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FROM THE EDITOR

Breaking Tradition: Changing Medical Education to Preserve the Patient-Doctor Relationship

In 2003, the Accreditation Council for Graduate Medical Education (ACGME) mandated that residents could work no more than 24 consecutive hours and limited resident hours to an average of 80 per week over the course of 1 month. The creation of this policy was prompted by the 1984 death of Libby Zion, an 18-year-old who was admitted to New York Hospital for a high fever and died while under the care of overworked and fatigued interns. The incident led to a critical reevaluation of resident work hours. The possible harm patients could experience under the traditional training system was serious enough to provide the impetus for a large-scale reform of residency education.

In developing the theme for this issue of *Virtual Mentor,* "Humanizing Physician Learning," I kept referring to the Libby Zion case. How and why did it take so long for the profession to realize that the traditional training system put patients at risk of harm and even death? During White Coat Ceremonies around the country each year, future physicians take the Hippocratic Oath and make a promise to "do no harm" and keep patients central in all aspects of care. But, are the ways that we are educating and training our future doctors—using standards that often have remained unchanged for years—preventing them from providing patient-centered care?

The static nature of medical education is at odds with a world that is rapidly changing. Advancements in medical technology, ever-changing financial incentives, growing and increasingly diverse patient populations, and potential health care reform have implications for how we will administer care to patients in the future. A number of the authors contributing to this issue have drawn from their experiences as medical educators, medical students, and policymakers to reflect on the current state of patient care. They have critically reevaluated long-standing methods of medical education and suggested ways that the medical profession can adapt to the future, while preserving and enhancing the patient-doctor relationship.

The three clinical cases that open this issue illustrate dilemmas that students, residents, and medical educators may face when attempting to break traditional practices and create new modes of training, evaluation, and admissions. The first clinical case examines the impact of work-hour limitations on surgical education and centers on a surgery intern's hesitancy to report her program for violation of the ACGME regulations because it would risk both her program's accreditation and her professional progress. Mary E. Klingensmith and Katrina S. Firlik suggest steps that residents and program directors can take to manage this dilemma. The clinical pearl,

by Holger Link and Robert Sack uses this case as the basis for a discussion of shift-work disorders.

Three perspectives are provided for the second clinical case, in which students at a hypothetical medical school debate the transition from a traditional letter-grading system to one that is pass/fail. Arguments in favor of pass/fail grading were born of a desire to reduce competition, which can negatively impact group learning. As students in the case argue, however, does pass/fail grading put students at a disadvantage when it comes to personal performance, achievement, and residency admissions? In the first commentary, Bonnie M. Miller draws from her experience helping with Vanderbilt's transition to a pass/fail grading system in 2003. Adina Kalet contends that *how* we are grading students is less important than *what* we are assessing with the grades. She argues that medical educators should focus on developing criterion-based measures that more appropriately assess whether students have acquired critical competencies necessary to become good physicians. Finally, three medical students, Ryan C. VanWoerkom, Nicholas Zorko, and Julia Halsey argue that pass/fail grading may reduce student acquisition of knowledge, with the potential to negatively impact patient care.

One-quarter of the U.S. population are members of ethic minority groups. As patient diversity continues to increase, do medical school admissions committees have a duty to increase the representation of underrepresented minorities in their ranks? The third clinical case sets up a scenario in which two members of a medical school admissions committee debate whether an applicant's ethnicity should be considered in the admissions process. The commentary, provided by Will Ross, discusses the benefits of diversifying the medical workforce to better care for a multicultural patient population. Charles Vega offers another perspective on this question in the medical education section with his description of PRIME-LC, a program aimed at reducing health disparities among Latinos. PRIME-LC graduates physicians who are dedicated to activism and health advocacy for the Latino community but does not use affirmative action in its admissions process.

In another medical education piece, Raymond De Vries and Jeffrey Gross force a rethinking of the current premedical experience and the standards presently used in medical school admissions. Ann N. Poncelet, Karen E. Hauer, and Bridget O'Brien closely examine the benefits of longitudinal integrated clerkships over the customary block rotations that comprise the clinical third and fourth years of medical school.

While the development of medical technologies has made us more sensitive to many disease processes, have these diagnostic tools further separated patient from doctor, to the detriment of both? In the medical narrative section, John Kugler and Abraham Verghese discuss the decline of clinical skills and bedside medicine due to an overreliance on technology. In the health law article, Kristin E. Schleiter highlights resident liability in medical malpractice cases. Because residency represents an intermediate stage in the transition from student to physician, when, and under what

circumstances, should a resident be held liable as a physician as opposed to a student or intern?

In the first policy forum piece, Paul Rockey and Daniel Winship argue that the goal of medical education should be to develop physicians who not only serve patients but also serve as leaders of the health care system. Richard A. Ortoski and Richard M. Raymond follow by describing the Primary Care Scholars Pathways, a 3-year medical school curriculum at their institution that is tailored to students interested in primary care and family medicine.

In the first op-ed piece, Leana S. Wen reflects on whether an MD degree is enough to provide for effective doctoring. For the second op-ed, Douglas Brown enumerates various approaches that he has used to help students and medical educators respond to ethical dilemmas during the clinical years. In medicine and society, Jordan J. Cohen, president emeritus of the Association of American Medical Colleges, delineates the ways in which medical educators can contribute to health care reform.

A year ago this month, our nation concluded an election season in which the theme of change was brought to the national forefront. We are indeed living in a world that is experiencing many changes, and the impact of transformative forces on patient care must be acknowledged by the medical profession. My hope as the editor of this issue is that the articles herein prompt discussions and critical reexamination of the traditional methods currently being used to teach and train our future doctors. If we can remember to keep patient care at the forefront during each stage of medical education, we will be able to adhere to those words that we each spoke on the first day of our medical journey, "Do no harm."

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