plague both American practitioners and patients. As we have seen, the stress on science, the rigors of an increasingly outmoded curriculum, and the pressures resulting from overwork, finances and litigation, direct physicians to methods of practice that fail to deliver adequate care. Along with competence and capabilities, compassion forms an essential element in patient's expectations. The reality of practice, then, conflicts with the ideal of expectations that would assure physician-patient satisfaction. But the nature of American culture seems to produce an inevitable disappointment that forms, perhaps, the basis of a conclusion to this study.

As we noted in the third chapter, the ideas set forth by Abraham Flexner ultimately changed the face of medical training and practice in America. Higher expectations encouraged a more intensive curriculum which, in turn, led to the creation of the standard format for medical education. In addition, we have seen that reforms inspired by Flexner created a medical setting more exclusive to certain practices and practitioners. The allopathic, scientifically based approach to medicine was embraced by the American Medical Association (AMA) at the exclusion of other medical practices. This remains apparent today in the fact that many non-allopathic forms of medical care, which are generally widely accepted in Europe, are not considered serious alternatives to treatment (Bauer 38). As we have already observed, allopathy focuses directly on the disease or physical condition, through various forms of intervention. Thus, American medicine can be described quite fundamentally as a process of search and destroy. It holds high expectations for curing and enhancing the lives of sick patients; and in many respects, it has enjoyed considerable success in the past eighty years. However, the nature of a medical system which depends upon ever more sophisticated
and refined treatments has also encouraged the practice of a forceful and intrusive form of care.

One would naturally assume that the aggressive approach to medicine was therefore created by the reforms initiated in the early part of this century. Yet, in all actuality, Flexner's report did not give rise to aggressive medicine, but was itself a manifestation of ideals and expectations deeply rooted in American culture.

A. Aggressive Medicine

In her book, *Culture and Medicine*, Lynn Payer suggests that the medicine practiced in the United States is a reflection of an aggressive culture. The American spirit that enabled results and change embraced conquest and achievement rather than passive acceptance. Early medical practice in the American colonies was shaped by the prominent Dr. Benjamin Rush, who was also one of the signers of the Declaration of Independence. His approach to medicine was centered on the belief that "desperate disease requires desperate remedies." Dr. Rush "promoted his therapies in part by convincing practitioner and patient alike that they were heroic, bold, courageous, manly and patriotic. Americans were tougher than Europeans; to cure Americans would require uniquely powerful doses administered by heroic American physicians" (128). Clearly, this approach favored action and intervention regardless of their consequences. Even futile and often adverse methods were considered preferable to inaction.

Although modern medicine diverges radically from the medical anarchy incorporated and encouraged by Dr. Rush, the "can-do" attitude has persisted (Payer 132). This remains apparent in the combat tactics employed by modern Americans in the wars against a variety of ailments and afflictions. If the most sophisticated and complete means of medical intervention are considered heroic by both physicians and patients, there is little wonder that the very infrastructure of American medicine accommodates and even supports this aggressive
approach. Surgery offers a case in point. In the United States, hundreds of thousands of surgical procedures are successfully performed each year, sometimes offering patients, suffering from a variety of conditions, with a renewed hope for leading a relatively normal lifestyle. But it remains questionable to what extent illness and physical impairment warrant these forms of treatment.

One study comparing the number of hysterectomies performed in Britain and the United States revealed that American women were twice to three times more likely the subjects of this operation (Payer 125). Moreover, American surgeons were shown to favor the much more radical hysterectomy to the milder but more time consuming myomectomy, preferred by French physicians, which leaves the patient's uterus intact (Payer 138). Likewise, American surgeons prefer radical mastectomies and double mastectomies to lumpectomies. Often, the rationale for these aggressive procedures draws upon the potential for recurrence when the less complete operation is undertaken. However, the fact that French physicians are far less concerned by the potential of recurrence raises questions on the need for these aggressive procedures.

