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Before I begin, I have to say it was pretty difficult for me to choose a topic for this paper. I wanted to pick something completely unrelated to what I want to do with my life. I considered love’s role in our decision-making process, wrestling’s near exclusion from the Olympic Games, and how F&M’s hazing policy is contradictory to the principles of a liberal education. However, since I am a hopeless romantic and I felt that analyzing love would steal away this romanticism, wrestling is safely back in the Olympic venue, and I am pretty sure critiquing our hazing policy is hazing in itself, I decided to settle on liberal education’s role in healthcare reform, which is actually very closely related to what I want to do with my life. Before I delve into this topic, I have a few matters of business to attend to. First, I have to thank and recognize Dawn Tice, the former Director of Quality Improvement of the Clinical Care Associates of Penn Medicine; Dr. Jeff Brenner, the CEO of the Camden Coalition of Healthcare Providers; F&M’s own Kirk Miller, professor of biology and public health; and various other people whose conversations have inspired this paper and whose ideas I am surely plagiarizing in one way or another. Second, I apologize in advance if any of my bad jokes offend anyone this evening.

Now that the formalities and technicalities are out of the way, I will assert that, without a doubt, our healthcare system is broken. The United States spends the most on healthcare relative to any other developed country, yet has some of the worst outcomes among those same countries. One out of six dollars spent in the United States is on healthcare, and only eighty cents of that dollar is spent on actual care (Balz, 2010). Numerous other factors contribute to our inherently flawed healthcare system. Incentives for hospitals, health systems, insurance and pharmaceutical companies, and healthcare providers are awry and often pit the system against the well-being of its patients. Clearly, our nation has a problem that current and future Americans involved in medicine and healthcare need to address and fix. It has become very evident that changes need to be made, but what changes will be made and how will they be made? Healthcare providers, doctors in particular, are very good at diagnosing disease and treating patients; however, the analysis and improvement of the organizations and structures of how medicine is practiced is a very new concept to a very old profession. Medicine has largely followed the apprenticeship model of training. New doctors and medical students learn how to practice medicine from older doctors. While new generations of doctors make tweaks to old modes of practice and discover “breakthroughs,” the structure of medical practice largely remains the same. After all, the motto of many medical students and residents has been, “‘Ours not to reason why, ours but to do and die’” (Coles, 2002). However, if vast improvements are to be made to the American healthcare system and how providers deliver care, physicians must break away from this apprenticeship model of education and take part instead in a model that allows the questioning of conventional practices and synthesis of information from across disciplines. To put it concisely, medicine and medical education needs a dose of the liberal education tradition. In the remainder of this paper, I argue that the future of American medicine largely lies in the application of principles of a liberal education and I illustrate the positive effects such efforts can have. First, I reflect on the traditional model of medical education. Then I utilize three articles by Dr. Atul Gawande to examine two examples of proposals and initiatives that reflect an Enlightenment or Liberally Educated thought process. Furthermore, I analyze critiques of these ideas to see if the proposal or initiative is flawed and to understand the reasons for resistance among professionals and the general public. Lastly, I look at the future of medical education and analyze potential problems as well as highlight possible positive aspects.
When I was meeting with Dr. Jeff Brenner, who is the CEO of the Camden Coalition of Healthcare Providers and whose work in Camden is the focus of one of Dr. Gawande’s articles that I examine, he asked me why America is one of the world’s top superpowers. Since I had just finished Professor Louise Stevenson’s American Studies junior methods course, I blurted out “imperialism.” After a few seconds of awkward silence, he looked at me and said, “Well, okay, maybe. But think how something like the automotive industry has improved. They constantly question the validity and efficiency of the way they are doing things. That is the opposite of medical education, which has largely remained unchanged since the nineteenth century.” Dr. Brenner is right. Medical education and training has not encouraged or promoted students to think broadly and make connections across disciplines. Furthermore, it seems that this mentality of rote memorization and blind obedience to the regurgitation of knowledge starts at the undergraduate level, during the “pre-med” years, even at liberal arts colleges such as ours. In his introduction to A Life in Medicine, Dr. Robert Coles (2002) illustrates how pre-medical students do not choose a course of study out of ardent love for it, but because of a fierce desire to prevail over others and ultimately “get in.” The state of mind Dr. Coles describes, which has started to take form almost eight years before any significant contact with patients, is grossly in opposition to values such as teamwork, empathy, collaboration, and human understanding. Any physicians’ reluctance to join a collaborative team effort is rooted in his or her socialization and training to be a cutthroat individualist. Therefore, the traditional mode of medical training not only cripples future physicians from questioning conventions and synthesizing complex solutions to complex problems, but it also stifles the development of skills, such as teamwork, that are crucial to almost any profession, especially medicine.

