medical leaders . org

PRIMARY CARE PHYSICIANS AS EXPERTS AND HEALTH ADVOCATES

Interview with Pieter Cohen MD, Associate Program Director at Cambridge Health Alliance and Harvard Medical School Tutorial Course Director

08/15/2009

Pieter Cohen MD

...short story... general Internist, medical educator, health advocate

footprints: interest in health advocacy for the underserved, especially immigrant patients, has led to evidence-based approach to health problems facing both the immigrant community as well as broader US public | **key areas of interest & expertise**: Immigrant care | medical education | management of obesity and adulterated dietary supplements | **key guides & inspirations:** two of the physicians who always inspire me because they have done a masterful job of melding their role caring for patients and health advocacy are David Himmelstein and Danny McCormick both at Cambridge Health Alliance | **motivations & passions**: it is extremely difficult to develop expertise as a generalist; this is one of the great intellectual challenges of medicine and that motivates me every day | **what makes it all worthwhile?** satisfaction that each day I might be able to improve the care of someone who might not otherwise receive the highest level of care | ability to amplify the effect of my work by teaching future generations of physicians

---

Delfini: What one or two issues would you like to address for this interview and why?

Pieter: I would like to address the importance of encouraging primary care clinicians to pursue expertise and debunking the common myth that only subspecialists can become experts. One specific example of how primary care clinicians can apply principles of expertise: use their clinical experiences to improve the care of not only their patients but also the broader community.

Most people assume that to be an expert you need to train to be a subspecialist. However, one need not be a subspecialist to become an expert. Primary care physicians can become expert clinicians just as painters, plumbers or violin makers can become masters. I have been influenced by Bereiter and Scardamalia who describe an expert as someone who tackles the key problems in one's field at the upper limit of the complexity he or she can handle and argue convincingly that it is not what one does but how one does it that makes one an expert. Trying to motivate future generations of clinicians to pursue expertise in primary care is a passion of mine.

Delfini: What do you see as potential barriers, pitfalls, risks, "opportunities," or remedies?

Pieter: Primary care clinicians need balance. Practicing only clinical care all day, every day is too much for almost anyone. So, clinicians must find special areas that particularly interest them and develop those interests to create a balanced career. One area in which many clinicians might find unexpected satisfaction is learning to become health advocates and applying lessons learned caring for individual patients to the larger community.

Clinicians have a tendency to get faster, but not better, with time. There are many opportunities to help primary care clinicians understand that a lifetime of scholarship can lead to the goal of becoming an expert clinician. Primary care physicians can adjust one's approach to the common problems that they face so that with time they can provide care that is not only more efficient, but also more thoughtful and nuanced.

Delfini: If you had one wish for an ideal, what would that be? Or a vision? However you want to answer this...

Pieter: My wish would be that practicing primary care medicine would be done with the same diligence and intensity that neurosurgery is performed at centers of excellence. In addition, I would hope that the practice of primary care medicine would much more naturally combine work in health advocacy, public health, research, medical education and health policy so that primary care physicians could develop satisfying careers that would also greatly improve public health.

Delfini: What would it take for that to happen?

Pieter: In the coming years we are likely to move to a system of healthcare in the US in which primary care will take center stage. It will be important to capture this moment to make sure that we reinvigorate the practice of primary care at the same time.

Medical education from the undergraduate level up needs to be revitalized to teach these principles and the importance and pleasure of primary care from the start.

One extremely creative model which has been used in parts of the country for years and has begun to be used in major medical centers is the concept of longitudinal integrated clerkships. With longitudinal integrated clerkships in the 3rd year of medical school, the students develop deep connections to patients. They follow their patients throughout the year. Students stay connected not only to patients, but also to their preceptors. This is appealing in that the students learn the importance of patients being the drivers of key clinical questions which, as health care professionals, they will need to answer. They learn core disciplines and how to find high quality information by answering the key questions. This approach also makes clear the importance of patients being the drivers of good health care systems. This way of organizing the 3rd year is much more effective than the traditional surgery, medicine and pediatric clerkships most of us experienced.

Delfini: Can you elaborate a bit on how students learn to answer key questions?

Pieter: We use small group learning experience complemented with individual work with individual patients. For example, we provide a tutorial half-day where we cover how to approach the medical literature. Students learn the different types of questions that will arise. For some questions even Wikipedia might be sufficient, but for others, the process becomes much more complex. We help students learn what sources to use and the various techniques for keeping up with the medical literature. We create a very large table in which in one column students list all the ways they sought information and then we participate in working through the pros and cons of each.