The "open heart boom" of recent years provides another example of the American affinity for surgery (Nash 63). Also known as bypass surgery, this procedure reroutes blood to a heart otherwise lacking adequate circulation. Such operations are performed in the United States an estimated 500,000 times per year with extremely high rates of success (Kassler 9). Yet, once again, their necessity comes into question. In a study conducted by the National Heart and Lung Institute, a few hundred patients with coronary artery blockages were randomly offered either a surgical or purely medical form of treatment (Nash 101). At the end of the three-year study, the results revealed that, although the patients who had been treated with surgery suffered less from angina, fewer heart-attacks had occurred in patient treated with medication alone. But in the final analysis, both groups were observed to have experienced identical survival rates. Thus, although open-heart surgery is performed in the
United States far more frequently than in any other European country, its benefits are not clearly superior to those of other, less aggressive treatments.

The aggressiveness of American medicine is no less apparent in non-surgical procedures: More diagnostic tests are performed by American physicians than by their French, British and German counterparts (Payer 125), although their benefits are not explicitly apparent. Another study estimated that 30 percent of the tests conducted were not useful or warranted under the specific clinical conditions (Nash 49). Ironically, though, evidence suggests that doctors are often disinterested by the results of the tests. In one experiment, a testing analysis laboratory purposely withheld test results from a number of clinics. Amazingly, not a single doctor who had ordered tests called the laboratory to request the results (Nash 52). This experiment suggests that testing has become more of a "knee-jerk reflex" than a thoughtful, useful procedure.

Is this single-minded, emphasis on surgery and testing necessarily harmful? There are, of course, numerous benefits to aggressive medicine, which are most apparent in the diminishing numbers of heart attacks and infectious diseases (Payer 132). In addition, the development of medical research, largely inspired by Abraham Flexner, has enabled many of the advancements and discoveries that benefit patients in this country and elsewhere in the world. Yet the American doctor's eagerness to employ these forceful and complete methods of treatment also presents numerous problems.

B. Harmful Care

The dependence on more sophisticated and intrusive procedures, has been associated with a number of problems. Physicians who perform more tests increase their potential for misdiagnoses based on human error. To the patient, such negligence can be extremely disconcerting, and sometimes even damaging. In one case, a healthy, middle-aged man was wrongly diagnosed with anemia based on the results of an inaccurate blood test. The patient
was then subjected to numerous additional tests, including a particularly unpleasant barium enema, none of which offered any evidence of the predetermined condition. Finally, after the arduous process, a subsequent blood test showed no trace of anemia. Thus, the patient had to endure physical and emotional distress as a result of a negligent testing procedure (Nash 47).

Additional testing and surgical procedures can also increase the patient's risk of developing or acquiring diseases as a direct result of treatment. These treatment-induced conditions, known as iatrogenic illnesses, can result from diagnostic or therapeutic side infections, often arising from an inadequately hygienic medical environment (Nash 69).

Physician errors constitute another type of iatrogenic conditions. These "errors of commission" include the unwarranted use of surgery or complications that result from inappropriate diagnostic testing and operations. Testimony to the United States Senate Appropriations Committee reported that "over a third of hospital patients studied develop iatrogenic illnesses as a result of medical treatment." Moreover, "ten percent of the patients contracted seriously disabling or life-threatening iatrogenic illnesses" (Jones 224).

Altogether, hospital-induced sickness results in the death of 50,000 American patients every year.

The damage of aggressive medical care also can be financial. Indeed, the escalating costs of medical care have been identified by numerous critics as the "chief complaint of [the American medical system]" (Kassler 3). The cost of general health care is growing at a vigorous rate. A report filed by the Congressional Budget Office found that in 1987, health care costs rose by 8.9 percent, approximately double the rate of inflation (Marsh and Yarborough 1). Who pays these exorbitant expenses? Whether the costs are deferred to a private insurance group or to the government subsidized insurance for the elderly and the poor (Medicare and Medicaid), the patient ultimately has to bear the brunt of higher insurance premiums and tax increases.

