

# Reflections

## Medical school revisited: 60 years later

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I am a retired physician who has experienced the many changes that have occurred in medical care, both in the private sector and at the federal level. During my 12 years of family medical practice, and a 20 year career as a medical officer in the United States Navy, I have participated in the slow evolution from private medical care to health care.

The education and training of medical students has also responded and adjusted accordingly. Therefore, medical school reunions may provide some personal insight into a number of these innovations.

As background to my recent reunion experience, let me review some of these remarkable alterations in the medical care delivery system since my graduation. Private practice today is far from private. Local, state, and federal regulations create an atmosphere that has become similar to a corporate enterprise. Fifty years ago, our local county health department initiated surprise inspections of private physicians' offices. As a result, I experienced such a visit to check on my office cleanliness and refrigerator temperatures. I sensed that this was just the beginning.

Local hospital administrators, many non-physicians with business training, began management and control of medical staff membership, duties, responsibilities, and privileges. Slowly, almost imperceptibly, the private became public without direct involvement of the physician or patient.

The focus began to shift over the years from the patient to a process or system of care. The result is providing more medical care in the form of technical procedures, and less personal interaction with the patient. Insurance guidelines and the pressure to include more patients per hour have decreased the actual time a physician spends with patients.

Physicians have become technicians rather than providers of medical care on a personal level. Much of medical practice today is called no touch medicine; personnel other than physicians (PAs or NPs) touch and examine the patient and inform the doctor who is now a reviewer and coordinator of care.

I attended my medical school reunions with the full knowledge and experience of these trends in current clinical practice. At our 50th reunion, changes were just beginning and so subtle they appeared to be generational adjustments for younger students in a changing world. Ten

years later, at the 60th reunion, there were major and remarkable alterations in educational goals and methods observed in the medical school classrooms. During this three day reunion, we met with medical students from each class and toured medical school classrooms and laboratories. There were also demonstrations of classroom interactions between instructors and students illustrating current teaching methods being implemented in the curriculum.

The dress code was the first noticeable change—casual, with white jacket, scrubs, and Nikes. The wearing of "whites" in our days was a privilege, granted only to students who survived the first two years of med school. I can still remember our professors saying: "If you want to be a doctor, dress like one." At that time, the wearing of a coat and tie was expected of professionals.

Current students told us there was less rote memorization from text books or lecture notes—iPhones and computers are necessities. There is more emphasis on understanding, functionality, reasoning, and conceptualization. Alumni at the reunion participated with six to eight students sitting around tables with computer screens involved in problem-solving exercises. There was sharing of information with friends and classmates; study habits were not solo endeavors but now involve group-think and consensus. Professors said they spend less time in the lecture halls and more time monitoring students in these group teaching sessions.

There are now less gross anatomy studies with cadaver dissection. Anatomy classes do not even begin until late in the freshman year. The program director told me that some medical schools have curtailed and even eliminated cadaver laboratories, explaining, "They cost too much to fund and maintain." We heard about classes utilizing mannequins, anatomical models, and simulated clinical problems as computer exercises.

There appears to be less fear of failure among the students. During our orientation week, we were warned that one-third of our class would not survive the first two years. One fear was the surprise pop quiz. These exercises were essential parts of the medical educational programs in the 1950s and 1960s, preparing students to confront the unexpected. Unscheduled quizzes were almost a weekly occurrence.

There is now apparently no sense of sudden jeopardy by failing to identify a cadaver part or to name the organ tissue on a pathology slide.

We lived in fear that we would not be prepared, ultimately failing medical school and disappointing our

parents, friends, and ourselves. After all these years, I still have occasional nightmares of these tests and their possible catastrophic consequences.

Currently, some exams are take home or even done at one's leisure over a weekend. Even the dreaded biochemistry lab is not part of the freshman year. Another fear eliminated.

One student said that he was relieved that some of his grades were just pass/fail. I personally still believe that exact standards of performance evaluations are more appropriate for the study of the medical sciences.

At the reunion dinner, I shared my thoughts of medical practice past and present. Medical education and training programs also have changed dramatically, becoming more responsive to expanding needs and demands for medical care. The acceptance and understanding of these changes has been a slow and difficult process; especially for an older generation of family physicians who, like myself, made house calls, and live today with fond memories of their student days of study.

I spoke directly to my younger colleagues:

My wish to you, as future physicians in this changing world of medicine, is that you stay focused on the real purpose of medical training. We were told that our goal was service to others, and that our only business should be the care of the patient. This is as true today as it was more than 60 years ago.

### **Celebrating three generations in practice**

Miriam A. Smith, MD, MBA (AQA, Albert Einstein College of Medicine/Montefiore Medical Center, 2001)

Who could have predicted after more than 36 years of marriage into a warm, inviting family I would be in a position to celebrate a practice which actively and enthusiastically engages three generations of ophthalmologists from one family in one office? Having searched the literature and the Internet, there were no other reports of three generation concurrent practices. My father-in-law, Lionel (Lee) Sorenson, along with his two sons, Robert (Bob) and Andrew (Andy) Sorenson, and granddaughter, Rebecca Sorenson Janik, exemplify physicians who are individually accomplished and able to work together in a thriving practice environment. This is especially remarkable, given the recent attention to physician burnout.<sup>1,2</sup>

I asked them why they chose to go into medicine, why private practice, and whether they feel confident in having achieved a work-life balance. I asked Lee what has kept him working so many years so that I might understand which factors contribute to longevity as a practitioner.

Lee, Bob, and Andy trained at a time with no restrictions

on work hours and patient loads. However, Rebecca's training was heavily regulated by ACGME rules.<sup>3</sup> All retain a very strong commitment to providing first-rate patient care while promoting personal and professional well-being.