The key to success of any organization, especially large organizations tasked with complex jobs, is standardization and protocolization. Such measures eliminate oversight and improve the efficiency and quality of a particular good or service and have been used in various business models. However, standardization is a new concept to American medicine. In his article “Big Med”, which compares the tight standardization of the Cheesecake Factory to the inconsistent quality of medicine, Atul Gawande (2012) asserts, “We’ve let health-care systems provide us with the equivalent of greasy-spoon fare at four-star prices, and the results have been ruinous.” Dr. Gawande’s metaphor illustrates that the quality, consistency, and efficiency of American medicine nowhere near reflects the astronomical amount of money we, as Americans, pour into it. He illustrates that the standardization exhibited in efforts in medicine, such as those by his colleague to improve knee replacement outcomes, is promising in increasing quality, producing better outcomes, and reducing costs (Gawande, 2012). Clearly, standardization in medicine, just like standardization elsewhere, yields better quality at lower costs. However, there is also much resistance to and criticism of efforts to standardize medicine. Forbes contributor Steve Denning reflects some of these critiques in his article “How Not to Fix US Health Care: Copy the Cheesecake Factory,” where he advances Dr. Gawande’s article as a misguided argument for a hierarchical bureaucracy. He claims, “Experienced doctors and nurses generally know more about the patient’s health than efficiency experts or cost-conscious administrators” (Denning, 2012). Furthermore, Mr. Denning (2012) expresses his fear of standardization of medicine when he uses rhetoric that compares the transformation to a “Frederick Taylor and Henry Ford” assembly line. Mr. Denning’s critiques reflect the fear that standardization will turn medicine into a mundane, impersonal “cookie cutter” system and experience. However, the implementation of protocol and the utilization of quality data to improve physicians’
performance and overall outcomes do not make patients an engine on a conveyor belt nor do they force doctors to become robots. The American Diabetic Association has declared that a patient with a hemoglobin A1C greater or equal to 5.7 should be considered diabetic and notes that metformin is a very good drug for controlling diabetes; however, neither of these measures, whether they are implemented nationwide or system-wide in a health system, forces a physician to prescribe metformin to anyone with an A1C over 5.7. Dawn Tice, the former Director of Quality Improvement at the Clinical Care Associates of Penn Medicine, affirms these measures are simply guidelines to help physicians make clinical judgments and improve the quality of diabetes management. A physician is still expected and encouraged to use judgment regarding each individual case because each individual is different, with a unique set of health issues.

Furthermore, Dr. Gawande illustrates that the lack of standardization means more personal care. He notes a patient of his had previously gone to another hospital and had spent almost twelve hours waiting unattended to be discharged. Furthermore, when hospital staff finally did attend to her she was treated roughly and impersonally (Gawande, 2012). If anything, standardization would allow for more personal interaction because certain tasks, such as discharging a patient, would be guided by protocol and not require staff to frantically run around hurriedly causing them to appear rude or disingenuous. Lastly, Mr. Denning’s fear of standardization and critique of the hierarchical bureaucracy supposedly commended in Dr. Gawande’s article neglects to recognize the bigger, overarching point. The quality of outcomes our healthcare system produces is nowhere near reflected in the money and energy we put into it. Dr. Gawande’s article recognizes the problem and creatively offers a suggestion toward a solution by synthesizing and applying information from other facets like the food service industry.