Finally, aggressive medicine helps contribute to the problems of compassionate care. In the nineteenth century, when the availability and understanding of treatments was limited,
often the doctor's most significant contribution was "to sit beside [his] patients, listen to them, and provide some special companionship and spiritual comfort to a troubled man or woman" (Odegaard 101). But as medicine has evolved, enabling more effective and complete methods of diagnosis and therapy, it has pushed itself further away from the ideals of compassionate care. As we have seen, medical practice and training are often more focused on the ailment than on the patient. In this respect, American health care is both incomplete and ineffective. Treatments for chronic or terminal illnesses exemplify the shortcomings of these aggressive, allopathic practices (Payer 137). Often patients with no hope of recovery from disease or physical trauma, including those living only by virtue of artificial life support systems, fill isolated intensive care wards.

This "never-say-die,' high tech, impersonal approach" offers a stark contrast to the hospice system (Kastenbaum 107-109; Payer 121). These centers of caring, founded in Dublin during the late nineteenth century, accept the limitations of medical intervention, and aim to raise the quality of life rather than trying to lengthen it at all costs. Similarly, the European health spas, originally believed to have mystical or spiritual abilities to treat various incurable diseases, have evolved into centers of treatment for chronic ailments (Payer 138).

C. Incentives for Aggressive Medicine

Inequitable compensation for surgery versus the less radical, patient-centered methods of care, illustrates the preference for aggressive surgical and diagnostic procedures. Insurance companies often refuse to pay claims for what they consider "health benefits," and reimburse only treatments for diseases and disorders (Kassler 139). Thus, third party payers, including Medicare and Medicaid, compensate fully for surgical procedures while incompletely reimbursing "cognitive or medical therapies" (Nash 50). This favoritism for aggressive medical intervention is also apparent in the differences in salaries between primary care physicians, who earn between $95,000 and $110,000 annually, and the average
$220,000 and $290,000 in compensation for anesthesiologist and cardiothoracic surgeons, respectively (Kassler 106).

These differences in salary and benefits do not necessarily reflect a greater effort on the part of specialists. Family practitioners, for instance, are known to work considerably longer hours than anesthesiologists. Indeed, "the doctor who stays up all night with a hospitalized cardiac patient receives very little compensation" (Nash 50). Yet, by performing sophisticated or advanced procedures, he stands to reap considerable financial rewards and prestige. It would therefore seem that in the American tradition, the doctor deemed most important is also the one who relies on intrusive and highly sophisticated procedures and treatments. Perhaps this explains why so many ambitious and aggressive individuals are attracted to the medical field. One British medical student noted that "an overwhelming number of type-A personalities are associated with the medical profession" in the United States, suggesting that "American medicine selects and is select by a different type of student than in England" (Payer 131). Indeed, this observation coincides with the personality types of medical students that we have already observed in chapter three. Another study reported that, as a whole, physicians tend to be highly impatient (LaDou and Likens 20). Type-A doctors, who are by definition not well suited to listen to and comfort patients, are also particularly vulnerable to the effects of emotional impairment and burnout. Ultimately, patient care suffers.

We have effectively traced the limitations of health care delivery and thus patient dissatisfaction to the fundamental expectations of the American culture. But ironically and paradoxically, the "can-do" mentality, which has ultimately afforded us aggressive doctors, is intimately related to the expectations and desires of American patients (Payer 155). With all the emphasis on the human body as some highly sophisticated piece of machinery, many patients feel, not surprisingly, that, however poorly they choose treat their bodies by smoking and overeating, medical technology can swiftly and efficiently intervene and "fix" the problem. Open-heart surgery is regarded as a "quick-fix," which yields the benefits of
moderately good health without requiring the otherwise necessary changes in lifestyle (Payer 150). In other cases, patient expectations for active intervention further encourage the prescription of needless and sometimes damaging medication and technical procedures. All the while, doctors are inclined to wonder "why should [I] be compassionate or humane to a machine?" (Hendrie and Lloyd 4). The practice of medicine in the United States is therefore rooted in ideals shared by recipients as well as by deliverers of health care.