We believe that pre-work is a key factor for making this effective. Each student identifies 3 or 4 questions from their recent experience and tries to search for answers. We look carefully at how they search and what sources they use and discuss this with them. We have them read relevant information from the JAMA Users' Guides to The Medical Literature, for example. Not only do students learn important approaches to answering various types of questions, they also learn to separate their learning needs from patient's needs and from faculty requirements. For residents, we focus more on critical appraisal (i.e., evaluating study design and methodology).

Unfortunately many of today's practicing physicians have never developed these skills and have in a sense "shut down." For example, a very bright physician I know recently told me he had pretty much stopped reading the medical literature—that he would hear about important developments just by being a busy clinician.

"…we are likely to move to a system of healthcare in the US in which primary care will take center stage. It will be important to capture this moment to …reinvigorate the practice of primary care at the same time…clinicians must find special areas that particularly interest them and develop those interests to create a balanced career.

One area in which many clinicians might find unexpected satisfaction is learning to become health advocates and applying lessons learned caring for individual patients to the larger community…"

Delfini: This is in keeping with our observation that many academic and full-time clinicians are not able to construct key clinical questions, identify appropriate sources and critically appraise primary or secondary studies for validity and clinical usefulness. And to make matters worse, they are unaware of the problem. Of course patients suffer because of this, because decisions should be based on reliable, relevant information about benefits and harms. It's great you're doing this work.

Pieter: Thanks! Part of what we are doing with students is trying to get them to grapple individually with questions and not just follow along with the group. There are so many biased experts creating biased guidelines.

And as to the longitudinal integrated clerkships, we really want to show the students the power of being connected with patients. This can really drive change and should really drive system changes. We want students to see the patient plus the illness, not just the

illness abstractly. Our goal is to be keeping patients in the center.

What do you see as potentially helping medical leaders and others with what you've selected to address?

Pieter: I could envision a national organization emerging that incorporates the best of family practice, pediatrics and primary care internal medicine into one strong organization focused on academic primary care. This organization might be modeled after the Society for General Internal Medicine which works to achieve this for internal medicine.

Delfini: Do you have favored resources for any groups on the topics you are addressing?

Pieter: I have already mentioned the Society for General Internal Medicine and many other organizations for disciplines that unfortunately today are balkanized.

In respect to reinvigorating medical education, I think no group is more innovate in this respect than the Consortium of Longitudinal Integrated Clerkships.

Delfini: Do you have a favorite story for us?

Pieter: I'd like to share a story of how the design of medical education can invigorate students to understand and engage in primary care, academic practice of medicine and health advocacy. One third-year medical student in a longitudinal integrated clerkship saw a patient with epilepsy with his internal medicine preceptor. The patient was recently started on a novel anti-seizure medication by his neurologist and shortly thereafter became suicidal. The student was able to follow the patient to the psychiatric emergency room and then during his psychiatric inpatient stay. After the patient was discharged, the student followed the patient to his primary care appointments as well as to his neurologist's appointments.

The student became concerned about the effect that the new seizure medication might have had on the patient developing suicidal behavior. In researching this question, he spoke to policy advocates in Washington, D.C. and with the guidance of his internal medicine, psychiatry and neurology preceptors, the student presented a fascinating talk at the medical school's grand rounds as well as at a regional meeting about the risks of novel anti-seizure medications as well as the options that the FDA has to respond to this potential risk. This presentation was noted by a journal editor who then asked the student to write up the case for their peer-reviewed journal and has been accepted for publication.

Delfini: And almost lastly, the best medicine is to be happy, yes? What's your favored flavor-of-the-moment to make you or any of us more happy? Toss us a little tidbit from your medicine cabinet, please.

Pieter: A day hike in the alpine region of the White Mountains, especially in the winter.

Delfini: Now tell us something fun about you?

Pieter: I love a good hoppy beer.

"In respect to reinvigorating medical education, I think no group is more innovate in this respect than the Consortium of Longitudinal Integrated Clerkships…. we really want to show the students the power of being connected with patients. This can really drive change and should really drive system changes. We want students to see the patient plus the illness, not just the illness abstractly. Our goal is to be keeping patients in the center…."