DOCTOR AND PATIENT

Rethinking the Way We Rank Medical Schools

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During my internship, the first year after graduating from medical school, I took care of a middle-aged woman who began our first conversation with a question that patients still ask me today.

“So doctor,” she said as I pulled my stethoscope out to listen to her heart, “where did you go to medical school?”

In a social context, I might have considered her question to be polite chatter, a filler during an awkward quiet moment. But on that particular afternoon her words felt more like a dart lobbed at what I had presumed to be a budding and promising patient-doctor relationship.

Trust from this patient, I remember thinking, is not going to depend on my bedside manner or clinical judgment but my medical school.

But even before I had placed my stethoscope bell against my patient’s chest, I realized that I, too, had been culpable of submitting doctors to the same line of questioning.

Once I had the information, I would do what my patient did that afternoon: I would mentally find its place within the medical school hierarchy in my mind. Like some existential fast forward button, the right answer to this question could raise the trust in any patient-doctor relationship to a whole new level without a second thought, because by virtue of having graduated from a “good” school, that doctor had the ability to address
the most pressing needs of all of his or her patients.

The thought process was easy — good school, good doctor; bad school, bad doctor.

Maybe.

Shaped by magazine lists, friends’ and strangers’ confirmations and professional hearsay, the notion that a medical school’s quality can be ranked and then passed on directly to their graduates has become an integral part of American culture. But most of these popular rankings reflect a school’s highly specialized research funding and capabilities, not the general quality of its medical school graduates. Criteria like research funding and cutting edge investigations are of course significant, but they more accurately reflect the social needs of the previous century when medicine, backed by scientific investigation, was just starting to make a difference in the health care outcomes of patients.

Thanks to many of those advances, the population as a whole has successfully aged. But the drive to elucidate, for example, the molecular basis of high blood pressure has in turn become less urgent. Instead, other, more social, health care issues have reached critical points: the shortage of primary care physicians; the lack of accessible health care and providers in certain areas of the country; and the yawning disparity between racial and economic backgrounds of those who become doctors and those who are their patients.

Despite the changes in patient needs, many patients, and their doctors, continue to fall back on old rankings, assuming that institutions that succeeded in addressing the needs of the 20th century can still do so in the 21st. But according to a report published this week in The Annals of Internal Medicine, it is time to reexamine that assumption.

Researchers from the George Washington University School of Medicine looked at the more than 60,000 graduates of America’s 141 medical schools — both allopathic and osteopathic — from 1999 to 2001. Putting the issues of primary care shortage, underserved communities and workforce diversity under the banner of “social mission,” the researchers found that many of the schools that were traditionally ranked highly were also among those least focused and least successful in addressing the most pressing issues facing the country right now.

“The absolute irreducible mission of medical schools is the education and graduation of doctors to care for the country as a whole,” said Dr. Fitzhugh Mullan, lead author of the study and a professor of health policy and pediatrics at the university. “U.S. medical education has drifted over to this highly rarified and specialized focus that has resulted in some major shortfalls.”

The funding system has encouraged this drift toward specialization and hi-tech research. The investigators also found that institutions that received more federally funded grants, in the form of research grants from the National Institutes of Health, also tended to...
in the form of research grants from the National Institutes of Health, also tended to devote fewer efforts to a school’s social mission. Grant money and the security it affords individuals and institutions drive institutions to emphasize research, sometimes at the expense of other urgent but less lucrative endeavors.

The opportunity to learn from and be mentored by faculty members involved with the latest research can be stimulating for medical students, but the pressure to bring grant money into an institution can draw even the most enthusiastic educator away from students and back to the laboratory bench. “Research is not the same as medical education,” Dr. Mullan observed. “Research is important, but it can overwhelm.”

And when medical schools “are already heavily invested in a mission that is traditional and research oriented,” noted Dr. Mullan, broadening their focus can be slow and difficult, even if they are aware of the growing crises in primary care and the health care work force.

In recent years, some visionary medical educators have left older institutions in an effort to jump-start such changes in new medical schools. Most of these new schools, sometimes referred to as “millennial medical schools,” embrace missions that unabashedly attempt to address some of the ills of the current health care system. The A.T. Still University of Health Sciences School of Osteopathic Medicine in Mesa, Ariz., and the Herbert Wertheim College of Medicine at Florida International University in Miami, for example, “embed” students in underserved areas from as early as the first year of medical school. Other institutions, like the Hofstra-North Shore -LIJ School of Medicine, which is due to begin classes in August 2011, have made it a priority to educate students from diverse, nontraditional backgrounds.

Naysayers warn that this redirection of focus, whether in established medical schools or new ones, will decrease the selectivity of students and produce less competitive and less competent future physicians. But educators like Dr. Mullan counter that traditional selection criteria based on cognitive exams and premedical course grades do not necessarily translate into clinical ability.

“Doctors who have done very well on everything from kindergarten to residency training in terms of getting into prestige places are assumed to have sharp intellects,” Dr. Mullan said. “But none of that correlates in any scientific way with their performance as physicians.” The more relevant measure of high level competency, Dr. Mullan asserts, is the multiple certification evaluations that take place during medical school, training and licensure. “They have to pass these, otherwise they cannot practice.”

Moreover, Dr. Mullan noted, “If there’s not even a doctor near where you live who can offer services, then the quality a priori is bad.”

“The mission and function of all schools won’t be and shouldn’t be the same,” Dr. Mullan added. “But we all might think about how we could be a little more responsive to the ongoing needs of patients and of our country. If we continue to produce more doctors in the system we have now, we won’t be able to address the needs, the health outcomes and certainly the populations that are underserved, dying and suffering as a result of it.”

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