The second technique that has recently been used to improve the way healthcare systems deliver care is hot spotting and is illustrated in Atul Gawande’s article, “The Hot Spotters,” which focuses on Dr. Jeff Brenner’s and the Camden Coalition of Healthcare Providers’ efforts to improve patient outcomes and to lower medical bills in Camden, New Jersey. Dr. Gawande describes how Dr. Brenner’s experience as a member of a police reform committee aimed to help reduce crime in Camden transformed into an effort to improve the quality of care delivered to the poorest, unhealthiest populations and reduce overall costs on the healthcare system. He took the techniques he had learned from the police, such as making color-coded block-by-block maps and identifying hot spots, and applied them to medicine (Gawande, 2011). However, this time the hot spots were not areas of high crime but populations with frequent emergency room visits and hospitalizations. Dr. Brenner found that 20% of the city’s population was accounting for 90% of the costs (Gawande, 2011). Furthermore, he utilized this data to direct resources accordingly. For example, he proposed putting a primary care physician’s office, which would also provide other services such as a social worker, on the ground floor of a low income housing tower whose residents accounted for a significant fraction of Camden’s healthcare costs and whose health was among the poorest in the city (Gawande, 2011). Yet allocating resources in this very specific way draws criticism from multiple directions. Larry Van Horn (2011), who is a contributor to Forbes, asserts medicine’s efforts to use hot spotting “reflect an unsustainable expansion of the medical establishment to address growing social ills that historically have fallen outside the scope of health care.” Mr. Van Horn’s assessments drastically neglect to account for the overlap and complex interactions between people’s social world and their physical health. Our social structures, norms, and institutions drastically impact our health everyday. For example, smoking, which is public health enemy number one, alcohol-related accidents, and diseases such as obesity,
diabetes, and cardiovascular disease all are rooted in social practices. Therefore, it seems the only social ill Mr. Van Horn says does not deserve medical attention is the social ill of being poor, underprivileged, underserved, and vulnerable. Furthermore, Mr. Van Horn’s neglect to consider that the complex relationship between people’s social environments and their physical health is antithetical to the interdisciplinary and integrative mindset that is needed to find solutions to our healthcare system’s current and future problems. Dr. Brenner’s use of hot spotting is another example of how a creative interdisciplinary approach to solving a problem provides promise for the future.

In addition to the creative efforts of current physicians like Atul Gawande and Jeff Brenner, future physicians are heeding the call that they need a more comprehensive and expansive educational background than a traditional medical education can provide. As Dr. Gawande (2011) points out in his commencement address, titled “Cowboys and Pit Crews,” to Harvard medical school graduates, more medical schools are offering more joint academic programs, such as Masters in Public Health, Business Administration, Medical Ethics, and many other disciplines, and more and more students are taking advantage of them. However, while future healthcare providers are willing to expand their knowledge and think across disciplines to rise up to the challenges that modern medicine throws at them, there are shortcomings that need to be addressed in order for my generation and future generations to maximize our potential to address the healthcare issues that plague our country. First, we need more federal support for medical residencies. Almost a thousand medical school graduates did not place into a residency this past year (Trice, 2013). While medical schools are making valiant attempts to do their part by expanding class sizes, incorporating cross-disciplinary curricula, and offering various joint degrees, improvement and progress will surely be stunted if we do not have enough physicians in the workforce to fulfill society’s needs. Second, the future health system and initiatives like Jeff Brenner’s depend largely on a healthy supply of budding young primary care physicians. However, the public health researcher Barbara Starfield (1998) reveals that only 34% of the physician workforce are primary care physicians, although an ideally efficient healthcare system requires 40-50% of its physician workforce to be primary care doctors. Therefore, there needs to be more incentives to enter the field of primary care. Although many physicians are currently challenging conventional structures of our healthcare system and the future generation appears eager to pick up where current healthcare professionals have left off, certain structural roadblocks must be eliminated to allow for progress to continue.

In conclusion, the principles of a liberal education, such as challenging conventions and synthesizing information from across disciplines, are currently and will continue to be crucial to reforming our healthcare system. Atul Gawande’s comparison of the standardization used in the food industry to the current state of medical efficiency and Jeff Brenner’s use of the police technique of hot spotting to improve quality and lower costs are prime examples of the liberal education tradition at work. They both identify a problem and offer creative and effective solutions. Furthermore, in the case of Jeff Brenner, he executes his solution. While medical education has traditionally been antithetical to Enlightenment practices and stifled such liberal thought, current changes in curricula and the increased popularity of joint degree programs provide promise of changes in medical education that are more likely to cultivate a liberal education tradition. While the future of our healthcare system is unclear and any sustained improvements will take at least a few decades to be realized, the increasing liberal-education
mindset among medical professionals and scholars is very promising and, at the very least, the first step in a very long journey.
Liberal Arts and Medicine

Works Cited


