The Hard Part

On the path to becoming a doctor, mastering clinical medicine is comparatively easy. A required clerkship teaches fourth-years something more difficult: how to navigate the U.S. health-care system.

By Beth Saulnier

Photographs by John Abbott

The lecturer launches a PowerPoint presentation and a rather gloomy photo fills the projection screen. It depicts a balding man hunched over a desk in a room filled floor to ceiling with patient records—so many that it looks as if he’s buried in manila folders. “Does anyone know what movie this is from?” she asks. A student identifies it as *American Splendor*, an indie picture starring Paul Giamatti as a beleaguered filing clerk who gains fame as an underground cartoonist. But the citation doesn’t matter as much as the image—one guy drowning in an ocean of paperwork. The headline on the PowerPoint slide: “Most of the American health-care system today.”
In a seminar room in the building that’s home to Weill Cornell’s public health department, Jessica Ancker, PhD, is giving a talk titled “Health Information Technology: Promises, Pitfalls, and Research Questions.” For the next hour, the assistant professor in the Division of Quality and Medical Informatics teaches some twenty students about the plusses and minuses of electronic medical records. She outlines the hurdles the technology could help overcome—from the statistic that up to 30 percent of lab tests are redundant to the fact that for every one hundred patients, a typical physician communicates with ninety-nine colleagues in fifty-three practices. But the benefits of easier data-sharing come with perils, such as compromised confidentiality.

“It makes it easy to access data you shouldn’t necessarily be looking at,” one student observes, citing the temptation to nose into the records of celebrity patients.

“Couldn’t you do that with paper files?” Ancker asks.

“You could,” he says, “but this way it’s much easier.”

On this Monday afternoon in February, Ancker is a guest lecturer for an innovative course that grounds fourth-year medical students in the workings of the American health-care system. Taught by professor of clinical public health Madelon Finkel, PhD, the required two-week
For one intensive week, senior medicine residents get some ‘nitty-gritty, day-to-day’ lessons

It’s nicknamed POX, a pithier spelling for POCHS: Perspectives on the Changing Health-Care System. Five times a year, about a dozen internal medicine residents put their clinical obligations aside for a solid week to attend a required block rotation on health policy. “This is a bit of a return to the classroom, which for residents is unusual,” says course co-director Oliver Fein, MD, a professor of clinical medicine and clinical public health who also serves as associate dean for affiliations. “It’s a fairly rigorous, lecture-based curriculum, but with a number of other things. We’re trying to expose young doctors in training to a variety of ways in which medicine is going to be practiced in the twenty-first century.”

The course’s lectures cover a variety of subjects, such as Medicare and Medicaid, risk management, and the “pitfalls and pleasures” of academic medicine. Participants go on a half-day site visit to the Westchester Medical Group, a 160-member, multiple-specialty practice in White Plains, New York, where residents take a tour and meet with the group’s president and medical director. They also attend that week’s David Rogers Health Policy Colloquium and Medicine Grand Rounds and get practical tips on topics like negotiating their first employment contract and planning their entry into practice. Each block rotation also includes two debates, in which the residents argue for and against topics like the “public option” in health-care reform.

“As a resident, it’s incredibly important to learn this stuff,” says Lee Shearer, MD, a third-year bound for a fellowship in adolescent medicine through the Weill Cornell-Columbia combined program. “We spend eighty hours a week for three years learning how to practice medicine—how to take care of patients and prescribe medications, when to order tests, how to manage care. We don’t have as much exposure to how the health-care system actually works. How do hospitals run? Who funds them? What implications do the political changes have on me and my career? What kind of advocacy do I want to be involved in? It’s being exposed to the nitty-gritty, day-to-day practice of medicine—taking us out of the ivory tower and teaching us some of the practical things that we need to know.”

