A Culture of Mastery

Decades ago, at the end of my medical residency, I felt, as did many of my peers, flush with the fullness of our training. I was in charge of several other young doctors on a renowned medical service. I was at the end of seven years of intense learning and the confidence within me resided quite close to ego. The evening before, we had admitted a young man to our service with high fevers. On his examination, he appeared to have spots on his feet that we believed, in our collective wisdom, to be signs that strongly suggested that he had an acute infection of a heart valve. If so, it was a critical diagnosis as rapid treatment could make a real difference.

To say that we saw ourselves as the 1927 Yankees is not far from the mood that prevailed when Attending Rounds began with Mort Schwartz. It was oft said that "Between Osler and God, was Mort Schwartz." Well, that morning, we too walked with the gods. Or so we thought. With more than graceful patience, Dr. Schwartz listened to our presentation and "insightful "conclusion. He stood by the bedside gently smiling at the young man whose anxiety rose in proportion to our confidence that he may have a very serious illness. The presentation ended and in the interval between our last word and Mort's first is the reason why I am writing this commentary. 'Young man, what kind of sneakers do you wear?" Mort asked with more innocence than guile. "Keds", the patient replied. I had seen him often enough to know what was coming and why. In the next few moments, he expounded on the difference in the construction of varied shoes and how they imprint the skin of the foot. By so doing, they leave a mark and, to young doctors filled with bravado, the mark can be mistaken, forgivingly, for those seen in acute heart valve infections. In a day, the viral illness over, the boy left. For the years, thereafter, the arc of my professional life was changed.

The proposal to merge Hartford Hospital and the John Dempsey Hospital is steeped in necessity and aspiration: necessity to solve longstanding financial uncertainties while aspiring to provide Connecticut with a first rank University Hospital. Connecticut has excellent and mature community health resources but Univeristy Hospitals are different and the nature and value of these unique "assets" are not always readily apparent.

As negotiations continue, we have a chance to make the "differences "visible, to develop consensus as to their worth and to assure their inclusion.

Benchmarks in the process of establishing a University Hospital 'culture"

1. Infuse the new clinical environment with a sense of inquiry. Curiosity and perpetual learning need to be part of the clinical mandate and not relegated to CME requirements for certification.
2. Bring scientists, of all disciplines, even closer. As bifurcated careers (clinician and scientist) become less common, science (especially that which increases knowledge of disease risk, mechanism or response to therapy) must become more intimate with clinical practice. Evidence based best practices mean far less when the practitioner does not truly understand the basis for the evidence.

3. Recognize and encourage the difference between apprenticeship and true clinical training. Fellowships may drift into "job" training and become front loaded with service requirements that do not challenge the actual depth of understanding.
4. Sprinkle the system with Masters: As institutions, Hartford Hospital and JDH have had a goodly share in many disciplines: Joe Pyrtek, Jim Foster, Arnie Katz, Naomi Rothfield, Steve Sulavik, John Shanley, Larry Raisz, Marv Henkin, and Gale Ramsby. There are fewer available now but we should create as many opportunities as possible to see such people in action.
5. Create a more accessible and virtual CME portfolio with podcasts, streaming videos and ready access to consulting physicians for dynamic curbside consultations. By compressing the time needed for exchange of information, the overall hospital stay and the frequency of clinic return visits may be altered.
6. Fund a library of recorded seminars by our leading scientists. Traditional "live" seminars have value only to those who attend. It is a poor return of intellectual gain for the effort expended.
7. Make Professor's Rounds a celebration of excellence. Invite Master clinicians from other medical centers and make the life choices that created such high level skills seem reasonable to consider.
8. Reward, in some way, the right diagnosis especially if it has seemed to be a mysterious and enigmatic case. Our payment system pays for action more than for thought. A wrong diagnosis pays just as much as an elegant and thoughtful one. We may not be able to raise the definition of "quality" beyond that of competence but we should provide some recognition for what other doctors recognize as exceptional skills.

As with all complex and multi vectored situation, the proposed partnership is also replete with risk as well as promise. It should be seen as a cautionary tale with delicate admonition as necessary as optimism.

1. *Anticipate* the new tensions that will appear with the admixture of practitioners operating under differing "rules of engagement". Many of the Hartford Hospital staff are derived from first rank residency and fellowship programs and retain an embedded memory of learning medicine for learning's' sake. The demands of practice are, however, real and the priorities demanded are easily justifiable. Nonetheless, if the new entity is truly meant to be a University Hospital, then an "academic clinical process" cannot be viewed as indifferent, much less adversarial, to the pragmatic practice of medicine or surgery. <u>Bed numbers do not a Mass General make.</u>

2. *Position* for more rather than less change even after a partnership is negotiated and the incremental steps initiated. Bricks and mortar are not inherent guarantees of modernity; new buildings can still reflect old ideas. The NIH roadmap and the goals of translational medicine were anticipatory of reconfigured assumptions (What doctors will need to know, what innovative collaborations will need to be formed (i.e., Schools of Engineering are rapidly moving to biologic studies and need clinical access for proof of concept), what genomics will tell us about when

risk begins and how soon it should be modified) Of necessity there is intense focus on the details of " merger " but an overarching idea should be so well articulated that a new "vision" trumps "reacting to circumstance". "One University" may be an excellent template for innovative thinking across innumerable disciplines. Even in hide bound New England, this can be a time of "Enlightenment".

3. *Be skeptical about "certainty"* Howard Spiro, a noted Master in Gastroenterology, once proved that what we affirmed to be right a decade ago was, a decade later, shown incomplete if not fundamentally wrong. While there is logic to P for P, care paths or consensus statements, part of the academic style must be contrary, if not heretical, thought. Conforming to "standards" alone may not encourage doubters to express their dissonance. It is not only Tenure that shields diverse opinion; it is the willingness of an organization to invest in "outliers". In the medical marketplace a determinant question is "What is the return on investment?" That will always have its place but the concept not yet embraced or the service not yet fully reimbursed must be vigorously argued for on scientific merit alone. Not that all such programs should be funded but that the debate should be seen as having a meaningful and restorative value.

4. *Sustain the Public Good*: Disease is distressingly democratic in whom it chooses to strike but resources are not always apportioned by risk alone or severity of illness. Reimbursement and "realization" can shape what and who we come to value. A public University Hospital was just that: a public good which, unfortunately, was often scrutinized as if it were a "private" good". Such are the realities of academic gaps, fringe differentials and payer mix. If the regional and national economy remains constrained, there will be a greater demand to provide services for patients whose insurance coverage may be below the obligatory costs of a private practice encounter. If we evolve to a more "private" corporate structure, there may be a gradient of referral from the practice to the residual "public sector" doctors. Other institutions have been cleaved along such lines and have been weakened in process.