### **Lee**

Lee received his medical degree from UC San Francisco (UCSF)/Berkeley School of Medicine in 1952. He completed an internship at San Francisco General Hospital in 1953, ophthalmology residency at the University of California, San Francisco in 1956, and started soon after in practice in Berkeley, CA. His presence every other night in the hospital defined what it meant to be housestaff. At 91 years-old, he is likely the oldest practicing ophthalmologist in the United States.

"My father was a small town doctor. His office was in our home, and our living room was the waiting room. When I was around seven- or eight-years old, during the depression, sometimes I would hide behind the sofa and listen to the conversations. They were always very complimentary to my Dad. His patients would often pay him with vegetables or chickens. I think that is when I decided to be a doctor instead of a fireman."

Lee went into private practice to have more control over his time and liked the close relationships with patients. When starting in practice, he always "tried to keep a balance between ophthalmology, family, sports, music, and teaching residents at UCSF.

"Today, I am in our office about three and-a-half days a week. Since two of our sons and a granddaughter are in the office, I have no desire to retire. I still have plenty of time to play the guitar with my wife at the piano."

### **Bob**

Bob graduated from the University of California, San Diego (UCSD) School of Medicine in 1980. He was an intern at Mercy Hospital, San Diego in 1981, an ophthalmology resident at California Pacific Medical Center (CPMC) from 1981-1984, and completed a fellowship in medical retina at CPMC in 1985 before joining his father in the Berkeley practice.

Bob says he is fortunate to have family members (both grandfathers, father, and older brother) in the medical profession who served as role models. When Lee's original partner reduced his patient volume, Bob saw a great opportunity to join the practice. He admits to living with a high level of stress but has learned to balance work demands with his personal life. Taking time off each week allows him to pursue interests outside medicine. He enjoys being in practice with family members whom he trusts and who are willing to make compromises to "make it work."

### Andy

Andy graduated from UCSD School of Medicine in 1993, did an internship at the Latter Day Saints Hospital in Salt Lake City, UT, and completed his ophthalmology residency at CPMC in 1998. He went on to the Duke University Eye Center for a one-year fellowship in cornea and refractive surgery before joining the family practice.

He says his decision to enter medical school was “more about the desire to do something helpful, productive, and positive for others,” and was influenced more directly by his two grandfathers, not his father.

After 20 years, Andy feels no burnout. He is “invigorated by the depth of commitment of my father...and by the new energy brought in by my niece.” He, too, takes time off each week to stay refreshed and active outside of medicine, and echoes Bob’s sentiment about trust and compromise engendered by the family’s practice environment.

### Rebecca

Rebecca, Bob’s daughter, graduated from the University of Illinois College of Medicine in Rockford, IL, in 2012. She spent her internship year at Penn State Milton S. Hershey Medical Center in Hershey, PA, and completed an ophthalmology residency at the same institution in 2016. Beginning in the fall of 2016, she joined the practice.

Rebecca holds a unique perspective by seeing patients who “seem to appreciate the multi-generational practice,” and frequently recount “stories about having surgery by my grandfather decades before, or receiving a difficult diagnosis from my uncle or father.”

She values the benefits of family mentorship and support as a new practitioner. She did not want to go into medicine to blindly follow in the “family footsteps” but was struck by how happy and fulfilled her grandfather, dad, and uncle were as medical practitioners. They serve as her role models.

More than half of U.S. physicians report significant symptoms of burnout, described as emotional exhaustion, depersonalization, a feeling of reduced personal accomplishment, loss of work fulfillment, and reduced effectiveness.<sup>1,2</sup> Attempts to address the causes and consequences have brought together a wide range of local and national organizations to provide interventions that focus on clinician well-being that may have durable effects.<sup>1,2</sup>

Extracting from the above vignettes, role modeling, trust, support, compromise, and the ability to achieve work-life balance certainly contribute to individual physician well-being, a successful family practice, and avoidance of burnout.

It is a privilege to be part of this family.

### References

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### A nursing story

Martin R. Liebowitz, MD, MACP (AQA, New York University, 1955)

It was the summer of 1956. I had just begun my medical internship at the Peter Bent Brigham (now Brigham and Women’s) Hospital in Boston. We admitted a 35-year-old woman with uncontrolled grand mal seizures to the medical floor. There were no intensive care units at that time; patients with serious illness were moved closer to the nursing station. The neurologists struggled to control her seizures with the limited list of anti-seizure medications available but the seizures continued.

There was concern for her safety, so I ordered one-on-one nursing attendance at the bedside. We worried that if the neurologists were not successful she would be transferred to a state hospital lessening the chance that she would be reunited with her children. Time was running out.

In that tense atmosphere, Miss Russo, the Assistant Director of Nursing, appeared on the floor and asked for me. She politely informed me that one-on-one nursing was too expensive for the hospital to sustain. The nurses would be discontinued the following day. Rudely and quite foolishly, I blurted out, “Florence Nightingale would never have said that.” Miss Russo was clearly taken aback, and without a word she turned and left the floor.

I was immediately filled with regret and apprehension. Here I was in a new city with my wife and son; surely I would be fired. Anxiously, I continued with the afternoon’s admissions.

Two hours later, a messenger appeared on the floor with an envelope for me. I thought, “This is it.” Without hope, I removed the folded single sheet. On it were the words, “We will continue the nurses.” Several days later, the seizures came under control, and the patient was ready for discharge.

I am not certain what all the lessons of that day were, but the impact was profound. I have never forgotten Miss Russo.