Except for one evening in their respective continuity clinics, the residents have no patient responsibilities and are not on call. That allows them to focus on the intricacies of the health-care system—a factor that many see as particularly valuable. “When you’re in the hospital, your mind is with your patients,” says Shearer. “And while we try to carve out time for dedicated learning, to some extent you’re always worrying about a sick patient, the discharge paperwork that needs to get done, or your pager going off. So it’s nice to be a student again, to be granted the leeway to just absorb and learn.” Carving out that kind of dedicated time for exploring the health-care system is rare, Fein says. “I don’t know of another residency program that does this the way we do it. Sometimes a program will take an hour every fourth week and devote a conference to it, but I don’t think you get the intensive, overall picture.”

When the rotation was established in 1997, it lasted two weeks; it has since been cut in half due to financial and logistical constraints. While it’s currently limited to residents in internal medicine—plus the occasional pediatric resident, geriatric fellow, or chief resident from an affiliated hospital who is allowed to participate—it may someday expand to other departments. Fein notes that when the rotation began, organizers weren’t sure how it would go over. “We were nervous, frankly, because it’s not clinical,” he recalls, “and there’s the whole attitude that residents have—or so we thought—that something that is not clinical is not valuable.” But like the required clerkship for fourth-year medical students, the block rotation has gotten rave reviews from participants; Fein says that on a scale of 1 to 5, it averages a score of 4.6 or higher.

Among its enthusiastic alumni is Johanna Martinez, MD, who took the rotation as a resident four years ago. Now an assistant professor of clinical medicine at Weill Cornell, she co-directs the program with Fein. “Being an internist and a primary care provider, I see myself as an advocate for my patients, helping them navigate the health-care system and all of its intricacies, so the course was extremely enlightening to me,” she says. “If it’s complex for a physician who works in the system, you can just imagine how complex it is for a patient.”
Students will have to navigate the health-care system, with all the myriad insurance policies—private, state, federal—and it really is a nightmare. Physicians don’t understand it, and patients certainly don’t. So we felt that by providing an introductory overview of how the U.S. health-care system is set up, organized, administered, and financed, it would help the students be better doctors—to be advocates for their patients and also for themselves.

The course offers insights into such topics as Medicare and Medicaid, prescription drug costs, health-care disparities, and the public insurance systems of such countries as Canada, Australia, and the U.K. That sort of comprehensive overview is rare among Weill Cornell’s peers, according to Finkel. “We are very much ahead of the curve,” she says. “This is unique. Most medical schools do not have this built into their curriculum. The excuse is there’s no time, the curriculum is already packed with required courses, et cetera. We are one of the few who include this, and not just as an elective. This is required; you cannot graduate without passing this course.”

Giving new MDs a basic understanding of how the health-care system works is seen as increasingly vital—not only by medical students and faculty but also the national body governing medical colleges. In July 2004, the AAMC issued “Educating Doctors to Provide High Quality Medical Care: A Vision for Medical Education in the United States,” a report by an ad hoc committee of deans. Under the missions of the medical education system, the report listed the need to promote “an understanding of the organization, financing, and delivery of health care in the United States.” Five years later, an article in Academic Medicine offered an assessment of how well schools were educating students in the complexities of the health-care system. The researchers studied data from more than 58,000 new MDs who had completed the
AAMC’s annual graduation questionnaire from 2003 to 2007, and also compared the responses of more than 1,000 graduates of two otherwise similar (and unnamed) schools: one with intensive offerings in health-care systems, the other without.

The authors found that a large majority of graduating students were satisfied with their clinical training. However, they wrote, “In stark contrast, fewer than half the students felt that appropriate instructional time was devoted to the practice of medicine, especially the component of medical economics.” Unsurprisingly, graduates of the school with extensive offerings in health-care systems reported being much more satisfied with their grounding in the subject—and furthermore, the researchers found, such instruction did not seem to come at the expense of other topics.