D. Conclusions

We can outline the interrelated issues which together constitute the problem of patient care, in the following manner. Cultural expectations determine medical practices that, in turn, influence a system of education designed to propagate and maintain these ideals. Such expectations extend to patients, who seek ready cures and thus embrace the intrusive form of medical practice fundamentally responsible for deficiencies in compassionate care. We can explain this apparent paradox quite simply as a problem of misdirected aims or misinterpreted expectations within this continuum. While the founders and reformers of American medicine acknowledged the patient's desire for intrusive and aggressive care, they did so at the cost of humanity and empathy. And although experts, including Flexner himself, have asserted that "...it is equally important and equally possible for physicians of all types to be humane and at the same time to employ the severest intellectual effort that they are severally capable of putting forth" (Vevier 80), findings reported in this section prove quite the contrary. Thus, patients wanting quick, complete treatments have unwittingly helped create and promote a system of health care unconcerned with their personal needs and expectations.
As we have seen, the health care system in the United States is complex and often confused. Ideals shape Americans' perception of medical care. For the patient, the development of technology and new therapies and the expectation of caring, concerned physicians hold hope for a cure to suffering and for a heightened quality of life. For the physician, similar ideals motivate the study and practice of medicine. Dreams, though, often end in disappointment. As various studies affirm, and as three doctors assert, the realities of an outmoded curriculum, costs of education and practice, bureaucracies, insurance company practices, and the fear of litigation puncture and frequently dispel these ideals. Patients become the victims of an impersonal system that governs care and disrupt the treatment of disease.

Reform is required. Certainly, through this examination of the perspectives and problems of the physician-patient relationship, numerous initiatives in medical training and practice identify the problems associated with costs and bureaucratic complexities. Such difficulties may be endemic to the profession. However, as we have also tangentially seen, health care delivery in Britain, France and Germany, appears to correct some of the inadequacies in the program in the United States. However, a similar study of the health care program in other countries would probably reveal other difficulties that American practitioners have avoided. Any correction in American health care calls for radical reform. And, ultimately, as our final perspective on this problem indicates, many of our attitudes to health care derive from a cultural consciousness that exercises a practice of combatting the disease and overlooks the reality of curing the patient. If this consciousness creates and continues the breach between the ideal of competent, compassionate treatment and the reality
of complex, confused health care, any resolution of the problem becomes even more remote. But in identifying some of the problems of adequate medical practice as perceived by physicians and patients, we can perhaps attempt to rectify current inadequacies. The reach may exceed the grasp, but the identification of the ideal may eventually result in some reforms equally beneficial to physician and patient.
Appendix: Interview Questions

The questions listed below served as a guideline for the interviews with Doctors Davis, Randall and Stein. Different areas of knowledge and experience were addressed according to each doctor's initial responses. These questions, therefore, represent a starting point for discussing and exploring the doctor's views.

Personal

1. Why did you choose to be a doctor? Was this what you always wanted to do?

2. What influenced this choice? How did the economic rewards of the trade affect your career decision?

3. What is your chosen field? Why? How long have you been in practice?

4. What aspects of medicine are as you had imagined them when you were in training?

5. What do you find most rewarding? How has the medical profession not met your ideals?

6. What would you say is the least inviting aspect of your professional practice? How do the problem areas weigh against the rewards?

Educational

1. To what extent do you feel that the scientific curriculum was relevant to your later studies? Were these areas important to your practice?

2. Were courses in sociology and psychology used in the medical school curriculum? To what extent do you feel that these areas are important in the education of doctors and in the practice of medicine?

3. Were you formally taught skills for communicating with patients? Did faculty direct students in developing a good working relationship with patients and listening to their complaints? What means, if any, did your educators use to encourage compassion and empathy in treating patients?
4. Were you formally instructed in dealing with chronically ill patients and with death? If yes, has this benefited you in practice? If not, do you feel such instruction would have helped you in practice?

5. Were courses in medical ethics required as a part of the curriculum? Did these courses impact your view of patient care or other aspects of medicine?

6. Were there any other areas which you feel were not sufficiently addressed during medical training? Do you feel that additional focus, either practical or informational, or a more diversified curriculum, would have benefited you?

7. Did the stress often associated with medical school and residency programs in any way alter your views and ideals of medicine (for better or worse)? Where there other specific aspects of the medical school environment that affected your professional development?

8. How would you describe your professors during the course of your medical education? Were instructors responsive and helpful? How influential to you were senior physicians and faculty? Overall, were you pleased with the instruction you received throughout your training? How could it have been better?

9. Did your medical training succeed in encouraging you to continue with the learning process?
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