Commonwealth Fund Helps Redefine Medical Teaching

Its Grants to Schools Enable Developments Looking to Total Care for Patients

By HOWARD A. RUSK, M.D.

As the financial plight of American medical schools has become increasingly acute in the last few years, the "problems" of medical education as interpreted by the public have largely been those of money. There are, however, according to last week's Annual Report of the Commonwealth Fund, many other problems. Many medical schools, the report says, are dissatisfied with the teaching they are doing and for the last year have been asking themselves with increasing frequency:

1. Are the right people now coming to medical schools?
2. How should students be chosen, and what prior educational experience should they have?
3. How can medical teaching build on what the student brings with him?
4. How can the medical sciences be woven together and related to the patient?
5. How can the break between "scientific" and "clinical" courses be closed?

Having been concerned with medical education and related subjects since it was established in 1918 by Mrs. Stephen V. Harkness "to do something for the welfare of mankind," the Commonwealth Fund realizes that the health of the public is the net result of a large and complex number of interacting forces. They have concluded, however, that as "the key figure in man's effort to conserve vigor, escape illness and postpone death," the physician is now and probably will continue to be health "tactician and field commander." It is for this reason that the group has put more and more of its funds into research in medical education.

"Tactics rest on technology, and doctors must have the best possible technological training" its report says. "But a good technologist is not necessarily a good tactician, and if the medical schools are to teach their students how to deploy all the resources of medicine, they must teach something more than technology."

Flexner Report Credited

Much of the present emphasis on the technical aspects of medical education had its roots in the historic report of Abraham Flexner in 1910, which laid the basis for modern medical education. At that time 97.5 per cent of the nation's medical schools did not require any previous college work as an entrance requirement and 93.8 per cent of the nation's physicians were graduated from schools of this caliber where almost all learning was by text and didactic lecture.

In these small, fly-by-night schools the professors were practitioners in the community, who came in for an occasional series of lectures. Some of the schools that vied for tuition fees did not even have an anatomy dissection course. There was little or no bedside teaching, and frequently a young graduate would perform his first delivery without ever having witnessed childbirth. It was truly medical "practice," for young physicians could learn only by practicing on their patients.

Another step toward better medical education already had been taken by Sir William Osler, a Canadian physician, who took over the chair in medicine at Johns Hopkins University in 1899. His concept was medical teaching at the bedside, with pathology as the proving ground for the diagnosis. Medicine was taught at the source —the patient.

Osler's influence and the Flexner report introduced a new era of medical teaching in this country, but with the great technological advances in medicine, increasing emphasis was placed on more and more specialized courses. The medical education pendulum swung to the side of compartmentalization and away from the patient. Too frequently now medical students learn a great deal about the patient's organs, but too little about his personality, family, job and social adaptation. As a result, the tendency is to treat diseases rather than patients.

A New Idea Takes Hold

Now, with the conquering of many of the infectious diseases and a fuller understanding of pathology, physiology, biochemistry and the other disciplines of medicine, thinking medical educators realize that we must again take stock and reset our sights if we are to meet the total needs of the patient as an individual.

The Commonwealth Fund's emphasis on redefining and strengthening the core of medical education started last year, when it made an appropriation of $269,400 (with reservations of an additional $164,000) to Western Reserve University School of Medicine in Cleveland to aid in working out and putting into effect methods of rebuilding its entire medical curriculum. The objective is to "bring the essentials of all the medical sciences together into an orderly experience through which the student, never losing sight of the living organism, will gradually come to understand its major mechanisms and governing principles."

Continuing this emphasis, the fund made grants this year to seven institutions to study other aspects of medical education. The largest of the grants, $344,725, went to the Cornell University Medical College for a new comprehensive medical care out-patient clinic to which medical students will be assigned for half of their senior year. The idea is to give a student time enough to see the same patient repeatedly so that he may gain an understanding of health and sickness as a continuing experience rather than a succession of unrelated episodes.

A grant of $264,912 was given to the University of Colorado School of Medicine "to demonstrate the practice of good general medicine", which this school emphasizes in its teaching. Junior and senior students will work for two years at the Denver General Hospital under a carefully balanced staff of general practitioners and specialists in a broad program of home, clinic and hospital care for Denver indigents.

The Commonwealth Fund's concept of fitting medical education to the student and medical care to the patient should have a significant impact on swinging the pendulum back into focus upon its primary objective—meeting the total needs of the patient.

The New York Times
Published: November 25, 1951