At Weill Cornell, exposure to health-care policy issues takes a variety of forms. While Finkel’s clerkship is required for fourth-year medical students, a similar course is mandatory for third-year residents in internal medicine (see sidebar). That one-week block rotation is the brainchild of the Medical College’s associate dean for affiliations, Oliver Fein, MD, who also coordinates the David Rogers Health Policy Colloquium—a weekly program that draws a diverse, interdisciplinary group of faculty and is especially popular among first- and second-year medical students. (Topics have ranged from the consumerization of genetic testing to a speech by a West Point general condemning torture; the series also includes regular “My Life in Medicine” talks by leaders in a variety of health-care fields.) “My hope is that participants in both the Rogers Colloquium and the block rotation learn to become more creative and positive actors in changing the health-care system,” Fein says. “And that they will play a role—not just in how they organize their practices, but also in the professional societies they join and the communities where they live—in shaping how medical care is delivered.”

Both the student clerkship and the resident
rotation offer a mixture of classroom instruction and field trips. Finkel's students visit medical practices, pharmaceutical companies, government agencies, private and public insurers, and more. "She's so knowledgeable about health-care policy, and she has so many contacts to get people in various areas to speak to us," Christin Price, MD '09, says of Finkel. "Not only was she a great teacher, but she exposed us to a lot of top people in the field." In general, students do site visits in the morning and have seminars in the afternoons; toward the end of the two weeks, they give oral presentations and turn in a paper. But the course content is always in flux. "I give this clerkship six times a year, and every time it's different, because the issues change," says Finkel. "We focus on current political, economic, and social issues pertaining to health-care delivery, and it has to reflect what's going on in the world."

The February session of the course was held in the thick of the controversy over the Obama Administration's health-care reform bill; tempers were running high as the opposing sides hurled invective, and critics of the bill fueled fears of "death panels." As Finkel says to the students: "I think more people are following the health-care debate than the Olympics."

The day after Ancker's talk, the students begin their oral presentations. This time around, Finkel has assigned teams to discuss health-care disparities from perspectives such as race, gender, geography, and sexual orientation. "What we want to focus on today is, what effect does it have on health status?" she tells them. "How detrimental is it, or isn't it?" Conversation turns to a New York Times piece from earlier in the month in which Finkel was quoted; the author, an MD, told a story about a former patient whose abdominal incision hadn't healed properly because he couldn't afford the gauze to change the dressing. Such tales are common in the current recession, Finkel tells the students.

In addition to issues of access—the fact that 80 percent of African American patients are seen by 20 percent of doctors, for example, or that women are more likely than men to have dependent insurance coverage and are therefore more vulnerable to losing it—the students discuss questions of cultural and educational competency. In what languages should patient information be offered? To what grade level should it be geared? After citing a survey that found that only one American in ten has the skills to manage his or her own health care—defined by basic tasks like filling out forms and reading prescription bottles—Finkel offers an anecdote about her husband's ninety-six-year-old Aunt Ruthie. "She takes twenty-two pills a day," Finkel says. "Before she went into assisted living, she was following instructions about taking her medications at breakfast and lunch, but breakfast was at eight-thirty and lunch at eleven-thirty—so she was overdosing."

According to Finkel, student feedback about the course has been overwhelmingly positive; more than three-quarters of exit surveys call it excellent or outstanding. She has also gotten strong feedback from former students now in postgraduate training—like Price, an internal medicine intern at Brigham and Women's Hospital in Boston. "I definitely would have been more naïve starting residency if I hadn't taken that course," Price says. "It has given me a leg up. As an intern, you're constantly dealing with the daily grind; you're so busy that you don't always get the chance to look at the big picture. But having gone through that course has made me pause before I order dozens of tests and scans, to make sure that it's cost effective. If I hadn't taken that class, I'm not sure that I'd do that in the hustle and bustle of internship."

Like the block rotation for residents, the fourth-year clerkship is full-time; students can give it their complete attention, without the pull of patient obligations. "It's a wonderful respite from the clinical curriculum," says Anthony Rosen '10, who plans to specialize in emergency medicine. "As medical students, we're focusing so closely on learning how to manage individual patients. A lot of the time we're quite sheltered from issues of insurance and ability to pay; we seldom get the opportunity to step back and think about what health-care delivery means as a policy issue."

'I definitely would have been more naïve starting residency if I hadn't taken that course,' says Christin Price, MD '09. 'It has given me a leg up.'